



PROFESSIONAL MANAGEMENT SKILL DEVELOPMENT TRAINING FOR TALUKA HEALTH OFFICERS



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**STATE INSTITUTE OF HEALTH & FAMILY WELFARE,
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PREFACE

The Taluka Health Officer is the bridge between District health Officer (DHO) and PHC medical Officer (MO). The Taluka Health Officer will remain in Charge of the curative, preventive and promotive Health services to the people of the entire Block area. In discharging the above-noted function he/she will have to carry various duties like: **1. Health Administration** i.e. to discharge administrative function in arranging total health care to the population of the Block, to render proper monitoring and effective supervision over all aspects of Health services of the Block, to render supervising visit to the new PHC/SHC, other Health Institutions in the Block area and Sub-centres, to manage manpower, material support and fiscal aspects involved in his administrative jurisdiction, to maintain optimum rapport with the collateral administrative bodies, Community Organizations, Vol. Organizations and the People's representatives, to build up effective public relations. **2. Medical Care Service** i.e. to arrange proper running of the indoor/OPD services in the Block-level PHC and advice M.O., PHC/SC accordingly for proper running of the same therein, to effectively deploy the services of the staff in the indoor and OPD, to supervise the services of other MOs in the PHC services, to maintain records and registers on the Medical Care Services. **3. Out-break Control and Environmental Sanitation, 4. Health Programmes** i.e. to organize and supervise the activities under various national health programmes.

In this module we have tried to cover all the topics. This module will help them to know their jobs in detail and help them to work more efficiently. This book was formulated by written contributions from many of the experts in the respective specialties. This book is mainly meant to be used by the taluka health officer at the block level.

This module is humble effort in the required direction and is expected to cater knowledge, skills and expertise necessary for day-to-day functioning of health centres and practical solutions to routine problems faced by the THO. Care has been taken to describe even the finer details of common difficulties and prescribe remedies based on the feedback of working staff, bureau chiefs and even the retired officers from the department.

We hope this Manual will be useful to Taluka Health Officers and it will help in developing their professional skills. We also hope that every Taluka Health Officer will read the manual thoroughly and work as a successful team-leader inspiring the confidence of the team members, local people and their representatives thereby ensuring peoples fullest co-operation and participation in the health programmes.

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This Training Module for Taluka Health Officers is a consolidation of the contents of various sections like Maternal Health, Child Health, National Health Programmes, Administration & Medico legal aspects. It represents the hard work of a large number of faculty members and institutions who were involved in developing this module and provided valuable insights and feedback. This module was compiled by Dr. Harsha Meshram (Wakodkar), Assistant Professor, SIHFW, Nagpur under the guidance of Dr. Sanjay Jaiswal, Director, SIHFW Nagpur with the help of valuable contribution from faculties.

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SECTION A

ADMINISTRATION

NATIONAL HEALTH POLICY 2017

The National Health Policy of 1983 and the National Health Policy of 2002 have served well in guiding the approach for the health sector in the Five-Year Plans. The current context has however changed in four major ways. First, the health priorities are changing. Although maternal and child mortality have rapidly declined, there is growing burden on account of non-communicable diseases and some infectious diseases. The second important change is the emergence of a robust health care industry estimated to be growing at double digit. The third change is the growing incidences of catastrophic expenditure due to health care costs, which are presently estimated to be one of the major contributors to poverty. Fourth, a rising economic growth enables enhanced fiscal capacity. Therefore, a new health policy responsive to these contextual changes is required.

The National Health Policy, 2017 (NHP, 2017) seeks to reach everyone in a comprehensive integrated way to move towards wellness. It aims at achieving universal health coverage and delivering quality health care services to all at affordable cost.

Goal

The policy envisages as its goal the attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery.

Objectives

Improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on quality.

Specific Quantitative Goals and Objectives

Health Status and Programme Impact

1. Life Expectancy and healthy life

- Increase Life Expectancy at birth from 67.5 to 70 by 2025.
- Establish regular tracking of Disability Adjusted Life Years (DALY) Index as a measure of burden of disease and its trends by major categories by 2022.
- Reduction of TFR to 2.1 at national and sub-national level by 2025.

2. Mortality by Age and/ or cause

- Reduce Under Five Mortality to 23 by 2025 and MMR from current levels to 100 by 2020.
- Reduce infant mortality rate to 28 by 2019.
- Reduce neo-natal mortality to 16 and still birth rate to “single digit” by 2025.

3. Reduction of disease prevalence/ incidence

- Achieve global target of 2020 which is also termed as target of 90:90:90, for HIV/AIDS i.e, - 90% of all people living with HIV know their HIV status, - 90% of all people diagnosed with HIV infection receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression.
- Achieve and maintain elimination status of Leprosy by 2018, Kala-Azar by 2017 and Lymphatic Filariasis in endemic pockets by 2017.
- To achieve and maintain a cure rate of >85% in new sputum positive patients for TB and reduce incidence of new cases, to reach elimination status by 2025.
- To reduce the prevalence of blindness to 0.25/ 1000 by 2025 and disease burden by one third from current levels.
- To reduce premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 25% by 2025.

Health Systems Performance

1. Coverage of Health Services

- Increase utilization of public health facilities by 50% from current levels by 2025.
- Antenatal care coverage to be sustained above 90% and skilled attendance at birth above 90% by 2025.
- More than 90% of the newborn are fully immunized by one year of age by 2025.
- Meet need of family planning above 90% at national and sub national level by 2025.
- 80% of known hypertensive and diabetic individuals at household level maintain "controlled disease status" by 2025.

2. Cross Sectoral goals related to health

- Relative reduction in prevalence of current tobacco use by 15% by 2020 and 30% by 2025.
- Reduction of 40% in prevalence of stunting of under-five children by 2025.
- Access to safe water and sanitation to all by 2020 (Swachh Bharat Mission).
- Reduction of occupational injury by half from current levels of 334 per lakh agricultural workers by 2020.
- National/ State level tracking of selected health behaviour.

Health Systems strengthening

1. Health finance

- Increase health expenditure by Government as a percentage of GDP from the existing 1.15 % to 2.5 % by 2025.
- Increase State sector health spending to > 8% of their budget by 2020.
- Decrease in proportion of households facing catastrophic health expenditure from the current levels by 25%, by 2025.

2. Health Infrastructure and Human Resource

- Ensure availability of paramedics and doctors as per Indian Public Health Standard (IPHS) norm in high priority districts by 2020.
- Increase community health volunteers to population ratio as per IPHS norm, in high priority districts by 2025.
- Establish primary and secondary care facility as per norms in high priority districts (population as well as time to reach norms) by 2025.

3. Health Management Information

- Ensure district - level electronic database of information on health system components by 2020.
- Strengthen the health surveillance system and establish registries for diseases of public health importance by 2020.
- Establish federated integrated health information architecture, Health Information Exchanges and National Health Information Network by 2025.

Policy thrust

1. **Ensuring Adequate Investment** - The policy proposes a potentially achievable target of raising public health expenditure to 2.5% of the GDP in a time bound manner.
2. **Preventive and Promotive Health** - The policy identifies coordinated action on seven priority areas for improving the environment for health:
 - The Swachh Bharat Abhiyan
 - Balanced, healthy diets and regular exercises.
 - Addressing tobacco, alcohol and substance abuse
 - Yatri Suraksha – preventing deaths due to rail and road traffic accidents
 - Nirbhaya Nari – action against gender violence
 - Reduced stress and improved safety in the work place
 - Reducing indoor and outdoor air pollution
2. **Organization of Public Health Care Delivery** - The policy proposes seven key policy shifts in organizing health care services.

SUSTAINABLE DEVELOPMENTAL GOALS



What are the Sustainable Development Goals?

The Sustainable Development Goals (SDGs), otherwise known as the Global Goals, are a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity.

These 17 Goals build on the successes of the MDGs, while including new areas such as climate change, economic inequality, innovation, sustainable consumption, peace and justice, among other priorities. The goals are interconnected – often the key to success on one will involve tackling issues more commonly associated with another.

The SDGs work in the spirit of partnership and pragmatism to make the right choices now to improve life, in a sustainable way, for future generations. They provide clear guidelines and targets for all countries to adopt in accordance with their own priorities and the environmental challenges of the world at large. The SDGs are an inclusive agenda. They tackle the root causes of poverty and unite us together to make a positive change for both people and planet. “Poverty eradication is at the heart of the 2030 Agenda, and so is the commitment to leave no-one behind,” UNDP Administrator Achim Steiner said. “The Agenda offers a unique opportunity to put the whole world on a more prosperous and sustainable development path. In many ways, it reflects what UNDP was created for.”

What is UNDP's role?

The SDGs came into effect in January 2016, and they will continue to guide UNDP policy and funding for the next 15 years. As the lead UN development agency, UNDP is uniquely placed to help implement the Goals through our work in some 170 countries and territories.

Our strategic plan focuses on key areas including poverty alleviation, democratic governance and peacebuilding, climate change and disaster risk, and economic inequality. UNDP provides support to governments to integrate the SDGs into their national development plans and policies. This work is already underway, as we support many countries in accelerating progress already achieved under the Millennium Development Goals.

Our track record working across multiple goals provides us with a valuable experience and proven policy expertise to ensure we all reach the targets set out in the SDGs by 2030. But we cannot do this alone.

Achieving the SDGs requires the partnership of governments, private sector, civil society and citizens alike to make sure we leave a better planet for future generations.

PANCHAYATI RAJ INSTITUTION

Evolution, Features, Composition, Powers, Functions

Panchayati Raj is a **system of rural local self-government in India**. It has been established in all the states of India by the acts of the state legislature to build democracy at the grass root level. It is entrusted with rural development and was constitutionalized through the **73rd Constitutional Amendment Act of 1992**.

Evolution of Panchayati Raj in India

Panchayati Raj was not a new concept to India. Indian villages had Panchayats (council of five persons) from very ancient time, which were having both executive and judicial powers and used to handle various issues (land distribution, tax collection etc.) or disputes arising in the village area.

Gandhiji also held the opinion of empowerment of Panchayats for the development of rural areas. Thus, recognizing their importance our Constitution makers included a provision for Panchayats in part IV of our constitution (directive principles of state policy).

Art. 40 confers the responsibility upon State to take steps to organise Village Panchayats and endow them with such powers and authority as may be necessary to enable them to function as units of self-government. But it does not give guidelines for organising village panchayats.

Thus, its formal organisation and structure was firstly recommended by **Balwant Rai** committee, 1957 (Committee to examine the Community Development Programme, 1952).

The Committee, in its report in November 1957, recommended the establishment of the scheme of 'democratic decentralisation', which ultimately came to be known as Panchayati Raj. It recommended for a three tier system at village, block and district level and it also recommended for direct election of village level panchayat. Rajasthan was the first state to establish Panchayati Raj at it started from Nagaur district on October 2, 1959.

After this, **Ashok Mehta Committee** on Panchayati Raj was appointed in December 1977 and in August 1978 submitted its report with various recommendations to revive and strengthen the declining Panchayati Raj system in the country.

Its major recommendation were two tier system of panchayat, regular social audit, representation of political parties at all level of panchayat elections, provisions for regular election, reservation to SCs/STs in panchayats and a minister for panchayati raj in state council of ministers.

Further, **G V K Rao Committee** appointed in 1985 again recommended some measures to strengthen Panchayati Raj institutions.

LM Singhvi Committee appointed in 1986 first time recommended for the constitutional status of Panchayati Raj institutions and it also suggested for constitutional provisions to ensure regular, free and fair elections to the Panchayati Raj Bodies.

In response to the recommendations of **LM Singhvi committee**, a bill was introduced in the Lok Sabha by Rajiv Gandhi's government in July 1989 to constitutionalize Panchayati Raj Institutions, but the bill was not passed in Rajya Sabha.

The V P Singh government also brought a bill, but fall of the government resulted in lapse of the bill. After this P V Narashima Rao's government introduced a bill for this purpose in Lok Sabha in September, 1991 and the bill finally emerged as the 73rd Constitutional Amendment Act, 1992 and came into force on 24th April, 1993.

Features of 73rd Amendment Act 1992

The 73rd Amendment to the Constitution enacted in 1992 added a new part-IX to the Constitution. It also added a new XI schedule containing list of 29 functional items for Panchayats and made statutory provisions for the establishment, empowerment and functioning of Panchayati Raj institutions. Some provisions of this amendment are binding on the States, while others have been left to be decided by respective State Legislatures at their discretion. The salient features of this amendment are as follows:

1. Organization of **Gram Sabhas**;
2. Creation of a **three-tier** Panchayati Raj Structure **at the District (Zila), Block and Village levels**;
3. Almost all posts, at all levels to be filled by **direct elections**;
4. Minimum age for contesting elections to the Panchayati Raj institutions be twenty one years;
5. The **post of Chairman at the District and Block levels should be filled by indirect election**;
6. There should be **reservation of seats for Scheduled Castes/ Scheduled Tribes** in Panchayats, in proportion to their population, and for women in Panchayats up to one-third seats;
7. **State Election Commission** to be set up in each State to conduct elections to Panchayati Raj institutions;
8. The **tenure of Panchayati Raj institutions is five years**, if dissolved earlier, fresh elections to be held within six months; and
9. A **State Finance Commission** is to be set up in each State every five years.

Some of the provisions, which are not binding on the States, but are only guidelines:

1. Giving representation to the members of the Central and State legislatures in these bodies;
2. Providing reservation for backward classes; and
3. The Panchayati Raj institutions should be given financial powers in relation to taxes, levy fees etc. and efforts shall be made to make Panchayats autonomous bodies.

Composition of Panchayats

The Panchayati Raj system, as established in accordance with the 73rd Amendment, is a three- tier structure based on direct elections at all the three tiers: village, intermediate and district. Exemption from the intermediate tier is given to the small States having less than 20

lakhs population. It means that they have freedom not to have the middle level of panchayat.

All members in a panchayat are directly elected. However, if a State so decides, members of the State Legislature and Parliament may also be represented in a district and middle-level panchayats.

The middle-level panchayats are generally known as Panchayat Samitis. Provisions have been made for the inclusion of the chairpersons of the village panchayats in the block and district level panchayats.

The provision regarding reservation of seats for Scheduled Castes/Scheduled Tribes has already been mentioned earlier. However it should also be noted here that one-third of total seats are reserved for women, and one-third for women out of the Quota fixed for Scheduled Castes/Tribes.

Reservation is also provided for offices of Chairpersons. The reserved seats are allotted by rotation to different constituencies in a panchayat area. State Legislatures can provide for further reservation for other backward classes (OBC) in panchayats.

Term of a Panchayat

The Amendment provides for the continuous existence of Panchayats. The normal term of a Panchayat is five years. If a Panchayat is dissolved earlier, elections are held within six months. There is a provision for State Election Commission, for superintendence, direction, and control of the preparation of electoral rolls and conduct of elections to Panchayats.

Powers and Responsibilities of Panchayats

State Legislatures may endow Panchayats with such powers and authority as may be necessary to enable the Panchayats to become institutions of self-government at the grassroots level.

Responsibility may be given to them to prepare plans for economic development and social justice. Schemes of economic development and social justice with regard to 29 important matters mentioned in XI schedule such as agriculture, primary and secondary education, health and sanitation, drinking water, rural housing, the welfare of weaker sections, social forestry and so forth may be made by them.

Three-tier Structure of Panchayati Raj

Panchayat Samiti

The second or middle tier of the Panchayati Raj is Panchayat Samiti, which provides a link between Gram Panchayat and a Zila Parishad.

The strength of a Panchayat Samiti also depends on the population in a Samiti area. In Panchayat Samiti, some members are directly elected. Sarpanchs of Gram Panchayats

Sarpanchs of Gram Panchayats are ex-officio members of Panchayat Samitis.

However, all the Sarpanchs of Gram Panchayats are not members of Panchayat Samitis at the same time.

The number varies from State to State and is rotated annually. It means that only chairpersons of some Gram Panchayats in a Samiti area are members of Panchayat Samiti at a time.

In some panchayats, members of Legislative Assemblies and Legislative Councils, as well as members of Parliament who belong to the Samiti area, are co-opted as its members.

Chairpersons of Panchayat Samitis are, elected indirectly- by and from amongst the elected members thereof.

Zila Parishad

Zila Parishad or district Panchayat is the uppermost tier of the Panchayati Raj system.

This institution has some directly elected members whose number differs from State to State as it is also based on population. Chairpersons of Panchayat Samitis are ex-officio members of Zila Parishads.

Members of Parliament, Legislative Assemblies and Councils belonging to the districts are also nominated members of Zila Parishads.

The chairperson of a Zila Parishad, called Adhyaksha or President is elected indirectly by and from amongst the elected members thereof. The vice-chairperson is also elected similarly. Zila Parishad meetings are conducted once a month. Special meetings can also be convened to discuss special matters. Subject committees are also formed.

Zila Parishad **meetings** are conducted **once a month**. Special meetings can also be convened to discuss special matters. Subject committees are also formed.

Functions of Panchayat

All Panchayati Raj Institutions perform such functions as are specified in state laws relating to panchayati raj. Some States distinguish between obligatory (compulsory) and optional functions of Gram Panchayats while other States do not make this distinction.

- The civic functions relating to sanitation, cleaning of public roads, minor irrigation, public toilets and lavatories, primary health care, vaccination, the supply of drinking water, constructing public wells, rural electrification, social health and primary and adult education, etc. are obligatory functions of village panchayats.
- The optional functions depend on the resources of the panchayats. They may or may not perform such functions as tree plantation on roadsides, setting up of breeding centers for cattle, organizing child and maternity welfare, promotion of agriculture, etc.
- **After the 73rd Amendment, the scope of functions of Gram Panchayat was widened.** Such important functions like preparation of annual development plan of panchayat area, annual budget, relief in natural calamities, removal of encroachment on public lands and implementation and monitoring of poverty alleviation programmes are now expected to be performed by panchayats.
- Selection of beneficiaries through Gram Sabhas, public distribution system, non-conventional energy source, improved Chullahs, biogas plants have also been given to Gram Panchayats in some states.

Functions of Panchayat Samiti

- Panchayat Samitis are at the **hub of developmental activities**.
- They are **headed by Block Development Officers (B.D.Os)**.
- Some functions are entrusted to them like agriculture, land improvement, watershed development, social and farm forestry, technical and vocational education, etc.
- The second type of functions relates to the implementation of some specific plans, schemes or programmes to which funds are earmarked. It means that a Panchayat Samiti has to spend money only on that specific project. The choice of location or beneficiaries is, however, available to the Panchayat Samiti.

Functions of Zila Parishad

- Zila Parishad **links Panchayat Samitis within the district.**
- It coordinates their activities and supervises their functioning.
- It prepares district plans and integrates Samiti plans into district plans for submission to the State Government.
- Zila Parishad looks after development works in the entire district.
- It undertakes schemes to improve agricultural production, exploit ground water resources, extend rural electrification and distribution and initiate employment generating activities, construct roads and other public works.
- It also performs welfare functions like relief during natural calamities and scarcity, the establishment of orphanages and poor homes, night shelters, the welfare of women and children, etc.
- In addition, Zila Parishads perform functions entrusted to them under the Central and State Government sponsored programmes. For example, Jawahar Rozgar Yojna is a big centrally sponsored scheme for which money is directly given to the districts to undertake employment-generating activities.

DUTIES / JOB RESPONSIBILITIES AND POWERS OF THO

तालुका आरोग्य अधिकाऱ्यांच्या नेमणूकीसाठीचे निकष-

- १) वैद्यकीय अधिकाऱ्यास त्याच्या कर्तव्याच्या अनुषंगाने कराव्या लागणाऱ्या फिरतीमुळे तालुका आरोग्य अधिकाऱ्याच्या जबाबदाऱ्या पार पाडण्यात अडचणी येणार नाहीत. तालुका आरोग्य अधिकाऱ्याची अतिरिक्त जबाबदारी पेलतांना त्यांच्या मुळ कार्यभाराच्या अनुषंगाने त्यांना सोपविण्यात आलेले उद्दिष्ट पूर्ण करावे लागेल.
- २) तालुका आरोग्य अधिकारी पदांवर नियुक्ती करतांना महाराष्ट्र लोकसेवा आयोग पुरस्कृत उमेदवार व जेष्ठताक्रम या दोन्ही बाबींना पसंतीक्रम देण्यात यावा तथापि, या संदर्भातील अंतीम निर्णय मुख्य कार्यकारी अधिकारी यांचा राहील.

तालुका आरोग्य अधिकारी कार्यालयाची रचना:-

- १) तालुका आरोग्य अधिकाऱ्यांना पंचायत समितीमधील विस्तार अधिकारी (आरोग्य) हे सहाय्यक म्हणून काम करतील. त्यांच्या अधिपत्याखाली एक आरोग्य सहाय्यक, आरोग्य सेवक व कंत्राटी पध्दतीवर लेखापाल, डेटा एन्ट्री ऑपरेटर व वर्ग-४ चा एक कर्मचारी उपलब्ध करून देण्यात येतील. कार्यालयात असलेल्या कर्मचाऱ्यांमधून उपलब्ध न झाल्यास राष्ट्रीय ग्रामीण आरोग्य अभियानांतर्गत कंत्राटी पध्दतीने कर्मचारी उपलब्ध करून देण्यात येतील.
- २) तालुका आरोग्य अधिकाऱ्यांचे मुख्यालय तालुक्याच्या ठिकाणी असलेल्या पंचायत समितीच्या कार्यालयात किंवा आरोग्य खात्याच्या इमारतीमध्ये राहिल. तालुका आरोग्य अधिकारी हे जिल्हा आरोग्य अधिकारी यांचे अधिनस्त काम पाहतील व गट विकास अधिकारी यांच्यासोबत सतत समन्वय ठेवतील.

तालुका आरोग्य अधिकाऱ्यांचे प्रशासकीय, तांत्रिक अधिकार व कर्तव्ये:-

- १) तालुका आरोग्य अधिकारी हे त्या तालुक्याचे सार्वजनिक आरोग्य विभागाचे तालुका प्रमुख म्हणून काम पाहतील.
- २) तालुका आरोग्य अधिकारी हे जिल्हा आरोग्य अधिकारी व तालुक्यातील प्राथमिक आरोग्य केंद्र/उपकेंद्र/ग्रामीण रुग्णालय/उपजिल्हा रुग्णालय/नगरपालिका रुग्णालय/ दवाखाने या मधील दुवा म्हणून काम करतील.
- ३) विविध स्वयंसेवी संघटनांशी देखील समन्वय साधतील.
- ४) आरोग्य सेवे अंतर्गत कार्यान्वित असणाऱ्या विविध योजनांच्या उदा.राष्ट्रीय ग्रामीण आरोग्य अभियान, आर.सी.एच. कार्यक्रम इत्यादी यशस्वी अंमलबजावणीसाठी त्यांच्या अधिनस्त असलेले प्राथमिक आरोग्य केंद्र व सर्व संबंधितांशी समन्वय साधून त्यांच्या सहकार्याने या योजनांची उद्दिष्टे पूर्ण करतील.
- ५) आणिव्यापीच्या प्रसंगी (साथरोग, नैसर्गिक आपत्ती इ.) वेळी आवश्यक उपाययोजना / प्रतिबंधात्मक कार्यवाही करण्यासाठी आरोग्य सेवेचे नियोजन करून त्याची अंमलबजावणी व सनियंत्रण करणे व अशावेळी गरजेनुसार एक ते दोन आठवड्यांपर्यंत आरोग्य सेवेतील अधिकारी/कर्मचारी यांना प्रतिनियुक्तीवर ठेवून काम करवून घेण्याचे अधिकार असतील. अशी प्रतिनियुक्ती केल्यास त्यांनी तात्काळ जिल्हा आरोग्य अधिकारी यांना कार्यात्तर मान्यतेसाठी कळवून रितसर मान्यता घेणे बंधनकारक राहील. तालुका आरोग्य अधिकारी यांनी असे कामाचे आदेश काढल्यानंतर त्या

आदेशांचे पालन करण्याची जबाबदारी संबंधित वैद्यकीय अधिकारी आणि आरोग्य कर्मचारी यांची राहिल.

- ६) तालुका आरोग्य अधिकाऱ्यांचे गोपनीय अहवाल जिल्हा आरोग्य अधिकाऱ्यांनी लिहावेत. मुख्य कार्यकारी अधिकारी हे पुनर्विलोकन अधिकारी असतील.
- ७) तालुका आरोग्य अधिकारी त्यांच्या अधिपत्याखालील प्राथमिक आरोग्य केंद्राची वैद्यकीय अधिकाऱ्यांच्या कामाबाबतचा वार्षिक अहवाल जिल्हा आरोग्य अधिकारी यांना सादर करतील. सदर अहवाल हा गोपनीय अहवालाचा भाग नसला तरी संबंधित वैद्यकीय अधिकाऱ्यांचे गोपनीय अहवाल लिहीताना जिल्हा आरोग्य अधिकाऱ्यांनी याबाबतची नोंद घेणे आवश्यक राहिल.
- ८) तालुका आरोग्य अधिकारी प्राथमिक आरोग्य केंद्र/ उपकेंद्रांना आवश्यकतेनुसार भेटी देवून आरोग्य कार्यक्रमांची तपासणी करतील आणि अहवाल जिल्हा आरोग्य अधिकाऱ्याकडे सादर करतील. वर्षभरात सर्व प्रा.आ.केंद्राची दोन वेळा संपूर्ण तपासणी व ५० टक्के उपकेंद्रांची तपासणी करणे बंधकारक राहिल. वैद्यकीय अधिकारी, प्रा.आ.केंद्र यांनी त्यांच्या अधिनस्त उपकेंद्राची १०० टक्के तपासणी प्रत्येक ९ महिन्यातून एक वेळ करणे बंधनकारक राहिल. निकषाप्रमाणे तपासणी होत आहे किंवा कसे याबाबत संनियंत्रण करण्याचे अधिकार तालुका आरोग्य अधिकारी यांना असतील. बीट/प्रा.आ.केंद्र सभांना मार्गदर्शन करण्याची जबाबदारी तालुका आरोग्य अधिकाऱ्याची राहिल. महिन्यातून किमान दोन बीटमधील सभांना हजर राहून आढावा घेणे तसेच मार्गदर्शन करणे बंधनकारक राहिल.
- ९) तालुका आरोग्य अधिकाऱ्यांनी प्रत्येक महिन्यात एकदा वैद्यकीय अधिकाऱ्यांची आणि आरोग्य कर्मचाऱ्यांची आढावा बैठक आयोजित करून आवश्यक एकत्रित संकलीत करून ती जिल्हा आरोग्य अधिकाऱ्याकडे पाठविणे आवश्यक राहिल.
- १०) तालुका आरोग्य अधिकारी हे त्यांच्या कार्यक्षेत्रातील सर्व अधिकारी व कर्मचारी यांच्या नैमत्तीक रजेबाबतच्या अर्जावर निर्णय घेण्यास व इतर रजेबाबतच्या अर्जावर शिफारस करण्यास सक्षम असतील. रजा मंजूरीसंदर्भात निर्णय घेण्यासाठी सक्षम अधिकारी तालुका आरोग्य अधिकाऱ्यांच्या शिफारशी लक्षात घेऊनच निर्णय घेतील.
- ११) तालुक्यातील सर्व आरोग्य संस्थांतील वैद्यकीय अधिकारी यांचा संभाव्य फिरती कार्यक्रम व मासिक दैनंदिन्याबाबत शिफारस तसेच अभिप्राय देण्याचा अधिकार तालुका आरोग्य अधिकाऱ्यांचा असेल व हे अभिप्राय लक्षात घेऊनच जिल्हा आरोग्य अधिकारी त्या मंजूर करतील.
- १२) तालुका आरोग्य अधिकारी कुपोषित बालकांची आरोग्य तपासणी/आरोग्य निदान आणि उपचारासाठी तालुक्यातील नजिकच्या/ सोयीच्या ग्रामीण रुग्णालयातील बालरोग तज्ज्ञांशी संपर्क साधून रोगनिदान आणि उपचाराबाबत आवश्यक ती कार्यवाही करावी. अशा बालकांची नावे ग्रामीण रुग्णालयाचे अधिक्षक आणि तालुका आरोग्य अधिकारी यांनी संयुक्तपणे जिल्हा शल्यचिकित्सक आणि जिल्हा आरोग्य अधिकाऱ्याकडे प्रत्येक महिन्यात सादर करावीत.
- १३) तालुका आरोग्य अधिकारी हे तालुक्यातील ANM, MPW, LHV यांना रक्तदाब व हिमोग्लोबीन इत्यादी बाबींची तपासणी करता येते किंवा नाही याबाबत खात्री करतील. तसेच त्यांना त्याबाबत आवश्यक ते प्रशिक्षण देण्याची जबाबदारी तालुका आरोग्य अधिकाऱ्यांची राहिल.
- १४) साथ व इतर आपत्कालीन परिस्थितीत नियंत्रण कक्ष तालुकास्तरावर स्थापन करणे, दैनंदिन अहवाल एकत्रित करून पाठविणे ही जबाबदारी तालुका आरोग्य अधिकाऱ्याची असेल.
- १५) रुग्ण कल्याण समित्यांच्या बैठकीस उपस्थित राहून या बैठकीमध्ये झालेल्या निर्णयांची योग्य प्रकारे अंमलबजावणी करण्याची जबाबदारी तालुका आरोग्य अधिकाऱ्याची असेल.

तालुका आरोग्य अधिकाऱ्यांचे आर्थिक अधिकार:-

तालुका आरोग्य अधिकाऱ्यांना त्यांच्या वाहनाच्या दुरुस्ती व इंधनासाठी आवश्यक ती तरतूद जिल्हा आरोग्य अधिकाऱ्यांनी जिल्हास्तरावरील निधीतून उपलब्ध करून द्यावी, जेणेकरून त्यांना तालुक्यातील

फिरती करणे, जिल्हास्तरावरील बैठकांना उपस्थित राहणे आणि इतर अनुषंगिक कामे करण्यास अडचण येणार नाही.

उपसंचालक आरोग्य सेवा मंडळ हे दरमहा विभागीय आयुक्तांच्या सल्ल्याने व त्यांच्या मार्गदर्शनाखाली तालुका आरोग्य अधिकाऱ्यांच्या कामाचा विभागीय स्तरावर आढावा घेतील. तसेच मुख्य कार्यकारी अधिकारी यांच्या सल्ल्याने जिल्ह्यातील सर्व वैद्यकीय अधिकारी यांचा महिन्यातून एक वेळ आढावा घेण्याची जबाबदारी उपसंचालक आरोग्य सेवा यांची असेल व हा त्यांच्या कर्तव्याचा भाग असेल.

महाराष्ट्र जिल्हा परिषद आणि पंचायत समिती अधिनियम १९६१ चे कलम ९५ अन्वये मुख्य कार्यकारी अधिकारी हे वरील शासन निर्णयाव्यतिरिक्त इतर जबाबदारी सोपविण्यासाठीचे अधिकार तालुका आरोग्य अधिकाऱ्यांच्या सक्षमतेनुसार विकेंद्रीत करतील.

तालुका आरोग्य अधिकारी हे पंचायत समितीच्या अधिनस्त राहून वरील बाबींची सर्व कामे पार पाडतील व ते पंचायत समितीस जबाबदार राहतील. सर्व आरोग्य विषयक कार्यक्रमांच्या अंमलबजावणीमध्ये पंचायत राज्य व्यवस्थेचा अधिकार सहभाग मिळविण्यासाठी तालुका आरोग्य अधिकारी प्रयत्नशील राहतील.

Motivation And Leaderships Skills of THO

Leadership as a personal quality and as an organizational function consists of different entities. As a personal characteristic it enables an individual to assume leadership. Certain qualities and characteristics that some individuals have, which may be either inborn or achieved, make them leaders of men. In the latter case, leadership in an organization is to be considered as a positional characteristic wherein the distribution of decision-making process and patterns of authority make an individual a leader of men. The process of leadership involves influencing the behavior of an individual or a group. It is the art of getting other people to follow you and to willingly do things that you want them to do." Leadership is the ability to influence the activities of an individual or a group, inspire and motivate them, develop confidence in them, support to achieve goals and finally raise performance.

Leadership is defined as **"The process whereby one individual influences other group members towards the attainment of defined group or organizational goals."**

This process is essential in an organization for achieving the organizational objectives. It is possible to identify leaders in organizations by the results which they produce and which can be appreciated. They may be associated with a high output and good performance in both quantitative and qualitative terms of the team, which they lead. The morale of the team led is of a high level with a commitment to achievement of goals, both personal and organizational, which correspond, and a high level of motivation. The team works in a spirit of co-operation and conflict may occur because of difference of opinion regarding the best way to further the achievements. Some people are born leaders and possess forceful personalities, are dominant in groups, enthuse others and are able to persuade others into accepting their suggestions. But the interest is in knowing if it is possible by purposeful attempts to cultivate habits, develop behavioural patterns and learn to be leaders. The technical skills and the human relation skills can be developed by purposeful effort. Some learn it by trial and error and become proficient with experience. They try to cultivate and develop their potential capabilities to maximum advantage by a conscious effort. A study of profiles of leaders, dominant personality traits and ways of achieving leadership becomes an interesting exercise. Numerous studies of the common traits of leaders with reference to physical, social and intellectual characteristics have brought out interesting results. They indicate that leaders are brighter, better adjusted psychologically, have better judgement and like to have more social interactions. They have ability to command and to listen. They have strong desire to achieve a sense of mission, self-confidence and belief in their capacity to lead. They are enthusiastic, emotionally stable and energetic. Finally it has also to be conceded that there are examples of excellent leaders who lack in many of these traits and yet have been effective.

The leadership is a function of three factors:

The leader himself

The group members, and

The situations or conditions

Leader's Power: The leader's influence over his or her followers is derived from various sources of power. The important sources of power of the leader, power enhancer, include:

- **Reward Power (Objective reward system):** Reward power refers to offering monetary or non-monetary rewards by the leader to his followers. This reward should always be based on objective evaluation with an impartial intention. The rewards may include salary hike, promotions, transfers, providing fringe benefit or even praise, recognition, freedom, empowerment, genuine autonomy etc.
- **Coercive Power (Rules and procedures):** Coercive power is the ability or the capacity of the leader to coerce or punish his/her followers for carrying out the assigned tasks. This coercive power includes deferring promotion, salary reduction, demotion, transfer or retrenchment etc.
- **Legitimate Power (Task clarity and satisfaction, feedback system, organizational structure, strong and self-governing team):** The job of the leader gives right to the leader regarding issuing orders, work assignment, delegation of authority and responsibility to his/her subordinates in order to get the work done.
- **Expert Power (Competence building):** The subordinates except the leader as a source of knowledge and skills in carrying-out their duties. They also expect timely and continuous support from their leader in the form of offering expertise that they do not have.
- **Referent Power (Professionalism, spatial distance):** The leader should be resourceful in terms of knowledge and skills. He/she should be capable of identifying who should be rewarded and discriminate the followers who avoid work and use his coercive power. Subordinate should like his/her extraordinary characters, abilities, qualities and skills in the leader and see him/her as their role model.

Leadership Style:

- **Autocratic Style (Dictatorial Leadership):** Authoritarian in attitude/gets the work done through fear. Expects subordinate to do what they are asked to do without asking any question, leads through domination and drive. Followers have no say in decision making or in implementation.
- **Laissez-faire style (Free-rein Leadership):** These leaders mostly avoid authority and responsibility and delegates all power and responsibilities.
- **Democratic Style (Participative Style):** Decentralize authority and encourage subordinates to take part in the process of decision making, implementation and usually takes decision in consultation with the subordinate, takes their suggestions.

Styles of effective leadership may be quite different. Some are authoritarian and do issuing direct orders do things. They are likely to have problems of morale and do not promote initiative. Some are democratic and involve followers in decision-making. But this process requisite time. It also assumes that followers have the requisite knowledge and skill to participate in decision-making. This may not be always true. Some leaders project themselves

in a low profile, present what is, to be accomplished and leave it to the followers to find ways of achieving objectives. This style is suitable for professionals and intellectuals but may produce chaos if followers are not capable.

Obviously there cannot be only one or ideal style of leadership. A lot would depend upon the characteristics of the followers as well as the situation. What is effective in one set of circumstances may not be effective or appropriate in another set. A professor of public health who with his mild manners is able to talk to a group of health officers and sway their opinions, making them agree to his line of thinking may be totally ineffective as a leader of health inspectors or workers. People in the lower category of hierarchy may be better led by one who issues clear-cut, unambiguous and direct orders. Leaders of thinkers may not be able to impress and be effective as leaders of "doers". The style of leadership will have to be suitable to the leader's personality also. It is difficult to put on airs and lead continuously. The basic style of behaviour will invariably be manifested.

How to be a good leader

There cannot be an infallible success formula for developing as a leader. However, some practical observations may be helpful. A sincere desire to understand people who work with him, sympathy for them and honest desire to help them is helpful. Taking care of their welfare, and fair, impartial and consistent treatment is appreciated. A leader must be predictable and consistent. A good leader must also be a good follower. A Taluka Health officer may be a team leader and learn to do a good job of leading but he must also be a good follower of his own leader. Respect is mutual; if one respects others, upholds their dignity and does not hurt their ego, it will be reciprocated. How an individual talks of and talks to his boss will also influence his subordinate's opinion of himself. Being loyal to followers and being loyal to one's superior win loyalty. A free and frank approach and communication is necessary. It is a good policy to admit mistakes and ignorance, for it is a sign of strength to admit not knowing all answers. A leader lets others take credit when it is their due. He is not vain or selfish.

In the long run the subordinates will develop respect for qualities. The courage, ability and decisiveness will impress others. It may be necessary to make demands firmly but they can be made quietly and with decorum. It is possible to develop the state of morale in the organization in which one does not have to shout to be heard and obeyed. A leader does not necessarily have to be popular. A superior may be friendly and popular but he may not necessarily inspire confidence and respect for himself or be a leader.

A leader does not make false promises for he knows that he cannot fool all the people for all the time. Loss of credibility is loss of leadership.

Formal training in leadership

In the last two decades, training programmes for managerial development, including leadership training, have become quite fashionable and popular. The beneficial effects of training for leadership, however, seem to be doubtful. Evaluation of training programmes for leadership training, by comparing the performance of those who have undergone such training with those who have not undergone any training, has been done. Such studies have not revealed any superior performance of those who were trained. Although some of these studies attract certain methodological criticism, thereby casting a doubt on validity of results, well-planned studies have also given similar results. An awareness of the concepts of leadership, of what should or should not be done and a self-motivation to give a better performance in this regard, is expected to have some desirable benefit. Even if it is accepted that formal leadership

training courses have not produced measurable changes, subjective experience indicates that an individual motivated to learn the skills of management does show a better awareness of the principles and practices them in his life.

Leadership Skills (Qualities of Leadership):

- **Personal Skills:** Developing self-awareness, determining values and priorities, decisiveness (ability to make decision), unerring judgment, identifying cognitive style
- **Responsibility:** Using the rational and creative approach, fostering innovation in others, readiness to admit his/her limitations and errors
- **Emotional stability:** Managing stress, coping with stressors
- **Obtain desired results:** Assessing attitude towards changes, managing time, delegating, solving problems creatively
- **Motivational skill:** Diagnosing poor performance, inspiring, lifting a man's vision, ability to energize his/her group, ability to guide, conduct, direct his/her team, creating a motivating environment, rewarding accomplishments
- **Conflict management:** Knowledge of human relation, diagnosing the conflicts, finding causes, developing and selecting the best strategies, resolving the confrontations
- **Communication skill:** Good listener, informing and listening, coaching and counseling
- **Technical competence:** Gaining power, exercise influence, empowering others, self-confidence etc.
- **Interpersonal skills:** Giving due respect to subordinates, clarity of vision, participative management skill
- **Good public relation**
- **Media Management**

JOB RESPONSIBILITIES OF OTHER HEALTH STAFF

Duties of Medical Officer

If there is more than one Medical Officer, the senior most will be in charge of the PHC and will be fully responsible for the administration. The area of the Centre should be divided amongst themselves on a sub-center / geographical basis, and each will be responsible for all the activities under the national and local health and family welfare programmes, and health development.

1) Medical or Curative Work-

- To organize and manage the dispensary, outpatient clinic, indoor beds, and allot duties to other staff to ensure smooth running of the PHC in all its functions and purposes.
- To arrange suitably for distribution of work in the treatment of emergency cases which come outside the usual hours of the O.P.D.
- To organize and develop laboratory services for diagnostic and follow-up purposes.
- To organize and arrange out-reach services for treatment of minor ailments and injuries at community level in the villages and hamlets, sub-centres and PHC through the Community Health Officer, Health Workers, Health Assistants, and others.
- To attend to the cases referred by paramedical and auxiliary staff of the PHC, and the HGs/CHWs, dais, teachers, etc.
- To examine and screen patients who need specialized medical or surgical attention, including dental and nursing care, and refer them in time to appropriate hospital / institution.
- To train and guide all his staff, health guides, community health workers, dais, school teachers, etc., in the treatment of minor ailments and injuries, and first-aid.
- To co-operate and co-ordinate with other institutions and organizations, private practitioners etc., who provide medical and health care services in his area.
- To visit each sub-centre in his area. Frequency of Medical Officer's visits at the subcentre: Every subcentre to be visited at least once every month. If two Medical Officers are posted, the subcentres should be divided amongst the two. If only one Medical Officer is posted, he should visit the subcenter in the afternoon. PHC vehicle or public transport are used for the visit. A board indicating the day and time of the visit to be displayed at the subcentre. Subcentre staff are expected to stay at the headquarters on the day of the Medical Officer's visit.

The following activities are to be performed during the visit:

- Meeting the Sarpanch, members of the village panchayat and functionaries of the other departments.
- Conducting OPD.
- Examination and IEC activities in the Ashram schools.
- Supervision
- Examination of TB and Leprosy patients.
- Motivating resistant couples for Family Planning
- Visit to the Village Panchayat for assessing the registration of vital events.

- Visit to the anganwadi for guidance and examination of children with Grade I and Grade II malnutrition.
- Examination of high risk mothers and children.
- Problem solving

A note in triplicate on the work done during the visits be prepared; one copy to the DHO, one to the concerned ANM and one for filing in the office.

2) Preventive and Promotive Work-

He has to train, guide and ensure that all the members of his staff are fully conversant and clear about the objectives and all activities of various national and local health and family welfare programmes. They should also know their area and all the programme activities. He has to prepare operational plans, calendar and fixed and other programme of work for all his staff with a view to ensure that different health programmes are effectively and efficiently implemented. He has to keep close liaison with the Block Development Officer and his staff, community leaders, voluntary and non-Governmental agencies, school teachers, etc. to actively involve them in the promotion of various health and development programmes in the area and to seek community participation.

He has to conduct field investigations to identify local health needs and problems, to find out local determinants and possible solutions, to study epidemics and other unusual happenings with a view to control and prevent them, and to generate data and information that will assist better delivery and/or planning health and family welfare services.

National Family Welfare Programme -

- To be responsible for effective implementation, including education and training, motivation, delivery of the services, and follow-up.
- To provide immediate and sustained attention to any complication or adverse effect occurring due to acceptance of any of the family planning methods.
- To motivate and encourage motivational advice to all the eligible persons / couples.
- To get trained and acquire proficiency in tubectomy and vasectomy operations, IUD insertions, M.T.P. and M.R. (Menstrual Regulation), organization of tubectomy and vasectomy camps, etc. To undertake this work at his PHC.
- To seek help from other agencies, centres and experts for sterilization operations, M.T.P, IUD insertions.
- To learn communication techniques, to improve leadership capabilities, to co-operate and maintain functional relationship with other organizations and local leaders so as to promote family welfare movement and acceptance of small family norm,
- To encourage and assist local private medical (of all systems) practitioners in implementation and promotion of the Family Welfare Programme.

Maternal and Child Health -

- To direct and provide services such as antenatal, natal and postnatal care to women; and infant and child care through O.P.D and special clinics regularly conducted at the PHC and sub-centers. It is desirable to conduct such clinics in remote and inaccessible villages, say once in two months at least.
- To ensure detection and special care as may be indicated to high-risk mothers, infants and children.

- To ensure successful implementation of National Programmes for Prevention of Nutritional Anaemia and of Prevention of Blindness through administration of the iron and folic acid tablets, and vitamin A doses, respectively, in adequate quantities and period to all the needy women and children.
- To treat all maternal and child cases, complicated or otherwise, referred by the Health Workers, Health Assistants, Dais etc.
- To maintain a tidy and clean delivery room, properly furnished, equipped, lighted, and readily available.
- To examine and screen cases that need specialist care, and to refer them in time to appropriate hospital or specialist.

Universal Immunization Programme -

- To plan and implement the programme according to the latest directive and guidelines, and ensure full protection of the target population of the women, infants and children.
- To procure and ensure adequate and timely supply of various vaccines and other items required, at places of immunization sessions.
- To ensure maintenance of the Cold Chain to ensure that potency of the vaccines is retained till administered.
- To treat promptly the cases of complications and adverse reactions following immunization.

National Malaria Eradication Programme -

- To be responsible for all administrative and technical activities for effective implementation of NMEP
- To get acquainted with all difficulties and problems regarding insecticide spray and surveillance operations in the PHC area, and to take necessary corrective measures immediately.
- To train and guide the field and other concerned staff on all treatment schedules such as for presumptive treatment of fever cases, and radical treatment for the cases which are blood-smear positive. To learn management and treatment of cerebral malaria, and to treat cases of cerebral malaria as and when they come.
- To investigate all outbreaks of malaria, i.e. more than two cases in a day at one place /village.
- To check laboratory work for diagnosis, and ensure that the prescribed percentage of slides are sent to the designated laboratory / authority for cross - check.
- To supervise maintenance of accounts of the microscopy slides, antimalarial drugs, etc.
- To ensure follow-up of treatment of malaria positive cases.

Control of Communicable Diseases -

- To ensure that strict surveillance is maintained for the control of common communicable disease.
- To promote improvement of sanitary condition and proper maintenance of sanitary facilities in villages.
- To investigate and act promptly in case of any outbreak of an epidemic in his area.
- To maintain accurate and up-dated data on mortality and morbidity data on the common communicable diseases in his area.

National Leprosy Eradication Programme -

- To be responsible for effective implementation of NLEP in the PHC area.
- To provide facilities for early detection of cases, confirmation of diagnosis, and treatment, c. To ensure regular procurement and supplies of drugs, d. To ensure follow-up of all cases for regular and complete treatment.
- To examine and screen cases who require physio-therapy, reconstructive surgery or rehabilitation, and to refer them to an appropriate centre / hospital or specialist.

National Tuberculosis Control Programme -

- To be responsible for all activities for effective implementation for the national programme.
- To provide facilities and ensure early detection, confirmation of diagnosis, and treatment.
- To ensure follow-up of all cases to ensure that they take treatment regularly and completely till declared as cured.

Control of Sexually Transmitted Diseases and AIDS -

- To provide facilities and ensure that all cases of STD are diagnosed and treated properly.
- To provide facilities or referral for confirmation of diagnosis and / or screening. It is necessary that VDRL test is done in all antenatal cases.
- To know the nearest laboratory where testing for AIDS is possible. Such a testing is important before blood transfusion.

School Health -

- To organize health inspection of the schools in the area.
- To arrange for medical check-up of school children, immunization, detection of physical and other defects and treatment, and follow-up and referral support.

National Programme for Prevention of Visual Impairment and Control of Blindness -

- To arrange for testing of vision, refraction and provision of spectacles.
- To ensure prompt treatment of eye ailments.
- To examine and refer suitable cases for specialist care to appropriate hospital expert.

National Diarrhoea! Diseases Control Programme -

- To organize and provide facilities for early detection of cases of watery diarrhoea, dysentery, etc.
- To promote use of oral rehydration solution, etc., by way of education and training of health staff and mothers,
- To examine and treat cases which come or are referred to sub-centres or PHC, or refer for specialized care to a hospital or an expert.

Control of Acute Respiratory Infections -

- To organize and ensure early detection of pneumonia in young children by the field staff and parents by way of educating and training them.

- To organize and facilitate home treatment of cold and cough, and mild pneumonias. This could be only supportive care or use of an antibiotic.
- To examine and treat cases of severe pneumonia who come or are referred to PHC with antibiotic treatment, and to refer them for specialized care to a hospital or an expert.

3) Training and Continuing Education –

- To organize and conduct staff meetings every month on a fixed day and time and review the work and progress made by each member of the staff, to understand and solve difficulties of the staff, to identify and solve problems, and to plan the next programme for action.
- To use the monthly review meetings for specific guidance. Generally, the weaknesses and gaps in the knowledge and skills are revealed in the course of such meetings. Correction of these provide a useful learning opportunity to the staff.
- To organize periodical training programmes with the help of the senior staff and District level staff. Updating and new programmes may be covered.
- To organize training programmes and inform the local leaders, dais, health guides and volunteers so that they can serve as effective communications to the people. They will be best agents for change, d. To select and periodically send staff for training at the Health and Family Welfare Training Centre, or other places

4) Administrative Work -

- To provide leadership to his team of staff and the people.
- To supervise and direct the work of all the staff working under him.
- To ensure good house-keeping and general cleanliness inside and outside the premises of PHC and sub-centres; and proper maintenance of all equipments and materials under his charge.
- To maintain up-to-date inventory and stock registers of all the stores, equipments and supplies provided / procured. To be responsible for correct accounting of all these items.
- To procure and ensure adequate, regular and timely supplies of equipments, drugs, contraceptives, educative materials, and other supplies required for efficient delivery of the services.
- To prepare indents for supply of drugs, instruments, linen, vaccines, contraceptives, chemicals, petty and miscellaneous supplies etc., sufficiently in advance, and submit to appropriate higher authority.
- To maintain the transport jeep, etc., in his charge.
- To plan and periodically scrutinize the working of his staff and suggest changes, if necessary, to improve performance and suit the priorities of work.
- To get prepared and display maps and charts in his office room to exhibit clearly the geographical area of the PHC, locations and areas of the sub-centres, morbidity and mortality rates for last two years and the current year, other health and demographic information, and performance under various health and family welfare programmes.
- To conduct monthly staff meeting with a view to review and evaluate the progress of work, and taking steps to further improve coverage, quality and effectiveness.
- To ensure regular and timely supplies of medicines and honorarium etc., to Health Guides and Dais.
- To properly constitute village and block level Health Committees and ensure that they are functional.

- To ensure maintenance of the prescribed registers and records at the PHC and the sub-centres. These should be made accurate, up-to-date and reliable by thorough checks, cross-checks and utilization.
- To ensure that he gets reports of the work done and happenings in the PHC area from all his staff regularly and in time, get these reports compiled, and send to the District Health Authorities on time. Such monthly reports should be studied by him and used for better management of the PHC work.
- To maintain personal diary of his visits and work. Relevant information should be included in monthly report of the PHC.
- To discharge all the financial duties entrusted to him.
- To discharge all the day-to-day administrative functions pertaining to the PHC and the people

आरोग्य सहाय्यक (पुरुष) या पदाची कर्तव्ये व जबाबदाऱ्या

आरोग्य सहाय्यक (पुरुष) यांची कर्तव्ये व जबाबदाऱ्या :

बहुउद्देशिय आरोग्य कर्मचारी योजनेअंतर्गत पुरुष आरोग्य सहाय्यकाने एकूण २०,००० लोकसंख्येला सेवा देणे अपेक्षित असून एकूण ४ उपकेंद्रे व ४ आरोग्य कर्मचारी (पु.) यांचे पर्यवेक्षण करणे बंधनकारक आहे. त्याचप्रमाणे प्रजनन व बाल आरोग्य कार्यक्रम व कुष्ठरोग दूरीकरण कार्यक्रमाचे प्राथमिक आरोग्य सेवेत होणाऱ्या विलीनीकरण अनुपंगाने व इतर राष्ट्रीय कार्यक्रमात झालेला बदल लक्षात घेता पुरुष आरोग्य सहाय्यकाच्या जबाबदाऱ्या खालीलप्रमाणे आहेत.

अ) पर्यवेक्षण व मार्गदर्शन -

१. कार्यक्षेत्रातील सर्व पुरुष आरोग्य कर्मचाऱ्यांच्या कार्याचे संनियंत्रण, त्यांच्या कामाची आखणी व कौशल्यवृद्धीसाठी आरोग्य कर्मचाऱ्यांना मार्गदर्शन.
२. पर्यवेक्षणासाठी नियमित व आकस्मिक भेटी.
३. वैद्यकीय अधिकारी, आरोग्य कर्मचारी व लाभार्थी यांच्यात आरोग्य सेवा संबंधाने योग्य समन्वय साधणे.
४. आरोग्य सहाय्यक (स्त्री) च्या सहाय्याने सर्व कर्मचाऱ्यांची सभा व कामाचा आढावा.
५. मासिक सभेत आरोग्य कर्मचाऱ्यांच्या कामाचा आढावा देणे.
६. आरोग्य सेवकाला साधनसामुग्रीचा पुरवठा.
७. आरोग्य सेवकांच्या नोंदवह्या व दप्तर पडताळणी व मार्गदर्शन.
८. आरोग्य सेवकांकडून आलेल्या अहवालाचे एकत्रीकरण, छाननी व अहवाल सादरीकरण.

ब) साहित्य सामुग्री व्यपस्थापन :

१. आरोग्य सहाय्यकेसोबत नियमित व आकस्मिक उपकेंद्र साठा तपासणी.
२. साहित्य सामुग्रीचे मागणीपत्र योग्य वेळी सादर करून पुरवठा प्राप्त करणे.
३. उपकेंद्र औपधीसाठी व इतर साहित्यांच्या योग्य साठवणुकीकडे नियमित लक्ष.
४. पुरुष आरोग्य कर्मचाऱ्यांच्या किटची नियमित पडताळणी.

क) संघकार्य :

१. पुरुष आरोग्य कर्मचाऱ्यांसह संघकार्य सुलभ करणे.
२. आरोग्य सहाय्यका व इतर कर्मचाऱ्यांसोबत कार्याचे समन्वय व नियमित बैठकीचे आयोजन.
३. इतर विभागाच्या शासकीय कर्मचाऱ्यांसोबत समन्वय व गटपातळीवर आयोजित सभेत सहभाग.
४. प्राथमिक आरोग्य केंद्राच्या सभेत नियमित सहभाग.
५. कार्यक्षेत्रात विविध आरोग्य सेवांचे आयोजनासाठी वैद्यकीय अधिकाऱ्यांना मदत करणे.
६. इतर कर्मचाऱ्यांसह आरोग्य सेवा शिबिरांचे आयोजन व सहभाग.

ड) अहवाल व नोंदी :

१. आवश्यक नोंदी व अहवाल तत्परतेने सादर करणे.
२. पुरुष आरोग्य कर्मचाऱ्यांकडून प्राप्त नोंदी व अहवालांचे योग्य संकलन करून वैद्यकीय अधिकाऱ्यांना सादर करणे.

१) राष्ट्रीय हिवताप प्रतिरोध कार्यक्रम :

- आरोग्य सेवकांच्या सर्वेक्षण भेटीचे नियोजन व पर्यवेक्षण.
- घरभेटीत आढळलेल्या रुग्णाचे रक्त नमुने, गृहीत उपचार, हिवताप रुग्णांना समूळ उपचार.
- ताप उपचार केंद्र व गोळ्या वाटप केंद्र यांची पडताळणी.

- किटकनाशक फवारणी कार्यक्रमावर देखरेख.
- डास उत्पत्ती स्थाने पडताळणी.
- गप्पी मासे पैदास केंद्र तपासणी.
- मजूर शिबिरांना (Labour camps) आठवडी भेट.
- मच्छरदाणी वाटप.

२) साथरोग नियंत्रण :

- हगवण, अतिसार, कावीळ, विषमज्वर, मेंदूज्वर, घटसर्प, गोवर इ. च्या साथीवर नियंत्रण व लक्ष.
- उद्रेकाच्या प्रसंगी त्वरीत कार्यवाही, उद्रेक नियंत्रण पथक तयार करणे, विहीरी निर्जंतुकीकरण, ओ. टी. पर्यवेक्षण, दूषित पाणी नमुन्यानुषंगाने कार्यवाही, ग्रामपंचायत भेटी, ब्लिचिंग पावडरसाठा तपासणी.
- प्रतिबंधात्मक कार्यवाही व वरिष्ठांना आवश्यक माहिती सादर करणे.
- उद्रेक होवू नये म्हणून साथरोग विषयक आरोग्य शिक्षण.
- रेबीज प्रतिबंध - बेवारस कुत्र्यांचा बंदोबस्त.

३) राष्ट्रीय अंधत्व निवारण कार्यक्रम :

- मोतीबिंदू रुग्णांची यादी तयार करून घेणे व शिबिराचे नियोजन.
- शाळेत जाणाऱ्या सर्व मुलांची दृष्टीदोष, तिरळेपणा व इतर नेत्र आजाराकरीता तपासणी होईल याची खात्री करणे व त्यांना उपचार देण्याची व्यवस्था करणे.

४) राष्ट्रीय कुष्ठरोग व निर्मूलन कार्यक्रम :

- निदान व नियमित उपचार.
- संशयित रुग्णांचा त्वचा नमुना घेणे व तपासणीसाठी पाठविणे.

५) राष्ट्रीय क्षयरोग नियंत्रण कार्यक्रम :

- नियमित औषधोपचार
- आरोग्य कर्मचाऱ्यांकडून घेतलेले थुंकी नमुन्यांची पडताळणी.

६) प्रजनन व बाल आरोग्य :

६.१ सार्वत्रिक लस टोचणी कार्यक्रम.

- लसीकरणासाठी लागणारा साधनसामुग्रीचा साठा अद्ययावत ठेवणे.
- पल्स पोलिओ लसीकरण
- लसीकरण गावाचे पर्यवेक्षण

६.२ क्षार संजीवनी उपचार.

- अतिसाराच्या रुग्णांना क्षार संजीवनी उपचार
- आरोग्य सेवक (स्त्री/पुरुष) यांना क्षार संजीवनीचा पुरवठा करणे.

६.३ शालेय आरोग्य कार्यक्रम

- लसीकरणासाठी आरोग्य कर्मचाऱ्यांना सहाय्य.
- विद्यार्थ्यांना आरोग्य शिक्षण.

६.४ कुटुंब कल्याण कार्यक्रम.

- कुटुंब पाहणीचे वेळी पर्यवेक्षण व गोपवारे काढणे.
- प्रतिसाद न देणाऱ्या जोडप्यांचे मतपरिवर्तन.
- निरोध डेपो होल्डर - नियमित साधन पुरवठा.
- कुटुंब नियोजन शिबीरे आयोजित करण्यासाठी सहाय्य.
- लाभार्थीचा पाठपुरावा व पर्यवेक्षण
- पुरुषांचा कार्यक्रमात सहभाग वाढविण्यासाठी मदत व मार्गदर्शन.

६.५ उपकेंद्र नियोजन मार्गदर्शन.

- आरोग्य सेविकेला उपकेंद्र नियोजन आराखडा तयार करण्यासाठी आवश्यक मार्गदर्शन व मदत.
- पुरुष आरोग्य कर्मचाऱ्यांचा सहभाग निश्चित करणे.
- लाभार्थ्यांच्या गरजा व निश्चितीसाठी मदत व मार्गदर्शन.

६.६ लोकसंख्या धोरण, आरोग्य शिक्षण.

- लोकसंख्या धोरणाची उद्दिष्टे व प्रमुख बाबी.
- प्रस्तावित उपाययोजनांची माहिती.
- सेवांची उपलब्धता व गुणवत्ता सुधारणे.
- विविध क्षेत्राचा व विभागांचा सहभाग.

६.७ प्रजनन मार्ग जंतुसंसर्ग - पुरुष रुग्णांसाठी निदान व उपचार

- प्रजननमार्ग जंतुसंसर्गाचे परिणाम व निदान.
- प्रतिबंधात्मक उपाययोजना.
- उपचार व पद्धती.

६.८ लैंगिक शिक्षण

- किशोरवयीन मुलामुलींना लैंगिक शिक्षण.
- सुरक्षात्मक उपाययोजना.
- दुष्परिणामांची जाणीव करून देणे.

फ) जीवन विषयक आकडेवारी :

- आरोग्य कर्मचाऱ्यांनी गोळा केलेल्या जन्ममृत्युच्या माहितीचे एकत्रिकरण.
- एम आय एस चालू असलेल्या प्राथमिक आरोग्य केंद्रामधील कार्यावर देखरेख व गळती पाहणे.
- ग्रामपंचायतमध्ये केल्या जाणाऱ्या जन्ममृत्यु नोंदीबाबत सर्वेक्षण व पडताळणी.
- अहवाल संकलन.

ग) परिसर स्वच्छता :

- सुरक्षित पाणी पुरवठा.
- शोष खड्डे, परसबाग, खत खड्डे, आरोग्यदायी संडास, बिनधूराची चूल तयार करण्यासाठी जनतेला प्रोत्साहन व मार्गदर्शन.
- पाण्याचे निर्जंतुकीकरणाबाबत ओ टी टेस्ट.
- पाणी नमुने गोळा करून चाचणीसाठी प्रयोगशाळेत पाठविणे व अहवाल ग्रामपंचायतीकडे पाठविणे व पाठपुरावा करणे.
- पाणी शुद्धीकरणासाठी ग्रामपंचायत कर्मचारी प्रशिक्षण.
- दुषित पाणी नमुना असलेल्या स्त्रोत्राकरिता योग्य उपाययोजना.

घ) प्रथमोपचार व किरकोळ आजार व संदर्भसेवा :

- आरोग्य सेवकाकडे प्रथमोपचार व किरकोळ आजारांच्या उपचारासाठी लागणारे सर्व साहित्य असल्याची खात्री.
- आरोग्य सेवकांचे निरंतर प्रशिक्षण.
- किरकोळ आजार, उपचार व अपघात प्रकरणी प्रथमोपचार व संदर्भ सेवा.
- आरोग्य कर्मचाऱ्यांकडून संदर्भीत रुग्णांवर योग्य उपचार व आवश्यक तेथे पुढील संदर्भ सेवेसाठी रुग्ण रवानगी.

न) आयोडिन न्यूनता विकार कार्यक्रम :

- आयोडिनच्या कमतरतेमुळे होणारे विकार/आजार आणि आयोडिनयुक्त मिठाचा आहारातील वापराबाबत लोकांना आरोग्य शिक्षण देणे.
- वापरण्यात येणाऱ्या मीठांचे नमुने आयोडिनचे प्रमाण तपासण्याकरिता प्रयोग शाळेत पाठविणे.

प) आरोग्य शिक्षण, प्रशिक्षण, संप्रेषण व समोपदेशन

- महत्वाच्या कार्यक्रमात गटसभांचे आयोजन.
- साथरोग, परिसर स्वच्छता, प्रजनन व बाल आरोग्य कार्यक्रमांतर्गत माहिती व संप्रेषण कार्यक्रमांचे आयोजन.
- शालेय भेटीद्वारे आरोग्य शिक्षण.
- यात्रा, समारंभ इत्यादींचे वेळी प्रदर्शनीचे आयोजन.
- पुरुष आरोग्य कर्मचाऱ्यांचे मदतीने स्थानिक नेत्यांचे प्रशिक्षण.
- आरोग्य कर्मचाऱ्यांचे प्रशिक्षण.

१) समोपदेशन सत्रांचे आयोजन :

- कुटुंब नियोजन साधने वापरण्यासाठी.
- लैंगिक मार्ग जंतुसंसर्ग.
- लैंगिक आजार व वैकल्ये
- एचआयव्ही/एड्स.

क्ष) अंगणवाडी तसेच आश्रमशाळेची भेट.

आरोग्य सहाय्यक (स्त्री) या पदाची कर्तव्ये व जबाबदाऱ्या

आरोग्य सहाय्यक (स्त्री) यांची कर्तव्ये व जबाबदाऱ्या :

बहुउद्देशीय आरोग्य सेवक योजनेअंतर्गत ग्रामीण विभागामध्ये एकूण १५,००० लोकसंख्येसाठी आणि आदिवासी भागामध्ये १०,००० लोकसंख्येसाठी किमान ३ उपकेंद्र कार्यरत असून आरोग्य सहाय्यकेला आरोग्य सेविकांच्या कामाचे पर्यवेक्षण आणि नियंत्रण करावे लागते त्यांच्या जबाबदाऱ्या खालीलप्रमाणे आहेत.

१) पर्यवेक्षण व मार्गदर्शन (Supervision & Guidance):

१. आरोग्य सेविकेला आरोग्य सेवा देतांना मार्गदर्शन करणे व त्यांच्या कामाचे पर्यवेक्षण करणे तसेच त्यांचे कौशल्य व ज्ञान वृद्धीकरिता करणे.
२. आरोग्य सेविकेला कार्यक्रम तयार करण्याकरिता आणि त्यांची अंमलबजावणी करण्याकरिता मदत करणे व मार्गदर्शन करणे.
३. प्रत्येक उपकेंद्राला आठवड्यातून एका विशिष्ट दिवशी भेट देऊन आरोग्य सेविकेने केलेल्या दैनंदिन कामाची पाहणी करणे व काही त्रुटी आढळल्यास त्यांना मार्गदर्शन करून त्रुटीची दुरुस्ती करणे.
४. आरोग्य सेविकेने केलेल्या कामाची नियमित पडताळणी करून पडताळणी अहवाल प्राथमिक आरोग्य केंद्रांच्या वैद्यकीय अधिकाऱ्यास सादर करणे.
५. आरोग्य सेविकेच्या क्षेत्रात पर्यवेक्षकीय गृहभेटी देणे.
६. राष्ट्रीय प्रजनन व बाल आरोग्य कार्यक्रमात व राष्ट्रीय कुष्ठरोग निर्मुलन कार्यक्रमात पर्यवेक्षण व मार्गदर्शन करणे.
७. प्राथमिक आरोग्य केंद्र येथे आरोग्य कर्मचाऱ्यांच्या सभेला उपस्थित राहणे व मार्गदर्शन करणे.
८. आरोग्य सेवक महिला यांनी केलेल्या कामाची कमीत-कमी १० टक्के घरांना भेटी देऊन पडताळणी करून पर्यवेक्षण करणे.
९. सर्व गर्भवती स्त्रियांना व्ही.डी.आर.एल. तपासणीकरिता सोई उपलब्ध असलेल्या हॉस्पिटलला पाठविणे.

२) सांघिक (Team Work):

१. सर्व आरोग्य कर्मचाऱ्यांना संघकार्याचे सदस्य म्हणून कार्य करण्यास मदत करणे.
२. आरोग्य सहाय्यक पुरुष व इतर आरोग्य कर्मचारी, आरोग्य मार्गदर्शक, दाई यांच्या मदतीने कार्य करणे.
३. क्षेत्रातील इतर विभागाच्या आणि संस्थांच्या कार्यक्रमासोबत आपले आरोग्य विषयक कार्यक्रम राबविणे आणि गटस्तरावरील सभांना उपस्थित राहणे.
४. आरोग्य सहाय्यक पुरुष यांच्या मदतीने उपकेंद्रातील आरोग्य कर्मचाऱ्यांना सभेचे नियमित आयोजन करणे.
५. कार्यक्षेत्रात निरनिराळ्या आरोग्य सेवांचे आयोजन करण्यामध्ये प्राथमिक आरोग्य केंद्रातील वैद्यकीय अधिकाऱ्यांना सहाय्य करणे.
६. आरोग्य संघाचे घटक म्हणून आरोग्य कार्यक्रमांतर्गत जनशिवीर आणि धडक मोहिमेमध्ये सहभाग घेणे.

३) पुरवठा, साहित्य व उपकेंद्राची देखभाल (Material Supply & Maintenance):

१. आरोग्य सहाय्यकाच्या सोबत प्रत्येक उपकेंद्रातील साहित्य पुरवठ्याची वेळोवेळी पाहणी करणे आणि साहित्य पुरवठा उपलब्ध करून देण्यात मदत करणे.
२. उपकेंद्रांवर औषधी व्यवस्थित ठेवलेल्या आहेत किंवा नाही ह्याची पडताळणी करणे व इतर साहित्याची देखभाल योग्यरित्या केली जाते किंवा नाही हे पाहणे.

३. आरोग्य सेवक महिला स्वतःची किट व प्रसुती किट व्यवस्थित ठेवते किंवा नाही ते पाहणे व त्याची खात्री करणे.
४. उपकेंद्र स्वच्छ व निटनेटके आहे याची दक्षता घेणे.
५. प्रजनन व बाल आरोग्य कार्यक्रमांतर्गत औषधी व साहित्याची देखभाल व व्यवस्थापन करणे.

४) नोंदवही आणि अहवाल (Register & Report):

१. आरोग्य सेविकांची नोंदवही तपासणे व त्यांना अडचण आल्यास मार्गदर्शन करणे.
२. नोंदवही व्यवस्थित ठेवणे व आवश्यक अहवाल तयार करणे.
३. आरोग्य सेविकांच्या अहवालाचा आढावा घेणे व अहवाल संकलित करून प्राथमिक आरोग्य केंद्राला सादर करणे.

५) प्रशिक्षण (Training):

१. आरोग्य सेविकेच्या मदतीने दाईचे प्रशिक्षण आयोजित करणे.
२. वेगवेगळ्या आरोग्य कर्मचारी, आरोग्य मार्गदर्शक, दाई ह्यांचे प्रशिक्षण आयोजित करण्याकरिता वैद्यकीय अधिकाऱ्यांस मदत करणे.

६) प्रजनन व बाल आरोग्य कार्यक्रम (R.C.H.):

१. आरोग्य सेविकेच्या मदतीने दर आठवड्याला उपकेंद्र स्तरांवर आरोग्य सेवा सत्र आयोजित करणे.
२. आरोग्य सेवक/ सेविका आणि प्रशिक्षित दाई यांना गरज पडेल तेव्हा मदत करणे.
३. कुटुंब कल्याण कार्यक्रमाचा स्वीकार न करणाऱ्या जोडप्यांना स्वतःजातीने भेटी देऊन मत परिवर्तन करणे.
४. जनतेला वैद्यकीय गर्भपाताविषयी उपलब्ध असलेल्या सेवांची माहिती देणे व गरजूंना योग्य शासनमान्य दवाखान्यात पाठविणे.
५. कुटुंब नियोजनाच्या प्रचलित साधनांच्या वितरणाकरिता आरोग्य सेविकेला डेपो होल्डरला तयार करण्याकरिता मदत करणे व त्या डेपोहोल्डरला आरोग्य सेविकेच्या मदतीने प्रशिक्षण देणे.
६. तांबी कार्यक्रम राबविणे व पाठपुरावा करणे तसेच सहाय्यक प्रसुती प्रसविका यांचे प्रशिक्षणे घेणे.
७. सर्व गर्भवती माता, नवजात शिशु व बालकांच्या लसीकरणाची व्यवस्था करणे व पर्यवेक्षण करणे.
८. शितसाखळी अखंड ठेवणे.

७) पोषण (Nutrition):

१. नवजात बालक व पाच वर्षाखालील बालकातील कुपोषणाचे रुग्ण शोधणे, त्यांना सल्ला व उपचार देणे आणि गंभीर मुलांना प्राथमिक आरोग्य केंद्राला रवानगी करणे.
२. अंगणवाडी कार्यकर्तीच्या मदतीने कामाचे पर्यवेक्षण व त्यांना मार्गदर्शन करणे.
३. लाभार्थींना लोह व फोलीक ॲसिडच्या गोळ्या व जीवनसत्व अ च्या मात्रा योग्य प्रमाणात योग्य कालावधीकरिता मिळतील याची दक्षता घेणे.
४. मातांना स्तनपानाविषयी शिक्षण देणे.

८) वैद्यकीय उपचार (Medical Treatment):

१. किरकोळ आजारावर उपचार, अपघात व आकस्मिक बाबीकरिता प्रथमोपचार देणे आणि गंभीर रुग्णांना प्राथमिक आरोग्य केंद्र येथे किंवा जवळच्या दवाखान्यात रवानगी करणे.
२. आरोग्य कर्मचारी यांनी पाठविलेल्या रुग्णांना सेवा पुरविणे आणि आवश्यकतेनुसार संदर्भ सेवेकरिता पाठविणे.

९) आरोग्य शिक्षण संवाद कौशल्य आणि समुपदेशन (H.E. Communication Skill & Counseling):

१. प्रजनन आणि बाल आरोग्य, कुटुंब कल्याण, पोषण आणि लसीकरण याबाबत आरोग्य सेविकेच्या सहकार्याने आरोग्य शिक्षण उपक्रम राबविणे.
२. समाजातील पुढाऱ्यांसोबत गटसभेचे आयोजन करणे आणि त्यांना आरोग्य कार्यक्रमाविषयीचे संदेश प्रसारीत करण्यामध्ये सहभागी करून घेणे.
३. आरोग्य सेविकेच्या मदतीने महिला नेत्यांकरिता प्रशिक्षण आयोजित करणे.
४. कुटुंब कल्याण कार्यक्रमांमध्ये महिला मंडळ, शिक्षण आणि समाजातील इतर महिला यांचा सहभाग मिळवून घेणे.
५. कुटुंब नियोजन साधनांचा स्विकार वैद्यकीय गर्भपात, प्रजनन मार्ग जंतुसंसर्ग, लैंगिक आजार आणि एड्स याविषयी आरोग्य सेवक (स्त्री/ पुरुष) यांच्या मदतीने समोपदेशन सत्राचे आयोजन करणे.

बहुउद्देशीय आरोग्य कर्मचारी (पुरुष) या पदाची कर्तव्ये व जबाबदाऱ्या

बहुउद्देशीय आरोग्य सेवक यांची जबाबदाऱ्या:

बहुउद्देशीय आरोग्य सेवक योजनेअंतर्गत प्रत्येक ५००० जनसंख्येकरिता, आदिवासी आणि डोंगरीभागात ३००० लोकसंख्येकरिता एक उपकेंद्र स्थापन करून तेथे एक आरोग्य सेवक व एक आरोग्य सेविका नियुक्त करण्यात आलेली आहे. आरोग्य सेवकाने त्याच्या कार्यक्षेत्रातील प्रत्येक घरी दर १५ दिवसात एकदा भेट देणे आवश्यक आहे.

आरोग्य सेवकांच्या जबाबदाऱ्या

हिवताप नियंत्रण कार्यक्रम:

१. दर पंधरवड्यात प्रत्येक घरी भेटी देवून तापाच्या रुग्णाची चौकशी करणे व तापाचा रुग्ण आढळल्यास रक्त नमुना घेवून हिवतापाचा गृहीत उपचार करणे.
२. हिवतापाचा जंतू आढळलेल्या रक्त नमुन्यांची नोंद करणे व आरोग्य सहाय्यकाला समूळ उपचारांसाठी कळविणे.
३. कार्यक्षेत्रात हिवताप फवारणी विषयक बाबींची देखरेख करणे.
४. कार्यक्षेत्रात कायमची व तात्पुरती डास उत्पत्ती स्थाने शोधून त्यात गप्पी मासे सोडणे.
५. हिवतापाचा अभिलेख काढणे व अहवाल ठेवणे.
६. लोकांना खालील गोष्टी बाबत आरोग्य शिक्षण देणे :-
तापाच्या रुग्णाचे तपासणीचे महत्व, घरात फवारणीचे महत्व, डास अळी नियंत्रणाचे महत्व, हिवतापाचा प्रसार होवू नये म्हणून विविध उपाय योजना.

साथरोग नियंत्रण:

१. गृहभेटी दरम्यान साथीच्या आजाराचे रुग्ण शोधून काढणे. उदा. अतिसार, हगवण, पुरळ असलेले तापाचे रुग्ण, मेंदूदाह, धनुर्वात, कावीळ, घटसर्प, पोलिओ इ. आणि अचानक साथीच्या आजाराचे अपेक्षेपेक्षा जास्त रुग्ण आढळल्यास आरोग्य सहाय्यक व वैद्यकीय अधिकारी यांना तातडीने कळविणे.
२. साथ नियंत्रण उपाययोजना राबविणे.
३. क्षार संजीवनी द्रावण तयार करून अतिसाराच्या रुग्णांना वयोगटाप्रमाणे देणे.

कुष्ठरोग:

१. गृहभेटीत कातडीवर चट्टा आढळल्यास किंवा कातडीच्या रंगामध्ये बदल व त्या ठिकाणी संवेदना नसल्यास अशा रुग्णांची नोंद करणे.
२. रुग्ण नियमित उपचार घेतो किंवा नाही याची खात्री करणे.
३. कुष्ठरोगामुळे व्यंगत्व येवू नये म्हणून आरोग्य शिक्षण देणे.
४. अनियमित व अर्धवट उपचार घेतलेल्या रुग्णांना नियमित व संपूर्ण औषधोपचारासाठी प्रवृत्त करणे व असे रुग्ण आरोग्य सहाय्यक (पु.) यांच्या निदर्शनास आणणे.
५. कुष्ठरोग व त्यांच्या कुटुंबातील सहवासित यांच्याशी सुसंवाद साधून कुष्ठरोगाबाबत असलेले गैरसमज दूर करणे.
६. बहुविध औषधोपचार योजनेची अंमलबजावणी करणे.
७. नवीन कुष्ठरोग शोध मोहिम राबविणे.
८. कुष्ठरुग्णांचा पाठपुरावा व सर्वेक्षण करणे.

क्षयरोग:

१. संशयित क्षयरोगी शोधून थुंकी नमुना घेणे व ते तपासणीसाठी प्रा.आ.केंद्र. किंवा क्षयरोग केंद्रात पाठविणे.
२. क्षयरुग्णांच्या नियमित उपचाराची खात्री करणे.
३. अनियमित व अर्धवट उपचार घेतलेल्या रुग्णांना नियमित व संपूर्ण औषधोपचारासाठी प्रवृत्त करणे व असे रुग्ण आरोग्य सहाय्यक (पु.) यांच्या निदर्शनास आणणे.
४. पंधरा दिवसापेक्षा जास्त दिवस खोकला व ताप असल्यास लोकांना थुंकी नमुना तपासून घेण्याविषयी आरोग्य शिक्षण देणे.

परिसर स्वच्छता:

१. सार्वजनिक पाण्याच्या साठ्यांची नियमित शुद्धीकरणाची खात्री करणे.
२. पाणी नमुना आणि विरंजक चूर्ण नमुना प्रयोगशाळेत तपासणीकरिता नियमित पाठविणे.
३. लोकांना खालील बाबींवर आरोग्य शिक्षण देणे -
४. घरातील स्वच्छता, बिनधुराची चूल व उपयोग, सुरक्षित संडासाचे फायदे व उपयोग, मलमुत्राची व सांडपाण्याची योग्य विल्हेवाट.
५. समाजाला खालील गोष्टी करून घेण्याबाबत मार्गदर्शन व मदत करणे - शोषखड्डा, परसबाग, खतखड्डा, सुरक्षित संडास.

जीवनविषयक आकडेवारी नोंद:

१. कार्यक्षेत्रात होणाऱ्या जन्ममृत्यूंची नोंद करणे व तसा अहवाल आरोग्य सहाय्यक यांना कळविणे.
२. कार्यक्षेत्रात होणाऱ्या रुग्णांची नोंद करणे आणि कायद्यानुसार कमी वय असणाऱ्या मुलामुलींचे लग्न ठरल्यास किंवा झाल्यास आरोग्य सहाय्यक (पु.) यांच्या निदर्शनास आणणे.
३. जन्म आणि मृत्युची नोंद वेळीच करण्याचे महत्त्व लोकांना सांगणे.

प्रथमोपचार व किरकोळ आजारांवर उपचार:

१. प्रथमोपचार साहित्य, क्षारसंजीवनीची पाकीटे व किरकोळ आजारांवरील औषधे योग्य त्या व्यक्तींना/रुग्णांना उपलब्ध करून देणे.
२. गंभीर आजार व गुंतागुंत झालेल्या, किरकोळ व साध्या आजारांच्या रुग्णांना वैद्यकीय अधिकारी प्रा. आ.केंद्र किंवा जवळच्या दवाखान्यात पाठविणे.
३. आरोग्य मार्गदर्शकाने पाठविलेल्या रुग्णांवर उपचार करणे व आवश्यक वाटल्यास रुग्ण पुढील उपचारासाठी पाठविणे.

अंधत्व नियंत्रण कार्यक्रम:

१. संशयित मोतीबिंदू रुग्णांची यादी तयार करणे, त्यांना तपासणीसाठी पाठविणे व पक्क मोतीबिंदू असणाऱ्या रुग्णांस मोतीबिंदू शस्त्रक्रिया करून घेण्यास प्रवृत्त करणे.
२. मोतीबिंदू शस्त्रक्रिया झालेल्या रुग्णांचा पाठपुरावा करणे.
३. डोळ्यांची योग्य निगा घेण्याबाबत आरोग्य शिक्षण देणे.

प्रजनन व बाल आरोग्य कार्यक्रम:

१. आरोग्य सेविकेसोबत समाजाच्या आरोग्य विषयक गरजांवर आधारित उपकेंद्राचा कृती आराखडा तयार करणे.

२. जोखमीचे गरोदरपणी वैद्यकीय उपचाराची आवश्यकता असलेल्या व प्रजननाविषयी समस्या असलेल्या स्त्रियांना आरोग्य सेविकेकडे पाठविणे.
३. गुंतागुंत आढळून आलेल्या नवजात अर्भकास व मातेस प्रथम स्तर संदर्भसेवा केंद्रात ताबडतोब पाठविण्यासाठी मदत व पाठपुरावा करणे.
४. मातांना व वयात येणाऱ्या मुलींना वैयक्तिक किंवा एकत्रित पणे खालील बाबींवर आरोग्य शिक्षण देणे:- कौटुंबिक आरोग्य, माता आणि मुलांचे आरोग्य, कुटुंब नियोजन, आहार, सांसर्गिक आजारावर नियंत्रण, लसीकरण, वैयक्तिक व परिसर स्वच्छता इ. जेणेकरून रोगांपासून बचाव करण्यासाठी आणि आरोग्य चांगले राखण्यासाठी लोक स्वतः पुढे येतील.
५. लैंगिक आजार व प्रजनन मार्गाचा जंतुसंसर्ग झालेल्या रुग्णांचा शोध घेणे आणि त्यांना आवश्यक त्या सेवा देणे.
६. प्रत्येक गावात आरोग्य सेवा सत्र आयोजित करून आरोग्य सेविकेसोबत आवश्यक त्या आरोग्य सेवा पुरविणे आणि लसीकरण कार्यक्रमात आरोग्य सहाय्यिकेला मदत करणे.
७. विविध सांसर्गिक आजाराविरुद्ध लसीकरणाचे महत्त्व आणि लसीकरण वेळापत्रकाबाबत लोकांना आरोग्य शिक्षण देणे.
८. लसीकरणांद्वारे टाळता येणाऱ्या आजारांचे रोगसर्वेक्षण करणे.
९. शालेय-पूर्व मुलांमध्ये आणि अर्भकांमध्ये कुपोषणाचे रुग्ण शोधून काढून अशा मुलांना आवश्यक तो उपचार देणे आणि नजीकच्या आंगणवाडी/ बालवाडी केंद्रात पुरक आहार घेण्याबाबत किंवा वैद्यकीय अधिकारी प्रा.आ.केंद्र यांचेकडे जाण्याचा सल्ला देणे.
१०. शालेय-पूर्व बालके, गरोदर माता, स्तनदा माता आणि कुटुंब नियोजनाची पध्दत स्वीकारणाऱ्यांना आरोग्य सेविकेशी समन्वय साधून लोहयुक्त गोळ्यांचे वाटप करणे.
११. तीन वर्षाखाली बालकांना जीवनसत्व अ च्या मात्रा पाजणे.
१२. स्थानिक पातळीवर उपलब्ध असणाऱ्या अन्न पदार्थांपासून समतोल आहार तयार करण्याबाबत लोकांना माहिती व आरोग्य शिक्षण देणे.
१३. कुटुंब पाहणी करणे व योग्य जोडप्यांची यादी अद्यावत ठेवणे.
१४. व्यक्तिगत किंवा एकत्रितपणे योग्य जोडप्यांना कुटुंब नियोजनाचा संदेश देणे आणि कुटुंब नियोजनासाठी प्रवृत्त करणे.
१५. पात्र योग्य जोडप्यांना पाळणा लांबवण्यासाठी साधने पुरविणे.
१६. कुटुंब कल्याण शस्त्रक्रिया करून घेण्यासाठी आणि तांबी बसवून घेण्यासाठी आलेल्या लाभार्थींना सुविधा पुरविणे व मदत करणे.
१७. कुटुंब कल्याण शस्त्रक्रिया करून घेतलेल्या पुरुष लाभार्थ्यांचा पाठपुरावा करणे आणि त्यांच्या समस्या सोडविणे.
१८. समाधानी पुरुष लाभार्थी, स्थानिक नेते, आरोग्य मार्गदर्शक, शिक्षक, स्वयंसेवक आणि इतरांशी चांगले स्नेहसंबंध प्रस्थापित करून कुटुंब कल्याण कार्यक्रमाला चालना देण्याबाबत प्रवृत्त करणे.
१९. निरोध आणि तोंडाने घ्यावयाच्या गर्भनिरोधक गोळ्यांच्या वाटपासाठी डेपो होल्डरांची निवड करणे, त्यांना प्रशिक्षण देण्यासाठी आरोग्य सहाय्यिकेला मदत करणे आणि डेपो होल्डरांना वरील साधनांचा नियमित पुरवठा करणे.
२०. जनसभेमध्ये सहभागी होऊन मुलांचे आरोग्य, कुटुंब कल्याण इ. वर माहिती व आरोग्य शिक्षण देणे.
२१. लैंगिक समानतेवर समाजाला प्रवृत्त करणे व प्रजनन व बाल आरोग्य कार्यक्रमात पुरुषांचा सहभाग साधण्याबाबत प्रवृत्त करणे.
२२. वैद्यकीय गर्भपात करून घेणाऱ्या स्त्रियांना जवळच्या सरकारमान्य केंद्रात पाठविण्यासाठी मदत करणे व आरोग्य सहाय्यिकेला कळविणे.

२३. वैद्यकीय गर्भपात करुन घेण्यासाठी उपलब्ध असलेल्या सुविधांची माहिती स्त्रियांना करुन देणे आणि त्याबाबत आरोग्य शिक्षण देणे.
२४. असुरक्षित गर्भपात केल्यामुळे होणाऱ्या गंभीर परिणामाबाबत लोकांना आरोग्य शिक्षण देणे आणि त्यांना असुरक्षित आणि बेकायदेशीर गर्भपात करुन घेण्यापासून परावृत्त करणे.

आयोडीन न्यूनता विकार नियंत्रण कार्यक्रम:

१. आयोडीनच्या कमतेरतेमुळे होणाऱ्या आजारांचे रुग्ण शोधून काढणे.
२. वापरण्यात येणाऱ्या मिठात आयोडीनचे प्रमाण तपासणी.
३. वापरात येणाऱ्या मिठाचे नमूने प्रयोगशाळेत तपासणीकरीता पाठविणे.
४. आयोडीनच्या कमतेरतेमुळे होणारे विकार/ आजार आणि आयोडीनयुक्त मिठाचा वापर व आहाराविषयी लोकांना आरोग्य शिक्षण देणे.

अहवाल व नोंदवही ठेवणे:

१. कार्यक्षेत्रात असणाऱ्या सर्व कुटुंबाचे सर्वेक्षण करुन प्रत्येक कुटुंबाची सर्वसाधारण माहिती अद्यावत ठेवणे.
२. गाव-निहाय कुटुंबांची नोंदवही तयार करणे, अद्यावत करणे. व त्यांचा उपयोग विविध कार्यक्रमांतर्गत येणाऱ्या लाभार्थींसाठी करणे.
३. आरोग्य सेविकेच्या मदतीने योग्य जोडप्यांची नोंदवही, कुटुंब पहाणी नोंदवहीवरुन तयार करुन अद्यावत ठेवणे.
४. केलेल्या कामांचा पुरावा म्हणून नोंदवही व अहवाल ठेवणे.
५. वेळोवेळी नियमितपणे पाठविण्यात येणारा अहवाल तयार करुन तो वेळेत आरोग्य सहाय्यकांना पाठविणे.
६. कार्यक्षेत्राचा नकाशा व आलेख तयार करुन त्याचा उपयोग कामाचे नियोजन करण्यासाठी करणे.

संघकार्य:

१. प्राथमिक आरोग्य केंद्रात होणाऱ्या कर्मचाऱ्यांच्या प्रत्येक सभेत हजर राहणे व सहभागी होणे.
२. आपल्या कार्याचा आरोग्य सेविकेशी आणि इतर आरोग्य कर्मचाऱ्यांशी समन्वय साधणे
३. प्रत्येक आठवड्याला एकदा तरी आरोग्य सहाय्यक (पु.) यांना भेट देणे आणि त्यांचा सल्ला व मार्गदर्शन आवश्यकतेप्रमाणे घेणे.
४. कार्यक्षेत्रात घेण्यात येणाऱ्या विविध शिबीरात आणि मोहिमेत सहभागी होणे.
५. स्थानिक स्वयंसेवी संस्था शोधून त्यांना समाजाचे आरोग्य चांगले राखण्यास प्रवृत्त करणे.

बहुउद्देशीय आरोग्य कर्मचारी (महिला) या पदाची कर्तव्ये व जबाबदाऱ्या

आरोग्य सेविकेच्या जबाबदाऱ्या

अ) प्रजनन व बाल आरोग्य कार्यक्रम :

१. समाजाच्या गरजांवर आधारित उपकेंद्र कृति आराखडा तयार करणे.
२. गरोदर मातांची नोंदणी करणे व त्यांना प्रसुती पूर्व, दरम्यान व प्रसुतीपश्चात सेवा देणे.
३. रक्तक्षयाकरिता शारीरिक तपासणी, लघवीतील साखर व प्रथिनांची तपासणी, रक्तातील लोहाचे प्रमाण, रक्तदाब घेणे, वजन घेणे आणि पोषण व विश्रांती बाबतचा सल्ला देणे.
४. सर्व गरोदर स्त्रियांची लैंगिक आजाराची तपासणी होईल ह्याची खात्री करणे.
५. जोखमीच्या गुंतागुत असलेल्या गरोदर मातांना वैद्यकीय उपचाराची आवश्यकता असलेल्या आणि प्रजनन विषयक समस्या असलेल्या स्त्रियांना संदर्भ सेवेकरिता पाठविणे.
६. कार्यक्षेत्रात होणाऱ्या एकूण प्रसुतींपैकी ५० टक्के प्रसुती स्वतःकरणे.
७. कार्यक्षेत्रातील सर्व प्रसुती केवळ प्रशिक्षित व्यक्तींकडून होतील याची खात्री करणे व प्रशिक्षित दाईकडून होणाऱ्या बाळंतपणावर देखरेख करणे व त्यांना मदत करणे.
८. अडचणीचे बाळंतपण व जोखमीचे नवजात अर्भकांना प्राथमिक आरोग्य केंद्रात/प्रथमस्तर संदर्भ केंद्रात ताबडतोब पाठविण्यासाठी मदत व पाठपुरावा करणे.
९. कार्यक्षेत्रात बाळंत झालेल्या प्रत्येक स्त्रीस कमीत कमी तीन भेटी देणे. आवश्यक त्या सेवा व सल्ला देणे. उदा. स्तनपान, अर्भकाची काळजी आणि मातेची काळजी.
१०. बालकांची वाढ व विकासाकडे लक्ष देणे आणि आवश्यकता असल्यास संदर्भ सेवा उपलब्ध करणे.
११. मातांना व वयात आलेल्या मुलींना व्यक्तिगत किंवा एकत्रितपणे खालील बाबींवर आरोग्य शिक्षण देणे. कौटुंबिक आरोग्य, माता आणि मुलांचे आरोग्य, कुटुंब नियोजन, आहार, सांसारिक आजारांवर नियंत्रण, लसीकरण व वैयक्तिक व परिसर स्वच्छता इ. जेणेकरून रोगापासून बचाव करण्यासाठी आणि चांगले आरोग्य राखण्यासाठी लोक स्वतः पुढे येतील.
१२. लैंगिक आजार व प्रजनन मार्गाचा जंतूसंसर्ग झालेल्या रुग्णांचा शोध घेणे आणि त्यांना आवश्यक त्या सेवा देणे.
१३. उपकेंद्र स्तरावर आरोग्य सेवा सत्रात आरोग्य सहाय्यिका व वैद्यकीय अधिकारी यांना मदत करणे.
१४. प्रत्येक गावात आरोग्य सेवा सत्राचे आयोजन करून लाभार्थ्यांना आवश्यक सर्व आरोग्य सेवा पुरविणे.
१५. सर्व गरोदर स्त्रियांना धनुर्वात प्रतिबंधक लसीच्या आवश्यक मात्रा देणे.
१६. कार्यक्षेत्रातील सर्व अर्भक व मुलांचे लसीकरण वेळापत्रकाप्रमाणे योग्य वयात करणे.
१७. लसीकरणासाठी आवश्यक असलेल्या सुया व सिरिंजेस आणि इतर साहित्याचे व्यवस्थितपणे निर्जंतुकीकरण झाले किंवा नाही याची खात्री करणे व प्रत्येक लाभार्थ्यांना वेगळी सिरिंज व सुई वापरणे.
१८. लसीची तपासणी करणे व दिलेल्या सूचनांचे पालन करणे. लसीकरण वेळापत्रक, महत्वाबाबत स्त्रियांना आरोग्य शिक्षण देणे.
१९. शालेय - पूर्व मुलांमध्ये आणि अर्भकांमध्ये कुपोषणाचे रुग्ण शोधून काढून अशा मुलांना आवश्यक तो उपचार देणे आणि नजीकच्या अंगणवाडी/बालवाडी केंद्रात पुरक आहार घेण्याबाबत किंवा आवश्यकता असल्यास वैद्यकीय अधिकारी प्रा.आ. केंद्र यांचेकडे संदर्भसेवेसाठी रवानगी करणे.
२०. शालेय - पूर्व बालके, गरोदर माता, स्तनदा माता आणि कुटुंब नियोजनाची पध्दत स्वीकारणाऱ्यांना आरोग्य सेविकांशी समन्वय साधून लोहयुक्त गोळ्यांचे वाटप करणे.
२१. तीन वर्षाखालील बालकांना जीवनसत्व अ च्या मात्रा पाजणे.
२२. स्थानिक पातळीवर उपलब्ध असणाऱ्या अन्न पदार्थांपासून समतोल आहार तयार करण्याबाबत लोकांना माहिती व आरोग्य शिक्षण देणे.

२३. योग्य जोडपी आणि लहान मुलांच्या नोंदवहयांच्या आधारे कुटुंब नियोजन स्वीकार करण्याकरीता जोडप्यांना व्यक्तिगत किंवा एकत्रितपणे प्रवृत्त करणे, कुटुंब कल्याण संबंधित सर्व नोंदवहया अद्यावत ठेवणे, योग्य जोडप्यांना कुटुंब नियोजनाचा संदेश देणे आणि कुटुंब नियोजनासाठी प्रवृत्त करणे.
२४. पात्र योग्य जोडप्यांना पाळणा लांबवण्यासाठी साधने पुरविणे.
२५. कुटुंब कल्याण शस्त्रक्रिया करून घेण्यासाठी आणि तांबी बसवून घेण्यासाठी आलेल्या लाभार्थींना सुविधा पुरविणे व मदत करणे.
२६. कुटुंब कल्याण शस्त्रक्रिया करून घेतलेल्या स्त्री लाभार्थ्यांचा पाठपुरावा करणे आणि त्यांच्या समस्या सोडविणे.
२७. समाधानी स्त्री लाभार्थी, स्थानिक नेते, आरोग्य मार्गदर्शक, शिक्षक, स्वयंसेवक आणि इतरांशी चांगले स्नेहसंबंध प्रस्थापित करून कुटुंब कल्याण कार्यक्रमाला चालना देण्याबाबत प्रवृत्त करणे.
२८. निरोध आणि तोंडाने घ्यावयाच्या गर्भनिरोधक गोळ्यांच्या वाटपासाठी डेपो होल्डर्सची निवड करणे, त्यांना प्रशिक्षण देण्यासाठी आरोग्य सहाय्यकेला मदत करणे आणि डेपो होल्डर्सना वरील साधनांचा नियमित पुरवठा करणे.
२९. महिला मंडळाच्या सभेत सहभागी होऊन जमलेल्या समुदायाला कुटुंब कल्याण, मुलांचे आरोग्य इ. बाबत माहिती व आरोग्य शिक्षण देणे.
३०. लैंगिक समानतेबाबत समाजाला प्रवृत्त करणे व प्रजनन व बाल आरोग्य कार्यक्रमात पुरुषांचा सहभाग साधण्याबाबत प्रवृत्त करणे.
३१. वैद्यकीय गर्भपात करून घेणाऱ्या स्त्रियांना जवळच्या सरकारमान्य केंद्रात पाठविण्यासाठी मदत करणे व आरोग्य सहाय्यकेला कळविणे.
३२. वैद्यकीय गर्भपात करून घेण्यासाठी उपलब्ध असलेल्या सुविधांची माहिती स्त्रियांना करून देणे आणि त्याबाबत आरोग्य शिक्षण व संदर्भसेवा पुरविणे.
३३. असुरक्षित गर्भपात केल्यामुळे होणाऱ्या गंभीर परिणामांबाबत लोकांना आरोग्य शिक्षण देणे आणि त्यांना असुरक्षित आणि बेकायदेशीर गर्भपात करून घेण्यापासून परावृत्त करणे.

ब) दाई प्रशिक्षण :

१. कार्यक्षेत्रातील सर्व दाईची यादी तयार करून त्यांना कुटुंब कल्याण व सुरक्षित प्रसूतिबाबत मार्गदर्शन करणे.
२. दाई प्रशिक्षणात आरोग्य सहाय्यकेला मदत करणे.

क) साथरोग नियंत्रण :

१. गृहभेटी दरम्यान साथीच्या आजारांचे रुग्ण शोधून काढणे. उदा. अतिसार, हगवण, पुरळ असलेले तापाचे रुग्ण, मेंदूदाह, धनुर्वात, कावीळ, घटसर्प, पोलिओ इ. आणि अचानक साथीचे आजाराची अपेक्षेपेक्षा जास्त रुग्ण आढळल्यास आरोग्य सहाय्यक व वैद्यकीय अधिकारी यांना तातडीने कळविणे.
२. अतिसाराच्या सर्व रुग्णांस क्षारसंजीवनीचे द्रावण वयोगटानुसार देणे.
३. संशयीत मोतीबिंदू आणि अंधत्वाच्या सर्व रुग्णाच्या नोंदी घेवून त्यांना पुढील उपचारांसाठी पाठविणे.
४. गृहभेटीच्या वेळी आढळून आलेल्या तापाच्या रुग्णांचा रक्त नमुना घेवून त्यांना गृहितोपचार देणे आणि पुढील कार्यवाही करण्यास आरोग्य सेवकाला कळविणे.
५. गृहभेटीच्या वेळी कातडीवर चट्टा आढळल्यास किंवा कातडीच्या रंगामध्ये बदल व त्या ठिकाणी संवेदना नसलेले रुग्ण शोधणे व ते आरोग्य सहाय्यकाच्या निर्देशनास आणणे.
६. क्षयरोग्यांची आणि कुष्ठरोगांची यादी करण्यास आरोग्य सेवकाला मदत करणे. वरील रुग्ण नियमित औषधोपचार घेतात काय यावर लक्ष ठेवणे, अनियमित व अर्धवट उपचार घेतलेल्या रुग्णांना

नियमित व संपूर्ण औषधोपचारासाठी प्रवृत्त करणे आणि असे रुग्ण आरोग्य सहाय्यक यांच्या निर्दर्शनास आणणे.

ड) जीवनविषयक आकडेवारीची नोंद :

१. कार्यक्षेत्रात होणाऱ्या जन्ममृत्युंची नोंद करणे व तसा अहवाल आरोग्य सहाय्यक यांना कळविणे.
२. कार्यक्षेत्रात होणाऱ्या रुग्णांची नोंद करणे आणि कायदानुसार कमी वय असणाऱ्या मुला मुलींचे लग्न ठरल्यास किंवा झाल्यास आरोग्य सहाय्यक (पुरुष) यांच्या निर्दर्शनास आणणे.
३. जन्म आणि मृत्युची नोंद वेळीच करण्याचे महत्व लोकांना सांगणे.

ई) प्रथमोपचार व किरकोळ आजारांवर उपचार :

१. प्रथमोपचाराचे साहित्य, क्षारसंजीवनीची पाकिटे व किरकोळ आजारांवरील औषधे योग्य त्या व्यक्तींना/ रुग्णांना उपलब्ध करून देणे.
२. गंभीर आजार व गुंतागुंत झालेल्या, किरकोळ व साध्या आजारांच्या रुग्णांना वैद्यकीय अधिकारी प्रा. आ. केंद्र किंवा जवळच्या दवाखान्यात पाठविणे.
३. आरोग्य मार्गदर्शकाने पाठविलेल्या रुग्णांवर उपचार करणे व आवश्यक वाटल्यास रुग्ण पुढील उपचारासाठी पाठविणे.

फ) संघकार्य :

१. प्राथमिक आरोग्य केंद्रात होणाऱ्या कर्मचाऱ्यांच्या प्रत्येक सभेत हजर राहणे व सहभागी होणे.
२. आपल्या कार्याचे आरोग्य सेविकेची आणि इतर आरोग्य कर्मचाऱ्यांशी समन्वय साधणे.
३. प्रत्येक आठवड्याला एकदा तरी आरोग्य सहाय्यक (स्त्री) यांना भेट देणे आणि त्यांचा सल्ला व मार्गदर्शन आवश्यकतेप्रमाणे घेणे.
४. कार्यक्षेत्रात घेण्यात येणाऱ्या विविध शिबीरात आणि मोहिमेत सहभागी होणे.
५. स्थानिक स्वयंसेवी संस्था शोधून त्यांना समाजाचे आरोग्य चांगले राखण्यास प्रवृत्त करणे.

म) अहवाल व नोंदवही ठेवणे :

१. सहा आठवड्यांनंतरच्या सर्व गरोदर माता, १२ महिने वयोगटातील सर्व बालके, शालेय-पूर्व बालके आणि १५ ते ४५ वयोगटातील सर्व स्त्रियांची नोंद करणे व नोंदवही तयार करणे.
२. प्रसुतीपूर्व, प्रसुतीसंबंधित आणि मुलांना देण्यात येणाऱ्या सेवांचे अहवाल तयार करणे.
३. योग्य जोडप्यांची यादी आणि लहान मुलांची यादी तयार करणे व अद्यावत ठेवण्यासाठी आरोग्य सेवकाला मदत करणे.
४. कुटुंब कल्याण साहित्य वाटप, तांबी बसविलेल्या स्त्रिया, कुटुंब कल्याण शस्त्रक्रिया करून घेणाऱ्या लाभार्थ्यांची यादी ठेवणे.
५. उपकेंद्र स्तरावर आरोग्य सेवा सत्रात वाटप केलेल्या स्त्रियांची नोंद ठेवणे.
६. आलेले साहित्य व वाटप केलेले साहित्याची नोंदवही ठेवणे.
७. मासिक प्रगती अहवाल तयार करून तो वेळीच आरोग्य सहाय्यकेकडे पाठविणे.

ह) इतर :

१. अंगणवाडीला भेट देऊन कुपोषित मुलांची यादी करून मातेला आहाराबाबत आरोग्य शिक्षण देणे.
२. शालेय आरोग्य तपासणीत वै.अ. व आरोग्य सहाय्यक यांना मदत करणे, नवीन कुष्ठरोगी शोध मोहिमेत सहभाग घेणे.

(संदर्भ: महाराष्ट्र शासन सार्वजनिक आरोग्य विभाग शासन निर्णय क्रमांक आरईएस १०.१००१/प्र.क्र. १२२/सेवा १ मंत्रालय, मुंबई ४०००३२. दिनांक : ११ डिसेंबर २००१)

सेवेच्या सर्वसाधारण सेवाशर्ती : नियम १९८१

महत्वाच्या व्याख्या :

- १) **शिकाऊ उमेदवार (नियम ९ (३) :-** शासकिय सेवेतील नोकरीच्या दृष्टीने एखाद्या व्यवसायामधील अथवा धंद्यातीलप्रशिक्षणासाठी पाठवलेली व्यक्ती. अशा प्रशिक्षणाच्या कालावधीत अशा व्यक्तिस शासनाकडून मासिक दराने रक्कम देण्यात येते, परंतु कायम रिक्त पदावर त्या व्यक्तीची नियुक्ती केली जात नाही.
- २) **दिवस : (नियम ९ (१३) :-** एका मध्यरात्रीपासून सुरु होणारा व दुसऱ्या मध्यरात्री संपणारा कालावधी
- ३) **राजपत्रित शासकीय कर्मचारी : (९ (१४) :-** अखिल भारतीय सेवेतील किंवा राज्य सेवेतील व्यक्ती किंवा संविदेतील किंवा करारातील, अटीनुसार जिची नियुक्ती केली आहे आणि जिची नियुक्ती शासनाने राजपत्रित केलेली आहे, अशी व्यक्ती.
- ४) **स्थायी पद (९/४०) :-** निश्चित वेतन दर असलेले व कालमर्यादा न घालता मंजूर केले पद.
- ५) **अस्थायी पद (९/५३) :-** निश्चित वेतन दर असलेले परंतु मर्यादित कालावधीसाठी मंजूर केलेले पद.
- ६) **सावधि नियुक्ती पद (९/५४) :-** एखाद्या शासकिय कर्मचाऱ्यांची पुर्ननियुक्ती न होता त्याला मर्यादीत कालावधीपेक्षा अधिक काळ जे पद धारण करता येणार नाही असे स्थायी पद.

वैद्यकिय प्रमाणपत्र (नियम क्र.११ ते १९) :-

सामान्यतः शासकिय सेवेत नियुक्त करावयाच्या कोणत्याही व्यक्तीची नियुक्तीपूर्वी वैद्यकिय तपासणी झाली पाहिजे तथापी एखाद्या व्यक्तीला तात्काळ रुजू होणे आवश्यक असेल तर वैद्यकिय अधिकाऱ्याने पात्र ठरविण्याच्या शर्तीच्या अधिन राहून वैद्यकिय प्रमाणपत्र मिळाल्याशिवाय त्याची नियुक्ती करता येईल अशा व्यक्तिस सेवेत रुजू झाल्याच्या तारखेपासून दोन महिन्यांच्या आत वैद्यकिय प्रमाणपत्र दाखल करण्यास सांगण्यात यावे. फेरनेमणुक वैद्यकिय प्रमाणपत्राच्या तारखेपासून सहा महिन्यांच्या आत झाली असल्यास त्या शासकिय कर्मचाऱ्याने वैद्यकिय प्रमाणपत्र नव्याने दाखल करण्याची आवश्यकता नाही.

अधिक जबाबदारीच्या पदावर एखाद्या कर्मचाऱ्याची नेमणुक / पदोन्नती झाल्यास व त्यासाठी वेगळी शारीरिक पात्रता आवश्यक असल्यास पुन्हा वेगळे वैद्यकिय प्रमाणपत्र सादर करावे लागेल.

कर्मचाऱ्यास वैद्यकिय तपासणीत पात्र ठरविण्यात आले असल्या बद्दलचे प्रमाणपत्र शासकिय कर्मचाऱ्यांच्या पहिल्या वेतन देयकासोबत किंवा हे शक्य नसेल तर नंतरच्या वेतन देयकासोबत जोडण्यात यावे.

एखाद्या कर्मचारी वैद्यकिय दृष्ट्या अपात्र आहे असे आढळून आल्यास तसे त्यास तात्काळ कळविण्यात यावे. असे कळविणारे पत्र त्यास ज्या तारखेस पाठविले त्या तारखेपासून एक महिन्याच्या आत संबंधित कार्यालय प्रमुखाच्या परवानगीने संचालक आरोग्य सेवा यांच्याकडे त्यास अपिल करता येईल. सदाचे अपिल स्विकारण्यात आल्यास त्याची सेवा सुरु ठेवण्यात यावी. दुसऱ्या वैद्यकिय तपासणीची त्याची विनंती अमान्य झाल्यास किंवा दुसऱ्या तपासणीचे निष्कर्ष मिळण्याच्या विलंबास तो कर्मचारी जबाबदार आहे असे आढळून आल्यास त्याची सेवा ताबडतोब समाप्त करण्यात यावी.

वैद्यकिय अधिकाऱ्याचे निष्कर्ष कळविण्यात आल्यापासून एक महिन्याच्या आत शासकिय कर्मचाऱ्याने अपिल दाखल केले नाही तर एक महिन्याचा कालावधी समाप्त झाल्यानंतर त्याची सेवा ताबडतोब समाप्त करण्यात यावी.

शासकिय कर्मचाऱ्याची वैद्यकिय दृष्ट्या तपासणी झाली आहे आणि तो पात्र ठरला आहे असे प्रमाणपत्र सादर केल्यानंतर त्या विषयीची नोंद तात्काळ त्याच्या सेवापुस्तकात केली पाहिजे आणि त्याच्या सेवाविषयीच्या इतर कागद पत्रांबरोबर वैद्यकिय पात्रता प्रमाणपत्र सुरक्षित ठेवले पाहिजे.

शासकिय कर्मचाऱ्यांने वैद्यकिय प्रमाणपत्र केव्हा सादर करावे...

नियम ११ (१) व (२) - शासकिय सेवेत नियुक्ती होण्यापूर्वीच नियुक्ती करण्यात यावयाच्या व्यक्तीची वैद्यकिय तपासणी होणे आवश्यक आहे, मात्र कामावर ताबडतोब रुजू होणे आवश्यक आहे, मात्र कामावर ताबडतोब रुजू होणे आवश्यक असल्यास वैद्यकिय प्रमाणपत्र नंतर सादर केले तरी चालू शकते.

नेमणुक सहा महिन्यापेक्षा जास्त कालावधीसाठी चालू राहणार असेल तर कर्मचाऱ्याने कार्यभार स्विकारल्यापासून दोन महिन्यांचे आत वैद्यकिय प्रमाणपत्र सादर केले पाहिजे.

नियम १५ (३) - एखाद्या कर्मचाऱ्याची वैद्यकिय तपासणी झाल्यानंतर त्यास नोकरीतून कमी करण्यात आले व वैद्यकिय प्रमाणपत्र दिल्याच्या तारखेपासून ६ महिन्यांचे आत पुन्हा कामावर घेण्यात आल्यास त्यास पुन्हा वैद्यकिय प्रमाणपत्र सादर करण्याची आवश्यकता नाही.

नियम १५ (४) - अधिक जबाबदारीच्या पदावर कर्मचाऱ्याची नेमणूक / पदोन्नती झाल्यास व त्या पदासाठी काही वेगळी शारीरिक पात्रता विहित करण्यात आली असल्यास, पुन्हा वैद्यकिय प्रमाणपत्र सादर करावे लागेल.

नियम १८ - सवोनिवृत्तीनंतर ६ महिन्यांचे आत कर्मचाऱ्यास पुन्हा नियुक्ती देण्यात येत असेल तर पुन्हा वैद्यकिय प्रमाणपत्र देण्याची आवश्यकता नाही. तथापि ६ महिन्यांनंतर नियुक्ती देण्यात येत असेल तर नियुक्ती अधिकाऱ्याने या संदर्भात योग्य तो निर्णय घ्यावा.

वैद्यकिय प्रमाणपत्राबाबत अपिल -

नियम क्र. ११(२) - टिप ४ व ५- एखादा कर्मचारी वैद्यकिय तपासणीत अपात्र ठरल्यास त्यास ताबडतोब कळविण्यात आले पाहिजे व असे कळविण्यात आल्यापासून १ महिन्यांचे आत त्याने या संदर्भात अपिल केले पाहिजे, मात्र या मुदतीत त्याने अपिल न केल्यास त्यास सेवामुक्त केले पाहिजे.

योग्य त्या मुदतीत अपिल केल्यास व ते स्विकारण्यात आल्यास कर्मचाऱ्यास पुन्हा वैद्यकिय तपासणीस पाठविण्यात येईल व अशी तपासणी होईस्तोवर त्याची सेवा चालू ठेवली जाईल मात्र या दुसऱ्या तपासणीस कर्मचारी उशीर लावतो आहे असे आढळून आल्यास वा त्याचे अपिल नाकारण्यात आल्यास त्यास ताबडतोब सेवामुक्त करण्यात येईल

वैद्यकिय प्रमाणपत्राबाबत कार्यालयाने करावयाची कार्यवाही - (नियम १५(२) व १६)

कर्मचारी वैद्यकिय तपासणीत पात्र ठरल्यानंतर त्याच्या पहिल्या वेतन देधकात तसे प्रमाणित करणे/ नोंदविणे आवश्यक आहे, काही कारणाने ते शक्य न झाल्यास दुसऱ्या महिन्याच्या वेतन देयकात तसे नोंदविण्यात यावे त्याचप्रमाणे आवश्यक ते वैद्यकिय प्रमाणपत्र प्राप्त झाल्याबद्दल लेखा परीक्षा कार्यालयास कळविले पाहिजे.

कर्मचाऱ्यांची वैद्यकिय तपासणी झाली असून त्यात तो पात्र ठरल्याबद्दलची नोंद, त्याच्या सेवापुस्तकात घेण्यात आली पाहिजे व वैद्यकिय प्रमाणपत्र, कर्मचाऱ्यांच्या इतर सेवा अभिलेखासोबत सुरक्षित ठेवण्यात आले पाहिजे.

धारणाधिकार (लिन)

एखाद्या कर्मचाऱ्याची एखाद्या कायम पदावर जेव्हा कायम स्वरूपात नेमणूक केली जाते तेव्हा त्या पदावर राहण्याचा त्याचा अधिकार म्हणजे धारणाधिकार होय (नियम क्र.९/३०) असा धारणाधिकार एखाद्या कर्मचाऱ्यास नेमणूक झाल्यापासून लगेच प्राप्त होतो. स्थायी पदावर कर्मचाऱ्याची कायमस्वरूपी नेमणूक झाल्यास त्याचा पूर्वीच्या पदावरील हक्क समाप्त होतो. (लिपिक म्हणून कर्मचारी कायम करण्यात आला त्यास वरीष्ठ लिपिक म्हणून पदोन्नती मिळाली त्या पदावर त्यांना कायम करण्यात आले तर त्यांचा लिपिक पदावरील धारणाधिकार संपुष्टात येईल.)

धारणाधिकार केव्हा अबाधित राहतो ...(नियम क्र.२२) -

- १) ज्या पदावर कर्मचाऱ्याची नेमणूक झाली आहे त्या पदाची कर्तव्ये पार पाडत असतांना
- २) कर्मचारी स्वीयेतर सेवेत असतांना
- ३) एखादे अस्थायी पद धारण करत असतांना
- ४) ज्या पदाचे वेतन आकस्मिक खर्चातून अथवा बांधकामाच्या खर्चातून दिले जात असेल असे पद धारण करत असतांना
- ५) पदग्रहण अवधिमध्ये
- ६) बदली जर खालच्या पदावर कायमपणे झाली असेल धारणाधिकार खालच्या पदावर जाईल.
- ७) कर्मचारी रजेवर असतांना
- ८) कोणत्याही कारणाने स्थायी पद अस्थगित ठेवण्यात आले असेल तर अस्थगित कालावधीत धारणाधिकार अबाधित राहिल.

धारणाधिकार केव्हा निलंबित होतो ...(नियम क्र.२३)

१. एखाद्या कर्मचाऱ्याची नियुक्ती पदावर स्थायी स्वरूपात नेमणूक झाल्यास त्याचा मुळ पदावरील धारणाधिकार निलंबित होतो.
२. छुसऱ्या कर्मचाऱ्याचा धारणाधिकार असलेल्या पदावर कर्मचाऱ्याची कायम स्वरूपी नियुक्ती झाल्यास त्याचा मुळ पदावरील धारणाधिकार निलंबित होतो.
३. कर्मचारी स्वीयेततर सेवेत अथवा प्रतिनियुक्तीवर गेल्यास अथवा दुसऱ्या संवर्गातील पदावर कायमस्वरूपी बदली झाल्यास व त्यापैकी कोणत्याही कारणाने ज्या पदावर त्याचा धारणाधिकार आहे त्या पदावर तो ३ वर्षांपेक्षा कमी नाही एखाद्या कालावधीसाठी अनुपस्थित असल्यास, मुळपदावरील त्याचा धारणाधिकार निलंबित होतो.

धारणाधिकार केव्हा निलंबित करता येत नाही...(नियम २३ (२) - टिप -३)

- १) संवर्गाबाहेरील पदावर कर्मचाऱ्याची बदली झाली असेल व बदली झाल्यापासून ३ वर्षांच्या आंत तो नियत वयोमानाने निवृत्त होत असल्यास मुळ पदावरील त्याचा धारणाधिकार निलंबित होत नाही.
- २) सावधिनियुक्त पदावरील कर्मचाऱ्यांचा, त्याच्या मुळ पदावरील धारणाधिकार निलंबित करता येत नाही.

भूतलक्षी प्रभावाने धारणाधिकार निलंबित होतो काय...

नियम २४- कर्मचाऱ्याची प्रतिनियुक्तीने / स्वीयेतर सेवेत अथवा दुसऱ्या संवर्गातील स्थायी / अस्थायी पदावर स्थानापन्न नात्याने बदली होते, तेव्हा त्या तारखेपासून अथवा त्या नंतरच्या तारखेपासून भूलक्षी प्रभावाने कर्मचाऱ्याचा मुळ पदावरील धारणाधिकार निलंबित होतो.

वेतन व भत्ते कोणत्या तारखेपासून देय होतात ...

नियम क्र.२८- सर्वसाधारणपणे एखाद्या पदाचा कार्यभार मध्यान्हपूर्व स्विकारला असेल तर त्या दिवसापासून त्या पदाचे वेतन देय ठरते, तर कार्यभार मध्यान्होत्तर स्विकारला असेल तर त्यानंतरच्या दिवसापासून

वेतन देय ठरते.त्याचप्रमाणे कार्यभार मध्यान्हपूर्व सोडला असेल तर त्या दिवसापासूनच तर मध्यान्होत्तर सोडला असेल तर दुसऱ्या दिवसापासून वेतन मिळणे बंद होईल.

कार्यभाराचे हस्तांतरण कोठे करण्यात येते ...

नियम क्र.३१- सर्वसाधारणपणे कार्यमुक्त व कार्यमोचक दोन्हीकर्मचाऱ्यांच्या उपस्थितीत व मुख्यालयीन कार्यभार हस्तांतरण झाले पाहिजे.

विशेष कारणास्तव कार्यभार अन्य ठिकाणी सोपविण्यास सक्षम अधिकारी परवानगी देवू शकेल, मात्र त्यासाठीची कारणे आदेशांत स्पष्ट केलेली असावीत.

अपवादात्मक परिस्थितीत कार्यमुक्त होणाऱ्या कर्मचाऱ्याच्या अनुपस्थितीत, कार्यभार मुख्यालयाच्या ठिकाणी वा अन्य ठिकाणी पत्राव्दारे वा अन्य प्रकारे कार्यभार सोपविण्यास सक्षम प्राधिकारी परवानगी देवू शकेल.

पदोन्नतीची तारीख निश्चित करणे -(नियम क्र.३२) -

समान जबाबदारीच्या पदावर कर्मचाऱ्याची पदोन्नती झाली असेल तर पदोन्नतीचे पद ज्या तारखेला रिक्त होईल त्या तारखेला पदोन्नती झाली असे समजण्यात येईल तर अधिक जबाबदारीच्या पदावर पदोन्नती होत असेल तर, जेव्हा ते पद प्रत्यक्षात धारण केले जाईल तेव्हापासून पदोन्नती झाली असे समजण्यात येईल.

शासकिय कर्मचाऱ्यांचा दैनंदिन कालावधी - (नियम क्र.३४)

शासकिय कर्मचारी २४ ही तास शासनाशी बांधील असतो त्यामुळे त्यास कोणत्याही वेळी व कोणत्याही कामावर नेमण्याचा अधिकार शासनास आहे.

LEAVE RULES

(Maharashtra Civil Services (Leave) Rules 1981)

Leave means written sanction from leave sanctioning authority to remain absent from duty & it cannot be claimed as a right. THO must know various kinds of leave and sanctioning procedure. Maximum amount of continuous leave permissible to a government servant should not exceed 5 years but ground for such leave should be convincing & acceptable by CEO ZP.

1. Guidelines for sanctioning leave (Rule 12)

- Leave is not the right of the employee but it is discretion of leave sanctioning authority who may sanction or refuse leave. (Rule 10 of MCSR leave Rules)
- Leave applied should be at credit of incumbent.
- Sanction of leave should not hamper PHC functioning.
- There should be specific mention regarding who should look after duties during leave period so that work of PHC will not suffer.
- MO can recall employee from leave if there is emergency or work of PHC is suffering.
- MO PHC must know address of employee during leave period.

2. Important aspects of leave

2.1. Commutation of one kind of leave into another (Rule-14): Authority who can grant leave may commute retrospectively leave of one kind into another kind which was due and admissible to government servant at the time when leave was granted, but employee can not claim such commutation as a matter of right. Commutation should be made at the request of government servant.

2.2. Combination of leave (Rule-15): Any kind of leave may be granted in combination with or in continuation of other kind of leave. However casual leave shall not be combined with any kind of leave.

2.3. Grant of leave & leave salary payment to a transferred government servant (Rule-30)

- When a government servant is already on leave, which is sanctioned by competent authority and is transferred to another office where he has to join on expiry of leave, then leave sanction and payment of leave salary will be responsibility of office from where he/she is transferred.
- If government servant applies for extension of leave in continuation of leave already granted to him by office from which he is transferred, issue of formal orders sanctioning extension of leave & payment of leave salary shall devolve on
 - Office where he has to report for duty, if transfer of government & ZP servant to such office is to take effect from date of expiry of original spell of leave.
 - OR**
 - Office from where he is transferred if his transfer is to take effect from date of expiry of extension of leave applied for.
 - When leave is applied during transit period from one department to another, leave will be sanctioned by office where he has to report for duty.

2.4. Casual Leave

Casual leave is not considered as kind of leave. It is an excuse for absence from duty. It is intended to meet special circumstances for which provision cannot be made by exact rules. Total casual leave admissible to a government servant during a calendar year is 8 days. However, this should normally be sanctioned proportionate to calendar year period. Some government servants may exhaust casual leave in first few months of year and request for short earned leave. Such practice should be discouraged.

2.4.1. Criteria

- Account of leave starts from 1st January of every year and ends on 31st December of that year. Total casual leave admissible in one year is eight days. Unconsumed casual leaves lapse at end of year and cannot be carried forward to next calendar year.
- Not more than 7 days CL can be enjoyed at a time to be extended to 8 days in exceptional circumstances.
- Total period of CL and holidays enjoyed in conjunction at a time should not exceed 7 days. Only in exceptional circumstances CL can be extended to 8 days, if it is due.
- Any number of holidays and or Sundays are permitted to be prefixed /suffixed so also holiday or series of holidays are permitted to interpose between period of CL. However total period of CL and holidays, enjoyed in continuation at one time should not ordinarily exceed 7 days & 10 days in exceptional circumstances.

3. Kinds of leave

3.1. Earned leave (MCSR (Leave) Rules -1981) Rule-50

- Thirty days Earned leave is admissible for one calendar year. Fifteen days of earned leave is added to the account of government servant on 1st January and fifteen days on 1st July of every year.
- Account of earned leave is maintained in service book. A separate page has been provided in service book for earned leave account.
- Unused earned leave gets credited to earned leave account. Maximum limit of earned leave at a credit of government servant is up to 300 days.
- When public servant is asked to join duties immediately without availing joining time in his transfer order, unexpired portion of joining time in days is to be credited to earned leave account.
- Encashment of earned leave at credit is permissible on or after the date of retirement (Maximum EL 300 days).

3.1.1. Calculation of earned leave (rule - 51)

- Leave at a rate of 2 ½ days for each completed calendar month of service, which the public servant is likely to render in half year of calendar year in which he is appointed.
- Credit at above rate should be accorded in case of resignation/retirement/removal/dismissal/death for every completed calendar month up to the end of calendar month in which instance occurred.

3.2. Half pay leave (Rule-60)

- Half pay leave of 20 days is admissible in respect of each completed year of service. For each half year on 1st January and 1st July 10 days leave is added to account of half pay leave.
- Account of half pay leave is maintained in service book on separate page.
- Half pay leave can get accumulated without any upper limit at the rate of 5/3 days for each completed month of service up to date of retirement/removal/dismissal/death.

3.3. Commuted leave (Rule no. 61)

- Commuted leave is always granted on medical ground.
- Commuted leave not exceeding half the amount of half pay leave due may be granted on medical grounds. If government servant avails 20 days commuted leave; 40 days half pay leave is debited to half pay leave account.
- Commuted leave up to a maximum 90 days may be allowed during entire service without production of medical certificate

3.4. Leave not due (Rule – 62)

- Only permanent employee can be granted this type of leave.
- It is advance sanction of half pay leave when there is no other kind of leave at the credit of the government servant.
- Leave not due during entire service period shall be limited to maximum 360 days, out of which not more than 90 days at a time and 180 days in all may be on medical certificate.
- Leave not due shall be debited against half pay leave a government servant may earn subsequently, e.g. if a government servant avails leave not due for 40 days then it will take 2 years to get it debited against half pay leave.

3.5. Extra ordinary leave (Rule-63)

Granted in following special circumstances

- When no other leave is admissible
- When other leave is admissible but government servant has applied in writing for grant of extra ordinary leave

3.5.1. Limits for extra-ordinary leave (Rule-63)

Limit for extra-ordinary leave is 3 months. Limits can be extended up to twenty-four months in following circumstances in any one occasion -

- Six months when government servant has completed 3 years continuous service and illness is certified by Civil Surgeon or Superintendent of Government Hospital
- Twelvemonths when government servant has completed 5 years service and illness is certified by Civil Surgeon or Superintendent of Government Hospital
- Twelvemonths when government servant has completed 1 year service and is undergoing treatment for cancer or mental illness.
- Eighteen months when government servant has completed 1 year continuous service and is undergoing treatment for pulmonary TB, pleurisy of TB origin and leprosy.
- Twenty-four months for prosecuting studies.

3.6. Grant of leave on Medical ground (Rule-40) –Medical leave/commuted leave

3.6.1. Grant of medical leave to Group-A/B government servant by competent authority

- If a leave with extension up to 2 months, certificate in form 3 from authorized medical attendant or Medical Officer of equal status is needed.
- If leave is more than 2 months, ask to appear before medical board.

3.6.2. Grant of Medical Leave to Group-C ZP government servant by competent authority

- Application of leave accompanied by certificate of authorized medical attendant or a registered medical practitioner defining nature and probable duration.
- In case of doubt, authority competent to grant leave can secure second medical opinion by Civil Surgeon to have medical examination.

3.6.3. Grant of leave to Group-D ZP government servants on medical grounds

- In support of application on medical grounds from government class IV servant, competent authority to grant leave may accept certificate, as it may deem sufficient.

3.6.4. Important aspects of medical leave

- If a government servant repeatedly applies for leave on medical ground, attention of medical board should be drawn, may be referred to medical board & if medical board opines that, he is no fit to continue / to carry out duties prescribed for the post, he should be asked for invalid retirement.
- If non-gazetted government/ZP servant has applied for 3 days leave on medical ground, exemption from submitting medical certificate may be given however such a leave should not be debited against leave other than commuted leave.

4. Leave salary (Rule no. 70)

- Earned leave: Leave salary equal to pay drawn in month immediately before proceeding on earned leave is admissible.
- Half pay leave: Half amount of pay drawn in month immediately before leave is admissible
- Commuted leave: Leave salary equal to pay drawn in month immediately before proceeding on leave is admissible.
- Extra ordinary leave: No leave salary is permissible. But House Rent Allowance (HRA) & City Compensatory Allowance (CCA) are admissible. However HRA etc. is permissible after ascertaining expenditure incurred by government servant during leave period.

5. Powers to grant leave and leave record

- Medical Officer is competent to sanction all kinds of leave to non-gazetted government ZP servant up to 30 days except special disability leave and study leave.
- Leave application extending leave beyond 120 days should be submitted to DHO with clear remarks about leave to be sanctioned or rejected.
- Junior Assistant should keep leave record of all PHC staff. He should enter leave in service book and leave salary must be drawn in next month without delay.
- MO must verify leave entry in service book while signing pay bill of leave period.

6. Special kinds of leave

Special kinds of leave are not debited to leave account, however a note in service book is required to be taken with due attestation.

6.1. Maternity leave for government servant (Rule-74)

- On date of application female servant in permanent employment having 2 or less living children, is entitled for 180 days maternity leave & during such a period of leave, salary equal to pay drawn immediately before proceeding on leave will be paid.
- If lady government servant demands for leave beyond maternity leave period, leave can be sanctioned for total period of one-year in continuation with maternity leave, it can be granted without asking to produce medical certificate. Earned leave or commuted leave should be deducted as per applicant's request.
- In case of abortion / MTP, 45 days leave irrespective of number of issues is admissible. However certificate from medical authority registered under MTP Act is necessary.
- Lady government servant who adopts a child is entitled for leave up to 1 year or till child completes his/her 1- year, whichever is earlier. Women who have 2 living issues on date of application are not entitled to this leave.

6.2. Special casual leave

6.2.1. A government servant whose wife is undergoing tubectomy operation for first time or re-surgery in case of failure is entitled for 7 days special leave.

6.2.2. Special casual leave of maximum 3 days or as certified by CS is permissible for anti rabies treatment. However it should be certified by Civil Surgeon or authorized medical attendant.

6.3. Special disability leave (Rule 75)

If a government servant gets injured and disabled, because of risk of his work or by somebody else, special disability leave up to maximum 24 months can be granted.

6.4. Special leave for tuberculosis, cancer, leprosy (Rule 79)

After 3 years continuous service, one-year full pay leave is admissible on submission of medical certificate for abovementioned reasons. If not cured, half pay leave and afterwards as per medical board certification extra ordinary leave is admissible. However total leave should not exceed 3 years.

6.5. Study leave (Rule 80)

For 12 months and maximum up to 24 months is permissible. Such cases will not come across Panchayat Samiti level.

7. Action that can be taken against government servant who remains absent without permission

- Refusal of CL if it is believed that it is asked for without adequate ground.
- Treatment of absence as leave without pay when a person has remained absent without obtaining prior permission. He should be asked in writing reasons why he remained absent without permission & after getting his explanation, if leave sanctioning authority is not satisfied, absence without permission can be treated as LWP.
- Refusal of earned leave for short period of a day or two, to a person who has exhausted his CL by taking it on flimsy pretext.

8. Compensatory holidays

- Compensatory holidays should not be accumulated for more than 3 days and should not be allowed to be carried forward to next calendar year.
- Compensatory holidays can be prefixed or suffixed or both to leave due and or holidays.
- It is permissible to only group C& D staff.

9. Transit period after transfer

- Transit period of seven days including Sundays & holidays is permissible in case of administrative transfer from one place to another for preparation.
- In addition to this, journey period of one day is admissible, if transfer is in same district or adjoining border districts and two days in any other district when there is no common boundary. Sunday does not count as day for purpose of calculating days of actual journey but a holiday shall be included there in.
- When journey days fall on Sunday, journey day is extended by one day.
- For request transfer only journey period is allowed.

SERVICE BOOK

Service book is history of service of government servant from date of appointment, till date of retirement. All incidences in service like pay scale, increment, promotions, penalties, leave account, transfer, joining time availed etc. of government servant are recorded in Service Book. It should be opened after joining service for all government servants appointed for more than one year.

All columns in service book should be filled in carefully after verifying original documents. Proof of caste/reservation category and date of birth should be personally verified by Medical Officer before entry in service book. PHC MO has responsibility of maintaining service book of all staff of PHC.

1. Entries in service book MCSR (General conditions of service) Rule 1981 (Rule-37)

- Every step in official life of government servant, promotions of all kinds, increments, transfers, leave availed should be recorded in service book. In addition to this, rewards/ praise & punishment should also be mentioned.
- Leave account should be maintained and regularly updated.
- Punishments such as reduction to lower post, removal, dismissal should be entered in service book with reasons.
- Entry of house building advance, motor cycle advance etc. should be taken on last page.
- Each entry should be duly verified with departmental orders, pay bills, leave account and attested by head of office.
- GPF account number should also be noted in service book.

1.1. Date of birth (Rule-38)

- Date of birth should be verified by documentary evidence and nature of document relied should be mentioned i.e. school leaving certificate, SSC certificate, certified extract of birth by Gram Panchayat, corporation, municipality etc.
- If year is known but exact date is not known, 1st July and if year, month known but exact date is not known, 16th of month is treated as date of birth.
- When approximate age is also not known, age given by appearance as per medical certificate by Civil Surgeon or authorized medical attendant should be noted. Incumbent should be assumed to have completed age as certified by MO on date of certificate & his date of birth deduced accordingly.
- No alteration in entry of age should be done by MO PHC for any reason without approval of District Health Officer.
- No alterations in birth date are allowed after a period of 5 years from date of entry.

2. Important aspects about service book

- Fingerprints of government servant who is unable to sign should be recorded in service book.
- Service books should be shown to government servant every year and his signature having inspected service book should be obtained.

- After transfer from one office to another, enter nature and reason for transfer in service book and forward to office by RPAD where government servant is transferred. Service book should not be handed over to concerned government servant in any circumstances.
- Service book should be verified in month of May every year by MO and certified that, entries have been verified up to end of preceding financial year from pay bills, acquaintance rolls and other records. Similarly entries on first page should be attested every five years.
- Service book should not be returned to government servant on retirement, resignation or discharge from service.
- Service Book should be preserved for 5 years after death or retirement of government servant.

2.1. Duplicate copy of service book to government servant -

Every government servant should be given duplicate copy of service book free of charge. In month of February of every year entries should be confirmed and made as per original copy of service book and head of office should sign all entries. Government servant should check whether entries made are correct and are attested by head of office and ensure that subsequent entries are also made in duplicate service book.

CONFIDENTIAL REPORTS

Medical officer at PHC has to initiate Confidential Reports (CR) of all group-Band C government servants working in PHC. For group-D government servants, work performance report should be recorded and submitted to DHO.

1. General guidelines

The CR should be written as per guidelines issued vide GAD resolution no. CFR-1295/PRA-KRA-36/95 dt. 1.2.96

- Confidential Reports are written for period 1 April to 31 March of each year.
- For all Group-B and C staff working at PHC, MO is reporting officer and DHO is reviewing officer (except for Jr. Clerk and driver in some districts).
- MO should initiate CR of all Group B and C government servants from PHC and submit to DHO before 30 April.
- CR should be hand written in Marathi.
- In case of temporary government servant, if service period is more than 3months and if s/he is likely to continue then CR should be written.
- If government servant has worked at more than one post during year then, CR should be written for all those periods that are more than 3months.
- Reports should be written objectively, in clear and specific words without any ambiguity.
- When writing CR of backward class servants ensure that no injustice is made.
- Maintain a register at PHC in which information like serial number, name of worker, period for which CR is written should be entered. Last column should be for signature of receiving person of DHO office.
- In some districts, CR of Junior assistant, driver and performance report of Group-D employees need to be submitted to Dy. CEO (GAD).

2. How to write Confidential Reports

- These reports should be written in a prescribed form B.
- Form B has five parts. Part 1 which has to be completed before writing CR. It includes name, designation of employee, period of writing CR, etc. and that has to be completed by Jr. Assistant. Part 2 indicates guidelines for filling self assessment form, in part 3 there is prescribed format for self assessment, part 4 is for reporting officer estimating general ability and character, part 5 is for reviewing officer.
- Self-assessment form should be submitted by all Group B&C staff of PHC to MO before 15April. Self-assessment should be written on place provided in form.
- When writing CR, MO should consider self-assessment given by worker and it should be mentioned that, self assessment was considered while writing CR.
- MO should maintain "Ephemeral Roll" for all workers at PHC. In Ephemeral Roll all incidences (outstanding or bad performances) during year of each worker are noted by giving details as and when they occur. This should be referred to while writing CR.
- For each aspect to be assessed alternatives are given on CR form and MO has to encircle most appropriate alternative. However for point number 3, 9, 10, 11 and 18 there are no alternatives given and MO has to write report in clear words.

- While writing adverse remarks regarding integrity and character, MO should be very careful. Unless there is strong evidence, adverse remarks regarding integrity and character should not be entered in CR. If MO has some doubts, then do not write anything in column. Separate report should be attached and higher officer will take action regarding this.
- In a column on general assessment write outstanding performance, admirable performance and also if any punishment has been given or bad qualities of that staff.
- Grading given at end should correlate with grading given for each aspect in CR.
- At end MO should sign and write name and designation with date.

महाराष्ट्र शासनाच्या कर्मचाऱ्यांसाठी विहित केलेले वर्तणूक व शिस्त नियम

वर्तणूक नियम :-

- इंग्रजी भाषेत अशी म्हण आहे की केवळ सीझर (राज्यकर्ता) नव्हे, तर त्याची पत्नी सुद्धा संशयातीत असली पाहिजे. सरकारी नोकरांची आणि त्यांच्या कुटुंबियांची वर्तणूक नेहमीच शुध्द असावयास हवी. त्यासाठी महाराष्ट्र शासनाने महाराष्ट्र नागरी सेवा (वर्तणूक) नियम, १९७९ प्रसृत केले असून शासनाचे सर्व अधिकारी व कर्मचारी यांना ते बंधनकारक आहेत. भारतीय प्रशासनिक सेवा, भारतीय पोलिस सेवा व भारतीय वन सेवा या अखिल भारतीय सेवांमधील अधिकाऱ्यांना मात्र हे नियम लागू नाहीत. कारण त्यांना अखिल भारतीय सेवा (वर्तणूक) नियम १९६८ हे अशाच प्रकारचे दुसरे नियम लागू आहेत.
- महाराष्ट्र नागरी सेवा (वर्तणूक) नियम, १९७९ मधील नियम (३) मध्ये म्हटले आहे की प्रत्येक शासकीय कर्मचाऱ्याने (त्यात अधिकारीही आले) नेहमीच :
 - अत्यंत सचोटीने वागावे
 - कर्तव्यनिष्ठ असावे आणि
 - शासकिय कर्मचाऱ्याला अशोभनीय अशी कोणतीही गोष्ट करू नये.

पर्यवेक्षकीय पद धारण करणाऱ्यांवर आणखी अधिक जबाबदारी आहे. ती अशी की त्यांच्या नियंत्रणाखालील सर्व कर्मचाऱ्यांच्या सचोटीची व कर्तव्यनिष्ठेची खात्री करून घेण्यासाठी शक्य ते सर्व उपाय त्यांनी योजले पाहिजेत.

- प्रत्येक शासकिय कर्मचाऱ्याने आपली कर्तव्ये पार पाडतांना किंवा अधिकारांचा वापर करतांना आपल्या स्वतःच्या निर्णय शक्तीचाच उपयोग करावा, वरिष्ठांच्या आदेशानुसार जर तो वागत असेल तर तत्पूर्वी त्यांचा लेखी आदेश त्याने मिळवावा व ते व्यवहार्य नसेल तेव्हा त्यांची कार्योत्तर मंजूरी शक्यतो लवकर प्राप्त करून घ्यावी. अर्थात नियमानुसार वरिष्ठांच्या आदेशाची आवश्यकता नसेल तेव्हा केवळ स्वतःची जबाबदारी टाळण्यासाठी कोणी वरिष्ठांचे आदेश वा मंजूरी मागू नये.
- वरील नियम ३ हा सर्वकष स्वरूपाचा व सदैव नजरेसमोर ठेवावयाचा आहे. तर त्यापुढील नियम ४ ते २८ मध्ये विवक्षित बाबतीत सरकारी नोकरांवर काय निर्बंध आहेत व त्यांनी कसे वागावे या संबंधीचे निदेश आहेत. पुरेशा जागे अभावी या सर्व नियमांचे तपशिल येथे देणे शक्य नाही. मात्र थोडक्यात त्यांचे विषय खाली नमूद केले आहेत :-

नियम क्रमांक	विषय
४	कुटुंबियांना खाजगी कंपनीत नोकरी मिळवून देणे.
५	राजकारणात वा निवडणुकांमध्ये सहभागी होणे.
६	निदर्शन करणे वा संपावर जाणे
७	काही प्रकारच्या संघटनांचे सदस्य होणे
८	कार्यालयीन माहिती अनधिकृतपणे इतरांस पुरविणे
९	वृत्तपत्रे/नियतकालिके या लिखण करणे वा रेडिओ / टिव्हीवर कार्यक्रम प्रसूत करणे.
१०	विविध समित्यांसमोर साक्ष देणे

११	कोणत्याही उपक्रमांसाठी वर्गणी गोळा करणे
१२	नातेवाईक मित्र वा अन्य व्यक्तींकडून भेटवस्तू वा देणग्या स्विकारणे.
१३	स्वतःच्या व अन्य सरकारी नोकरांच्या सार्वजनिक सत्कारात वा निरोप समारंभात सहभागी होणे
१४	तसविरीसाठी किंवा पुतळ्यासाठी बसणे
१५	सरकारी नोकराचा राजीनामा खरेदी करणे.
१६	खाजगी व्यवसाय किंवा नोकरी करणे
१७	पैसे गुंतविणे, उसने देणे किंवा उसणे घेणे
१८	नादार या कर्जबाजारी होणे
१९	स्थावर किंवा जंगम मालमत्तेची खरेदी किंवा विक्री करणे या मालमत्तेसंबंधी विवरणपत्रे सादर करणे.
२०	महसूल व भूमिअभिलेख विभागातील कर्मचाऱ्यांनी आपल्या नोकरीच्या जिल्ह्यात मालमत्ता खरेदी करणे.
२१	खाजगी प्रकरणात लवाद म्हणून काम करणे
२२	स्वतःचे चारित्र्य हनन करणाऱ्यांवर अश्रू नुकसानीचा दावा लावणे
२३	स्वतःचे सेवाविषयक बाबींमध्ये वरिष्ठांवर राजकिय वा अन्य दबाव आणणे
२४	जतीय, धार्मिक वांशिक वा प्रादेशिक व्देष पसरविणे.
२५	स्वतःचे किंवा कुटुंबियाचे नाव सार्वजनिक संस्था इ.ना लावण्यास परवानगी देणे
२६	विवाहविषयक निर्बंध
२७	हुंडा देणे किंवा घेणे
२८	मादक पेये वा अमली द्रव्ये यांचे सेवन करणे.

- नियम २९ व ३० मध्ये सरकारी नोकरांच्या संघटनांना मान्यता देण्याविषयी या तरतुदी आहेत. मान्यतेच्या शर्ती व अशा संघटनांकरीता आदर्श नियमावली, वर्तणूक नियम पुस्तिकेच्या शेवटी परिशिष्टांमध्ये दिलेल्या आहेत.
- एखाद्या सरकारी नोकरांकडून कोणत्याही वर्तणूक नियमांचे उल्लंघन झाल्यास तो शिस्त भंगाच्या कार्यवाहीस पात्र होतो. सदर कार्यवाही महाराष्ट्र नागरी सेवा (शिस्त व अपील) नियम १९७९ मधील तरतुदी अन्वये करण्यात येते. हे नियम खालील अपवाद वगळता महाराष्ट्र शासनाच्या इतर सर्व कर्मचाऱ्यांना व अधिकाऱ्यांना लागू आहेत.
 - अखिल भारतीय सेवेतील अधिकारी त्यांना अखिल भारतीय सेवा (शिस्त व अपील) नियम १९६९ लागू आहेत.
 - पोलिस निरीक्षक व त्याहून दुय्यम दर्जाचे पोलिस, त्यांची प्रकरणे मुंबई पोलिस अधिनियम १९५१ व मुंबई पोलिस (शिक्षा व अपील) नियम १९५६ अनुसार हाताळली जातात.
 - ज्यांच्याकरीता कायद्याद्वारे किंवा करारानुसार विशेष तरतुदी करण्यात आल्या आहेत अशा व्यक्ती (उदा.कामगार कायद्याखाली येणारे कामगार) त्यांना अशा विशेष तरतुदी लागू असतात.
 - नैमित्तिक सेवेतील व्यक्ती.

संविधानिक तरतुदी :-

- शासन यंत्रणेमधील सरकारी नोकरांचे विशेष स्थान लक्षात घेऊन त्यांच्या वर्तणुकीवर काही खास बंधने जशी टाकण्यात आली आहेत. तसेच उलटपक्षी त्यांना सेवेमध्ये आवश्यक ती सुरक्षा व न्याय मिळवून देण्यासाठी भारताच्या संविधानामध्ये (भाग १४ व १४ अ) काही खास तरतुदी करण्यात आल्या आहेत.

त्यातील सर्वात महत्वाच्या तरतुदी संविधानाच्या अनुच्छेद ३ मध्ये आढळतात त्या थोडक्यात खालीलप्रमाणे -

- केंद्र किंवा राज्य शासनाच्या नागरी सेवेतील कोणत्याही माणसास त्याची नेमणूक ज्याने केली होती त्याहून कनिष्ठ दर्जाचा अधिकारी सेवेतून बडतर्फ करू शकणार नाही वा काढून टाकू शकणार नाही.
- अशा माणसास बडतर्फ करावयाचे असेल किंवा सेवेतून काढून टाकावयाचे असेल किंवा पदावतन करावयाचे असेल तर तत्पूर्वी त्याच्या विरुद्ध असलेले दोषारोप त्याला कळवून त्याबाबत चौकशी करावयास हवी या चौकशीत सदर दोषारोपांबाबतचे त्याचे म्हणणे मांडण्याची वाजवी संधी त्याला दिली पाहिजे. चौकशी अंती निष्पन्न झालेल्या पुराव्याआधारे वरीलपैकी कोणतीही शिक्षा सदर माणसास देता येईल व तत्पूर्वी अशा प्रस्तावित शिक्षेविरुद्ध आपले अभिवेदन सादर करण्याची संधी त्याला देण्याची आवश्यकता नाही.
- मात्र खालील परिस्थितीत वरील तरतूद २ लागू असणार नाही.
 - सदर माणसास फौजदारी गुन्ह्यात शिक्षा झालेली असून त्याच गुन्ह्यासाठी त्याला वरीलपैकी शिक्षा द्यावयाची असल्यास
 - वरीलप्रमाणे चौकशी करणे वाजवीरित्या व्यवहार्य नाही अशी शिक्षा देण्यास सक्षम अधिकाऱ्यांची खात्री पटली असल्यास व त्याबाबतची कारणे त्याने लेखी नमूद केलेली असल्यास
 - वरीलप्रमाणे चौकशी करणे राज्याच्या सुरक्षिततेच्या दृष्टीने इष्ट नाही अशी राष्ट्रपती किंवा राज्यपाल खात्री पटलेली असल्यास.
- संविधानाच्या अनुच्छेद ३१५ अन्वये केंद्रस्तरावर तसेच प्रत्येक राज्यासाठी एक लोकसेवा आयोग असणे आवश्यक आहे. या आयोगाची कर्तव्ये अनुच्छेद ३२० मध्ये दिली आहेत. त्यानुसार सरकारी नोकरांच्या विविध सेवाविषयक बाबीत अंतिम निर्णय घेण्यापूर्वी केंद्र व राज्य शासनांना आपल्या लोकसेवा आयोगाचा सल्ला घ्यावा लागतो. सरकारी अधिकाऱ्यांविरुद्ध शिस्तभंगाविषयक कार्यवाहीचा या बाबीत समावेश आहे. त्यामुळे आयोगाच्या सल्ल्याचा फायदा या अधिकाऱ्यांना मिळू शकतो. अनुच्छेद ३२३ (२) अन्वये राज्य लोकसेवा आयोगास दरसाल आपल्या कामासंबंधीचा अहवाल राज्यपालांकडे सादर करावा लागतो. शासनाने आयोगाचा सल्ला ज्या बाबतीत स्विकारला नाही त्याबाबत अस्विकृतीची कारणे नमूद करून शासनास वार्षिक अहवाल विधानमंडळासमोर ठेवावा लागतो.
- सेवाभरती व सेवाशर्ती यासंबंधीच्या सरकारी नोकरांच्या तक्रारींवर न्याय देण्यासाठी केंद्र, राज्य स्तरांवर शासनिक न्यायाधिकरणे स्थापन करण्याची तरतूद संविधानाच्या अनुच्छेद ३ अ मध्ये करण्यात आली आहे. त्यानुसार महाराष्ट्र राज्यासाठी असे न्यायाधिकरण स्थापिक करण्यात आले आहे. शिस्तभंगाविषयक प्रकरणांत आपल्यावर अन्याय झाला हे अशी एखाद्या राज्य सरकारी नोकराची धारणा असल्यास तो त्याबाबत या न्यायाधिकरणाकडे दाद मागू शकतो. न्यायाधिकरणाच्या निर्णयाविरुद्ध उच्चतम न्यायालयात अपील करता येते.

नैसर्गिक न्यायाची तत्वे :-

- कोणत्याही माणसास शिक्षा देण्यापूर्वी त्याला न्याय मिळवून देण्याच्या दृष्टीने काही अनुसरली पाहिजेत. तत्वांना नैसर्गिक न्यायाची तत्वे म्हणतात ती थोडक्यात खालीलप्रमाणे
 - सदर माणसास ज्या कथित गुन्ह्याकरीता शिक्षा द्यावयाची आहे त्या गुन्ह्यासंबंधी आरोप त्याला तपशिलवार स्पष्टपणे कळविले पाहिजेत.
 - या आरोपांबाबत चौकशी व्हावयास हवी. त्या चौकशीत स्वतःचा बचाव करण्यास संपूर्ण संधी आरोपीस दिली पाहिजे. कोणासही त्याचे म्हणणे ऐकून न घेता दोषी योग्य नव्हे.

- चौकशी करणाऱ्या अधिकाऱ्याच्या मनात कोणत्याही प्रकारचा पूर्वग्रह असता नसे. त्याने शुध्द अंतःकरणाने व प्रामाणिकपणे चौकशीचे काम केले पाहिजे.
- चौकशी अंती घेतलेल्या अंतिम निर्णयाची कारणे आरोपीला कळविली पाहिजे कोणत्याही प्रकरणात केवळ न्याय देणे ऐवढेच पुरेसे नसून योग्य तो न्याय दिला आहे हे स्पष्ट दिसले पाहिजे.

- संविधानाच्या अनुच्छेद ३११ मधील तरतुदी वरील तत्वांवर आधारीत आहेत तरतुदींना अनुसरून शिस्तभंगाच्या कार्यवाहीची तपशिलवार कार्यपद्धती आपल्या शिस्तविषयी नियमांमध्ये विहित केली आहे. सदर पद्धतीचा काटेकोरपणे अवलंब केल्यास संबंधित शासकिय कर्मचाऱ्यास योग्य तो नैसर्गिक न्याय मिळेल अशी त्यामागील भूमिका आहे.

शिक्षा (नियम ५) :-

- पुरेशा कारणांसाठी ज्या विविध शिक्षा शासकिय कर्मचाऱ्यांना करता येतात त्यांची महाराष्ट्र नागरी सेवा (शिस्त व अपील) नियम १९७९ मधील नियम ५ मध्ये दिली आहे शिक्षांचे २ मुख्य प्रकार आहेत (अ) किरकोळ शिक्षा व (ब) जबर शिक्षा. या खालीलप्रमाणे आहेत.

अ) किरकोळ शिक्षा :-

- ठपका ठेवणे
- बढती रोखणे
- कर्मचाऱ्यांच्या निष्काळजीपणामुळे किंवा त्याने आदेशांचा भंग केल्यामुळे शासनास झालेली आर्थिक हानी पूर्णतः किंवा अंशतः त्याच्या वेतनामधून वसूल करणे.
- वेतन वाढी रोखणे, (पुढील वेतनावेढीवर परिणाम करून अगर न करता ठराविक वर्षासाठी वेतनवाढ रोखावयाची असते. वित्तीय वर्षासाठी वेतनवाढ रोखली आहे व त्याचा पुढील वेतनवेढीवर परिणाम होईल काय हे शिक्षेच्या आदेशात स्पष्ट करावे.)

ब) जबर शिक्षा :-

- ठराविक कालावधीसाठी समय श्रेणीतील खालच्या टप्प्यावर आणणे. (सदर कालावधीत संबंधित कर्मचाऱ्यास वेतनवाढी द्याव्या की देऊ नये, तसेच तो कालावधी संपल्यानंतर त्याच्या भावी वेतनवाढी पुढे ढकलल्या जाव्या की नाही यासंबंधीच्या सूचना शिक्षेच्या आदेशात द्याव्या. तसेच शिक्षेच्या कालावधीत रजा घेतल्यास तेवढ्या मुदतीने शिक्षेचा कालावधी वाढेल हे देखील आदेशात नमूद करावे.)
 - कनिष्ठ वेतनश्रेणीवर कनिष्ठ पदावर किंवा कनिष्ठ सेवेत पदावती (पदावती ठराविक कालावधीसाठी आहे की कायमची आहे तसेच ती ठराविक कालावधीसाठी असल्यास मूळ पदावर पुनःस्थापित झाल्यानंतर संबंधित कर्मचाऱ्याची जेष्ठता व वेतन यांची निश्चिती कशी करावी यासंबंधीच्या सूचना शिक्षेच्या आदेशात द्याव्या तसेच शिक्षेच्या कालावधीत रजा घेतल्यास तेवढ्या मुदतीने शिक्षेचा कालावधी वाढेल हे नमूद करावे.)
 - सक्तीची सेवानिवृत्ती
 - सेवेतून काढून टाकणे
 - सेवेतून बडतर्फ करणे
- सेवेतून बडतर्फ झालेल्या कर्मचाऱ्यास कोणत्याही प्रकारचे निवृत्तीवेतन दिले जात नाही. तसेच भविष्यकालात शासकीय सेवेसाठी अपात्र ठरतो. सेवेतून काढून टाकलेल्या किंवा सक्तीने सेवानिवृत्त

केलेल्या कर्मचाऱ्यास महाराष्ट्र नागरी सेवा (निवृत्तीवेतन) नियम १९८२ अनुक्रमे मधील नियम १०० व १०१ अनुसार निवृत्तीवेतन दिले जाते. तसेच भावी कालात ते शासकिय सेवेसाठी अपात्र ठरत नाहीत.

- १९६९ पूर्वी विशेषतः वर्ग ४ मधील कर्मचाऱ्यांना दंड भरण्याची शिक्षा केली जात असे. परंतु सध्याच्या नियमांनुसार ती शिक्षा अनुज्ञेय नाही.
- खाली प्रकारची कार्यवाही शिक्षा म्हणून गणली जात नाही. यास्तव ती करण्यापूर्वी शिस्त नियमांमध्ये विहित केलेली कार्यपद्धती अनुसरावी लागत नाही.
 - सेवाशर्तीनुसार विहित केलेली विभागीय किंवा भाषा परीक्षा कर्मचारी उत्तीर्ण झाला नाही म्हणून त्याची वेतनवाढ रोखणे.
 - कर्मचारी दक्षता रोघ पार करण्यास अयोग्य असल्याच्या कारणावरून समयश्रेणीतील दक्षतारोधावर त्याची वेतनवाढ थांबविणे.
 - बढतीसाठी कर्मचाऱ्यांचा विचार करून त्याच्या वर्तणुकीशी संबंधित नसलेल्या प्रशासकिय कारणांसाठी त्याला बढती न देणे.
 - वरील पदावर स्थानापन्न असलेल्या कर्मचाऱ्यास तो त्या पदासाठी अयोग्य आहे म्हणून किंवा त्याच्या वर्तणुकीशी असंबंधित अशा प्रशासकिय कारणास्तव पदवनत करणे.
 - अन्य पदावर परिविक्षाधीन नियुक्ती असलेल्या कर्मचाऱ्यास परिविक्षा नियमांनुसार त्याच्या मूळ पदावर परत पाठविणे.
 - भारतातील अन्य शासनाकडून प्रतिनियुक्तीवर घेतलेल्या कर्मचाऱ्यास त्या शासनाकडे परत पाठविणे.
 - नियत सेवावधी व सेवानिवृत्ती यासंबंधीच्या नियमांनुसार कर्मचाऱ्यास सक्तीने सेवानिवृत्त करणे. (उदा. वयानी ५० किंवा ५५ वर्षे पूर्ण झाल्यानंतर ३ महिन्यांची नोटीस देऊन सदर नियमांनुसार सेवानिवृत्त करणे किंवा वयाची ५८ वर्षे पूर्ण झाल्यानंतर सक्तीने सेवानिवृत्त करणे)
 - परिविक्षाधीन नियुक्ती केलेल्या कर्मचाऱ्याच्या सेवा परिविक्षा नियमांनुसार समाप्त करणे.
 - अस्थायी कर्मचाऱ्याच्या सेवा त्याच्या वर्तणुकीशी संबंधित नसलेल्या कारणास्तव समाप्त करणे.
 - करारानुसार नियुक्त केलेल्या कर्मचाऱ्यांची सेवा कराराच्या अटीनुसार समाप्त करणे.
- लाच घेतल्याचा आरोप ज्याच्याविरुद्ध सिध्द झाला आहे अशा कर्मचाऱ्यास सेवेतून काढून टाकण्यात यावे किंवा बडतर्फ करावे. एखाद्या अपवादात्मक प्रकरणात अशा कर्मचाऱ्यास अन्य शिक्षा करता येईल, पण त्याबाबतच्या खास कारणांची लेखी नोंद करावयास हवी. या एका तरतुदीव्यतिरीक्त कोणत्या गैरवर्तणुकीसाठी कोणती शिक्षा करावी. यासंबंधीचे अन्य काही मार्गदर्शन या नियमात केलेले नाही. त्याबाबतचा निर्णय शिस्तभंगाविषयक प्राधिकाऱ्याने संबंधित प्रकरणाचा समग्र विचार करून घ्यावयाचा असतो. साहजिकच या नियमांमध्ये शिस्तभंगविषयक प्राधिकाऱ्याचे स्थल फार महत्वाचे आहे.

शिस्तभंगाविषयी प्राधिकारी (नियम ६ व ७)

- एखाद्या शासकिय कर्मचाऱ्याला नियम ५ मधील कोणतील किरकोळ किंवा जबर शिक्षा करण्यास सक्षम असलेला प्राधिकारी हा त्या कर्मचाऱ्याचा शिस्तभंगविषयक अधिकारी होय. शिस्तभंगविषयक प्राधिकारी असू शकतात. तर इतर कर्मचाऱ्यांच्या बाबतीत दोन्ही प्रकारच्या शिक्षांसाठी एकच शिस्तभंगविषयक प्राधिकारी असतो.

- शिस्त व अपील नियमांतील नियम ६ मध्ये शिस्तभंगविषयक प्राधिकाऱ्यांसंबंधी तरतूदी आहेत त्या खालीलप्रमाणे :-
 - राज्यपाल (म्हणजेच राज्य शासन) कोणत्याही शासकिय कर्मचाऱ्यास कोणतीही शिक्षा करू शकतात.
 - वर्ग ३ व वर्ग ४ च्या कर्मचाऱ्यांचे नियुक्ती प्राधिकारी आपल्या नियंत्रणाखालील सदर वर्गाच्या कर्मचाऱ्यांना कोणतीही शिक्षा करू शकतात.
 - कार्यालया प्रमुख आपल्या नियंत्रणाखालील वर्ग ३ व वर्ग ४ च्या कर्मचाऱ्यांना गौण शिक्षा करू शकतात.
 - विभाग प्रमुख व प्रादेशिक विभागाप्रमुख आपल्या नियंत्रणाखालील वर्ग २ च्या अधिकाऱ्यांना किरकोळ शिक्षा करू शकतात.
 - ज्यांच्या वेतनश्रेणीचा किमान टप्पा रु.३०००/- पेक्षा अधिक नाही अशा आपल्या नियंत्रणाखालील वर्ग ३ व ४ च्या कर्मचाऱ्यांना व ज्यांच्या वेतनश्रेणीचा किमान टप्पा रु. ३००० किंवा त्याहून कमी आहे अशा वर्ग १ च्या अधिकाऱ्यांना विभागीय आयुक्त किरकोळ शिक्षा करून शकतात.
- पाटबंधारे विभाग व सार्वजनिक बांधकाम विभाग यांमधील विविध कर्मचाऱ्यांच्या संदर्भात त्यांचे शिस्तभंगविषयक अधिकारी खालीलप्रमाणे :-

अ.क्र.	कर्मचाऱ्यांचा दर्जा	किरकोळ शिक्षा करण्यास सक्षम शिस्तभंगविषयक प्राधिकारी	जबर शिक्षा करण्यास सक्षम शिस्तभंगविषयक प्राधिकारी
१	वर्ग ४ चे कर्मचारी	कार्यकारी अभियंता	कार्यकारी अभियंता
२	वर्ग ३ चे कर्मचारी	कार्यकारी अभियंता	अधिक्षक अभियंता
३	वर्ग २ चे कर्मचारी	अधिक्षक अभियंता	राज्यपाल
४	कार्यकारी अभियंता	अधिक्षक अभियंता	राज्यपाल
५	अधिक्षक अभियंता व त्यावरील दर्जाचे अधिकारी	राज्यपाल	राज्यपाल

ज्याला शिक्षा करावयाची तो कर्मचारी शिस्तभंगविषयक प्राधिकाऱ्याच्या प्रशासकिय नियंत्रणाखाली असणे आवश्यक आहे.

- नियम ७ (२) अन्वये कोणत्याही शासकिय कर्मचाऱ्याचा शिस्तभंगविषयक प्राधिकारी (मग तो गौण शिक्षेसाठी सक्षम व जबर शिक्षेसाठी) सदर कर्मचाऱ्यांविरुद्ध शिस्तभंगाची कार्यवाही सुरु करू शकतो. अशी कार्यवाही गौण शिक्षेकरीता जबर शिक्षेकरीताही असू शकते. पण जबर शिक्षेचा अंतिम आदेश जबर शिक्षा देण्यासाठी सक्षम असलेला प्राधिकारीच करू शकतो. म्हणून केवळ गौण शिक्षेसाठी सक्षम प्राधिकाऱ्याने सुरु केलेल्या जबर शिक्षेच्या कार्यवाहीत जबर शिक्षा देण्याचे येत असेल तर त्या टप्प्यावर कार्यवाहीचे कागदपत्र पुढील आवश्यक कार्यवाहीसाठी जबर शिक्षेसाठी सक्षम प्राधिकाऱ्याकडे द्यावे लागतात.

प्रारंभिक चौकशी :-

- शासकिय कर्मचाऱ्याने केलेली गैरवर्तणुक अनेक प्रकारे शासनाच्या किंवा अन्य शिस्तभंगविषयक प्राधिकाऱ्याच्या नजरेस येते. उदा. १) अचानक केलेल्या तपासणीतून २) निरीक्षण अहवालांमधून ३) लेखा परिच्छेदांद्वारा ४) विभागातील किंवा विभागाबाहेरील व्यक्तींनी केलेल्या तोंडी किंवा लेखी

तक्रारीमधून ५) वर्तमानपत्रात प्रसिद्ध झालेल्या माहितीद्वारा. यानंतर रितसर विभागीय चौकशीचा आदेश देण्यापूर्वी संबंधित कर्मचाऱ्याविरुद्ध नेमके दोषारोप ठेवण्याकरीता व ते चौकशी मध्ये सिद्ध करण्याकरीता पुरेसा पुरावा उपलब्ध आहे काय याबाबतचा विचार शिस्तभंगविषयक प्राधिकाऱ्याने करणे आवश्यक आहे. त्यासाठी एक प्रारंभिक चौकशी करावी लागते या चौकशीची काही विशिष्ट कार्यपद्धती नेमून दिलेली नाही. प्रत्येक प्रकरणाच्या आवश्यकतेनुसार ती नियुक्त करावी लागते. साधारणतः एखाद्या वरीष्ठ व अनुभवी अधिकाऱ्याकडे ही चौकशी सोपविली जाते व कोणताही पूर्वग्रह मनात न बाळगता त्याने ती पूर्ण करावयाची असते.

- प्रारंभिक चौकशी उद्दिष्टांमध्ये मुख्यत्वेकरून खालीलप्रमाणे असतात.
 - कर्मचाऱ्यांविरुद्ध करण्यात आलेल्या आरोपांची सत्यासत्यता पडताळून पाहणे
 - प्रत्यक्ष दोषी व्यक्ती शोधून काढून त्याच्या गुन्ह्यांचे स्वरूप स्पष्ट करणे.
 - सरकारी पैशांची अफरातफर, मालाची चोरी, कंत्राटदारास अतिप्रदान इ. प्रकरणात शासनास झालेल्या नुकसानीच्या रकमेचा अंदाज घेणे.
 - रीतसर विभागीय चौकशीमध्ये गुन्हा सिद्ध करण्यासाठी आवश्यक असलेला तोंडी तसेच कागदोपत्रीचा पुरावा गोळा करणे.
- प्रारंभिक चौकशी अधिकाऱ्याने वरीलप्रमाणे चौकशी करून आपला अहवाल, गोळा केलेल्या साक्षी पुराव्यांसह व आपले निष्कर्ष नोंदवून, शिस्तभंगविषयक प्राधिकाऱ्याकडे पाठवावयाचा असतो. शासकिय कर्मचाऱ्यांविरुद्ध संदिग्ध स्वरूपाचे गैरवर्तणुकीची विवक्षित उदाहरणे पुरेशा तपशिलांसह दिलेली असल्यास, तो अर्ज निनावी किंवा खोट्या नावाचा असला तरी त्याबाबत चौकशी करणे आवश्यक आहे.
- क्षेत्रीय कार्यालयातील भ्रष्टाचार, लाचलुचपत, गैरव्यवहार इ. बाबतच्या तक्रारींची चौकशी करण्यासाठी व अशा गैरप्रकारांना आळा घालण्यासाठी प्रत्येक महसूल विभागात एक अशी एकूण ६ दक्षता पथके, पाटबंधारे विभागाने निर्माण केली असून प्रत्येक पथक एका अधिक्षक अभियंत्याच्या नियंत्रणाखाली काम करते. अशाच प्रकारची ६ दक्षता व गुण नियंत्रण मंडळे सार्वजनिक बांधकाम विभागाने स्थापन केली आहेत व प्रत्येक मंडळाचे अधिपत्य मंडळाचे अधिपत्य एका अधिक्षक अभियंत्याकडे सोपविली आहे. शासन वा मुख्य अभियंता यांकडे वर्ग १ व २ मधील अधिकाऱ्यांच्या गैरव्यवहाराबाबत आलेल्या तक्रारी प्रारंभिक चौकशीसाठी या दक्षता पथकांकडे किंवा मंडळांकडे पाठविण्यात येतात. त्याचप्रमाणे वर्ग ३ व ४ मधील कर्मचाऱ्यांविरुद्ध भ्रष्टाचार इ. बाबतच्या तक्रारींची प्रारंभिक चौकशी करण्यासाठी पाटबंधारे विभागाच्या मुख्य अभियंत्यांच्या कार्यालयात दक्षता कक्ष निर्माण करण्यात आले आहेत.
- घराची झडती घेणे, बँकेतील रकमांची तपासणी करणे, सापळा लावणे इ. गोष्टी जेथे आवश्यक असतील अशी प्रकरणे प्रारंभिक चौकशीसाठी लाचलुचपत विरोधी केंद्राकडे (म्हणजे एसीबीकडे) पाठविली जातात. विशेषतः उत्पन्नाच्या ज्ञात साधनांच्या तुलनेने प्रमाणाबाहेर मालमत्ता असल्याच्या तक्रारी या सदरात मोडतात.
- प्रारंभिक चौकशी शक्य तो लवकर पूर्ण केली पाहिजे. सदर चौकशीचा अहवाल प्राप्त झाल्यानंतर शिस्तभंगविषयक प्राधिकाऱ्याने तो विचारात घेऊन पुढील आवश्यक कार्यवाहीसंबंधी निर्णय घ्यावयाचा असतो. संबंधित कर्मचाऱ्यांबाबतची तक्रार बिनबुडाची असल्याने आढळल्यास त्याच्या विरुद्ध शिस्तभंगाची कार्यवाही करण्याचा प्रश्नच उद्भवत नाही. त्या उलट, तक्रारीत तथ्य असल्याचे दिसून आल्यास प्रकरण परतवे किरकोळ किंवा जबर शिक्षेसंबंधीची कार्यवाही शिस्तभंग विषयक प्राधिकाऱ्यास सुरु करावी लागते. काही प्रकरणात आरोपी कर्मचाऱ्यावर फौजदारी खटला भरण्याची कार्यवाही देखील

आवश्यक असते. प्रारंभिक चौकशी जितक्या व्यवस्थितपणे केली असेल व त्यातून निष्पन्न झालेला पुरावा जितका परिपूर्ण असेल तितकीच पुढील कार्यवाही यशस्वी होईल. यावरून प्रारंभिक चौकशीचे महत्व लक्षात येईल.

निलंबन (नियम ४) :-

- शिस्त व अपील नियम ४ अन्वये शासकीय कर्मचाऱ्यास खालील परिस्थितीत निलंबित करता येते.
 - जेव्हा त्याच्या विरुद्ध शिस्तभंगाची कार्यवाही करण्याचे योजले असते किंवा तशी कार्यवाही चालू असते.
 - जेव्हा त्याच्या विरुद्ध एखाद्या फौजदारी गुन्ह्यांसंदर्भात तपास, चौकशी किंवा खटला चालू असतो.
 - जेव्हा राज्याच्या सुरक्षिततेला बाधक अशा कामामध्ये तो गुंतलेला असतो.
- निलंबनाचे आदेश काढण्यास सक्षम प्राधिकारी खालीलप्रमाणे :-
 - संबंधित कर्मचाऱ्याचा नियुक्ती प्राधिकारी
 - नियुक्ती प्राधिकाऱ्याचा कोणताही वरीष्ठ
 - शिस्तभंगाविषयक प्राधिकारी
 - राज्यपालांनी या बाबतीत शक्तीप्रदान केलेला कोणताही अन्य प्राधिकारी नियुक्ती प्राधिकाऱ्यापेक्षा खालच्या दर्जाच्या अधिकाऱ्याने निलंबनाचा आदेश काढला असल्यास कोणत्या परिस्थितीत तो काढण्यात आला त्याबाबतचा अहवाल सदर अधिकाऱ्याने तात्काळ नियुक्ती प्राधिकाऱ्याकडे पाठविला पाहिजे.
- निलंबनाचा आदेश पुरेशा समर्थनाशिवाय किंवा बेफिकीरीने काढू नये. संबंधित शासकीय कर्मचाऱ्यावरील आरोप जेव्हा गंभीर स्वरूपाचे असतात व सुकृतदर्शनी त्याला सेवेतून काढून टाकण्यासारखी किंवा बडतर्फ करण्यासारखी परिस्थिती असते किंवा तो कामावर राहिल्याने चौकशीमध्ये अडचणी निर्माण होण्याची जेव्हा शक्यता असते, तेव्हाच त्याला निलंबित करावे. इतर बाबतीत त्याची दूर बदली करावी जेणेकरून त्याला साक्षीदार किंवा पुरावे यांच्यात ढवळाढवळ करण्यास संधी मिळणार नाही.
- निलंबनाचा आदेश निलंबित कर्मचाऱ्याला मिळाल्याच्या दिनांकापासून परिणामकारक होतो. मात्र रजेवर असलेल्या कर्मचाऱ्याच्या बाबतीत आदेशाच्या दिनांकापासून किंवा त्यात नमूद केलेल्या पुढील दिनांकापासून तो परिणामकारक होतो.
- निलंबित कर्मचाऱ्यास कामावर जाता येत नाही, तथापि तो शासनाच्या सेवेत राहतो व सरकारी नोकरांचे वर्तणूक नियम त्याला लागू असतात, त्यामुळे निलंबनाच्या कालावधीत शासनाच्या मंजूरीखेरीज दुसरा कोणताही व्यवसाय किंवा नोकरी त्याला करता येत नाही. म्हणून त्याच्या निर्वाहासाठी निलंबनाच्या पहिल्या तीन महिन्यात त्याला खालीलप्रमाणे भत्ते देण्यात येतात -
 - अर्धवेतनी रजेच्या काळात अनुज्ञेय रजावेतनाइतका निर्वाह भत्ता
 - त्यावर आधारित महागाई भत्ता व
 - निलंबनापूर्वी अनुज्ञेय असलेले इतर पूरक भत्ते
 - पहिल्या तीन महिन्यांनंतर जर असे आढळून आले की निलंबनाचा कालावधी लांबला त्यासाठी निलंबित कर्मचारी जबाबदार नाही तर त्याच्या निर्वाह भत्त्यामध्ये ५० टक्के पर्यंत कपात केली

जाते. महागाई भत्त्याचा दर वाढलेल्या किंवा कमी केलेल्या निर्वाह भत्त्याच्या रक्कमेवर आधारित असतो. इतर पूरक भत्ते पूर्वीप्रमाणेच मिळवतात.

- खालील परिस्थितीत नियुक्ती प्राधिकाऱ्याच्या आदेशान्वये शासकिय कर्मचाऱ्यास निलंबित केले असे मानण्यात येते.
 - फौजदारी आरोपाखाली किंवा अन्यथा ४८ तासांहून अधिक काळ त्याला पोलिसांच्या किंवा न्यायालयीन कोठडीत अटकेत ठेवले असल्यास अटकेच्या दिनांकापासून
 - त्याला सिध्दापराध ठरवून ४८ तासांहून अधिक काळापर्यंत कारावासाची शिक्षा झाली असल्यास व त्यानंतर तात्काळ त्याला बडतर्फ केले नसेल. नोकरीतून काढून टाकले नसेल वा सवतीने सेवानिवृत्त केले नसेल तर त्याच्या अपराधसिध्दीच्या दिनांकापासून निलंबनाच्या किंवा मानीव निलंबनाचा आदेश ज्या प्राधिकाऱ्याने काढला असेल तो प्राधिकारी किंवा सदर अधिकाऱ्यांचा कोणताही वरीष्ठ अधिकारी तो आदेश सुधारीत किंवा रद्द करू शकतो.
- निलंबनानंतर संबंधित कर्मचाऱ्याची सेवेत पुनःस्थापना झाल्यास सक्षम प्राधिकाऱ्याने खालील बाबींसंबंधी आदेश काढणे आवश्यक आहे.
 - निलंबनाच्या कालावधीत सदर कर्मचाऱ्यास वेतन व भत्ते कोणत्या दराने देय असतील ...
 - रजा, निवृत्ती वेतन इ.निश्चित करण्यासाठी निलंबनाचा कालावधी कर्तव्यकाल म्हणून गणला जाईल काय ...
- यासंबंधीचे मार्गदर्शन महाराष्ट्र नगरी सेवा (पदग्रहण अवधी, स्वीयेत्तर सेवा आणि निलंबन, बडतर्फी व सेवेतून काढून टाकणे या कालावधीतील प्रदाने) नियम १९८९ मधील ७२ मध्ये आढळते. थोडक्यात ते खालीलप्रमाणे -
 - १) निलंबित कर्मचारी विभागीय चौकशीअंती किंवा न्यायालयात संपूर्ण त्या निर्दोष ठरल्यास त्याच्या निलंबनाचा कालावधी सर्व प्रयोजनांसाठी कर्तव्यकाल म्हणून मानला जावा. सदर कालावधी त्याला निलंबित केले नसते तर वेळोवेळी त्याला जे वेतन व भत्ते मिळाले असते ते त्याला पूर्णतया अनुज्ञेय असावे. मात्र त्याविरुद्धच्या कार्यवाहीतील विलंबास तो कारणीभूत असल्याचे आढल्यास त्याला तशी कारणे दाखवा नोटीस देऊन व त्याचे अभिवेदन विचारात घेऊन सक्षम अधिकारी विलंबाच्या कालावधीसाठी वेतन व भत्ते यांपोटी निश्चित करील एवढी रक्कम (संपूर्ण नव्हे) त्याला देय राहिल.
 - २) इतर प्रकरणात (जेथे संबंधित कर्मचाऱ्याचे निलंबन पूर्णतया असमर्थनीय होते असे म्हणता येत नाही) सदर कर्मचाऱ्यास कारणे दाखवा नोटीस देऊन व त्या नोटीसीस त्याने दिलेले उत्तर विचारात घेऊन निलंबनाच्या कालावधीत त्याला देय वेतन व भत्ते व त्याच्या निलंबनकालाचे नियमन यासंबंधीचा निर्णय सक्षम प्राधिकाऱ्याने द्यावा. अशा कर्मचाऱ्यास १०० टक्के पेक्षा कमी वेतन व भत्ते दिले जातात. तसेच निलंबनाचा कालावधी हा एखाद्या विनिर्दिष्ट प्रयोजनाकरीता कर्तव्य काल म्हणून मानता येतो. कर्मचाऱ्याची तशी इच्छा असल्यास निलंबनाचा कालावधी त्याला अनुज्ञेय रजेमध्ये रुपांतरीत करता येतो.
 - ३) कोणत्याही प्रकरणात निलंबन कालामध्ये देय निर्वाह भत्ता व इतर भत्ते यापेक्षा कमी निलंबनकालावसाठी देय ठरू नये. निलंबन कालावधी नियमित केल्यानंतर संबंधित कर्मचाऱ्यास प्रदान करावयाच्या फरकाने रक्कम रु.२००० पेक्षा अधिक असल्यास ती देण्यासाठी शासनाची मंजूरी घेणे आवश्यक आहे.

किरकोळ शिक्षा करण्याची पध्दती (नियम १०) :-

- किरकोळ शिक्षा व जबर शिक्षा यांच्या कार्यपध्दती भिन्न आहेत. जबर शिक्षेची कार्यपध्दती बरीच वेळखाऊ आहे. त्यात शिस्तभंगविषयक प्राधिकारी व आरोपी कर्मचारी यांखेरीज चौकशी प्राधिकारी, सादरकर्ता अधिकारी, बचाव सहाय्यक, साक्षीदार अशा अनेक व्यक्तींचे श्रम व वेळ खर्ची पडतात. त्याऊलट किरकोळ शिक्षेची कार्यपध्दती छोटी व सुटसुटीत अशी आहे. म्हणून सकृतदर्शनी जबर शिक्षा देण्यालायक असे गंभीर स्वरूपाचे आरोप एखाद्या कर्मचाऱ्याविरुद्ध असतील तेव्हाच जबर शिक्षेची कार्यवाही अवलंबावी. अन्यथा किरकोळ शिक्षेची कार्यकाही चालू करुन ती शक्य तो लवकर पूर्ण करावी हे श्रेयस्कर.
- किरकोळ शिक्षेची कार्यपध्दती शिस्त व अपील नियम १० मध्ये विहित केली आहे. त्यानुसार प्रथम शिस्तभंगविषयक प्राधिकाऱ्याने आरोपी कर्मचाऱ्यास त्याच्याविरुद्ध करावयाच्या प्रस्तावित कार्यवाहीबाबत ज्ञापनाद्वारे लेखी कळवावे. त्याच्या ज्या गैरवर्तणुकीसंबंधात कार्यवाही करावयाची आहे त्या बाबतीत त्याला काही अभिवेदन करावयाचे असल्यास त्याकरीता वाजवी संधी म्हणजे साधारणतः १० दिवसांची मुदत त्याला द्यावी. ज्ञापनावर शिस्तभंगविषयक प्राधिकाऱ्याने स्वतः सही करणे आवश्यक आहे. त्याच्या वतीने इतर कोणी सही करू नये. ज्ञापन आरोपी कर्मचाऱ्यास व्यक्तिशः द्यावे किंवा पोच देय नोंदणी डाकेने त्याच्या योग्य पत्त्यावर पाठवावे. त्याने दिलेली पोच प्रकरणाच्या कागदपत्रात ठेवावी.
- आरोपी कर्मचाऱ्याला आपल्या बचावाचे अभिवेदन तयार करण्यासाठी कार्यालयीन कागदपत्र तपासण्याची सवलत देण्यासंबंधीची तरतूद नियम १० मध्ये केलेली नाही. तथापि ज्या कागदपत्रांवर आरोप आधारीत आहेत. तसेच अभिवेदन करण्यासाठी जे कागदपत्र पहाणे आवश्यक असेल असे सर्व कार्यालयीन कागदपत्र तपासण्याची मुभा आरोपी कर्मचाऱ्यास देणे त्याला बचावाची वाजवी संधी देण्याच्या दृष्टीने योग्य होईल.
- जबर शिक्षेसाठी तपशिलवार मौखिक चौकशीची जी कार्यपध्दती विहित केली आहे ती किरकोळ शिक्षेसाठी सर्वसाधारणतः आवश्यक नाही. तथापि किरकोळ शिक्षेच्या एखाद्या प्रकरणात अशी चौकशी करणे जरूरीचे आहे. असे शिस्तभंगविषयक प्राधिकाऱ्यास वाटल्यास तो तशी चौकशी करू शकतो.
- शिक्षा म्हणून आरोपी कर्मचाऱ्याची वेतनवाढ, पुढील वेतनवाढीवर परिणाम न होता ३ वर्षांहून अधिक काळ राखावयाचा असेल किंवा पुढील वेतनवाढीवर परिणाम करुन कितीही काळ राखावयाची असेल किंवा वेतनवाढ रोखल्यामुळे त्याच्या निवृत्तीवेतनाच्या रकमेवर प्रतिकूल परिणाम होणार असेल तर अशा प्रकरणात मात्र सदर शिक्षा देण्यापूर्वी जबर शिक्षेसाठी विहित केलेली कार्यपध्दती अनुसरली पाहिजे.
- आरोपी कर्मचाऱ्याने सादर केलेले अभिवेदन व तपशिलवार चौकशी केली असल्यास त्यासंबंधीचे कागदपत्र विचारात घेऊन त्याच्या गैरवर्तणुकीच्या प्रत्येक आरोपाबाबतचा आपला निष्कर्ष शिस्तभंगविषयक प्राधिकाऱ्याने लेखी नोंदविला पाहिजे.
- त्यानंतर शिस्तभंगविषयक प्राधिकाऱ्याने अंतिम आदेश काढावयाचे असतात. आरोपी कर्मचाऱ्यावरील आरोप सिध्द होत नाहीत अशी त्या प्राधिकाऱ्याची खात्री पटल्यास सदर कर्मचाऱ्यास दोषमुक्त करुन त्यानुसार त्याला लेखी कळवावे.

- शिस्तभंगविषयक प्राधिकाऱ्याच्या मते आरोपी कर्मचारी दोषी ठरल्यास त्याला योग्य ती किरकोळ शिक्षा करण्यासंबंधीचा आदेश काढता येईल. मात्र वर्ग १ किंवा २ मधील अधिकाऱ्याच्या वेतनातून शासकिय नुकसानीची वसुली करण्याचा प्रस्ताव असल्यास त्याबाबत अंतिम आदेश काढण्यापूर्वी राज्य लोकसेवा आयोगाचा सल्ला घेणे आवश्यक आहे. अन्य बाबतीत (म्हणजे वर्ग १ किंवा २ मधील अधिकाऱ्यांस इतर किरकोळ शिक्षा देण्यापूर्वी तसेच वर्ग ३ किंवा ४ मधील कर्मचाऱ्याला कोणतीही शिक्षा देण्यापूर्वी) लोकसेवा आयोगाच्या पूर्व सल्ल्याची आवश्यकता नाही.
- किरकोळ शिक्षेचा आदेश स्वयंस्पष्ट असावा. त्यात आरोपी कर्मचाऱ्याच्या अभिवेदनातील मुद्यांवर आपले अभिप्राय देऊन शिस्तभंगविषयक प्राधिकाऱ्याने आपल्या अंतिम निर्णयाची कारणे नमूद केली पाहिजेत. राज्य लोकसेवा आयोगाचा सल्ला घेतला असल्यास त्याची प्रत आदेशाबरोबर जोडावी. तसेच आयोगाचा सल्ला मान्य केला नसल्यास त्याबाबतची संक्षिप्त कारणे नमूद करावी.

जबर शिक्षा करण्याची पध्दती (नियम ८,९ व ११)

दोषारोपपत्र बजावणे :

- जबर शिक्षेची कार्यपध्दती शिस्त व अपील नियम ८,९ व ११ मध्ये विहित केली आहे. त्यानुसार प्रथम शिस्तभंगविषयक प्राधिकाऱ्याने स्वतः सही केलेल्या ज्ञापनाद्वारे खालील जोडपत्रे आरोपी कर्मचाऱ्यास पोचती करावी :-
 - दोषारोपांच्या बाबींची प्रत
 - प्रत्येक दोषारोपाच्या पुष्ट्यर्थ गैरवर्तणुकीच्या आरोपांचे विवरणपत्र
 - ज्या साक्षीदारांचय साक्षीआधारे दोषारोप सिध्द करावयाचे आहेत त्या साक्षीदारांची यादी.
 - ज्या दस्तऐवजांच्या आधारे दोषारोप सिध्द करावयाचे आहेत त्या दस्तऐवजांची यादी. (पुढील चौकशीची कार्यवाही त्वरीत होण्याच्या दृष्टीने या दस्तऐवजांच्या प्रती देखील ज्ञापनासोबत आरोपी कर्मचाऱ्यास पुरविण्यात याव्या.)
- दोषारोप म्हणजे आरोपी कर्मचाऱ्याविरुध्द करण्यात आलेल्या अभिकयनांचा सारांश उदा. कार्यालयीन कामात दुर्लक्ष खोटी प्रवासभत्ता देयके प्रस्तुत करणे, सरकारी पैशांची अफरातफर इ. उपनिर्दिष्ट ज्ञापनाच्या जोडपत्र (१) मध्ये दोषारोपाची प्रत्येक बाबत सुस्पष्टपणे व नेमक्या शब्दांत मांडावी. त्यात संदिग्धता नसावी. (उदा. प्आणि इतर आरोप असा उल्लेख). वेगवेगळ्या अभिकयनांच्या संदर्भात वेगवेगळे दोषारोप नमूद करावे. उलटपक्षी एकाच अभिकयनाच्या आधारे दोषारोपाची व्दिरुक्ती किंवा विभागणी करण्याचे टाळावे. ज्याबाबी संबंधात पूर्वी चौकशी व निर्णय झाला असेल अशा बाबींचा समावेश दोषारोपपत्रात करू नये.
- गैरवर्तणुकीच्या आरोपांच्या विवरणपत्रात (जोडपत्र २) मूळ कागदपत्रांच्या आधारे आरोपी कर्मचाऱ्यांच्या गैरवर्तणुकीसंबंधी तपशिलवार वस्तुस्थितीदर्शक निवेदन करण्यात यावे. आरोपी कर्मचाऱ्याने एखाद्या विवक्षित वर्तणूक नियमाचा त्याने भंग केलेला असला तर तो नियम नमूद करावा. तसेच त्याची पूर्वीची गैरवर्तणूक शिक्षा देताना विचारात घ्यावयाची असल्यास अशा गैरवर्तणुकीचा उल्लेखही या विवरणपत्रात करावा.
- प्रारंभिक चौकशीत अनेक साक्षीदारांचे जबाब घेतले जातात. त्यापैकी जे साक्षीदार आरोप साधार असल्याबद्दल निश्चित पुरावा देऊ शकतील अशा साक्षीदारांना शिस्तभंगविषयक प्राधिकाऱ्यातर्फे विभागीय चौकशीत बोलाविण्याच्या दृष्टीने केवळ त्यांच्याच नावांचा समावेश जोडपत्र (३) मध्ये करावा.

- प्रारंभिक चौकशीमध्ये गोळा केलेला जो कागदोपत्री पुरावा विभागीय चौकशीत आरोपी कर्मचाऱ्याविरुद्ध वापरावयाचा आहे त्याचा उल्लेख जोडपत्र (४) मधील दस्तऐवजांच्या यादीत करून त्याच्या प्रती त्याला द्याव्या. मात्र प्रारंभिक चौकशी अधिकाऱ्याच्या अहवालाचा उल्लेख कोणत्याही जोडपत्रात किंवा एकूण चौकशी मध्ये करू नये.
- थोडक्यात आरोपी कर्मचाऱ्यास त्याविरुद्ध असलेल्या संपूर्ण प्रकरणाची माहिती आवश्यक तपशिलासह देण्यात यावी म्हणजे नेमक्या कोणत्या आरोपांना आपल्यास उत्तरे द्यावयाची आहेत त्याची स्पष्ट कल्पना त्याला येईल. दोषारोपांच्या बाबी किंवा गैरवर्तणूकीच्या आरोपांचे विवरणपत्र मोघम असल्यास, अशा मोघमपणामुळे आरोपी कर्मचाऱ्यास दिलेली बचावाची संधी वाजवी नव्हती त्या निष्कर्षास दुजोरा मिळू शकेल.
- उपरिनिर्दिष्ट चार जोडपत्रांसह पाठवावयाच्या ज्ञापनात आरोपी कर्मचाऱ्यास कळवावे. त्याने आपल्या बचावाचे लेखी निवेदन त्याला दिलेल्या ठराविक मुदतीत (साधारणतः १० दिवस) शिस्तभंगविषयक प्राधिकाऱ्यास प्रस्तुत करावे व आपले म्हणणे व्यक्तिशः मांडण्याची इच्छा असल्यास तसे कळवावे. ज्ञापन व जोडपत्रे आरोपी कर्मचाऱ्यास व्यक्तिशः देऊन त्याची पोच घ्यावी किंवा पोच देय नोंदणी डाकेने ती त्याच्या योग्य पत्त्यावर पाठवावीत. त्याची पोचपावती संबंधित प्रकरणाच्या कागदपत्रात ठेवावी.
- आरोपी कर्मचाऱ्याने आपल्या लेखी निवेदनात सर्व आरोप मान्य केल्यास शिस्तभंगविषयक प्राधिकाऱ्याने योग्य तो पुरावा लक्षात घेऊन प्रत्येक आरोपाबाबतचे आपले निष्कर्ष नोंदवावे व त्यानुसार पुढील कार्यवाही करावी.

चौकशी प्राधिकाऱ्याची नियुक्ती :-

- आरोपी कर्मचाऱ्याने आपल्या लेखी निवेदनात काही किंवा सर्व आरोप अमान्य केल्यास तसेच त्याने कोणतेही निवेदन न दिल्यास मान्य न केलेल्या आरोपांबाबत शिस्तभंगविषयक प्राधिकाऱ्याने स्वतः चौकशी करावी किंवा चौकशी प्राधिकारी हा साधारणतः आरोपी कर्मचाऱ्यापेक्षा वरिष्ठ दर्जाचा असावा. विभागीय चौकशीचे कामकाज न्यायसदृश असते. तेव्हा चौकशी प्राधिकाऱ्याने नियमास अनुसरून काटेकोरपणे व सद्भावनेने आपले काम केले पाहिजे. साहजिकच त्याला विभागीय चौकशीचे नियम व कार्यपद्धती यांची संपूर्ण माहिती असावी. तसेच तो आरोपी कर्मचाऱ्यांविषयी पूर्वग्रदूषित नसावा. आरोपी कर्मचाऱ्यांविरुद्ध केलेल्या प्रारंभिक चौकशी कामाशी संबंधित असलेल्या व्यक्तिस तसेच विभागीय चौकशीत कोणत्याही बाजून साक्षीदार म्हणून बोलावले जाण्याची शक्यता असलेल्या व्यक्तिस चौकशी
- निरनिराळ्या दर्जाच्या कर्मचाऱ्याविरुद्ध विभागीय चौकशी चालविण्यासाठी खालीलप्रमाणे विविध स्तरांवर विभागीय चौकशी अधिकाऱ्यांची खास पदे शासनाने निर्माण केली आहेत.
 - वरीष्ठ अधिकाऱ्यांविरुद्ध शासनाने विशेषकरून सोपविलेल्या चौकशी चालविण्यासाठी मंत्रालयीन स्तरांवर सामान्य प्रशासन विभागात एक विशेष चौकशी अधिकाऱ्याचे पद निर्माण करण्यात आले आहे.
 - वर्ग १ व २ मधील अन्य अधिकाऱ्यांविरुद्ध चौकशी चालविण्यासाठी प्रत्येक विभागीय आयुक्तांच्या कार्यालयात एक अशी एकूण सह प्रादेशिक विशेष अधिकारी, विभागीय चौकशी यांची पदे निर्माण केली आहेत.
 - वर्ग ३ व ४ मधील कर्मचाऱ्यांविरुद्ध चौकशी चालविण्यासाठी साधारणतः प्रत्येक जिल्हाधिकारी कार्यालयात एक अशी एकूण एकोणतीस जिल्हा चौकशी अधिकाऱ्यांची पदे निर्माण केली आहेत.

- कोणत्याही विभागाच्या चौकशी प्रकरणात शिस्तभंगविषयक प्राधिकाऱ्याने वरीलपैकी संबंधित अधिकाऱ्यांची चौकशी प्राधिकारी म्हणून नियुक्ती करावी. ही नेमणूक नावाने न करता पदनामाने करावी. म्हणजे संबंधित अधिकाऱ्याची बदली झाली तरी त्याचा उत्तराधिकारी चौकशी चालू ठेवू शकतो व त्यासाठी शिस्तभंगविषयक प्राधिकाऱ्यास नव्याने काही आदेश काढण्याची आवश्यकता नसते. चौकशी प्राधिकाऱ्याच्या नेमणूकीच आदेशावर शिस्तभंगविषयक प्राधिकाऱ्याने स्वतः सही करावी. चौकशी प्राधिकारी देखील चौकशीचे काम अन्य कोणत्याही व्यक्तीकडे सोपवू शकत नाही.

सादरकर्त्या अधिकाऱ्यांची नियुक्ती :-

- ज्या प्रकरणात चौकशी प्राधिकारी नियुक्ती करण्यात आला आहे. तेथे त्याच्यासमोर आरोपी कर्मचाऱ्याविरुद्धचे प्रकरण सादर करण्यासाठी शिस्तभंगविषयक प्राधिकाऱ्यास एखाद्या शासकिय कर्मचाऱ्याची किंवा वकीलीचा व्यवसाय करणाऱ्या व्यक्तीची सादरकर्ता अधिकारी म्हणून नियुक्ती करता येते. तथापि वकिलाची नियुक्ती शक्य तो टाळावी व प्रत्येक प्रकरणात सादरकर्ता अधिकारी म्हणून शासकिय कर्मचाऱ्याची नियुक्ती करावी.
- प्रत्येक विभागीय आयुक्तांच्या कार्यालयात शासनाने सादरकर्त्या अधिकाऱ्याचे एक खास पद निर्माण केले आहे. कोणत्याही विभागाच्या वर्ग १ व २ मधील अधिकाऱ्यांविरुद्धच्या चौकशात शिस्तभंगविषयक प्राधिकाऱ्याने या अधिकाऱ्यालाच सादरकर्ता अधिकारी म्हणून नियुक्त करावे. सार्वजनिक बांधकाम विभाग किंवा पाटबंधारे विभाग यांसारख्या विभागांच्या चौकशांमध्ये सादरकर्त्या अधिकाऱ्यास कधी कधी तांत्रिक अधिकाऱ्याची मदत सादरकर्त्या अधिकाऱ्यास देऊ शकतो.
- वर्ग ३ व ४ मधील कर्मचाऱ्यांविरुद्धच्या विभागीय चौकशात शिस्तभंगविषयक प्राधिकाऱ्याने आपल्या विभागातील एखाद्या योग्य अधिकाऱ्याची सादरकर्ता अधिकारी म्हणून नेमणूक करावी. प्रारंभिक चौकशी केलेल्या अधिकाऱ्यास तसेच विभागीय चौकशी मध्ये ज्याला साक्षीदार म्हणून बोलावले जाण्याची शक्यता आहे अशा व्यक्तिसादरकर्ता अधिकारी म्हणून नेमू नये.

बचाव सहायकाची नियुक्ती :-

- विभागीय चौकशीमध्ये आपली बाजू मांडण्यासाठी आरोपी कर्मचारी राज्यशासना सेवेतील किंवा सेवानिवृत्त अशा कोणत्याही कर्मचाऱ्याची मदत घेऊ शकतो. पण त्याकरीता वकीलीचा व्यवसाय करणाऱ्या व्यक्तीची मदत साधारणतः घेऊ शकत नाही. सादरकर्ता अधिकारी वकीलीच्या व्यवसायातील व्यक्तीची मदत घेण्यास शिस्तभंगविषयक प्राधिकारी परवानगी देवू शकतो.
- शासन सेवेत असलेल्या बचाव सहाय्यकास चौकशीच्या कामापित्यर्थ प्रवासखर्च व दैनिकभत्ता त्याच्या कार्यालयातून मिळतो. त्याउलट सेवानिवृत्त कर्मचाऱ्यास बचाव सहाय्यक म्हणून सहाय्यक घेतल्यास त्याचा खर्च आरोपी कर्मचाऱ्यास सोसावा लागतो. सेवेत असलेल्या व्यक्तीस बचाव सहाय्यक म्हणून काम करण्यासाठी नियंत्रक अधिकाऱ्याची परवानगी घ्यावी लागते. सेवानिवृत्त कर्मचाऱ्याच्या बाबतीत तो प्रश्न उद्भवत नाही.

प्राथमिक बाबी व पहिली सुनावणी :-

- शिस्तभंगविषयक प्राधिकाऱ्याने सुरुवातीलाच खालील कागदपत्रे चौकशी प्राधिकाऱ्याकडून पाठविली पाहिजेत. चौकशी प्राधिकाऱ्याच्या नेमणूकीच्या आदेशाबरोबरच ती पाठविण्यात यावी.
 - दोषारोपांच्या बाबींची प्रत व गैरवर्तणूकीच्या आरोपांचे विवरणपत्र

- आरोपी कर्मचाऱ्याने प्रस्तुत केलेल्या बनाव्याच्या लेखी निवेदनाची प्रत
 - साक्षीदारांच्या साक्षीच्या प्रती
 - दोषारोपादि सहपत्र आरोपी कर्मचाऱ्यास पोचती केल्याचा पुरावा व
 - सादरकर्ता अधिकाऱ्याच्या नेमणूकीच्या आदेशाची प्रत
- वरीलप्रमाणे कागदपत्रे मिळाल्यानंतर चौकशी प्राधिकाऱ्याने आरोपी कर्मचाऱ्यास लेखी नोटीस पाठवून ठरवलेल्या तारखेस, ठरवलेल्या वेळी, ठरवलेल्या ठिकाणी चौकशीसाठी आपल्यासमोर उपस्थित राहण्यास कळवावे. या पहिल्या सुनावणीत चौकशी प्राधिकाऱ्याने आरोपी कर्मचाऱ्यास विचारावे की त्याजविरुद्धचे दोषारोप त्याला मान्य आहेत काय दोषारोपाची कोणतीही बाब त्याने मान्य केल्यास त्याच्या सहीनिशी तशी नोंद करून चौकशी प्राधिकाऱ्याने त्यावर आपली स्वाक्षरी करावी. आरोपी कर्मचाऱ्याने मान्य केलेल्या दोषारोपीबाबत अधिक चौकशीची आवश्यकता नाही व सदर दोषारोप सिद्ध झाले असा निष्कर्ष चौकशी प्राधिकाऱ्याने काढावा. त्यानंतर आरोपी कर्मचाऱ्याने मान्य न केलेल्या दोषारोपांबाबतचा पुरावा सादर करण्यास चौकशी प्राधिकाऱ्याने सादरकर्त्या अधिकाऱ्यास सांगावे.

आरोपी कर्मचाऱ्याच्या बचावासाठी दस्तऐवज व साक्षीदार बोलाविणे :-

- त्यानंतर चौकशी प्राधिकाऱ्याने आरोपी कर्मचाऱ्यास खालीलप्रमाणे कळवून चौकशी कमाल ३० दिवसांची ठेवावी.
 - आरोपी कर्मचाऱ्याने दोषारोपपत्रासोबतच्या यादीतील दस्तऐवजांची तपासणी पुढील पाच दिवसांत (जास्तीत जास्त दहा दिवसांत) दिवसांत करावी.
 - सदर यादीत नसलेले शासनाच्या कब्जातील कोणतेही दस्तऐवज आरोपी कर्मचाऱ्यास स्वतःच्या बचावासाठी हवे असल्यास त्यांचा आपल्या प्रकरणाशी असलेला संबंध स्पष्ट करून दहा दिवसांत (जास्तीत जास्त वीस दिवसांत) त्याने त्यांसाठी मागणी करावी.
 - तसेच आपल्या वतीने तपासणी करावयाच्या साक्षीदारांची यादी त्यांच्या संपूर्ण पत्त्यासह आरोपी कर्मचाऱ्याने प्रस्तुत करावी.
- आरोपी कर्मचाऱ्याने मागितलेला कोणताही दस्तऐवज चौकशी प्रकरणाशी संबंधित नाही असे चौकशी प्राधिकाऱ्याचे मत झाल्यास तो त्याबाबतची कारणे लेखी नोंदवून सदर दस्तऐवज मागवून घेण्यास नकार देऊ शकतो. तथापि आरोपी कर्मचाऱ्यास आपल्या बचावाचीवाजवी संधी प्राप्त व्हावी याकरीता संबंधितेच्या प्रश्नाकडे शक्यतो त्याच्या दृष्टीकोनातून पहाणेयोग्य होईल. दस्तऐवज ज्या अधिकाऱ्यांच्या कब्जात असतील त्यांच्याकडून चौकशी प्राधिकाऱ्याने ते मागवून घ्यावे. कोणताही असा दस्तऐवज देणे लोकहिताच्या किंवा राज्याच्या सुरक्षिततेला बाधक होईल असे कब्जेदार अधिकाऱ्याचे मत झाल्यास त्याबाबतची कारणे लेखी नोंदवून तो चौकशी प्राधिकाऱ्यास तसे कळवू शकतो. मग चौकशी प्राधिकाऱ्यास तसे कळवू शकतो. मग चौकशी प्राधिकाऱ्याने त्यानुसार आरोपी कर्मचाऱ्यास आरोपी कर्मचाऱ्यास कळवावे.
- दोषारोप पत्रासोबतच्या यादीतील साक्षीदारांनी प्रारंभिक चौकशीमध्ये दिलेल्या साक्षीच्या प्रती आरोपी कर्मचाऱ्याने सांगितल्यास शिस्तभंगविषयक प्राधिकाऱ्याच्या वतीने सदर साक्षीदारांची तपासणी सुरु होण्यापूर्वी किमान तीन दिवस अगोदर चौकशी प्राधिकाऱ्याने त्या आरोपी कर्मचाऱ्याने सांगितल्यास शिस्तभंगविषयक प्राधिकाऱ्याच्या वतीने सदर साक्षीदांची तपासणी सुरु होण्यापूर्वी किमान तीन दिवस अगोदर चौकशी प्राधिकाऱ्याने त्या आरोपी कर्मचाऱ्यास दिल्या पाहिजेत.

- कोणत्याही व्यक्तीला विभागीय चौकशीमध्ये साक्षीदार म्हणून हजर राहण्यास किंवा एखादा दस्तऐवज सादर करण्यास भाग पाडण्यास अधिकार चौकशी प्राधिकाऱ्यास सामान्यतः नसतो. तथापि महाराष्ट्र विभागीय चौकशी (साक्षीदारांना हजर राहिल्यास आणि दस्तऐवज सादर करण्यास भाग पाडणे) अधिनियम १९८६ मधील कलम ४ अन्वये प्राधिकृत करण्यात आलेल्याचौकशी प्राधिकाऱ्यास हे अधिकार प्राप्त होतात. तसेच तो अशा साक्षीदारांची शपथेवर तपासणीही करू शकतो. मात्र सचोटीच्या अभावाबाबत दोषारोप असलेल्या चौकशांनाच उपरिनिर्दिष्ट अधिनियम लागू आहे.
- दोन्ही बाजूच्या साक्षीदारांना उपस्थित होण्यासाठी सक्ती करण्याचा प्राधिकार जरी चौकशी प्राधिकाऱ्यास सामान्यतः नसला तरी त्यांच्या उपस्थितीसाठी उचित ते सर्व उपाय योजना हे त्याचे कर्तव्य आहे. साक्षीदारांना पाठवावयाच्या नोटीसांवर चौकशी प्राधिकाऱ्याने स्वतः सही करावी. साक्षीदार शासकीय कर्मचारी असल्यास त्याच्या विभाग/कार्यालया प्रमुखद्वारा / त्याला नोटीस पाठवावी. या नोटीसचा त्याने अवमान केल्यास ते शासकीय कर्मचाऱ्याला अशोभनीय वर्तन ठरेल व तो शिस्तभंगाच्या कार्यवाहीस पात्र होईल. अशासकीय साक्षीदारांना नोंदणीकृत पोच देच डाकेने नोटीस पाठवाव्यात. एखाद्या साक्षीदाराला बोलावून अडचण किंवा पेच निर्माण करणे हाच आरोपी कर्मचाऱ्याचा एकमेव हेतू असेल व साक्षीदार असंबद्ध, अप्रस्तुत असेल तर कारणे लखी नोंदवून चौकशी प्राधिकारी अशा साक्षीदाराला बोलावण्याचे नाकारू शकतो.

शिस्तभंगविषयक प्राधिकाऱ्यातर्फे बाजू मांडणे :-

- चौकशी प्राधिकाऱ्याने ठरविलेल्या तारखेस प्रत्यक्ष चौकशीस प्रारंभ होतो. प्रथम शिस्तभंगविषयक प्राधिकाऱ्याच्या वतीने दोषारोपांच्या पृष्ठयर्थ कागदोपत्रांची अभिरक्षा करणारा अधिकारी किंवा त्याचा प्रतिनिधी सादर करतो. या कागदोपत्रांना निशाणी पी १, निशाणी पी यांप्रमाणे क्रमांक दिले जातात. म्हणजे या क्रमांकाद्वारा त्यांचा उल्लेख करणे पुढे सोयीचे जाते.
- एखाद्या दस्तऐवजाच्या विश्वासाहतेबद्दल आरोपी कर्मचाऱ्याने वाजवी शंका व्यक्त केल्यास त्या शंकेचे निरसन करण्यासाठी पुरावाप्रस्तुत करण्यास सादरकर्त्या अधिकाऱ्यास सांगितले जाते. दस्तऐवजावरील हस्ताक्षर किंवा सही वादग्रस्त असल्यास ज्या व्यक्तीने तो दस्तऐवज लिहिला किंवा त्यावर सही केली त्या व्यक्तीचा पुरावा घेता येतो किंवा त्या व्यक्तीच्या हस्ताक्षराशी परिचित अशा तज्ञाची किंवा हस्ताक्षर तज्ञाची साक्ष घेता येते. आरोपी कर्मचारी अशा तज्ञाची उलटतपासणी करू शकतो.
- त्यानंतर सादरकर्ता अधिकारी दोषारोपपत्रासोबतच्या यादीतीलसाक्षीदारांची एकामागून एक अशी तपासणी करतो यास सरतपासणी म्हणतात. एखाद्या विशिष्ट सुनावणीच्या वेळी सादरकर्ता अधिकारी गैरहजर असल्यास त्याच्या वतीने अन्य प्राधिकृत व्यक्ती तपासणीचे काम पुढे चालू ठेवू शकते. प्रत्येक साक्षीदाराच्या सरतपासणीनंतर आरोपी कर्मचारी किंवा त्याचा बचाव सहायक सदर साक्षीदाराची उलटतपासणी करू शकतो.
- आरोपी कर्मचाऱ्याविरुद्ध ज्याने साक्ष दिली आहे अशा साक्षीदाराची उलटतपासणी करणे हा आरोपी कर्मचाऱ्याचा एक महत्वाचा हक्क आहे. कारण उलटतपासणी ही खोट्यावर प्रकाश पाडण्याची व सत्य शोधून काढण्याची एक प्रभावी पद्धती आहे. सरतपासणीचे साक्षीदारज्याच्या वतीने पुरावा सादर करील आहे त्या पक्षकाराला अनुकूल अशा गोष्टी सांगून विरोधी पक्षाला लाभदायक अशा सत्य गोष्टी तो सहेतूकपणे लपवू शकतो हे लपविलेले सत्य शोधून काढता येईल अशा पद्धतीने साक्षीदाराला प्रश्न विचारण्यात उलटतपासणीची खरी कला असते.

- शिस्त नियमांमध्ये उलटतपासणीची पध्दती किंवा व्याप्ती विशद केलेली नाही. या बाबतीत भारतीय पुरावा अधिनियम यातील उलटतपासणीची स्वीकृत तत्वे अनुसरणे योग्य होईल. त्यापैकी तीन महत्वाची तत्वे खालीलप्रमाणे -
 - प्रश्न विचारणारी व्यक्ती ज्या उत्तराची इच्छा किंवा अपेक्षा करते ते उत्तर सूचित करणाऱ्या प्रश्नावर सूचक प्रश्न म्हणतात. असे प्रश्न सरतपासणीत किंवा फेरतपासणीत साधारणतः अनुज्ञेय नसतात. परंतु उलटतपासणीत सूचक प्रश्न विचारता येतात.
 - ज्या बाबींविषयी एखाद्या साक्षीदाराची सरतपासणी झाली आहे तेवढ्याच बाबींपुरती त्याची उलटतपासणी मर्यादीत करणे आवश्यक नाही उलटतपासणी संपूर्ण प्रकरणाइतकी व्यापक करता येते.
 - उलटतपासणीत साक्षीदारास (अ) तो खरे बोलत आहे किंवा नाही याची पारख करण्यासाठी (ब) तो कोण आहे व समाजात त्याची लायकी काय आहे हे उघड करण्यासाठी तसे (क) त्याच्या लौकिकास लांछन लावून त्याच्या खरेपणाबद्दल संदेह उत्पन्न करण्यासाठी प्रश्न विचारता येतात. मात्र केवळ त्याचा अपमान किंवा छळ करण्याच्या हेतुने
- आरोपी कर्मचार्याने किंवा त्याच्या बचाव सहाय्यकाने ज्या मुद्यांवर साक्षीदाराची उलटतपासणी केली असेल त्या मुद्यांबाबत सादरकर्ता अधिकारी त्याची फेरतपासणी करू शकतो. मात्र एखाद्या नवीन मुद्यावर फेरतपासणी करावयाची असल्यास चौकशी अधिकाऱ्याची परवानगी आवश्यक आहे.
- चौकशी अधिकारी देखील साक्षीदाराला योग्य ते प्रश्न विचारू शकतो. त्या प्रश्नांच्या उत्तरासंदर्भात चौकशी प्राधिकाऱ्याच्या परवानगीने आरोपी कर्मचारी किंवा त्याचा बचाव सहाय्यक साक्षीदाराची उलटतपासणी करू शकतो.
- दोषारोपपत्रासोबत आरोपी कर्मचार्यास दिलेल्या याद्यात समाविष्ट नसलेला तोंडी किंवा कागदपत्रांचा नवा पुरावा उपस्थित करण्यास सादरकर्त्या अधिकाऱ्यास चौकशी प्राधिकारी परवानगी देऊ शकतो. चौकशी प्राधिकारी स्वतः देखील नवा पुरावा मागवू शकतो किंवा एखाद्या साक्षीदाराला पुन्हा बोलावून त्याची फेरतपासणी करू शकतो. या सर्व बाबतीत अशा अधिक पुराव्याची यादी मिळण्याचा, नवीन कागदपत्रांची तपासणी करण्याचा व चौकशी तीन दिवसांनी पुढे ढकलून घेण्याचा आरोपी कर्मचार्यास हक्क असतो. तसेच अधिक पुरावा सादर करणे किंवा साक्षीदाराची फेरतपासणी करणे हे पूर्वीच्या पुराव्यातील तफावत भरून काढण्यासाठी अनुज्ञेय असेल.

आरोपी कर्मचार्यातर्फे बाजू मांडणे :-

- अशा प्रकारे शिस्तभंगविषयक प्राधिकाऱ्याची बाजू मांडून संपल्यावर चौकशी प्राधिकाऱ्याने आरोपी कर्मचार्यास आपला बचाव तोंडी किंवा लेखी सादर करण्यास सांगावे. बचाव तोंडी दिल्यास तो लिहून काढावा. बचावाच्या निवेदनाची प्रत सादरकर्त्या अधिकाऱ्यास द्यावी.
- त्यानंतर आरोपी कर्मचार्याच्या वतीने पुरावा सादर करण्यात यावा. त्याच्या साक्षीदारांची सरतपासणी स्वतः आरोपी कर्मचारी किंवा त्याचा बचाव सहाय्यक करील, तर सादरकर्ता अधिकारी या साक्षीदारांची उलटतपासणी करील. उलटतपासणीतील मुद्यांवर व चौकशी प्राधिकाऱ्याच्या पदवानगीने इतर मुद्यांवर, आरोपी कर्मचार्यास वा त्याचा बचाव सहाय्यकास या साक्षीदारांची फेरतपासणी करता येईल. चौकशी प्राधिकारी देखील साक्षीदारांस योग्य ते प्रश्न विचारू शकतो व त्या प्रश्नांच्या उत्तरासंदर्भात सादरकर्ता अधिकारी चौकशी प्राधिकाऱ्याच्या परवानगीने साक्षीदारांची उलटतपासणी करू शकतो.

- आरोपी कर्मचारी इच्छा असल्यास आपल्या बाजून स्वतः साक्ष देऊ शकतो. मग सादरकर्ता अधिकारी त्याची उलट तपासणी करू शकतो. व चौकशी प्राधिकारी सुद्धा त्याला प्रश्न विचारू शकतो.
- न्यायोचित असल्यास, चौकशी प्राधिकाऱ्यास वर परिच्छेद ७४ मध्ये नमूद केलेल्या पद्धतीनुसार आरोपी कर्मचाऱ्याला नवीन पुरावा पुढे आणण्यास परवानगी देता येते. मात्र वर म्हटल्याप्रमाणे मूळ पुराव्यात अंगभूत उणीवा किंवा दोष असले तरच असा नवा पुरावा मांडता येईल. पूर्वीच्या पुराव्यातील तफावत भरून काढण्यासाठी नवीन पुरावा मांडण्याची परवानगी दिली जाणार नाही.
- आरोपी कर्मचाऱ्यातर्फे बाजू मांडून झाल्यावर एकूण पुराव्या मध्ये त्याच्या विरुद्ध जात असलेल्या मुद्द्यांबाबत स्पष्टीकरण करणे त्याला शकत व्हावे याकरीता चौकशी प्राधिकाऱ्याने त्याला सदर मुद्द्यांबाबत प्रश्न विचारावे. आरोपी कर्मचाऱ्याने आपल्या वतीने स्वतः साक्ष दिली नसल्यास चौकशी प्राधिकाऱ्यास असे प्रश्न विचारणे बंधनकारक आहे.

अंतिम सुनावणी :-

- अशा प्रकारे दोन्ही बाजूंनी पुरावा मांडून झाल्यानंतर चौकशी प्राधिकाऱ्याने सादरकर्त्या अधिकाऱ्यास त्याच्या युक्तीवादाचे टाचण प्रस्तुत करण्यास सांगावे. ते प्राप्त झाल्यानंतर त्याची एक प्रत आरोपी कर्मचाऱ्यास द्यावी व त्याकडून त्याच्या उत्तराचे टाचण घ्यावे.

एकतर्फी चौकशी :-

- आरोपी कर्मचाऱ्यास द्यावी दोषारोपत्र पोचते केल्यानंतर विनिर्दिष्ट तारखेपर्यंत त्याने आपल्या बचावाचे लेखी निवेदन सादर केले नाही किंवा चौकशी प्राधिकाऱ्यासमोर तो हजर झाला नाही किंवा नियमांतील तरतुदींचे त्याने अनुपालन केले नाही तर चौकशी प्राधिकारी एकतर्फी चौकशी करू शकतो. अशा एकतर्फी चौकशीमध्ये आरोपी कर्मचाऱ्याच्या अनुपस्थितीत शक्य असेल ती सर्व चौकशी नियमानुसार केली पाहिजे. सादरकर्त्या अधिकाऱ्यास कागदपत्रांचा पुरावा व कोणत्याही टप्प्यावर तो त्यात सहभागी होण्यास तयार झाला तर त्याला सहभागी होऊ द्यावे. त्यापूर्वी नोंदविलेल्या साक्षीच्या प्रतीही त्याला द्याव्या, पण साक्षीदारांना पुनःश्च बोलावण्याची आवश्यकता नाही.

नव्या चौकशी प्राधिकाऱ्याची नियुक्ती :-

- चौकशी प्राधिकाऱ्याने चौकशीतील पुरावा पूर्णतः किंवा अंशतः नोंदविल्यानंतर त्याच्या जागी अन्य चौकशी प्राधिकारी आल्यास, नवीन चौकशी प्राधिकारी आपल्या पूर्वाधिकाऱ्याने ज्या टप्प्यापर्यंत चौकशी आणली होती तेथून ती पुढे चालू करील. ज्याची साक्ष अगोदरच नोंदविली आहे अशा कोणत्याही साक्षीदारांनी पुन्हा तपासणी करणे न्यायोचित होईल असे नवीन चौकशी प्राधिकाऱ्यास वाटल्यास तो अशा साक्षीदारांना पुन्हा बोलावून त्यांची तपासणी, उलटतपासणी किंवा फेरतपासणी करून घेऊ शकेल. मात्र पुन्हा बोलविलेल्या कोणत्याही साक्षीदाराची उलटतपासणी करण्याचा अधिकार आरोपी कर्मचाऱ्यास राहील.

पुरावा अभिलिखित करण्याची पद्धती :-

- आरोपी कर्मचाऱ्याला नैसर्गिक न्याय मिळवून देण्याच्या दृष्टीने विभागीय चौकशीचे निरनिराळे टप्पे आणि एकूण कार्यपद्धती नियमांमध्ये विहित केली आहेत. त्यानुसार प्रत्यक्ष कार्यवाही करण्यात आली याचा पुरावा असणे आवश्यक आहे. त्यासाठी चौकशी प्राधिकाऱ्याने चौकशीच्या प्रारंभापासून एक रोजनामा म्हणजे दैनंदिन कामाची रोजनिशी ठेवली पाहिजे. त्यात खालील नोंदी असाव्यात:-

- चौकशीच्या प्रत्येक दिवशी उपस्थित व्यक्तींची नावे

- त्या दिवशी केलेल्या कार्यवाहीची संक्षिप्त माहिती
 - आरोपी कर्मचार्याने चौकशी कामासंबंधात वेळोवेळी केलेल्या विनंत्या व त्यावर चौकशी प्राधिकाऱ्याने दिलेले आदेश यांचा सारांश
 - पुढील सुनावणीच्या तारखांसंबंधी चौकशी प्राधिकाऱ्याने दिलेले आदेशरोजनाम्यातील प्रत्येक दिवसाच्या नोंदीखाली चौकशी प्राधिकाऱ्याने तारखेसह स्वाक्षरी करावी. तसेच सादरकर्ता अधिकारी आरोपी कर्मचारी यांच्या तारखेसह स्वाक्षऱ्या घ्याव्या. प्रत्येक दिवसाच्या नोंदीच्या प्रती सादरकर्ता अधिकारी व आरोपी यांना हव्या असल्यास द्याव्या.
- साक्षीदारांच्या साक्षी लिहून घेताना खालील पध्दती अनुसरावी.
 - प्रत्येक साक्षीदाराची साक्ष वेगळ्या कागदावर नमूद करावी. ह्या कागदाच्या शीर्षस्थानी प्रकरण क्रमांक साक्षीदाराची ओळख पटण्यासाठी, त्यांचे नाव, वय, पलकत्व, व्यवसाय, पत्ता, इ. संबंधीची पुरेशी माहिती लिहावी.
 - साक्ष साधारणपणे निवेदनाच्या स्वरूपात लिहावी. आवश्यक तेथे (विशेषतः उलटतपासणीत) विशिष्ट प्रश्न व उत्तरे शब्दशः उद्धृत करावी.
 - प्रत्येक साक्षीदाराच्या साक्षी अखेरीस चौकशी प्राधिकाऱ्याने आरोपी कर्मचार्या समक्ष साक्षीदारास वाचून व त्यात शाब्दिक चुका बसल्यास त्यांच्या उपस्थितीत त्या दुरुस्त कराव्या. मात्र साक्षीदार साक्षीच्या काही भागाचा अचूकपणा नाकारीत असल्यास पुराव्यात दुरुस्ती करण्याऐवजी चौकशी प्राधिकाऱ्याने साक्षीदाराचे आक्षेप
 - प्रत्येक साक्षीदाराच्या साक्षी अखेरीस चौकशी प्राधिकाऱ्याने पुढील प्रमाणपत्र देवून त्यावर स्वाक्षरी करावी.
 - "आरोपीच्या उपस्थितीत साक्षीदाराला वाचून दाखवली आणि त्याने ती अचूक असल्याचे मान्य केले/साक्षीदाराचे आक्षेप अभिलिखित केला."
 - साक्ष नोंदविलेल्या प्रत्येक पृष्ठावर साक्षीदाराची सही घ्यावी. तसेच प्रत्येक पृष्ठावर चौकशी प्राधिकाऱ्याने स्वाक्षरी करवी. आरोपी कर्मचार्यालाही सही करण्यास सांगावे. साक्षीदाराने सही करण्याचे नाकारल्यास चौकशी प्राधिकाऱ्याने आपल्या सहीनिशी तशी नोंद करावी.
 - प्रत्येक दिवशी सुनावणी संपल्यानंतर साक्षीच्या प्रती सादरकर्ता अधिकारी व आरोपी कर्मचार्यांना उपलब्ध करून द्याव्या.

चौकशी प्राधिकाऱ्याचा अहवाल :-

- चौकशीचे काम संपल्यानंतर चौकशी प्राधिकाऱ्याने आपला अहवाल तयार करावयाचा असतो, तो स्वयंपूर्ण तसेच तर्कशुद्ध असावा. चौकशीमध्ये पुढे आलेल्या कागदोपत्री व तोंडी पुराव्यांचे नीट विश्लेषण करून तसेच सर्व परिस्थिती व घटना लक्षात घेऊन एखाद्या सुबुद्ध व सुजाण व्यक्तीप्रमाणे चौकशी प्राधिकाऱ्याने तर्कसंगत व समंजस असे अनुमान काढले पाहिजे. चौकशीतील आरोप सिद्ध झाले की नाही याबाबतचा आपला निष्कर्ष नोंदविला पाहिजे तसेच आरोपी कर्मचारी दोषी आहे असा निष्कर्ष निघाल्यास त्याला कोणती शिक्षा करावी यासंबंधीची आपली शिफारसही चौकशी प्राधिकाऱ्याने आपल्या अहवालात केली पाहिजे.
- चौकशी प्राधिकाऱ्याच्या अहवालात खालील बाबींचा समावेश असता पाहिजे.
 - चौकशीचा थोडक्यात विषय चौकशी प्राधिकाऱ्याची नेमणूक व त्यानंतर वेळोवेळी सुनावण्यांच्या तारखा व ठिकाणे यांचा संदर्भ देणारा प्रास्ताविक परिच्छेद.
 - आरोपी कर्मचार्यावरील दोषारोप व त्याचा गैरवर्तणुकीच्या तपशिलांचे विवरण

- वगळण्यात आलेले तसेच आरोपी कर्मचाऱ्याने कबूल केलेले दोषारोप
 - प्रत्यक्षात चौकशी केलेले दोषारोप
 - वस्तुस्थितीचे संक्षिप्त कथन व स्वीकृत केलेले दस्तऐवज
 - चौकशी केलेल्या आरोपांच्या बाबतीत शिस्तभंगविषयक प्राधिकाऱ्यांची बाजू मांडणारे संक्षिप्त निवेदन
 - सदर आरोपांसंदर्भात बचावाचे संक्षिप्त निवेदन
 - निर्णयासाठी मुद्दे
 - निर्णय घ्यावयाच्या प्रत्येक मुद्द्याच्या अनुषंगाने कागदोपात्री व तोंडी पुराव्याचे मुल्यमापन व त्यावरील निष्कर्ष
 - प्रत्येक दोषारोपाबाबतचे निष्कर्ष व त्यांची कारणे
 - शिक्षेसंबंधी शिफारस
- चौकशी प्राधिकाऱ्याने वरीलप्रमाणे तयार केलेला आपला अहवाल खालील कागदपत्रांसह शिस्तभंगविषयक प्राधिकाऱ्याकडे पाठवावा .

याचिका (१)

- अ) दोषारोपपत्रामधील आरोपाच्या बाबींच्या पुराव्यादाखल सादर केलेला दस्तऐवज व त्यांची सूची
- ब) आरोपी कर्मचाऱ्याने स्वतःच्या बचावासाठी सादर केलेले दस्तऐवज व त्यांची सूची
- क) शिस्तभंगविषय प्राधिकाऱ्यातर्फच्या साक्षीदारांची सूची
- ड) बचावाच्या साक्षीदारांची सूची

याचिका (२) ज्या क्रमाने साक्षीदारांची तपासणी करण्यात आली त्या क्रमाने सर्व साक्षीदारांच्या जबाब्या

याचिका (३) रोजनामा किंवा दैनंदिन कामाची रोजनिशी

याचिका (४)

- अ) आरोपी कर्मचाऱ्याचे बचावाचे लेखी निवेदनपत्र (दिले असल्यास)
- ब) दोषी पक्षांनी दाखल केलेली लेखी टाचणे
- क) चौकशीच्या ओघात केलेले अर्ज व त्यावरील चौकशी प्राधिकारी किंवा शिस्तभंगविषयक प्राधिकारी यांचे आदेश तसेच सदर प्राधिकाऱ्याचे कोणत्याही तोंडी विनंतीनुसार मंजूर केलेले किंवा इतर आदेश

- चौकशी प्राधिकाऱ्याचे मते, चौकशीच्या कार्यवाहीतून मूळ दोषारोपांपेक्षा वेगळा एखादा दोषारोप सिध्द होत असल्यास त्याबाबतचा आपला निष्कर्ष तो नोंदवू शकतो . तथापि हा वेगळा दोषारोप जिच्यावर आधारीत आहे ती वस्तुस्थिती आरोपी कर्मचाऱ्याने मान्य केली नसेल किंवा चौकशीमध्ये सदर आरोपीविरुद्ध स्वतःचा बचाव करण्याची वाजवी संधी त्याला मिळाली नसेल तर त्यासंबंधीचा आपला निष्कर्ष चौकशी प्राधिकारी नोंदवू शकणार नाही .
- अहवालावर सही केल्यानंतर चौकशी अधिकारी कार्यमुक्त होतो व त्यानंतर त्याला अहवालामध्ये कोणताही बदल करता येत नाही .

चौकशी प्राधिकाऱ्याच्या अहवालातील कार्यवाही :-

- विभागीय चौकशीच्या कागदपत्रांसह चौकशी प्राधिकाऱ्याचा अहवाल मिळाल्यानंतर शिस्तभंगविषयक प्राधिकाऱ्याने तो काळजीपूर्वक तपासणे आवश्यक आहे . रोजनामा व चौकशीचे इतर कागदपत्र यांच्या

आधारे प्रथम त्याने शहानिशा केली पाहिजे की चौकशी विहित कार्यपद्धतीनुसार योग्य प्रकारे करण्यात आली काय व आरोपी कर्मचाऱ्याला आपला बचाव करण्याची संधी देण्यात आली काय. चौकशीच्या कार्यवाहीत कोणताही दोष आढळून आल्यास किंवा आरोपी कर्मचाऱ्यास बचावाची वाजवी संधी देण्यात काही उणीव राहिल्याचे दिसून आल्यास शिस्तभंगविषयक प्राधिकाऱ्याने सदर करणे लेखी नमूद करून चौकशी प्रकरण पुन्हा चौकशी प्राधिकाऱ्याकडे पाठवावे. मग चौकशीच्या ज्या टप्प्यावर दोष किंवा उणीव निर्माण झाली तेथून पुढे चौकशीची कार्यवाही नव्याने करून चौकशीत कार्यपद्धतीचा दोष किंवा उणीव असेल तरच अशा प्रकारे प्रकरण चौकशी प्राधिकाऱ्याकडे परत पाठवावे. चौकशी प्राधिकाऱ्याचे निष्कर्ष किंवा शिफारशी यांच्याशी शिस्तभंगविषयक प्राधिकारी सहमत नाही एवढ्याच कारणावरून प्रकरण फेरचौकशीसाठी किंवा सुधारित अहवाल पाठविण्यासाठी चौकशी प्राधिकाऱ्याकडे धाडू नये.

- चौकशी नीटपणे झालेली असल्यास शिस्तभंगविषयक प्राधिकाऱ्याने चौकशी प्राधिकाऱ्याच्या अहवालाची एक प्रत खालील पृष्ठांकनाद्वारे आरोपी कर्मचाऱ्यास पाठवावी. चौकशी प्राधिकाऱ्याचा अहवाल सोबत पाठविण्यात येत आहे. चौकशी अहवाल विचारात घेऊन शिस्तभंगविषयक प्राधिकारी योग्य तो निर्णय घेतील. आपल्याला (चौकशी अहवालाच्या अनुषंगाने) जर काही लेखी अभिवेदन/निवेदन सादर करावयाचे असेल तर हे पत्र मिळाल्यापासून १५ दिवसांच्या आत असे अभिवेदन शिस्तभंगविषयक प्राधिकाऱ्याकडे सादर करावे.
- त्यानंतर चौकशीचे कागदपत्र चौकशी प्राधिकाऱ्यांना अहवाल व आरोपी कर्मचाऱ्याने सादर केलेले अभिवेदन यांचा समग्र विचार करून प्रत्येक दोषारोपाविषयीचे आपले निष्कर्ष शिस्तभंगविषयक प्राधिकाऱ्याने लेखी नोंदवावे. कोणत्याही दोषारोपासंदर्भात शिस्तभंगविषयक प्राधिकारी चौकशी प्राधिकाऱ्याच्या निष्कार्पाशी सहमत नसल्यास असहमतीची कारणे त्याने नमूद करावी. तसेच आरोपी कर्मचाऱ्याच्या अंतिम अभिवेदनातील मुद्यांबाबतचे आपले अभिप्रायही द्यावे.
- आरोपी कर्मचाऱ्यावरील दोषारोप चौकशीमध्ये सिद्ध झाले नाहीत व तो पूर्णतया निर्दोष आहे या निष्कर्षाप्रत शिस्तभंगविषयक प्राधिकारी आल्यास त्याने त्यानुसार अंतिम आदेश काढून त्याची प्रत आरोपी कर्मचाऱ्यास पाठवावी.
- शिस्तभंगविषयक प्राधिकाऱ्याच्या मते आरोपी कर्मचारी दोषी सिद्ध झाला असल्यास त्याला योग्य ती किरकोळ अथवा जबर शिक्षा देण्याचा आदेश तो प्राधिकारी काढू शकतो. अर्थात दोन्ही प्रकारच्या शिक्षा करण्यास तो सक्षम असला पाहिजे. आरोपी कर्मचारी वर्ग १ किंवा २ चा अधिकारी असल्यास त्याला कोणतीही जबर शिक्षा देण्यापूर्वी तसेच वेतनातून शासकिय नुकसारनीची वसुली करण्याबाबतची किरकोळ शिक्षा त्याला देण्यापूर्वी लोकसेवा आयोगाचा सल्ला घेणे आवश्यक आहे. त्यासाठी विहित प्रपत्रातील माहितीसह व संबंधित कर्मचाऱ्याच्या गोपनीय अभिलेखांसह विभागीय चौकशीचे सर्व कागदपत्र लोकसेवा आयोगाकडे पाठविले पाहिजेत. अशा प्रकरणात आयोगाचा सल्ला मिळाल्यानंतर तो विचारात घेऊन शिस्तभंगविषयक प्राधिकाऱ्याने अंतिम आदेश काढावयाचे असतात.
- आरोपी कर्मचाऱ्यास किरकोळ शिक्षा करण्यास सक्षम असणाऱ्या परंतु त्याला जबर शिक्षा करण्यास सक्षम नसणाऱ्या प्राधिकाऱ्याने त्याच्याविरुद्ध शिस्तभंगाची कार्यवाही सुरु केली व चौकशीअंती त्या प्राधिकाऱ्याचे असे मत झाले की त्याला एखादी जबर शिक्षा करावी तर अशावेळी त्या प्राधिकाऱ्याने चौकशीचे कागदपत्र आरोपी कर्मचाऱ्यास जबर शिक्षा करण्यास सक्षम असणाऱ्या प्राधिकाऱ्याकडे पाठविले पाहिजेत. त्यानंतर त्या प्राधिकाऱ्याने चौकशीच्या कागदपत्राआधारे सदर प्रकरणत पुढील आवश्यक कार्यवाही करावी. न्यायोचित वाटल्यास तो कोणत्याही साक्षीदारास परत बोलावून त्याची तपासणी उलटतपासणी किंवा फेरतपासणी करून घेऊ शकतो. आरोपी कर्मचाऱ्यालाही या साक्षीदारांची

उलटतपासणी करण्याची मुभा राहिल त्यानंतर त्या प्राधिकाऱ्याने चौकशीच्या कागदपत्राआधारे सदर प्रकरणात पुढील आवश्यक कार्यवाही करावी. न्यायोचित वाटल्यास तो कोणत्याही साक्षीदारास परत बोलावून त्याची तपासणी उलटतपासणी करण्याची मुभा राहिल त्यानंतर सदर सक्षम प्राधिकारी वरील परिच्छेदातील कार्यपद्धतीनुसार अंतिम आदेश काढू शकेल.

चौकशीतील अंतिम आदेश :-

- शिस्तभंगविषयक प्राधिकाऱ्याचा अंतिम आदेश हा एक बोलका आदेश असला पाहिजे. म्हणजे तो वाचल्यानंतर त्यातील निर्णय व त्यामागची कारणे स्पष्ट झाली पाहिजेत. याचे दोन मुख्य उद्देश आहेत.
 - न्यायिक शक्ती प्रदान केलेला प्रशासकिय प्राधिकारी स्वच्छतेनुसार कार्यवाही करील अशी शक्यता असल्यास त्या शक्यतेस कारणांची नोंद करण्याच्या बंधनामुळे प्रतिरोध होईल.
 - व्यथित पक्षाला ज्या कारणांमुळे आपले प्रकरण फेटाळण्यात आले ती कारणे चुकीची आहेत हे अपीलात किंवा न्यायालयीन कार्यवाहीत दाखवून देण्याची संधी मिळेल.
- शिस्तभंगविषयक प्राधिकाऱ्याच्या अंतिम आदेशात खालील बाबींचा अंतर्भाव असावा.
 - आरोपी कर्मचाऱ्यांच्या अंतिम आदेशातील मुद्यांबाबतीचे शिस्तभंगविषयक प्राधिकाऱ्याने अभिप्राय व त्या अनुषंगाने प्रत्येक दोषारोपाबाबत सदर अधिकाऱ्याने काढलेले निष्कर्ष व त्यांची थोडक्यात कारणे.
 - कोणत्याही दोषारोपासंदर्भात शिस्तभंगविषयक प्राधिकारी चौकशी प्राधिकाऱ्याच्या निष्कर्षाशी सहमत नसल्यास असहमतीची थोडक्यात कारणे.
 - लोकसेवा आयोगाचा सल्ला घेतला असल्यास आयोगाच्या सल्ल्याची प्रत व शिस्तभंगविषयक प्राधिकाऱ्याने तो स्विकृत केला नसल्यास अस्वीकृतीची थोडक्यात कारणे
 - शिक्षेसंबंधीचा निर्णय
- अंतिम आदेशान्वये दिलेली शिक्षा लादण्यास सक्षम असलेल्या प्राधिकाऱ्याने त्या आदेशावर सही केली पाहिजे. या प्रकरणात राज्यपाल हे सक्षम प्राधिकारी आहेत तेथे संविधानाचा अनुच्छेद १६६ अन्वये राज्यपालांच्या नावाने काढलेले आदेश अधिप्रमाणित करण्यासाठी प्राधिकृत केलेल्या अधिकाऱ्याने अंतिम आदेशावर सही करावी.
- सेवेतून काढून टाकण्याचे किंवा बडतर्फ करण्याचे आदेश संबंधित शासकिय कर्मचाऱ्यास मिळाल्याच्या बँकापासून परिणामकारक होतात तर इतर शिक्षांचे आदेश ते निर्गमित केलेल्या दिनांकापासून परिणामकारक होतात. शिक्षेच्या कोणत्याही आदेशात तिच्या परिणामकारकतेचा पुढील कोणताही दिनांक नमूद करता येतो व मग त्या दिनांकापासून परिणामकारक होतो.

सामाईक कार्यवाही (नियम १२) :-

- शिस्तभंगाच्या एखाद्या प्रकरणात दोन किंवा त्याहून अधिक शासकिय कर्मचारी गुंतलेले असल्यास त्यांच्याविरुद्ध कार्यवाही करता येते. त्याबबतची विशेष कार्यपद्धती शिस्त नियम १२ मध्ये विहित केली आहे ती थोडक्यात खालीलप्रमाणे :-
 - राज्यपाल किंवा त्या सर्व कर्मचाऱ्यांना सेवेतून बडतर्फ करण्यास सक्षम असलेला अन्य प्राधिकारी अशा सामाईक कार्यवाहीचा आदेश काढू शकतो. चौकशी प्राधिकाऱ्याचा अहवाल सोबत पाठविण्यात येत आहे. चौकशी अहवाल विचारात घेऊन शिस्तभंगविषयक प्राधिकारी योग्य तो निर्णय घेतील. आपल्याला (चौकशी अहवालाच्या अनुषंगाने) जर काही लेखी अभिवेदन/

निवेदन सादर करावयाचे असेल तर हे पत्र मिळाल्यापासून १५ दिवसांच्या आत असे अभिवेदन शिस्तभंगविषयक प्राधिकाऱ्याकडे सादर करावे.

- सदर कर्मचाऱ्यांना सेवेतून बडतर्फ करू शकणारे प्राधिकारी भिन्न असल्यास त्यातील उच्चतम प्राधिकाऱ्याने इतर प्राधिकाऱ्यांच्या संमतीने सामाईक कार्यवाहीचे आदेश काढावेत.

सामाईक कार्यवाहीच्या आदेशात खालील बाबी स्पष्ट कराव्या.

- या कार्यवाहीमध्ये शिस्तभंगविषयक प्राधिकारी म्हणून कोणी काम करावे
 - सदर प्राधिकारी नियम ५ मधील कोणत्या शिक्षा फर्मावू शकेल.
 - या कार्यवाहीमध्ये किरकोळ शिक्षासंबंधीची कार्यपद्धती अनुसरावी की जबर शिक्षासंबंधीची
- त्यानंतर चौकशीचे कागदपत्र चौकशी प्राधिकाऱ्यांना अहवाल व आरोपी कर्मचाऱ्याने सादर केलेले अभिवेदन यांचा समग्र विचार करून प्रत्येक दोषारोपाविषयीचे आपले निष्कर्ष शिस्तभंगविषयक प्राधिकाऱ्याने लेखी नोंदवावे. कोणत्याही दोषारोपासंदर्भात शिस्तभंगविषयक प्राधिकारी चौकशी प्राधिकाऱ्याच्या निष्कर्षाशी सहमत नसल्यास असहमतीची कारणे त्याने नमूद करावी. तसेच आरोपी कर्मचाऱ्याच्या अंतिम अभिवेदनातील मुद्यांबाबतचे आपले अभिप्रायही द्यावे.
 - आरोपी कर्मचाऱ्यावरील दोषारोप चौकशीमध्ये सिद्ध झाले नाहीत व तो पूर्णतया निर्दोष आहे या निष्कर्षाप्रत शिस्तभंगविषयक प्राधिकारी आल्यास त्याने त्यानुसार अंतिम आदेश काढून त्याची प्रत आरोपी कर्मचाऱ्यास पाठवावी.
 - शिस्तभंगविषयक प्राधिकाऱ्याच्या मते आरोपी कर्मचारी दोषी सिद्ध झाला असल्यास त्याला योग्य ती किरकोळ अथवा जबर शिक्षा देण्याचा आदेश तो प्राधिकारी काढू शकतो. अर्थात दोन्ही प्रकारच्या शिक्षा करण्यास तो सक्षम असला पाहिजे. आरोपी कर्मचारी वर्ग १ किंवा २ चा अधिकारी असल्यास त्याला कोणतीही जबर शिक्षा देण्यापूर्वी तसेच वेतनातून शासकिय नुकसानीची वसुली करण्याबाबतची किरकोळ शिक्षा त्याला देण्यापूर्वी लोकसेवा आयोगाचा सल्ला घेणे आवश्यक आहे. त्यासाठी विहित प्रपत्रातील माहितीसह व संबंधित कर्मचाऱ्याच्या गोपनीय अभिलेखांसह विभागीय चौकशीचे सर्व कागदपत्र लोकसेवा आयोगाकडे पाठविले पाहिजेत. अशा प्रकरणात आयोगाचा सल्ला मिळाल्यानंतर तो विचारात घेऊन शिस्तभंगविषयक प्राधिकाऱ्याने अंतिम आदेश काढावयाचे असतात.
 - आरोपी कर्मचाऱ्यास किरकोळ शिक्षा करण्यास सक्षम असणाऱ्या परंतु त्याला जबर शिक्षा करण्यास सक्षम नसणाऱ्या प्राधिकाऱ्याने त्याच्याविरुद्ध शिस्तभंगाची कार्यवाही सुरु केली व चौकशीअंती त्या प्राधिकाऱ्याचे असे मत झाले की त्याला एखादी जबर शिक्षा करावी तर अशावेळी त्या प्राधिकाऱ्याने चौकशीचे कागदपत्र आरोपी कर्मचाऱ्यास जबर शिक्षा करण्यास सक्षम असणाऱ्या प्राधिकाऱ्याकडे पाठविले पाहिजेत. त्यानंतर त्या प्राधिकाऱ्याने चौकशीच्या कागदपत्राआधारे सदर प्रकरणात पुढील आवश्यक कार्यवाही करावी. न्यायोचित वाटल्यास तो कोणत्याही साक्षीदारास परत बोलावून त्याची तपासणी उलटतपासणी किंवा फेरतपासणी करून घेऊ शकतो. आरोपी कर्मचाऱ्यालाही या साक्षीदारांची उलटतपासणी करण्याची मुभा राहिल त्यानंतर सदर सक्षम प्राधिकारी वरील परिच्छेदातील कार्यपद्धतीनुसार अंतिम आदेश काढू शकेल.

प्रतिनियुक्तीवरील कर्मचाऱ्यांविरुद्ध कार्यवाही (नियम १४ व १५) :-

- प्रतिनियुक्तीवरील कर्मचाऱ्यांच्या बाबतीत (मग ते महाराष्ट्र शासनामधून अन्यत्र प्रतिनियुक्तीवर केलेले असोत किंवा बाहेरून शासनाकडे प्रतिनियुक्तीवर आलेले असोत किंवा महाराष्ट्र शासनाच्या एका

विभागाकडून दुसऱ्या विभागाकडे प्रतिनियुक्तीवर असोत) शिस्तभंगाची कार्यवाही करतांना शिस्त नियम १४ व १५ मधील तरतुदी लक्षात घेणे आवश्यक आहे. या तरतुदी थोडक्यात खालीलप्रमाणे आहेत.

- एखाद्या शासकिय कर्मचाऱ्याच्या सेवा जेव्हा दुसऱ्या शासकिय विभागाला किंवा भारतातील दुसऱ्या शासनाला किंवा एखाद्या स्थानिक किंवा इतर प्राधिकरणाकडे (उदा. शासकिय कंपनी किंवा महामंडळ) उसन्या दिलेल्या असतात. तेव्हा सेवा उसन्या घेणाऱ्या प्राधिकरणाला त्या कर्मचाऱ्यास निलंबित करता येते. तसेच त्याच्याविरुद्ध शिस्तभंगाची कार्यवाही करता येते. मात्र कोणत्या परिस्थितीत निलंबनाचा आदेश काढला किंवा शिस्तभंगाची कार्यवाही सुरु केली त्यासंबंधीची माहिती सदर कर्मचाऱ्याच्या सेवा उसन्या घेणाऱ्या प्राधिकरणाने सेवा उसन्या देणाऱ्या प्राधिकरणास तात्काळ दिली पाहिजे.
- सेवा उसन्या घेणारे प्राधिकरण शिस्तभंगाच्या कार्यवाहीतील निष्कर्षाच्या अनुषंगाने सदर कर्मचाऱ्यास एखादी किरकोळ शिक्षा करू शकते. पण त्याकरीता सेवा उसन्या देणाऱ्या प्राधिकरणाची पूर्वसंगती घेणे आवश्यक आहे. सेवा उसन्या देणारे प्राधिकरण अशी संमती देण्यास तयार नसल्यास त्या कर्मचाऱ्यास त्या प्राधिकरणाकडे परत पाठवावे.
- सेवा उसन्या घेणारे प्राधिकरणाच्या मते सदर कर्मचाऱ्यास एखादी जबर शिक्षा देणे आवश्यक असल्यास त्या कर्मचाऱ्याला सेवा उसन्या देणाऱ्या प्राधिकरणाकडे परत पाठवावे. तसेच शिस्तभंगाच्या चौकशीचे कागदपत्रही सेवा उसन्या देणाऱ्या प्राधिकरणाकडे धाडावे. त्यानंतर त्या प्राधिकरणातील संबंधित शिस्तभंगविषयक प्राधिकाऱ्याने चौकशीच्या उपलब्ध कागदपत्रांआधारे किंवा आवश्यक तर नियमांनुसार पुन्हा चौकशी करून योग्य ते पुढील आदेश काढावे.
- एखाद्या कर्मचाऱ्याच्या सेवा त्याच्या मुळ विभागाकडे प्रत्यावर्तित केल्यानंतर तो पूर्वी जेथे प्रतिनियुक्तीवर होता त्या प्राधिकरणास त्याजविरुद्ध काही कार्यवाही करता येत नाही. त्याच्या प्रतिनियुक्तीच्या काळातील काही गैरवर्तणुक त्याच्या सेवा परत केल्या नंतर लक्षात आल्यास त्यासंबंधीची माहिती त्याच्या सेवा उसन्या देणाऱ्या प्राधिकरणास आवश्यक कार्यवाहीसाठी देता येईल.

कर्मचारी न्यायालयात दोषी ठरल्यानंतर करवयाची कार्यवाही (नियम १३ (१) :-

- एखाद्या शासकिय कर्मचाऱ्याला न्यायालयाने आरोपाखाली ठरवून शिक्षा दिल्यास त्याच गुन्ह्यासाठी त्याच्याविरुद्ध विभागीय कार्यवाही देखील करता येते. त्याचा तपशिलवार विभागीय चौकशीची आवश्यकता नसते. कारण विभागीय चौकशीमध्ये लागणाऱ्या पुराव्यापेक्षा अधिक काटेकारे पुराव्याआधारे त्याचा गुन्हा न्यायालयामध्ये सिध्द झालेला आहे. अशा प्राधिकाऱ्याविरुद्ध सिध्द झालेल्या गुन्ह्याचे स्वरूप या विचारात घेऊन सदर कर्मचाऱ्याला विभागामार्फत कोणती शिक्षा देणे योग्य होईल या संबंधी तात्पुरता निर्णय शिस्तभंगविषयक प्राधिकाऱ्याने घ्यावा व त्या प्रस्तावित निर्णयाविरुद्ध अभिवेदन करण्याची संधी त्या कर्मचाऱ्याला द्यावी. त्याचे अभिवेदन प्राप्त झाल्या ते विचारात घेऊन मग अंतिम निर्णय घ्यावा आरोपी कर्मचारी हा वर्ग - किंवा २ चा अधिकारी असल्यास त्याला कोणतीही जबर शिक्षा किंवा वेतनातून शासकिय नुकसानीची वसुली करण्याची किरकोळ शिक्षा देण्याचे प्रस्तावित असल्यास अंतिम निर्णय घेण्यापूर्वी लोकसेवा आयोगाचा सल्ला मागवून तो विचारात घेणे आवश्यक आहे.
- एखाद्या प्रकरणात न्यायालयाने शिक्षा दिलेल्या कर्मचाऱ्याच्या आरोपाचे स्वरूप पाहता त्याला पुढे सार्वजनिक सेवेत राहू देणे सुकृदर्शनी अनिष्ट ठरत असल्यास त्याला शासकिय सेवेतून सक्तीने सेवानिवृत्त सेवेतून कमी किंवा बडतर्फ करणे योग्य होईल. त्याकरीता वर नमूद केलेली कार्यपद्धती अनुसरणे आवश्यक आहे. परंतु न्यायालयीन शिक्षेविरुद्ध अपील करण्याचा कालावधी समाप्त होण्याची अथवा अपील दाखल केले असल्यास प्रथम अपील न्यायालयाच्या निकालाची वाट पाहण्याची आवश्यकता नाही.

न्यायालयात कर्मचारी दोषमुक्त ठरल्यानंतर करावयाची कार्यवाही :-

- एखाद्या शासकीय कर्मचारी त्याच्यावरील फौजदारी खटल्यात न्यायालयाद्वारे दोषमुक्त ठरविला जातो तेव्हा देखील त्याच्या शिस्तभंगविषयक प्राधिकाऱ्याने प्रथम न्यायालयाच्या निर्णयाची प्रत तातडीने मागवावी व तिचा अभ्यास करावा. त्याअनुषंगाने जर असे आढळून आले की एखाद्या तांत्रिक मुद्याआधारे किंवा संशयाचा फायदा देऊन आरोपी कर्मचाऱ्यास दोषमुक्त केलेले आहे. तर विभागीय चौकशीमध्ये त्याचा गुन्हा सिद्ध करण्यासाठी पुरेसा पुरावा उपलब्ध असल्यास त्याच्याविरुद्ध विभागीय चौकशी चालू करावी. उलटपक्षी न्यायालयाने त्याला पूर्णतया निर्दोष ठरविले असेल व एखाद्या तांत्रिक मुद्यांचा किंवा संशयाचा फायदा त्याला दिलेला नसेल तर अशा प्रकरणात त्याच्याविरुद्ध विभागातर्फे काही कार्यवाही करणे योग्य होणार नाही.

विभागीय चौकशी चालू असताना पदोन्नती देण्याबाबत :-

- एखाद्या शासकीय कर्मचाऱ्याविरुद्ध विभागीय चौकशी चालू असताना त्याच्या जेष्ठताक्रमानुसार तो पदोन्नतीसाठी विचारार्थ पात्र झाल्यास पदोन्नतीची निवडसूची तयार करताना इतर पात्र कर्मचाऱ्याबरोबर त्याचाही विचार त्याच्या गोपनीय अभिलेखाआधारे करण्यात यावा. त्यावेळी तो निलंबित असला तरीही त्याचा विचार व्हावा. निवडसूचीत समाविष्ट करण्यास तो पात्र ठरला तर त्याचे नाव तात्पुरते निवडसूचीत ठेवावे व त्याजविरुद्धची विभागीय चौकशी पूर्ण झाल्यानंतर त्यातील निर्णयाच्या अनुषंगाने निवडसूचीतील त्याच्या नावाचा फेरविचार व्हावा.
- अशा प्रकारे निवडसूचीत तात्पुरते नव असलेल्या कर्मचाऱ्याच्या प्रत्यक्ष पदोन्नतीची वेळ येऊन ठेपते. तेव्हा देखील त्याजविरुद्ध विभागीय चौकशी असल्यास व तो निलंबित नसल्यास चौकशीमधील त्याजविरुद्धच्या दोषारोपांचे स्वरूप लक्षात घेऊन त्याला चौकशी पूर्ण होण्यापूर्वी देखील पदोन्नती देता येईल काय यासंबंधीचा विचारपूर्वक निर्णय झाल्यास त्याची पदोन्नती तात्पुरत्या स्वरूपाची राहिल व विभागीय चौकशी पूर्ण झाल्यानंतर त्यातील निर्णयाच्या अनुषंगाने त्याच्या पदोन्नतीचा फेरविचार करावा लागेल.
- विभागीय चौकशीत सदर कर्मचारी पूर्णपणे दोषमुक्त ठरल्यास पुढीलप्रमाणे कार्यवाही करण्यात यावी :-
 - चौकशी चालू असताना त्याला तात्पुरती पदोन्नती दिलेली असल्यास ती पदोन्नती नियमित समजावी.
 - निवडसूचीत नाव असून व त्यानुसार पदोन्नतीची वेळ येऊन ठेपलेली असूनही विभागीय चौकशीच्या कारणासाठी त्याला पदोन्नती दिलेली नसल्यास त्याच्या दोषमुक्तीनंतर पहिली संधी घेऊन त्याला पदोन्नती द्यावी. निवडसूचीतील त्याच्या क्रमांकानुसार त्याला जेष्ठताही द्यावी व त्या जेष्ठतेनुसार त्याला प्रत्यक्ष पदोन्नती मिळाली असती तर त्याची जी वेतननिश्चिती झाली असती त्यानुसार पदोन्नतीनंतर त्याला वेतन द्यावे पण प्रत्यक्ष पदोन्नतीच्या आधीची थकबाकी त्याला देय असणार नाही.
- विभागीय चौकशीत कर्मचारी पूर्णपणे निर्दोष न ठरल्यास त्याच्या पदोन्नतीच्या प्रकरणाचा फेरविचार करावा फेरविचाराअंती -
 - तो पदोन्नतीस पात्र नाही असा निष्कर्ष निघाल्यास त्याला तत्पुर्वी पदोन्नती दिलेली असली तरी ती पदोन्नती संपुष्टात आणावी.
 - तो पदोन्नतीस पात्र आहे असा निष्कर्ष निघाल्यास त्याला निवडसूचीत सुधारीत योग्य स्थान द्यावे विभागीय चौकशीतील कलंकामुळे त्याचे हे सुधारीत स्थान त्याला पूर्वी दिलेल्या तात्पुरत्या

स्थानापेक्षा खालचे असेल त्याची पदोन्नती व त्यानंतरचे वेतन निवडसूचीतील त्याच्या सुधारीत जेष्ठताक्रमानुसारच नियमित करावी.

विभागीय चौकशी चालू असताना पदोन्नती देण्याबाबत:-

- शासकीय कर्मचाऱ्यास लागू असणारे वर्तणूक व शिस्त विषयक नियम तो सेवानिवृत्त झाल्यानंतर त्याला लागू नसतात. कारण निवृत्तीनंतर तो सरकारचा नोकर राहिलेला नसतो. तथापि तो निवृत्तीवेतन घेत असल्यामुळे त्याला महाराष्ट्र नागरी सेवा (निवृत्तीवेतन) नियम १९८२ लागू असतात या नियमानुसार :-
 - मंजूर झालेले निवृत्तिवेतन पुढे चालू राहण्यासाठी निवृत्तिवेतनधारकांची वर्तणूक सतत चांगली असणे आवश्यक आहे. निवृत्तिवेतनधारकास एखाद्या गंभीर गुन्ह्याबद्दल किंवा गंभीर गैरवर्तणुकीबद्दल दोषी ठरविण्यात आल्यास विहित कार्यपद्धती अनुसरून शासनास त्याचे निवृत्तिवेतन पूर्णतः किंवा अंशतः कायमचे किंवा ठराविक कालावधीसाठी रोखून ठेवता येते किंवा रद्द करता येते (निवृत्तिवेतन नियम २६)
 - निवृत्तिवेतनधारकास त्याच्या सेवेच्या काळातील किंवा पुर्ननियुक्तीनंतरच्या सेवेच्या काळातील गंभीर गैरवर्तणुकीबद्दल किंवा निष्काळजीपणाबद्दल विभागीय किंवा न्यायालयीन कार्यवाहीमध्ये दोषी ठरविण्यात आल्यास विहित कार्यपद्धती अनुसरून शासनास त्याचे निवृत्तिवेतन पूर्णतः किंवा अंशतः कायमचे किंवा ठराविक कालावधीसाठी रोखून ठेवता येते किंवा रद्द करता येते तसेच त्याच्यामुळे शासनास झालेले कोणतेही आर्थिक नुकसान पूर्णतः किंवा अंशतः त्याच्या निवृत्तिवेतनातून वसूल करात येतो. (निवृत्तिवेतन नियम २७)
 - वरील परिच्छेद १ किंवा २ नुसार निवृत्तिवेतन अंशतः रोखण्यात येते किंवा अंशतः रद्द केले जाते तेव्हा ते दरमहा रु.३७५ पेक्षा कमी करू नये.
 - जेव्हा फक्त निवृत्तिवेतनातून शासनाच्या आर्थिक नुकसानीची वसुली करावयाची असते तेव्हा सामान्यपणे कर्मचाऱ्यांच्या सेवानिवृत्तिच्या दिनांकास अनुज्ञेय असलेल्या निवृत्तिवेतनाच्या एकतृतीयांशपेक्षा अधिक दराने वसुली करू नये.

निवृत्तीपूर्वी सुरु केलेली कार्यवाही:-

- शासकीय कर्मचारी सेवेत असताना किंवा पुर्ननियुक्तीनंतर सेवेत असताना महाराष्ट्र नागरी सेवा (शिस्त व अपील नियम १९७९) अनुसार त्याच्याविरुद्ध सुरु केलेली विभागीय कार्यवाही त्याच्या अंतिम सेवानिवृत्तिच्यावेळी प्रलंबित त्यानंतर महाराष्ट्र नागरी सेवा (निवृत्तिवेतन) नियम १९८२ मधील नियम २७ खाली चालू राहते.
- अशा प्रकरणात संबंधित कर्मचाऱ्यास अनुज्ञेय असलेले पूर्ण निवृत्तिवेतन तात्पुरते म्हणून त्याला देण्यात येते. निवृत्तिवेतनाचे अंशराशीकरण तसेच उपदान यांच्या रकमा विभागीय कार्यवाही पूर्ण होईपर्यंत त्याला दिल्या जातात.
- निवृत्तिवेतन नियम २७ खाली अंतिम आदेश काढण्याचा अधिकार केवळ शासनास असल्याकारणाने त्याहून खालच्या स्तरावरील अशा सर्व प्रकरणात चौकशी प्राधिकाऱ्याचा अहवाल (खालच्या स्तरावरील संबंधित शिस्तभंगविषयक प्राधिकाऱ्याच्या निष्कर्षासह) प्राप्त झाल्यानंतर पुढील कार्यवाही शासनाद्वारे करण्यात सदर अहवाल विचारात घेऊन संबंधित निवृत्तिवेतनधारकाचे निवृत्तिवेतन अंशतः किंवा पूर्णतः रोखून ठेवण्याचा रद्द करण्याचा किंवा निवृत्तिवेतनातून शासनाच्या नुकसानीची पूर्णतः किंवा अंशतः वसुली करण्याचा शासनाचा प्रस्ताव त्यानुसार कारणे दाखवा नोटीस त्या निवृत्तिवेतनधारकावर बजावण्यात येते व त्याचे उत्तर विचारात घेतले जाते. निवृत्तिवेतनधारक वर्ग १ किंवा २ सेवेतून

निवृत्त झालेला असल्यास शासनास लोकसेवा आयोगाचाही सल्ला घ्यावा नंतर निवृत्तिवेतनधारकास नोटिसस दिलेले उत्तर व लोकसेवा आयोगाचाही सल्ला (घेतलेला असल्यास) विचारात योग्य ते अंतिम आदेश शासनाद्वारे काढले जातात.

सेवाकालीन गैरवर्तणुकीसाठी निवृत्तीनंतर करावयाची कार्यवाही:-

- शासकीय कर्मचारी सेवानिवृत्त होण्यापूर्वी किंवा तो पुर्ननियुक्तीनंतर सेवेत असताना त्याच्याविरुद्ध विभागीय कार्यवाही सुरु केली नसल्यास त्याच्या सेवानिवृत्तीनंतर त्याच्याविरुद्ध निवृत्तिवेतन नियम २७ अन्वये कार्यवाही केवळ खालील परिस्थितीतच सुरु करता येते.
सदर कार्यवाहीस शासनाची मंजूरी घेतली पाहिजे. ज्या घटनेसंबंधातील गैरवर्तणुकीबाबत ही कार्यवाही करावयाची आहे ती घटना कार्यवाही सुरु करण्याच्या तारखेस चार वर्षांपेक्षा अधिक जुनी असता कामा नये.
- वरील परिच्छेद १११ व ११४ मधील तरतुदींच्या प्रयोजनासाठी कार्यवाही सुरु करण्याची तारीख खालील प्रमाणे असेल. शासकीय कर्मचाऱ्यावर किंवा निवृत्तिवेतनधारकावर ज्या तारखेस दोषारोपपत्र बजावण्यात आले ती तारीख. त्या आधीच्या तारखेपासून शासकीय कर्मचाऱ्यास निलंबित करण्यात आले असल्यास निलंबनाची तारीख
- उपरिनिर्दिष्ट कार्यवाही जबर शिक्षांसाठी विहित केलेल्या पद्धतीनुसार शासन निदेश देईल त्या प्राधिकाऱ्यांकडून व त्या ठिकाणी करण्यात येईल. सदर कार्यवाहीत चौकशी प्राधिकाऱ्याचा अहवाल प्राप्त झाल्यावर निवृत्तिवेतन नियम २७ अनुसार पुढील कार्यवाही करण्याचा शासनाचा प्रस्ताव असल्यास निवृत्तिवेतनधारकास त्यानुसार कारणे दाखवा नोटिस देण्यात येईल व त्याचे उत्तर विचारात घेऊन शासन अंतिम निर्णय घेईल. संबंधित निवृत्तिवेतनधारक वर्ग १ किंवा २ सेवेतून निवृत्त झालेला असल्यास अंतिम निर्णय घेण्यापूर्वी शासन लोकसेवा आयोगाचा सल्ला मागवून तोही विचारात घेईल.

विभागीय चौकशीत प्रवासभत्त्याची अनुज्ञेयता:-

- विभागीय चौकशीमध्ये आरोपी कर्मचाऱ्यास तसेच चौकशी प्राधिकाऱ्याने बोलाविलेल्या दोन्ही बाजूंच्य साक्षीदारांना तोंडी सुनावणीच्या वेळी उपस्थित राहण्यासाठी एका ठिकाणाहून दुसऱ्या ठिकाणी जावे लागत असल्यास त्यांना खालीलप्रमाणे प्रवासभत्ता अनुज्ञेय असतो.
 - आरोपी कर्मचाऱ्यास प्रवास दौऱ्यावर असल्याप्रमाणे मुंबई नागरी सेवा नियम ५३६ अनुसार प्रवासभत्ता द्यावा.
 - शासकीय कर्मचारी असलेल्या साक्षीदारास प्रवास दौऱ्यावर असल्याप्रमाणे मुंबई नागरी सेवा नियम ५३६ अनुसार प्रवासभत्ता द्यावा.
 - शासकीय कर्मचारी नसलेल्या साक्षीदारांना मुंबई नागरी सेवा नियम खंड २ च्या परिशिष्ट ४२ ए च्या भाग १ मधील नियम १ च्या उपनियम ३ अनुसार प्रवासभत्ता.
- आरोपी कर्मचाऱ्याच्या विनंतीवरून त्याच्या मुख्यालयाव्यतिरिक्त त्याने निवडलेल्या अन्य ठिकाणी चौकशी असल्यास त्याला प्रवासभत्ता मिळण्याचा हक्क नसतो.
- जेव्हा आरोपी कर्मचाऱ्यास आपल्या बचावासाठी काही कागदपत्राचे निरीक्षण करावयाचे असते व ती कागदपत्रे त्याच्या मुख्यालयकडे पाठविणे शक्य नसते. त्या कागदपत्राचे निरीक्षण आवश्यक आहे असे शिस्तभंगविषयक प्राधिकाऱ्यास / चौकशी प्राधिकाऱ्याने ... केल्यास सदर याकरीता कर्मचाऱ्यास करावया लागणाऱ्या प्रवासासाठी त्यास प्रवासभत्ता मिळतो.

- शासनसेवेमध्ये असलेले सादरकर्ता अधिकारी व बचाव सहायक यांनाही विभागीय चौकशीच्या कामासाठी मुंबई नागरी सेवा नियम ५३६ अनुसार प्रवासभत्ता अनुज्ञेय आहे.

चौकशी अभिलेखांचे जतन:-

- चौकशी प्राधिकाऱ्याने चौकशी पूर्ण करून आपले निष्कर्ष व शिफारशी असलेला अहवाल शिस्तभंगविषयक प्राधिकाऱ्याकडे प्रस्तुत केल्याबरोबर त्याचे काम संपुष्टात येते. चौकशीची कागदपत्रे पुढील आवश्यक कार्यवाही करून शिस्तभंगविषयक प्राधिकाऱ्याने आपल्याकडे ठेवावयाची असतात.
- विभागीय चौकशीसंबंधीची कागदपत्र अंतिम आदेश काढल्याच्या तारखेपासून कमीत कमी ६ १/२ वर्षांच्या कालावधीपर्यंत जतन करून ठेवली पाहिजेत. मात्र चौकशीतील अंतिम निर्णयविरुद्ध अपील करण्यात आले असेल तर अपील करणाऱ्या व्यक्तीला अपीलीय प्राधिकाऱ्याने अपीलावरील आदेश ज्या तारखेस कळविले असतील ती तारीख अंतिम आदेश दिल्याची तारीख मानली जाईल.

विभागीय चौकशी त्वरीत पूर्ण करण्याची आवश्यकता:-

- काही विभागीय चौकशी वर्षानुवर्षे चालू राहातात व त्यामुळे आरोपी कर्मचाऱ्याची एक प्रकारे सतावणूक होते. आरोपी कर्मचारी निलंबित असतो तेव्हा तर या दिरंगाईची झळ त्याला प्रकर्षाने पोचते. काही प्रकरणात दोषारोपपत्र तयार होण्यापूर्वीच त्याला निलंबित केलेले असते व निलंबनानंतर कित्येक महिनेपर्यंत त्याच्यावर दोषारोपपत्र तयार होण्यापूर्वीच त्याला निलंबित केलेले असते व निलंबनानंतर कित्येक महिनेपर्यंत त्याच्यावर दोषारोपपत्र देखील बजावले जात नाही. विशेषतः एखाद्या कर्मचाऱ्याकडे त्याच्या ज्ञात उत्पन्नाच्या प्रमाणाबाहेर मालमत्ता असल्याचा आरोप असतो, तेव्हा त्यासंबंधीची प्रारंभिक चौकशी विविध ठिकाणी बारकाईने करावी लागते व पुरेसा पुरावा उपलब्ध होण्यास बराच अवधी लागतो. चौकशी पूर्ण होईपर्यंत आरोपपत्र बजावता येत नाही.
- विभागीय चौकशा शक्य तो लवकर पूर्ण करण्याच्या आवश्यकतेवर शासनाने वेळोवेळी भर दिला आहे. या संदर्भात शासनाचे खालील आदेश लक्षात घेणे आवश्यक आहे.
 - निलंबनाधीन शासकीय कर्मचाऱ्याच्या प्रकरणात प्रारंभिक, चौकशी पूर्ण करून न्यायालयात किंवा विभागीय चौकशीत दोषारोपपत्र दाखल करण्याची कार्यवाही निलंबनाच्या दिनांकापासून शक्यतो सहा महिन्यांच्या आत करावी.
 - प्रकरणात वरील सहा महिन्यांची मुदत पाळणे अशक्य होईल तेथे प्रारंभिक चौकशी पूर्ण करून दोषारोपपत्र पूर्ण करून दोषारोपपत्र दाखले करण्याच्या कार्यवाहीस निलंबनाच्या दिनांकापासून एक वर्षापर्यंतची मुदतवाढ मिळण्यासाठी मुख्य सचिवांची पूर्व मंजूरी घेणे आवश्यक राहिल.
 - ज्या प्रकरणी मुख्य सचिवांनी दिलेली एक वर्षापर्यंतची मुदतवाढही प्रकरणाच्या क्लिष्टतेमुळे व सबळ कारणास्तव अपुरी पडत असेल तेथे एक वर्षापुढील मुदतवाढीस शासनाची पूर्वमंजूरी घेणे आवश्यक राहिल अशी प्रकरणे शासनास मुख्य सचिवांच्या मार्फत सादर केली जावी.
 - चौकशी प्राधिकाऱ्यांनी निलंबनाधीन कर्मचाऱ्यांविरुद्धच्या चौकशांना अग्रक्रमे देऊन त्या सहा महिन्यात पूर्ण कराव्या व तोपर्यंत त्या पूर्ण न झाल्यास मुदतवाढीसाठी वेळोवेळी विहित प्राधिकाऱ्याची मंजूरी घ्यावी.
 - आरोपी कर्मचाऱ्यास निलंबित केलेले नाही अशा विभागीय चौकशा साधारणतः एक वर्षात पूर्ण कराव्या व ते शक्य न झाल्यास विहित प्रपत्रात माहिती पाठवून चौकशी प्राधिकाऱ्याने संबंधित प्रशासकीय विभागातर्फे सामान्य प्रशासन विभागास मुदतवाढीचा प्रस्ताव वेळोवेळी पाठवावा.

- विभागीय चौकशी अधिक लवकर पूर्ण व्हाव्या या करीता गेल्या काही वर्षांत शासनाने खालील प्रमाणे विशेष उपाययोजना केल्या आहेत.
 - सर्व विभागांतर्गत चौकशा चालविण्यासाठी पूर्ण वेळ काम करणाऱ्या विशेष चौकशी प्राधिकाऱ्यांची तसेच सादरकर्त्या अधिकाऱ्यांची पदे ठिकठिकाणी निर्माण केली आहेत. (वरील परिच्छेद ५३ व ५६)
 - राज्यातील विभागीय चौकशांवर लक्ष ठेवण्यासाठी सामान्य प्रशासन विभागात एक संनियंत्रण कक्ष निर्माण करण्यात आला असून या कक्षाद्वारे निरनिराळ्या विभागातील प्रलंबित चौकशांचा आढावा घेतला जातो व त्या अनुषंगाने आवश्यक सूचना/आदेश वेळोवेळी दिले जातात. आवश्यक तेव्हा चौकशी प्राधिकाऱ्यांना त्यांच्या मुख्यालयाच्या बाहेरील दूरवरच्या ठिकाणी सुनावण्या घेणे शक्य व्हावे. तसेच तेथे कागदपत्रे इ. नेणे सोईचे व्हावे याकरीता त्यांना वाहने उपलब्ध करून देण्याची व्यवस्था करण्यात आली आहे.
 - मराठी मध्ये "विभागीय चौकशी नियम पुस्तिका" या नावाची एक मार्गदर्शनपर पुस्तिका शासनाने १९९१ मध्ये कार्यालयीन वापराकरीता प्रसिध्द केली असून या पुस्तिकेमध्ये संबंधित नियम व शासकीय आदेशांचा सारांश दिलेला आहे. तसेच विभागीय कार्यवाहीमध्ये आरोपी कर्मचारी साक्षीदार इ.ना वेळोवेळी जी ज्ञापने, नोटिसा, आदेश वगैरे पाडवावे लागतात. त्याने तसेच चौकशी प्राधिकाऱ्याची नियुक्ती, आरोपी कर्मचाऱ्याचे निलंबन या बाबतच्या आदेशांचे प्रमाणे नमुने या पुस्तिकेत दिले आहेत. शिस्तभंगविषयक प्राधिकारी व चौकशी प्राधिकारी यांनी अवश्य या नमुन्यांचा वापर करावा.
 - विभागीय चौकशीसंबंधीचे प्रशिक्षण कार्यक्रमही निरनिराळ्या स्तरांवरील कर्मचाऱ्यांसाठी आयोजित केले जातात.

राष्ट्रीय आरोग्य अभियान

ऐतिहासिक पार्श्वभूमी

गरीब दुर्लक्षित तसेच गरजू ग्रामीण जनतेस सहजसाध्य, परवडण्याजोगी, कार्यक्षम, उत्तरदायी आणि विश्वासाह आरोग्य सेवा उपलब्ध करून देण्याच्या उद्देशाने केंद्र शासनाने संपूर्ण देशात १२ एप्रिल २००५ पासून राष्ट्रीय ग्रामीण आरोग्य अभियान सुरु केले आहे. आरोग्यावर परिणाम करणाऱ्या महत्वाच्या घटकांचा (उदा.आहार, परिसर स्वच्छता, सुरक्षित पाणीपुरवठा, महिला व बालविकास इत्यादी) बाबींचा या अभियानामध्ये एकत्रित विचार करण्यात आला आहे.

भारताने मृत्यू दर कमी करण्यात महत्वपूर्ण प्रगती केली आहे. मागील काही दशकांमध्ये मलेरिया या रोगामुळे होणाऱ्या मृत्यूचे प्रमाण त्याच बरोबर माता व अर्भक मृत्यूदरात घट झाली आहे. सदर प्रगती लक्षात घेतली तरीही, ग्रामीण भागामध्ये लोकसंख्या दरात मोठ्या प्रमाणात वाढ, नियंत्रण करण्याजोग्या आजाराचा प्रादुर्भाव व मृत्यू, गुंतागुंतीच्या प्रसुती या बरोबरच कुपोषणात वाढ झाल्याचे दिसून येते. याशिवाय जुन्या न सुटणाऱ्या प्रश्नांसोबत देशातील आरोग्य यंत्रणांसमोर नवीन आव्हाने जसे की देशातील अंदाजे ५ लक्ष रुग्ण एचआयव्ही / एड्स ग्रस्त, असंसर्गजन्य रोग जसे हृदयरोग, कर्करोग, अंधत्व, मानसिक आजार आणि तंबाखुजन्य आजार यासारख्या दुर्धर आजारांमुळे देशातील आरोग्य सेवेवर प्रचंड ताण पडला आहे. भारत संसर्गजन्य रोग विषयक व लोकसंख्या विषयक स्थित्यंतरातून जात असून याबरोबरच दुर्धर रोगांचा भार आणि मृत्यूदरात घट व प्रजनन दरात वाढ यामुळे वयस्क लोकसंख्येत वाढ होत आहे. अर्भक मृत्यू आणि दुर्धर आजाराने मृत्यू यामुळे भारताची महत्वाची आर्थिक व मनुष्यबळाची हानी होत आहे. देशाच्या संपूर्ण सार्वजनिक खर्चामध्ये गुणकारी आरोग्य सेवेपेक्षा प्रतिबंधात्मक आरोग्य सेवेस कमी प्राधान्य दिले जाते. भारतीय जनता जगाच्या तुलनेत आरोग्यावर सर्वात कमी खर्च करते, असे असले तरीही खाजगीस्तरावरील आरोग्य खर्चाचा दर सर्वात जास्त आहे. वार्षिक रु.१००,००० करोड आरोग्यावर प्रति कुटूंब खर्च करण्यात येत आहे. जे आरोग्यावरील सार्वजनिक खर्चाच्या तीन पट आहे. खाजगी क्षेत्रातील आरोग्य सेवेवर नियंत्रण नसल्याने आरोग्य सेवेवरील खर्चात वाढ झाली असून ती ग्रामीण भागातील जनतेस न परवडण्याजोगी आहे. देशाला निरनिराळ्या आरोग्यविषयक पेचप्रसंगास सामोरे जावे लागल्याने आरोग्य सेवेच्या खर्च आणि जनतेच्या अपेक्षांमध्ये वाढ होते. दुर्गम ग्रामीण भागात गुणवत्तापूर्ण आरोग्य सेवा देण्याचे आव्हान अधिक महत्वाचे आहे. सदर प्रश्नाचे गांभीर्य व व्याप्ती लक्षात घेता लहान योजनांवर लक्ष केंद्रीत करणे पुरेसे नाही. सार्वजनिक आरोग्य सेवेचे सहजसाध्य, परवडण्याजोगी, कार्यक्षम, उत्तरदायी व गुणवत्तापूर्ण सेवेत रुपांतरीत करणे अत्यंत आवश्यक आहे. याच भावनेतून देशातील आरोग्य अभियान संकल्पनेचा विकास झाला.

अभियानाची उद्दिष्टे:

- देशातील ग्रामीण भागातील जनतेस प्रभावी, सहजसाध्य, गुणवत्तापूर्ण सेवा उपलब्ध करून देणे, आरोग्य निर्देशक व संसाधन यामध्ये मागे असलेल्या १८ राज्यांवर विशेष लक्ष.
- १८ विशेष लक्ष असणाऱ्या राज्यांमध्ये अरुणाचल प्रदेश, आसाम, बिहार, छत्तिसगढ, हिमाचल प्रदेश, झारखंड, जम्मू आणि काश्मिर, मणीपूर, मिझोराम, मेघालय, मध्यप्रदेश, नागालॅंड, ओरीसा, राजस्थान, सिक्कीम, त्रिपुरा, उत्तरांचल व उत्तर प्रदेश या राज्यांचा समावेश आहे.
- सार्वजनिक खर्चाच्या ०.९% (जीडीपी) वरून २ ते ३% (जीडीपी) पर्यंत आरोग्यावर वाढ करणे.

- योजनांची प्रभावीपणे अंमलबजावणी करणे व सार्वजनिक आरोग्य व्यवस्थेचे बळकटीकरण करणे यासाठी आरोग्य यंत्रणेच्या संरचनेत बदल करणे.
- परंपरागत उपचार पद्धतीचे पुर्नजीवन आणि आयुष्य चा सार्वजनिक आरोग्य यंत्रणेच्या मुख्यप्रवाहात समावेश करणे.
- आरोग्य, पोषण, स्वच्छ पाणीपुरवठा, स्त्री-पुरुष समानता इ. च्या समावेशासह जिल्हास्तरावर विकेंद्रीकरण पद्धतीने आरोग्य सेवेचे प्रभावी एकत्रिकरण.
- आंतर राज्य व आंतर जिल्हा आरोग्य असमानता या बाबीवर निवेदन करणे.
- प्रगतीच्या दृष्टीने लक्ष निर्धारित करणे व तसा सार्वजनिक अहवाल सादर करणे.
- ग्रामीण भागातील जनतेस, विशेषतः गरीब स्त्रिया व बालके यांना सहजसाध्य, परवडण्याजोगी, कार्यक्षम, उत्तरदायी आणि विश्वासार्ह प्राथमिक आरोग्य सेवा उपलब्ध करून देणे.

राष्ट्रीय ग्रामीण आरोग्य अभियानाचे ५ महत्वाची धोरणे

राष्ट्रीय ग्रामीण आरोग्य अभियान हे राज्यांमध्ये आवश्यक असे परिवर्तन करणेसाठी राज्यांच्या बळकटीकरणाचा प्रयत्न आहे. हे अभियान राज्यांना राज्यातील त्यांच्या स्थानिक, सामाजिक व सांस्कृतिक परिस्थितीनुसार निर्णय घेण्यासाठी स्वातंत्र्य देण्यात आले आहे. यामुळे राज्य अभियानासाठी नियोजन व अंमलबजावणी चे विकेंद्रीकरण करतील जेणेकरून गरजेप्रमाणे व सामाजिक आधार असणारे असे जिल्हा आरोग्य कृती आराखडा राज्यात आरोग्य विभागात होणारे महत्वपूर्ण परिवर्तनाचे आधार असतील. राज्य हे स्थानिक बाबींचे निराकरण करणेकरीता नाविन्यपूर्ण योजना हाती घेतील.

राष्ट्रीय ग्रामीण आरोग्य अभियान अंतर्गत केलेले विकेंद्रीकरण लक्षात घेता, राज्यांना, पंचायत राज्य संस्थांना पुरेसे प्रशासकिय / वित्तीय अधिकार प्रदान करणे गरजेचे आहे. याचबरोबर दरवर्षी राज्यांना अभियानाच्या कालावधीत आरोग्य विभागावर होणारे खर्च कमीत कमी १० कोटी रुपये पर्यंत वाढविण्यासाठी प्रयत्न करावे लागतील. राज्यांना आरोग्यविषयक बाबी हाताळण्यासाठी कार्यक्षमता वाढविण्याच्या दृष्टीने प्रयत्न करावे लागतील. राज्याकडून अपेक्षा आहे की ते परस्पर संमतीने निश्चित केलेल्या टप्प्यांची पूर्तता करतील याची नोंद राज्यासोबत करण्यात आलेल्या करारात करण्यात येईल.

भारताच्या तुलनात्मक दृष्टीने महाराष्ट्र राज्यास विकसित राज्य मानले जाते. तथापि एकत्रित दृष्टीने महाराष्ट्र राज्याच्या आरोग्यसेवेचा स्तर व इतर राज्यांच्या आरोग्य सेवेचा स्तर यामध्ये मोठे अंतर आहे. राज्याच्या विविध जिल्ह्यांमध्ये दखल घेण्याजोगी भिन्नता असल्याने जिल्हानिहाय उद्दिष्टे निश्चित करणे आवश्यक आहे. राष्ट्रीय ग्रामीण आरोग्य अभियानात अशा विषयांचा विचार करण्याची संधी देण्यात आली आहे. ग्रामीण लोकांच्या गतीमध्ये सुधारणा करणे विशेषतः गरीब महिला व मूल बरोबर दाखवणे परवडणारे, जबाबदार प्रभावी प्राथमिक आरोग्याची काळजी व उपयोगात सुधारणा.

राष्ट्रीय ग्रामीण आरोग्य अभियानाचा राज्यांचे हात मजबूत करण्यासाठी व सुधारणा करण्याचे प्रयत्न आहेत. अभियान राज्यांना जास्तीचे संसाधन पुरवेल (देईल) ज्याद्वारे विविध नागरिकांच्या आरोग्याच्या गरजा पूर्ण करण्यासाठी सक्षम आहे. यामध्ये राज्यांची नेतृत्वाची भूमिका ओळखताना स्थानिक गरजा व सामाजिक सांस्कृतिक विविधतांची काळजी घेताना आवश्यक ती लवचिकता पुरवण्याचा प्रस्ताव आहे. राज्य

नियोजन व कार्यवाही विकेंद्रित करतील व खात्री देतील की, किंवा निश्चित करतील आधार व सामुहिक मालकी जिल्ह्यांमध्ये “ जिल्हा आरोग्य कृती आराखडा” आरोग्य क्षेत्रातला आधार बनतो. राज्यांना आग्रह (विनंती) केला जाईल की, राज्यांनी नव्या योजना स्थानिक विषयांसाठी संबंध ठेवण्यासाठी घ्याव्यात, विकेंद्रीकरणावर दृष्टी ठेवत राष्ट्रीय ग्रामीण आरोग्य अभियानाच्या मदतीने तोंड देणे, राज्यांना आवश्यक प्रशासकिय आर्थिक शक्ती पंचायत राज संस्थेच्या प्रदान करण्याची गरज असेल. त्याचवेळेस राज्यांना कार्यवाही करण्यासाठी कृती करण्याची गरज आरोग्य विभाग वरील खर्च वाढवणे कमीतकमी १०% प्रत्येक वर्ष तेही अभियानाच्या काळात राज्यांना त्यांच्या प्रयत्नांमध्ये आधार देणे कठीण आरोग्य विषयांमध्ये क्षमता वाढविणे आधार दिला जाईल. राज्यांकडून अपेक्षा असेल की राज व प्रगतिदर्शक घटनांशी परस्परांशी चिकटतील, प्रत्येक राज्य स्वाक्षरीसाठी सहमती असेल.

महाराष्ट्र भारतातील विकसित राज्यांपैकी एक आहे. तथापि, इतर राज्यांच्या तुलनेत महाराष्ट्राची आरोग्य स्थिती पूर्ण स्वरूपामध्ये बरेच अंतर आहे. जिल्ह्यांमध्ये अनेक बदल, जिल्हे अनेक लक्षांच्या पूर्तीसाठी अजूनही गरज आहे. अभियानाने या विषयांना संबोधित करण्याची संधी दिली आहे. भारत सरकारच्या आदेशानुसार, राज्य आरोग्य अभियान मा.मुख्यमंत्रिंच्या अध्यक्षतेखाली स्थापन करण्यात आलेली आहे.

उद्देश

- १) माता व बालमृत्यू दर कमी करणे.
- २) अन्न व पोषण, स्वच्छ व आरोग्यदायी बनविण्यासाठी सार्वजनिक सुविधा उपलब्ध करून देणे आणि माता व बाल आरोग्य तसेच लसीकरण हे ध्येय समोर ठेवून सार्वजनिक आरोग्य सेवा पुरविणे.
- ३) संसर्गजन्य व असंसर्गजन्य तसेच स्थानिक रोगांच्या साथीचा प्रतिकार व नियंत्रण ठेवणे.
- ४) एकात्मिक प्राथमिक आरोग्य सुविधांचा वापर वाढविणे.
- ५) लोकसंख्या स्थिरता व लिंग आणि लोकसंख्येचे प्रामाण राखणे.
- ६) स्थानिक परंपरागत आरोग्य पद्धती सक्षम करणे व आयुष्यला मुख्य प्रवाहात आणणे.
- ७) आरोग्यदायी जीवनाचा प्रचार व प्रसार करणे.

संघटीत कार्यक्रम पद्धत

- सार्वजनिक आरोग्य सुविधा व्यवस्थित चालू ठेवण्यासाठी व त्यांच्यावर नियंत्रण स्थानिक पंचायत संस्थाना प्रशिक्षण देऊन स्वायत्त बनविणे.
- महिला आरोग्य कार्यकर्ता (आशा) मार्फत घराघरांपर्यंत सुधारलेल्या आरोग्य सेवांचा वापर वाढविणे.
- ग्रामपंचायतीतील गाव आरोग्य समिती मार्फत गावाचा आरोग्य आराखडा तयार करणे.
- बंदमुक्त निधीतून उपकेंद्राला स्थानिक नियोजन करण्यासाठी सक्षम करणे आणि बहुउद्देशिय कार्यकर्त्यांची उपलब्धता वाढविणे.
- प्राथमिक आरोग्य केंद्र व सामाजिक आरोग्य केंद्राचे सक्षमीकरण करणे आणि प्रत्येक १ लाख लोकसंख्येमागे ३० ते ५० रुग्ण बेड क्षमता असलेले प्राथमिक आरोग्य केंद्र उपलब्ध करून आजारावर उपचार करून आरोग्यदायी जीवनासाठी प्रयत्न करणे. (भारतीय आरोग्य सुविधांचा नियमानुसार मनुष्यबळ साधणे व नियंत्रण नियम)
- जिल्हा आरोग्य अभियानातर्गत एकत्रित जिल्हा आरोग्य आराखडा तयार व अंमलबजावणी करणे यात पिण्याचे पाणी, स्वच्छता व आरोग्यदायीपणा व पोषणाचा समावेश करणे.

रुग्ण कल्याण समिती (RKS)

राज्यातील सर्व प्राथमिक आरोग्य केंद्र, ग्रामीण/उपजिल्हा रुग्णालये, स्त्री रुग्णालय व जिल्हा रुग्णालयांमध्ये रुग्ण कल्याण समिती स्थापन करण्यात आली आहे. आरोग्य संस्थाना येत असलेल्या अडचणी दूर करणे व समित्यांमार्फत रुग्ण सेवा जास्तीत जास्त गुणवत्तापूर्ण देणे हे रुग्ण कल्याण समिती चे उद्दिष्ट आहे. रुग्ण कल्याण कल्याण समित्यांच्या निर्णय प्रक्रियेची रचना विस्तरीय करण्यात आली आहे.

१) नियामक समिती २) कार्यकारी समिती

१) नियामक समितीची संरचना

नियामक समितीची सभा दर तीन महिन्यातून एकदा घेण्यात यावी. नियामक समितीची संरचना खालील प्रमाणे असते.

अ.क्र.	पदनाम	PRI सदस्य / अधिकाऱ्याचे नाव
१	अध्यक्ष	स्थानिक जि.प.सदस्य
२	उपाध्यक्ष	तालुका आरोग्य अधिकारी
३	सदस्य	प्रा.आ.केंद्राच्या गावाचा सरपंच
४	सदस्य	महिला जि.प. सदस्य
५	सदस्य	स्थानिक स्वयंसेविसंस्थेचा सदस्य
६	सदस्य	अध्यक्ष / पंचायत समिती ने नामांकित केलेला उपकेंद्राचा प्रतिनिधि
७	सदस्य	बाल विकास प्रकल्प अधिकारी
८	सदस्य	खंड विकास अधिकारी
९	सदस्य	तालुका विस्तार अधिकारी
१०	सदस्य सचिव	प्रा.आ.केंद्राचा वैद्यकीय अधिकारी

नियामक समितीची कर्तव्य व जबाबदाऱ्या.

१. रुग्णालयामध्ये प्रत्येक रुग्णास गुणवत्तापूर्ण आरोग्य सेवा मिळावी यासाठी दयावयांच्या सेवा बाबत धोरणात्मक निर्णय घेणे.
२. रुग्ण कल्याण समितीस प्राप्त होणाऱ्या सर्व निधीचे (रुग्ण कल्याण निधी, वार्षिक देखभाल, अंबधित निधी व भारतीय सार्वजनिक आरोग्य मानक निधी) वार्षिक नियोजन कार्यकारी समिती कडून प्राप्त करून घेणे व त्यास आवश्यक त्या बदलासह मंजुरी देणे.
३. रुग्णालयाच्या नियोजन व विकासामध्ये समाजाच्या जास्तीत जास्त सहभाग होईल या दृष्टीने उपाय योजना करणे.
४. जिल्हा आरोग्य सोसायटी कडून प्राप्त होणाऱ्या निधी व्यतिरिक्त इतर स्रोतांची माहिती घेणे व रुग्णालयास रोख व वस्तु स्वरूपात जास्तीत जास्त निधी प्राप्त होईल या दृष्टीने योजना आखणे.
५. रुग्णालयाच्या कामकाजाचा व प्रगतीचा आढावा घेणे.
६. रुग्णालयासाठी आवश्यक असलेल्या विशेषज्ञांच्या सेवा उपलब्ध करून देण्यासाठी प्रयत्न करणे.
७. यापूर्वी घेतलेल्या निर्णयाच्या अंमलबजावणीचा आढावा घेणे.

२) कार्यकारी समितीची संरचना

कार्यकारी समितीची सभा दर महिन्यात एकदा घेण्यात यावी. कार्यकारी समितीची संरचना खालील प्रमाणे असते.

अ.क्र.	पदनाम	PRI सदस्य / अधिकार्याचे नाव
१	अध्यक्ष	तालुका आरोग्य अधिकारी
२	सदस्य	एकात्मिक बालविकास प्रकल्प पर्यवेक्षक
३	सदस्य	पंचायत समिती सदस्य
४	सदस्य	स्थानिक ग्राम आरोग्य स्वच्छता व पोषण समितीचा अध्यक्ष
५	सदस्य	विस्तार अधिकारी (आरोग्य)
६	सदस्य	विस्तार अधिकारी (शिक्षण)
७	सदस्य	वैद्यकीय अधिकारी (आयुष)
८	सदस्य सचिव	प्रा.आ.केंद्राचा वैद्यकीय अधिकारी

कार्यकारी समितीची कर्तव्ये व जबाबदाऱ्या.

कार्यकारी समितीचे मुख्य कर्तव्य नियामक समितीने आखून दिलेल्या धोरणात्मक निर्णयाच्या चौकटीच्या अधिन राहून प्रत्यक्ष अंमलबजावणीसाठी लागणारे निर्णय घेणे हे आहे. त्यानुसार कार्यकारी समितीची कर्तव्ये व जबाबदाऱ्या पुढीलप्रमाणे आहेत.

१. रुग्णांना गुणवत्तापूर्ण आरोग्य सेवा मिळाव्यात व कोणीही रुग्ण आर्थिक वा इतर कारणांमुळे सेवेसाठी वंचित राहू नये यासाठी नियामक मंडळाच्या धोरणात्मक निर्णयाच्या अधिन राहून वेगवेगळ्या योजना आखणे.
२. नियामक मंडळाच्या बैठकीसाठी विषयसूची तयार करणे व त्यास मंजूरी देणे.
३. नियामक मंडळाने घेतलेल्या धोरणात्मक निर्णयांच्या प्रत्यक्ष अंमलबजावणीसाठी रुग्णालय प्रमुखास निश्चित स्वरूपाचा सुचना देणे.
४. प्रदान करण्यात आलेल्या शक्तीचा मर्यादेमध्ये रुग्णालय प्रमुखाने सादर केलेल्या प्रस्तावाना मान्यता देणे.
५. रुग्णालयाचे दैनंदिन कामकाज व प्रगती याचा आढावा घेणे त्यानुसार रुग्णालय प्रमुखास सुचना देणे व आवश्यक असल्यास धोरणात्मक निर्णयासाठी नियामक मंडळाकडे शिफारस करणे.
६. राष्ट्रीय कार्यक्रमाची प्रभावी अंमलबजावणी करणे व ह्या बाबतीत वार्षिक मुल्यमापन तयार करणे.

ग्राम आरोग्य, पोषण, पाणी पुरवठा व स्वच्छता समिती (VHNSC)

पाणी पुरवठा, स्वच्छता, पोषण व आरोग्य सुविधेचा उपयोग करून घेणे ही ग्रामीण समुदायाच्या आरोग्यासाठी जबाबदार कारणे आहेत. VHNSC सर्व ९२२ महसूल गावांमध्ये स्थापित केले गेले आहेत. आरोग्य सुविधा बळकटीकरणात जनसमुदायाचा सहभाग वाढविण्याच्या दृष्टिने हे एक महत्वाचे पाऊल आहे. या समितीचे अध्यक्ष ग्राम पंचायत चे सरपंच असतील आणि स्थानिक आंगणवाडी कार्यकर्ती या समितीची सदस्य सचिव असेल. या समितीचे ५० टक्के सदस्य महिला सदस्य असले पाहिजेत. अनुसूचित जाति / अनुसूचित जमातीचे देखील या समिती मध्ये प्रतिनिधित्व असणे आवश्यक आहे. स्थानिक आरोग्य सेविका व बचत गट (SHG) सदस्य सुद्धा या समितीचे सदस्य असले पाहिजेत. या समितीच्या निधिचा वापर करण्याकरीता सरपंच व आंगणवाडी कार्यकर्ती यांचे संयुक्त बँक खाते असावे.

उद्देश्य:

१. स्थानिक समितीमध्ये आरोग्य कार्यक्रमांची जागरूकता निर्माण करणे.
२. सरकारी आरोग्य सेवांबद्दल लोकांमध्ये जागरूकता निर्माण करणे.
३. स्थानिक आरोग्य विषयक समस्यांनुसार ग्राम आरोग्य योजना विकसित करणे.
४. गर्भवती आणि सहा वर्षा खालील मुलांची विशेषतः अतिजोखमीची माता व अतिजोखमीचे बाळ यांची काळजी घेण्यासाठी मोफत रेफरल ट्रान्सपोर्ट ची सुविधा उपलब्ध करून देणे.
५. श्रेणी ३ व ४ च्या कुपोषित बालकांना आवश्यक पोषक अन्न व औषधे यांचा पुरवठा करणे.

या समितीचा निधी गावाच्या लोकसंख्येनुसार मंजूर करण्यात येतो. VHNSC च्या निधीचा वाटप खालील प्रमाणे करण्यात येतो.

VHNSC करीता निधी वाटप

अ.क्र.	लोकसंख्या (जनगणना २०११)	निधीचा वाटप
१	१५०० पर्यंत	रु.१०,०००/-
२	१५०० ते ३०००	रु.१५,०००/-
३	३००१ किंवा त्यापेक्षा जास्त	रु.२०,०००/-

रुग्ण कल्याण समिती निधी विनियोग

- गरीब रुग्णांसाठी मोफत औषध खरेदी
- रुग्णालयाच्या बाहेर प्रयोगशाळा तपासणीसाठी लागणारा खर्च
- संदर्भ सेवा
- रुग्णांसाठी व नवजात बालकांसाठी कपडे
- रुग्णांसाठी व नातेवाईकांसाठी रुग्णालयात बसण्याची सुविधा
- रुग्णांसाठी करमणूकीची साधने
- रुग्णांसाठी रुग्णालयात स्वच्छ पिण्याच्या पाण्याची सुविधा
- रुग्णांसाठी गरम पाण्याची सुविधा
- धर्मशाळा व स्वयंपाक घराची दुरुस्ती
- रुग्णांसाठी जेवणाची सुविधा
- इतर नाविन्यपूर्ण योजना
- रुग्णांसाठी आवश्यक औषध खरेदी (जी रुग्णालयात उपलब्ध नाहीत)
- आवश्यक उपकरणे (जी रुग्णालयात उपलब्ध नाहीत)
- क्लार्क मानधन
- जैविक कचरा निचरा करण्यासाठी झालेला खर्च

वार्षिक देखभाल दुरुस्ती निधीचा विनियोग

- आरोग्य संस्थेची दुरुस्ती कामे
- पाणी पुरवठा व ड्रेनेज दुरुस्ती कामे
- साहित्य उपकरणे, प्रसुती टेबल दुरुस्तीची कामे
- फर्निचर, दरवाजे, खिडक्या दुरुस्तीची कामे
- आरोग्य संस्थेमध्ये व संस्थेच्या परिसरामध्ये स्वच्छतेसाठी दिलेले मानधन
- दुष्काळ परिस्थितीत पाणीपुरवठा
- संगणक दुरुस्तीची कामे

ग्राम आरोग्य पोषण पाणी पुरवठा व स्वच्छता निधी विनियोग

- ग्राम आरोग्य कृती आराखडा तयार करणे

- ग्राम आरोग्य पोषण दिन साजरा करणे
- आरोग्यविषयक ग्राम सभा आयोजित करणे
- ग्राम आरोग्य पोषण दिन साजरा करणेसाठी लागणाऱ्या वस्तूंची खरेदी करणे
- कुपोषित बालकांसाठी सकस आहार व आरोग्य सेवा पुरविण्यासाठी उपाययोजना आखणे
- प्रसुतीसाठी दाखल होणाऱ्या मातांसाठी आणि अतिगंभीर रुग्णांसाठी संदर्भ सेवा देणे
- डास उत्पत्ती स्थाने नष्ट करणे
- आरोग्यविषयक जनजागृती करणे
- शुध्द पाण्यासाठी टी.सी.एल. पाऊंडर खरेदी करणे
- सार्वजनिक विहिरींची देखभाल करणे
- ग्रामपंचायत हद्दीतील परिसर स्वच्छता

वित्तीय व्यवस्थापन विषयक मार्गदर्शन

- राष्ट्रीय ग्रामीण आरोग्य अभियान अंतर्गत ठेवण्यात येणारे लेखे डबल एन्ट्री बुककिपिंग पध्दतीने ठेवावयाचे आहेत.
- केंद्र शासनाच्या मार्गदर्शक सूचनांस अनुसरून राज्यभरात सर्वस्तरावर लेख्यांमध्ये साम्यता येण्याच्या दृष्टीकोनातून संगणकीकृत टॅली ईआरपी ९ या कस्टमाईज्ड प्रणालीचा वापर होणे बंधनकारक आहे.
- संगणकीकृत टॅली ईआरपी ९ ही कस्टमाईज्ड प्रणाली जरी वापरात असली तरी हस्तलिखित कॅशबुक अद्यावत स्थितीत दप्तरी असणे बंधनकारक आहे.
- लेखा पुस्तके वित्तीय वर्ष निहाय ठेवण्यात यावी.
- कॅश व्हाऊचर्स फाईल मधील सर्व व्हाऊचर्स अनुक्रमांक निहाय फाईल करण्यात यावे.
- निम्न स्तरावरून संस्थेने पाठविलेल्या एसओईची नोंद थेट कॅशबुकमध्ये न करता जर्नल रजिस्टर द्वारे नोंद करावी.
- कार्यालयीन अधिकारी/कर्मचाऱ्यांना दिलेल्या अग्रिमाचे समायोजन ३० दिवसात करणे बंधनकारक आहे.
- स्वाक्षऱ्या केलेले कोरे धनादेश दप्तरी ठेवण्यात येऊ नयेत.
- वापरण्यात न आलेले धनादेश त्वरित रद्द करावेत.
- धनादेश पुस्तिका सुरक्षित ठिकाणी ठेवण्यात यावी. तसेच केवळ अधिकृत अधिकारी/कर्मचाऱ्यांने धनादेश पुस्तिका हाताळावी.
- दरमहा कॅशबुक मधील शिल्लक व बँकेतील शिल्लक या रक्कमेचा ताळमेळ होण्यासाठी बँक रिकन्सलेशन स्टेटमेंट बनविण्यात यावे.
- प्रत्येक व्यवहाराची वेगळी नस्ती ठेवणेत यावी. अनुदान वितरणाचीही नस्ती ठेवणेत यावी.
- नस्तीमध्ये मंजूर अनुदान, प्राप्त अनुदान, खर्च अनुदान शिल्लक अनुदान, प्रस्तावित खर्च याचा उल्लेख असावा.
- मंजूर कृती आराखडा व मार्गदर्शक सूचना जोडणेत याव्यात.
- रुग्ण कल्याण समिती ठरावाची प्रत जोडणे आवश्यक आहे.
- प्रत्येक चेक चे डेबिट व्हावचर बनवणे आवश्यक आहे.
- नस्तीला अंतीम अधिकारी यांची स्वाक्षरी झाल्याखेरीज PFMS काढणेत येऊ नये.
- देयकांवर व्हाऊचर क्रमांक नमुद असावा. तसेच देयकांवर प्रदानार्थ मंजूरीस्तव अधिकृत अधिकाऱ्यांची सही व शिक्का “Passed For Payment” असावा. देयकांची अदायगी झाल्या नंतर देयकांवर “Paid & Cancelled” असा शिक्का मारावा.
- अदायगी झालेल्या व्हाऊचर्स सोबत संबंधित देयके तथा इतर दस्तावेज असणे बंधनकारक आहे.
- देयकांतील दिनांक तथा रकमेमध्ये बदल करण्यात येऊ नये.
- प्राप्त देयके ही संस्थेच्या नावे असावीत. उदा. रुग्ण कल्याण समिती
- धनादेशावर राज्य आरोग्य सोसायटीच्या मार्गदर्शक सूचनास अनुसरून अधिकृत स्वाक्षऱ्या असणे बंधनकारक आहे.
- पुरवठादारास धनादेश अदा केल्या नंतर त्वरित पावती दप्तरी घेऊन ठेवावी.
- धनादेश क्रॉस करून अकाउंटंट पेई स्वरूपात लिहिण्यात यावा.
- बेअरर चेक ने अदायगी शक्यतो टाळवी.

- अधिकृत अधिकाऱ्यांनी वेळोवेळी दफ्तरी असलेली रोख रक्कम, कॅशबुक मधील शिल्लक रकमेस अनुसरून असल्याची आकस्मिक रित्या तपासणी करून शहानिशा करावी व त्या बाबतचा दाखला प्रमाणित करून दफ्तरी ठेवावा.
- आपल्या अंतर्गत आरोग्य संस्थांना वितरीत झालेल्या अग्रिम रक्कमांच्या समायोजनासाठी सतत पाठपुरावा करावा.
- एसओई/विनियोजन प्रमाणपत्र (Utilization Certificate) हे निर्देशित केलेल्या विहित नमुन्यात असणे बंधनकारक आहे.
- अग्रिम रजिस्टर मध्ये नोंदविलेल्या अग्रिमांचे समायोजन न होण्याचा कालावधी पडताळावा व त्या नुसार संबंधित संस्था किंवा व्यक्ती यांना खर्च किंवा खर्चाचे समायोजन न केल्या प्रित्यर्थ विचारणा व्हावी व त्वरित खर्चाचे समायोजन करून घेण्यात यावे. समायोजनास विलंब होत असल्यास आवश्यकतेनुसार शिबीरे आयोजित करावी.
- प्रकल्पांतर्गत प्राप्त होणाऱ्या निधीवर नफा कमविणे हा उद्देश नसल्याने खरेदी केलेल्या फिक्स ॲसेटवर घसारा रक्कम (Depreciation) काढण्यात येऊ नये.
- जंगल मालकत्ता (फिक्स ॲसेट्स) खरेदी केल्यानंतर त्यावर अनुक्रमांक व खरेदीचे वर्ष ऑईल पेंटने नमुद करणे आवश्यक आहे.
- वित्तीय वर्ष अखेर पूर्वी तसेच चालू आर्थिक वर्षात खरेदी केलेल्या जंगम मालमत्तेचे सुस्थितीत कार्यरत असल्याबाबत व ज्यांच्याकडे त्या वस्तु आहेत त्यांच्या स्वाक्षरीचे प्रमाणपत्र दफ्तरी ठेवण्यात यावे.
- कार्यालयीन रोख रक्कमेचा तसेच बँकेतून रोख रक्कम काढून कार्यालयात आणे पर्यंतचा विमा उतरविण्यात यावा. विमा उतरवितेवेळी विम्याचा हप्ता हा मागित ३ वर्षांच्या लेखापरिक्षण अहवालातील वर्षा अखेरच्या रोख शिल्लक रकमेची सरासरी काढून विमा रक्कम/हप्ता निश्चीत करावा.
- राज्य आरोग्य सोसायटी मार्फत केंद्र शासनाच्या मार्गदर्शन सुचनांस अनुसरून प्राप्त परिपत्रकाप्रमाणे (दि. २१.०४.२००८) केवळ एकच बँकेचे खाते ठेवण्यात यावे. सदर चे खाते आय.सी.आय.सी.आय बँकेत असणे बंधनकारक आहे. ज्या ठिकाणी आय.सी.आय.सी.आय बँकेची शाखा उपलब्ध नसेल त्या ठिकाणी राष्ट्रीयकृत बँकेची शाखा उपलब्ध नसेल अशा ठिकाणी आर टी जी एस सुविधा उपलब्ध बँकेत खाते उघडण्यात यावे. ज्या ठिकाणी आय सी आय सी आय बँक, राष्ट्रीयकृत बँकेची शाखा तथा आर टी जी एस सुविधा उपलब्ध नाही त्या ठिकाणी जिल्हा मध्यवर्ती सहकारी बँकेच्या शाखेत खाते उघडण्यात प्राधान्य द्यावे.
- सर्व संस्थांनी निधीचे वितरण जलदरित्या होण्याच्या दृष्टीकोनातून इ-ट्रान्सफर/आर टी जी एस पध्दतीचा अवलंब करावा.
- पल्स पोलिओ तथा लसीकरणासाठी वितरीत केलेल्या निधी पोटी झालेल्या खर्चाचे अहवाल २१ दिवसांच्या आत कार्यालयात प्राप्त करून घ्यावेत व खर्चाच्या नोंदी अद्ययावत कराव्यात.

निधी वाटप -

राज्य आरोग्य सोसायटीकडून निधी प्राप्त होताच पुढील ७ दिवसात आपल्या कार्य क्षेत्रातील आरोग्य संस्थांना निधी वितरण होणे बंधनकारक आहे.

- ग्राम आरोग्य पोषक पाणीपुरवठा व स्वच्छता समिती तसेच उपकेंद्रस्तरावरील खर्चाची विवरण पत्रे (SOE) वार्षिक विनियोजन प्रमाणपत्रे (UC) तसेच घटकनिहाय खर्चाचे व्हाउचर्स व त्या सोबतची संबंधित देयके ज्या आरोग्य संस्थेच्या संनियंत्रण/परिवेक्षणाखाली आहेत त्या आरोग्य संस्थेच्या अखत्यारित ठेवावित.
- वित्तीय वर्षात बँकेच्या खाती प्राप्त होणारी व्याजाची रक्कम ही वर्षाअखेर वित्तीय विवरणपत्रे तयार करतेवेळी निधी समजून आवश्यकतेनुसार घटकनिहाय वर्गीकरणे करावे.

- संगणकीकृत Tally ERP9 चा Backup सुरक्षित राहण्याच्या दृष्टीने कार्यालयीन इमारती शिवाय दुसऱ्या सुरक्षित ठिकाणी ठेवण्यात यावा. इमारतीस दुर्घटना/आग लागल्यास Tally ERP9 चा Backup सुरक्षित राहण्याच्या दृष्टीने कार्यवाही करण्यात यावी.
- अशासकीय स्वयंसेवी संस्थांना वितरीत झालेला निधी हा संबंधित संस्थेकडून खर्चाची प्रमाणित वित्तीय विवरणपत्रे व विनियोजन प्रमाणपत्रे (SOE & UC) प्राप्त होईपर्यंत वितरीत निधी हा अग्रीम समजावा.
- राज्य आरोग्य सोसायटीने वेळोवेळी निर्देशित केलेल्या मार्गदर्शक सुचनांस अनुसरून अधिकची बँकेची खाती त्वरीत बंद करावीत.
- खरेदी करण्यात आलेल्या वस्तुंची नोंद साठा नोंदवही/जंगम मालमत्ता नोंदवहीमध्ये वेळेत घेवून अद्ययावत ठेवावीत.
- विज देयके व दुरध्वनी देयके वेळेत अदा करावीत जेणे करून त्यावर विलंब आकार लागणार नाही.
- राज्य आरोग्य सोसायटीने वेळोवेळी निर्देशित केलेल्या मार्गदर्शक सुचनांस अनुसरून मोठ्या प्रमाणात रोख शिल्लक दफ्तरी ठेवण्यात येवू नयेत तसेच रु.५०००/- मर्यादे बाहेरील खर्च रोख स्वरूपात करणे टाळून सदरचे खर्च PFMS द्वारे करण्यात यावे.
- खरेदी तथा बांधकाम विषयक बाबींमध्ये आवश्यक त्या ठिकाणी अनामत रक्कम (Earnest Money Deposit) व सुरक्षा ठेव रक्कम (Security Deposit) संबंधित पुरवठादारांकडून घेणे बंधनकारक आहे. याबाबत नियमानुसार कार्यवाही करण्यात यावी.
- वैधानिक लेखापरिक्षण केंद्र शासनाच्या मार्गदर्शक सूचनांस अनुसरून विहित वेळेत पूर्ण होण्याच्या दृष्टीकोणातून सर्व आरोग्य संस्थांतील वित्तीय विवरण पत्रे केंद्र शासनाच्या विहित नमुन्यात ३० एप्रिल पूर्वी तयार होणे आवश्यक आहे.
- राज्य आरोग्य सोसायटीने वेळोवेळी निर्देशित केलेल्या मार्गदर्शक सुचनांस अनुसरून विहित खरेदी पध्दतीचा अवलंब करावा.
 - खरेदी करण्यापूर्वी संबंधित कक्षाकडून वस्तुंची मागणी असणे आवश्यक आहे.
 - वस्तुंच्या मागणीस अनुसरून एकूण किती नगाची आवश्यकता आहे याचा उल्लेख करून एकूण अंदाजीत रकमेस तसेच खरेदी प्रक्रिया पध्दतीस टिपणी द्वारे मान्यता घेण्यात यावी.
 - प्रशासकीय मान्यतेस्तव सादर केलेल्या टिपणी मध्ये मागणी केलेल्या वस्तुचे नाव, नग, वस्तुचे वर्णन, अंदाजे रक्कम, अवलंब करावयाची खरेदी प्रक्रिया, उपलब्ध अनुदान व खर्चाचे लेख शिर्षक इ.सर्व बाबींचा स्पष्ट उल्लेख असावा.
 - खरेदी दरपत्रक, दर करार, निविदा प्रक्रियेद्वारे करता येते. शक्यतो खरेदी दर करार पध्दतीने करण्यात प्राधान्य देण्यात यावे. दरकरार पध्दतीने खरेदी करण्यास कमाल मर्यादेची निश्चीत नाही.
 - रु.५०००/- कमाल मर्यादे पर्यंतची खरेदी रोख स्वरूपात करता येते. मात्र रु.५०००/- पेक्षा जास्तीच्या रकमेच्या खरेदीची विभागणी विहित खरेदी प्रक्रियेच्या अवलंब टाळण्यासाठी रु. ५०००/- च्या आतील देयकान्वये खरेदी करणे नियमबाह्य ठरते.
 - रु.५००१/- ते रु.३००,०००/- मर्यादेतील खरेदी दरपत्रक किंवा दरकरार पध्दतीने करण्यात यावी शक्यतो खरेदी दर करार पध्दतीने करण्यात प्राधान्य देण्यात यावे.
 - रु.३००,०००/- मर्यादे बाहेरील खरेदी निविदा प्रक्रिये द्वारे करण्यात यावी.
 - दरपत्रक पध्दतीसाठी पुरवठादारांनी वित्तीय दर सादर करण्यासाठी किमान ७ दिवसांचा कालावधी देणे बंधनकारक आहे तसेच निविदा पध्दतीसाठी पुरवठादारांनी वित्तीय दर सादर करण्यासाठी किमान १० दिवसांचा कालावधी देणे बंधनकारक आहे.

- विहित खरेदी प्रक्रियेस प्रशासकीय मान्यता मिळाल्यानंतर सर्व अटी व शर्तीचा उल्लेख करून पुरवठादारास खरेदी आदेश देण्यात यावे. उदा.दिनांक, जावक क्रमांक, पुरवठा दाराचे नाव,पत्ता, मंजुर दरपत्रक/दरकराचा संदर्भ, मंजुर दर (करा सहित/ करा व्यतिरिक्त), आवश्यक नग, माल पुरवठा करावयाची ठिकाणे, पुरवठा करावयाचा मर्यादित कालावधी, विलंब आकार, करकपात इ. सर्व बाबींचा स्पष्ट उल्लेख असावा.
- माल पुरवठा झाल्यानंतर माल प्राप्तीच्या चलनावर स्वीकारणाऱ्याची स्वाक्षरी, शिक्का तसेच मालाची साठा नोंद वहीत घेतलेल्या नोंदीचे प्रमाणीकरणे करण्यात यावे.
- देयकांच्या अदायगीसाठी टिपणी द्वारे मान्यता घेण्यात यावी व देयकांवर प्रदानार्थ मंजूरीस्तव अधिकृत अधिकाऱ्यांनी स्वाक्षरी व शिक्का मारल्यानंतरच PFMS द्वारे संबधीत पुरवठादारास अदायगी करावी व त्वरील पावती देयका सोबत ठेवावी.
- राष्ट्रीय ग्रामीण आरोग्य अभियान निधीवर बँकेने दिलेले व्याज हे त्या वर्षाचे अनुदान (Grant-in-Aid) समजण्यात यावे. वार्षिक खर्चाची विवरणपत्रे, उपयोगिता प्रमाणपत्रे आय व व्ययपत्रक, जमा व खर्चपत्रक, ताळेबंद व त्यासंबंधित असणारी विवरण पत्रे सनदी लेखा परिक्षकांकडून प्रमाणित करून वरिष्ठ कार्यालयास सादर करणे आवश्यक आहे.
- कार्यक्रमासाठी वापरण्यात येणाऱ्या वाहनाचे स्वतंत्र लॉगबुक ठेवणे आवश्यक आहे. तसेच लेखापरिक्षकांनी पडताळणीसाठी मागितल्यास लॉगबॅक उपलब्ध करणे आवश्यक आहे.
- कर्मचाऱ्यांच्या वेतनामधून कपात करण्यात आलेला आयकर व कपात करण्यात आलेली TDS ची रक्कम संबंधित खात्यास विहित कालावधीत भरणा करणे आवश्यक आहे तसेच भरण्यात आलेली चलने कार्यालयात जतन करून ठेवणे आवश्यक आहे.
- संस्थेने वेळोवेळी घेतलेल्या बैठकांचे इतिवृत्त तसेच झालेले ठराव दप्तरी उपलब्ध असणे आवश्यक आहे. तसेच आवश्यकतेनुसार लेखा परिक्षणासाठी उपलब्ध करून द्यावयाचे आहेत.
- मंजुर तरतूदीपेक्षा ज्यादा झालेला खर्च अमान्य करण्यात येईल.
- वित्तीय वर्षाअखेर रुग्ण कल्याण समितीचे वार्षिक वैधानिक लेखा परिक्षण राज्य आरोग्य सोसायटीच्या मार्गदर्शक सूचनांस अनुसरून विहित वेळेत करून घ्यावे.
- तालुका स्तरापासून वरील आरोग्य संस्थांचे वर्षा अखेरची वित्तीय विवरण पत्रे ही केंद्र शासनाच्या मार्गदर्शक सूचनांस अनुसरून विहित नमुन्यात बनविण्यात यावी तसेच वरिष्ठ कार्यालयास संयुक्तीकरणासाठी विहित वेळेत सादर करावा.

लेखापरिक्षण

- समवर्ती लेखापरिक्षण तिमाही (१०० टक्के)
- वैधानिक लेखापरिक्षण वार्षिक (४० टक्के)
- रुग्ण कल्याण समिती वैधानिक लेखापरिक्षण वार्षिक (१०० टक्के)
- विभागीय आयुक्त तपासणी
- महालेखाकार यांचे मार्फत लेखापरिक्षण
- राज्य आरोग्य सोसायटी मार्फत नियुक्त केलेल्या समवर्ती लेखा परिक्षण त्रैमासिक पद्धतीने करून घ्यावे व नमुद त्रुटींचा पुर्तता अहवाल तात्काळ लेखा परिक्षकांस सादर करून त्यांची प्रत या कार्यालयास सादर करावी.

- समवर्ती लेखा परिक्षणापूर्वी तिमाही अखेरची वित्तीय विवरण पत्रे Tally ERP9 संगणिकृत लेखे, Cashbook, बँकेचे ताळमेळ पत्रक तथा इतर आवश्यक त्या सर्व बाबी अद्ययावत करुन ठेवाव्यात जेणे करुन लेखा परिक्षक लेखा परिक्षणासाठी हजर राहिल्या नंतर वेळेचा अपव्यय होणार नाही तसेच त्रुटीचे प्रमाण कमी होण्यास मदत होईल.
- समवर्ती तसेच वैधानिक लेखा परिक्षणासाठी संबंधित लेखा परिक्षकांशी सविस्तर चर्चा करुन आपल्या कार्यक्षेत्रातील आरोग्य संस्थांच्या लेखा परिक्षणाबाबतचा दिनांक व संस्थानिहाय कृती आराखडा तयार करुन सर्व आरोग्य संस्थांना आगावु स्वरुपात कळवावा जेणे करुन सर्व संस्थांना लेखा परिक्षणासाठी अद्ययावत माहिती विहित वेळेत तयार करणे शक्य होईल.
- समवर्ती लेखा परिक्षकांकडून कर विषयक बाबींच्या अडचणी सोडवून घ्याव्यात व विहित वेळेत Returns भरण्यात याव्यात.
- आपल्या कार्यक्षेत्रातील सर्व आरोग्य संस्थांचे समवर्ती व वैधानिक लेखा परिक्षण झाले आहे किंवा नाही याची शहानिशा करुन घ्यावी व लेखा परिक्षणासाठी हजर न राहणाऱ्या संस्थेबाबत स्थायी लेखा परिक्षण समिती सदस्यासमक्ष चर्चा करुन ही बाब निर्दशनास आणून द्यावी व त्यांच्या विरुद्ध योग्य ती कार्यवाही करावी..
- महालेखापाल मुंबई व नागपुर यांचेकडील प्रलंबित परिच्छेदांचा निपटारा तात्काळ करणे आवश्यक आहे. जिल्ह्याच्या मासिक बैठकीमध्ये प्रलंबित परिच्छेदांचा आढावा आपल्या स्तरावरुन घेण्यात यावा. महालेखापालांना पाठविण्यात आलेले अनुपालनानुसार परिच्छेद मान्य करुन घेणे आवश्यक आहे. त्या दृष्टीने महालेखापाल कार्यालयाशी संपर्क साधुन परिच्छेद मान्य होण्याच्या दृष्टीने प्रयत्न करावे. महालेखापालांच्या परिच्छेदांचे अनुपालन सादर केले नाही तर सदरचे परिच्छेद भारताचे नियंत्रक व महालेखा परिक्षक यांच्या नागरी अहवालामध्ये समाविष्ट होण्याची शक्यता असते. त्यामुळे याबाबीस प्राधान्य देण्यात यावे.
- आपल्या स्तरावरील स्थायी लेखा परिक्षण समितीची स्थापना करुन त्रैमासिक पध्दतीने आपल्या कार्यालयातील तसेच आपल्या कार्यक्षेत्रातील सर्व आरोग्य संस्थांच्या लेखा परिक्षणातील नमुद त्रुटी व त्यांच्या अनुपालन अहवालावर चर्चा करण्यात येवून त्यानुसार आवश्यक ती प्रशासकीय कार्यवाही/वसुलीची कार्यवाही तसेच मार्गदर्शनपर सुचना देण्यात याव्यात.

रजिस्टर, नोंदवहीबाबत

- नविन रजिस्टर सुरवात करताना रजिस्टरला पुष्ठांकित व मुद्रांकित करणेत यावे. तसेच याबाबतचा दाखला लिहून त्याला कार्यालय प्रमुखांची स्वाक्षरी घेणेत यावी.
- जर काही नजर चुकीने एखादया पानावर चुकिच्या नोंदी केल्यास सदरील पान फाडू नये.
- संस्थेतील सर्व रजिस्टर नोंदी वेळोवेळी घेऊन रजिस्टर अद्ययावत ठेवणेत यावे.
- रजिस्टर मध्ये नोंदी घेतल्यानंतर कार्यालय प्रमुख्यांच्या स्वाक्षऱ्या वेळोवेळी घेणेत याव्यात.
- हस्तलिखित स्वरुपात दप्तरी अभिप्रेत असलेली लेखा पुस्तके खालील प्रमाणे आहेत :-

अ.लेखा पुस्तके :

१. कॅश बुक

- नविन कॅशबुक सुरवात करताना रजिस्टरला पृष्ठांकित व मुद्रांकित करणेत यावे. तसेच याबाबतचा दाखला लिहून त्याला कार्यालय प्रमुखांची स्वाक्षरी घेणेत यावी.
- कॅशबुक जमा रक्कम कोणत्या योजनेची व कोणाकडून प्राप्त तसेच खर्च रक्कम कोणत्या अनुदान मधुन व कोणाला अदा केली, चेक क्रमांक, व्हावचर क्रमांक याचा उल्लेख करावा.

- जर काही नजर चुकीने एखादया पानावर चुकीच्या नोंदी केल्यास सदरील पान फाडु नये. सदरील पानावर झालेल्या चुकीचे कारण नमुद करुन त्यावर कार्यालयीन प्रमुखाची स्वाक्षरी घेणेत यावी.
- कॅशबुक लिहिताना दिवसानिहाय लिहावे.
- कॅशबुक मधील नोंदी रोजच्या रोज अदयावत करण्यात याव्यात तसेच प्रत्येक पानावर अधिकृत अधिकाऱ्यांची स्वाक्षरी व शिक्का घेऊन प्रमाणित करण्यात यावे.
- अभियान अंतर्गत घटकनिहाय तथा कार्यक्रम निहाय Cash Book न ठेवता एकच Cash Book ठेवावेत (बँक खातेनिहाय)
- दरमहा बँक ताळमेळ पत्रक तयार करणेत यावे. सदरील पत्रकामध्ये न वटलेले चेक बाबत चेक क्रमांक, दिनांक, रक्कम यांचा उल्लेख असावा. जर चेक तीन महिन्यापेक्षा जास्त कालावधी झालेला असेल तर तो रद्द ठरवुन कॅशबुकला जमा करणेत यावा.
- तसेच दरमहा कॅशबुक शिल्लक रक्कमेचा योजनानिहाय गोपवारा काढणेत यावा. सदरील योजनानिहाय शिल्लक रक्कम व खर्च अहवाल मधील शिल्लक रक्कम यात तफावत नसावी.
- जर काही कारणास्तव कॅशबुक शिल्लक रक्कम लिहिताना, बेरीज करताना चुक झाल्यास व्हाइटनर चा वापर न करता सदरील रक्कमेवर पेनाने २ काट मारुन सुधारीत रक्कम बाजुला लिहिणेत यावी व अधिकृत अधिकाऱ्यांची स्वाक्षरी घेणेत यावी.

२. लेजर बुक
३. जर्नल बुक
४. अँडव्हान्स ट्रॅकिंग रजिस्टर (स्टाफ, पेरीफेरी)
५. चेक्स इशु रजिस्टर/ई बँकिंग रजिस्टर
६. स्टॉक बुक (काम्प्युमेबल/नॉन कम्प्युमेबल)
७. फिक्स असेट्स रजिस्टर
८. आवक रजिस्टर
९. जावक रजिस्टर
१०. अटेन्डन्स रजिस्टर
११. ई एम डी/बँक ड्राफ्ट रजिस्टर

ब.दफ्तरी अभिप्रेत असलेल्या फाईल्स

१. कॅश व्हाऊचर फाईल
२. संबंधित खर्चाच्या प्रशासकीय मान्यतेच्या फाईल्स
३. सक्क्युलर्स फाईल
४. एफ एम आर /एसओई फाईल
५. महालेखाकार (सी अँड ए जी) ऑडिट फाईल
६. वैधानिक (Statutory) लेखापरिक्षण फाईल
७. समवर्ती लेखापरिक्षण (Concurrent) फाईल
८. रुग्ण कल्याण समिती लेखापरिक्षण फाईल (आर के एस ऑडिट)
९. जनरल/सादील खर्चाच्या फाईल्स
१०. बँक रिकन्सलेशन स्टेटमेंट फाईल
११. मिनिट्स बुक

१२. टीडीएस/आयकर चलन्स/रिटर्न फाईल

१३. इतर फाईल्स उदा. सॅलरी, टीए/डीए, टेलीफोन, इलेक्ट्रीसिटी, कॉन्टीजन्सी फाईल्स इत्यादी.

बँक ताळमेळ पत्रक

- दरमहा बँक ताळमेळ पत्रक तयार करणेत यावे. सदरील पत्रकामध्ये न वटलेले चेक बाबत चेक क्रमांक, दिनांक, रक्कम यांचा उल्लेख असावा

Balance as per Cash Book

Add:

(i) Cheque issued but not cashed

(ii) Credit entries made in the bank

but not shown in the cash book

Total

Less:

(i) Amount deposited to Bank but not

credited in Bank Account

(ii) Bank charges debited in the bank account

but not accounted for in the cash book

Total

Balance as per Pass Book/Bank Statement

खर्चाची विवरण पत्रे (SOE) वार्षिक विनियोजन प्रमाणपत्रे (UC)

- खर्च अहवाल दरमहा तयार करणेत यावा.
- खर्च अहवाल तयार करताना मागील महातील प्रगतीपर खर्चामध्ये चालु महातील खर्च अधिक करून चालुमहाचा प्रगतीपर खर्च काढणेत यावा.
- खर्च अहवाल मध्ये दोन प्रकाराचा खर्च येतो १) संस्था स्तरावरील प्रत्यक्ष खर्च २) संस्था अंतर्गत संस्थांचा खर्च. प्रत्यक्ष खर्च हा कॅशबुक प्रमाणे असावा व अधिनिस्त संस्थांचा खर्च हा संस्थांकडून प्राप्त उपयोगिता प्रमाणपत्रांचे बेरजे इतकाच असावा.
- खर्च अहवाल मधील योजनानिहाय शिल्लक रक्कम व माहे अखेर कॅशबुक मध्ये काढणेत आलेल्या शिल्लक रक्कमेतील गोषवारा यात तफावत असु नये.
- खर्चाची विवरण पत्र /विनियोजन प्रमाणपत्र (SOE / Utilization Certificate) हे निर्देशित केलेल्या विहित नमुन्यात असणे बंधनकारक आहे.

Statement of Expenditure For The Year _____

Name of Scheme: – -----

A – FUNDS

- | | |
|--|-----------|
| 1. Carried from the previous year ----- | Rs. ----- |
| 2. Grants Received during the year ----- | Rs. ----- |

Total	Rs. -----
-------	-----------

B. Expenditure incurred during the year -----	Rs. -----
---	-----------

C. Balance Available AS On -----(A - B)	Rs. -----
---	-----------

Date:	Seal	Signature
Block:		Name :
District :		Designation:

FORM GFR 19-A

Utilization Certificate For The Year -----

Sr. No.	Letter Number and date	Purpose	Amount
1.			
	Total		

Certified that out of Rs. ----- of grant in aid sanctioned during the financial year ----- in favour of (Name of Society) vide letter Number (given above) and Rs. ----- on account of unspent balance of the previous year, a sum of Rs. ----- has been utilized for the purpose for which it was sanctioned and that the balance of Rs. ----- remained as unutilized at the end of year-----.

Certified that I have satisfied my self that the conditions on which the grants in aid was sanctioned have been duly fulfilled and that I have exercised the following checks to see that the money was actually utilized for the purpose for which it was sanctioned.

Kind of checks exercised

- 1.Ledgers
- 2.Fund position reports
- 3.Statement of Expenditure

Date:	Seal	Signature
Block:		Name :
District :		Designation:

लेखा विषयक मार्गदर्शन

नस्ती

- प्रत्येक व्यवहाराची वेगळी नस्ती ठेवणेत यावी. अनुदान वितरणाचीही नस्ती ठेवणेत यावी.
- नस्तीमध्ये मंजुर अनुदान, प्राप्त अनुदान, खर्च अनुदान शिल्लक अनुदान, प्रस्तावित खर्च याचा उल्लेख असावा.
- मंजुर कृती आराखडा व मार्गदर्शक सुचना जोडणेत याव्यात.
- रुग्ण कल्याण समिती ठरावाची प्रत जोडणे आवश्यक आहे.
- प्रत्येक चेक चे डेबिट व्हावचर बनवणे आवश्यक आहे.
- नस्तीला अंतीम अधिकारी यांची स्वाक्षरी झाल्याखेरीज चेक काढणेत येऊ नये.

खरेदी पद्धती

- जर एकुण खरेदी रु.५००० पर्यंत असेल तर थेट रोख रक्कम द्वारे खरेदी करणेत यावी.
- जर एकुण खरेदी रु.५००१ पेक्षा जास्त असेल तर प्रथम प्राधान्य शासन दर करार ला देणेत यावे.
- शासन दर करार नसल्यास रु.३००००० पर्यंतची एकुण खरेदी दरपत्रक प्रक्रियेद्वारे करणेत यावी.
- रु. ३००००० पेक्षा जास्त रक्कमेची खरेदी करताना शासन दर करार नसेल तर ई - निविदा प्रक्रिया करणेत यावी.

दरपत्रक प्रक्रिया

- कोणतीही खरेदी प्रक्रिया करताना प्रथम प्रशासकिय व वित्तीय मान्यता घेणेत यावी. प्रशासकिय मान्यता घेताना मंजुर अनुदान, प्राप्त अनुदान, खर्च अनुदान, शिल्लक अनुदान, वस्तुचे वर्णन, अपेक्षित खर्च याचा उल्लेख असावा.
- दरपत्रक नोटीस करतेवेळी जे साहित्य खरेदी करावयाचे त्यांचे वर्णन व साहित्य नग यांचा उल्लेख असणे आवश्यक आहे.
- दरपत्रक नोटीस मध्ये अटी शर्ती असणे आवश्यक असुन दरपत्रक मागविणेचा किमान कालावधी ७ दिवस आहे.

दरपत्रक मागविताना अटी शर्ती मध्ये

1. दरपत्रक लखोटयावर करीता दरपत्रक असा उल्लेख असावा.
2. मक्तेदाराकडुन सादर करणेत येणारे दर हे सर्व करांसहीत असावेत.
3. मुदतीत साहित्य पुरवठा न झाल्यास प्रती आठवडा ०.०५ टक्के दंड करणेत येईल.
4. छपाई असल्यास Proof Reading नंतरच छपाई करणेत यावी.
5. प्राप्त दरपत्रक हाती न स्विकारता कार्यालयीन टपालामार्फतच स्विकारणे बंधनकारक आहे. लखोटयावर आवक क्रमांक दिनांक असणे आवश्यक आहे.
6. दरपत्रक नोटीस नुसार दरपत्रक मागविणेचा कालावधी संपल्यानंतर प्राप्त दरपत्रके समिती समोर उघडणेत यावीत. किमान ३ दरपत्रक मुदतीत प्राप्त होणे आवश्यक आहे.
7. दरपत्रके समिती समोर उघडणेत यावीत. समितीमध्ये कार्यालय प्रमुख, लेखाविषयक कर्मचारी तसेच तांत्रिक कर्मचारी यांचा समावेश असावा. दरपत्रक उघडणेपुर्वी सर्व दरपत्रक लखोटयावर तिघांच्या स्वाक्षऱ्या घेणेत याव्यात तसेच लखोटयावर Open before us as on (Date) at (Time) असे लिहिणेत यावा.

8. दरपत्रक लखोटयातुन काढलेनंतर प्राप्त दरपत्रकावरही समिती सदस्यांची स्वाक्षरी असणे बंधनकारक आहे.
9. दरपत्रक उघडल्यानंतर प्राप्त दरपत्रकानुसार तुलनात्मक तक्ता करणेत यावा व त्यावर कार्यालयीन प्रमुखाची स्वाक्षरी घेणेत यावी.
10. साहित्य पुरवठा आदेश देणेपुर्वी प्राप्त दरपत्रक मधील न्युनतम दरपत्रक दर व अंदाजित दर यात जास्त तफावत नाही याची खात्री केलेनंतरच पुरवठा आदेश देणेत यावेत.
11. साहित्य व देय्यक प्राप्त झाल्यानंतरच देय्यक अदा करावे. देय्यक अदा करताना नियमानुसार करवजावटी करणेत यावी. देय्यक थेट मक्तेदाराला रेखांकित धनादेशाद्वारे अदा करणेत यावे. साहित्य नोंद स्टॉकबुक ला घेणेत यावी तसेच साहित्यावर मार्कर पेन ने नोंद करणेत यावे.
12. पत्रक प्रक्रियेद्वारे निश्चित केलेले दर हे दरपत्रकामध्ये नमुद नग संख्या खरेदी करीता मर्यादीत असतात. दरपत्रक प्रक्रियेद्वारे निश्चित केलेले दर हे दरकरारप्रमाणे दुबार खरेदीस वापरता येत नाहीत.

निविदा प्रक्रिया

- एकुण खरेदी रक्कम रु. ३००,०००/- पेक्षा जास्त असल्यास ई - निविदा प्रक्रिया करणेत बंधनकारक आहे. मात्र रुग्ण कल्याण समिती वित्तीय नियमानुसार बाबनिहाय निविदा प्रक्रिया निश्चित करणेत आलेली आहे.
- निविदा प्रक्रिया करताना वृत्तपत्रात जाहिरात प्रसिद्धी करणेत आवश्यक आहे.
- निविदा द्विलखोटा पद्धतीने मावगविणेत यावी.
- सदरील निविदा प्रसिद्धी कालावधी हा किमान २१ दिवसांचा (तीन आठवडे) असावा.
- निविदा प्रक्रियेमध्ये कामाची अंदापत्रकिय रक्कम रु. १ लक्ष पेक्षा कमी असल्यास निविदा संचाची किंमत रु. १००/- व रु. १ लक्ष पेक्षा जास्त ते १५ लक्षापर्यंत असल्यास निविदा संचाची किंमत रु. ५००/- आकारण्यात यावी.
- बयाणा रक्कम अंदाजपत्रकिय रक्कमेच्या ३ टक्के घेणेत यावी.
- अनामत रक्कम अंदाजपत्रकिय रक्कमेच्या ५ टक्के घेणेत यावी.
- किमान ३ निविदा मुदतीत प्राप्त होणे आवश्यक आहे.
- निविदा बंद पेटीमध्ये स्विकारणेत याव्यात.
- निविदा स्विकृती वेळ संपल्यानंतर सदरील पेटीला सील करुन त्यावर कार्यालय प्रमुखांची स्वाक्षरी घेणेत यावी.
- निविदा उघडताना प्राप्त निविदा पैकी सर्व मक्तेदारांचा पहिला लखोटा अगोदर उघडणेत यावा. लखोटा क्रमांक १ मधील किमान ३ मक्तेदारांचे दस्तऐवज निविदा अटी शर्तीनुसार योग्य न ठरल्यास कोणाचा दुसरा लखोटा न उघडता फेर निविदा करणेत यावी.
- तीन वेळा जाहिरात प्रसिद्धी करुन एकच निविदा प्राप्त झाल्यास पुरवठा धारकास बोलावुन समिती समोर वाटाघाटी करुन एकच निविदा मान्य करणेचे अधिकार समितीला आहेत.

औषध खरेदी

- औषध खरेदी करणेपुर्वी संबधितांचे मागणीपत्रक घेणे बंधनकारक राहिल.
- मागणी मधील औषधे जिल्हा औषध भांडारकडे उपलब्ध नसलेबाबतचा दाखला घेतलेनंतरच औषध खरेदी संस्था स्तरावर करणेत यावी.
- शासन दरकरार वरील औषध खरेदी दरपत्रकाद्वारे करणे टाळावे.

- प्राप्त औषध साठा "औषध साठा नोंदवही" मध्ये घेणेत यावा.
- रुग्ण कल्याण समिती अंतर्गत औषध खरेदी हि आवश्यकतेनुसार करणेत यावी मात्र सदरील खरेदीस रुग्ण कल्याण समितीची मान्यता घेणेत यावी.

देय्यक

- बिलावर तारीख व नंबर असावा.
- बिल नावे असावे.
- खरेदी साहित्याचा तपशिल बीलामध्ये नमुद असावा.
- बिल रक्कम अंकात तसेच अक्षरी लिहिलेली असावी.
- बिल Pass वित्त payment करावे.
- बिल Paid & Cancel करावे.
- देयक कोणाकडून अगोदर अदा केलेले असल्यास Paid by me व अग्रीम मधुन अदा केले असल्यास Paid from advance याचा उल्लेख करावा.
- बिलाला प्रमाणपत्र देणेत यावे.
- स्टॉक बुक नोंदी नमुद कराव्यात.

कर वजावटी

- व्यवसाय कर हा मानधनातुन दर महा वजा करणेत यावा. मानधन (पुरुष) रु. ७,५००/- ते रु. १०,०००/- असेल तर दरमहा रु. १७५/- वजा करावा. मानधन (महिला) रु. १०,०००/- पर्यंत व्यवसाय कर कपात करण्यात येवु नये. रु. १०,०००/- पेक्षा जास्त मानधन असेल तर दरमहा रु. २००/- व माहे फेब्रुवारी मध्ये रु. ३००/- कर वजा करावा.
- एखादया मक्तेदाराकडून एका आर्थिक वर्षात रु. ७०,०००/- किंवा एका वेळी रु. ३०,०००/- पेक्षा जास्त खरेदी केल्यास ज्वै वजा करणेत यावा. मक्तेदार एकल व्यापारी असेल तर देयकाचे १ टक्के व भागीदारी असेल तर २ टक्के कर वजावटी करणेत यावी. सदरील कर वजावटी मक्तेदाराचे पॅन कार्ड झेरोक्स घेणे आवश्यक आहे. सदरील झेरोक्स प्राप्त न झाल्यास किंवा पॅन कार्ड नसल्यास २० टक्के कर वजा करणेत यावा.
- TDS वजा केलेनंतर पुढील महाचे ७ तारीख चे आत चलनाने भरणे बंधनकारक आहे. सदरील कर मुदतीत न भरल्यास प्रती दिन रु. २००/- दंड आकारला जाईल.
- दर तिमाहीची TDS रिटन फाईल करणे आवश्यक आहे. सदरील रिटन फाईल तिमाही संपल्यानंतर पुढील महाचे १५ तारीखचे आत सादर करणे बंधनकारक आहे.
- मक्तेदाराचा विक्रिकर नोंदणी क्रमांक असल्यास २ टक्के व नसल्यास ५ VDDs Works Tax वजा करणेत यावा.
- अनामत रक्कम एकुण ५ टक्के वजा करणेत यावी.
- विमा अंदाजपत्रकिय रक्कमेच्या १ टक्के वजा करणेत यावा.
- कामगार कर देयकाचे १ टक्के वजा करणेत याव. धनादेश
- महाराष्ट्र राज्य इमारत व इतर बांधकाम कामगार कल्याण मंडळ, मुंबई. या नावे काढणेत यावा.

कर वजावटी भरणा

- व्यवसाय कर चलन क्रमांक MTR ६ ने भरणा करणेत यावा. आपले कार्यालयाचा TIN नंबर व कर वाजावटी कालावधी चलनामध्ये नमुद करावा.

- TDS वजा करुन स्टेट बँक ऑफ इंडिया चे नावे चेक ने आयकर विभागाचे चलन क्र.२८१ ने भरणा करावा. कर वजावटीचे महिन्याचे पुढील महाचे ७ तारीख चे आत भरणा करणेत यावा. तिमाही रिटर्न आयकर विभागाला २६ Q मध्ये पुढील महाचे १५ तारीख चे आत भरणे बंधनकारक आहे.
- व्हॅट वजावट केल्यास MVAT चे नावे धनादेश काढुन विक्रिकर विभाग चलन क्र.४०५ ने भरणा करणेत यावा.
- रॉयल्टी वजावट केलेनंतर खणीकर्म विभागकडे जमा करणेत यावी.
- बांधकाम देय्याकातुन वजा केलेला विमा "विमा संचालक, विमा संचालनालय, महाराष्ट्र" यांचे नावे धनाकर्ष काढणेत यावा.
- अनामत रक्कम दुरुस्ती काम असेल तर ६ महिने व नविन काम असेल तर १२ महिने ठेवणेत यावी.

कॅशबुक बाबत

- नविन कॅशबुक सुरवात करताना रजिस्टरला पृष्ठांकित व मुद्रांकित करणेत यावे. तसेच याबाबतचा दाखला लिहुन त्याला कार्यालय प्रमुखांची स्वाक्षरी घेणेत यावी.
- कॅशबुक जमा रक्कम कोणत्या योजनेची व कोणाकडुन प्राप्त तसेच खर्च रक्कम कोणत्या अनुदान मधुन व कोणाला अदा केली, चेक क्रमांक, व्हावचर क्रमांक याचा उल्लेख करावा.
- जर काही नजर चुकीने एखादया पानावर चुकीच्या नोंदी केल्यास सदरील पान फाडु नये. सदरील पानावर झालेल्या चुकीचे कारण नमुद करुन त्यावर कार्यालयीन प्रमुखाची स्वाक्षरी घेणेत यावी.
- कॅशबुक लिहिताना दिवसानिहाय लिहावे.
- दरमहा बँक ताळमेळ पत्रक तयार करणेत यावे. सदरील पत्रकामध्ये न वटलेले चेक बाबत चेक क्रमांक, दिनांक, रक्कम यांचा उल्लेख असावा. जर चेक तीन महिन्यापेक्षा जास्त कालावधी झालेला असेल तर तो रद्द ठरवुन कॅशबुकला जमा करणेत यावा.
- तसेच दरमहा कॅशबुक शिल्लक रक्कमेचा योजनानिहाय गोपवारा काढणेत यावा. सदरील योजनानिहाय शिल्लक रक्कम व खर्च अहवाल मधील शिल्लक रक्कम यात तफावत नसावी.
- जर काही कारणास्तव कॅशबुक शिल्लक रक्कम लिहिताना, बेरीज करताना चुक झाल्यास व्हाइटनर चा वापर न करता सदरील रक्कमेवर पेनाने २ काट मारुन सुधारीत रक्कम बाजुला लिहिणेत यावी व अधिकृत अधिकाऱ्यांची स्वाक्षरी घेणेत यावी.

रजिस्टर / नोंदवहीबाबत

- नविन रजिस्टर सुरवात करताना रजिस्टरला पुष्ठांकित व मुद्रांकित करणेत यावे. तसेच याबाबतचा दाखला लिहुन त्याला कार्यालय प्रमुखांची स्वाक्षरी घेणेत यावी.
- जर काही नजर चुकीने एखादया पानावर चुकीच्या नोंदी केल्यास सदरील पान फाडू नये.
- संस्थेतील सर्व रजिस्टर नोंदी वेळोवेळी घेऊन रजिस्टर अद्ययावत ठेवणेत यावे.
- रजिस्टर मध्ये नोंदी घेतल्यानंतर कार्यालय प्रमुखांच्या स्वाक्षऱ्या वेळोवेळी घेणेत याव्यात.

आवश्यक रजिस्टर

- कॅश बुक
- लेजर
- चेक इश्यु रजिस्टर

- अग्रीम नोंद वही
- स्टॉक बुक
- डेड स्टॉक
- लॉगबुक
- अनुदान नोंद रजिस्टर
- सभा इतिवृत्त रजिस्टर

खर्च अहवाल

- खर्च अहवाल दरमहा तयार करणेत यावा.
- खर्च अहवाल तयार करताना मागील महातील प्रगतीपर खर्चामध्ये चालु महातील खर्च अधिक करुन चालुमहाचा प्रगतीपर खर्च काढणेत यावा.
- खर्च अहवाल मध्ये दोन प्रकाराचा खर्च येतो १) संस्था स्तरावरील प्रत्यक्ष खर्च २) संस्था अंतर्गत संस्थांचा खर्च. प्रत्यक्ष खर्च हा कॅशबुक प्रमाणे असावा व अधिनिस्त संस्थांचा खर्च हा संस्थांकडुन प्राप्त उपयोगीता प्रमाणपत्रांचे बेरजे इतकाच असावा.
- खर्च अहवाल मधील योजनानिहाय शिल्लक रक्कम व माहे अखेर कॅशबुक मध्ये काढणेत आलेल्या शिल्लक रक्कमेतील गोषवारा यात तफावत असु नये.

लेखापरिक्षण

- दर महा लेखापाल यांचे मार्फत संस्था भेटी
- जिल्हा लेखा व्यवस्थापक यांचे मार्फत तपासणी
- समवर्ती लेखापरिक्षण तिमाही (१०० टक्के)
- वैधानिक लेखापरिक्षण वार्षिक (४० टक्के)
- रुग्ण कल्याण समिती वैधानिक लेखापरिक्षण वार्षिक (१०० टक्के)
- विभागीय आयुक्त तपासणी
- महालेखाकार यांचे मार्फत लेखापरिक्षण

आय. पी. एच. एस

- आय. पी. एच. एस. अंतर्गत प्राप्त अनुदान हे राज्य आरोग्य सोसायटी कडुन मंजुर होऊन आलेल्या Planning Formate नुसारच करणेत यावी.
- मंजुर अनुदान त्याच शिर्षकी खर्च होणे आवश्यक आहे. त्यात बदल करणेचे अधिकार राज्य आरोग्य सोसायटी यांचेकडे राखुन ठेवणेत आलेले आहेत.
- सभा आयोजन खर्च नस्तीस सभा उपस्थिती रजिस्टर झेरोक्स प्रत जोडणेत यावी.
- सभा साहित्य वाटप तक्ता तयार करुन त्यास साहित्य स्विकारणाऱ्यांच्या स्वाक्षऱ्या घेणेत याव्यात.
- इंधन अनुदानाचा उपयोग शासकिय वाहनाचे इंधनाकरीताच करणेत यावा. दुसऱ्या संस्थेचे वाहनाकरीता इंधन खर्च केल्यास त्या वाहनाचे लॉगबुक ची झेरोक्स प्रत घेण्यात यावी.
- बांधकाम किंवा दुरुस्ती कामास मुल्यांकन अहवालानुसार देयक अदा करणेत यावे.

उपकेंद्र स्तरावरील आवश्यक रेकॉर्ड

- खर्च नोंद वही
- सभा इतिवृत्त फाईल
- व्हावचर फाईल
- खर्च अहवाल फाईल
- जननी सुरक्षा योजना रजिस्टर
- स्टॉक बुक

VHNSC स्तरावरील आवश्यक रेकॉर्ड

- खर्च नोंद वही
- सभा इतिवृत्त फाईल
- व्हावचर फाईल
- खर्च अहवाल फाईल
- स्टॉक बुक

जिल्हा आरोग्य कृती आराखडा (प्रकल्प अंमलबजावणी आराखडा)

मार्गदर्शक सूचना

जिल्हा आरोग्य कृती हे सहभागातून तसेच Bottom up approach द्वारे नियोजन अंमलबजावणी व संनियंत्रण करण्यासाठी एक महत्वाचे साधन आहे. जिल्हा आरोग्य अभियान हे जिल्ह्याच्या आरोग्य कृती आराखड्याच्या नियोजनासाठी जबाबदार राहील.

Bottom up approach चा विचार करिता जिल्यांना वितरीत केलेला निधी हा प्रत्येक तालुक्यासाठी रु. ४०,०००/- प्रमाणे वितरित करण्यात आलेला आहे. सदर निधी जिल्हा आरोग्य कृती आराखडा तयार करण्याकरीता, मंजूर कृती आराखड्याचे वितरण करण्याकरीता कार्यशाळा आयोजित करणे याकरीता वापरण्यात यावा. तसेच या निधीमधून तालुक्यातील प्राथमिक आरोग्य केंद्रे, ग्रामीण रुग्णालये तसेच गावपातळीपसून ते जिल्हास्तरापर्यंत अंमलबजावणी आराखडा तयार करणे आणि मंजूर कृती आराखड्याचे वितरण करण्यासाठी कार्यशाळा आयोजित करणेकरीता मंजूर आहे.

१. जिल्हा आरोग्य कृती आराखडा तयार करणे तसेच मंजूर जिल्हा आरोग्य कृती आराखड्याचे वितरण करणे संबंधी जिल्हास्तरावरील अधिकारी तसेच सर्व वैद्यकीय अधिकारी प्राथमिक आरोग्य केंद्र, वैद्यकीय अधिक्षक उपजिल्हा रुग्णालय, वैद्यकीय अधिक्षक ग्रामीण रुग्णालय, रोग नियंत्रण कार्यक्रम व इतर कार्यक्रमाचे संबंधित सर्व अधिकारी यांच्या कार्यशाळेचे आयोजन करावे.
२. जिल्हा आरोग्य कृती आराखडा कार्यशाळेनंतर प्राथमिक आरोग्य केंद्र स्तरावरील कार्यशाळेचे आयोजन करावे. यामध्ये गावपातळीवरील नियोजनावर चर्चा करून प्रपत्राचे वितरण करावे.
३. गावपातळीवरील आरोग्य कृती आराखडा एक सप्ताहात तयार करून तो व्हीलेज हेल्थ कमिटी कडे सादर करावा.
४. वैद्यकीय अधिकारी प्राथमिक आरोग्य केंद्र आणि पर्यवेक्षकांनी याबाबत तालुकास्तरावर बैठक घेऊन प्राथमिक आरोग्य केंद्र स्तरावरील आराखडा तयार करावे तसेच ग्रामीण रुग्णालय / उपजिल्हा रुग्णालये स्तरावरील कृती आराखडा त्यांच्या स्तरावर तयार करावा आणि आरोग्य कृती आराखडा तयार केल्यावर त्यास रुग्ण कल्याण समितीची मंजूर घ्यावी.
५. वैद्यकीय अधिकारी प्राथमिक आरोग्य केंद्र, वैद्यकीय अधिक्षक उपजिल्हा रुग्णालय / ग्रामीण रुग्णालय आणि पर्यवेक्षकांची जिल्हास्तरावर बैठक आयोजित करून तालुका स्तरीय आराखडा अंतिम करून तो तालुका आरोग्य अभियान यांच्याकडे सादर करावा. तालुका आरोग्य अभियान यांनी तो जिल्हा आरोग्य अभियानास सादर करावा.
६. सर्व तालुकास्तरीय आरोग्य कृती आराखडे एकत्रित केल्यावर त्यात सर्व जिल्हास्तरीय आरोग्य कृती आराखडा तयार करण्यासाठी तसेच परिमंडळ सस्तरावरील आरोग्य कृती आराखडा तयार करण्यासाठी आवकुक्कप्रके स्तरावर सप्ताहीक कार्यशाळेचे आयोजन करावे. सदर कार्यशाळेत आरसीएच अधिकारी, निवासी वैद्यकीय अधिकारी (बाह्य संपर्क) जिल्हा कार्यक्रम व्यवस्थापक, जिल्हा लेखा व्यवस्थापक आणि जिल्हा पर्यवेक्षक (प्रति जिल्हा सहा अधिकारी) परिमंडळ कार्यक्रम व्यवस्थापक यांनी उपस्थित राहणे अनिवार्य आहे. परिमंडळ स्तरवरील आरोग्य कृती आराखडा अंतिम करण्याकरीता उपसंचालक (आ.से), जिल्हा आरोग्य अधिकारी आणि जिल्हा शल्य चिकित्सक यांनी सप्ताहांच्या शेवटच्या दोन दिवस कार्यशाळेस उपस्थित राहून जिल्हा आरोग्य कृती आराखडा अंतिम करावा.

७. जिल्हा आरोग्य कृती आराखडा अंतिम केल्यावर तो जिल्हा आरोग्य अभियानांस सादर करून मंजूरी घ्यावी त्यानंतर जिल्हा आरोग्य कृती आराखडा आणि राज्यस्तरावर सदर सादर करावा.

➤ सन २०१-१- या आर्थिक वर्षाचा प्रकल्प अंमलबजावणी आराखडा तयार करणे, केंद्र शासनाच्या मार्गदर्शक सूचनेनुसार या वर्षाचा आराखडा तयार करतांना, तसेच वितरण करताना गावपातळीपासून नियोजित वेळेत घेण्यात येणाऱ्या कार्यशाळाकरीता या लेखाशीर्षातर्गत अनुदान उपलब्ध करून देण्यात येत आहे. प्रकल्प अंमलबजावणी आराखडा तयार करतांना खालील प्रमाणे नियोजन करण्यात यावे.

- प्रकल्प अंमलबजावणी आराखडा: गावपातळीवरील माहिती ग्रामसभेच्या माध्यापातून प्राप्त करून घेणे. यामध्ये गावपातळीवरील माहिती व मागील वर्षी करण्यात आलेल्या सर्वेक्षणाची माहितीच्या आधारे गावपातळीवर नियोजन करावे.
- संपूर्ण गावाचे नियोजन विचारात घेऊन प्राथमिक आरोग्य केंद्राचा आराखडा तयार करावा. आरोग्य पथके, उपकेंद्रे, मुख्यालये, इत्यादी बाबी यामध्ये समाविष्ट करण्यात याव्यात.
- प्राथमिक आरोग्य केंद्र, ग्रामीण रुग्णालय व तालुका आरोग्य अधिकारी कार्यालय यांचा एकत्रित मिळून तालुक्याचा आराखडा तयार करावा.
- सर्व तालुक्यांचा मिळून जिल्ह्याचा आराखडा तयार करण्यात यावा.
- प्रत्येकस्तरावर आराखडा तयार करण्याकरीता मार्गदर्शक सूचना आणि प्रपत्रांचा वापर करावा.

➤ पूर्व तयारी

१. प्रपत्र क्रं. १ गावाच्या नियोजनासाठी ग्रामपातळीवर वापरण्यात येणार असल्यामुळे ते मराठीमध्ये रुपांतरित करणे आवश्यक आहे. त्यासाठी प्रथम देण्यात आलेल्या गापातळीवरील प्रपत्र.१ चा आढावा घ्यावा. यामध्ये काही नवीन बाबींची आवश्यकता असल्यास त्याचा आंतरभाव करावा व त्यानंतर सदर प्रपत्र मराठीत भाषांतरीत करावे.
२. जिल्ह्यांनी सोबतच्या Time Line नुसार तालुका आरोग्य अधिकारी, वैद्यकीय अधिक्षक, उपजिल्हा व ग्रामीण रुग्णालय व वैद्यकीय अधिकारी, प्राथमिक आरोग्य केंद्र यांची कार्यशाळा (प्रशिक्षण) घ्यावे. सदर कार्यशाळेत ग्रामपातळी, पथक, प्राथमिक आरोग्य केंद्र, ग्रामीण / उपजिल्हा रुग्णालय व तालुका स्तरावरील प्रपत्रे कशी भरावीत याबाबत तपशीलवार चर्चा करण्यात यावी. सदर कार्यशाळेचा खर्च B.7 DHAP अंतर्गत उपलब्ध अनुदानातून करण्यात यावा.
३. जिल्हास्तरीय कार्यशाळेत प्रत्येक प्राथमिक आरोग्य केंद्रास त्या कार्यक्षेत्रात येणाऱ्या गावांची + १०% इतके गावपातळीवरील प्रपत्रे आणि मार्गदर्शक सूचना यांच्या प्रती देण्यात याव्यात. यांचा खर्च जिल्ह्यास या B.7 DHAP शिर्षातर्गत प्रकल्प अंमलबजावणी आराखडा तयार करण्यासाठी मंजूर केलेला आहे. यातून सदर खर्च भागविण्यात यावा.

➤ गावपातळीवरील नियोजन

गावपातळीवरील नियोजन प्रक्रियेत दिलेल्या प्रपत्र क्रं.१ मधील तक्त्यानुसार ग्रामसभेद्वारे करणे आवश्यक आहे. गावपातळीवरील नियोजनाची संपूर्ण जबाबदारी वैद्यकीय अधिकारी, प्रा.आ.केंद्र यांची राहिल. गावपातळीवरील नियोजनासाठी पुढीलप्रमाणे कार्यवाही करण्यात यावी.

१. प्राथमिक आरोग्य केंद्रातर्गत सर्व गावांची उपकेंद्रावर यादी तयार करावी. उपकेंद्राच्या मुख्यालयाच्या गावात पहिल्या दिवशी व त्यानंतर प्रत्येक गावात एक दिवस असे ग्राम सभेचे नियोजन करण्यात यावे. यासाठी पुढील तक्त्याचा वापर करण्यात यावा.

अ.क्र.	उपकेंद्राचे नाव	गावाचे नाव	ग्रामसभेची तारीख	ग्रामसभेस उपस्थित राहणाऱ्या एएनएम चे ओ एमपीडब्ल्यू (एम) चे नाव	एएनएम जागा रिक्त असल्यास उपस्थित राहणारे आरोग्य सहाय्यक एमपीडब्ल्यू (एम) किंवा इतर आरोग्य अधिकारी

२. प्राथमिक आरोग्य केंद्रातील ग्रामसभेच्या सर्व गावांच्या तारखा, जानेवारीच्या दुसऱ्या सप्ताहातच्या कलावधीत उपरोक्त सुचनांप्रमाणे निश्चित कराव्यात, त्यानंतर याबाबतचे पत्र तारीख, वेळ व ठिकाण नमूद करून ग्राम पंचायत अध्यक्ष, ग्राम आरोग्य पोषण व स्वच्छता समिती यांना पाठविण्यात यावे. सदरची कार्यवाही या मार्गदर्शक सूचना मिळताच त्वरीत सुरु करण्यात यावी.
३. ग्राम सभेच्या तारखांच्या प्रती सर्व संबंधित ग्रामसेवक, अंगणवाडी कार्यकर्ती व पर्यवेक्षक, तलाठी गटविकास अधिकारी, बालविकास प्रकल्प अधिकारी, तालुका आरोग्य अधिकारी, कनिष्ठ अभियंता (एनएचएम) आणि जिल्हा आरोग्य अधिकारी यांना देण्यात याव्यात.
४. ग्रामसभेसाठी त्या भागातील उपकेंद्राच्या एएनएम, एमपीडब्ल्यू (एम). अंगणवाडी कार्यकर्ती व ग्रामसेवक उपस्थित राहतील.
५. एएनएम पद रिक्त असल्यास त्या ठिकाणी प्राथमिक आरोग्य केंद्राचे आरोग्य सहाय्यक आणि एमपीडब्ल्यू (एम) उपस्थित राहतील. कोणत्याही परिस्थित प्रत्येक गावाची ग्रामसभा दिलेल्या तारखेस व मुदतीत घेणे.
६. तालुकास्तरीय व जिल्हास्तरीय अधिकारी / पर्यवेक्षक कर्मचारी यांना २-३ प्राथमिक आरोग्य केंद्राची जबाबदारी निश्चित करण्यात यावी. ग्रामसभांच्या काळात या सर्व कर्मचाऱ्यांनी सर्व ठिकाणी भेटी द्याव्यात. या भेटींचा खर्च डीएचएपी साठी जिल्हास्तरीय निधीमधून भागविण्यात यावा.
७. ग्राम सभेमध्ये प्रपत्र भरल्यानंतर ग्राम आरोग्य समितीची मंजूरी घेण्यात यावी आणि एएनएम नी हे प्रपत्र त्वरीत वैद्यकीय अधिकारी यांना सादर करावे.
८. वैद्यकीय अधिकारी यांनी सर्व गावांची माहिती एकत्रित करून प्राथमिक आरोग्य केंद्राची माहिती तयार करावी तालुकास्तरावरील सभेसाठी तयार करावी.

➤ प्राथमिक आरोग्य केंद्र स्तरावरील नियोजन:

१. प्राथमिक केंद्र स्तरावरील नियोजन हे तालुकास्तरावर प्रकल्प अंमलबजावणी आराखडा कार्यशाळा आयोजित करून करण्यात यावे.
२. सदरची कार्यशाळा जानेवारीच्या शेवटच्या सप्ताहाच्या सुरवातीला तालुकास्तरावर आयोजित करण्यात यावी.
३. कार्यशाळेमध्ये प्रत्येक प्राथमिक आरोग्य केंद्राचे स्वतंत्र गट तयार करण्यात येऊन त्यांची वेगळी व्यवस्था करावी.

४. जिल्हा स्तरावरून प्रत्येक तालुक्यास एक अधिकारी किंवा अनुभवी पर्यवेक्षक कर्मचारी निश्चित करण्यात यावा.
५. तालुका आरोग्य अधिकारी, वैद्यकीय अधिक्षक व जिल्हास्तरीय अधिकारी यांना या कार्यशाळेमध्ये प्रत्येक प्राथमिक आरोग्य केंद्राचे प्रपत्र योग्य पद्धतीने भरले जात आहेत वा नाही याची खात्री करावी.
६. प्राथमिक आरोग्य केंद्रातील गावपातळीवरील आराखड्यात सामील असणारे सर्व कर्मचारी व आरोग्य सहाय्यक या कार्यशाहेस उपस्थित राहणे आवश्यक आहे.
७. उपकेंद्र व प्राथमिक आरोग्य केंद्र इमारत दुरुस्त्या व नवी बांधकामे बाबत अंदाजपत्रके कनिष्ठ अभियंता यांनी तयार करून घ्यावीत व या अंदाजपत्रकानुसार बांधकामविषयीची माहिती एकत्रित करण्यात यावी.

➤ तालुकास्तरावरील नियोजन:

- तालुका स्तरावरील प्रकल्प अंमलबजावणी आराखडा हा दोन भागांमध्ये तयार करण्यात यावा. भाग-१ मध्ये तालुक्यातील सर्व प्राथमिक आरोग्य केंद्राचे आराखडे, तालुका आरोग्य अधिकारी कार्यालय व तालुका स्तरावरील कार्यरत व प्रस्तावित योजनांचा समावेश असावा. या भागाचे संनियंत्रण जिल्हा आरोग्य अधिकारी यांचे मार्फत करता येईल. भाग-२ मध्ये तालुक्यातील सर्व उपजिल्हा व ग्रामीण रुग्णालयांचा आराखडा असावा. या भागाचे संनियंत्रण जिल्हा शल्य चिकित्सक यांचे मार्फत करण्यात येईल.
- तालुका स्तरावरील प्रकल्प अंमलबजावणी आराखडा जिल्हा पातळीवर तयार करण्यात येईल. त्याचे नियोजन पुढील प्रमाणे असावे.
१. तालुका पातळीवर प्रकल्प अंमलबजावणी आराखडा तयार करण्याची कार्यशाळा जिल्हा मुख्यालय किंवा सोईचे ठिकाणी जानेवारीच्या शेवटच्या सप्ताहात च्या कालावधीमध्ये घेण्यात यावी.
 २. या कार्यशाळेत प्रत्येक तालुक्यातून तालुका आरोग्य अधिकारी, वैद्यकीय अधिक्षक, उपजिल्हा / ग्रामीण रुग्णालय, तालुक्यातील ४-५ चांगले वैद्यकीय अधिकारी व कर्मचारी यांना बोलवण्यात यावे.
 ३. प्रत्येक तालुक्यास बसण्याची स्वतंत्र व्यवस्था करण्यात यावी. प्रत्येक गटाने त्यांच्या तालुक्यातील प्राथमिक आरोग्य केंद्राचे आराखडे एकत्रीत करून दिलेल्या प्रपत्राप्रमाणे तालुक्याच्या एकत्रीत अहवाल तयार करावा.
 ४. जिल्हा स्तरावरून २-३ तालुक्यास एक अधिकारी निश्चित करण्यात यावा. या अधिकाऱ्याने आराखडा व्यवस्थित होत असल्यास खात्री करावी.
 ५. जिल्हा आरोग्य अधिकारी तालुकांचे (भाग-१) यांनी आराखडे तयार झाल्यानंतर त्यांची प्राथमिक छाननी करून आराखडे तालुका आरोग्य अधिकारी यांचेकडे तालुकास्तरीय मंजूरीसाठी सुपुर्द करावीत.
 ६. ग्रामीण रुग्णालयांचे आराखडे (भाग-२) ग्रामीण रुग्णालयांचे वैद्यकीय अधिकारी यांनी तयार करावेत. या आराखड्याची प्राथमिक छाननी जिल्हा शल्य चिकित्सक यांनी करावी.
 ७. प्रकल्प अंमलबजावणी आराखड्यांचे तालुकावर दोन्हीही भाग एकत्रीत करून ते तालुका संनियंत्रण व नियोजन समितीस सादर करून या समितीची मान्यता घेण्याची जबाबदारी तालुका आरोग्य अधिकारी यांची राहिल.
 ८. तालुका संनियंत्रण व नियोजन समितीची रचना पुढील प्रमाणे राहिल.

- | | |
|--|------------|
| ● सभापती पंचायत समिती | अध्यक्ष |
| ● गटविकास अधिकारी | सदस्य |
| ● बालविकास प्रकल्प अधिकारी | सदस्य |
| ● अशासकीय संख्या प्रतिनिधी | सदस्य |
| ● ग्रामीण रुग्णालयाच्या रुग्ण कल्याण समितीचे अध्यक्ष | सदस्य |
| ● सर्व ग्रामीण रुग्णालयाचे वैद्यकीय अधिक्षक | सदस्य |
| ● तालुका आरोग्य अधिकारी | सदस्य सचिव |
९. तालुका प्रकल्प अंमलबजावणी आराखड्याची एक प्रत पुढील कार्यवाहीसाठी जिल्हास्तरावर सादर करण्यात यावी व मुळप्रत तालुका संनियंत्रण व नियोजन समितीस सादर करावी.
१०. तालुका नियोजनासाठी जिल्हा स्तरावर घेण्यात येत असलेल्या कार्यशाळेसाठीचा DHAP च्या तरतुदीमधून भागवण्यात यावा.

HEALTH SCHEMES UNDER NHM

- 1. ASHA**
- 2. Janani Suraksha Yojana: JSY**
- 3. Janani Shishu Suraksha Karyakaram (JSSK)**
- 4. Pradhan Mantri Matru Vandana Yojana (PMMVY)**
- 5. Health Advice Call Center (HACC)**
- 6. Maharashtra Emergency Medical Services (MEMS)**
- 7. Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY)**
- 8. Human Development Programme (मानव विकास कार्यक्रम)**
- 9. Navsanjeevani Yojana**
- 10. Savitribai Phule Kanya Kalyan Yajana**
- 11. Rashtriya Bal Swasthya Karyakram (RBSK)**
- 12. Rashtriya Kishor Swasthya Karyakram (RKSK)**
- 13. AYUSH**
- 14. IPHS**

1. ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA) SCHEME

INTRODUCTION:

The NRHM covers all the villages through village-based "Accredited Social Health Activists" (ASHA) who would act as a link between the health centers and the villagers. The general norm as decided under the Programme is 'One ASHA per 1,000 population' in tribal area and 1,500 population in non-tribal area. The ASHA would be trained to advise villagers about Sanitation, Hygiene, Contraception, and Immunization to provide Primary Medical Care for Diarrhea, Minor Injuries, and Fevers; and to escort patients to Medical Centers. They would also deliver Directly Observed Treatment Short (DOTS) course for tuberculosis and oral rehydration; distribute folic acid tablets and chloroquine to patients and alert authorities to unusual outbreaks. Although these ASHAs would be honorary volunteers, there is a provision to provide them with performance-based incentive for undertaking specific health or other social sector programmes with measurable outputs, thus promoting employment for volunteers.

If rural women want counseling on important issues such as birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child, they may contact the concerned ASHA who shall be happy to provide them with all relevant guidance and assistance.

SALIENT FEATURES OF ASHA:

1. Accredited Social Health Activist (ASHA) is a community based functionary.
2. ASHA is trained link worker who Acts as bridge between the Government functionaries and tribal & non-tribal population who find it difficult to access the health services.
3. She is a first port of call for any health related demands of the community.
4. She creates health awareness in community.
5. She is promoter of good health practices.
6. In Maharashtra State ASHA works in 15 tribal & 31 non-tribal districts.
7. Compensation to ASHA is linked with her performance.

SELECTION OF ASHA:

Tribal Area:

1. One ASHA per 1000 Population.
2. ASHA is primary resident of village with formal education up to class 8th in Tribal area.
3. Age group of 20-45 years.
4. She should be married woman.

Non-Tribal Area:

1. One ASHA per 1500 population.
2. ASHA is primary resident of village with formal education up to class 10th in non-tribal area.
3. Age group of 25-45 years.
4. She should be married woman.

SELECTION PROCEDURE OF ASHA:

1. VHNSC will recommend three names of suitable candidates to Gramsabha.
2. Gramsabha will select one lady as ASHA amongst these shortlisted candidates.
3. Appointment letter of ASHA will be issued by Taluka Health Officer.

SUPPORT MECHANISM OF ASHA:

1. One District Community Mobiliser (DCM) for one district.
2. One Block Community Mobiliser (BCM) for each block in tribal area.
3. One Block Facilitator for 10 ASHAs in tribal area.
4. One Block Facilitator per PHC in non-tribal area.
5. State, District & Taluka Mentoring Committees are being constituted for supporting ASHAs.

TRAINING OF ASHA:

1. After selection as ASHA by Gramsabha & appointment letter issued by THO, she is eligible to undergo ASHA Training.
2. Training is divided in to 5 sessions, each one of 7+ 4 +4 +4 +4 day's duration, Total 23 days.
3. After completion of 1st Module of 7 days, ASHA is eligible to receive performance based incentive.
4. She is eligible to receive stipend for attending training.

INCENTIVE TO ASHA:

1. Incentive to ASHA is based on her performance.
2. Performance of ASHA is recorded in one register and she is paid based on this record.
3. Incentive to ASHA is paid at PHC level in monthly meeting.
4. Incentive to ASHA is paid by Cheque.

2. JANANI SURAKSHA YOJANA: JSY**Selection Criteria for Clients:**

- Ante-natal women from SC / ST / BPL families.
- Age at least 19 years at the time of ANC registration.
- Up to two living issue.
- Gravida not to be considered.

Amount to be paid:

- For institutional delivery in rural areas Rs. 700/-.
- For institutional delivery in urban areas Rs. 600/-.
- For home delivery in rural areas Rs.500/-.
- For institutional delivery with LSCS Rs. 1500/-.

Time limit to make payment:

- Within 7 days of delivery.

Mode of payment:

- Through cheque only except in Dharni and Chikaldara block of Amrawati district.

Administrative cost:

- 4% of total expenditure on:
 - Cashier Rs. 5/- per case.
 - Nurse Rs. 10/- per case.
 - Other as OE and IEC activities.

Register and Formats:

- JSY-I: by ANM of Sub Centre or Health Post nurse.
- JSY-II: Reporting format.
- JSY-III: By health institutes.

3. JANANI SHISHU SURAKSHA KARYAKARAM (JSSK) (TOLLFREE NO. 102)

Introduction

Government of India has launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011.

The scheme will provide benefit to all pregnant women who access Government health facilities for their delivery. Moreover it will motivate those who still choose to deliver at their homes to opt for institutional deliveries. . It is an initiative to ensure that benefits under JSSK would reach every needy pregnant woman coming to government institutional facility.

Govt of Maharashtra has started implementation of the scheme in all the districts..

The following are the Free Entitlements for pregnant women:

- Free delivery
- Free C-Section
- Free drugs and consumables
- Free diagnostics
- Free diet during stay in the health institutions
- Free provision of blood
- Exemption from user charges
- Free transport from home to health institutions
- Free transport between facilities in case of referral
- Free drop back from Institutions to home after 48hrs stay

The following are the Free Entitlements for Sick newborns and infants under 1 yr of age.

- Free treatment
- Free drugs and consumables
- Free diagnostics
- Free provision of blood
- Exemption from user charges

- Free Transport from Home to Health Institutions
- Free Transport between facilities in case of referral
- Free drop Back from Institutions to home

Under JSSK free referral transport is available from civil surgeon and district Health officer by calling the toll free no. 102.

4. PRADHAN MANTRI MATRU VANDANA YOJANA (PMMVY)

INTRODUCTION

Under-nutrition continues to adversely affect majority of women in India. In India, every third woman is undernourished and every second woman is anaemic. An undernourished mother almost inevitably gives birth to a low birth weight baby. When poor nutrition starts in-utero, it extends throughout the life cycle since the changes are largely irreversible. Owing to economic and social distress many women continue to work to earn a living for their family right up to the last days of their pregnancy. Furthermore, they resume working soon after childbirth, even though their bodies might not permit it, thus preventing their bodies from fully recovering on one hand, and also impeding their ability to exclusively breastfeed their young infant in the first six months.

From 01.01.2017, the Maternity Benefit Programme would be implemented in all the districts of the country in accordance with the provision of the National Food Security Act, 2013. The programme is named as 'Pradhan Mantri Matru Vandana Yojana' (PMMVY).

Under PMMVY, a cash incentive of Rs. 5000/- would be provided directly in the account of Pregnant Women and Lactating Mothers (PW&LM) for first living child of the family subject to their fulfilling specific conditions relating to Maternal and Child Health. The eligible beneficiaries would receive the remaining cash incentives as per approved norms towards maternity benefit under Janani Suraksha Yojana (JSY) after institutional delivery so that on an average, a woman will get Rs. 6000/- .

PMMVY, a Centrally Sponsored Scheme, would provide grants-in-aid to the State Governments/ Union Territory Administrations (UTs) in a dedicated Escrow account for the purpose of direct benefit transfer to the beneficiaries. PMMVY will be implemented using the platform of Anganwadi Services scheme of Umbrella ICDS under Ministry of Women and Child Development in respect of States/ UTs implementing scheme through Women and Child Development Department/ Social Welfare Department and through Health system in respect of States/ UTs where scheme will be implemented by Health & Family Welfare Department. PMMVY shall be implemented through a centrally deployed Web Based MIS Software application and the focal point of implementation would be the Anganwadi Centre (AWC) and ASHA/ ANM workers.

Objectives of PMMVY

1. Providing partial compensation for the wage loss in terms of cash incentives so that the woman can take adequate rest before and after delivery of the first living child.
2. The cash incentive provided would lead to improved health seeking behaviour amongst the Pregnant Women and Lactating Mothers (PW & LM).

Target beneficiaries

1. All Pregnant Women and Lactating Mothers, excluding PW&LM who are in regular employment with the Central Government or the State Governments or PSUs or those who are in receipt of similar benefits under any law for the time being in force.
2. All eligible Pregnant Women and Lactating Mothers who have their pregnancy on or after 01.01.2017 for first child in family.
3. The date and stage of pregnancy for a beneficiary would be counted with respect to her LMP date as mentioned in the MCP card.
4. **Case of Miscarriage/Still Birth:**
 - is eligible to receive benefits under the scheme only once.
 - In case of miscarriage/still birth, the beneficiary would be eligible to claim the remaining installment(s) in event of any future pregnancy.
 - Thus, after receiving the 1st installment, if the beneficiary has a miscarriage, she would only be eligible for receiving 2nd and 3rd installment in event of future pregnancy subject to fulfilment of eligibility criterion and conditionalities of the scheme. Similarly, if the beneficiary has a miscarriage or still birth after receiving 1st and 2nd installments, she would only be eligible for receiving 3rd installment in event of future pregnancy subject to fulfilment of eligibility criterion and conditionalities of the scheme.
5. **Case of Infant Mortality:**

A beneficiary is eligible to receive benefits under the scheme only once. That is, in case of infant mortality, she will not be eligible for claiming benefits under the scheme, if she has already received all the installments of the maternity benefit under PMMVY earlier.
6. Pregnant and Lactating AWWs/ AWHs/ ASHA may also avail the benefits under the PMMVY subject to fulfilment of scheme conditionalities

Benefits under PMMVY

1. Cash incentives in three installments i.e. first installment of Rs. 1000/- on early registration of pregnancy at the Anganwadi Centre (AWC)/ approved Health facility as may be identified by the respective administering State/ UT, second installment of Rs. 2000/- after six months of pregnancy on receiving at least one ante-natal check-up (ANC) and third installment of ₹ 2000/- after child birth is registered and the child has received the first cycle of BCG, OPV, DPT and Hepatitis-B, or its equivalent/ substitute.
2. The eligible beneficiaries would receive the incentive given under the Janani Suraksha Yojana (JSY) for Institutional delivery and the incentive received under JSY would be accounted towards maternity benefits so that on an average a woman gets Rs. 6000/-.

Conditionalities and Installments

- PW & LM shall receive a cash benefit of Rs. 5000/- in three installments at the following stages as specified in the table given below:

Conditionalities and Installments		
Installment	Conditions	Amount
First Installment	Early Registration of pregnancy	Rs. 1,000/-
Second Installment	Received at least one ANC (can be claimed after 6 months of pregnancy)	Rs. 2,000/-
Third Installment	i. Child Birth is registered ii. Child has received first cycle of BCG, OPV,DPT and Hepatitis-B or its equivalent/substitute	Rs. 2,000/-

- The eligible beneficiaries would receive the remaining cash incentive as per approved norms towards the Maternity Benefit under JSY after institutional delivery so that on an average, a woman will get Rs. 6000/-.

Closure of old Maternity Benefit Programme

- The beneficiaries under old Maternity Benefit Programme in 53 pilot districts, who have already received first installment of maternity benefit, shall be entitled for receiving cash incentive as per approved norms towards maternity benefit under JSY and also the third installment under PMMVY if they or otherwise eligible under the scheme and fulfil the conditions laid down for incentive under JSY and third installment under PMMVY.
- The eligible beneficiaries in 53 pilot districts who have registered under old Maternity Benefit Programme (IGMSY) on or after 01.01.2017, but have not received first installment may register under PMMVY.
- Conditions for subsuming registered beneficiaries under old Maternity Benefit Programme in PMMVY for 53 pilot Districts: -
 - a. Under the old Maternity Benefit Programme, maternity benefit of Rs. 6000/- was disbursed to the beneficiaries in two equal installment of Rs. 3000/- each. The first installment of Rs. 3000/- was provided after second trimester of pregnancy to those beneficiaries who have got them registered at the Anganwadi Centre/ health centre with at least two antenatal check-ups. The second installment was provided after registering the birth of the child and completing immunization of the child, as per the conditions of the scheme.
 - b. Thus, if a woman has already received first installment of maternity benefit under old Maternity Benefit Programme, she shall be entitled for receiving the cash incentives as per approved norms under JSY for institutional delivery and for third installment under the PMMVY, if she is otherwise eligible under the scheme and fulfil the conditions laid down for incentives under JSY for institutional delivery and third installment under PMMVY.

PROCESSING OF CLAIMS

The following procedure shall be followed for processing of the cases so as to ensure that the payment of the installment is made in the account of the eligible beneficiary preferably within 30 days of registration and submission of the claim along with complete details of fulfilment of the conditionalities under the scheme.

Registration and submission of claims to AWW/ASHA/ANM

1. Registration under the Scheme:

- a) The eligible women desirous of availing maternity benefits are required to register under the scheme at the Anganwadi Centre (AWC)/ approved Health facility depending upon the implementing department for that particular State/UT.
- b) For registration, the beneficiary shall submit the prescribed application **Form 1-A**, complete in all respects, along with the relevant documents and undertaking/consent duly signed by her and her husband, at the AWC/ approved Health facility. While submitting the form, the beneficiary will be required to submit her and her husband's Aadhaar details with their written consents, her/husband/family member's Mobile Number and her Bank/Post Office account details.
- c) The prescribed form(s) can be obtained from the AWC/ approved Health facility free of cost. The form(s) can also be downloaded from the website of Ministry of Women and Child Development (<http://wcd.nic.in>).
- d) The beneficiary would be required to fill up the prescribed scheme forms for registration and claim of the installment and submit the same at the Anganwadi Centre/ approved Health facility. The beneficiary should obtain acknowledgment from Anganwadi Worker/ASHA/ANM for record and future reference.
- e) Brief instructions on filling up of the prescribed form(s) are as follows:
 - i. For registration and claim of first installment, duly filled Form 1-A along with copy of MCP Card (Mother and Child Protection Card), Proof of Identity of Beneficiary and her Husband (Aadhaar Card or permitted Alternate ID Proof of both) and Bank/ Post Office Account details of the beneficiary is required to be submitted.
 - ii. For claiming second installment, beneficiary is required to submit duly filled up **Form 1-B** after six months of pregnancy, along with the copy of MCP Card showing at least one ANC.
 - iii. For claiming third installment, beneficiary is required to submit duly filled up **Form 1-C** along with copy of child birth registration and copy of MCP card showing that the child has received first cycle of immunization or its equivalent/substitute.
 - iv. In case a beneficiary has complied the conditionalities stipulated under the scheme but could not register/submit claims within the stipulated time can submit claim(s)
 - v. The AWW / ASHA / ANM will facilitate opening of the beneficiary's Aadhaar seeded Bank / Post Office account in case she does not already have the same in her name or seeding the existing Bank / Post Office account with Aadhaar.
 - vi. The beneficiary may submit **Form 2-A** for seeding of her Bank Account with her Aadhaar, if not seeded earlier.
 - vii. The beneficiary may submit **Form 2-B** for seeding of her Post Office Account with her Aadhaar, if not seeded earlier.
 - viii. Even if the beneficiary does not have the Aadhaar, the AWW / ASHA/ ANM will ensure opening of the Bank / Post Office Account and facilitate getting the Aadhaar Card.
 - The beneficiary/ her husband may submit **Form 2-C** to enrol for Aadhaar or update the details registered with UIDAI.
 - ix. Beneficiary may submit **Form 3** for updating/change of details registered under the scheme in the following conditions:

- Change in address and/or mobile number;
 - Inclusion of Aadhaar Number of Beneficiary or her Husband in case it is not provided at the time of registration;
 - Change in Bank/ Post Office Account;
 - Change in name as in Aadhaar;
- x. The beneficiaries already registered under old MBP scheme and received only the first installment may submit duly filled up Form 1-A and Form 1-C for claiming the third installment under PMMVY subject to fulfillment of eligibility and conditionalities.
- xi. 11. If the beneficiary and/or her husband does not have Aadhaar, they can provide an Aadhaar EID number or register their request for Aadhaar enrolment (Form 2-C) along with any proof of identity in Form 1-A.

General Instructions:

- a) Beneficiary and her husband are required to enrol for Aadhaar on their own or through facilitation by the implementing Department in the State/UT to become entitled for third installment for which Aadhaar numbers of beneficiary & her husband are mandatory. For anyone providing Alternate ID proof under the scheme, it is compulsory to enrol for Aadhaar within 90 days from date of registration under the scheme.
- b) The beneficiaries from the State of Assam, Meghalaya and Jammu & Kashmir are exempted from the requirement for submission of Aadhaar as per notification issues under Section-7 of Aadhaar Act, 2016 (refer Annexure D).
- c) The pregnancy of a beneficiary would be counted with respect to her LMP date as mentioned in the MCP card.
- d) Every registered beneficiary under **PMMVY** will receive a Mother and Child Protection (MCP) Card from Anganwadi Centre/ ASHA / ANM of the locality. The MCP Card will be used as a means of verification of the conditionality (ies) for payment.

Processing of the claim for First Installment

- a) For claiming the installment, the beneficiary shall submit duly filled up Form 1-A along with the relevant documents at the AWC/ Village/ Approved health facility.
- b) The beneficiary will be eligible to claim the first installment under the scheme only if she registers her pregnancy at the AWC or with ASHA/ANM within a time frame of 5 months (i.e. 150 days) from the LMP date (both dates are as captured in the MCP card).
- c) The processing for disbursement of benefits to the beneficiary shall be completed well before 30 days of registration at AWC/ Village/ approved health facility so that the benefits could be transferred within 30 days to the beneficiary from the date of registration under the scheme.
- d) The individual desirous of availing benefits under PMMVY shall submit the details as prescribed in Registration Form & fulfilment of conditionalities in Form 1-A to AWW/ASHA/ANM along with requisite documents.
- e) On receipt of complete application form and requisite documents, the AWW/ASHA/ANM will register the beneficiary under PMMVY and send the details within a week to Supervisor/ANM.
- f) The proposal received from AWW/ASHA/ANM would be checked by Supervisor/ ANM, consolidated and shall be submitted every week to the concerned CDPO/ Health Block Officer (Medical Officer) for the payment processing/ online registration.

Processing of the claim for Second Installment

- a) For claiming the second installment, the beneficiary shall submit duly filled Form 1-B along with the relevant documents to AWW/ASHA/ANM along with requisite documents.
- b) The beneficiary shall submit the proof of fulfilment of conditionalities in Form 1-B along with photocopies of the requisite documents.
- c) On receipt of complete claim form and requisite documents, the AWW/ASHA/ANM will send the details within a week to Supervisor/ANM for processing disbursement of second installment of maternity benefit.
- d) The proposal received from AWW/ASHA/ANM would be checked by Supervisor/ ANM, consolidated and shall be submitted every week to the concerned CDPO/ Health Block Officer (Medical Officer) for the payment processing.
- e) The processing for disbursement of second installments of maternity benefits to the beneficiary shall be completed well before 30 days from the date of receiving claim in Form –1-B related to proof of fulfilment of conditionalities.

Processing of the claim for Third Installment

- a) For claiming the installment, the beneficiary shall submit duly filled up Form 1-C along with the relevant documents to AWW/ASHA/ANM.
- b) The beneficiary shall submit the proof of fulfilment of conditionalities in Form 1-C along with photocopies of the requisite documents.
- c) The beneficiary must furnish details of her and her husband's Aadhaar, if not already furnished, in order to become eligible for receiving third installment under PMMVY.
- d) On receipt of complete claim form and requisite documents, the AWW/ASHA/ANM will send the details within a week to Supervisor/ANM for processing disbursement of third installment of maternity benefit.
- e) The proposal received from AWW/ASHA/ANM would be checked by Supervisor/ ANM, consolidated and shall be submitted within a week to the concerned CDPO/ Health Block Officer (Medical Officer) for the payment processing.
- f) The processing for disbursement of third installments of maternity benefits to the beneficiary shall be completed well before 30 days from the date of receiving claim in Form 1-C related to proof of fulfilment of conditionalities.

Processing by Supervisor/ANM

The form received from AWW/ASHA/ANM shall be verified and submitted to CDPO/MO within a week from the date of receipt. The detailed instructions in this regard are at Annexure B and Annexure C.

Processing by CDPO/MO

The form received from Supervisor/ANM will be verified and entered into the WWW.PMMVY-CAS.GOV.IN web-based MIS for disbursal of benefits to eligible beneficiaries, as per the details given in User Manual for the PMMVY-CAS software. CDPO/MO will ensure that the details received or entered in the database and sanctioned within a week from the data of receipt of the forms.

Processing for initiation of payment by State Nodal Officer (SNO)

The SNO will ensure that the payments are initiated within three working days from the receipt of sanctioned list from CDPO/MO after verifying the correctness of the data.

Amount and conditions for payment of incentives

- a) The beneficiary will receive a total cash incentive of ₹ 5000/- in three installments, subject to the fulfilment of specific conditions.
- b) The payment shall be credited to the Bank/ Post office account of the beneficiary, as the case may be and not in the husband's/family member's/joint account.
- c) The conditionalities for the three installments under the scheme are (**refer Annexure E** for details):

- i. **First Installment**

Amount: ₹ 1000/- in case of early registration of pregnancy on fulfilment of the conditions mentioned below:

Proof of early registration of pregnancy in MCP card (registration of pregnancy within 150 days from the date of LMP), duly certified by an officer/functionary of Health Department not below the rank of ANM.

- ii. **Second Installment**

Amount: ₹ 2000/- after 6 months of pregnancy on fulfilment of the conditions mentioned below:

At least one Ante-Natal Check-up of beneficiary duly certified on MCP card by an officer/ functionary of Health Department not below the rank of ANM.

- iii. **Third Installment**

Amount: ₹ 2000/- on fulfilment of the conditionalities mentioned below:

- Child birth is registered. Birth Certificate issued by an authorised authority of the State/UT will be accepted as proof of child birth.
- Proof that child has received first cycle of BCG, OPV, DPT and Hepatitis-B or its equivalent/substitute, the MCP card being duly certified on MCP card by an officer/functionary of Health Department not below the rank of ANM.

- d) The immunization is to be completed preferably within 14 weeks of birth of the child as per the schedule issued by MHFW (Annexure L). The AWW/ ASHA/ ANM will check the MCP card of the beneficiary at the beginning of the fifth month to ensure that all the immunization of the infant has taken place.

Bunching of Installments

Beneficiaries should apply preferably just after fulfilment of conditionalities to make proper use of the benefits received under the scheme towards meeting the scheme objectives. In case she could not apply within the normal time frame, the following may be considered:

- i. No maternity claim under the scheme shall be admitted after 730 days of pregnancy. LMP registered in the MCP card will be the date of pregnancy to be considered in this respect.
- ii. The installments may be claimed independently and not interlinked with each other, subject to fulfilment of eligibility criteria and conditionalities.
- iii. A beneficiary can apply, at any point of time but not later than 730 days of pregnancy, even if she had not claimed any of the installments earlier but fulfils eligibility criterion and conditionalities for receiving benefits.

- iv. In cases where LMP date is not recorded in MCP card viz. a beneficiary is coming for claim of third installment under the scheme, the claim in such cases must be submitted within **460 days** from the date of birth of the child beyond which period no claim shall be entertained.
- v. Under bunching of installments, a number of combinations are possible. For the sake of clarity, the forms to be submitted and conditionalities to be verified are given in table below:

Table: Bunching Combinations

S.No	Case	Forms to be filled by Beneficiary	Verification by AWW/ASHA/ANM
1	Beneficiary has not claimed the first installment under the scheme and applies for claiming the first installment only .	Form 1-A	<ul style="list-style-type: none"> • Early registration of pregnancy within 150 days from the date of LMP
2	Beneficiary who has not claimed the first installment under the scheme but applies directly for claiming the second installment only .	Form 1-A; Form 1-B	<ul style="list-style-type: none"> • At least one ANC
3	Beneficiary who has not claimed the first installment under the scheme and applies directly for claiming both first and second installments	Form 1-A; Form 1-B	<ul style="list-style-type: none"> • Early registration of pregnancy within 150 days from the date of LMP • At least one ANC
4	Beneficiary who has registered herself under the scheme and claimed the first installment , and applies directly for claiming the third installment only under the scheme	Form 1-C	<ul style="list-style-type: none"> • Child Birth Registration • Child has received first cycle of BCG, OPV, DPT and Hepatitis-B or its equivalent/substitute
5	Beneficiary who has registered herself under the scheme and claimed the first installment , and applies directly for claiming both second and third installment together under the scheme	Form 1-B; Form 1-C	<ul style="list-style-type: none"> • At least one ANC • Child Birth Registration • Child has received first cycle of BCG, OPV, DPT and Hepatitis-B or its equivalent/substitute.
6	Beneficiary who has not claimed the first and second installment under the scheme and applies directly for claiming the third installment only under the scheme	Form 1-A; Form 1-C	<ul style="list-style-type: none"> • Early registration of pregnancy within 150 days from the date of LMP • Child Birth Registration • Child has received first cycle of BCG, OPV, DPT and Hepatitis-B or its equivalent/substitute.

7	Beneficiary who has not claimed the first and second installment under the scheme and applies directly for claiming second and third installment together under the scheme	Form 1-A; Form 1-B; Form 1-C	<ul style="list-style-type: none"> • At least one ANC • Child Birth Registration • Child has received first cycle of BCG, OPV, DPT and Hepatitis-B or its equivalent/substitute.
8	Beneficiary has not claimed the first and second installment under the scheme and applies directly for claiming first, second and third installment together under the scheme	Form 1-A; Form 1-B; Form 1-C	<ul style="list-style-type: none"> • Early registration of pregnancy within 150 days from the date of LMP • At least one ANC • Child Birth Registration • Child has received first cycle of BCG, OPV, DPT and Hepatitis-B or its equivalent/substitute.

5. HEALTH ADVICE CALL CENTER (HACC) (TOLL FREE NO.104)

- HACC has been launched in Maharashtra under National Rural Health Mission.
- Objective is to provide 24 X 7 information / guidelines to deliver quality health services.
- By dialing 104 from a landline or mobile any Medical Officer from PHC, health workers, ANM, MPW, ASHA, school health team and mobile medical unit can get information from HACC.
- HACC is functioning at Chest Hospital, Aundh, Pune.
- Specialists like Gynaecologists, Paediatricians, Public Health Specialist will provide guidance from HACC.
- Information regarding Government Hospitals, Blood Bank and Eye Bank will be available.
- NGO working for Sickle Cell Disease and other programmes under NRHM may also obtain information by calling 104.
- All queries will be answered by call centre, if required additional information may also be provided to the caller by calling him /her back.
- Information will be provided live, but in case of advising medicines / drugs, SMS may also be sent to the caller.
- Most of the phone / mobile numbers of Medical officers, health workers, ASHA have already been uploaded in the software by collecting their numbers. Other person may register their number by **calling 104**.

6. MAHARASHTRA EMERGENCY MEDICAL SERVICES (MEMS) TOLL FREE NO. 108

Maharashtra Emergency Medical Services (MEMS) is a project of Government of Maharashtra under National Rural Health Mission (NRHM) and implemented and operated by BVG India Ltd. Citizens across Maharashtra can avail free ambulance in case of any medical emergency by dialing **toll free number '108'**. BVG has implemented a network of ambulances across the state of Maharashtra, well equipped with medicines, life saving equipment and a doctor on call 24 X 7.

Emergency is the situation between Life and Death. Emergency Medical Services (EMS) is a specialized field where emergency healthcare needs are addressed through well-defined care processes by trained EMS professionals. Important aspect of EMS includes early detection of any emergency, immediate response, reporting, on-scene care, en route care and transfer to hospitals.

All Ambulances manned by BAMS Doctors who are trained to perform in Emergency situations. These EMS professionals will respond to emergency calls, performing medical services and transporting patients to appropriate hospitals as required.

Emergency Medical Services professionals are immersed in saving lives in response to a wide variety of emergency medical situations. Duties include quickly assessing and prioritizing patient needs with the goal of providing life support in situations where trauma, respiratory, diabetic, behavioral, cardiac, allergic, poisoning, and childbirth emergency situations might exist.

This service provides 24/7 pre-hospital emergency medical service across the state, especially in the “Golden Hour” during which most fatalities occur.

7. MAHATMA JYOTIBA PHULE JAN AROGYA YOJANA (MJPJAY)

Mahatma Jyotiba Phule Jan Arogya Yojana

The State Government of Maharashtra launched its flagship health insurance scheme, Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) on 2nd July 2012 in 8 districts of Maharashtra (Phase 1) and later on introduced it to remaining 28 districts of Maharashtra (Phase 2). The scheme is renamed as Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY) from 1st April 2017.

Objective:

To improve access of Below Poverty Line (BPL) and Above Poverty Line (APL) families (excluding White Card Holders as defined by Civil Supplies Department) to quality medical care for identified speciality services requiring hospitalization for surgeries and therapies or consultations through an identified Network of health care providers.

Scheme:

Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) has been implemented throughout the state of Maharashtra in a phased manner over a period of 4 years. Government resolution issued on 13th April 2017 regarding the change into the name of Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) to Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY) and continuation of the same from 1st April 2017.

The insurance policy/coverage under the MJPJAY can be availed by eligible beneficiary families residing in all the 36 districts of Maharashtra viz. Gadchiroli, Amravati, Nanded, Sholapur, Dhule, Raigad, Mumbai and Mumbai Suburban, Akola, Buldhana, Yavatmal, Washim, Aurangabad, Beed, Hingoli, Jalna, Latur, Osmanabad, Parbhani, Thane, Palghar, Ratnagiri, Sindhudurga, Bhandara, Chandrapur, Gondia, Nagpur, Wardha, Ahmednagar, Jalgaon, Nadurbar, Nashik, Kolhapur, Pune, Sangli, Satara.

Benefits: The scheme entails around 971 surgeries/therapies/procedures along with 121 follow up packages in following 30 identified specialized categories:

1	GENERAL SURGERY
2	ENT SURGERY
3	OPHTHALMOLOGY SURGERY
4	GYNAECOLOGY AND OBSTETRICS SURGERY
5	ORTHOPEDIC SURGERY AND PROCEDURES
6	SURGICAL GASTRO ENTEROLOGY
7	CARDIAC AND CARDIOTHORACIC SURGERY
8	PEDIATRIC SURGERY
9	GENITOURINARY SYSTEM
10	NEUROSURGERY
11	SURGICAL ONCOLOGY

12	MEDICAL ONCOLOGY
13	RADIATION ONCOLOGY
14	PLASTIC SURGERY
15	BURNS
16	POLY TRAUMA
17	PROSTHESES
18	CRITICAL CARE
19	GENERAL MEDICINE
20	INFECTIOUS DISEASES
21	PEDIATRICS MEDICAL MANAGEMENT
22	CARDIOLOGY
23	NEPHROLOGY
24	NEUROLOGY
25	PULMONOLOGY
26	DERMATOLOGY
27	RHEUMATOLOGY
28	ENDOCRINOLOGY
29	GASTROENTEROLOGY
30	INTERVENTIONAL RADIOLOGY

The 132 Government reserved Procedures are to be performed only in empanelled Government Hospital / Government Medical College subjects to availability of facility and procedures.

Beneficiary Families:

Families belonging to any of the 36 districts of Maharashtra and holding Yellow Ration Card, Antyodaya Anna Yojana Card (AAY), Annapurna Card and Orange Ration Card along with Farmers from 14 agriculturally distressed districts of Maharashtra (Amravati, Akola, Aurangabad, Buldhana, Beed, Hingoli, Jalna, Nanded, Latur, Osmanabad, Parbhani, Wardha, Washim and Yavatmal). The identification for farmers from 14 agriculturally distressed districts of Maharashtra will be based on White Ration Card along with 7/12 extract bearing the name of the beneficiary / head of the family or certificate from the concerned Talathi / Patwari stating that the beneficiary is a farmer or a family member of farmer with valid photo ID proof of the beneficiary.

Family:

Family means members as listed on the valid Orange/Yellow Ration Card from 36 districts and White ration card holder with 7/12 from 14 agriculturally distressed districts.

Identification: Valid ration card Orange/Yellow/White Ration Card with

- 1) Pan Card
- 2) Aadhar Card
- 3) Driving License
- 4) Voter Id
- 5) Nationalized Bank Passbook with Photo
- 6) Handicap Certificate
- 7) School/College Id

- 8) In rural areas Tahsildar/ along with stamp and signature is there on Photo then it is accepted
- 9) In Urban areas Tahsildar/Government Local bodies along with stamp and signature is there on Photo then it is accepted.
- 10) Passport
- 11) Senior citizen card issued by central and state government Of India
- 12) Freedom Fighter Id Card
- 13) Defence ex-service card issued by sainik board
- 14) Marine Fishers Identity card (Issue by Ministry of Agriculture Government of Maharashtra).
- 15) Any photo ID proof issued by Govt. of Maharashtra/ Govt. of India

The photo ID proof will act as a tool for beneficiary identification for availing the health insurance facility. Following actions would be undertaken by Network hospitals in case of exceptional situations:

Situation	Validations / Check
Children born after issue of card i.e. name and photo not available on health card or on valid yellow/Orange ration card	Photograph of child with either parent along with valid Yellow/Orange/White ration card of parent and Birth certificate issued by authorized office.

Pre Existing Diseases:

All diseases under the scheme shall be covered from day one. A person suffering from disease prior to the inception of the policy shall also be covered under approved procedures for that disease.

Sum Insured On Floater Basis & Period Of Insurance:

The Scheme shall provide coverage for meeting all expenses relating to hospitalization of beneficiary up to Rs. 1, 50,000/- per family per year in any of the Empanelled Hospital subject to Package Rates on cashless basis through valid Ration Card. The benefit shall be available to each and every member of the family on floater basis i.e. the total annual coverage of Rs. 1.5 lakh can be availed by one individual or collectively by all members of the family. In case of renal transplant surgery, the immunosuppressive therapy is required for a period of 1 year. So the upper ceiling for Renal Transplant would be Rs. 2, 50,000 per operation as an exceptional package exclusively for this procedure. The cases are likely to be very few and well controlled by Human Organ Transplant Act 1994. The claims related to this have to be settled by Insurer. The insurance coverage under the scheme for the beneficiary families shall be in force for an initial period of one year from the date of commencement of the policy.

Run Off Period:

“ Run Off period ” of one month will be allowed after the expiry of the policy period i.e. till one month after the date of policy period. This means that pre-authorizations can be done till the end of policy period and surgeries for such pre-authorizations can be done up to one month after the expiry of policy period and such claim will be honored by the Insurance Company.

Package:

The insurer should ensure that the Network hospitals follow the packages worked out by MJPJAY. The package rates will include bed charges in General ward, Nursing and boarding charges, Surgeons, Anaesthetists, Medical Practitioner, Consultants fees, Anaesthesia, Blood, Oxygen, O.T. Charges, Cost of Surgical Appliances, Medicines and Drugs, Cost of Prosthetic Devices, implants, X-Ray and Diagnostic Tests, food to inpatient, one time transport cost by State Transport or second class rail fare (from Hospital to residence of patient only). In other words the package should cover the entire cost of treatment of Beneficiary from date of reporting to his discharge from hospital for a period of 10 days after discharge following surgery including complications if any, making the transaction truly cashless to the beneficiary. In the instance of death, the carriage of dead body from network hospital to the village/township would also be part of package. The planned 131 procedures like hernia, vaginal or abdominal hysterectomy, appendicectomy, cholecystectomy, Discectomy, etc. will be performed only in empaneled Government Hospitals/Government Medical Colleges. The rates for each procedure are indicative and represent upper ceiling and the Insurer may negotiate with the given empanelled hospitals to bring them down amicably without compromising quality.

Cashless Transaction:

It is envisaged that for each hospitalization the transaction shall be cashless for covered procedures. Enrolled beneficiary will go to hospital and come out without making any payment to the hospital subject to the procedures covered under the scheme. When the beneficiary visits the selected network hospital, services of selected network hospital should be made available (Subject to availability of beds). In instance of non- availability of beds at network hospital, the facility of cross referral to a nearest Network hospital is to be made available and Arogyamitra will also provide the beneficiary with the list of nearby network hospitals.

Online Claim Settlement:

The Insurance Company shall settle the claims of the hospitals online within 15 working days on receipt of complete claim document from the Network Hospital including the Originals bills, Diagnostics reports, Case sheet, Satisfaction letter from patient, Discharge Summary duly signed by the doctor, acknowledgement of payments of transportation cost and other relevant documents to Insurer for settlement of the claim. The online progress of claim settlement will be scrutinized and reviewed by MJPJAY.

Steps for Treatment in the Network Hospital**STEP 01:**

Beneficiary families shall approach nearby General, Women/District Hospital/Network Hospital. Arogyamitra placed in the above hospitals shall facilitate the beneficiary. If beneficiary visits Government Health Facility other than the Network Hospital, he/she will be given a referral card to the Network Hospital with preliminary diagnosis by the doctors. The Beneficiary may also attend the Health Camps being conducted by the Network Hospital in the villages and can get that referral card based on the diagnosis. The information on the outpatient and referred cases in the General, Women/DH and the camps will be collected from all Arogyamitra /Hospitals on regular basis and captured in the dedicated database through a well-established call center.

STEP 02:

The Arogyamitra at the Network Hospital examine the referral card and health card or Yellow/Orange Ration Card, Annapurna or Antyodaya card register the patients and facilitate the beneficiary to undergo specialist consultation, preliminary diagnosis, basic tests and admission process. The information like admission notes, test done will be captured in the dedicated database by the Medical Coordinator of the Network Hospital as per the requirement of the MJPJAY.

STEP 03:

The Network Hospital, based on the diagnosis, admits the patient and sends E-preauthorization request to the insurer, same can be reviewed by MJPJAY.

STEP 04:

Recognized Medical Specialists of the Insurer and MJPJAY examine the preauthorization request and approve preauthorization, if, all the conditions are satisfied. This will be done within 24 working hours and immediately in case of emergency wherein e-preauthorization is marked as "EM".

STEP 05:

The Network Hospital extends cashless treatment and surgery to the beneficiary. The Postoperative notes of the Network Hospitals will be updated on the website by the medical coordinator of the Network Hospital.

STEP 06:

Network Hospital after performing the covered surgery/ therapy/ procedure forwards the Originals bills, Diagnostics reports, Case sheet, and Satisfaction letter from patient, Discharge Summary duly signed by the doctor, acknowledgement of payments of transportation cost and other relevant documents to Insurer for settlement of the claim. The Discharge Summary and follow-up details will be part of the MJPJAY portal.

STEP 07:

Insurer scrutinizes the bills and gives approval for the sanction of the bill and shall make the payment within agreed period as per agreed package rates. The claim settlement module along with electronic clearance and payment gateway will be part of the workflow in MJPJAY portal and will be operated by the Insurer. The reports will be available for scrutiny on the MJPJAY login.

STEP 08 :

The Network Hospital will provide free follow-up consultation, diagnostics, and medicines under the scheme up to 10 days from the date of discharge.

Health Camps:

Health Camps are to be conducted in Taluka Head Quarters, major village Gram Panchayats and Municipalities. Minimum of two camps per week per empanelled hospital has to be held in the all districts in the policy year at the place suggested by SHAS. Medical Camp Coordinator MCCOs of the hospital shall coordinate the entire activity. Network hospital shall carry

necessary screening equipment along with specialists (as suggested by the SHAS) and other Para-medical staff. The Insurer shall put in the minimum requirements as regards the health camp in the MOU with the hospitals. The empanelled hospital shall work in close liaison with District Coordinators of the SHAS, Civil Surgeon/District Health Officer in consultation with District Collector. Hospital shall follow the Camp policy of SHAS.

8. HUMAN DEVELOPMENT PROGRAMME (मानव विकास कार्यक्रम)

Historical Background

Human Development Program was launched in 12 backward districts in the state as per Government Resolution Niyojan Vibhag, no.MMV-2006/P.K.20/KA.1413, Mantralaya Mumbai, Dated 29th June 2006 to improve the Human Development Index (HDI). Later on as per Government Resolution MVM-2010/P.K.81/KA1418, Mantralaya Mumbai, Dated 19th July 2011, the programme was extended in identified 125 backward blocks in 22 districts viz. Thane, Raigad, Sindhudurg, Nashik, Dhule, Nandurbar, Jalgaon, Jalna, Parbhani, Hingoli, Beed, Nanded, Buldhana, Akola, Washim, Amaravati, Yeotmal, Nagpur, Bhandara, Gondia, Chandrapur & Gadchiroli.

As per the Government of Maharashtra GR No. MVK-2012/P.K. 22/K.1418, Niyojan Vibhag, Mantralaya Mumbai, dated 26/04/ 2012, the program was continued for year 2012-13. Implementation of program is being continued in year 2013-14.

As per Government Resolution MVM-2012/P.K.69/KA1418, Mantralaya Mumbai, Date 12th July 2012. Human Development Program has been extended to identified 43 Type C Municipal Councils in 15 districts, so as to cover more beneficiaries.

Objectives

To improve Human Development Index (HDI) in selected 125 backward blocks of 22 districts and 43 Type C Municipal Councils of 15 districts.

Various Schemes & Activities

- Examination & Treatment of pregnant women, 0 to 6 months Infant and Lactating Mothers by OBGY Specialists done in HDP Camp and also examination of 6 months to 2 year children done by paediatrician.
- Payment of Rs. 800/- to pregnant mothers (SC/ST/BPL) in the 9th month in favour of loss of wages. (Excluding Bhandara & Amravati – In these Districts Indira Gandhi Matrutva Sahyog Yojana (IGMSY) is being implemented)

Training of adolescent girls in context with adolescence health and life skills. (Excluding Gondia, Gadchiroli, Nashik, Amravati, Nanded, Beed, Nagpur, Buldhana- In these Districts Sabla Yojana is implemented)

Implementation Strategies

The program is being implemented in Primary Health Centers of 125 blocks of 22 districts. Commissioner, Human Development, Aurangabad is the implementing and monitoring authority at state level. District Collector is empowered to give administrative approvals for the same.

Medical Officers in charge of Primary Health Centers are responsible for implementation of Human Development Program in rural area and District Civil Surgeon has the responsibility of implementation in council area i.e. in rural hospital/sub district hospitals. District Health Officer and District Civil Surgeon supervise and have the overall responsibility of implementation of the program in the district.

Fund Distribution

District Collector releases the fund to District Health Officer who in turn releases fund to District Civil Surgeon who releases fund to Medical Superintendents of hospitals. District Health Officer releases fund directly to in charge medical officer of Primary Health Centers under the monitoring of respective Taluka health officers. It is mandatory to open separate Saving Account in Nationalized Bank to receive the fund at every level. The grants are distributed as Rs.14,500/- per camp.

Facilities Providing Services

Under Human Development Programme camps are arranged in Primary Health Centres and Rural Hospitals and Sub-district hospital.

Schemes and Activities

- Examination & Treatment of pregnant women, 0 to 6 months neonate and Lactating Mothers by OBGY Specialists under this activity to give following benefit to beneficiary.
 - Counseling of pregnant mothers and lactating mothers.
 - Examination & Treatment of pregnant women by OBGY Specialists.
 - Counseling pregnant mothers for good nutrition & and proper care in pregnancy.
 - Examination and Counseling of lactating mothers for contraception, prevention of infection, exclusive breast feeding & weaning practices and overall promotion of health.
 - 0 to 6 months neonate examination and treatment by Child Specialist.
 - Payment of Rs. 800/- to pregnant mothers (SC/ST/BPL) in the 9th month in favour of loss of wages. (Excluding Bhandara & Amravati – In this Districts Indira Gandhi Matrutva Anudan Yojana is implemented)

Training of adolescent girls (12 to 18 Years) in context with adolescence health and life skills. (Excluding Gondia, Gadchiroli, Nashik, Amravati, Nanded, Beed, Nagpur, Buldhana- In this Districts Sabla Yojana is implemented)

Period of Implementation and Methods

Every month 2 camps are organized in Primary Health Centres and Rural Hospital and Sub-district hospital. The camps are organized with prior information to Grampanchayat and field level workers and community. All Pregnant mothers and children in the age group of 0 to 6 months and 6 months to 2 years are provided to and fro free transport services. OBGY Specialist and Paediatrician examine the beneficiaries and necessary investigations and treatment are provided. Snacks are provided to beneficiaries on Camp day. Pregnant mothers and lactating mothers followed up for 6 months. High Risk Mothers are referred to higher centre accordingly and followed up.

Benefits and Services

At Health institution vehicle is used for free transport of beneficiaries. If there is no transport facility available then 1 or 2 vehicles can be hired for camp. OBGY Specialist and Paediatrician provide their services in the camp. They are given honorarium for their service. Budget is provided for medicine, lab materials and pendal for camp. Rs. 800/- is given to Pregnant woman (SC/ST/BPL) in the 9th month in favour of loss of wages.

Performance till January 2013

Number of HDP Camps planned:	20370
Number of HDP Camps organized:	11991
Number of preg. Mothers examined by Obgy. Spe.:	371218
Number of Lact. Mothers examined by Obgy. Spe.:	221712
Number of Children examined by Pead. Spe.:	227128
Number of mothers paid loss of wages under HDP:	81453 (Rs.800/- in 9th month of their pregnancy)
Number of Prerikas identified in the districts:	6146
Number of Adolescent girls trained:	154717
Budget Recieved:	Rs. 1974.16 Lakhs
Expenditure:	Rs. 1788.95 Lakhs

Status of Programme

Human Development Programme is currently implementated in 22 Districts 125 Talukas. 58.87 % camp has been completed by Jan 2013. In Beed and Raigad District 100.00 % camps has been arranged.

- Districts having above 60% performance:- Thane (78.65%), Nashik (71.14%), Jalgaon (75.48%), Sindhudurg (68.75%), Parbhani (74.82%), Hingoli (73.70%), Nanded (69.59%), Nagpur (87.85%), Bhandara (81.51%), Gondia (70.81%), Chandrapur (71.49%), Akola (67.08%)

Districts having less than 50% performance:- Dhule (47.71%), Nandurabar (43.86%), Jalna (46.23%), Washim (47.38%), Amaravati (44.29%), Buldhana (39.27%), Yavatmal (35.80%) in this districts camps arranged above 30 % and very poor performance in Gadchiroli (16.22%) The meeting was held on 09th November 2012 for reconstruct the various schemes to implement under Human Development Programme through Health Department. Accordingly the schemes will be revised as per the minuted decisions which are yet to be finalized

Major Achievements

- Human Developement Mission established in Year 2006 and initially Human Development Programme was launched in 25 Talukas of 12 Districts.
- With success and improvement in Human Development Index the programme was extended to 125 block in 22 districts in year 2011.

In year 2012, C Cadre Council area was also included in implementation of Human Development Programme in 22 districts.

9. NAVSANJEEVANI YOJANA

Historical Background

In order to bring about co-ordinated efforts and effectiveness in the implementation of various schemes, which were implementing in tribal areas, the government aggregated all such schemes in one and started Navsanjivani Yojana as per G.R. dated 25/6/1995. Health related activities in this scheme include filling up of vacant posts, keeping vehicles in good condition, provision of medicine & equipments in adequate quantities, pre-monsoon surveillance of tribal villages & padas and implementation of preventive & curative services, monitoring of water chlorination activity, health check-up of Anganwadi children by Medical Officers.

Objectives

To improve the health of population in Tribal areas by providing them health services, ample clean water, by providing food supply, giving proper treatment to malnourished children and ultimately giving productive and long life to tribal population is the main aim of Navsanjivani scheme

Implementation of Programme

Various activities are carried out through this programme.

- Matrutva Anudan Yojana
- Bharari Pathak Yojana
- Dai Meetings
- Water Quality Monitoring
- Pre Monsoon Activities

Provision of food and loss of wages to relatives accompanying SAM/MAM children

Strategy

Various schemes under Navsanjivani Yojana

- Matrutva Anudan Yojana :- A pregnant women is paid Rs. 400 /- in cash for visiting health center for antenatal check up along with medicines worth Rs. 400/- to ensure a better health. This Scheme is applicable to tribal women having current pregnancy and live two issues.
- Bharari Pathak Yojana:- In tribal areas for tribal people, mostly for women & children to provide medical health at their homes and if required to shift nearest health centre Bharari Pathaks are functional. 172 Bharari Pathaks have been constituted with one Medical officer with 2 Para-Medical staff which are appointed on deputation. 172 Bharari Pathaks are doing medical checkup and provide medicines. Bharari Pathaks Medical Officers are being provided Govt grants and grant of Rs. 6000/- per month per Pathak is provided. Additional funds of Rs 12000/- through RCH PIP (NRHM) are provided.
- Dai Meetings :- In this scheme regular re-orientation regarding safe motherhood & neonatal care of trained and untrained Dais is being carried out by organizing quarterly meetings of Dais at sub centre level.
- Provision of food and loss of wages for SAM /MAM children and their relatives - Provision of food and loss of wages to relatives accompanying SAM/MAM children taking treatment at PHC/RH. Relatives accompanying SAM/MAM children Rs.40 per day is given as compensation for loss of wages till the child is admitted and Rs 65 per child is given, for food till the child is admitted. The funds for same are distributed to Zillah Parishad from Tribal Development Dept.

Pre Monsoon Activities - Accessibility in tribal area is a problem in monsoon season due to geographical situation of area & limited transport facilities. Hence it is planned to conduct Health check up Immunization / Nutritional assessment of all tribal Population in said area. In the months of May & June various Bharari Pathaks are deputed in hilly areas to facilitate uninterrupted treatment, vaccination, referral services.

Health Facilities proving services

Under Navsanjivani Yojana in tribal area Rural Hospital, PHC, Subcentres, Ayurvedic Hospital give free services for patients, Bharari Pathaks also provide such Health Services.

Special Features

- **Matrutva Anudan Yojana:-** This scheme is being implemented in 15 Tribal districts since 1997-98. A pregnant women is paid Rs. 400 /- in cash for visiting health center for antenatal check up along with medicines worth Rs. 400/- to ensure a better health and to reduce maternal and Neonatal morbidity and mortality. This Scheme is applicable to tribal women having current pregnancy and live two issues.
- **Mobile Medical Squad:-** 172 Mobile Medical squads have been constituted with one Medical Officer with a vehicle and 2 Para-Medical staff to go to each and every village and hamlet to identify malnourished and sick children and provide medical health at their homes and if required to shift them to the nearest health center. Appropriate medical treatment and/or intensified food supplementation is given to all children. Since year 2012-13 Medical Officers are being provided Rs. 12000/- per month through RCHPIP (NRHM) funds to their earlier Rs. 6000/- honorarium.
- **Dai Meetings:-** Regular re-orientation regarding safe motherhood & neonatal care of trained Dais and untrained is being carried by organized quarterly meetings of Dais at sub centre level since year 1996-97.
- **Water Quality Monitoring:-** Water samples are collected every month from all the water sources used for drinking in the village and are tested at public health laboratory for bacterial contamination and results are communicated to concerned Gram Panchayat through PHC for further necessary action like administration of bleaching powder.
- **Pre Monsoon Activities:-** Accessibility in tribal area is a problem in monsoon season due to geographical situation of area & limited transport facilities. Hence it is planned to conduct Health check up Immunization / Nutritional assessment of all tribal Population in said area. In the months of May & June various Mobile Medical Squads are deputed in hilly areas to facilitate uninterrupted treatment, vaccination, referral services.

Provision of food and loss of wages to relatives accompanying SAM/MAM children taking treatment at PHC/RH. Relatives accompanying SAM/MAM children are provided food twice Rs.65 only & loss of wages Rs.40 per day compensation as loss of wages until the child is admitted. The funds are provided by Tribal Department.

Service Centers

Services Under Navsanjivani Yojana are provided by Sub-district Hospitals Rural Hospitals, Primary Health Centers, Sub-center, in tribal area. Mobile units also provide such Health Services.

10. SAVITRIBAI FULE KANYA KALYAN YAJANA

To promote the couples to accept sterilization only on one or two female issues, state has declared Revised Savitribai Phule Kanya Kalyan Yojana from 1st April 2007. The scheme is applicable for 1) Couples belong to Below Poverty Line. 2) Couples having No son and accepting sterilization with only one or/ & two daughters. After undergoing sterilization couple having 1 daughter will get financial benefits of Person undergoing sterilization Rs,2000/- (in cash) and Rs.8000/- in the form of NSC in the name of daughter. The couple having 2 daughters Rs,2000/- (in cash) and Rs,4000/- in the form of NSC in the name of each daughter (Total Rs,8000/-)

11. RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK)

Introduction

Under National Rural Health Mission, School Health Programme was being implemented in the State in association with Sarva Shiksha Abhiyan since February 2008 wherein health screening of children in the age group of 6 to 18 years was ensured at all Schools in rural and urban area through 440 teams appointed for this purpose.

With the success of school health programme in Maharashtra, Govt of India launched Rashtriya Bal Swasthya Karyakram (RBSK) on 6th February 2013 by Hon. UPA Chairperson Smt. Sonia Gandhi at Palghar in Thane district. RBSK aims at early detection and management of the '4Ds' (Defects at birth, Diseases in children, Deficiency conditions and Developmental delays including disabilities) prevalent in children.

Implementation

Rashtriya Bal Swasthya Karyakram has been started from 1st April 2013 in 33 districts of Maharashtra. With a view to ensure the health screening of 0 to 18 years children, 1130 teams comprising with 2 Medical Officer (one male & one female), one ANM and one Pharmacist in each team have been deputed in all 33 districts. The RBSK Teams are placed at Taluka level at Rural Hospital /Sub District Hospital level under supervision and monitoring of Medical superintendant. For the efficiency of the programme all the members have gone through proper training before joining the team.

Teams will screen all the children 0-6 years of age registered with the Anganwadi centres of rural areas and urban slums and in addition to children enrolled in classes 1st to 12th in Government and Government aided schools. Medicines and a tool kit with essential medical equipment for screening of children have been provided with the every team. After screening, children identified with defects, deficiencies, diseases and developmental delays are referred to the Rural Hospital /Sub District Hospital.

For successful implementation of RBSK, convergence of various departments like DWCD, Education and tribal is envisaged.

12. RASHTRIYA KISHOR SWASTHYA KARYAKRAM (RKSK)

Background:

At 253 million, India has the largest share of the adolescent population in the world. With a view to address the health and development needs of this age group which is 21 percent of India's population, Ministry of Health and Family Welfare launched the **Rashtriya Kishor Swasthya Karyakram (RKSK)** on the 7th of January 2014.

RKSK has been developed to strengthen the adolescent component of the RMNCH+A strategy which, as we are all aware, is one of the weakest and a sub-critical programme area. Whilst core programming principles for RKSK are health promotion and a community based approach expanded scope of the programme includes nutrition, sexual & reproductive health, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse.

Implementation plan: selection of districts/ CHCs/ PHCs/ Sub-Centres:

Given the scope of the programme, an executive decision has been taken to implement RKSK in a **phased manner**. During the first phase, 231 districts as selected by the states have been identified for implementation. Within, these 231 districts 50% blocks will be covered. Thus, if there are 10 blocks in a district (normatively speaking) we are looking at covering 5 blocks/ 5 CHCs. Further, out of 5/6 normative PHCs under one block CHC, two PHCs will be identified (basis ability and wherewithal to implement RKSK viz trained service provider, existing Adolescent Health programme with reasonable footfall and good infrastructure with dedicated space for AFHS etc.) All sub-centres under these PHCs and, all villages under these sub-centres will be selected for provision of all interventions and services envisaged under RKSK.

Target Groups

The new adolescent health (AH) strategy focuses on age groups 10-14 years and 15-19 years with universal coverage, i.e. males and females; urban and rural; in school and out of school; married and unmarried; and vulnerable and under-served.

Objectives

The new AH strategy seeks to achieve the following objectives:

1. Improve nutrition

- Reduce the prevalence of malnutrition among adolescent girls and boys (including overweight/obesity)
- Reduce the prevalence of iron-deficiency anaemia (IDA) among adolescent girls and boys

2. Enable sexual and reproductive health

- Improve knowledge, attitudes and behaviour, in relation to SRH
- Reduce teenage pregnancies
- Improve birth preparedness, complication readiness and provide early parenting support for adolescent parents

3. Enhance mental health

- Address mental health concerns of adolescents

4. Prevent injuries and violence

- Promote favourable attitudes for preventing injuries and violence (including GBV) among adolescents

5. Prevent substance misuse

- Increase adolescents' awareness of the adverse effects and consequences of substance misuse.

6. Address conditions for NCDs

- Promote behaviour change in adolescents to prevent NCDs such as cancer, diabetes, cardio-vascular diseases and strokes

The strategy is operationalised through six key components i.e. Communication (including Social and Behaviour Change Communication for improved health seeking behaviour); provision of commodities; provision of services; capacity building; monitoring & evaluation and programme management including supportive supervision.

Strategies

Strategies/interventions to achieve objectives can be broadly grouped as:

A. Community based interventions

- Peer Education (PE)
- Quarterly Adolescent Health Day (AHD)
- Weekly Iron and Folic Acid Supplementation Programme (WIFS)
- Menstrual Hygiene Scheme (MHS)

B. Facility based interventions

- Strengthening of Adolescent Friendly Health Clinics (AFHC)

C. Convergence

- **Within Health & Family Welfare** - FP, MH (incl VHND), RBSK, NACP, National Tobacco Control Programme, National Mental Health Programme, NCDs and IEC
- **With other departments/schemes** - WCD (ICDS, KSY, BSY, SABLA), HRD (AEP, MDM), Youth Affairs and Sports (Adolescent Empowerment Scheme, National Service Scheme, NYKS, NPYAD)

D. Social and Behaviour Change Communication with focus on Inter Personal Communication

१३. आयुष

कार्यक्रमाची ओळख

भारतीय चिकित्सा पद्धती व होमिओपॅथी विभागआरोग्य व कुटुंब कल्याण मंत्रालय, केंद्र शासन नवी दिल्ली यांच्या अधिपत्याखाली १९९५ मध्येकार्यरत करण्यात आला. सन २००३ मध्ये त्या विभागाचे आयुष (आयुर्वेद, योग वनिसर्गपचार, युनानी, सिद्ध व होमिओपॅथी) असे नामांतर करण्यात आले.

उद्देश व उद्दिष्टे

- आयुष मुख्य प्रवाहात आणणे वस्थानिक चिकित्सा पद्धतीचे राष्ट्रीय ग्रामीण आरोग्य अभियानांतर्गत पुनरुज्जीवन करणे.
- आयुष वैद्यकीय अधिकारी व सहाय्यककर्मचारी यांचे प्रशिक्षण घेणे.
- आशा आणि आरोग्य सेवक / सेविकायांचा आयुष कार्यक्रमांमध्ये सहभाग करून घेणे.

अंमलबजावणी पद्धती

राष्ट्रीय ग्रामीण आरोग्य अभियानांतर्गत आयुष मुख्य प्रवाहात आणणे हा घटक राबविण्यासाठी शासकीय आरोग्य संस्थामध्ये आयुष सेवांची सह स्थापना करण्याची प्रक्रिया सुरु आहे.

तसेच राज्यातील काही जिल्हा रुग्णालयात केंद्र शासन आयुष विभागातर्फे वितरीत निधी द्वारा विशेष आयुष विंगची स्थापना करण्यात आली असून ठाणे, पुणे, नाशिक, अमरावती, बीड व परभणी या ६ जिल्हा रुग्णालयात विशेष आयुष विंग कार्यरत आहेत. यामध्ये आयुष सेवा देण्यासाठी सदस्य इमारतीचे नूतनीकरण केले गेले आहे. सदर आयुष विंग मध्ये विशेष उपकरणे व औषधी यांची उपलब्धता करून देण्यात आलेली आहे. आयुष विंग मध्ये आयुर्वेद, होमिओपॅथी व युनानी या पद्धतीच्या तज्ञा द्वारा बाह्यरुग्ण व अंतरुग्ण सेवे सोबत पंचकर्म, क्षारसूत्र, इल्लाज-बीद-तदबीर इ. विशेष सेवा उपलब्ध करून दिल्या जातात तसेच योग व निसोर्गोपचार तज्ञाच्या सेवाही उपलब्ध आहेत.

१४. भारतीय सार्वजनिक आरोग्य मानके (IPHS)

सहजसाध्य अशी परिणामकारक आरोग्य सेवा ग्रामीण जनतेस उपलब्ध करून देणे हे राष्ट्रीय आरोग्य अभियानाचे प्रमुख उद्दिष्ट आहे. या उद्दिष्टापुरतीसाठी राज्यात असलेल्या आरोग्य संस्था सक्षम करण्यासाठी विविध उपक्रम राष्ट्रीय आरोग्य अभियानांतर्गत राबविले जातात. राष्ट्रीय आरोग्य अभियानाची उद्दिष्टे साध्य होण्यासाठी राज्यभरात असलेले प्राथमिक आरोग्य केंद्र, ग्रामिण रुग्णालय, उपजिल्हा रुग्णालय व जिल्हा रुग्णालय यांचा दर्जा सुधारण्याच्या दृष्टिकोनातून आवश्यक ते बांधकाम, मनुष्यबळ व साधनसामग्री पुरविण्यात येईल, जेनेकरून आरोग्य सेवांचा दर्जा सुधारेल यासाठी भारतीय सार्वजनिक आरोग्य मानके (Indian Public Health Standard) तयार केले आहेत.

आयपीएचएस अंतर्गत आरोग्य संस्थांची निवड ही प्रसुतीचे मापदंडानुसार केलेले आहे.

आयपीएचएस ह्या कार्यक्रमाचे लक्ष्य व उद्दिष्टे :-

- १) राज्य शासनामार्फत आरोग्य संस्थांना उपलब्ध करून द्यावयाच्या अपेक्षित, अत्यावश्यक व इतर सेवा.
- २) सदर सेवांची गुणवत्ता साध्य करून ती कायम ठेवणे.
- ३) सेवांचे पर्यवेक्षण व देखभाल करणे.
- ४) आरोग्य सेवा ह्या अपेक्षित दर्जाच्या व लाभार्थीच्या गरजांची परिपुर्ती करणाऱ्या असाव्यात.

MAINTENANCE OF RECORD

Maintenance of record at PHC level which should be verified by THO during PHC visit

MO should assign responsibility for maintenance of stock books for various items as below and check them regularly.

1) Stock register

Any item received by PHC should be entered in respective stock registers which are in prescribed formats according to nature of items. Stock registers to be maintained at PHC are as below:

Instructions to be followed:

- All stock registers are important record of your PHC. They must be kept in safe custody of responsible person.
- After receiving or purchasing any item for PHC, record item in appropriate register on the same day. Enter stock register page number on bills or vouchers of item. Do not certify any bill before checking entry in stock register.

Table 1 : Stock registers in PHC and responsible persons

Sr.No.	Name of register	Items to be entered	Responsible Person
1	Dead stock register	Items of permanent / durable nature (Furniture, cots, etc.)	Jr.Clerk
2	Medicine stock register	All medicines received in PHC	Pharmacist
3	Instrument, equipment register	OT and routine instruments, cotton, gauze, thread, linen	Pharmacist
4	RCH stock register other than vaccine	Cold chain equipment, contraceptives, needles, syringes	HA (F)
5	Consumable items stock register	Stationary, house keeping items like soap, brooms etc.	Jr. Clerk
6	Vaccine stock register	All vaccines	HA (F)

- Do not use plain register as stock register. Stock registers have specific formats and are supplied by DHO office.
- Before starting use of new register, personally examine whether all pages are machine numbered. If not then give page numbers to stock book by ballpoint pen.
- Certificate mentioning total pages on stock book and manner of numbering (Machine or hand written) should be recorded on first page i.e. number one of stock register.
- Separate page(s) should be allotted for each type of item.
- Appropriate entry has to be made as soon as fresh stock of item is supplied. New stock is to be added to balance of previous stock, if any.
- Any article mentioned in stock register can be written off by following laid down write-off procedure.

Role of Medical Officer

- All entries of stock register should be under signature of MO. Medical Officer should ensure that all columns against particular item are filled while signing entry of newly received item. This includes name, brief description and specification of item, make, size, date of purchase, voucher (bill) date and number, name and address of supplier, price etc.
- Medical Officer should ensure that entry of item purchased is made in stock register before paying bill to supplier.
- Whenever any item is issued for use, this is recorded in register and entry has to be signed by MO.

2) Dead stock register

All items of a permanent or durable nature such as furniture, equipment machinery etc. should be recorded in dead stock or movable property register.

- There is a prescribed register for dead stock entry.
- Each page has to be numbered and certified accordingly at the end of register.
- Allot separate page for each category of article.
- Entry should be taken immediately after receipt of any material.
- Donated items should also be entered in register.
- For each item full description of article such as name, brief description and specification, make, size, date of purchase, voucher number, date, name and address of supplier, price etc. should be entered in register.
- MO PHC should physically verify all dead stock i.e. movable property items once in a six months. A certificate of verification should be recorded by MO at the end of register.
- Any article in following prescribed procedure dead stock register can be written off (Condemned) following prescribed procedure if it is damaged beyond repairs or rendered useless due to wear and tear.

3) Expiry date drugs register

- Separate register should be maintained for expiry date drugs in prescribed format.
- In addition to this register, a list has to be made to show items, which will be date expired in coming three months along with quantity.
- If stock available is not going to be consumed before date of expiry, then MO should give these medicines to nearby PHC or other health institute and get receipt.

4) Daily tablet account register

- Drugs dispensed to each OPD patient are recorded daily in this register.
- This register should be maintained in prescribed format by pharmacist and should be completed daily.
- MO should check this register for daily completion.
- Cross check prescription on case papers and number of tablets entered in daily tablet account register to tally entries. Check about 10% case papers once in a week.

5) Verification of stock

- MO should physically verify balance of all items six monthly and also spot-checking should be done for some items randomly 2-3 times in a month.
- Stock of expensive drugs should be checked frequently.

- See if there are any discrepancies in balance shown in stock book and actual balance.
- A certificate of physical verification should be recorded and signed at end of register in April and October every year.
- All stock mentioned in stock registers should be personally verified by Medical Officer in June and December of every year and certified as follows –

This is to certify that stock of all items mentioned in this stock register is personally verified by me on date——— and is found as per record in stock register except following items:

Table 2: Verification of Stock

Sr. No.	Name of item	Page number on stock book	Date of purchase	Number on stock book	Number during physical verification	Remarks

CLASSIFICATION OF PHC RECORD

Classification of PHC record should be carried out as per Maharashtra Zilla Parishad and Panchayat Samiti (Classification, preservation and destruction of records) Rules 1964.

1. Classification of record

All record of PHC shall be classified in following classes, based on period for which it has to be preserved.

A class record: To be preserved permanently

B class record: To be preserved for 30 years

C class record: To be preserved for 10 years

C-1 class record: To be preserved for 5 years

D class records To be preserved till completion of annual inspection of Office or completion of audit/account matters.

1.1. Categorization of common record of PHC

Table 3: Categorization of PHC record

Sr.No.	Subject matter of record	Class of record
1	PHC / SC property record file	A
2	Manuals, standing orders, circulars of Zilla Parishad and PS	A
3	Government resolution	A
4	Acts, rules and regulations	A
5	Inward and outward register	A
6	Legal matters	A
7	Orders related to delegation of powers	A
8	Registers of dead stock	A
9	Registers of record destroyed	A
10	Visitor book	A
11	Used counterfoils of cheque books	A
12	Audit notes and action taken thereon	B
13	Proceedings of Zilla Parishad / PS meetings	B
14	Establishment matters (posting, transfer, promotion)	B
15	Budget files	B

16	Pay bills and acquaintance rolls	B
17	Supply o equipment instrument	B
18	Inspection notes and action taken thereon	C
19	Worksheets	C
20	Representations in connections with service matters	C
21	Service book (after retirement)	C
22	Leave account	C
23	Rural sanitation records	C
24	Measures in inerest of public health	C
25	School health services records	C
26	Tour programs and diaries	C-1
27	Indent forms	C-1
28	General cash book	C-1
29	Register of contingent expenditure	C-1
30	Contingency bills with vouchers	C-1
31	Challans of District Central Cooperative banks	C-1
32	Tapal and peons delivery book	D
33	Casual leave register and muster roll	D
34	Applications for casual leave	D

2. Storing the record

- Enter all record generated in the year in record register as per classification.
- Keep D classified record separately and preserve other record in boxes, separate box for each year with classification.
- Regularly update record register.

3. Procedure for destroying record

- Every year after completion of annual inspection or audit, destroy D record.
- Review record register and identify record to be destroyed from class-B (30 years old), C (10 years old), C-1 (5 years old) and D (one year old) for that year.
- Write destroyed in remarks column and destroy old record either by tearing or burning in presence of MO.

सहा गठ्ठे पध्दती (सिक्स बंडल सिस्टिम)

प्रत्येक टिपणी लिपिकाने आपल्या ताब्यातील सर्व दफतर / फाईल्स सहा गठ्ठे पध्दतीने बांधून ठेवणे आवश्यक आहे. हे सहा गठ्ठे पुढील प्रमाणे होते:-

- २) प्रलंबित प्रकरणे
- ३) प्रतिक्षाधीन प्रकरणे
- ४) नियतकालीक अहवाल
- ५) स्थायी आदेश नस्ती
- ६) अभिलेख कक्षाकडे पाठवावयाची कागदपत्रे
- ७) "ड" वर्गीकरण केलेली कागदपत्रे

वरील सहा गठ्ठायावरून एखाद्या कर्मचाऱ्याकडील कामाची समग्र कल्पना येवु शकते-

- १) **प्रलंबित प्रकरणे** - कर्मचाऱ्याकडे आलेले टपाल त्याने त्या त्या विषयाच्या महत्वानुसार व निकाली काढण्याच्या आवश्यकतेनुसार क्रमाने रचून ठेवणे आवश्यक आहे. तातडीच्या कामाना सर्वोच्च प्राधान्य देवुन इतरही पत्रे त्याने लवकरच निकाली काढली पाहिजेत. अशा प्रलंबित प्रकरणांचा समावेश पहिल्या गठ्ठ्यांत होईल.
- २) **प्रतिक्षाधीन प्रकरणे** - एखाद्या प्रकरणावर पत्रव्यवहार सुरु केलेला असतो व प्रकरण पूर्णपणे निकाली काढण्यासाठी आणखी काही कार्यालालकडून माहिती येणे बाकी असते. त्याबाबतील स्मरणपत्रे वगैरे द्यावी लागतात. स्मरणपत्र देवुन व पाठपुरावा करुन प्रकरण निकाली काढणे सोपे व्हावे म्हणून अशा फाईल्स दुसऱ्या गठ्ठ्यामध्ये वेगळ्या ठेवणे आवश्यक आहे.
- ३) **नियतकालीन अहवाल** - एखाद्या विषयातील प्रगतीवर सतत लक्ष ठेवणे आवश्यक असते. त्यासाठी पत्रव्यवहारातून माहिती मागविण्याऐवजी काही विवरणपत्रे विहित केलेली असतात. काही वेळा ही विवरणपत्रे पत्र व्यवहारापेक्षा चांगले काम करतात. लिपिकाने आपल्याशी संबंधीत नियतकालीक अहवालाच्या फाईलच्या वेगळ्या गठ्ठा ठेवणे आवश्यक आहे. त्यामुळे सर्व अहवाल वेळेवर पाठविले जातील व त्याच्याकडे कामे प्रलंबित रहाणार नाहीत.
- ४) **स्थायी आदेश नस्ती** - एखाद्या कर्मचाऱ्याकडे जेवढे विषय सोपविलेले असतात त्या प्रत्येक विषयातील सर्व शासन निर्णय, आदेश किंवा परिपत्रके समाविष्ट असणाऱ्या स्थायी आदेश नस्तीचा वेगळ्या गठ्ठा देखील आवश्यक आहे. त्यामुळे प्रकरणे निकाली काढतांना त्यास या फाईल्सचा चांगला उपयोग घेता येतो.
- ५) **अभिलेख कक्षाकडे पाठवावयाची कागदपत्रे** - कर्मचाऱ्याने आपल्याकडे असणाऱ्या फाईल्सचे अबकड वर्गीकरण करुन अभिलेख कक्षाकडे किंवा रॅकवर ठेवता कामा नये. त्याने असे वर्गीकरण केले आहे काय व अभिलेख कक्षाकडे पाठवावयाची कागदपत्रे वेगळी बावी दफतर तपासणी मध्ये पहाणे त्यामुळे शक्य होते.
- ६) **"ड" वर्गीकरण केलेली कागदपत्रे** - तात्पुरत्या स्वरुपात तयार केलेल्या ज्या एक वर्षानंतर नष्ट केल्या तरी चालतील अशा फाईल्स वेगळ्या काढून अभिलेख कक्षाकडे न पाठविता संबंधित शाखेने नष्ट करावयाच्या असतात. त्यामुळे शाखेमध्ये फाईल्सची निष्कारण अडचण होण्याची टळते. परंतु वेळच्या वेळी असा आढावा घेवुन पुढील कृती झाली आहे काय हे देखील दफतर तपासणीमध्ये पाहिले पाहिजे.

अशा रितीने सहा गठ्ठे पध्दतीमुळे कर्मचाऱ्यांच्या कामात सुसुत्रता निर्माण होते व त्यामुळे दफतर तपासणीस मदत होते व परिणामी कार्यालयीन कामकाजाची प्रत सुधारते.

तक्ता क्र. १: अभिलेख जतन कालावधीनुसार वर्गीकरण

१. अ वर्ग	कायमस्वरूपी	गठ्ठ्यातील लाल कापड वापरले जाते
२. ब वर्ग	३० वर्षाकरीता	गठ्ठ्यातील पिवळे कापड वापरले जाते
३. क वर्ग	१० वर्षाकरीता	गठ्ठ्यातील पांढरे कापड वापरले जाते
४. क - १ वर्ग	५ वर्षाकरीता	गठ्ठ्यातील हिरवे कापड वापरले जाते
५. ड वर्ग	तात्पुरते - १ वर्ष	

RIGHT TO INFORMATION (RTI)

The right to information is implicitly guaranteed by the Constitution. However, with a view to set out a practical regime for the citizens to secure information as a matter of right, the Indian Parliament enacted the Right to Information Act, 2005. This law is very comprehensive and covers almost all matters of governance. This Law has a wide reach, being applicable to Government at all levels- Union, State and Local as well as to the recipients of substantial government funds.

This guide contains five parts. Part I of the guide discusses some aspects of the Act which all the stake-holders are required to know. Rest of the four parts are specifically relevant to the public authorities, the information seekers, the public information officers and the first appellate authorities respectively.

Contents of this guide are specifically relevant in relation to the Central Government but are equally applicable to the State Governments except in relation to rules about payment of fee or deciding of appeals by the Information Commissions. It may be noted that this guide uses the term Public Information Officer in place of Central Public Information Officer/State Public Information Officer. Likewise Assistant Public Information Officer has been used for Central Assistant Public Information Officer/State Assistant Public Information Officer and Information Commission for Central Information Commission/State Information Commission except where it was considered necessary to make specific reference to the Central Public Information Officer/Central Information Commission etc.

Part I: FOR ALL STAKEHOLDERS

Object of the Right to Information Act

The basic object of the Right to Information Act is to empower the citizens, to promote transparency and accountability in the working of the Government, to contain corruption, and to enhance people's participation in democratic process thereby making our democracy work for the people in a real sense. It goes without saying that an informed citizen is better equipped to keep necessary vigil on the instruments of governance and make the government more accountable to the governed. The Act is a big step towards making the citizens informed about the activities of the Government.

What is Information

Information is any material in any form. It includes records, documents, memos, e-mails, opinions, advices, press releases, circulars, orders, logbooks, contracts, reports, papers, samples, models, data material held in any electronic form. It also includes information relating to any private body which can be accessed by the public authority under any law for the time being in force.

What is a Public Authority

A "public authority" is any authority or body or institution of self government established or constituted by or under the Constitution; or by any other law made by the Parliament or a State Legislature; or by notification issued or order made by the Central Government or a State

Government. The bodies owned, controlled or substantially financed by the Central Government or a State Government are also public authorities. Non-Government organisations substantially financed by the Central Government or a State Government also fall within the definition of public authority. The substantial financing by the Central Government or a State Government may be direct or indirect. The Act does not define substantial financing. Various courts/Information Commissions have been deciding on this issue on case to case basis, depending upon the merits of each case.

Public Information Officer

Public authorities have designated some of its officers as Public Information Officers. They are responsible to give information to a person who seeks information under the RTI Act.

Assistant Public Information Officer

These are the officers at sub-divisional level to whom a person can give his RTI application or appeal. These officers send the application or appeal to the Public Information Officer of the public authority or the concerned appellate authority. An Assistant Public Information Officer is not responsible to supply the information.

The Assistant Public Information Officers appointed by the Department of Posts in various post offices are working as Assistant Public Information Officers for all the public authorities under the Government of India.

Right to Information under the Act

A citizen has a right to seek such information from a public authority which is held by the public authority or which is held under its control. This right includes inspection of work, documents and records; taking notes, extracts or certified copies of documents or records; and taking certified samples of material held by the public authority or held under the control of the public authority. It is important to note that only such information can be supplied under the Act that is available and existing and is held by the public authority or is held under the control of the public authority. The Public Information Officer is not supposed to create information that is not a part of the record of the public authority. The Public Information Officer is also not required to furnish information which require drawing of inference and/or making of assumptions; or to interpret information; or to solve the problems raised by the applicants; or to furnish replies to hypothetical questions.

A citizen has a right to obtain information from a public authority in the form of diskettes, floppies, tapes, video cassettes or in any other electronic mode or through print-outs provided such information is already stored in a computer or in any other device.

The information to the applicant should ordinarily be provided in the form in which it is sought. However, if the supply of information sought in a particular form would disproportionately divert the resources of the public authority or may cause harm to the safety or preservation of the records, supply of information in that form may be denied.

In some cases, the applicants expect the Public Information Officer to give information in some particular proforma devised by them on the plea that they have a right to get information in the form in which it is sought. It need be noted that the provision in the Act simply means that if the information is sought in the form of photocopy, it shall be provided in the form of photocopy, or if

it is sought in the form of a floppy or in any other electronic mode, it shall be provided in that form, subject to the conditions given in the Act. It does not mean that the PIO shall re-shape the information.

Some Information Seekers request the Public Information Officers to cull out information from some document(s) and give such extracted information to them. A citizen has a right to get 'material' from a public authority which is held by or under the control of that public authority. The Act, however, does not require the Public Information Officer to deduce some conclusion from the 'material' and supply the 'conclusion' so deduced to the applicant. It means that the Public Information Officer is required to supply the 'material' in the form as held by the public authority, but not to do research on behalf of the citizen to deduce anything from the material and then supply it to him.

Right to Information Vis-a-Vis other Acts

The RTI Act has over-riding effect vis-à-vis other laws. It implies that if any of the provisions of the RTI Act are not consistent with any other law for the time being in force including the Official Secrets Act, 1923, the provisions of the RTI Act would have effect.

Supply of Information to Associations etc.

The Act gives the right to information only to the citizens of India. It does not make provision for giving information to Corporations, Associations, Companies etc. which are legal entities/persons, but not citizens. However, if an application is made by an employee or office-bearer of any Corporation, Association, Company, NGO etc. indicating his name and such employee/office bearer is a citizen of India, information may be supplied to him/her. In such cases, it would be presumed that a citizen has sought information at the address of the Corporation etc.

Fee for Seeking Information

A citizen who desires to seek some information from a public authority is required to send, along with the application, a demand draft or a bankers cheque or an Indian Postal Order of Rs.10/- (Rupees ten), payable to the Accounts Officer of the public authority as fee prescribed for seeking information. The payment of fee can also be made by way of cash to the public authority or to the Assistant Public Information Officer, against a proper receipt. The payment of fee to the Central

Ministries/departments can also be made online through internet banking of State Bank of India or through Master/Visa Debit/credit cards.

The applicant may also be required to pay further fee towards the cost of providing the information, details of which shall be intimated to the applicant by the PIO as prescribed by the Right to Information Rules, 2012. Rates of fee as prescribed in the Rules are given below:

- a. Rupees two (Rs. 2/-) for each page (in A-3 or smaller size paper) ;
- b. Actual cost or price of a photocopy in larger size paper;
- c. Actual cost or price for samples or models;
- d. Rupees fifty (rs.50/-) per diskette or floppy; and
- e. Price fixed for a publication or rupees two per page of photocopy for extracts from the publication.

f. So much of postal charges involved in supply of information that exceeds fifty rupees. A citizen has a right to inspect the records of a public authority. For inspection of records, the public authority shall charge no fee for the first hour. But a fee of rupees five (Rs.5/-) for each subsequent hour (or fraction thereof) shall be charged. If the applicant belongs to the below poverty line (BPL) category, he is not required to pay any fee. However, he should submit a proof in support of his claim as belonging to the below poverty line category. The application not accompanied by the prescribed fee of Rs.10/- or proof of the applicant's belonging to below poverty line category, as the case may be, shall not be a valid application under the Act. It may be pointed out that there is no bar on the public authority to supply information in response to such applications. However, provisions of Act would not apply to such cases.

Format of Application

There is no prescribed format of application for seeking information. The application can be made on plain paper. The applicant should mention the address at which the information is required to be sent. The information seeker is not required to give reasons for seeking information.

Information Exempted From Disclosure

Sub-section (1) of section 8 and section 9 of the Act enumerate the types of information which is exempt from disclosure. Sub-section (2) of section 8, however, provides that information exempted under sub-section (1) or exempted under the Official Secrets Act, 1923 can be disclosed if public interest in disclosure overweighs the harm to the protected interests. The information which, in normal course, is exempt from disclosure under subsection (1) of Section 8 of the Act, would cease to be exempted if 20 years have lapsed after occurrence of the incident to which the information relates. However, the following types of information would continue to be exempt and there would be no obligation, even after lapse of 20 years, to give any citizen-

- i. Information, disclosure of which would prejudicially affect the sovereignty and integrity of India, the security, strategic, scientific or economic interest of the State, relation with foreign state or lead to incitement of an offence;
- ii. Information, the disclosure of which would cause a breach of privilege of Parliament or State Legislature; or
- iii. cabinet papers including records of deliberations of the Council of Ministers, Secretaries and other Officers subject to the conditions given in proviso to clause (i) of sub-section(1) of Section 8 of the Act.

Record Retention Schedule and the Act

The Act does not require the public authorities to retain records for indefinite period. The records need be retained as per the record retention schedule applicable to the concerned public authority.

Assistance Available to the Applicant

If a person is unable to make a request in writing, he may seek the help of the Public Information Officer to write his application and the Public Information Officer should render him reasonable assistance. Where a decision is taken to give access to a sensorily disabled person to any document, the Public Information Officer, shall provide such assistance to the person as may be appropriate for inspection.

Time Period for Supply of Information

In normal course, information to an applicant shall be supplied within 30 days from the receipt of application by the public authority. If information sought concerns the life or liberty of a person, it shall be supplied within 48 hours. Further details in this regard are given in part IV viz. 'For the Public Information Officers.'

Appeals

If an applicant is not supplied information within the prescribed time of thirty days or 48 hours, as the case may be, or is not satisfied with the information furnished to him, he may prefer an appeal to the first appellate authority who is an officer senior in rank to the Public Information Officer. Such an appeal should be filed within a period of thirty days from the date on which the limit of 30 days of supply of information is expired or from the date on which the information or decision of the Public Information Officer is received. The appellate authority of the public authority shall dispose of the appeal within a period of thirty days or in exceptional cases within 45 days of the receipt of the appeal.

If the first appellate authority fails to pass an order on the appeal within the prescribed period or if the appellant is not satisfied with the order of the first appellate authority, he may prefer a second appeal with the Information Commission within ninety days from the date on which the decision should have been made by the first appellate authority or was actually received by the appellant.

Complaints

If any person is unable to submit a request to a Public Information Officer either by reason that such an officer has not been appointed by the concerned public authority; or the Assistant Public Information Officer has refused to accept his or her application or appeal for forwarding the same to the Public Information Officer or the appellate authority, as the case may be; or he has been refused access to any information requested by him under the RTI Act; or he has not been given a response to a request for information within the time limit specified in the Act; or he has been required to pay an amount of fee which he considers unreasonable; or he believes that he has been given incomplete, misleading or false information, he can make a complaint to the Information Commission.

Third Party Information

Third party in relation to the Act means a person other than the citizen making a request for information. The definition of third party includes a public authority other than the public authority to which the request has been made.

Disclosure of Third Party Information

Information including commercial confidence, trade secrets or intellectual property, the disclosure of which would harm the competitive position of a third party, is exempt from disclosure. Such information should not be disclosed unless the competent authority is satisfied that larger public interest warrants the disclosure of such information.

In regard to a third party information which the third party has treated as confidential, the Public Information Officer should follow the procedure as given in part IV viz. **'FOR PUBLIC**

INFORMATION OFFICERS’. The third party should be given full opportunity to put his case for non-disclosure if he desires that the information should not be disclosed.

RTI ONLINE

Department of Personnel & Training has launched a web portal namely RTI online with URL www.rtionline.gov.in for all Central Ministries/Departments. This is a facility for the Indian citizens to file RTI applications and first appeals online to all Central Ministries/Departments. The prescribed RTI fees can also be paid online. Reply to the RTI applications and first appeals received online can also be given online by the respective PIOs/FAAs.

Compilation of OMs and notifications on RTI

Department of Personnel and Training has launched an online compilation of its Office Memorandums and Notifications on Right to Information Act, 2005, with topic based search facility. This compilation is available on the website of the Department namely www.persmin.nic.in and is beneficial to all the stake holders.

Part II

FOR PUBLIC AUTHORITIES

1. Public authorities are the repository of information which the citizens have a right to access under the Right to Information Act, 2005. The Act casts important obligations on public authorities so as to facilitate the citizens of the country to access the information held under their control.

Maintenance and Computerisation of Records

2. Proper management of records is of utmost importance for effective implementation of the provisions of the Act. A public authority should, therefore, maintain all its records properly. It should ensure that the records are duly catalogued and indexed in such a manner and form that it may facilitate the right to information.

Suo Motu Disclosure

3. Every public authority should provide as much information suo motu to the public through various means of communications so that the public have minimum need to use the Act to obtain information. Internet being one of the most effective means of communication, the information may be posted on the website.
4. Section 4(1)(b) of the Act, in particular, requires every public authority to publish following sixteen categories of information:
 - i. the particulars of its organisation, functions and duties;
 - ii. the powers and duties of its officers and employees;
 - iii. the procedure followed in the decision making process, including channels of supervision and accountability;
 - iv. the norms set by it for the discharge of its functions;
 - v. the rules, regulations, instructions, manuals and records, held by it or under its control or used by its employees for discharging its functions; a statement of the categories of documents that are held by it or under its control;

- vi. the particulars of any arrangement that exists for consultation with, or representation by, the members of the public in relation to the formulation of its policy or implementation thereof;
 - vii. a statement of the boards, councils, committees and other bodies consisting of two or more persons constituted as its part or for the purpose of its advice, and as to whether meetings of those boards, councils, committees and other bodies are open to the public, or the minutes of such meetings are accessible for public;
 - viii. directory of its officers and employees;
 - ix. the monthly remuneration received by each of its officers and employees, including the system of compensation as provided in its regulations;
 - x. the budget allocated to each of its agency, indicating the particulars of all plans, proposed expenditures and reports on disbursements made;
 - xi. the manner of execution of subsidy programmes, including the amounts allocated and the details of beneficiaries of such programmes;
 - xii. particulars of recipients of concessions, permits or authorisations granted by it;
 - xiii. details in respect of the information, available to or held by it, reduced in an electronic form;
 - xiv. the particulars of facilities available to citizens for obtaining information, including the working hours of a library or reading room, if maintained for public use;
 - xv. the names, designations and other particulars of the Public Information Officers.
5. Besides the categories of information enumerated above, the Government has issued guidelines that the following categories of information may be published by the public authorities:
- i. Information relating to procurement
 - ii. Public Private Partnerships
 - iii. Transfer Policy and Transfer Orders
 - iv. RTI Applications
 - v. CAG & PAC paras
 - vi. Citizens Charter
 - vii. Discretionary and Non-discretionary grants
 - viii. Foreign Tours of PM/Ministers and senior officers
6. In addition, the Government may prescribe other categories of information to be published by any public authority. It need be stressed that publication of the information as referred to above is not optional. It is a statutory requirement which every public authority is bound to meet.
7. Proactive disclosure should be done in the local language so that it remains accessible to public. It should be presented in a form that is easily understood and if technical words are used they should be carefully explained. As provided in section 4, disclosure should be made in as many mediums as feasible such as notice boards, newspapers, public announcements, media broadcast, the internet or any other means. The disclosures should be kept up to date. The disclosure of Information may be made keeping in mind the provisions of Section 8 to 11 of the RTI Act.

8. Every public authority should keep in view that Proactive disclosures on its website are complete, easily accessible, technology and platform neutral and in a form which conveys the desired information in an effective and user-friendly manner.
9. Each Central Ministry/ Public Authority should get its proactive disclosure package audited by third party every year. Such audit should be communicated to the Central Information Commission annually through publication on their own websites. All Public Authorities should proactively disclose the names of the third party auditors on their website. For carrying out third party audit through outside consultants also, Ministries/Public Authorities should utilize their plan/non-plan funds.
10. Each Central Ministry/ Public Authority should appoint a senior officer not below the rank of a Joint Secretary and not below rank of Additional HOD in case of attached offices for ensuring compliance with the proactive disclosure guidelines.

Designation of PIOs and APIOs etc.

11. Every public authority is required to designate Public Information Officers in all the administrative units or offices under it. Every public authority is also required to designate Assistant Public Information Officers at each sub-divisional level. The Government of India has decided that Central Assistant Public Information Officers (CAPIOs) appointed by the Department of Posts would act as CAPIOs for all the public authorities under the Government of India.

Designation of Appellate Authority

12. Sub-section (8) of Section 7 of the RTI Act provides that where a request for information is rejected, the Public Information Officer shall, inter-alia, communicate the particulars of the Appellate Authority to the person making the request. Thus, the applicant is informed about the particulars of the Appellate Authority when a request for information is rejected but there may be cases where the Public Information Officer does not reject the application, but the applicant does not receive a decision within the time as specified in the Act or he is aggrieved by the decision of the Public Information Officer. In such a case the applicant may like to exercise his right to appeal. But in absence of the particulars of the appellate authority, the applicant may face difficulty in making an appeal. All the public authorities should also designate the First Appellate Authorities and publish their particulars alongwith the particulars of the Public Information Officers.

Acceptance of Fee

13. According to the Right to Information Rules, 2012, an applicant can make payment of fee in cash to the public authority or CAPIO or by demand draft or banker's cheque or Indian Postal Order payable to the Accounts Officer of the public authority. The payment of fee to the Central Ministries/departments can also be made online through internet banking of State Bank of India or through Master/Visa Debit/credit cards. The public authority should ensure that payment by any of the above modes is not denied or the applicant is not compelled to draw IPO etc. in the name of any officer other than the Accounts Officer. If any public authority does not have any Accounts Officer, it should designate an officer as such for the purpose of receiving fee under the RTI Act and Rules made thereunder.

Compliance of the Orders of the Information Commission

14. The decisions of the Commission are binding. The public authority should ensure that the orders passed by the Commission are implemented. If any public authority or a PIO is of the view that an order of the Commission is not in consonance with the provisions of the Act, it may approach the High Court by way of a Writ Petition.

Creation of RTI Cell

15. Sub-section (1) of Section 5 of the Right to Information Act, 2005 mandates all public authorities to designate as many Public Information Officers as necessary to provide information under the Act. Where a public authority designates more than one Public Information Officer (PIO), an applicant is likely to face difficulty in approaching the appropriate Public Information Officer. The applicants would also face problem in identifying the officer senior in rank to the Public Information Officer to whom an appeal under sub-section (1) of Section 19 of the Act can be made. Therefore all public authorities with more than one PIO should create a RTI Cell within the organisation to receive all the RTI applications and first appeals and to route them to the concerned PIOs/FAAs. Detailed instructions regarding setting up of RTI Cell, its functions and financial assistance in setting up RTI Cell have been issued by the Department.

Transfer of Applications

16. The Act provides that if an application is made to a public authority requesting for an information, which is held by another public authority; or the subject matter of which is more closely connected with the functions of another public authority, the public authority, to which such application is made, shall transfer the application or relevant part of it to that other public authority within five days from the receipt of the application. The public authority should sensitize its officers about this provision of the Act lest the public authority is held responsible for delay.
17. If a person makes an application to a public authority for information, a part of which is available with that public authority and the rest of the information is scattered with more than one other public authorities, in such a case, the PIO of the public authority receiving the application should give information relating to it and advise the applicant to make separate applications to the concerned public authorities for obtaining information from them. If no part of the information sought, is available with it but is scattered with more than one other public authorities, the PIO should inform the applicant that information is not available with the public authority and that the applicant should make separate applications to the concerned public authorities for obtaining information from them. However, if the details of public authorities who may have the information sought by the applicant are available with the PIO, such details may also be provided to the applicant.
18. If a person makes an application to a public authority for some information which is the concern of a public authority under any State Government or the Union Territory Administration, the Central Public Information Officer (CPIO) of the public authority receiving the application should inform the applicant that the information may be had from the concerned State Government/UT Administration. Application, in such a case, need not be transferred to the State Government/UT Administration.

Annual Report of the CIC

19. The Information Commissions, after the end of each year, are required to prepare reports on the implementation of the provisions of the Act during that year. Each Ministry or Department is required, in relation to the public authorities within its jurisdiction, to collect and provide information to the concerned Information Commission for preparation of the report. The report of the Commission, inter-alia, contains following information in respect of the year to which the report relates—
- a. the number of requests made to each public authority;
 - b. the number of decisions where applicants were not entitled to access to the documents pursuant to the requests, the provisions of the Act under which these decisions were made and the number of times such provisions were invoked;
 - c. particulars of any disciplinary action taken against any officer in respect of the administration of the Act;
 - d. the amount of charges collected by each public authority under the Act; and
 - e. any facts which indicate an effort by the public authorities to administer and implement the spirit and intention of the Act.
20. Every public authority should send necessary material to its administrative Ministry/Department soon after the end of the year so that the Ministry/Department may send the information to the Commission and the Commission may incorporate the same in its report. For this purpose, a web based software called “RTI Annual Report Information System” is available on the website of CIC namely www.cic.gov.in through which public authorities are required to upload requisite reports on quarterly basis. It is important that all public authorities should get themselves registered with CIC for the purpose of this report and also upload their quarterly returns regularly and on time.
21. If it appears to the Information Commission that a practice of a public authority in relation to the exercise of its functions under the Act does not conform with the provisions or spirit of the Act, it may give a recommendation to the authority specifying the steps ought to be taken for promoting such conformity. The concerned public authority should take necessary action to bring its practice in conformity with the Act.

Part III

FOR INFORMATION SEEKERS

Method of Seeking Information

1. A citizen, who desires to obtain any information under the Act, should make an application to the Public Information Officer of the concerned public authority in writing in English or Hindi or in the official language of the area in which the application is made. The application should be precise and specific. He should make payment of application fee at the time of submitting the application as prescribed in the RTI Rules, 2012. The applicant can send the application by post or through electronic means or can deliver it personally in the office of the public authority. The application can also be sent through an Assistant Public Information Officer.

Application to the concerned Public Authority

2. The applicant should make application to the Public Information Officer of the concerned public authority. He should make all efforts to ascertain as to which the public authority is concerned with the information. If the information sought by an applicant is related to different PIOs in a Public Authority or is related to different Public authorities, the supply of information is likely to take a lot more time than if the information sought is related to a single PIO in one Public Authority.
3. The applicant should not list out his grievances in the RTI application but should clearly mention which information or record he would like to seek. Further, if the drafting of the application is such that it pin points towards the specific documents required in relation to the information sought, there would be less scope of ambiguity, thereby resulting in less chances of denial of information by the Public Information Officer. For example instead of simply asking why my area is not being cleaned, cleaning schedule of the area should be asked. Similarly, instead of asking when we will get water supply, water supply planning of the area should be asked.

Fee for Seeking Information

4. Along with the application, the applicant should send application fee to the Public Information Officer. In case of Government of India, the prescribed application fee is Rs. 10/- which can be paid through a demand draft or a banker's cheque or an Indian Postal Order payable to the Accounts Officer of the public authority. The payment of fee can also be made by way of cash to the public authority or to the Assistant Public Information Officer against proper receipt. In case of online applications to Central Ministries/departments, fee can be paid online through internet banking of State Bank of India or through Master/Visa credit/debit cards.
5. The applicant may also be required to pay further fee towards the cost of providing the information, details of which shall be intimated to the applicant by the Public Information Officer. The fee so demanded can be paid the same way as application fee.
6. If the applicant belongs to below poverty line (BPL) category, he is not required to pay any fee. However, he should submit a proof in support of his claim as belonging to the below poverty line category. The application not accompanied by the prescribed application fee or proof of the applicant's belonging to below poverty line category, as the case may be, shall not be a valid application under the Act.

Format of Application

7. There is no prescribed format of application for seeking information. The application can be made on a plain paper. The applicant should mention the address at which the information is required to be sent. The information seeker is not required to give reasons for seeking information.

Filing of Appeal

8. An applicant can file an appeal to the first appellate authority if the information is not supplied to him within the prescribed time of thirty days or 48 hours, as the case may be, or is not satisfied with the information furnished to him. Such an appeal should be filed within a period of thirty days from the date on which the limit of 30 days of supply of information is

expired or from the date on which the information or decision of the Public Information Officer is received. The first appellate authority of the public authority shall dispose of the appeal within a period of thirty days or in exceptional cases within 45 days of the receipt of the appeal.

9. If the first appellate authority fails to pass an order on the appeal within the prescribed period or if the appellant is not satisfied with the order of the first appellate authority, he may prefer a second appeal with the Information Commission within ninety days from the date on which the decision should have been made by the first appellate authority or was actually received by the appellant.
10. The appeal made to the Central Information Commission should contain the following information: -
 - i. Name and address of the appellant;
 - ii. Name and address of the Public Information Officer to whom the application was addressed;
 - iii. Name and address of the Public Information Officer who gave reply to the application;
 - iv. Name and address of the First Appellate Authority who decided the first appeal;
 - v. Particulars of the application;
 - vi. Particulars of the order including number, if any, against which the appeal is preferred;
 - vii. Brief facts leading to the appeal;
 - viii. Prayer or relief sought;
 - ix. Grounds for prayer or relief;
 - x. Any other information relevant to the appeal;
 - xi. Verification/authentication by the appellant.
11. The appeal made to the Central Information Commission should be accompanied by the following documents, duly authenticated and verified by the appellant, namely:
 - i. a copy of the application submitted to the CPIO;
 - ii. a copy of the reply received, if any, from the CPIO;
 - iii. a copy of the appeal made to the FAA;
 - iv. a copy of the order received, if any, from the FAA;
 - v. Copies of other documents relied upon by the appellant and referred to in his
 - vi. appeal; and
 - vii. an index of the documents referred to in the appeal.

Filing of Complaints

12. A person can make a complaint to the Information Commission if he is unable to submit a request to a Public Information Officer either by reason that such an officer has not been appointed by the concerned public authority; or the Assistant Public Information Officer has refused to accept his or her application or appeal for forwarding the same to the Public Information Officer or the appellate authority, as the case may be; or he has been refused access to any information requested by him under the RTI Act; or he has not been given a response to a request for information within the time limit specified in the Act; or he has

been required to pay an amount of fee which he considers unreasonable; or he believes that he has been given incomplete, misleading or false information.

Part IV

FOR PUBLIC INFORMATION OFFICERS

1. The Public Information Officer of a public authority plays a pivotal role in making the right of citizens to information a reality. The Act casts specific duties on him and makes him liable for penalty in case of default. It is, therefore, essential for a Public Information Officer to study the Act carefully and understand its provisions correctly. Besides the issues discussed elsewhere in this document, a Public Information Officer should keep the following aspects in view while dealing with the applications under the Act.

Applications Received Without Fee

2. Soon after receiving the application, the Public Information Officer should check whether the applicant has made the payment of application fee or whether the applicant is a person belonging to a Below Poverty Line (BPL) category. If application is not accompanied by the prescribed fee or the BPL Certificate, it cannot be treated as an application under the RTI Act. It may, however, be noted that the Public Information Officer should consider such an application sympathetically and try to supply information sought by way of such an application.
3. A public authority may designate as many Public Information Officers for it, as it may deem necessary. It is possible that in a public authority with more than one Public Information Officer, an application is received by the Public Information Officer other than the concerned Public Information Officer. In such a case, the Public Information Officer receiving the application should transfer it to the concerned Public Information Officer immediately, preferably the same day. Time period of five days for transfer of the application applies only when the application is transferred from one public authority to another public authority and not for transfer from one Public Information Officer to another in the same public authority.

Rendering Assistance to Applicants

4. The RTI Act provides that the Public Information Officer has a duty to render reasonable assistance to the persons seeking information. As per provisions of the Act, a person, who desires to obtain any information is required to make a request in writing or through electronic means in English or Hindi or in the official language of the area in which the application is made. If a person seeking information is not able to make such request in writing, the Public Information Officer should render reasonable assistance to him to reduce the same in writing.
5. Where access to a record is required to be provided to a sensorily disabled person, the Public Information Officer should provide assistance to such person to enable him to access the information. He should also provide such assistance to the person as may be appropriate for the inspection of records where such inspection is involved.

Assistance Available to PIO

6. The Public Information Officer may seek the assistance of any other officer as he or she considers necessary for the proper discharge of his or her duties. The officer, whose

assistance is so sought by the Public Information Officer, would render all assistance to him. Such an officer shall be deemed to be a Public Information Officer and would be liable for contravention of any provisions of the Act the same way as any other Public Information Officer. It would be advisable for the Public Information Officer to inform the officer whose assistance is sought, about the above provision, at the time of seeking his assistance.

7. Some Public Information Officers, on the basis of above referred provision of the Act, transfer the RTI applications received by them to other officers and direct them to send information to the applicants as deemed Public Information Officer. Thus, they use the above referred provision to designate other officers as Public Information Officer. According to the Act, it is the responsibility of the officer who is designated as the Public Information Officer by the public authority to provide information to the applicant or reject the application for any reasons specified in Sections 8 and 9 of the Act. The Act enables the Public Information Officer to seek assistance of any other officer to enable him to provide information to the information seeker, but it does not give him authority to designate any other officer as Public Information Officer and direct him to send reply to the applicant. The import of the provision is that, if the officer whose assistance is sought by the Public Information Officer, does not render necessary help to him, the Information Commission may impose penalty on such officer or recommend disciplinary action against him the same way as the Commission may impose penalty on or recommend disciplinary action against the Public Information Officer.

Supply of Information

8. The answering Public Information Officer should check whether the information sought or a part thereof is exempt from disclosure under Section 8 or Section 9 of the Act. Request in respect of the part of the application which is so exempt may be rejected and rest of the information should be provided immediately or after receipt of additional fees, as the case may be.
9. Where a request for information is rejected, the Public Information Officer should communicate to the person making the request—
 - i. the reasons for such rejection;
 - ii. the period within which an appeal against such rejection may be preferred; and
 - iii. the particulars of the authority to whom an appeal can be made.
10. If additional fee is required to be paid by the applicant as provided in the Fee and Cost Rules, the Public Information Officer should inform the applicant:
 - i. the details of further fees required to be paid;
 - ii. the calculations made to arrive at the amount of fees asked for;
 - iii. the fact that the applicant has a right to make appeal about the amount of fees so demanded;
 - iv. the particulars of the authority to whom such an appeal can be made; and
 - v. the time limit within which the appeal can be made.
11. Though there is no hard and fast rule as to when exactly intimation about additional fees is to be given to the applicant, such intimation should be given soon after receipt of RTI application.

Supply of Part Information by Severance

12. Where a request is received for access to information which is exempt from disclosure but a part of which is not exempt, and such part can be severed in such a way that the severed part does not contain exempt information then, access to that part of the information/record may be provided to the applicant. Where access is granted to a part of the record in such a way, the Public Information Officer should inform the applicant that the information asked for is exempt from disclosure and that only part of the record is being provided, after severance, which is not exempt from disclosure. While doing so, he should give the reasons for the decision, including any findings on any material question of fact, referring to the material on which those findings were based.

Time Period for Supply of Information

13. The following table shows the **maximum** time (from the receipt of application) which may be taken to dispose off the applications in different situations:

Sr.No.	Situation	Time limit for disposing off applications
---------------	------------------	--

- | | | |
|----|--|--|
| 1. | Supply of information in normal course. | 30 days |
| 2. | Supply of information if the application is received through APIO. | 05 days shall be added to the time period indicated at Sr. No. 1 |
| 3. | Supply of information if it concerns the life or liberty of a person | 48 hours |
| 4. | Transfer of application to other public authority under section 6(3) of the Act | 05 days |
| 5. | Supply of information if application/request is received after transfer from another public authority: | |
| | a. In normal course | |
| | b. In case the information concerns the life or liberty of a person. | |
| | a. Within 30 days of the receipt of the application by the concerned public authority. | |
| | b. Within 48 hours of receipt of the application by the concerned public authority. | |
| 6. | Supply of information where the applicant is asked to pay additional fee. The period intervening between informing the applicant about additional fee and the receipt of such fee by the public authority shall be excluded for calculating the period of reply. | |
| 7. | Supply of information by organizations specified in the Second Schedule: | |
| | a. If information relates to allegations of violation of human rights (after approval of the Central Information Commission) | |
| | b. In case information relates to allegations of corruption. | |
| | a. 45 days from the receipt of application. | |
| | b. Within 30 days of the receipt of application. | |

14. If the Public Information Officer fails to give decision on the request for information within the prescribed period, he shall be deemed to have refused the request. It is pertinent to note that if a public authority fails to comply with the specified time limit, the information to the concerned applicant would have to be provided free of charge.

Disclosure of Third Party Information

15. Information including commercial confidence, trade secrets or intellectual property, the disclosure of which would harm the competitive position of a third party, is exempt from

disclosure. Such information shall not be disclosed unless the competent authority is satisfied that larger public interest warrants the disclosure of such information.

16. If an applicant seeks any information which relates to or has been supplied by a third party and that third party has treated that information as confidential, the Public Information Officer shall consider whether the information should be disclosed or not. The guiding principle in such cases is that except in the case of trade or commercial secrets protected by law, disclosure may be allowed if the public interest in disclosure outweighs in importance any possible harm or injury to the interests of such third party. However, the Public Information Officer would have to follow the following procedure before disclosing such information.
17. If the Public Information Officer intends to disclose the information, he shall within five days from the receipt of the application, give a written notice to the third party that the information has been sought by the applicant under the RTI Act and that he intends to disclose the information. He shall request the third party to make a submission in writing or orally, regarding whether the information may be disclosed. The third party shall be given a time of ten days, from the date of receipt of the notice by him, to make representation against the proposed disclosure, if any.
18. The Public Information Officer shall make a decision regarding disclosure of the information keeping in view the submission of the third party. Such a decision should be taken within forty days from the receipt of the request for information. After taking the decision, the Public Information Officer should give a notice of his decision to the third party in writing. The notice given to the third party should include a statement that the third party is entitled to prefer an appeal under section 19 against the decision.
19. The third party can prefer an appeal to the First Appellate Authority against the decision made by the Public Information Officer within thirty days from the date of the receipt of notice. If not satisfied with the decision of the First Appellate Authority, the third party can prefer a second appeal to the Information Commission.
20. If an appeal has been filed by the third party against the decision of the Public Information Officer to disclose the third party information, the information should not be disclosed till the appeal is decided.

Imposition of Penalty

21. An applicant under the Act has a right to appeal to the Information Commission and also to make complaint to the Commission. Where the Information Commission at the time of deciding any complaint or appeal is of the opinion that the Public Information Officer has without any reasonable cause, refused to receive an application for information or has not furnished information within the time specified or malafidely denied the request for information or knowingly given incorrect, incomplete or misleading information or destroyed information which was the subject of the request or obstructed in any manner in furnishing the information, it shall impose a penalty of two hundred and fifty rupees each day till application is received or information is furnished subject to the condition that the total amount of such penalty shall not exceed twentyfive thousand rupees. The Public Information

Officer shall, however, be given a reasonable opportunity of being heard before any penalty is imposed on him. The burden of proving that he acted reasonably and diligently and in case of denial of a request that such denial was justified shall be on the Public Information Officer.

Disciplinary Action Against PIO

22. Where the Information Commission at the time of deciding any complaint or appeal is of the opinion that the Public Information Officer has without any reasonable cause and persistently, failed to receive an application for information or has not furnished information within the time specified or malafidely denied the request for information or knowingly given incorrect, incomplete or misleading information or destroyed information which was the subject of the request or obstructed in any manner in furnishing the information, it may recommend disciplinary action against the Public Information Officer.

Protection for Work Done in Good Faith

23. Section 21 of the Act provides that no suit, prosecution or other legal proceeding shall lie against any person for anything which is in good faith done or intended to be done under the Act or any rule made thereunder. A Public Information Officer should, however, note that it would be his responsibility to prove that his action was in good faith.

Part V

FOR FIRST APPELLATE AUTHORITIES

1. The first Appellate Authority has a very important role under the RTI Act, 2005. The independent and judicious examination of appeals by the First Appellate Authorities would lead to higher satisfaction to the appellants. This would, in turn, result in less number of second appeals to the Information Commission.
2. The information sought by an applicant should either be supplied to him by the Public Information Officer or his application should be rejected within the time prescribed under the Act. If additional fee need be charged from the applicant, timely communication in this regard should be sent to him.

First Appeal

3. If the applicant does not receive information or decision about rejection of request or communication about payment of additional fee within the specified time, he can make an appeal to the First Appellate Authority. Appeal can also be made if the applicant is aggrieved by the decision of the Public Information Officer regarding supply of information or the quantum of fee decided by the Public Information Officer. The applicant may prefer the first appeal within thirty days from the expiry of such period or from the receipt of such a decision of the Public Information Officer.
4. The First Appellate Authority may admit the appeal after expiry of the period of thirty days if he or she is satisfied that the appellant was prevented by sufficient cause from filing the appeal in time.
5. A third party can also prefer an appeal to the First Appellate Authority against the order of the Public Information Officer to disclose third party information. Such an appeal shall be made within thirty days from the date of the order.

Disposal of Appeal

6. While disposing off first appeals, the first Appellate Authorities should act in a fair and judicious manner. It is very important that the order passed by the first appellate authority should be a detailed and speaking order, giving justification for the decision arrived at.
7. If an appellate authority while deciding an appeal comes to a conclusion that the appellant should be supplied information in addition to what has been supplied by the

SECTION B

NATIONAL HEALTH PROGRAMMES

1. MATERNAL HEALTH

ANTENATAL CARE

Antenatal period is the most crucial period as the services provided during this period can have positive impact on health of both the mother and her child.

1. Essential obstetric care to every pregnant woman:

- Registration of all pregnant women before 12 weeks

2. Detailed history at first visit:

- **Menstrual history:** Regularity of cycles, date of LMP, calculate EDD and record on Mother Child Protection (MCP) card
- **Obstetric history:** Number of prior pregnancies and outcome of each pregnancy (full term birth, preterm birth, abortion), place and mode of delivery, weight of baby, Live birth/stillbirth, complications during after delivery (PPH, Retained Placenta, Infection)
- **Past history :** Hypertension, Diabetes Mellitus, Tuberculosis, Asthma, Heart disease, any other, surgical procedures undergone, medications taken during pre conceptional period, history of bleeding.
- H/O current symptoms, perception of fetal movements if pregnancy > 16 weeks

3. Schedule of Examination:

- **1st visit:** Within 12 weeks—preferably as soon as pregnancy is suspected—for registration of pregnancy and first antenatal check-up
- **2nd visit:** Between 14 and 26 weeks
- **3rd visit:** Between 28 and 34 weeks
- **4th visit:** Between 36 weeks and term

4. Examination at antenatal clinic

Table 1: Examination at antenatal clinic.

* During first check up

*Height	*Breast examination
Weight : Compare with previous visit (calculate BMI in first trimester)	*Systemic examination : Auscultate chest
Pallor, icterus	P/A: Fundal height & its correlation with period of amenorrhoea (POA)
Edema over feet, hands, face	Fetal presentation and position after 32 weeks
Blood pressure	Fetal heart rate

- The last two visits are important as many of the pregnancy complications are detected during last trimester. For 'high risk' mothers more frequent examinations will be required.
- Medical officer should perform at least one check up during the third trimester and auscultate her chest to rule out any systemic abnormality.

5. Investigations

Table 2: Investigations

Hemoglobin estimation	VDRL
Urine Analysis: Protein and sugar	Voluntary HIV testing
Test for sickling in selected tribal area	Blood sugar testing
Blood grouping, Rh typing	Hepatitis B surface antigen (HsAg)
Ultrasonography (16 to 18 weeks)	Malarial parasite in Endemic area.

Table 3: Examination and action to be taken during ANC check up.

Examination	Action
Edema	<ul style="list-style-type: none"> ➤ Examine whether edema is on one leg or both legs and is it pitting. Look for edema over face, hands, abdomen. Check for proteinuria and hypertension. ➤ High blood pressure and albuminuria, refer to specialist as she has pre-eclampsia. ➤ History of kidney disease, if yes refer to specialist. ➤ If edema is on one leg, refer to specialist. ➤ If bilateral pedal edema without albuminuria and normal BP: Reassure mother, check for anaemia and give IFA tablets as required
Weight gain	<p>Record monthly weight on MCP card of mother, calculate weight gain since the previous visit</p> <p>Weight gain more than 3 kg. in a month: Suspect pre-eclampsia</p> <ul style="list-style-type: none"> ➤ Weight gain less than 1 kg. in a month: Suspect fetal growth retardation.
Blood Pressure	<ul style="list-style-type: none"> ➤ If 140 / 90 mm Hg or more, advise mother to rest for half hour and then repeat the BP recording. Check for proteinuria ➤ If systolic between 140-160 and /or diastolic 90 or above: advise extra rest and refer to MO PHC ➤ If systolic 160 or more or diastolic > 100 : refer to specialist

Fundal Height	Examine fundal height in weeks and compare with calculated duration of pregnancy as per LMP. If it is greater or lesser refer to specialist. Causes of fundal height less or more than expected are given in table below
Fetal Presentation	Noncephalic (correction can be attempted at 36 weeks in suitable cases) by Obs/Gyn specialist.
Fetal Heart Rate	FHR < 120 or > 160 /minute : Refer to specialist
Hemoglobin %	<p>Hb 11 gm% or more: IFA 100 tablets</p> <p>Hb between 7-11 gram%: Start IFA double dose* and reexamine after one month - If improvement of Hb by more than 1gm%, continue IFA. Give tab Albendazole (during second trimester)</p> <p>Hb < 7 gm % - Refer anemia treatment guidelines</p>
Proteinuria	If proteinuria present suspect pre-eclampsia and refer to specialist
Risk factors	All high-risk pregnancies should be checked by MO and then referred to specialist if necessary for further check up or during delivery depending upon the risk factor.

* For better absorption, IFA tablets should be taken 1.5 hours before meals

Table 4: Fundal Examination

Fundal height < Period of Amenorrhea	Fundal height > Period of Amenorrhea
Wrong dates	Wrong dates
Infrequent periods prior to conception	Poly hydramnios
Intrauterine Growth retardation(IUGR)	Twins
Oligohydramnios	Big baby
Intrauterine fetal death.	Hydatidiform mole
	Uterine fibroids

6. Education and counseling regarding care during pregnancy

6.1. First and second trimester:

- **Diet:** More than one meal a day and evening snacks (most important), inclusion of sprouted legumes, pulses, green leafy and other vegetables, seasonal fruits.
- **Rest:** 2 Hours in afternoon and 8 hours at night in lateral position
- **Exercise:** Walking for 30 minutes daily
- **Habits:** Avoid tobacco in any form, avoid alcohol
- Practicing safe sex
- Self-reporting of danger signals, e.g. Abdominal pain, severe headache, giddiness, palpitations, easy fatigability, breathlessness, fever, generalized edema, vaginal bleeding, watery discharge per vaginum, blurred vision, excessive vomiting, reduced fetal movements
- Consumption of iron folic acid 100 tablets for anemia prophylaxis.
- Tetanus Toxoid 2 doses/booster dose
- Calcium through diet and Calcium carbonate tablets 1.2 Gm daily.

6.2. Third trimester:

- Avoid heavy work and jerky travel on bad roads.
- Importance of institutional delivery, safe delivery, inform TOLL free No.102 and 108 for free ambulance service, JSY, JSSK and other benefits, Plan for place of delivery, preparation for delivery.
- Importance of early initiation of colostrum feeding within Half an hour of birth & exclusive breast-feeding for 6 months, child immunization and contraception especially PPIUCD.
- Ask about birth companion.

Table5: Identify high-risk mothers

Risk factors detectable during first check up	Abnormalities developing during Current pregnancy
<ul style="list-style-type: none"> • Age : Teenage/ elderly primi, • Para 4 and above • Short stature, limping gait, vertebral spine abnormalities • Bad obstetric history: H/O stillbirth, neonatal death, LBW baby, recurrent abortions • Previous Caesarean delivery • H/O PE/eclampsia, PPH, retained placenta during previous pregnancies • Preexisting medical conditions : Heart disease, diabetes mellitus, renal disease • HIV /VDRL positive gravida • Rh negative gravida 	<ul style="list-style-type: none"> • Anemia • Hypertension, proteinuria • Vaginal bleeding during pregnancy • Premature rupture of membranes (PROM) • Gestational diabetes mellitus (GDM) • Fundal height < POA or > POA • Uterus over distension: Twins, Polyhydramnios • Fetal malpresentation persisting near term • Pregnancy > 41 weeks • Reduced fetal movements

Table 6: Actions suggested for some high risk indicators

RISKS	ACTION
1. Elderly Primi	
<ul style="list-style-type: none"> ➤ Hypertension during pregnancy ➤ Gestational diabetes ➤ Difficult labor - Chances of caesarean section are higher ➤ Fetal abnormalities. 	<ul style="list-style-type: none"> ➤ Refer to specialist soon after registration for evaluations to exclude fetal anomalies (biochemical markers and ultrasonography) ➤ Regular ANC: B.P, urine analysis every month ➤ Pelvic assessment at or after 36 weeks. ➤ Institutional delivery under care of specialist.
2. Teenage primi	
<ul style="list-style-type: none"> ➤ Hypertension during pregnancy ➤ Anemia ➤ Pre-term labor ➤ Fetal growth retardation. ➤ Difficult labor 	<ul style="list-style-type: none"> ➤ Regular antenatal care ➤ Hb%, BP, urine analysis more frequently ➤ Adequate rest ➤ IFA tablets, nutrition guidance ➤ Pelvic assessment at 36 weeks ➤ Hospital delivery.
3. Primi : Height less than 145 cms	Regular ANC check. Assessment of place of delivery by specialist. Observe progress of labor partographically.
4. Primi having vertebral /limb deformity	Regular check up at PHC, Assessment by specialist for place of delivery.
5. Grand multipara (para 4 and more)	
<ul style="list-style-type: none"> ➤ Anemia ➤ Malpresentation ➤ Atonic PPH ➤ Uterine rupture 	<ul style="list-style-type: none"> ➤ Supplement IFA, nutrition guidance ➤ At 34 and 36 weeks look for fetal malpresentation ➤ Hospital delivery - Avoid injudicious use of oxytocics for augmenting labor ➤ Active management of 3rd stage of labor - Keep IV line ready

KEY MESSAGES

- Register every pregnancy within 12 weeks.
- Track every pregnancy by name for provision of quality ANC, skilled birth attendance and postnatal services.
- Ensure four antenatal visits to monitor the progress of pregnancy. This includes the registration and 1st ANC in the first trimester.
- Give every pregnant woman Tetanus Toxoid (TT) injections and Iron Folic Acid (IFA) supplementation.
- Test the blood for haemoglobin, urine for sugar and protein

EVERY VISIT.

- Record blood pressure and weight at every visit.
- Advise and encourage the woman to opt for institutional delivery.
- Maintain proper records for better case management and follow up.
- Do not give a pregnant woman any medication during the first trimester unless advised by a physician.

Expected Place of Delivery {EPD} and Calculation of EDD:

It is important to record the date of the LMP during the first visit as this helps to calculate the EDD and prepare a birth plan.

Remember that the LMP refers to the FIRST day of the woman's last menstrual period. Make sure that the woman is not referring to the date of the first missed period, i.e. the date when menstruation was expected to occur the following month and failed to occur. This mistake will lead to a miscalculation of the gestational age and EDD by about four weeks.

- If the woman is unable to remember the exact date, encourage her to remember some major event, festival or occurrence which she might link with her LMP. A calendar with the Indian system of months and local festivals might come in handy while determining the LMP.
- If the exact date of the LMP is not known and it is late in the pregnancy, ask for the date when the foetal movements were first felt. This is known as 'quickening' and is felt at around 20 weeks of gestation. This information would give a rough idea about the period of gestation, which needs to be correlated with the fundal height to estimate the gestational age. Calculate the EDD on this basis. A special note should be made of such cases in the records.
- If the woman is not able to recollect any of the above things, encourage her to mention what she believes is her current month of pregnancy. For example, if a woman has come to the ANC clinic on 20 September and says that she completed eight months of her pregnancy 10 days ago, it becomes clear that she will be completing her ninth month on 10 October and her EDD (9 months plus 7 days) is 17 October.
- If the woman has undergone a test to confirm the pregnancy, ask her the approximate date of the test and also, after how many days of amenorrhoea it was conducted. This will also assist you in estimating her LMP. The LMP is used to calculate the gestational age at the time of check-up and the EDD. The following formula is used to calculate the EDD. It is based on the assumption that the menstrual cycle of the woman was regular before conception and that it was a 28–30 days' cycle.

EDD = Date of LMP + 9 months + 7 days

It is important to also know her expected place of Delivery {EPD} for smooth monitoring and follow up of ANC .

Each Village wise chart should be displayed indicating EDD and EPD of all ANC mother.

- 1 month prior to EDD, mother should be counseled for delivery at health centre.[table 1]
- High risk ANC mothers should be visited regularly and give the referral services

Table 1: Village wise EDD:

Village name:

Subcentre:

sr.no	Name of the ANC mother	Village name	EDD	EPD	Remark

Table 2 : High risk mother and follow up up register.

Name of the village:.....

subcentre:

Sr.no	Name of the ANC mother	Cause of high risk	EDD	Follow up*visit date or condition/treatment and referral services					Result
				date	condition	date	Condition	

Note- from the date of high risk condition according to the type of risk regular follow up and visit to be given enter the visit date and follow up date should be mentioned in the register.

BIRTH PREPAREDNESS AND COMPLICATION READINESS (BPACR)

Birth preparedness and complication readiness (BPACR) is one intervention that addresses these delays by encouraging pregnant women, their families, and communities to effectively plan for births and deal with emergencies, if they occur. It is a key component of globally accepted safe motherhood programs, which helps ensure women to reach professional care when labor begins and to reduce delays that occur when mothers in labor experience obstetric complications.

BPACR include many elements, including:

- Registration of pregnancy,
- Knowledge of danger signs,
- Plan for where to give birth,
- Plan for a skilled birth attendant,
- Plan for transportation,
- A birth companion, and
- Identification of compatible blood donors in case of emergency.

Counselling Birth preparedness and complication readiness 4 out of 10 pregnant or postpartum women will experience some complication related to their pregnancy; for about 15% of these

women, the complication will be potentially life-threatening and will require immediate emergency obstetric care. Since most of these complications cannot be predicted, every pregnancy necessitates preparation for a possible emergency.

Birth preparedness: Identification of a skilled provider for birth: All pregnant women should be helped to reach a decision regarding the health provider they want for conducting their delivery. An **SBA should be preferred** over an unskilled one. (Note that TBAs, trained or untrained, do not fall into the category of SBAs). Other factors such as the condition of the pregnancy (complicated or uncomplicated), the distance to the provider, transport facilities, financial situation, etc. all need to be kept in mind before finally reaching a decision about the choice of birth attendant.

ALL PREGNANT WOMEN MUST BE ENCOURAGED TO OPT FOR AN INSTITUTIONAL DELIVERY. Explain to the woman why delivery at a health facility is recommended. Tell her that

- * Any complication can develop during delivery; complications are not always predictable; they can cost the life of the mother and/or the baby.
- * A health facility has staff, equipment, supplies and drugs available to provide the best care, if needed. It even has a referral system should the need to refer arise.

• **Delivery kit:** All pregnant women, especially when they are nearing completion of their term, should be equipped with supplies required for conducting the delivery at home, especially if the woman has decided to deliver at home. The kit is also required in case of emergencies, in case the woman cannot make it to the health facility in time, and is forced to deliver at home. If the woman, despite all arguments to the contrary, decides that she wishes to be delivered by the TBA you, as the health personnel providing ANC, must contact the TBA in question, and ensure that she knows how to conduct a clean delivery.

If a **delivery kit is not available**, the following items should be made available individually to ensure the **five "cleans"** (i.e. Clean surface, Clean hands, Clean cord cut, Clean cord tie and Clean umbilical stump):

- A clean plastic sheet (for ensuring "clean surface")
- Soap and clean water (for ensuring "clean hands")
- A new razor blade (for ensuring "clean cord cut")
- A clean piece of thread (for ensuring "clean cord tie")
- Nothing to be applied to cord (for ensuring a "clean cord stump ")

The other items that are required during and immediately after delivery include:

- Home-based antenatal card (for complete information regarding the antenatal period)
- Clean towels/cloth for washing, drying and wrapping the baby
- Clean clothes for the mother and the baby
- Sanitary pads/clean cloth for the mother
- Food and water for the woman and the support person.

Identify support people: These people are needed to help the woman care for her children and/or household, arrange for transportation, and/or accompany the woman to the health facility

in an emergency. Seek help from either the close relatives of the woman or community-based health functionaries such as the AWW and the TBA.

Finances: The woman and her family should be given an estimate of the expected expenses for the delivery and related aspects (such as transport, etc.). They should also be advised to keep some emergency fund, or have a source for emergency funding, should a complication arise and more money is required than initially anticipated.

You should also be aware of the existing schemes that provide funds for maternal health, and any other schemes that may be launched from time to time.

Help the women and their families access these schemes and receive the allocated funds to pay for the delivery

Preparing for Safe Delivery:

Labour Process: Challenges

- Multiple stages, client may be at different places during different stages
- Long duration, provider may change during the process
- Multiple actions need to be performed
- All actions need to be performed at appropriate times e.g. Uterotonic should be given immediately after birth during third stage Baby, if not crying spontaneously, should be revived within 1 minute of delivery
- Complications can occur any time and in any case

The Safe Childbirth Checklist

- Is a tool focusing on essential practices for safe childbirth • Aims to help the service providers to:
 - o Know what essential activities need to be performed
 - o Know when these essential activities need to be performed
 - o Know how to perform these activities• Breaks down the care process into 4 pause points or checks

What is a Pause Point/Check?

It is a time during the delivery process where the service provider can briefly stop and : -

Review the condition of the woman and the newborn baby

- Check whether he/she has performed all the essential activities for safe care

- Prepare for safe care activities that need to be performed next

What is a Pause Point/Check?
On Admission Just Before and during birth (or Cesarean), At Discharge, Soon After Delivery (within 1 hour)

The Checklist Is Organized Around

Check 1, On Admission

- This is the first contact of the mother with us. We can pause and review whether we have assessed mother properly, briefed the mother and companions about the process, and are prepared for her delivery in the facility
- If the mother's condition cannot be managed in this facility, she can be referred

Check 2, Just Before and During Birth (or Cesarean)

We can review our preparation for the delivery immediately before delivery, as we might not have time to look for necessary supplies when delivery is happening

- “Golden Minute” for the Baby, look for PPH for mother

Check 3, Soon After Birth (within 1 hour)

The first hour after the delivery is important for both mother and babies as the mother is recovering after the delivery and the baby is transitioning from a life in the womb to that in the world

- We can pause at this time to review that mother and baby are fine and ensure practices such as breast feeding and skin to skin contact

Check 4, At Discharge

The mother and baby are leaving from the facility and hence our constant supervision • This is an important time to pause and review their condition before discharge and give appropriate follow up advice

Key Messages:

- Intra and immediate postpartum period is the most risky period for mother and baby
- There are 4 checks or pause points in SCC related to the stages of labor with the key activities to be performed at each point
- SCC helps service providers remember key activities to perform timely and in a standardized way to improve quality of care during childbirth and immediate postpartum period.

Safe Birthing Checklist: Before Birth

Registration No.

Check 1

On Admission

Record temperature of mother:.....
Record BP of mother:.....
Record Fetal Heart Rate (FHS):

Does Mother need referral?

- ☐ No
- ☐ Yes, organized

Partograph started?

- ☐ No, will start at ≥ 4 cm
- ☐ Yes

Does Mother need:

Antibiotics?

- ☐ No
- ☐ Yes, given

Magnesium sulfate?

- ☐ No
- ☐ Yes, given

Corticosteroid

- ☐ No
- ☐ Yes, given

HIV status of Mother:

- ☐ Positive
- ☐ Negative
- ☐ Not known

☐ Encourage birth companion to be present at birth

Are soap, water and gloves available?

- ☐ No
- ☐ Yes, I will wash hands and wear gloves for each vaginal exam

☐ Confirmed that Mother or companion will call for help during labour if needed

Refer to FRU/higher centre if any of following danger signs are present and state reason on transfer note:

- ☐ Vaginal bleeding
- ☐ High fever
- ☐ Severe headache and blurred vision
- ☐ Convulsions
- ☐ Severe abdominal pain
- ☐ History of heart disease or other major illnesses
- ☐ Difficulty in breathing

Start when cervix ≥ 4 cm then cervix should dilate ≥ 1 cm/hr

- ☐ Every 30 min plot contractions, FHR, and maternal pulse, colour of amniotic fluid
- ☐ Every 4 hours: plot temperature, blood pressure, and cervical dilation in cm

Give antibiotics to Mother if:

- ☐ Mother's temperature $> 38.0^{\circ}\text{C}$ ($> 100.50^{\circ}\text{F}$)
- ☐ Foul-smelling Vaginal discharge
- ☐ Rupture of membranes > 12 hrs without labor or > 18 hrs with labour
- ☐ Labor > 24 hrs on obstructed labor
- ☐ Rupture of membranes < 37 wks gestation

If mother has systolic BP ≥ 140 or diastolic ≥ 90 along with proteinuria upto 2+ AND has any one of the following, give magnesium sulfate — manage as per the level of facility

- ☐ Convulsions
- ☐ Increase in BP with proteinuria with systolic ≥ 160 or diastolic ≥ 110 along with proteinuria 3+ or more
- ☐ Presence of any symptom like:
 - Severe headache
 - Pain in upper abdomen
 - Blurring of vision
 - Oliguria (passing < 400 ml urine in 24 hrs)

If there is premature onset of labor (between 23 to 34 weeks), ensure corticosteroids are given to mother for fetal lung maturity

If HIV+ and in labour:

- ☐ Give Nevirapine
- ☐ If not available, refer the patient immediately after birth
- ☐ Advise testing

Call for help if any of

- Bleeding
- Severe abdominal pain
- Difficulty in breathing
- Severe headache and blurred vision
- Urge to push
- Cannot empty bladder frequently

Check 2**Just Before Pushing (or Before Caesarean)**

Does Mother need:

Antibiotics?

- ☐ No
- ☐ Yes, given

Magnesium sulfate?

- ☐ No
- ☐ Yes, given

Give antibiotics to Mother if any of:

- ☐ Mother's temperature > 38.0°C (>100.5°F)
- ☐ Foul-smelling vaginal discharge
- ☐ Rupture of membranes > 18 hrs with labor
- ☐ Labor > 24 hrs on obstructed labor now
- ☐ Cesarean section

If mother has systolic BP ≥ 140 or diastolic ≥ 90 along with proteinuria upto 2+ AND has any one of the following, give first dose of magnesium sulfate and refer immediately to FRU/ higher centre:

- ☐ Convulsions
- ☐ Increase in BP with proteinuria with systolic ≥ 160 or diastolic 110 along with proteinuria 3+ or more
- ☐ Presence of any symptom like:
 - Severe headache
 - Blurring of vision
 - Pain in upper abdomen
 - Oligouria (passing <400 ml urine in 24 hrs)

Confirm essential supplies are at bedside:

For Mother

- ☐ Gloves
- ☐ Soap and clean water
- ☐ Oxytocin 10 units in syringe
- ☐ Pads for Mother

Prepare to care for Mother immediately after birth

- ☐ Confirm single baby only (not multiple birth)
- ☐ Give oxytocin IM within 1 minute
- ☐ Controlled cord traction to deliver placenta
- ☐ Massage uterus after placenta is delivered

For Baby

- ☐ Clean towel
- ☐ Sterile scissors/blade to cut cord
- ☐ Cord ligature
- ☐ Mucus extractor
- ☐ Bag-and-mask

Prepare to care for Baby immediately after birth

- ☐ Dry baby, wrap, and keep warm, give vit. K
- ☐ If not breathing: stimulate and clear airway
- ☐ If still not breathing:
 - ☐ Cut cord
 - ☐ Ventilate with bag-and-mask
 - ☐ Shout for help (pediatrician/F-IMCI doctor if available).

- ☐ Skilled assistant identified and ready to help at birth if needed?

After Birth - Safe Childbirth Checklist

Registration No.

Check 3

Soon After birth (within 1 hour)

Record temperature of mother:.....
Record BP of mother:.....
Record temperature of baby:.....
Record respiratory rate of baby:.....

Is Mother bleeding too much?

- ☐ No
- ☐ yes, shout for help

Does Mother need:

Antibiotics?

- ☐ No
- ☐ Yes, given

Megneslum sulfate?

- ☐ No
- ☐ Yes, given

Does Baby need:

Antibiotics?

- ☐ No
- ☐ Yes, given

Referral?

- ☐ No
- ☐ Yes, organized

Special Care and monitoring?

- ☐ No
- ☐ Yes, organized

Zidovudine?

- ☐ No
- ☐ Yes, given

- ☐ Started breastfeeding and skin-to-skin contact (if mother and baby well). Explain that colostrum feeding is important for baby
- ☐ Explain the danger signs and confirm mother/companion will call for help if danger signs present

If bleeding is > 500ml, or 1 pad soaked in < 5 min:

- ◆ Massage uterus
- ◆ Start I/V fluids
- ◆ Treat cause
- ◆ If placenta not delivered or completely retained: give IM or IV Oxytocin, stabilize, and refer to FRU/higher centre
- ◆ If placenta is incomplete: remove if any visible pieces, and refer immediately to FRU/higher centre

Give antibiotics to Mother if manual removal of placenta performed, or if Mother's temperature $\geq 38^{\circ}\text{C}$ ($>100.5^{\circ}\text{F}$) and any of:

- ☐ Chills
- ☐ Foul-smelling Vaginal discharge
- ☐ Lower abdominal tenderness
- ☐ Rupture of membranes > 18 hrs. now
- ☐ Labor > 24 hours now

If mother has systolic BP ≥ 140 or diastolic ≥ 90 along with proteinuria upto 2+ AND has any one of the following, give first dose of magnesium sulfate and refer immediately to FRU/ higher centre:

- ☐ Convulsions
- ☐ Increase in BP with proteinuria with systolic ≥ 160 or diastolic ≥ 110 along with proteinuria 3+ or more
- ☐ Presence of any symptom like:
 - Severe headache
 - Blurring of vision
 - Pain in upper abdomen
 - Oligouria (passing < 400 ml urine in 24 hrs)

Give Baby antibiotics if antibiotics were given to Mother, or if Baby has any of:

- ☐ Breathing too fast ($> 60/\text{min}$) or too slow ($< 30/\text{min}$)
- ☐ Chest in-drawing, grunting, or convulsions
- ☐ Looks sick (lethargic or irritable)
- ☐ Too cold (Baby's temp $< 36^{\circ}\text{C}$ and not rising after warming) or too hot (Baby's temp $> 38^{\circ}\text{C}$)

Refer baby to FRU/higher centre if:

- ☐ Any of the above (antibiotics indications)
- ☐ Baby looks yellow, pale or blush

Arrange special care/monitoring for Baby if any of:

- ☐ Preterm baby
- ☐ Birth weight < 2500 gms
- ☐ Needs antibiotics
- ☐ Required resuscitation

Give if mother is HIV+

After Birth - Safe Childbirth Checklist

Registration No.

Check 4

Before Discharge

Is Mothers bleeding controlled ?

- ☐ No, treat, observe and refer to FRU/higher centre if needed
- ☐ Yes:

Record temperature of mother:.....
Record BP of mother:.....
Record temperature of baby:.....
Record respiratory rate of baby:.....

Does Mother need antibiotics?

- ☐ No
- ☐ Yes: Give antibiotics and delay discharge

Give antibiotics to mother if mother has any of:

- ☐ Mother's temperature $>38^{\circ}\text{C}$ or $>100.5^{\circ}\text{F}$
- ☐ Chills
- ☐ Foul-smelling vaginal discharge
- ☐ Lower abdomen tenderness

Does Baby need antibiotics?

- ☐ No
- ☐ Yes, give, delay discharge and refer to FRU/higher centre

Give Baby antibiotics if baby has any of:

- ☐ Breathing too fast ($>60/\text{min}$) or too slow ($<30/\text{min}$)
- ☐ Chest in-drawing, grunting, or convulsions
- ☐ Looks sick (lethargic or irritable)
- ☐ Too cold (baby's temp $<36^{\circ}\text{C}$ and not rising after warming) or too hot (baby's temp $>38^{\circ}\text{C}$)
- ☐ Stopped breastfeeding
- ☐ Umbilicus redness extending to skin or draining pus/any other discharge

Is Baby feeding well?

- ☐ No, help, delay discharge, refer to FRU/higher centre if needed
- ☐ Yes, teach mother exclusive breastfeeding
- ☐ Arrange transport home and follow-up for mother and baby
- ☐ Discuss and offer family planning options to mother
- ☐ Explain the danger signs and confirm mother/companion will seek help if danger signs are present after discharge

Danger Signs

Mother has any of:

- ☐ Bleeding
- ☐ Severe abdominal pain
- ☐ Severe headache or visual disturbance
- ☐ Breathing difficulty
- ☐ Fever or chills
- ☐ Difficulty emptying bladder

Baby has any of:

- ☐ Fast/difficulty breathing
- ☐ Fever
- ☐ Unusually cold
- ☐ Stops feeding well
- ☐ Less activity than normal
- ☐ Whole body becomes yellow

Intra-partum Care

Introduction

Normal labour is a spontaneous process of expulsion of the foetus and placenta. However it is important to remember that during the intra partum period the woman and the baby go through physical as well as mental trauma. You, as an SBA, have the responsibility of providing the necessary care for the management of labour as well as emotional support, and must ensure a successful outcome for the mother and the baby.

Assessment, Supportive Care and Vaginal Examination during Labour

Assessment

Assessment consists of the following components:

- Inquire about the woman's history of labour, asking the following questions:
 - When did the contractions begin?
 - How frequent are the contractions? How strong are they?
 - Has there been any watery discharge? If so, what colour was it?
 - Has there been any bleeding? If so, how much?
 - Is the baby moving?
 - Are there any other complaints?
- Check the woman's record for history of the present pregnancy, e.g. the haemoglobin status, TT immunisation, Rh status, any complications and any other significant history.
- If there is no record, then ask the following:
 - When was the LMP/what is the period of amenorrhea? On this basis, determine the EDD.
 - Ask for the history of any past pregnancy.
 - Any other significant history.
- Conduct general physical examinations; record the temperature, pulse, blood pressure and weight, and check for pallor, oedema, and so on. Conduct an abdominal examination to assess the foetal lie and presentation, FHR, and frequency and duration of contractions.
- Conduct a P/V examination to decide the stage of labour (as mentioned later in this section).

Vaginal examination

During a vaginal examination, determine the following:

- A. Pelvic adequacy
- B. Progress of labour
- C. Stage of labour

Remember

- Vaginal examinations are rarely required during pregnancy.
- During labour, vaginal examination should not be attempted more than once every four hours (to avoid unnecessary infection).

Do not carry out a vaginal examination if the woman is bleeding at the time of Labour or at any time during pregnancy. Manage this as a case of 'vaginal bleeding in pregnancy'

- Do not start a vaginal examination during a contraction.

Steps for doing a P/V examination:

- Do not shave the perineal area.

- Explain to the woman what is being done and always ask for her consent before doing a vaginal examination.
- Ask the woman to pass urine.
- Wash your hands with soap and water before and after each examination. Carry out the vaginal examination under strict aseptic conditions.
- Place the woman in the supine position with her legs flexed and apart.
- Perform the vaginal examination very gently, wearing clean/sterile gloves.
- Clean the vulva and perineal area with a mild antiseptic solution. Wipe the vulva first, then labia majora and lastly labia minora with cotton swabs from the anterior to the posterior direction. Use a swab only once. Use separate swabs for each side.
- Separate the labia with the thumb and forefinger of the left hand and clean the area once again.
- Use two fingers of the right hand (index and middle fingers) and insert them gently into the vaginal orifice without hurting the woman.

A. Pelvic adequacy

Pelvic assessment is important in the case of both primigravidas and multigravidas, who have a past history of prolonged or difficult labour, which could be associated with Cephalopelvic Disproportion (CPD).

Table 1: Pelvic Assessment

Parameter	Adequate	Suggestive of abnormality
Sacral promontory	Not felt	Felt easily
Diagonal Conjugate*	>11.5 cms	< 11.5 cms
Sacral curvature	Well curved	Flat
Lateral Pelvic walls	Parallel	Converging
Ischial spines	Both cannot be palpated simultaneously	Both spines can be palpated simultaneously
Subpubic Angle	Accommodates two fingers (85°)	Acute
Inter tuberos diameter	Accommodates closed fist (4 Knuckles)	Cannot accommodate 4 knuckles

* If sacral promontory is felt, the distance between the sacral promontory and the lower border of pubic symphysis is measured.

Clinical Examination for CPD

- Place the woman in dorsal position.
- Hold the fetal head by left hand.
- Place two fingers of gloved right hand into the vagina at the level of ischial spines.
- Place the thumb of right hand on the pubic symphysis.
- Push the head into the pelvic inlet and note whether it descends into the pelvis (felt by fingers in vagina) or overhangs on the public symphysis.
- If head descends with no overlap at public symphysis : No inlet CPD.
- If the head is engaged it indicates that the pelvic inlet is adequate.

B. Determining progress of labour—cervical effacement and cervical dilatation in centimeters

Assessing cervical effacement and dilatation during a vaginal examination is important to monitor the progress of labour.

- **Cervical effacement:** This is progressive shortening and thinning of the cervix during labour.
- **Cervical dilatation:** This is an increase in the diameter of the cervical opening in centimeters (distance in centimeters between the outer aspects of both examining fingers.) A fully dilated cervix has an opening of 10 cm—at this stage, the cervix is no longer felt on vaginal examination.

Normal effacement and dilatation will facilitate expulsion of the foetus in the second stage of labour

Table2: Recognizing True Labour

True labour pains	False labour pains
Regular and predictable	Irregular
Felt first in lower back and sweeps towards lower abdomen	Remains confined to lower abdomen
Not relieved by rest	Often relieved by rest
Increase in duration, intensity and frequency with time	Does not increase in duration, intensity or frequency
“Show” blood stained mucus discharge present	“Show” absent
Accompanied by cervical changes	Not accompanied by cervical changes

STAGES OF LABOUR:

Key Actions associated with Stages of Labour:

- Stage 1 – Monitoring of labour with partograph
- Stage 2 – Preparation for birth of baby
- Stage 3 – Performing AMTSL
- Stage 4 – Review of condition of mother and newborn

1. **First stage:** From onset of labour pains till full dilatation of cervix. Has two parts:

- **Latent Phase** (maximum 8 hours)
 - Cervix dilatation < 4 cms
 - 2 or less contractions per ten minutes
- **Active phase**
 - Cervix dilatation > or = 4 cms
 - Contractions 3 or more per 10 min lasting >40 sec
 - Rate of cervical dilatation 1cm / hour or more

True labour pains are associated with changes in cervical condition

2. **Second Stage of Labour:**

Part of labour beginning with full dilatation of cervix and ends with the expulsion of the foetus

- Normally lasts between 1 – 2 hours

Care during Early part of Second Stage:

Watch for signs of imminent delivery (provide supportive care)

Gaping of vulva
Thinning and bulging of perineum
Pouting of anus
Head of the baby seen at vulva
Urge to push

- Encourage the woman to push during contractions when she has an urge to do so while taking deep breaths

✓	<ul style="list-style-type: none">• When the cervix is fully dilated, during a contraction, encourage the woman to take deep breaths and push down.
X	<ul style="list-style-type: none">• Bearing down efforts are not required until the head has descended into the perineum. Therefore, the woman should be advised not to push actively until the foetal head is distending the perineum.• Occasionally, the woman may feel the urge to push before the cervix is fully dilated. This must be discouraged as it can result in oedema of the cervix, which may delay the progress of labour.• Do not apply fundal pressure on the abdomen to facilitate expulsion of the baby.

Supporting Delivery of Head

- Clean the perineum with anti-septic solution with strokes of swabs from above downward
- Ensure controlled delivery of the head:
- Keep one hand gently on the head as it advances with contractions.
- Support perineum with other hand and cover anus with pad held in position by palm of the hand during delivery.
- Ask the mother to breathe steadily and push only during contraction.
- Encourage rapid breathing with mouth open.
- Allow spontaneous rotation and restitution of head after delivery

Managing Cord around Neck

Feel gently around the baby's neck for presence of umbilical cord. If it is loose around the neck, deliver the baby through the loop of the cord, or slip the cord over the baby's head. If it is tight around the neck, doubly clamp and cut in between.

Delivery of Shoulders and Rest of the Body

- Wait for the spontaneous rotation and delivery of the shoulders. This usually happens within 1-2 minutes of delivery of head
- Apply gentle pressure downwards to deliver the top (anterior) shoulder
- Then lift the baby up, towards the mother's abdomen, to deliver the lower (posterior) shoulder
- Rest of the baby's body follows smoothly
- Note the time of birth

3. Third stage of labour:-

Active Management of the Third Stage of Labour (AMTSL)

AMTSL is recommended for all deliveries and consists of the following three activities:

- a. Uterotonic drug—.**
- b. Controlled cord traction.**
- c. Uterine massage.**

a) Uterotonic drug

Inj. Oxytocin is the drug of choice for all health facilities (including SC), whereas Tab. Misoprostol is to be used when adequate refrigeration of Injection Oxytocin is not possible during high temperature. Tab. Misoprostol can also be used for home delivery or any OR delivery

An uterotonic drug enhances contraction of the uterine muscles, thereby facilitating expulsion of the placenta and diminishing bleeding. Th is helps to prevent PPH. An uterotonic drug should be given after the delivery. Rule out the presence of another baby before giving the uterotonic drug.

- Oxytocin is the drug of choice for AMTSL at the SC/PHC/FRU/health facility. It should be kept at a temperature 4-8°C but should not be frozen. It should ideally be stored in a refrigerator.
- Administer 10 units of oxytocin injection (intramuscular) to the mother if the delivery has taken place at the SC/PHC/FRU/health facility or give her a Tablet Misoprostol tablet (600 mcg) orally if the mother has been delivered at home and Injection Oxytocin is not available due to the problems of high ambient temperatures and unavailability of a refrigerator.
- You can also use it at the SC/PHC in case an Oxytocin injection is not available or if there are problems related to refrigeration. Inform the woman that shivering and gastrointestinal disturbances are common side-eff ects of Misoprostol, and should not be a cause for worry.

b) Controlled Cord Traction (CCT)

CCT is a technique that assists in the expulsion of the placenta, and helps to reduce the chances of a retained placenta and subsequent bleeding, i.e. PPH.

- Clamp the maternal end of the umbilical cord close to the perineum with a pair of artery forceps.
- Hold the clamped end of the cord with one hand.
- Place the other hand on the mother's abdomen to feel the uterine contraction.
- Maintain slight tension on the cord.

When the uterus contracts, as will be evidenced by the uterus becoming hard and globular, gently pull downwards on the cord to deliver the placenta. Simultaneously, place one hand just above the pubic symphysis to apply counter-traction (pressure in the opposite/upward direction towards the umbilicus) on the uterine fundus.

- If the placenta does not descend within 30–40 seconds of CCT, do not continue to pull on the cord.
- Wait for the uterus to contract strongly again and repeat CCT with counter-traction.
- Do not exert excessive traction on the cord while performing CCT. Do not repeat the manoeuvre more than once.
- As the placenta delivers, hold it with both hands to prevent tearing of the membranes.

Normally, the placenta delivers within five minutes of the birth of the baby if the third stage of labour is managed actively.

- If the membranes do not slip out spontaneously, gently turn the placenta so that the membranes are twisted into a rope and move them up and down to assist separation. If pulled at, the thin membranes can tear off and get retained in the uterus.
- If the membranes tear, use your fingers or a pair of sponge forceps to remove any pieces placenta of membrane that might be present.
- Ensure that the placenta is delivered completely with all Uterus the membranes. Retained placental fragments or pieces of membrane will cause PPH. This can be suspected if a portion of the maternal surface of the placenta is missing or the membranes with their vessels are torn.
- If the placenta is not delivered after 30 minutes give inj.Oxytocin or Tablet Misoprostol, refer the woman to an FRU. Information on the drugs given, the dosage and time of administration on the referral slip, should also be sent along with the woman.
- **Remember, you should never apply cord traction (pull) without a contraction and without applying counter traction (push) above the pubic symphysis with the other hand.**

Examination of the placenta, membranes and the umbilical cord

Examine the placenta and the membranes for completeness as follows:

- Maternal surface of the placenta:
- Hold the placenta in the palms of the hands, keeping the palms flat and the maternal surface facing you. Look for the following:
- All the lobules (15–20) must be present.
- The lobules should fit together.
- There should be no irregularities in the margins.
- If any of the lobes are missing or the lobules do not fit together, suspect that some placental fragments may have been left behind in the uterus.

Foetal surface

- Hold the umbilical cord in one hand and let the placenta and membranes hang down like an inverted umbrella.
- The umbilical vessels will be seen passing from the cord and gradually fading into the edge of the placenta.
- Look for free-ending vessels and holes which may indicate that a lobule has been left behind in the uterus.
- Look for the insertion of the cord, particularly the velamentous insertion (the point where the cord is inserted into the membranes and from where it travels to the placenta).

Membranes

- Both the layers (chorion and amnion) can be seen at the edge of the hole where the membranes rupture and the foetus comes out.
- If the membranes are ragged, place them together and make sure that they are complete.
- Umbilical cord
- Normally, the umbilical cord has two arteries and one vein. If only one artery is

found, look for congenital malformations in the baby.

c) Uterine massage

This technique helps in contraction of the uterus and thus prevents PPH.

- Immediately after delivery of the placenta, massage the fundus of the uterus through the woman's abdomen until it is well contracted. Repeat the uterine massage every 15 minutes for the first two hours.
- Ensure that the uterus does not become relaxed (soft) after you stop the uterine massage. If the uterus remains soft and flabby, the woman may be suffering from Atonic PPH.
- Approximately 66% cases of PPH can be prevented if AMTSL is done in all cases after delivery
- It helps in expulsion of placenta and reduction in blood loss to mother

Key Messages

- Encourage woman to push down only during contractions and after she feels an urge to push
- Ensure delayed cord clamping and cutting (after 1-3 minutes of delivery of baby)
- Perform active management of third stage of labour in all cases to help in separation of placenta and prevent PPH: Give uterotonic (injection Oxytocin 10 IU IM) immediately after the delivery of baby
- Perform controlled cord traction to help deliver the placenta
- Perform uterine massage

After delivery:

- Examine the perineum, vulva, lower vagina for tears.
- Examine the placenta and membranes carefully for completeness and any abnormality
- Observe the mother every 15 minutes for two hours for general condition, pulse, vaginal bleeding, pallor, uterine contraction.
- Repeat uterine massage every 15 minutes for 2 hours
- Encourage mother to take the baby to breast within ½ hour of delivery.

4. Fourth stage of labour

The first two hours after the delivery of the placenta are referred to as the fourth stage of labour. This stage comprises both observation and care of the mother and newborn. The mother and her newborn should not be separated, unless required.

Care of the mother

- After the delivery of the placenta, check to see if the uterus is well contracted (i.e. it is hard and round) and ascertain that there is no heavy bleeding. Repeat the check every 15 minutes.
- If the uterus is not well contracted and there is bleeding, massage the uterus and expel the clots. If the bleeding continues, manage as indicated under 'Management of postpartum haemorrhage'.
- Examine the perineum, lower vagina and vulva for tears. If present, manage accordingly.

- Clean the woman and the area beneath her. Put a sanitary pad or a folded cloth under her buttocks to collect the blood. Counting the number of pads/cloths soaked will help in estimating the amount of blood lost.
- Estimate the amount of blood loss throughout the third stage of labour and immediately afterwards. If the bleeding has stopped, observe the woman for the next 24 hours. If bleeding has not stopped, then manage as post-partum haemorrhage, as per steps given in module II.
- Check the following every 15 minutes for the first two hours:
 - General condition, blood pressure and pulse
 - Vaginal bleeding
 - Uterus, to make sure that it is well contracted.
- Dispose of the placenta and others waste according to BMW 2016 guidelines.
- Counsel the mother to breastfeed, including colostrum feeding, within an hour of the birth. Ask her to take warm fluids, eat well, take adequate rest, sleep and maintain hygiene. The latter would include maintaining perineal hygiene, taking a bath every day and washing her hands before handling the baby.
- Encourage the woman to pass urine. If the woman has difficulty in passing urine, or the bladder is full (as evidenced by a swelling over the lower abdomen just above the symphysis pubis) and she is uncomfortable, help her pass urine by gently pouring warm water over her vulva.
- Ask the birth companion to stay with the mother and not leave her and the newborn alone. Ask the companion to call for help if any of the following conditions occur:
 - Excessive bleeding per vaginum
 - Dizziness, severe headache, visual disturbance or epigastric pain
 - Convulsions
 - Increased pain in the perineum
 - Urinary incontinence or inability to pass urine.

Care of the newborn

- Place an identity label with the mother's name and any other identification information as may be required on the baby's wrist or ankle, if not done earlier.
- Give the baby a vitamin K injection 1.0 mg, intra muscular to all newborns weighing 1500 gms and above and in a dose of 0.5 mg to newborns weighing less than 1500 gm. As per the current provision SNs/LHVs are permitted to administer Injectable drugs like Vitamin K to new born.
- The site for the injection is the quadriceps muscle group of the upper, outer thigh by Sterile 1-inch needle of the smallest size, available.
- Vitamin K is needed for prevention of hemorrhagic disease of new born. Babies have very little vitamin K in their bodies at birth. Vitamin K does not cross the placenta into the developing baby, and the gut does not have any bacteria to make vitamin K before birth. There is very little vitamin K in breast milk and it takes several weeks before the normal gut bacteria start making it.
- Examine the baby quickly for malformations or any birth injury. If there is major malformation or severe birth injury, refer the baby to the newborn unit in the FRU. Ensure that the baby is warm during the examination and when being transported. Check the baby's colour and breathing every five minutes.

- If the baby becomes cyanotic (bluish) or is having difficulty in breathing (less than 30 or more than 60 breaths per minute), make initial attempts at resuscitation. If this does not help, a referral to the MO at the FRU is necessary.
- Check if the baby is warm, by feeling his/her feet every 15 minutes.
- If the baby's feet feel cold, check the axillary temperature.
- If the baby's temperature is below 36.5°C, provide warmth to the baby by placing him/her under a radiant warmer.
- Teach the mother to provide skin-to-skin contact, a component of Kangaroo Mother Care (KMC).
- Two components of KMC are skin-to-skin contact and exclusive breastfeeding.

Check the cord for bleeding every 15 minutes.

- If the cord is bleeding, re-tie it more tightly.
- Do not apply any substance to the stump.
- Leave the stump uncovered and dry.
- Wipe off any meconium or blood from the baby's skin.
- Encourage breastfeeding within an hour of birth.
- Emphasise the importance of colostrum, which helps to protect the baby against infections.
- Check if the baby's position and his/her attachment to the breast are correct at the first feed.

The baby can feed whether the mother is lying down or sitting. What is important is that both mother and baby should be comfortable.

- Do not give artificial teats or pre-lacteal feeds, such as sugar water or local foods, or even water to the newborn.
- Weigh all babies before they leave the delivery room.
- Delay the baby's first bath to beyond 24 hours of birth.
- Ensure that the baby is dressed warmly and is with the mother.
- Watch for complications such as convulsions, coma and feeding problems. Refer the baby if these are present.

Post-partum Care

KEY MESSAGES

Mother

- Make at least four post-partum visits to ensure that complications during the post-partum period are recognised in time.
- Look out for symptoms and signs of PPH and puerperal sepsis during post-partum visits as they are the major causes of maternal mortality.
- Advise the mother on colostrum feeding and exclusive breastfeeding.
- Advise the couple on family planning.

Newborn

- Keep the baby warm.
- Ensure care of the umbilicus, skin and eyes.
- Ensure good suckling while breastfeeding.
- Screen the newborn for danger signs.
- Advise the mother and family members on immunisation.

POSTPARTUM CARE

Conventionally, the first 42 days (six weeks) after delivery are considered the post-partum period. The first 48 hours of the post-partum period, followed by the first one week, are the most crucial period for the health and survival both of the mother and her newborn. Most of the fatal and near-fatal maternal and neonatal complications occur during this period. Evidence has shown that more than 60% of maternal deaths take place during the post-partum period.

PPH—blood loss of 500 ml or more following and up to six weeks after delivery

- Types of PPH:
- Immediate PPH/primary PPH—during and within 24 hours of delivery
- Delayed PPH/secondary PPH—after 24 hours of delivery until six weeks postpartum

Bleeding during and within 24 hours of delivery (immediate PPH)

PPH is defined as the loss of 500 ml or more of blood during or within 24 hours of the birth and up to six weeks after delivery.

PPH may be immediate or delayed.

Immediate PPH may be due to a number of causes, such as:

- Atonic uterus
- Tears in the lower vagina, cervix or perineum
- Retained placenta or placental fragments
- Inverted or ruptured uterus.

The general steps to be taken for the management of PPH, before referring the woman to an FRU, are as follows:

- Evaluate her general condition and look for signs of shock (cold, clammy skin), check the level of consciousness, pulse (should not be weak or fast, at 110 per minute or

more), blood pressure (systolic should not be less than 90 mmHg), respiration (the RR should not be more than 30 breaths per minute) and temperature

- Monitor the vital signs every 15 minutes and estimate the amount of blood loss.
- Try and ascertain the cause of PPH using the flowchart given above.
- Give the woman an Oxytocin injection (10 IU, intramuscular stat). (If she has already
- Received a prophylactic Oxytocin injection or a Misoprostol tablet during AMTSL, this is not required).
- Massage the uterus to expel blood and blood clots. Blood clots trapped in the uterus will inhibit effective contractions.
- Establish an intravenous line and start an intravenous infusion of Ringer Lactate or normal saline. Do not use dextrose solutions unless others are unavailable.
- Add 20 IU of oxytocin to 500 ml of Ringer Lactate/normal saline that is running intravenously at the rate of 40–60 drops per minute. (If an intravenous line cannot be established, give her an intramuscular Oxytocin injection (10 IU) stat).
- If the bleeding persists and the uterus continues to be in the relaxed state (i.e. it is soft), make arrangements for transporting the woman to the FRU, where facilities for blood transfusion and appropriate surgical care are available.
- Do not give the woman anything to eat or drink since she may require an obstetric intervention under anaesthesia.
- If the woman is bleeding heavily, i.e. soaking one pad or cloth in less than five minutes, or if she is in shock, give her fluids rapidly (60 drops per minute) through another drip.
- Raise the foot end of the bed so that her head is lower than her body. This will help increase the flow of blood to the heart.
- Keep the woman warm and covered with a blanket. If she is in shock, she might feel cold even in warm weather.
- Utilise the intervening time to perform bimanual compression.

2. CHILD HEALTH

CARE AT BIRTH

Introduction

The first 24 hours of life is a very significant and highly vulnerable time due to critical transition from intrauterine to extra uterine life. Effective care at birth is needed for anticipation of problems with this transition and to provide support to ensure stabilization.

Steps for care at birth

1. Call out time of birth
2. Receive the baby onto a warm clean towel and place on mother's chest
3. Clamp and cut the umbilical cord
4. Dry the baby with a warm, clean towel or piece of cloth
5. Assess baby's breathing while drying
6. Wipe both eyes (separately) with sterile gauze pieces
7. Put the baby between mother's breasts for skin-to-skin contact
8. Place an identity label on the baby
9. Cover mother and baby with warm cloth; put a cap on the baby's head
10. Initiate breastfeeding

The four basic needs of ALL newborns at the time of birth and for the first few weeks of life are:

1. Thermal protection
2. Normal breathing
3. Mother's milk
4. Protection from infection

1. Thermal protection

Newborn baby's temperature falls within seconds of being born. There are 4 ways by which a baby may lose heat. If the temperature continues to fall the baby will become sick and may even die.

Method of heat loss	Prevention
Evaporation (e.g. Wet baby)	Immediately after birth dry baby with a clean, warm, dry cloth
Conduction (e.g. contact with a cold surface of a weighing scale).	Put the baby on the mother's abdomen or on a warm surface
Convection(e.g exposure to draught)	Provide a warm, draught free room for delivery at 25°C
Radiation (e.g. Cold surroundings)	Keep the room warm

At delivery:

- Ensure the delivery room is warm (25° C), with no draughts.
- Dry the baby immediately; remove wet cloth
- Wrap the baby with clean dry cloth
- Keep the baby skin-to-skin with mother

After delivery:

- Keep the baby clothed and wrapped; cover the head
- Postpone bathing particularly for small babies
- Keep baby close to the mother
- Use kangaroo care for stable LBW babies
- Show mother how to avoid hypothermia and to recognize
- Initiate breastfeeding

If mother and baby's separation is necessary, do the following.

- Wrap the baby in a clean dry warm cloth and place under a radiant warmer. If warmer is not available ensure warmth by wrapping the baby in a clean dry warm cloth and cover with a blanket. Ensure baby's head, hands and feet are covered.
- Re-start Skin-to-skin contact as soon as mother and baby can be roomed-in

2. Normal breathing

Oxygen is needed to keep the baby's brain and other vital organs normal. When the umbilical cord is cut the placenta is no longer a source of oxygen and the baby needs to support his oxygenation through the lungs.

Assess baby's breathing at the time of drying:

- If the baby is crying vigorously or breathing adequately, then no intervention is needed.
- Suction gently and quickly using bulb syringe or suction catheter.
- Start in the mouth then, the nose to prevent aspiration.
- If the baby is not breathing or gasping, then skilled care in the form of positive pressure ventilation etc. (i.e. RESUSCITATION) would be required

3. Mother's milk

Initiating breastfeeding

- Keep the baby in skin-to-skin contact between mother's breasts immediately after drying
- Help the mother in her first few attempts to breastfeed
- Make her and the baby comfortable
- Explain and show her proper positioning and attachment

Initiate breastfeeding within 1 hour

- Support mother to initiate breast feeding within the first hour.
- The baby's first feed of colostrums is very important because it helps to protect against infections.
- The baby can feed from its mother whether she is lying down or sitting; baby and mother must be comfortable

Do not give artificial teats or pre-lacteal feeds to the newborn e.g. sugar water or local foods or even water.

Even mothers who deliver by Cesarean Section or Assisted delivery should be supported for early breast feeding and should not be separated from their newborns

4. Prevention of Infections

At delivery: seven cleans

- Clean hand: Hands of attendants (washed with soap)
- Clean surface: Surface for delivery
- Clean Blade: Cutting instrument for cord(i.e. razor, blade)
- Clean Cord Tie: String to tie cord
- Clean Towel: Cloth to wrap baby and mother
- Clean Cord Stump
- Clean Water

Cord Care

- Apply a sterile tie tightly around cord at 2 cm and 5 cm from the abdomen
- Cut between the ties with a sterile instrument
- Observe for oozing blood every 15 minutes; if blood oozes, place a second tie
- Do not apply any substance to the stump
- DO NOT bind or bandage stump
- Leave stump uncovered

Care of the eyes

- No routine eye care is required
- Clean eyes immediately after birth with swab soaked in sterile water
- Use separate swabs for each eye; clean from medial to lateral side
- Do not put anything else in baby's eyes

Examine the baby quickly for malformations/birth injury

Quick but thorough clinical screening is essential to identify any life threatening congenital anomalies e.g meningomyelocele, omphalocele, anal atresia.

Weighing baby/ Anthropometric measurements

Weigh all babies before transfer from the delivery room.

POSTNATAL CARE

Examine the baby

- Count the breaths in one minute.
- Look for severe chest indrawing.
- Look and listen for grunting.
- Look at the umbilicus. Is it red or draining pus?
- Look for skin pustules. Are there 10 or more pustules or a big boil?
- Measure axillary temperature (if not possible, feel for fever or low body temperature):
 - Normal (36.5-37.4° C)
 - Mild hypothermia (36.0-36.4° C/ cold feet)
 - Moderate hypothermia (32.0° C – 35.9° C, cold feet and abdomen)
 - Severe hypothermia (< 32° C)
 - Fever (≥ 37.5° C/ feels hot)

- See if young infant is lethargic
- Look for jaundice are the face, abdomen or soles yellow?
- Look for malformations

ASSESS BREASTFEEDING

If infant has not fed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfeed for 4 minutes.

- Is the infant able to attach? To check attachment, look for:
 - Chin touching breast
 - Mouth wide open
 - Lower lip turned outward
 - More areola above than below the mouth
 - If not well attached, help the mother to position so that the baby attaches well to the breast.
 - Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)?
 - If not sucking well, then look for:
 - ulcers or white patches in the mouth(thrush).
 - If there is difficulty or pain while feeding, then look for
 - Engorged breasts or breast abscess
 - Flat or inverted or sore nipples

Look for Normal Phenomena

There are several phenomena after birth that is normal and mothers only need reassurance.

- **Milia, Epstein pearls, Mongolian Spots, capillary nevi**, etc. There are a few developmental variants which may be present and be of concern to the mother. The mother needs to be reassured.
- **Red rashes** on the skin may be seen on 2-3 days of life. These are normal.
- **Weight loss** of 6-8% (10-12% in preterm infants) in the first few days of life is normal and most infants regain their birth weight by 10-14 days.
- **Regurgitation of feeds and vomiting.** Unlike vomiting, non-projectile expulsion of stomach contents without force (regurgitation) is normal and simply needs advice regarding feeding technique.
- **Bowel disorders.** No medication should be prescribed for passage of stools after each feed (exaggerated gastro-colic reflex) as this is normal in some babies. From 3rd to 14days many exclusively breastfed babies pass loose stools (10-15 times/day) without illness/dehydration. These are transitional stools and require no medication.
- **Delayed passage of urine.** Non-passage of urine by 48 hours after birth may suggest urinary tract anomalies. Such babies need to be investigated. Crying before passing urine is normal.
- **Jitteriness** is abnormal only when it is excessive or persists even during feeding and then it may suggest hypoglycemia or hypocalcaemia.
- **Dehydration fever.** Transitory moderate fever (up to 38.50C) usually during the second or third day of life in summer months in an active baby, who sucks well, is normal and responds to lowering the environmental temperature.

- **Excessive crying.** Most baby cry when either they are hungry or are having discomfort such as due to full bladder before passing urine, wet napkin, nose block, etc. Excessive inconsolable crying or high-pitched crying is indicative of meningitis or any other painful inflammatory conditions.
- **Umbilical sepsis.** If there is pus discharge not extending to periumbilical skin, apply 10% Gentian violet or Povidone Iodine locally twice a day. However, if there is periumbilical erythema or induration administer syrup erythromycin – 40 mg/kg/day in 3-4 divided doses. If the newborn has any other high-risk factor, refer to a higher centre.
- **Umbilical granuloma.** A red flesh-like nodule at the base of umbilical cord can be managed by cautery with Silver Nitrate or application of common salt for 3 to 4 days.
- **Engorgement of breasts** in both sexes and vaginal bleeding after 4 days of birth is normal.

Cord Care

Instruct the mother not to apply anything on the cord and keep it dry. Umbilical cord is an important portal of entry for pathogenic organism. Umbilical stump must be inspected after 2-4 hours of clamping. Bleeding may occur at this time due to shrinkage of the cord and loosening of the ligature.

Skin and Eye Care

Babies are not bathed routinely in the hospital to prevent complications like hypothermia and infection, they may however be sponged with lukewarm water. No routine eye care is required.

Vitamin K

Give Vitamin K 1.0 mg (0.5 mg in preterm) IM if not already received at birth.

Counsel the mother

- Warmth.
- Breastfeed frequently.
- Advise mother to wash hands with soap and water after using the toilet and after cleaning the bottom of the baby.
- Advise mother regarding danger signs and care seeking.

Immunization

- The baby should receive BCG, OPV-0, Hepatitis B (HB-0)

Follow-up

Schedule a postnatal visit within the first week on day 3 and day 7 of delivery. Also visit on day 14, 21 and 28 if baby is LBW.

In the follow up the baby should be assessed for growth and development and early diagnosis and management of illnesses. In addition, health education of parents should be done. It is preferable that every baby is seen and assessed by a health worker at least once every month for 3 months and subsequently 3 monthly till 1 year.

MANAGEMENT OF HYPOTHERMIA

Introduction

Hypothermia can lead to hypoglycemia, bleeding diathesis, pulmonary hemorrhage, acidosis, apnea, respiratory failure, shock and eventually death. Neonatal hypothermia continues to be a very important cause of neonatal deaths due to lack of attention by health care providers.

Why are newborns prone to develop hypothermia?

- Larger surface areas
- Decrease thermal insulation due to lack of subcutaneous fat (LBW infant)
- Reduced amount of brown fat (LBW infant)

Mechanisms of heat loss

Newborn loses heat by evaporation (particularly soon after birth due to evaporation of amniotic fluid from skin surface), conduction (by coming in contact with cold objects- cloth, tray, etc.) convection (by air currents in which cold air replaces warm air around baby – open window, fans) and radiation (to colder solid objects in vicinity-walls). The process of heat gains is by conduction, convection and radiation.

Concept of warm chain

In order to prevent heat loss which can occur in a newborn after delivery, the baby must be kept warm at all times right from birth. Satisfactory control of temperature demands both prevention of heat loss and promotion of heat gain. The "warm chain" is a set of 10 interlinked interventions carried out at birth and later, which will minimize the likelihood of hypothermia in all newborns:

- Warm delivery room (26-28°C)
- Warm resuscitation
- Immediate drying
- Skin-to-skin contact between baby and the mother
- Breastfeeding
- Postponing bathing and weighing
- Appropriate clothing and together
- Warm transportation
- Awareness-raising of healthcare provider

Assessment of hypothermia

What is hypothermia?

Normal axillary temperature is 36.5-37.5°C (97.7-99.5°F). In hypothermia the temperature is below 36.5°C.

Grading of hypothermia

- | | | |
|------------------------|---|---------------------------|
| • Cold stress | : | 36.4-36.0°C (97.5-96.8°F) |
| • Moderate hypothermia | : | 35.9-32.0°C (96.2-89.6°F) |
| • Severe hypothermia | : | <32°C (89.6°F) |

Temperature recording

Following are the methods of assessment of temperature in a newborn:

- Axillary temperature is as good as rectal and safer (Less risk of injury or infection).
 - a. **Digital thermometer:** A digital thermometer needs to be switched on for recording the temperature. Temperature is recorded by placing the bulb of thermometer against the roof of dry axilla, free from moisture, Baby's arm is held close to the body to keep the thermometer in place. The temperature is read when the thermometer beeps.
 - b. **Mercury thermometer:** These are being phase out due to environmental pollution by mercury.
- Skin temperature: In a baby being nursed under a radiant warmer, the baby's temperature is usually recorded by a thermister probe. The thermister probe is attached to the skin over upper abdomen. The thermister senses the skin temperature and displays it on the panel.
- Human touch: Baby temperature can be assessed with reasonable precision by human touch, the reliability of which can be enhanced by training. Abdominal temperature is representative of the core temperature and it is reliable in the diagnosis of hypothermia. The warm and pink feet of the baby indicate that the baby is in thermal comfort, but when feet are cold and abdomen is warm, it indicates that the baby is in cold stress. In hypothermia, both feet and abdomen are cold to touch.

Clinical signs and symptoms

The signs and symptoms in a hypothermic baby may be subtle and nonspecific, therefore it is essential to have a high index of suspicion for hypothermia especially in LBW and preterm babies. The common signs and symptoms in a hypothermic baby are lethargy, irritability, poor feeding and breathing difficulty (tachypnea/apnea). Severe hypothermia may manifest with hypoglycemia, sclerema, DIC and internal bleeding.

Prevention and management of hypothermia

Common situations where hypothermia can occur:

- At birth (Delivery Room)
- During changing of nappy/clothes
- Malfunctioning heat source or removing the baby from heat source
- While transporting a sick baby

Prevention of hypothermia

Steps to prevent heat loss in the delivery room:

- Warm room (26-28°C)
- Skin-to-skin contact (Kangaroo mother care)
- Immediately dry newborn with a dry, sterile and warm towel.
- Use another warm towel to wrap the baby in two layers.
- Ensure head is well covered.
- Keep the baby with the mother (mother's temperature will keep the baby warm)

Kangaroo mother care (KMC)

KMC is a technique used to keep LBW babies warm. The neonate is held, skin-to-skin, with mother or any other adult caretaker. Kangaroo Mother Care should be given to all these babies whenever and wherever possible for maximum duration of time.

KMC helps in

- Better thermal protection of neonates.
- Increasing milk production.
- Increasing the exclusive breastfeeding rates.
- Reducing respiratory tract and nosocomial infections.
- Improving weight of the baby
- Improving emotional bonding and
- Reducing hospital stay.

Assessing the eligibility for KMC

Mother/Father or any adult caretaker who is willing, free of illness and maintains a good hygiene can provide KMC.

Baby: KMC can be initiated immediately in all babies except those clinically unstable. The ongoing medical support, like oxygen therapy. IV fluids and tube feeding are not contraindications to KMC.

Technique and position

Counsel the mother regarding KMC, provide privacy, and request her to sit or recline comfortably. Place the baby between the breasts of the mother in skin to skin contact in upright position. Turn the head to one side to prevent airway obstruction. Slight extended position of the head facilitates eye contact with the mother. Ensure that the epigastrium of the baby is in close proximity to the epigastrium of the mother. Regular respiratory movements of mother prevent the occurrence of apnea. The hips should be flexed and the bottom of the baby should be supported, in this way the baby clings to the mother in a frog like position.

Skin to skin contact is the most practical, preferred method of warming a hypothermic infant in a health facility.

Clothing for the mother and baby

The mother can wear whatever she finds comfortable as per the environmental temperature prevailing at that time, provide the dress accommodates the baby, that is keeps the baby comfortably in contact with her skin. Special garments are not needed unless traditional ones are too tight. The baby is placed naked in kangaroo position, except for a diaper, cap socks and mittens.

Duration of KMC

KMC should be provided for as long as possible. Each session should be for a duration of at least one hour. KMC may be continued till the baby finds it comfortable. When the baby on KMC wriggles, pulls limbs out or cries, KMC can be discontinued.

Management of hypothermia

At a health facility (FRU/SNCU), confirm diagnosis of hypothermia by recording actual body temperature. A hypothermia baby has to be rewarmed as quickly as possible. The most feasible method should be used.

For management purpose, hypothermia is graded as mild if the body temperature is between 35.5 to 36.4°C and Significant when the body temperature is below 35.5°C. As stated, the method of rewarming will depend on the severity of hypothermia. Severe hypothermia will require additional steps of management which will be discussed in this section.

Management of mild hypothermia (35.5° to 36.4°C)

- Provide supervised Kangaroo Mother Care (KMC), skin to skin contact is the best method to re-warm a baby with mild hypothermia.
- If KMC is not practical, warm the room using radiant heater or other appropriate heating device.
- Cover adequately and ensure to replace the cold clothes of the baby with warm clothes.
- Keep the room warm (26-28°C) and draught free.
- Continue breastfeeding.
- Monitor temperature and capillary filling time during re-warming. Watch for apnea and hypoglycemia.
- Monitor axillary temperature every ½ hour till it reaches 36.5°C, then hourly for next 4 hours, 2 hourly for 12 hours thereafter and 3 hourly as a routine.

Most of the babies will regain their temperature. However, if the baby remains hypothermic one hour after supervised KMC, or if danger signs appear at any stage of monitoring the baby, sepsis should be suspected and treated accordingly.

Wrapping the baby

The baby should be comfortable and clothed in multiple layers. Head should be covered with a cap and then the baby should be wrapped in 1-2 layers of sheets/blankets. The technique of wrapping will be demonstrated in the skill station.

Management of significant hypothermia (temp<35.5°C)

- Remove cold clothes from the baby and replace with warm clothes.
- Place under radiant warmer.
- Alternately, one may use room heater or other means to warm the baby.
- At times, KMC may be only option.
- Monitor temperature every 15-30 minutes.
- Monitor B.P., HR, temperature and glucose as needed (if facilities are available).
- The baby should be stabilized before being transported to higher centre.
- Following additional steps may be required in some babies.
 - Start IV 10% Dextrose.
 - If perfusion is poor, give 10ml/kg of Ringer Lactate or Normal Saline.
 - Give Inj Vit K (Refer to Chapter 2).
 - Provide oxygen and monitor O₂ saturation between 90-94%

MANAGEMENT OF LOW BIRTH WEIGHT BABIES

Nearly 75 percent neonatal deaths and 50 percent infant deaths occur among the low birth weight neonates. Even after recovering from neonatal complications, some LBW babies may remain more prone to malnutrition, recurrent infections, and neurodevelopment handicaps. Low birth weight, therefore, is a key risk factor of adverse outcome in early life.

- Low birth weight (LBW) baby is the one who weighs less than 2500 g at birth.
- Low birth, weight may result from either prematurity (gestational age <37 weeks) or intrauterine growth retardation (IUGR), which is also called small – for – date baby (SFD).

Treatment :

Indication for hospitalization are:

- Birth weight of less than 1800g;
- Gestational age of less than 34 weeks;
- Neonate who is not able to take feeds from the breast or by cup (Katori) and spoon (irrespective of birth weight and gestation);
- A sick neonate (irrespective of birth weight and gestation).

Keeping LBW Babies warm:

- Room temperature should be kept between 28-30⁰ C.
- Baby should be provided skin to skin contact care (KMC) in the following ways:
- Provide privacy to the mother. If mother is not available, skin to skin contact may be provided by the father or any other adult.
- Request the mother to sit or recline comfortably.
- Undress the baby gently, except for cap, nappy and socks.
- Place the baby prone on mother's chest in an upright and extended posture, between her breasts, in Skin to Skin contact; turn baby's head to one side to keep airways clear.
- Cover the baby with mother's blouse, 'pallu' or gown; wrap the baby-mother duo with an added blanket or shawl.
- Breastfeed the baby frequently.
- If possible, warm the room (>25⁰ C) with a heating device.
- Skin to Skin contact is the most practical, preferred method of warming a hypothermic infant in a primary health care facility. If not possible:
- Cloth the baby in 3-4 layers, cover head with a cap and body with a blanket or a shawl; hold baby close to caregiver's body, OR
- Place the baby under overhead radiant warmer, if available.
- Keep the young infant warm on the way to the hospital
- By Skin to Skin contact OR
- Clothe the baby in 3-4 layers, cover head with a cap and body with a blanket or a shawl; hold baby close to caregiver's body.

Nutrition & Fluids

- Neonates weighing less than 1200 g. or those having sickness should receive

intravenous fluid initially.

- Enteral feeds should be introduced gradually by gavage as the baby's acute problem begins to settle.
- Infants weighing 1200-1800 g and not having significant illness should be put on gavage feeds initially.
- In order to promote lactation and enable the baby to learn sucking, all babies on gavage or katori-spoon feeds should be put on the breasts before each feed for 5 to 10 minutes. This will promote lactational and enable the baby to learn who to suck.
- When shifting a baby from one mode of feeding to another, be very careful. Introduce in new mode for only some of the feeds to begin with.
- The feeding of every baby should be individualized. The above recommendations should only serve as broad guidelines.
- Ensure use of expressed breast milk & start with small volume, and gradually buildup.
- Most LBW babies weighing more than 1800 g are able to feed directly from the breast. In a stable, growing LBW baby daily intake of feeds should be gradually built upto 180-200ml/kg.
- LBW babies should be fed every 2-3 hours starting at 2 hours of age.

Guidelines for the modes of providing fluids and feeding			
Age	Categories of neonates		
Birth weight (gm) Gestation (weeks)	< 1200 < 30	1200-1800 30-34	> 1800 > 34
Initial	<ul style="list-style-type: none"> • IV fluids • Triage • Gavage feeds 	Gavage feeds	<ul style="list-style-type: none"> • Breastfeeds • If unsatisfactory, give cup-spoon
After 1-3 days	Gavage feeds	Cup-spoon	Breast feeds
Later (1-3 wks)	Cup-spoon feeds	Breast feeds	Breast feeds
After some time (4-6 wks)	Breast feeds	Breast feeds	Breast feeds

Vitamin Supplements:

- All LBW Babies should receive intramuscular Vitamin K at birth. Every new born should receive Injection Vitamin K 1 mg and 0.5 mg, Intramuscular, as per the birth weight > = 1000 gm and < 1000 gm respectively.
- All pre-terms <2000 gms should receive oral Vitamin and mineral supplement in doses shown below :
 - Multivitamin preparation 0.3-0.6 ml (5-10 drops) / day (which usually provides vitamin A of 1000 IU/day and vitamin D 400IU/day)
 - Calcium 80-100mg/kg/day
 - Phosphorous 40-50mg/kg/day.

All these supplements to be given till atleast 6 months of age.

- Iron should be started at a dose of 1mg/kg/day at 4 weeks of age and provided till 12 months of age.

- Vaccination in LBW Babies
 - If the LBW baby is not sick, the vaccination schedule is the same for as the normal babies. A sick LBW babies however, should receive these vaccines only on recovery.
- Vitamin A 1000 IU orally daily – from 1 week age onwards

Immunization in special circumstances

- 1. Immunization in preterm infants** :In general, all vaccines may be administered as per schedule according to the chronological age irrespective of birth weight or period of gestation. Very low birth weight / preterm babies can be given or period of gestation. Very low birth weight / preterm babies can be given immunization, if they are stable otherwise.
- 2. Children receiving corticosteroids** :Children receiving oral corticosteroids in high doses (Prednisolone 1-2 mg/kg/day) for more than 14 days should not receive live virus vaccines until the steroid has been discontinued for at least one month. Killed vaccines are safe but may not be completely effective in such situations. Patients on topical or inhaled steroids should not be denied their age appropriate vaccine.
- 3. Children awaiting splenectomy** :Immunization with pneumococcal, Hib, and meningococcal vaccine should be initiated a few weeks prior to splenectomy.
- 4. Vaccination in children with HIV infection** :Immune response may be suboptimal as it depends on the degree of immunodeficiency at that point of time. Re-administration of childhood immunization may be considered when their immune status has improved following anti-retroviral therapy.
- 5. Lapsed immunization** :There is no need to restart a vaccine series regardless of the time that has elapsed between individuals doses. In case of unknown or uncertain immunization status, however, it is appropriate to start the schedule as for an unimmunized child.
- 6. Minor illnesses**, e.g. fever, diarrhea, respiratory infections and malnutrition should not be construed as contraindications to immunization.

Follow up of LBW

Look and asses for:

- They are feeding from breast or breast and cup
- Gaining weight for 3 consecutive days
- No signs of illness
- Are able to maintain normal body temperature when roomed-in with mother
- Mother is confident of taking care of the baby

Counseling of Mother and family LBW

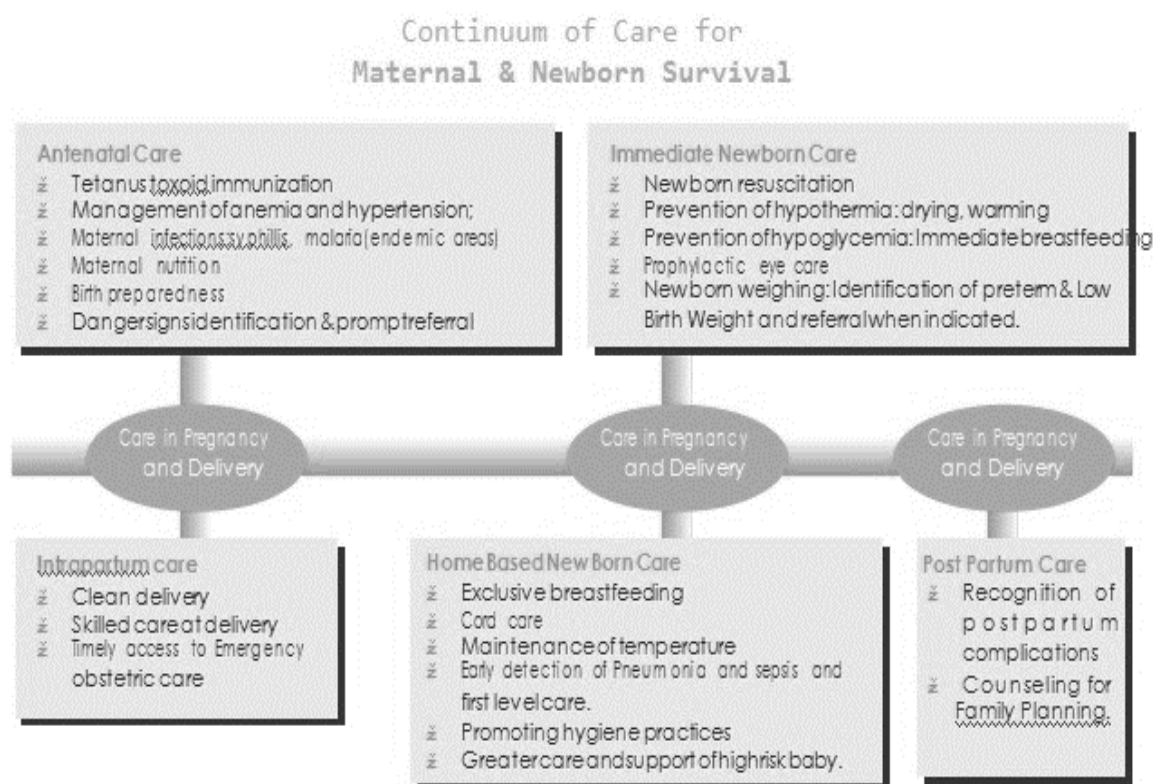
Mother and family must be provided counseling for care of LBW at home. They should be informed about

- Providing exclusive breast milk to the baby
- How to keep baby warm at home
- Identifying ‘Danger signs’ for seeking medical help
- Scheduled visits for assessing growth, monitoring illness and providing immunization. These visits should be at weekly intervals till the infant reaches **2.5kg**
- Mother must be informed about her nutrition and health

HOME BASED NEONATAL CARE (HBNC)

A new scheme has been launched to incentivize ASHA for providing Home Based Newborn Care. ASHA will make visits to all newborns according to specified schedule up to 42 days of life. The proposed incentive is Rs. 50 per home visit of around one hour duration, amounting to a total of Rs. 250 for five visits. This would be paid at one time after 45 days of delivery, subject to the following:

- Recording of weight of the newborn in MCP card
- Ensuring BCG, 1st dose of OPV and DPT vaccination
- Both the mother and the newborn are safe till 42 days of the delivery, and
- Registration of birth has been done



Rationale for Home Based Newborn care.

- In cases of institutional delivery, where the baby and mother are discharged after 48 hours according to current guidelines, it is expected that care for the new born during this period is provided in the institution. When the mother and baby return home, although the newborn has crossed the critical first day, there is still the remainder of the first week and month during which neonatal mortality could be as high as 54%, and for which care has to be provided. Any illness during this period could result in the newborn dying at home, unless the baby is provided with appropriate care or referred to a facility equipped to treat sick newborns.
- A significant proportion of mothers prefer to return home within a few hours after delivery, which means that home based newborn care needs to be available even for such babies born in institutions to tide them over the first day and thereafter. Although

this is noted sir able and all efforts should be made to convince them others to stay in the institutions for the first 48 hours, existing evidence shows that while at an all India level nearly 45% %of mothers return home before 48 hours. However in this percentage is very low instate so Bihar(15.3%),Haryana (29.2%), Nagaland(21.1%) and Orissa(28.3%), (Coverage Evaluation Survey, 2009, UNICEF)

- Despite the impressive increases in institutional deliveries there is a persistence of home deliveries ranging from between 25% to 50% across the states. For such deliveries, home based new born care, is essential even on the first day. There is evidence that many home deliveries are not conducted by skilled birth attendants, particularly in underserved areas, and among the marginalized.
- The strategy of universal access to home based newborn care must necessarily complement the strategy of institutional delivery to achieve a significant reduction in postpartum and neonatal mortality and morbidity. HBNC also needs the ready access and backing from Sick Newborn Care Units (SNCU) and Newborn Stabilization Units (NBSU) that are well staffed, well equipped and are functioning effectively.

Who is the provider of HBNC?

This includes the AWW, the ANM and the Medical officers. However, the main vehicle to provide this is the ASHA. There as on for this include:

1. She is resident and available in every village.
2. She is being equipped with the skills and support to provide such care.
3. The findings of a recent evaluation show that the ASHA is much more likely to visit the new born and post- partum mother at home than the ANM or AWW, and is also more likely to be consulted for care of the sick child. The ASHA is emerging as the first port of call for sick new born and children.
4. The ASHA is supported and guided by the health system which is directly responsible for new born and child survival. This relationship with the health system is essential for facilitating referral.

Objectives of HBNC

The major objective of HBNC is to decrease neonatal mortality and morbidity through:

1. The provision of essential newborn care to all newborns and the prevention of complications.
2. Early detection and special care of preterm and low birth weight newborns.
3. Early identification of illness in the newborn and provision of appropriate care and referral
4. Support the family for adoption of healthy practices and build confidence and skills of the mother to safeguard her health and that of the newborn.

Key activities in HBNC

The key activities in HBNC constitute the provision of:

1. Care for every newborn through a series of home visits by a ASHA in the first six weeks of life. In most state contexts this health worker is the ASHA.
2. Information and skills to the mother and family of every newborn to ensure better health outcomes.

3. An examination of every newborn for prematurity and low birth weight. Extra home visits for preterm and low birth weight babies by the ASHA or ANM, and referred for appropriate care as defined in the protocols.
4. Early identification of illness in the newborn and provision of appropriate care at home or referral as defined in the protocols.
5. Follow up for sick newborns after they are discharged from facilities.
6. Counselling the mother on postpartum care, recognition of postpartum complications and enabling referral
7. Counseling the mother for adoption of an appropriate family planning method.

In case of those deliveries that occur on the way to the health institutions or at home out of choice, despite motivation for institutional delivery, the ASHA must be equipped with the skills and competencies required to provide appropriate newborn care.

This would exclude the states of Goa, Puducherry, Daman and Diu, and then on tribal areas of Tamil Nadu

Skills needed by the ASHA in the provision of HBNC

1. Mobilize all pregnant mothers and ensure that they receive the full package of antenatal care.
2. Undertake birth planning and birth preparedness with the mother and family to ensure access to safe delivery.
3. Provide newborn care through a series of home visit which include the skills for:
 - Weighing the newborn
 - Measuring newborn temperature
 - Ensuring warmth
 - Supporting exclusive breastfeeding through teaching the mother proper positioning and attachment for initiating and maintaining breastfeeding
 - Diagnosing and counseling in case of problems with breastfeeding
 - Promoting hand washing
 - Providing skin, cord and eye care
 - Health Promotion and counseling mothers and families on key messages on newborn care which includes discouraging unhealthy practices such as early bathing, and bottle feeding
 - Ensuring identification and prompt referral of sepsis or other illnesses.
4. Assessing if the baby is high risk (preterm or low birth weight), through the use of protocols and managing such LBW or preterm babies through
 - a) Increasing the number of home visits
 - b) Monitoring weight gain
 - c) Supporting and counseling the mother and family to keep the baby warm and enabling frequent and exclusive breast feeding
 - d) Teaching the mother to express breast milk and feed baby using cup and spoon or paladi, if required.
5. Detect signs and symptoms of sepsis, provide first level care and refer the baby to an appropriate center, after counseling the mother to keep the baby warm. If the family is unable to go, the ASHA should ensure that the ANM visits the sick newborn on a priority basis.

6. Recognize postpartum complications in them other and refer appropriately.
7. Counsel the couple to choose an appropriate family planning method.
8. Use the checklist for first Visit to the Newborn (Annexure1b) and Home visit form (Annexure1c) to remind her to ask the key questions and ensure that she follows the steps of examination and counseling them other.
9. Provide immediate newborn care, in case of those deliveries that do not occur in institutions (home deliveries / deliveries occurring on the way to the institution)

Support to the ASHA to ensure positive newborn health outcomes

For the ASHA to be effective in providing HBNC and to enable reductions in neonatal mortality, the following support needs to be provided:

Payments: Training in round one of Module 6 & 7 equips ASHAs with the skills required for Home based newborn care such as hand washing, measuring temperature of newborn, weighing of new born, post natal care, managing hypothermia etc. All ASHAs who have completed training of Round one of Module 6 & 7 are eligible to undertake the HBNC visits and are entitled for the HBNC incentive. The ASHA is to be paid Rs.250 for conducting home visits for the care of the newborn and postpartum mother. HBNC incentive is applicable per newborn ,thus in cases of twins or triplets the incentive amount for ASHA would be two times of the regular HBNC incentive of Rs. 250 (i.e,Rs.500) or three times of Rs.250 (i.e,Rs.750) respectively.

The schedule of payment is as follows:

- Six visits in the case of institutional delivery (Days3,7,14,21,28and42), and
- Seven visits in the case of home delivery (Day 1, 3, 7, 14, 21, 28, and 42).
- In cases of Caesarean section delivery, where the mother returns home after 5-6 days, ASHAs are entitled to full incentive of Rs. 250 if she completes all five visits starting from Day 7 to Day 42.
- In cases when a newborn is discharged from SNCU, ASHAs are eligible to full incentive amount of Rs. 250 for completing the remaining visits. In addition, ASHAs are also eligible for an incentive of Rs. 50 for monthly follow up of low birth weight babies and newborns discharged from SNCU (as approved by MSG of the National Health Mission on December 6th , 2013). The low birth weight are followed up for two years and SNCU discharged babies for one year.
- In cases where the woman delivers at her maternal house and returns to her husband's house, two ASHAs undertake the HBNC visits i.e, one at maternal house immediately after delivery and another one at husband's house when the newborn returns home or viceversa. In such cases the HBNC incentive of Rs.250 can be divided into two parts in a way that each ASHA who completes 3 visits or more is entitled to Rs.125. This would be done only after ANM / ASHA. Facilitator have visited the household and verified the home visits. In these instances, if an ASHA undertakes less than 3 visits she would not be entitled for the HBNC incentive. The other ASHA completing five or more visits in this case would get the whole amount of Rs.250.
- In order to claim the HBNC incentive, ASHAs are expected to fill and submit two forms – First examination of newborn form and Home Visit form for each newborn. The HBNC card (Annexure1a) can be used as a voucher for the purpose of payment and verification by ASHA facilitator / ANM.

- The amount is to be paid based on the completed home visit form and first examination of the newborn, forms, validated by the ASHA facilitator / ANM. The payments to the ASHA should be made on time and with dignity. The payments are made on the 45th day (using the state mechanism for JSY payment) subject to the following:
 - Enabling that birth weight is recorded in the Maternal and Child Protection (MCP) Card
 - Ensuring that the newborn is immunized with : BCG, first doses of OPV and DPT / Pentavalent*, and entered into the MCP card
 - Enabling Birth Registration
 - Both mother and newborn are safe until the 42nd day of delivery

Monitoring

The progress of implementation of the HBNC programme will be closely monitored by the MoHFW on a quarterly basis. States would be expected to provide details of the status of ASHA training and equipment related to HBNC along with details of the HBNC visits and referrals made by ASHAs and the total expenditure on HBNC by the state. (Annexure 4 – HBNC Quarterly Progress Report)

The following indicators will be used to measure the programmatic outcomes.

Indicators		
Process Indicators	Output indicators	Outcomes
1. Percentage of ASHA trained in Round 1 of Module 6 & 7	1. Percentage of Newborns who were visited in the first two days of birth at home.	1. Percentage of Newborn received home visit for HBNC by ASHA against total estimated live birth
2. Percentage of ASHA trained in Round 2 of Module 6 & 7	2. Percentage of newborns who received full schedule of HBNC visits	2. Percentage of new borns who were breast fed in the first hour
3. Percentage of ASHA trained in Round 3 of Module 6 & 7	3. Percentage of newborns who were weighed at birth	3. Percentage of Low Birth Weight/Preterm (high risk) babies reported
4. Percentage of ASHA trained in Round 4 of Module 6 & 7	4. Percentage of low birth weight recorded	4. Percentage of sick newborns admitted at referral sites–(SNCU)
5. Percentage of ASHA with complete HBNC kit.	5. Percentage of sick newborns referred	5. No. of newborns deaths
	6. Percentage of SNCU discharged babies visited as per schedule	

Steps of monitoring–

1. ASHA's home visit forms can be used to assess the number and content of her visits. ASHAs have to fill the home visit form during every visit to the house hold with a newborn.
2. ASHA facilitator / ANM should verify and sign the home visit forms filled by ASHA during the monthly meeting with the ASHAs.
3. Based on the performance of the ASHAs, the ASHA facilitator / ANM should issue and submit assigned token/slip to the PHC staff (clerk/accountant)
4. The ANM should review the performance of all ASHA with respect to home visits for newborns in her sub center area during the VHND / village visit.

5. Payment to ASHAs should be made by the PHC staff (clerk/accountant) after taking approval from the MO / PHC who will review the implementation during meetings.
6. At district level, the district nodal officer should monitor and follow up on the implementation on the programme. The CMOs would also review the progress during the CMO's meeting at district level.
7. The State nodal officer will monitor the implementation and effectiveness of the programme. State Mission Director would also review the progress of the programme in each district with district CMOs at the CMOs meeting held at state level.
8. At the National level, the scheme will be monitored by National Health System Resource Centre, under guidance and support from Child Health Division, Ministry of Health & Family Welfare, Government of India.

CHILDHOOD NUTRITION

Childhood is a stage in human life associated with growth and development. Growth proceeds rapidly in early life, slows down in middle childhood and acceleration at puberty before linear growth ceases with increasing age there is also physical and psychomotor malnutrition which influences activity, body composition, feeding skill & food choices. Adequate nutrition is essential for growth health & development of children.

Nutrition is the intake of food, considered in relation to the babies dietary needs. In order for children to grow properly, they must eat a well- balanced diet. The nutrients needed by children are the same needed by adults, but the amounts vary. An adequate, well balanced diet combined with regular physical activity is a cornerstone for good health.

Poor nutrition increases the risk of illness & is responsible directly or indirectly for one third of estimated deaths that occur in under 5 yr. children.

A period of 12 months of age after birth.

Early infancy : 0-6 months or age

Middle infancy : 6-9 month

Late infancy : 9-12 months

Infants are totally dependent on caregivers for the provision of nutritional needs infants and good child feeding practice is most effective interventions to improve child health. The WHO & UNICEF is global recommendations for optimal infant feeding state an infant's of life. Nutritionally adequate complementary feeding should be started after completing 6 months of age with continued breast feeding upto 2 yr of age or beyond that. However poor breast feeding & practices are widespread.

Breast feeding:

Human breast milk is specifically designed for the requirement of a human baby. Breast milk contains all the nutrients that an infant needs in the first 6 months of life, including fat, carbohydrates, proteins vitamins, minerals & water.

Normal human growth is greatest during infancy. The infant gains about 10 g /kg/day until about 4 weeks post birth, at that point, the gain drops to 1g/kg by the end of the first year of life.

Around the world, breast milk composition is remarkably stable, varying only within a relatively narrow range. The nutritional status of mother does not appear to affect milk volume unless the mother is malnourished.

Composition of human milk

- 1) **Fat:-** fat of human milk provides half of the milk's calories. It is the most variable component fat content in human milk ranges from 22 to 62 g & is independent of breast feeding frequency. Fats provide about half of the baby energy intake.

The lipid fraction of human milk provides essential fatty acids. It has effect on brain growth.

- 2) **DHA:** LCPUFAs include docosahexanoic acid (DHA) and arachidonic acid (AA) which are associated higher visual acuity and cognitive ability of the child. DHA & AA are involved

in early neurodevelopment by promoting healthy neurological growth, repair & maturation.

- 3) **Lactose:** Lactose, disaccharide, accounts for most of the carbohydrates in human milk, although small quantities of disaccharides, galactose & fructose are also present. Lactose concentration is relatively constant in mature milk (7.0 g/dl). It is affected by maternal diet the more frequent the feeds the higher is concentration of lactose. Lactose enhances calcium absorption and metabolizes readily to galactose & glucose, which supply energy to rapidly growing brain of the infant.
- 4) **Probiotic & prebiotic bacteria:** Probiotic bacteria are live micro organisms that can be a health benefit for ex. some probiotic bacteria that have lactobacillus strains act by competing other bacteria for nutrients thereby reducing the number of potentially pathogenic microbes. Certain lactobacillus strains may ameliorate the symptoms of rotavirus infections.
- 5) **Protein:** Protein content of mature human milk in malnourished mother is about 0.8 to 0.9 g of protein / dl. Human milk contains casein & whey protein. Levels change as lactation progresses to meet the nutritional need of the infant.
Whey protein is composed of five major components.
1) Lactalbumin 2) Serum albumin 3) Lactoferrin 4) immunoglobulin 5) lysozymes
The latter three elements play important roles in immunological defense. The lactoferrin concentration in milk is higher in iron deficient women as compared to well nourished mothers, therefore milk lactoferrin may also help protect the infant against iron deficiency. A large number of other proteins (enzymes, growth modulators & hormones) are present in low concentration.
- 6) **NPN – Non protein nitrogen:** Milk proteins are synthesized from amino acid derived from the blood stream. Non protein nitrogen contain a number of free amino acids including glutamic acid, glycine, alanine, valine, leucine, aspartic acid, serine, threonine, proline & taurine. The percentage of protein in human colostrums is greater than that in mature breast milk. All 10 essential amino acids are present in colostrums and account for approximately 45% of its total nitrogen content.
- 7) **Nucleosides :**
Nucleosides are low molecular weight compounds with a nitrogenous base. Necessary for energy metabolism enzymatic reaction and growth & maturation of developing gastro intestinal tract. They also play several roles in immune function including enhancing lymphatic proliferation, stimulating immunoglobulin production in lymphocytes and increasing natural killer cell activity.
- 8) **Vitamins & micronutrients :-**
The amounts of vitamin & micronutrients in human milk vary from one mother to another because of diet & genetic differences.
Vit A :- Human milk is good source of Vit A (200 IU/dl) which is present mainly as retinol (40-53 IU/dl). Required for vision & maintenance of epithelial structures. Vit A reaches its highest level in breast milk in first week after birth & then gradually declines.

Vit D :- Human milk contains very little fat soluble vit D, consequently, breastfed infant can develop rickets although such event is uncommon.

Vit E :- Human colostrums is particularly rich in Vit E (tocopheral). A deficiency of Vit E in infancy can result in hermetic anemia, especially in premature infant because it is an antioxidant, Vit E protects cell membranes in retina & lungs against oxidant induced injury.

Vit K :- Vit K which is required for synthesis of blood clotting factor is present in human milk in small amounts.

Water soluble vitamin – ascorbic acid, nicotinic acid, B12, riboflavin and R B6 are readily influenced by the maternal diet. If maternal supplements are present the vitamin level in the milk increase & then plateau.

Vit B12 :- Vit B12 is needed for early development of the babies central nervous system. A deficiency of B vitamin folate during pregnancy is associated neural tube defects. Campaign to educate women on the importance of taking folic acid supplements during preconception & pregnancy has reduced neural tube deformities. Folate (which is bound to folate binding protein) remain at same level throughout all stages of lactation.

- 9) **Minerals** :- Total mineral content in human milk is fairly constant. Except for magnesium, minerals tend to reach their highest concentration in human milk in first few days after birth & then decrease slightly in consistent pattern throughout lactation, Maternal age, parity & did even when mother taken supplements, usually have minimal influence on mineral concentrations' in milk, probably because of their regulation from maternal body stores.

Sodium :- Breast milk sodium is elevated in early colostrums but falls dramatically by the third day postpartum & subsequently declines at a slower rate for 6 months. Elevated levels of sodium in human milk occur during weaning, mastitis & first month of gestation.

Zinc :- Zinc is 8 times abundant in human colostrums than nature milk. Requirement for this mineral is relatively high in very young infants.

Iron :- Human milk contains only a small amount of iron (0.5 – 1.0 mg/dl). Breast fed infants are sustained by sufficient iron stores laid down in utero & by the high factor & vit C levels in human milk is observed five times as well as a smaller amount from cow milk.

Calcium :- Calcium appears in only small quantities in human milk (20-34 mg/dl) yet babies observe 67% of calcium in human milk as compared to only 25% of that in cow milk.

Magnesium :- Magnesium is present in low level in breast milk greater & diverse in mature milk over the course of 3 to 6 month.

Other minerals :- Copper levels are highest on the first few days post partum, decrease for about 5 to 6 months & then tend to remain stable. Selenium concentrations are usually higher in human milk than in formula. Minute amount of aluminum, iodine, chromium & fluorine are also found in breast milk.

Formula fed infant ingest as much as 80 times more manganese than do breastfed infant. Because manganese enters the neonatal brain at much higher rate than in the adult brain, neonates are at risk of neurotoxicity from excess manganese. High manganese levels in infant formula have been identified as being possibly related to neurocognitive deficits. (Trane et al 2002)

Anti infective properties :-

Breast milk offers the newborn protection against disease & can reduce the risk of deaths for infants. When researchers compared centre's for disease control & prevention records of children who died between 28 days and 1 year, children who were breastfed. The lower the risk of illness (Chen & Rogan, 2004)

Key concepts

- Human milk – the gold standard for infant nutrition has between 57 to 65 kcal of energy per deciliter
- Breastfed infants ingest less volume than formula fed infants because human milk is more energy efficient.
- Babies do not usually remove all the milk available in the breast during the single feeding, instead, they usually take about two thirds of available milk in the breast.
- Small amounts of colostrums are produced in the first day or two after delivery, followed by rapid increase to about 500 ml at five days postpartum.
- Babies take 11 breastfeeds per day on average, but this frequency ranges from 6 to 18 feed per day.
- Differences in milk output from the right & left breast are common.
- Milk storage capacity differs among women. Women with larger breast have a greater milk storage capacity and may breastfeed less often. Women with small capacity and may breastfeed less often, women with small breast may need to breastfeed more often. Otherwise, breast size does not affect the ability to breastfeed.
- Milk synthesis and volume differ between breasts.
- The nutritional status of a lactating mother has a minimal effect on milk volume unless she is malnourished.
- Multifarious women produce more breast milk than primiparous women, mothers produce significantly more breast milk with their second baby.
- Breastfed infants grow at about the same rate as those not breastfed for the first 3 to 4 months.
- Fat in human milk varies according to the degree which the breast is emptied high volume is associated a low milk fat content, accordingly, fat content progressively increases during a single feeding.
- Breast feeding should occur early & frequently, the larger the interval between feeding the lower the fat content.
- The type of fat the mother eats affects the type of fatty acid present in her milk.
- Primary or congenital lactose deficiency or intolerance in infants is rare or nonexistent.
- Lactose in human milk supplies which energy to the infants is rapidly growing brain.
- Human milk contains two main protein : casein & whey. Casein is tough & less digestible curd, whey is soft and flocculent & is digested rapidly.
- The amount of protein in colostrums is greater than that in mature milk because of the immune factors (IgA, Lactoferrin) present in colostrums.
- Preterm mother's milk contains high level of protein & fat compared with non preterm milk, thus using the milk of the preterm infants own mother is preferred. Generally speaking, human milk contains sufficient amounts of vitamin & minerals to meet the needs of full term infants.
- Mineral content in human milk is fairly constant, tending to be the highest right after birth & decreasing slightly throughout lactation.

- Healthy infants who consume enough breast milk to meet their energy needs to receive enough fluid to satisfy their requirement even in hot & dry environments.
- In the first 1 to 2 days after birth, the infant ingest small amounts, approximately 1 to 14 ml of colostrums at each feeding. Milk yield gradually increase for the first 36 hours, then rapidly increase. By day 5 volumes is about 500ml /day, it reaches 800ml/day (range 550 to 1150) during months 1 to 6 of full breast feeding.
- Immunity occurs actively & passively. Colostrums is densely packed antibodies & immunoglobulin.
- Human milk contain two types of white cells : phagocytes & lymphocytes. Phagocytes engulf & absorb pathogens & release IGA.) Release IGA lymphocytes (83% are T cells) protect an infant by destroying the cell walls of viruses in a process called cell mediated immunity.
- Antibodies are immunoglobulins that act against specific antigen or pathogen. Secretory Ig A is major immunoglobulin total SIGA remains relatively constant throughout lactation
- SIGA passes from the mother's mucosa (intestinal, respiratory) to the mammary gland good/ breast milk through lymphocyte traffic pathways (GALT & BALT)
- Immunity has dose, response effects the more breast milk the infant ingest the greater the immunity.

Exclusive breast feeding

What is exclusive breast feeding?

Exclusive breastfeeding means to feed the baby with only breast milk from birth till the completion of six months nothing else like (Water, balaadu, guti, food sugar water or other fluids like gripe water etc.) should be given only mother's milk and medicines prescribed by doctor should be given.

Benefits of exclusive breastfeeding

- 1) Promote production of more milk
- 2) It decreases the chances of infection caused by feeding bottles, water and nutrients.
- 3) It gives infants the best chance to grow and stay healthy as it contains all nutrients.
- 4) Decreases the risk of ovarian and uterine cancer in mother.

Benefits to the child

- 1) The child gets complete food for first six months
- 2) The child is saved from illness like asthma pneumonia and other respiratory breast infections.
- 3) It helps brain development
- 4) Breast milk is easily digestible
- 5) It builds a loving relationship between the mother & child
- 6) Breast feeding protects the child against ear infection such as otitis media
- 7) Breast milk offers protection against illnesses beyond infancy to childhood and adulthood. Contributes to prevention of celiac disease, diabetes, multiple sclerosis, prevents hypothermia

Sudden infant death syndrome, childhood cancer and many other health problems.

Benefits to the mother

- 1) Stops bleeding after delivery

- 2) Saves her from anemia after delivery
- 3) Builds her confidence
- 4) Helps delay her next pregnancy.
- 5) Saves her from risk of ovarian & breast cancer.

Benefits to the family

- 1) Saves money spent in buying milk from outside
- 2) Saves fuel & time spent on preparing milk.

Also benefits the society by reducing the load of biomedical waste and recycling of bottles and nipples and formulated tins.

Introduction of complementary food

Complementary feeding means introducing solids to an infant's milk diet. Breastfeeding has been shown to provide sufficient energy for normal growth and to meet recommended energy requirements for most infants at 6 months of age. After that nutritive food should be started.

After completion of six months introduce

- 1) Appropriate
- 2) Hygienically prepared
- 3) Home made
- 4) Mashed complementary feeds in adequate quantities
- 5) Do not give watery items like rice water, dal water etc.

What food is to be given after six months?

Appropriately thick complementary foods of homogenous consistency made from locally available foods should be introduced at 6 completed months to all babies while continuing breast feeding along with it.

To address the issue of small stomach size which can be accommodate limited quantity at a time, each meal must be energy dense by adding sugar / jiggery and ghee/ butter/ oil. When the child is six months old, soft and mashed food prepared at home should be started on cooked and mashed vegetables, potatoes, cauliflower, carrots etc. use cereals and fruits, soft banana & papaya may be given. This food should be easy to prepare from the food item available at home. Food should be introduced gradually one by one. Different types of food should not be started at a time. Complementary food should be given 2-3 times a day. It should not be very watery.

Good complementary foods are prepared by mixing 3-4 types of food.

6 months : Soft porridge, well mashed vegetables, fruit 2-3 table spoonful 2-3 times per day plus frequent breastfeeds.

7-8 months : Mashed foods 3 times per day increasing gradually to 2/3 of a 250 ml katori/bowl plus frequent breastfeeds.

9-11 months : Finely chopped or mashed foods & food that baby can pick up, ¾ of a 250 ml katori/bowl, 3 meals plus snack between meals plus breastfeeds.

12-24 months : finally foods chopped or mashed if necessary, A full 250 ml katori/bowl or more, 3 meals plus 2 snacks between meals plus breastfeeds.

Provide snack in between like :

- Mashed banana
- Dalia or milk
- Roti mashed in dal
- Continue to encourage the child to eat so that he eats happily.
- Continue breastfeeding
- Give him variety of foods to eat.

Consistency

To provide more calories from smaller volume, food must be thick in consistency – thick enough to stay on spoon without running off, when the spoon is tilted.

Complementary food diversity

To improve the content of various nutrient and density of nutrients in the young Child's diet, WHO recommends four or more different types of food to be fed at least once in a day from completed six months.

A nutrition rich diet requires a variety of foods, micronutrients like iron, Vit A and iodine which are very important for development of brain as well as Child's growth. Zinc helps to prevent illness.

Sources of important micronutrient

Iron : Exclusive breastfeeding for 6 months meets the iron needs of the growing infant. Non vegetarian foods leafy vegetable, jaggery, dates are good sources of iron.

Zinc : Same as iron.

Vitamin A : Carrots, tomatoes, drumstick, leaves/pods, beetroot, papaya, mango, leafy vegetables, milk & milk products, egg yolk & fish are rich in Vit A.

Iodine : It is available in iodized salt. It is very important for brain development.

Remember :

- Giving drinks with low nutritive value, such as tea, coffee & sugary drinks should be avoided.
- Hygiene practices are essential for food safety during all the involved steps viz preparation, storage and feeding.
- Practice of responsive feeding is to be promoted
- Consistency of food should be appropriate to the developmental readiness of child in munching, chewing & swallowing.
- Avoid obstacles (ex. Television, gossiping with others) while feeding.
- Promote child to eat by singing nursing rhymes and strong telling.
- Eating with family during meal times encourages child to eat more than eating alone.

MAA

MAA – Mothers Absolute affection is a nationwide breast feeding promotion and support campaign. It is an intensified programme for promotion of IYCF (Infant and young child feeding) practices. Infant & young child feeding practices of children from time of birth to completion of 23 months of age. Attempts to intensify efforts to promote optimal infant and young child feeding practices, with focus on breast feeding.

Goal :- To revitalize efforts towards promotion, protection and support of breastfeeding practices to achieve higher breast feeding rates.

Objectives :

- 1) Build on enabling environment for breastfeeding through awareness generation activities.
- 2) Reinforce support services at health facilities through trained healthcare providers & through skilled community health workers.
- 3) To incentivize & recognize those health facilities that show high rates of breast feeding along with processes in place for location management.

To reduce the neonatal mortality and child mortality is the priority of health services 22% newborn deaths can be prevented if all children receive breastfeeding within one hour of birth optimal breastfeeding can prevent 156000 child deaths every year.

Infants not breast fed are

- 15 times more likely to die from pneumonia.
- 11 times more likely to die from diarrhea than children who are exclusively breastfed.

NFHS – 4 in Maharashtra

- More than 90.3% deliveries take place in health facilities. 57.5% children receive breastfeeding within one hour of birth.
- 56.6% are exclusively breastfed for the first six months.
- 43.3% children between 6-8 months given complementary foods along with breastfeeding.

The interventions expected under MAA programme :

- 1) **Facility based intervention:** BFHI, four dimensional immunization clinics, baby friendly NICU, Hirkani room
- 2) **Community based activities:** Mother support meeting (Present & lactating mother)
- 3) Follow up of mother infant pair at home till breast feeding is established.
- 4) Continued support at home after the newborn period till second birthday for successful IYCN. (includes explaining complementary feeding to the family at half year birthday)
- 5) Establishing Hirkani rooms
- 6) Public advocacy.

Baby friendly hospital initiative

- The baby friendly hospital initiative was launched in 1992 with aim of forming maternity facilities to provide this standard of care.

- The baby friendly – approach has been shown to be effective in increasing exclusive breastfeeding rates.
- Hospitals become baby friendly by implementing the ten steps to successful breastfeeding.

Criteria for admission to SNCU

(Special newborn care unit) (SAM)

- 1) Birth wt < 1800 gm, gestation < 34 wt.
- 2) Refusal to feed
- 3) Major malformation feeding problem.

Treat hypoglycemia

If the child is hypoglycemic and he is lethargic unconscious or convulsing give 5 ml/kg body weight of sterile 10% glucose by IV, followed by 50 ml of 10% glucose by IV, followed by 50 ml of 10% glucose or sucrose by NG tube. If the IV dose cannot be given the NG dose first. If the child will be given IV fluids for shock, there is no need to follow the 10% IV glucose can NG bolus, as the child will continue to receive glucose in the IV fluids.

Start feeding starter diet half an hour after giving glucose & give it every half hours during the first 2 hrs for a hypoglycemic child, the amount to give every half hour is 1/4 of the 2 Harley amount. Hypoglycemia & hypothermia may co exist. So make sure to keep the child warm. Administer antibiotics as hypoglycemia may be a feature of underlying infection.

Continue blood glucose monitoring every 30 min till all blood glucose level becomes normal & stabilizes thereafter.

Management of Malnutrition in children

Three tier approaches is adopted in Maharashtra

- 1) Village child development centers/ Camps (VCDC) at AWCs – 30 days camp.
- 2) Child treatment centers / Camps (CTC) at PHC/ sub district / District hospitals – 21 days camp on residential basis
- 3) Nutrition Rehabilitation centers (NRC) – Medical college / superspeciality hospitals – as per need

Village child development camps / centers

- 1) Both SAM & MAM children can be admitted.
- 2) Conducted at village level at Anganwadi Centers.
- 3) It managed by Anganwadi worker & her helper.

Under nutrition is an underlying cause of more than one third of global deaths in children below the age of 5 yrs. It is also associated & growth fettering (i.e. deficit in height or stunting), micronutrient deficiencies, delayed cognitive development and mortality. Stunting and micronutrient deficiencies are significant health problems among infant and young children.

MALNUTRITION

INTRODUCTION

Malnutrition often refers to under nutrition resulting from inadequate consumption, poor absorption or excessive loss of nutrients but the term also encompasses over nutrition, resulting from excessive intake of specific nutrients.

Malnutrition in children is widely prevalent in developing countries including India. More than 33% of deaths in 0-5 years are associated with malnutrition.

Measuring Under nutrition

Measuring weight and height is the most common way of assessing malnutrition in a given population.

Anthropometry is a widely used, inexpensive and non-invasive measure of the general nutritional status of an individual or a population group. The three commonly used anthropometric indices are:

- Weight-for-age (WFA)
- Height/Length-for-age (HFA)
- Weight-for-Height/Length (WFH).

Types of Under nutrition

The three indices - weight-for-age, height/length-for-age, weight-for-height/length are used to identify three nutrition conditions: underweight, stunting and wasting, respectively. Each of the three nutrition indicators is expressed in standard deviation units (Z-scores) from the median of the reference population based on which under nutrition may be further classified as moderate or severe.

Underweight

Underweight, based on weight-for-age, is a composite measure of stunting and wasting and is recommended as the indicator to assess changes in the magnitude of malnutrition over time.

This condition can result from either chronic or acute malnutrition, or both.

An underweight child has a weight-for-age Z score that is at least two standard deviations (-2SD) below the median in the World Health Organization (WHO) Child Growth Standards.

Stunting

Failure to achieve expected height/length as compared to healthy, well-nourished children of the same age is a sign of stunting. Stunting is an indicator of linear growth retardation that results from failure to receive adequate nutrition over a long period or recurrent infections. Stunting often results in delayed mental development, poor school performance and reduced intellectual capacity.

A stunted child has a height-for-age Z score that is at least two standard deviations (-2 SD) below the median for the WHO Child Growth Standards.

Wasting

Wasting indicates current or acute malnutrition resulting from failure to gain weight or actual weight loss, episodes of diarrhea and other acute illnesses.

A wasted child has a weight-for-height Z score that is at least two standard deviations (-2SD) below the median for the WHO Child Growth Standards.

Severe Acute Malnutrition (SAM)

Severe acute malnutrition is defined by very low weight-for-height/length (Z- score below -3 SD of the median WHO child growth standards), or a mid-upper arm circumference < 11.5 cm, or by the presence of nutritional edema.

Severe Acute Malnutrition is both a medical and social disorder. Lack of exclusive breast feeding, late introduction of complementary feeds, feeding diluted feeds containing less amount of nutrients, repeated enteric and respiratory tract infections, ignorance, and poverty are some of the factors responsible for Severe Acute Malnutrition (SAM).

Effects of SAM

- Increases the risk of death in children under five years of age.
- Can be a direct or indirect cause of child death by increasing the case fatality rate infections.

Moderate Acute Malnutrition

A child with 70-80% of median weight-for- height (Z score of <-3SD to <-2 SD), or a Mid Upper Arm Circumference of 11.5-12.5 cm and no edema is classified as a case of Moderate Acute Malnutrition. In addition the child should have appetite, be alert and clinically well. Children with moderate acute malnutrition can be managed in the Outpatients setting where there is a provision for supplementary feeding.

Case Fatality in children with Severe Acute Malnutrition

The high case fatality has been attributed to various factors related to the management and includes:

1. Inability to distinguish between acute and rehabilitation phases
2. Excessive use of intravenous (IV) fluids
3. Fluid overload due to lack of monitoring during rehydration
4. Use of diuretics (for edema) and albumin
5. Not keeping the child warm and euglycaemic (normal blood glucose levels)
6. Low index of suspicion for infection
7. Early use of diets high in protein, sodium, energy
8. Failure to monitor food intake
9. Early treatment of anemia with oral iron

The case fatality can be brought down to approximately 7-10% by standard case management protocol, which the participant will learn in this course.

Identification of children with severe acute malnutrition

SAM children should be identified at every health contact:

- Primary health centre
- Sub-centre
- health posts

- hospitals
- day-care centres
- Anganwadi centres

Recommended criteria for identifying SAM in infants >6 months of age

Any child who has following features are treated as severe acute malnutrition:

Weight-for-height less than -3 SD and/or

- Visible severe wasting and/or
- Mid arm circumference (MUAC) < 11.5 cm and/or
- Edema of both feet*

Recommended criteria for identifying SAM in infants <6 months of age

Any infant more than 49 cm** in length who has following features are treated as severe acute malnutrition:

- Weight-for-height less than -3 SD and/or
- Visible severe wasting and/or
- Edema of both feet*

* Other causes of edema e.g. nephrotic syndrome should be excluded.

** For children with length less than 49 cm in length, visible severe wasting can be used as criteria to identify SAM .

Standard Deviation

For identifying a child with severe acute malnutrition standard deviation score (SD-score) based on child's weight and length/height is determined.

An SD-score is a way of comparing a measurement, in this case a child's weight-for-length, to an "average". The "averages" referred to in the manual are WHO Growth Reference values for weight-for-height and weight-for-length.

SD-scores may be loosely interpreted as follows:

- 1 SD approximately corresponds to 90% of the median weight-for-height.
- 2 SD approximately corresponds to 80% of the median weight-for-height.
- 3 SD approximately corresponds to 70% of the median weight-for-height.

To use the reference table

- First find the child's length or height in the middle of the table. If the length or height is between those listed, rounds up or down: If the length/ height is 0.5 or more cm then take the next higher value.
- Look at the top of the column to see what the child's SD-score is. The child's weight may be between two SD-scores. If so, indicate that the weight is between these scores by writing less than (<). For example, if the score is between - 1 SD and -2 SD, write < -1 SD.

Assessment of Severe Acute Malnutrition

Identification of Edema

1. To assess edema, normal thumb pressure is applied to both feet up to 30 seconds
2. If a shallow pit persists on both feet then the child presents edema

3. Only bilateral edema is recorded as nutritional edema
4. Always test for edema by thumb pressure and not merely by looking
5. Degree of edema (0 to +++ is assessed each day)
 - +++ Gross edema
 - (Generalised, all over body)
 - ++ Moderate edema
 - (Upto thigh & hands)
 - +
 - Mild edema (dorsum of both feet)

ANTHROPOMETRY

Measurement of MUAC

1. Alternative measure of thinness
2. Used for children 6-59 months
3. Measured on left upper arm
4. Indicates muscle mass and fat reserves
5. Is age independent
6. Best predictor of mortality

Procedure

1. Locate tip of child's shoulder
2. Bend child's elbow to make right angle
3. Place tape at tip of shoulder at zero
4. Pull tape straight down to the tip of elbow
5. Read no to nearest 0.1 cm. Divide no by 2 to get mid point
6. Mark midpoint on arm with a pen

Procedure

1. Straighten child's arm and wrap tape around the arm at midpoint
2. Ensure proper tension of tape – not too tight or too loose
3. At correct position with correct tension read measurement to the nearest 0.1cm
4. Record measurement immediately

Procedure for measurement of Weight

- Preferably by an electronic scale
- Use Calibrated machine
- Put weighing balance on flat surface
- Each time adjust to zero
- Keep the pan clean
- Weigh child with minimum clothing
- Weigh everyday at fixed time of the day
- Record weight to the nearest gram
- Standardize machine regularly
- Explain mother
- Plot daily weight chart

Measurement of Length

- Use length boards
- Put / mount on flat surface
- For children less than 87cm take length
- For children more than 87 cm take height
- If not then subtract 0.7 cm from length
- Clean everyday with disinfectant
- Record closest to 0.1 cm

To measure length

Use a measuring board like infantometer with a headboard and sliding foot piece.

Work with a partner. One person should stand or kneel behind the headboard and:

- Position the child lying on his back on the measuring board, supporting the head and placing it against the headboard.
- Position the crown of the head against the headboard, compressing the hair.
- Hold the head with two hands and tilt upwards until the eyes look straight up, and the line of sight is perpendicular to the measuring board.
- Check that the child lies straight along the centre line of the measuring board and does not change position.

To measure height

Use a Stadiometer with a vertical back board, a fixed base board, and a movable head board.

Work with a partner. One person should kneel or crouch near the child's feet and:

- Help the child stand with back of the head, shoulder blades, buttocks, calves and heels touching the vertical board.
- Hold the child's knees & ankles to keep the legs straight and feet flat.
- Prevent children from standing on their toes.
- Young children may have difficulty standing to full height. If necessary, gently push on the tummy to help the child stand to full height.

The other person should bend to level of the child's face and :

- Position the head so that the child is looking straight ahead (line of sight is parallel to the base of the board)
- Place thumb and forefinger over the child's chin to help keep the head in an upright position
- With the other, pull down the head board to rest firmly on top of the head and compress hair.
- Measure the height to the last complete 0.1 cm and record it immediately on the case recording sheet.

How to use growth chart?

World health organization (WHO) growth charts are used most often and considered the standard around the world:

Typical measurements taken for children 0-24 months include :

- Head circumference
- Length
- Weight

Measurement should be taken at regular intervals in order to observe reliable trends. Recommendation for measurement intervals include:

- Infants (0-12 months) : every 2 months
- Young children at 15, 18, 24 & 30 months
- Age 3+ every year.

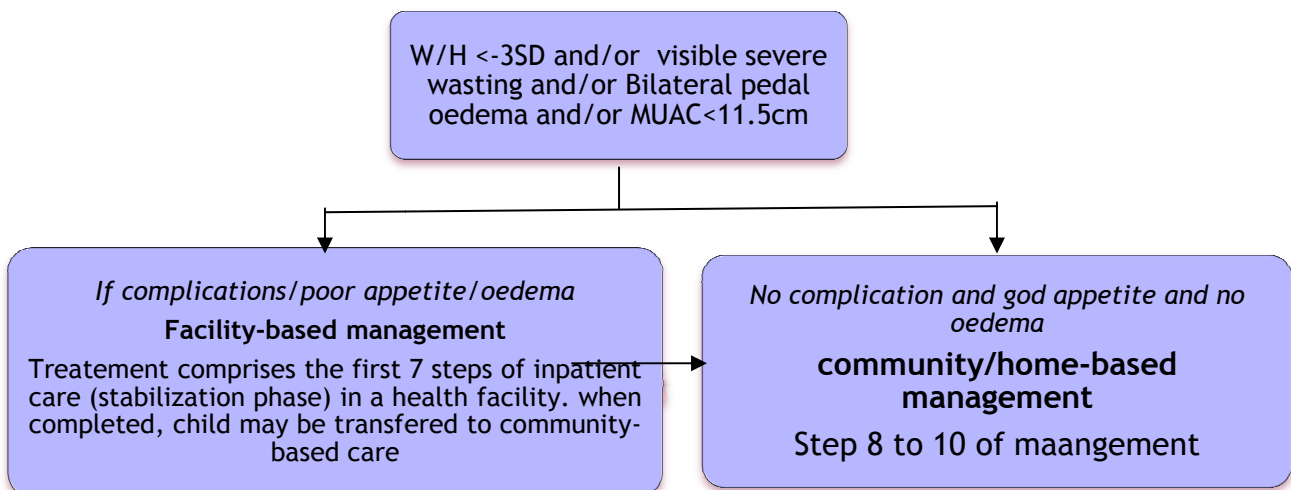
How to use growth charts

The following measurements can be applied to the most commonly used growth chart :

- Head circumference for age
- Length for age
- Weight for age
- Weight for length / weight for height

On the WHO growth charts, there are five curves. The middle curve (labelled 0) is the median on average. This line is also called the 50th percentile, because 50 percent of all children are above the median and 50 percent fall below. A normally growing child will typically have a growth curve that is parallel to the median.

Other lines in the curves, called z-score lines, indicate distance from the median curve. Points far from the median, such as a 3 or -3, typically indicate some kind of growth problem. One point on its own does not give an accurate assessment of a child's growth. Instead, a series of points provides insight into a child's growth patterns & tendencies over time.



Appetite test can be conducted poor appetite is a reliable indicator for severity of illness and thus need for hospitalization.

Children with following medical complications should be admitted in a Nutrition Rehabilitation centre or a health facility

- Presence of any of emergency signs
- Edema

- Persistent vomiting
- Very weak, apathetic
- Fever (Axillary temperature > 38.5 degree Celsius)
- Children with fast breathing / chest in drawing/ cyanosis (Fast breathing is said to be present if number of breaths per minute is 60 or more in children up-to 2 months, 50 or more in children 2 months up-to 1 year and 40 or more in children 1 year up-to 5 years)
- Extensive skin lesions, eye lesions, post-measles states
- Diarrhoea with dehydration based on history and clinical signs
- Severe anaemia
- Hypothermia (Axillary temperature <35 degree centigrade)
- Any other general sign which the clinician thinks warrants transfer to in-patient facility for assessment or care

In addition to above criteria if the caregiver is unable to take care of the child at home, the child should be admitted.

- A. General principles of routine care (the 10 steps)
- B. Emergency treatment of shock and severe anaemia
- C. Treatment of associated conditions
- D. Failure to respond to treatment
- E. Discharge before recovery is complete

PREPARE FOR DISCHARGE

Criteria for Discharge from in patient care.

Child	<ul style="list-style-type: none"> • Achieved weight gain $\geq 15\%$ (See Annex 20 for target weight at 15 % weight gain) and has satisfactory weight gain for 3 consecutive days ($>5\text{gm/kg/day}$) • Edema has resolved • Child eating an adequate amount of nutrition food that the mother can prepare at home • All infections and other medical complications have been treated • Child is provided with micronutrients • Immunization is updated
Mother/caregiver	<ul style="list-style-type: none"> • Knows how to prepare appropriate foods and to feed the child • Knows how to make appropriate toys and play with the child • Knows how to give home treatment for diarrhea, fever and acute respiratory infections and how to recognize the signs that/he must seek medical assistance • Follow –up plan is completed

All children with SAM should be followed by the health workers at home or at community centers till s/he reaches weight for-height of -1 SD.

Teaching parents to care for the child and prevent recurring malnutrition

Parents should be educated about:

- Correct breastfeeding and feeding practices (frequent feeding with energy and nutrient dense foods)
- Taking the child for vitamin A supplementation (children aged 9-59 months) 6 monthly
- Taking the child to the health facility for vaccination as per the schedule in Mother and Child Protection card/Immunization card
- Giving structured play therapy to the child.

Follow-up

- Before discharge, make a plan with the parent for a follow-up visit at 1 week after discharge. Regular check-ups should also be made at 2 weeks in first month and then monthly thereafter until WHZ reaches -1 SD or above. If a problem is found, visits should be more frequent until it is resolved.

Give general discharge instructions

In addition to feeding instructions, mothers will need to be taught:

- How to continue any needed medications, vitamins, folic acid (for 2-weeks), and iron (for 2-3 months) at home.
- when to bring the child back for immediate care:
 - Not able to drink or breastfeed. Stops feeding.
 - Develops fever.
 - Has fast or difficult breathing.
 - Has a convulsion.
 - Has diarrhoea for more than a day, or blood in stool.

If early discharge is unavoidable, make special arrangements for follow- up

If a child must be discharged before the discharge criteria are met it is critical to make arrangements for follow-up of the child (for example, special visits by a health worker to the child's home, or outpatient care at a health facility or nutritional rehabilitation centre). Mothers will need special training to prepare feeds and give iron, folic acid, and multivitamins at home. Admission criteria management protocol discharge and follow up for CTC is same as NRC

VCDC (Village child development centre)

Criteria of admission :

- W/H <-3SD **and/or**
- visible severe wasting **and/or**
- Bilateral pedal edema **and/or**
- MUAC < 11.5cm

Functioning of VCDC

- Village level management of SAM and MAM at Anganwadi centre normal AWC functioning goes on simultaneously. SAM/ MAM children come at 8 am while regular AW starts around 9 am or 10 am.
- Anganwadi worker is the in charge personnel for VCDC.
- Duration – 1 month (30 days) excluding the holidays.
- Organization of VCDC- even one SAM or MAM child.
- Admission procedure-

- A) Primary screening by AWW of SAM/ MAM without complication.
- B) Medical checkup by MO
- Discharge criteria: After 30 days (after adopting new protocols after 21 days) irrespective of weight gain.
- If no/poor weight gain then child is to be referred to CTC/NRC
- No need for parents to stay with the child with some exceptions
- Low cost intervention

Nutrition Management

- Feeds are given in AWW from 9 to 12 pm and 2 to 4 pm.
- Various food items are given using THR, milk powder. The AWC meal of that day, banana, roasted potatoes, etc.
- The mother feeds between 12 to 2 pm at home.
- Occasionally eggs are served.
- All this is expected to improve the child's status.
- Not enough provision to meet the requirements.

Special Amylase feeds

- Amylase develops in sprouting grain & legumes
- Amylase helps digestion. For this wheat and green gram which are sprouted, dried and powdered.
- This flour mixed with groundnut flour, oil, sugar & makes a good paste for the child, most children like this.
- Micronutrients sachet is added to this once daily.

Medical management-

Medicines and their Dosage

Sr. No	Name of drug	Dose	Time
1	Albendazole	1-2 years 200mg (5ml)	Once before admitting in VCDC
		2-3 years 400mg (10ml)	
		3-6 years 400mg (1 tab)	
2	Vitamin A (Confirm not given last 6 months)	1ml below 1 yr child	
		2ml above 1 yr child	
3	Tab Folic Acid	1mg, 1 tablet (everyday)	In the morning for 1 st 7 days
4	Amoxicillin	50 mg/kg/day	Morning/Afternoon/Evening for 7 days, all SAM and infected children
	Antibiotics (syr)		
5	Syrup Hovite RB/ Visyneral-Z / Containing medicine	1 to 2 yrs – 2ml	Afternoon
		2 to 6 yrs – 4ml	
6	Mecalvit Plus/ Containing medicine	1ml/kg/day	Morning
7	Orofex-XT/ Containing medicine	3mg iron/kg/day	Evening (After 7 days if the child starts gaining weight and is free from infection)

3. ROUTINE IMMUNIZATION (RI) PROGRAMME

INTRODUCTION

- Expanded programme on immunization initiated in India in 1978
- Universal immunization programme launched on 19th November 1985
- Immunizations programme is one of the major components of national technology mission

OBJECTIVES OF REVIEWING VACCINATION PROGRAMME

1. Review the policies, strategies and plans of action
2. Measure the progress
3. Identify the bottlenecks and constraints
4. Make recommendations

MAJOR OBSERVATIONS

1. POLICY ASPECT:

- Included in the 20 point programme
- a technology mission for immunization has been created
- states have accepted to carry out the programme and formed technology mission
- policy decision to integrate immunization programme with primary health care
- provided through PHC and subcentres
- government of India provided 100 % financial support to states
- clear-cut policies for implementing immunization programme in urban areas almost non-existence

2. ORGANISATIONAL AND OPERATIONAL ASPECTS

- Programme is being implemented in an integrated manner
- d.i.o. faced the problems of lack of adequate administrative authority, ambiguity regarding relationship with other district health official

3. RESOURCE AVAILABILITY

- 30.95 % districts with less number of functional sub-centres
- 24% of subcentres with female staff residing outside area

IMMUNIZATION SCHEDULE POST-PENTAVALENT & IPV INTRODUCTION

Age	Immunization schedule (Post pentavalent & IPV Introduction)	Remarks
At birth	BCG, OPV (O Dose) hepatitis B (birth dose)	<ul style="list-style-type: none">• BCG vaccine can be given up to 1 year of age.• DPT vaccine can be given up to 5-6 years (not beyond 7)
6 weeks (1 ½ months)	OPV-1, pentavalent-1, IPV-1	
10 weeks (2 ½ months)	OPV-2, pentavalent-2	

14 weeks (3 ½ months)	OPV-3, pentavalent-3, IPV-2	years)of age. • Measles vaccine can be given up to 5 year of age. • JE vaccine can be given up to 15 years of age. • B-OPV Instead of T-OPV
9 months	Measles first dose, JE-1 (where applicable)	
16-24 months	DPT-booster first dose, measles second dose, OPV booster dose, JE second dose (where applicable)	
5-6 years	DPT-booster second dose	
10 years	TT first booster dose	
16 years	TT secondbooster dose	

Remember

- Do NOT repeat BCG if given once, even if the eschar /scar does not appear.
- Do NOT give BCG if child is over one year old.
- Giving DPT/PENTA in buttocks (gluteal region) may injure the sciatic nerve and cause paralysis. Never give DPT /PENTA in buttocks
- Always give DPT/PENTA in outer mid thigh (Lt.Antero-lateral Thigh in vastus lateralis muscle
- Wait at least 4 weeks (one month) after previous dose of PENTA-OPV before giving next dose.
- If child comes after gap of more than 4 weeks for its next dose of PENTA-OPV, give next dose of series. Do NOT repeat previous dose, as there is no maximum interval between doses.
- Give DPT and OPV Booster dose at 16 months till 24 months (Wait at least 6 months after OPV3 & PENTA3)
- Give DPT at 5 years of age
- If no DPT is given till 5 years, give 2 doses of TT one month apart as soon as possible
- Give TT at 10 years and 16 years
- Give TT Booster only if already received at least two TT injections within last 3 years
- Try to give TT2 or TT Booster at least one month before Expected Date of Delivery. However, give even if less than 1 month remains.
- All due vaccines can be given at same time but in different limbs (sites)
- e.g. it is safe and effective to give BCG, PENTA, OPV, IPV, Measles & VitA at same time to a 9 month old child who has never been immunized
- After Pentavalant do not keep baby in zoli for 48 hrs.
- Even if the child is suffering from diarrhea, mild fever or malnutrition, it should be vaccinated.Unless a child is so sick that it has to be taken to hospital, do not stop its vaccination

The goal is to fully immunise each child before its first birthday

Give these 4 Key Messages to the Care-giver:

1. What vaccine was given and what disease it prevents (e.g. BCG for preventing TB)
2. When to come for the next visit.
3. What are the minor side-effects and how to deal with them.
4. To keep the vaccination card safe and to bring it along for the next visit

PLANNING & IMPLEMENTATION

Planning immunization services

Immunization Microplan

- State Plan = Compiled District Plans + state specific activities
- District Plan = Area map, Compiled PHC plans + supervision, budget, IEC, training etc.
- PHC Plan = Area map, Compiled SC plans, supervision plan + alternate vaccine delivery, waste disposal
- SC Plan = Area Map, estimation of beneficiaries, vaccine logistics and ANM work plan

Step 1

- List all villages and hamlets in SC area. If hamlets have too small a population, tag these along with larger nearby villages

Step 2

- Write population of each village and hamlet based on actual headcount

Steps 3 and 4

- Write the annual target of pregnant women and infants

Steps 5 and 6

- Write the monthly target of pregnant women and infants

Step 7

- Calculate the beneficiaries per month for each vaccine and Vitamin A

TT = Monthly target of pregnant women x 2 doses

BCG = Monthly target of infants x 1 dose

PENTA = Monthly target of infant x 3 dose

DPT = Monthly target of infants x 2 doses

OPV = Monthly target of infants x 6 doses

IPV = Monthly target of infant x 2 doses

HepB = Monthly target of infants x 1 doses

Measles = Monthly target of infants x 2 dose

Vit.A = Monthly target of infants x 9 doses

Step 8

Calculate the requirement of vaccine vials and Vitamin A per month

$$\text{❖ BCG} = \frac{\text{Beneficiaries per month} \times 2}{10}$$

$$\text{❖ TT/ PENTA/DPT/HepB/DT} = \frac{\text{Beneficiaries per month} \times 1.11}{10}$$

$$\text{❖ OPV} = \frac{\text{Beneficiaries per month} \times 1.11}{20}$$

$$\text{❖ IPV} = \frac{\text{Beneficiaries per month} \times 1.11}{50}$$

$$\text{❖ Measles} = \frac{\text{Beneficiaries per month} \times 1.33}{5}$$

$$\text{❖ VitA} = \{(\text{monthly target of infants} \times 1 \text{ ml}) + (\text{monthly target of infants} \times 2 \text{ ml} \times 8)\} \times 1.11^{**}$$

• Vaccines = 25% wastage rate or 1.33 WMF (Wastage Multiplication Factor) ** VitA = 10% wastage rate or 1.11 WMF

• For – BCG = 50 % wastage rate or 2 WMF

• For – PENTA = 15 % wastage rate or 1.11 WMF

For – Measles = 25 % wastage rate or 1.33WMF

Step 9

- Calculate the requirement of Syringes per month
 $0.1 \text{ ml ADS} = \text{Beneficiaries for BCG} + \text{Beneficiaries for IPV 2} \times 1.1^*$
 $0.5 \text{ ml ADS} = \text{Beneficiaries for (TT+ Penta + HepB+ Measles + DPT)} \times 1.1^*$
 Reconstitution Syringes = (BCG + Measles+ JE vials) X 1.1*
** Syringes = 10% wastage rate or 1.11 WMF (Wastage Multiplication Factor)*

Steps 10 to 13

- List all villages & hamlets in Sub-Center area in the same order as Step 1
- Write distance of village from the closest ILR
- List names of the AWW and ASHA
- Write the monthly injection load per village
- Write the monthly injection load per village

Step 14 to 15

Calculate the number of sessions required per month (in column sessions required per month)

Outreach sites	Fixed sites
<ul style="list-style-type: none"> 1-24 injections = 1 session every alternate month 25-50 injections= 1 session per month 51-100 injections = 2 sessions per month, etc <p><i>For hard-to-reach areas with popn. less than 1000 = minimum of 4 sessions a year</i></p>	<ul style="list-style-type: none"> 1-39 injections = 1 session every alternate month 40-70 injections= 1 session per month 71-140 injections = 2 sessions per month, etc <p><i>For a busy CHC/RH, plan daily sessions.</i></p>

- Write day of immunization session in village

Step 16

Area Map

- Prepare a map of the Sub-Center area including all villages and hamlets with their:
- Total population and annual target infants
- Anganwadi Centers and session sites
- Distance from the ILR point and transport mode
- Landmarks e.g. Panchayat, school, roads etc.

Sessions days

Step 17

Prepare a quarterly supervision plan at the PHC level

F. A. Q.s	
Scenario	Answer
< 6 week child	No IPV
At 6 weeks, without birth dose	OPV 1 + IPV 1 (rt.u.l), BCG (lt.u.l), penta 1(lt. Thigh)
Child taken OPV 1 & penta 1	No IPV
> 6weeks but <1yr, no OPV, no penta	OPV 1, IPV 1 (rt.u.l), penta 1(lt.thigh):if>9 months; measles 1+Vit A
BCG syringe requirement	3 per child (1:bcg, 2:IPV)

OPV 1, IPV 1& penta 1 and OPV 2, penta 2 between 6 weeks-1yr age: child comes after 1 yr	OPV3, IPV 2, penta 3 at earliest available opportunity
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DISEASE SURVEILLANCE

- **Diphtheria:**
 - Sore throat with gray patch(es) in throat
- **Pertussis (whooping cough):**
 - Repeated & violent coughing, with:
 - Cough persisting for 2+ weeks, fits of coughing,
 - Cough followed by vomiting, typical whoop in older infants.
- **Tetanus:**
 - Suck& cry in first 2 days of life,
 - Illness between 3- 28 days of life,
 - Inability to suck foll. by stiffness of neck & body &/or muscle jerking

DELIVERY OF IMMUNISATION SERVICES

Reasons for failure of immunization

- Unaware of need
- unaware of need to return
- place and time unknown
- fear of side reaction
- wrong ideas about
- place too far to go
- Inconvenient time
- vaccinator absent
- mothers too busy
- child ill
- postponed
- no faith
- rumours

Why families do not use immunization services

- Lack Of Information
- Poor Services
- Long Wait
- Rudeness Or Insensitivity
- Unauthorized Fees Charged
- Unscheduled Facility Closures
- Shortage Of Personnel, Vaccines, Drugs Or Other Supplies
- Time Constraints
- Not Be The First Priority For A Mother
- Social, Cultural Or Political Barriers
- Misinformation
- Distance

STRATEGIES FOR INCREASING THE USE OF ROUTINE IMMUNISATION SERVICES

(A) Reaching The Unreached

- Improvement in scheduling
- raising awareness
- improving and expanding outreach
- targeting services to meet urban needs

B) Reducing Drop-Outs:

Example:

DISTRICT 'A'

50% of children have access to immunization

Services using penta - 1 coverage as an indicator. 42% complete the three - dose series of penta calculate the drop-out rate

$$\frac{(50\% - 42\%) * 100}{50\%} = 16\%$$

DISTRICT 'B'

85% of children have received penta-1 and 58% completed the three dose series of penta calculate the drop-out rate

$$\frac{(85\% - 58\%) * 100}{85\%} = 32\%$$

(C) Limiting Missed Opportunities

- Improve Screening
- Give All Vaccines Due
- Eliminate False Contraindications
- Clarify Policy On Multi-Dose Vials
- Clarify Open Vial Policy
- Supplemental Immunization Strategies
- Accelerated Disease Control
- Catch-Up Campaigns
- Door-To-Door Vaccination
- Mop-Up Strategies
- Out-Break Response
- Special Population

OPEN VIAL POLICY

Open vial policy states that vials of liquid DPT, TT, HepB OPV and Pentavalent vaccines left after immunization session should be used within 4 weeks maintaining the cold chain temperature and before the expiry date.

- Applicable to DPT, Hep B, TT, OPV, IPV and pentavalent vaccines
- Not applicable for BCG, Measles containing vaccine, JE, rotavirus vaccines.
- Write date and time of opening on labels of all vials.
- Partially used vials can be used at more than one immunization session up to four weeks of opening the vial provided
 1. The expiry date has not passed.
 2. The vaccines are stored under appropriate cold chain conditions.
 3. The vaccine vial septum has not been submerged in water.
 4. Aseptic technique has been used to withdraw all doses.
 5. The vaccine vial monitor (VVM), if attached, has not reached the discard Point.
 6. If the VVM on the Vial is in good condition then use the vaccine

COLD CHAIN AND LOGISTICS

Definition

Cold Chain is a system of transporting and storing vaccines at recommended temperature from the point of manufacture to the point of use.

Essential Elements of Cold Chain

- PERSONNEL to organize and manage vaccine distribution
- EQUIPMENT for storage and transport of vaccines.
- Transport facilities
- Maintenance of equipment
- Monitoring

In general

- All Vaccines tend to lose potency on exposure to heat above +8⁰ C
- Some Vaccines lose potency when exposed to freezing temperatures
- The damage is irreversible

Ice lined reffridgerators (ILRs)

- Capacity: 140 litres at PHC level(1200 vials)
- Ideal Temperature: +2°C to 8°C(Effective with electricity supply of 8/24 hrs)
- Safe Storage: Always in the basket section(all T series,PENTA, Hepatitis-B and Diluents)
- OPV/Measles/BCG ,JE may be kept below basket in case space is not available
- Thermometer: Place in the ILR-basket

Right way of keeping vaccines in ILR

- Keep all vaccines in baskets
- Avoid placing vaccines at bottom of ILR. (never diluents, freeze sensitive)
- Leave space between the vaccine boxes
- Place a thermometer in the center of the ILR.
- Same vaccines in same area.
- Diluent / freeze sensitive/ Closer expiry date vaccines on top
- Heat sensitive / Further expiry date vaccines in the bottom of basket

Deep freezers (DF)

- Capacity: 140 litres at PHC level
- Ideal Temperature: -18°C to -20°C(In case of power failure - maintain temperature for 18-20 hrs)
- Ice Pack Freezing Capacity: freezes 20 ice packs every 24 hours.

Cold Boxes

- Type: Insulated boxes of 5 litre capacity
- Usage: Stores & transports vaccine. Also stores frozen Ice Packs
- Capacity: 1500 doses (mixed antigen) or 5000 doses (only OPV) with 24 ice packs.
- Holdover Time:3 days (Keep thermometer inside)
- Vaccine Layout: Direct contact of frozen Ice packs spoil the vaccine. Give carton spacers/surround vaccine by OPV vials.
- Label Protection: Place vaccine in cartons or polythene bags.

Vaccine Carrier

- Type: Insulated boxes used for carrying small quantities of vaccine.
- Capacity: 16-20 vials
- Holdover Time: Maintain +2 to +8°C for about 24 hours (one day)
- Ice packs: A maximum of 4 frozen packs
- Vaccine Layout: Keep vaccines in a plastic bag (not in direct touch with the Ice packs)

Ice Packs

- Do not fill 100%.
- Leave 10 mm room for expansion as water freezes.
- Close the cap tightly
- Clean the outer surface dry before freezing

Ice Pack Freezing

- Ice Packs to be frozen ROCK Solid
- Freezing is faster & uniform if gap /breathing space is left between ice packs
- Ice Packs are best frozen in Deep Freezers

CONDITIONING BEFORE USE

Preparing icepacks for use: Conditioning

- On the session day, take the frozen ice-packs you need from the freezer and place on a table

- Allow ice-packs to sweat (droplets of water) at room temperature
- Shake the ice pack to listen to sound of water.

Maintenance of Equipment

- Defrosting/Cleaning: Ice deposit 5mm & over in freezer or at the bottom of ILR results in rise in temperature. Periodic defrosting & cleaning ensures trouble free performance for a long period.
- Cold boxes/Vaccine Carriers: Cold box hinges, lid knobs & chains are often damaged. Replace or repair locally. Minor insulation casing cracks/gaps can also be repaired with fresh PUF insulation
- Ice Packs: Fill clean water for freezing & leave 10mm room for expansion as water freezes. Cap tightly to avoid leakage. Keep pack clean & dry.

Vaccine Distribution

- Follow first-in-first - out rule (FIFO)
- Also: first to expire - first out. (FEFO)
- Vaccines are not stored at the sub-centre level and must be supplied on the day of use
- Note manufacturer, batch no, VVM status
- Use VVM stage-II vaccine near the cold chain point (do not distribute to remote areas)

Storage Temperature

- Monitor temperature twice daily.
- All vaccines at PHC are stored between +2 to +8°C

Vaccine/Diluent storage in ILR

- On Ice Pack- BCG and Measles (place them in the holes on ice pack), OPV and JE vaccine should be placed on the surface of the ice pack.
- Remember – IPV, HepB, TT, DPT and Penta should never be kept on the ice pack.

ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI)

What is an AEFI ?

A medical event that takes place after an immunization, causes concern, is believed to be caused by immunization and ranges from mild side effects to life-threatening, but rare, illnesses.

CAUSE SPECIFIC DEFINITION OF AEFI

S.N	Type of AEFI	Definition	Example
1	Vaccine product-related reaction	An AEFI that is caused or precipitated by a vaccine due to one or more of the inherent properties of the vaccine product.	Extensive limb swelling following DTP vaccination.
2	Vaccine quality defect-related reaction	An AEFI that is caused or precipitated by a vaccine that is due to one or more quality defects of the vaccine product including its administration device as provided by the manufacturer.	Failure by the manufacturer to completely inactivate a lot of inactivated polio vaccine leads to cases of paralytic polio.
3	Immunization error-related reaction	An AEFI that is caused by inappropriate vaccine handling, prescribing or administration.	Transmission of infection by contaminated multidose via
4	Immunization anxiety-related reaction	An AEFI arising from anxiety about the immunization.	Vasovagal syncope in an adolescent following vaccination.
5	Coincidental event	An AEFI that is caused by something other than the vaccine product, immunization error or immunization anxiety	A fever after vaccination (temporal association) and malarial parasite isolated from blood.

Elicit past history of AEFIs

Ask parents about history of any adverse reaction following earlier vaccinations, such as convulsion after DPT vaccination.

Preventing AEFIs

- Training health workers - reconstitution procedures, administration techniques - safe injection practices
- Train cold chain handlers and vaccinators and monitor correct storage procedures
 - **Do not store drugs and other substances in ILR, use exclusively for vaccine**
 - **Keep reconstituted vaccines on one ice pack per session**
 - **Strictly follow Open Vial Policy guidelines**
- Ensure only one session per day. Use separate vaccine carriers for separate sessions
- Strictly no house to house vaccination!!
- Direct observation of vaccinated children for 1/2 hour for AEFI

- Investigate, identify program or operational error and correct immediately to avoid recurrence.

How to minimize AEFIs?

1. Use separate site for each vaccine.
2. Use one syringe and one needle for each injection.
3. Use auto-disable syringes for all immunization injections.
4. Reconstitute vaccines only with diluents supplied by the manufacturer for that vaccine.
5. Use Measles and BCG vaccine within 4 hours of reconstitution.
6. Keep diluents of BCG and measles vaccine separate from other potentially harmful liquids.
7. Do not keep needles in the rubber cap (stopper) of vaccine vials. This can cause toxic shock syndrome, a deadly and completely avoidable adverse event.
8. Do not store other drugs or substances in the ice-lined refrigerator or deep freezer

What to Report?

- All abscesses
- Serious events requiring hospitalizations
- Deaths
- Clustering of Cases

Management of anaphylaxis

- Clear the airway
- Cardiopulmonary resuscitation
- Injection Adranalin 1:1000 (by deep intramuscular into opposite lymph, subcutaneous in mild cases).
 - Adranalin in doses :- 1:1000 at the dose of 0.01 ml/kg maximum .05 ml ,IM/SC
 - Less than 2 years :- 0.0625 ml (1/16th of a ml)
 - 2 to 5 years :- 0.125 ml (1/8th of a ml)
 - 6 to 11 years :- 0.25 ml (1/4th of a ml)
 - 11 + years :- 0.5 ml (1/1/2 of a ml)
- If no improvement, repeat within 10-20 minutes of the first injection, up to a maximum of three doses, in total.
- Give Inj. Hydrocortisone IM or slow IV per dosage
- If patient conscious after adrenaline is given, place his/her head lower than the feet and keep the patient warm.
- Give oxygen by face mask, if available.
- Mark the immunization card clearly to prevent future repeat dose of offending vaccine.
- Report anaphylaxis to the appropriate officer

State/district AEFI committee meetings

- Constitute district/corporation AEFI Committees; review membership of existing committees
- Every state/district under Intensified Mission Indradhanush should conduct two AEFI committee meetings

- Organise one meeting of at least two hours duration before IMI to orient members on UIP, AEFI surveillance, their role in investigations and managing media
- Second meeting a week after IMI to help investigate any case reported during IMI. Even if no AEFI has been reported, discuss why, decide and take corrective actions
- Track AEFI committee meetings and forward information to local WHO office
- Minutes of state and district AEFI committee meetings should be recorded, shared with state, national level and local WHO office

Response to an AEFI

Provide immediate primary management for any adverse event

- Minor AEFIs – provide symptomatic treatment and refer, if needed
- Serious/severe AEFIs -
 - Refer immediately to nearest health facility/AEFI management centre and inform appropriate authority to ensure proper treatment
 - In case state ambulance service (108/102) is not available or delayed, arrange local transportation. Costs may be borne through untied funds (sub centre/Village Health and Sanitation Committee)

AEFI surveillance: roles

- All ANMs/ASHAs/AWWs and MOs must
 - be sensitized/oriented/trained to recognize and notify/report AEFI promptly.
 - know what to do when an AEFI occurs
 - be aware of location of the nearest AEFI management centre.
- Job Aids for Medical officers should be printed and displayed in OPDs, casualty/emergency wards and paediatric OPDs.
- Job Aids for ANMs should be translated into vernacular language and disseminated prior to campaign
- The State/district AEFI committee should be
 - Aware of intensified Mission Indradhanush
 - Prepared to support SEPIO/DIO in investigating serious/severe AEFIs
 - Involved in managing media during times of crises as secondary spokesperson
- Every government health facility (PHC and above with at least one medical officer) will function as an AEFI management centre
 - Private clinics / hospitals may also be designated as an AEFI management centre if possible with arrangements for reimbursement of treatment costs on case-to-case basis
 - Ensure AEFI kits are available at all AEFI management centres with contents within expiry dates, especially adrenaline
- All clinicians to be trained in standard AEFI management and reporting procedures
- All medical officers acting as supervisors will carry an emergency AEFI treatment kit.
- Micro-plans and session tally-sheets must include names, address & contact numbers of the nearest AEFI management centre
- State ambulance services (108 or 102) may be instructed to be on standby to ensure immediate transportation

FREQUENTLY ASKED QUESTION (FAQ)

Que. 1) If a child is brought late for a subsequent dose, should one re-start with the first dose of a Vaccine?

Ans . No do not restart the schedule again: pick up where the schedule was left off. For example – If a child who has received BCG, PENTA 1 and OPV 1 at 5 months of age returns at 11 months of age, then vaccinate the child with PENTA 2, OPV 2, Measles, Rotavirus vaccine (Where applicable) and JE (Where applicable).

Que. 2) If a child who has never been vaccinated is brought in at 9 completed months but before 12 completed months of age, then can all the due vaccines be given to a child on the same day?

Ans . Yes all the due vaccines can be given during the same session but at recommended injection sites, using separate AD syringes. It is safe and effective to give BCG, PENTA, OPV, IPV, Measles, RVV (Where applicable), JE (Where applicable) Vaccine and Vit. A at the same time to a 9 month old child who has never been vaccinated.

Ques. 3) If a child who has never been vaccinated is brought in immediately after completing 12 month of age, (beyond one year) what vaccines would you give?

Ans. As per the national Immunization schedule this child need not be given – BCG, Hepatitis B, Rotavirus, PENTA and IPV.

This child should be administered DPT1, OPV 1, Measles 1, JE 1 (if applicable) and also Vit A solution.

The subsequent doses of DPT and OPV should be given at an interval of 4 weeks. Administer Measles 2, JE 2 (if applicable), Vit A and a booster dose of DPT at recommended age as per national Immunization schedule.

Ques. 4) Which vaccines can be given to a child between 1 and 5 years of age who has never been vaccinated ?

Ans . Such a child will not receive BCG, Hepatitis B, Rotavirus, PENTA and IPV. Give DPT 1, OPV 1 Measles 1, JE 1 (Where applicable) and 2ml of Vit. A solution.

Then follow with the second and third doses of DPT and OPV at 1 month intervals. Give measles 2 as per the schedule / 1 month later* Give booster dose of OPV/DPT at a minimum of 6 month after administering OPV 3/DPT3. Also give Vit. A at 6 months interval till 5 years of age.

*Note:- In an unvaccinated child more than 16 months of age remember the interval between Measles 1 and Measles 2 is 4 weeks and for JE 2 (where applicable) the interval is 3 months.

Ques 5) Which vaccine can be given to a child between 5 and 7 years of age who has never been vaccinated?

Ans. Give of DPT1, 2 and 3 at month intervals. Give booster dose of DPT at a minimum of 6 months after administering DPT 3 up to the age of 7 years.

Ques. 6) If no scar appears after administering BCG, should one re-vaccinate the child?

Ans. There is no need to re-vaccinate the child even if there is no scar.

Ques. 7) For what reasons should a child not be given PENTA valent vaccine?

Ans .: A) Age – a child below 6 weeks of age should not be given pentavalent vaccine.

B) Vaccination history – a child whose vaccination schedule has been initiated with DPT/Hepatitis B vaccine will continue to receive subsequent doses of DPT/Hepatitis B and not pentavalent vaccine.

C) Severe allergic reactions – although serious side effects have not been reported, a child who has had a severe reaction to pentavalent vaccine earlier should not be given another dose.

D) Children with moderate or severe Acute illness should not be administered pentavalent vaccine until their condition improves. Minor illnesses, however such as upper respiratory infections (URI) are not a contraindication to vaccination.

Ques. 8) What vaccine will be given to a child who has received at least one dose of pentavalent vaccine before his/her first birthday?

Ans. If a child has received at least one dose pentavalent vaccine before his/her first birthday, the child should be administered the due pentavalent doses at a minimum interval of 4 weeks, at the earliest available opportunity.

Ques. 9) What are the common side-effects of pentavalent vaccine?

Ans. Pentavalent vaccine has not been associated with any serious side-effects. However, redness, swelling and pain may occur at the site where the injection was given. These symptoms may appear the day after the injection is given and last from 1 to 3 days. Less commonly, children may develop fever for a short time after immunization.

Ques. 10) After introduction of pentavalent vaccine, will DPT and Hepatitis B be required?

Ans. Yes, Hepatitis B birth dose (within 24 hours) for institutional deliveries and DPT boosters at 16 – 24 months and 5 – 7 years will continue as before – introduced.

Ques. 11) What is IPV?

Ans. IPV refers to inactivated Poliovirus Vaccine administered by injection. Evidence suggests that this vaccine, when used along with OPV, increases the protection to the individual as well as the community. IPV together with OPV prevents re-emergence and reinfection of wild poliovirus (WPV).

Ques. 12) Will IPV (Injection) replace OPV (drops)?

Ans. No, IPV (Injection) will not replace OPV (polio drops), since IPV is recommended to be administered in addition to OPV.

Ques. 13) Is IPV a new vaccine?

Ans. No, IPV is not a new vaccine. It is being used in many countries. IPV was licensed in 1955 for use in United States, Canada, and Western Europe.

IPV was licensed for use in India in 2006. Based on recommendations of the Indian Academy of Paediatrics (IAP), IPV is being used in the private sector in addition to OPV schedules since 2007.

Ques. 14) What is the benefit of IPV?

Ans. IPV provides much needed additional protection against polio and protects a child as well as other children in our community. Evidence shows that when IPV is used along with OPV, it builds better mucosal (intestinal) immunity than when OPV is used alone: it thereby increases

both the protection to the individual and the community. To maximize childhood immunity and move towards global polio eradication, it is recommended that both vaccine be used together.

Ques. 15) Is IPV safe?

Ans. Yes, IPV is considered very safe, whether given alone or in combination with other vaccines.

Ques. 16) Are there any contraindications for use of IPV?

Ans. IPV should not be administered to children with a documented or known allergy to streptomycin, Neomycin or polymyxin B or with a history of a previous allergic reaction after IPV injection.

Ques. 17) If a child has received the Measles Rubella vaccine before 9 months of age, is it necessary to repeat the vaccine later?

Ans. Yes, the Measles Rubella vaccine needs to be administered, according to the National Immunization Schedule, after the completion of 9 months until 12 months of age as 1st dose and at 16-24 months for age first dose, then can months as 2nd dose in RI.

Ques. 18) If a child comes after 2 years for the first dose, then can he/she get the 2nd dose?

Ans. All efforts should be made to immunize all children at right age that is 1st dose at completed 9 month to 12 month & 2nd dose at 16 – 24 months. However if child comes late (beyond 2 year) then 2 dose of the vaccine can be given at one month intervals until 5 years of age under UIP.

Ques. 19) If the child has received all vaccines as per the immunization schedule, does she ;/ he need to be vaccinated during supplementary MR Camp ?

Ans. Yes, in addition to the recommended national immunization schedule the child (if eligible as per age group targeted) must be vaccinated with supplementary MR vaccines during campaigns.

Ques. 20) As Measles and JE vaccine doses are recommended for the same age group , can they be given together?

Ans. Yes, two live injectable vaccine can be administered simultaneously at different site other wise at a minimum interval of 28 days.

Ques 21) How to keep vaccines at RI session site?

Ans. Placement of vaccines at RI session site in following way



Placement of vaccines at RI session site

MONITORING, EVALUATION & INFORMATION MANAGEMENT

Microplanning for Routine Immunization

What is a Micro plan?

Work-plan and estimate of requirements

Helps you identify

- What services need to be provided
- Who will provide
- When to provide
- Where to provide (including hard to reach)
- How to provide
- How many to provide for (beneficiaries)
- How much to provide (vaccines & logistics)

Steps in preparation of Micro plan

- Step 1 – List all villages and hamlets
- Step 2 – Write the population of each village
- Step 3 – Write the number of beneficiaries
- Step 4 - Prepare a map of the sub center / PHC

Basic monitoring tools

- Maps
- Patient registers
- vaccination cards
- tickler files
- tally sheets
- immunisation monitoring charts

MONITORING & EVALUATION

Indicators	What it may indicate
Penta -1	coverage availability of, access to, and initial use of immunization services
Penta-3	coverage continuity of use, client satisfaction, capability of the system measles coverage protection against disease a major public health importance
Penta -1 to penta -3	quality of services, quality of communication
T.T. -1	coverage availability of, access to, and use of immunization services by A.N.C.
T.T. -2	continuity of use, client satisfaction, capability of the system fully immunized capability of the child system
Number of immunization sessions	quality of program sessions held compared to number planned, Supply of un-expired effectiveness of vaccine vaccines procurement, delivery, management vaccine uses / waste effectiveness of fixed and outreach session scheduling, vaccination administration and vaccine handling
Temperature of	quality of cold chain chain equipment management

cold chain equipment	
Updated inventory	quality of cold chain management
Use of sterile syringes	quality of injection

Using Routine Data for Action

- PENTA 1 Doses administered
- PENTA 3 Doses administered
- PENTA 1 Coverage (%)
- PENTA 3 Coverage (%)
- Unimmunized with PENTA 3 (No.)
- PENTA 1 , PENTA 3 Drop- out rates (%)
- Access
 - High (80%) Good access
 - Low (<80%) Poor access
- Utilization
 - Low (10%) Good utilization
 - High (>10%) Poor utilization

Analysis and use of routine data

A) Immunisation coverage:

No. Immunised by penta -3 in a year *100

Penta -3 coverage:-----

No. Of surviving infants < 12 months of Age in the same year

No. Immunised by 12 months with measles in a year * 100

Measles coverage:-----

No. Of surviving infants < 12 months of Age in the same year

B) Drop-out rates:

Penta 1 cumulative total - penta 3 cumulative total * 100

Drop-out of Penta-1 and Penta-3: = -----

Penta cumulative total

Doses of highest coverage - doses of lowest coverage *100

Drop-out of highest -lowest coverage vaccine = -----

Doses of highest coverage

Regular monitoring and review of Micro plan

- Analysis of Monthly reports
 - Sessions held vs planned
 - coverage and drop outs
- Regular Review meeting
 - coverage monitoring chart
 - Review missed sessions
 - other problems

- revise session plan and work plan (if needed)
 - Supportive supervisory visits
 - monitoring the work in the field,
 - providing on-the-job training,
- taking notes for future discussion at review meetings

How to calculate vaccine requirement for PHC:

1. Annual target beneficiaries of your PHC
2. Number of doses per child per antigen as per national immunization schedule

Calculation of monthly working stock requirement for each antigen in doses as under:

- **BCG** = $\frac{\text{Yearly target infant} \times 1 \text{ dose} \times 2.0 \text{ (wastage)}}{12}$
- **DPT** = $\frac{\text{Yearly target infant} \times 2 \text{ doses} \times 1.11 \text{ (wastage)}}{12}$
- **OPV** = $\frac{\text{Yearly target infant} \times 5 \text{ doses} \times 1.11 \text{ (wastage)}}{12}$
- **IPV** = $\frac{\text{Yearly target infant} \times 1 \text{ dose} \times 1.11 \text{ (wastage)}}{12}$
- **Measles** = $\frac{\text{Yearly target infant} \times 2 \text{ doses} \times 1.33 \text{ (wastage)}}{12}$
- **TT** = $\frac{\text{Yearly target (PW)} \times 3.5 \text{ doses} \times 1.11 \text{ (wastage)}}{12}$
- **Hep. B** = $\frac{\text{Yearly target infant} \times 1 \text{ dose} \times 1.11 \text{ (wastage)}}{12}$
- **Pentavalent** = $\frac{\text{Yearly target infant} \times 3 \text{ doses} \times 1.11 \text{ (wastage)}}{12}$
- **JE** = $\frac{\text{Yearly target infant} \times 2 \text{ doses} \times 1.33 \text{ (wastage)}}{12}$

CALCULATION OF REQUIREMENT OF AD AND DISPOSABLE SYRINGES

Calculate monthly syringes requirement:

$$\text{0.1 ml AD syringes} = \frac{\text{Yearly target infants} \times 1 \text{ dose} \times 1.1 \text{ (wastage)}}{12 \text{ Months}}$$

$$\text{0.5 ml AD syringes} = \frac{\text{Yearly target infants} \times (1 \text{ doses Hep B} + 2 \text{ doses DPT} + 3 \text{ doses of Pentavalent} + 1 \text{ dose of IPV} + 2 \text{ doses Measles} + 3.5 \text{ doses TT} + 2 \text{ doses JE}^*) \times 1.1 \text{ (wastage)}}{12 \text{ Months}}$$

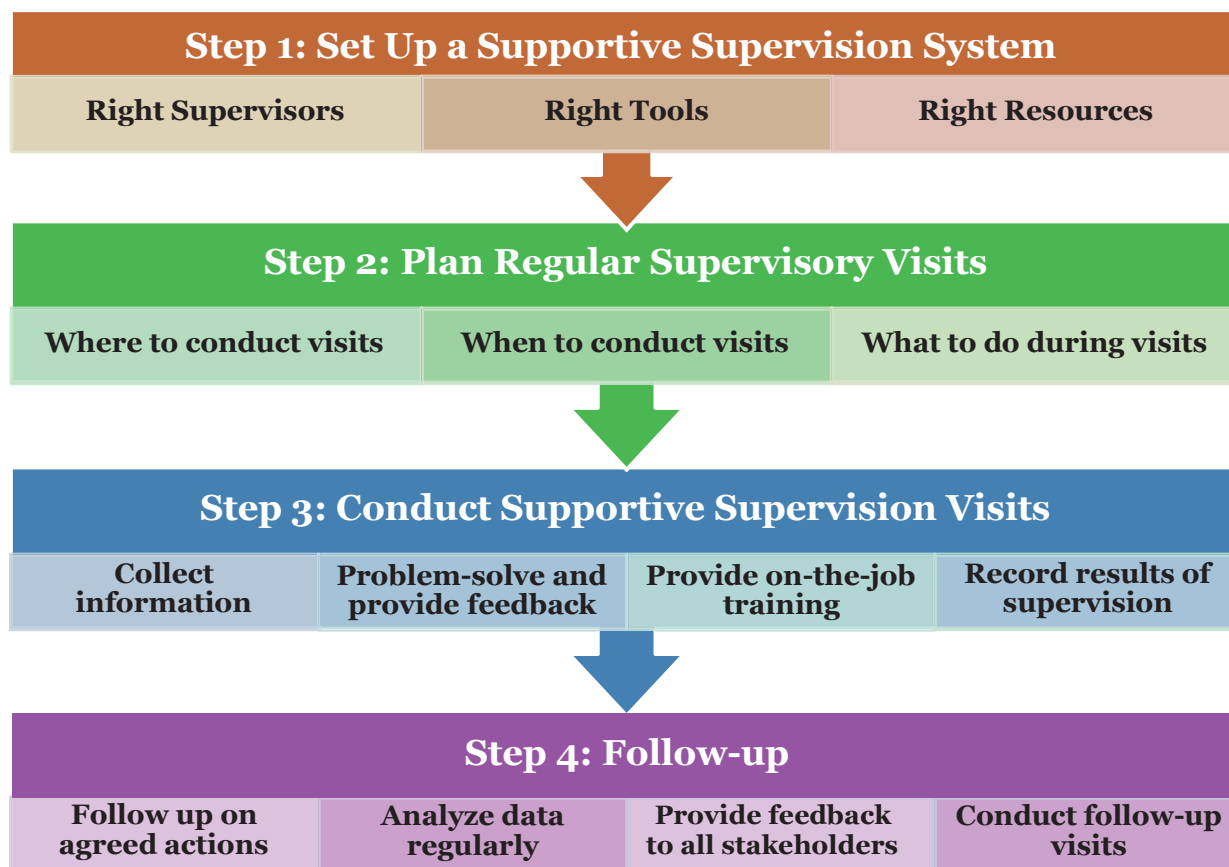
$$\text{5 ml disposable reconstitution syringes} = \frac{\text{Annual requirement of (BCG + Measles + JE}^*) \times 1.1 \text{ (wastage)}}{12 \text{ Months}}$$

SUPPORTIVE SUPERVISION

Supportive supervision is a process of guiding and assisting staff to continuously improve their own work performance. It is carried out in a respectful and non-authoritarian way with a focus on using supervisory visits as an opportunity to improve the knowledge and skills of health staff. Supervision encourages open, two-way communication and builds team approaches that facilitate problem solving.

Monitoring involves regular collection and analysis of data on various aspects of programme activities. Monitoring can be done through desk review of reports, providing feedback on phone or by e-mail/letter during the review meetings as well as during supervisory visits

Fig. 1 Supervision matrix



Supervision must involve interaction with staff and usually also has an element of monitoring. During the supervisory visit, the supervisor can monitor the quality of service delivery, find out the reasons for unimmunized and under-immunized children and plan interventions to reach and sustain them. It can be done at session site and house-to-house (community) using the monitoring formats at the end of this Unit.

STEPS FOR CONDUCTING SUPPORTIVE SUPERVISION

Step 1: Prepare for effective supportive supervision

Ensure the following three main “Rights” as follows:

- **Right supervisors**
Identify and prepare a pool from the available staff, i.e. MOs (including AYUSH), health supervisors, ICDS supervisors, block programme managers, immunization field volunteers, etc. Train them on the immunization schedule, the process and the information to be collected.
- **Right tools**
Use monitoring formats and SOPs for session, house-to-house and block (for recording observations) , also use training materials and job aids (to update skills of HWs during the visits).
- **Right resources**
Ensure that sufficient mobility and time is allocated for the visits and followup.

Step 2: Plan regular supervisory visits

Plan regular supervisory visits as per the microplan, considering three “Ws”:

- **Where** to conduct visits (priority areas)
- **When** to conduct visits (on immunization session days after informing the HWs)
- **What** to do during visits (review data and previous supervision and monitoring reports)

Prioritization of areas

An updated RI microplan is a prerequisite for monitoring, as it helps to prioritize the areas for monitoring visits. The priority should be to visit:

- listed HRAs in the microplan
- areas missed in the microplans
- villages with vacant SCs
- peri-urban underserved areas
- ANM with large catchment population
- area with reported measles outbreak, wild polio virus (WPV) or vaccine derived polio virus (VDPV)
- migrant and mobile populations
- areas with low RI coverage/resistance.

Step 3: Conduct supportive supervision visits Session site visit

After deciding the area to be visited, plan to visit the nearest session site catering to that area. Visit the session site on the scheduled day and time and collect information using the session monitoring format. If the session is held, do the following:

- observe the ongoing session, e.g. who is mobilizing the children, how the HW is vaccinating each child, messages provided by HWs, etc.
- interview the HWs for additional information, e.g. supervisor visits made, Measles/ MR2 dose, RCH register, ASHA incentives, etc.
- interview any three caregivers to know who has mobilized them.
- House-to-house visit
 - If the session is not being held, (find out the reason for the same) proceed for house-to-house monitoring. House-to-house monitoring helps in rapid assessment of RI coverage in the community. Visit 10 households with children aged 0–35 months (<3 years) and collect data on the house-to-house monitoring format through RI/MCP card and interviews of caregivers.

- Before leaving the field
 - Provide feedback to the health staff concerned. Start with positive feedback followed by the specific weaknesses
 - Identify problems, discuss the causes of the problem with health staff and plan the solutions
 - When required, provide on the job training as an immediate solution. First explain and demonstrate the skill, then allow the HWs to practice the skill, providing feedback till they learn.

Step 4: Followup After the supervisory visit, you should:

- Followup on the agreed actions in the implementation plan;
- Discuss with other block officials (MOIC, etc.) the issues of RI implementation in the block, if related to their department – e.g. departments of education, women and child development (ICDS), power supply, etc.
- Provide a feedback to higher levels for support in problem solving;
- Conduct follow-up visits to see if the recommendations are being implemented and if there is improvement in the performance of the HWs.
- Record results of supervision and prepare the report.

Common issues observed during monitoring and supervision of the immunization programme.

The following issues have been identified during regular monitoring in the field. This is not an all inclusive list but helps to categorize issues to enable corrective actions.

Human resource issues

- Vacant SCs
- Inadequate hiring of alternate vaccinators for vacant urban and rural areas
- Irrational distribution of the workload/areas among the HWs within a block
- Absenteeism of HWs
- Lack of designated cold chain handlers at cold chain points
- Lack of regular capacity building of knowledge and skills of health staff.

Microplanning issues

- Microplan not prepared or incomplete with only roster of the HW
- Missed areas and population groups, e.g. migratory and mobile population, urban slums, hamlets and geographically distant population not included
- Microplans not based on head count survey
- Map of the SC and PHC not prepared/displayed
- Area demarcation of SC with two ANMs is not done to clarify their individual roles
- Microplans are not reviewed at regular intervals.

Operational issues

- List of due beneficiaries for the sessions is not prepared
- All the planned sessions are not held by ANM due to leave, post being vacant, ANM not going to the site
- Poor attendance at outreach sessions due to poor mobilization by ASHA and AWW

- Late start of session and early closing of session site
- Non-availability of all vaccines and logistics at the session site
- Incorrect route/site/technique used for vaccine administration
- Date and time not recorded on reconstituted vaccine vials
- 4 key messages not conveyed to the beneficiary/caregiver
- Coverage monitoring chart and tracking bags not available at PHC or SC

Cold chain and logistics management issues

- No dedicated trained person in charge of cold chain at PHC level
- Job aids for cold chain maintenance not displayed at cold chain point
- Guidelines for correct storage of vaccines and diluents in ILR not followed
- Temperature not recorded twice a day; recording by cold chain handler not monitored
- Contingency plan for emergencies not prepared/followed
- Preventive maintenance of cold chain equipment not in place
- Presence of snake anti venom/other drugs/eatables in ILR along with vaccines
- Stock registers not updated and supervised for record of issue and balance of vaccines and other logistics
- Timely indenting of vaccines and logistics not done resulting in stock-outs being reported.

Recording and reporting system issues

- RCH/MCTS register not updated regularly and not used in preparation of beneficiary due list.
- Careless recording in immunization/MCP card; counterfoils not maintained
- Due list-cum-tally sheets not used for session-wise recording
- No system for identification and tracking of dropouts and left outs
- Monthly reports – incomplete and not analyzed for feedback and action
- AEFI and VPD cases not being reported or being underreported
- Block AEFI registers not being used.

Injection safety and waste disposal issues

- Hub cutter not available/not being used immediately after vaccination/reconstitution
- Red and black bags not available/not being used
- Disinfection of immunization waste not practiced before disposal
- Sharps pits for needles not constructed/functional at PHCs.

Monitoring and supervision issues

- Supervisory visits not planned/conducted by health and ICDS supervisors in priority areas
- Review meetings not used for providing feedback of monitoring and use of data for action.

Issues in community involvement and communication

- Weak coordination with other related agencies and sectors such as private and NGO sectors
- Lack of information, education and communication (IEC) and social mobilization activities

- contributing to poor utilization of services
- Four key messages not being given to beneficiaries at sessions.

STEPS FOR CONDUCTING EFFECTIVE RI REVIEW MEETINGS

Meetings are regular event at a PHC, use each meeting as an opportunity to identify, solve issues with service delivery.

Prepare for the meeting

- Determine the objectives of the meeting based on review of the minutes of previous meetings, monitoring reports and any new guidelines/topics to be discussed
- Prepare the agenda including objectives, list of topics to be covered, name of the facilitator for each topic and the time duration
- Assign logistic arrangements to the members of the team
- Assign talks on specific technical topics to concerned supervisors and colleagues
- Inform the date, time and place of the meeting to all participants.

Conduct the meeting

- Start the meeting on time
- Enquire if participants are comfortable. Make changes if needed.
- Follow the agenda closely during the meeting to ensure that set objectives are met
- Ensure that the meeting is focused and participatory
- Keep listening and summarizing the key points raised at regular intervals
- Ensure that minutes are taken with actionable points and timelines
- Summarize the action points, including persons responsible and deadlines
- Agree upon date of next meeting
- Thank participants.

Followup

- Forward unresolved issues to the district level for necessary action
- Examine the meeting process. Assess and make a plan to improve the next meeting
- Followup in writing to document key action points.

A sample agenda for a PHC review meeting of ANMs is given in Table

Table: Sample agenda for PHC review meeting of ANMs

Time	Activities				Facilitators
10:00–10:15	Welcome & objectives of the meeting				MOIC
10:15–11:15	Feedback on monitoring data	supervisory	visits	and	MO/health supervisor/partner
11:15–11:45	Feedback on data analysis from the monthly reports for left-outs and dropouts				health supervisor
11:45–12:30	Review of microplans, immunization records/ reports, any other issues such as ASHA/AWWs involvement in mobilization of beneficiaries				MOIC
12:30 –13:00	Action plan to improve coverage and track missed children				MOIC/health supervisor
13:00–13:15	Summary and conclusion				MOIC

Quarterly review meetings

Under National Health Mission, there is a provision to conducting quarterly review meetings for RI at block level under part C, FMR code c.1.f (refer Unit 13) for ASHAs. As per norms, Rs. 50/per person as honorarium for ASHA (Travel) and Rs. 25/person at the disposal of MO-IC for meeting expenses (refreshment, stationary and misc. expenses) is available for conducting review meeting four times in a year. These funds should be utilized for improved planning and supervision of front line health workers for Routine Immunization activities.

Tracking tools to track 'dropouts'

Various tracking tools are as follows:

- MCP Card with counterfoil
- Tracking bag
- Immunization/RCH/MCTS Registers
- Name-based list of due beneficiaries (refer SOP RI form 6 - Unit 3)

Mother and Child Protection (MCP) card with counterfoil

The MCP Card is a tool for families to learn, understand and follow positive practices for achieving good health of pregnant women, young mothers and children. The card gives information on the immunization schedule and the doses of Vitamin A to be given to the child during the first five years. Boxes in the chart indicate each type of vaccine, date to be given, date when it was given and age.

Details that would be available from MCP Card are:

- the date in the pink box when the child is expected to come for next immunization
- the date in the white box when the child came for immunization.

How to use the card

- During the first visit, fill the information on the cover page on "Family Identification and Birth Record".
- Record the date, month and year of all entries clearly.
- Explain the section on immunization by explaining which vaccines have been given and which vaccines are due, with dates.
- Do not leave any cells or columns blank.
- After filling up all the columns, retain the smaller portion of the card (counterfoil).
- Give the rest of the filled-in card to the parent of the child after immunization and ask her to bring the same card during her subsequent visits to the health centre.
- Advise families to keep the card in a safe place to prevent it from damage.
- Advise families to bring the card along when they visit the Anganwadi Centre (AWC), SC, health centre, private doctor or a hospital.
- At the end of each session, the counterfoils should be placed in the appropriate pocket of the tracking bag.
- Each month, look at the counterfoils in the tracking bag and make sure those children come for immunization. If they miss the session, ask the ASHA/AWW to follow up with those families and ensure that they attend the next session.

Tracking bag

Keeping counterfoils in tracking bag helps in:

- Preparing a session-wise name-based list of due beneficiaries for sharing with the ASHA/AWW/mobilizer
- Estimating the vaccine requirement for the next session
- Tracking the dropouts
- Providing information, if the beneficiary/parent has lost the immunization card.

The counterfoils need to be filed separately for each session site. A cloth tracking bag with 15 pockets is a simple, easy to use tool for filing the counterfoils. The first 12 pockets indicate each of the 12 months of the year. The thirteenth pocket is for those who left/died during the period, the fourteenth pocket is for fully immunized children and the fifteenth pocket is to store blank MCP cards.

Once a beneficiary is immunized, the counterfoil would be placed in the month (pocket) due for the next dose. For example, if a child comes for Penta 1 in January, Penta 2 is due in February. Update and place the counterfoil in the February pocket

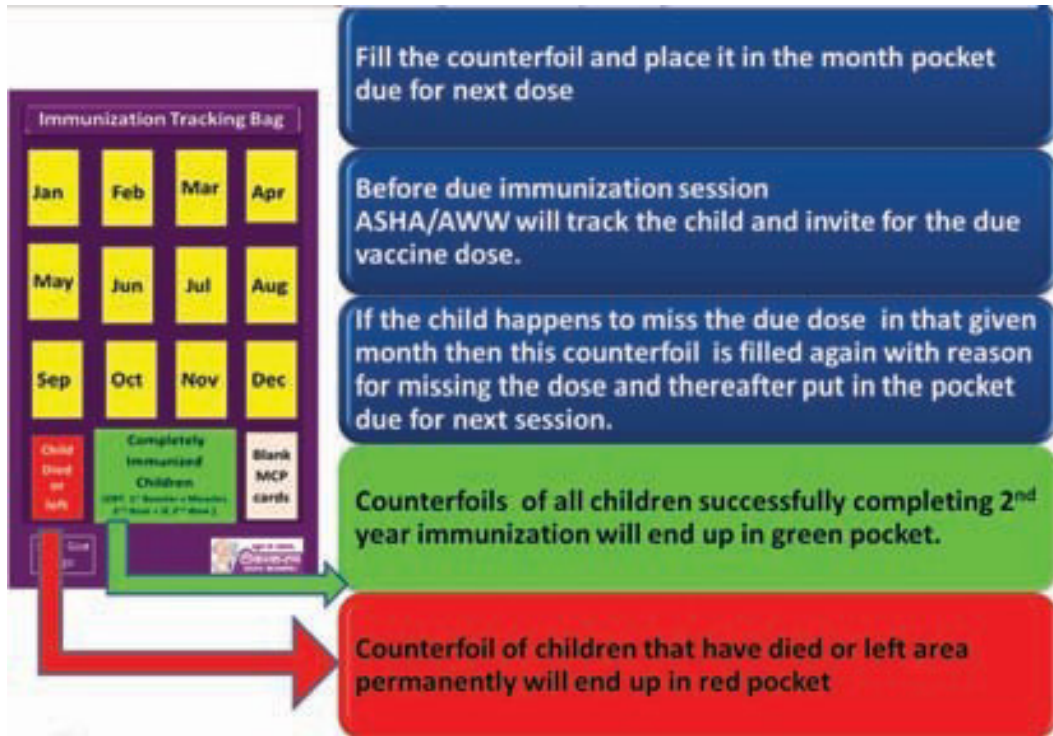
When the Penta 2 dose is given in February, update the counterfoil and move to the pocket for March. When the Penta 3 dose is given in March, then update and place the counterfoil in the September/October pocket since the child has to return for measles/MR vaccine.

Figure 1: Immunization tracking



- If some cards are left in the pocket at the end of the month, it indicates that the beneficiaries are the dropouts.
- Move these cards to the next month's pocket and track them.

Fig 2 How to use tracking bag



In case no tracking bag is available, counterfoils for each month can be separately tied with different rubber bands and labelled. File counterfoils for each session site separately and do not forget to carry them to the session.

Immunization/RCH/MCTS Registers

Immunization / RCH / MCTS registers help to record and track each pregnancy and immunization. It should be:

- updated to include new pregnancies and births from the records of AWWs and ASHAs before each immunization session;
- updated after each session on the basis of counterfoils filled during the session;
- if the beneficiary is from outside the catchment area, the HW should issue a new card and give appropriate vaccination. Record should be entered in the non-resident column of the register;
- if the beneficiary receives vaccination from a private practitioner, the HW should record the same in the MCH register and the immunization card and write "P" after the date.

Conducting an effective RI session

For an RI session to be effective, there are some points that need to be addressed. These are enlisted below:

- Appropriateness of location
- Setting up the site for safe injections:
 - Basic furnishings and spacing
 - IEC display
- Advance information to community

- Information on arrival.

Field Tip: “SAME DAY, SAME SITE, SAME TIME”

Ensuring the RI session is conducted on the same day, at the same site and at the same time builds community confidence and faith in the system and health worker.

APPROPRIATENESS OF LOCATION

The RI session site should be:

- Easily accessible and identifiable – using the IEC posters/banners at a visible point;
- Located in the same place each and every time;
- In a clean area, out of the sun and rain – avoid open-air sites;
- Having space either within the premises or near a sheltered/shaded area where those needing vaccination can wait;
- Large enough to provide space to have separate stations for—registration and assessment; immunization and record keeping; and screening/education on other health issues;
- Quiet enough for HWs to be able to explain what they are doing and to give advice.

All these parameters may not be possible at all places. However, in many instances it is possible with community support to ensure the best resources in the available circumstances. The MOs must visit all the RI session sites over the course of a few months and ascertain their appropriateness.

All communities are very proactive and supportive towards immunization services if they are involved in the planning process. It is necessary at times to reach out to the community through key influencers and local leaders in areas where ground realities make it difficult to identify or locate the site.

An ideal set-up for an RI session is shown in Fig.

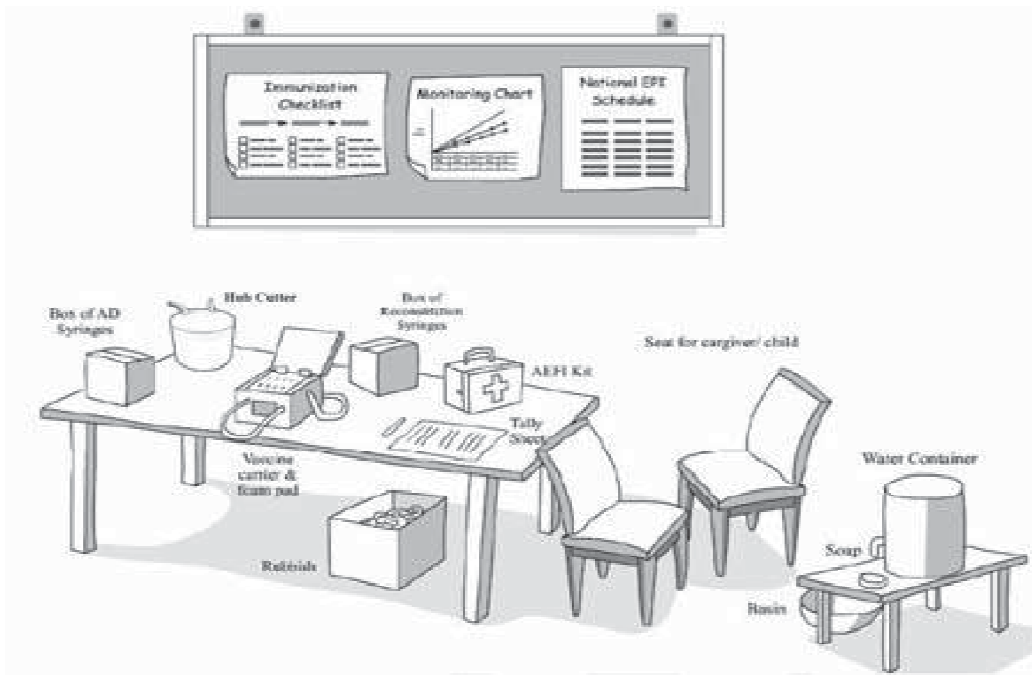
Setting up the site

Displaying IEC material, i.e. either the poster or banner or even both outside the session site informs the community of the arrival of the ANM and that the RI session site is now functional. The IEC display should be visible from the approach road and clearly identify the session site. The ANM should spend time after arriving at the session site to arrange the site to make it as convenient as possible for her and her supporting ASHA/AWW and also for the community that comes for services.

Sourcing furniture or requesting support from the community reflects the rapport of HWs and community involvement. In places where there is less support, it is necessary to address the issue with the community leaders at the earliest. Though this may seem an unimportant or minor issue, lack of community involvement is a factor that has a negative impact on RI coverage and mobilization of beneficiaries. A well setup RI session helps to build community confidence and also contributes to providing a quality experience for the HWs and beneficiaries.

Advance information to the community

Providing advance information of the upcoming RI session in an area has many advantages. Various




examples exist across the country, e.g. issuing invitation cards to beneficiaries, house-to-house visits by ASHA/AWW workers 2 days before the session, using mothers' meetings to announce the upcoming date and the beneficiaries. These are some of the innovative ways of informing beneficiaries. Explore what could work in your area.

Information on arrival of ANM

While the ASHA/AWW/mobilizer will visit the beneficiaries to come for immunization, word of the arrival of the ANM can also be spread through using any public address system at a religious or community centre. With support from local leaders, information can also be passed through students or local shopkeepers. The intention is to announce the starting of the session and any other local methodologies should be explored and encouraged.

The four key messages the HW should give to the caregiver



Four key messages for caregivers	
	What vaccine was given and what diseases it prevents?
	What minor adverse events could occur and how to deal with them?
	When and where to come for the next visit?
	Keep the immunization card safe and bring it along at the next visit

Using RI monitoring formats

Monitoring in routine immunization is an essential tool for a medical officer. It provides an opportunity to:

- observe service delivery and practices
- identify issues and provide solutions at field level
- identify training needs of staff
- interact directly with the community
- interact and motivate frontline health care workers at field level
- build confidence in health workers and community
- increase understanding of the RI delivery mechanism

Two types of formats are in use – RI session site and House to house monitoring formats.

1. The RI session format focuses on the following: Microplanning, session due list & its quality, safe injection practices, vaccine availability at session site, implementation of open vial policy, logistics, IEC and ASHA incentives.
2. The house to house format focuses on collecting information from at least 10 children below the age of 35 months in an area. Information on the child's vaccination status including the dates of administration is to be collected, the source of information being the MCP card. However in the absence of the card, parent recall by identifying the sites of injection may be utilized. The rear of the format has a ready reckoner to easily identify if a child has received due vaccine as per age. When a child is found unimmunized or partially immunized information on the reason should also be collected.

4. FAMILY PLANNING

Oral Contraceptive Pills:

The Oral Contraceptive Pill (OCP) is one method of preventing pregnancy that can be controlled by a woman. OCPs are highly effective and can be taken for long time without any adverse effects, and there is quick return of fertility after discontinuation. OCPs are widely and easily available through primary healthcare providers, community-based volunteers, social marketing channels and also from commercial channels.

Oral contraceptives pills, commonly known as ‘the pill,’ are a widely accepted, safe, reliable, effective and reversible method of fertility control. The types of oral contraceptive pills are:-

- Combined oral contraceptive pills
- Monophasic pills
- Standard dose pills
- Low dose pills
- Very low dose pills
- Multiphasic pills
- Triphasic pills
- Biphasic pills

Progesterone only pills/minipills

Monophasic pills

The oestrogen used currently is ethinyl estradiol. The dose of estradiol in the pills was gradually lowered from 0.5mg to 0.3mg to the currently used dose of 0.2mg in the very low dose pills. The progesterone used initially was from the C-21 group e.g. Medroxyprogesterone acetate and megestrol, which were then abandoned due to suspected risk of breast cancer. Now there are two groups of progesterone in use:

Norethisterone group: Norethisterone, norethynodrol, Norethisterone acetate, Ethinodiol diacetate
Norgestrel group: d-Norgestrel, L-Norgestrel
Newer Progesterones: Desogestrel, gestodene, and norgestemate. They have contraceptive effect similar to other progesterones but have almost no androgenic or anabolic effect.

Multiphasic pills

These were developed with the aim of reducing the total monthly hormone intake while maintaining the efficacy. Biphasic pills: EE- 0.035 mg constant Low dose progesterone first 10 days High dose progesterone next 11 days. These have higher failure rates and are not available in India.

Triphasic pills:

EE- 0.03mg + LNG 0.05mg for 6 days

EE- 0.03mg + LNG 0.075mg for 5 days

EE- 0.03mg + LNG 0.125mg for 10 day

These pills have fewer side effects like amenorrhoea, breakthrough bleeding and decreased incidence of acne. The drawbacks include errors in pill taking, increased failure and difficulty in postponing menstruation if required.

Combined Oral - Contraceptive Pills (COCs)

Mechanism of action and effects

COCs have an effectiveness of 99.97% to 99.99%. The failure rate is 0.3% as commonly used and only 0.1% on correct and consistent use. The mechanism of action is as follows:

Inhibition of ovulation by suppressing FSH and LH

Alternation of endometrium to make it unsuitable for implantation even if the ovum is fertilized.

Changes in cervical mucus, which make it hostile to the sperm

Important health benefits

Fertility-related benefits

Prevention of pregnancy

Offers protection against ectopic pregnancy

Reduction in acne

Decreased incidence of rheumatoid arthritis

Side effects

Nausea, vomiting, decreased appetite; usually subsides after 2 to 3 months of use

Progesterone - Only Pills (POPs) - Minipills

There are not many contraceptive options available for a woman in India for preventing unwanted pregnancies and the threat of conceiving during lactational amenorrhoea remains one of the major problems. In such a situation Progesterone-only Pills are one of the best options available to a woman or couple, besides natural methods including the Lactational Amenorrhea Method (LAM). POPs do not affect the quality of breast milk and help in proper child nutrition, while preventing unwanted pregnancy. A success rate of 99.5% makes it an ideal option for breastfeeding mothers.

Mechanism of action and results

Progestin-only oral contraceptives (also known as mini-pills) are the best oral contraceptives for breastfeeding women, as they apparently do not reduce milk production. They also do not have any estrogen side-effects, unlike combined oral contraceptives. The POPs can also be used as emergency contraception after unprotected sex.

Products available:

There are several brands containing following progestin are available:

Norethindrone

Levonorgestrel

Norgestrel

Mechanism of action:

Thickening of cervical mucous
Suppression of ovulation
Involution of endometrium

Disadvantages:

For women who are not breastfeeding, the common side effects are changes in menstrual bleeding including irregular periods, spotting or bleeding between periods and amenorrhea or missed periods, possibly for several months. A few women may have prolonged or heavy periods. Other less common side-effects include headaches and breast tenderness.

Emergency Contraceptive Pills (ECPs)

Progestin-only OCPs containing the hormone levonorgestrel can be used for emergency contraception. If the correct dose is started within 72 hours after unprotected intercourse, it reduces the chances of pregnancy. Emergency contraception has a special role for groups such as the adolescents and women who suffer from sexual violence. There is a need to increase access to ECPs by training healthcare providers and also by ensuring easy availability of ECPs.

Levonorgesterel only EC pills

Several such dedicated commercial products are available in India. Emergency Contraceptive Pills containing levonorgesterel have been included in schedule K, which makes them over the counter drugs. A prescription is not needed for getting ECPs. In the national programme also, a dedicated product is available at the facilities. The current recommendation is that 1 pill of LNG 0.75 mg to be taken as soon as possible after unprotected coitus (within 72 hours), followed by another pill 12 hours later. This method has been found to be highly effective and has only mild and less frequent side effects compared to other combinations/regimen. In order to simplify the LNG regimen.

Injectable Contraceptives: (POIs)

About 12 million couples throughout the world now use injectable contraceptives. Progestin-only injectables are the most widely used. DMPA (Depot Medroxyprogesterone acetate), provides three months of protection, and NET-EN (Norethidrone enanthate), provides protection for two months.

Throughout the world many women value injectables because they are highly effective, long lasting, reversible, convenient and can be used privately. Also, breastfeeding women who want to use a hormonal contraceptive can use progestin-only DMPA or NET-EN.

Women experience a variety of side-effects with injectables. Disruption of menstrual bleeding is common, which some women find troublesome. Good counselling helps women understand that frequent and irregular bleeding and amenorrhoea are not dangerous, and that many clients continue to use injectables despite irregularities in bleeding pattern.

Intrauterine Devices (IUDs)

The intrauterine devices (IUDs) offer almost complete protection from pregnancy. The newer IUDs have a longer life-span and are more effective. In practice the CuT-380A and other currently available IUDs such as CuT-220C, the Multiload-375, and the LNG-20 are more effective than oral contraceptives if used correctly and consistently, and are on par with injectables and voluntary sterilization. The hormone-releasing IUS, LNG-20 is one of the most effective IUDs, with just 0.3 pregnancies per 100 women after five years of use.

The providers of IUDs play a very crucial role in the increasing use of IUDs. The provider's good judgment, training and skills help ensure good counseling for clients, proper screening for medical eligibility, careful and gentle insertion using appropriate infection prevention techniques and adequate follow up support to the IUD users.

The different types of IUD now available are :

Copper-bearing IUDs: Made of plastic with copper sleeves and/or copper wire on the plastic, such as TCu-380A, MLCu-375.

Hormone-releasing IUDs: Made of plastic, steadily released small amounts of hormone progesterone or progestins such as levonorgestrol, LNG-20 and Progestasert.

Male Sterilization:

Despite the development of many new contraceptive methods over the last 15 years, sterilization is the most widely used in the world, in developing and developed countries alike. Couples and individuals around the world choose sterilization because they want to limit or end childbearing, rather than space future births. The method requires no action on the part of the user beyond selection of the initial surgical procedure. It produces minimum side effects, while generally offering a lifetime of contraceptive protection. Hence, quality sterilization services will always be a crucial component of any comprehensive family planning service.

Vasectomy, especially no-scalpel vasectomy (NSV), is one of the safest and most effective contraceptive methods, with very low complication rates and failure rates thought to be in the range of 2 to 4 per 1000. While potential physiological effects and long-term effects of vasectomy have been studied extensively over the past few decades, research has offered reassurance that this method has no serious long-term negative affect on men's physical and mental health. There is little evidence for a causal association between prostate cancer and vasectomy and experts after reviewing available evidence have concluded that no change was necessary in the practice of vasectomy.

Advantages

- Very effective
- Permanent. A small, quick procedure leads to lifelong, safe and very effective family planning. Nothing to remember except to use condoms or another family planning method for at least 3 months.

Disadvantages:

- Common minor short-term complications of surgery:
- Usually uncomfortable for 2 or 3 days.
- Pain in scrotum, swelling and bruising
- Brief feeling of faintness after the procedure
- Uncommon complications of surgery:
- Requires minor surgery by a trained provider.

Female Sterilization:

Even though tubal sterilization usually involves abdominal surgery, female sterilization is one of the safest operative procedures. Complications are rare and occur in fewer than 1% of all

female sterilization procedures. Moreover, the likelihood of failure is very low, at less than 2%, even 10 years after the surgery.

There are two broad elements in the performance of female sterilization: the means of reaching the fallopian tubes, and the methods used to occlude the tubes. The selection of a procedure is determined by such factors as the timing of sterilization in relationship to the pregnancy; the need for other gynaecological procedures; the women's health; the provider's training, expertise and experience; the cost and logistics of maintaining equipment; and the availability of backup services.

Female sterilization results in few long-term side effects. The overall risk of ectopic pregnancy is low. Perceived alteration of women's menstrual flow, length, or pain following tubal sterilization (referred to as the post-sterilization syndrome), have been debated and studied, but research carried out in the United States has shown no strong evidence for the existence of such a syndrome.

Female sterilization procedures can be grouped into two broad categories: procedures for reaching the fallopian tubes (primarily abdominal approaches such as minilaparotomy, laparoscopy and laparotomy), and methods for occluding the fallopian tubes (mainly ligation and excision, mechanical devices such as clips or rings, and electro coagulation).

About 2-6% sterilized women in developed countries and 0.2% women in developing countries are estimated to seek information about reversal, but the actual rate may be substantially higher. In developing countries especially, women's potential interest in restoration of fertility is probably greatly underestimated, given the inaccessibility of such services and the corresponding lack of knowledge about them.

Advantages

- Very effective method of contraception
- Permanent.
- A single procedure leads to lifelong, safe, and very effective family planning.
- Nothing to remember (as in many other methods), no supplies needed, and no repeated clinic visits required.
- Minilaparotomy can be performed just after a woman gives birth.
- Helps protect against ovarian cancer.

Disadvantages

Usually painful at first, but pain recedes after a day or two.

Uncommon complications of surgery:

1. Infection or bleeding at the incision
2. Internal infection or bleeding
3. Injury to internal organs

Male Condoms:

Condom is a simple but very effective method of contraception if used correctly and consistently. It holds a special place among the contraceptives due to the dual protection it provides both from unwanted pregnancy as well as sexually transmitted infections. It is one of the methods of contraception which ensures male involvement in preventing unwanted births. The higher failure rate of condoms is mostly due to its inappropriate use by the clients, which in turn is partly due to inadequate client instructions by the FP providers.

Introduction

- Condom is a sheath made to fit over a man's erect penis.
- Most condoms are made of latex rubber
- Some condoms are coated with a lubricant or with spermicide
- Condoms may be available in different size, shapes, colours and textures
- Condoms help in preventing pregnancy as well as the spread of sexually transmitted infections. If used correctly, they prevent sperm and ST infections entering the vagina, or organisms from the vagina from entering the penis.

How effective are condoms

If the partners of 100 women start using condoms, with typical use there is likelihood of 14 of these women getting pregnant in the first year of use of condoms. With correct and consistent use every time, there are 3 pregnancies per 100 women in the first year of use.

Prevent transmission of sexually transmitted infections

During sex, condoms are the best protection against catching STIs or transmitting STIs to one's partner. Condoms can stop sexual transmission of many diseases including HIV/AIDS, gonorrhoea, syphilis, Chlamydia, and trichomoniasis. Condoms probably protect somewhat, but not as well, against herpes, genital wart virus (HPV), and other diseases that can cause sores on the skin not covered by condoms.

In general, studies show that condom users have about two-thirds as much risk of getting gonorrhoea, trichomoniasis or chlamydial infection as people who never use condoms. Condom users have less than half the risk of HIV infection, which may lead to AIDS. These studies, however, included some people who used condoms incorrectly or inconsistently.

People who use condoms correctly and consistently face even less risk of disease. They reduce their risk of STDs to a very low level.

Advantages:

- Prevent STIs including HIV, as well as pregnancy, when used correctly and consistently with every act of sexual intercourse.
- Can be used soon after childbirth
- Safe. No hormonal side effects.
- Help prevent ectopic pregnancies

Disadvantages

- Latex condoms may cause itching for a few people who are allergic to latex. Also, some people may be allergic to the lubricant on some brands of condoms.
- The couple must take the time to put the condom on the erect penis before sex.
- Small possibility that condom might slip off or break during sexual intercourse.
- If not properly stored or if used with oil-based lubricants, condoms can go weak and break.

Female Condom:

The Female Condom (FC) is a viable option for women to protect themselves from pregnancy and STIs including HIV. Female condom is the only currently available method which woman

can initiate and in some ways control, which provides dual protection from both unwanted pregnancy and STIs including HIV.

The female condom is a thin, soft, loose-fitting polyurethane plastic pouch-like device that lines the vagina. It has two flexible rings, an inner ring at the closed end, used to insert the device inside the vagina and hold it in place, and an outer ring which remains outside the vagina and covers the external genitalia. The device, being made of polyurethane, can be used with any type of lubricant without compromising its integrity. This is advantageous in countries where water-based lubricants are hard to find.

How effective is the female condom

Pregnancies per 100 women in the first year of use as commonly used is 21. If used correctly and consistently there are 5 pregnancies per 100 women.

Advantages:

- Female-controlled
- No medical condition limits use.
- More comfortable to men, less decrease in sensation than male latex condoms. As a result, sensitivity of male partner is not substantially reduced. It also offers ease of use by men with erectile dysfunction.
- Offers greater protection as it covers both internal and external genitalia.
- Stronger (polyurethane is 40% more stronger than latex), and therefore there is less frequent breakage (1% compared to 4% for male condoms)

Disadvantages:

Difficulties in insertion and removal. Some participants noted difficulties associated with insertion and removal of the female condom, discomfort, messiness and inconvenience associated with use and movement of device during use.

More expensive than male condoms.

- Effectiveness after 6 months is not certain
- Frequent breastfeeding may be inconvenient or difficult for some women, especially working mothers
- No protection against STIs including HIV
- If the mother has HIV, there is a small chance that breast milk will pass HIV to the baby.

The Standard Days Method - (SDM)

“Fertility Awareness” means that a woman learns how to tell when the fertile time of her menstrual cycle starts and ends. The fertile time is the time when she can get pregnant. The Standard Days Method involves identifying the fertile days during each menstrual cycle. Women with menstrual cycles ranging between 26 and 32 days can prevent pregnancy by avoiding unprotected sexual intercourse on days 8 to 19.

The Standard Days Method (SDM) is a new natural family planning method for women with menstrual cycles ranging between 26 and 32 days. This method involves identifying the fertile days during each menstrual cycle. Women with menstrual cycles ranging between 26 and 32 days can prevent pregnancy by avoiding unprotected sexual intercourse on days 8 to 19.

5. REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP)

The Revised National Tuberculosis Control Programme (RNTCP) was launched in India in 1997 based on World Health Organization endorsed Directly Observed Treatment Short-Course (DOTS) strategy, employing the thrice weekly treatment regimen.

The Standards for TB Care in India, 2014, which were jointly laid down by Ministry of Health & Family Welfare, Government of India and World Health Organization, in consultation with experts, based on available evidences and WHO Treatment of TB Guidelines (2010), state that 'all patients should be given daily regimen. The initial phase should consist of two months of Isoniazid (H), Rifampicin (R), Pyrazinamide (Z), and Ethambutol (E). The continuation phase should consist of three drugs, Isoniazid (H), Rifampicin (R) and Ethambutol (E) given for at least four months'.

The National Technical Working Group (NTWG) on TB/HIV (2013) has recommended use of daily regimen using Fixed Dose Combination (FDC) first line TB treatment for PLHIV patients.

Considering the above, the National Expert Committee to examine type of drug regimen for drug sensitive TB has recommended RNTCP to move towards introducing daily regimen for drug sensitive Tuberculosis in India.

Signs and Symptoms

Common symptoms include:

- Cough more than 2 weeks
- weight loss
- fatigue
- evening rise of fever
- night sweats
- chest pain
- shortness of breath
- loss of appetite

TREATMENT OF TUBERCULOSIS

The principle of treatment for tuberculosis (other than confirmed Drug Resistant forms of TB) henceforth will be to administer daily fixed dose combinations of first – line anti-tuberculosis drugs in appropriate weight bands.

Fixed dose combination drugs for TB under daily regimen are packaged to cover 4 weeks of treatment, i.e. 28 days, and would be dispensed on a daily basis. Thus, the effective number of doses that the patient would be receiving in a month would be 28.

For a new TB case, the treatment will be of 6 months (24weeks). The intensive phase (IP) will consist of 8 weeks of Isoniazid, Rifampicin, Pyrazinamide & Ethambutol in daily Fixed Dose Combinations in four weight bands. There will be no need for extension of IP. Only Pyrazinamide will be stopped in the Continuation Phase (CP) while the rest of the three drugs will be continued for another 16 weeks as daily dosages. The CP can be extended by 12 to 24 weeks in certain forms of TB like CNS TB, Skeletal TB and Disseminated TB, based on clinical decision of the treating physician.

For previously treated case of TB, the treatment will be of 8 months (32 weeks). The intensive phase will consist of Injection Streptomycin, INH, Rifampicin, Pyrazinamide & Ethambutol in

daily dosages as per weight bands. Injection Streptomycin will be stopped after 8 weeks and the remaining four drugs will be continued for another 4 weeks. There will be no need for extension of IP. At the start of CP, Pyrazinamide will be stopped while the rest of the drugs- Rifampicin, INH & Ethambutol will be continued for another 20 weeks as daily dosages in the CP. The CP can be extended by three to six months in certain forms of TB like CNS TB, Skeletal TB, and Disseminated TB, based on clinical decision of the treating physician.

As recommended by National Expert Committee on Diagnosis and Treatment of TB under RNTCP and the Drug Specification Committee, the following daily short-course treatment regimen and dosages are being adopted:

Table 1 : RNTCP Daily Treatment Regimen

Type of TB Case	Treatment regimen in IP	Treatment regimen CP
New	2 HRZE	4 HRE
Previously treated	2HRZES + 1 HRZE	5 HRE

Prefix to the drugs stands for number of months

Treatment under the daily regimen would be administered as per following drug dosages in 4 weight bands for Adults :

Table 2: Daily Dosage Schedule for Adults

Weight Category	Number of tablets to be consumed		Inj. Streptomycin*
	Intensive phase	Continuation phase	
	H R Z E	H R E	
	75/150/400/275 Mg per tab	75/150/275 mg per Tab	
25-39 kg	2	2	0.5 gm
40-54 kg	3	3	0.75 gm
55-69 kg	4	4	1 gm
≥ 70	5	5	1 gm

* Inj. Streptomycin (15 mg/kg (12–18 mg/kg) daily, maximum daily dose 1000 mg). Patients aged over 50 years may not be able to tolerate more than 750 mg daily. Similarly, patients weighing less than 50 kg may not tolerate doses above 500-750 mg daily.

Adults weighing less than 25 kg will be given loose drugs as per body weight.

It may be noted that the pill load for TB patients across various weight bands will be as mentioned in table 2 (for example, a patient in the weight band range of 25-39 kg needs to consume only 2 tablets whereas another patient in 55-69 kg range would need 4 tablets)

Table 3: Dose of essential first line anti-TB Drugs under daily regimen (Adult)

Name of Drug	Daily Dose (mg/kg body wt.)
Isoniazid	5 mg/kg (4-6 mg/kg) daily
Rifampicin	10 mg/kg (8-12 mg/kg) daily
Pyrazinamide	25 mg/kg (20-30 mg/kg) daily
Streptomycin	15 mg/kg (12-18 mg/kg) daily
Ethambutol	15 mg/kg (15-20 mg/kg) daily

As the drugs under daily regimen are packaged to cover 4 weeks of treatment, i.e. 28 days, and would be dispensed on a daily basis, the effective number of doses that the patient would be receiving in a month would be 28, hence the total no. of doses would be as follows:

Table 4: Doses in RNTCP Daily Regimen

Type of TB Case	Doses in IP	Doses in CP
New	56 doses (8 weeks x 7 days/week) or 28*2	112 doses (16 weeks x 7 days/week) or 28*4
Previously treated	84 doses (12 weeks x 7 days/week) or 28*3	140 doses (20 weeks x 7 days/week) or 28*5

For the time being, pediatric patients would continue to be treated with the currently available drugs/ regimen till the time the required pediatric formulations are available with the programme.

As practiced for intermittent regimen, RNTCP has retained the concept of 'One Patient-One Box' for daily regimen also. The daily regimen patient-wise box consists of blister packs of Schedule 9 (for Intensive Phase) and Schedule 10 (for Continuation Phase) packed in separate laminated pouches in a single millboard/ grey board box; the number of blister packs in each pouch will be as per the weight band.

OPERATIONAL GUIDELINE FOR TREATMENT INITIATION

Treatment should be initiated by a trained medical officer (MO). Efforts should also be made to look for co-morbidities like diabetes, liver disease, renal disease, neurological disorders, substance abuse, especially tobacco (in any form) & alcoholism. The patient should be assured that s/he will be supported during the entire course of treatment by the MO and peripheral health care workers.

The TB patient should be counselled about the disease, its mode of spread and the treatment (dosage schedule, duration, common side-effects, etc.) and should be encouraged to involve family members for treatment support. Counselling should be offered on methods to prevent transmission of disease (cough etiquettes, proper disposal of sputum) and to get all close contacts (especially household contacts) screened at the earliest.

The MO needs to initiate a treatment card (in duplicate when required) for each patient at the time of initiation of treatment. Each patient must be given a TB Identity Card. Patient-wise box as per weight band is to be made available at the treatment centre.

The product-code-wise details of PWBs are given below:

Table 5: Product Code-wise details of PWBs

Product code	Product Description	No. of strips in IP	No. of strips in CP	Unit
PC-1D-I	Daily regimen treatment Box for New Cases for weight Band (25-39 kg)	4	8	PWB
PC-1D-II	Daily regimen treatment Box for New Cases for weight Band (40-54 kg)	6	12	PWB
PC-1D-III	Daily regimen treatment	8	16	PWB

	Box for New Cases for weight Band (55-69 kg)			
PC-1D-IV	Daily regimen treatment Box for New Cases for weight Band (≥ 70 kg)	10	20	PWB
PC-2D-I	Daily regimen treatment Box for New Cases for weight Band (25-39 kg)	6	10	PWB
PC-2D-II	Daily regimen treatment Box for New Cases for weight Band (40-54 kg)	9	15	PWB
PC-2D-III	Daily regimen treatment Box for New Cases for weight Band (55-69 kg)	12	20	PWB
PC-2D-IV	Daily regimen treatment Box for New Cases for weight Band (≥ 70 kg)	15	25	PWB
PC-5D-I	Inj. Streptomycin 500 mg Vial	56 doses	-	Vials/kit
PC-5D-II	Inj. Streptomycin 750 mg Vial	56 doses	-	Vials/kit
PC-5D-III	Inj. Streptomycin 1 gm Vial	56 doses	-	Vials/kit

The concerned health worker should register the treatment card in Nikshay immediately after initiation of treatment by the Medical Officer and note the Nikshay ID in the treatment card. Till paper- based registration of cases in TU level treatment register continues, STS should note the Nikshay ID in the TB register.

TREATMENT SUPPORT

Adherence to regular and complete treatment is one of the important factors for relapse free cure from TB. To assess and foster adherence, a patient-centred approach to administration of drug treatment should be adopted. It should be based on the patient's needs and mutual respect between patient and the provider. A good treatment support plan should be developed at the time of initiation of treatment.

All efforts should be made to monitor adherence to treatment. An extensive network of treatment supporters already exists within the programme. The principle of direct observation is to be applied logically and judiciously. In situations where an institutional or community DOT provider is not accessible, a family member or other suitable person may act as a treatment supporter. While all efforts must be put in to find a treatment supporter close to the patient's residence and acceptable to the patient, treatment should not be denied to any patient who is unable to undergo treatment from a DOT provider for any valid reason. In addition, other measures to promote treatment adherence among patients may be explored as per local needs. ICT modalities like frequent calls, SMS reminders, IVRS etc. may also be deployed to promote adherence.

Treatment support program is not restricted to observation of treatment alone. Nutritional and financial support, ancillary drugs, co-morbidity management, etc. are some other requirements. To avail these, patient has to be linked to appropriate social support schemes like RasthriyaSwasthyaBimaYojana (RSBY), State-supported schemes for financial support for TB

patients, Corporate Social Responsibility (CSR) initiatives, counselling services, etc. Capacity building and engaging with local community based organizations, self-help groups, patient support groups, Panchayati Raj Institutions (PRI) should be explored and effectively utilized to promote treatment adherence.

FOLLOW-UP OF TREATMENT

Patients should be closely monitored for treatment progress and disease response. There are two components of follow up:

Clinical follow-up: Patients will be clinically followed-up on a monthly basis at the nearest health facility. Additionally, the medical officer should also conduct the review when he visits the house of the patient. Improvement in symptoms, weight gain etc. may indicate good prognosis. Symptoms and signs of adverse reactions to drugs should be specifically looked for. Appropriate management of co-morbid conditions is essential for getting a better prognosis to TB treatment.

Laboratory investigations. Necessary laboratory investigations need to be done to assess prognosis of the disease or to manage co-morbidities or adverse reaction. In case of pulmonary tuberculosis, sputum smear microscopy should be done at the end of IP and end of treatment. A negative sputum smear microscopy result at the end of IP may indicate good prognosis. However, in the presence of clinical deterioration, the medical officer needs to thoroughly review the patient, both clinically and with investigations including culture & DST or repeat sputum examination. Response to treatment in extra-pulmonary TB may be best assessed clinically. Help of radiological and other relevant investigations may be taken.

Results of sputum smear examination and weight should be updated in Nikshay by the concerned health worker.

PREVENTION AND MANAGEMENT OF ADVERSE DRUG REACTIONS

Most TB patients complete their treatment without any significant adverse drug effects. Most of the adverse effects can be prevented by proper counselling of patients, and their impact minimized through early identification and management.

A serious event or reaction is any untoward medical occurrence that, at any time during treatment, which:

- Resulted in death
- Drug induced hepatitis
- Required in-patient hospitalization or prolongation of existing hospitalization
- Resulted in persistent or significant disability/ incapacity
- Resulted in termination of drugs due to ADR

The patient treatment cards should be modified for recording any adverse events and their management. All adverse drug reactions reported by patients or observed are to be recorded in the treatment card and captured in the NIKSHAY-ADR reporting system and existing Pharmacovigilance practices.

6. NATIONAL LEPROSY ERADICATION PROGRAMME

The **National Leprosy Eradication Programme (NLEP)** was started in the year 1983 with the objective of achieving eradication of the disease from the country.

Elimination has been achieved against this dreaded disease in 2005 when the leprosy recorded cases load had come down to less than 1 case for 10,000 Population at National level.

Although the country has achieved elimination of leprosy as a public health problem, yet new case detection has remained about to 1.3 lacks annually. These newly detected cases have to be provided quality leprosy services through the General Health Care system so that they are diagnosed and treated early with MDT.

GLOBAL LEPROSY STRATEGY: 2016-2020

1. Vision :

The vision of the strategy is a leprosy-free world.

- Zero disease
- Zero transmission of leprosy infection
- Zero disability due to leprosy
- Zero stigma and discrimination

2. Goal:

The goal of the strategy is to further reduce the global and local leprosy burden.

3. Main targets:

The following are the targets envisaged by the Strategy by 2020:

- Zero G2 Deformity among pediatric leprosy patients.
- Reduction of new leprosy cases with G2 Deformity to less than one case per million population.
- Zero countries with legislation allowing discrimination on basis of leprosy.

Aims of NLEP under the Twelfth Five Year Plan:

- Decentralization of NLEP to States & Districts.
- Leprosy Services integrated with General Health Care Services.
- Early diagnosis and prompt MDT treatment through routine and special efforts.
- Information, Education and Communication (IEC), also called "Behavioral Change & Communication (BCC) using local and Mass Media for reduction of Social Stigma and Discrimination so that self reporting of the Leprosy disease to the Primary Health Centers (PHCs) is encouraged.
- Renewed emphasis on Disability Prevention and Medical Rehabilitation (DPMR).
- Monitoring and Periodic Evaluation.
- Inter-Sectoral collaboration.

Objectives under the Twelfth Five Year Plan:

- Elimination of leprosy i.e. prevalence of less than 1 case per 10,000 population in all districts of the country.

- Strengthen Disability Prevention & Medical Rehabilitation of persons affected by leprosy.
- Reduction in the level of stigma associated with leprosy.

Programme Strategy:

- Integrated Leprosy services through General Health Care Services.
- Early diagnosis and prompt MDT treatment of new Leprosy cases through routine and special efforts.
- Carrying out household contact survey for early detection of cases.
- Involvement of Accredited Social Health Activists (ASHAs) in detection and completion of treatment of Leprosy cases on time.
- Strengthening of Disability Prevention and Medical Rehabilitation (DPMR) services.
- Intensive monitoring and supervision at Primary Health Centers (PHCs) / Community Health Centers (CHCs).

Integration of NLEP in General Health Services:

Integration with GHC will help in following way:

- New case detection will improve; access to MDT coverage will improve.
- Overall disability burden will be reduced due to early detection
- General health services staff will be trained to provide leprosy services.
- Increased public awareness will lead to early voluntary reporting.
- Apprehension of leprosy and stigma will decline

Identification of suspected leprosy case

ANY person with discoloration of skin

and / or thickened and / or shiny and / or oily skin and /or nodules

and /or inability to close eyes

and / or ulcerations in hands and/or feet

and/or clawing of fingers

and/or foot drop

and /or informs tingling or numbness in hands or feet

and/or loss of sensations in palms or soles

and/or inability to feel cold or hot objects

and/or weakness in hands or feet for holding/grasping objects these all are the symptoms in suspect case of leprosy.

Suspected leprosy case will be reported to health facility as follows –

- Voluntary reporting by patient of skin lesion (most important)
- Identified by MPW/HA during field visit.
- Identification of patient in OPD who has come for some other complaints.
- Referral from private practitioner.

Important job responsibilities of health staff under NLEP:

Sr. No.	Activity	Responsibility of PHC Staff	
		Designation	Responsibility

1	New case detection through IEC activities and encouraging voluntary reporting.	MPW/HA	Health education and active search for patients of skin patch.
		MO	Passive search of skin patch patient in OPD.
2	Drug stock management	Pharmacist	Calculate MDT blister pack requirement, indent drugs, stock at PHC and issue to SC and ensure continuous supply. Keep record.
3	Diagnosis, prepare treatment card and start treatment	MO	Diagnosis on the basis of clinical examination. Prepare treatment card, arrange for MDT and refer to SC for subsequent doses.
4	Treatment Card	Pharmacist	Send treatment card to concerned MPW(M)
		MPW(M)	Keep treatment card at SC, give subsequent doses to patient, complete card regularly and store card at SC after completion of treatment (RFT)
5	Counseling patient	MO	Counseling for cause of disease, spread, MDT, importance of regularity of treatment, follow up etc.
6	Follow up of patient	MPW(M)	Follow up patient for regularity of treatment, adverse effects of MDT drugs and lepra reaction. In case of complications, refer patient to MO.
7	Defaulter action	MPW(M)	Immediately contacting patient if he/she does not attend SC for next blister pack.
8	Records and reports	HA(M)	Treatment card, patient register, receiving reports from MPW(M) and monthly report preparation.
		MPW (M)	Maintenance of treatment card, submitting information of treatment to PHC
9	Review	MO	Review Leprosy activity during monthly meetings.
10	Data Analysis	MO	Analyze collected data of PHC, calculate important indicators, study progress of indicators and formulate strategy on basis of this finding.
11	Continuing success of NLEP in your PHC	MO	Training retraining of PHC staff, diagnosis, and treatment of leprosy cases, IEC.
12	Monitor success of NLEP in your PHC	MO	Calculate various indicators and take corrective actions.

Records and reports under NLEP:

- | | |
|--|------------------------|
| • Patient card | LF – 01 |
| • PHC treatment record | LF – 02 |
| • Leprosy drug stock record | LF – 03 |
| • NLEP monthly reporting form | MLF – 04(page 1 and 2) |
| • Disability Register | Form - P.I |
| • Assessment of Disability and Nerve Function | Form - P.II |
| • Record of Lepra Reaction/ Neuritis (LRN) cases | Form - P.III |
| • Prednisolone Card | Form - P.IV |
| • Referral Register | Form - P.V |
| • Referral Slip for health workers to refer to PHC | Form - P.VI |
| • Referral Slip for MO PHC | Form - P.VII |
| • Profile of disabled leprosy cases at PHC. | Form - P.VIII |

Suspect Case Register:

In addition to above, entries of all suspect cases of leprosy sent by health workers are to be made and monitored worker wise in the suspect case register. This register should be maintained worker wise and no. of cases referred by every worker should be reviewed at every meeting with the workers. All suspect cases of leprosy must be examined within a week by MO to confirm the diagnosis of leprosy or otherwise.

Essential indicators and their significance:

Essential indicators should be calculated every month in each health facility so that MO PHC knows as to which way disease is heading and what corrective measures should be taken. Essential indicators are:-

1. Prevalence Rate or PR

It is total number of cases on record at a given point of time in an area.

$$\frac{\text{Total number of cases on record} \times 10,000}{\text{Total Population in given area.}}$$

Interpretation: Elimination target is defined as prevalence rate below one per 10,000 populations. High prevalence may indicate high transmission in area. High prevalence can also be as a result of intensified elimination activities.

If data for prevalence of past years are available, see the trend to assess progress being made towards leprosy elimination. If PR is increasing then some intensification of NLEP activities will have to be taken in villages/sub centers from where maximum number of cases are reported.

2. Annual New Case Detection Rate

Total number of cases newly detected (and never treated before) at a given point of time in an area.

$$\frac{\text{Total number of cases newly detected} \times 1,00,000}{\text{Total population in a given time in a given area.}}$$

A high new case detection rate indicates.

- High transmission in the given area.
- Result of intensified elimination activities
- Result of over diagnosis
- Result of recycling of old patients
- Increasing community awareness

If data are available for past years, trend should be analyzed.

Decreasing trend can indicate following possibilities:-

- Transmission is decreasing
- New case detection service is becoming less active.
- Community participation in leprosy needs improvement

3. Proportion of visible Deformity among New Cases Detected

$$\frac{\text{Number of newly detected cases with deformity in year} \times 100}{\text{Total number of newly detected cases in year}}$$

Total number of newly detected cases in same year.

It should be close to zero. If it is higher it may be due to low community awareness and late reporting of cases. IEC activities should be strengthened to reduce proportion of deformity in newly detected patient.

4. Proportion of child cases among New Cases Detected

Proportion of new leprosy patients, up to 14 years of age among newly detected patients.

$$\frac{\text{Total number of 0-14 years new leprosy cases in year} \times 100}{\text{Total number of newly detected cases during same period.}}$$

A high proportion can be as a result of elimination activities targeted to this age group, such as school surveys and IEC in schools or high leprosy transmission in area.

5. Proportion of MB case among New Cases Detected

$$\frac{\text{Number of MB patients among new cases detected}}{\text{Total number of cases among whom grouping has been recorded}} \times 100$$

Total number of cases among whom grouping has been recorded

A high MB rate indicates delay in diagnosis, lack of awareness among community or wrong grouping or re-registration of cases.

6. Proportion of Females among New Cases Detected

$$\frac{\text{Total number of new female patients in year} \times 100}{\text{Total number of newly detected cases in same year}}$$

This should be close to 50%. If less than 50% it indicates that coverage of female population is inadequate. To improve new case detection among females, intensify IEC to this segment of population and involve female workers/women group in Programme.

7. Treatment Completion Rate (TCR)

Under NLEP, TCR is to be calculated for PB/MB, Male/Female and Urban/Rural areas separately, every year in the months of May-June. Calculation of TCR is done as below:

PB TCR = Number of new PB cases who completed MDT in 9 months $\times 100$ / Number of new PB cases who started MDT in cohort of one year back.

MB TCR = Number of New MB cases who completed MDT in 18 months $\times 100$ / Number of new MB cases who started MDT in a cohort of two years back.

When the treatment completion rate is low, the medical officer should monitor and assess the factors responsible for this low completion of treatment.

8. Defaulters Rate : The indicator is to be calculated as below:-

Defaulters Rate = Number of cases defaulted (continuous absence for >3 months in PB and >6 months in MB) from taking treatment $\times 100$ / Total Number of new cases started treatment as a cohort.

The purpose of calculating the proportion of defaulter is to assess the case holding at the centre i.e. whether the workers and the staff is sensitive to ensure that none of the cases under treatment default (remain absent for >3 or >6 months as the case may be).

Disability Prevention and Medical rehabilitation (DPMR)

Objectives of DPMR

1. To prevent disabilities & worsening of disabilities.
2. To develop a referral system to provide POD services.

Now as the number of new cases detected has reduced considerably emphasis has been shifted to providing quality services through prevention of disability and care of the disabled. Operational guidelines for primary, secondary level institutions have already been circulated giving details on POD care

- All Health Workers will suspect cases of leprosy reaction, relapse, insensitive hands and feet and refer to PHC for diagnosis. They will also empower patients with self care procedure for prevention of deformity.
- All PHC Medical Officers will diagnose cases of reaction and treat them. Severe reaction cases will be referred to the District Hospital, if not responded well within 2 weeks of starting treatment.
- Service and care for impairment such as ulcers, cracks and wounds, septic hand or feet etc. will be available from all the Health Institutions routinely. Complicated ulcer cases will be referred to District Hospital.
- Microcellular Rubber (MCR) footwear are to be supplied to all needy patients by the District nucleus staff at the concerned Health institution.
- PHCs will provide follow up treatment to all patients referred back by the secondary and tertiary level units for reaction, complication or post surgery care.

Medical Rehabilitation Services for the Deformed-Re Constructive Surgery (RCS)

All patients with grade II disability diagnosed at the PHC will be referred to the District Hospital/ District nucleus for further assessment and care. Treatment with MDT for the required duration will however be continued in the PHC.

- Cases suitable for RCS will be referred by District Hospital to the tertiary level care hospital for further care.
- RCS operations are being carried out in Govt. and NGOs
- Aids and appliances for Medical Rehabilitation will be supplied to the patients.
- ✓ **Incentive to patient** :As an incentive and to offset the financial difficulties leprosy affected persons who are generally below Poverty Line (BPL) families, undergoing major reconstructive surgery at the identified institutions (Government Hospital or NGO Institutions), it is decided to pay an amount of Rs.8000/- (Rupees five thousand only) per major RCS in three instalments.
 - After surgery before discharge – Rs. 5000/-
 - 1st Follow up(4-6 weeks) - Rs. 1500/-

- 2nd follow up (after 3 months) - Rs. 1500/-
- ✓ **Incentive to Institutions:** It is felt necessary that Government Sector Medical Colleges/ Physical Medicine and Rehabilitation (PMR) centre also need to be facilitated to enable these centers to carry out RCS. Hence RCS will be initiated at Dist. Hospital, NGOs & Private Institute. Incentive to Institutions is Rs. 5000/- per MAJOR RCS for addl. Drugs, dressing material, POP, Splints etc. There will be no remuneration to surgeon / PT etc

Leprosy Referral Centre:

A referral system is required primarily for -

- Diagnosis of doubtful cases with diffuse infiltration or with only nerve involvement or nodular form of lesions, where insensitive patch may not be there or partial loss of sensation is observed.
- Cases of severe type of lepra reactions.
- Complications with other system involvement including eye involvement.
- Reconstructive surgery (RCS)

Following equipments/articles should be available in readiness in all the Referral Centers at Civil Hospitals.

- a) Wax bath along with wax
- b) Electrical Muscle Stimulator
- c) Massage Vibrator
- d) Water Tub (for soaking of feet)
- e) Dressing Material with instruments
- f) Sterilizer
- g) Foot Scraper
- h) Plaster of Paris Rolls
- i) Crutches
- j) Pre fabricated splints
- k) Exercise Table
- l) Benches
- m) Vaseline
- n) Infrared-Lamp
- o) Fitness bicycle

Checklist For THO For Supervision and Monitoring

राष्ट्रीय कुष्ठरोग निर्मूलन कार्यक्रम

चेक लिस्ट

कार्यालय :- कुष्ठरोग प्रशिक्षण केंद्र नागपूर

प्रा.आ.केंद्र :-

जिल्हा :-

दिनांक :-

अ. क्र.	पडताळणीचे मुद्दे	आढळलेल्या बाबी
१	वैद्यकीय अधिका-यांचे नाव :-	
२	एकूण लोकसंख्या :-	
३	एकूण गावे :-	
४	एकूण उपकेंद्र :-	
५	एकूण आरोग्य कर्मचारी :- १) HA..... २) HV.	३) ANM..... ४) MPW.
६	कुष्ठरोग तंत्रज्ञ / आरोग्य सहाय्यक यांचे नाव :-	
७	एकूण आशा	
८	एकूण उपचारा खालिल रुग्ण	एमबी. पीबी.
९	एप्रिल पासून नविन नोंदलेले रुग्ण :-	एमबी. पीबी.
१०	आरोग्य शिक्षण साहित्य दर्शनी भागावर लावलेले आहे/ नाही.	
११	कुष्ठरोगाचे प्रमाण (पी.आर.)	
१२	नविन रुग्णांचे प्रमाण (एन.सी.डी.आर.)	
१३	नविन रुग्णात मुलांचे प्रमाण	
१४	नविन रुग्णात विकृती दर्जा २ चे प्रमाण	
१५	नविन रुग्णात एमबी रुग्णांचे प्रमाण	
१६	नविन रुग्णात स्त्री रुग्णांचे प्रमाण	
१७	संयुक्त रुग्ण नोंदवही आहे / नाही. प्रती महिना कर्मचारी निहाय २ संशयित रुग्ण प्रमाणे नोंदणी आहे / नाही.	
१८	७ दिवसांचे आत संशयित रुग्णांची तपासणी केली जात आहे/ नाही.	
१९	उपचार कार्ड भरलेले आहे / नाही. सेन्सरी असेसमेन्ट फार्म भरलेला आहे/ नाही.	
२०	सहवासीतांची नोंदणी व तपासणी केली आहे / नाही.	
२१	उपचार नोंदवही पूर्ण भरलेली आहे / नाही. गोपवारा काढलेला आहे / नाही.	
२२	शून्य क्रमांकाने नोंदलेले कुष्ठरुग्ण संख्या..... नोंदणी केल्याचे कारण...	

२३	एप्रिल पासून रोगतुक्त झालेली रुग्ण संख्या..... इतर कारणांने कमी केल्याचे कारण व रुग्ण संख्या	
२४	पुनर्लागन झालेल्या कुष्ठरुग्णांची संख्या... पुनर्लागन झाल्याचे कारण..	
२५	प्रतिक्रिया व मज्जादाह उपचार सुरु असलेल्या रुग्णांची संख्या...	
२६	विकृती नोंदवही आहे / नाही. एकूण विकृती रुग्ण..... ग्रेड १ ग्रेड २	
२७	विकृती रुग्णांना डीपीएमआर सेवा दिल्याच्या नोंदी आहे/ नाही	
२८	विकृती, प्रतिक्रिया, रिलॅप्स, व उपचार खंडीत असलेल्या रुग्णांचा भेटी / पाठपूरावा होत आहे / नाही.	
२९	औषधी साठा नोंदवही आहे / नाही. १) एमबी (प्रौढ)..... २) एमबी (मुले) ३) पीबी (पौढ) ४) पीबी(मुले)...	
३०	प्रेडनिसोलोन गोळ्यांची संख्या.....	
३१	मासिक अहवाल फाईल आहे / नाही.	
३२	माहे एप्रिल पासूनचे अहवाल आहे / नाही.	
३३	मासिक सभेत कार्यक्रमाचा आढावा घेतल्याच्या नोंदी आहेत/ नाही.	
३४	आरोग्य शिक्षण साहित्य नोंदवही आहे / नाही.	
३५	निर्देशांक निहाय चार्ट / ग्राफ लावलेला आहे / नाही.	
३६	बाह्य रुग्ण विभागात संशयित कुष्ठरुग्णांची नियमित तपासणी केली जाते / नाही.	
३७	एक दिवसीय ॲक्टिव्हिटी (आयपीसी) सुरु आहे / नाही.	
३८	निरंक रुग्ण असलेले एकूण उपकेंद्र..... आणी त्याचे कारण	
३९	निरंक रुग्ण असलेले एकूण गावे आणी त्याचे कारण	
४०	निरंक रुग्ण असलेल्या उपकेंद्र/ गावात करावयाच्या कार्याचे नियोजन केले आहे / नाही	
४१	सांसर्गिक, बाल व विकृती रुग्ण असलेल्या भागांचे/ गावांचे सर्व्हेक्षणाचे नियोजन केले आहे / नाही.	
४२	आरोग्य शिक्षण दिलेले ठिकाण..	
४३	प्रशिक्षण झाला/नाही...वैद्यकीय अधिकारी/ आरोग्य कर्मचारी	
४४	इतर उल्लेखनिय कार्य.....	

स्वाक्षरी

राष्ट्रीय कुष्ठरोग निर्मूलन कार्यक्रम
कुष्ठरोग संदर्भ सेवा केंद्र.

चेक लिस्ट

कार्यालय :- कुष्ठरोग प्रशिक्षण केंद्र नागपूर.

संदर्भ सेवा केंद्र :-जिल्हा.....दिनांक:- / /

अलर्ट इंडिया सपोर्ट आहे / नाही.....

Staff at Referral Center as per GOI guidelines

Sr.No	Designation	Trained	Untrained
1	Dermatologist		
2	Orthopedic Surgen		
3	Genral Surgen / Medical Officer		
4	Physiotherapist		
5	Physiotherapy Technician		
6	Laboratory Technician		
7	NMA/ LT /PMW/ HA/ MPW/ ANM		
8	Dresser		

अ. क्र.	पडताळणीचे मुद्दे	आढळलेल्या बाबी
१	कुष्ठरोग संदर्भ सेवा केंद्राचा बोर्ड दर्शनी भागावर लावलेला आहे काय	
२	वेगळी खोली आहे काय, पिण्याच्या पाण्याची सोय, विद्युत पुरवठा व भरपूर सूर्यप्रकाश आहे काय	
३	अहवाल लिहीण्यासाठी टेबल, खुर्ची व रुग्णांना बसण्याची व्यवस्था आहे / नाही.	
४	सेवा केंद्रामध्ये मार्गदर्शक सुचने प्रमाणे पूर्ण स्टाफ आहे / नाही.	
५	सेवा केंद्रामध्ये कार्यरत असलेल्या स्टाफचे प्रशिक्षण झाले आहे / नाही.	
६	ठरलेल्या दिवसी सेवा केंद्र सुरु असते / नाही.	
७	केंद्राला आरोग्य शिक्षण साहित्य दर्शनी भागावर लावले आहे / नाही.	
८	रुग्ण नोंदणी नोंदवही आहे / नाही.	
९	रुग्णांना समुपदेशन केल्याच्या नोंदी नोंदवहीत आहेत / नाही.	
१०	त्वचा विलेपन घेण्या करिता साहित्य उपजब्ध आहे काय ... त्वचा विलेपन घेतलेल्या रुग्णांची संख्या.....	
११	तालुक्यातील एकूण विकृती रुग्णांची संख्या.....	ग्रेड १..... ग्रेड २.....
१२	विकृती नोंदवहीला डिपीएमआर सेवा दिल्याच्या नोंदी आहेत काय ...	
१३	तालुक्यातील हॉय रिस्क रुग्णांची यादी, व रुग्णांचा	एकूण हॉयरिस्क रुग्ण.....

	पाठपूरावा केल्याच्या नोंदी आहेत / नाही.	
१४	रुग्ण रेफर स्लिप घेवून येतात काय ...	
१५	केंद्रात नविन रुग्णांचे उपचार कार्ड भरल्या जातात काय ...	
१६	वॉक्स बाथ, सेवा दिलेल्या रुग्णोची संख्या.....	
१७	इलेक्ट्रीक मसल स्टिम्युलेटर, सेवा दिलेल्या रुग्णांची संख्या.....	
१८	स्प्लिन्ट (चार प्रकारचे) आहेत काय ... स्प्लिन्ट दिलेल्या रुग्णांची संख्या.....	
१९	एम.सी.आर.चप्पल उपलब्ध असलेली संख्या..... एम.सी.आर.चप्पल दिलेल्या रुग्णांची संख्या.....	
२०	अल्सर किट उपलब्ध आहे काय ... आणी सेवा दिलेल्या रुग्णांची संख्या.....	
२१	होप थेरापी सेवा देतात काय ... उपलब्ध असलेल्या टप ची संख्या..... आणी होप थेरापी दिलेल्या रुग्णांची संख्या.....	
२२	रुग्णांची उपस्थिती संख्या.....	
२३	संशयित रुग्णांची एकूण संख्या.....	
२४	निदान निश्चित केलेल्या रुग्णांची संख्या.....	एमबी..... पीबी
२५	निदान निश्चित झाल्या नंतर संबंधित केंद्राला रेफर केल्याच्या नोंदी घेतल्या जात आहेत काय ...	
२६	प्रतिक्रिया व मज्जादाह रुग्णांचे व्यवस्थापन उपचार / संदर्भित संख्या....	
२७	पुर्नलागन झालेल्या रुग्णांची नोंद आहे / नाही . एकूण रुग्ण संख्या...	
२८	आरसीएस करीता पात्र विकृती रुग्णांची नोंदवही आहे / नाही. पात्र रुग्णांची संख्या	
२९	रुग्ण पाठपूरावा नोंदवही अद्यावत आहे / नाही.	
३०	आरोग्य शिक्षण साहित्य उपलब्ध आहे / नाही.	
३१	संदर्भ सेवा केंद्राचे मासिक प्रगतिपर अहवाल फाईल आहे / नाही.	
३२	औषधी साठा :- एमडीटी एमबी (पौढ)..... . पीबी (पौढ)...	एमबी (मुले).... पीबी (मुले)....
३३	प्रेडनिसोलोन गोळ्यांची संख्या.....	
३४	जनरल औषधी साठा पुरेसा आहे काय ...	
३५	इतर सग्रहित माहिती	
३६	भेट पुस्तीका उपलब्ध आहे काय ...	

स्वाक्षरी

7. NATIONAL VECTOR BORNE DISEASES CONTROL PROGRAMME (NVBDP)

- Launched in 2003-04 by merging NAMP, NFCP & Kala Azar Control programmes. Japanese B Encephalitis and Dengue/DHF have also been included in this Program
- Directorate of NAMP is the nodal agency for prevention and control of major Vector Borne Diseases

Strategies for National Vector Control Program

The basic approach for vector borne diseases control involves a strategy directed against the parasite and vector and to enlist the involvement of community in practicing various preventive measures Strategies contd.

- Disease management
- Insecticide resistance
- Involvement of NGOs /private sector/community
- Quality assurance on laboratory diagnosis
- Long lasting insecticide treated bed net
- Improve quality and efficiency of services at primary, secondary and tertiary levels
- Environmental management
- Monitoring and evaluation
- Collaboration with National Malaria Institute of malaria research and medical colleges
- Inter-sectoral collaboration

Modified Plan of Operation'

- Objectives
 - to prevent deaths due to malaria
 - to reduce malaria morbidity
 - to maintain agriculture and Industrial
 - production through intensive anti malaria measures in such areas
 - to consolidate the gains achieved so far

Areas were reclassified based on the Annual Parasitic Incidence (API) as those having API > 2 and those having < than 2 for operational purposes

Areas having Annual Parasite Index (API) > 2

- Regular 2 rounds of insecticidal spray with Synthetic Pyrethroids at the dose of 0.5 mg/sq meter.
- Entomological assessment for vector behavior and development of insecticidal resistance
- Active and passive surveillance is carried out on regular basis every fortnight

Presumptive Treatment to all fever cases Where Examination result do not get within 24 hrs. and Rdt is not available . Radical treatment to all slide positive cases is given Areas having Annual Parasite Index(API) < 2

- Regular spray is not carried out but 'focal' spray is carried out around falciparum cases detected during surveillance

- Regular Active surveillance once in a fortnight
- Treatment –All positive cases to receive radical treatment
- Follow up- All positive cases to be followed up for 6 month at monthly intervals after completion of radical treatment

Epidemiological investigation of all malaria positive cases.

▪ **Investigation of all Malaria Deaths-**

All cases suspected to have died due to malaria are to be investigated

▪ **Monitoring and control of all epidemics and focal out breaks of malaria –**

Any increase in the number of fever cases suggestive of malaria should be promptly investigated and measures to contain the outbreak should be instituted.

Vectors of malaria

- *Anopheles culicifacies* is the main vector of malaria
 1. Feeding habits
 - It is a zoophilic species
 - When high densities build up relatively large numbers feed on men
 2. Resting habits. Rests during daytime in human dwellings and cattle sheds
 3. Breeding places
 - Breeds in rainwater pools and puddles, borrow pits, river bed pools, irrigation channels, seepages, rice fields, wells, pond margins, sluggish streams with sandy margins.
 - Extensive breeding is generally encountered following monsoon rains.
 4. Biting time
 - Biting time of each vector species is determined by its generic character, but can be readily influenced by environmental conditions.

Most of the vectors, including *Anopheles culicifacies*, start biting soon after dusk. Therefore, biting starts much earlier in winter than in summer but the peak time varies from species to species.

2. Vector Control

(i) Chemical Control

- Use of Indoor Residual Spray (IRS) with insecticides recommended under the programme
- Use of chemical larvicides like Abate in potable water
- Aerosol space spray during day time

Malathion fogging during outbreaks

Chemical control- I.R.S.

- In Maharashtra state. Alfacypermethrin 5% is used for IRS.
- Dilution-200gm/10 lit of Water.
- 2750 Kg. Alf Cy. 5% is required for 2round in 1lack population.
- Discharge rate of nozzle tip-740cc to 850cc per min.
- Spray lance should be 45cm from the wall.
- The swaths should be parallel overlapping 1/3 area of the preceding swath.
- The pump man should give 20 to 26 strocks per min. to obtain the proper discharge rate i.e.10 PSI pressure

The spray nozzle should not be against wind direction

(ii) Biological Control

- Use of larvivorous fish in ornamental tanks, fountains etc.
- Use of biocides.

(iii) Personal Prophylactic Measures that individuals/communities can take up

- Use of mosquito repellent creams, liquids, coils, mats etc.
- Screening of the houses with wire mesh
- Use of bed nets treated with insecticide

Wearing clothes that cover maximum surface area of the body

EPIDEMIOLOGICAL INDICES:

Monthly Blood Examination Rate

$$MBER = \frac{\text{No. of B.S. Examined during the Month}}{\text{Population covered under surveillance}} \times 100$$

Slide Positivity Rate

$$S.P.R. = \frac{\text{No. of B.S. found +ve for M. parasite}}{\text{No. of B.S. examined}} \times 100$$

$$P. \text{ falciparum } \% = \frac{\text{No. of B.S. found +ve for P.f.}}{\text{No. of B.S. found +ve for M. parasite}} \times 100$$

Annual Parasite Incidence

$$A.P.I. = \frac{\text{No. of B.S. found positive for parasite}}{\text{Total Population under Surveillance}} \times 1000$$

House Index

$$HI = \frac{\text{Total Houses Positive for larvae}}{\text{Total Houses Checked}} \times 100$$

Container Index

$$CI = \frac{\text{Total Container Positive for larvae}}{\text{Total Container Checked}} \times 100$$

Bratue Index

$$\text{BI} = \frac{\text{Total Container Positive for larvae}}{\text{Total Houses Chacked}} \times 100$$

Malaria control strategies

- **1. Early case Detection and Prompt Treatment (EDPT)** is the main strategy of malaria control – radical treatment is necessary for all the cases of malaria to prevent transmission of malaria
- Chloroquine is drug of choice in Pv cases and ACT is drug of choice in Pf cases.

Surveillance

- **Active Survey-**
- M.O. Should plan fortnightly surveillance programme of MPW/ANM in such a way that each house in every village should be covered in Active survey in respective sub center.
- MPW should visit 150 house per day.
- ANM Should visit 50 house in Sub center Hq. Village.
- If No. House are more Surveillance from Asha worker should be done in her Hq village i.e. 40 house per day.
- B.S. collected from villages must be sent on the same day to the PHC laboratory.
- Positive malaria patient must get full radical treatment.
- Primaquine is gametocytocidal drug which is used in radical treatment.

Passive Survey-

- All fever cases in the OPD should be Examined for M.P.
- Suspected Malaria patient must be tested for M.P. immediately in laboratory. If the post of Technician is not available use RDK.
- In any case time lag of B.S. coll and Examination should not be more than 1 day
- MO Should ensure the completion & Consumption of Radical Treatment to the patient by HA.
- First dose of radical treatment should be given by HA and remaining doses by ASHA

Community Participation

- Sensitizing and involving the community for detection of *Anopheles* breeding places and their elimination
- NGO schemes involving them in programme strategies
- Collaboration with private sector.

5. Environmental Management & Source Reduction Methods

- Source reduction i.e. filling of the breeding places
- Proper covering of stored water
- Channelization of breeding source

Monitoring and Evaluation of the Program

- Monthly Computerized Management Information System(CMIS)
- Field visits by state by State National Program Officers
- Field visits by Malaria Research Centers and other ICMR Institutes
- Feedback to states on field observations for correction actions.

National Drug Policy on Malaria 2013

Diagnosis and Treatment for Malaria Where microscopy result is available within 24 hours

Suspected malaria case

- Take slide and send for microscopic examination
- Result?
- Positive for Pv Treat with CQ 3 days+PQ0.25 mg per kg B.W. for 14 days
- Positive for Pf Treat with ACT-Sp for 3 days+PQ single dose on second day
- Positive for Mix infectiion SP –ACT 3days+ PQ 0.25 mg per kg B.W. for 14 days
- Negative No antimalarial treatment treat as per clinical dignosis

Suspected malaria case

- Where Tfr>=1% and Pf%>30% in any of last 3years
- Do RDT for detection of malaria & prepare slide
- **Positive for Pf** Treat with ACT-SP for 3days+ PQ single dose on second day
- **RDT negative:** wait for slide result give CQ 25mg/kg over 3dayonly if high suspicious of malaria
- **If confirmed as Pv**CQ if not already given PQ 0.25mg /kg/day over 14 days
- In other areas
- **Wait for slide result** give CQ 25mg/kg over 3dayonly if high suspicious of malaria
- **Positive for Pv** CQ if not already given PQ 0.25mg /kg/day over 14 days
- **Positive for Pf** Treat with ACT-SP for 3days+ PQ single dose on second day

Suspected malaria case

- Do RDT and Prepare slide
- **Positive for Pv**Discard slide Treat with CQ 3 days+PQ0.25 mg per kg B.W. for 14 days
- **Positive for Pf** Discard slide treat with :i ACT-Sp for 3 days+PQ single dose on second day
- **Positive for Mix infectiion**Discard slide SP –ACT 3days+ PQ 0.25 mg per kg B.W. for 14 days
- **Negative** No anti-malarial treatment However,if malaria suspected send slide for microscopy

Treatment of Vivax Malaria

- **Chloroquine:**25mg/kg BW divided over three days
- 10 mg/kg bw on day 1
- 10 mg/kg bw on day 2
- 5 mg/kg bw on day 3
- **Primaquine:** 0.25 mg/kg bw daily for 14 days

Primaquine is contraindicated in infants, ANCs & G6PD deficiency individuals

Doses chart for treatment of Pv

Age	Day 1		Day 2		Day 3		Day 4 to 14
	CQ (250 mg)	PQ (2.5 mg)	CQ (250 mg)	PQ (2.5 mg)	CQ(250 mg)	PQ (2.5 mg)	PQ(2.5 mg)
Less than1Yea r	1/2	0	1/2	0	1/4	0	0
1-4years	1	1	1	1	1/2	1	1
5-8 year	2	2	2	2	1	2	2
9-14 years	3	4	3	4	1 +1/2	4	4

15 years or more	4	6	4	6	2	6	6
pregnancy	4	0	4	0	2	0	0

Treatment of uncomplicated Pf cases

Artemisinin based combination therapy (ACT-SP)

- Artesunate 4mg/kg bw daily for 3 days plus Sulfadoxine (25mg/kg bw)-Pyrimethamine (1.25mg/kg bw) on first day
- **Primaquine:** 0.75mg/kg bw on day 2

ACT is not to be given in first trimester of pregnancy.

Doses chart for treatment of Pf Artemisinin based combination therapy

Age	Day 1		Day 2		Day 3
	AS	SP	AS	PQ	AS
Less than 1 Year	25 mg	250+12.5 mg	25 mg	0	25 mg
1-4 years	50 mg	500+25 mg	50 mg	7.5 mg	50 mg
5-8 year	100 mg	750+37.5 mg	100 mg	15 mg	100 mg
9-14 years	150 mg	1000+50mg	150 mg	30 mg	150 mg
15 years or more	200 mg	1500+75mg	200 mg	45 mg	200 mg

Pf Treatment for ANC

- Ist Trimester: Quinine 10mg/Kg TDS for 7 days. (It may induce hypoglycemia, pregnant woman should not start taking Quinine on an empty stomach and should eat regularly while on Quinine Treatment.)
- IInd and IIIrd Trimester: Full course of ACT. (Primaquine should not be given)

Chemoprophylaxis

For short stay up to 6 week in high endemic areas- Doxycycline 100mg once daily for adult and children above 8 years 1.5mg/kg Body wt. The drug should be started 2 days before travel & continued for 4 weeks after leaving the malarious area (**not recommended for pregnant women and children less than 8 years.**) For Longer stay More than 6 week in high endemic areas- Mefloquine 250mg weekly for adult. The drug should be started 2 weeks before travel & continued for 4 weeks after leaving the malarious area

(Contraindicated in individuals with history of convulsions, neuropsychiatric problems and cardiac condition.)

Note:

Pregnant women with severe malaria in any trimester can be treated with artemisinin derivatives, which, in contrast to quinine, do not risk aggravating hypoglycaemia.

- The parenteral treatment should be given for minimum of 48 hours
- Once the patient can take oral therapy, give:
- Quinine 10 mg/kg three times a day with doxycycline 100 mg once a day or clindamycin in pregnant women and children under 8 years of age, to complete 7 days of treatment, in patients started on parenteral quinine.
- Full course of ACT to patients started on artemisinin derivatives.
- Use of mefloquine should be avoided in cerebral malaria due to neuropsychiatric complications associated with it.

Criteria for immediate referral to R.H./G.H.

- a) Persistence of fever after 24 hours of initial treatment.
- b) Continuous vomiting and inability to retain oral drugs.
- c) Headache continues to increase
- d) Severe dehydration – dry, parched skin, sunken face
- e) Too weak to walk in the absence of any other obvious reason
- f) Change in sensorium e.g. confusion, drowsiness, blurring of vision, photophobia, disorientation
- g) Convulsions or muscle twitchings
- h) Bleeding and clotting disorders
- i) Suspicion of severe anaemia
- j) Jaundice
- k) Hypothermia

Control of Dengue/DHF

WHAT IS DENGUE?

- Dengue is a viral disease
- It is transmitted by the infective bite of *Aedes Aegypti*
- Man develops disease after 5-6 days of being bitten by an infective mosquito
- It occurs in two forms: Dengue Fever and Dengue Haemorrhagic Fever (DHF)
- Dengue Fever is a severe, flu-like illness
- Dengue Haemorrhagic Fever (DHF) is a more severe form of disease, which may cause death
- Person suspected of having dengue fever or DHF must see a doctor at once
- There was a major out break of Dengue /DHF in Delhi in 1996
- Since then many focal outbreaks have been reported from different areas of the country mainly from urban areas.
- This disease has been included in NVBDCP in 2003 -04

Strategies: Dengue & Chikungunya

Early case detection and prompt treatment

- Identified 13 Apex Referral Laboratories for advanced diagnosis and regular surveillance in India.
- Identified 137 sentinel surveillance hospitals for proactive surveillance in India.
- NIV Pune entrusted to supply ELISA test kits to these institutes
- In Maharashtra 26 sentinel Centers are established for examination of serum sample

Control Strategy

- Public awareness and community involvement is the key issue in the strategy to control Dengue/DHF
- All efforts should be made against the breeding of *Aedes aegypti* mosquitoes by source reduction
- Protection from mosquito bites
- Early diagnosis and prompt treatment of cases
- Programme strategy included:
 - Vector control through Insecticidal residual spray (IRS) with Synthetic Pyrethroid up to 6 feet height from the ground twice annually
 - Early Diagnosis and Complete treatment

- Information Education Communication
- Capacity Building
- Programme intensified in 1991-92 which led to improved case registration through primary health care system

(ii) Biological Control

- Use of larvivorous fish in ornamental tanks, fountains etc.
- Use of biocides.

iii) Personal Prophylactic Measures that individuals/communities can take up

- Use of mosquito repellent creams, liquids, coils, mats etc.
- Screening of the houses with wire mesh
- Use of bed nets treated with insecticide
- Wearing clothes that cover maximum surface area of the body.

Japanese encephalitis control

- Japanese Encephalitis is a viral disease
- It is transmitted by infective bites of female mosquitoes mainly belonging to *Culex tritaeniorhynchus*, *Culex vishnui* and *Culex pseudovishnui* group. However, some other mosquito species also play a role in transmission under specific conditions
- JE virus is primarily zoonotic in its natural cycle and man is an accidental host.
- JE virus is neurotropic and arbovirus and primarily affects central nervous system
- Japanese Encephalitis is becoming a health problem in a number of States especially in AP, TN, Kerala, Karnataka, WB, Assam, Bihar, & Haryana,
- There was no national programme for this disease and the affected states were managing the problem with the technical Assistance from the centre
- This disease was included under the NVBDCP in 2003-04

How JE is transmitted?

- Japanese encephalitis is a vector borne disease.
- Several species of mosquitoes are capable of transmitting JE virus.
- JE is a zoonotic infection. Natural hosts of JE virus include water birds of *Ardeidae* family (mainly pond herons and cattle egrets). Pigs play an important role in the natural cycle and serve as an amplifier host since they allow manifold virus multiplication without suffering from disease and maintain prolonged viraemia.
- Due to prolonged viraemia, mosquitoes get opportunity to pick up infection from pigs easily.
- Man is a dead end in transmission cycle due to low and short-lived viraemia. Mosquitoes do not get infection from JE patient

Sign and Symptoms of JE

- JE virus infection presents classical symptoms similar to any other virus causing encephalitis
- JE virus infection may result in febrile illness of variable severity associated with neurological symptoms ranging from headache to meningitis or encephalitis. Symptoms can include headache, fever, meningeal signs, stupor, disorientation, coma, tremors, paralysis (generalized), hypertonia, loss of coordination, etc.

- Prodromal stage may be abrupt (1-6 hours), acute (6-24 hours) or more commonly subacute (2-5 days)
- In acute encephalitic stage, symptoms noted in prodromal phase convulsions, alteration of sensorium, behavioural changes, motor paralysis and involuntary movement supervene and focal neurological deficit is common. Usually lasts for a week but may prolong due to complications.
- Amongst patients who survive, some lead to full recovery through steady improvement and some suffer with stabilization of neurological deficit. Convalescent phase is prolonged and vary from a few weeks to several months.
- Clinically it is difficult to differentiate between JE and other viral encephalitis
- JE virus infection presents classical symptoms similar to any other virus causing encephalitis

Strategies: Japanese Encephalitis

Early case detection and prompt treatment-

- Clinical surveillance in endemic areas

JE Vaccination Program-

- In 2006, 11 endemic districts of 4 states covered
- Children in 1-15 years age group immunized as an integral component of Universal Immunization
- Mouse-brain derived inactivated JE vaccine manufactured by CRI kasauli
- 3 doses of 0.5 to 1 ml (day 0, 7, 30) followed by Booste

Control Strategy

1. Care of the patient to prevent sequaele
2. Development of a safe & Standard vaccine
3. Sentinel surveillance including clinical surveillance of suspected cases.
4. Studies to identify high risk cases
5. Epidemiological monitoring of the disease and effective implementation of preventive and control measures

CHANDIPURA VIRAL ENCEPHALITIES

Chandipura viral encephalities is important Sandfly viral disease and one of the leading causes of viral encephalitis and neurological infections in india.

The discovery of CHV (1965)

- An outbreak of febril illness was reported from Nagpur city in India during April to June 1965.
- Two serum sample from the cases were negative from Dengue and CHK viruses, but produce cytopathic effect when innoculated in BS-C-1 cells.
- The filterable agent recovered was identified as a new virus "Chandipura virus".
- The studies on sera collected earlier showed that virus was widely prevalent in many parts of India both in human and variety of animals.

Virus isolated from Encephalopathy case 1980

- CHP was isolated from serum of a case of acute encephalopathy during an outbreak of viral encephalitis in Raipur, Jabalpur and MP in India 1980.

Discovery of CHP Encephalitis 2003

- In 2003 between June to August there was outbreak of acute encephalitis involving 329 children with 183 deaths from many districts of AP.
- CHP was found to be etiological agent.
- During the same period 15 districts of Maharashtra outbreak of acute encephalitis involving 400 cases and 115 deaths were reported in this outbreak also CHP virus was important etiological virus.

Clinical Characteristic

- High grade fever of short duration , vomiting, altered sensorium, generalised convulsions, and decerebrate posture leading to grade iv coma, acute encephalopathy and death within a few to 48 hrs. of hospitalisation.
- Transmission of CHP virus- CHP Virus is transmitted by Infected sandflies

SANDFLIES

- Sandflies are small insects, light or dark brown in colour. They are smaller than mosquitoes, measuring 1.5 to 2.5 mm in length with their bodies and wings densely clothed with hair.
- Some 30 species of sand-flies have been recorded in India.
- The important ones are –Phlebotomus argentipes, P.papatasi, P.sergenti and Sergentomyia punjabensis

HABITS

- Sandflies are troublesome nocturnal pests. Their bite is irritating and painful, while their presence is scarcely observed.
- They infest dwellings during night and take shelter during day in holes and crevices in walls, holes in trees, dark rooms, stables and store rooms.
- The females alone bite, as they require a blood meal every third or fourth day for oviposition.
- Sandflies are incapable of flying over long distances, they merely hop about from one place another. Sandflies are generally confined to within 50 yards of their breeding places.

CONTROL OF SANDFLIES

- Sandflies are easily controlled because they do not move long distances from the place of their breeding.
- Insecticides: Resistance to DDT has not been demonstrated. A single application of 1 to 2 g/m² of DDT or 0.25 g/m² of lindane has been found effective in reducing sandflies. DDT residue may remain effective for a period of 1 to 2 yrs. And lindane only for a period of 3 months. Spraying should be done in the human dwellings, cattle sheds and other places.
- Sanitation: Sanitation measures such as removal of shrubs and vegetation within 50 yards of human dwellings, filling up cracks and crevices in walls and floors, and **location** of cattle sheds and poultry houses at a fair distance from human habitations should receive attention.

National Filaria Control Program

Magnitude of the problem

- Filariasis has been a major public health problem in India next only to malaria. The discovery of microfilariae (mf) in the peripheral blood was made first by Lewis in 1872 in Calcutta (Kolkata).
- Indigenous cases have been reported from about 250 districts in 20 states/Union Territories.
- The North-Western States/UTs are known to be free from indigenously acquired filarial infection.

Cases of filariasis have been recorded from Andhra Pradesh, Assam, Bihar, Chhattisgarh, Goa, Jharkhand, Karnataka, Gujarat, Kerala, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu, Uttar Pradesh, West Bengal, Pondicherry, Andaman & Nicobar Islands, Daman & Diu, Dadra & Nagar Haveli and Lakshadweep(20)

Signs and symptoms of Filariasis

- Recurrent fever intermittent or remittent with often double rise
- loss of appetite, pallor and weight loss with progressive emaciation
- weakness
- Splenomegaly – spleen enlarges rapidly to massive enlargement, usually soft and nontender

Liver – enlargement not to the extent of spleen, soft, smooth surface, sharp edge

- Lymphadenopathy – not very common in India
- Skin – dry, thin and scaly and hair may be lost. Light colored persons show grayish discoloration of the skin of hands, feet, abdomen and face which gives the Indian name Kala-azar meaning “Black fever”
- Anemia – develops rapidly

Anemia with emaciation and gross splenomegaly produces a typical appearance of the patients

National Filaria Control Program

- This program was started in 1955
- In 1998 the operational component was merged with Urban Malaria Scheme
- In 2003 -04 it was merged with
- Territories.

Revised Filaria Control Strategy

- The National Health Policy 2002 aims at Elimination of Lymphatic Filariasis by 2015

REVISED STRATEGY

- Annual Mass Drug Administration with single dose of Diethyl carbamazine(DEC)was taken up as a pilot .latter on Albendazole is added
- During 2004 about 400 million population were brought under MDA.
- This strategy is to be continued for 5 years or more to the population excluding children below two years, pregnant women and seriously ill persons in affected areas to interrupt transmission of disease.
- Vector control through anti larval spray at weekly intervals.
- Biological control through larvivorous fishes
- Environmental engineering through source reduction and water management
- Information, education and communication

8. NATIONAL AIDS CONTROL PROGRAMME (NACO)

Program Description

In 1992, the Government of India launched the first National AIDS Control Programme (NACP I) followed by NACP II in 1999. Based on the lessons from NACP I and II, the government designed and implemented NACP-III (2007-2012) with the objective to “halt and reverse the HIV epidemic in India”. NACP has been successful in achieving a steady decline in overall HIV prevalence. India has witnessed nearly 50% decrease in new HIV infections over the last ten years.

NACP has been exemplified by community involvement and ownership in developing appropriate strategies and in reaching out to high-risk and vulnerable populations. The programme has greatly benefited from the critical role of civil society and networks of People Living with HIV/AIDS (PLHIV) in community mobilization, increasing access to services, addressing stigma and discrimination and developing appropriate societal response. NACP-IV will build on the motivation of these stakeholders at the community level - non-government organizations (NGOs), social activists, service providers and consumers - to actively engage with the complex issues of HIV. It will focus on reducing stigma and discrimination at health care settings, work places and at educational institutions.

Goal and Objectives of NACP-IV

Having initiated the process of reversal in several high-prevalence areas the next phase of NACP will focus on accelerating the reversal process and ensure integration of the programme response with continued emphasis on prevention.

GOAL: Is to accelerate reversal of the hiv/aids epidemic with an integrated response.

OBJECTIVE

1. Reduce new infections by 50% (2007 Baseline of NACP III). Objective
2. Provide comprehensive care and support to all persons living the HIV/AIDS and treatment services for all those who require it.

STRATEGIES

The following strategies will be implemented to achieve the goals and objectives as mentioned above.

Strategy 1:

- Intensifying and consolidating prevention services with a focus on
- (a) high-risk groups and vulnerable population and
 - (b) general population.

Strategy 2

- Expanding IEC services for
- (a) general population and
 - (b) high-risk groups with a focus on behavior change and demand generation.

Strategy 3:

Increasing access and promoting comprehensive care, support and treatment

Strategy 4:

Building capacities at national, state, district and facility levels

Strategy 5:

Strengthening Strategic Information Management Systems

KEY PRIORITIES FOR NACP-IV

The primary goal of NACP–IV is to accelerate the process of reversal and further strengthen the epidemic response in India through a cautious and well-defined integration process over the next 5 years.

THE GUIDING PRINCIPLES FOR NACP-IV WILL BE:

- Continued emphasis on the Three Ones (i.e. One Agreed Action Framework, One National HIV/AIDS Coordinating Authority and One Agreed National Monitoring and Evaluation System [M&E])
- Equity
- Gender
- Respect for the rights of the PLHIV
- Civil society representation and participation
- Improved public-private partnerships.
- Evidence-based and results-oriented programme implementation.

In addition, NACP-IV will reinforce the focus on the following five cross-cutting themes:

- Quality
- Innovation
- Integration
- Leveraging Partnerships
- Reducing Stigma and Discrimination

NACP-IV COMPONENTS

Component 1: Intensifying and Consolidating Prevention services with a focus on HRG and vulnerable populations

This component will support the scaling up of TIs with the aim of reaching out to the hard to reach population groups who do not yet access and use the prevention services of the program, and saturate coverage among the HRGs. In addition, this component will support the bridge population, i.e. migrants and truckers. Component 1 includes the following two subcomponents:

Scaling up coverage of TIs among HRG

The interventions under this sub-component will include:

- a. the provision of behavior change interventions to increase safe practices, testing and counseling, and adherence to treatment, and demand for other services;
- b. the promotion and provision of condoms to HRG to promote their use in each sexual encounter;
- c. provision or referral for STI services including counseling at service provision centers to increase compliance of patients with treatment, risk reduction counseling with focus on partner referral and management;

- d. needle and syringe exchange for IDUs as well as scaling up of Opioid Substitution Therapy (OST) provision. This sub-component also includes the financing of operating costs for about 25 State Training Resource Centers as well as participant training costs over a period of 5 years.

Scaling up of interventions among other vulnerable populations

The activities under this subcomponent will include:

- a. risk assessment and size estimation of migrant population groups and truckers at transit points and at workplaces;
- b. behavior change communications (BCC) for creating awareness about risk and vulnerability, prevention methods, availability and location of services, increase safe behavior and demand for services as well as reduce stigma;
- c. promotion and provisioning of condoms through different channels including social marketing;
- d. development of linkages with local institutions, both public and NGO owned, for testing, counseling and STI treatment services;
- e. creation of “peer support groups” and “safe spaces” for migrants at destination;
- f. establishment of need-based and gender-sensitive services for partners of IDUs; and
- g. strengthening networks of vulnerable populations with enhanced linkages to service centers and risk reduction interventions, specifically condom use.

Component 2: IEC

Expanding IEC services for (a) general population and (b) high risk groups with a focus on behavior change and demand generation. IEC has been an important component of the NACP. With the expansion of services for counseling and testing, ART, STI treatment and condom promotion, the demand generation campaigns will continue to be the focus of the NACP-IV communication strategy. IEC will remain an important component of all prevention efforts and will include:

- Behavior change communication strategies for HRGs, vulnerable groups and hard to reach populations
- Increasing awareness among general population, particularly women and youth.

Component 3: Comprehensive Care, Support and Treatment

NACP IV will implement comprehensive HIV care for all those who are in need of such services and facilitate additional support systems for women and children affected and infected with HIV / AIDS. It is envisaged that greater adherence and compliance would be possible with wide network of treatment facilities and collaborative support from PLHIV and civil society groups. Additional Centers of Excellence (CoEs) and upgraded ART Plus centers will be established to provide high-quality treatment and follow-up services, positive prevention and better linkages with health care providers in the periphery.

With increasing maturity of the epidemic, it is very likely that there will be greater demand for 2nd line ART, opportunistic infections management. NACP IV will address these needs adequately. It is proposed that the comprehensive care, support and treatment of HIV/AIDS will inter alia include: (i) anti-retroviral treatment (ART) including second line (ii) management of opportunistic infections and (iii) facilitating social protection through linkages with concerned Departments/Ministries. The program will explore avenues of public-private partnerships. The

program will enhance activities to reduce stigma and discrimination at all levels particularly at health care settings.

Component 4: Strengthening institutional capacities

The objective of NACP IV will be to consolidate the trend of reversal of the epidemic seen at the national level to all the key districts in India. Programme planning and management responsibilities will be strengthened at state and district levels to ensure high quality, timely and effective implementation of field level activities and desired programmatic outcomes.

The planning processes and systems will be further strengthened to ensure that the annual action plans are based on evidence, local priorities and in alignment with NACP IV objectives. Sustaining the epidemic response through increased collaboration and convergence, where feasible, with other departments will be given a high priority during NACP IV. This will involve phased integration of the HIV services with the routine public sector health delivery systems, streamlining the supply chain mechanisms and quality control mechanisms and building capacities of governmental and non-governmental institutions and networks.

Component 5: Strategic Information Management Systems (SIMS)

The roll-out of SIMS is ongoing and will be firmly established at all levels to support evidence based planning, program monitoring and measuring of programmatic impacts. The surveillance system will be further strengthened with focus on tracking the epidemic, incidence analysis, identifying pockets of infection and estimating the burden of infection. Research priorities will also be customized to the emerging needs of the program. NACP IV will also document, manage and disseminate evidence and effective utilization of programmatic and research data. The relevant, measurable and verifiable indicators will be identified and used appropriately.

TARGETED INTERVENTION FOR HIGH RISK GROUP

A) Targeted Intervention (TI) Approach

The prevention of HIV infection among the high risk group (HRGs) is the main thrust area for the NACP and the TI program has demonstrated that it is the most effective way of controlling the epidemic among this population. The approach for providing services to this population began by conducting various mapping exercises that helped in arriving at a specific denominator for service provision. In order to measure the program efficiency a system of HIV Sentinel Surveillance was introduced and over the years India's efficient response to HIV has resulted in reduction of HIV prevalence among most of the core group with the exception of IDUs and TGs/Hijra. The HIV prevalence among ANC is 0.29% and Female Sex Worker 2.20%, Men who have Sex with Men 4.30%, Injecting Drug Users 9.90%, and Transgender/Hijra population 7.20% (IBBS 2015). The bridge population consisting of Truckers and Migrants had HIV prevalence of 2.59% and 0.99% respectively. (HSS 2012-13 Technical Brief)

As per the IBBS conducted in 2014-15, HIV prevalence among FSWs found to be 2.2%, which is eight times more than among pregnant women attending antenatal clinics (0.29%) as per HSS 2014-15. However there has been a steady decline in the HIV prevalence among this population as a result of effective interventions over the years.

Men having Sex with Men (MSM)

Men Having Sex with Men (MSM) are another important group who are highly vulnerable to HIV and are also a strategically important group for focusing HIV prevention programmes. The term 'men who have sex with men' (MSM) is used to denote all men who have sex with other men as a matter of preference or practice, regardless of their sexual identity or sexual orientation and irrespective of whether they also have sex with women or not.

As per the IBBS conducted in 2014-15, HIV prevalence among MSMs found to be 4.30%.

Transgender/Hijra

NACO has initiated exclusive TG/Hijra intervention under NACP IV

B) TIs for Bridge Populations

Individuals who have sexual partners in the high risk groups as well as other partners of lower risk (General population) are called a "bridge population", because they form a transmission bridge from the HRGs to the general population. Quite often they are clients or partners of male and female sex workers. Truckers and Migrant workers are named as bridge population through close proximity to high risk groups and are at the risk of contracting HIV.

They are a critical group because of their 'mobility with HIV'. Their living and working conditions, sexually active age and separation from regular partners for extended periods of time predispose them to paid sex or sex with non-regular partners. Further, inadequate access to treatment for sexually transmitted infections aggravates the risk of contracting and transmitting the virus.

TIs to Reduce the Vulnerabilities of Bridge Population

The NACO interventions are aimed at controlling the spread of HIV and STI through increasing awareness about their transmission and prevention. All interventions are aimed at promoting safe sex through use of condoms. They also facilitate easy access to condoms, treatment for STIs, counselling, testing and treatment services.

How are Interventions reached to Truckers?

These interventions involve interaction with the target community about sexually transmitted infections, HIV/AIDS and safe sex. Peer educational activities are also undertaken for effective outreach of the messages.

The ultimate aim is to harness the trucking community, associations, brokers and others in driving these interventions.

C) Interventions aimed at Migrants

The interventions for migrants are focused on 8.64 million temporary, short duration migrants. They are of special significance to the epidemic because of their frequent movement between source and destination areas. Therefore, to provide continuum of services to these migrants and their spouses, interventions are proposed at destination, source and transit areas. As all migrants are not at equal risk of HIV, only the high risk migrants (both male & female) are covered at the destinations through Targeted Interventions run by NGOs. Industrial houses, factory owners, construction companies and other employers engaging these migrants are also being motivated to provide HIV prevention services to these migrants. For reaching to migrants, NGOs identify volunteers among the migrants community and train them in spreading preventive messages among their fellow workers.

D) Link Worker Scheme

Rural HIV infection was another challenge area that needed to be addressed. Owing to poor infrastructure, weak health care systems and poor connectivity with most facilities, large number

of vulnerable population, HRGs, Bridge Population and PLHIVs needed to be provided services. In order to bridge this gap Link Worker Scheme (LWS) was initiated. For more details please [click here](#) for the operational guideline of LWS.

Harm Reduction Program

NACO has adopted the harm reduction policy as a strategy for prevention of HIV/AIDS amongst IDUs in 2002 during the second phase of the National AIDS Control Program (NACP II). Counselling, behavior change communication (BCC), Needle Syringe Exchange Program (NSEP), abscess prevention and management, STI treatment, referral and linkages, etc are the service components of the strategy. These services are being provided through the NGOs known as the IDU TI.

In the current NACP IV, the provision of female outreach worker (ORW) was added in all the IDU TIs for reaching out to the spouses of male IDUs. Female Injecting Drug User (FIDU) is also an additional typology being included in NACP IV.

The key aspects of the strategy to provide services to FIDUs include:

- Comprehensive package of services including services specifically addressing needs of Female IDUs
- Female friendly service delivery mechanisms
- Gender responsive and need based services
- Community participation in programme planning and implementation
- Evidence driven response- Collection and application of strategic information for program design and improvement in quality implementation

Services for Prevention

- Awareness-raising
- Management STI /RTI
- Integrated Counselling and Testing Centre (ICTC)
- PPTCT
- PEP
- Condom Promotion Programme
- Access to Safe blood

Awareness Raising

HIV infection is entirely preventable through awareness raising. Therefore, awareness raising about its occurrence and spread is very significant in protecting the people from the epidemic. It is for this reason that the National AIDS Control Programme lays maximum emphasis on the widespread reach of information, education and communication on HIV/AIDS prevention. Changing knowledge, attitudes and behaviour as a prevention strategy of HIV/AIDS thus is a key thrust area of the National AIDS Control Programme.

Addressing the Vulnerable

Awareness raising brings behaviour change. Through this route the programme promotes prevention, and aims to reach out to 80 percent of the high risk groups and 95 percent of the young people. In fact, the awareness campaign of NACP has received a big boost with the

formation of National Council on AIDS that has mainstreamed HIV prevention activities in various government institutions and programmes.

The programme focuses on saturating an estimated four million high risk groups (commercial sex workers, injecting drug users, men-who-have-sex-with-men), twelve million highly vulnerable populations – migrants and truckers, and a large number of young women and men in the general community, who constitute almost 40 percent of the country's population, with information on various aspects of vulnerability to HIV infection.

MANAGEMENT OF STI/RTI

Sexually transmitted diseases are one of the determinants of HIV transmission. An estimated five percent adult population affected by STDs, also has HIV infection. HIV vulnerability from STDs is furthermore increased as access to treatment or medical care for these diseases is very low, especially among the high risk groups. Limited diagnostic facilities to manage complicated STDs and drug resistance to major STDs are the other issues of concern that NACP-III addresses.

Making STD Services Common

Under NACP-III, a demand for STD services is generated through its awareness on one hand and on the other STD services are expanded through its integration with the Reproductive and Child Health Programme. The Programme supports increased demand for the services through capacity building among the medical practitioners of primary healthcare centres community healthcare centres, and the private regional medical practitioners providing STD services. The Programme also supports not-for-profit private practitioners and NGOs in the management of STDs among the high risk groups.

Checking Drug resistance and improving Surveillance

Apart from expanding the network providing STD services, NACP-III plans routine screening of HRGs for drug resistance to certain STDs. Regional centres are planned to be set up for this during the programme period to monitor drug resistance in syndromic oral/anal STDs, and develop guidelines for their treatment.

INTEGRATED COUNSELLING AND TESTING CENTRE

HIV counselling and testing services were started in India in 1997. As on 31st August 2016 in India, there are 20,756 Integrated Counselling and Testing Centres (ICTC), mainly located in government hospitals. An ICTC is a place where a person is counselled and tested for HIV, of his own free will or as advised by a medical provider. The main functions of an ICTC are:

- Conducting HIV diagnostic tests.
- Providing basic information on the modes of HIV transmission, and promoting behavioural change to reduce vulnerability.
- Link people with other HIV prevention, care and treatment services.

Ideally, a health facility should have one Integrated Counselling and Testing centre for all groups of people. However, an ICTC is located in facilities that serve specific categories such as high risk group, pregnant women, STI cases, TB Patients, HIV/ AIDS symptomatic patients. Accordingly, an ICTC is located in the General OPD or Obstetrics and Gynaecology Department

of a medical college or a district hospital or in a maternity home where the majority of clients can access counselling and testing services.

As on 31st March 2016, in India, 74.4% percent of PLHIV are aware of their HIV status. The challenge before NACO is to reach to all HIV infected people in the country so that they adopt a healthy lifestyle; access life-saving care and treatment and help prevent further transmission of HIV. Thus, counselling and testing services are important components of prevention and control of HIV/AIDS in the country.

It is not the mandate of an ICTC to counsel and test everyone in the general population. The sub-populations that are more vulnerable or practice high risk behaviour or have higher HIV prevalence levels are the target group for counselling and testing services in the country. In FY 2015-16, more than 29 million clients accessed counselling and testing services in the ICTC throughout the country.

HIV counselling and testing service is a key entry point to prevention of HIV infection and to treatment and care of people who are infected with HIV. When availing counselling and testing services, people can access accurate information about HIV prevention and care and undergo HIV test in a supportive and confidential environment. People who are found HIV negative are supported with information and counselling to reduce risks and remain HIV negative. People who are found HIV positive are provided psycho-social support and linked to treatment and care

PREVENTION OF PARENT TO CHILD TRANSMISSION (PPTCT)

The Prevention of Parent to Child Transmission of HIV/AIDS (PPTCT) programme was launched in the country in the year 2002 following a feasibility study in 11 major hospitals in the five high HIV prevalence states. As on 31st August 2016 in India there are 20,756 Integrated Counselling and Testing Centres (ICTC), most of these in government hospitals, which offer PPTCT services to pregnant women.

The NACO Technical Estimate Report (2015) estimated that out of 29 million annual pregnancies in India, 35,255 occur in HIV positive pregnant women. In the absence of any intervention, an estimated (2015) cohort of 10,361 infected babies will be born annually. The PPTCT programme aims to prevent the perinatal transmission of HIV from an HIV infected pregnant mother to her newborn baby. The programme entails counselling and testing of pregnant women in the ICTCs.

With effect from 1st January 2014, pregnant women who are found to be HIV positive are initiated on lifelong ART irrespective of CD4 count and WHO clinical Staging; their newborn (HIV exposed) babies are initiated on 6 weeks of Syrup Nevirapine immediately after birth so as to prevent transmission of HIV from mother to child and is extended to 12 weeks of Syrup Nevirapine if the duration of the ART of mother is less than 24 weeks.

The HIV exposed baby is initiated on Cotrimoxazole prophylaxis at 6 weeks and is tested for HIV DNA PCR at 6 weeks by DBS (Dry Blood Spot) collection. If the DBS sample is positive for HIV DNA PCR, then a repeat DBS sample is tested for HIV DNA PCR. The HIV exposed baby is then initiated on lifelong ART at the earliest if confirmed HIV positive through 2 DNA PCR test.

The PPTCT services cover about 47 percent annual estimated pregnancies in the country. In the year 2015-16, 12.7 million pregnant women accessed this service. Of these, 11,918 pregnant women were HIV positive. In order to provide universal access to these services further scale up is planned up to the level of Community Health Centre and the Primary Health Centre through NHM integration, as well as private sector by forging public-private partnerships.

POST EXPOSURE PROPHYLAXIS (PEP)

Occupational exposure

Occupational exposure refers to exposure to potential blood-borne infections (HIV, HBV and HCV) that may occur in healthcare settings during performance of job duties. Post exposure prophylaxis (PEP) refers to comprehensive medical management to minimise the risk of infection among Health Care Personnel (HCP) following potential exposure to blood-borne pathogens (HIV, HBV, HCV). This includes counselling, risk assessment, relevant laboratory investigations based on informed consent of the source and exposed person, first aid and depending on the risk assessment, the provision of short term (four weeks) of antiretroviral drugs, with follow up and support.

CONDOM PROMOTION PROGRAMME

Consistent condom use has been one of the most critical aspects of NACO's prevention strategy for HIV/AIDS control. To this effect, NACO started its Condom Promotion Programme under National AIDS Control Program (NACP) phase III and continued expanding in Phase IV also. The specific Condom Promotion objectives are:

1. Increase demand for condoms among high risk, bridge and general population
2. Expanding social marketing programme to saturate coverage in high HIV prevalence and/or high fertility districts and to increase the demand for condoms among high risk, bridge and general population
3. Maximize access of free condoms with most vulnerable groups – while minimizing wastage
4. Increase sales in rural areas and expand availability through condom sales through non-traditional outlets (stores not previously selling/ that do not usually sell condoms)
5. Introduce brand management innovations and demand generation activities to promote consistent condom use
6. Increase the accessibility of condoms to make it available within 15 minutes of walking distance from any location

NACO's Condom Promotion strategy focuses on two aspects: ensuring availability and creating demand for condoms.

The availability of condoms is addressed through three sub components of Condom Promotion Programme: Free Condom, Socially Marketed Condom (Paid-subsidized) and Female Condom.

1. **Free Condom (Nirodh):** Free Condoms are procured by Ministry of Health & Family Welfare and distributed by NACO/ SACS to High Risk Group (HRGs) through TI NGOs/ICTC/ART centers for HIV/AIDS Prevention.
2. **Social Marketing Condom:** Socially marketed condoms are distributed by NACO through its Social Marketing Organizations (SMOs) under Targeted Condom Social Marketing Programme (CSMP). The Programme focuses geographically on high prevalence and/or high fertility districts with additional emphasis on ensuring condom availability in HRG sites

- vulnerable population intensive areas. The Programme also focuses on expansion of condom availability of hitherto underserved areas such as rural markets and increasing the numbers and types of outlets stocking and selling condoms and make it a ubiquitous product.

3. Female Condom Program

The Female Condom Programme empowers FSWs to protect herself from HIV infection by using Female Condom in low-negotiable environment.

Contribution of Condom Promotion Programme in National Condom Promotion Programme:

Total Condom Distribution has grown from 1.8 billion pieces in 2007-08 to 2.7 billion pieces in 2012-13 (Source: NIELSEN and Ministry of Health & Family Welfare).

Accessibility of condoms at any location of walking distance has been reduced from 30 minutes to 19 minutes (15 minutes in Urban and 21 minutes in Rural) (Source: Condom Promotion Impact Survey 2010).

ACCESS TO SAFE BLOOD

NACO has been primarily responsible for ensuring provision of safe blood for the country since 1992. NACO supports a network of blood banks across the country in over 600 districts.

Government has adopted a comprehensive, efficient and total quality management approach. Government has taken number of steps towards the modernization of blood banks in the country by providing the critical inputs under the blood safety programme through all phases of the National AIDS Control Programme and has been primarily responsible for ensuring provision of safe blood for the country throughout the first four phases of National AIDS Control Programme.

Key strategies:

1. Assessing blood needs and requirements of the country.
2. Increasing regular voluntary non-remunerated blood donation to meet the safe blood requirements of the country.
3. Promoting component preparation and availability along with rational use of blood in healthcare facilities.
4. Capacity building of health care providers.
5. Enhancing blood access through a well networked centrally coordinated, efficient and self sufficient blood transfusion service.
6. Establishing Quality Management Systems to ensure Safe Blood.
7. Building implementation structures and referral linkages.

CARE, SUPPORT AND TREATMENT

The care, support and treatment needs of HIV positive people vary with the stage of the infection. The HIV infected person remains asymptomatic for the initial few years; it manifests by six to eight years. As immunity falls over time the person becomes susceptible to various opportunistic infections (OIs). At this stage, medical treatment and psycho-social support is needed. Access to prompt diagnosis and treatment of OIs ensures that PLHAs live longer and have a better quality of life.

To achieve this objective, 350 Community Care Centres are planned to be set up in partnership with PLHA in high prevalence and moderate prevalence districts. These centres will be

established based on the epidemiological profile and PLHA load of the districts, and linked to the nearest ART centre. The centres will provide counselling for drug adherence, nutritional needs, treatment support, referral and outreach for follow up, social support and legal services. State AIDS Prevention and Control Societies will ensure access of high risk groups to community care centres through linkages between TIs and the centres.

By strengthening local responses, NACP–III seeks high levels of drug adherence (>95 percent) and compliance of the prescribed ART regimen. This approach to care, support and treatment also creates awareness about the prevention of HIV infection and, thus, is a very significant part of NACP–III in achieving NACO's mission of containing and reversing HIV/AIDS incidence in India.

Care and Support for Children

Approximately 50,000 children below 15 years are infected by HIV every year. So far, care and support response to these children was at a very minimal level. NACP–III plans to improve this through early diagnosis and treatment of HIV exposed children; comprehensive guidelines on paediatric HIV care for each level of the health system; special training to counsellors for counselling HIV positive children; linkages with social sector programmes for accessing social support for infected children; outreach and transportation subsidy to facilitate ART and follow up, nutritional, educational, recreational and skill development support, and by establishing and enforcing minimum standards of care and protection in institutional, foster care and community-based care systems.

When is ART Given?

WHO Clinical Staging	Recommendations
HIV Infected Adults & Adolescents	
Clinical Stage I and II	Start ART if CD4 \leq 500
Clinical Stage III and IV	Start ART irrespective of CD4 count
All Pregnant / Breast Feeding Women	
All clinical Stages	Start ART irrespective of CD4 count
HIV-TB Co-Infected Patients	
Patients with HIV and TB co-infection (Pulmonary or Extra Pulmonary)	Start ART irrespective of CD4 count Start ATT first, initiate ART as early as possible between 2 weeks-2months. For patients with CD4 below 50, ART might be initiated simultaneously with ATT with strict clinical and laboratory monitoring
HIV-Hepatitis B/C Co-Infected Patients	
HIV and HBV / HCV co-infection – without any evidence of severe chronic liver disease	Start ART if CD4 \leq 500
HIV and HBV / HCV co-infection – with evidence of severe chronic liver disease	Start ART irrespective of CD4 count
HIV-Visceral Leishmaniasis (KalaAzar) Co-Infected Patients	
Patients with HIV-Visceral Leishmaniasis co-infected	Start ART irrespective of CD4 count

9. NATIONAL MENTAL HEALTH PROGRAMME (NMHP)

Background

It is estimated that 6-7 % of population suffers from mental disorders. The World Bank report (1993) revealed that the Disability Adjusted Life Year (DALY) loss due to neuropsychiatric disorder is much higher than diarrhea, malaria, worm infestations and tuberculosis if taken individually. Together these disorders account for 12% of the global burden of disease (GBD) and an analysis of trends indicates this will increase to 15% by 2020 (World Health Report, 2001). One in four families is likely to have at least one member with a behavioral or mental disorder (WHO 2001). These families not only provide physical and emotional support, but also bear the negative impact of stigma and discrimination. Most of them (>90%) remain un-treated. Poor awareness about symptoms of mental illness, myths & stigma related to it, lack of knowledge on the treatment availability & potential benefits of seeking treatment are important causes for the high treatment gap.

The Government of India has launched the National Mental Health Programme (NMHP) in 1982, with the following components and objectives.

Components

1. Treatment of mentally ill
2. Rehabilitation
3. Prevention and promotion of positive mental health

Objectives of National Mental Health Programme

1. To ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population;
2. To encourage the application of mental health knowledge in general healthcare and in social development; and
3. To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

District Mental Health Programme

The District Mental Health Programme (DMHP) was initiated in 1996 during the Ninth Five Year Plan based on Bellary Model developed by the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangaluru. During the plan period, 27 districts were covered under DMHP. At present DMHP is covering 123 districts in 30 States and Union Territories. In addition to early identification and treatment of mentally ill, District Mental Health Programme has now incorporated promotive and preventive activities for positive mental health which include School Mental Health Services, College Counselling Services, Work place Stress Management and Suicide Prevention Services. The issues of awareness regarding mental illness and availability of treatment are addressed through Information, Education and Communication (IEC) activities at District level by the DMHP- The components of District Mental Health Programme include- training programmes of all workers in the mental health team at the identified Nodal Institute in the State; public education in the mental health to increase awareness and reduce stigma; for early detection and treatment, the OPD and indoor services

are provided ; providing valuable data and experience at the level of community to the state and Centre for future planning, improvement in service and research.

In Maharashtra, DMHP programme and Prerna Prakalp to address the farmer suicide is presently working in following district.Akola, Washim, Buldhana, Yavatmal, Wardha, Aurangabad, Jalna, Beed, Hingoli, Parbani, Nanded, Osmanabad, Latur, Amravati, Gadchirlori, Bhandara, Wardha, Satara Jalgaon.

The state of Maharashtra has four Regional Mental Hospital situated at Thane, Pune, Nagpur and Ratnagiri of varying Bed capacity. The Regional Mental Hospitals are the tertiary care center, catering to various districts under their jurisdiction. The bed capacity of Nagpur mental hospital is 940 beds, thane mental hospital has 1800beds, mental hospital Pune has 1590 beds, and Ratnagiri has 250 beds. Most of these beds are occupied by long stay patients. Occupational therapy is one of the integral part of treatment apart from medicines and counseling which is carried out in mental hospital which helps in rehabilitation of patients.

Spreading awareness about the mental health is one of activity carried out in mental hospitals, so following days are celebrated.

Mental Health Day

- World health day- 7TH APRIL
- Schizophrenia day- 24TH MAY
- De-addiction day- 26TH JUNE
- Suicide Prevention day- 10TH SEPTEMBER
- Mental Health day - 10TH OCT
- Alzheimer day – 21 SEP
- Epilepsy day - 26TH MAR

Mental Health Care act 2017

The Mental Health act 2017 seeks to provide for mental health care and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental health care

The key features of the act are:

1. The Central and State Mental Health Authorities will continue as regulatory agencies.
2. All persons have the right to access mental health care and treatment from mental health services run or funded by the Government. Such services should be affordable, of good quality and available without discrimination.
3. Any person with or without mental illness can make an Advance Directive stating how he/she wishes to be treated for a future mental illness and also how he does not wish to be treated.
4. A person with mental illness had the right to live in, be part of and not segregated from society The Government has an obligation to provide for half way homes, community caring centres etc.
5. Provision for Mental Health Review Commission (MHRC). The MHRC is a quasijudicial body to provide an independent oversight to the functioning of mental health facilities and protect the rights of persons with mental illness in these facilities.

10. NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF CANCER, DIABETES, CARDIOVASCULAR DISEASES AND STROKE (NPCDCS)

PROGRAMME BACKGROUND

India is experiencing a rapid health transition with a rising burden of Non-Communicable Diseases (NCD) surpassing the burden of Communicable diseases like water-borne or vectorborne diseases, TB, HIV, etc. The Non-Communicable Diseases like Cardiovascular diseases, Cancer, Chronic Respiratory Diseases, Diabetes, etc. are estimated to account for around 60% of all deaths. NCDs cause considerable loss in potentially productive years of life. Losses due to premature deaths related to heart diseases, stroke and Diabetes are also projected to increase over the years. In order to prevent and control major NCDs, the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) was launched in 2010 with focus on strengthening infrastructure, human resource development, health promotion, early diagnosis, management and referral. Under NPCDCS, NCD Cells are being established at National, State and District levels for programme management, and NCD Clinics are being set up at District and CHC levels, to provide services for early diagnosis, treatment and follow-up for common NCDs. Provision has been made under the programme to provide free diagnostic facilities and drugs for patients attending the NCD clinics. Cardiac Care Units (CCU) are also being set up in identified districts for providing facilities for emergency Cardiac Care. Day Care Centres at the identified districts are setup to provide facilities for Cancer care. During the period 2010-2012, the programme was implemented in 100 districts across 21 States. Review of the initial phase of programme implementation helped to identify the bottlenecks and accordingly the programme was re-strategised and scaled-up. The programme aims to cover the entire country by March 2017.

Total cost of the programme for period 2012-2017 is Rs. 8,096 crore (share of Government of India is Rs. 6,535 crore and that of State Governments is Rs. 1,561 crore). The funds are being provided to the States under NCD Flexi-Pool through State PIPs of respective States/UTs, with the Centre to State share in ratio of 60:40 (except for NE and Hilly States, where the share is 90:10). For the Cancer component, there is the Tertiary Care Cancer Centers (TCCC) scheme, which aims at setting up/strengthening of 20 State Cancer Institutes (SCI) and 50 TCCCs for providing comprehensive cancer care in the country. Under the scheme there is provision for giving a 'one time grant' of Rs. 120 crore per SCI and Rs. 45 crore per TCCC, to be used for building construction and procurement of equipment, with the Centre to State share in the ratio of 60:40 (except for North-Eastern and Hilly States, where the share is 90:10).

Major risk factors to NCDs

Most NCDs are strongly associated and causally linked with following four major behaviour risk factors:

- Tobacco use
- Physical inactivity
- Unhealthy diet including high intake of salt, Sugar & Transfats and low intake of fruits & vegetables
- Harmful use of alcohol

The other risk factors include stress and household air pollution.

If the above behavioural risk factors are not being managed /modified then they may lead to following biological risk factors:

- Over weight/obesity
- High blood pressure
- Raised blood sugar
- Raised total cholesterol/lipids

The other non-modifiable risk factors such as age, sex and heredity are also associated with the occurrence of NCDs.

Objectives of NPCDCS

1. Health promotion through behavior change with involvement of community, civil society, community based organizations, media etc.
2. Opportunistic screening at all levels in the health care delivery system from sub-centre and above for early detection of diabetes, hypertension and common cancers. Outreach camps are also envisaged.
3. To prevent and control chronic Non-Communicable diseases, especially Cancer, Diabetes, CVDs and Stroke.
4. To build capacity at various levels of health care for prevention, early diagnosis, treatment, IEC/BCC, operational research and rehabilitation.
5. To support for diagnosis and cost effective treatment at primary, secondary and tertiary levels of health care.
6. To support for development of database of NCDs through Surveillance System and to monitor NCD morbidity and mortality and risk factors.

Strategy

1. Health promotion, awareness generation and promotion of healthy lifestyle
2. Screening and early detection
3. Timely, affordable and accurate diagnosis
4. Access to affordable treatment,
5. Rehabilitation

1. Health Promotion, Awareness Generation And Promotion Of Healthy Lifestyle

Given that the major determinants to hypertension, obesity, high blood glucose and high blood lipid levels are unhealthy diet, physical inactivity, stress and consumption of tobacco and alcohol, awareness will be generated in the community to promote healthy life style habits. For such awareness generation and community education, various strategies will be devised /formulated for behavior change and communication by inter personal communication (IPC), involvement of various categories of mass media, civil society, community based organization, panchayats/local bodies, other government departments and private sector.

The focus of health promotion activities will be on:

- Increased intake of healthy foods
- Salt reduction
- Increased physical activity/regular exercise

- Avoidance of tobacco and alcohol
- Reduction of obesity
- Stress management
- Awareness about warning signs of cancer etc.
- Regular health check-up

Screening, diagnosis and treatment

- Screening and early detection of non-communicable diseases especially diabetes, high blood pressure and common cancers would be an important component. The suspected cases will be referred to higher health facilities for further diagnosis and treatment
- Common cancers (breast, cervical and oral), diabetes and high blood pressure screening of target population (age 30 years and above,) will be conducted either through opportunistic and/or camp approach at different levels of health facilities and also in urban slums of large cities.
- The screening of the urban slum population would be carried out by the local government/municipalities in cities with population of more than 1 million.
- The ANMs will be trained for conducting screening so that the same can be also conducted at sub centre level. Each district will be linked to nearby tertiary cancer care (TCC) facilities to provide referral and outreach services. The suspected cases will be referred to District Hospital and tertiary cancer care (TCC) facilities.
- For screening of diabetes, support for Glucometers, Glucostrips and lancets may be provided to the state or rate contract may be utilised for this purpose. Efforts are being made to have rate contract at central level failing which it may be done by states themselves.
- The common infrastructure/manpower envisaged can be utilized for early detection of cases, diagnosis, treatment, training and monitoring of different program such as National Program for Prevention Control of Cancer, Diabetes, CVDs and Stroke (NPCDCS), National Program for Health Care of Elderly
- (NPHCE), National Tobacco Control Program (NTCP), National Mental Health Program (NMHP) etc.

2. Establishment/Strengthening of Health infrastructure

Community health centers and district hospitals would be supported for prevention, early detection and management of Cancer, Diabetes, Cardiovascular Diseases and Stroke. Support would be provided for establishing NCD clinics and strengthening laboratory at Community health centers and district hospitals.

In order to provide cardiac care and cancer care at district level, the districts not having Medical College hospitals and not covered under Scheme for Upgradation of District Hospitals to Medical College hospitals, would be provided financial assistance for establishing at least 4 bedded cardiac care unit. This includes provision for renovation and purchase of equipments such as ventilators, monitors, defibrillator, CCU beds, portable ECG machine and pulse oxymeter etc. for cardiac care and chemotherapy beds for . Financial support for the essential contractual staff such as doctors and nurses at these units would also be provided under the programme.

The contractual manpower at district level will be utilized for NCD Clinic and CCU as well as for day care Chemotherapy unit. The contractual manpower provided at CHC level will be utilized to run the NCD Clinic.

The details of establishment/strengthening of health infrastructure are given separately along with details of manpower on contract at Sub Centre, PHC, CHC, district NCD Clinic and district CCU/ICU and cancer care units.

1. Human Resource development

Under NPCDCS, health professionals and health care providers at various levels of health care would be trained for health promotion, NCD prevention, early detection and management of Cancer, Diabetes, CVDs and Stroke. For imparting training both for the programme management and for specialized training for diagnosis, treatment of cancer, diabetes, CVDs and strokes, the nodal agency/agencies will be identified to develop the training material, organize training of health care providers at different levels and for monitoring the quality of the training. Structures Training programmes will be developed to provide quality training with appropriate curriculum to various category of staff.

2. Miscellaneous services:

Financial support would be provided to district and CHC/FRU/PHC for procurement of screening devices , essential drugs, consumables, transport of referral cases as per the details annexed for treatment of Cancer, Diabetes, CVDs and Stroke. 7

3. Outreach services:

These services are proposed to be provided periodically in the programme districts in collaboration with tertiary care hospitals / institutes for early detection of common cancers, diabetes, CVDs and stroke.

4. Integration with AYUSH:

AYUSH doctors can play an important role in prevention and control of NCDs through primary health care network. They can be involved in health promotion activities through behavior change, counseling of patients and their relatives on healthy lifestyle (healthy diet, physical activity, salt reduction, avoidance of alcohol and tobacco) meditation, Yoga, opportunistic screening for early detection of non-communicable diseases and their risk factors, and treatment using Indigenous System of Medicines. The AYUSH practitioner can supplement the efforts to operationalizing these activities and thus need to be integrated with the National NCD prevention and control programs especially NPCDCS.

5. Public private partnership:

It is proposed to involve NGOs, civil society and private sector in health promotion, early diagnosis and treatment of common NCDs through appropriate guidelines as per the need at Central, State, District levels and below.

6. Research and surveillance

Support would be given to States and Institutes for surveillance & research on NCDs. Emphasis would be given on creating database, applied and operational research related to the programme. Survey for risk factors for NCDs would be conducted at frequency and by methods decided by experts.

Cancer registry programme of ICMR would be supported for having a data base for cancer cases in the country including rural areas. Registries for other NCDs can also be considered in due course of time.

7. Monitoring & evaluation

Monitoring and evaluation of the programme would be carried out at different levels through NCD cells, reports, regular visits to the field and periodic review meetings. National, State and

District NCD Cell would be established/strengthened to monitor and supervise the programme by providing the support for contractual manpower, establishment of physical infrastructure and for field visits, contingencies etc. Management Information System (MIS) would be developed for capturing and analysis of data.

The strategies proposed will be implemented in all States /UTs covering all districts in the country and will be implemented at secondary and primary levels of health delivery system.

The guidelines on operational aspects and financial norms of the programme have been given in details to facilitate the effective implementation of the programme.

Package of Services

Health Facility	Packages of services
Sub centre	Health promotion for behavior change and counseling 'Opportunistic' Screening of Diabetes using glucometer kits and Blood Pressure measurement. Awareness generation of early warning signals of common cancer Referral of suspected cases to CHC/ nearby health facility
PHC	Health promotion for behavior change and counseling 'Opportunistic' Screening of Diabetes using glucometer kits and Blood Pressure measurement. Clinical diagnosis and treatment of common CVDs including Hypertension and Diabetes Identification of early warning signals of common cancer Referral of suspected cases to CHC
CHC/FRU	Prevention and health promotion including counseling Early diagnosis through clinical and laboratory investigations Management of common CVDs, diabetes and stroke cases Lab. investigations and Diagnostics: Blood sugar, Total Cholesterol, Lipid Profile, Blood Urea, XR, ECG,USG (To be outsourced, if not available) 'Opportunistic' Screening of common cancers (Oral, Breast and Cervix) Referral of complicated cases to District Hospital/higher health care facility
District Hospital	Diagnosis and management of cases of CVDs, Diabetes, Stroke and Cancer (outpatient, inpatient and intensive Care) including emergency services particularly for Myocardial Infarction & Stroke. Lab. investigations and Diagnostics: Blood sugar, Lipid Profile, KFT, XR, ECG,USG ECHO, CT Scan, MRI etc (To be outsourced, if not available) Referral of complicated cases to higher health care facility Health promotion for behavior change and counseling 'Opportunistic' Screening of NCDs including common cancers(Oral, Breast and Cervix) Follow up chemotherapy in cancer cases Rehabilitation and physiotherapy services
Medical College	Mentoring of District Hospitals Early diagnosis and management of Cancer, Diabetes, CVDs and other associated illnesses Training of health personnel Operational Research

Tertiary Cancer Centre	Mentoring of District Hospital and outreach activities Comprehensive cancer care including prevention, early detection, diagnosis, treatment, palliative care and rehabilitation Training of health personnel Operational Research
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- It is envisaged providing preventive, promotive, curative and supportive services (core and integrated services) in Cancer, Diabetes, Cardio-Vascular Diseases (CVD) & Stroke at various government health facilities.
- The package of services would depend on the level of health facility and may vary from facility to facility. The range of services will include health promotion, psycho-social counselling, management (out-and-in-patient), day care services, home based care and palliative care as well as referral for specialized services as needed. Linkages of District Hospitals to private laboratories and NGOs will help to provide the additional components of continuum of care and support for outreach services. The district may be linked to tertiary cancer care health facilities for providing comprehensive and advanced secondary care.
- The Non-Communicable Diseases are expensive to treat. National strategies have to focus on prevention and health promotion as key to reduce disease burden. Health education programme that promote exercise, weight reduction, early diagnosis, screening are some of the key interventions that need to be promoted at various levels of health facilities.
- The services under the programme would be integrated below district level and will be integral part of existing primary health care delivery system, and vertical at district and above as more specialized health care are needed both for cancer component and diabetes, CVD, and stroke.

Expected Outcomes:

The programmes and interventions would establish a comprehensive sustainable system for reducing rapid rise of NCDs, disability as well as deaths due to NCDs.

Broadly, following outcomes are expected at the end of the 12th Plan:

Early detection and timely treatment leading to increase in cure rate and survival

Reduction in exposure to risk factors, life style changes leading to reduction in NCDs

Improved quality of life

Reduction in prevalence of physical disabilities including blindness and deafness

Providing user friendly health services to the elderly population of the country

Reduction in deaths and disability due to trauma, burns and disasters

Reduction in out-of-pocket expenditure on management of NCDs and thereby preventing catastrophic implication on affected individual

ACHIEVEMENTS

a) Details of Infrastructure established

- For programme management, State NCD Cells have been established in all 36 States/UTs, and District NCD Cells have been established in 390 district headquarters till March 2017.
- Provision has been made under the programme to provide free diagnostic facilities and free drugs for NCD patients attending the NCD clinics at the District and CHC

levels. Till March 2017, 388 District NCD Clinics and 2115 CHC NCD Clinics have been established in the country. Also, 133 Cardiac Care Units (CCU) for emergency Cardiac Care and 82 Day Care Centres for cancer chemotherapy have been set up in identified districts.

b) Details of NCD screening under the programme:

- As per monthly reports received from the State/UTs, the data is compiled at the National NCD Cell. A snapshot of the last three years data on the common NCDs collected in the designated NCD Clinics is as below:

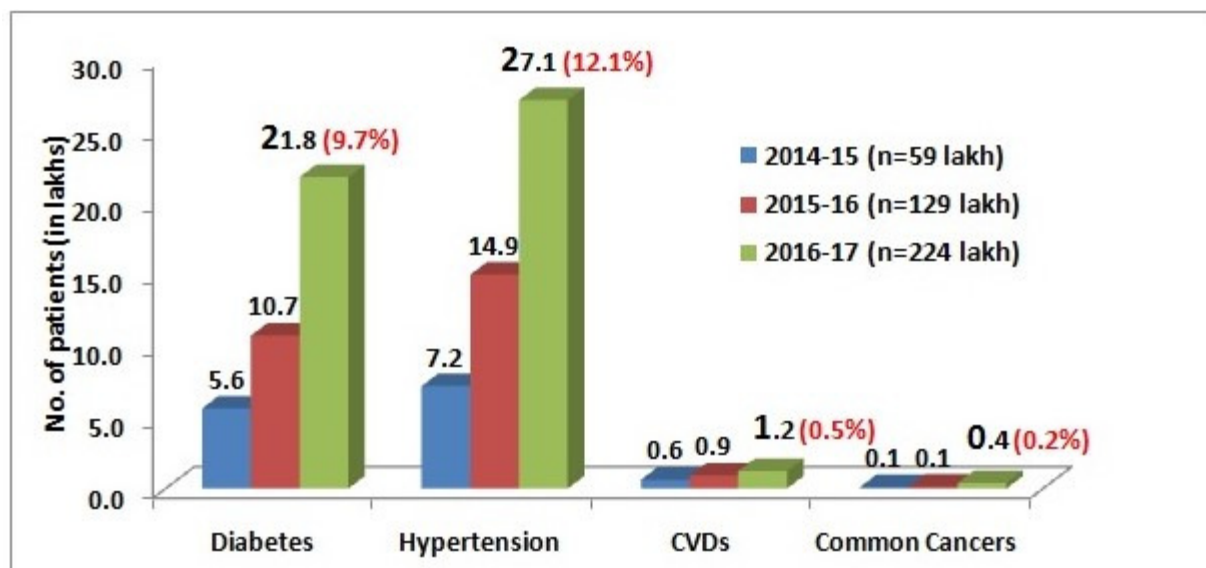


Fig 1: Number of attendees of NCD Clinics diagnosed with common NCDs in the period

2014-15 till 2016-17.

- As per the reports received from States, around 2.24 crore persons attended NCD Clinics and were screened for common NCDs like Diabetes, Hypertension, CVDs and common Cancers during 2016-2017. Among the attendees of NCD Clinics, 9.7 % were diagnosed to be Diabetics, 12.09% were Hypertensive, 0.55% had cardiovascular diseases and 0.17% were patients of common cancers including oral, cervical and breast cancers. After confirmation of diagnosis these persons were either managed in the NCD Clinics or referred to higher facilities. Around 79 lakh persons underwent counselling for health promotion for prevention of NCDs or lifestyle modification for management of NCDs.
- During 2016-2017 around 1.67 crore persons were screened for common NCDs under various outreach activities including health-camps and primary healthcare facility level. Among them, Diabetes was suspected in around 8.4%, Hypertension was suspected in 8.7%, and Common Cancers were suspected in around 0.2% persons screened. They were referred to higher centres for confirmation of diagnosis and management.

RECENT INITIATIVES UNDER THE PROGRAMME:

- a) For combating common NCDs in the community, a new strategy for Population-based Screening of common NCDs like Diabetes, Hypertension and common Cancers is being initiated under the umbrella of NHM in 100 districts of the country in the first phase. This will utilize the services of the Frontline-workers (ASHA) and Health-staff (Staff Nurse/ANM, etc.) of the existing Primary Healthcare System in screening of NCD risk factors as well as early detection and referral of NCDs. For this, Operational Guidelines have been launched and training of the States has been undertaken.
- b) Guidelines for prevention and management of Chronic Obstructive Pulmonary Disease (COPD) and Chronic Kidney Disease (CKD) are being included under the programme to prevent and manage the chronic respiratory and kidney diseases respectively, which are also major causes of death due to NCDs.
- c) For comprehensive management of lifestyle related disorders, a pilot project on 'Integration of AYUSH with NPCDCS' has been initiated in six districts, namely Bhilwara (Rajasthan), Gaya (Bihar), Surendranagar (Gujarat) under Central Council for Research in Ayurvedic Sciences (CCRAS); Lakhimpur-Kheri (Uttar Pradesh) under Central Council for Research in Unani Medicine (CCRUM); and Krishna (Andhra Pradesh) and Darjeeling (West Bengal) under Central Council for Research in Homeopathy (CCRH). Synergy is being harnessed between the Allopathy system under NPCDCS and the alternative systems of medicine under AYUSH, for prevention and management of 'lifestyle-related' common NCDs. Besides health promotion and patient management services at the NCD/Lifestyle Clinics, training on Yoga are also provided through an integrated Yoga programme. The government is planning to expand NPCDCS-AYUSH integration project to more districts of the country.
- d) Pilot intervention has been initiated for the prevention and control of Rheumatic Fever and Rheumatic Heart Disease under the platforms of NPCDCS and RBSK (Rashtriya Bal Swasthya Karyakram), in three select districts (Gaya in Bihar, Firozabad in Uttar Pradesh and Hoshangabad in Madhya Pradesh). This intervention is planned to be scaled up to other districts in a phased manner.
- e) Another initiative is the integration of RNTCP with NPCDCS, wherein the "National Framework for Joint Tuberculosis-Diabetes collaborative activities" has been developed to articulate a national strategy for 'bi-directional screening', early detection and better management of Tuberculosis and Diabetes co-morbidities in India
- f) Opportunistic screening of common NCDs including Diabetes, Hypertension and Cancer, is being done among the attendees of the India International Trade Fair (IITF) at Pragati Maidan, New Delhi during 14-27 November, every year. Besides screening NCDs and lifestyle related risk factors, this initiative also helps to increase awareness about the prevention and control of NCDs. Every year more than 70,000 persons are screened at the IITF and suspected cases of Diabetes, Hypertension and common Cancers are referred to designated hospitals for further management.

- g) Along with different forms of media, social media is also being used to generate awareness about prevention and control of NCDs. To leverage mobile technology, an application called mDiabetes has been launched to generate awareness, to promote adherence of treatment and to inculcate healthy habits among the masses with special focus on target groups.

11. SICKLE CELL DISEASE CONTROL PROGRAMME

Sickle Cell anaemia is genetic disorder in which the red blood cells can become sickle-shaped (that is, shaped like a "C"). Normal red blood cells are smooth and round like a doughnut without a hole. They move easily through blood vessels to carry oxygen to all parts of the body. Sickle-shaped cells do not move easily through blood vessels; they are stiff and sticky, and tend to form clumps and get stuck in blood vessels. The clumps of sickle cells block blood flow in the blood vessels to the limbs and organs. Blocked blood vessels can cause pain, serious infections and organ damage.

As per DMER draft proposal June 2008 and recommendation by Lokayukta Maharashtra
a. Sickle Cell Disease is prevalent in 19 districts. The Program is being implemented in these districts in phase wise manner by NRHM since 2008.

GOAL AND OBJECTIVES

- 1) To create awareness and disseminating information regarding Sickle Cell Disease and facilities available for detection & treatment.
- 2) Screening general population. (Target age group 1 to 30 years, special focus is on 1-12 years, adolescent age group & pregnant mother)
- 3) Providing screening facilities at Primary Health Centre, Rural Hospital, Sub District Hospital, District Hospital & Women Hospital.
- 4) Conducting solubility testing (screening test) at PHCs free of cost & referring positive cases for electrophoresis to the nearest RH.
- 5) To make Prophylactic Antibiotics and symptomatic treatment available at PHC, RH & DH level.
- 6) To make Specialist treatment available at District Hospital & Medical College

Sr. No	Institute	Services to be provided	Investigation to be made available
1	SC PHC	1)Free Solubility testing TARGET:- Age group 1-30, Unmarried and Pregnant women 2)Counseling 3)Regular Health check up of Sufferer 4)Prophylactic & Symptomatic treatment to be provided 5)Maintenance of records & register	Hb, CBC, Solubility Test <u>NEGATIVE</u> -persons not on sicklers (white card) POSITIVE - ref to RH.
2	RH/ SDH/ WH	1)Free Solubility testing 2)Free Electrophoresis testing (only if Electrophoresis centre) 3)Counseling 4)Regular Health check up of Sufferer 5)Prophylactic & Symptomatic treatment to be provided 6)Blood transfusion to Sickle Sufferer if blood storage centre or blood bank is available 7)Maintenance of records & registers 8) to provide Hydroxyurea t/t if trained Physician & investigation facilities are available	Hb. CBC, Solubility test, Electrophoresis test if it is testing center. Yellow card for SA Red card for homozygous SS

IMPLEMENTATION GUIDELINES AND ROLE AND RESPONSIBILITIES OF MEDICAL OFFICER AT PHC LEVEL IN SICKLE CELL PROGRAM:

- 1) To monitor and effectively implement Sickle cell disease control program.
- 2) He/she should create awareness in population regarding sickle cell disease.
- 3) To provide free solubility testing of all patients, pregnant mothers and patients coming for immunization at Primary Health Centres.
- 4) He/she should have list of villages attached to their respective PHC.
- 5) He/she should complete solubility testing (screening) of target population village wise.
- 6) He/she should have updated list of all sufferers and carriers identified in their PHC and same should be made available to ASHA's/NGO for regular follow up.
- 7) He/she should ensure proper distribution of health cards to carriers and sufferers after confirming results through electrophoresis and HPLC test. (with high-performance liquid chromatography)
- 8) He/she should encourage sufferers for regular prophylactic and symptomatic treatment also they should keep updated list of sufferers who are not taking regular treatment.
- 9) He/she should ensure that ASHA/NGO is taking regular follow up of sufferers and are bringing sufferers for regular treatment and health check-up to PHC.
- 10) He/she should give marriage counselling to carriers and sufferers and counselling to sickle cell sufferer pregnant women for CVS testing.
- 11) Ensure proper treatment of patients in crisis.
- 12) He/she should make sure round the clock availability of solubility kits, medicines and other consumables at PHC. In case of unavailability same should be conveyed to higher authority.
- 13) Providing regular training to ASHA's/ANM's and other staff at Primary Health centre for better implementation of program.
- 14) He/she should do expenditure under program as per approved PIP.
- 15) He/she has to make sure records and registers available at primary health centre should be complete and same to be produced whenever necessary.
- 16) He/she should take regular review of program through monthly meetings.

ACTION POINTS :-

- ASHA will create awareness through Gramsabha, meeting with youth, Mahila Mandal, SHG etc
- Testing will be arranged on camp basis on Arogya Sava Satra Day or any other day.
- Every PHC will arrange four to five camps every month having minimum hundred patients depending upon the target given to them.
- Health Asst. will carry consumables, syringes, needles, EDTA bulbs, cards, registers, and solubility test to camp place.
- Testing will be done by ANM/MPW preceded with known positive & negative quality control
- White cards will be distributed immediately by ASHA to all negative people.
- Blood will be collected from solubility positive patients in EDTA bulbs & send for Electrophoresis in cold box or vaccine carrier to PHC and then to Electrophoresis center
- For every ten to twelve PHC there will be one electrophoresis centre at SDH/RH having

- ng two Electrophoresis machines & one Lab Technician
- Reports from electrophoresis center will be collected on same day.
- Red & yellow cards will be prepared at PHC under supervision of MO. Depending upon electrophoresis results and these would be distributed by ASHA after counseling by MO PHC & ANM.
- ASHA will visit these patients frequently (sufferer every month & carrier every three months) for regular treatment & provide marriage counseling. Coloured (Yellow / Red) card holders should not marry with each other.
- Sufferer will be examined by PHC MO every month & provide prophylactic treatment & symptomatic treatment as and when required.
- RH/SDH/DH will also provide facilities for free testing, counseling & treatment
- Specialty treatments (blood transfusion, hydroxyurea hip replacement etc) will be provided at DH & Medical Collages.
- Each taluka will have taluka sickle cell assistant to counsel & keep line list of all sufferer & carrier in their taluka.
- District sickle cell coordinator will monitor programme in district.

Symptoms of sickle cell disease

People born with sickle cell disease sometimes experience problems from early childhood, although most children have few symptoms and lead normal lives most of the time. Carriers are asymptomatic.

The main symptoms of sickle cell disease are:

- painful episodes called sickle cell crises, which can be very severe and can last up to a week
- an increased risk of serious infections
- anaemia (where red blood cells can't carry enough oxygen around the body), which can cause tiredness and shortness of breath

SOLUBILITY TESTS FOR SICKLE CELL

The solubility test is the most common screening test for sickle cell or presence of HbS. It is based on the relative insolubility of HbS when combined with a reducing agent such as sodium dithionite. When anticoagulated blood is mixed with the reducing agent, the red cells will lyse due to the presence of saponin and the hemoglobin in the red cells will be released. If HbS is present, it will form liquid crystals and give a cloudy or turbid appearance to the solution. If HbS is not present, the solution will appear transparent, with rare exceptions (see below). The solubility test cannot be used to differentiate sickle cell disease (homozygous for HbS) from sickle cell trait (heterozygous for HbS).

Hemoglobin Electrophoresis Test

A hemoglobin electrophoresis test is a blood test used to measure and identify the different types of hemoglobin in your bloodstream. Hemoglobin is the protein inside red blood cells responsible for transporting oxygen throughout your circulatory system to your tissues and organs.

If your hemoglobin is healthy, it will transport and release oxygen with maximum efficiency. If it's abnormal in some way, it may cause too little oxygen to reach your tissues and organs.

The types of hemoglobin include the following:

- **hemoglobin F:** This type is found in growing fetuses and newborns. Soon after birth, it's replaced with hemoglobin A.
- **hemoglobin A:** This is the most common type of hemoglobin found in healthy children and adults.
- **hemoglobin C, D, E, M, and S:** These (and many other, rarer variations) are types of abnormal hemoglobin.

Diagnosis

In HbSS, the complete blood count reveals haemoglobin levels in the range of 6–8 g/dl with a high reticulocyte count (as the bone marrow compensates for the destruction of sickled cells by producing more red blood cells). In other forms of sickle-cell disease, Hb levels tend to be higher. A blood film may show features of hyposplenism (target cells and Howell-Jolly bodies).

Sickling of the red blood cells, on a blood film, can be induced by the addition of sodium metabisulfite. The presence of sickle haemoglobin can also be demonstrated with the "sickle solubility test". A mixture of haemoglobin S (Hb S) in a reducing solution (such as sodium dithionite) gives a turbid appearance, whereas normal Hb gives a clear solution.

Abnormal haemoglobin forms can be detected on haemoglobin electrophoresis, a form of gel electrophoresis on which the various types of haemoglobin move at varying speeds. Sickle-cell haemoglobin (HbS) and haemoglobin C with sickling (HbSC)—the two most common forms—can be identified from there. The diagnosis can be confirmed with high-performance liquid chromatography. Genetic testing is rarely performed, as other investigations are highly specific for HbS and HbC.

Treatment

- mainly symptomatic
- drugs such as hydroxyurea are used to increase fetal hemoglobin
- vasodilators and lubricants used to prevent microvascular blockage with very little success

Counselling

Inheritance

- Sickle cell disease is inherited in an autosomal recessive fashion
 - people with sickle cell disease have two copies of the mutated gene
 - people with sickle cell trait have one normal gene and one mutated gene
- Parents who both have sickle cell trait will have a 25% chance of having a child with sickle cell disease, a 50% chance of having a child with sickle cell trait, and a 25% chance of having a normal child who is not a carrier
- If one parent has sickle cell disease and one parent has sickle cell trait, they have a 50% chance of having a child with sickle cell disease but the child will have sickle cell trait.
- If one parent has sickle cell disease and the other parent is normal the child will have sickle cell trait but 0% chance of having sickle cell disease.

Clarification: In order for a child to have sickle cell disease both parents must have at least one copy of the abnormal sickle cell gene, or in other words both parents must have sickle cell trait for the child to have sickle cell disease.

12. DIARRHOEAL DISEASES CONTROL PROGRAMME

1. Definition of diarrhoea

By definition, diarrhoea is passage of three or more liquid / watery stools in 24 hours. However, change in consistency has more importance than number of stools passed.

2. Diagnosis of dehydration

Although number of organisms are responsible for causing diarrhoea, clinical presentation is same i.e. passage of watery stools leading to dehydration in all these cases. Therefore assessment of dehydration status and correct management of dehydration by ORT is mainstay of diarrhoeal disease control programme.

2.1. General guidelines

- Diagnosis of dehydration is very simple, provided you examine patient systematically. MO, HAs, MPWs, and Anganwadi Workers from PHC must know how to examine diarrhoea patient for diagnosis of dehydration.
- Discuss diagnosis and management of dehydration in detail during monthly meetings of April and May and revise important points in subsequent meetings at least up to month of September.
- All Anganwadis and sub centers must have charts indicating diagnosis and management of dehydration. Also keep charts in the room of MO, HA, Pharmacist and ward in PHC.
- All MPWs must keep with them dehydration treatment card and 10 packets of ORS during home visits.

There is no need to give other medicines not mentioned in these guidelines, e.g. higher antibiotics, other IV fluids, multivitamins, anti-motility drugs, etc. to patients during management of dehydration. Addition of these medicines will unnecessarily increase cost of treatment and may divert your attention from correct management of dehydration, which is vital to save life of patient.

For systematic examination for dehydration, special indoor paper for patients of diarrhoea/dysentery should be used so that no point will be missed in correct assessment and management of dehydration. MO or health worker should only tick mark appropriate boxes of examination points, diagnosis and management. Printed indoor paper will cover all points and improve management practices of diarrhoea cases.

Following steps should be carried out in given sequence for management of diarrhoeal diseases.

2.2. Classify patient into type of diarrhoea.

Important clinical types are acute diarrhoea, persistent diarrhoea and dysentery. Table below will help in classifying the patients.

Diagnosis of diarrhea

Sign/symptom	Acute diarrhoea	Persistent diarrhoea	Dysentery
Frequency of stools/day	Three or more	Three or more	Three or more
Consistency of stools	Watery	Variable	Variable
Duration of diarrhea	Less than 2 weeks	Two or more weeks	Less than 2 weeks
H/o fever	No	Variable	Yes
H/o blood stained mucus	No	Variable	Yes
Effect on appetite	No	Loss of appetite	Loss of appetite
Dehydration	Important, may lead to severe dehydration if not treated in time.	Patient may have some dehydration.	Patient may have some dehydration
Treatment principle	Management of dehydration is priority	Start management of dehydration. Simultaneously find cause of persistent diarrhoea and treat accordingly.	Start management of dehydration. Simultaneously start appropriate antibiotics.
Long term effects	No long term effect for occasional episodes. Repeated attacks may lead to PEM.	If not treated correctly, child may get severe Protein Energy Malnutrition	Repeated attacks may lead to Protein Energy Malnutrition

2.3. Assess status of dehydration of patient

Sign/Symptom	Severity of symptoms and signs (Encircle the finding)		
	No dehydration	Some dehydration	Severe dehydration
General condition of Patient	Patient well alert	Restless and irritable	Lethargic, unconscious, floppy
Presence of thirst	Normal/not thirsty	Thirsty, drinks water immediately when offered	Not able to drink
Dryness of mouth and tongue	Moist mouth and tongue	Mouth and tongue dry	Mouth and tongue very dry
Condition of eyes	Normal	Sunken	Very sunken, patient's face looks like old man's face.
Condition of tears	Tears appear while crying	Tears appear while crying	No tears, dry eyes even in crying child
Skin turgor	Normal. Pinch to skin immediately goes back to normal.	Pinch slowly goes back and takes some time to become flat.	Pinch remains as it is for 2-3 seconds and then slowly goes back.
Classification of dehydration	No dehydration	Some dehydration	Severe dehydration
Treatment of dehydration	Plan – A	Plan – B	Plan - C

Important:

- Dehydration status should be decided by the column from which maximum signs and symptoms are observed.
- Patient with only thirst without any other sign or symptoms of dehydration should be classified as having some dehydration and given Plan-B rehydration treatment.

- Lethargic child not able to drink with history of acute diarrhoea should be classified as having severe dehydration and given Plan-C rehydration treatment.

3. Management of dehydration

Most important aspect in management of diarrhoeal diseases is correction of dehydration.

Treatment of dehydration is divided into three plans as follows -

- Plan-A: For patients with no dehydration – principle is to prevent dehydration.
- Plan-B: For patients with some dehydration – principle is treatment of some dehydration and preventing patient from going into severe dehydration.
- Plan-C: For patients with severe dehydration - This is life saving plan. Rehydrate patient as early as possible and prevent from going again into severe dehydration.

Description of treatment plans in details is as follows-

3.1. Plan-A

Plan-A is for patients who are having diarrhoea but no signs of dehydration.

3.1.1. Principle of treatment

As diarrhoea is continuing, there is continuous loss of water and electrolytes from body of patient which may lead to dehydration. Therefore principle of Plan-A schedule is correction of whatever loss of water and electrolytes before the patient develops signs of dehydration. Plan-A can be advised at home to caretaker of patient. However make sure that care taker has understood danger signs of dehydration (like thirst) before you leave the house. Following steps are recommended in Plan-A –

a. Home available fluids

- Advise to give Home Available Fluids (HAF) e.g. sarbat, lassi, vegetable soup, khir, buttermilk, tea, coconut water, etc. i.e. any liquid available at home to patient as much he/she can drink. In case of under-five children, MPW/HA should not leave house of child till the mother has started giving ORS/HAF to child as child may quickly go into dehydration.
- Continue breast feeding and feeding – If child is being breastfed, then breast-feeding should be continued. Regular feeding of non-breast fed child should also be continued.

b. ORS to prevent dehydration

- If frequency and amount of diarrhoea is not declining or amount of stool is large, then start ORS. For other patients, if you have sufficient ORS packets, give one packet to mother for maintenance of hydration of child.
- Contents of WHO ORS are as follows – (New low osmolarity ORS)

Sodium chloride	2.6 grams
Potassium Chloride	1.5 grams
Trisodium Citrate	2.9 grams
Glucose	13.5 grams

 Dissolve the packet in one litre of water to prepare ORS.
- Show caretaker how to prepare ORS. Following steps should be carried out for preparation of ORS -
 - Take clean pot of one and half litre capacity and one clean spoon.
 - Pour 1 litre of clean drinking water in the pot. (No need to boil water).

- Add whole packet of ORS into one-litre of water and stir till all powder is dissolved. Now ORS is ready for use.
- Give ORS by cup or spoon to small children and by glass to bigger children and to adults as per indicated dose.
- If patient has vomiting, wait for 5 minutes and start again.
- Keep ORS covered. Once prepared ORS should be used within 24 hours. Do not use ORS beyond 24 hours, as there are chances of contamination.
- If child develops swelling on eyelids, stop ORS as it indicates overdose.
- Ask her to give ORS in following doses after passage of each liquid stool
 - Less than 6 months - 50ml
 - 6 months to 2 years - 50 - 100 ml
 - 2 to 5 years - 100 - 200 ml

c. Watch for signs of dehydration

- Ask mother to watch for signs of dehydration – Advise mother to bring child to SC/PHC in case of following conditions -
 - Increase in severity and/or frequency of diarrhoea
 - Child becomes thirsty
 - Irritable child.

3.2. Plan -B

Start Plan-B treatment to patients showing signs and symptoms of some dehydration as per dehydration diagnosis chart. Aim of this plan is to correct dehydration and prevent patient from going into severe dehydration.

3.2.1. Principle of treatment

Patient with some dehydration should be given ORS for correction of dehydration.

Steps in preparation of ORS are given in Plan-A

Dose of ORS: Dose of ORS is calculated preferably according to weight of patient.

Give ORS in a dose of 100ml/kg in 4 hrs. If weighing is not possible, calculate age wise ORS requirement for four hours as follows –

Table -: Age wise ORS requirement for four hours

Age	< 4 months	4–11 months	12–23 months	2 – 4 years	5 – 14 years	15 + years
Dose	200-400 ml	400 – 600 ml	600 – 800 ml	800 – 1200 ml	1200 – 2200 ml	2200-4000 ml

Continue breast feeding and feeding – If child is being breastfed, then breast-feeding should be continued. Regular feeding of non-breast fed child should also be continued.

3.2.2. Re-examination of patient

Re-examine patient after every four hours for status of dehydration with the help of dehydration diagnosis chart and decide plan freshly as per dehydration status as follows -

Condition of patient on re-examination	Management advise
Patient improves, no signs of dehydration on examination and diarrhoea stops	Keep patient under observation for 24 hours. Continue HAF. Observe if diarrhoea and/or vomiting start again.
Patient improves, no signs of dehydration on examination but diarrhoea continues	Continue giving ORS in doses suggested in Plan-A, re-examine after four hours.
Dehydration status same	Continue with Plan-B. Check whether ORS is being given in correct dose. Re-examine after four hours. If severity and frequency of diarrhoea increases and patient is at home or SC, shift patient to PHC.
Signs of severe dehydration appear	Switch on to Plan - C (start IV fluids). Shift patient to PHC if patient is at home or SC. Continue to give ORS as much as possible during shifting.

3.3. Plan – C

If signs and symptoms of patient are suggestive of severe dehydration, start Plan – C. This is emergency plan. Incorrect or incomplete management of severely dehydrated patient may lead to death of patient. Medical Officer must personally examine patient and treat for severe dehydration.

3.3.1. Principles of management

Principle of management of severe dehydration is replacing fluid loss by giving rapid IV infusion. Only Ringer's lactate should be used as IV fluid and the dose is 100ml/kg body weight. MO should personally verify that said quantity of IV fluid is being pushed to patient within prescribed time during treatment. This is extremely important as majority of deaths due to dehydration in hospitals are because of insufficient or slow IV infusion or use of incorrect IV fluid.

Table -: Details of Ringer's Lactate administration

Age group	Intensive phase	Maintenance phase	Duration of treatment	Remarks
Infants (0-1 year)	30-ml/kg body wt. during first 1 hour.	70ml/kg body wt in next 5 hours.	6 hrs	Assess patient after every 6 hours
Older children and adults	30-ml/kg body wt. in first half hour.	70ml/kg body wt in next 2½ hrs.	3 hrs	Assess patient after every 3 hours

Examples

Example-1: Infant of 4 kg body weight.

- Total dose of IV Ringer's lactate is 400 ml. (100 ml/kg body weight)
- Give 120 ml (30 ml/kg body weight) in first one hour and remaining 280 ml (70 ml/kg body weight) in next 5 hours.
- Assess child after 6 hours and advise further treatment according to dehydration status.

Example -2: Adult of 60 kg body weight

- Total dose of IV Ringer's Lactate is 6000 ml. (100 ml/kg body weight)
- Give 1800 ml (30 ml/kg body weight) i.e. 3-4 bottles of Ringer's Lactate in first 30 minutes and remaining 4200 ml (70 ml/kg body weight) i.e. 8 bottles of Ringer's Lactate in next 2½ hours.
- Assess patient after 3 hours and advise further treatment according to dehydration status.
- Continue breast feeding and feeding – If child is being breastfed, then breast-feeding should be continued. Regular feeding of non-breast fed child should also be continued.

3.3.2. Re-examination of patient

Re-examine patient after every six hours in infants and three hours in adults for status of dehydration with the help of dehydration diagnosis chart and decide management plan as follows –

Condition of patient	Treatment advise
Patient improves, no signs of dehydration on examination and diarrhoea stops	Keep patient under observation for 24 hours as patient may start diarrhoea/vomiting again
Patient improves, no signs of dehydration on examination but diarrhoea continues	Continue giving ORS (Plan-A)
Patient improves, signs of some dehydration on examination.	Stop IV fluids after required dose is administered. Continue giving ORS (Plan-B)
Dehydration status same	Continue with Plan-C. Check for any complications like anuria. If yes carefully examine the patient and decide for referral. Continue giving IV during transportation of patient.

3.4. Use of antibiotics and other drugs

Antibiotics are recommended only to suspected patients of cholera and dysentery. Other drugs like anti motility drugs, binding agents, anti secretory agents and steroids are not of any use in management of diarrhoea and are harmful to patients and therefore not at all recommended for treatment.

3.5 Use of Zinc Tablets

Zinc Dosage Recommendation:

Zinc is very safe drug and has a very large window of safety. Zinc dispersible tablets are to be given in each diarrhoeal episode along with low osmolality ORS or Oral rehydration therapy (in case ORS is not available), irrespective of type of dehydration

3.5.1 Zinc administration as per age of child:

a) Children from 2-6 months:

Children aged between 2-6 months should be given 10 mg of elemental zinc per day for a total period of 14 days from the day of onset of diarrhoea. A tablet of zinc contains 20 mg of elemental zinc. Therefore half tablet should be given to the children in this age group. Zinc when supplied in the form of dispersible tablets, easily dissolves in breast milk or water.

Therefore, in infants below 6 months of age, the tablet should be given by dissolving in breast milk and in infants above 6 months of age, it should be given by dissolving in breast milk or water.

Role of Zinc – It helps to reduce frequency of diarrhea, reduces quantity of loose motions. Patient recovers early. Chances of getting diarrhea & pneumonia in next 3 months are reduced.

b) Children above 6 months:

One full tablet should be given to all children with diarrhoea above 6 months of age. It should start from the day of onset of diarrhoea and continued for a total period of 14 days. In case of severe dehydration, oral zinc administration should begin as soon as the child is stabilized and able to eat.

4. Strategies for lowering diarrhoea deaths

Following important actions will help to reduce incidence of diarrhoea and deaths -

- Promote healthy environmental and personal hygiene practices. Coordinate with Gram Panchayat for safe drinking water supply and sanitation.
- Discuss correct assessment and management of dehydration with PHC staff during monthly meetings especially before and during rainy season.
- Make ORS & Zinc tablets readily/freely available. Widen the net of providers who can treat diarrhoea. Train AWWs, link workers and ASHA in management of dehydration. Train private practitioners of modern and ISM systems in rational treatment of diarrhoea.
- Ensure prompt emergency care on admission, correct diagnosis and treatment of diarrhoea cases in PHC.
- Always keep sufficient supply of Ringer's Lactate, ORS and Tablet Zinc / Syrup Zinc. Ensure adequate supply of ORS at village level through health workers, AWW, ASHA etc.
- Continue to emphasize on following points:
 - Exclusive breastfeeding up to the age of 6 months
 - Never use bottle for feeding a child
 - Dangers of diarrhoea – dehydration, malnutrition
 - Use of HAF in case of diarrhoea
 - Use of ORS/ Zinc tablets and availability of ORS in village
 - Measles immunization as a preventive measure for diarrhoea/dysentery
 - Hand washing

13. WATER BORNE DISEASES AND EPIDEMIC CONTROL

DIARRHOEAL DISEASES

Diarrhoeal diseases include acute diarrhoea, persistent diarrhoea (diarrhoea duration two weeks or more) and dysentery (blood stained stools with fever). Diarrhoeal diseases are one of the most common causes of epidemic in our state.

Most of the deaths in diarrhoeal diseases are due to dehydration which is preventable by timely and adequate replacement of fluids. Following are important causes of diarrhoeal diseases in rural areas

- **Acute diarrhea** – Cholera, Rota virus, Food poisoning, gastrointestinal disorders and medications (rare)
- **Persistent diarrhea** – Chronic bacterial infections, inflammatory bowel disorders, malabsorption syndrome
- **Dysentery** – Amoebiasis, Giardiasis, Shigellosis Some Important Water born diseases

1.Cholera

Cholera is the most important diarrhoeal disease which leads to rapid dehydration. Although number of Epidemics is reduced still some epidemics are observed in few districts.

1.1.1. Etiologic agent

Cholera is caused by bacteria *Vibrio cholerae* which exists in two biotypes, Classical and El tor. Each biotype is further divided into three subgroups Inaba, Hikojima and Ogawa.

1.1.2. Epidemiology

V. cholerae can survive in water for three weeks and on soiled linen up to one week. Transmission occurs by faeco-oral route through contaminated water. Epidemics of cholera are usually single source, explosive type & spread rapidly.

1.1.2. Clinical manifestations

Cholera is an acute infection of small intestine manifested as watery diarrhoea and vomiting. Clinical spectrum of cholera is broad, ranging from in-apparent infection to cholera gravis, which may be fatal in few hours. Incubation period of 24 to 48 hours is followed by abrupt onset of painless, profuse and watery diarrhoea associated with vomiting.

Symptoms and signs of cholera are entirely due to loss of large volume of isotonic fluid and resultant depletion of intravascular and extra vascular fluid leading to severe dehydration, metabolic acidosis and hypokalemia. Patient develops thirst, cramps, and anxiety due to depleting isotonic fluid.

1.1.3. Diagnosis

Suspect cholera when patient has severe watery diarrhoea and vomiting. Collect stool sample of suspected cases in Cary Blair media and transport to District Public Health Laboratory. However, treatment and control measures should be started immediately on the basis of clinical symptomatology without waiting for laboratory confirmation.

1.1.5. Treatment

Carefully examine patient for signs of dehydration and treat as per dehydration status. Most important treatment of cholera is rehydration of patient with ORS and Ringer's Lactate. In addition to this, start one of the following antibiotics to patient -

- Cap. Doxycycline 6 mg/kg/ day as a single dose for 3 days OR
- Cap. Tetracycline 50mg/kg/day in 4 divided doses for 3 days OR
- Tab. Erythromycin 30mg/kg/day in 3 divided doses for 3 days.

1.1.6. Prevention

Disinfection of water is an important preventive measure. *Vibrio Cholera* is sensitive to chlorine. Daily water chlorination, personal and environmental hygiene and food safety measures prevent cholera.

1.2. Amoebiasis

Human infection with *Entamoeba* is called as amoebiasis.

1.2.1. Etiologic agent

Amoebiasis is contracted by ingestion of cyst form of *Entamoeba histolytica*. After entering the bowel, cysts develop into trophozoites which colonize in colon.

Large numbers of cysts are developed from trophozoites which pass through stools completing life cycle.

1.2.2. Epidemiology

Man is the major reservoir of amoebiasis. Untreated water and contaminated food are important source of infection. Chlorination has little or no effect on amoebic cysts. Intestinal amoebiasis may occur within two weeks of infection or may be delayed for months.

1.2.3. Clinical features

More than ninety percent individuals infected with *E. histolytica* are asymptomatic. Many infected persons have nonspecific gastrointestinal symptoms such as abdominal pain, bloating or watery diarrhoea. Few patients develop amoebic dysentery and manifest as abdominal pain and bloody diarrhoea.

Rarely patient may develop fulminant amoebic colitis with high fever, peritonitis and colonic perforation resulting into high mortality. Few patients develop extra intestinal complications, commonest of which is liver abscess.

1.2.4. Diagnosis

Diagnosis of amoebiasis depends upon microscopic examination of stools. Finding of trophozoites in stools indicates occurrence of invasive colitis.

1.2.5. Treatment

Metronidazole 30 mg / kg / day in 3 divided doses after meals for 8-10 days OR Tinidazole can be used.

ENTERIC FEVER

Enteric fever is an acute, febrile illness, caused by bacterium *Salmonella typhi* which may become sometimes life threatening.

1. Etiologic agent

Enteric fever is caused by *Salmonella typhi* and *S. paratyphi*. Enteric fever caused by *S. typhi* is more severe and frequent. (Commonly called as typhoid).

2. Epidemiology

Man is the only natural reservoir of *S. typhi*. Ingestion of food or water contaminated with human feces is most common mode of transmission. *S. typhi* is present for about 1-2 months in stools of patients. Carriers are important epidemiologically because they are mainly responsible for spread of typhoid in community. Complete antimicrobial therapy reduces chances of carrier stage.

3. Clinical manifestations

After incubation period of 10-14 days, typhoid fever has an insidious onset characterized by fever, headache, constipation, malaise, chills and myalgia. Splenomegaly, leucopenia, abdominal distention and tenderness are generally present. If untreated, fever increases up to 40°C and fatigue, anorexia, abdominal symptoms and cough may appear with increase in severity. Nausea and vomiting in second and third week suggest complications.

4. Diagnosis

S. Typhi is most frequently isolated from blood during first week of illness. Collect blood sample of suspected enteric fever case before starting antibiotic. Widal test, which measures antibody response to H and O antigens, can only suggest diagnosis of enteric fever. Widal test results are not definitive and must be interpreted with care because Enteric Fever being endemic titre may be elevated without enteric fever. If Widal test is performed, repeat the test after 10 days. Four-fold rise in antibody titre of second sample should be used for diagnosis rather than single test result.

Sample for Blood culture should be collected aseptically for confirmed diagnosis. (Ref – Laboratory Manual of IDSP)

5. Treatment

Effective antimicrobial therapy reduces morbidity and mortality from typhoid fever. Without therapy, illness may last for 3 to 4 weeks, and there could be 12-30% deaths.

Multi-drug resistant typhoid fever is reported from many places in the state. Therefore presently drug of choice for typhoid fever is Ciprofloxacin 500-750 mg twice a day for 15 days. Alternatively Ceftriaxone and Cefaperazone can be used if resistance to Ciprofloxacin is documented.

6. Control of Typhoid outbreak

Following steps should be carried out for confirmation of diagnosis of fever outbreak -

6.1. Confirmation of diagnosis

- Start survey of affected area. Decide whether cases are clearly in excess than expected fever cases from village. If yes inform DHO about fever outbreak and your clinical diagnosis of cases.
- First collect and examine PBS of all fever cases for malaria even if your clinical diagnosis is not malaria. Exclude malaria on the basis of negative PBS results.
- Once malaria is excluded try to differentiate fever cases on the basis of clinical examination into viral fever or typhoid fever. Diagnostic features of typhoid fever are atypical fever pattern, coated tongue, relative bradycardia, tender splenomegaly and relative leucopenia.

- If you suspect typhoid, collect 5 ml blood for culture, inoculate on enriched media (available at District Public health laboratory) and send to District Public Health Laboratory by special messenger. Keep media at room temperature during transportation. Alternatively you can request DHO to send Public health laboratory microbiologist for blood culture examination. Also request laboratory for antibiotic sensitivity pattern.
- Do not declare epidemic as of typhoid on the basis of serological examination such as Widal test as this test is not confirmative of Typhoid fever.
- If you are confident about clinical diagnosis then start antibiotic after collection of blood for culture.
- Once you get result of blood culture, and if blood culture is positive for *S. typhi*, then label epidemic as of Typhoid fever. Change antibiotics suitably if investigations indicate resistance of *S. typhi* to Ciprofloxacin.

6.2. Prevention and Control of Enteric Fever

- Preventive and control measures of enteric fever are described in chapter of control of water born diseases.

VIRAL HEPATITIS

Presently five viruses are responsible for viral hepatitis as they have common characteristics as primary replication in liver. Each virus belongs to different taxonomic family. Amongst these, two viruses, Hepatitis A virus (HAV) and Hepatitis E virus (HEV) are transmitted by fecal-oral route, produce acute self-limiting infections and they have ability to develop into epidemic form. Hepatitis B virus (HBV), Hepatitis C virus (HCV) and Delta Hepatitis virus (HDV) are transmitted by blood and body fluids and have ability to produce a persistent infection and chronic liver diseases. They rarely present in epidemic form.

Clinical symptomatology does not distinguish between different types of viral hepatitis. Therefore clinical symptoms alone should not be used to establish etiologic diagnosis in jaundice patients. Enterically transmitted viral hepatitis (Viral Hepatitis A and E) is described in this chapter.

1. Characteristics of Enterically transmitted Viral Hepatitis

Salient characteristics of enterically transmitted types of hepatitis are given below.

1.1. Hepatitis-A

Hepatitis-A is endemic in our state. HAV is non-enveloped single-stranded RNA virus. It spreads through fecal-oral route.

1.1.1. Clinical characteristics

Incubation period of HAV is between 14-45 days with median of 28 days.

Characteristics of HAV infection are - fecal shedding of virus, viremia, jaundice, occasional occurrence of liver failure and absence of chronic liver disease.

Children under six years of age generally have mild, nonspecific symptoms that include malaise, nausea, vomiting, diarrhoea, fever and dark urine. Jaundice is uncommon in this age group. Among adolescent and adults infected with HAV, majority have classic signs and symptoms, including jaundice, fever, malaise, nausea, vomiting, loss of appetite and dark urine.

Susceptible household contacts have a 10 to 50 percent risk of acquiring disease from a family member with acute illness. During epidemic of Hepatitis A, contact with children under six years of age appears to be a risk factor for infection.

1.1.2. Prevention of Hepatitis-A

Hepatitis-A is prevented by avoiding contamination of water, boiling drinking water during epidemic and personal hygiene. Effective vaccine against Hepatitis-A is available. As HAV infection is very common among preschool children, it is asymptomatic in this age group and gives immunity after infection; Hepatitis-A vaccine is not yet included in National Immunization Schedule.

1.2. Hepatitis-E

Epidemics of Hepatitis-E are now becoming very common for last few years. Incubation period of Hepatitis-E is longer than Hepatitis-A with a range of 22-60 days. A prodromal phase lasting for 1 to 10 days is followed by nausea, dark urine, abdominal pain, vomiting, pruritis, diarrhoea, etc in varying number of patients. Children have lower rate of symptomatic infection.

A high case fatality rate among pregnant women has been consistent feature of Hepatitis-E and has ranged from 5-25%. Most persons with Hepatitis-E have a self-limiting disease with complete recovery.

1.2.1. Spread

HEV is primarily transmitted by faeco-oral route. In endemic areas, primary source of infection is fecally contaminated drinking water, although food-borne transmission is suggested but not proven. Person to person transmission is rare and secondary attack rate among household is low (less than one percent).

1.2.2. Diagnosis

It is difficult to differentiate Hepatitis-E clinically from other forms of hepatitis. Hepatitis-E is observed in areas where Hepatitis-A is endemic. However, few epidemiological features distinguish Hepatitis-E from Hepatitis-A. In Hepatitis-E there is high attack rate among adults and high case fatality among pregnant women. Highest prevalence of Hepatitis-E is observed in age group of 20-29 years. As secondary attack rate in Hepatitis-E is very low, it is rare to find secondary case in same house.

1.2.3. Prevention

Most important means of prevention of Hepatitis-E is protection of water from fecal contamination. Chlorination of water has no definite effect on HEV. Boiling water for 10 minutes definitely kills HEV, especially during epidemic.

2. Investigation and control of Hepatitis outbreak

Once you get report of jaundice case, immediately visit the village along with PHC team. Following points will help you to arrive at conclusion whether outbreak is due to enterically transmitted viral hepatitis:

- If single case is reported then diagnosis could be any type of hepatitis including obstructive jaundice. However occurrence of multiple cases in same village within one incubation period (3-6 weeks) almost rules out parenterally transmitted hepatitis and obstructive jaundice.
- Examine clinically the reported case. First try to rule out obstructive causes of jaundice. Severe abdominal pain, absences of prodromal symptoms particularly fever and malaise, rapid deep jaundice, itching of skin, etc. are important factors to distinguish obstructive jaundice from viral hepatitis.
- Carefully ask patient about H/O blood transfusion, surgery, injections, safe sex etc. in last 6 months to rule out parenterally transmitted Viral Hepatitis.

If you suspect jaundice in cases is due to enterically transmitted hepatitis, start control measures as described for control of water borne diseases in addition to special precautions for pregnant women as follows -

- Ask MPWs to identify pregnant women & personally advise them about -
 - Drinking only boiled water
 - Follow personal hygiene rules strictly

Epidemic Management

Epidemic

- It is a sudden and unexpected increase in a disease or health related event in an unidentified area
- Severity of increase and spread depends on the Geographic location, environmental condition and distribution of host population and socio- cultural behavior of people.
- Management of epidemics involve step by step activities starting from forecasting to prevention for future occurrences.

The severity of the epidemic depends on

- Geographic environment condition
- Characteristic of host population
- Socio cultural behaviour.

Types of Epidemics

- Common source epidemic
- Point or single exposure
- Multiple exposure from viable source
- Propagated epidemic
- Seasonal epidemic
- Cyclic epidemics
- Epidemic of non communicable diseases

EPIDEMIC MANAGEMENT STEPS

Forecasting

Preventing

Controlling

FORECASTING EPIDEMIC

- Forecasting is an early warning system to get prepared to meet the challenge of impending epidemics. It is more appropriate in cyclic and seasonal epidemics where the pattern has been studied from the past data. By forecasting one may not totally prevent the epidemic, but definitely control its severity and spread to other areas.

The various methods needed for forecasting are:

- Study of incidence and prevalence rate
- Disease specific morbidity rate
- Age and sex wise morbidity and disease specific mortality
- The various data are tabulated month wise/ year wise for last three years for comparison and study pattern

- Then the collected data is plotted on graph for immediate detection and visual appreciation through trend analysis of the disease.
- Plotting of data on the map of local area helps in immediate assessment, whether the cases are grouped or clustered.
- Developing a surveillance system for continuous data reporting and observation

CASE INVESTIGATION

To define the magnitude in terms of time, place and person and to identify source and possible cause.

- **Factors contributing to spread.**
- To make recommendation to prevent. In spite of accurate forecasting an epidemic may not be aborted. In an unfortunate occurrence of an expected epidemic, investigation must be started to confirm epidemic
- **STEPS IN INVESTIGATION OF EPIDEMICS**
- Verification of diagnosis
- Confirmation of existence of epidemics
- Defining the population at risk
- Rapid search for all cases in the area.
- Analysis the data
- Evaluation of ecological factor
- Expand the search in other areas
- Write a final report

EPIDEMIC INVESTIGATION

- By asking questions
- By making comparison

Asking questions

- What is the problem
- What can be done to reduce the problem
- Where is the problem
- What action to be taken by different groups.
- When is the problem
- How activities to be planned.
- What is the magnitude
- What constraints may be faced
- Who all are effected
- To what extent these can be over come
- Why did it happen
- What action be taken to prevent in future
- How did it started
- What resources are required

By making comparison

- Between two groups or two locations compare to find out the crucial difference between the host or environmental factors of effected area and not effected area.
- Define population at risk
- to Confirm existence of cases Start screening of area

CONFIRMATION OF CASES

Confirmation of existence of epidemics is done through following process:

- Confirm diagnosis through clinical and lab tests.
- Define the gravity of situation by grouping/ clustering of cases on the local map
- Age and sex wise people are suffering
- Type of disease/ health condition and risk factors
- Approximate number of cases suffering

DEFINE POPULATION AT RISK

1. The population at risk can be found by:
2. Population survey.
3. Watch on migration of cases from other areas
4. Study of environmental conditions like air, water, sewarege pollution, food poisoning
5. Mapping on local maps
6. Source of infection and family/ contact tracing

CONTROL OF EPIDEMIC.

- Removal of Source of Infection:
- Treatment of infected cases
- Destruction of reservoir of infection
- Removal/ correction of source of infection
- Isolation of infected cases
- Hand washing and personal protective measures
- Use of sterile supply
- Proper disposal of fomites
- Improve environmental sanitation
- Contact tracing, family, neighbor
- Screening of suspected cases
- Quarantine of migrated cases
- Health education
- Increase resistance of suspects through immunization, prophylactic drugs or immuno globulins.
- Vector control measures:
- Prevent breeding of mosquitoes, flies and fleas
- Destruction of adult vectors through insecticide, pesticide
- Personal protection like prevent bite, use mosquito nets, use hot food, filtered water
- Increase personal hygiene

14. WATER QUALITY MONITORING AND SURVEILLANCE

Important aspects in safe water supply to community

Water Quality Monitoring

As Gram Panchayat (GP) is responsible for safe water supply to community in rural areas, it is responsible for maintaining water quality supplied to village.

Responsibilities of GP included in water quality monitoring

- Daily disinfection of water at source at least half hour before supply
- Daily OT test to check water disinfection. If OT test is negative then repeat chlorination and ensure proper chlorination.
- Regular inspection of leakages, blocks, etc. In water supply scheme and timely repairs of these defects.
- Keeping surrounding of water supply source, overhead tanks, valves, pipeline and stand posts clean.
- Proper storage of TCL, Uninterrupted supply of TCL to water supply scheme.

Record related to water supply kept at Gram Panchayat

- Information of all water source, total water quantity in each source, dose of TCL required for chlorination of each source.
- Daily OT test record
- TCL stock and quality monitoring
- TCL daily use and daily chlorination record
- Water sample reports received and corrective action taken.

Water quality surveillance

Water quality surveillance is carried out to ensure that safe water is being supplied by Gram Panchayat to the community. This responsibility has been entrusted to health department. Medical Officer is responsible for water quality surveillance of all the villages in PHC area.

Activities for water quality surveillance

- OT test of water in all villages in maximum possible frequency.
- Collection and sending of water samples to laboratory.
- Communication and advice on results of testing to water distribution authority.
- Notify and document the trends in seasonal changes in water quality.
- If water sample of any Gram Panchayat is reported as unsafe, identify the reason(s) for water contamination and advise the water supply authority accordingly.
- Meeting with members of village water supply committee at least once in year.
- Training of water supply workers and Gram Sevaks in water disinfection and record.

Responsibilities of BharariPathak MO

Medical officer should visit each GP in his area at least once a week. Following are the responsibilities of MO in quality water supply.

Training

MO should conduct training of Village water supply and sanitation committee members, Gram Sevak & water supply worker in water quality monitoring once a year before monsoon. Concerned HA and MPW should also be involved in this training. Water quality monitoring training includes following aspects.

- Importance of safe water supply and water quality monitoring.
- Measuring the water quantity in water sources like well and calculation of TCL requirement of water supply scheme.
- Water chlorination procedure
- OT test procedure and interpretation
- Storage of TCL
- Water quality monitoring records and their significance.

Ensure regularity of chlorination of water

Following points will give medical officer the idea of regularity of chlorination of water

- Check OT register and see whether daily OT test is taken and result noted. Free chlorine should be within 0.2 to 0.5 PPM.
- Check the time of water chlorination and time of OT test and see whether place of OT test is changed daily and last stand post are included.
- Review the action taken by GP when the OT test was negative.
- Inspect the stock of OT reagent and condition of chloroscope.
- Enquire in houses about smell of chlorine to water
- Personally go and inspect TCL residual heap at the place of chlorination.

TCL stock and inventory

- Check the TCL stock: Availability of TCL on the day of visit: Not more than 3 months requirement of TCL should be purchased each time.
- Check ISI mark on the TCL used by GP as only ISI mark Grade-I (Chlorine 34%) or Grade-II (Chlorine 32%) TCL should be purchased.
- Place of TCL bag- It should be dry, cool, dark place.
- Closing of TCL bag- TCL bag is in two layers. Both the layers should be separately closed. Inside polythene/plastic layer should be firmly closed and then outside layer should be closed.
- Check how TCL is measured daily for chlorination.

Chlorination of water

1 Chlorination of well water

- Calculate volume of water in litres (All the measurements should be in meter).
- Square well- Length x breadth x height of water x 1000 = water in liters
- Round well – well Diameter² x height of water x 785 = water in liters
- Calculate the dose of TCL: For 1000 litres of water 5 gm of TCL containing 33% chlorine is used.

2 Chlorination by liquid chlorine

- Liquid chlorine mixes with water quickly without residue. So when house to house chlorination or chlorination of water containers is to be done, liquid chlorine is more convenient than TCL. Liquid chlorine is mainly used during epidemics, fairs and festivals. The liquid chlorine supplied is usually having concentration of 5% chlorine.
- Add 1 ml liquid chlorine (5%) solution to 50 liters of water to get 1 PPM chlorine level.
- Add two drops of liquid chlorine solution to one bucket water (Approx 10 liters)

3 Chlorination by using stock (mother) solution

When liquid chlorine is not available, stock (mother) solution can be prepared from TCL and used as liquid chlorine. Steps in preparation of stock solutions are as follows.

Preparation of 5% stock (mother) solution

- Take 5 liters of water in plastic bucket. Add 1 kg bleaching powder to water. Stir well and cover bucket for 15 minutes.
- Supernatant liquid is 5% stock solution. Use solution immediately after preparation. If you want to stock solution for future use, pour supernatant liquid in water tight container and close the lid tightly.
- Concentration of chlorine in stock solution slowly decreases even if it is stored in water tight container. To avoid this, stock solution should be prepared only when it is required and should not be kept for more than 7 days.

Uses of stock (mother) solution

Stock solution should be used for water disinfection in following conditions.

- House to house chlorination
- At the time of epidemic of water borne diseases
- When water source can not be disinfected e.g. Lake, river, etc.
- When multiple water sources are used by community and it is difficult to chlorinate each water source. This situation particularly arises in tribal and hilly areas.
- Disinfection of water containers during fairs, festivals and large gathering of people for any reasons.

4 Chlorination by use of chlorine tablets

Chlorine tablets are also used sometimes in place of liquid chlorine. These tablets are different sizes. Indications for use of these tablets are similar to liquid chlorine. As it takes 10-15 minutes for dispersal of tablets, the water container should be kept covered for 45 minutes before use if chlorine tablet is used for disinfection. Dose of chlorine tablets should be used as per guidelines given by manufacturer.

5 Chlorination of hand pump

This is not routinely done. If water sample is found to be contaminated, then corrective actions like repairing handle of hand pump, clearing cracks in the platform, cleaning the area etc. has to be done on priority. In addition to this as a supplementary action, chlorination of hand pump is done as follows:

Dose of TCL depends on the diameter of bore well. If diameter is 4 inches, dose is 150gm and when diameter is 6 inches dose is 300 gm.

TCL is mixed with ½ litre of water and solution is added by removing 3 bolts of hand pump. This should be done in the evening and hand pump should not be used for 6-12 hrs.

Orthotolidine Test

OT test indicates amount of chlorine available in water. It is used to verify whether correct dose of TCL has been used and chlorination is proper or not.

At source free chlorine from chlorinated water should be 1 PPM and at the end of distribution system, it should be 0.2 to 0.5 ppm.

MO should ensure that, each worker has good quality working chloroscope.

OT test is carried out with the help of chloroscope as follows

- Fill up both the tubes with water to be tested.
- Place the tubes in chloroscope.
- Add two drops of OT reagent in tube on right side of chloroscope.
- Match the colour of tube with small discs of yellow colour shades parallel to tube.
- Nearest matching yellow coloured disc indicates concentration of chlorination.

Precaution

Do not allow the OT reagent to spill on hands or never smell the OT reagent. In case of accidental contact with OT reagent, wash with plenty of water.

Water sample testing (H2S-Strip field test)

Important aspects

- At Every block there are water testing laboratories, where H2S-Strip field test for detection of fecal pollution of water sample is being performed. Report is received within 24 hours and time is saved on transportation.
- Reliable, rapid method, simple, low testing cost, easy interpretation of results (black colour formation), technical compatibility are the advantages of the test.
- It is useful during outbreaks as a rapid screening test.
- Principal of the test is that, presence of coliforms in drinking water is consistently associated with the organisms that produce Hydrogen sulfide (H₂S), such as Salmonella, Proteus, and Citrobacter etc. When contaminated water is being tested it contains these organisms. They produce Hydrogen Sulfide gas and this gas leads to black colour in the tested water sample

Method and results

- Ready to use medium bottles are provided, which contain filter paper with 1 ml. concentrated media.
- Add 20 ml. of water sample under test to already prepared media bottle. Incubate the inoculated bottle at 37 C for 24 hours.
- Observe the results after 24 hours.
- Fecal contamination is indicated by the development of black colour of the contents in the bottle and water is graded as unfit for human consumption.
- If there is no colour change in the contents, incubate further for 24 hours. If no colour change even after 48 hours, water is fit for human consumption bacteriologically.

Water samples for Quality Surveillance

- Arrange for the transport of water samples to RH for field-testing and also to Public Health laboratory (District/Taluka) for crosschecking and detailed analysis.

- Communicate the results to the concerned water distribution authority with advice about corrective measures.
- GP is supposed to take corrective measures as proposed by Medical Officer if the report of water sample indicates contamination. Medical officer should verify whether the actions as per recommendations have been taken by GP.
- If GP is not responding to the instruction given by the Medical Officer which may lead to unsafe water supply to community then following procedure should be adopted.

Reminder to GP regarding corrective measures to be taken

- If no response in two weeks, write to BDO stating the importance of corrective measures.
- If no response to this letter in two weeks then write to DHO and send copies to GP, BDO and Dy.CEO (Panchayat)
- DHO should bring such matter immediately to the notice of Dy.CEO (panchayat) and discuss in Health Committee and Coordination Committee meeting of ZillaParishad.
- Conduct sanitary survey of water supply scheme once a year and issue Green/Red card and identify high-risk villages holding red cards.

Collection of Water sample for bacteriological examination

Water sampling should fulfill following requirement

- Sampling should be properly planned.
- Sampling points should be representative of water source and located in proportion to population served.
- Sample should be collected properly, in adequate quantity (at least 200 ml), in a sterile glass bottle with properly fitting stoppers or caps and properly dispatched.

Method of water sample collection

1. Tap or fixed hand pump outlet

When water is taken from tap, flame the mouth of tap and allow the water to run for 3 minutes before filling the bottle.

2. Sampling from water source or reservoir (Lake, River, tank. Etc.)

Insert the bottle with stopper on mouth, 12-15 inches below the surface of water. Open the stopper carefully without touching the bottle. Replace the stopper after the bottle is filled with water. Avoid the collection of surface water as it contains organic matter.

3. Sampling from dug well

Attach a suitable sized stone (after washing thoroughly) with a string to the sampling bottle in such a way that while immersing, the bottle will have 45 angle with water surface. Remove the stopper or unscrew the cap, Lower the bottle slowly, immerse the bottle about 12-15 inches below water surface, fill and bring up. Discard some top water and replace the stopper.

Storage and transportation of the samples

There can be changes in coliform and E. coli content of the water during storage hence prolonged storage should be avoided and therefore in no case the time interval between the collection and examination of the sample should exceed 24 hours.

Labeling

Sample should carry the label on the bottle giving following particulars:

- Name of the sender
- Source
- Location
- Place
- Date and time of collection
- Collected by

Collection of water sample for chemical examination

- Collect the water sample in glass or plastic container.
- Ideally a new container should be used but if unavailable, wash the used containers first with chromic acid cleaning mixture, then rinse with tap water and then with distilled water
- Collect two samples of 2.5 litres each. First sample is for chemical analysis and second sample for chlorine dose estimation.
- Avoid surface scam.

Collection of bleaching powder sample for chemical examination

- Sample shall not be exposed to atmosphere for longer time than necessary and sampling shall be done as rapidly and thoroughly as possible.
- Sampling instrument should be clean and dry when used.
- To draw a representative sample, content of each container shall be mixed as thoroughly as possible by rolling, shaking or stirring by suitable means while container is closed.
- Draw with an appropriate galvanized iron or other suitable plastic sampling instrument, small portion of material from different parts of each selected container.
- Sample shall be placed in clean, dry and airtight glass or polythene bag on which the material has no action.
- Sample containers shall be of such a size that they are nearly filled by sample.
- Each sample container so filled shall be sealed airtight after filling and marked with the full details of sampling, the date of sampling, the month and year of manufacture of material and its grade.
- Precautions shall be taken to protect the sample; the material being sampled, the sampling instrument and containers of the sample from adventitious contamination.
- Care should be taken to avoid direct contact of bleaching powder with skin. Face should be kept a safe distance from the container when it is opened.

Storage of bleaching powder sample

- Sample shall be placed in a cool and dry place.
- Sample should be stored in such a manner that the temperature of material does not vary unduly from the normal shade temperature.

- The label should not come in contact with bleaching powder sample. In order to protect the label it should be kept in a sealed plastic bag along with the sample.
- Samples should be sent to the district Public Health Laboratory at an earliest.

Sanitary Survey of the water supply scheme

- Medical officer should conduct sanitary survey of all the water supply schemes in PHC area every year during the months of October to January.
- Survey should start from the water source and should end last stand post of the distribution system.
- If there is possibility of water contamination from source to last stand post due to any of the reasons given below MO should issue Red card to the GP indicating the faults:
 - * Irregular water disinfection
 - * Lack of cleanliness of surroundings of water supply scheme
 - * Leakages
 - * Inadequate or no stock of TCL
 - * Unprotected wells with dirty surroundings
 - * Cracked bore well platforms and stand posts.
 - * Any other findings that may contaminate water supply.
- MO should also suggest corrective measures needed to be taken for making the water supply safe at the time of issuing the red card.
- If the water supply scheme is without any faults and water disinfection is regular then Green card is issued to GP.
- Red and Green cards will be supplied by District Health Officer.
- All the villages that were issued red cards should be again surveyed before Monsoon i.e. in last week of May or first week of June by the Medical Officer. If the corrective measures are taken and water supply is safe then Green card should be issued. If no or inadequate corrective measures are taken then maintain the red card status of GP
- Inform the BDO about Green/Red status of all the GPs from your PHC area along with the reason for giving red card on 10th June every year.
- If there is outbreak in the village that was issued Red card then bring this matter to the notice of BDO and DHO by DO letter. Mention the status of village (Green/Red card) while submitting the epidemic investigation report to DHO with one copy to BDO.

SECTION C:

MEDICO LEGAL

ASPECTS

1. MEDICOLEGAL ASPECTS OF STERILIZATION DEATH

Definition: Death of a sterilization case on the table to within 4 weeks of the operation is called as sterilization death. Tubectomy deaths are classified as

- T1-** Death of a case on the table
- T2-** Death within 24 hours of operation
- T3-** Death within 7 days of operation
- T4-** Death from more than 8 days to 4 weeks

Investigation of sterilization death

District level officers investigate sterilization death. MO PHC should immediately report death to DHO giving detail information of the case.

- Reporting of death : immediately to higher authority
- Preliminary investigation reports : Within 8 days.
- Detail report : Within 30 days.
- Quality assurance committee report : Within 60 days.

Quality Assurance committee

Quality assurance committee at regional level investigates all deaths following sterilization, IUD insertion and MTP occurring in the circle.

Every circle has the Quality Assurance Committee comprising of following members

- Dy. Director of Health Services Chairman
- Civil Surgeon of concerned district Member
- Professor of Surgery Member
- Professor of Pathology Member
- Professor of OBGY Member
- Professor of Medicine Member
- Professor of Anesthesia Member
- DHO of concerned ZP where death/complication has occurred will be member of circle level Quality Assurance Committee.

Responsibilities of the committee

- To investigate all cases of complications/reaction or death due to sterilization, IUD insertion, MTP & other FW related interventions.
- Fixing responsibilities & recommending actions.
- Ensuring delivery of prompt services.
- Reporting of deficiencies & lapses observed & suggest for improvement.
- Submit its report to DHS within 2 months from the date of occurrence of incidence.

Ex-gratia financial assistance in cases of fatality/ complications

PM in case of death due to sterilization

- After sterilization death postmortem is a must. PM should be performed by 2 MOs & one of them should be senior experienced officer. If gynecologist available it is preferable.
- Sterilization death should be considered as medico legal case & reported to police.
- Viscera should be preserved for chemical analysis & specimen should be sent for histopathological examination. (Especially tubes, ovaries & uterus). If there is problem with intestine, intestine should be sent for HP examination.

Record of tubectomy death & police department

- All record related to investigation of tubectomy death, report of Quality Assurance Committee is confidential.
- Prior permission of govt. has to be taken before giving record to police department.
- If police complaint is lodged against Medical Officer in case of sterilization death, prior permission of health department authority has to be taken before taking action against doctor.

FAMILY PLANNING INDEMNITY SCHEME

India was the first country to launch a National Family Planning Programme way back in 1952, emphasizing fertility regulation for reducing birth rates to the extent necessary to stabilize the population at a level consistent with the socio-economic development and environment protection. Since then the demographic and health profiles of India have steadily improved. Sterilization is still the most popular family planning method adopted by the clients to limit their family size.

Quality of services plays a major role in acceptance of any service. Poor quality of services leads to unsatisfied clients resulting in under-utilization of services. To build the confidence of clients it is necessary to provide them safeguards against adverse events. Family planning services are largely being provided through a network of public and private accredited facilities. However, persistent high unmet need for limiting methods and lack of trained providers at peripheral level leads to dependence on the camp approach. There has been growing concern about the quality of sterilization services being offered, particularly at the camp facilities.

There is a continuing concern about the number of adverse events following sterilization as well as litigations faced by the facilities /doctors against such cases.

To mitigate this, the Government of India introduced the National Family Planning Insurance Scheme which was later modified as Family Planning Indemnity Scheme “FPIS”, now operational through State NHM Program Implementation Plan instead of private sector insurance company.

Against the backdrop of the directions of the Hon'ble Supreme Court, the “NFPIS” was introduced from 29th Nov, 2005 so as to do away with the complicated process of payment of ex-gratia to the beneficiaries of sterilization for treatment of post-operative complications, failure of sterilization or death attributable to the procedure of sterilization. Since then, the scheme has witnessed changes in the insurers and modifications in limits and payment procedures. Initially the scheme was operated by The Oriental Insurance Company Limited from 29th Nov, 2005 and renewed w.e.f. 29-11-2006 with modification in the limits and payment procedures. Later, the scheme was operated by ICICI Lombard General Insurance company w.e.f. 01-01-08 up to 31-03-2013 with yearly renewals. The scheme thereafter has been modified as “Family Planning Indemnity Scheme” and is operational from 01.04.2013.

Family Planning Indeminty Scheme (FPIS)

(Under NHM State Programme Implementation Plans (PIPs) w.e.f. 1st April 2013) Under the Family Planning Indemnity Scheme it has been decided that States/UTs would process and make payment of claims to beneficiaries of sterilization in the event of death/failure/complication and indemnity cover to doctors/health facilities. It is envisaged that States/UTs would make suitable budget provisions for implementation of the scheme through their respective Program Implementation Plans (PIPs) in the relevant head under the National Health Mission (NHM). The scheme is uniformly applicable for all States/UTs.

The available benefits under the Family Planning Indemnity Scheme are as under

Section	Coverage	Limits
SECTION I (A-D) : For Beneficiaries		
I A	Death following sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital	Rs.2 Lakh
I B	Death following sterilization within 8-30 days from the hospital	Rs.50,000/-
I C	Failure of sterilization	Rs.30,000/
I D	Cost of treatment in hospital and up to 60 days arising out of complication following sterilization operation (inclusive of complication during process of sterilization operation) from the date of discharge	Actual not exceeding Rs.25,000/
SECTION II : Empanelled Doctors under Public and Accredited Private / NGO Sector and Health Facilities under Public and Accredited Private / NGO Sector		
II *	Indemnity coverage up to 4 cases of intigations per doctor and per health facility in a year	Up to Rs.2 Lakh per case of intigation

Quality Assurance Committee

Subsequent to the orders of the hon'ble Supreme Court of India in the Ramakant Rai vs. Union of India case dated 1.3.2005 regarding quality of sterilisation services in India, Quality Assurance Committees have been formed by all states at the State and District level to ensure that the standards for female and male sterilization as laid down by the GOI are followed in respect of pre-operative measures, operational facilities etc. The committee consisted of 10 members at the state level and 9 members at the district level.

District Indemnity Sub-Committee (DISC) will also be formed at district level. The subcommittee at district level would comprise of the following:

1. District Collector, (Chairperson)
2. Chief Medical Officer/District Health Officer (convener)
3. District Family Welfare Officer/RCHO/ equivalent (member secretary)
4. Empanelled gynaecologist (from public institutions)
5. Empanelled surgeon (from public institutions)

This 5 member DFPIS "District Family Planning Indemnity Subcommittee" from within the DQAC would process claims received from the clients and complaints/ claims lodged against the surgeons and accredited facilities, as per procedures and time frame laid down in the FPIS manual. The "District Family Planning Indemnity Subcommittee" would **meet every three**

months or sooner if warranted. At least three members would constitute the quorum of this sub-committee

At Facility level: Quality Circle (QC): (Suggestive)

Sterilization services are being provided to the people at various government and accredited private/NGO outlets. At each service delivery site, sterilization service needs to be monitored and reviewed periodically.

For institutions such as District/Civil/Sub-divisional/Referral/Rural Hospitals/CHCs/ BPHCs Quality Circles comprising of a team of medical, paramedical and other support staff should be constituted, depending on the size of the institution being monitored, for reviewing the quality of services periodically.

The suggested composition of the Quality Circles is as follows: I/C Hospital/Medical Superintendent: Chairperson, I/C Operation Theatre/ I/C Anaesthesia, I/C Surgery, I/C Obstetrics and Gynaecology, I/C Nursing, I/C Ancillary Services (ward boys), I/C Transport, I/C Stores, I/C Records

Mechanism of Monitoring of the Scheme-

- District Quality Assurance Committee (DQAC) shall review quarterly the status of accredited facilities, empanelled providers, claim status, period of pendency of claims and advise the district officials to respond/comply with the deficiencies, if any. In case the numbers of pending claims are high, the committees can meet sooner if warranted. Moreover, SISC may intervene to fast track the claim disbursement process.
- In case of death attributable to sterilization DISC should audit every single case as per procedure laid in Quality Assurance Guidelines issued by Ministry of Health and Family Welfare, GOI in compliance with the Hon'ble Supreme Court directions
- The claims after due diligence by the DISC should be put up to the SISC who would be the final arbiter for the same.
- SQAC/DQAC shall ensure that each district and health facility is provided with FPIS Manual and mandatory documents required for claims. SISC/DISC shall ensure that District Officials are filing the FPIS Claims well within the stipulated period as per the scheme.
- Convener of SISC (Director Family Welfare or Equivalent) designated for this purpose at state level shall review all pending matters including pending claims on monthly basis. State shall organize review meetings on biannual basis to review all pending matters including pending claims under the chairmanship of Mission Director (NHM) with the designated district machinery. The MOHFW, GOI shall conduct annual review on all matters relating to FPIS.

Reporting of Sterilization Deaths, Complications and Failures

Report on Sterilization Deaths

- Sterilization deaths are to be reported in the Death Notification Form to the District CMO, i.e. the convener of the District QAC, within 24 hours of death by telephone, e-mail, or in person. The operating surgeon of the case should also be informed simultaneously of the occurrence of death so that he/she may fill up Death Notification Form within 7 days of intimation and send it to the District QAC. It is the responsibility of the Medical Officer

at the institution where the death occurred to fill in Death Notification Form. A copy of the Death Notification Form must also be sent to the state-level convener.

- Following the immediate notification of death by the medical officer, the operating surgeon should review the records and complete on sterilization deaths and send it to the convener of the District QAC within 7 days. A copy of the records and the autopsy report and other pertinent information should be forwarded along with this report to officials as indicated earlier.
- The District QAC will review the report, discuss the findings, conduct a field investigation and make recommendations for corrective action. The District QAC will then complete the Death Audit Report.
- The Death Audit Report should be presented by the District QAC within 30 days to the state-level committee, which will then forward it to the Government of India.

Report on Sterilization Complications

The report on complications requiring hospitalization attributable to sterilization is to be filled in by the District QAC of the district where the client has reported.

The reportable complications are as follows:

- Any problem directly related to surgery and/or anaesthesia that occurs within 60 days of the operation and intervention or management beyond what is normally required and that necessitates hospitalization;
- Blood transfusion is required;
- Any problem arising out of additional unplanned surgery other than that of the fallopian tubes, mesosalpinx or vas deferens at the time of the sterilization procedure;
- Any subsequent operation/operations related to the original surgery.

The DQAC should conduct a field investigation/enquiry, review the case record, discuss the findings and make recommendations for corrective action.

Report on Sterilization Failures

Sterilization failure is defined as any pregnancy that occurs after certification of the sterilization operation. In case of suspected pregnancy after the sterilization procedure, investigations such as urine test for pregnancy, USG and semen examination (in the case of male clients) should be conducted.

The report on failure attributable to sterilization is to be filled in by the District QAC of the district where the client has reported within two weeks of reporting.. The District QAC will conduct a field investigation /enquiry, review the case record and report the findings to the state committee.

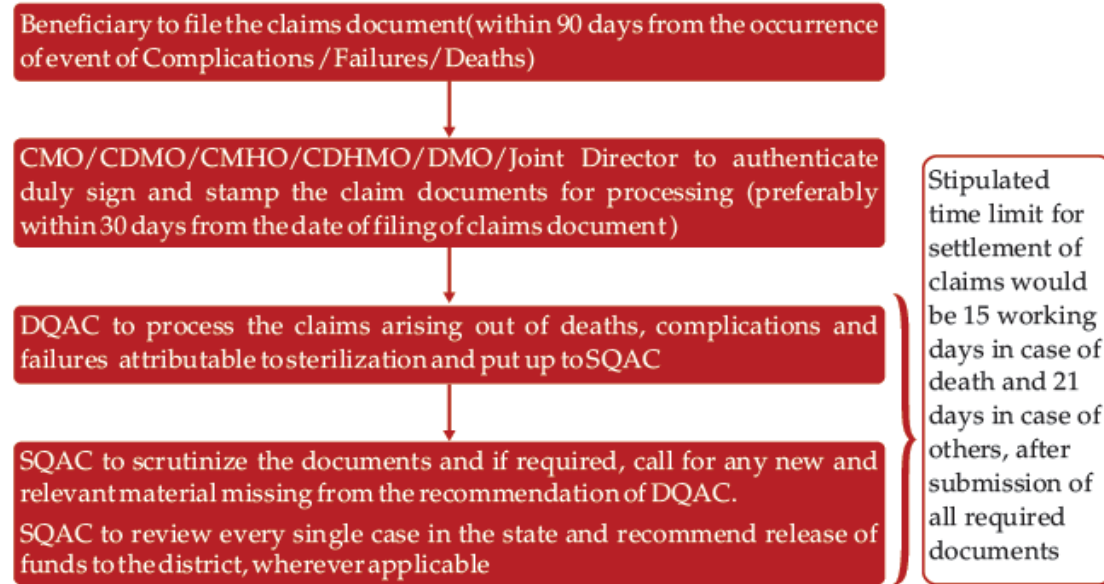
A final report of the audit is to be sent to all those who are involved in the audit process, including the Medical Superintendent /Officer In-Charge/Administrator and other appropriate persons concerned at the institution where the death has occurred. The recommendations are to be shared with the concerned staff.

The audit records should be kept for ten years for the purpose of comparison and for facilitating future audits. Copies are to be kept in a medical audit binder.

Claim procedure-

- In the event of death/failure/complication following sterilization, the beneficiary shall immediately fill up claim form.
- On receiving the claim papers, proper acknowledgement must be made by the DISC, for further processing and payment of the claims. Based on the submitted documents, claims shall be processed by the DISC under different sections of the scheme.
- Stipulated time limit for settlement of claims would be 15 working days in case of death and 21 days in case of others, after completion of processing.

Steps of the Claim Process



Checklist of FPIS claim documents –

Section IA-IB	Section IC	Section ID	Section II
Death	Failure	Complication	Indemnity cover for Doctor/Facility
Original & duly Completed "Claim Form Cum Medical certificate."	Original & duly Completed "Claim Form Cum Medical certificate."	Original & duly Completed "Claim Form Cum Medical certificate."	Intimation in writing
Copy of Consent From & Medical record and Checklist	Copy of Consent From & Medical record and Checklist	Copy of Consent From & Medical record and Checklist	Copy of Consent
Copy of Post- Operative Card/ Discharge certificate	Copy of Sterilization Certificate.	Copy of Post- Operative Card/ Discharge certificate	Copy of Sterilization Certificate.
Copy of Death certificate issued by hospital/municipality or any other designated authority.	Copy of any of the diagnostic Report confirming failure of Sterilization.	Original Bills/ Receipts / Cash Memos along with Original Prescription and Case Sheet	Certificate from the convener of DISC (CMO or equivalent) designated for this purpose at district level confirming that the Sterilization Operation was conducted by the doctor etc.
			Copy of Summon / FIR
Proforma for	Report on Failure	Report on Complication	Copy of the Award

Conducting Audit of Death by DISC	following sterilization by DQAC	following sterilization by DQAC	given by the court along with the original receipts for which payment is made to the lawyer.
Note: All the document should be duly attested by the convener of DISC (CMO or equivalent) designated for this purpose at district level.			

2. MEDICO LEGAL EXAMINATION

MEDICO-LEGAL WORK AT PHC

Medical Officer is concerned with medico-legal work along with clinical & administrative jobs at PHC. MO should apply medical knowledge to certain branches of law. MO needs to depose in court as an expert witness. Therefore MO should carefully note all the facts observed & learn to draw conclusions correctly & logically.

1. Medico legal cases

Cases sent by police only do not constitute whole quota of medico legal work. Cases at the time of admission may be purely medical or surgical; however they may assume medico legal importance later on due to changed circumstances. Following cases should be considered as medico-legal cases and recorded in detail, even if they are not sent by police.

- All accident cases
- Burns, poisoning, snake bite, scorpion bite, human bites, tetanus etc.
- Un-natural or suspicious death e.g. sudden death due to unknown cause, suicide, homicide, death in anesthesia or on operation table, death of a convict in jail, police custody etc.
- Death of a patient within 24 hours of admission.
- Patient brought unconscious or already dead to PHC/ hospital.
- Complaint of rape.
- Person under influence of alcohol.
- Any doubtful case or death for which cause cannot be certified.
- Injury after hospital admission e.g. falls from cot.

2. Identification marks

It is advisable to write one or two identification marks of the party examined. Whenever MO is called in a court of law to give evidence, he/she is asked whether he/she remembers to have examined the party. Identification marks have legal significance as actual verification can be done in court. Signature or left thumb impression of patient would also be very useful for subsequent examination.

3. Summons

It is issued by the court in writing, in duplicate & signed by presiding officer of the court. It is served on witness by police officer or officer of the court. MO should know following important aspects of summons -

- MO should sign first copy & return back to police and should retain second copy
- When summons is served, MO must attend court and give evidence.
- Attendance can be excused if MO is ill or is rendering a genuine emergency service for which no other doctor is available.
- Criminal courts get precedence over civil courts.
- It is necessary to maintain a summons register, indicating name of MO called, name of the court, date & time of hearing, name & register number of case.

4. Recording of evidence

- Examination in chief: Witness is first examined by the side, which has called him. In government set up, this is commenced by public prosecutor.
- Cross-examination: By opposite counsel.
- Re-examination: After cross-examination, witness maybe re examined by counsel who has called him.
- Court question: Judge may ask questions to witness to clear doubtful points.

5. Medico legal reports

Medico-legal report consists of three parts -

- Introduction, date, place & time of examination including identification marks.
- Facts observed on examination.
- Opinion or inference drawn from the fact.

Report should be written at the time of examination or immediately afterwards. Copy of report should be preserved in same form as original. Examples: Injury report, PM report.

6. Dying declaration

- Accepted in court as legal evidence after death of a person who made the declaration.
- This is the statement verbal or written made by a person narrating circumstances leading to death. No oath is required.
- It is admissible in all cases where cause of death is under inquiry.
- As a rule, Magistrate should be present for dying declaration. Attending doctor should arrange for a magistrate to record dying declaration. However in exceptional cases MO can him/herself take dying declaration if dictated by circumstances.
- If the patient's condition is grave, medical attendant should record statement him/herself.
- MO should certify that, patient is in sound mental condition to make declaration.
- There should not be police officer nearby, no extraneous person around & no prompting to the person making declaration.
- Declaration may be oral, but MO should write it down in presence of two disinterested/unrelated witnesses. Preferably witness should be female. It should be recorded in words of declarant in the form of questions put to him & answers. If patient is unable to speak, then it should be recorded in the form of signs.
- Declaration when concluded should be read over to the patient & signature or left thumb impression should be recorded.
- Doctor & 2 witnesses should sign it.
- Investigating officer should not be present while recording.
- It should be forwarded to concerned Magistrate in sealed cover.
- If the victim survives it ceases to have legal value, but is still useful as a supporting statement in case that person is examined.

7. Doctor in Witness Box

7.1. General aspects

- When summons is served, MO must attend court & produce document.
- Dress properly. Take MLC register, OPD/IPD case papers, etc. with you.
- Master the facts, refresh memory & carefully study related recent literature.

7.2. Giving evidence

- Address the judges as “Sir” or “Your Honour”.
- Answers should be brief & precise. Give evidence slowly in a loud clear voice. Use simple words, avoid technical words. Avoid indiscriminate talk.
- If you do not know the answer of any question, clearly say so. Never give opinion without knowledge.
- Never lose temper. Always appear cool & dignified.
- Sometimes council quotes a passage from text book & asks you as a witness whether you agree with it. Request the council to show textbook to you before replying, note the date of publication, read the paragraph contents and then state whether you agree or not.
- When evidence is concluded, this should be read, signed by MO after getting corrections.
- Do not leave court till permission is granted.

8. Preservation of medico legal record

All medico legal record should be preserved for 30 years where evidence has been recorded under 1 or 2 subsections of the section 512 of code of criminal procedures. Other medico legal record may be destroyed after 5 years from final date of case.

In ML cases where no court proceedings are taken, record may be destroyed after 5 years from initial date of case in consultation with police authorities.

Similar rule is applied for X ray plates i.e. if under section 512 (subsection 1 or 2) preserve for 30 years & all other for 5 years.

9. OPD and IPD case papers

- These case papers must have the stamp ‘MLC’. In addition to this, any correspondence related to any MLC must bear MLC stamp.
- Outdoor & indoor register has to be separately maintained for MLC cases. Each case should have separate MLC number in addition to usual register number.
- After thorough examination, case paper should have detailed notes of findings along with laboratory, X-ray, other investigations, operation notes, treatment given etc.
- Case paper should not be handed over to patient.
- MLC Record (case papers, registers) should be kept by MO in his/her custody under lock & key. Indoor case papers should be kept by ward sister under lock & key until patient is discharged & thereafter it should be with MO.
- Record including indoor, outdoor case papers should be maintained in duplicate as some times original record may be required to be handed over to the court.
- Case papers & correspondence should be maintained month & year wise.

10. X-ray plates & laboratory report

It is often necessary to refer medico legal cases for X-ray or laboratory examination. X-ray plates are positive proof & accepted as evidence in court of law. X-ray plates should be carefully marked with name of patient.

Detailed X-ray & laboratory report should be properly recorded on case paper immediately on receipt. Time & date of receipt should be written on paper.

11. Medico legal register

Every institute dealing with medico legal work must maintain “medico legal register” which is also called as “police register” or “Emergency police register (EPR)”.

- Enter all the information recorded on case paper in MLC register, which includes Sr. no., date & time of attendance, buckle number of police constable, findings, treatment given, medico legal case paper number etc.
- In remarks column, enter information regarding dispatch of letters and replies received.

12. Medico legal report

- MLC report should be issued promptly to police without waiting for demand letter.
- Information recorded on case paper, MLC register and report should be same.
- Report should be complete in all respects. Keep O/C of report in lock along with case papers. If case papers are in ward then keep them locked in ward.
- Sometimes patient has to be investigated further or is kept under observation, in such cases provisional report has to be given & this has to be mentioned in covering letter as well as in remarks column of report.
- If patient is referred to higher center for advanced treatment, concerned authority will give final report. In any case never give backdated report.
- Each MLC report must have outward number of PHC.
- If patient demands MLC certificate-
 - Patient has to give request letter demanding certificate.
 - MO can issue a copy of certificate to patient on his demand. However MO should ensure that certificate is handed over to police before giving it to patient.
 - Signature of patient should be taken after issuing certificate.

3. MEDICO LEGAL AUTOPSY OR POST MORTEM EXAMINATION

1. OBJECTIVES OF MEDICO LEGAL AUTOPSY

- To determine identity of a person when not known.
- To determine cause of death, manner of death.
- Ascertain time since death.
- In case of newborns, to determine live birth & viability of child.
- To collect evidentiary material.

2. RULES

PM examination should be considered as an urgent work taking into account psychology of relatives waiting for the body to be handed over. In addition, decomposition changes advance rapidly in our country due to weather condition, which may affect findings on PM examination.

Following rules should be observed for PM examination.

- PM examination should not be undertaken unless there is written order (authorization) from a police officer or magistrate.
- Once written order (authorization) is obtained, there should be no delay in holding PM examination. It should be performed as early as possible.
- MO should carefully read the police report about appearance of body, when it was first found & cause of death.
- Examination should be conducted in daylight. Government of Maharashtra has directed that, PM maybe done at night if adequate quantity & quality of light can be assured so as to have correct interpretation.
- Examination should be thorough & complete.
- Some MOs refuse to accept dead body on ground that it is from outside their jurisdiction. This is not correct. MO should perform PM examination in first instance & make representation in the matter if necessary later on.

3. CARRYING OUT POST MORTEM

3.1. Check following record

Ask the accompanying police officer for following records while accepting body.

- Dead body challan
 - Inquest report / panchanama
 - In case of admitted patient summary of hospital record.
- a) **Dead body challan** - It is a requisition submitted by investigating police officer to MO while handing over body for PM. It contains general information like name, age, sex, religion etc. It also contains place from where body has come, distance, name of person accompanying, identification, time since dispatch and suspected cause of death. MO has to fill time of arrival & time of PM examination in the same challan.
- b) **Inquest report** - This includes description of the incidence, circumstances under which body was found, opinion of witnesses & police officer regarding injuries, cause of death etc.

3.2. Verify record and findings on body examination

Verification of injuries noticed & recorded by investigating police officer is important. After identification of body, verify injuries recorded in panchanama. If MO fails to find injuries recorded by police officer, this should be clearly mentioned in report. If there are major discrepancies in observations by police officer & MO, it is preferable to ask for second panchanama by Magistrate.

3.3. Conducting post mortem

Even if cause of death is obvious from examination of a particular part of body; all parts must be systematically examined.

1) External Examination

- Body should be identified by police constable who brought it & also by relatives present on the spot before starting postmortem.
- In case of unknown body, general appearance of body describing age, sex, race, stature, features, scars, colour, hair, tattoo marks etc should be noted for purpose of identification. Body should be photographed & finger prints taken.
- If there are clothes on body, they should be examined for stains of blood, saliva, semen, vomit, faecal matter etc. & preserved for chemical analysis.
- In case of firearm deaths, residues/used bullets if any, be preserved & handed over to investigating authority.
- Approximate age should be given from presence of teeth other appearances.
- Time since death should be noted from rectal temperature, post mortem lividity, rigor mortis, putrefaction, maggots etc.
- Natural orifices should be examined for injuries, foreign bodies, discharges like blood, pus etc.
- Careful search for presence of injuries from head to foot on the front & back should be made.
- In case of burns, position, extent & degree should be noted.

2) Time since death

Estimation of exact time since death is difficult but approximation is possible. Following table gives guidelines to decide time since death.

Table - 1: Guidelines to decide time since death

Time since death	Condition of body
Less than 1 hour	Body warm.
3 hours	Patch of post mortem lividity.
6-8 hours	Lividity fully developed & fixed.
12 hours	Rigor present all over, Green patch on skin / over caecum
24-36 hours	Rigor receding or absent. Green discolouration over whole body , abdomen distended with gases. Ova of flies seen.
48 hours	Trunk bloated. Face discoloured & swollen. Blisters present. Moving maggots seen.
72 hours	Whole body grossly swollen & disfigured. Hair & nail loose. Tissues soft & discoloured.
1 Week	Soft viscera putrefied.
2 Week	Only more resistant viscera distinguishable.

1-3 Month	Body skeletonised.
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Important points to remember

- In tropical country like India, average heat loss is roughly 0.50 to 0.70C per hour & body attains environmental temperature in about 16-20 hours after death.
- Post Mortem lividity is fully developed & fixed in about 6-8 hours.
- Rigor mortis usually commences in 2-3 hours after death, takes 12 hours to develop from head to foot, persists for another 12 hours and takes 12 hours to pass off.
- In 12-18 hours, gases collect in intestines & distend the abdomen. In 18-36/48 hours after death gas formation is abundant.
- Flies are attracted to putrefying body & lay their eggs in open wounds & moist natural orifices. Eggs hatch into maggots or larvae in about 12-24 hours and in course of 4-5 days maggots develop into pupae. In another 4-5 days pupae into adult flies.
- State of digestion of food contents help to fix time interval between food consumption and death. If at autopsy stomach is full, it would suggest that victim died within 2 hours of taking last meal. Food becomes indistinguishable in less than 4 hours and stomach is emptied in 4-6 hours.

3) Internal examination

If there is fatal wound leading to one of the cavities, that cavity should be opened first. Otherwise head should be opened first, then thorax and finally abdomen. Every organ from the cavities must be examined but spinal cord need not be ordinarily examined unless suspicion of injury to vertebral column.

4) Preservation of viscera & other material

In fatal cases of suspected poisoning, viscera and other material should be preserved for chemical analysis. Clean, wide mouthed, white glass bottles fitted with glass stopper with one liter capacity should be used to preserve viscera. Such bottles are available in the office of the chemical examiner.

a. Guidelines for preserving & sending viscera

- Preserving viscera& sending for analysis are two separate acts.
- Only in genuine cases with direct or indirect evidence of poisoning, vomit, viscera etc. should be submitted for analysis.
- MO should preserve viscera in following cases:
 - Drowning, burns, hanging, strangulation, suspected poisoning.
 - Where cause of death cannot be ascertained.
 - In all other cases MO should preserve viscera & explain to the police in writing why viscera is preserved & only if analysis is absolutely necessary it should be sent.
 - In all cases of drowning viscera has to be preserved but not dispatched unless police desires so preservation & dispatch of viscera is not substitute for careful PM examination.

b. Viscera & its quantity

Following viscera/material should be preserved and handed over to investigating authority:

- Whole stomach & its contents about 300 ml or all if less.
- Small intestine - 3 feet in adults, 5 feet in children & whole in infants. 100ml small intestine contents or whole if less.
- Liver- 400-500 gm; whole in infants. Preferably portion containing gall bladder.
- Spleen - Half in adult, whole in children.
- Kidneys - Half of each kidney in adults & both whole kidneys in children.
- Blood- 10 ml or more.
- Urine - 100 -200 ml. If less available, whole quantity.
- Piece of long bone or plucked hair in case arsenic or lead poisoning is suspected.
- Examination of blood & urine is useful in suspected poisoning cases. Collect blood and urine directly from heart & bladder respectively.

c. How to preserve viscera

i. Number of bottles

- Preserve stomach, its contents and small intestine in one bottle.
- Preserve pieces of liver, spleen & kidney in one bottle.
- Urine sample should be preserved in separate bottle.

ii. Preservative to be used

In all poisoning cases (including alcohol poisoning) except by acid, saturated solution of common salt should be used as preservative.

- For all acid poisoning cases rectified spirit should be used as preservative.
- Formaline & denatured spirit should never be used as preservative in any poisoning case. Pieces of viscera should be cut into small pieces to ensure penetration of preservative.
- All material should be submerged in preservative otherwise decomposition will take place & gases formed may cause lid spilling or even break the bottle.
- Stoppers should be treated with grease or vaseline to prevent sticking & should be securely tied in position by tape or string.

iii. Labeling, sealing & sending bottles

- Bottles should be labelled & sealed.
- A forwarding letter along with post mortem report, full history of patient in case of poisoning along with name of suspected poison if known is essential. Name of victim, nature of exhibit & case number given in forwarding letter should tally with labels on bottle.
- Copy of seal should be sent with forwarding letter.
- Bottles to be sent to chemical analysis should be sealed by concerned MO & sent to the officer I/C of near by police station (under intimation to the office at whose instance examination was conducted) for sealing & safe custody until order of magistrate or superintendent of police.

d. Fingertips & bones

Whenever bodies are not identified, MO should preserve fingertips. Dissecting terminal phalanx can do this. Occasionally bones require special examination & bones are sent to the Professor of Anatomy for such examination.

4. VISIT TO PLACE OF CRIME

Medical Officer can visit place of crime if he/she feels necessary to arrive at cause of death. PM should be performed on spot in circumstances where body is severely decomposed or vital evidence may be lost during transportation.

In case of on the spot PM examination MO should note following

- Place & nature of soil where body is found, its position, state of clothes.
- In case of death from violence, position of body in reference to surrounding objects such as sharp stones & like, contact with which may produce injury, whether blood stains are visible on such objects or anywhere near the corpse, whether any weapon lying near it.
- In case of suspected poisoning any vomited matter in neighbourhood.

5. OUTSIDERS DURING PM EXAMINATION

Unauthorized persons should not be allowed to be present during examination except medical students undergoing training. Police officer accompanying corpse for PM examination should not be allowed to be present in PM room at the time of autopsy.

6. WRITING CAUSE OF DEATH & AUTOPSY REPORT

Following important points should be kept in mind when writing PM report -

- Report should be written on printed form.
- No.5: Do not write 'as per inquest report', but write summary of the important facts & mention injuries as given in panchanama & confirmed by you.
- No.9: Do not write 'nil', as it is improbable not to find any identification mark.
- No.11: Rigor mortis should be described in detail i.e. whether present on whole body or part of body.
- No.17: Enter details about injuries e.g. their exact site from fixed bony points, length, breadth, depth & character. It is advisable to attach diagram of injuries.
- Injuries should be measured individually though numerous in number. Age and cause of each injury must also be mentioned.
- If blood is present in any of body cavities, always mention approximate quantity.
- After complete PM examination, MO should form opinion about cause & manner of death or probable cause of death & probable time since death based on finding of examination. He/she should immediately give abstract of opinion to the police constable accompanying body for communication to investigating officer.
- A certificate should be given to police constable in charge of body immediately after PM examination is over in following form

"This is to certify that, PM examination has been held on the body of the deceased.....today betweento The cause of death / probable cause of death as derived from PM examination is as follows"

Signature of MO performing PM exam.

- Write detailed PM report in triplicate. One copy is sent to investigating police officer within 24 hours by hand of police constable who brought body for examination & another to the superintendent of police/magistrate. Third copy is retained as office copy for future reference.
- At the time of performance of PM examination, MO should complete original PM report in his/her own handwriting in PM room itself. Other copies can be typed. MO should keep original with him/herself.
- When cause of death requires further examination, opinion about cause of death should be reserved pending such examination.

7. PM REPORT TO PRIVATE PARTIES

Sometimes, private parties request for PM examination report. However this report is confidential document & cannot be given to private parties. Private party may be asked to approach police authorities or concerned magistrate.

8. PM ROOM

- Light should be adequate.
- Colour of walls, floor & ceiling should be natural white, off white or gray.
- Each PM room should have at least two light sources situated on opposite sides so that there are minimum shadows & total power being not less than 160W & not more than 200W.

9. RECORD IN PM ROOM

Following registers should be kept in PM room -

- Dead stock registers of equipment & supplies.
- Incoming & outgoing dead body register giving time & date of dead body arrival, identification, time of handing over body, signature of person receiving dead body & his relationship with dead body.
- Register for consent in case of non-medico legal PM examination.

10. EXHUMATION

It is lawful disinterment or digging out of a buried body from the grave, which is sometimes necessary for purpose of identification & to determine cause of death when foul play is suspected. Guidelines to be followed for exhumation are -

- Police officer cannot order for exhumation, only magistrate can order it.
- Exhumation is carried out under supervision of MO & in the presence of police officer.
- About 500 grams sample of earth is collected from above, below & sides of the body.
- PM should be conducted as per regular procedure.

4. Consumer Protection Act (CPA / COPRA) Related to Medical Profession

Introduction:

With the fast pace of commercialization and globalization on all spheres of life, the medical profession is no exception. Since the passing of the Consumer Protection Act in 1986, the doctor-patient's relationship has deteriorated significantly and litigation against doctors is increasing day by day. This review article enlightens medical practitioners regarding Consumer Protection Act and how to prevent litigations.

The Doctor patient relationship in our country has undergone a sea change in the last decade and a half. The fortunate doctors of the past were treated like God and earned respect. Commercialization and globalization on all spheres of life has not even spared the medical profession as well. As a result, the doctor-patients relationship has deteriorated considerably. Earlier too, doctors were covered by various laws, i.e. the Law of Torts, IPC etc., but since the passing of the Consumer Protection Act in 1986, litigation against doctors is on the increase. Doctors practicing ethically and honestly should not have any reason for fear. Law whether civil, criminal or consumer law, can only set the outer limits of acceptable conduct i.e. minimum standards of professional care and skill, leaving the question of ideal to the profession itself.

The purpose of the Act:

To protect the interest of the consumers of different commodities available to them for which they pay but do not get standard quality of service. e.g. patient pay for the treatment but do not get correct treatment. Any sufferer consumer, State / Central govt. may lodge the complaint against the erring trader or suppliers, etc for the deficient service which cause some harm to the consumer in the different redressal forum. e.g. District Forum, State Commission, National Commission.

Nature of Complaint:

Any unfair trade practice adopted by the trader, and defective goods, deficiency in services /Deficiency in treatment, excess price charged by the trader /doctor by doing unnecessary investigation, prolonged hospital stay etc. for unlawful goods sale, which is hazardous to life and safety when used. A complaint hand written or typed can be filed by a consumer. Usually complaint should be decided within 90 days from the date of notice issued to the opposite party. Where sample of any goods is required to tested, case may be disposed within 150 days or it may take more time due to practical problems. The complaint should be filed in the District forum, State commission or National Commission within two years from the date on which the cause of action has arisen. In case there is sufficient ground for not filing the complaint within such period delay may be condoned at the discretion of the consumer forum/Commission.

How to Avoid Litigation?

a) Prevention at personal Level

- MCI approved qualification, training and experience of recognized center are the primary safeguard against any litigation.

- **Communication:** This is the key to doctor Patient relationship. We should have polite and sympathetic attitude toward patients and their relatives. Increasing crowds of patients and improper communication to the patient about diagnostic and treatment procedures, complications and claims of guaranteed success are the main reasons for Patient's dissatisfaction. Answers all queries of the patients / relatives without getting irritated. Academic and Technical up gradations- One should regularly attend Conferences, CMEs & Workshops to keep pace with progress in medical science. Other academic sessions should also be organized to up grade our junior staff and nursing team.
- **Medical Ethics Laws:** A thorough knowledge of medical ethics and laws is essential for all medical professional. We should always get feed back from our patients about our setup, our staff & charges etc. Special training should be for doctors, paramedical staff, nursing staff etc from HRD experts about dealing with patients /relatives under grievous mental stress due to some loss or injury.

b) Prevention at Practice:

- Should have reasonable skill and care in diagnosis and treatment.
- Proper documentation of facts and legally valid informed Consent. The reasonable Skill and care.
- There are three aspects of reasonable skill and care - Medical, Social & Legal
 - **Medical Aspect**-First and foremost it is essential for every Doctor /Hospital /Nursing home to exercise reasonable skill and care expected of an average person with equivalent qualification and experience in similar circumstances.
 - **Social Aspects**-We should always exhibit our reasonable skill and care to the patients / attendants / relatives through expression, body language, action and discussion. We may be very sincere toward patient but failure to exhibit these gestures may leads to doubts in the mind of patients and their relatives.
 - **Legal aspects** - This include proper documentation about exercising reasonable skill and care in consultation, diagnosis and treatment. This can be done by making good clinical notes of finding on examination and treatment given. When there is failure to follow instruction, refusal for investigation, failure to come for review on specified day by patient, should always be recorded in underline way. These negative records act as important tool while defending our case in court of law.

Prevention by professional indemnity by insurance cover -Professional indemnity insurance is a tool which not only meets the claim of compensation awarded against the doctor /hospital but also gives sense of mental security that even if same negligence is proved the insurance company will take care of it. Prevention by people support groups-By forming societies like I.M.A , Medical Collage Teachers Welfare Society we get a type of social security. It also prohibit the doctor speaking foul against there own colleague.

Factual defenses:

Mention qualification, training, experience etc. We can say that complainant or patient has not come to the court with clean hand i.e he has suppressed material facts e.g. previous illness, treatment etc. Written consent of the patients / relative / attendant especially, involving special risk in the treatment. Circumstances of the case e.g. there was emergency, lack of

facility (e.g. rural area) no one to give history of patients illness etc. Burden of proof of duty of care, breach of that duty, causation, damage etc, is on the patients or complainants. Reasonable knowledge, skill and care exercised. Treatment by patient from other doctor / other system of medicine simultaneously. More than one reason for occurrence of damage. Contributory Negligence.

DO'S AND DON'TS FOR DOCTORS:

Do's for Doctors:

- Mention your qualifications/ training/ experience/ designation on the prescription.
- Always mention date and timing of the consultation.
- Mention age and sex of the patient.
- In a pediatric prescription weight of the patient must also be mentioned.
- Always put your hand on the part that the patient/ attendant say is painful.
- Apply your stethoscope on him, even if for cosmetic reasons.
- Listen attentively. Look carefully, ask questions intelligently.
- Always face the patient. Do not stare, especially female patients.
- Ask the patient to come back for review on the next day, if you are not sure about the diagnosis/ treatment.
- Mention "diagnosis under review" until the diagnosis is finally settled.
- In complicated cases record precisely history of illness and substantial physical findings about the patient on your prescription.
- Record history of drug allergy.
- Write names of drugs clearly. Use correct dosages.
- Always advise the patient not to stop taking a drug suddenly which is required to be tapered before it is stopped.
- Remember major drug interactions.
- Mention if patient/ attendant are/ is under effect of alcohol/ drugs.
- Adjust doses in case of a child/ elderly patient and in renal or hepatic disorders.
- In case of chronic ailments, mention treatment to be taken immediately in case of an emergency.
- For example, a patient on anti-epileptic treatment should be advised to take an injection of diazepam when convulsions occur.
- Mention where the patient should contact in case of your non-availability/ emergency.
- If you are not sure what disease a patient has after a thorough workup, get a consultation.
- Whenever referring a patient, provide him with a referring note.
- In case of emergency/ serious illness, ring up the concerned doctor in the patient's presence in hospital casualty.
- Participate in at least one national / international conference of respective subjects every year.
- Update your knowledge and skill from time to time.
- Update not only your own knowledge and skill, but also that of your staff.
- Update the facilities and equipment according to prevailing current standards in your area.
- Preferably employ qualified assistants. If not available, impart proper training and skill at your or some appropriate centre and obtain a certificate for the same.
- Routinely advice X-rays in injury to bones and joints and related diseases of bones/ joints.
- Always rule out pregnancy before subjecting the uterus to X-ray.

- The period for the responsibility of the surgeon extends to and includes the post-operative care.
- Always seek proper legal and medical advice before filing reply to the complainant referred to you from a consumer court.

Don'ts for Doctors:

- Don't prescribe without examining the patient, even if he is a close friend or relative.
- Never examine a female patient without presence of female nurse/ attendant, especially during genital and breast examinations.
- Don't smoke while examining a patient.
- Don't examine a patient when you are sick, exhausted, or under influence of alcohol or any intoxicated substance.
- Don't be overconfident. Don't look overconfident.
- Don't prescribe/ administer a drug which is banned, e.g. Analgin.
- Don't over-prescribe/ administer too much of the drug, too large a dose, for too long.
- Don't under-prescribe: dose is too small, length of treatment is too short.
- Never talk loose of your colleagues, despite intense professional enemy.
- Possibilities of drug interactions increase with polypharmacy.
- Don't allow substitutions.
- Don't do anything beyond your level of competence.
- Competence is defined by your qualification, training and experience.
- Don't give a drug parentally if it can be given orally. There may be some exceptions.
- When you are not sure what and why to do. Consult your senior/ specialist/ colleague.
- Don't refuse the patient's right to know about the hospital rules, regulations and hospital charges.
- Don't refuse if the patient/ attendants want to leave against medical advice (LAMA). It is their right. Document this properly.
- Never avoid a call for help from a nurse on duty at night. A genuine emergency may be there.
- Never label any condition as "functional" until you are as certain as possible of the accuracy.
- Don't leave at the moment of death. There is a tendency especially on the part of senior doctors to go away at this time when his presence and experience are most needed.
- Don't hesitate to extend your condolences and sympathies to the bereaved persons.
- Don't issue death certificates unless you have yourself verified it.
- Don't divulge secrets you come to know during discharge of your professional duties.
- Don't deny medical care to a patient with HIV infection/ AIDS. Observe all necessary precautions.
- Don't inform that the person is infected with HIV unless confirmatory test results are received.
- Don't give untrue, misleading or improper reports, documents, etc.
- Do not leave a patient unattended during labor.

SECTION D:

**OTHER
IMPORTANT
TOPICS**

1. VITAL STATISTICS

While working in Health Department it is necessary to know the information regarding various VITAL statistics and DEMOGRAPHIC indicators. These indicators are useful for monitoring, supervising various health programmes.

Demography:

- **Demography** is the “scientific study of human population in which includes study of changes in population size, composition and its distribution.”
- “**Demo**” means “the people” and “**graphy**” means “measurement.”
(Demos=population, Graphy=picture)

Demographic characteristic of a county provide an overview of its

- Population size,
- Composition territorial distribution,
- Changes therein and
- The components of changes such as
 - Nativity
 - Mortality,
 - Social mobility.

This section on demographic indicators has been subdivided into two Parts.

- Population Statistics
- Vital Statistics

Population Statistics include indicators that measure the

1. Population size
2. Sex ratio
3. Density and
4. Dependency ratio.

While Vital Statistics include indicators such as

1. Birth rate
2. Death rate
3. Natural growth rate
4. Life expectancy at birth
5. Mortality
6. Fertility rates.

These indicators for the country as well as states help in identifying areas that need

- Policy and programmed interventions,
- Setting near far-term goals,
- Deciding priorities.

Importance of Demographic data

- Health status of a community depends upon the dynamic relationship between number of people, their composition and distribution.
- Planning of health services can be guided by demographic variables, for example:
 - i) How many health units do we need?
 - ii) How to distribute them in the community in order to be accessible to the target population?
 - iii) What type of manpower is needed?

Source of demography

- Population censuses
- National Sample
- Surveys Registration
- Vital Events

Vital Statistics

Definition: Vital statistics are conventionally numerical records of marriage, births, sickness and death by which the health and growth of community may be studied.

Or

It is a branch of biometry deals with data and law of human mortality, morbidity and demography.

Vital Events

Vital events plays very important role in Health Statistic

This includes

- Births
- Deaths
- Marriage
- Divorce

Source of Vital Statistics

- **Civil Registration System:**

It is defined as the continuous permanent and compulsory recording of the occurrence of vital events like live births, deaths, fetal deaths, marriages, divorces, as well as annulments, judicial separation, adoption. Civil registration is performed under a law and regulation so as to provide legal basis to the records and certificate made from system.

- **National Sample Survey:**

The data collected from the census are not very reliable and available only once in years. In absence of reliable data from the civil registration system (SRS), the need for reliable statistics at national and state levels is being met through sample surveys launched from time to time.

- **Sample Registration System:**

In this system, there is continuous enumeration of births and deaths in sample of villages/urban areas by a resident part time enumerator and then an independent six monthly retrospective survey by a full time supervisor.

- **Survey of Cause of Death :**

The scheme was previously known as Model Registration Scheme.

This scheme is ruled in only one selected village of every PHC in Maharashtra with the help of MPW(M/F). Monthly report is send to District HQ and State. An independent six monthly retrospective survey is carried out by MPW(M/F) & Supervisor. Another source is MIS which was started in 1981. Now various softwares are developed for data. eg. DHIS II, RCH web poratal, CRS software, Training software, Niramay, e-Aaushadhi, etc.

- **Health Surveys :**

A few important sources for demographic data have emerged. These are **National Family Health Surveys(NFHS)** and the **District Levels Household Surveys (DLHS)** conducted for evaluation of reproductive and child health programmes.

NFHS provide estimates of fertility, child mortality and a no. of fertility, child mortality and a no. of health parameters relating to infants and children at state level.

The **DLHS** provide information at the district level on a no. of indicators relating to child health, reproductive health problems and quality of services availability to them.

Purpose:

1. **Community Health:** To describe the level of community health, to diagnose community illness & to discover solutions to health problems.
2. **Administrative Purpose:** It provides clues for administrative action to create administrative standards of health activities.
3. **Health Programmed Organization:** To determine success or failure of specific health programmed or undertake overall evaluation of public health work.
4. **Legislation Purpose:** To promote health legislation at local, state & national level.
5. **Government Purpose:** Todevelop, policies, procedure at state and central level.

- **Uses :**

1. To evaluate the impact of various National Health Programmes.
2. To plan for better future measures of disease control.
3. To explain the hereditary nature of the disease.
4. To plan and evaluate economic and social development.
5. It is a primary tool in research activities.
6. To determine the health status of individual.
7. To compare the health status of individual one nation with others.

- **Population Projection :**

We know the accurate population of a particular region during the census conducted by GOI. The census is carried out once in a decade (10 years). If we require a population between two censuses, we have to project it. There are various tools for projection of population for a particular point of time. One of them is Arithmetic method of projection. In this method we estimate the Mid Year Estimated Population (MYEP) or Mid Year Population (MYP).

- **Mid Year Population (MYP) :**

It is nothing but the population as on 1st July for calendar year of a particular year.e.g. Mid Year Population of 2017 means the population as on 1st July 2017.MYP is calculated by number of methods, few are as follows-

A. MYP by arithmetic increase method

The formula is

$$P = P_2 + \frac{(P_2 + P_1)}{N} \times (D + 1/3)$$

Where, P is Mid Year Population.

P₂ is Population of recent census.

P₁ is Population of previous census.

D is Difference in years between the year for which we want to calculate MYP & recent census year. N is d

B. FERTILITY INDICATORS

1. AGE SPECIFIC FERTILITY RATE (ASFR):

This rate expresses number of live births given by 1000 women of the specific age group.

$$\text{ASFR} = \frac{\text{Total No. of Bs given by Particular age gr. of female} \times 1000}{\text{Midyear Female population of same age group}}$$

Generally ASFR is calculated for 7 age groups.

These are 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, & 45-49.

2. GENERAL FERTILITY RATE (GFR) :

This rate gives number of births per 1000 women of child bearing ages.

$$\text{GFR} = \frac{\text{Total No. of Births}}{\text{No. of women in child bearing age}} \times 1000$$

3. TOTAL FERTILITY RATE (TFR) :

Under specific fertility pattern a woman can have number of births in child bearing period. This is a hypothetical measure.

$$\text{TFR} = \frac{5 \times \text{Sum of all A.S.F.R.}}{1000}$$

- **GROSS REPRODUCTION RATE (GRR) :**

GRR is an average no. of daughters that would be born to woman if she experiences the current fertility pattern through her reproductive span(15-49 yrs.).

$$\text{GRR} = \frac{5 \times \text{Sum of all A.S.F.R. for females}}{1000}$$

What indicates GRR for Raigad District?

- **Crude Birth Rate (CBR) :**

It is the simplest measure of fertility, expressing number of births per 1000 persons in the population during the given year for the given region.

$$\text{CBR} = \frac{\text{Total No.of Births}}{\text{Mid Year Population}} \times 1000$$

CBR gives number of births occurred in 1000 population. This rate is useful to estimate no. of births in specific area.

- **Still Birth Rate (SBR):**

Still Birth is number of still births per one thousand live births in a year.

$$\text{SBR} = \frac{\text{Total No.of Still Birth}}{(\text{Total live Births} + \text{Still Births})} \times 1000$$

(Based on the WHO definition of third-trimester stillbirth used for international comparability, i.e. dead fetus of 1000 g or more at birth or after 28 completed weeks of gestation or attainment of at least 35 cm crown-heel length.)

Note: SBR gives us how many still births have occurred per 1000 births. This rate is used to plan to improve services to pregnant and at the pregnancy and at the time of delivery.

C. MORTALITY INDICATORS:

1. CRUDE DEATH RATE (CDR) :

$$\text{Crude Death Rate} = \frac{\text{Total No.of Deaths}}{\text{Mid Year Population}} \times 1000$$

Note : For survey study we can use surveyed population instead of MYP

CDR gives number of deaths occurred in 1000 population. This rate is useful to estimate no. of deaths in specific area.

2. INFANT MORTALITY RATE (IMR):

Infant Mortality Rate is no. of deaths of children in one year of age per thousand live births in that year.

$$\text{Infant Mortality Rate} = \frac{\text{Total No.of Infant Deaths (0-1Yr.)}}{\text{Total No. of Live Births}} \times 1000$$

3. CHILD MORTALITY RATE (CMR) :

$$\text{Child Mortality Rate} = \frac{\text{Total No. of Child Deaths (0-5 Yr.)} \times 1000}{\text{Total No. of 0-5 years children}}$$

4. AGE SPECIFIC MORTALITY RATE (ASFR) :

Number of deaths in specific age group per 1000 population in that specific age group in a given year.

$$\text{ASMR} = \frac{\text{No. of Deaths in a particular age group} \times 1000}{\text{Population of the same age group}}$$

5. MORTALITY RATES OF UNDER ONE YEAR OF AGE

5a) PERI-NATAL MORTALITY RATE (PNMR):

For this rate still births and deaths at the age less than one week are taken in numerator, While the still births and live are taken in the denominator, multiplied by 1000.

$$\text{PNMR} = \frac{\text{No. of Still Births} + \text{No. of deaths} < 7 \text{ days i.e. 1 wks.} \times 1000}{\text{No. of live Births} + \text{No. of Still Births}}$$

This rate is useful to identify how much is the mortality of children under 1 week. By knowing this a medical person can plan to avoid these deaths.

In spite of this there are various rate regarding mortality of children under 1 year. Their formulae are as follows -

5b) EARLY NEONATAL MORTALITY RATE :

$$\text{ENMR} = \frac{\text{No. of ID less than 7 days during the yr.} \times 1000}{\text{No. live Births during the year}}$$

5c) LATE NEONATAL MORTALITY RATE :

$$\text{LNMR} = \frac{\text{No. of ID between 8-28 days during the yr.} \times 1000}{\text{No. live Births during the year}}$$

5d) NEONATAL MORTALITY RATE :

$$\text{NMR} = \frac{\text{No. of ID upto 28 days during the yr.} \times 1000}{\text{No. live Births during the year}}$$

5e) POST NEONATAL MORTALITY RATE :

$$\text{PNM} = \frac{\text{No. of ID from 29 days to 1yr. during the yr.} \times 1000}{\text{No. live Births during the year}}$$

6. MATERNAL MORTALITY RATE (MMR) :

This is a very important and sensitive indicator, because we can judge the services received by pregnant women given by medical personnel.

$$\text{MMR} = \frac{\text{Total No. of Maternal Deaths}}{\text{Total No. of live Births}} \times 1000$$

Note – Maternal deaths is the female deaths due to complications of pregnancy, child birth or within 42 days of delivery due to “puerperal causes”

7. COUPLE PROTECTION RATE (CPR) :

$$\text{CPR} = \frac{\text{Couples using various methods of FP}}{\text{Total No. of Eligible couple}} \times 1000$$

8. HOSPITAL RATES :

Some of the hospital utilization rates are given below :

$$\text{Bed occupancy Rate (B.O.R.)} = \frac{\sum \text{Daily census of month}}{\text{No. of sanctioned beds} \times \text{No. of days in a month}} \times 100$$

Note - Where daily census refers to per day remaining admitted patients in the hospital

$$\text{Bed Turnover Rate (B.T.R.)} = \frac{\text{Total no. of discharge Pt.+Deaths in a month}}{\text{Number of sanctioned beds}}$$

$$\text{Average length of stay (ALOS.)} = \frac{\sum \text{daily census of month}}{\text{No. discharge} + \text{No. of Deaths in a month}}$$

$$\text{Out patient for inpatient} = \frac{\text{Total number of OPD (Old + New)}}{\sum \text{daily census}}$$

$$\text{Major Surgery Rate} = \frac{\text{No. of Surgery}}{\text{Total No. of Admissions}} \times 100$$

$$\text{LSCS Ra} = \frac{\text{Total No. of LSCS}}{\text{Total No. of Deliveries (Normal +LSCS)}} \times 100$$

$$\text{Incidence Rate} = \frac{\text{No. of new cases of disease during specified period}}{\text{Total Population during the same period for that place}} \times 1000$$

It is calculated where high incidence occur. eg. Cholera, Measles, Diphtheria etc.

$$\text{Prevalance Rate} = \frac{\text{No. of (O+N) cases of disease during specified period}}{\text{MYP of that area during specified period}} \times 1000$$

HEALTH OUTCOME GOALS ESTABLISHED IN THE 12TH FIVE YEAR PLAN (OBJECTIVIES)

- Reduction of Infant Mortality Rate (IMR) to 25 per 1,000 live births by 2017.
- Reduction in Maternal Mortality Ratio (MMR) to 100 per 100,000 live births by 2017.
- Reduction in Total Fertility Rate (TFR) to 2.1 by 2017.
- Providing clean drinking water for all by 2009 and ensuring no slip- backs. Reducing malnutrition among children of age group 0-3 years to half its present level.
- Reducing anemia among women and girls by 50%.
- Raising the sex ratio for age group 0-6 to 935 by 2011-12 and 950 by 2016-17.

2. SOFTWARES USED IN PUBLIC HEALTH

RCH पोर्टल

कुटुंब कल्याण मंत्रालय, भारत सरकारने MCTS ही संगणकीय प्रणाली विकसित केली होती.

उद्देश

- १) गरोदर माता व बालके यांना दिलेल्या सेवांचे ट्रॅकींग करणे
- २) लाभार्थी गर्भवती महिला व बालके यांना योग्य वेळी आरोग्य सेवा मिळणे
- ३) आरोग्य सेवा बळकटीकरण
- ४) आरोग्य सेवांची व्याप्ती वाढविणे, जास्तीत जास्त लाभार्थ्यांपर्यंत सेवा पोहचविणे
- ५) उपकेन्द्र स्तरापासून ते राज्य स्तरापर्यंत पर्यवेक्षण करणे

उपलब्ध घटक

लोकसंख्या नोंदणी, पात्रजननक्षम जोडपी, गरोदर माता यांचा पाठपुरावा, गरोदरपणची निष्पत्ती, अर्भक तपशील, प्रसुतीनंतरची काळजी, बालक नोंदणी

कार्यक्षेत्र - ग्रामीण व शहरी भाग

डाटा एन्ट्री - लाभार्थी निहाय ,गाव निहाय

डाटा एन्ट्रीस्तर - उपकेन्द्रस्तर/प्रा.आ.केन्द्र ,ग्रामीण/उपजिल्हा/जिल्हा रुग्णालये

डाटा एन्ट्री करणे - आठवडी

MCTS मध्ये सर्व राज्यांचे अहवाल सादर केले जात होते. मात्र योग्य जोडप्यांची आकडेवारी व त्याबाबतचा पाठपुरावा याचा MCTS मध्ये अंतर्भाव नसल्यामुळे केन्द्र सरकारने नविन RCH पोर्टल विकसित केलेले आहे ज्यामध्ये योग्य जोडपी, गर्भवती महिला आणि बालके यांचे त्यांना देण्यात येणाऱ्या आरोग्य सेवांबाबत पर्यवेक्षण करण्यात येते. त्यामुळे राज्यातसुद्धा MCTS ऐवजी आता RCH पोर्टल वापरण्यात येत आहे.

RCH पोर्टलमुळे आरोग्य सेवा बळकटीकरण, जास्तीत जास्त लाभार्थ्यांपर्यंत सेवा पोहचविणे व सर्व स्तरांवर देण्यात येणाऱ्या सेवांबाबत पर्यवेक्षण करणे हे शक्य झाले आहे. यावरील माहिती व अहवालांचा उपयोग वेळीच जोखमीच्या माता ओळखून प्रतिबंधात्मक उपाय करणे, तसेच वर्कप्लॅनद्वारे योग्य वेळी सेवा पुरवून मातामृत्यु व बालमृत्युच्या प्रमाणात घट घडवून आणणे याकरीता होत आहे.

योग्य अहवाल प्राप्त होण्याकरीता अचूक डेटाएन्ट्री होणे आवश्यक आहे. त्यामुळे उपकेन्द्र स्तरावरून योग्य डेटाएन्ट्री करण्याकरीता तसेच वर्कप्लॅननुसार सेवा देण्यास्तव आरोग्य सेवक यांना सदर पोर्टल वापरता येणे आवश्यक आहे.

सदर पोर्टल करता Google Chrome या वेब ब्राऊझरवर जाऊन www.rch.nhm.gov.in हा URL टाईप करावा. त्यानंतर विंडो येईल.

- १) यानंतर माहिती भरण्याकरीता **Data Entry** या बटनावर क्लीक करावे. पूढील विंडो येईल. यात स्टेट महाराष्ट्र सिलेक्ट करुन आपल्या उपकेन्द्र त्या प्रा.आ.केन्द्रामध्ये येते त्या प्रा.आ.केन्द्राचे युजर नेम व पासवर्ड टाकून आणि त्यानंतर तेथे देण्यात आलेला इमेज कोट टाकून Login बटनावर क्लीक करावे.
- २) लॉग इन केल्यानंतर खालील विंडो येईल. यामध्ये उजवीकडे वरच्या टोकाला ज्यांचे लॉग इन असेल त्या प्रा.आ.केन्द्राचे नाव व राज्याचे नाव दिसेल.
- ३) यानंतर सेट लोकेशन या बटनावर क्लीक करावे. पूढील विंडो आल्यानंतर डेटा एन्ट्री करावयाचे सब सेंटर व गावाचे नाव सिलेक्ट करावे आणि Set बटनावर क्लीक करावे.
- ४) लोकेशन सेट केल्यानंतर डेटा एन्ट्री बटनावर क्लीक करावे. यानंतर स्क्रीनवर खालील प्रमाणे आयकॉन्स दिसतील. त्यानुसार डेटा एन्ट्री करण्याकरीता आवश्यक आयकॉनवर क्लीक करावे.

अ) Profile Entry मध्ये सेवा पुरविणाऱ्या ए.एन.एम., आशा व अंगणवाडी कार्यकर्तीचे नाव व मोबाईल नंबर, गावाची लोकसंख्या, एकूण योग्य जोडप्यांची संख्या इत्यादी तसेच जवळचे २४x७ प्रा.आ.के., FRU चा पत्ता व संपर्क क्रमांक आणि रुग्णवाहीकेचा संपर्क क्र.इत्यादी बाबी आहेत.

ब) सेवा पुरविणाऱ्या एएनएम व आशा यांचा प्रोफाईल Health Provider/ASHA Entry या बटनावर क्लीक करुन करावी.

योग्य जोडपी, गर्भवती महिला व बालके यांची डाटा एन्ट्री योग्य त्या बटनावर क्लीक करुन करण्यात यावी. गर्भवती महिलेची प्रसुति झाल्यानंतर पून्हा तीची योग्य जोडपे म्हणून नोंद करण्याकरीता डाटा एन्ट्री EC Reregistration या बटनावर क्लीक करुन करावी.

वर्कप्लॅनमधून लाभार्थींना दिलेल्या व उर्वरित आरोग्य सेवांची माहिती घेता येते.

वेबसाईट www.rch.nhm.gov.in

HMIS पोर्टल

HMIS (हेल्थ मॅनेजमेन्ट इन्फॉर्मेशन सिस्टीम) हे वेब पोर्टल कुटुंब कल्याण मंत्रालय, भारत सरकारद्वारा २१ ऑक्टोबर, २००८ साली ग्रामीण तथा शहरी भागातील शासकीय तसेच खाजगी आरोग्य संस्थांमधील सार्वजनिक आरोग्याशी संबंधित माहिती तसेच अहवाल प्राप्त होण्याकरीता कार्यान्वीत करण्यात आले. हे पोर्टल सार्वजनिक आरोग्याबाबत सर्व माहिती एका ठिकाणी उपलब्ध होण्यास्तव एक खिडकी (single window) आहे.

उद्देश: आरोग्य संस्था निहाय आकडेवारी गोळा करणे, उद्दिष्ट्य व साध्य बाबत माहिती घेणे.

उपलब्ध घटक: माता व बाल संगोपन निर्देशांक, लॅब टेस्ट, लसीकरण, कुटूंक कल्याण कार्यक्रम, आंतर व बाह्य रुग्ण, माता मृत्यू बाल मृत्यू व इतर मृत्यू बाबत माहिती व हिवताप, क्षयरोग कार्यक्रम, व्हॅक्सीन, औषध साठा उपलब्धता

DHIS - 2 पोर्टल (New version)

- DHIS-2 Software हे राज्य शासनाचे साफ्टवेअर आहे.
- उद्देश- जे निर्देशांक केंद्र शासनाचे साफ्टवेअरमध्ये नाही ति आरोग्य संस्था निहाय आकडेवारी गोळा करणे, उद्दिष्ट व साध्य या साफ्टवेअरमध्ये आहे
- उपलब्ध घटक -माता व बाल संगोपन, जननी सुरक्षा योजना, जननी शिशु सुरक्षा कार्यक्रम, साथरोग, अंससर्गजन्य आजार, **National Programme on Prevention and control of Cancer, Diabetes, CVDs & Stroke (NPCDCS)**, पाणी गुणवत्ता नियंत्रण
- कार्यक्षेत्र-ग्रामीण व शहरी भाग (फक्त कार्यक्षेत्रामध्ये दिलेल्या/घडलेल्या सेवांची नोंदी) व खाजगी दवाखाने
- डाटा एन्ट्रीस्तर - उपकेद्रस्तर/प्रा.आ.केद्र, ग्रामीण/उपजिल्हा/जिल्हा रुग्णालये
- डाटा एन्ट्री करणे - मासिक

वेबसाईट - www.nrhm-mis.nic.in

e-AUSHADHI

Aushadhi is a web based application which deals with the management of stock of various drugs, sutures and surgical items required by various District Drug warehouse, CHC, PHC & DDC of Maharashtra state.

"e-Aushadhi" helps in determining the needs of various Sub-stores such that all the required drugs are constantly issued by DDW to its Sub-store, to Patient by DDC without delay.

Features of e-Aushadhi -

- Role Based Access.
- Supplier Interface & Lab Interface.
- Supplier Payment Process.
- Budgeting, Stock Ledger & Drill-Down Reports.
- Various kinds of Analysis like ABC, VED, FSN.
- Customizable Alert Management & Reports.
- Categorization of Drugs as per CIMS guidelines.
- Provision of maintaining expiry date / shelf life for an item wherever applicable

e-Aushadhi Process

S.No	Module	Forms	Users
E-Aushadhi Services			
1	Demand	Transfer Demand Request(Short) Transfer Request(Excess) Indent Generation Demand Generation Purchase	<ul style="list-style-type: none">• DDW's• Sub Stores
2	Receive	Challan Process	DDW's

		Acknowledge Desk Transfer Acknowledge Desk	DDW's, Sub stores
4.	Return	Offline Return	DDW's
5.		Sample Receiving At Hq	QC
6.	Order Mgmt	Purchase Order Generation Desk (Local PO) Purchase Order Approval	DDW's.
7.	Modification & Backlog	Drug Inventory	DDW, Sub stores.
E-Aushadhi Reports			
7.1	Inventory Management	Inward / Challan Register Return Details Sale / Issue Register Stock On Hand Record Expiry Details Pending Sample For DDW Sample Issue/Receive Detail To Quality Dept Stock Ledger	Headquarters, DDW
7.2	Order Mgmt	PO Register Rate Contract Detail Report	Headquarter
7.3	Financial Mgmt	Material Inward Register Report Material Outward Register Report	Headquarter, DDW
7.4	Quality Control Mgmt	Drug Quality Status Report Pending Sample Detail Sample Issue Detail To Lab Inventory Management Summary List Of Samples	QC headquarter

Benefits of Software based Inventory Management System:-

- Better Planning, executing and controlling.
- Online Tracking of Drug Inventory.
- Streamlining of Inter-Drug warehouse Transfer.
- Efficient control of Inventory.
- Multi user, Multi location storage.
- Comprehensive Help.
- Customizable Reports

Display screen

- The main screen will be displayed to the user as soon as he/she will run the xecutable file.
- Default System Date will be visible in Current Date Textbox. If the user finds system Date incorrect, h/she can change the same. The selected date should be accurate. Error in date selection may create problem while uploading files.

- If the required files will not be found on place i.e. 'user.xml', there will be a message asking to browse the file and the checkbox will be checked by default.
- Successful upload and accurate credentials will allow the user to login.
- As soon as the user will login, there will be a screen called 'Display Screen'.
- Here you can see a list of sub-menus under 3 main menus: Services, Setup & Reports.
- Before starting any transaction, it is mandatory to upload the stock file.

Upload Stock File Screen

- There are 2 modes available for a stock update: Offline Mode and Online Mode (by default).
- Online Mode is for stores where web connection is available and offline mode is for stores with no internet connection.
- In Online mode, click on Sync Stock to first-time upload stock into the desktop application from the main e-Aushadhi application using internet connection.
- After button click, a popup will appear informing that stock has been uploaded successfully.
- If the user is going for offline mode, above screen will be visible.
- The user can browse the stock file and upload the same to load current stock into a desktop application.

Current Inventory

1. The user will reach to Current Inventory Screen which will display the current stock with the following details:
 - a. Item Name
 - b. Batch No.
 - c. Available Quantity
 - d. Expiry Date
2. The user can search the stock based on an Item name or Batch No.
3. Back button will navigate the user to Issue to Patient Screen.

Diagnosis Configuration

1. There are 2 modes available for a stock update: Offline Mode and Online Mode (by default).
2. Online Mode is for stores where web connection is available and offline mode is for stores with no internet connection.
3. In Online mode, click on Sync Data to sync master data(information about department, diagnosis and doctor) into the desktop application from the main e-Aushadhi application using internet connection.

Issue to Patient Screen

1. If the stock file will be uploaded successfully, the user will view a screen i.e. 'Issue to Patient'.
2. Drug finder has been modified to a search box, with the help of which the user can issue drugs by typing the name of the drug.
3. Successful entry for required data will save the details and a voucher will be generated with respect to the medicines issued.

Issue Voucher Screen

1. Issue Voucher will be generated as soon as the user will save the details.
2. The user can print the same and hand it over to the patient.

Patient List Screen

1. The screen will display the list of Patients with their details.
2. View button will display the voucher with all the details related to the selected patient.
3. Cancel button will cancel the issue and will update the current stock.

Upload Stock File (Sync Stock)

1. After Issuing drugs, Go to Upload Stock Screen.
2. Click on Sync Stock for online sync of stock with main application.
3. Successful Stock sync will result into 'data sync successful' popup.

Website: <http://>

NIKSHAY SOFTWARE

This is the web based application software for different level of users for the monitoring of tuberculosis under RNTCP.

There are four levels of users in the software:

1. National Level Users
2. State Level Users
3. District Level Users
4. Tuberculosis Level Users

1. National Level Users:

There will be 2 National level users viz. rntcp-helpdesk and rntcp-national. Rntcp-helpdesk will be used to solve the problems of the users at any level where rntcp-national will be used by Central TB Division for the purpose of reports.

2. State Level Users

35 State level users have been created with structure as sto-xx where xx is 2 character RNTCP state code. In case, any state level user faces password related problem, then user need to contact rntcp-helpdesk for resetting of password.

3. District level Users

District level users have been created on the pattern dto-ssddd where ss is RNTCP State Code and ddd is RNTCP District level RNTCP code. In case, any district level user faces password related problem, then user need to contact concerned STO or rntcp-helpdesk for resetting of password.

4. Tuberculosis Unit Level Users

Tuberculosis Unit level users have been created on the pattern tbu-ssdddtu where ss is RNTCP State Code and ddd is RNTCP District level RNTCP code and tu is RNTCP TB Unit level code.

In case, any Tuberculosis level user faces password related problem, then user need to contact concerned DTO or STO or rntcp-helpdesk for resetting of password.

For login operations, following need to be taken care of:

- User must have valid Username and Password.
- Software will display error in case username or password is not correct.
- In case of any exceptional error, it will display “Please contact Administrator”. In this case, user needs to send mail to the Administrator.
- Users will get the menu based on the role in which she/he has logged in.

Website: <http://nikshay.gov.in>

NIKUSHTH

This is the web based application for monitoring of National Leprosy Eradication Programme (NLEP).

Objectives:

- To design and develop a system for systematic data management of Leprosy patients to achieve the objectives of National Leprosy Eradication programme (NLEP)
- To enable ASHAs/ field executives in the field and doctors/ paramedical staff at Health Centres to deliver services in real-time, thereby reducing efforts, human errors and increasing efficiency and performance.
- To enable Health officials in monitoring and assessing the performance of users.
- To cater to the need of data collection, recording, reporting and indicators for analysis.

OPERATIONS

1. Suspect Record Management
2. Patient Record Management
3. Patient Treatment Record Management
4. Disability Prevention and Medical Rehabilitation
5. Patient Follow-up
6. Patient Relocation
7. Drug Stock Register
8. Queries and Indicators
9. Reports Contacts Tracing
10. Feedback/ Suggestions
11. Informative Content
12. Trail Log

COMPONENTS

➤ Web based application

- User: Sub Centres, Primary Health Centres (PHCs), Block, District, State & Centre
- Store, view data (online)
- Suspect & Patient Record
- Patient Treatment Record

- Drug Stock Register
- Queries, indicators and reports
- Updates and Reminders
- Contacts Tracing
- GIS Location Indicator

➤ **Android Based Application:**

- User: ASHAs/ field workers
- Suspect Record
- Patient Record View (offline).
- Pulse Date Reminders

➤ **Server side services**

- Synchronization between Android and web based application.
- Reminder messages to field executives and Patients.

Types of reports

Sl. No.	Type of Report
1	Pending Suspect as on selected date Report
2	District-wise yearly Report
3	Block Monthly Report-I
4	District Monthly Report-I
5	State Quarterly Report
6	Block Yearly Report
7	Urban Locality wise Yearly Report
8	Block Monthly Report-II
9	District Monthly Report-II

Indicators

Sl. No.	INDICATOR
1	% Grade II Disability
2	% cases developing grade II disability during the course of treatment
3	% child disability
4	Treatment Completion Rate for PB cases
5	Treatment Completion Rate for MB cases
Indicators for analysis of IEC	
6	% patients who are aware about symptoms of leprosy
7	% patients who are aware about symptoms of leprosy

Website: www.leprosy.gov.in (In Mozilla Firefox and not in Google window)

ASHA SOFT

What is ASHA Soft?

- It is a web-based software for online payment to their bank account and monitoring the performance.
- It will capture beneficiary wise details of services given by ASHA to the community.
- It will generate various reports to monitor the progress of the program.
- ASHA Soft is integrated with PCTS for name based reporting and verification of beneficiary

Why ASHA Soft?

- To ensure timely and transparent online payment to ASHAs
- To improve the system for effective monitoring their performance on all the parameters.

ASHA Soft REQUIRES

- Circular authorizing ASHA Soft
- ASHA claim forms for ASHAs
- ASHA Soft Program (NIC)
- ASHA Soft Manual for guidance
- Mechanism for data entry and verification
- Digital Signature Certificates for release of payments
- SMS Gateway
- Payment arrangements with Bank
- Reliable PCTS/MCTS database

Strengths of ASHA Soft

- No capital investment in any manner and at any level (Existing PC is used)
- Existing information Assistants/Computer operators used –No new HR hired
- Existing SMS Gateway is used...better used
- Existing banker can be made partner
- Utility of PCTS/MCTS, which in turn strengthens entry regime
- No need to compile information manually
- Informed decisions are encouraged

What information has been collected and fed in the default?

- Name
- Location/posting details
- Qualification
- Training status
- Mobile number
- Bank account details

3. MATERNAL DEATH REVIEW

Background Information

Each year in India, roughly 28 million women experience pregnancy and 26 million have a live birth. Of these, an estimated 67,000 maternal deaths and one million newborn deaths occur each year. In addition, millions more women and newborns suffer pregnancy and birth related ill-health. Thus, pregnancy-related mortality and morbidity continues to have a huge impact on the lives of Indian women and their newborns.

Maternal death is defined as the death of a woman who dies from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy or child birth or within 42 days of termination of pregnancy, irrespective of duration and site of the pregnancy.

Maternal Mortality Ratio (MMR) is the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 1,00,000 live births.

Maternal Mortality Ratio (MMR) in India has shown an appreciable decline. Levels of maternal mortality vary greatly across the regions, due to variation in underlying access to emergency obstetric care, antenatal care, anemia rates among women, education levels of women, and other factors.

Maternal Death Review (MDR) as a strategy has been spelt out clearly in the RCH – II National Programme Implementation Plan document. It is an important strategy:

- To improve the quality of obstetric care and reduce maternal mortality and morbidity.
- To generate evidence for determining interventions, to fill the gaps in service.
- To provide the data needed to feed into the national civil registration system for the computing of MMR.
- A commitment to Act upon the findings. Not for punitive action.

Avoiding maternal death is possible even in resource-limited countries, but the correct information on which to base maternal health programmers is required. Maternal death review is one of the oldest and the most documented. The importance of MDR lies in the fact that it provides detailed information on various factors at facility, district, community, regional and national level that are needed to be addressed to reduce maternal deaths. Analysis of these deaths can identify the delays that contribute to maternal deaths at various levels and the information used to adopt measures to fill the gaps in service. MDR has been conducted as an established intervention for the last few years by some states like Tamil Nadu, Kerala and West Bengal.

Different approaches for investigation of maternal deaths

1. Community based maternal death review (Verbal autopsy)
2. Facility based maternal death review
3. Confidential enquiries into maternal deaths
4. Surveys of severe morbidity (near miss)
5. Clinical audit

Government of India has decided to take up Community based maternal death review (CBMDR) and the Facility based maternal death review (FBMDR) which would help in identifying the gaps in the existing health care delivery systems, prioritize and plan for intervention strategies and to reconfigure health services.

1. Community-Based Maternal Death Review / Verbal Autopsy

Definition: Community based MDR using a verbal autopsy format is a method of finding out the medical causes of death and ascertaining the personal, family or community factors that may have contributed to the death of a woman. The verbal autopsy consists of interviewing people who are knowledgeable about the events leading to the death such as family members, neighbors and traditional birth attendants.

Community based reviews must be taken up for all deaths that occurred in the specified geographical area, irrespective of the place of death, be it at home, facility or in transit.

Requirements: Co-operation from the family of the woman who died and sensitivity is needed in discussing the circumstances of the death.

Advantages: Provides means to arrive at medical cause of death when a woman dies at home, allows both medical and non-medical factors to be explored and provides the opportunity to include the family's perspective on health services.

Disadvantages: Different assessors may arrive at different causes of death, deaths from indirect causes may be over-looked / under-reported.

Steps of community-based MDR

a) Notification

The ASHA/AWW/ANM will notify all women deaths in the age group of 15 to 49 years from her area by telephone to the BMO within 24 hour. The local panchayats and other relevant persons/ groups may also be encouraged to inform the BMO about women's deaths in their area.

The ASHA/AWW/ANM will fill up the format for primary informer (Annex 6) for all women's deaths (age 15-49) and send the format to the BMO within 24 hours. Format for primary informer gives information whether the death is a suspected maternal death or a non-maternal death.

Line listing of maternal deaths should be submitted to the BMO by the ASHA, using annex 4, by the 5th of every month. In case no death has occurred during the month, the ASHA has to submit a nil report. The ASHA/AWW/ANM should also ensure the availability of the respondents during the visit of the investigation team.

b) Investigation

Investigation of the maternal deaths will be done using Verbal Autopsy Format (annex 2). In section 11 of the format, narration on the various events which led to the death of the mother, should be explained in detail.

The Block Medical Nodal Officer (BMNO): is the MO in charge of the Block PHC. The BMNO is overall responsible for the MD review process at the block and will act as a supervisor for the investigation team.

Responsibilities:

- Appoint the ANM/LHV to visit the family of the deceased to verify whether or not it is a maternal or non- maternal death, after receiving annex 6 from the notifier.
- Report all suspected maternal deaths to the district DNO based on the report from the primary informant (by phone and by sending Format for Primary Informer (Annex6).
- Report suspected maternal deaths to the state nodal officer by telephone within 24hours.
- Maintain registers of all women deaths (15-49 yrs) (Annex – 5) & maternal deaths (Annex4).
- Assigns interview team to investigate and fills the first page of the Format for Verbal Autopsy (Annex 2). The cause of the death in Page 1 of Annex – 2 can be filled based on the findings after the investigation is completed.
- It is desirable that the BMO should be part of the investigation team. In his absence, he may nominate another medical officer from the block PHC to be a part of the team.
- Scrutinize filled up forms to ensure the form is complete and filled correctly.
- Prepare Case summary (Annex 3) for all the maternal deaths in consultation with the team which investigated and send it to the DNO along with the filled in investigation format (Annex 2), within a month of the date of notification.
- Conduct monthly meetings to review the whole process and take corrective actions at his level. Reporting system should be reviewed even if there are no cases in his block.
- The BMO would pay Rs. 50/- to the primary informant (only ASHA and AWW is eligible) and Rs 100/- per person for conducting the investigation in the field (subject to a maximum of 3persons)

Investigators: The investigators could be the Block Medical Officer (BMO)/ other Medical Officers (MO), Lady Health Visitor (LHV), Block Public Health Nurse (BPHN), Sector Health Nurse, Health supervisor, Nurse tutor or Auxiliary Nurse Midwife (ANM). The investigating team should ideally comprise of 3 persons; one for conducting the interview, one for recording and the other to co- ordinate the process. The investigators must be properly trained to communicate with bereaved families.

Responsibilities:

- To investigate the maternal death using the format for Verbal Autopsy (Annex2) within 3 weeks of notification.
- Make sure all relevant information is captured during interview. If not, a follow up interview may be required. If needed, with another respondent.
- Assist the BMO in preparation of Case summary (Annex3)
- Hand over the filled up Format for Verbal Autopsy (Annex 2) to the BMO for onward transmission to the District Nodal Officer (DNO) who will prepare a compiled Line Listing for Maternal Deaths (Annex 4) of all maternal deaths from all blocks.

2. Facility-Based Maternal Death Review

Definition: A qualitative, in-depth investigation of the causes of and circumstances surrounding a maternal death at a health facility; the death is initially identified at the facility level but such reviews are also concerned with identifying the combination of factors at the facility and in the community that contributed to the death, and which ones were avoidable.

Requirements: Cooperation from those who provided care to the woman who died, and their willingness to report accurately on the management of the case.

Advantages: Is a well-understood process in some settings, allows for complete review of medical aspects, provides a learning opportunity for all staff, and can stimulate improvements to medical care.

Disadvantages: Requires committed leadership at the facility level, does not provide information about deaths occurring in the community.

Facility Based Maternal Deaths Reviews will be taken up for all Government teaching hospitals, referral hospitals and other hospitals (District, Sub district, CHCs) where more than 500 deliveries are conducted in a year.

Steps of Facility-based MDR

a) Notification

- All Maternal deaths occurring in the hospital, including abortions and ectopic gestation related deaths, in pregnant women or within 42 days after termination of pregnancy irrespective of duration or site of pregnancy should be informed immediately by the Medical officer who has treated the mother and was on duty at the time of occurrence of death to the Facility Nodal officer (FNO)
- The FNO of the hospital should inform the maternal death to the District Nodal Officer (DNO) and state nodal officer by telephone within 24 hours of the occurrence of death. The Nodal officer of the hospital should complete the primary informant format Annex 6 and send it to the DNO within 24hrs of the occurrence of maternal death

b) Investigation

- Any maternal death which occurred in the hospital should be immediately investigated within 24hrs by the Medical officer who had treated the mother and was on duty at the time of occurrence of death using the Facility Based Maternal Death Review (FBMDR) Format (Annex 1) The form would be submitted under the guidance and approval of the FNO. The FBMDR format should be filled in triplicate, one copy would be retained by the FNO, one would be sent by the FNO to the DNO within 24hrs and the other to the Facility Maternal Death Review (MDR) committee of the Hospital.
- All medical officers in the facility must be aware about the MDR program and oriented on the use of the FBR form. All pregnant and postpartum women that were treated, and died, in other departments than the OB/GYN department, must also be reported and investigated.

Facility Nodal Officer (FNO)

- Inform the District Nodal officer and state nodal officer on the occurrence of maternal death in the hospital within 24 hours.
- Send the primary informant format (Annex 6) duly filled to the District Nodal officer within 24 hours
- To review the FBMDR format filled by the medical officer and approve it.
- Retain one copy of the FBR format with him/her, send one copy to the Facility based Maternal Death Review Committee and the other to the DNO within 24 hrs of the maternal death.
- He/ She have to prepare a case summary and send it to the Facility based Maternal Death Review Committee along with a copy of the case sheet.
- The case sheet should be numbered and have the patient name and registration number on each page.
- Will keep a register of all maternal deaths in the facility; line listing of maternal deaths (Annexure 4)
- Even if there is no death in a month, the facility should report that there was no death in that month. (Nil death report)
- He/ She will be the nodal persons for organizing the FBMDR Committee at the hospital.
- He/ She will be attending the FBMDR Committee meeting at the District level and also the Review conducted by the District Magistrate (DM).
- Another senior officer may be nominated in his/her absence.

Facility Maternal Death Review Committee (FMDRC)

Members of the FMDRC may be the following:

➤ **Teaching hospital:**

- Superintendent of the Hospital/ Other Administrative Head of the Institution
- Head Of Department (OBG dept)
- FNO (Obstetrician from the department): At least three members should be OBG specialists from the Dept
- One anesthetist
- One blood bank MO
- Nursing representative
- One physician

➤ **District/Other hospitals: Hospital superintendent**

- FNO (Obstetrician from the Dept): At least two obstetricians/MO in OBG department as members
- One anesthetist
- One blood bank MO
- Nursing representative
- One physician

➤ **FBMDR committee:**

- The FNO fixes the monthly meeting in discussion with the Hospital superintendent of the hospital

- Conducts monthly review meeting once in a month with the FBMDR format and case summary.
- Suggests corrective measures and steps to be taken to improve quality of care at the hospital
- Suggests steps to be taken at the District level and State level.
- Sends minutes of meeting to DNO along with the case summary prepared.

(FBMDR + CBMDR)

Monthly review meeting of the District MDR Committee chaired by Civil Surgeon and convened by District Nodal Officer every month on a prefixed date.

Monthly review meeting chaired by D.C., convened by the Civil Surgeon and assisted by the District Nodal Officer (2 relatives of the deceased to attend).

3. “Near Miss” Review

Definition: The identification and assessment of cases in which a pregnant woman survives an obstetric complication; there is no universally acceptable definition for such cases and it is important that the definition used be appropriate to local circumstances to enable local improvements in maternal care.

Requirements: Good-quality medical record system, a management culture where life-threatening events can be discussed freely without fear of blame, and a commitment from management and clinical staff to act upon findings.

Advantages: A “near-miss” may occur more frequently than a maternal death, it is possible to interview the woman herself during the review process, and can reduce the likelihood of future maternal deaths through quality improvement.

Disadvantages: Requires clear definition of severe maternal morbidity, selection criteria are required for settings with a high volume of life-threatening events.

MDR at District Level

At district level there will be two review meetings, one under the chairmanship of the CMO, second led by the District Magistrate.

District Maternal Death Review Committee

- The Chief Medical Officer (CMO) is mainly responsible for the Maternal Death Reviews at the District level. Both facility and community based reviews would be taken up at this level.
- The District CMO should form a Maternal Death Review Committee. Preferably, the District CMO can utilize existing quality assurance committee of the district or a new committee could be formed at the district level for MDR.
- The existing quality assurance committee or a newly formed committee should have following members: -
 - CMO/CS(chairman)

- DNO(member secretary)
- ACO
- Head of Department of Obstetrics & Gynecology (teaching hospital/district hospital)
- Anesthetist
- Officer in charge of blood bank/blood storage center
- Senior nurse nominated by the CMO/CS/DPHNO
- MO who had attended the case in the facility should be invited

The district level nodal officer convenes the meeting of the committee under the chairmanship of CMO/CS/ACO once every month and will put up for review by committee all maternal death reports received in the last month.

Responsibilities of CMO

- Ensure the reception of all formats (facility and community) every month
- Review all the maternal deaths from both facility and community
- Hold monthly review meetings and recommend corrective measures.
- Select a few cases for review by the DM. Ensure participation of the family members. Selection of cases for review by DM, based on specified criteria (more deaths in one particular place, same type of deaths, unwanted referrals) in consultation with DM
- Conduct quarterly review meetings with analyzed data and process indicators identified.
- Find means of sharing the district level data from the verbal autopsy with the communities to create awareness and initiate action at village level.
- Facilitate, through the DNO, the monthly review meeting with the District Magistrate (DM), and send minutes of both meetings (District MDR committee meeting and the meeting with DM) to state level.
- Facilitate the data entry and analysis at the district level (including HMIS).

The minutes of the meeting will be recorded in a register. The corrective measures will be grouped into 3 categories with timelines:

- Corrective measures at the community level
- Corrective measures needed at the facility level
- Corrective measures for which state support is needed

District Nodal Officer (DNO)

The nodal officer is responsible for taking up the entire review process and follows up at the district level. The CMO has to provide necessary support to the District Nodal Officer for taking up the process.

Responsibilities

- Supervise MDR implementation in the district - both at facility and community level.
- Receive notification of all suspected maternal deaths from the BMO and maternal deaths from the nodal officer of the hospital (by phone and by Annex6)
- Receive investigation format and case summary of CBMDR from the blocks and FBMDR from the hospitals.
- Create a combined Line-listing of Maternal death (Annex 4) based on the case summary formats from both facility and community from all blocks
- Prepare a compiled case summary, when applicable

- Coordinate the District MDR committee meeting and the review meeting with the district magistrate(DM)
- Arrange to bring two relatives of the deceased to attend the review meeting with DM. Only relatives who were with the mother during the treatment of complications may be invited for the meeting.
- Paying Rs. 200/- per person to the relative of the deceased person who attends the DMs meeting. (subject to a maximum of 2 persons only)
- Ensure that the training of the block level interviewers and the BMO have taken place
- Ensure availability of funds for payment of incentives
- Facilitate the printing of formats by the District Health Society (DHS) (forms used at all levels) and ensure its availability at blocks and facilities.
- Represent the district in state level review meetings
- Prepare the minutes of the District MDR committee meeting and the meeting with the DM
- Follow up the recommendations/corrective actions at district, block and facility level
- Orientation to the Medical Officers of the hospital on use of FBMDR formats

MDR review meetings with the District Magistrate

All the Maternal Death Reports compiled by the District MDR Committee will be put up to the District Magistrate, who will have the option of reviewing a sample of these deaths, which will be representative of deaths occurring at home, at facilities and in transit.

This committee should have the following members:

- Chair: District Magistrate
- CMO
- DNO
- Facility based nodal officers
- FOGSI
- IMA
- The close relatives/friends who were with the deceased mother during the time would be invited for the meeting, as well as the service providers who had attended on the case.

Process of the meeting

The relatives of the deceased will first narrate the events leading to the death of the mother in front of the DM and the service providers who attended the deceased mother. The case history of each of the selected maternal deaths will be heard separately. After the deposition and getting clarifications from the relatives they will be sent back. Then the various delays, the decision making at the family, getting the transport and institutional delays would be discussed in detail. The outcome of the meeting will be recorded as minutes and corrective actions will be listed with time line to prevent similar delays in future.

Outcome

- To institute measures to prevent maternal deaths due to similar reasons in the district in future
- To sensitize the service providers to improve the in-accountability

- To find out the system gaps including the facility level gaps to take appropriate corrective measures with time-line
- To allocate funds from the district health society for the interventions
- Take necessary actions both with health and other allied departments and review action taken
- Liaise with the state on the recommendation made by the District level committees.

Activity	Time line
Reporting death of women (15-49 years) by ASHA/other person to the Block PHC MO	Within 24 hours of occurrence of death by phone
Reporting death of woman by Block MO to the DNO	Within 24 hours of occurrence of death by phone
Community based investigation	Within 3 weeks of occurrence of death
Submission of report by Block PHC MO/facility MDR Nodal MO to DNO in the prescribed form	Within 4 weeks of occurrence of death
Reporting deaths of women by Block MO/ Nodal Officer of Facility to the DNO	Within 24 hours of occurrence of death by phone
Conduct of facility based review meetings and preparation of district MDR report for all deaths in district by the District committee (chaired by the CMO)	Every Month for the deaths reported in previous month.
Conduct of MDR meeting chaired by District Magistrate/Dist. Collector	Once in a month

MDR at State Level

- The overall responsibility of the Maternal Death Review process lies with the state. The key steps to be taken by the state are:
- Nomination of the state nodal Officer (member of the Quality Assurance (QA) Cell/any other person)
- Formation of a state level taskforce.

State Nodal Officer (SNO)

Responsibilities

- Collect relevant data on maternal death from the district and carry out detailed analysis.
- Nominate the district level nodal officers.
- Facilitate the preparation of an annual maternal death report for the state and organize a dissemination meeting to sensitize the various service providers and managers. The annual report may contain typical maternal death case studies which may be used during the training of medical and paramedical functionaries.

State Level Taskforce (SLF)

The State level task force will be formed headed by Principal Secretary Health and Family Welfare, Mission Director SHS, Senior Obstetrician of the Medical College Hospital, IMA/FOGSI and any other members nominated by Government.

Responsibilities

- The State Level Task Force will meet once in 6 months under the chairmanship of Principal Secretary Health and Family Welfare to review data and minutes sent from district level, discuss the actions taken on the minutes of the last state level meeting and make recommendations to Government for policy and strategy formulations.
- Share operational issues /feedback with GOI.

Current Challenges and Issues in Implementation of MDR Process

- Under-reporting (only 17.6% of total expected deaths reported).
- Quality of maternal death reviews at district/facility level
- Focus on high case load facilities in high mortality district—need to prioritize on constitution of FBMDR Committees at High Case Load “Delivery Points”
- Capacity building of health care providers and community health workers

KEY POINTS TO REMEMBER

- Maternal death is defined as the death of a woman who dies from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy or child birth or within 42 days of termination of pregnancy, irrespective of duration and site of the pregnancy.
- Different approaches for investigation of maternal deaths
 - Community based maternal death review (Verbal autopsy)
 - Facility based maternal death review
 - Confidential enquiries into maternal deaths
 - Surveys of severe morbidity (near miss)
 - Clinical audit
- Community based reviews must be taken up for all deaths that occurred in the specified geographical area, irrespective of the place of death, be it at home, facility or in transit.

4. CHILD DEATH REVIEW

Background

Reducing infant mortality is one of the key goals under NHM. Multi pronged, evidence based strategies have been adopted in the national programme to prevent neonatal, infant and child deaths. The infant and under five child mortality has shown a steady decline over the last three years. However the progress is not uniform across the states. Moreover the decline in neonatal mortality is slow and has not kept pace with the overall decline in child mortality. For specific interventions to be made, the medical and systemic causes leading to mortality in newborns and children < 5 years within a particular geographic area and populations must be known.

It is also essential that the annual planning process in districts and states takes into account the local context and implementation of key child health strategies are prioritized based on local morbidity and mortality patterns. This is possible only when a special effort is made to investigate and record the sequence of events leading to child deaths and inferences are drawn from the data generated locally. Such an analysis should guide the programme managers at all levels to recognize the key gap areas for service delivery and to institute corrective measures.

What is Child Death Review?

Child Death Review (CDR) is a strategy to understand the geographical variation in causes of child deaths and thereby initiating specific child health interventions.

Analysis of child deaths provides information about the medical causes of death, helps to identify the gaps in health service delivery and social factors that contribute to child deaths. This information can be used to adopt corrective measures and fill the gaps in community and facility level service delivery. With uniform CDR process and formats across the states, information can be compared over a period of time and common factors identified and addressed through the national programme. This contributes to overall improvement in quality of care and reducing child mortality.

Data on causes of neonatal and child deaths are also useful for health planners, administrators, and medical professionals to evaluate trends in causes of mortality over time and thus assess the impact of the on-going health programmes and to make a decision on allocation of resources for different strategies to prevent and manage neonatal and childhood illnesses.

Definitions*

Neonatal Deaths: Neonatal deaths are deaths occurring during the neonatal period, commencing at birth and ending 28 completed days after birth.

Post-Neonatal Deaths: Deaths occurring from 29 days of life to less than one year are called post-neonatal deaths.

Infant Deaths: Deaths of children less than 1 year of age.

Child Deaths: Deaths of children less than 5 years of age.

Still Birth: Still birth is the birth of a new born after 20th completed week of gestation, weighing 500gm or more, when the baby does not breathe or show any sign of life after delivery.

*Working definitions for the conduct of CDR

Key Steps in Child Death Review

Children in the age group 0-5 years will be included in the review. All deaths in this age group will be reported irrespective of the place it takes place: at home, in health facility or in transit. The review processes will remain the same for all children; however the details to be investigated will vary in neonates (0-28 days) and children (29 days-5 years).

Child Death Review will be of two types:

1. Community Based Child Death Review (CBCDR)
2. Facility Based Child Death Review (FBCDR)

Guidelines for Community Based Child Death Review (CBCDR)

Community based reviews are undertaken for deaths that occur in the specified geographical area, irrespective of the place it takes place: at home, in health facility or in transit.

Steps for CBCDR are as follows:

- Step 1: Notification of child death
- Step 2: Investigation of child death
- Step 3: Data transmission
- Step 4: Analysis of the data followed by making suitable action plans from it – this step is common for both CBCDR & FBCDR.

Step 1: Notification of child death

- **Primary Informant:**
 - In rural areas **ASHA** will be the primary informant of child deaths within her area. Others who could also notify the death are: AWW, ANM, Panchayat member and Panchayat Secretary.
 - In urban areas, Link worker, AWW or any other person employed in the municipal wards can be engaged as the primary informant.
 - Each state should clearly specify the primary informant/s for reporting child deaths in rural and urban areas respectively.
- **Process of notification:** ASHA is to follow a dual reporting system wherein she informs the ANM and the Taluka health Officer (THO) **within 24 hours** of receiving information either through phone or SMS. ANM, when she gets to know about the child death directly or through ASHA, reports to the THO within 24 hours by SMS/Phone call.

In case of SMS, text of the message may read as follows:

CDR-Name/Baby of (name of the baby/name of the mother), son/daughter of (name of the father), Age (age of the deceased), Resident of (name of the block/tehsil) (name of the village), Date and time of death.

(Eg: CDR-Manju, D/O Sh. Nathu Singh, 2 months, Chalakkudy block, Koratty village, 01-07-2014 at 5.00 PM.)

If the SMS/Phone facilities are not yet established in the district, informant will adopt a suitable mechanism to ensure that the death is reported to THO.

All states must aim to establish an automated system which ensures that the SMS is transferred into a server data base of line-lists, by date and region. Dedicated call centre for patient transport are now functional in many states and they can be used for centralised reporting of all under five deaths in the district. Information from call centre can then be forwarded by the call centre to THOs on daily basis and to the District Nodal Officer on weekly/monthly basis. Until such a system is in place the THO must ensure that the messages he receives are recorded in a register kept specifically for the purpose at the block PHC.

ASHA (and AWW where ASHA is not available) will visit the family of the deceased child and fill the **Notification Card (Form 1)** in duplicate. One copy of the notification card will be submitted to the ANM and the other handed over to the family. This process has to be completed **within 48 hours** of the child death.

Informant, who contacts family thereafter, will first enquire whether someone has already given them the Notification Card. If yes, then s/he would address bereavement issues, offer support and leave.

THO is required to maintain line-listing of all deaths in his/her area. The line list will be transmitted to the District Nodal Officer (DNO) at the end of each month.

- **Honorarium & mobility support:** Where ASHA is the primary informant, she may be given Rs. 50/- per child death reported. Incentives will be built into the state PIPs.
- **Means of verification:** Reporting of the child death by ASHA or any other primary informant can be confirmed by the Notification Card retrievable from the family by the concerned ANM.
- **Maintenance of records:** The Notification Cards should be maintained as records in the Sub centre.

Step 2: Investigation of child death

A. First Brief Investigation

- First Brief Investigation will be conducted for all child deaths.
- First brief investigation will be done by the ANM/equivalent urban health worker of the area, by interviewing the parents/close caregivers of the deceased, who were present at the time of death. ASHA would accompany the ANM for First Brief Investigation.
- Format: First Brief Investigation Report (FBIR) (Form 2) will be the format used to record the basic information about the child's overall health status and narrative account of the illness and treatment history. ANM will record the relevant information in the format including the cause of death based on the interpretation of the information shared by the parents/ caregivers.
- Honorarium & mobility support: ANM/ equivalent urban health worker may be given Rs. 100/- per child death investigation carried out by her/him.
- Time period: The First Brief Investigation should be done within 2 weeks after the notification of death and report should be submitted to THO, by one month of notification of death.

- Maintenance of records: FBIRs of all child deaths in the block should be maintained as records at the office of THO.
- Transmission of information: Key information regarding all child deaths will be compiled from the FBIRs in *Block and District Level Line List* (Form 5a) every month. Data will be transferred by the THO to the DNO electronically for further compilation from all blocks and for data analysis. The DNO is the person designated by the State as the overall 'in charge' for the planning and implementation of the CDR process in the district.

B. Detailed Investigation

Detailed investigation is undertaken by performing a Verbal Autopsy. Verbal Autopsy is an investigation of chain of events, circumstances, symptoms and signs of illness leading to death through an interview of the family/relatives of the deceased.

- Line listing: A line list of all deaths that have taken place during the month in a block will be prepared in the office of the THO. The line list will include all those deaths for which FBIR has been submitted by the ANM (Form 5a should be used to prepare the Line list). The names are to be sequenced in the line list according to the date of death as recorded in the FBIR. Line list will serve as the sampling frame for the selection of cases for detailed investigation.
- Sampling: Detailed investigation will be carried out only in selected cases of child deaths and not for all cases. A minimum of 6 cases per block per month will be investigated; two each from neonatal (up to 28 days of life), post-neonatal (29 days -1 year) and children (1-5 years) age groups.

Following guidelines may be followed by the THO for drawing equity-based sample every month:

1. Make separate line list for each category of death (neonate, post neonate and 1-5 years).
2. From the line list, select deaths from different PHCs. Do not include more than one death from any age category occurring in a PHC area, unless there are no deaths reported from other PHCs.
3. While selecting deaths from a PHC, select from different sub centres, following the same principle as above so as to have wider representation.
4. Give priority to common causes of deaths in each category; for example possible asphyxia, infection, prematurity (neonatal deaths), pneumonia, diarrhea, and fever (post neonatal and childhood).
5. While selecting deaths in subsequent months look at the selections of previous months to avoid repetition of the geographic areas as well as causes of deaths.
6. Prioritize blocks with underserved and marginalized population.
7. If there is clustering of deaths in certain population groups or blocks or village in a certain month, select cases from this cluster in order to identify if there are common underlying or direct causes/factors.

In blocks having less than 6 deaths each month, all cases may be investigated.

- Formats: Verbal Autopsy Forms are used for recording structured information and narrative for determining the cause specific mortality by sex and age. As the causes of death in the neonatal period and in infancy/childhood are very different, two forms have been developed

for this purpose. Investigation details of selected neonatal cases will be recorded in Verbal Autopsy Form: Neonatal Deaths (Form 3a) and all others selected child deaths in Verbal Autopsy Form: Post Neonatal Deaths (Form 3b).

In addition, “Social autopsy” is carried out using the format provided as Form 3c. Social autopsy refers to an interview process aimed at identifying social, behavioural, and health system contributors to neonatal and child deaths. It is combined with the verbal autopsy interview to establish the social and systemic causes of death.

- Investigation Team: The investigating team should comprise of at-least 2 persons, one for conducting the interview and the other for recording. In the team one will be from medical and the other from non-medical background.

The team should include at least one of the following medical persons: PHC Medical Officer, Public Health Nurse, Lady Health visitor (LHV), Staff Nurse or Nursing Tutor.

The non-medical persons could be the Block Supervisor, ASHA Facilitator, NGO facilitator or any other person specified by the state.

States/districts can involve specialists from medical colleges, civil society organizations and the PRI. States/districts may also assign independent teams, for example from medical colleges, for ensuring quality reporting & investigation.

The investigators must be adequately trained to communicate with bereaved families, and to elicit and record appropriate responses.

The THO is responsible for the conduct of detailed investigation (Verbal Autopsy) in selected cases and ensuring that the reports are submitted timely to his/her office. Reimbursement of travel costs and honorarium for conducting the Verbal Autopsy will be cleared only after the office of THO certifies that report has been submitted within the acceptable time frame and is complete in all respects.

- Time period: Detailed investigation is to be undertaken within 1-2 months of notification of death.
- Honorarium & mobility support: A sum of Rs. 150/- can be given to each member of the investigating team for each death investigated. In addition upto Rs. 100/- may be provided to cover the cost of travel to the household and back, depending on the distance to be travelled.
- Maintenance of records: One copy of the Verbal Autopsy Form of all child deaths investigated in the block will be kept on record at the office of the THO. The original format will be sent to DNO within one week of receiving the report.
- Transmission of information: The information from all the blocks will be compiled by the office of the DNO and forwarded to the SNO each month in *District Level Reporting form* for verbal autopsies conducted for Child Deaths (0-5 years) (Form 5b).

For the purpose of providing necessary feedback at the district level, detailed analysis of the Verbal Autopsy forms will be undertaken by the office of the DNO. Data Manager at the district level will enter the CDR information from the Verbal Autopsy forms. Two medical officers trained in ‘assigning the cause of death’ will assist the DNO in the final diagnosis.

Reports prepared by the office of the DNO will be shared every month in the meeting of the District Child Death Review Committee (DCDRC).

Step 3: Data Transmission

Block level

- THO office will receive notification about the occurrence of death from the ASHA/ANM within 24 hours of death by phone.
- In response to the notification, the THO will inform the ANM to proceed with the First Brief Investigation. THO will receive the FBIRs for all child deaths in the area from the ANM within one month of death.
- The office of the THO will prepare a line list of all child deaths reported by ANMs in the block every month. In addition, information compiled from FBIRs sent by ANMs into Form 5a will be sent to the DNO on the 5th day of next month.
- The Block Data Manager/Block Data Entry Operator will enter information about the deceased along with the probable cause of death from all the FBIRs into the computerised Form 5a. It will also be specified in the same form which cases have been selected for detailed investigation.
- Reports must be sent to the District every month from the block, even if there are no deaths (report as NIL).
- Most importantly the deaths reported from the district/state through the CDR must also be reported in the HMIS, starting right from the Sub centre level.
- The THO will select the sample for detailed investigation (Verbal Autopsy) based on the data from the First Brief Investigations and ensure that this is communicated to the designated teams and the Verbal Autopsies are undertaken. A copy of the Verbal Autopsy form will be sent to the DNO within a week of receiving the form making sure that it is complete in all respects.
- All the verbal autopsies of the month should reach the DNO within 1 month of line listing/case selection.

District level

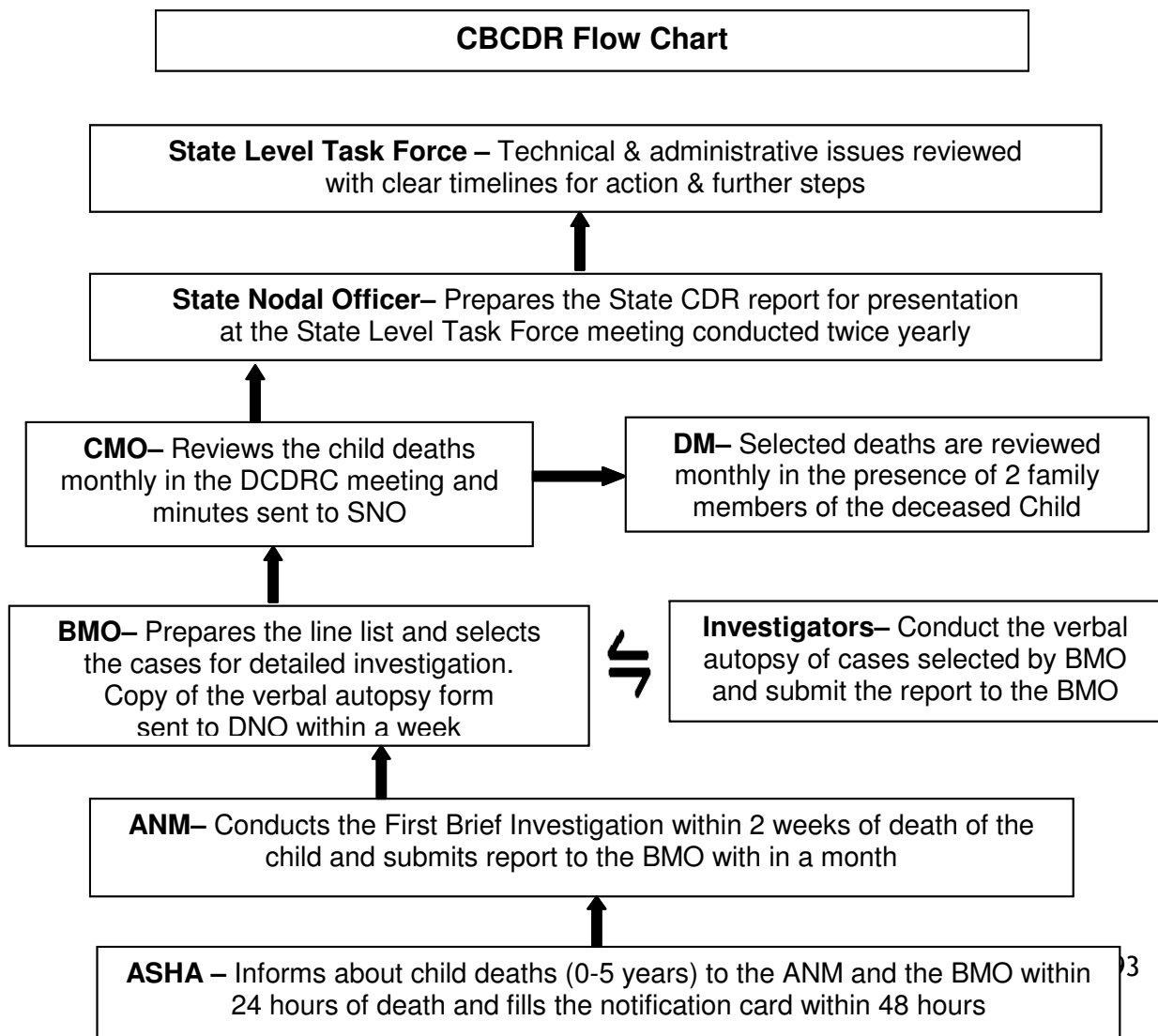
- The DNO, through his/her office (and with support from Data Managers/Data Entry Operators) will get all the parameters from the Verbal Autopsy forms entered into the formats including the details of the deceased, nature of illness and sequence of events leading to the child death.
- In addition, the Verbal Autopsy forms will be reviewed and the cause of death is assigned by two Medical Officers in the district who are trained in assigning the cause of death independently. Where feasible, capacities to assign the cause of death should be developed at the block level itself. Detailed analysis will be undertaken regarding the profile of children who died in the month/quarter and the levels of delay, if any. Medical cause of death is to be ascertained based on the ICD 10*.

BNOs & DNOs shall be assisted in this process by the doctors from CHC/District Hospital (DH) or the faculty of medical colleges or any other local agency which has the expertise to review the forms and assign the medical cause of death as well as undertake the analysis of social factors and delays associated with the death. A detailed District Report should be prepared.

- The office of the DNO will provide key information from the Brief and Detailed investigations undertaken in the entire district through forms 5a, 5b and send it to the office of the SNO.
- In addition, a District Child Death Review Report will be prepared for presentation in the DCDRC based on the detailed analysis. Subsequent to the DCDRC meeting, the DM will review a sample of cases (3) submitted to him by the DNO/CMO. Detailed report prepared from the analysis of Verbal Autopsy forms should also be shared with the state.
- The DNO must ensure that all the deaths reported through this system are also fed into the HMIS at appropriate levels: for example facility based formats must reflect the deaths taking place there.

State Level

- The Office of the SNO will compile reports from all the districts for onward transmission to the national level in the **State level Reporting Form (Form 5d)**, and will forward it **quarterly** to the national programme managers in the Ministry of Health and Family welfare.
- The CDR Reports from all the districts will be reviewed and a consolidated **State CDR Report** is prepared for presentation in the **State Level Task-force** meeting and disseminated to key stakeholders.



GUIDELINES FOR FACILITY-BASED CHILD DEATH REVIEW

Facility based reviews will be taken up in all government teaching, referral hospitals and First Referral Units (District, Sub district, Area Hospitals/Taluq Hospitals) that conduct **more than 500 deliveries per year** (excluding institutions below block level).

Steps for FBCDR are as follows:

- **Step 1: Notification of child death**
- **Step 2: Investigation of child death**
- **Step 3: Data transmission**
- **Step 4: *Analysis of the data followed by making suitable action plans from it*** is common for both CBCDR & FBCDR and is explained at the end of this chapter

Step 1: Notification of child death

All infant deaths occurring in the hospital should be informed immediately by the Medical Officer/Specialist on duty (at the time of death) to the Facility Nodal Officer (FNO) who could be the Paediatrician/Medical Superintendent/Principal Medical Officer/CHC In-charge. The Duty Medical Officer (DMO) shall act as the Primary Informant and fill in the *Notification Card* (Form 1) and send it to the office of the FNO within 24 hours of death. The office of the FNO should inform the child death to the DNO within 48 hours of death.

Step 2: Investigation of child death

Detailed investigation should be conducted in all cases of child deaths taking place in a hospital. The Facility Based Neonatal & Post-Neonatal Death Review Forms (Forms 4a & 4b) should be filled for the child death (depending on the age category) by the DMO. The Treating Medical Officer (Doctor under whose care the child was primarily admitted in the hospital) will assign the medical cause of death and add any other information that s/he has regarding the social factors and delays associated with the death. Medical cause of death is to be ascertained based on the ICD 10 (Annexure - II) and recorded in the Death Certificate. It is possible that the Treating Medical Officer and the Doctor certifying death (DMO) is the same person. In such a situation s/he will fill in the complete form.

The FNO should support the Medical Officers in completing these processes. The form should be filled within 48 hours of death and in duplicate.

Subsequently, FNO will review the FBCDR form for completeness and also corroborate the information with the available medical records. S/he will then approve it for onward submission to the DNO. One copy of the form will be sent to the DNO **within one month** of death and the second copy retained at the hospital for review by FBCDR committee.

All children treated and died in departments other than the Paediatrics department must also be reported and investigated.

Step 3: Data Transmission

- The office of the FNO will prepare a line list of all child deaths (0-5 years) that have taken place in the hospital during the month. The line list and key information will also be

electronically transmitted to the DNO for information and compilation in the Facility Level Reporting Form (Form 5c).

- The FBCDR forms will be directly received from all the health facilities in the district at the office of the DNO. These reports will also be compiled and analysed at the district level and key findings and recommendations will be included in the report to be presented in the DCDRC meeting.
- Effort should also be made to generate the Facility Specific CDR Report so that the main causes of death and delays at various levels can be identified. Facility specific issues may emerge and can be addressed locally. The report is also likely to provide a trend of the neonatal and childhood illnesses occurring locally (in the district or in neighbouring districts) and will facilitate building capacities and systems to manage these conditions better in the future.

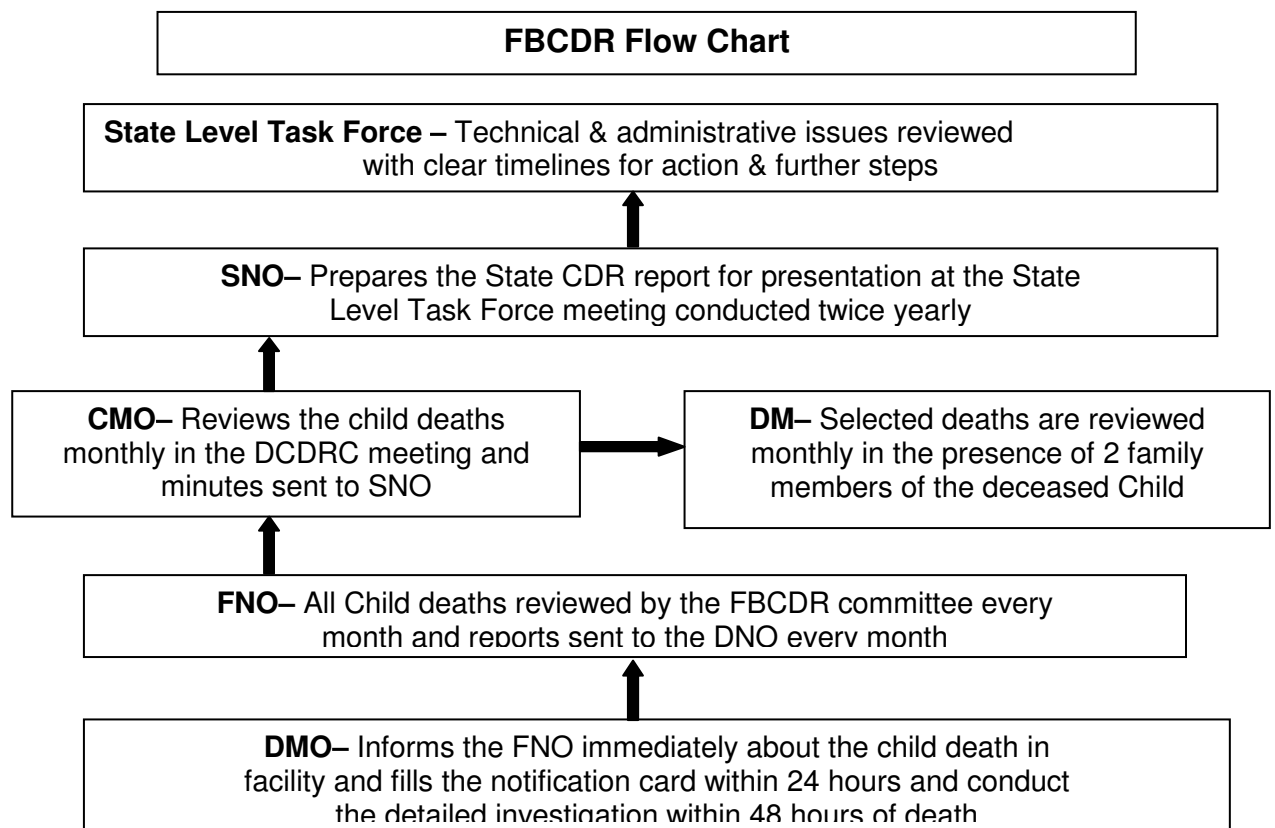


Table 1: CDR summary

The table below summarises the various formats to be filled, the persons responsible, the process of onward transmission of information and other important details.

Forms	Filled by	Transmitted to	Comments
1. Notification card - CBCDR	Primary informant (which includes ASHA)	Dual reporting to ANM and Block Medical Officer or to centralised call centre	May use mobile, landline, or SMS facility; all deaths 0-5 years to be notified, irrespective of where the death took place
Notification card - FBCDR	Primary informant - DMO	Facility Nodal Officer	
2. First Brief Investigation format (FBIR)	ANM or alternative health worker identified by the district/ state	Block Medical Officer	To be filled for all child deaths, irrespective of where the death took place
Verbal autopsy forms			
3a. Neonatal Death (0-28 days)	Detailed Investigation team comprising of one medical & one non-medical person; team to be assigned by the BMO	District Nodal Officer	VA conducted for selected cases only; cases to be selected by BMO from the line list Only one VA format to be filled per case (either neonatal or post neonatal) Social autopsy format to be filled for all VAs conducted One copy of the VA form to be maintained at BMO office Assign cause of death.
3b. Post Neonatal Death (29 days-5 years)			
3c. Social Autopsy Format			
Facility Based Death review forms			
4a. Neonatal Death (0-28 days)	DMO; with support from Facility Nodal officer	District Nodal Officer	All child deaths in the identified health facilities that conduct more than 500 deliveries per year (excluding institutions below block level) to be investigated. One copy to be maintained at facility level
4b. Post Neonatal Death (29 days-5 years)			
Reporting formats			
5a. Block and District Level Line List	Block Medical Officer District Nodal Officer	District Nodal Officer State Nodal Officer	Data will be entered into appropriate formats by Data Entry Operators & supervised by Block/District Data Managers Data may be entered online when such facility is made available by State/Centre
5b. District Level Reporting Format for detailed investigations	District Nodal Officer	State Nodal Officer	
5c. Facility Level Reporting Format	Facility Nodal Officer	District Nodal Officer	
5d. State Level Reporting Format	State Nodal Officer	Programme Officer (MOHFW)	

Child Death Review Committees

A. FBCDR Committee

FBCDR committee may have the following members:

- **Teaching Hospital:**
 - Hospital superintendent/other administrative head of the institution
 - Head of the Pediatrics Dept..
 - FNO (Pediatrician)
 - At least two members from the Pediatrics Dept.. (Pediatrician/MO posted in the dept..)
 - One Anesthesiologist
 - Nurse posted in Pediatrics Dept.

District/Other Hospitals:

Hospital superintendent

FNO (Pediatrician)

Pediatrician/Medical officer posted in the Pediatrics

One Anesthesiologist

Nurse posted in Pediatrics

FBCDR Committee:

- The committee meets once every month. FNO fixes the meeting in discussion with the Hospital superintendent
- The main focus of the review is to check the clinical protocols and the line of treatment followed
- FBCDR formats and case summary will be discussed in the review meeting
- Suggests corrective measures and steps to be taken to improve quality of care at the hospital
- Suggests steps to be taken at the District level and State level.
- Sends minutes of the meeting to the DNO along with the case summary prepared.

B. District Child Death Review Committee

The DNO will be selecting a total of 6 cases (including both CBCDR and FBCDR) for review at the DCDRC meetings. He will take into account the following criteria for selecting cases.

1. Cause of death
2. Place of death (home, facility, in transit)
3. Age (neonatal, post-neonatal, child)
4. Sex
5. Children from vulnerable groups
6. Clustering of cases (if any)

The District MDR Committee should be assigned the responsibility of reviewing Child Death Reports as there are inter-linkages between maternal and neonatal deaths and the indirect causes are likely to be the same in many cases. Additional members may be brought on the same committee for review of child deaths and the following composition is suggested:

Members

1. Chief Medical Officer/Civil Surgeon (Chairperson)
2. Additional Chief Medical Officer
3. District Nodal Officer (Member Secretary)
4. Paediatrician
5. Obstetrician/Gynaecologist
6. Anesthesiologist
7. Senior Nurse nominated by the CMO/CS
8. Medical Officer who had attended the case in the facility
9. District Project Officer for ICDS
10. Representative/s from recognised professional bodies (Indian Academy of Paediatrics, National Neonatology Forum, IAPSM)
11. Experts from medical college/development agency (if present in the district)
12. Any other official or person deemed important for providing specific technical inputs (at the discretion of the Chairperson)

All FNOs and BMOs should be invited to attend this meeting.

The CDR meeting should be conducted simultaneously with the MDR meeting, which is supposed to take place every month, with the purpose of reviewing the causes and trends of child deaths in the district. The Action Taken Reports, the minutes of the last meeting should be reviewed by the Chairperson.

The DCDRC should undertake the task of identification and discussion on the modifiable factors contributing to child deaths at the community and facility level and come up with recommendations for short term, medium term and long term implementation. The DNO should bring together the recommendations made by members of the DCDRC and convert it into an actionable plan.

At the end of the DCDRC meeting, CMO in consultation with the DNO will select 3 cases (including CBCDR, FBCDR) for review by the District Magistrate.

C. District Magistrate (DM) review meetings of CDR

A sample of child deaths reviewed by the DCDRC will be put up for the DM review. This sample will be chosen in accordance with the selection criteria explained before. The DM has the option to select any case which is reported in a month and also to review more than 3 cases if he chooses to.

This review will be attended by the following members:

1. District Magistrate – Chairperson
2. Chief Medical Officer
3. District Nodal Officer
4. Facility Nodal Officers
5. IAP representative

The parents/relatives (max. 2 persons) of the deceased child would be invited for the meeting by the DNO. The service providers (in case of FBCDR) who had attended the child will also be

called for this meeting. To cover the expenditure incurred by the family of the deceased child on account of travel to the district headquarters a sum of Rs. 200/- should be given to the family.

The parents/relatives of the deceased child will first narrate the events leading to the death of the child, in front of the DM and the service providers who attended the deceased child. The case history of each of the selected child deaths will be heard separately. After the deposition and getting clarifications from the relatives they will be sent back. Then the various delays - the decision making at the family, getting the transport and institutional delays would be discussed in detail. The outcome of the meeting will be recorded as minutes and corrective actions will be listed with a time line to prevent similar delays in future.

The DM will try to ensure the release of necessary resources and providing an enabling environment for implementation of the key recommendations emerging from the meeting. In addition the DM should be able to promote inter-sectoral co-ordination in order to bridge the gaps falling in non-health sectors such as nutrition, safe drinking water, sanitation and so on.

State Level Task-force

The State Level Task-force constituted for the review of maternal deaths (with additional members co-opted as listed below) will review the CDR process. The meeting of the task-force is to be convened every 6 months. The task-force may review both maternal and child deaths at the same time or schedule it on different days. The interlinkages between the maternal and neonatal causes of death should be explored and a common set of recommendations be made to prevent them. The data from the districts compiled at the state level should be reviewed and trends observed and analyzed. DNOs should be invited to attend this meeting. The Action Taken Report on the Minutes of last meeting of the State Task-force should be presented by the SNO. Minutes of the meeting should be put on record. Key decisions and action points should be circulated to all stakeholders in various departments with clear time lines for action and steps forward.

Members:

1. Principal Secretary Health & Family Welfare
2. State Mission Director NHM
3. Commissioner Health
4. Director General of Health Services
5. Deputy Director/Director Child Health under NHM
6. State Nodal Officer
7. Pediatricians and Public Health Experts from State Govt. and Private Medical Colleges (max. 3)
8. Obstetric Specialists from State Govt. and Private Medical Colleges (max.1)
9. State ICDS Officer
10. Deputy Director/Director Nursing
11. Deputy Director/Director MSD (materials/supplies and disposables)
12. IAP representative
13. Any other expert, official, person deemed important for discussion on a particular issue (at the discretion of the Chairperson)

ROLES AND RESPONSIBILITIES OF NODAL PERSONS

A. Block Nodal Officer (BNO)

The **Block Medical Officer** should be designated as the Block Nodal Officer for the CDR by an office order issued by the District CMO. The BNO will be responsible for the CDR process at the block, and will also act as a supervisor for the investigating teams carrying out the verbal autopsy.

Roles and Responsibilities

1. Maintain the line-list of all child deaths in the block
2. Select cases for detailed investigation; delegate teams for conducting the Verbal Autopsy; ensure the timely reception of all formats every month
3. Ensure the quality of data and timely reporting to the district
4. Transmit data to the district in the agreed time frame and formats
5. Participate in the meetings of the DCDRC and present the block report (when asked to do so); follow up on specific recommendations pertaining to the block

B. Facility Nodal Officer (FNO)

The Facility Nodal Officers will be designated by the CMO. S/he can be the Paediatrician (preferable), or Medical Superintendent of the hospital.

1. Inform the DNO about the occurrence of child death in the hospital within one week of occurrence of death and maintain the line list of facility based child deaths
2. Ensure that FBCDR form is completed within 48 hours of child death
3. Review the FBCDR form and approve it for onward transmission
4. Prepare FBCDR Report every month
5. Participate in the meetings of the DCDRC; follow up on specific recommendations pertaining to the health facility

C. District Nodal Officer (DNO)

- **District RCH Officer** can be designated as the District Nodal Officer.
 1. Maintain the line list of both facility based and community based child deaths in the district; facilitate the data entry and analysis of CBCDR and FBCDR at the district level
 2. Prepare the District CDR Report for presentation in the DCDRC meetings
 3. Timely transmission of information from all blocks and the district to state level; overall responsibility for the quality of CDR undertaken in the district
 4. Organize monthly DCDRC meetings under the directions of the CMO; maintain the minutes of meetings; follow up on actions to be taken; prepare the Action Taken Report
 5. Coordinate the DM review meeting every month
 6. Participate in meetings of the State Level Task-force; follow up on specific recommendations pertaining to the district
 7. Share the district and state CDR reports with the key stakeholders and the communities to create awareness and to initiate action at the village level

D. State Nodal Officer (SNO)

1. Provide support to State Level Task Force
2. Organize the state level orientation meeting and the training workshop

3. Ensure the trainings at district, block and facility level
4. Nominate the DNOs
5. Collect relevant data on child death from the districts and carry out detailed analysis
6. Facilitate the preparation of annual child death report for the state and organize a dissemination meeting to sensitize the various service providers and managers. The annual report may contain typical child death case studies which may be used during the training of medical and para-medical functionaries

MONITORING:

The BMO will ensure timely reporting and investigation through regular feedback to the ANMs and the investigating team. S/he will be responsible for scrutinizing the filled in formats and provide hand-holding support to the block investigation team to improve the quality of investigation. The BMO as a supervisor of the block team will also participate in the field level investigation himself/herself, as the time permits.

Process indicators

- a. Child deaths reported/estimated number of child deaths (District-wise)
- b. Detailed Child Death Investigation (Verbal Autopsy) Formats submitted/child deaths selected for detailed investigation (Data to be computed district wise)
- c. Proportion of child deaths investigated (denominator: All child deaths taking place in public health facilities) (Data to be computed district wise)
- d. No. of districts conducting the DCDRC meetings
- e. No. of districts conducting the DM review of CDR
- f. No. of State Level Task-force meetings held/No.s planned

5. BASIC EPIDEMIOLOGY AND EPIDEMIC MANAGEMENT

Epidemic is public health emergency. When information of epidemic is received, PHC staff should rush to affected village. This is because delay by few hours may result into increase in the number of cases and possibly deaths that could have been prevented with quick action by PHC staff.

The data collected during outbreak must be utilized for improving programme activities and the surveillance system. This helps to strengthen the surveillance system by filling the gaps. The results should be documented in prescribed formats for Primary and final reporting.

Definition: It is an unusual occurrence of the disease or health related event in a community or region, clearly in excess of "Expected occurrence".

Outbreak: It is used for small usually localized epidemic.

The severity of epidemic depends on-

1. Environmental condition
2. Characteristics of host population
3. Socio-cultural behavior of people

Types of epidemics

1. Common source epidemics

- Point source or single exposure
- Continuous or multiple exposure

2. Propagated epidemics

- Person to person
- Arthropod vector
- Animal vector

3. Slow or modern epidemics

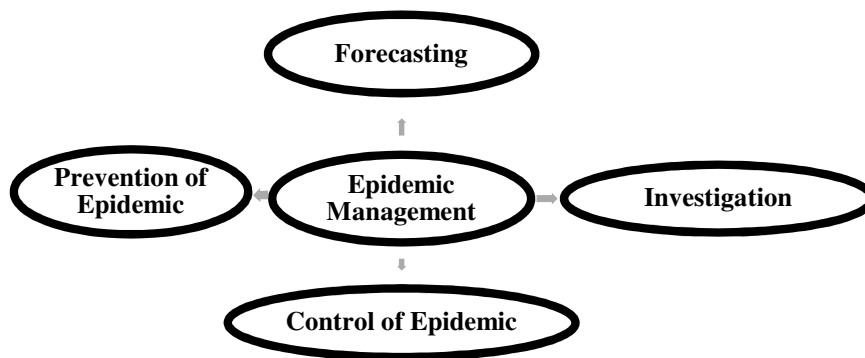
Management of epidemic

Two major areas of epidemic investigation and control

- Diagnosis, investigation and management of patients
- Epidemic investigation leading to identification of the cause and extent of epidemic and to start control measures on the basis of findings of investigations.

Activities related to both the areas should be carried out simultaneously and in coordination. MO should divide the PHC staff in two groups. First group will help MO in treatment of patients and collection of laboratory material for diagnosis by opening the isolation ward. Second group will assist medical officer in epidemic investigation and control measures. It involves step by step activities starting from forecasting to prevention for future occurrence.

Steps of epidemic management



A. FORECASTING OF EPIDEMIC

Forecasting is an early warning system to get prepared to meet the challenges of impending epidemics. It is more appropriate in cyclic and seasonal epidemics where the pattern has been studied from the past data. By forecasting one may not totally prevent the epidemic, but definitely control its severity and spread to other areas.

Methods of Forecasting:

For forecasting the epidemic the prerequisite are

- Study of incidence and prevalence rate.
- Disease specific morbidity and mortality rate.
- Age and Sex wise morbidity and mortality rates.

The various data are tabulated month wise and year wise for the last three years for comparison study of the pattern of disease. Then the collected data is plotted on graph for immediate detection and visual appreciation through trend analysis of the disease. Plotting of data on the map of local area helps in immediate assessment, whether the cases are grouped or clustered. In spite of accurate forecasting an epidemic cannot be aborted.

B. INVESTIGATION OF EPIDEMIC

• Objectives of Investigation

1. To define the magnitude of the epidemic in terms of time, place and person.
2. To determine particular conditions and factors responsible for the occurrence.
3. To identify the cause, source and mode of transmission.
4. To make recommendations to prevent recurrence.

• Steps In Investigation

1. Verification of diagnosis.
2. Confirmation of existence of epidemic.
3. Defining population at risk.
4. Rapid search for all cases in area.
5. Analysis of data.
6. Formulation of hypothesis.
7. Testing of hypothesis.
8. Evaluation of ecological factor.
9. Expand the search in other areas.
10. Writing the final report.

Information of epidemic

Information of outbreak is responsibility of local Gram Panchayat (RDD Gr. No 1096/1280/07 dated 28 November 1996). Early information of epidemic is very important and has many advantages -

- Patients will get treatment at early stage, due to which there will be less morbidity and mortality.
- Early starting of control measures will slow/stop progress of epidemic to adjacent areas leading to further reduction in morbidity and mortality.
- As epidemic is confined to small area in early stage, it is easier to investigate the epidemic and start control activities in small area.
- Medical officer is expected to do following activities for early information of epidemic:
- Whenever you are visiting the village, always remind the Sarpanch, Gramsevak and prominent leaders of village about informing either to PHC or to health worker, in case of increase in number of cases of outbreak prone diseases.
- Try to develop at least two to three informers from each village / wadi / pada to give immediate epidemic information to PHC. Give more attention to remote and small villages. Take the help of Anganwadi worker, ASHA, dai, teachers etc.
- Patient himself is most important and early source of epidemic information. When any patient of epidemic prone disease attends the OPD, always enquire whether there are more cases of similar symptoms in the village.
- Request private practitioners in area to inform PHC if they notice unusually more number of cases of similar symptoms attending their hospitals.
- During the sanitary survey of water supply scheme of village, inform Gram Panchayat in writing about its responsibility regarding information and control measures of natural calamity like epidemic.

1. Verification of Diagnosis

- The initial report may be spurious & arise from misinterpretation of the clinical features. It is therefore necessary to have the verification of diagnosis on the spot.
- A clinical examination of sample cases are sufficient, the first step should be to examine the cases and arrive at probable diagnosis with the help of Standard Case Definition.
- If it is known disease, examination of few cases will help in diagnosis. However for unknown disease, large number of cases may have to be examined to clearly understand the syndrome complex and actual disease.
- Take the help of laboratory facilities. For example, you can immediately examine PBS for malaria in fever outbreak. You should send the samples to District Laboratory for diagnosis of other diseases. Laboratory investigations are most useful to confirm the diagnosis.

2. Confirmation of existence of epidemic

- An epidemic is said to exist when the number of cases (observed frequency) is in excess of the expected frequency for that population, based on past experience. Once the diagnosis of patient is verified, confirmation of existence of epidemic is essential. Compare the number of reported cases of this disease with the normally expected cases for that village during the same period of year. Normal expectation is decided

with the help of weekly disease surveillance record of the disease in same week of last five years or monthly cases for the same month of last five years.

- If this information is not available then following working definition should be used for confirmation of epidemic-
 - Single case of disease, which is eliminated from the state e.g. Guinea worm, Plague, etc.
 - Single case of disease, which is not common in area, e.g. Japanese Encephalitis, Dengue Haemorrhagic Fever, Chikungunya, Chandipura etc.
 - A single case of vaccine preventable disease, e.g. Polio, Diphtheria, Tetanus etc.
 - For commonly occurring water-borne diseases, if number of cases are more than 5 per 1000 population within one incubation period time.
 - Any single death due to any of the diseases under surveillance.

Reporting to DHO

Immediate report: after confirmation of epidemic immediate report has to be sent to the DHO by telegram, telephone, fax or by special messenger. Following information should be included in first report.

- Name of the village, population, PHC and Taluka.
- Name or symptom complex of disease (provisional diagnosis)
- Date and time of receiving the information of epidemic.
- Mode of information.
- Date and time of visit of Medical Officer to the village
- Cause of epidemic (if possible)
- Number of cases and deaths.
- Details of each death including name, age, sex, symptom complex, treatment history and cause of death.
- Control measures initiated
- Assistance required from District Health Officer.
 - Expert advice (Visit of RRT)
 - Medicines
 - Manpower

Daily report of epidemic

Daily report has to be sent from the day of first report. It should include number of attacks and deaths on the day of reporting and progressive attacks and deaths. If there is death then name of the death case and probable cause of death. Detailed death investigation report should be dispatched on the same day by post. The daily report should be sent by telegram, fax, telephone. or e-mail Continue to send the daily report till the epidemic is officially declared as over.

Primary report of epidemic

Primary report should be submitted to DHO within 3 days of starting of epidemic. There is prescribed form for the primary epidemic reporting (given in annex). It includes information regarding date of starting epidemic, date of report received, visit by MO after reporting, visits of district level officers during epidemic, details about previous visits by health

staff and MO, information about water samples during last 3 months, laboratory samples taken and probable cause of epidemic.

Establishment of treatment facility

Early and correct treatment is important to save the life of patient. This will also help in controlling the epidemic by making the patient noninfectious and preventing transmission of disease. Following activities should be carried out for treatment facility:

Select suitable place to establish treatment center and isolation ward. Always admit all the cases with severe diarrhea irrespective of their dehydration status and keep under observation as such cases may go into severe dehydration any time. For diseases like Malaria, Viral hepatitis, Dengue/chikungunya fever, AES etc. treat the patients on OPD basis; admit or refer to Sub-District hospital if any complications are noticed.

3. Defining Population at risk

- Obtain a local area map containing natural landmarks, roads and location of all dwellings.
- Counting the population by age and sex should be carried out.

4. Rapid search for all cases in area

Medical survey should be carried out in defined area to identify all cases. Epidemiological case sheet or Case Interview Form should be designed to collect relevant information. The information should be collected relevant to the disease under study.

House to house survey

Once the treatment facility is established, house-to-house survey of affected village and surrounding villages is essential. This will help to get correct idea of extent of epidemic. Health worker should identify patients during house-to-house survey and refer them to temporary treatment facility. Opportunity of house-to-house survey should be utilized to give important health education messages to community.

Planning of house-to-house survey is essential to carry out quick and useful survey. Call quick meeting of all health workers to brief on survey. Follow the steps given below to plan the survey during epidemic.

- Use suspect case definition for the survey. Discuss this definition with the health workers during briefing. Simple and objective criteria should be used in defining the case. Make sure that all the workers have understood the definition.
- Develop survey format. Make Copies of the format and give to the health workers. Following format can be used as guideline for the survey.
- List all the areas of the village including surrounding hamlets. Make map of village which should include all the areas mentioned in list.
- Allot the area among all workers selected for survey. One health worker can survey up to 500 populations in one day. Survey should be finished within two days. Show the area of each health worker in the map. If the survey cannot be completed within two days through available PHC staff, request THO/DHO for additional staff.
- Make one HA responsible for collection of reports and immediate compilation daily in the evening.

- Prepare daily report of epidemic on the basis of survey findings and OPD. Cross check the patients, as there may be duplication. Send report to DHO.

5. Analysis of Data

- The data collected should be analyzed on ongoing basis under classical parameters- Time, Place and Person.
- The characteristic of time, place and person should be rearranged in Agent-Host-Environment model.
- Information collected during house-to-house survey should be utilized to know the extent and cause of epidemic, age and sex distribution. Analyze the data by age and sex distribution of cases. This indicates which age group or sex is maximum affected.

Develop epidemic curve

Following steps should be carried out to develop the epidemic curve.

- Tabulate the date wise distribution of cases according to the date of onset (and not the date of reporting). You will know the index case. Case first reported may not be the index case.
- On a graph paper, indicate days on x-axis and number of cases on y-axis. Plot the number of cases on each date by point at appropriate place on graph. Joining these points by line will give epidemic curve.
- Epidemic curve will give idea whether the epidemic is in rising trend or declining. It will also give idea about probable day(s) of contamination if we subtract one incubation period days from first case.

Prepare spot map of the epidemic

- Enquiry of village map should be first made with Gram Panchayat. If map is not available prepare the village map.
- To prepare village map, go to centre of village. Stand at the center facing towards north. First mark the place you are standing at center of paper, then roads starting from the place to all directions. Indicate temple, school, Anganwadi, Gram Panchayat etc. in relation to roads. Mark houses on map. If epidemic is waterborne, mark the water supply system (pipeline, wells, hand pumps) & if mosquito borne then breeding places on the graph.
- Put approximate M numbers/number of houses in each area on map.
- With the help of survey tables given above in which number of cases in each household along with M number is mentioned, put one dot per case on the houses shown in the map. Now the spot map is ready.
- Spot Map will indicate most affected area in the village. You should now concentrate on these areas to know the causes of epidemic.
- Prepare 5-6 serial spot maps showing situation of disease on each day, starting from first day of epidemic. Interval between two serial spot maps will depend on the incubation period of disease under investigation. It should be per day for diseases like gastroenteritis, cholera, measles, DF etc. and weekly or biweekly for diseases like hepatitis, enteric fever etc. These spot maps will indicate where the epidemic started and how it is spreading to other areas of village.
- Serial spot maps will indicate direction of spread of the epidemic.

6, 7. Formulation & Testing of Hypothesis

- On the basis of time, place and person distribution and agent-host-environment model formulate the hypothesis to explain the epidemics in terms of –
 - (a) possible source.
 - (b) causative agents
 - (c) possible modes of spread and
 - (d) the environmental factors.
- Testing of all reasonable hypothesis should be done with known facts.

Identify the cause of epidemic

- You have identified the time of introduction of disease in community with the help of epidemic curve and area first affected with the help of serial spot map. Concentrate on the indicated time period and area from where the epidemic has started as indicated in spot map for further investigation.
- If it is water borne epidemic, identify the place of contamination.
- For vector borne epidemics, search for breeding places. Breeding places are different for each type of mosquito. For example, anopheles mosquitoes breed in clean and large water sources like, wells, seepages from irrigation fields, canals, irrigation tanks, etc; Aedes mosquito breed in small artificial water collections like water collected in tires, broken bottles, house hold water collections (barrels, earthen pots), etc.
- Detailed enquiry with the help of these tools will provide enough information about the nature, origin and cause of epidemic.

8. Evaluation of Ecological Factors

- Ecological factors which have made epidemic possible should be investigated such as sanitary status of eating establishments, water supply, movement of human population and atmospheric changes.
- One of the primary concern is to relate the disease to environmental factors to know the source, reservoir and modes of transmission.
- Additional relevant information like source of water supply, large movement of people like yatra, presence of Aedes larva in household water collection, flies in village, etc. should also be collected during the survey.

9. Further Investigation of Population at Risk

A study of population at risk should be done to obtain additional information. This may involve medical examination, screening test, examination of suspected food, feces or blood samples.

Laboratory investigations depend upon nature of disease, epidemiology and laboratory facilities available in the area. Laboratory samples are to be collected from active patients, carriers, vectors and zoonotic reservoirs.

Following are the general guidelines for Laboratory investigation:

- **Form A: SURVEY INFORMATION**
- **NAME OF VILLAGE**-----
- **DATE OF SURVEY**:-----
- **NAME OF HEALTH WORKER**:-----

M No.	Name of head of family	No. of family members								No. of patients in family
		0-5		6-15		16-55		56 +		
		M	F	M	F	M	F	M	F	

- **Form B: PATIENT INFORMATION**
- Line listing of cases should be made as below:
- Name of PHC:-----
- Name of Village :-----
- Date of line listing:-----
- Probable diagnosis:-----

Sr. No.	Name of Patient	Address	Age	Sex	Complaints	Date of onset	Date and place of treatment if taken	Present condition	Remarks

- Specimen should be collected before administration of specific treatment or antibiotics.
- All aseptic precautions should be taken while collecting blood sample, container should be sterile, and no contamination should occur when transporting specimen.
- Proper labeling of the sample, which includes name of the patient, age, sex, address is essential for sample identification.
- Samples collected should be sent to laboratory immediately.
- The samples collected should be in adequate quantity e.g. blood or serum sample should be minimum 5 ml and stool sample 8-10 grams or properly stained rectal swab in CB medium.
- In large outbreaks collecting samples from all patients and sending them to laboratory places puts unnecessary burden on laboratory facilities and it is also not necessary for management of cases and epidemic control. Except PBS for malaria, do not collect serum/stool or other samples from all patients during the epidemic. Samples from 5 - 10% of cases are sufficient to know cause of epidemic. However in case of small outbreak, send adequate number of samples to confirm the diagnosis (Not less than 10)
- Sometimes immunological studies are necessary to detect antibody titer in sera. In many cases, especially viral diseases, paired sera are required to study four folds rising antibody titer. Keep photocopy of first list of samples sent to laboratory. After about 10 days, collect second samples of these cases. Mention these samples as second samples in laboratory form.

- Control activities and treatment should not be delayed till the laboratory results are received. Action should be based on clinical, epidemiological and entomological findings.
- Always submit information of patient along with sample (laboratory form) to laboratory. This should include specimen number, name of patient, date of onset of symptoms, nature of symptoms, provisional diagnosis, date of sample collection and condition of patient at the time of sample collection. Forward this information along with the specimen to laboratory.
- Different types of samples (stool, blood, sputum etc.) are required to diagnose the diseases under investigation. Samples required to be collected for common diseases are given in the table below

Table - 3: Laboratory samples required for diagnosing particular causative agent

SN	Suspected disease	Specimen	How to transport	Where to send	Remarks
1	Cholera, Gastroenteritis	Stool for isolation/ culture	In CB media at room temperature	District Public health Laboratory(DPHL)	Collect in early stage.
2	Viral hepatitis	Stool for isolation	Plain bulb in cold chain (8-10gm)	National Institute of Virology (NIV), Pune	
3		5 ml blood for serum antibody titre	Plain bulb in cold chain at 4 ⁰ c	National Institute of Virology, Pune	
4	Enteric fever	5 ml. blood for culture	Enriched media at room temperature	District Public health Laboratory (DPHL)	Media available in DPHL
5	Dengue fever	5 ml. blood for antibody titre	Plain, sterile bulb. Maintain cold chain at 4 ⁰ c	NIV Pune.DH/RH laboratory for hematology tests and platelet count	Paired samples required
		Aedes mosquitoes	In test tube at room temperature	NIV Pune	Contact DMO
6	Meningococcal meningitis	5 ml. blood for culture. CSF for serology and microscopy	Sterile plain bulb at room temp./blood in blood culture broth	Nearest Medical College Hospital	Contact HOD of Microbiology department of Medical College
7	Plague	Bubo fluid. Blood for culture and serology. Sputum for staining/culture	Sterile container Plain bulb, plain sterile container		

Other epidemiological data

Additional relevant information like source of water supply, large movement of people like yatra, presence of Aedes larva in household water collection, flies in village, etc. should also be collected during the survey.

Declaration of epidemic as over

Surveillance activities should be continued for double the incubation period of the particular disease from occurrence of last case. If there is no case during that period then it is declared that the epidemic is over.

10. Writing Final Report

This is the detailed report of epidemic to be submitted by MO within 10 days after the epidemic is over. The final responsibility of the investigative team is to prepare a written report to document the investigation's findings and the recommendations. The written report should be submitted in a standardized format to the public health authorities including the ministry of health.

Final reporting should be in prescribed format. There are six separate formats of final report, which give detail information about following components –

- General information of epidemic.
- Date wise line listing of cases
- Details of water/stool/blood samples taken during epidemic period
- Water supply and chlorination
- Investigation of death if occurred during the epidemic
- Control measures

C. CONTROL OF EPIDEMIC

Medical Officer should immediately start control measures on the basis of information available through primary investigations and should not wait for confirmation of diagnosis. Inform the Gram Panchayat in writing about control measures to be taken. Medical Officer should personally meet the Sarpanch and other leaders and inform them about cause of epidemic and important actions necessary by Gram Panchayat and community. If the Gram Panchayat has not responded within 24 hours, inform BDO and DHO. Daily review the progress of measures taken by village till the epidemic is over.

- To control of an epidemic one must have information –
 1. Source / Causative organism.
 2. Dynamics of disease transmission.
 3. Mode of transmission.
- Three principles of dynamics of disease transmission is used to control the epidemic –
 1. Removal of source of infection.
 2. Prevention of Transmission.
 3. Vector control measures.

1. Removal of source of infection:

- Treatment of infected cases,
- Destruction of reservoir of infection
- Removal or correction of source of infection.

2. Prevention of transmission

- Isolation of infected cases.
- Hand washing and personal protective measures.
- Proper disposal of fomites.

- Improve environmental sanitation.
- Contact tracing. (family, neighbor).
- Screening of suspected cases.
- Quarantine of migrated cases.
- Health education.
- Increase resistance of suspects through immunization and prophylactic drugs.

3. Vector Control Measures

- Prevention of breeding of mosquitoes, flies and fleas.
- Destruction of adult vector through insecticide, pesticide.
- Personal protection like use of mosquito net, use hot food and filtered water.
- Increase personal hygiene.
- Improve environmental sanitation.

D. PREVENTION OF EPIDEMIC

Appropriate measures at right time, right place in right quantity can prevent the severity of any epidemic.

Preventive measures

1. Improvement of the hygienic level of population.
2. Vaccination.
3. Prophylactic disinfection.
4. Registration and control of carriers.
5. Health education.
6. Environmental Measures.
 - Lighted and well ventilated houses.
 - Clean potable water supply
 - Proper disposal of waste.
 - Adequate sewerage system.

Epidemic Preparedness

- Identify a nodal officer at state/district level.
- Strengthen routine surveillance system.
- Constitute rapid response teams.
- Train medical & other health personnel.
- Prepare a list of laboratories.
- List the "high risk" pockets.
- Establish rapid communication network.
- Undertake IEC activities.
- Ensure availability of essential supplies
- Inter - sectoral coordination.
- The basic general lines of action during epidemics include – Preparedness and Interventions (investigations).
- Success in dealing with an epidemic depends largely on the state of preparedness achieved in advance of any action.

6. DISASTER MANAGEMENT

The term disaster usually refers to the natural event (e.g. flood or earthquake) in combination with its damaging effects (e.g. loss of life and destruction of houses).

Following important points should be considered during disaster management.

- There is relationship between the type of disaster and its effect on health. For example, earthquake causes many injuries requiring medical care while floods and tidal waves cause relatively few.
- Actual and potential health risks of disaster do not occur at same time. Thus, casualties occur mainly at the time and place of impact and require immediate medical care, while risk of increased disease transmission takes longer to develop and are greatest where there is overcrowding and standards of sanitation have declined.
- Disaster affected people generally recover quickly from their immediate shock and spontaneously engage in search and rescue and transporting to health facility. They are most important as they extend help when it is maximally needed.
- Try to organize them and get their maximum help during disaster.

Table - 1: Short term effects of major disasters

Effect	Earthquake	High wind (without flood)	Flash floods	Landslides
Deaths	Many	Few	Many	Many
Severe injury requiring extensive treatment	Many	Moderate	Few	Few
Increased risk of communicable diseases	Yes	Yes	Yes	Yes
Damage to health facilities	Severe	Severe	Severe but localized	Severe but localized
Damage to water system	Severe	Light	Severe	Severe but localized
Food storages	Rare	Rare	Common	Rare

Effective management of health services depends on anticipating and identifying problems as they arise and implementing specific measures wherever needed.

1. Health problem in natural disasters

Health problems common to all natural disasters

- **Injuries:** Injured persons require immediate medical care and referral. Proportion of injured depends upon type of disaster.
- **Communicable diseases:** Risk of communicable diseases is proportional to population density and displacement. These conditions increase the pressure on water and food supplies and risk of contamination. Initially there is risk of diarrheal diseases; afterwards vector borne diseases may appear in some areas particularly after floods.

- **Water supply and sanitation:** Drinking water supply and sewerage system are particularly vulnerable to natural disasters, and disruption that occur in them may lead to outbreak of water borne diseases.
- **Mental health:** Anxiety, neurosis and depression are not major, acute public health problems immediately following disasters. Help the community to support themselves through community structure. Indiscriminate use of sedatives and tranquilizers during emergency relief phase is discouraged.

2. Immediate health problems related to type of disaster

- **Earthquake:**
 - Usually because of dwelling destruction, earthquake may cause many deaths and injure large number of people. Toll depends mostly on three factors –
 - Housing type: Houses of adobe, stone, un-reinforced masonry cause more deaths whereas houses with wooden frame causes less deaths.
 - Time of earthquake: Earthquake at night causes more deaths.
 - Population density: Deaths and injuries are likely to be much higher in densely populated areas.
 - Most of demand of health services occurs within 24 hours of event. Injured persons may continue to show up to facility only during first three to five days. Afterwards health services have to concentrate on disease surveillance and outbreak prevention activities.
- **Destructive winds :**Unless they are complicated by secondary disasters such as folds or sea surges, destructive winds cause relatively few deaths and injuries.
- **Flash floods and sea surges:** Floods and sea surges can cause many deaths, but leave relatively few severely injuries in their wake. Deaths result mainly from drowning and are most common among weakest members of population.
- **Landslides:** Landslides have become increasingly common disaster in Maharashtra state. Intense deforestation, soil erosion and human settlements in landslide prone areas have resulted into catastrophic events in recent years. Landslides cause high mortality with few injuries.

3. Disaster preparedness

Objective of disaster preparedness is to ensure that appropriate systems, procedures and resources are in place to provide prompt, effective assistance to disaster victims, thus facilitating relief measures and rehabilitation of services.

Following points must be kept in mind for disaster preparedness –

- List probable events that may occur in the PHC area, e.g. floods, landslide, earthquake, etc.
- Plan for main features of administrative response, such as location of various officers, support agencies, hospitals, etc. who will be helpful at the time of disaster.
- Develop system of early information of any such incidences in your areas.
- Compile important information of area which includes population of each villages, transportation facilities, hospital facilities, water supply, etc.

4. Actions to be taken during disaster

In the event of disaster, health sector is responsible for treatment of casualties, epidemiological surveillance and disease control, basic sanitation, health care delivery at temporary settlements, logistic resources and support and health education measures.

Treatment of casualties

- When information of disaster is received, PHC staff should rush to the site. First aid treatment should be administered at the site. Injured are identified and tagged at disaster site and classified according to priority for treatment and /or transfer to hospital. If required, doctors and other staff from nearby PHC should be called for help.
- It is always better to inform hospital where the casualties are being sent about the disaster, pattern of injury and likely number of patients.
- If large numbers of casualties are likely or rescue operation needs to be done, take help of community volunteers.
- Inform revenue and panchayat department for further help in rescue and transportation of patients.

Epidemiological surveillance and disease control

Establish house to house survey system to all the areas of the PHC including new settlement if any. All the surveying health workers must come together daily and report about the cases registered during the day. Compile the information daily and carefully observe whether there is any increase in number of patients of particular symptoms in affected areas.

Water disinfection

Most common cause of epidemic in disaster affected areas is infected water source. Assign duty of chlorination of all the water sources in and around affected area to senior health assistant. In addition to this, prepare stock solution in sufficient quantity and chlorinate drinking water by house to house chlorination.

Laboratory services

Establish makeshift laboratory adjacent to camp health facility. This laboratory should have facility to examine blood smear for malaria and water field test.

Vaccination

WHO does not recommend cholera or typhoid vaccination in disaster situation. Do not start mass tetanus vaccination as increase in number of tetanus cases after disaster is never observed. However, injured persons can be vaccinated considering risk of contamination and previous tetanus vaccination.

Vector control

Control programs for vector-borne diseases should be intensified in the emergency and rehabilitation period, especially in areas where such diseases are known to be endemic. Of specific concern in emergency situation are: leptospirosis (rats), dengue fever (aedes mosquito) and Malaria (anopheles mosquito). In flooded areas, rats will escape their burrows in search for

dry hiding places, often in dwellings. Similarly flood waters provide ample breeding opportunities for mosquitoes.

Following measures should be taken for vector control measures –

- Guide Gram Panchayat about safe disposal of waste
- Conduct public education campaign to eliminate vector breeding sites in and near houses and on measures to prevent infection, including personal hygiene.
- Survey camps and densely populated areas to identify potential mosquito, rodent and other vector breeding sites,
- Eliminate vector breeding sites by draining, filling and by releasing guppy fish
- Advise community to store food in closed and protected containers.
- Well organized vector control measures will drastically reduce the need of insecticide spraying.

7. INFORMATION EDUCATION AND COMMUNICATION

Information, Education, Communication is the important component of all the national health programmes. Unless community is made aware about various aspects of health, it is difficult to bring the desirable behavioral change among the people. Aim of IEC is to bring desirable behavioral change; therefore it is said as 'Behavior Change Communication' (BCC). Behavioral change is the slow process and repeated. Continuous attempts are needed by THO and health workers to get desired behavioral changes in the community. Informing and educating people will help to improve utilization of health services and will help for demand generation from the community.

BCC is a dynamic process, which involves an exchange of ideas & is concerned with information, attitudes, beliefs, myths, misconceptions and practices. BCC uses multiple channels to transmit and reinforce messages that address well defined target groups. This helps to change current behavior to the desired behavior by providing people skills and tools. It is not only necessary to adopt new behavior change but also need to maintain the same for better health outcomes. Hence, BCC is a process that promotes positive change in the individual and the environment.

1. Effective communication is based on

- Thorough understanding of behavior responsible for poor health outcomes of people, knowledge, practices, beliefs, myths and misconceptions, value systems, cultural and religious practices & educational level of community.
- A clear idea regarding changes that needs to be brought about.
- An understanding of messages that need to be given to bring about the changes.
- Medium and media mix that can effectively bring about the change process.
- An analysis of the key influencers and involving them in the communication strategy.
- Use of material, which can enhance effectiveness of communication

Continuum of behavior change ranges from becoming aware, improving understanding through repeated exposure, openness to trial of new behavior, experience of the product/service, reinforcement, sustaining new behavior and propagating new behavior through word-of-mouth.

Every opportunity should be utilized for creating awareness among the people by using appropriate health education material provided by DHO/MO PHC. Use of such visual material improves effectiveness of your programme. IEC is not independent vertical programme, but it is the part of regular health services and activities performed by health staff.

2. Areas to be covered for health education

- Services provided by PHC for various groups of people.
- Importance of personal hygiene and environmental sanitation.
- Nutrition and nutritional requirements of various groups.
- National health programmes.
- Important health related acts like PC PNDT age at marriage etc.

3. Opportunities for health education

There are many opportunities for informing, educating people regarding health related matters.

3.1 Inter personal communication

- MO can educate patients regarding specific illness during OPD and during Arogya seva satra.
- Health worker has a very good opportunity for informing people during house visit, in Arogya seva satra or at the time of administering vaccine to child.
- Any new or follow up patient of leprosy or tuberculosis coming to MO has to be educated well.
- When informing individuals, use health education material provided like flipbook, flash card so that person understands message better.
- Inter personal communication being a two-way communication, is the best method. It gives patient a chance to discuss, ask questions and clear all the doubts in mind.

3.2. Group communication

- Important groups for whom awareness needs to be created are mothers attending clinic, school children, college students, youth groups, mahila mandals etc. In addition to this, Gramsabha, School advisory committee, VHNSC meeting, ASHA meeting are also good opportunities.
- Health education activities of particular group should be planned taking into consideration area of interest of that group.
- Do not mix groups with different background, as interest of persons with different background differ.
- Use of flipbook, flipchart is essential for good understanding of group.
- Significant number of people can be addressed at one time and if group is small chances of clearing doubts are more by this method.

3.3 Mass communication

- Large number of people can be addressed at a time by using audiovisual media or print media like use of loudspeaker, distribution of handbills at public places, use of video etc.
- Opportunities for mass communication at PHC are disease diagnostic camps, weekly bazaar etc.
- In a short time span you can reach large number of people. However there is no opportunity for individual discussion.

4. IEC material

At district level District Education and Media Officer is looking after all IEC activities in the district. All IEC materials are supplied to PHC.

4.1. Posters

- Exhibit posters at public places where large number of people can see the poster e.g. Grampanchayat, schools, bus stand, railway station, etc.
- Height of poster should be such that people can see/read it.
- Change posters regularly.

- Replace the torn or damaged posters immediately. All health staff should be given instruction that if they come across torn or damaged poster, it should be immediately replaced by other poster.
- Subject of the poster should be such that it is of concern to the group of people who are going to see it.

4.2 Banners

- Banners are used usually for campaigns or any intensive short period activity.
- Banners should be exhibited at public places like Gram Panchayat, schools, bus stand, railway station etc. where large number of people can see.
- Most of the times banners are related to date / place of some programmers or campaign. When activity is over, remove these banners from area.

4.3. Stickers

- They should be stucked on vehicles, shops, indoor places both private and public, in PHC, sub center, schools.
- Stickers are essentially small size. They are placed in such a way that interested person can read it from close distance.
- Stickers can also be used as ready reference for professionals e.g. treatment of malaria, treatment schedule of dehydration etc.

4.4. Danglers

- They dangle and attract the people. Can be displayed outside OPD, in sub centers, gram panchayat office, schools etc.

4.5. Flipchart

- This is used for health education in small group, in schools, for mothers meetings etc.
- It is also useful for imparting training to health workers, ASHA,AWW or any other training.

4.6. Flip book

- This is used for health education in small groups, in schools for mothers meetings.
- On front side of each page there is picture and on backside information is given regarding the picture shown.
- While using, fold the flipbook on the hand of user so that people can see it.
- Keep this at the eye level of viewers.
- Correct method of use is important. Picture should be shown to the group and explanation regarding this should be given by reading information given on backside.

4.7. Folders

- These are used for informing large number of people as a mass communication method.
- Ensure that people for whom you are using folders are literate.
- Folders are also useful for group communication.

4.8. Handbills

- These are used for informing large number of people as a mass communication method and therefore can be distributed in places like bazaar, bus stand, rail way station etc.
- Useful for literate people.
In addition to this audio and video CDs are also provided to PHCs. Make proper use of these cassettes.

5. Important health days

Taking into consideration important public health related issues, health days are celebrated. In addition to this, for some issues, week eg Breast feeding week, fortnight eg Diarrhoeal diseases control Fortnight or even month eg Antimalaria activities month is celebrated. Importance of celebrating health days is that, as one day or specific period is fixed, information related to the subject is given to the community through various methods, creating awareness at the same time all over the state.

MO bharari pathak should take this opportunity & celebrate various health days in allotted area as per the guidelines given by DHO by using local resources. Important health days are as below:

Table: Important health days

Sr.	Day/Period	Importance
1	1 st January	Anti Smoking day
2	30 th January	Anti Leprosy day
3	5 th February	Oral Health Day
4	8 th March	World Women's Day
5	22 nd March	World Water Day
6	24 th March	World Anti Tuberculosis Day
7	7 th April	World Health Day
8	1-7 May	Malaria Control Week
9	12 th May	World Nurses Day
10	15 May to 15 June	Awareness Campaign – Water Borne Diseases
11	31 st May	No Tobacco Day
12	5 th June	Filariasis Control Day
13	10 – 16 June	Eye Donation Week
14	10 th July	Safe Motherhood Day
15	11 th July	World Population Day
16	1-7 August	World Breast Feeding Promotion Week
17	1-7 September	Nutrition Week
18	1 st October	Voluntary Blood Donation Day
19	16 th October	World Food Day
20	21 st October	Iodine Deficiency Disorders Control Day
21	Oct. – November	School Health Campaign
22	1 st December	World AIDS Day

6. Role of Taluka Health Officer In IEC activities

6.1 Planning IEC activities

- Most important role of Taluka Health Officer is to plan IEC activities for the year. This should be part of routine health activities and not separate independent activity. Planning should also be done for IEC activities for Schools, fairs, festivals and melas.

6.2 Celebration of health days

Encourage medical officers PHC and other health staff to celebrate various health days in allotted area.

6.3 Training

Train health staff and about appropriate use of IEC material, conducting effective group meeting, effective interpersonal communication.

6.4 Health education material

- Obtain health education material from MO PHC/District Health Officer from time to time
- Review available IEC material in Health Center and give instructions to staff for its proper utilization as below:
- Posters should be exhibited at public places from where they can be easily seen.
- Cloth banner should be exhibited outside Primary Health Center / Sub center building or near Grampanchayat / Bus stops.
- Flip books should be utilized for Inter Personal Communication (IPC), for group communication.
- Ensure proper utilization of Audio Visual aids (e.g. Tape recorders, V.C.R., Television, Audio / Video Cassettes, Exhibition sets)
- Inventory of the IEC material received from DHO should be maintained. Distribute material to PHCs and health workers and see that they use it properly.

8. BASIC COMMUNICATION AND COUSELLING

What is communication?

Communication is a vital part of our daily routines. The workplace is no different. 70–80 percent of our working time is spent in some kind of communication. We're reading and writing memos, listening to our co-workers, or having one-to-one conversations with our supervisors.

Communication involves at least two people: the sender and the receiver.

Whether you're writing, listening, speaking, or attending meetings, communication skills are critical to your success in the workplace. We'll look at some of the skills that will enable your communications to be more successful. These include:

- Understanding the purpose of a communication
- Analyzing the audience
- Communicating with words as well as with body language
- Giving each communication greater impact

Information Overload

In the workplace, information seems to come from all directions. Each day, managers are expected to read memos, letters, and reports. You must have a clear purpose and state that purpose as quickly as possible. It's also essential that you know your audience and give them the information they want.

Define Your Purpose

Many people just start communication, and hope for the best. Sometimes they are lucky. However, most of the time they produce poorly drafted communication and confusing message. Before you begin communication, state your purpose and how you propose to carry it out. This information can be stated briefly in one or two summary sentences. These sentences sum up the purpose of your writing.

- The purpose of some communication is to persuade. People often confuse communication with persuasion. Communication is the transmission of messages among people or groups; persuasion is a person or group's deliberate attempt to make another person or group adopt a certain idea, belief, or action. Expressing differences is a vital part of workplace communication, as long as you avoid an accusatory tone when doing so.
- The purpose of some communication is to explain.
- Some communication is primarily designed to describe.

The 4 Cs Of Successful Communication

All good writing starts by defining your purpose and knowing your reader. But that's only the beginning.

There are four other elements that you should keep in mind. They are known as 4 Cs:

1. Concise
2. Compelling
3. Clear
4. Correct

People in the audience genuinely want you to succeed. They've come to hear you speak. They want to know what you have to say to them. They may be experts on the subject of your talk or they may know nothing about it; regardless, they want to hear what you have to say about it. The most important step in preparing any presentation is to understand your audience. Before you start, it's wise to reflect on who your audience will be and what their primary interests are. As you prepare a talk, conduct a listener analysis—analyze the people who are going to receive your talk.

Ask yourself the following questions:

What do my listeners want to know?

If you don't provide information that interests them, you'll put them to sleep. Find out what they care about and cover this material in your talk. How much do they already know? They maybe experts or they may know almost nothing about your topic. You don't want to "talk down" to your listeners. But you also don't want to speak over their heads. Determine what your audience knows and pitch your talk to your audience's level of understanding.

Where do they stand? Your listeners may be likely to agree with what you're saying, or they may need a lot of convincing. Find out their attitudes; then determine what to say to persuade them of your point of view.

One of the best ways of organizing any presentation is also the simplest. It's called the 3 Ts, which are as follows:

1. Tell the audience what you're going to say at the beginning of the talk.
2. Tell the audience what you're going to say to them in the body of the talk.
3. Tell the audience what you told them in the conclusion.

In the work world, communication skills are critical in many situations.

People fail to communicate because they lack effective communication skills. They simply don't know how to handle audience. It's 90 percent chemistry. You need to get the audience to like you.

How do you accomplish these goals? Some tips are:

- Do your homework.
- Know your purpose.
- Watch your body language.
- Be prepared.

Communication is not only verbal. It also involves body language. Eye contact is also necessary during the communication. Looking at your hands, twisting your ring, or looking out the window communicates a lack of interest in the audience/receiver. Your body posture is an important part of this.

Effective communication is important not only with other people inside hospital but with people from the outside as well. No matter what is your nature of practice — Anaesthetists, Surgeon, General Physician, Cardiologist... And the impression you make tells them a great deal about you and hospital.

EFFECTIVE LISTENING

For a team to work smoothly, its members must be able to communicate effectively. They must speak clearly and concisely so everyone understands what they are saying. They must also be willing to listen and learn from each other.

If members are not cooperating as a team, nothing can be accomplished. Here are five things to avoid when working as a team:

1. Don't interrupt.
2. Don't jump to conclusions.
3. Don't judge the messenger.
4. Don't be self-centered.
5. Don't tune out.

Don't Interrupt

How many times has someone interrupted what you're trying to say? Perhaps it was one of your parents, a friend, or even a co-worker. Chances are you felt pretty irritated. Some people don't mean to be rude. They just can't seem to control themselves. They are so eager to express their opinion that they simply can't wait for the speaker to finish. Unfortunately, teams don't operate well when others interrupt. Everyone deserves an equal chance to be heard. If a team member / patient is cut off in mid- sentence, is interrupted while presenting an important idea / symptoms, he or she is likely to feel unappreciated. This person may even begin to feel resentful. Teams can't function efficiently if resentment has built up among different members. Imagine trying to run a basketball team on which the players don't get along with each other. The spirit of teamwork disappears, and the team might even have less desire to win. Interrupting might also prevent a person from saying something vital to the future of the treatment and the success. In the best teams, every team member has a chance to contribute.

Since we (doctor) can process information much faster than patient speaks, it's easy to stop paying attention to the patient and begin thinking about something else. Sometimes doctors tend to jump to the wrong conclusion. The average speaker talks at about 160 words per minute, but we can absorb information at three times that rate. However, according to one study, we listen with only 25 percent efficiency. This accounts for many of them is understandings that occur on the job.

If one is used to dealing with people / patients who speak quickly and that they like to talk pretty fast oneself. They admitted that whenever they have to listen to someone who talks slowly, they begin to get impatient and even stop listening. "Why can't they just get to the point?" they insist.

Whether we like to admit it or not, each of us has certain biases, which may get in the way of effective listening. Some common biases are triggered by the following questions:

How does the patient sound?

If a person has an unfamiliar accent, you may find yourself judging what he or she is going to say without really listening. Perhaps this individual comes from a different region of the country or a different part of the world. Perhaps he or she speaks more quickly or more slowly than you. None of these reasons excuse jumping to conclusions and dismissing what the person may say before giving him or her a fair chance.

What does the speaker look like?

The first thing you notice about people is their appearance.

What kind of clothes do they have?

How much jewellery do they wear?

It's easy to let someone's appearance—especially someone who looks different from you—stand in the way of effective communication. In his book

Are You Communicating?

You Can't Manage Without. It, Donald Walton points out that judging people based on appearance is one of the emotional obstacles that can prevent you from giving rational consideration to what someone is saying.

How old is the speaker?

Age can be an enormous barrier to effective communication. If a person has grey hair, you may assume that he or she can't relate to you. Likewise, some adults feel that a teenager is too young or inexperienced to teach them anything. This is another example of an emotional generalization that can prevent effective listening. Instead, individuals and their messages should be evaluated on their own merits. Sometimes patient and their relatives insist on information from senior doctor only.

Put Yourself in the Speaker's Place

Relatives bring in patients not only for routine visits, but for serious illnesses and major operations. It's important to understand why the patient is there and what the relative is feeling. If the relative is worried, pick up on that. Listen to what they say and watch their body language. Then try to make small talk to help them feel better. Sometimes a relative will call the hospital after a patient has undergone surgery to find out how the patient is doing. We should understand they are worried and try to understand that. Give them all the information one can. Tell them how their patient is feeling, whether the anaesthesia has worn off—anything that will reassure relatives that their patient is all right. Good listeners have the ability to empathize with a speaker. They try to read the speaker's body language. Perhaps the speaker has a pained expression or looks tense. Any of these clues may indicate that he or she is nervous. A halting style of speech or emotional tone of voice may also indicate that the individual is upset.

Doctors can then use what management consultant Ron Me is calls "openers" and "encouragers" to enable the patient/relative to communicate more easily. The doctor might say, "It looks to me that there's something you'd like to talk about," or "Is something bothering you?" These openers may get the patient/relative started. Doctors can also communicate their interest in what the patient / relative is saying by nodding their heads, making eye contact with them. These signals encourage them to keep expressing.

How do we communicate a message? Only 7percent of our message comes through the words we use, 38 percent comes through our tone of voice, and 55 percent comes through our body language.

EFFECTIVE SPEAKING

Effective speaking skills mean you spell out objectives clearly. And be sure you add energy to your delivery. If you've ever heard speakers who talk in a dull monotone, you know how boring it can sound. Speaking with energy can keep people involved and prevent them from daydreaming or even falling asleep!

You can add energy with your voice by emphasizing certain words or ideas as you speak to indicate their importance. By changing your speaking volume, you can also add variety to your presentation. Gestures are another way to add energy. As you talk, use your hands to reinforce what you're saying. For example, if you're listing three objectives, use your fingers to indicate the first, second, and third points. If you're making a key point, try jabbing the air with your forefinger. Gestures automatically raise the vocal energy of your talk. In fact, if you use gestures, it's almost impossible to speak in a monotone.

Making eye contact with your listeners is another way to keep them involved. As you begin a thought, look at one listener. Continue looking at that individual until you complete the thought. Then select another listener and repeat the process. This enables you to establish a dialogue with all receivers, which is an effective way to keep them focused on what you're saying.

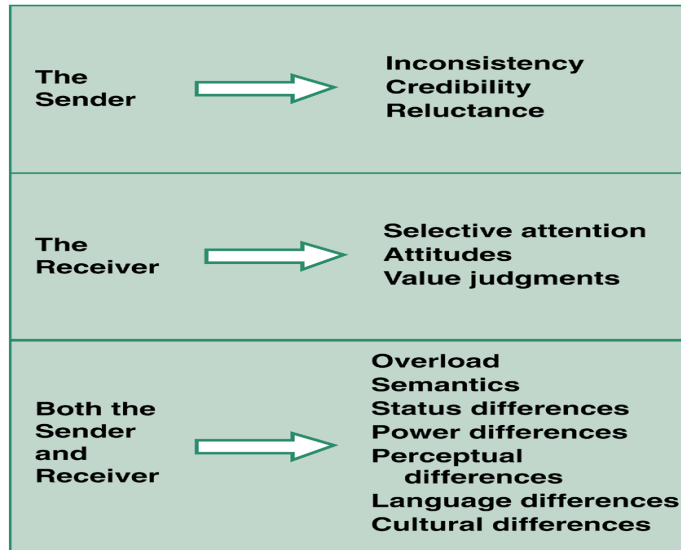
Communication skills have been categorized in a variety of ways. There are a number of key functions of communication between physicians and patients, and for each function there are specific skills that enable a productive conversation. These functions include fostering healing relationships; exchanging information, such as what patients want and need; responding to patients emotions; engaging in informed and collaborative decision making; and enabling patient self-management. Each requires a set of specific communication skills. To assess patients' wants and needs, the physician must ask questions about patients' concerns, priorities, and values. The physician must listen attentively to patients' answers and ask follow-up questions if the answers need clarification.

The astute clinician would realize that "everything possible" could have a number of very different meanings, and that correctly understanding what this patient wants will require an exploration of his fears about illness and opinions of possible treatments. Further questioning may also be needed to explore what the patient hopes to achieve, to correct unrealistic expectations, and to explore the possibility that treatment might result in increased suffering. Only after the patient's values and preferences have been clarified will the physician and the patient be able to make truly collaborative decisions that are in the patient's best interest. Evidence suggests that after such discussions, patients with terminal illnesses receive fewer intensive interventions in the last week of life, generate lower health care spending, and—with their families—report better quality of life in their final days.

To write well, express yourself like common people, but think like a wise man. Or, think as wise men do, but speak as common people do.

- Aristotle, Greek philosopher
If you cannot express in a sentence or two what you intend to get across, then it is not focused well enough.
- Charles Osgood, TV commentator
Nothing builds rapport faster than eye contact. Building rapport is critical for achieving audience buy-in—and without 100 percent buy-in, it's terribly difficult to inspire an audience to act.
- Tony Jeary in *Inspire Any Audience: Proven Secrets of the Pros for Powerful Presentations*

Barriers to effective communication



9. SOCIAL & BEHAVIOURAL CHANGE COMMUNICATION (SBCC)

Introduction:

Social & Behavioural Change Communication (SBCC) helps in:

1. Improved communication and interpersonal skills in using various approaches and materials/tools and are more confident about handling individual as well as group/community sessions aimed at bringing about desired behavior change.
2. The ability to develop a Social and Behavior Change Communication Plan, often in coordination with other functionaries and community representatives, and contribute actively in the implementation of the plan.
3. An improved understanding of appropriate values and attitudes that make them better communicators by being sensitive to the needs of individuals, families and communities and respecting their right to make informed choices.
4. Enhanced abilities in effectively using various communication tools like flip charts, films and other community dialogue and counseling tools to bring about the desired behavior changes.

The behaviour change process and the role of the communicator at each stage of the change process is important. Interpersonal communication and counselling, as well as the various materials used to support communication, is discussed next.

A very high premium is placed on creating a lively, friendly and joyous learning environment where the participants feel free to share not only their ideas and thoughts but also their feelings. Ice breakers, energisers, songs and various games have been used to create and sustain that environment. **Training is most effective when the facilitators themselves become one among the participants and bridge any gap that exists between the participants and them.** By getting involved in singing, games and various other activities that are part of the sessions, each participant is actually improving her/his communication skills and enhancing her/his self-confidence and self-esteem. It is crucial that we convert the participants from passive to active learners so that what they learn remains with them for life. Hence, it is essential for the facilitators to ensure that every participant takes active part in the discussions and activities.

An Introduction to Communication

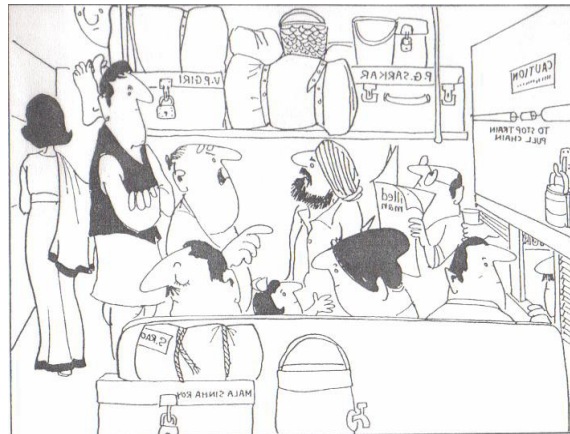
In this session, we will focus on understanding “what communication is?” what are different types of communications? The process of communication and also the qualities of good communicator.

Objectives:

Describe the communication loop with the different steps:

Explain the need for the communicator and the receiver to be on the same wavelength for effective communication to happen.

Understand from examples of why one-way communication invariably leads to distorted messages.



The Process:

Select 10 participants.

Take participant No. 1 outside training hall and show him the picture for 2 minutes and ask him to study the same.

Take all 9 participants out. Call participant No. 2 and ask participant No. 1 to explain what the picture to Participant No. 2. Participant No. 2 will only listen but would not see the picture and not ask any question to participant No 1. Now same process will be repeated till participant No. 6. All other participants would observe the distortions passed on by participant No 2 to participant No.6.

Call participant No 7 and let him describe the picture to participant No. 8. However, this time though participant No 8 will not see the picture, but he can ask the questions to participant No. 7. Once volunteer No.7 completes describing the picture to the satisfaction of volunteer 8, ask volunteer 8 to describe the picture to all the participants. Once again show the picture to all participants so that they are able to make out the distortions.

Call in volunteers 9 and 10 and give the picture to volunteer 9. Ask her/him to study the picture so that s/he is able to convey what s/he sees to volunteer10. Once s/he is ready, ask her/him to describe the picture to volunteer 10 and tell her/him there are no restrictions. S/he can even show the picture to volunteer 10 and describe it. Now tell volunteer 10 to describe the picture to the participants. Stop the exercise here; ask all participants to go back to their original seats.

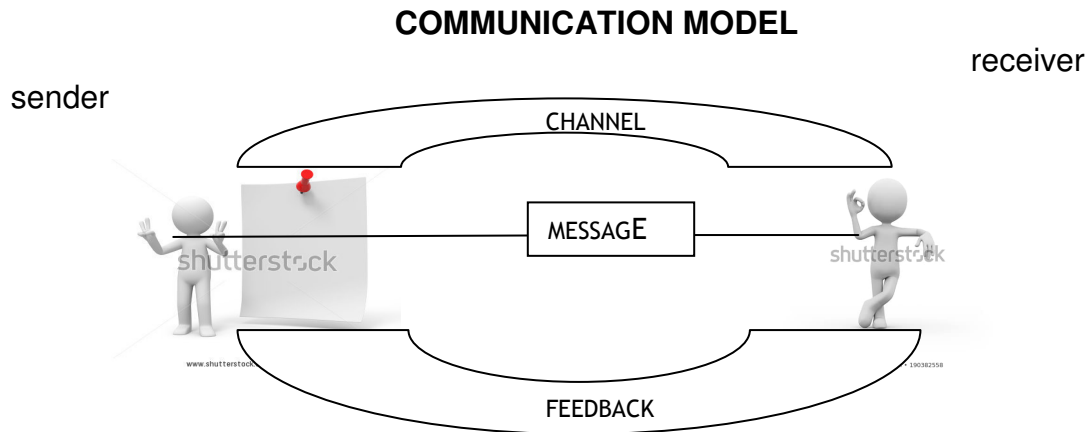
The Learning:

We saw three different communication methods here.

Case 1: The communication was one-way where the listener could not ask any questions; s/he could only listen to what the volunteer was saying.

Case 2: The listener was free to ask questions and get clarifications. In this case the message was better delivered compared to the first case.

Case 3: Both the messenger and the listener were able to discuss the picture while looking at it. The listener fully participated in deciding what the picture depicted. The listener was not just a receiver who could only ask questions but was actively involved in deciding what the picture depicted. The third communication style gave the best description.



Effective Communication Dos and Don'ts

Dos

- Involve your receiver in the feedback process. (Remember Case 2 and 3 from the exercise.)
- Try to develop a shared experience of communication as equal partners. (Remember Case 3 from the exercise.)
- Act on the feedback and create opportunities for clarifications. (Remember Case 3 from the exercise.)

Don'ts

- Avoid one-way communication. (Remember Case 1 from the exercise.)
- Avoid lengthy communication. In order to be effective, communication should be broken into short pieces. (Remember how lengthy communication was less effective in Case 1, and how small pieces of information coming one after another improved the communication in Case 3.)

Qualities of a good communicator:

What is competency?

Competency is the ability of a person to carry out an activity or a task effectively, producing the desired results.

“What are the essential ingredients that constitute competency?”

Competency consists of three key elements: **Knowledge** of the task, **skills** to perform the task and the right **values and attitudes** that make one to perform the task well. In the case of a communicator, the skills required are good communication skills. *There is a chart given below which lists knowledge, communication skills, values, etc.*

Knowledge, Skills and Attitudes / Values that a Good Communicator Should Have		
Knowledge	Communication Skills	Values / Attitudes
Knowledge on the topic and how it has to be handled	Ability to build rapport with individuals and groups	Being honest and transparent.
Knowledge about the target population being addressed – their beliefs, values, traditions, social norms etc.	Ability to see oneself as part of the community	Respect for all, including the poor and marginalised
Knowledge of the region where one is working	Ability to speak effectively	Treating all equally irrespective of religion, caste, gender, age, physical condition and socio-economic status.
Knowledge of the local leaders, opinion makers, functionaries, etc.	Ability to listen attentively	Commitment to one's work and mission
	Ability to negotiate and handle arguments etc.	A sense of fairness and justice.
	Ability to analyse situations and different points of view	A belief that every individual or family has the right to make its choices and that one's role is to provide them with the right knowledge and skills to make 'informed choices'.
	Ability to use positive body language for best impact	
	Ability to empathise.	
	Ability to use different tools for effective communication – posters, flip charts, exercises, community dialogue tools etc.	

Understanding Counselling

The purpose of counseling is to empower others to help themselves in making informed choices and adopting new attitudes and behaviours. Counselling is one of the most effective tools for bringing about behaviour and attitudinal changes.

This requires the frontline functionaries (FFs) to first adopt new attitudes and enabling behaviours themselves before helping others.

What does counselling do?

1. Provides psychosocial support
2. Strengthens the sense of individual responsibility
3. Helps to build on new information and bring about positive changes
4. Assists in making realistic decisions
5. Facilitates the building up of self-confidence, self-esteem and self-respect
6. Facilitates behaviour change

Listen to the following story carefully and respond individually to the comments given below

Sujata of Riteshgarh

Sujata, with her two children, lives in Riteshgarh, 30 kilometres from Kanpur. Pappu, her older son is one and a half years old and her daughter, Veenita is almost three months old. Sujata does not take her children to the Anganwadi Centre. She has not attended school in her childhood and belongs to a very poor family. She lives on wages that she earns whenever she gets work.

Sl. No	Sujata	Your Opinion
	When asked about the capital of UP, her answer was: Kanpur	
	When asked if she attends the VHND sessions her answer was: Yes	
	When asked she has undergone sterilisation, her answer was: Yes	
	When asked whether she boils the water before feeding children her answer was: Yes	
	When asked if she regularly took IFA tablets during her pregnancy, her answer was: Yes	
	When asked if she exclusively breastfeeds Veenita, her answer was: Yes	

Against each of the statements above indicate your opinion in column provided by writing the A / B / C / D/E or F (any one of the six letters).

A = Sujata is illiterate

B = She is telling a lie

C = She does not know or understand

D = She is from a dalit community

E = She is telling the truth

F = None of the above

Counselling involves the following:

- 1) Attending Behaviour
- 2) Closed and Open-Ended Questions
- 3) Paraphrase
- 4) Summary
- 5) Reflection

Attending Behaviour

- Face the other squarely
- Nod Head
- Adopt an open posture
- Verbal following
- Speech
- Lean towards the other
- Make eye contact
- Be relatively relaxed

Listening

Listening is the most important skill in counselling. It is the process of 'hearing' the other person. The three aspects of listening are:

- 1) **Linguistic:** actual words, phrases and metaphors used to convey feelings.

- 2) **Paralinguistic:** Not words themselves but timing, accent, volume, pitch, etc.
- 3) **Non-verbal:** 'Body language' or facial expression, use of gestures, body position and movement, proximity or touch in relation to the counsellor.

All these express the internal state of the counselee and can be 'listened' to by the attentive counsellor.

* "Not just the words but also the music behind the words!"

What we communicate without speaking!!

- When we **face our counselee squarely** we are saying: *"I am available to you"*
- When we **nod our head** we are saying: *"I am in agreement with you, or I understand you"*.
- When we display an **open posture** we are saying: *"I am open to you – non defensive"*
- When we **lean forward** we are saying: *"I am with you"*
- When we establish **eye contact** we are saying: *"I am interested in you"*

When we maintain a **relaxed composed posture and facial expression** we are saying: *"I feel confident and ready to listen and interact"*

Closed vs. Open-Ended Question

Closed-ended Questions	Open-Ended Questions
Are you scared?	How do you feel?
Are you concerned about that your mother-in-law will not allow you to get your daughter immunised?	What do you think you might do if your mother-in-law opposes immunisation of your daughter?

Reflection is the echoing of the last few words that the counselee has spoken during a session. It helps the counselee realise that the counsellor is with her/him and is able to follow her/him.

Purpose of Reflection

Helps counselee:

- ✓ Feel Understood
- ✓ Express more feelings
- ✓ Manage feelings
- ✓ Distinguish between various feelings

Example

Counselee: "So many things are going on right now -the sowing season has started, my daughter's sick, and my mother-in-law is down with jaundice. I find myself running around trying to take care of everything. I'm not sure I can take it anymore."

Counsellor: "You're feeling pretty overwhelmed by all the things that are going on right now."

Paraphrasing

Purpose of Paraphrasing	When to use it
<ul style="list-style-type: none"> • To convey that you are understanding the counselee • Help the counselees by simplifying, focusing and crystallizing what they said 	<ul style="list-style-type: none"> • When you have a hypothesis about what is going on with the counselee • When the counselee is in a decision making conflict • When the counselee has presented a lot of

<ul style="list-style-type: none"> • May encourage the counselee to elaborate • Provides a check on the accuracy of your perceptions 	material and you feel confused
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Summarization:

A summary is a collection of two or more paraphrases or reflections that condenses the counselee's messages or the session

Covers more material

Covers a longer period of counselee's discussion

Purpose of a Summary

- ❖ To tie together multiple elements of client messages
- ❖ To identify a common theme or pattern
- ❖ To interrupt excessive rambling
- ❖ To start a session or to end a session
- ❖ To pace a session
- ❖ To review progress
- ❖ To serve as a transition when changing topics

Nurturing Effectiveness

It is important that the frontline functionaries work and improve on the following in order to provide effective counselling:

1. **Gaining trust:** Earn the trust of the people, especially the counselees.
2. **Being objective:** Should be able view the counselee's issues objectively without allowing personal biases to influence any views presented by the counselee.
3. **Being an effective communicator:** Should be well versed in the art of effective communication.
4. **Being open minded:** Should accept everything that the counselee may present with an open mind.
5. **Being Perceptive:** Must understand the need to be observant to give feedback to the counselee.
6. **Becoming self aware:** During a session s/he must be aware of what s/he says and does and the capabilities and abilities that s/he possesses as well as her/his limitations.
7. **Becoming an effective listener:** Must be a good listener.
8. **Being committed and responsible:** Must be committed to the role as a counsellor and assume responsibility for her/his actions and words.
9. **Being non-judgmental and tolerant:** Must be completely impartial in her/his interactions on the views, opinions and actions of the counselee as well as be tolerant towards the attitudes and beliefs of the counselee.
10. **Being attentive:** Should be minutely attentive to the words as well as actions of the counselee.
11. **Being informed:** Should strive to be sufficiently well informed so as to provide the right information whenever required during the course of interaction with the counselee.

10. RESEARCH IN PUBLIC HEALTH

Introduction

Scientific research plays a very important role in our efforts to maintain health and combating diseases. Research helps us create new knowledge and develop proper tools for the use of existing knowledge. Not only does it enable health care providers to diagnose and treat diseases, research also provides evidence for policies and decisions on health and development.

The research process is the cornerstone for informed and effective decision-making, and is integral to countries' efforts to improve the health of their populations and the effectiveness of their health systems, particularly during times of dramatic epidemiological, demographic, and economic changes that profoundly affect health systems.

The spectrum of health research is broad and includes:

- Biomedical research
- Public health research
- Health policy and systems research
- Environmental health research
- Social sciences and behavioral research
- Operational research
- Health research as part of general “science and technology” research

However, considering the definition of health used earlier, it is evident that the range of research needed to “protect and promote health and reduce disease” is even broader than this.

Definition

Research is a quest for knowledge through diligent search or investigation or experimentation aimed at the discovery and interpretation of new knowledge. Scientific method is a systematic body of procedures and techniques applied in carrying out investigation or experimentation targeted at obtaining new knowledge. In the context of this manual, research and scientific methods may be considered a course of critical inquiry leading to the discovery of fact or information which increases our understanding of human health and disease.

Categories of research

1. Empirical and theoretical research

The philosophical approach to research is basically of two types: empirical and theoretical. Health research mainly follows the empirical approach, i.e. it is based upon observation and experience more than upon theory and abstraction. Epidemiological research, for example, depends upon the systematic collection of observations on the health related phenomena of interest in defined populations. Moreover, even in abstraction with mathematical models, advances in understanding of disease occurrence and causation cannot be made without a comparison of the theoretical constructs with that which we actually observe in populations. Empirical and theoretical research complement each other in developing an understanding of the phenomena, in predicting future events, and in the prevention of events harmful to the general welfare of the population of interest.

Empirical research in the health sciences can be qualitative or quantitative in nature. Generally, health science research deals with information of a quantitative nature, and this manual deals exclusively with this type of research. For the most part, this involves the identification of the population of interest, the characteristics (variables) of the individuals (units) in the population, and the study of the variability of these characteristics among the individuals in the population. Thus the quantification in empirical research is achieved by three related numerical procedures:

- Measurement of variables
- Estimation of population parameters (parameters of the probability distribution that captures the variability of observations in the population) and
- Statistical testing of hypotheses, or estimating the extent to which 'chance' alone may account for the variation among the individuals or groups under observation.

2. Basic and applied

Research can be functionally divided into basic (or pure) research and applied research. Basic research is usually considered to involve a search for knowledge without a defined goal of utility or specific purpose. Applied research is problem-oriented, and is directed towards the solution of an existing problem.

3. Health research triangle

Yet another way of classifying health research, be it empirical or theoretical, basic or applied, is to describe it under three operational interlinked categories of biomedical, health services and behavioural research, the so-called health research triangle. Biomedical research deals primarily with basic research involving processes at the cellular level; health research deals with issues in the environment surrounding man, which promote changes at the cellular level; and behavioural research deals with the interaction of man and the environment in a manner reflecting the beliefs, attitudes and practices of the individual in society.

Guidelines for Successful Research

1. Focus on priority problems
2. Action-oriented
3. Multi-disciplinary
4. Participatory
5. Timely
6. Cost-effective
7. Simple, short-term designs
8. Clear results
9. Honest limitations
10. Expressed implications and recommendations

It is a must for any research to be:

- Purposeful
- Targeted
- Credible
- Timely

Scientific foundations of research

Several fundamental principles are used in scientific inquiry:

1. Order

The scientific method differs from 'common sense' in arriving at conclusions by employing an organized observation of entities or events which are classified or ordered on the basis of common properties and behaviours. It is this commonality of properties and behaviours that allows predictions, which, carried to the ultimate, become laws.

2. Inference and chance

Reasoning or inference is the force of advances in research. In terms of logic, it means that a statement or conclusion ought to be accepted because one or more other statements or premises (evidence) are true. Inferential suppositions, presumptions or theories may be so developed, through careful construction, as to pose testable hypothesis. The testing of hypothesis is the basic method of advancing knowledge in science. Two distinct approaches or arguments have evolved in the development of inferences: deductive and inductive.

3. Evaluation of probability

The critical requirement in the design of research, the one that ensures validity, is the evaluation of probability from beginning to end. The most salient elements of design, which are meant to ensure the integrity of probability and the prevention of bias, are: representative sampling, randomization in the selection of study groups, maintenance of comparison groups as controls, blinding of experiments and subjects, and the use of probability (statistical) methods in the analysis and interpretation of outcome. Probability is a measure of the uncertainty or variability of the characteristic among individuals in the population.

4. Hypothesis

Hypotheses are carefully constructed statements about a phenomenon in the population. The hypotheses may have been generated by deductive reasoning, or based on inductive reasoning from prior observations. One of the most useful tools of health research is the generation of hypotheses which, when tested, will lead to the identification of the most likely causes of disease or changes in the condition being observed.

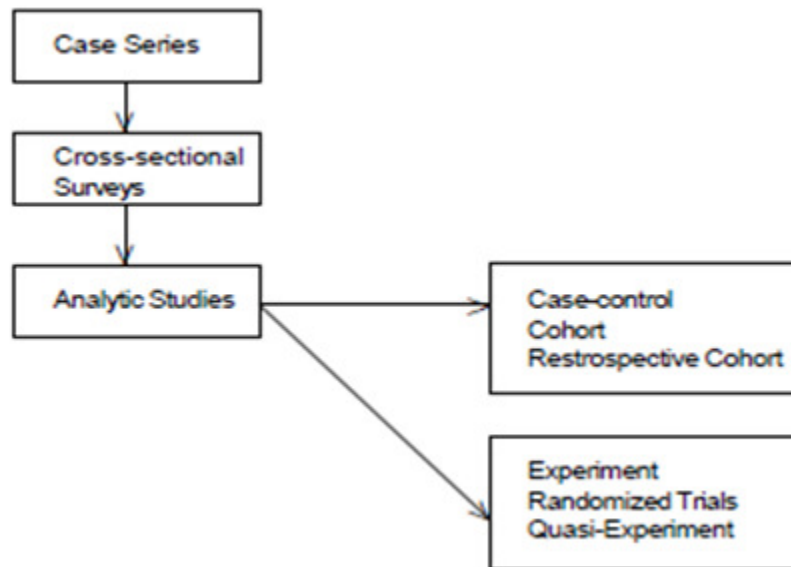
Study design

The epidemiological approach is based upon statistical principles in the structuring of research design. In this approach, research can be divided into that which is basically observational in type, and that which is experimental.

Observational types of studies generally employ the method of sample surveys, where a sample of the population is observed for various characteristics. This may be by actual interviews of the subjects, by obtaining measurements of physical characteristics, or by simply extracting information from existing sources, such as disease registries, hospital or employment records. Surveys of the cross-sectional type (where the information on cause and effect is simultaneously gathered, and the time sequence cannot be determined) are considered to be hypothesis-generating studies, whereas surveys where the observations on cause and effect differ by way of a period of time (such as case-control studies and cohort studies) are considered to be analytical in nature, and inference of associations can be made.

Testing of hypotheses is best done by experiment, where all the factors other than those under consideration can be controlled. However, in human diseases, this is not often possible, due to ethical and practical considerations.

An observation, or series of observations triggers a hypothesis; a cross-sectional survey is undertaken to generate proper hypotheses; an observational study establishes associations and supports (or rejects) the hypothesis; and an experiment is conducted to test the hypothesis.



Some basic steps necessary in developing a research programme include:

1. Defining the intended role and scope of the unit undertaking the research;
2. Determining the capabilities and resources of the research unit, to include personnel, facilities, equipment, supplies, time and budget, and accessibility of research material;
3. Selecting the research topic, considering factors such as
 - Magnitude of the problem and its impact;
 - Urgency of the need for a solution;
 - Relevance to the aims of the funding agency;
 - Amenability of the problem to investigation;
 - Feasibility of the approach;
 - Chances of success;
 - Expected impact of a successful outcome;
 - Spin-off in terms of training of staff and other research capability strengthening elements;
4. Constructing research protocols which will serve as the guiding documents for the execution, monitoring and evaluation of the research;
5. Setting up a well-defined administrative structure with lines of direction, supervision, consultation and collaboration based upon task-specific job descriptions;
6. Formulating a schedule of targets for consolidation of results and preparation of these results for dissemination, including publication in the scientific literature.

2. Execution of Research

The mechanics of conducting research follow the simple steps of formulating the problem, planning the approach (research design) and executing activities within a strategic network leading to specific objectives which will give the solution to the problem.

The following provides a framework for a research proposal into which the basic elements of a research study can be

a. Conceptualizing the problem:

- Identifying the problem (what is the problem?);
- Prioritizing the problem (why is this an important problem?);
- Rationale (can the problem be solved, and what are the benefits to society if the problem is solved?);

Statement of the problem is the *first major section* in a research proposal. It is very important to state and define the problem well because,

- It is a foundation for a research
- It facilitates search of information
- It justifies why the research should be conducted

b. Background:

- Literature review (what do we already know?)
- It is a systematic analysis and interpretation of available information about a topic of study
- It is an excellent opportunity to develop professional confidence in the field of study

Why do we review literature? (reasons)

- To know **more** about a problem
- To avoid **duplication** of information
- To learn the **gaps** in the arena of study
- To learn various **methods** that others used
- To forecast **challenges** that might be faced in the conduct of study

What do we review? (Sources)

- Library (published information)
- Electronic search engines (internet)
- Gray literature (Unpublished ones)

c. Formulating the objectives:

- Framing the questions according to general and specific objectives;
- Developing a testable hypothesis to achieve the objectives.

Types of objectives

1. Estimation objectives: Estimates magnitude of an event
2. Association objectives: Analyses factors associated with an event
3. Evaluation objectives : Evaluates associations

Categories of objectives

- **General objective:**
 - Summarizes what is to be achieved by the study
 - Should be clearly related to the statement of the problem
- **Specific objectives**
 - Logically connected parts of the general objective
 - Focus the study on the essentials
 - Direct the design of investigation
 - Orient collection, analysis & interpretation of data

In short Objectives must be **SMART** Specific, **M**easurable, **A**chievable. **R**ealistic & **T**ime-bound.

d. Research methodology:

- Defining the population, characteristics of interest and probability distributions;
- Type of study (observational or analytical, surveys or experiments);
- Method of data collection, management and analysis:
- Sample selection;
- Measuring instruments (reliability and validity of instruments);
- Training of interviewers;
- Quality control of measurements;
- Computerization, checking and validating measurements;
- The issue of missing observations;
- Statistical summarization of information;
- Testing of hypothesis;
- Ethical considerations;

Types of data

1. **Primary data:** data that one has collected oneself
 - Better understood by the researcher
 - Usually contains few variables
2. **Secondary data:** data that has already been collected by somebody else
 - Not well understood by the researcher
 - Very large number of variables

Data collection

Two broad categories of data collection

1. Quantitative data collection
2. Qualitative data collection

Quantitative data collection Techniques

- Interview administered questionnaire
- Self-administered questionnaire
- Direct measurement
- Review of record

e. Workplan:

- Personnel;
- Timetable (who will do what, and when);
- Project administration;

f. Plans for dissemination:

- Presentation to authorities to implement the results of the research (if applicable);
- Publication in scientific journals and other works (including those of the agency which funded the project) for wide distribution of the research findings.

A good proposal will also contain an executive summary giving an overview of the above topics in clear and simple language understandable by lay persons, and a list of references.

The research worker

Among the important qualities associated with successful research are:

- A spirit of adventure in seeking new facts;
- Perseverance and patience;
- Integrity to oneself and to the value of the scientific Method;
- An analytical mind able to participate in critical Thinking;
- A receptivity to criticism at the professional level;
- Openness of mind, and the ability to see the Significance of the unexpected observation;
- Objectivity.

3. Conclusion

Scientific inquiry is one of the most challenging enterprises of mankind, and the support that it receives is a measure of the strength, vitality and vision of a society. The approach and methods of research have slowly evolved to become ever more precise and efficient. The technology is at hand to explore the unknown. The success of this however, depends as ever on the individual and collective talents of the researchers bound by the tenets of science, such as those dealing with order, inference and chance, as accounted for and encompassed by solid research design and methodology.