



PRIMARY HEALTH CENTRE MANUAL VOLUME I

**PUBLIC HEALTH DEPARTMENT,
GOVERNMENT OF MAHARASHTRA**



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**PUBLIC HEALTH DEPARTMENT,
GOVERNMENT OF MAHARASHTRA**



मिलिंद म्हासकर, भा.प्र.से.

अपर मुख्य सचिव (१)

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Foreword

It is with great pleasure and a deep sense of responsibility that I present the Primary Health Centre Manual.

Maharashtra remains steadfast in its commitment to providing accessible, integrated, and high-quality healthcare to all, particularly to our rural populations and vulnerable groups such as women and children.

Today, through the National Health Mission (NHM), initiatives like Ayushman Arogya Mandir (AB-HWC) and the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) have strengthened our efforts to ensure comprehensive healthcare at the grassroots level. These programs emphasise preventive care, maternal and child health, immunisation, and health awareness to address the needs of underserved communities.

The updated PHC Manual has been meticulously crafted to equip Medical Officers with the latest guidelines, strategies, and protocols aligned with national programs, including the Health Management Information System (HMIS) and the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) framework. This manual is designed to empower Medical Officers with the tools and knowledge necessary to deliver excellence in healthcare at PHCs and beyond.

In conclusion, I commend the effort put in by the Director of Health Services, Pune, & Executive Director SHSRC and the team for their dedicated efforts in revising this manual. This updated PHC Manual is also a testament to the tireless work of the State Health Resource Centre (SHSRC), the State Institute of Health & Family Welfare (SIHFW), and the hundreds of committed committee members of Public Health Department who have ensured it meets the evolving needs of our PHC Medical Officers and the communities they serve.

I am confident that it will contribute significantly to the improvement of primary healthcare services across the state. Together, we can make meaningful strides towards a healthier and happier Maharashtra.



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Preface

The Public Health Department (PHD) of Government of Maharashtra, a vital role in ensuring the well-being of the state's residents. Public Health Department provide accessible and comprehensive healthcare, particularly at the primary level, serves as the foundation of Maharashtra's public health system. By focusing on prevention and early intervention, PHCs play a crucial role in reducing disease burden and improving overall health outcomes in the state.

Medical Officer is the backbone of the Primary Health system in Maharashtra. Their diverse skillset in clinical care, public health, and leadership is crucial for delivering comprehensive and accessible healthcare services to the community.

Previous edition of PHC Manual was published in 2009. Since 2009, the field of public health has undergone significant advancements. New medical practices, protocols, and guidelines have emerged, necessitating an update to the existing PHC Manual for Medical Officers.

The State Health Resource Centre (SHSRC), State Institute of Health & Family Welfare (SIHFW) and along with a dedicated Committee, has this revised edition of the manual. This comprehensive resource incorporates the latest medical knowledge and best practices to equip Medical Officers with the necessary tools to deliver exceptional care at the Primary Health Care (PHC) level. This manual serves as a cornerstone for Medical Officers working in PHCs across Maharashtra. It provides clear and concise guidance on various aspects of public health delivery.

I would like to thank the State Health Systems Resource Centre, Pune, for their effort towards the revision of this Primary Health Centre manual. I would also like to thank the Director, Bureau Chiefs, and officials from the state and district levels for their valuable inputs. Last but not least, I certainly wish to appreciate the Herculean efforts taken by the Committee Members in revising this manual. I am confident that this Primary Health Centre manual will provide the necessary information and support to the Medical Officers of Primary Health Centres in imparting their services.

(Amgothu Sri Ranga Naik, IAS)



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Acknowledgement

I am delighted to acknowledge the release of the revised edition of the Primary Health Care (PHC) Manual for Medical Officers in Maharashtra. This comprehensive resource incorporates the latest advancements in healthcare delivery of State.

Primary Health Centers have become integral to rural life, often regarded as temples of health in these areas. With the evolving field of public health and the introduction of new programs, revising the PHC manual was long overdue as previous edition was published in 2008. Beyond their role as doctors, Medical Officers are expected to be effective leaders, efficient managers, skilled communicators, and trusted by the communities they serve. This manual outline team responsibilities, modern management principles, leadership essentials and technical guidelines.

Despite best efforts, certain constraints, especially space constraints, have prohibited the pictorial depiction of many relevant contents. Additionally, several technical changes have occurred and are still occurring in ongoing national health programs, which may not have been fully incorporated in the manual. It is requested that unnoticed omissions be taken in the right spirit and not as lapses, which can be rectified as the need arises.

This updated manual is a testament to the tireless efforts of the State Health Resource Centre (SHSRC), State Institute of Health & Family Welfare (SIHFW) and the dedicated committee members. We hope this PHC Manual will be useful to Medical Officers inspiring them to care for the reputation of the services in the public eye. We also hope that every Medical Officer will read the manual thoroughly and work as a successful team leader. I extend my gratitude to the SHSRC, Bureau Chiefs, state and the Committee Members for their efforts in revising this manual. This resource will undoubtedly support Medical Officers in providing exceptional services at the primary level.

I also wish to acknowledge the invaluable guidance and support of Hon. Shri Milind Mhaikar, Additional Chief Secretary, and Hon. Shri N. Nawin Sona, Principal Secretary-2, Public Health Department, Government of Maharashtra. Their leadership and insights have been instrumental in shaping this manual.

Finally, I express my sincere gratitude to Hon. Shri Amgothu Sri Ranga Naik, Commissioner (Health Services) & Mission Director, National Health Mission, Govt. of Maharashtra, for his invaluable support in ensuring the manual addresses the critical needs of healthcare delivery in Maharashtra.


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Section 1: Background

The Public Health Department continuously strives to improve health care by preventive as well as curative approach. The Public Health Department (PHD) of Government of Maharashtra, plays a vital role in ensuring the well-being of the state's residents. In prevention and early intervention, PHCs has a crucial role by focusing on Primary Care in reducing disease burden and improving overall health outcomes in the state. Primary Health Centre provides, an accessible and comprehensive healthcare package.

Primary Health Centre is key component in health sector reform. It is an integral part of rural life, treated as place of worship across the state.

Medical Officer is the backbone of the Primary Health system in Maharashtra. Their diverse skill set in clinical care, public health, and leadership is crucial for delivering comprehensive and accessible healthcare services to the community. More than a doctor, the Medical Officer in charge of a PHC is expected to be a better leader, an efficient manager, a successful communicator and most importantly acceptable to the people they serve. He/ she supports the entire PHC team in delivering health care outcomes.

Previous edition of PHC Manual was published in 2006. Since then, the field of public health has undergone significant advancements. New medical practices, protocols, and guidelines have emerged, necessitating in updating the existing PHC Manual for Medical Officers. With the ever-changing field of public health and the introduction of numerous new programs, the revision of the existing PHC manual was overdue.

This manual addresses the duties of individuals and PHC team. It also focusses on principles of modern management, essentials of successful leadership, supervision and monitoring mechanisms, essential aspects of communication, and technical details.

Why revision of manual?

Various reforms and change in approach pave the way towards, accessible, affordable and acceptable health services with reduction of out-of-pocket expenditure (OOPE).

Since PHC Manual was published in 2006, to ensure recent advances, holistic approach and involvement of National Health Mission in big way, PHC Manual has to transform from older version.

Continuous changes and evolution in field of public health led to the revision of the existing PHC manual.

Many topics like MJPJAY & PMJAY insurances schemes, Ambulance management, & introduction of new national health programmes guidelines are added in this edition. This book is based on Indian Public Health Standards (IPHS) designed by MoHFW. While writing this Manual, newer initiatives, Departmental guidelines, Government Resolution & various standards from other Government department are also amalgamated.

In 2006, NHM was in nascent stage, which occupied front seat in today's scenario. Norms of Human Resources, Infrastructures, Guidelines changed markedly. This also necessitated need of revision of book.

With lots of new information, guidelines & programmes revised Manual became bulky. Thus, to make it handy in size, present edition is divided into two volumes.

In first volume, Scope and Objectives of PHC, Administrative Aspect, Information Education and Communication (IEC) needs as well as Health Information System (HMIS) topics are elaborated with special emphasis on National Health Mission. Medico Legal cases are integral part of PHC functioning, hence it is discussed in depth. This volume also covers updated information, various Laws, Acts & Directives issued time to time. Many formats regarding MLC, Postmortem cases will be easily available in this volume.

Second volume of manual consist mainly clinical knowledge and technical information regarding Communicable & Non communicable diseases, medical care, Maternal & Child health, Immunization and National Health programmes at PHC level.

Annexure mentioned in Manual, are presented in QR code. Hyperlink is also provided for same.

This system will help Medical Officer to access forms, Formats, tables, Charts as well as Guideline Handbooks.

Scope and Objectives of PHC: In this topic, important Goals to be achieved by 2025 are redefined as per National Health Policy 2017. Goals & strategy of NHM has been included. Additional Staff pattern of PHC, based on work performance enlisted in this section. Role of Community Health Officer (CHO) & Health Wellness Center has been elaborated afresh.

In Administrative aspect, Responsibilities of PHC Staff section, leave, penalties & punishments are added. DCPS, Calculation of Gratuity, New GIS rates (as per prevalent rules), details of registers to be maintained at PHC are clearly listed at end of section as well as in Annexures.

Information Education and Communication (IEC) section is newly added in this volume. It gives information about Health Education, Communication skills (BCC, IPC, SBCC, etc.) and information about IEC material.

Display material & use of AV media has further stressed in detail. Role of Counselling is also discussed. All Health Days are given in Annexure as ready Reckoner.

Technical aspect of IHIP integrated Health information Platform, Reproductive & Child Health (RCH) Portal, e-Aushadhi, e- Governance are included in Health Information System (HMIS) section.

National Health Mission was just born when previous edition of PHC Manual was circulated in 2006. Only NRHM part was reflected sporadically in that edition. Hence, separate section of National Health Mission has been added with extensive details about programme management & Service delivery components.

Guidelines for preservation of viscera/blood/urine/skin are enlisted in Medico legal aspects section. To help in decision making about referring MLC cases to higher centres has been narrated. Injury & Drunkenness proforma and certificates are given in this section. Guidelines about Sexual violence has been given as per guidelines of MoHFW.

Every caution has been taken in to account to includes latest clinical, technical and administrative changes. By going through famous Quote by Benjamin Franklin "*Change is the only constant in life. One's ability to adapt to those changes will determine your success in life*". Change in modalities in medicine is routine phenomena & may change scenario even tomorrow after publication of this edition.

This Manual will Help Medical Officer of Primary Health Centre in delivering services with quality. It will improve reputation of Public Health Department. As a team leader, Medical Officer will become successful & will inspire as well as build confidence of team members. It also aims to update knowledge & skill of various health staff by providing Charts, SOP's, formats etc. given in Manual.

Hoping expectation of feedback about Manual, in order to improve it further!

Section 2: Scope and Objectives of Primary Health Centre

2.1 Evolution of Primary Health Centre:

The concept of providing medical aid and other essential health services through the medium of Rural Health Centers dates back to 1931.

Primary health care system has undergone various phases of development through suggestions by various health planning committees. Many administrative, infrastructural, operational and other strategic changes were accepted from time to time and various new health programmes were introduced to strengthen the primary health care delivery system. Primary Health centres always maintained the status as basic pillar – the strong trunk of this flourishing tree of health Services. Primary Health Centre provides comprehensive promotive, preventive, curative, rehabilitative and palliative Services in rural areas of India. PHC medical officer is the team leader of his health unit.

2.1.1 National Health Policy:

Policy is the system which provides the logical frame & rationality of decision making for the achievement of intended objectives. Policy states priorities & guides resource allocation. First National Health policy was formulated in 1983 & after that it was revised in 2002 & 2017.

Important Goals to be achieved by 2025 as per National Health Policy 2017.

1	Increase Life Expectancy at birth from 67.5 to 70.
2	Reduction of TFR to 2.1 at national and sub-national level.
3	Reduce Under Five Mortality to 23 per 1000 live births.
4	Reduce neo-natal mortality to 16 per 1000 live births and still birth rate to “single digit”
5	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.
6	To reduce the prevalence of blindness to 0.25/ 1000 Population.
7	To reduce premature mortality from cardiovascular diseases, cancer, diabetes and chronic respiratory diseases by 25%
8	Increase utilization of public health facilities by 50% from current levels.
9	Antenatal care coverage to be sustained above 90% and skilled attendance at birth above 90%
10	More than 90% of the newborn are fully immunized by one year of age.

(Ref: Maharashtra State specific health goals- Health Vision Elements Maharashtra in Chapter no. 5- RCH Maternal Health)

Objectives:

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

The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. The approach would be to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions.

Financial resources:

- Increase health expenditure by Government as a percentage of GDP from the existing percentage to 2.5 % by 2025.
- Decrease in proportion of households facing catastrophic health expenditure from the current level by 25%, by 2025.

2.1.2 National Rural Health Mission (NRHM):

Recognizing the importance of health in the process of economic & social development & improving the quality of life of our citizens, the Government of India has launched the National Rural Health Mission during January 2005.

NRHM has been transformed in National Health Mission for improving health status of rural and urban areas in 2013.

The National Health Mission (NHM) encompasses its two Sub-Missions, **The National Rural Health Mission (NRHM)** and **The National Urban Health Mission (NUHM)**. The main programmatic components include Health System Strengthening, Reproductive-Maternal-Neonatal-Child and Adolescent Health (RMNCH+A), Communicable and Non-Communicable Diseases. The NHM envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs.

Within the broad national parameters and priorities, states would have the flexibility to plan and implement state specific action plans. The state PIP would spell out the key strategies, activities undertaken, budgetary requirements and key health outputs and outcomes.

The State PIPs would be an aggregate of the district and city health action plans, and include activities to be carried out at the state level. The state PIP will also include all the individual district and city plans. This has several advantages:

- It will strengthen local planning at the district and city level,
- It would ensure approval of adequate resources for high priority district action plan,
- Enable communication of approvals to the districts at the same time as to the state.

The fund flow from the Central Government to the states/UTs would be as per the procedure prescribed by the Government of India.

The State PIP is approved by the Union Secretary of Health & Family Welfare as Chairman of the EPC, based on appraisal by the National Programme Coordination Committee (NPCC) which is chaired by the Mission Director and includes representatives of the state, technical and programme divisions of the MOHFW, National Technical Assistance agencies providing support to the respective states, other departments of the MOHFW and other Ministries as appropriate.

The goal of the Mission:

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

Goals: -

- Reduce MMR to 1/1000 live births.
- Reduce IMR to 25/1000 live births
- Reduce TFR to 2.1
- Prevention and reduction of anaemia in women aged 15–49 years
- Prevent and reduce mortality & morbidity from communicable, non- communicable; injuries and emerging diseases.
- Reduce household out-of-pocket expenditure (OOPE) on total health care expenditure
- Reduce annual incidence and mortality from Tuberculosis by half
- Reduce the prevalence of Leprosy to <1/10000 population and incidence to zero in all districts
- Annual Malaria Incidence to be <1/1000 Population.
- Less than 1 percent microfilaria prevalence in all districts
- Kala-azar Elimination by 2015, <1 case per 10000 population in all blocks

Strategy:

The NHM is basically a strategy for integrating ongoing vertical programmes of health & family welfare and addressing issues related to the determinants of health like sanitation, nutrition & safe drinking water.

- Train and enhance capacity of Panchayat Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the female Accredited Social Health Activist (ASHA).
- Health Plan for each village through Village Health and Nutrition Committee of the Panchayat. (VHSNC- Village Health Sanitation Nutrition Committee)
- Strengthening Sub-Centre through an untied fund to enable local planning and action.

- Strengthening of PHCs, RH/SDH and provision of 30-50 bedded CHC per lakh population for improved curative care as per Indian Public Health Standards (defining personnel, equipment and management standards).
- Preparation and Implementation of an inter-sectoral District Health Action Plan prepared by the District Health Mission, including drinking water, sanitation, hygiene and nutrition.
- Integrating vertical Health and Family Welfare programmes at National, State, District and Block levels.
- Development of health and wellness centres upto sub centre level.

2.2 Medical officer as a team leader:

The health team consists of a team of people who share a common health goal and common objectives, as determined by community and Programme needs. Medical Officer is a Team Leader of the health team, which includes Health Assistants (HAs), Multi-Purpose Workers (MPWs), Pharmacist, administrative staff and Sub-Centres having CHO, ANM, and ASHA at satellite locations. Each member contributes according to his or her competence and skills and in coordination with the others. Some contractual health personnel have been incorporated in this team.

The health care team of the PHC is ultimately responsible for implementation of various national health programmes in the community.

The leader is not expected to make all the decisions or do all the work, but must encourage others and coordinate efforts of team members. Final responsibility for any endeavour rests with the leader.

System and the situation:

At times, systems and individuals can be overwhelmed. Some factors will go beyond your control, such as a shortage of supplies. The balance between advocating for improvement and driving yourself crazy with an inflexible problem can be difficult. Be realistic about what you can accomplish as an individual and as part of an organization. You did not create the situation, but you can speak the truth about it and give suggestions for improvement.

Working in leadership and management roles means you will be dealing with your colleagues and co-workers and be faced with many of their problems. You will have to deal with absenteeism, poor job performance and the results of illness and disease. These are problems that you did not create and may not be able to fix. Be clear about your expectations and put systems for reporting, evaluation and remedy in place. This will help to make expectations clear and avoid the problem of dealing with things on a person-by-person basis.

2.2.1 Responsibilities of Medical officers:

- Planning, Implementation and monitoring of health programmes.
- Provide basic preventive and curative services.
- Organize and supervise preventive and promotive health related activities.
- Develop a viable and functional referral system.
- Supervise the sub-centre functioning.

Key points:

- Leadership is part of your job.
- Apply the skills of evaluation and planning to your work as a manager.
- Respect the knowledge and expertise of senior PHC staff.
- Every institution has a history and the legacy of what has happened and why things have worked or not worked.

2.2.2. Qualities of Team Leader:

Committed	Humble
Productive	Visionary
Analytical	Respectful

Good Communicator	Good Delegator
Hard Working	Strategic
Process Driven	Creative
Decisive	Trustworthy
Gives Feedback	

2.3 Establishment & Functioning of Primary Health Centre:

Primary Health Centers play a very vital role in the health care of the rural population of our state and the country. These are expected to serve as centres for promotion of positive health, make people health conscious and ensure their full participation. Primary Health Centre is a multipurpose unit which renders promotive, preventive, curative, rehabilitative and palliative health care services to the people living in defined geographical area. It is an organization, which endeavours to provide basic health care to safeguard and promote the health of the community. With the democratic decentralization, primary health centres are expected to fully involve local people and their leaders in planning and implementation of day-to-day health care rendered by the centres. A primary health centre provides out-patient clinic, MCH/FW clinic, minor surgery room, small laboratory, labour room, Operation theatre and a ward of 06 beds, 2 being reserved for maternity. There are 1908 PHCs and 10748 Sub Centres in the state.

Health services have to be developed with local participation and in full coordination with leaders of the community. In view of this the Medical Officer of the Primary Health Centre should always inform local leaders about planning and development of health services in PHC area.

2.3.1. Establishment of PHC:

Criteria of selection and location of Primary Health Centre and Sub-Centre laid down by Public Health Department are given below.

Primary Health Centre:

- There will be one PHC for 30,000 populations in non-tribal areas, and for 20,000 populations in tribal and hilly areas. As per the new Master plan based on 2001 census for establishment of new PHC in addition to the population norm mentioned, distance norm is also added. From any village PHC facility should be available within 25 km. In addition to this, if the distance norm is fulfilled and if PHC is having more population than the norm then additional staff is sanctioned.
- Headquarter of Primary Health Centre should be located in a place which is centrally situated place/village with good communication and adequate electricity, water supply etc.
- Land required for construction of PHC should be obtained free of cost.

Sub-Centre:

- There will be one sub centre for 5000 populations in non-tribal area, and for 3000 population in tribal and hilly area. As per the new Master Plan based on 2001 census for establishment of new SC in addition to the population norm mentioned, distance norm is also added. From any village, SC facility should be available within 6 km. In addition to this if distance norm is fulfilled and if Sub-centre having population more than the norm then additional staff is sanctioned. (सा.आ.वि. शासन निर्णय क्र. पी.एच.सी. १०९४/४१९९ प्र.क्र. १३/९५/आ. ४, मंत्रालय दि. १ जाने. १९९६).
- The Headquarters of the sub centre should be located as far as possible in a place which is centrally situated with good communication and adequate electricity, water-supply etc.
- Land required for construction of SC should be obtained free of cost.

The scheme of establishment of Primary Health Centers has been transferred to Zilla Parishad under Government Notification Co-operation and Rural Development Department No. TWS/1062-N, dated 1st May 1962 (the date from which Zilla Parishad got established). The Government takes decision of establishment of new PHCs and SCs and Zilla Parishad recommends the place. Once

established, Zilla Parishad cannot shift PHC/SC from its present location. It can only be shifted with the permission of government, if Rural Hospital is established at that place.

Shifting of SC criteria are:

- SC in corporation area.
- If for any SC land is not available,
- Because of dam construction/ forest notification, SC headquarter village shifted and
- If DPDC has proposed shifting of particular SC.

2.3.2. Functions of PHC:

- Provision of medical care.
- Control of communicable and non-communicable diseases.
- Plan & provide Reproductive and Child Health services.
- Family welfare services.
- Adolescent Friendly Health Services
- Safe water supply and basic sanitation.
- Prevention and control of local endemic diseases.
- Health education/ Behaviour Change Communication.
- Nutrition education Programme.
- Collection and maintenance of vital statistics.
- Referral Services
- Basic laboratory services.
- Training of health workers and other staff.
- Wellness activities.

2.3.3. Staffing pattern for PHC and Sub Centre:

Staffing pattern for the Primary Health Centre and Sub Centre is defined as per the GR no. PHC-1097/286/No. 26/97/Health-4 Date 16 January 2003 and after modification in 2007 is now as follows:

Table: Staffing pattern at PHC

Name of Posts	No. of sanctioned posts		No. of sanctioned posts
Technical posts		Non-Technical posts	
Medical officer Group-A	2*	Junior Assistant	1
Health Assistant (Male)	2	Driver	1
Health Assistant (Female)	1	Sweeper	1
Auxiliary Nurse Midwife	1	Lady attendant	1
Laboratory Technician	1	Male attendant	3
Pharmacist	1		
TOTAL 15			

(* In tribal PHCs, one MO is Group A & another MO is Group B)

Table: Staffing pattern at sub centre

No.	Name of Posts	No. of Sanctioned posts
1	Auxiliary Nurse Midwife (MPW-F)	1
2	Multi-Purpose Worker (Male)	1
3	Part Time Lady Attendant (Voluntary Worker)	1

Table: Additional Staff pattern (DHS circular no.5260-5341 dated 17/03/2017).

It is based on work performance converted into points.

No.	Point received		Medical Officer	ANM	Pharmacy Officer	Lab. Technician
1	0 to 15	Current Human Resource	2	1	1	1
2	16 to 20	Additional	1	1	1	1
3	21 to 25	Additional	2	2	2	2

2.3.4 Part Time Lady Attendant (PTLA):

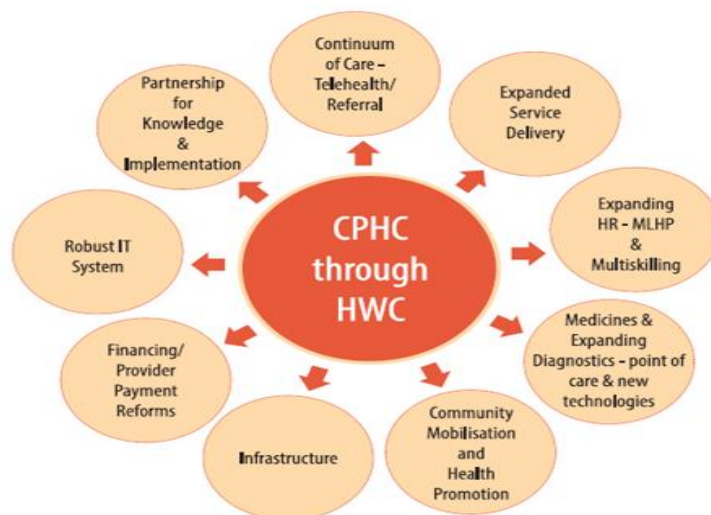
Medical officer should ensure that all ANMs are provided with a Part Time Lady Attendant. In case of vacancy of PTLA, submit a proposal to CEO ZP for appointment of new PTLA. Guidelines for selection & recruitment are as per the *GR Urban Development, Public Health & Housing Department, resolution number FPL1062/56599-II, dated 10th January 1966* as given below - CEO ZP is authorized to appoint PTLA.

Eligibility criteria for PTLA:

- Appointment should be made from amongst the literate ladies of age less than 45 years.
- MO should verify character of candidate. Approval from Gramsabha should be obtained in this regard.
- Candidate should be physically fit and capable of carrying out her duties as attendant, such as carry kit, provide security to ANM etc.
- Candidate should be medically examined by Medical Officer i/c of PHC and certificate about physical fitness should be obtained.
- Written undertaking regarding temporary nature of services & one month's notice in case leaving the job should be taken.
- As per GR of शासन निर्णय क्रमांक: वेपुर-2019/प्र. क्र.6/ सेवा-9, दिनांक १ मार्च २०१९, remuneration for PTLA is Rs. 3000/- per month.

MO PHC should prepare proposal of appointment of PTLA on the basis of above guidelines and submit to CEO ZP. Appointment order of PTLA is issued by CEO ZP.

2.4. Ayushman Bharat: Ayushman Aarogya Mandir (AAM), Health and Wellness Centre:



In phase manner Sub Centres are upgraded to health and wellness centres. There is separate grant provision for medicine, equipment, repairs etc. as per NHM Norms.

Ayushman Bharat (AB) is an attempt to move from a selective approach to health care to deliver comprehensive range of services spanning preventive, promotive, curative, rehabilitative and palliative care. It has two components which are complementary to each other. Under its first component, 1,50,000 Health & Wellness Centres (HWCs) will be created to deliver Comprehensive Primary Health Care that is universal and free to users, with a focus on wellness and the delivery of an expanded range of services closer to the community. The second component is the Pradhan Mantri Jan Arogya Yojana (PM-JAY) which provides health insurance cover of Rs. 5 lakhs per year to over 10 crore poor and vulnerable families for seeking secondary and tertiary care.

HWC are envisaged to deliver expanded range services that go beyond Maternal and child health care services to include care for non -communicable diseases, palliative and rehabilitative care, Oral, Eye and ENT care, mental health and first level care for emergencies and trauma, including free essential drugs and diagnostic services.

In phase manner Sub Centers and PHC are upgraded to health and wellness centres.

2.4.1. Sub Centre HWC services:

1. Care in pregnancy and child-birth.
2. Neonatal and infant health care services.
3. Childhood and adolescent health care services.
4. Family planning, Contraceptive services and other Reproductive Health Care services.
5. Management of Communicable diseases including National Health Programmes.
6. Management of Common Communicable Diseases and Outpatient care for acute simple illnesses and minor ailments.
7. Screening, Prevention, Control and Management of Non-Communicable diseases.
8. Care for Common Ophthalmic and ENT problems.
9. Basic Oral health care.
10. Elderly and Palliative health care services.
11. Emergency Medical Services.
12. Screening and Basic management of Mental health ailments.
13. Yoga and AYUSH services.

2.4.2. CHO in Health and Wellness Centre:

Mid-Level Health Provider (MLHP)- A key addition to the primary health team at the SHC-HWC, would be the Mid-level Health Provider (MLHP) who would be a Community Health Officer (CHO) B.SC Nursing or BAMS OR BUMS. They are expected to carry out public health functions, ambulatory care, management and provide leadership at the HWCs.

2.5. Monitoring PHC Activities:

Monitoring of various activities or records periodically is essential for ensuring smooth and efficient functioning of Primary Health Centre. Frequency of monitoring may be daily, weekly, monthly, bi-annually or annually as per the need of Programme. MO should prepare a register called as 'Monitoring Activities Register'. This register should have sections for activities to be monitored daily, weekly, monthly, etc.

2.5.1. Reporting Formats:

Various Reporting formats Daily, Weekly, Monthly, Half Yearly and Yearly (Refer Annexure 2.1(Vol. I))

2.5.2. Information to be submitted to higher offices:

Besides MIS, lot of information is required by DHO for various reasons. Letters and emails are sent by DHO for the information. Carefully read the daily tapal. If any information is required to be submitted to DHO, give this responsibility to one of the HQ staff. Before preparation for the

compliance, always discuss with the staff about how the information should be given. Remember that compliance should be made in stipulated time. Enter all such information required in following format in Monitoring Register.

Table: Information to be submitted to higher office:

Sr. no.	Information required	Reference number and date of letter	To whom the information should be submitted and	Person responsible to collect the information	Date of compilation	Date of dispatch	Remark

2.6. Meetings:

Medical Officer has to conduct PHC level meeting and participate in block and district level meetings. MO should do homework before and remain fully prepared for all meetings.

2.6.1. General guidelines for effective PHC level meetings:

- Medical Officers has to conduct PHC staff meetings as team leader.
- Have clear objectives and expected outcomes.
- Have an agenda or a plan of how things will proceed.
- Meeting should be conducted in a way that makes all participants feel welcome and comfortable.
- Send minutes of the meeting to all staff & ask for compliance.
- Also colleague MO and other staff members to contribute /Express their views on any topic.
- A principle of Praise in Public Reprimand in Private should be kept in mind, while communicating good /poor performance of employee.
- Meeting Feedback should be specific, timely, constructive and given in a respectful manner.
- Date for monthly HMIS meeting should be fixed.
- Start meeting by recording names of staff attending. This should be followed by reading minutes of the last meeting and review of compliance of activities agreed in last meeting.
- Separate session of problem solving should be conducted at the end of monthly meeting. Junior Assistant must be present for this session.
- Positive approach for problem solving by MO will improve efficiency of staff, minimize complaints & motivate them for better work.
- Do not allow personal grudges / views, prejudiced ideas in the meetings, which many times results in the personal quarrels amongst the workers which ruins the main purpose of the meeting.

2.6.2. Report submission:

DHIS2 / IHIP (HMIS) – Every month PHC & Sub centre wise online performance report should be filled by health workers (MPW-Male reporting format and sub-centre report format is provided at sub centre level).

- MPW-male should prepare his report and this should be added to sub-centre format available with MPW (Female). Report of MPWs should be based on daily diary.
- Instructions should be given to all MPWs to prepare monthly MIS reports one day before the meeting and submit to concern HA at 10 AM on the day of MIS meeting.
- For DHIS2 data entry, each SC is a reporting unit. Therefore, each SC has to complete online data entry by 5th of each month. Before online data entry report should be checked by concerned HA. PHC being reporting unit has to complete data entry of work done in PHC only and not as a compilation of all SC data.
- RCH Portal data should be analysed for performance of registration and updation of services and should be reviewed by MO during review meetings
- All portals and software data should be updated regularly.
- Follow up of regular review of all online data by MOPHC

2.6.3. Scrutiny and analysis:

Sub-centres should be equally divided among available HA (M/F). All Medical officers are responsible for supervision and monitoring.

- Review of work done should start after reports are corrected by concerned HA (M/F).
- Before meeting MO should have line list of EDD / EPD, high risk mothers, severely anaemic mothers, LBW babies from RCH Portal software. Based on these, review should be taken.
- Indicator wise, worker wise and village wise review should be carried out with the help of critical indicator performance register.
- Depending on this analysis, planning for next month should be done. During this monthly meeting give work plan generated in RCH Portal to each ANM. Review of work done as per work plan should be taken by MO. Supervise poor performing areas more closely and support with more resources like medicines, equipments, supervisory help etc. for improving the performance.
- Review NHM related Activities with respect to Financial & Physical Achievements.

2.6.4. Capacity building:

Discussion about important letters received in the month and Programme Implementation guidelines should be carried out to update knowledge of HA(M/F) and MPWs/ ANM.

- Continuing Medical Education: One technical topic should be discussed for at least 30 minutes during every monthly meeting. Topic should be of practical importance and of relevance for the season (e.g. treatment of diarrheal diseases in June, malaria / fever outbreak in July, Dengue fever outbreak in summer season, etc.)
- Technical topic to be discussed in next meeting should be fixed at the end of technical discussion and all the staff should be instructed to come prepared. This will improve the quality of discussion.

2.6.5. Death audit:

- During the monthly meeting, discuss all infant and children upto 5years & maternal deaths that have taken Place in reporting month.
- MO should investigate all stillbirths, infant and maternal deaths every month to understand ground realities and to highlight the deficiencies correctly during meeting.
- While conducting death audit, analyse as per delay I, II, III. Delay I is at the level of beneficiary and her family to take the decision. Delay II is delay to organize transport. Delay III is at Health institution level to give the services.
- Death audit is not a fault-finding mission. Discussion should be constructive and conducted in such a way that workers understand the mistake at each stage with a view to prevent such deaths in future.

2.6.6. PHC Weekly/ Fortnightly Meeting:

- PHC weekly meeting is basically to follow and assess the progress made regarding decisions taken during the last monthly meeting. All PHC headquarter staff should attend weekly meeting.
- Review of progress of actions planned as per decision in monthly meeting.
- Weekly disease surveillance situation, identification of problem areas and instruction for problem solving.
- Problem solving: progress of actions on problems put forward by the staff during monthly meeting.
- Instruction to Concerned Staff to attend Panchayat Samiti or DHO office to solve the problems.
- Review of All Contractual NHM Staff (CHO, ANM, ASHA & other workers)

2.6.7. ICDS sector meeting:

Four out of six activities of ICDS are related to health sector and are implemented by PHC Staff. Therefore, it is extremely important for Medical Officer to Conduct ICDS meeting. ICDS

meetings are scheduled during last week of every month. All the Anganwadi Workers (AWWs), Mukhya Sevika, ANM and HA (F) must attend this meeting.

- AAA Meeting (ANM ASHA & Anganwadi Worker): Meeting to be conducted in Last week of every month. (महाराष्ट्र शासन, साआवि, शा.नि. क्र : साआ वि -२०१७ /प्र. क्र. ७६ /आरोम्य -७ दि. १८-जून-२०२१)
- CHO should conduct a joint meeting of ANM, ASHA and AWW at least once in every month at Sub-centre level. Mukhya Sevika should also attend the meeting. (महाराष्ट्र शासन, साआवि, शा.नि. क्र : अेनौसं 26/प्र.क्र.463/आरोम्य 7 dated 23 Nov. 2023)
- Tally the performance figures, reports of Anganwadi worker and MPW (F), especially immunization, ANC registration, etc.
- Check whether all births and deaths especially infants deaths reported by AWW are included in MPW (F) register and vice versa.
- Review the status of Severe Acute Malnutrition (SAM) and moderate Acute Malnutrition (MAM) Prepare Plan for their check up and referral if necessary.
- Plan Anganwadi visit of MO for next month
- Discuss on important technical topic related to ICDS services during the meeting as continuing education.

2.6.8 Panchayat Samiti (PS) meeting:

- Panchayat Samiti meeting is held once in a month at Panchayat Samiti head quarter and Taluka Health Officer should attend the meeting. MO PHC is not expected to attend this meeting unless it's being asked to attend the same.
- Panchayat Samiti meeting is held under ZP/PS Act. Carefully go through the agenda of meeting and prepare meeting notes on the basis of agenda. Make three more copies. Give copies of meeting notes and brief the Block Development Officer (BDO) and Chairman Panchayat Samiti about agenda and important issues related to all PHCs in block before meeting.
- Brief BDO and Chairman Panchayat Samiti about difficulties of various PHCs, difficulties in achieving the targets and support required by PS before meeting.
- Prepare a note on progress of all PHCs in all National Health Programmes against expected level of achievements. Also mention action taken on important issues raised during last meeting in the note.
- When any question is asked, answer the question on the basis of actual facts, never give wrong information to house. Answer the questions sincerely, to the point and politely.

2.6.9 District level MO meeting:

- Keep one register exclusively for District level meeting and always carry the same register to DHO meeting without fail.
- Arrange meeting file according to the sequence given in the agenda.
- Go through your notes and minutes of last meeting, to check whether any action or information called for is not submitted by you. If so, prepare the information / report for submission to DHO.
- Prepare plan for next month and keep copy of the plan.
- After coming back to PHC, conduct weekly meeting of that week immediately on next working day,
- If instructed specifically by DHO, do not forget to send action taken report

2.7. Maps, Charts & Graphs to be exhibited at PHC:

Following is the minimum essential list of the standard maps, charts and graphs that should be exhibited in the Primary Health Centre. Few important maps, charts and graphs should be displayed in MO room and remaining in suitable places like HA room, pharmacy officer room, office etc.

2.7.1. Maps, charts and graphs to be displayed in MO room:

Maps:

- Map of PHC showing location of Primary Health Centre, sub-centres, all villages, Private hospitals, dispensaries (Govt. Zilla Parishad and voluntary organization) with standard sign for individual category.
- For Survey of Causes of Death (Rural) scheme, map of the village selected for the scheme, areas allotted to the workers, supervisors.

Boards:

- Jan Arogya Samiti
- District Health Committee
- Staff pattern of PHC
- Various health days
- Citizen Charter
- Duty Chart
- OPD Timing Board

Charts and Graphs:

- VHND plans.
- DQAC / ISO Certification if any.
- Fixed tour Programme of MOs, HA (Male), HA (Female), MPW, ANM.
- EDD / EPD monitoring chart for one month.
- High Risk ANC monitoring chart.
- Monitoring chart of severely anaemic pregnant mothers
- Vital rates including Performance of sterilization

2.7.2. Maps, Charts and Graphs (Laboratory, Supervisor Room):

- Graph of annual figures of institutional, domiciliary deliveries.
- SAM/MAM children in the area
- Active, passive surveillance – Year wise total fever cases, number of blood smears collected, number of blood smears examined, positive cases for vivax, falciparum & mixed infection and radical treatment given.
- Month wise statement showing above-mentioned details for the current year.
- RBSK- checkup/ Performance of AWW / School.
- JSY beneficiaries line list – update every month.

2.7.3 Other chart display

Table: Other charts to be displayed at PHC:

Sr. No.	Place	Charts to be displayed
1.	MO room	Treatment Charts (Standard Treatment Guidelines- STG):
		Diagnosis and Management of Dehydration
		Classification of ARI and Management
		Dog Bite Classification and Treatment
		Categorization and Management of patients of TB & diagnosis algorithm
		Classification of Leprosy Cases and Management Age wise
		Treatment of Malaria as per new Drug Policy.
		Treatment Protocol for Diabetes and Hypertension
		ELA & Achievements Chart Month wise
		Basic Life Support method.
2.	Sterilization room	Procedure of Autoclaving

3.	Delivery room	Important protocols e.g., Hand washing, Management of APH/PPH/Eclampsia/AMTSL/ Parto-graph, NBC, Neonatal Resuscitation, Breastfeeding, BMW Management, Charts of Contents of Trays, etc.
4.	ANC Clinic	Immunization Schedule Injection Iron Sucrose dose calculation and procedure. Diet chart for ANC
5.	OT	Area of OT and dose of Hydrogen Peroxide and Silver Nitrate (OT fumigation guidelines)
6.	HA (M)	Method of calculation of volume of Water for round, square well, tank
		Dose of TCL & method of chlorination of water, OT test
		Preparation of mother solution
7.	HA (F)	Board showing stock of vaccines, number of frozen ice packs ready every day
		Plan for shifting of vaccine in case of electricity failure
		Method of defrosting ILR.
8.	Pharmacy Officer	Medicines stock, SDL
9.	Cold chain equipment room	Charts of how to keep ILR / Deep freezer vaccine storage, Ice packs, arrangements, emergency plans etc.
10	Hirkani Kaksh	IEC regarding Breast feeding
11	Indoor Ward	Cleanliness chart (Daily & weekly)
12	Corners	Oral Rehydration Therapy (ORT), Family Welfare (FW), TB, MMDP(Filariasis)

2.7.4. PHC Master File:

Sequence of information should be maintained uniformly as follows-

- Name of PHC, year of establishment.
- Map of district showing all blocks and your PHC
- Map of PHC showing all the villages, sub centres along with population (different color for each sub centre). Approach roads along with population, places of public health importance, rivers, dams, etc.
- All vital indicators of PHC e.g. birth rate, death rate, IMR, etc.
- ASHA, Anganwadi, Dais, Schools, Ashram Schools, Gram panchayat in PHC area with contact numbers
- Village wise water sources, water samples, TCL samples.
- Waterborne or vector borne out breaks if any
- List of facilities available at PHC.
- Information of various surveys carried out in PHC
- Table and graphs of target & achievements of important Performance indicators of last three years
- List of guppy fish hatcheries and mosquito breeding place along with code numbers
- Important activities / events in last year along with photographs if available
- RKS Committee (JAS)
- ZP Health Committee.
- JSY & JSSK Information.
- Epidemic outbreak, Disaster Preparedness and Management plan for PHC area.
- Referral plan

- Status of National Health Programs.
- Performance in Adolescent Health Program i.e. ARSH clinics, WIFS performance.
- Child health - SAM/MAM children in PHC area and Anganwadi check-up.
- Various Health Days - celebration reports.
- For Navsanjivani areas- Bharari Pathak fixed day schedule, performance
- Any other relevant information as applicable.

Reference:

Annexure 2.2(Vol. I) For additional information regarding NQAS Certification criteria and checklist refer NHSRC website & other resource material:

<https://www.nhsrcindia.org/search/node?keys=NQAS>

Annexure 2.3(Vol. I) Guidelines for Certification of Public Health Facility under NQAS NHSRC

Website:https://gps.nhsrcindia.org/sites/default/files/2021-05/Guidelines%20for%20Certification%20of%20Public%20Health%20Facilities%20based%20on%20NQAS%20%281%29_0.pdf

Annexure 2.4(Vol. I) Certification Process under NQAS refer NHSRC website:

<https://gps.nhsrcindia.org/sites/default/files/2022-09/Certification%20at%20HWC.pdf>

Section 3: PHC Administration

3.1. Powers of Medical Officer:

Professional competence in health field has been traditionally identified with technical capabilities. However, this needs to be supplemented by equally good managerial skills for effective functioning of PHC. Variable managerial skills are required for everyone working in health services, depending on level in hierarchy.

Primary Health Centre is single administrative unit & Medical Officer is designated as head of office; he/she has to take decisions on all administrative matters of PHC. Junior Assistant is posted to assist Medical Officer in administrative matters. To discharge duty as head of office efficiently, MO must know powers and responsibilities, various civil services rules related to leave, penalty, pension, financial aspects relevant to PHC functioning etc.

Important administrative matters at the level of Primary Health Centre:

- Powers delegated to PHC Medical Officer
- Types of Leave
- Service book
- Confidential Reports (CR)
- Penalties and punishment
- Financial aspects
- Records and registers
- Inventories of consumables, equipment's, movable/immovable property etc.

Powers delegated to Medical Officer PHC:

Primary Health Centre functions under administrative control of Zilla Parishad. All the administrative powers in Zilla Parishad are vested to Chief Executive Officer (CEO) of Zilla Parishad. CEO delegates some of these powers, essential for day-to-day administration to Medical Officer. Powers delegation may not be similar for all Zilla Parishads. However, list given below indicates, powers delegated to MO in majority of districts.

Administrative powers:

- To approve monthly diary and advance tour program (ATP) of PHC staff.
- To grant casual leave to staff working in PHC.
- To certify, entries in service book i.e. maintenance of service record of staff.
- Disciplinary actions (minor penalties) like censure, withholding promotion, recovery from the pay (whole or part) of loss caused to government due to negligence or breach of orders and withhold increments of pay, etc.
- Recommendation of minor and major penalties to DHO.
- To classify records (as per government guidelines), preservation and destroy them when period specified for preservation is over.
- To write Confidential Report of Group-B and Group-C staff and to record report of working of Group-D staff in a prescribed format and submit to DHO.

Financial powers:

- To grant earned leave up to 90 days.
- To grant annual increment.
- To grant transfer TA and festival advance.
- To grant refundable GPF advance.
- Condemnation of articles not exceeding the cost of Rs. 250 after depreciation.
- Repair of vehicle within financial powers after getting written report from driver
- Pay fixation after promotion, time scale promotion and issue of guidelines when new pay commission is declared, getting options.

Powers related to health and sanitation:

Medical officer has following powers related to health and sanitation for establishments located within PHC jurisdiction.

- To enter any building for inspection from health point of view.
- To enter and examine buildings with problem of communicable diseases.
- Inspection of hotels, cinema halls and other public places from health point of view.
- Inspection of poultries, piggeries, goat farms or any similar establishment from health point of view.

- To give notice to unhygienic buildings.
- To advice, Taluka Magistrate about declaration of area as epidemic prone or with ongoing epidemic under Epidemic Control Act.
- To conduct sanitary survey of all villages under PHC jurisdiction.
- To monitor chlorination of water, cleanliness of & around water sources
- To advice the Taluka Magistrate about declaration of area as epidemic prone or with ongoing epidemic under Epidemic Control Act.

To exercise above mentioned powers, MO needs to keep himself updated about various administrative rules and acts, e.g. Maharashtra Civil Services Rules, Maharashtra Gram Panchayat Rules, related acts like Epidemic control act, etc. The information given below is derived from these rules and acts which is required for day-to-day functioning.

3.2. Leave:

Leave means written sanction from leave sanctioning authority to remain absent from duty & it cannot be claimed as a right. MO PHC 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. (***Maharashtra Civil Services (Leave) Rules 1981***)

3.2.1 Guidelines for sanctioning leave (Rule12):

- 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.

Important aspects of leave:

Commutation of one kind of leave into another (MCSR 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 cannot claim such commutation as a matter of right. Commutation should be made at the request of government servant.

Combination of leave (MCSR 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.

3.2.2 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.

Various kinds of Leaves are applicable to Health Staff in PHC such as:

- Causal Leave
- Earned Leave
- Half Pay Leave
- Commuted Leave
- Leave Not Due

- Extra Ordinary Leave
- Medical Leave

For details Refer Annexure 3.1(Vol. I)

3.2.3 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.

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 120 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.

3.2.4 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.

Maternity leave for government servant (Rule-74) (*GR-a ra ja-1409/prs kra 8/09/seva-6 dated 24 august 2009 finance department*)

- On date of application female servant in permanent employment is entitled for 180 days fully paid maternity leave for first two pregnancy.
- A lady government / ZP servant not in permanent employment who has put up at least one-year continuous service but less than two years' service is also entitled for 180 days maternity leave & leave salary equal to half the pay drawn immediately before proceeding on leave.
- Female government/ZP servant who has put up in two or more years continuous service will get leave salary equal to pay drawn before proceeding on leave.
- 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.

Special Casual Leave:

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.

3.2.5 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.

3.2.6 Special leave for tuberculosis, cancer, leprosy (Rule79)

After 3 years continuous service, one-year full pay leave is admissible on submission of medical certificate for above mentioned 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.

3.2.7 Study leave (Rule 80)

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

3.2.8 Special Childcare leave (Bal-Sangopan raja):

Government female employees as well as non-wife male employees can be granted leave within a maximum limit of 180 days subjects to be terms and conditions of the finance department GR dated 23/07/2018

Special childcare leaves up to maximum of 730 days is granted to state government employees having disabled children. (Finance Department GR. Dates 21/09/2016 and 09/03/2023)

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 (LWP) 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.

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 & group D staff.

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 their in.
- When journey days fall on Sunday, journey day is extended by one day.
- For request transfer only journey period is allowed.

Table: Responsibilities of PHC staff for leave:

Sr.	Activity	Responsibility of PHC staff	
		Designation	Responsibility
1	Sanctioning of leave	MO	MO will sanction leave as per delegated powers. Health care delivery system of PHC should not be affected. No staff should be permitted to go on leave during epidemic, special campaigns, assembly sessions and any other occasions.
2	Keeping record of leave	Junior assistant	Keeping records of all leaves, timely updating the leave record on service books.

3.3 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, Training's, 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.

3.3.1 Entries in service book

- 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, computer 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.
- On last page, entry of house building advance, motor cycle advance etc. with due attention should be taken.
- Each entry should be duly verified with departmental orders, pay bills, leave account and attested by head of the office.
- GPF/DCPS account number should also be noted in the service book.
- Entry of annual increment should be taken on 1st of July every year.
- Entry regarding Group Insurance Scheme, MSCIT, Marathi/Hindi Exemption, Character Verification, Medical Fitness, permanency benefit, Hometown, PH conditions certificate etc. should also be taken in the Service Book.

Entry regarding Caste Validity Certificate should also be taken in Service Book in respect of employees belonging to backward community.

(MCSR -General conditions of service Rule -37/1981)

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/her 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.

3.3.2 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.
- Entry of Annual Increment should be taken invariably.

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.

3.4 Confidential Reports:

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

General guidelines:

The CR should be written as per guidelines. *(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 3 months 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 3 months.
- 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).
- Staff appointed under NHM, performance report in prescribed format has to be submitted to Taluka Health Officer at end of the financial year.

(Revised the format of writing the CR should be as per GR No. GAD no.CFR-1211/257/ 13 dated .02 Feb.2017).

3.4.1 Writing of 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 15 April. 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.
- Excellent and adverse remarks must be communicated in writing.
- DHO is the custodian of Confidential Reports of group C, ZP Servants of Health Department while Directorate of Health Services is the custodian of CR of Medical Officers.

3.4.2 Responsibilities about Confidential report

Table: Responsibilities of PHC Staff:

Sr.	Activity	Responsibility of PHC staff	
		Designation	Responsibility
1	Obtaining the CR forms and entering the information of Part-I on the forms	Junior assistant	Junior assistant will obtain the CR forms from DHO office/Panchayat Samiti and fill up the Part-I of the form before 7th April of every year

Sr.	Activity	Responsibility of PHC staff	
		Designation	Responsibility
2	Filling up of CR register	Junior assistant	Write the names of all the PHC staff according to the office of submission. Usually the CR of Jr. Assistant, Driver and work performance report of Group-D staff is submitted to Dy. CEO (GAD), Leprosy technician to Asst. Director (Leprosy), Malaria staff to DMO and other staff to DHO.
3	Filling up of self-assessment	Each of the staff	All the staff members will fill up the self-assessment (including medical officer) and submit to MO before 15th April every year
4	Writing the CR	MO	MO will write the CR of all the staff members before 15th April. As far as possible all the CR should be written in one sitting. Refer Ephemeral role and daily monitoring register before writing the CR.
5	Closing the CR forms.	MO	Make separate envelops according to the office of submission. Seal the envelope. Write confidential reports in red ink on the envelope and hand over to Junior Assistant for submission to concerned office.
6	Submitting the CR to concerned authorities	Junior assistant	Junior Assistant will submit the sealed envelope to all concerned offices and get the signature on CR register from each office.

3.5. Penalty and Punishment:

Important aspects related to penalty and punishment described below are based on Maharashtra Civil Services (Conduct Discipline & Appeal) Rules 1979 and relevant government resolutions. Information is simplified for benefit of MO and staff of PHC. For details, original rules and government resolutions should be referred.

Penalties are classified as minor and major penalties. There should be sufficient reason to impose penalty on any government servant. Laid down procedure should be strictly followed for imposing penalty. Medical Officer PHC must know types of penalties, procedure to be adopted and authorities who can impose these penalties.

3.5.1 Types of penalties (Rule 5 - Discipline and Appeal Rules)

A. Minor penalties:

- Censure
- Withholding of promotion
- Recovery from pay- Whole or part of loss caused to government due to negligence or breach of orders.
- Withholding increments and pay Reduction in lower stage in time scale of pay for a specified period without effecting further increments.
- Reduction in lower stage in time scale of pay for a specified period with effecting further increments.
- Reduction to lower scale of pay, grade, post or service.

B. Major penalties:

- Compulsory retirement
- Removal from service, which shall not be a disqualification for future employment under government.
- Dismissal from service, which shall ordinarily be a disqualification for future employment under government.

3.5.2 Disciplinary Authorities (Rule 6 - Discipline and Appeal Rules)

- Appointing authority may impose any of the penalties specified in Rule – 5 (Major or Minor) upon member of Group – C and D services.
- Head of office shall exercise power of imposing minor penalties on member of Group C and D category services.
- Medical officer is head of office for PHC staff, therefore, after going through laid down procedure can impose minor penalties when there is sufficient cause and going through the lay down procedure

3.5.3 Procedure for imposing penalties:

Procedure for imposing minor penalties (Rule 10 of Discipline & Appeal Rules)

- MO PHC can impose minor penalty on the staff working in PHC
- After noticing misconduct or misbehaviour of government servant, if MO PHC is of opinion that there is sufficient reason to believe that government servant may be guilty then Medical Officer may start inquiry against that person.
- Inform Government/ZP servant in writing of reason of misconduct or misbehaviour and proposal to take action against him/her.
- Give reasonable opportunity to government servant for making such representation as he may wish to make against proposal.
- Record of proceedings of inquiry should include:
 - A copy of intimation to government / ZP servant about proposal to take action against him.
 - A copy of statement indicating misconduct or misbehaviour
 - His representation if any
 - Evidence produced during inquiry
 - Findings of each misconduct or misbehaviour
 - Orders on case with reasons thereof.
- If disciplinary authority has proposed withholding increment that may adversely affect amount of pension or if it is proposed to stop increment for more than three years, inquiry should be held in manner of inquiry conducted for major penalty.

Procedure for imposing major penalties:

Rule No. 8 and 9 of Maharashtra Civil Services (Discipline and Appeal) Rules have specified procedure to be adopted for imposing major penalties.

When Medical Officer PHC has reason to believe that any of PHC staff is engaged in misconduct or misbehaviour and feels misconduct or misbehaviour is sufficient for major penalty, following procedure should be adopted:

- Medical Officer should inform CEO (Disciplinary Authority) through DHO about misconduct or misbehaviour of PHC staff along with following documents-
 - Definite and distinct charges describing misbehaviour or misconduct.
 - Statement of all relevant facts, which support charges.
 - Copies of any memo given to government servant and his explanations along with comments of MO on explanations.
 - List of documents by which, and list of witnesses by whom, charges are proposed to be sustained.
- Disciplinary authority appoints inquiry officer under (rule- 8) to conduct inquiry.
- Inquiry officer goes through documents provided by MO, can ask for additional documents and fixes charges on person under inquiry.
- Copy of articles of charges fixed by inquiry officer is delivered to government/ZP servant. This includes.
 - Charges fixed on government/ZP servant.
 - List of documents and witnesses.
 - Giving specified period for written statement on his defence and to state whether he desires to be heard in person.
- Inquiry authority shall record his findings on each charge after taking such evidence that he/she may think fit.
- Disciplinary authority appoints a government / ZP servant or legal practitioner as “Presenting Officer” to present case in support of article of charges before inquiry authority.
- Government servant under inquiry shall appear in person before inquiring authority within ten working days from date of receipt of charges.
- Presenting officer will produce evidences, which can be cross-examined by government servant in front of inquiry authority.
- On the basis of findings of inquiry on charges put on government servant, his defence, documents and evidence produced, inquiry officer will produce his remarks on each article of charges and penalty proposed.

3.5.4 Action on inquiry report (Rule 9)

- Disciplinary authority furnishes a copy of inquiry report to government servant along with proposed penalty and calling upon him to submit explanation within 15 days of receipt of notice.
- After considering representation submitted by government servant, disciplinary authority will determine what penalty if any, should be imposed on government servant.

3.5.5 Communication of orders:

Orders made by disciplinary authority should be communicated to government servant along with copy of report of inquiry and receipt should be obtained. If the concerned official is not accepting the written orders, then with the sign of 2 witnesses the order copy can be pasted at residence.

3.5.6 Suspension

Suspension is not a penalty but administrative decision.

- Appointing authority or any authority superior to appointing authority may place government servant under suspension. For Zilla Parishad staff, CEO is appointing authority and for state government staff (TB, Leprosy, and Malaria department staff) concerned bureau chief / regional Deputy Director is appointing authority. (rule – 4 of MCSR (Discipline and Appeal) Rules 1979)

When the government / ZP servant is suspended?

- When disciplinary proceeding against government / ZP servant is contemplated or is pending.
- When government / ZP servant is engaged in activities prejudicial to interest of security of country or when any criminal offence is under investigation, inquiry or trial.
- When government servant is in police or judicial custody for a period exceeding 48 hours.
- When government / ZP servant is sentenced to a term of imprisonment exceeding 48 hours and is not dismissed or removed.

If any PHC staff member is engaged in any above-mentioned activity and his/her presence on duty is detrimental to public service or detrimental to inquiry against him, Medical Officer may recommend with reasons in details about suspension of person to CEO through District Health Officer.

Headquarter during suspension:

- Normally HQ of suspended person is same place from where person is suspended. However, suspending authority can change headquarter of person in view of public interest.
- If any suspended Zilla Parishad staff is posted to your PHC as a result of changed headquarter, accept joining. Suspended person need not sign daily muster but should remain present at headquarter and should not get employed or start any business.
- Subsistence allowance is drawn by office from where person is suspended. Govt. Servant under suspension is entitled for subsistence allowance equivalent to the pay admissible for half pay leave plus DA admissible for such leave for 3 months & if period of suspension is more than 3 months then allowance should be increased to the maximum limit of 50% of the subsistence allowance admissible for the first 6 months.

Table: Responsibilities of PHC staff in punishment procedures:

Sr.no.	Activity	Responsibility of PHC staff	
		Designation	Responsibility
1	Initiating the penalty and punishment procedure	MO	MO will initiate the penalty and punishment procedures when there is sufficient reason for the procedure.
2	Keeping the record and assisting the MO for procedure	Junior assistant	Junior assistant will keep file of all the records required, collect relevant documents and submit the MO relevant government resolutions.

3.6. Financial Management:

3.6.1 PHC Budget:

Medical Officer and Junior Assistant must understand following important aspects of PHC budget:

- Money allotted for functioning of PHC is called budget. There are two sources of budget
 - ZP fund budget under section 8 Public Health.
 - Agency scheme budget under section 123
- Public Health Department sanctions budget grants to Zilla Parishad in the month of April-May.
- Once grants are available to DHO office, they are distributed to all PHCs in the form of budget statement.
- Budget statements are different for each head of account. Statement indicates how much amount is allotted for various purposes like pay, traveling allowances, contingency, Petrol/Oil/Lubricant (POL), etc.

- When you receive budget statement, read it carefully. First see head of account, note down duration of budget i.e. for 4 months, 8 months or whole year. Locate name of your PHC in statement and finally note down amount provided for each activity e.g. pay, TA, POL, contingency, etc. against name of your PHC.
- Payment of all staff and budget for PHC functioning do not come under one budget head but different heads. This is because posts are sanctioned under various health schemes. Get idea about what budget head is applicable to which PHC staff.
- If budget allocation for any particular head is not sufficient, additional demand should be submitted in next quarterly budget with reasoning.
- Budget shown in statement for various purposes is actually deposited to Panchayat Samiti. Medical Officer should submit bills to Panchayat Samiti against budget allotment and get bills sanctioned.
- Medical Officer cannot submit bill once amount allotted under particular head is exhausted. To monitor this, Junior Assistant must write down budget allocation and monthly expenditure of PHC under each budget head and update this account before submission of bills to Panchayat Samiti.
- Total budget allotment for particular head and expenditure so far needs to be mentioned in each bill. Check this with expenditure register before signing bill.
- Budget allocation for one purpose cannot be utilized for another purpose.
- Budget is released to PHC for following purposes:
 - Pay and allowances of PHC staff
 - Contingency
 - POL and minor repairs (Vehicle grants)
 - Contingency and compensation for sterilization operations
 - Special campaigns like Pulse Polio Immunization, Family Health Awareness Campaign, school health, etc.
- Do not finish budget quickly but use budget in such a way that it should be sufficient for period mentioned.
- MO should watch budget provision through monthly expenditure statement submitted to BDO.

3.6.2 Cash Book

This is important record at PHC which has to be maintained by Junior Assistant and should be daily checked by MO. (form no. 7 as per MZP & PS Account code)

General aspects:

- Three cashbooks should be maintained at PHC. One for transferred scheme i.e. District fund, second for NHM & another for Agency scheme.
- PHC transactions take place under two major heads (2210- Medical and 2211-Family Planning). Transactions of both these heads should be entered in one cashbook. However, particulars of head of account should be mentioned for each transaction.
- Each page of cashbook must be serially numbered with office stamp. Certificate indicating number of pages in cashbook should be mentioned.
- Cashbook should be written and closed daily. If there is no transaction on any day, that should also be mentioned. Junior Assistant must get each entry signed by MO daily at time of closing office.
- At end of each month MO should check abstract of closing balance.
- MO should verify whether there is any payment remaining not disbursed for a period exceeding three months. Enquire why payment is not made. If payment cannot be made then Junior Assistant should put a note to MO indicating reasons for non-payment and money should be deposited back to Panchayat Samiti. Enter Challan number in cashbook.

Entries in cashbook

- All monetary transactions should be entered in cashbook as soon as they occur and should be attested by Medical Officer.
- Erasing or overwriting of an entry in cashbook is strictly prohibited. If there is a mistake then put straight line on entry in such a way that it can be read clearly and write corrected entry by red ink in between lines. MO should sign every such correction with date.
- Closing balance of preceding date should be opening balance for next day.
- Receipts collected by means of receipts should be accounted for, on same day
- Cheques received from BDO PS & government should be accounted for in cashbook on date of receipt, irrespective of date of realization and they should be checked with cheque receipt register.

- Totals of receipt and expenditure should be verified and closing balance be worked out. Closing balance should be recorded in figures and words & it should be attested.

Verification by MO:

- MO should do short signature for every entry of receipt and expenditure.
- Payments/expenditure should be verified with payees' acquaintance rolls duly dated.
- At end of each month MO should verify cash balance in cashbook and record a signed and dated certificate to that effect, mentioning balance in words and also in figures.
- Verification of cash and certificate of same indicating balance as per cashbook and actual balance in cash box has to be given by MO.

Cash and cashier:

- Cash should be utilized for same purpose for which it has been drawn.
- To carry money when amount exceeds Rs. 5000/- two persons must be sent and one of them must be cashier or clerk.
- Security bond from cashier should be obtained within 30 days from date of taking over charge as per rule 43 of MZP & PS Account code.
- Cash should be kept in double locking pattern cash box. One key should be kept with MO as per rule no. 42 of MZP & PS Account code.
- No heavy cash balances should be kept.
- Cash drawn should be disbursed immediately for the purpose for which it was drawn.
- The security bond from cashier will be Rs.1500/- for clerk Rs.200/- for Store Keeper Rs.2000/-

3.6.3 Bills at PHC:

Junior Assistant prepares bills, which are scrutinized and signed by MO PHC. Bills are as below-

- Pay bills of staff.
- Bills of contingency and other purchases
- Vehicle bills- Diesel, oil, servicing and repairs.
- Traveling allowance bills
- Bills of various campaigns organized at PHC.
- NHM related Activities bills

Pay bills:

This is the most important financial activity in PHC. Monthly and timely payment of staff is primary responsibility of Junior Assistant and MO PHC.

- Pay bills need to be submitted in prescribed format. Junior Assistant should start preparing pay bills on 15th of each month and pay bills should be submitted to Panchayat Samiti by 20th of each month.
- All posts under PHC are derived under various heads of account. Separate bills are required for each head of account.
- Account head wise register of entire staff in PHC is maintained giving details about post, including GR no. By which post is sanctioned, permanent or temporary nature of post and budget head of pay. This is called "Establishment Schedule."
- Deductions made in pay bill in respect of provident fund, income tax, postal life insurance premium, CTD, ZP servants' society should be invariably made through PFMS to respective authorities & acknowledgement thereof should be obtained vide rule 75 (3) of MZP & PS Account code.
- Medical Officer should check following registers before signing pay bills.
 - Establishment schedule - To check correct head of account for each staff.
 - Muster roll- Indicating daily attendance of staff. If any staff is absent without permission, MO has to take decision to consider this absence as without pay or not. In that case payment of staff should not be drawn.
 - Increment register - Check whether any staff member is due for increment in that month. Confirm that all increments are added in pay bill. If due increment is not drawn, sanction increment, ask Junior Assistant to make necessary changes and sign pay bill.
 - Long leave register - If leave of any staff is sanctioned, payment should be drawn and if not sanctioned, payment should not be drawn.
- Check whether all deductions are shown in schedule attached to pay bills. Randomly counter check amount on schedule and that on pay bills.
- In case of supplementary claims, note has to be taken in original pay bill to avoid double claim. Verify note taken on original pay bill before signing supplementary bill.

- Un disbursed amount of payment more than 3 months should be credited by challan to respective head vide rule 77 (3) of MZP & PS Account code.

Bills of office contingency:

- Ensure budget provision is available before expenditure.
- MO must be sure that material to be purchased is essential for functioning of PHC.
- For telephone bill, scrutiny certificate of MO on bills is necessary indicating, "Certified that all local and trunk calls made on this telephone are for official purpose and registers of local calls and trunk calls are verified."
- Electricity bills - Meter reading book should be maintained. Tally bill with this book and forward for payment. Since 2001, electricity bills can be paid through OPD registration fees.
- After receipt of above bills, MO should check bill number, date and amount.
- Enter name and page number of register in which entry of material has been taken on backside of bill.
- Ensure required material is received in mentioned quantity, specification and in good condition before paying bills.
- After payment, take entry of bill in cashbook. Record cash book number and page number on backside of bill and put Paid and Cancelled stamp on bill.
- At close of month, reconciliation with bill register, cheque receipt register should be carried out. An abstract of bills sent for drawl of Cheques, Cheques received & bill pending at end of month should be drawn & attested after verification/ BRS (Bank Reconciliations) should be done.

Diesel, oil, repair bills of vehicle:

Diesel and oil purchases should be entered in logbook of vehicle. Certificate of entry with logbook page number, vehicle number should be entered on receipt.

3.6.4 General Provident Fund (GPF):

- It is compulsory for all permanent government / ZP servants and for all temporary government servants after completion of one year government service.
- Monthly subscription for GPF is minimum 6% of basic pay and maximum up to full basic pay. Account of GPF is maintained from March paid in April to February paid in March.
- Entire balance of credit along with interest is paid to government /ZP servant on retirement or to nominee in case of death of a government servant.
- For ZP employees, Chief Accounts & Finance Officer (CAFO), Finance department, ZP will allot PF number.
- In case of Group-A government servant, Accountant General (AG) gives GPF number and AG maintains all account.

Important points about GPF:

- GPF account number must be entered in service book.
- After transfer, account number needs to be mentioned in LPC.
- Nomination for GPF should be made in prescribed format and sent to AG & in case of ZP servant to CAFO, ZP. Note of nomination should also be taken in service book.
- Lady government servant can omit name of her husband from nomination if she desires. But a male servant has to nominate his wife.
- Yearly account of GPF is sent by AG by September end and if not received it is necessary to contact AG.
- In case of missing credits, following information should be sent to AG / CAFO, ZP:
 - Designation of DDO
 - Account head of monthly salary
 - Month, voucher number and total amount of bill
 - Certificate of DDO about deduction from salary of amount.
- When employee is on half pay or without pay leave, deduction will be as per his/her willingness.
- GPF account of class IV servant should be maintained by head of office.

Advance from GPF:

Government servant can get advance from GPF as below-

- Ordinary advance or refundable advance: Admissible limit is three months basic pay or half of balance at credit, whichever is less.
- Nonrefundable or special advance: Admissible limit is one half of balance at credit or six months' pay whichever is less. However sanctioning authority may sanction up to $\frac{3}{4}$ of balance.

- Advance from GPF (Ordinary or special) may be sanctioned for religious ceremonies, medical treatment of family members, higher education, purchase of plot or house etc.
- Government servant requests for advance in prescribed format. Controlling officer (MO in case of PHC staff) can sanction advance if he/she is satisfied about reason given and amount specified for reason. Bill should be submitted to Panchayat Samiti along with GPF slip and sanction letter.
- Advance from GPF should be paid back by deduction in minimum of twelve, maximum of twenty-four instalments and in special case thirty-six instalments from salary of government servant.
- Government servant cannot take another GPF loan before first loan is fully paid except for medical treatment, higher education, marriage, house building.
- Non-refundable loan is permissible after completion of 20 years' service. However, for house building or repair, renovation of ancestral house or buying plot it is permitted after completion of 10 years' service.

Final payment of GPF at the time of retirement:

- For ZP servant final payment is made by CA & FO.
- For government servant authorization is issued by concerned AG.

3.6.5 Defined Contribution Pension Scheme (DCPS)

The Government has discontinued the regular pension scheme applicable to Govt. Servants w.e.f., 1st November, 2005 and has introduced new Defined Contribution Pension Scheme (DCPS) for all employees who have joined service of State Government on or after 1st November, 2005 vide *GR dated 31.10.2005*. Accordingly, those who join service on or after 1st November, 2005 are not eligible for pension scheme under Maharashtra Civil Services (Pension) Rules, 1982 and Maharashtra Civil Services (Commutation of Pension) Rules, 1984 as well as General Provident Fund Scheme.

3.6.6 Group Insurance Scheme (GIS):

This is an insurance scheme covering life of employee while in service. In case of a death of government servant while in service, monetary benefit is given to family members as shown below:

Besides, amount of saving component as per table prescribed may also be released to family of diseased government/ ZP servant. In case government/ZP servant is retired or quits service he/she is entitled to saving component only.

Table: Group Insurance Scheme:

Sr.	Group	Monthly subscription w.e.f. 1.1.90	Amount payable to family members in case of death
1	Group – A	960	960000
2	Group – B	480	480000
3	Group – C	360	360000
4	Group – D	240	240000

(Finance Department GR dated 02/08/2010 and 30/01/2016)

3.6.7 Retirement benefits:

Following retirement benefits are admissible to a government servant:

- Pension including family pension
- Gratuity
- Commutation of pension
- GIS and GPF at credit
- Earned leave encashment
- Transfer TA to hometown

Pension, family pension and gratuity

- MO should maintain directory showing staff retiring in each month & take periodical review.
- Ten years qualifying service is a must for entitlement of pension benefit.
- If service is less than 10 years, service gratuity should be paid as lump sum amount at rate of ½ pay for one year of service.
- In case of death of a government servant, family pension and death gratuity is payable to his/her family.
- Family pension is 30% of basic pay.

Pension papers should be prepared in following stages

- Completion of service records including confirmation, verification of pay.
- No dues, no departmental enquiry certificate.

- Preparation of pension documents.
- Verification of pay fixed as per various pay commissions by Accounts officer FD, pay verification unit & for ZP servants by Accounts officer CAFO of ZP.
- All records must be submitted to Accountant General six months prior to date of retirement.

Pension is worked out as below

- Qualifying service – Continuous service from date of joining service in substantive / officiating/temporary capacity to date of retirement.
- Pensionable pay - Pensionable pay is average of basic pay for last 10 months preceding to date of retirement.
- Pension is calculated on 33/66 formula basis. 50% of pension is admissible if servant completes 33 years of service. If service is less than 33 years pension is proportionately reduced, as per prevailing pension rules.

Calculation of gratuity:

Entitled retirement gratuity / death gratuity is 16.5 times of basic pay or Rs. 2,50,000 whichever is less. Formula for calculating gratuity is as follow:

Last basic pay drawn $\times \frac{1}{4} \times$ completed six months of qualifying service = Gratuity

Payment of interest on delayed pension & gratuity:

Provision of interest on delayed payment of pension & gratuity has been made in pension rule vide GR dt. 14.5.1987. Therefore, care should be taken to make timely payment of pension & gratuity.

Voluntary retirement

Voluntary retirement after completion of 20 years of service is permissible.

Commutation of payment

1/3 of original pension can be commuted & commutation amount in lump sum is eligible. Commutation value at age of 59 is Rs. 10.46 per Rupee. It differs from age to age. Commutation of pension is restored on completion of 15 years from date of commutation.

3.6.8 TA and DA:

- Availability of budget should be ascertained while examining claims of TA/DA.
- Bills should be prepared for each month.
- Diaries for visit program should be approved. TA and DA claims should be checked along with diaries.
- Purpose of journey, distance, mode of travel should be written on bills.
- MO can cut down claims during scrutiny of bills if claims are not correct.

Table: Calculation of DA

Period	DA
More than 12 hrs. up to 24 hrs.	Full DA
More than 6 hrs. up to 12 hrs.	50%
Up to 6 hrs.	30%

3.6.9 Purchase Procedure:

Articles like soap, blades, bulbs, tubes, stationary, etc. are required for day-to-day purpose in PHC. These are purchased through regular contingency. Minor repairs of instrument, equipment and PHC building are required which are carried out through RKS/ JAS Funds. In addition, PHC gets funds for campaigns like Pulse Polio Campaign, Family Health Awareness Campaign, Modified Leprosy Elimination Campaign, etc. MO must follow laid down guidelines for financial transaction of government money, irrespective of source and whether specific guidelines are given or not.

(Refer Purchase GR- 2016 & 2021)

Purchase of articles of less than Rs. 5000/-price

Medical Officer can directly purchase articles of less than Rs. 5000/- price. Following aspects should be kept in mind while purchasing any article:

- Budget provision must be available for purchase of article
- MO must be sure that article to be purchased is definitely essential in PHC
- Price quoted by shopkeeper should not exceed maximum retail price printed on the article. For articles without printed price, MO must be sure that price is reasonable as compared to market rates.
- Immediately pay bill to shop keeper & obtain receipt. Delay in payment increases possibility of financial irregularity.

Purchase of articles of price Rs. 5001/- and above

- Budget must be available for purchase of article
- MO must be sure that article to be purchased is definitely essential for PHC.
- Quotations should be called from shopkeepers. Following guidelines should be followed for calling quotations:
 - Send letter to at least five shopkeepers mentioning name and specification of article to be purchased.
 - It is desirable to send letters through post.
 - At least three parties should respond to your letter by submitting quotations in closed envelopes. Wait for one week for response of shopkeepers.
 - Quotations received (at least three) after one week in front of MO and two senior staff members from PHC. They should put signature on envelope and quotation stating that envelopes are opened before them with label as seen by me and opened by me.
 - Junior Assistant should make comparative statement of rates of all parties and submit to MO.
 - Party who is willing to supply article of desired quality at lowest price should be selected for purchase and given orders.
 - MO should compare quotation price with market price and printed price on article. If MO feels prices quoted are higher than market prices, MO can cancel whole process of purchase & start the procedure for different shopkeepers or negotiate for lower price.
 - For payments above Rs. 5000/- obtain stamped receipt from the supplier.
 - Enter the article name, quantity, and date of purchase etc. in stock book before paying the bill.
 - For procurement follow up G.R. of State Industry department 1st Dec 2016 which states that direct purchase up to Rs. 5000/- the Rs. 5001/- to 3 lakhs by minimum 3 quotations and above Rs. 3 lakhs is by e-tender.
 - Updated GR of State Industry Department dated 7/05/2021 increase limit of purchase by quotations upto Rs.10 lakhs.

3.6.10 Various allowances applicable to PHC staff:

House Rent Allowance:

Table: House Rent Allowance:

Sr.no.	Classification of city	Rate of house rent allowances (% of actual basic pay drawn)
1	X	24%
2	Y	16%
3	Z	8%

(Ref. GR of finance department number Gha-bha-bh-2019/Pra Kra.2/SER-5 dated 5.2.2019)

When quarters are available at PHC, staff designated for that quarter (including MO) should not be paid HRA even if staff is not staying in quarter.

Staff not staying at Government headquarters should not be paid HRA

Transport allowance:

Table: Transport allowance

Sr.	Pay level of employee	Rate of transport allowance (Rs. per month)	
		BMCC (UA), Pune (UA), Nagpur (UA)	Other places
1	S-20 and above	5400	2700
2	S-7 to S-19	2700	1350
3	S-1 to S-6	1000	675

Transport allowance is not permissible to government servant who stays within a distance of one kilometer from office. This allowance is not admissible during absence from duty.

(GR No. Va-ha-bha/2020/Pra. Kra. 03/ 2020/seva-5 dated 20.04.2022)

3.6.11 Registers to be maintained at PHC

Following important registers should be maintained at PHC.

• Register for Cheques

A separate register is maintained for Cheques issued by Panchayat Samiti office or DHO. In this register date of receipt, issuing office, name of bank, cheque number, amount, date of sending to bank and date of encashment must be mentioned. Entry of these Cheques must be taken in cashbook on date of receipt.

(rule 50 of MZP & PS Account code)

- **Bill register**

For every office there must be a bill register and every bill submitted to Panchayat Samiti should be registered in it.

Serial number starts since April and this number should be written on bill. While entering bill in this register, number, date and details of bill e.g. TA bill of _____ etc. Should be mentioned.

At end of month summary of pending bills must be made.

- **Register of un-disbursed pay and allowances**

If a government servant on establishment of office is not disbursed allowances due to any reason, these should be noted in this register. Non-disbursed amounts can be kept for 3 months and after 3 months amount should be deposited by challan in Panchayat Samiti.

- **Postage register**

Register for postage received in office has to be maintained in registers A and B. In register A, number of tickets received and its daily expenditure is noted. In register B, number of envelopes, parcels posted and postage used is mentioned.

- **Electricity bill register**

Electricity bills should be recorded in this register giving details about meter reading, units used, rate, previous pending bills, late fee, date when bills paid etc. These bills should be paid as per meter reading and as per domestic rate. Meter-reading book in form no. 34 (Rule 92) should be maintained.

- **Telephone register**

In order to avoid misuse of telephone, this register needs to be maintained giving details of each call made indicating telephone number, by whom, to whom, for what purpose etc.

- **Challan register**

Amount deposited in Panchayat Samiti / treasury by challan is entered in this register, giving details about date, amount, head, reason for depositing etc.

At the end of each month, a summary chart should be prepared indicating amount deposited under each heading.

- **Other registers**

- Stock account of blank receipt books for OPD collection & blank cheque books if any in form no. 1 (Rule 11 & 26).
- Register of security bonds from cashier, storekeeper, stamp clerk & driver.
- Register of movable property in form no. 32 (Rule 90) & form 33.

3.6.12 Audit of PHC

- Internal audit is carried out by internal audit wing of finance department of ZP.
- Statutory audit of PHC is carried out by Deputy Chief Auditor Local Fund Accounts.
- Audit objections raised by auditors should be complied with immediately.
- PRC Audit (Panchayat Raj Committee)
- AG Audit
- NHM Audit (Concurrent and Statutory)
- Local fund audit.

3.7. Materials Management

Objective of materials management system is to establish and operate an efficient and effective system, which ensures supply of required quantity of quality materials when and where it is needed.

Materials management includes indenting, stocking, and supply of various items essential at PHC. These items include:

- Medicines, bandages, instrument, equipment, etc.
- Contraceptives
- Mattresses and linen
- Cold chain equipment and vaccines
- Information Education Communication (IEC) material
- Dead stock

Important aspects in materials management

Assessing requirement and placing demand

3.7.1 Medicines:

Medicines are important for smooth functioning of PHC. It is the responsibility of pharmacist and Medical Officer to keep adequate stock of required medicine in PHC. Management of PHC medicines will be helpful with VED analysis i.e. categorization of medicines as Vital, Essential and Desirable. Standard list of medicines for PHC along with VED categorization is given in annex. Short description of VED analysis is as follows-

- ‘V’ items are **Vital drugs**, forming about **10%** of total (104 in number) and as they are vital life-saving drugs, their non availability cannot be accepted. Therefore, every effort has to be made to avoid out of stock position for any of these items.
- ‘E’ items are **Essential items**, constituting about **40%** of total items and their absence can be tolerated for short stretches of time. Alternative medicines may be available for these medicines.
- ‘D’ items are **Desirable items**, which form remaining **50%** of drugs, and their non-availability can be tolerated for longer period of time. They may be required for treatment of chronic and less serious patients.
- Revised State Drug list 2024 (SDL) contains 926 medicines and State consumable list 2024 contains 314 consumables.

Procedure for getting medicines from DHO

Use of e-Aushadhi Software developed by Public Health Department for Inventory control is essential for all PHC/ ZP Medicine Stores.

Calculation of yearly demand of medicines:

Study prevalent disease pattern of your area from OPD/IPD records and number of patients of these diseases in one year. Choose medicines required to treat these diseases from standard PHC medicine list and put demand to District Health Officer.

Alternatively, medicine demand can be calculated from average consumption of each type of medicine in last three years.

Prepare indent for submission to DHO:

- List out all required medicines for PHC. Preference should be given to vital and essential group medicines for indenting.
- Once yearly consumption is calculated, add 10% to consumption, which will be provision for increase in number of patients during next year. This is demand of medicine for next year.
- Subtract quantity of medicines available at present in the store of the PHC from yearly requirement. This will give you quantity of each medicine required for next year.
- Prepare indent on basis of demand in prescribed format and submit to DHO.
- Indent is prepared annually or quarterly as per system laid down in district.
- Do not indent large stocks than requirement, as drugs may not be utilized before date of expiry or there may be pilferage.

Receiving medicines

- Do not accept medicine in excess quantity than your requirement, as Medical Officer is responsible for use of medicines within expiry period and excess medicines may not be utilized within this period.
- Do not accept medicines that were not included in demand and not useful to your PHC.
- When medicine supply is brought to PHC, MO should personally check whether number of medicines and quantity of each medicine is as per delivery Challan.
- If you have not received medicines from vital group, purchase these medicines from OPD registration fees and get technical sanction from DHO.

Contraceptives

Assessment of quantity required of contraceptives is based on eligible couples willing to accept particular methods as per Community Needs Assessment. Also consider expected level of achievement while placing demand of various contraceptives.

Vaccines

Vaccine requirement will be as per number of beneficiaries, number of doses of that vaccine and wastage multiplication factor. Details about calculation of vaccine requirement are given in immunization chapter.

Use of e-VIN (Electronic Vaccine Intelligence Network) App is Mandatory for all PHCs and ZP Cold chain Points

3.7.2 Storage

- Store should be in cool and dry place with sufficient light and ventilation, as medicines can lose potency in hot and humid places.

- Store must be free from rodent nuisance and doors should be tightly closed.
- Keep medicines with similar action together e.g. antibiotics, analgesics, antipyretic, ointments etc. Poisonous, narcotics should be stored separately and in locked cupboard.
- Keep near expiry date medicines in front irrespective of date of receipt. While issuing medicine, always first issue early expiry medicines so that they can be first utilized and medicines will not be wasted due to expiry. This is called First Expiry First Out principle.
- MO should frequently check and confirm that all vital drugs are available at all times in sufficient quantity. Check expiry date of vital drugs frequently. Do not worry about expiry of vital medicines without use, as they are lifesaving.
- If any of the emergency drugs are not received from DHO, MO can purchase emergency medicines from OPD registration fees with permission of advisory committee.

3.7.3 Supply

- All items should be supplied to all those who need it, as per their requirement and at proper time.
- Check demand of health staff whether it is as per requirement or not. This can be checked on the basis of last three years consumption or population norms of beneficiaries.
- Always call stock book of sub centres while issuing material to SC. This will help in keeping SC stock book updated.
- Sign PHC stock book at the time of supply. Never keep stock book completion pending as it will be difficult for pharmacist to remember afterwards that how much medicines were supplied and to whom.

3.7.4 Maintenance of record

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

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:

Table: Stock registers in PHC and responsible persons

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 registers	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	Stationery, housekeeping items like soap, brooms etc	Jr. Clerk
6	Vaccine stock register**	All vaccines	HA(F)

*For Medicine - use E-Aushadhi App

**For Vaccines - use E-VIN App

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.
- 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.

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 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.

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.

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.

3.7.5 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: Verification of Stock

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

3.8 Vehicle Maintenance

Vehicles have been provided to PHCs for patient transport and implementation of various activities under national health programs. Vehicle provided to Primary Health Centre is a vital resource and MO should ensure that vehicle is in roadworthy condition throughout the year.

3.8.1 Responsibilities of MO about Vehicle

- Vehicle budget is distributed by DHO. You also get diesel grant for transport of family planning cases. In addition to this, mobility support as POL budget is sanctioned for implementation of various campaigns or surveys, e.g. PPI, MLEC, GW survey, etc.
- Expenditure on POL should not exceed sanctioned grants. Maintenance and repairs of vehicle should be carried out as per laid down norms.
- Get servicing of vehicle done as per instructions given in vehicle manual.
- Avoid use of vehicle when speedometer is defective. Get speedometer repaired immediately and then use vehicle. Enter km on logbook before and after repair of speedometer.
- Use vehicle in your jurisdiction only.
- Ensure that authorized PHC driver drives vehicle. Do not allow any other person to drive PHC vehicle. If it is done so, responsibility lies with MO.
- Protect your vehicle from fire, flood, accident, theft, riots etc.
- MO is not allowed to hand over vehicle to officers of other departments without permission of DHO except in election time / emergency situation.
- Vehicle being property of Public Health Department should be returned to State Health Transport Organization after completion of its useful life with all accessories, seats, tools, RC/TC books etc. for final disposal.
- Keep warranty card, free service card, owner's manual, and battery card of vehicle in your custody till vehicle is in the name of your PHC.
- Ensure that driver has valid license and license is renewed before expiry.
- Monthly report should be submitted every month to DHO in prescribed format.

3.8.2 Responsibilities of driver about Vehicle

- Keep logbook in vehicle and make daily entries of vehicle operation in it.
- Have a valid driving license and renew it from time to time.
- Obey orders of MO.
- Do not drive vehicle under influence of alcohol or narcotics, which is a punishable crime.
- Get Panchanama done and FIR registered if vehicle meets with an accident.
- Do not give vehicle for driving to any other person.
- If you find any defects in vehicle, which may damage vehicle, bring this to notice of MO and submit report in writing regarding defects in vehicle.
- Ensure that only government officials, staff and patients travel in vehicle for government purpose. Ensure that no article not pertaining to government is transported in vehicle.
- Observe traffic rules, drive vehicle with moderate speed and avoid damage to vehicle.
- It is obligatory on part of driver to provide all necessary record to officers from squad appointed by SHTO (State Health Transport Organization)
- Get servicing done at prescribed interval at authorized service centre (with permission from district Motor Workshop unit) as per owner's manual provided with vehicle.
- Regular daily and weekly maintenance of vehicle is prime responsibility of driver.
 - Ensure fuel is sufficient in vehicle.
 - Check and maintain water/coolant level in radiator.
 - Check fan belt tension, bolt tension, and adjust if necessary.
 - Check engine oil, vacuum, air pressure, and adjust if necessary.
 - Check and maintain engine oil level, steering box oil level, gearbox oil level.
 - Check and adjust free play of clutch and brake pedal.
 - Always clean covers and terminals of batteries. Also ensure sufficient electrolyte and distilled water in battery.
 - Check headlight of vehicle.
 - Park the vehicle at protected & authorized place only.

If any individual gets injured due to PHC vehicle, then its responsibility of driver and MO to take injured person to hospital and then complete all formalities.

3.8.3 Registers & record related to vehicle

It is responsibility of Driver and MO to maintain logbook and history book of PHC vehicle.

Logbook

- While opening new logbook, check whether all pages are printed numbered. If not write down missing page numbers by ballpoint pen.
- Certify on first page that logbook is for vehicle (number and make) and it contains pages from — to — with page numbers—— written by ballpoint pen.
- Entry of journey made, diesel/oil purchased, etc. Should be made on same day evening against date of journey.
- Summary of vehicle movement, amount of diesel/oil used in month, average km run per litre of diesel and total diesel expenditure etc. has to be mentioned.

History book

- Each aspect related to repair of vehicle must be entered in history book. Servicing, oil change, major/minor repair, tire/ battery change, etc. has to be included in history book.
- For any repair work, a written report from driver is essential. Certificate of repairs is to be attached in history sheet of vehicle.

Vehicle file

Keep a separate file for vehicle. Instructions and guidelines for vehicle use, correspondence related to vehicle, details about repair and maintenance should be kept in file

3.8.4 Condemnation of vehicle

Vehicle condemnation is responsibility of State Health Transport Organization. When PHC vehicle is older than 10 years and/or has travelled more than 2.5 lakh kilometres, get vehicle checked by Mobile Vehicle Maintenance Team and report to DHO.

3.8.5 Hired vehicle

For PHCs where vehicle has been condemned and new vehicle is not provided, provision of hired vehicle has been made by government resolutions, which are modified from time to time. Procedure for hiring vehicle is completed at district level.

Guidelines for use of hired vehicle provided to PHC, as per *GR no. Sankirna-1000/518/CR-224/ health-5 dated 13 January 2003*

are as follows:

- Vehicle will be under control of MO PHC. MO will be responsible for recording of travel details daily.
- Vehicle will run 1200 to 1500 km per month.
- Owner should keep vehicle in a good condition and expenditure for POL, driver allowance will be made by vehicle owner.
- Vehicle will be available 24 hours and will be used in rural, hilly and interior difficult areas.
- Responsibility of major or minor repairs will be of vehicle owner.
- Minor repair should be completed within 1 day and major repair in 3 days.
- Running of vehicle for purpose of repairs will not be included in Zilla Parishad work.
- Filters, oil and labour charges for periodical maintenance will be included in repair and maintenance of vehicle.
- If vehicle remains off-road due to inefficiency of owner of vehicle, amount per day will be deducted from payment as per contract.
- At the end of every month, MO should record number of kilometres travelled by vehicle, no. of days vehicle was off-road and any other important event pertaining to use of vehicle and report to DHO.

3.9 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.

3.9.1 Classification of record

All record of PHC shall be classified in following classes, based on period for which it has to be preserved.
(G. R. no.: sankirna- 2018/Pra. kra. 9/18 (Ra. Va. Ka.) zero pendency and daily disposal. Dated 15-02-2018)

A class record:	To be preserved permanently
B class record:	To be preserved for 30 years
C class record:	To be preserved for 5 years
D class record:	To be preserved for 1 year.
Z class record:	Not classified in A, B, C, D

Categorization of common record of PHC

Table: Categorization of PHC record

Sr.	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 resolutions	A
4	Acts, rules and regulations A	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 of 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 interest of public health	C
25	School health services records	C
26	Tour programs and diaries	C
27	Indent forms	C
28	General cash book	C
29	Register of contingent expenditure	C
30	Contingency bills with vouchers	C
31	Challans of District Central Cooperative banks	C
32	Tapal and peons' delivery book	D
33	Casual leave register and muster roll	D
34	Applications for causal leave	D

3.9.2 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.

3.9.3 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

3.10 Write-Off Procedure for Unserviceable Articles

Competent authority should write off all articles that become unserviceable in due course of time. MO PHC should initiate write-off procedure. If write-off procedure is not initiated in time, unrequited articles go on accumulating in PHC occupying most of space in cupboards, rooms, verandah, bathrooms, etc. Write-off procedure for common articles supplied to PHC is mentioned in this chapter except for vehicles. Condemnation procedure for vehicles is mentioned in vehicle management chapter.

3.10.1 Linen, mattresses and similar material

- HA (F) should scrutinize all linen and mattresses twice a year. She should single out torn and discardable linen and mattresses after repeated use.
- HA (F) should submit note to MO PHC giving details of linen, e.g. type, number in each type, date of supply, duration of use, etc. in form 33 and remarks that this linen cannot be used further.
- MO should inspect linen and certify that linen should be written-off.
- Discard linen and mention how it is discarded on note.
- As per mentioned in Account code Rule-98, MO should inform DHO in writing with photocopy of note and procedure adopted. Minus linen from stock register during next stock verification (in next June or December).

3.10.2 Dead stock, instrument and equipment

- Medical Officer PHC should prepare up-to-date list of unserviceable articles as per Account Code Rule 98, once in six months. All these articles should be collected at one place in PHC for inspection of DHO. Prepare write-off proposal to be submitted to DHO as follows:

Table: Format for unserviceable articles.

Sr.	Name of the article	Quantity	Year and date of article received	Year and date when article became unserviceable	Page number of stock register	Cost of article if known	Depreciation cost of article on day when it became unserviceable	Remarks of DHO
1	2	3	4	5	6	7	8	9

Calculation of depreciation cost

- Depreciation cost of article should be calculated as per Account Code Rule 241 (10% deduction in cost per year from date of manufacture). Following table explains how to calculate depreciation cost of a suction machine purchased in 1991 for Rs. 5000/ & had become unserviceable in 2005.

Table: Calculation of depreciation cost table: (example)

Year	Depreciation cost	Year	Depreciation cost	Year	Depreciation cost
1991	5000(full cost)	1996	2952	2001	1743
1992	4500	1997	2657	2002	1569
1993	4050	1998	2391	2003	1412
1994	3645	1999	2152	2004	1270
1995	3280	2000	1937	2005	1143

Remarks of DHO & handing over to DHO office

- When format is completely filled, show articles along with filled in format and relevant stock books to DHO and obtain remarks of DHO for write-off.
- All articles for write-off should be handed over to DHO store after permission from DHO. Get receipt of handover of articles and keep it in write-off file of PHC.
- As mentioned in Account Code Rule-98, drop entries of write-off articles during next dead stock inspection (half yearly inspection).

3.10.3 Electrical equipment (ILR, Deep freezer, Stabilizer, etc.)

- Powers of write-off of electrical equipment are with State Health Transport Organization.
- Medical Officer is required to start procedure of write-off of equipment as follows-
- Collect information of electrical equipment in following format and get certificate from cold chain technician of district in writing that equipment is unserviceable.
 - Show equipment to DHO when he visits PHC and obtain permission to deposit equipment in district store & mention this in remarks column.

- Transport equipment to district health store for further transportation to SHTO.
- Get receipt of equipment for condemnation from district store and attach to write-off file.
- Drop entries of equipment during next inspection.

Table: Form for write-off of cold chain equipment

Sr.	Name of Equipment	Quantity	Year and date of receipt of equipment	Year and date when equipment became unserviceable	Page number of stock book entry	Remarks of DHO

3.10.4 Benefits of regular write-off procedure

PHC staff gets valuable space in building for day-to-day functioning. It becomes easier to keep premises clean if there are minimum unserviceable articles in PHC.

Regular inspection of dead stock, equipment is useful to update position of these articles, which is important to minimize future complications.

3.11 Panchayat Raj

Primary Health Centre functions under administrative control of Zilla Parishad. Therefore, MO must know structure and functioning of Panchayat Raj institutions.

Three tiers of Panchayat Raj institutions in Maharashtra

- Zilla Parishad at District level,
- Panchayat Samiti at Block level
- Gram Panchayat at Village level.

3.11.1 Zilla Parishad

- Zilla Parishad members are elected from Zilla Parishad constituencies spread throughout the rural area of district. All these members constitute general body of Zilla Parishad.
- President, Vice-President and Chairperson of Subject Committees are elected from amongst Zilla Parishad members. President is political head of Zilla Parishad.
- Chief Executive Officer is administrative head of Zilla Parishad. There are various departments like Health, Education, Building and Communication, Animal Husbandry, Finance, etc. in Zilla Parishad.
- Meeting of all Zilla Parishad members (General body meeting) is held every three months. DHO as head of health department attends meeting and provides health related information to house.
- Subject committee meetings are held under chairmanship of Chairman (Subject Committee). Accordingly, health committee meeting is held once in a month under chairmanship of Chairman Health committee. It looks after health related matters of district. District Health Officer is member secretary of Health Committee.
- Decisions regarding health-related matters like establishment of new PHCs/Sub Centers, distribution of funds for construction, purchase of medicines, instruments, equipment's etc. for PHCs is taken by health committee.
- In Zilla Parishad, responsibility of various functions is entrusted to different heads of departments. Medical Officer may need to contact other departments in case of difficulties. Table below gives information of various departments that have relationship with PHC functions.

Table: Important Departments in Zilla Parishads

Name of department	Head of department	Relationship with PHC functioning
General Administration Department (GAD)	Dy CEO (GAD)	• Establishment matters related to jr. assistant, drivers and class IV servants of PHC • Promotion, time scale, transfer files of PHC staff move through GAD.
Finance Department	Chief Accounts and Finance Officer	Finance related matters of district
B & C Dept.	Executive Engineer	Construction & repair of PHC/SC

Women and Child Welfare department	Dy CEO (ICDS)	ICDS scheme implementation
Education Department	Education Officer (Primary)	School Health services

3.11.2 Panchayat Samiti

- Panchayat Samiti members are elected from Panchayat Samiti constituencies spread in rural area of taluka. All elected members form Panchayat Samiti. These members elect Chairman and Vice-Chairman of Panchayat Samiti.
- Panchayat Samiti keeps watch on implementation of development programs within taluka.
- Meeting of all Panchayat Samiti members (PS meeting) is held once a month. It is essential for MO PHC to attend meeting unless prior permission is given by Chairman Panchayat Samiti to remain absent.
- It is duty of MO to submit all health related information of PHC to Panchayat Samiti if asked for.
- It is good practice to keep Panchayat Samiti member of your PHC area informed about progress of your PHC in various health programs and your expectations from Panchayat Samiti for smooth PHC functioning.
- As in ZP, responsibility of various functions within the block is entrusted to different heads of departments. Medical Officer may need to contact other departments in case of difficulties. Table below gives information of various departments that have relationship with PHC functions.

Table: Important Departments in Panchayat Samiti

Name of the Department	Head of the Department	Relationship with PHC functioning
Panchayat samiti	Block Development Officer	• Payments of PHC staff • Contingency bills sanctions
B & C Dept.	Dy. Engineer	Construction & repair of PHC/SC
Women and Child Welfare Department	CDPO	ICDS scheme implementation
Education Department	Education Officer (Primary)	School Health services

Panchayat Samiti Aam Sabha

Aam Sabha is organized for each Panchayat Samiti once a year. Panchayat Samiti Aam Sabha is chaired by local MLA. BDO is secretary of Aam Sabha. Aim of Aam Sabha is to review developmental activities performed during year and to plan for next year. All Panchayat Samiti members, Sarpanch, social activists, local NGOs, all officers from block, headmasters, Gramsevak, etc. attend Aam Sabha.

Role of MO PHC in Aam Sabha

Any health related problem could be raised during Aam Sabha. Therefore, MO should be fully prepared for answering all health related issues from PHC.

- Prepare a short note, which should include compliance of last year's Aam Sabha decisions, progress in national health programs and any other additional information called by BDO. Submit information in time to Panchayat Samiti.
- Know basic information of your PHC such as number of villages, population, total eligible couples, and performance in national health programs.
- Discuss important points raised during last Aam Sabha, compliance made, etc. with BDO at least one week before Aam Sabha.
- MO should remain present for Aam Sabha in time. Answer briefly and to the point if any question is asked.
- Note if any decision is taken related to your PHC for future compliance.

3.11.3 Gram Panchayat

- Gram Panchayat is village level local body. Village is divided into wards. One Gram Panchayat member is elected from each ward. Sarpanch and Dy. Sarpanch are elected from among members of Gram Panchayat.
- Cleanliness, sanitation, safe water supply, information to PHC about any natural calamity including epidemic, etc. are health related functions of Gram Panchayat.

- MO should visit all villages at least once in a month. Meet Sarpanch and discuss about health related needs of village. Inform Sarpanch and Gram Sevak if you notice anything hazardous to health of community.
- Check record related to safe water supply and environmental sanitation during visit to Gram Panchayat. MO should discuss with Gram Sevak if there are any problems related to safe water supply and sanitation.

Important issues directly or indirectly related to Panchayat Raj

- Village Health Committee
- PHC Advisory Committee
- Donations to PHC
- Utilization of PHC OPD registration charges
- NHM Committees like Executive Committee, Governing Body, VHNSC etc. (Please refer Chapter 1 NHM)

3.11.4 PHC Advisory Committee:

Idea behind establishment of Primary Health Centre Advisory Committee is involvement of community in health care delivery and community participation in planning and implementation of health programs. Establishment of PHC advisory committee is as per *government resolution number PHC/1085/3026/Arogya-5 dated 19.12.1985*.

Structure of committee:

- Chairman: Local Zilla Parishad member or Sarpanch of PHC headquarter village.
- Other members:
 - Block Development Officer or his representative.
 - Sarpanch of PHC headquarter village.
 - Panchayat Samiti members from PHC area.
 - Lady member of Gram Panchayat or Municipality or lady social worker.
 - Three non-official members, out of them one should be retired army person and one should be from backward class.
- Member secretary: In-charge Medical Officer of PHC

General rules regarding working of PHC advisory committee:

- Block Development Officer issues order of committee formation in consultation with Chairman, Panchayat Samiti.
- Tenure of all members (except ex-officio members) will be generally for three years; however previous advisory committee will continue to work till new committee is formed.
- Committee will meet at least once in three months. Meeting can be called by issue of notice seven days in advance by Chairman of committee.
- No TA/DA or travel expenses are admissible to members
- DHO and district level senior officers can attend any of advisory committee meeting and can participate during deliberations.
- Member secretary will forward report of committee with his remarks to District Health Officer within one week.
- Members of advisory committee cannot give instructions to any of PHC staff directly but members should inspect PHC along with senior Medical Officer and advise accordingly.

Functions of PHC advisory committee:

- Advise about improvement in functioning of PHC within framework of government rules and regulations.
- Monitor and advise about utilization of grants received by PHC.
- Receive donations from public and advise PHC about its utilization within regulations of government framework.
- Keep watch on availability of medicines in PHC.
- Regular review of complaint register, visit book and advise accordingly.

3.11.6 Donations to PHC:

Expectations and demands of community are increasing regarding health services provided by PHCs. In order to increase availability of resources to PHC and active participation of community, government has given permission for accepting donations by *GR no. 2002/223/Arogya-3 dated 23.8.2002*. As per this

resolution, equipment's required for PHCs can be accepted in cash or kind from individuals/private organizations/ foreign organizations / NRI as a donation.

Guidelines for accepting and utilization of donations:

- Acceptance of donation must be through PHC advisory committee.
- Donation amount can be used for repair and maintenance of instruments and equipment's.
- If equipment/instrument has been given as donation, 5 years maintenance needs to be given by donor.
- No expenditure should be done from government grants for equipment's received as donation. This should be made from separate account maintained of such donation.
- Furniture, computer also can be accepted as donation.
- If private practitioner is ready to install his own equipment or machinery at PHC, he can be allowed by accepting rent from him. However, it is mandatory for him to use that machinery for Below Poverty Line patients as per government guidelines.
- Separate cashbook or register has to be maintained at PHC for such types of donations.

3.11.7 Utilization of revenue collected at PHC:

Revenue collected at PHC from various sources can be utilized for day-to-day functioning as well as maintenance of PHC. Decision for utilization of PHC revenue is entrusted to PHC Advisory Committee. Committee can allow Medical Officer to use revenue for items indicated under government resolution.

The revenue is generated at PHC from following sources:

(As Per Govt Decision Dated 15 August 2023 all such OPD fees Charges Across all Public Health Department Institutes are Waived off).

- Training charges from Intern Doctors from private Medical Colleges.
- Training charges from trainee nurses from private Nursing Schools.
- Donations.

Guidelines for utilization of OPD registration fees:

Guidelines regarding utilization of revenue collected through above mentioned sources have been given by Government Resolution no. PHC/1093/3507/no 414/Arogya-4 dated 6 March 1997 and updated thereafter on 28.9.98 and 30.3.2001. Guidelines are as below:

- Amount collected as above can only be utilized by same PHC.
 - Rs. 5000/- per year for minor repairs of PHC. (Minor repairs include masonry, carpenter, smith and electric works).
 - Rs. 1500/- per year for cleaning courtyard of PHC.
 - Rs. 2000/- per year for purchase of life saving medicines required for Below Poverty Line patients admitted in PHC.
 - Rs. 1500/- per year for painting equipment, cots, fans, furniture and also repair of fans, equipment. (Colouring of PHC is not allowed).
 - Rs. 1000/- per year for transport arrangement of serious Below Poverty Line patients to Rural Hospital or District Hospital when PHC vehicle is not available.
 - Rs. 9000/- for purchase of stationary.
 - There is no upper limit for expenditure on electricity bills of Primary Health Centre.
- If amount required for any of above-mentioned items is more than prescribed for each item, and if sufficient funds are available in PHC account, expenditure is allowed with prior permission of CEO Zilla Parishad.

3.12 Job Responsibilities of PHC Functionaries:

Job Responsibilities of:

- Medical Officer, Primary Health Centre.
- First & Second Medical officer
- Taluka Health Officer
- Health Assistant (Male & female)
- MPW (Male & female)

Programme specific Job responsibilities are enumerated in relevant programme. For general Role & Responsibilities Refer Annexure 3.2(Vol. I)

3.13 Registers in PHC:

Following registers should be maintained at PHC: (For details Refer Annexure 3.3(Vol. I))

RCH Registers: (R1 to R20)

- आर १ आरोग्य सेवा सत्र नोंदवही
- आर २ उपकेंद्र साठा नोंदवही
- आर ३ शस्त्रक्रिया लाभार्थी नोंद नोंदवही
- आर ३ शस्त्रक्रिया लाभार्थी नोंद नोंदवही
- आर ४ तांबी लाभार्थी नोंद नोंदवही
- आर ५ प्रा.आ. केंद्र कार्यक्षेत्रातील योग्य जोडप्यांच्या कार्यक्षेत्राबाहेर शस्त्रक्रियांची नोंदवही
- आर ६ गर्भनिरोधक गोळ्या लाभार्थी नोंदवही
- आर ७ निरोध लाभार्थी नोंदवही
- आर ८ अ/व संदर्भसेवा नोंद नोंदवही
- आर ९ जीवनविषयक आकडेवारी नोंदवही
- आर ११ आरसीएच साठा नोंदवही
- आर १२ आरोग्य शिक्षण व प्रचार कार्य नोंदवही
- आर १३ प्रशिक्षण नोंदणी अ,ब,क
- आर १४ प्रजनन आरोग्य पहाणी नोंदवही
- आर १५ माता सेवा नोंदवही
- आर १६ ०-२ वर्षे बालक सेवा नोंदवही
- आर १७ २-१६ वर्ष सेवा नोंदवही
- आर १९ महिला मंडळ, तरुण नोंदवही
- आर २० मासिक दैनंदिनी नोंदवही

All these registers are now clubbed into one RCH Register. It should be updated regularly.

- राष्ट्रीय किटकजन्य आजार नियंत्रण कार्यक्रमांतर्गत हिवतापाशी संबंधित नोंदवह्या
- एम एफ १ कुटुंब आरोग्य नोंदवही
- एम एफ २ रक्तनमुना नोंदवही व अहवाल नोंदवही
- एम एफ ३ आरोग्य सहाय्यक (हिवताप) कार्य नोंदवही
- एम एफ ४ मासिक हिवताप कार्य (रक्त नमुने वयानुसार) नोंदवही
- एम एफ ५ मासिक हिवताप कार्य (साथनियंत्रण) नोंदवही
- एम एफ ६ हिवताप रुग्ण नोंदवही
- एम एफ ७ ताप उपचार केंद्र नोंदवही

इतर नोंदवह्या

- क्षयरोग नोंदवही
- कुष्ठरोग नोंदवही
- अंधत्व नियंत्रण कार्य नोंदवही
- ग्राम पंचायतनिहाय पाणी स्रोतांची नोंद नोंदवही
- पाणी नमुने तपासणी आणि ओ.टी. टेस्ट नोंदवही
- पाणी नमुने तपासणी नोंदवही
- पाणी पुरवठा योजना सर्वेक्षण नोंदवही

प्रा.आ.केंद्र स्तरावरील नोंदवह्या

- बाह्यरुग्ण नोंदवही
- दैनिक औषध खर्च नोंदवही
- औषधसाठा नोंदवही

- औषधे मुदतबाहय नोंदवही
- ऑटोक्लोव्ह नोंदवही
- शस्त्रक्रिया गृह निर्जंतुकीकरण नोंदवही
- आरएलआर, डीप फ्रिजर तापमान नोंदवही
- आर.सी.एच.साठा नोंदवही
- लस साठा नोंदवही
- आंतररुग्ण नोंदवही
- कर्मचारी निहाय कार्य (एमआयएस) नोंदवही
- ग्रंथालय नोंद नोंदवही
- सभा इतिवृत्त नोंदवही
- वैद्यकिय अधिकारी सभा नोंदवही
- दैनंदिन हजेरी पत्रक
- हालचाल नोंदवही
- आवक/जावक नोंदवही
- शेरा नोंदवही

प्रा.आ.केंद्रात ठेवावयाच्या प्रशासकीय फाईल्स

- स्टॅडींग ऑर्डर फाईल
- शासन निर्णय फाईल
- कर्मचारी वैयक्तीक फाईल
- विषयवार फाईल
- मोहिम फाईल
- पाणीपुरवठा फाईल

लेखापियक मार्गदर्शक बाबी

वैद्यकिय अधिकारी हा त्या प्राथमिक आरोग्य केंद्राचा प्रमुख असून प्रशासकीय व आर्थिक बाबींवर प्रमुख नियंत्रक म्हणून काम पहावे लागते. लेखाविषयक अनियमितता झाल्यास त्यांना जबाबदार धरले जाते. त्यामुळे प्रत्येक लेखाविषयक कागदपत्रावर सही करताना समजावून घेऊन व विचारविनीमय करून स्वाक्षरी करावी. यासाठी आवश्यकता वाटल्यास अनुभवी वैद्यकिय अधिकारी , तालुका आरोग्य अधिकारी किंवा गटविकास अधिकारी यांचा सल्ला घ्यावा.

- रोकड नोंदवही
- पावती पुस्तक
- धनादेश स्विकृती नोंदवही
- बँकेचे चलन
- जमा खर्चाच्या नोंदवह्या
- सादीलवार खर्च नोंदवही
- जंगम मालमत्ता नोंदवही
- साठा नोंदवही
- विद्युत वापर नोंदवही
- पेट्रोल व डिझेल साठा नोंदवही
- वाहनाची तपशील नोंदवही व इतिहास नोंदवही (हिस्ट्रीशिट्स)
- स्थावर व जंगम मालमत्ता नोंदवही
- तसलमात नोंदवही
- बिल नोंदवही
- पी एफ एम स व डी. बी. टी नोंदवही

प्राथमिक आरोग्य केंद्र /उपकेंद्र येथे आवश्यक लेखाविवरण रजिस्टर्स

अ. क्र.	नमुना क्र.	नोंदवहीचे नांव	नियम
१	१	साठा नोंदवही (पावती/चेक)	११ व २६
२	२	वैकेचे चलन	१३
३	४	रोकड नोंदवही	४२/५०/५७
४	५	वैयक्तीक सुरक्षिता लेख (जामिन कदबा)	४३
५	६	सुरक्षितता लेख नोंदवही (जामिन कदबा)	४३
६	१०	पावती पुस्तक	५०
७	११	धनोदश स्वीकृती नोंदवही	५०
८	१२	बिल रजिस्टर्स	५४
९	१३	जमेची नोंदवही	५५
१०	१४	खर्चाची नोंदवही	५८ व ६०
११	३०	सदिलवार खर्च नोंदवही	८०
१२	३२	जंगम मालमत्ता नोंदवही	९०
१३	३३	साठा नोंदवही	९१
१४	३४	विद्युत वापर नोंदवही	९२
१५	३६	पेट्रोल/डिझेल साठा नोंदवही	९४
१६	३८	वाहनाचे तपशील नोंदवही	९४-९५
१७	३९	स्थावर जंगम मालमत्ता नोंदवही	५७
१८	७९	वसलमात नोंदवही	१०१

Reference:

1. Maharashtra Civil Services Rules, Maharashtra Gram Panchayat Rules, related acts like Epidemic control act, etc.
2. Maharashtra Civil Services (Leave) Rules 1981)
3. Guidelines for sanctioning leave (Rule12):
4. Commutation of one kind of leave into another (MCSR Rule-14)
5. Combination of leave (MCSR Rule-15)
6. Grant of leave & leave salary payment to a transferred government servant (Rule-30)
7. Earned leave (MCSR (Leave) Rules -1981) Rule-50:
8. Calculation of earned leave (rule - 51)
9. Half pay leave (Rule-60)
10. Commuted leave (Rule no. 61)
11. Leave not due (Rule – 62):
12. Finance Department GR. Dates 21/09/2016 and 09/03/2023
13. finance department GR dated 23/07/2018
14. Revised the format of writing the CR should be as per GR No. GAD no.CFR-1211/257/ 13 dated .02 Feb.2017.
15. Rule 5 - Discipline and Appeal Rules).
16. Defined Contribution Pension Scheme (DCPS) for all employees who have joined service of State Government on or after 1st November, 2005 vide GR dated 31.10.2005.(GR of finance department number Gha-bha-bh-2019/Pra Kra.2/SER-5 dated 5.2.2019)

Section 4: Information Education and Communication (IEC)

Information, Education, Communication/ BCC/ SBCC is the important concepts of all the National health programme. Unless community is made aware about various aspects of health, it is difficult to bring the desirable behavioural change among the people. IEC/BCC is a dynamic process, which involves an exchange or sharing of ideas & is concerned with information, attitudes, beliefs, myths, misconceptions and practices. IEC/BCC uses multiple channels to transmit and reinforce messages that address well defined target groups. This helps to change the behaviour to the desired behaviour by providing people skills and tools. It is not only necessary to adopt new behaviour change but also need to maintain the same for better health outcomes. Hence, IEC/BCC is a process that promotes positive change in the individual and the environment.

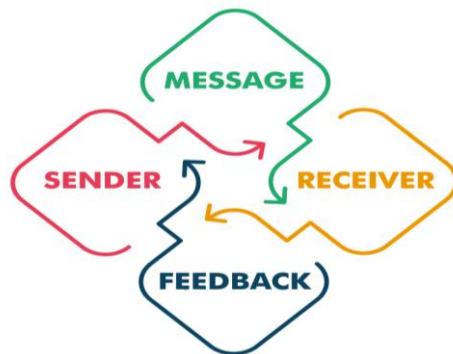
Changing the behaviour of individuals and community through Information Education and Communication (IEC) is the core of public health. A person working for public health, a doctor or a health worker, must first be a good communicator as well as educator. The aim of the information education and communication/ BCC is to establish friendly relations with people and influence their behaviour so that they can achieve high quality health.

4.1 Health Education:

Health Education (HE) may be defined as a type of education designed for individual or the public at large to gain the knowledge, skills, value, and attitudes necessary to promote, maintain, improve, and restore their health. Health Education is an integral part of any National Health Programme (NHP) to make people aware of the importance of the programme as well as acceptance of the health services by the community under this National Health Programme. Health education comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy.

4.1.1 Communication:

The word communication may be defined as “A process of transforming information between two or more persons with understanding”. Communication is about exchanging information, sharing ideas & knowledge. The word ‘communication’ is derived from the Latin word ‘communis’ which means ‘common’ or ‘sharing ideas in common’, in which information, thoughts, ideas, feelings or opinions are shared through words, actions or signs, in order to reach a mutual understanding. The process of communication is having following three components, namely sender, message and the receiver. To understand the impact of IEC feedback component to be added as a mandatory step.



Sender: Sender or facilitator is a person who has something to communicate, he/she is the source where the ideas originates and he/she is the one who begins the process of communication. The sender or facilitator should have following qualities:

- Know the subject thoroughly,
- Know the reason for giving message,

- Must be aware of the educational status, social background, economic status, language known, and understanding capacity of the audience,
- Ability to bring the group together and maintain it.
- Creating a learning environment that generates and uses the ideas and skills.
- Organizing ability, so that resources are booked and logistical arrangements are smoothly handled
- Must be able to use media skill-fully,
- Must be able to coordinate message and action or body language,
- Must be a good listener,
- Must be able to get feedback to take necessary action needed,
- Sender should have a warm personality and also be credible, trust worthy, acceptable by the audience.
- Skill in noticing and resolving learners' problems.



Message: When the information is encoded into a physical form it is called ‘message.’ A message must be:

- Media friendly,
- Encouraging,
- Simple,
- Specific,
- Audience centred
- Goal oriented, and
- Effective.



In addition to these, a message should also be timely, relevant, consistent, uniform, clear, acceptable, brief, accurate, realistic, reliable and complete.

Receiver: Receiver is a person who has to perceive the meaning of the message in its proper sense. A receiver should be:

- Interested in learning,
- A good listener,
- Sound in physical and mental status,
- Taking decision after proper understanding and
- Should not be over enthusiastic.

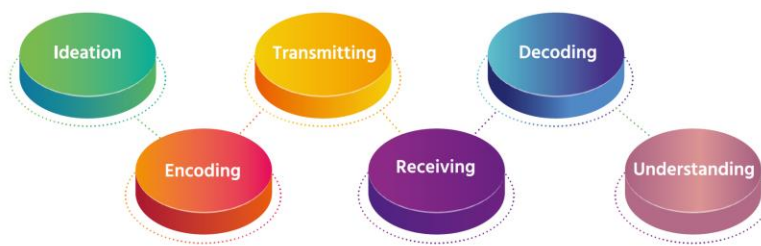


Facilitation Skills for Effective Communication:

- **Verbal communication:**
 - Clear and audible voice.
 - Voice modulation to generate energy and interest.
- **Non-Verbal**
 - Relaxed posture -firm stand, relaxed breathing, no visible stiffness or abrupt movements.
 - Arms relaxed - uncrossed arms and hands open (palms up or otherwise visible to the other person).

- Good eye contact - looking the other person in the eyes indicates interest in that person. Proper eye contact involves looking away occasionally to avoid staring.
- Nodding agreement – shows interest and understanding. However, continual, unconscious bobbing of the head usually indicates that the listener is tuning out.
- Smiling/adding humour - it signals a warm personal relationship.
- Leaning closer - reducing the distance between two people indicates interest is up and barriers are down.
- Gesturing warmly - talking with hands, particularly with palms open, indicates involvement and openness.
- **Facilitation Skills-Listening:**
 - Passive Listening - remain silent and let the other person talk. We can communicate our interest and concern by our non-verbal behaviour.
 - Acknowledgement - use brief expressions that communicate our understanding and acceptance, such as “aha”, “hmmm”, “I see”.
 - Door Openers - instead of direct questions, use expressions which invite the person to expand on or to continue expressing their thoughts and feelings. For example, “Tell me about it”, “I’d like to hear more about that”.
 - Content Paraphrase - repeat what we have heard to confirm that we have accurate understanding. For example, “So you’re saying that if the plan works the problem regarding on-time disbursement of honorarium would be solved”.
 - Active Listening - help the person understand both the thoughts and feelings of his/her communication by describing your impression of what has been said and the feelings which are observed. For example, “You sound upset about her sending the report without discussing it with you” or “You seem unsure about what to do next”.

For better understanding of the process of communication following stages need to be understood properly, like **ideation, encoding, transmitting, receiving, decoding and understanding**.



4.2 Information, Education and Communication:

Information, Education & Communication (IEC) means sharing information and ideas in a way that is culturally sensitive, acceptable to the community, using appropriate channels, messages and methods. IEC in health programme aims to increase awareness, change attitudes and bring about a change in specific behaviour. It is, therefore, broader than health education, because it includes the process of communication and building social networks for communication information.

IEC interventions should involve the active participation of the target audience; adopt channels, methods and techniques that are familiar to them. Information, education and communication is an important tool in health promotion for creating supportive environments and strengthening community action, in addition to playing an important role in changing behaviour.

4.2.1 Behavioural Change Communication (BCC):

Aim of IEC is to bring desirable behavioural change, hence, now a days it is also known as 'Behaviour Change Communication' (BCC). Unless community is made aware about various aspects of health, it is difficult to bring the desirable behavioural change among the people. Behavioural change is the slow and repetitive

process and therefore, continuous attempts are needed by Medical Officers (MO) and health workers to get desired behavioural changes in individual and in the community. Informing and educating people will help in demand generation and acceptance to improve utilization of health services. The Long-term goal of IEC and BCC activities is improving sustainable health status of the community.

BCC is a dynamic process, which involves an exchange or sharing of ideas and 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 behaviour to the desired behaviour by providing people skills and tools. It is not only necessary to adopt new behaviour change but also need to maintain the same for better health outcomes. Hence, BCC is a process that promotes positive and sustainable change in the individual and the community.

All human activities involve communication, but because people do not always think about how we communicate with others and whether or not we do this effectively. Good communication involves understanding how people relate to each other, listening to what that have to say and learning from them. Good communication means that people are actively involved. This helps them to experience a new way of doing or thinking about things and is sometime called participatory learning.

Process of Behavioural Change:

People go through different stages in the process of behaviour change, starting from being unaware of an issue, to concern, to seeking knowledge and skills, to adopting behaviour, and finally reaching a maintenance stage. These stages have also been described as the ‘**Innovation decision – making process**’. This process of behavioural change ranges from the stage of pre-awareness to awareness, improving knowledge leads to approval and understanding through repeated exposure, then they develop an intention leading to a decision to openness to trial of new behaviour, experience of the health services, further reinforcement develop sustainability to new behaviour i.e. practice, then finally they start propagating new behaviour through word-of-mouth which is called advocacy.

Understanding the process of behaviour change:

There is an established social norm and it influences behaviour. We need to understand that how can the norm be changed? Recognize what are the problems with the current norm. Whether there is a lack of knowledge of alternatives? Do we not see any problem with the current norm? Do we not want to talk about it? Norms are not in isolation, they are embedded in values, beliefs, practices. These help us understand the world we live in and so changing them can change the norms.

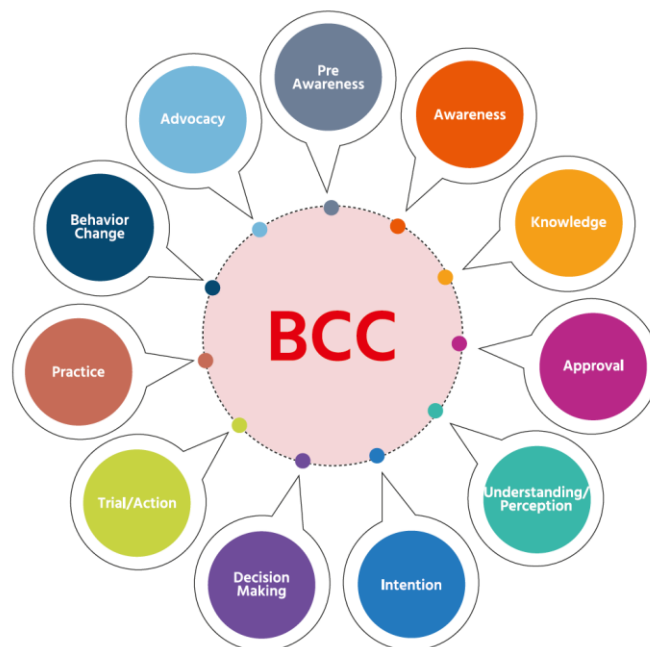


Fig. Behaviour Change Communication

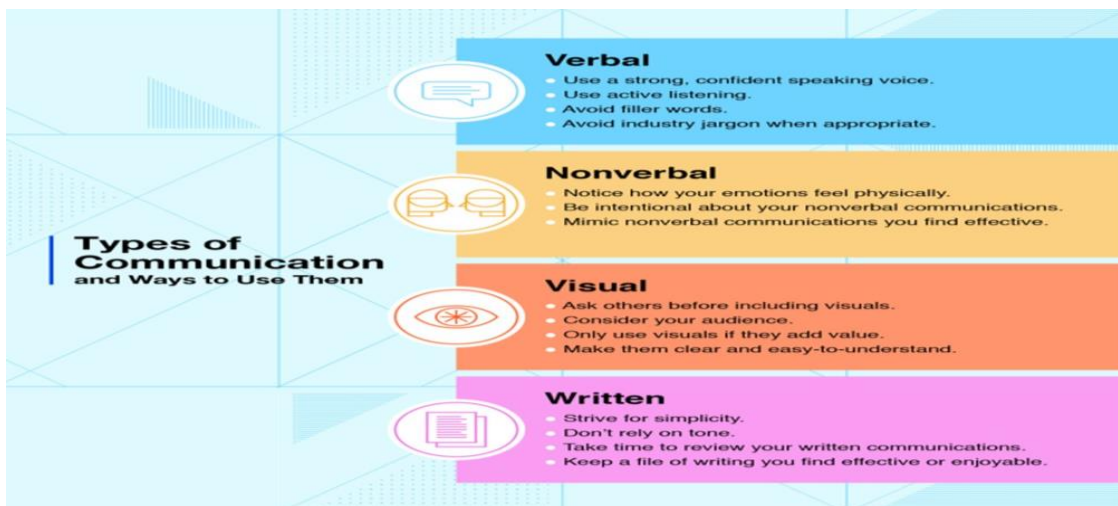
At the knowledge stage, the intended audience is exposed to information about the desired behaviour change, is attracted to the message and pays attention to it, understanding the message and what the new behaviour involves. The audience has to be persuaded or convinced that the new behaviour is relevant to them. Having understood the message, the audience must develop a positive attitude towards the desired behaviour and remember what they need to do and when they need to do it, before they will be motivated to put the new behaviour in to practice. Once they are motivated, people will decide to adopt the behaviour and implement their decision by putting the behaviour change in to practice. At the maintenance or confirmation stage people who have tried the behaviour once continue to practice it regularly.

Functions and Objectives of IEC/BCC/ SBCC:

- **Information:** to sensitize people,
- **Education:** to raise the level of knowledge and understanding,
- **Direction:** to instruct or guide,
- **Persuasion:** to provide motivational activities,
- **Felt-need:** to generate demands,
- **Facilitation:** to empower to act,
- **Control:** to organize to do their work, and
- **Indoctrination:** accomplishment of goal.
- **Resource mobilization:** involvement of available resources.
- **Community Participation:** involvement of community and society.

4.2.2 Types of Communication:

- One-way (Radio, TV), Two-way (Workshop, Focus Group Discussion, Interview) and Serial communication (Circular, Guidelines).
- Upward (From junior to senior), Downward (From senior to junior) and lateral or Diagonal communication (Communication between two or more person with same cadre or position).
- Verbal (Oral or Written like lecture, circular, letter) and Non-verbal Communication Body language like maintaining eye contact, positive gesture).
- Formal (Planned and using educational materials) Non-formal communication (Unplanned and without the use of educational materials).
- Mass or Group communication (communication with a large audience) and Inter-personal communication (Face to face two-way communication between two or three persons with possible immediate feedback).



Inter-personal communication (IPC) is a special type of communication which is to be face-to-face, based on the need, interests and circumstances of the beneficiaries. The process of IPC starts with establishing an affectionate relationship and walks through listening and asking questions, obtaining information and solving problems, provide information in simple language and finally encouraging positive and desirable behaviour change.

Barriers to Communication:

There are certain factors that impede the proper flow of communication. All those factors that adversely affect effectiveness of communication, may be called barriers to communication. The barriers to communication may be classified as follows:

- **External Barriers:**
 - **Semantic Barrier:** These barriers arise at the stage of encoding or decoding in the process of communication. This is due to assigning different meaning to one specific message.
 - **Physical Barriers:** The effectiveness and accuracy of communication is also affected by the physical barriers like distance, noise, improper use of media etc.
- **Emotional and Psychological Barriers:** This is also called individual barriers which arise due to difference in individual competencies to think and act. This class also include premature evaluation, existence of preconceived notions, inattention due to lack of interest, distrust in communication, fears, poor retention, defensive behaviour.
- **Organizational Barriers:** This type of barriers develops due to the problems with physical distance between members with respect to their functional specialization of tasks, power, authority, status relationship etc.
- **Cross-cultural (Geographic) Barriers:** This occurs because of difference in time, geographic location and other cultural factors.

Areas and Scope of IEC and BCC in Health Care Delivery:

IEC and BCC should be an integral part of all the services provided by the Primary Health Centre (PHC) for various groups of people. Communication will help in demand generation as well as utilization of health services in the following areas:

- Medical Officer and health staff/ worker should educate patients and community regarding specific illnesses during Out Patient Department (OPD) and during 'Arogya Seva Satra' as well as during home visits.
- Important groups for whom awareness needs to be created are mothers attending clinic, school children, college students, youth groups, mahila mandals, religious functions, Major fairs etc. In addition to this, Gram sabha and group meetings are also good opportunities.
- Personal hygiene and environmental sanitation.
- Nutrition and nutritional requirements of various groups.
- All National Health Programmes like acceptance of small family norm, spacing methods, immunization, Lifestyle related illnesses, etc.
- Implementation of important health related acts like Pre-Conception and Prenatal Diagnostic Techniques (PCPNDT), age at marriage etc.
- Importance of Antenatal care, Intra-natal and post-natal care including institutional deliveries.
- Treatment adherence and drug compliance etc.

4.3 IEC material

At district level District Education and Media Officer is looking after all IEC activities in the district.

IEC material provided to PHC is as below:

Posters:

- Subject of the poster should be such that it is of concern to the group of people who are going to see it.

- Exhibit posters at public places where large number of people can see the poster e.g. Gram-panchayat, schools, bus stand, railway station, etc.
- Height of poster should be such that people can see/read it.
- 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.

Banners:

- Banners are used usually for campaigns or any intensive short period activity.
- Banners should also 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 programmes or campaign.
- When activity is over, remove these banners from area.

Stickers:

- They should be stuck on vehicles, shops, indoor places both private and public, in PHC, sub center, schools.
- Stickers are essentially of 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.

Danglers:

- They dangle and attract the people. Can be displayed outside PHC, in sub centers, gram panchayat office, schools etc.

Flip chart/ Health Calender:

- 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.

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 flip book 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.

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.

Hand bills/ Pamphlets:

- 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, video material are also provided to PHCs.

4.4 Inter Personal Communication:

Following media are useful for IPC:

- Laminated cards
- Flip book
- Folders
- Photographs
- Telephone
- Audio recorder

- Model
- Letter/ Email
- Social-media (WhatsApp, Facebook, X, Instagram, You Tube, etc.)

4.5 Group Communication

Following media are useful for Group Communication:

Flip chart	Flip book
Flash cards	Charts
Photograph	Board writing
Slideshow	Model
Street play	Audio recorder
Folk Arts	Rallies
Films	T.V/Radio
Puppet show	Cultural programmes
Role Play	Social-media channels

4.6 Mass Communication:

Following media are useful for Mass Communication:

Hoardings	Bus panel Advt.
Wall painting	Stickers
Tin plates	PVC Banners
Folders	Posters
Cinema	Amplifier
Drama/Road show	T.V/Video/AV Van
Radio	News papers
Exhibition sets	Printing materials
Handbills	Pocket book
Floats	Mural Display
Social Media	

4.7 Role of Medical Officer in IEC Activities:



Planning: Planning is the process of identifying areas where we need to focus in health education, deciding where we want to be from where we are right now. It includes the work to be completed and the action to be taken to achieve/implement those works. Proper planning is one of the most important roles of Medical Officer. He/she has to plan IEC activities for the year including for fairs, festivals and Jatra/Yatra based on the need. This should be part of routine health activities and not separate independent activity.

Organizing: In organizing, the managerial staffs are instructed to organize for all the essential resources i.e.

materials, financial resources, human resources, and equipment. It includes obtaining health education material from District Health Officer from time to time, review available IEC material at Primary Health Centre, proper displaying of the IEC material, implementation of various health activities etc.

Staffing: It basically refers to the personnel and human resources. Staffing includes having right person in the right place at the time. This also include training of health staff about appropriate use if IEC material, conducting effective group meeting, effective interpersonal communication.

Directing: It includes giving directions/instructions and showing ways to the team members/staffs to achieve the goals by proper utilization of the IEC materials and other resources.

Coordination: Coordination also involves interlinking various components of the work. This includes both intra-departmental as well as inter-departmental coordination.

Reporting: Reporting means communicating about the actions/events to the concern authority. Medical Officer must take regular review of IEC activities in monthly meeting, maintain and update records, send monthly report of IEC to DHO every month.

Budgeting: Budgeting involves the activities of fiscal planning and controlling, accounting and auditing. Its use must be transparent to all the concerned team members.

4.8 Social and Behavioural Change Communication:(SBCC)

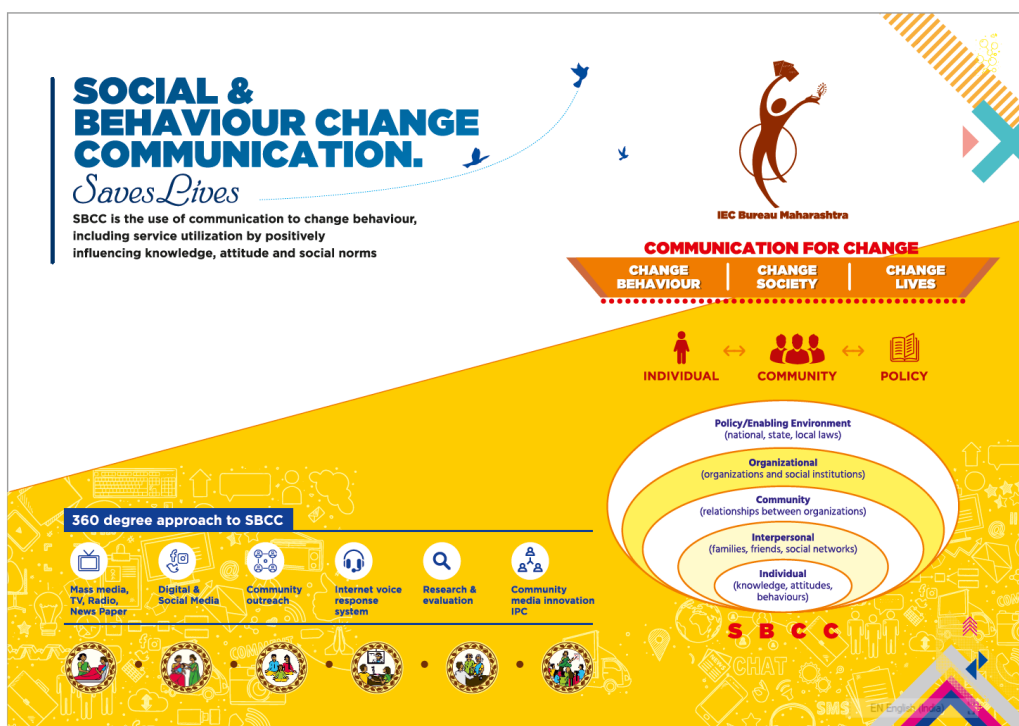
The key strategies of Social and Behavioural Change Communication (SBCC) are:

- **Behaviour Change Communication (BCC)** using mass and social media, community level activities, and interpersonal communication for changes in knowledge, attitudes, and practices among specific audiences.
- **Social mobilization** for wider participation, coalition building, and ownership, including community mobilization.
- **Advocacy to raise resources** as well as political and social leadership commitment to development actions and goals.

4.9 IEC to BCC to SBCC: An Evolution:

- SBCC evolved from IEC and health-education.
- Earlier models used a linear ‘expert- learner’ or ‘sender-receiver’ paradigm to transfer information.
- Focus then shifted to BCC, which emphasized analysis of behaviours and determinants to affect changes in inappropriate behaviour to a healthy and desirable behaviour.
- Now, the focus is SBCC, which uses a comprehensive approach to address social change and behavior change.

Socio - Ecological Model of SBCC:



4.10 Counselling:

4.10.1 Definition:

Counselling is the exchange of information between two people sitting face to face to resolve a problem or to make a decision.

It is a process between a client and provider of identifying the problem of a client and enhance client's knowledge and skill to make the client empower in making decision to resolve the problem through an interpersonal communication.

4.10.2 Purpose of Counselling:

The purpose of counselling is to empower others to help themselves in making informed choices and adopting new attitudes and behaviour where necessary. Counselling plays a vital role in addressing the concerns of the individual, her or his immediate family as well as the community by providing inputs which facilitate behaviour change and create an enabling environment for it. Thus, counselling is one of the most effective tools for bringing about behaviour changes; indeed, it is also equally effective in ensuring success in adoption of preventive measures in situations detrimental to life, livelihood and living. Provider's attitude towards clients has an impact on the quality of counselling and quality of care provided to the clients.

4.10.3 Principles of Good Client-Provider Interaction or Counselling:

- It should always be a two-way interaction between a client and provider.
- It must be an interpersonal, dynamic communication process that involves a contractual agreement between a client and counselor.
- Maintain audio-visual privacy and confidentiality.
- Respectful, non-judgmental, accepting and caring attitude.
- Simple, culturally appropriate language easy for client to understand.
- Good verbal and non-verbal interpersonal communication skills.

- Brief, simple and specific information with key messages.
- Opportunity for client to ask questions and express any concerns.
- Effective use of audio-visual aids, models and contraceptive samples.
- Repeat key information shared by the client, confirm that you have understood correctly what they are saying.
- Voluntary informed decision making by the client.
- It requires empathy, genuineness, and the absence of any moral or personal judgment.

4.10.4 Steps of Good Counselling:

- Welcome your client warmly.
- Introduce yourself.
- Sit closely enough.
- Make eye contact and look at the client as s/he speaks.
- Use language that the client understands.
- Listen and take note of the client's body language.
- Seek to understand feelings, experiences and points of view.
- Be encouraging.
- Use open-ended questions.
- Provide relevant information.
- Try to identify the client's real concerns.
- Provide various options for the client.
- Respect the client's choices.
- Always verify that the client has understood

4.10.5 Approach to counselling - GATHER Approach:

G–GREET the caregivers (establish rapport): It is necessary to overcome biases to meet people as equals. Greeting people personally helps in building rapport to a great extent.

A–ASK caregivers (gather information): It is important to elicit the needs of the caregivers, prioritizing information to make it more relevant. Asking should not be limited to mere medical history because other aspects of a person's life (life stage, lifestyle, personality, etc.) often impact an individual's post-counselling behaviour more than his/her medical history.

T–TELL (provide information): Avoid information overload avoid details on all the processes at one time, there is a limit to information people can retain. Package information in smaller module and check for understanding after delivery of each module.

Specific information organized logically is retained longer and more completely, especially if the individuals are encouraged to ask questions.

H–HELP the individual: This is the decision-making or problem-solving moment. The provider is helping the individual sort through the information, lifestyle and life-stage issues to come up with various alternatives, and to consider the advantages and disadvantages of each alternative.

E –EXPLAIN to the individual: Once the individual has made a choice, the provider uses IEC material to help the individual remember key information. The provider also uses IEC material to remind them of important discussion points. IEC materials reinforce key information, advantages and disadvantages.

R –RETURN/REFER/REALITY CHECK: Return visits or referrals should be planned. If necessary, repeat the information given.

4.10.6 Benefits of Counselling:

- Increases acceptance.
- Enhances continuation of services.
- Dispels myths /rumours and corrects misunderstandings about health services.
- Promotes effective use.
- Increases client satisfaction.

Area	Communication	Counselling
Starting Point	Awareness	Problem/Need
Objective	Demand Generation	Problem Solving
Topic Selection	By Messenger	By Client
Number of Participants	Any (two or more)	2 to 3
Confidentiality	Not Required Always	Must
Judgement	May Suggest	Non-judgmental
Explain Advantages/Disadvantages	Not Necessary Always	Must
To Suggest Options	Not Necessary Always	Must

4.11 Social Media:

IEC Bureau, Pune has developed Social Media sites/portals as follows:

- Facebook: <https://www.facebook.com/MahaArogyaIECBureau>
- Twitter: <https://twitter.com/MahaHealthIEC>
- Instagram: <https://www.instagram.com/mahahealthiec/>
- YouTube: <http://bit.ly/MahaArogyaYT>
- LinkedIn: <https://www.linkedin.com/company/maha-arogya-iec-bureau>

From State various health activities were posted on these portals especially on different Health Days and as a routine. The Medical Officer, In-charge, PHC staff should like and subscribe to these portals and promote to the staff, religious leaders, influencers, local opinion leaders and the people in the area to do the same.

4.12 Branding of Arogya Patrika:

- **Availability of Arogya Patrika at each Health Institute:** At Present upto PHC level Arogya Patrika is supplied free of cost. In future, there is a plan to supply Arogya Patrika in digital format.
- **Yashogatha (Success Stories):** MO, PHC is requested to send success stories from his area to Taluka Health Officers (THO) or District Health Officer (DHO). After scrutiny, selected stories will be sent to Arogya Patrika for publishing in Arogya Patrika other social media, which may improve image of Health Department.
- **Article for Arogya Patrika:** MO, PHC may send an article or motivate the staff and people from his area to write regarding his experience in health programmes implementation, about health days and other related health issues and send the best articles through the Taluka Health Officers or District Health Officer.

4.13 Health Management & Information System:

You may be aware that State has started Health Management Information System (HMIS) reports of IEC and SBCC for Sub Centre, PHC, Block and District level. It will soon be added in DHIS-2. After that at each level, concerned persons should fill-up the report every month and monitoring will be done from State/District/Block/PHC level. It will help to prepare Annual PIP and also improve the credibility of health institutes by improving performance in sensitive indicators of health.

4.14 Celebration of Health Days.

Taking into consideration important public health related issues, health days are celebrated at National and

International levels. These various health days provide opportunity to make general public aware about important public health issues. Medical Officers should take this opportunity and observe or celebrate various health days in PHC area as per the guidelines given by the DHO by using local resources involving ASHA, AWW and other influential people.

Important Health Days

The list of important health days: (Refer Annexure 9.1(Vol. I))

Section 5: Health Information System

5.1 Vital statistics:

Births, deaths and stillbirths are vital events. These are basic components influencing population growth. Medical Officer must know the sources of vital events, various schemes to collect this information, reporting system and calculation of important rates and ratios for PHC. Calculation of rates and ratios will help to evaluate the health programs implemented in PHC area.

Medical Officer and health staff should know following important schemes related to collection of vital statistics in which Primary Health Center is directly involved.

- Civil Registration System – (CRS)
- Medical Certification of Causes of Death (MCCD)
- Survey of Cause of Death (Rural) (SCD)

5.1.1 Civil Registration Systems (CRS):

Civil Registration System is the continuous, permanent, systematic and legal recording of births, deaths and stillbirths under Registration of Births and Death Act 1969. Director Health Services Pune is the Chief Registrar of Births and Deaths of Maharashtra State and is assisted by Deputy Director Health Services (State Bureau of Health Intelligence and Vital Statistics) Pune, who is Deputy Chief Registrar of Births and Deaths of Maharashtra State.

Organizational structure of Civil Registration System in district:

Table: Designated officers under CRS

Sr.	Designation of officers	Designation specified under the act	Area of operation
1	District Health Officer	Dist. Registrar of Births and Deaths	Concerned revenue District
2	Deputy Chief Executive Officer (Panchayat)	Add. Dist. Registrar of Births and Deaths	Concerned revenue District (Rural)
3	Block Development Officer	Add. District Registrar of Births and Deaths	Concerned revenue Block (Rural)
4	Medical Superintendent (RH, SDH, WH, DH Health institutes)	Registrar of Births and Deaths	Concerned Health Institute building campus
5	Medical Officer PHC	Registrar of Births and Deaths	Concerned Health Institute building campus
6	Village Development Officer/Gram Sevak	Registrar of Births and Deaths	Concerned Gram Panchayat
7	Medical Officer of Health, Municipal Corporation	Registrar of Births and Deaths	Concerned Municipal Corporation area
8	Chief Officer of Municipal Council	Registrar of Births and Deaths	Concerned Municipal Council

Registration of vital events under CRS is done on the basis of place of occurrence of event. Thus, birth or death is recorded at the place where the event has occurred irrespective of residential status of the person.

In case of institutional event,

The responsibility of Medical Superintendent (RH, SDH, WH, DH Health institutes) to register birth or death event occurred within PHC building and premises.

It is the responsibility of in-charge of hospital (other than PHC, RH, SDH, WH, DH) to report an event to the respective Registrar. It is the responsibility of In-charge of organization (other than PHC, RH, SDH, WH, DH) to report birth or death event occurred within hospital building and premises to respective Registrar.

Formats:

There are three forms for giving information regarding birth, death and stillbirth to Registrar of births and deaths as follows -

- Form no. 1 Reporting of births
- Form no. 2 Reporting of deaths
- Form no. 3 Reporting of still births
- Form no. 4 Reporting of MCCD hospital death

Form no. 4 A Reporting of MCD non-hospital death

Role of PHC staff in Civil Registration System:

- It is the responsibility of Medical Officer to register all the births, deaths and stillbirths occurring within his/her institute i.e. PHC (ANM/MPW in case of SC) building and premises to respective Registrar.
- Medical Officer should assign the responsibility to one Health Assistant of informing birth and death events happening in the field to respective Registrar. MO should check delivery and indoor register weekly and ensure that all births and deaths are either registered or informed to respective Registrar in relevant form.
- MO should ensure registration of all vital events under CRS by taking review of ANM/MPW. Medical Officer should inform concerned Gram Panchayat about dates of PHC monthly meeting so that Gram Panchayat and health workers can exchange and update the information of vital events from whole PHC jurisdiction.

Data generated is widely used for planning, evaluation of national programs and also for research purposes.

Registration of Birth and Death Act 1969 & Maharashtra Registration of Births and Deaths Rules 2000:

Registration of Births and Deaths Act has made reporting and registration of births and deaths compulsory. Government of Maharashtra has framed revised rules of registration known as, "Maharashtra Registration of Births and Deaths Rules-2000" that came into operation with effect from 1st May 2000. Some of the important procedures of revised Rules, which should be known to PHC staff, are given below –

Reporting of births and deaths as per the Act:

Births and deaths are to be reported by person responsible for registration to the Registrar of Births and Deaths notified by the state government in the Rules. In Maharashtra, VDO/Gram Sevak is a Registrar of Births and Deaths for rural areas and Chief Officer/ Medical Officer of Health of Municipal council/ Corporation for urban areas. Births and Deaths are registered only at the place of occurrence. Person responsible for reporting events for registration as per the place of occurrence of event as below-

Table: Reporting and vital events according to place of occurrence:

Sr.	Place of occurrence	Person responsible for informing (Informant)
1	House	Head of the household or in his absence nearest relative
2	Govt/Private Health Facility (other than PHC, RH/SDH/WH/DH)	In-charge of medical facility or person authorized by him/her on his/her behalf, with medical certification cause of death form in case of death information (Form No. 4)
3	Jail	Jailer In-charge
4	Hotel, Lodging, Boarding house, Dharmashala etc.	Person In-charge
5	New born or dead body found in Public Place	Police Patil/ Sarpanch and In-charge Police station outside residential area of village.
6	Birth or death in moving vehicle (Plane, Train, Bus, Rickshaw, etc.)	Vehicle driver/relative present in vehicle should report at the first place of halt after the occurrence of event.

How to report:

All vital events i.e. live births, stillbirths and deaths are to be reported in the forms prescribed by the state government. These are Form1 for Birth report, Form 2 and Form 4/ Form 4 A for death report and Form 3 for stillbirth report.

Information has to be given with signature / thumb impression of informant. Name of the child if not reported at the time of registration, then it can be reported later on within 15 years after registration.

It is desirable to register name of child within 12 months from date of registering event of birth.

When to report:

All events are to be reported within 21 days of their occurrence (possibly within 7 days). Events reported later than 21 days can be registered on completion of formalities as mentioned below -

Table: Formalities to be completed for late reporting

When reported	Formalities to be completed	Late fee
After 21 days but within 30 days of occurrence	Payment of prescribed late fee	Rs. 2/-
After 30 days but within one year of occurrence	Written permission from Block Development Officer in rural areas, Chief Officer Municipal council in urban areas and on payment of late fee	Rs. 5/-

Over one year of occurrence	Order of Judicial Magistrate First Class of respective area and on payment of late fee	Rs. 10/-
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Issue of certificate:

On registration of an event reported within 21 days, first copy of certificate is issued free of charge. Additional copies of certificate can be obtained on payment of nominal fee.

Committees at various levels for monitoring registration of births and deaths:

Approximately 98% of birth and 88% of deaths are registered under CRS. For improving the Birth & Death registration qualitatively & quantitatively, *GR no. Sankirn 2001/Pra Kra 1192/21 dated 12 Dec 2001* was issued by the Rural Development Department. Co-ordination committees are already established for reviewing ICDS scheme at village, block & district level. Area of work of these committees has been extended for improving 100% birth & death registration.

GR no. VPM-2021/Pra Kra 52/Panra 3 dated 12 Feb 2021 by the Rural Development Department. As per this GR committees at village, block and district level had been revised.

The details are as below:

Village level committee:

Gram Sevak	Chairman
ASHA Worker	Member
Anganwadi worker	Member
NGO/Mahila Mandal Representative	Member
Auxiliary Nurse Midwife	Member Secretary

Meeting of this committee is to be held every three months. Review of birth, death and still birth registration is taken in this meeting. Also review of birth, death and still birth registration is taken in VHNSC monthly meeting.

Responsibilities of Village level committee-

- To monitor and review births-deaths and still births registration of village/hamlets.
- To see whether 100 percent registration of births-deaths and still births events is done or not and to discuss and implement strategies for the same at village/hamlet level.
- To keep coordination with government department at village/hamlet for timely registration of birth and death events.

Block level Committee:

1	Block Development Officer:	Chairman
2	Child Development Project Officer	Member
3	Medical Superintendent, Rural Hospital (where Rural	Member
4	Hospital comes in rural area their Medical Superintendent)	Member
5	Medical Officer, Primary Health Centre (All from Block)	Member
6	Block level NGO representative working in health sector	Member
7	Extension Officer (Health)	Member
8	Extension Officer (Panchayat)	Member
9	Taluka Health Officer	Member Secretary

Functions of the committee:

- Monitor & review birth, death and still birth registration in the block
- Discuss and implement actions required for 100% registration of births, deaths and still births in the block.
- To co-ordinate with various departments at village/block levels for timely registration of births and deaths.

District level committee:

1	Collector	Chairman
2	Chief Executive Officer, Zilla Parishad	Co-Chairman
3	Deputy CEO (Panchayat)	Member
4	Civil Surgeon	Member
5	Project Officer, ZP (WCD)	Member
6	District Information Officer	Member
7	Block Development Officer (All Blocks)	Member
8	District Chairman (Indian Medical Association)	Member
9	District Health Officer, Zilla Parishad	Member Secretary

CRS Reporting process:

After filling form No.1,2,3 respectively for Birth, death & Still Births by informant accordingly; Birth, Death & Still Births are registered by concerned Registrar. These forms have two parts, first part is Legal part which remains at Registrar level as permanent legal record, while other part is Statistical part which contains statistical information. This information is filled in online software at block level & it can be accessed directly at State level. This Statistical information will be used for preparing AVSR (Annual Vital Statistical Report). RGI developed New Birth & Death Registration software which is introduced all over state from Jan.2016. The overall information will be filled online in this software by Registrar, which will generate all statistical reports as well as Birth & Death Certificate in Local & English Language. The added benefit of this software is that beneficiary can download online Birth & Death Certificate in bilingual form.

5.1.2 Medical certification of cause of death (MCCD):

Mortality statistics is an essential part of the vital statistics system which is undertaking control measures for better health planning and management of programmes for welfare of people. Medical Certification of Cause of Death Scheme is an important tool of obtaining authentic and scientific information regarding the causes of mortality which is formulated by office of the Registrar General, India.

Legal provision has been made for MCCD under section 10(2), 10(3) and Section 17(1)(b). According to this, A medical person attending the deceased in his/her last illness, after death of a person shall fill form No. 4 for institutional deaths/ 4A for non-institutional deaths, to the best of his knowledge & belief the cause of Death; All such certificates of cause of deaths are sent to the local Registrar.

The standard format of the certificate prescribed by WHO is incorporated in the Rules 2000 viz. **form No. 4 & form No. 4A**.

The cause of Death: The cause of death is a disease, abnormality, injury or poisoning that contributed directly or indirectly to death. "Cause of death" of MCCD form has two parts.

Part I of the cause of death statement:

Only one cause is to be entered on each line of part I. The underlying cause of death should be entered on the lowest line used in this part. The underlying cause of death is the condition that started the sequence of events between normal health and the immediate cause of death.

- Line (a): Immediate cause.
- Line (b): antecedent condition [Due to (or as a consequence of)]
- Line (c): is the underlying cause,

However, many conditions are involved, write the full sequence one condition per line, with the most recent condition (immediate cause) at the top and the earliest (the condition that started the sequence of events between normal health and death) last.

Normally the condition on the lowest line of part - I will be taken as a underlying cause and used for statistical classification of causes of deaths by International Classification of Diseases (ICD-10).

Part II: Other significant conditions:

Enter all other conditions contributed to death but which were not related to the disease or conditions directly causing the death.

A form has a **detachable portion** separated by perforation mark, containing information on the fact of death, which after filling Form No. 4/4A will be handed over to relatives of the deceased for further procedures.

Normally the medical part of the MCCD certificate is the responsibility of the attending physician and based

on his individual assessment. In case of medico-legal cases, cause of death should be written by medical officer who performs post-mortem & on the basis of evidence noticed by him.

Role of MO PHC in MCCD:

In case of death occurred in PHC/premises of PHC than as per provisions of RBD Act attending MO after death of a person shall fill in Form No.4 with proper ICD-10 code for disease classification in a,b,c category for death in PHC. All such certificates of causes of deaths are sent to state bureau of Health Intelligence and Vital Statistics, Pune after registration of that death physically by 10th of every month.

5.1.3 Survey of Cause of Death (Rural) Scheme:

Reliable information regarding causes of deaths in rural area particularly in case of deaths at residence is not available. This information is essential for planning of health services.

Considering the problems, Model Registration Scheme (MRS) was introduced by GOI in 1967. Later, it was renamed as Survey of Cause of Death -Rural (SCD-R) in 1982. The Scheme was closed by Government of India but was then modified by State Government in 2002 and had been implemented in 1817 villages (one from each PHC) among the 34 districts which were selected by using statistical method. Currently the scheme is implemented in 1838 villages, covering about 40 lakh population. The data collected is related to resident population only (de jure).

Health workers of selected villages use the verbal autopsy technique (VAT) to collect signs & symptoms of deceased at the time of death. Medical Officer PHC ascertains the cause of death according to signs & symptoms reported by health workers. In case of doubt/ suspicion/ query about signs & symptoms, medical officer is supposed to visit the deceased persons home/relatives. List of causes is provided, which is based on International Classification of Diseases 10th Revision (ICD-10). Causes of deaths are analyzed according to different socio-economical categories (e.g. age, sex, occupation).

Implementation of SCD-(R):

Following steps should be carried out for implementation of SCD-R scheme in PHC.

Selection of village under SCD-(R):

Only one village per PHC is selected as per predetermined statistical method, modification in this village can be done only after sanction given by Chief Registrar (Births & Deaths) Maharashtra State.

Planning of scheme:

- Name of village selected for SCD-(R) scheme will be informed to respective PHC through DHO office.
- Preparation of map: prepare map of 45 cm X 45 cm size showing whole area of PHC. Village selected under SCD (R) should be marked by red color village border. Do not ignore single farmhouses scattered around the village and surrounding pada and vasti. Also show all the roads up to boundary and other important landmarks in village e.g. school, temple, Gram Panchayat, etc.
- Selection of field agent: MPW(Male and Female) is designated as field agent under SCD (R). Divide the population among the male and female MPW's equally, maintaining the natural divisions.
- Selection of field recorder: HA is designated as field recorder under SCD (R). Appoint one Health Assistant (M/F) for supervision and for six monthly surveys.

Implementation of scheme:

Step I: Continuous enumeration by Field Agent (MPW):

Field Agent visits every house of the area allotted to him/her twice a month with interval of not more than 15 days and collects information of all deaths (including infant deaths, child deaths, maternal deaths), births, stillbirths occurred in the population. Birth/death of resident population occurred outside the village should also be recorded. (Such births or deaths are not recorded under CRS). In case of death, MPW should collect the detailed information from the near relative about signs/symptoms before death and events leading to death.

Step II: Ascertaining cause of death:

MO PHC should ascertain the cause of death on the basis of information collected by field agent about the disease or incidence leading to death. Medical officer has to classify and code cause of death according to the list provided in the SCD manual. This is based on International Classification of Diseases 10th Revision. SCD code should be used which starts with number and not with alphabet. There are total 19 groups of conditions based on disease wise, system wise or as per incidence leading to death. Cause of death should not be given as mode of dying e.g. cardiac failure or respiratory failure etc., but specific disease condition leading to death should be given. For each death, separate form-C should be filled.

Step III: Compilation, analysis of the reports:

Field recorder collects all the reports from MPW (Male and Female), compiles, gets the cause of death from MO, prepares monthly report of PHC and submits the monthly report to DHO along with other MIS.

Step IV: Six monthly surveys by field recorder (HA):

Field recorder surveys all houses in the village twice a year and records vital events independent of records submitted by field agent. All vital events occurring during January to June are recorded in July and those occurring during July to December are recorded in January. Missing events are identified and supplementary reports are submitted to the state. At the time of first half yearly survey Age and Sex wise composition of the population is also recorded.

Step V: Cross checking the events:

Medical Officer should organize SCD meeting of field agents and field recorder immediately after six monthly survey is completed by field recorder. All the events are cross checked on the basis of monthly reports submitted by Field Agents, Six monthly surveys by field recorder and sub center registers (R-15, R-16). Annual report should be prepared after cross checking of all the events mentioned in continuous enumeration, six monthly report and sub center record.

Records and reports under SCD (R):

Total four forms are to be filled while recording vital events as below:

- Field agent should fill up ' Family Information Form' during survey.
- 'Form-A' for all the information related to the births
- 'Form-B' for information related to deaths.
- 'Form-C' for recording cause of death by using VAT and other medical.

Recording of stillbirths and infant deaths:

Stillbirths should be recorded in birth record form, (Form-A) & serial number '0' should be given to stillbirth with mention as "Still Birth" in remark column. Many times, newborn deaths occurred within short period after birth and are recorded as stillbirth instead of infant death. This is very common mistake. To avoid this, ask the birth attendant specifically about history of cry (which may be once only and feeble) or any active movements of new born immediately after birth to ensure whether it was actually stillbirth or death of live born baby within short period after birth. Such live birth with early deaths should be recorded first in birth register and then in death register. Thus, if the field agent notices any vital event in the house surveyed, he/she should fill up all the required information related to the births in 'Form-A' and related to deaths in 'Form-B'. Medical Officer should fill cause of death in 'Form-C'.

Registers and records required in SCD(R):**Table: Registers and records in SCD (R)**

Sr.	Register / File / Record	Responsible Person	Utilization
1	Map of SCD village	HA (Male)	To show village covered under SCD with distribution of area among field agents.
2	List of field agents	HA (Male)	To know field agents under SCD.
3	Birth Register: Form - A	HA (Male)	List all the births recorded by Field Agents, verify and correct if any missing / wrong. Evaluation of work done by Field Agent.
		MPW (M/F)	Record all birth events related to resident population of jurisdiction and report to MO PHC.
4	Death Register: Form - B	HA (Male)	List all the deaths recorded by Field Agents, verify and correct if any missing / wrong. Evaluation of work done by Field Agent.
		MPW (M/F)	Record all death events related to resident population of jurisdiction and report to MO PHC. With the help of verbal autopsy collect the signs and symptoms of probable cause of death and report to MO PHC.
5	Cause of Death Register: Form - C	MO PHC	Investigate the cause of death with the help of signs and symptoms recorded by MPW and conclude the cause of death. Visit to deceased persons relatives if recorded signs and symptoms are doubtful. Coding of cause of death and reporting.
6	House wise list	MPW (M/F)	Collect the family information of all houses from selected village.

Sr.	Register / File / Record	Responsible Person	Utilization
7	Fortnightly continuous enumeration report	HA (Male)	Keep date wise separate file for fortnightly continuous enumeration reports of each Field Agent. One file for one year. Close the file and keep in record room at the end of year.
		MPW (M/F)	Keep record of fortnightly continuous enumeration and report to HA.
8	Six Monthly Survey Report file	HA (Male)	Report of six monthly surveys carried out, by field recorder, compare with fortnightly enumeration done by Field Agent and preparation of annual report. One file for one year. Keep in record room after completion of year.
9	Annual Report File	MO PHC HA (Male) MPW (M/F)	Annual report should be prepared by conducting meeting of MPWs(M&F) and HAs by using fortnightly enumeration, six monthly survey, records and registers of sub center. Keep the file of reports year wise for last ten years.
10	SCD correspondence file	HA (Male)	Instructions, information, guidelines regarding implementation and reporting of SCD to be kept date wise. Helpful as ready reference for program implementation.

Vital Rates Scheme (VRS)

Information about vital events like births, deaths and mortality pattern is very important for planning and evaluation of health schemes. Births and deaths in rural areas are registered through Civil Registration System. However registration is incomplete.

Another important problem is getting reliable vital rates for each district of the state. Sample Registration Scheme (SRS) by Government of India provides vital rates but they are for the state and are not available as district specific rates for district planning. The problem is overcome by this scheme and **it is the only scheme that gives information about various rates district wise.**

Thus, Vital Rates Scheme is being implemented for getting district wise information about vital rates and fertility rates from this scheme was previously known as 10% survey which was started in 1995–96. The scheme is known as Vital Rate Scheme (VRS), in this scheme out of total revenue villages covered under CRS, 10% villages are selected randomly. This scheme was clubbed with SCD in 2002.

This scheme collects data related to resident population of that village (jurisdiction)

Important activities to be carried out by PHC for VRS

Selection of village

Villages from your PHC will be selected by DHO for VRS. Name of the villages selected from your PHC, population covered and prescribed formats will be provided by DHO.

Planning of scheme

Planning of village survey is responsibility of MO PHC. Select one MPW(Male /Female) per one thousand population for survey. Divide village among MPWs keeping natural divisions (e.g. pada, vasti, galli etc.) intact. For collection of data, MPW (Male / Female) should take help from Asha, Anganwadi Worker etc.

Data Recording

Three types of forms should be filled during survey. Form- I should be filled for all the families survey. If there are births in the family, fill up Form-II and in case of death in the family fill up Form -III.

Scheme implementation

- Survey will be carried out in the month of January and information of vital events occurred in previous calendar year will be collected. For example, if survey is carried out in January 2004, information of vital events occurred during 1st January 2003 to 31st December 2003 is collected.
- All the vital events related to residents of identified village are recorded even if they have not occurred in the village. Resident of a village is a person residing for minimum 6 months in a village.
- Information of guests coming to a village on the day of survey should not be collected.
- MPW will fill up the Form -I by house-to-house visit. Information of vital events e.g. births, stillbirths, infant deaths, maternal deaths and other deaths is collected & recorded in the prescribed formats.
- Appoint one HA for every two MPWs to supervise the survey. HA should verify 100% houses. HA should continue the survey in absence of MPW.

- Each house is stenciled on the door during the survey. Supervisors e.g. HA, Statistical Assistant, MO should also stencil the verified houses.

Supervision

Medical Officer must remain present in the village during survey and visit at least 10% houses and all the houses from where infant and maternal deaths are recorded.

Rechecking

Once survey is completed, Medical Officer must verify all events with help of R-15 and R-16 registers, AWW records, CRS records and note down if any vital event is missed during survey. This verification will also give idea of quality of survey.

Send the information to the DHO office within time.

Hospital morbidity & mortality statistics

Information on morbidity and mortality is collected from all PHCs in prescribed format recommended by Central Bureau of Health Intelligence, New Delhi. Format is based on International Classifications of Diseases (ICD) that comprises a condensed list having 194-major causes. This is based on diagnosis of OPD/IPD patients attending the PHC.

Important instructions for MO

- Hospital morbidity & mortality statistics is information of disease pattern in PHC area.
- Most important aspect of correctness of this statistic is writing accurate diagnosis on case paper of each patient. This will help in getting meaningful data from scheme.
- In case of injury, it is essential to write part of the body involved (e.g. fracture skull), type of injury e.g. fracture, contusion, laceration, crushed injury, as well as supplementary cause of injury e.g. H/O fall, road traffic accident etc., homicide, suicide.
- This information is helpful in planning specific health programs and for evaluation of the progress of existing health programs.

5.2 Fertility Indicators

Fertility indicators are important for measuring fertility pattern from PHC area. Fertility indicators are basic to understand population policy goals and base for population control. Medical officer can calculate the fertility indicators of PHC area to understand progress of PHC in family welfare program.

5.2.1 Important fertility indicators

- Crude Birth Rate
- General Fertility Rate
- Age Specific Fertility Rate
- Total Fertility Rate
- Gross Reproduction Rate
- Net Reproduction Rate

Crude Birth Rate (CBR)

- It is the simplest measure of fertility, expressing number of live births per 1000 population in specific year for the specific region.
- This rate is called crude because all variations in population composition are ignored in calculating it.

Importance:

- It points to the contribution of fertility to the growth rate of population.
- It requires minimum data for computation.
- It indicates the level of fertility of society.

General Fertility Rate (GFR)

- It is the first refinement of crude birth rate.
- It is the number of births per 1000 women in reproductive age group in specific year and in specific area.
- It uses the number of women of child bearing age in a population as denominator.
- It is usually four to five times higher than CBR because women of these ages normally contribute from one fourth to one fifth of total population.

Age Specific Fertility Rate (ASFR)

- The ASFR is number of births per year per woman in a given age group in a given year and given geographical area.
- This rate is essential because fertility rate varies as per age groups of women.
- ASFR is not affected by any variation in age structure.
- While calculating fertility by this rate, it is accepted that all women in all age groups do not have same reproductive capacity and that changes with age.
- It is possible to calculate TFR with the help of ASFR.
- It is possible to study actual cohorts of women to see whether reproductive capacity is changing with age.

Total Fertility Rate (TFR)

- It is a hypothetical measure giving an idea about the average number of births, a woman can have during her complete reproductive period assuming that child bearing pattern of the same women in different age group in her entire reproductive span, will remain same as today's existing pattern in the population.
- TFR is not affected by age structure of women under study.
- It is also useful when comparisons between two groups of women are made.
- TFR can be thought as the completed family size, i.e. it can be treated as number of children born to a woman in her entire reproductive span. Slight differences occur because of deaths, migration and change in child bearing pattern of a women over a period till end of her entire reproductive span.

How to compute (TFR)

- Make sum of ASFR.
- The sum is multiplied by 5(the width of age groups), as each age group consists of women of 5 different ages.
- TFR is expressed as per woman, therefore above figure is divided by 1000.

Gross Reproduction Rate (GRR)

GRR is restricted to the number of female children. It is about half of the TFR. It indicates number of daughters, each woman can bear during her entire reproductive span.

This rate indicates how many daughters i.e. potential future mothers would be born to 1000 women passing through their child bearing years, assuming ASFR of a given year remained constant and no woman entering child bearing period dies before reaching menopause. In other words a today's single mother is replaced by number of mothers equal to GRR.

How to compute (GRR)

- If data on births by sex is available for each reproductive age group, then ASFR may be computed for female children. Sum of ASFR for females is multiplied by 5 and product is divided by 1000.
- However, data on births by sex is not usually available. In such cases GRR is calculated as multiplying TFR by 0.49.
- This 0.49 factor is derived by assuming that sex ratio at birth is 105 male babies for 100 female babies. Thus, proportion of female babies in total number of births is $100/205$, which is approximately 0.49.

Net Reproduction Rate (NRR)

- NRR takes into account both fertility and mortality. As is considered in GRR, is not realistic to assume that all women in the cohort will survive up to the end of childbearing period. Therefore, a refinement in the GRR is introduced by taking into account mortality of the women and the NRR is computed.
- This indicator is concerned with the extent to which a group of females replaces its own female members by the mutual process of fertility and mortality. NRR indicates number of daughters ever born to a cohort of women, if they give birth according to fixed schedule of ASFR and experience fixed age specific mortality rates up to the end of their child bearing period.
- This measure is sometimes called a replacement rate, as it provides a consistent index of how many daughters are in the next generation per woman in the previous one.
- NRR 1 means that, combination of fertility and mortality is such that one mother is replaced by one daughter.
- If $NRR > 1$, it indicates population growth and
- if $NRR < 1$, it indicates population decline.

How to Compute (NRR)

This is constructed by calculating number of girls surviving at the current mortality from a thousand births from the ages of reproductive period.

- At each age corresponding specific fertility rates are applied to surviving women to give resulting births.

- Summation over all ages gives the total births to the original 1000.
- These are translated into daughters i.e. multiplication by proportion of births, which are female births ($100/205=0.49$)
- Thus, NRR is GRR multiplied by proportion of females surviving from birth to the age at which they replace their mothers on average.

5.2.2 Calculation of fertility indicators: (Refer Annexure 5.1(Vol. I))

5.3 Vital Rates, Mid-Year Population & Census

Life events such as birth and deaths are called as vital events. These events have direct relationship with fertility and health condition of the population. Various rates that indicate health status of community can be calculated with the help of these vital events, which are called as vital rates.

5.3.1 Important aspects of various vital rates for MO

- MO should calculate various rates like birth rate, death rate for his PHC. For calculation of IMR and SBR for PHC the sample size for these rates is low at PHC level. However, IMR calculated at PHC level although may not be statistically accurate still will give approximate rate. MMR should be calculated only at district level onwards.
- MO should study the birth and death rates sub center wise and also village wise.
- Compare these rates with state figures from SRS as well as with district rates from SCD (R). (The PHC rates may differ from these because of the change in socio-economical pattern)
- After calculation of the rates, analysis is more important e.g. if rates are much less, it indicates reporting is incomplete, try to find out the reasons for this. Find out which villages have under reporting and try to correct it.
- MO can plan & evaluate the health programs by studying these rates.
- After studying infant mortality and its causes, educate the staff and plan specific interventions according to prevalent causes of infant mortality in PHC area.

5.3.2 Mid-Year Population

Mid-Year population (MYP) is the population on 1st July in that year. Medical Officer of PHC must know how to calculate Mid-Year Population. MYP is required for following purposes:

- To assess Correctness of survey.
- To estimate beneficiaries based on MYP under various national health programs, especially Pulse Polio Immunization Programme.
- For Planning of Services.
- Calculation of MYP, expected vital events, Total expected birth in year, Total expected deaths in a year & expected infant deaths in a year: (Refer Annexure 5.2(Vol. I))

5.3.4 Important Vital Rates

Crude Birth rate	(already described)
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Crude Deaths rate	(Number of deaths in a year / Mid-year population) × 1000
Infant mortality Rate	(Number of deaths below 1 year / Number of live births) × 1000
Neonatal Mortality rate a. Early neonatal mortality rate: From 0 to 7 days b. Late neonatal mortality rate: From 8 days to 28 days	(Number of deaths from birth to 28 days / Number of live births) × 1000
Still birth rate	(Number of stillbirths in a year / Number of total births in a year) × 1000
Maternal mortality ratio (MMR)	(Number of maternal deaths in a year / Number of live births in a year) × 100000
Perinatal mortality rate	(Number of deaths from 28 weeks of gestation to 7 days of births in a year / Number of total births (live births + still births) in a year × 1000
Post neonatal mortality rate	(Number of newborn deaths aging between 28 days to 365 days of age in a year/Number of live birth in a year) × 1000

5.3.5 Investigation of infant and maternal death (Refer MDR & CDR guidelines)

MO PHC has to investigate personally all maternal and infant deaths that occur in his PHC area in a prescribed format. (Do not calculate the IMR and MMR for PHC area)

Death audit

- MO should investigate all maternal and infant deaths occurring in PHC area by personally visiting that house and using verbal autopsy technique (VAT).
- Person who was attending the deceased at the time of death must be interviewed.
- Discuss in detail with the relatives about signs symptoms, duration of illness, complications, treatment received if any, whether case was referred, problem in referral, whether deceased was hospitalized and problems in transportation etc.
- If patient was hospitalized, go through the hospital records. In case of maternal death, visit the hospital where the mother was admitted for treatment. Discuss with treating doctor and go through the patient file in hospital.
- You can arrive to probable cause of death with the help of history and medical records of patient.
- It is good practice to discuss the infant and maternal deaths occurring in PHC area during monthly meeting. First narrate the total history of patient from starting of illness to death. Discuss the steps of intervention by which death could have been prevented by each level of function, i.e. MPW (Male & Female), HA and MO. Details of discussion of death audit during meeting is given in Section -I of guidelines.
- This will help MPW/HA to take actions so as to prevent such type of deaths if same situation arises in future.

5.3.6 Important vital rates for Maharashtra and India

Table: Important vital Rates of Maharashtra & India			
No	Rate	Maharashtra	India
1	Crude Birth Rate	15	19.5
2	Crude Death Rate	5.5	6.0
3	Maternal Mortality Ratio *	33	97
4	Infant Mortality Rate	16	28
5	Neonatal Mortality Rate	11	20
6	Early Neonatal Morality Rate	8	15
7	Late Neonatal Mortality Rate	3	5
8	Post Neonatal Morality Rate	5	8
9	Perinatal Mortality Rate	11	18
10	Stillbirth Rate	3	3
11	Under five Mortality Rate	18	32
Source: Sample registration system 2020 Published in 2022			
* Source: Special Bulletin on Maternal Mortality In India 2018-20 Published in 2022			

5.3.7 Census

The first complete census of India was conducted in 1881, on a uniform basis throughout the country. Since, the census is being conducted regularly after every 10 years. The Census of India 2011 is 15th Census in the series & is 7th since independence. This is second Census of this millennium & century.

Table: 2011 at a glance: salient features of Maharashtra.

Census Population:		
Total	Persons	11,23,74,333
	Male	5,82,43,056
	Female	5,41,31,277
Rural	Persons	6,15,56,074
	Male	3,15,39,034
	Female	3,00,17,040
Urban	Persons	5,08,18,259
	Male	2,67,04,022
	Female	2,41,11,42,37
Total Number of Districts including Mumbai + Mumbai suburban		36
Number of villages		40,961
Census Towns		279
Number of municipal Corporations		26
Number of Municipal Councils / Nagar Panchayats		222
Number of Cantonment Boards		7
Decadal Population growth Rate (2001-2011)		15.99%
Urban Population		45.23%
Sex Ratio	Total	925
	Rural	948
	Urban	899
Sex ratio 0-6 Years		883
Literacy rate	Total	82.91
	Male	89.82
	Female	75.48

5.4 Health Management Information System

Health Management Information System is one of the most important managerial tools available for PHC MO. HMIS has been developed to make available the required information for decision-making.

Health staff of Primary Health Center provides various types of services to community. Services provided need to be recorded properly which helps in proper planning and regular monitoring of all activities under any program. Thus, daily recording of work done is not wastage of time but it is part of program implementation.

Health management information system comprises of recording of data related to services provided & health status information. Analysis of the data and using findings to improve program implementation are the inherent components of HMIS.

MIS includes

- Collection of data at a fixed frequency
- Compilation and transmission of data
- Analysis and interpretation of data
- Storage and retrieval
- Feedback to the concerned individuals

5.4.1 Frequency of data collection

- Daily e.g. during epidemic period
- Weekly e.g. weekly health condition report
- Monthly e.g. regular monthly reports

5.4.2 Working of HMIS

Preparation of sub center MIS report

- MPW (male and female) have separate diaries. They record work done on each day date wise in their diary, which includes all activities carried out by MPW (M&F).
- MPW (M&F) compiles work done during the month with the help of diary and registers provided.
- MPW (F) should first complete the HMIS booklet and hand over to MPW (M). MPW (M&F) then prepare collective sub center HMIS report for submission to MO.
- Sub-centre level validation committee meeting should be held on last day of each month. In this meeting reports received from CHO, MPW (M&F) and ASHA should be validated with each other.

Submission at PHC level

- PHC validation cum HMIS meeting is held on 3rd of every next month. Sub enter MIS booklet is scrutinized by HA & then submitted by MPW (M&F) to MO. In this meeting physical & financial report should be reviewed. Junior Clerk should submit financial report based on physical performance.
- Medical officer will receive reports from following sources-
 - Work done by CHO at Sub-centre level.
 - Work done by MPW (M) and (F) in sub centers.
 - Work carried out by ASHA/Link worker etc. (Included in sub center report)
 - Work carried out at PHC HQ
 - Work done by HA during field visit
 - Work done at Private hospitals / NGOS.

Compilation at PHC

- Compilation of report and development of PHC report is responsibility of HAs, Pharmacist and Lab Technician as per their subjects under supervision of MO.
- PHC MIS report is prepared by compilation of all reports received to PHC as above.
- Medical officer should personally review work done by each CHO, HA (M&F), MPW (M&F), and Block Facilitator (ASHA) and plan for next month.
- Work done by CHO, ASHA and BF should be verified and approved by PHC MO and then forwarded to district/block level for fund disbursing.

Submission of report to district level

- Block level validation cum HMIS meeting to be taken on every 5th of next month.
- District level validation cum HMIS meeting to be taken on every 8th of next month. In this meeting one HA (M/F) should be assigned duty to submit the HMIS at district level.
- Based on this HMIS report monthly meeting of Medical Officers is should be held on 16th of every next month at DHO office.

5.4.3 MIS in Maharashtra

Computerization of HMIS

Recently updated Web based HMIS has been developed in Maharashtra. Software has been prepared & it is hosted on NIC server. Now HA can enter PHC MIS data online which will be available to all the levels in department. HA should maintain approved & signed hard copy of compiled monthly HMIS for online HMIS data entry.

How the system will work

For sub center & PHC level, data will be collected & compiled manually as per the present system. At Sub Centre, PHC, Block HQ level the data entry, will be through web-based system on fixed dates. Compiled reports will be available to the district, regional & state level after data entry at all level is completed. Therefore, no manual compilation will be done district onwards.

5.4.4 Analysis and interpretation of MIS reports by MO

Medical Officer should analyze and interpret MIS reports and judge quantitative and qualitative performance of all workers in PHC, try to find areas lagging behind and also nature of support required.

Timeliness, regularity & completeness of reports are essential.

- For assessing regularity and timeliness of reports, make the register, in which month wise reports received from each sub center should be noted along with date of receipt.
- Confirm whether all reports are in given format, all columns are filled, monthly, progressive figures are given and report is signed by MPW & checked by HA.

Quantity of performance

- Examine performance of key indicators as per population norm and also as per expected level of achievement. Key indicators should be analyzed village wise. This helps to identify villages with poor performance, where MO has to concentrate.
- Compare inter linked indicators with each other to identify gaps in service delivery. For example, compare ANC registration with TD immunization, IFA supplementation, deliveries etc.
- Compare BCG immunization with 3rd dose of Penta, OPV and also with MR 1st and 2nd coverage.

Quality of performance

Assess quality of the performance by analyzing indicators such as proportion of ANC registration before 12 weeks among total ANC registration, proportion of fully protected ANCs and percent of fully immunized children below 1 year etc.

Comparison of performance with the available stock

Compare performance with inventory report submitted by the worker. Services given and stock utilized should coincide e.g. number of women given therapeutic and prophylactic IFA should be tallied with consumption of IFA during the month, number of OP & CC available & expended should tally with the reports of number of users of these methods.

Check validity of the data

Validity of the data should be assessed by cross checking the indicators e.g. report of total live births and report on number of newborns with birth weight recorded and not recorded, etc.

Calculate various rates

- Calculate various rates like birth rate, death rate, infant mortality rate for PHC and also for each sub center and compare with district or state vital rates. If there is difference, find out reasons for difference and take necessary action.
- In addition to these rates, calculate dropout rate for multiple doses vaccines, this should not be more than 3 percent. Calculate Couple Protection Rate, which will help to identify areas with low use of FP methods and hence requiring more concentration.

Monitor other important indicators

- Review new case detection and cure of important communicable diseases like tuberculosis, leprosy against the targets.

5.4.5 Uses of MIS

- Monitoring and review of performance with expected level of achievement.
- Compare performance between two different years/ workers/ Sub Centers.
- MIS helps for identification of problem areas.
- Planning of the services is dependent on analysis of reports.
- Proper distribution of resources e.g. medicines, equipment's, supervisors etc.
- Reviewing their performance makes appraisal of PHC staff.
- Decision making for corrective actions.
- Proper guidance and support to concerned staff.
- It helps to identify training needs of the staff.

5.4.6 MIS meeting at PHC

Some important aspects of PHC meeting are:

- Meeting should start in time at 10.00 am.
- Senior MO should conduct meeting & should remain present throughout the day.
- Clinical work of that day should be assigned to second MO.
- Agenda should be pre decided and communicated to health workers in time.
- Sequence of meeting should be:
 - Communicating instructions received from the district level, related to health workers.
 - Informing about important letters and technical
 - Circulars received from higher authorities.
 - Problem solving
 - Continued Medical Education.
 - Death audit: Detailed discussion about infant deaths and maternal deaths that have occurred in PHC area during last month.

5.4.7 Responsibilities of various functionaries for effective use of MIS:

MPW (M&F)

- Prompt and correct record of work done after daily home visit and Arogya Seva Satra
- Updating the registers
- Monthly summary of all registers
- Utilization of this information for improving the work
- Planning for next month
- Preparing MIS report

MPW (M)

Along with above mentioned responsibilities MPW (M) should do -

- First fortnight reporting
- Second fortnight and monthly reporting

HA

- Checking all reports for correctness
- Helping MPW to update registers
- Helping MPW to prepare monthly summary of each register
- Review of records once a week
- Comparison with ELA (target) and give feedback accordingly
- Preparation & submission of monthly PHC MIS report in time.

Medical Officer

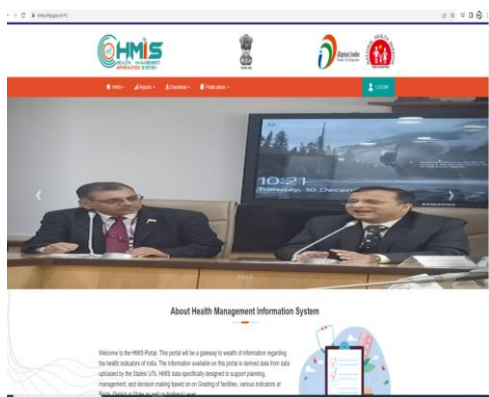
- Detail inspection of records of one MPW (M) and one MPW (F) once a month
- Twice a month review of critical indicators of each program
- Supervising MIS of the PHC
- Utilization of MIS reports to assess progress of PHC
- Feedback on MIS report to MPWs
- Planning for the next month
- Evaluation of the programs implemented

5.4.8 Integrated Health Information Platform (IHIP) Data Entry

HMIS Portal was in use for Data entry till April 2020, since than IHIP is used.

IHIP Web site URL - hmis.mohfw.gov.in/#/

Home Page



Select Login



Enter User Name, Password, Captcha

User Name and Password given Different to all health facility, like Health sub center, primary health center, Rural hospital, Sub district hospital, District Hospital, Medical College, Block HQ, District HQ.

After Login Page



Select Entry for Data Entry

- 1) Monthly Service Delivery
- 2) Infrastructure and Human Resources

>>> Start from Infrastructure and Human Resources

>>> Select Reporting Month

5 data elements of Infrastructure data entry (Indicators)

- Services
- Human resources
- Physical Infrastructure
- Equipment Drugs and furniture
- Quality control

STEP

>>> Enter Data and Submit

Or no changes of previous month data so carry Forward

Next select

>>> **Monthly Service Delivery**

1 to19 Data Elements of monthly Service Delivery

1	M1	11	M13
2	M2-M3	12	M14
3	M4	13	M15
4	M5	14	M16
5	M6	15	M17
6	M7	16	M18-M19
7	M8	17	M20
8	M9-M10	18	M21
9	M11	19	M22
10	M12		

STEP

>>> Monthly Service Delivery Data entry page

>>> Select month

```
>>> Enter data of data entry month.
```







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 Data Entry
 Reports
 View Map
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 User Profile

[Home](#) > [Data Entry](#) > [Monthly Service Delivery](#)

Monthly Service Delivery

Village Name: Jarabe (1-Subed)	Facility Type: Hc-4Cbc	Sub-Type: Hc-4Cbc (I)	Category: Not available	Reference No: 347073
Village: Jarabe	Village Panchayat: Jarabe	Block Name: Madhi (4320)	Sub District: Madhi (4192)	Health Block: Not Available
District: Pune (400)	State: Maharashtra (27)	User Id: hm27psad144	Ownership: Public	Sanctioned Bed count:

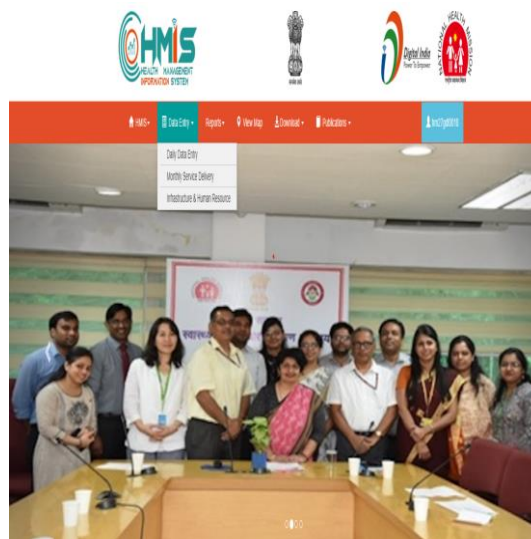
Reporting Month: Apr-2023 **Program Division :** A-H **Services :** A-H

Document Number: 37-400-4192-0127-4000200-4000000-1

Please enter the data accurately and check before submission.

PartA
M1
PartB
M2-M4
PartC
M5-M9
PartD
M10-M12
PartE
M13
PartF
M14
PartG
M15
PartH
M16

Indicator Number	Indicator Name	Apr-2023		Remarks
		In-Facility	Outreach	
Part A	REPRODUCTIVE AND CHILD HEALTH			
M1	Ante Natal Care (ANC) Services & High Risk Pregnancies			
1.1	Total number of NEWN Pregnant Women registered for ANC	37	0	37
1.1.a	Out of total number of NEWN Pregnant Women registered with age <15 years	0	0	0
1.1.b	Out of total number of NEWN Pregnant Women registered with age >15-19 years	0	0	0
1.1.c	Out of total number of NEWN Pregnant Women registered with age >19 to	37	0	37



For PHC, indicator no. 2 data entry part

- Monthly Service Delivery
- Infrastructure and Human resources



**HEALTH MANAGEMENT
INFORMATION SYSTEM**



GOVERNMENT OF INDIA



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Facility Information

Facility Name: Kurud tr (6 - Bedded)	Facility Type: Primary health centre	Facility NIN: 5115247529	Facility Location: Kurud
Village: Kurud (538493)	Village Panchayat: Kurud (174900)	Block Name: Not Available (N/A)	Sub District: Desaijanj (vadasa) (4052)
District: Gadchiroli (475)	State: Maharashtra (27)	User Name: Purushottam Khurse	User Id: hm27gd0018

Today: Wed, 27 April 2022

Document Number: 27-475-4052-538493-5115247529-27042022-D-1

[Nil Reporting](#) | [Reset](#) | [Print](#) | [Export Excel](#) | [Submit](#)

Reporting Date
27/04/2022

Please enter the data accurately and check before submission

COVID-19 (Mandatory)			
Indicator Number	Indicator Name	27-Apr-2022	Remarks
1	Total number of outpatients (OPD)		
2	Total number of inpatients (IPD)		
3	Total SARI - Severe Acute Respiratory Infection (OPD + IPD)		
4	Total ILI - Influenza Like Illness (OPD + IPD)		
5	Total fever cases >= 7 Days (OPD + IPD)		

[Nil Reporting](#) | [Reset](#) | [Print](#) | [Export Excel](#) | [Submit](#)

Data Validation

Health Sub Center

Validation Meeting should be conducted at Health Sub Center level on 3rd of each month.

- Validation Committee Members
 - Auxiliary Nursing Midwifery (ANM)
 - Multipurpose Health Worker (MPW)
 - Anganwadi Worker (AWW)
 - ASHA
- Responsibility of Validation Committee Members
 - Physical report of all the indicators should be validated with HMIS Portal Report.
 - Discrepancy found should be corrected.
 - These corrected data entries should be done on HMIS Portal up to same day.

Primary Health Center

- Validation Meeting should be conducted at Primary Health Center level on 4th of each month.
- Validation Committee Members
 - Medical Officer (MO)
 - Lady Health Visitor (LHV)
 - Health Assistant (HA)
 - Auxiliary Nursing Midwifery (ANM)

- Multipurpose Health Worker (MPW)
- Block Facilitator (BF)
- Responsibility of Validation Committee Members
 - Physical report of all the indicators should be validated with HMIS Portal Report.
 - Discrepancy found should be corrected.
 - These corrected data entries should be done on HMIS Portal up to same day.

Block Level

- Validation Meeting should be conducted at Bloc level on 5th of each month.
- Validation Meeting Members
 - Medical Superintendent (MS)
 - Taluka Health Officer (THO)
 - Medical Officer PHC (MO)
 - Block Health Assistant (HA)
 - All program Co-Ordinator (NHM)
 - Statistical Assistant (SA)
 - Programme Assistant (PA)
 - Block Community Mobiliser (BCM)
- Responsibility of Validation Committee Members
 - Physical report of all the indicators should be validated with HMIS Portal Report.
 - Discrepancy found should be corrected.
 - These corrected data entries should be done on HMIS Portal up to same day.

5.5 Record Keeping

Medical Record

Medical record is essential and mandatory for health care providers for systematic study, which helps in improving health care delivery system. Patient records are confidential and should be available only to people involved directly in patient care.

Well maintained records provide evidence of quality work done by the team & can always protect the concerned staff in difficulties. Clinical notes are important means of communication for the team involved in patients care by documenting management and care offered; they can also be used to improve patient care when reviewed as part of an audit.

Notes may also be requested for insurance and medico legal purposes.

All members of the health care team are responsible for ensuring that records are:

- Complete
- Accurate
- Legible and easily understood
- Written at the time of patient contact
- Signed, with date, time, name and position of person making entry.

Once written, notes must not be changed; a subsequent entry can be made if there is a change in the patient's condition or management.

Admission note/pre-operative note

Preoperative assessment should be documented; including full history and physical examination, patient consent where required.

Operating room records

Operating room records should be kept in Operation Theater Patient Register. Standardized forms save time and encourage staff to record all required information. Operation theatre record should include -

- Patient identity
- Procedure performed
- Persons involved
- Complications

By looking at records of all procedures, MO can evaluate complication rate and postoperative wound infections or review number of procedures performed. Such evaluation, which should be regular duty of one HA (Female) helps in assessment of aseptic routine within PHC and allows for future planning.

Delivery register

Delivery register should contain a chronological list of deliveries and procedures, including interventions, complications and outcome. It should also contain information about sex of baby, birth weight, condition at the time of birth.

Indoor patient record

All patients should be assessed at least twice a day, even those who are not seriously ill. Vital signs should be taken as dictated by the patient's condition and recorded; this can be done on a standard form as well as graph and can also include fluid balance record. Progress notes need not be long, but must comment on patient's condition and any changes required in management plan. MO writing note should sign them.

Notes can be organized in the "SOAP" format:

Subjective	How the patient feels
Objective	Findings from physical examination, vital signs, and laboratory results
Assessment	What MO thinks
Plan	Management plan; this may also include directives which can be written in a specific location as 'order'.

A consistent approach such as this ensures that all areas are included and that it is easy for other members of team to find information.

Discharge note

On discharging patient from ward, record:

- Diagnosis on admission and definitive diagnosis
- Summary of patient's course in hospital
- Instructions about further management as an outpatient, including any medication, length of administration and planned follow-up.

Registers & record to be maintained and their use

Various registers are required to be maintained by PHC staff related to the national health programmes, services provided, water supply and sanitation etc. These registers help to assess coverage of services and also for tracing course of particular event and outcome of individual case.

PHC staff and Medical Officer do not fully utilize registers and records for planning and implementation of service. This has led to common belief that registers and records are unnecessary burden on health worker. In reality, if these registers are used properly for planning and implementation of services in PHC, quality services can be delivered to a greater number of beneficiaries in less time with proper planning. This helps to save time and energy of all health staff. List and use of Register/records to be maintained by each category of staff is given in *Chapter 13 Miscellaneous*. Regular updating of this record is also responsibility of concerned staff. MO should regularly check these registers for completeness and correctness.

Not only maintenance of technical record is important but administrative record and filing is equally important. List of these is also given along with importance of each in Chapter 13 Miscellaneous.

5.6 RCH Portal Reproductive & Child Health (RCH) Portal

(Formerly MCTS-Mother & Child Tracking System):

Background:

Reproductive & Child Health (RCH) portal, is web-based reporting software, under RCH-II programme for name based tracking of health services delivered to eligible couples, pregnant women and children. As per the instructions by Ministry of Health & Family Welfare (MoHFW), Delhi, it has been rolled out in the state primarily as Mother & Child Tracking System (MCTS) since January 2011. In July 2011, Central Government declared it as Mission Mode Project (MMP) under National e-Governance Plan (NeGP) to expedite its implementation.

It was implemented both in rural & urban area from year 2014-15.

It was switched over to RCH portal which is expanded version of MCTS. The software is accepted by GoI and hosted on Central Server of National Informatics Centre (NIC), Delhi and data is being captured from all over the nation in uniform parameters.

5.6.1 Aim and Objectives:

Aim: To strengthen the monitoring of RCH indicators – IMR, MMR & TFR through name based tracking of health services delivered to eligible couples, pregnant women & children.

Objectives:

Name Based Tracking of:

- Eligible couples – registration and updation for contraceptive usage & sterilization services.
- Pregnant women - registration and updation for ANC, Delivery & PNC services.
- Children - registration and updation for immunization services.

To Facilitate:

- Follow up of contraceptive usage & provision of sterilization services to eligible couples.
- Close monitoring of regular checkups & service delivery to pregnant women with essential health services
- Full immunization of pregnant women & children.
- Follow up of dropouts and track service delivery
- To promote safe institutional deliveries.

5.6.2 Coverage:

All districts and corporations of Maharashtra State – All rural, urban and slum & slum like areas in corporation are covered under RCH.

5.6.3 Physical data capturing:

New Village wise integrated RCH-1 Register was printed as per MoHFW guidelines & implemented from year 2015-16 replacing old registers. The data required for uploading on RCH portal need to be captured in RCH register. RCH-II register version 2.0 is now being implemented in the state, in this version all type of services of one beneficiary are captured in one page.

5.6.4 Online Data Capturing:

- Village profile - Census Population, estimated annual targets for eligible couple, pregnant women & live births, service providers for the village etc.
- Health providers - ANM, ANM2, MPW, GNM, etc.
- ASHA workers, Link workers, CHV, AWW etc –in rural and urban areas.
- Eligible couples –as per family health survey.
- Pregnant Women – from women registered in eligible couples & tested positive in pregnancy test.
- Children – for immunization services.

5.6.5 Modes of Data Entry:

Online data entry by using RCH Register is the mode of data uploading in the software. Data is entered at respective facility level where computer system & internet connectivity is available. It is being implemented in the state from year 2023-24. ANMOL android application is used for online and offline data entry, the application is available on google play store. The application can be downloaded by ANM/MPW. The eligibility criteria for use of this application is ANM/MPW registered on RCH portal with her/his mobile number. After that ANM/MPW is eligible to login ANMOL application, user ID is RCH ID of ANM/MPW. All RCH portal data elements are added through ANMOL application. After login ANMOL application registered ANM sub-health facility data will be downloaded by ANMOL application. Online and offline both modes are available. Data needs to be synchronized time to time whenever internet connectivity is available, data gets automatically updated on RCH portal server through ANMOL application.

5.6.6 Approach to RCH Portal:

The following steps need to be observed to use RCH Portal.

- Go to RCH portal website using Internet browser.
- Open the portal with the help of user login ID and password provided. OTP will be received on user's mobile number.
- At first, every time observe the notice board for any new instructions, letters, circulars, scroll message on the website etc.

- Complete the health provider & ASHA worker registration and regularly update the information in case of any change. Facility available in RCH portal to transfer ANM, MPW, ASHA etc. from one location to other.
- For the registration of village profile, service providers, beneficiary registration & service delivery updates use data entry section.
- Data entry section can also be used for search of beneficiary, migration of beneficiary and telephonic data verification over the portal by GOI - MCTFC (Mother and child tracking facilitation centre).
- Various types of reports can be accessed through Report section.

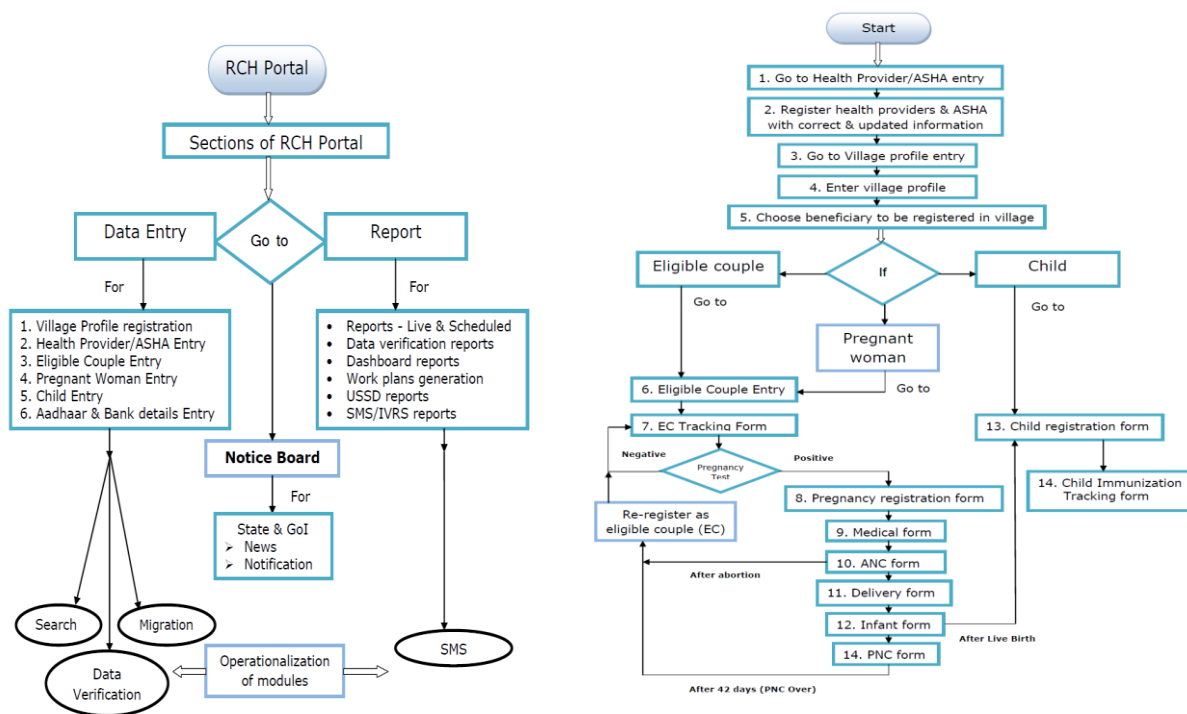


Fig: RCH Portal

5.6.7 Operationalization of RCH Portal:

- Ensure that all prospective & retrospective information of beneficiary is recorded in RCH register at any time of service.
- Ensure all correct hierarchy of mapping from district to village level in RCH software Application.
- Health providers, ASHA & Anganwadi Workers need to be mapped correctly at appropriate centres and villages.
- All questions in the data entry form with red star mark are mandatory fields & data need to be provided without fail. For that matter the same data need to be recorded compulsorily in RCH register and portal.
- Village/health facility profile registration needs to be completed before registration of beneficiaries in respective areas. Without registration of village/health facility profile entry we cannot do anything in RCH portal. Village/health facility profile registered once in a year but can be updated throughout the year.
- The age group for women in Eligible couple (EC) registration form is 15 to 49 completed years & for child it is from 0 to 5 completed years. Accordingly, the beneficiaries need to be registered properly.
- Direct entry of pregnant woman is not allowed in the RCH software and she must be first registered as eligible couple in EC form wherein she can be marked as pregnant to be shown in pregnancy registration module.
- 12-digit ID number generated for wife in eligible active couple will be continued same as her pregnant woman ID when she will become pregnant.
- Pregnant woman's record need to be entered in various sub sections like Registration form, Medical Form, ANC Form, Delivery form, Infant form followed PNC form through inbuilt validity checks.
- After abortion or after PNC gets over for a pregnant woman, she needs to be re-register in EC tracking form with same ID.
- After delivery & registration of live birth in the system, 12-digit unique ID will be generated for a child and the child will be shown in immunization tracking form for immunization services.
- A case of eligible couple will be closed in event of inactive, death, sterilization, age barred etc. while a case of pregnant woman will be closed in event of death, age barred, post-partum sterilization etc. A case of child will be closed in event of death, age barred etc.

5.6.8 Computer generated 12-digit unique ID:

After registration of new beneficiary on RCH portal 12-digit unique ID is generated for every case. Initial 12-digit ID is generated for wife when she is in eligible couple which get carry forward (same ID) when she becomes pregnant. Separate 12-digit ID is generated for child when he/she will be registered as live birth immediately after delivery. The 12 digits will include 1 for (Mother) or 2 for (Child) + 2 digits (state code) + 9 digit (auto generated number-running over the state). The 12-digit unique ID is most important part of RCH system to track the beneficiaries in the software database.

5.6.9 System of Tracking:

RCH software enables tracking of following three components.

- Beneficiaries –for health service delivery & drop outs.
- Service providers – for reporting of services provided.
- RCH Portal users –on the basis of use of facility/ sub-health facility level login IDs & user activity log.

The various phases of tracking system for beneficiaries can be explained in following steps.

New registration:

The new beneficiaries (Eligible couple for Contraceptive usage & sterilization services, Pregnant Women for ANC, Delivery & PNC and Live births for immunization) are registered in the online RCH software using their identification profile to generate 12-digit unique ID.

Allotment of health provider & ASHA Worker:

At the time of beneficiary registration in the software health provider (like ANM, ANM2, MPW, link worker, GNM, CHV) is linked with each beneficiary as per the service area allotted. In rural area each beneficiary is also linked with respective ASHA of that village.

Transfer of Unique ID to RCH Register & beneficiary

At the same time after registration of beneficiary on the portal, 12-digit unique ID generated is noted down by user on the RCH register against the name of beneficiary and later on transferred to beneficiary card (ANC card & immunization card) by respective ANM. The ID is also can be communicated to concerned beneficiary through ANM/portal.

Work plan generation for due services -

As per the beneficiaries allotted, monthly work plan is generated on RCH portal data entry section of the health provider & ASHA worker depending on the due services. They are supposed to track these beneficiaries on priority basis in their respective catchment area for delivery of services. The mandatory captured mobile number of beneficiaries can be used to take information of services and to record on the work plan if beneficiary is outside catchment area. The filled work plans with recorded service delivery dates need to be returned to data entry point for data entry. Due services work plan should be utilized in every outreach session for effective services.

Service delivery record update –

To update health services & other related parameters, beneficiary can be tracked in the system by name within district and by ID within state. The beneficiary can also be tracked with the help of registration number as well as with her available identification details registered in the portal data base.

5.6.10 Reporting and monitoring:

- **Registration Count reports:** They are useful to monitor registration of beneficiaries and need to be monitored on daily basis. It must be ensured that all beneficiaries in the catchment area need to be enrolled in RCH portal at the earliest to provide 12-digit unique ID.
- **Services updation reports:** They are useful to monitor ANC, Delivery & PNC services provided to pregnant women & immunization services provided to children against their corresponding due services for each month. It should be ensured that service data of beneficiary need to be updated regularly in the software as soon as it is collected & recorded in the RCH register. ANMOL application should be used for real time data updation.
- **Work plan generations:** Following types of work plans for due services are useful for micro planning of health service delivery.

Work plan for:

- ANC
- Delivery
- PNC
- Infant and Child Immunization.
- Facility wise
- Health provider wise
- Beneficiary wise

Printouts of work plans need to be provided to ANM & ASHA workers on regular basis to track the beneficiaries for due services. Furthermore, the work plans need to be generated using facility logins to have a track on users.

- **Dash Board Report** – Various Dash board reports including mother & child fact sheet as well as indicator wise reports in tabular & graphical form are displayed. They represent qualitative data & need to be reviewed regularly.
- **Tracking Reports** – They are most important reports to monitor the drop outs during service delivery on the basis of LMP cohort for pregnant women and DOB cohort for children. tracking for LBW babies, tracking for severely anaemic and with ANC complication pregnant women reports are generated
- **Line listing of Targeted Focussed Group beneficiaries** - Tracking of high risk, severely anaemic pregnant women as well as low birth weight babies & teenage pregnancies is importing activity of monitoring through RCH portal. The line listing of all such beneficiaries need to be generated for further tracking purpose.

- **Data verification reports** - The contact detail information of beneficiaries as well as health providers & ASHA workers verified through direct telephonic calls to them, need to be updated instantly whenever any wrong, incorrect or incomplete information is found on portal.
- **RCH user activity log** – User can be tracked for RCH website activity with the help of internet protocol (IP) address.

5.6.11 Data Verification by Call Centre:

Data related to contact details, identification details of Health providers & ASHA workers and services provided to beneficiaries which is being entered at the field level is verified by directly telephonic calls through call centres at national level on regular basis. The various health program information is also being provided to health workers & beneficiaries during verification. Hence it is expected to provide correct information over portal including updated contact details.

5.6.12 Validation of Health Providers & ASHA and their contact details:

This is one time activity and need to be worked out soon after the registration of new Health worker & ASHA worker in RCH portal or in case of change of mobile number. The mobile number of all Health workers & ASHA workers registered in RCH portal must be validated by direct telephonic call on the mobile number and reporting correct response in verification module in the portal.

5.6.13 Notice Board:

Central Governments & State Governments guidelines, notifications, letters, circulars, informative material in the form of manuals, videos, presentation are displayed on the notice board for widespread awareness.

5.6.14 PFMS (formerly CPSMS):

It is web portal for Public Financial Management System (PFMS), formerly known as Central Plan Scheme Monitoring System (CPSMS). It is the scheme of the Planning Commission which is being implemented by the Office of Controller General of Accounts, Ministry of Finance. RCH portal is linked with PFMS for Janani Suraksha Yojana (JSY) Payments under Direct Benefit Transfer (DBT) through Aadhar based & non Aadhar based payments.

5.6.15 Facilities covered under RCH portal:

All Public Health Institutions providing RCH Services– SC, PHC, RH, SDH, DH, WH, MCH, & institutes from corporation & council area along with other peripheral units are the facilities who can access RCH portal for data registration and recording of services.

5.6.16 Manpower & infrastructure:

There is availability of Health providers/ANM/MPW/DEO's at all facilities for data entry. Existing manpower should be deployed and infrastructure to be utilized. The state RCH portal cell is located at State Family Welfare Bureau, Pune for technical support.

5.6.17 Effective Implementation of RCH

- **Real Time Data Entry:** The service delivery date needs to be updated in RCH software within 3 days of service delivery in the field.
- RCH implementation in the area need to be monitored on real time data entry basis.
- All eligible couples, ANC's & Live Births must be enrolled in RCH and any backlog registration thereof should be completed on campaign mode.
- Services to be delivered should be as per the work plan of current month which should be updated on the portal in same month for effective reflection of real time data.
- Line listing should be generated every month and kept at District to Sub-center level for tracking of beneficiaries of:
 - Severe anemic Pregnant Women
 - High Risk Pregnant Women
 - Low Birth Weight Babies
- Ensure following regular activity
 - Complete reporting of data & full service updation

- Correct & updated mobile numbers, information of beneficiaries
- Correct & validated mobile numbers, information of all Health Providers and ASHA workers.

5.6.18 Key action points for Medical Officer

- Self-sensitization & training of Staff in RCH concepts – All staff need to be trained in active tracking concept of RCH, Real Time Data Uploading, and utilization of data.
- It should be kept in mind that for RCH portal there is Continuous Data Entry –
 - Beneficiary Registration at the earliest as on when detected & recorded.
 - Service Data Updation by Real Time Data Entry immediately after service delivery.
- The data need to be registered at appropriate levels & in proper villages.
- There should be proper allotment of beneficiaries to Service Providers in the software as per the availability.
- Work plan should be generated in each month for each health worker & for facility level.
- There should be regular distribution of blank work plans to health workers & timely collection of filled work plans for regular service data updation.
- Line Listing for follow up Tracking of beneficiaries need to be generated like Severe anemic, High Risk, Teenage pregnant women & LBW babies
- Mobile number of beneficiaries along with other information need to be corrected immediately which has been found during online data verification.
- Every health provider/ANM/MPW should use ANMOL application regularly.
- Always keep correct, valid & updated information of beneficiaries as well as service providers in RCH portal

5.7 e-Governance

Maharashtra government has formulated and declared State E-Governance Policy vide GR NO.MTS2011/125/39 date: 23-09-2011 for implementing e-Governance initiatives/projects in the state. The department with its wide array of e-Governance initiatives has introduced efficient new ways of delivering services, internal to the organization as well as for the citizens.

Benefits:

- E-governance with the use of information technologies, has the ability to transform relations with citizens, business and other arms of government and these technologies can serve better delivery of government services to citizens.
- E-governance can transform citizen services provide access to information to empower citizens enable their participation in government and enhance citizen economic and social opportunities so that they can make better lives for themselves and for the next generation.
- Better access to information and quality services to the citizens, simplicity, easy retrieval, efficiency and accountability in the government and expanded reach of governance are the benefits of E-governance.

Need for e-Governance Cell Formation in Directorate of Health Services:

PHD under its e-Governance ambit has developed an array of applications catering to the internal needs of the department. The focus of the department has been primarily on five pillars as:

Human Resource Management, Hospitals and Medicines, Communication, Administration and Citizen Centric Programme. DHS & NHM has successfully conceptualized, designed and implemented E-Governance Policy. (Refer Annexure 5.3(Vol. I))

5.8 e-Aushadhi

e-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, RH, SDH, PHC & WARDS of Maharashtra state. e-Aushadhi software started across the state from November 2013. The main aim of 'e-Aushadhi' is to ascertain the needs of various district drug warehouses such that all the required materials/drugs are constantly available to be supplied to the user district drug warehouses without delay. This includes classification/categorization of items, codification of items, quality check of these items, etc. and finally issuing drugs to the patients, who is the final consumer in the chain. "e-Aushadhi" helps

in determining the needs of various Sub-stores such that all the required drugs are constantly issued by District drug warehouse to its Sub-store.

5.8.1 Salient Features of e-Aushadhi -

- Role Based Access.
- Interface of Drug warehouses & Lab Interface.
- Supplier Payment Process.
- Budgeting, Stock Ledger & Drill-Down Reports.
- Various kinds of Analysis of data.
- Customizable Alert Management & Reports.
- Provision of maintaining expiry date / shelf life for an item wherever applicable
- Medicine demand generation.

5.8.2 e-Aushadhi enables the health services in following activities:

- Purchase order
- Supply chain management
- Stock management
- Quality Control
- Near expiry drug stock
- Supplier Payment
- Issue to sub stores and patient
- Demand module including indent and Annual demand
- Excess and shortage medicine notification facility.

5.8.3 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.
- Customizable Reports
- Establish Quality Assurance systems for testing of medicine

There are 76 drug ware houses functional in all districts. In each district there are two DDWs- one is for CS and other is of DHO. Drugs are directly supplied to District warehouses from the manufacturers. “e-Aushadhi” is used for the supply chain management and inventory management. Through e-Aushadhi Software, review of stock position at every district is taken and necessary steps are taken to maintain adequate quantity of drugs. Pharmacy Officer is providing updated stock position of medicines & consumables to medical officer which are conducting OPD. Based on the consumption it will be easier to forecast the requirement of medicine.

State Drug List- 929

State Consumable List- 316

Essential Drugs are marked as “E” in State Drug

(List attached in Annexure 5.4)

5.8.4 Quality testing of drugs.

As soon as the drugs are received in the district warehouses from the suppliers, batch wise samples are drawn from the consignee locations. The samples drawn are sent to the Procurement Cell through courier. After the samples are received in the Procurement Cell from all the warehouses. The Empaneled Laboratories would analyze the drugs as per specifications; and suitable test protocols. Upon receipt of reports from the Empaneled laboratories, the results are entered in e-Aushadhi software

If any sample sent to the Empaneled laboratories fails in quality, the result is confirmed with the other Empaneled laboratories/ Government Analyst before taking final decision.

5.8.5 Major Achievement:

- Faster process from purchase to supply to payment

- Brings transparency in supply chain process
- Real time data made available for various levels
- No need to maintain manual stock registers

5.8.6 Responsibility of Medical Officers-

- Daily Login mandatory (MO Login)
- Regular monitoring of e-Aushadhi software.
- To supervise the updation of records to be done by Pharmacy officers of PHCs.
- Routine monitoring of near expiry and vital drugs.
- Making internet facility available at PHC

5.8.7 Responsibilities of Pharmacy Officers:

- Daily Login mandatory (PO Login).
- Checking entry of each and every drug and consumables in e-Aushadhi after receipt from district store.
- Online demand (indent) to district.
- Entry of each and every medicine and consumables purchased at PHC RH, SDH level.
- Regular review of various reports.
- Weekly updation in e-Aushadhi software at least 2 times in a week.

Section 6: Medico Legal Aspects

6.1 Medico-Legal Work

Medical Officer is concerned with medico-legal work along with clinical & administrative jobs while working at PHC. He should apply his medical knowledge to certain branches of law. MO needs to be present in court as an expert witness. Therefore, he should carefully note all the facts observed & learn to draw conclusions correctly & logically. The post-mortem examination & other medico-legal work form a very important part of the duties of Medical Officer serving in PHCs. It is superfluous to stress the necessity of correct medico-legal work as it is a vital part of maintenance of law and order. Since this work is a vital link in the dispensation of justice, it goes without saying that careful attention and promptness is quite essential in dealing with it.

6.1.1 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 police does not send them to PHC.

- 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 anaesthesia 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.
- Complaints of rape, POCSO, unnatural sexual offence, impotency, indecent assault
- Person under influence of alcohol or any other intoxicant drug.
- Any doubtful case or death for which cause cannot be certified.
- Injury after hospital admission e.g. falls from cot.
- Rare cases like Battered baby syndrome / Body Packer's syndrome.

6.1.2 Identification marks

It is advisable to write two identification marks of the party examined. Whenever MO is called in a court of law to give evidence, he is asked whether he remembers to have examined the party. Identification marks have legal significance as actual verification can be done in court. Left thumb impression of patient would also be very useful for subsequent examination.

Identification marks like mole, tattoo, old healed scar should be described in details, site should be described with respect to two anatomical bony landmarks. Anybody peculiarity like supernumerary fingers/toes shall also be noted. Draw sketches/diagrams of identification mark if required.

If no specific identification mark found then the fingerprints plain as well as rolled should be taken.

6.1.3 Summons

It is issued by the court in writing, in duplicate & signed by presiding officer of the court. It is served on the witness by police officer or officer of the court. MO should know following important aspects of summons:

- MO should sign (with date and time) first copy & return back to police and should retain second copy
- When summons is served on a witness, 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. But MO should duly inform about this to the court in writing well in advance or as early as possible and inform higher authority accordingly.
- Criminal courts get precedence over civil courts.
- It is necessary to maintain a summons register, indicating name of the MO called, name of the court, date & time of hearing, name & register number of the case.
- M.O should study the case details & relevant standard text before attending the court.
- M.O should carry original documents pertaining to the case for the reference of the court.
- MO should prepare a list of MOs worked in previous years along with their working tenure so as to ensure appropriate serving of Summons.

6.1.4 Recording of evidence

- Examination - in chief: Witness first examined by the side, which has called him. In government set up this is commenced by public prosecutor.
- Cross Examination: By the opposite counsel.
- Re-Examination: After cross-examination witness may be re-examined by counsel who has called him.
- Court Question: Judge may ask questions to witness to clear doubtful points.

6.1.5 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 afterward. Copy of the report should be preserved in the same form as original (MLC record to be kept with office clerk. These records must be produced to MO whenever required). Examples: Injury report, PM report.

6.1.6 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 his 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 himself take dying declaration if dictated by circumstances
- If the patient's condition is grave, medical attendant should record statement himself
- 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 down it in the presence of two disinterested witnesses. Preferably witness should be female. It should be recorded in the 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.
- Should be signed by doctor & 2 witnesses.
- 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 still useful as a supporting statement in case that person is examined.

6.1.7 Doctor in Witness Box

- **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.
- **Giving evidence**
 - Address the judges as "Sir".
 - 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 loose temper. Always appear cool & dignified.
 - Sometimes counsel quotes a passage from text book & asks you as a witness whether you agree with it. Request the counsel to show textbook to you before replying, note the date of

publication, read the paragraph contents and also paragraphs above and below of the quoted paragraph and then opine based on the findings.

- When evidence is concluded, this should be read, signed by MO after getting corrections.
- Do not leave court till permission is granted and attendance should be obtained from court.

6.1.8 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 the disposal 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.

- **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 (MLC no. will be in format- MLC no...../ Dr. ABC/ date/time).
- 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.
- When MO is transferred to some other Health Institute, he should hand over all ML records to the record keeper (office clerk) of the PHC and shall obtain receipt of transferring such record from In-charge of the PHC.
- 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.

- **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.

- **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.

- **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 centre for advanced treatment, concerned authority (Primary Examiner) will give final report based on his/her primary findings.
- 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.
- The report/case record should not be issued to third party without consent of patient or investigating authority.

6.2 Post Mortem Examination

6.2.1 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, cause & manner of death.
- To collect evidentiary material.

6.2.2 Rules

- PM examination should be considered as an urgent work taking into account psychology of relatives waiting for the body to be handed over & also 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 may be done at night if adequate quantity & quality of light can be assured so as to have correct interpretation.
- The reason why postmortem examinations should not be done at night is that it is not possible to appreciate the superficial as well as the deep injuries and pathological changes in the various organs properly in artificial light. Many points of medico-legal significance are likely to escape notice. Post mortem examinations are always to be done in broad day light. It is often very difficult for the Medical Officer to convince the relatives of the deceased that such a procedure is necessary. The reason why post mortem examinations should not be done at night is that it is not possible to appreciate the superficial as well as the deep injuries and pathological changes in the various organs properly in artificial light. Many points of medico-legal significance are likely to escape notice. At present Government of Maharashtra have allowed Post mortem examinations to be made during night time if lighting arrangement are satisfactory. However, cases under categories such as homicides, suicides, rape, decomposed bodies; suspected foul play should not be subjected for post mortem during night time unless there is a law and order situation.
- Ref: F. No. H-11021/07/2021-H-I, GOI, MOHFW dated 15/11/2021
- 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.

6.2.3 Carrying out postmortem

Check following record:

First check the Records of the body:

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 etc

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.

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.

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.

Conducting postmortem

Even if cause of death is obvious from examination of a particular part of body; all parts must be systematically examined.

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.
- Apparent 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.
- Photographs, video, sketches can be taken whenever necessary.

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: 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
24-36hrs	Rigor receding or absent. Green discoloration over whole body, abdomen distended with gases. Ova of flies seen.
48 hrs	Trunk bloated. Face discoloured & swollen. Blisters present. Moving maggots seen.
72 hrs	Whole body grossly swollen & disfigured. Hair & nail loose. Tissues soft & discoloured.
1 week	Soft viscera putrefied.
2 weeks	Only more resistant viscera distinguishable, (like prostate, uterus)
1-3 months	Body skeletonized.

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.

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.

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 litre capacity should be used to preserve viscera. Such bottles are available in the office of the chemical examiner.

Guidelines for preserving & sending viscera

- Preservation of viscera is no panacea to solve all difficulties in post mortem examinations. Preservation is necessary in cases of suspected poisoning or in drowning cases and where the cause of death cannot be given in spite of all possible attempts. The provision of preservation of viscera should not influence the post mortem examination in such a way as to detract from the importance of carrying out each step of the post mortem examination carefully.
Whenever viscera or other samples are preserved, the required form for that particular viscera/samples should be filled in, duly signed and both the viscera/samples should be handed over to the Police accompanying the body in the mortuary only. This prevents allegation of exchanging viscera.
- MO should preserve viscera in following cases if needed:
 - Drowning, burns, hanging, strangulation, suspected poisoning.
 - Where cause of death cannot be ascertained.
 - If Investigating Officer has requested for the same.
 - In decomposed cases.
- Bone marrows, liver spleen kidney, brain should be preserved for diatom test in suspected drowning case along with control water sample from scene.
- Viscera which are preserved should be handed over to concerned police immediately along with the appropriate form and receipt should be taken after that.
- Preservation & dispatch of viscera is not substitute for careful PM examination.

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. 100 ml small intestine contents or whole if less.
- Liver- 400-500 gm; whole in infants 1/3 in Adult 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.
- If viscera/tissue are to be kept for histopathological examination- pieces of lungs, brain, liver, spleen, kidneys and whole heart pancreas should be preserved in 10% formalin. (Additional viscera can be preserved as per need of case).
- In cases of suspected electrocution, the skin from suspected site of contact or entry wound should be sent for chemical analysis along with the control skin in separate bottle.

- In cases of suspected snake bite, the skin from suspected site of bite or wound should be sent for chemical analysis along with the control skin and blood in separate bottle also same in case of post injection anaphylactic death.
- In cases of firearm death-skin piece from site of entry, hand washings, recovered bullets or pellets should be preserved in separate bottles.

How to preserve viscera?

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.
- Blood sample should be preserved in separate bottle.

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.
- Formalin & 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.
- $\frac{1}{4}$ th part of container must be kept empty.

The following material is required for preserving viscera to carry out necessary tests:

Sr.No.	Material	Quantity
1	Stomach	Whole
2	Stomach contents	300 cc. If less, the whole quantity.
3	Small Intestine	3 ft. in adult, 6 ft. in children, and whole in infants.
4	Small Intestine contents	100 cc. If less, the whole quantity.
5	Liver	400 to 600 grams in adult. Whole in infants.
6	Spleen	$\frac{1}{2}$ in adult. Whole in children and infants.
7	Kidney	$\frac{1}{2}$ of each in adult. Both whole in children and infants.
8	Brain	300 grams.
9	Bones	A piece of long bone about 6 inches.
10	Hair	20 grams. If less, the whole quantity.
11	Blood (Post Mortem)	10 cc or more.
12	Vomit	300 cc. If less, whole quantity.
13	Stomach Wash	500 cc. If less, whole quantity.

Brain should be sent in cases with positive history of poisoning with either Barbiturate or Opium.

Following material should be collected and sent through the Medical Officer:

- Post mortem blood sample with preservative in a sealed vial for blood grouping. In case of inability to collect blood, a piece of muscle, teeth or big bone should be sent.
- Fresh preserved blood sample of all concerned persons (injured/accused) whose blood is likely to be present on the articles sent for analysis, should be sent in sealed sterile blood vials for blood grouping.
- In rape/sodomy cases, preserved blood of both victim and accused should be sent in sterile vial. In such cases semen from accused for grouping should not be sent unless it is demanded from laboratory. In case of married woman (victim), fresh blood of husband should be sent in found necessary.
- Blood sample should be sent as follows:
 - (2 ml blood + 2 ml preservative)
 - (Add 5 gm of Sodium Citrate + 5 drops of formalin in 100 ml. distilled water)
 - Tooth sample should be washed, dried and sent in sterile sealed vial.

- 5 cm diameter blood stain should be prepared on sterile cloth, dried, put in an envelope and sent along with blood sample.
- While sending blood sample for blood grouping 5 to 10 pulled hair strands stuck on glass slide should be sent for enzyme blood grouping in an envelope.
- In snake bite cases, 5 to 10gms. of muscle or tissue portion at the site of bite should be sent in bottle in saturated saline along with the 5 ml venous blood in 5% Sodium Citrate in separate sealed bottle and control skin piece.

Biological samples should be collected in following priority order from body of deceased:

- Skeletal muscle (deep muscle)/Tissue: The least decomposed portion of the tissue should be collected and be forwarded as soon as possible to avoid further decomposition.
- Tough tissue: If the decomposition has already started collect the tougher tissue for which decomposition rate is comparatively slow viz. Muscle Tendon, Foot i. e. heel Skin, Scalp Skin, Palm Skin, Stomach Wall.
- Tooth: Forward all the teeth present with dead body.
- Scalp Hairs with roots: Pluck the scalp hairs, don't cut them with scissors.
- PM Blood
- Bones: If the skeletonization of the deceased is complete and no tissue or other options are available, then the longer bones of the body such as Femur should be forwarded. If some dried tissues or tendons are stuck up with the bones, then do not remove it, as there are some chances to get the DNA from it.

Modes of parcel and proper preservatives for respective samples

Sr. No.	Sample	Mode of Parcel	Preservative
1	Tissue, Muscle piece, Scalp skin etc.	Clean, sterile plastic or glass container. Send the sample in the ice.	DMSO or Normal physiological saline or 4% EDTA or keep the tissue as it is in -20°C (refrigerated).
2	Blood	Clean, sterile glass vial. Send the samples in ice.	4% EDTA
3	Teeth	Air dry. Dry, clean and sterile plastic or glass container.	No preservative
4	Scalp Hairs	Air dry. Dry, clean and sterile plastic or glass container.	No preservative
5	Bone	Air dry. Wrap in clean brown paper.	No preservative
6	Blood and seminal stained clothes and scrapings etc.	Air dry. Wrap in clean brown paper.	No preservative

General Guidelines for preservation of viscera/blood/urine/skin etc.:

Viscera I : Stomach, Intestine with contents.

Viscera II : Pieces of Liver, Spleen and both Kidneys.

Case History	Material to be sent	Preservative to be used	Should not be used as preservative
Routine case, drug, insecticides oral poisoning	Viscera I, II Blood Urine	Saturated common salt solution Potassium Oxalate/Sodium Fluoride	Rectifies Spirit/Formalin
Acid poisoning	Viscera I, II	Rectified Spirit	Common salt or its saturated solution
Alcohol poisoning	Viscera I, II Blood Urine	Saturated common salt solution Potassium Oxalate/Sodium Fluoride	Rectifies Spirit/Formalin
Cyanide poisoning	Viscera I, II Blood Urine	Saturated common salt solution Potassium Oxalate/Sodium Fluoride	Formalin
Carbon Monoxide and other gas poisoning	Lungs Blood	Saturated common salt solution Potassium Oxalate/Sodium Fluoride with layer of paraffin	
Arsenic poisoning	Viscera I, II	Saturated common salt solution	
Snake Bite/injection	Skin with tissue	Saturated common salt solution Potassium Oxalate/Sodium Fluoride	

	Blood		
Bleaching powder/Chlorine gas	Viscera I, II	Rectifies Spirit	Common Salt
Blood for grouping	Blood	Potassium Oxalate/Sodium Fluoride	
Chloroform poisoning	Liver/Lung/Brain/Perirenal fats	Saturated common salt solution	
Firing	Skin piece around the entry wound	Saturated common salt solution	

When the case is having combined history of alcohol and acid consumption, then two viscera samples, one in rectified spirit and other in common salt should be preserved separately.

Instructions for MOs for collecting and sending blood sample in alcohol consumption cases:

[Refer “Bombay Prohibition Act, 1949(Medical Examination and Blood Test) Rules, 1959]

- Use a sterilized syringe. The area should be cleaned with sterile water. No alcohol shall be touched at any stage while withdrawing the blood.
- Withdraw 5 cc of venous blood in the syringe and transfer into a phial containing anticoagulant and preservative (5 mg of Sodium Fluoride, 15 mg of Potassium Oxalate in solid state only) and the phial shall be shaken vigorously to dissolve the anticoagulant and preservative in the blood.
- The phial shall be labelled and its cap sealed.
- The sample should be accompanied by a forwarding letter (FORM ‘B’) and medical examination certificate (FORM ‘A’).

Labelling, 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.
- Articles preserved for necessary analysis including Viscera which are preserved, either for chemical analysis or histopathological examination; should be handed over to concerned police officer immediately and receipt should be taken after that. Bottles to be sent to chemical analysis should be sealed by concerned MO with the help of mortuary assistant.
- Bottles to be sent to chemical analysis should be sealed by concerned MO & sent to the officer I/C of nearby 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.

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 Forensic Medicine/Anatomy for such examination.

Visit to place of crime

Medical Officer can visit place of crime if he/she feels necessary to come to the cause of death. PM should be performed on spot in circumstances where body is severely decomposed or vital evidence may be lost during transportation.

Medical officers should not avoid post-mortem examination because the bodies are decomposed. The examination should be done with the same care and precision as in a fresh body. Decomposed body should be shifted to the nearest mortuary by investigating authority and examined there only.

Ref: Article 21 of the Constitution.

The right to life with dignity extended to dead body. It is not the dignified way to perform autopsy on the spot in open space. It would also amount to offering indignity to the corpse within the meaning of Section 297 of IPC. Post Mortem Examination is done to enable to make a fair assessment, interpretation, framing opinions, documentation and help in administration of justice. Precise scientific approach by doctor is necessary. On the spot examination does not provide a scientific meaning. However, in unavoidable circumstances if Investigating Officer can arrange a temporary mortuary the same can be done on the spot.

Ref: 1. Article 21 of the Constitution, Section 297 of IPC

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 be alleged has 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.
- Necessary samples should be preserved from the body for respective analysis

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.

Writing cause of death & autopsy report

Following important points should be kept in mind when writing PM report -

- Report should be typed form. (*Reference: Letter no. DHS/PMR/Court Case/T-3/14 Dated 06/01/2014.*)
- 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.
- 23 Colum is newly added in pm report
 - Whether the ante - mortem injuries found on the dead body were sufficient in the ordinary course of nature to cause death.
 - If yes, which kind of the injuries were individually sufficient in the ordinary course of nature to cause death.
 - Which of the injuries collectively are sufficient in the ordinary course of nature to cause death.
- 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 (advanced death certificate)
- Type-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.

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. These persons may be asked to approach police authorities or concerned magistrate.

PM room

- Light should be adequate.
- Colour of walls, floor & ceiling should be natural white, off white or grey.
- 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.

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.
- Post mortem register with all detailed tabulated relevant information of the case including viscera dispatch receipt
- Register for consent in case of non-medico legal PM examination.
- Cold storage register.

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.
- Magistrate's inquest is required for exhumation. It is carried out under supervision of MO and Magistrate in presence of concerned police officer.
- 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.

Cases to be referred at the higher centre.

- Deaths related to surgical operative, diagnostic procedures, e.g. On Table Deaths, Deaths within 24 hrs. of surgical procedure or radiological investigations or MTP or ART(Assisted Reproductive Techniques) techniques, PCPNDT, Vasectomies, Tubectomies, Drug trial, Surgical trials, second autopsy, medical negligence etc. should be referred to district hospital, if Medico legal Expert is available or else to the nearest GOVT. Medical college and Hospital, only with permission of civil surgeon/medical superintendent and along with authorised requisition of police officer not below the rank of Dy. SP./ ACP addressing to concerned referral authority.

All custody deaths of prisoners should be referred to the FMT dept. of Govt. Medical College as per National Human Right Commission directions.

Other important instructions.

- On duty MO should not start post mortem examination without the presence of concerned investigating officer in office premises but none of the official (Police or magistrate) should be present in the post-mortem room, other than concerned MO performing autopsy procedure.
- In cases related to NATIONAL HUMAN RIGHTS COMMISSION, they should be referred to authorised Govt. Hospitals & medical colleges designated for it.
- If delay is expected, then the body must be preserved properly by covering with the help of bed sheet/body bag. If facilities are available, body should be preserved in cold storage.
- If police request for conducting PM examination after some time then on duty MO must take such requisition letter from the police and should inform to seniors. If the requisition letter is denied, it should be informed to seniors.

6.3 Mechanical Injuries

An injury or a wound is disruption of anatomical continuity of any of the tissues of the body. Injuries caused by application of physical violence to body are mechanical injuries. Under section 44 IPC an injury is defined as - any harm, whatever illegally caused to any person in body, mind, reputation or property.

6.3.1 Classification of injuries

Injuries are classified depending upon their nature as follows:

- Abrasions
- Bruises (Contusions)
- Lacerations (Tear)
- Incised wounds (Cuts)
- Stab wounds (Punctures)
- Firearm injuries

Abrasion

- It is injury involving only superficial layer of skin.
- Caused by friction or pressure between skin & some rough object.
- Bleeds very slightly, heals rapidly in few days and leaves no scar. Abrasions are caused by pin, thorn, fingernail, as a result of road accidents, fall on ground & by ligature mark in hanging / strangulation etc.

Bruise (Contusion)

Bruise is an infiltration of blood into tissues following rupture of capillaries. It is the result of application of blunt force

e.g. stick, stone, fist, whips etc.

- Bruises are subcutaneous & there is no disruption in the continuity of skin.

- They vary in size, from small pinhead to a large collection of blood (hematoma).
- Bruise may not always be present at the site of impact as blood may gravitate & appear at any different area.
- A superficial bruise usually appears red & swelling may come on almost at once.
- A deep bruise may take one or two days to appear. Therefore, such person should have a second examination after 1-2 days.
- Bruising is more marked on parts overlying bones e.g. over tibia. It occurs easily in lax tissues around eyes, face etc. than firmly tacked tissues like scalp.
- Sub conjunctival haemorrhages do not show usual colour changes. It is red first, then yellow & finally disappears.

Laceration

Wounds in which skin & underlying tissues are torn as a result of blunt force. If underlying tissue is rigid structure e.g. skull beneath the scalp lacerations occur readily & may simulate incised wound. Characteristic features of laceration are -

- Margins are commonly abraded.
- Edges are ragged, irregular & frequently bruised.
- Deeper tissues are unevenly divided.
- Majority of lacerated wounds are caused due to blows from blunt instruments such as sticks, iron bars & stones, falls on rough objects, fist blows & kicks.
- Lacerated wounds caused by stones, bricks, bottles, earthen pots, fall on rocks etc. contain foreign matter in the wound, which is of value for investigation. Some times external evidence of injury may be minimal or absent but there can be massive internal injuries.

Incised wound

Incised wound is caused by a weapon with sharp cutting edge when it is drawn across the skin e.g. by knives, pieces of broken glass etc.

- Injury is usually straight but may be irregular. Tissues are divided more deeply at the commencement of the cuts, than at its termination.
- Length of injury is greater than its breadth.
- Margins are clean cut and no bruising of wound edges.
- Tissues are clearly divided and as blood vessels are cut across, bleeding is profuse.
- These wounds tend to gape due to retraction of skin.

Stab wound (Punctured wound)

Injury caused by more or less pointed weapon when it is driven in through the skin. Weapons include knife, dagger, needle, arrow, scissors, bitchva, ice pick etc.

- When weapon enters body cavity such as thorax or abdomen, injury is called as penetrating injury.
- When weapon after penetrating comes out from other side making an exit wound injuries called as perforating injury.
- Description of stab wound should include entry, depth, direction and exit of wound.
- Wound of entry is generally bigger than wound of exit. Clothes may be pushed into the wound of entry.
- Shape of wound may correspond to the weapon used. However, skin aperture is smaller than breadth of weapon due to elasticity of skin.
- Margins at entry are clean cut & inverted. Margins at exit are everted.
- External examination gives no indication of depth, direction or extent of stab injury. Depth of a stab wound is greater than its length & breadth. Direction can be ascertained by drawing line joining wound of entry & exit.
- Stab wounds should not be probed.

6.3.2 Nature of injury

Simple injury

Injury which is neither extensive nor serious & which heals rapidly without leaving any permanent deformity or disfigurement is known as simple injury.

Grievous injury

Following injuries are grievous

- Emasculation (cutting penis, castration or loss of erection due to spinal injury)
- Permanent loss of sight of either eye.
- Permanent loss of hearing of either ear.

- Privation of any part, organ, limb or joint.
- Destruction or permanent impairing of the power of any member or joint.
- Permanent disfigurement of head or face.
- Fracture or dislocation of bone or tooth.
- Any hurt which endangers life or which causes the sufferer during the period of 20 days, severe bodily pain or unable to follow daily routine.

Dangerous injury

It is type of grievous injury, which poses immediate danger to life. It is either extensive or serious in relation to the organ or part wounded e.g. gunshot injuries, compound fracture of skull, trauma to a large or important blood vessel, rupture of internal organ.

6.3.3 Medico legal aspects of wounds

Examination of injured person

Details of the examination of injured person must be entered in accident register, which is confidential record (both out patient cases & indoor cases).

Entry of following points has to be made in accident register

- Place, date, time of examination.
- Name, age, sex, occupation, address of injured person.
- Identification marks.
- Consent for examination.
- Name & address of accompanying person.
- Name & number of police constable, police station.
- Brief summary of how injury was caused as told by injured person.
- Detailed description of injuries.
- Opinion & signature of MO.

No erasers should be made & if any alterations are made they must be initialized.

Nature of injuries

- Nature & number of injuries, character of their edges, size (length, breadth, depth), direction, and situation.
- Presence of any extraneous material in the wound should be noted.
- Measurement - Exact measures in cm. with measuring tape should be noted without any guess about measurement.
- When mentioning situation, reference to some body prominence or anatomical landmark should be made. Whether injury is simple, grievous or dangerous need to be mentioned.

Age of injury

Important for 2 reasons

- Signifies time of occurrence of crime.
- All injuries may not have been inflicted by the same assailant or at the same time.

It is not easy to give, exact time of infliction of any injury, but approximate time can be given.

Therefore, it is necessary to mention "about" when giving period of an injury.

Age of abrasions

- Bright red in colour.
- Bright red scab in 12-24 hours.
- Scab becomes reddish brown in 2-3 days.
- Heals from periphery in about 4- 7 days & by that time scab falls off.
- Healing is completed by 10 days.

Age of the bruise (From colour changes)

- Fresh bruise is red.
- From red to blue in one day.
- Bluish black to brown in 2-4 days.
- Green in 5- 7 days.
- Yellow in about 7 -10 days.
- Normal skin colour in 14-15 days.

Aseptic incised wound

- Edges are red & swollen after 12 hrs.
- Appreciable healing begins with formation of crust or scab in 24 to 36 hours.
- Divided surfaces are in opposition & are covered with lymph in 36 hrs.
- Edges join together in 3 days.
- Healing with red, tender linear scar by 7th day.
- Such wound on vascular part like face heals in about 3-5 days.

Wound, which is not aseptic & is gaping due to loss of tissue

- Edges are bound together by blood & lymph during first 12 hours. Margins are red & swollen.
- Pus may appear in about 36 to 48 hrs & granulation tissue within a week.
- Does not heal for days or even weeks.

Fracture of bone

- S/o inflammation, hematoma in soft parts 1-3 day.
- Soft provisional callus 3-14th day.
- Starts ossifying 14th day -5th week.
- 6-8 weeks for complete callus absorption, bone formation.

Tooth has been knocked out

- Bleeding from socket stops in 24 hrs, sometimes in 2-3 days & clot is formed.
- Clot is obliterated by fibrous tissue in about 14 days.
- Socket is completely filled with gradual new callus formation & remoulding of socket bone in about a year.

6.3.4 Management of mass casualties

Sometimes large number of casualties (e.g. accident) have to be managed by MO. In such case following points should be kept in mind:

- Screening of patients according to severity has to be made.
- Gasping patients need immediate referral. For such cases noting all medico legal aspects may be difficult.
- Names of referred cases, vital parameters, nature of treatment given and identification marks should be noted.
- Police should be informed immediately.
- When patient is kept under observation for some time before referral or treated by MO, then whole medico legal procedure should be completed as per rules.
- In case of referral to higher centre, MO has to mention that, details have not been noted & are to be noted at hospital where patient is referred.
- Primary Preparation at PHC level to treat the patient load should be organized.
- Storage transport of dead bodies should be planned.

PROFORMA FOR EXAMINATION AND REPORT OF A CASE OF INJURY

Requisition from S.I. of Police vide letter no. Dated.....for examination ofescorted by P.C. no.Name

Place of Examination: Date and Time of Examination:

1. Name:

2. Address:

3. Age as stated:

4. Religion:

5. Occupation:

6. Brought and identified by:

7. Consent given in writing:
.....

8. Examination in presence of:

9. Identification marks:

a.

b.

10. History as given by the patient (if unable to speak by the person accompanying the patient: a. How the injury was sustained, if assaulted, no. of persons who assaulted b. Whether any weapon was used, if so what type of weapon; if it was hard, blunt or sharp cutting or pointed etc. c. Date and time of infliction of injury. d. Whether any first aid treatment was given anywhere e. Whether dying declaration is/was recorded as required.

11. Physical examination: Each injury is to be described as follows: a. Nature of injury; abrasion/bruise/laceration/incised injury/stab injury/gunshot injury/ scalds/burns/fracture/dislocation of bone. b. Size of each injury eg, length, breadth, depth. c. Situation of each injury. d. Shape of each injury if discernible. e. Direction of each injury. f. Evidence of bleeding/spurting/oozing/concealed etc. g. Any foreign body in and around injury h. Age of injury: Recent/old i. Injury: Simple/Grievous/Dangerous j. Nature of weapon responsible for the injury

12. On Examination: a. If unconscious: degree of unconsciousness b. Pulse: c. BP d. Respiratory rate e. Pupils f. Any bleeding from nostrils, ear, mouth etc. g. Prognosis good/Uncertain

13. Opinion: Taking into consideration the history, the data on clinical examination and findings on investigations (if any) and examination (if any), all considered together, I am of the opinion that the patient (name as per requisition sent) sustained injuries which are as noted in this report, are consistent with fall/ traffic or any accident/assault etc. which on all probability was caused by hard blunt object/impact or sharp/blunt edged/pointed instrument or object.

Note: The report needs preferably be prepared always using a pencil with carbon copies, the original be handed over to the police and the carbon copies to be maintained in the office register. This injury report when sent to police may at times can be treated as FIR.

(If admitted as an indoor patient, Indoor Police Case Report is to be prepared: where by the attending doctor had given details about the injuries. If the magistrate/police was called to record dying declaration, or the doctor himself recorded it, it is to be noted. Investigations: Detailed notes of Surgical exploration, X-ray reports, laboratory investigations)

Station:

Signature

Date:

Name

Time:

Reg. No.

- Copy of Injury Certificate- Refer Annexure 6.1(Vol. I)

6.4 Thermal Injuries - Burns

Burns are injuries produced by application of dry heat such as flame, radiant heat or some heated solid substance like metal or glass to body surface. Scalds are moist heat injuries produced by liquid at or near its boiling point or in its gaseous form such as steam.

Burns may constitute grievous injuries involving loss of sight or permanent disfigurement from unsightly scars on head or face.

6.4.1 Classification

“Dupuytren” surgically divided burns into six degrees of severity. “Wilson” has modified this into 3 degrees as follows:

Epidermal

These burns are very painful but repair is complete.

- Affected part is red.
- There may be acute inflammation & formation of blister.
- No scar results, as only superficial layer of epithelium is destroyed. Some slight staining of the skin may subsequently remain.

Dermo-epidermal

- Whole thickness of skin is destroyed.
- Affected part appears shrivelled, depressed area of coagulated tissue surrounded by hyperemic blistered skin.
- Necrosed tissue separates within about a week leaving ulcer, which heals with scar formation.
- Scar may contract causing disfigurement.
- They may or may not be associated with pain.

Deep burns

- Affected area is completely charred.
- Gross destruction of skin, subcutaneous tissue, muscles & bone.
- Nerve endings are destroyed. Therefore, burns are relatively painless.

6.4.2 Estimation of surface area of burns - Rule of nine.

Entire head & neck	9%
Both arms (9% each)	18%
Both legs (18% each)	36%
Front of trunk	18%
Back of trunk	18%
Perineum	1 %
Total	100%

Child 1 to 12 Yrs.	Child 1 to 12 Yrs.	Adult
Entire head & neck	18%	20%
Both arms (9% each)	18%	16%
Both legs (18% each)	27%	32%
Front of trunk	18%	16%
Back of trunk	18%	16%
Perineum	1%	Negligible
Total	100%	100%

There is marked fluid loss resulting in shock when 20% body is affected & burns over 50% are usually fatal.

6.4.3 Nature of burns in the absence of death

- Burns of epidermal type are mostly classified as simple injury.
- Burns are grievous, if they cause scars causing permanent disfigurement of head or face, permanent loss of sight of either eye or a permanent impairment of a joint due to formation of cicatrix & contraction.

- Burns are grievous if individual has suffered from shock so as to endanger life or if he/she has been in severe bodily pain or bed ridden & unable to follow his ordinary duties for 20 days or more.

6.4.4 Age of a Burn

- Redness occurs immediately after burn and vesiculation within 2-3 hours.
- Exudates from partial thickness burn usually begin to dry in 12-24 hrs & within 48- 72 hrs. forms dry crust.
- Pus within 36-72 hours.
- Superficial slough separates out in about a week & deeper slough in about a fortnight. After this, granulation tissue begins to cover the surface of burn.
- Last result is formation of cicatrix & deformity after several weeks or even months.

6.4.5 Medico legal aspects of burns

Distinction between ante mortem & post mortem burns is based on evidence of vital reaction as below:

Line of redness: In case of burns caused during life, a line of redness involving whole true skin is formed round about the injured part. This is a permanent line persisting even after death. Line of redness being a vital function separates living from dead tissue & is always present in burns caused during life.

Vesiculation - Vesiculation caused by a burn during life contains a serous fluid & skin surrounding this is of bright red or coppery colour.

Vesiculation formed after death contains air only but may contain a very small quantity of serum. Its base is dry, hard, horny & yellow instead of red.

Reparative process- Signs of inflammation, formation of granulation tissue, pus & slough will indicate that burns were caused during life.

Burns caused after death show no vital reaction & have a dull white appearance. Evidence of black soot in trachea, bronchi, up to bronchioles & in esophagus and stomach are also important signs of ante mortem burns in spot death cases.

- Dying declaration should be arranged.
- While recording dying declaration medical observations should be documented meticulously with date & signature.
- Medicolegal post mortem should be conducted if death occurs.

6.5 Drunkenness

Drunkenness is the condition, which results from excessive intake of alcohol & person concerned is so much under influence of alcohol that -

- He loses control over his mental faculties.
- He is unable to perform his duties.
- He may be a source of danger to himself or to others. When drunken person is brought for examination, Medical Officer has to answer whether concerned person is so much under influence of alcohol that he has lost control of his mental faculties. He is unable to execute safely occupation in which he is engaged or is a nuisance to public or is endangering life of another person.

Diagnosis

When a drunken person is brought by police requesting for medical examination of accused, MO can carry out examination even without his consent & if necessary by force.

6.5.1 Diagnosis is based on following observations

- Full history of incident from police.
- Smell of alcoholic liquor in his breath & or vomited matter.
- Excited, talkative, abusive with slurred and incoherent speech. Clothes are disarranged or disorderly clothes.
- Eyes - Extreme dilatation to extreme contraction. Fine lateral nystagmus.
- Tongue - Dry, furred or excessive salivation
- Memory- Loss or confusion as regards recent events & time.
- Coordination- Impaired e.g. unable to thread a needle, button clothes, unable to walk along a straight line, finger nose test impaired.
- Reflexes- Sluggish or delayed.

- Unusual actions - Hiccups, vomiting, bleaching, and fighting.

6.5.2 Laboratory tests

Common tests performed include estimation of alcohol from blood & urine sample. Blood is a better index of alcohol level than urine. Urine sample is collected only when it is not possible to collect blood sample. Following precautions should be taken when collecting blood sample -

- Spirit must not be used to clean skin. It should be cleaned with sterilized water.
- Syringe must be sterilized and free from alcohol & other chemicals.
- Blood should be preserved in fluoride bulb.

After taking sample, container should be vigorously shaken to dissolve anticoagulant & preservative in blood sample. Urine sample should be preserved by adding 2-3 ml. concentrated hydrochloric acid or 2-3 ml of chloroform/100 ml urine.

Container should be tightly stoppered to prevent loss of alcohol by evaporation and should not be kept in hot place / near hot substance. Sample should be labelled as name, date & time of taking sample. It should be sealed by means of wax with official seal or the monogram of PHC. Sample should be immediately handed over to police along with prescribed „B“ form.

6.5.3 Interpretation of results

- Alcohol concentration in blood below 0.05% (50 mg %) is without any effect
- At 0.1 % (100 mg %) some impairment is observed.
- At 0.15 % (150 mg %) person is under influence of alcohol.
- Under BPA a person having a blood alcohol level of 0.05% (50 mg %) & above has legally committed the offence of consumption.
- Under motor vehicle act it is an offence to drive or attempt to drive a motor vehicle with any quantity of alcohol (no threshold limit specified.)

Formats:

Requisition from the SI ofpolice station with his letterhead

Datedfor the examination ofand brought by P.C. no Name..... for evidence of drunkenness.

1. Date and Exact time of examination:

2. Name , age and address:

3. Consent: (Informed consent)

.....
.....

Signature/Thumb impression

4. Identification marks:

.....
.....

5. History: Engage in Conversation and enquire

- Whether he did take alcohol or not; how he feels?
- What food and drink he took last and when ?
- Does he suffer from any fits, illness or other disability previously?
- If a diabetic, when insulin was taken last and how much ?

6. General appearance and demeanor: Observe the following during conversation

- State of clothing-decent , disarrayed , soiled
- Disposition- calm, talkative, abusive, obscene
- Speech- normal, thick and slurred, overprices

- d. Gait- Steady or staggering, self-control
- 7. Higher functions:
 - a. Co-operative/ non co-operative
 - b. Intelligence: Normal/ Abnormal
 - c. Power of interpretation: normal/impaired
 - d. Memory: Ask suitable questions about his movements during the preceding few hours, details of accident if any, the time of arrest etc.
 - e. Orientation of time and space: Normal/impaired.
- 8. Mouth: Smell of alcohol (repeat after 20 min); dribbling of saliva; lips – dry/wet; teeth natural or artificial; tongue dry, moist, furred bitten; hiccups etc.
- 9. Eyes: Test for visual acuity across 20 feet; nystagmus; conjunctive suffused or not; state of pupil and its reaction to light.
- 10. Ears: Impairing of hearing, if any.
- 11. Pulse:
- 12. Blood Pressure:
- 13. Temperature:
- 14. Respiratory rate:
- 15. Reflexes: superficial and deep
- 16. Muscular coordination: Perform any of the test enumerated below
 - a. Walking along a straight line
 - b. Finger nose test
 - c. Picking up a coin from the floor
 - d. Romberg's sign/test
 - e. Handwriting
 - f. Copying simple geometric figures
- 17. Examination of (to exclude any other condition)
 - a. CNS
 - b. CVS
 - c. RS
 - d. Abdomen
- 18. Examination of Injuries
- 19. Blood for chemical examination:
 - a. Collect 2 ml by venepuncture.
 - b. Disinfect skin with 1:1000 Mercuric Chloride, soap and water
 - c. Blood preserved in 100 mg Sodium Fluoride for 10 ml blood
 - d. Container stoppered tightly and sealed with Paraffin or candle wax.
 - e. Label: name, date and time of collection of sample, sign of Medical officer.

f. Sealed Sample handed over to Police constable with requisition to Chemical Examiner, with findings and opinion. (Receipt to be taken from Police constable). If sample cannot be sent to FSL immediately, it should be refrigerated.

20. Urine for chemical examination:

- a. Collect 30 ml of urine.
- b. Sodium fluoride 50mg/10ml is added as preservative.
- c. Container stoppered tightly and sealed with Paraffin or candle wax.
- d. Label: name, date and time of collection of sample, sig of Medical officer.
- e. Sealed Sample handed over to Police constable with requisition to Chemical Examiner, with findings and opinion. (Receipt to be taken from Police constable). If sample cannot be sent to FSL immediately, it should be refrigerated.

DRUNKENNESS CERTIFICATE

Ref. No. Certified that Mr/Mrs/Ms, a male/female
..... aged.....resident of
.....
.....Who was sent by the S.I. of
..... Police station vide letter no. dated and accompanied
by the P.C. No..... Name For report on drunkenness.

Identification marks :

- a.
- b.

The person was first seen by the undersigned at on and examination was
completed at when the following signs were found:
.....
.....
.....

I am of the opinion that the above person has :

Consumed alcohol and is under its influence (intoxicated)/ Consumed alcohol but is not under its influence/
Not consumed alcohol.*

Station:

Date:

Time:

Signature

Name

Reg. No.

Designation

Address

Official seal * Strike off whichever is not applicable

REQUESTION TO FSL FOR ANALYSIS OF SAMPLE FOR ALCOHOL

From:

Name and designation Doctor:

Date:

To,

The Director/Regional Director,

Forensic Science Laboratory,

City:

Sir/ Madam,

I am forwarding herewith following samples, by registered post/ with P.C. no.
Name of police station
containingml of blood and /or urine sample collected by me on at
..... AM/PM from the body of Mr/Mrs/Ms who
was produced before me for medical examination and/or collection of blood/ urine sample by S.I. P.s.
..... vide letter no dated It is requested that the samples may be
examined and a certificate be issued in duplicate regarding the results of the test. necessary details of the
person examined by me for qualitative and quantitative estimation of alcohol.

Facsimile of the Seal used for

Sealing the samples

Signature of the doctor

(With name and designation)

6.6 Poisoning

Poison is the substance, which on its administration by various routes (including local exposure or contact) produces ill health or death. It may be chemical, animal, microbial or vegetable origin. In India, suicidal or homicidal cases are common due to availability of poisons in bazaar. Insecticides are commonest poisons in our country. Now a days accidental poisoning cases are increasing significantly.

6.6.1 Duty of MO in case of suspected poisoning

- In all cases, MO should record preliminary particulars like name in full, sex, age, occupation, address, date & time, brought by whom, history. Arrange for dying declaration if necessary.
- Immediately start treatment to the patient.
- MO must report all suicidal, homicidal or accidental poisoning cases admitted in PHC to police.
- Collect stomach wash & samples of vomit & urine passed in your presence & preserve properly in separate containers.

6.6.2 Post mortem of poisoning case

Read police report carefully. Get as much as possible information from relatives of the deceased regarding characteristic of symptoms, time of taking poison, duration between taking of poison and treatment and time of death. Many of the poisons except corrosives & irritants do not show any characteristic post mortem signs, particularly when bodies are in advanced state of decomposition.

External examination

- Some poisons e.g. ether, alcohol & opium give off a peculiar smell on opening the body.

- Body surface & clothes may show stains or marks of vomit, faeces or of the poison.
- Natural orifices such as mouth, nostrils, rectum & vagina may show presence of some poisonous material or evidence of corrosive changes in mouth or lips etc.
- Marks of injection may sometimes give clue to injected poison.

It is necessary to preserve viscera & urine in all cases of suspected poisoning even if there are no positive post mortem signs of poisoning.

Internal examination

- Alimentary system should be chiefly examined & contents preserved, as signs of irritant & corrosive poisons are likely to be found in stomach, oesophagus & intestines.
- Changes produced by irritants, corrosive poisons in the digestive tract especially stomach are hyperaemia, softening, ulceration of mucous membrane, perforation.

Stomach examination

- In all cases of death from presumed poisoning, stomach should be tied at both the ends & removed from the body, so that its contents may be retained.
- After removal it should be opened, its smell noted, acidity checked with litmus paper, contents received in clean bottles, mucus membrane carefully examined for appearance & for presence of suspicious particles like pills or fragments thereof. If found adherent, pick off & place in separate container.

6.6.3 Chemical analysis

Most important proof of poisoning is detection of poison in vomit, urine etc., in blood during life & in contents of stomach, bowel & in tissues of body after death. MO after obtaining necessary orders from Judicial Magistrate should forward viscera to chemical examiner or State Forensic Laboratory for analysis.

6.7 Death from Asphyxia

Death from asphyxia occurs when supply of oxygen to the tissues is reduced below normal working level due to interference with respiration.

6.7.1 Hanging

Hanging means death caused by suspension of body by a ligature around neck.

- Usually suicidal and no s/o struggle.
- Neck is stretched due to round pull of ligature and head inclined to opposite the knot.
- Face usually pale, pupils are usually dilated, tongue is swollen & blue.
- Saliva dribbling from the corner of mouth opposite the side of knot, vertically down along the neck & front of chest & abdomen.
- Ligature mark above thyroid cartilage, between larynx & chin directed obliquely upwards.
- Absence of fatal injuries.

Internal appearance

- A careful dissection of neck, layer by layer is essential.
- Injuries to the muscles of neck rare.
- Fracture or dislocation of cervical vertebrae along with compression or laceration of spinal cord may be noticed.
- Mucus membrane of trachea red & congested.
- Right side of heart full of blood & left empty and abdominal organs congested.

6.7.2 Strangulation

Constricting neck by force other than weight of body (ligature, hand, stick etc.)

- Mostly homicidal. S/o struggle present.
- Well-defined & slightly depressed mark corresponding roughly to breadth of ligature, low down below thyroid cartilage completely encircles the neck horizontally below hyoid bone. Abrasions & ecchymosis around edges of the ligature mark common.
- If fingers are used, marks of pressure by thumb & fingertips on either side of wind pipe.
- Fracture dislocation of cervical vertebra rare.
- Face congested, marked with petechiae.

External appearance

Face is puffy & cyanosed, marked with petechiae. Eyes prominent & open, conjunctiva congested, pupil dilated, lips blue, tongue swollen, bruised, protruding & dark in colour.

Internal appearance

- Extravasations of blood into subcutaneous tissues under ligature mark.
- Muscles of neck are usually lacerated.
- Larynx, trachea congested, contains frothy mucus.
- Fracture of larynx, trachea & also hyoid bone.
- Injury to carotid artery common. Injury to muscles of neck common.
- Lungs congested, haemorrhagic patches & petechiae, may show emphysematous bullae on surface.
- Right side of heart full of dark blood & left empty. Brain is congested.

Sr. No.	Alleged Cause of Death	Important points to be seen	Samples to be preserved	To be sent to	Remarks
1	Road Traffic Accidents	1. Carefully note all injuries. 2. Whether ante-mortem or Post-mortem	1. Blood for grouping 2. Blood for chemical analysis. 3. Body hair for matching (In hit and run cases.)	Forensic Science Laboratory.	Any other relevant sample either asked by Police or require my MO.
2	Hanging/Strangulation	1. First open skull cavity, then chest, abdominal cavity and lastly open neck for dissection. 2. Carefully note the ligature mark. 3. Note any other injuries over the body. 4. Look for salivary dribbling.	1. Cello tape taken from ligature mark for detection and matching of fibres. 2. Nail clipping and scrapings for detection of blood or foreign epithelial cells. 3. Blood for grouping/chemical analysis. 4. Genital swabs in cases of sexual assault.	Forensic Science Laboratory.	Any other relevant sample either asked by Police or require my MO..
3	Drowning	1. Look for froth at mouth, Nostrils, wet skin, cloths. 2. Look for Injuries, aquatic animals bite marks. 3. Open chest cavity first; watch for ballooning of lungs and signs of asphyxia.	1. Sternum bone or spleen, liver, brain tissue for diatom study and Matching.	Forensic Medicine Department of Any Medical College.	Any other relevant sample either asked by Police or require my MO.
4	Sexual Offences against women and children.	1. Look for injuries over face, breasts, and genitalia, buttocks. 2. Carefully note even minor abrasions and the colour of injuries. Look for bite marks. 3. Very cautiously note the genital injuries.	1. Oral swab, or vaginal swab and anal swab for detection of semen. 2. Nail clippings and scrapings for detection of blood or foreign epithelial cells. 3. Blood for grouping and for chemical analysis. 4. Viscera for chemical analysis.	Forensic Science Laboratory.	Any other relevant sample either asked by Police or require my MO.
5	Burns	1. Note injuries with percentage of burns injuries.	1. Blood/blood clot for grouping/chemical analysis.	1. and 2. Forensic	Any other relevant sample either

		2. Look for soot in trachea, blackening and charring of skin. 3. Look for red line of demarcation (Vital reaction). 4. Look for skull fracture/heat fracture. 5. Note whether ante-mortem/post mortem burns.	2. Swab from burnt area of skin/body for detection of inflammable substance. 3. Skin partly burnt and partly spared for histo-pathology examination.	Science Laboratory 3. Forensic Medicine Department of Any Medical College.	asked by Police or require my MO.
6	Poisoning	1. Look for traces of poison over face/body/clothes. 2. Look for other bodily injuries. If died during treatment, always preserve gastric lavage sample.	1. Always preserve routine viscera for chemical analysis. 2. Preserve special viscera in certain conditions like adipose tissue in cases of OP poisoning.	Forensic Science Laboratory.	Any other relevant sample either asked by Police or require my MO.
7	Decomposed bodies	1. Look for condition of skin, marbling, swelling of body. 2. Look for any surface injury and also look for skeletal injury. Look for stage of decomposition	1. Teeth/bones for DNA analysis. 2. Preserve viscera as much complete as possible. Preserve maggots in rectified spirit or live maggots for entomological studies.	1. and 2. Forensic Science Laboratory 3. Institute of entomology, Fort Mumbai.	Any other relevant sample either asked by Police or require my MO.
8	Skeletal Remains	1. Carefully count and mention all separated and articulated bones. 2. Arrange all the bones in their anatomical positions. 3. Take measurements of all bones especially all long bones and skull. Try to decide sex with help of skull and pelvic bones. Look whether bones are moist/dry/articulated/separated. Look for visible skeletal fractures along with blood infiltration. Take opinion of Forensic Medicine Expert.	1. Send teeth for DNA analysis. 2. Any wet tissue for chemical analysis. 3. Send remaining bones for anatomical study.	1. Forensic Science Laboratory. 3. Anatomy Department of nearest Medical College	Any other relevant sample either asked by Police or require my MO.

6.7.3 Drowning

It is asphyxia death in which access of air to lungs is prevented by submersion of body in water or fluid medium.

External appearance

- Clothes on the body wet.
- Face is pale, conjunctiva congested, pupil dilated, and tongue swollen & protruded.
- Profuse, fine froth at mouth & nose. If not visible, appears on compression of chest. This is the diagnostic sign of drowning.
- Material firmly grasped in hands like weeds, mud, sand, twigs or leaves etc.

Internal appearance

- Increased volume & oedematous condition of the lungs. Distended balloon like lungs overlap heart. Often indented by ribs, heavy, doughy to feel.
- On section, exude large quantity of frothy, blood stained fluid.
- Larynx, trachea, bronchial tubes usually contain fine white froth, mucus membrane congested.
- Right side of heart full & left empty.
- Presence of water in stomach & some times in small intestine.

- Liver usually gorged with dark fluid blood. Spleen & kidneys are dark in colour.

Important Points to be Remembered while handling Medico-Legal Cases:

Age of contusion

Age	Changes	Caused by
Fresh	Red	Fresh extravasations of blood
1-3 days	Bluish	Deoxyhaemoglobins
4 days	Bluish black to brown	Hemosiderin pigments
5-6 days	Greenish	Hematoidin pigments
7-12 days	Yellow	Bilirubin pigments
2 week	Complete disappearance of contusion	----

Age of abrasion

Age	Features
Fresh	Reddish no scab
12-24 hour	Dark red scab
1-2 days	Reddish brown scab
3-5 days	Dark brown scab
5-7 days	Blackish scab shrinks and falling begins from margin
7-10 days	Scab falls off, leaving hypo pigmented area

Commonly done Post-Mortem Examinations at Government Hospitals:

Special points to be observed by Medical Officers while performing Autopsy Examination in addition to Standard Autopsy Protocol.

6.8 Medicolegal Aspects of Sterilization Death

6.8.1 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

6.8.2 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.

6.8.3 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 Anaesthesia	Member

DHO of concerned ZP where death/complication has occurred will be member of circle level Quality Assurance Committee.

6.8.4 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 (Family Planning Indemnity scheme)

Family Welfare Indemnity Scheme indemnifies all clients of sterilization as also doctors/ health facilities conducting sterilization operation in both public and accredited private/NGO sector health facilities for unlikely events of complications/failures/deaths attributable to sterilization operations

The available benefits under the Family Welfare Indemnity Scheme are as under:

Section	Coverage	Limits
IA	Death attributable to 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
IB	Death attributable to sterilization within 8-30 days from the date of discharge from the hospital	Rs. 50,000/
IC	Failure of sterilization	Rs 30,000/
ID	Cost of treatment in hospital and upto 60 days arising out of complication attributable to sterilization operation (inclusive of complication during process of sterilization operation) from the date of discharge	Actual not exceeding Rs. 25,000/
II	Indemnity per Doctor/Health Facilities but not more than 4 in a year	Upto Rs 2 Lakh per claim

Note: The details of the scheme are available in the 'Manual for Family Welfare Indemnity Scheme, available on <http://nrhm.gov.in/nehm-components/rmncha/family.planning/schemes.html>

PM in case of death due to sterilization

- After sterilization death post mortem is a must. PM should be performed by 2 MOs & one of them should be senior experienced officer. If gynaecologist 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.

6.9 AIDS Autopsy

Although universal precautions should be taken for all autopsies, AIDS autopsy should be carried

out with special care & additional protective clothing.

6.9.1 Pre-requisites

Sodium hypochlorite solution, pyjama, shirt, gown, cap, mask, double latex gloves, shoes with plastic shoe cover, plastic apron, protective goggles or face shield.

6.9.2 Important precautions to be observed

During the procedure

- Use all personal protective devices, never take chance.
- Tips of fingers are particularly prone to needle or blade injury during procedure, therefore handle needles & blade carefully. Take care when loading scalpel or removing blade.
- Never put one hand under the tissue or organ that you are cutting with other hand.
- Removal of the sternum should be done carefully preferably with the help of bone cutter. Ribs should be cut with cartilaginous portion; this prevents injury to hand by tips of already cut ribs.

After postmortem procedure

- After PM procedure, stitch cadaver properly so that no fluid can come out.
- Wash cadaver with tap water & then with 2:1 sodium hypochlorite solution.
- Plug nose & mouth with cotton swab soaked with sodium hypochlorite solution.
- Put cadaver in a plastic bag for handing over to relatives to avoid dissemination of HIV.

Tables & floors

Wipe carefully tables & floors with 2:1 sodium hypochlorite solution to remove blood stains & body fluids & then with soap & water.

Instruments

Instruments used should be wiped with sodium hypochlorite solution. Aluminium & stainless steel instruments are damaged by sodium hypochlorite solution & therefore decontaminated with 2% aqueous glutaraldehyde solution. After 4 hours instruments should be washed & autoclaved.

Autopsy staff & MO

- After completion of procedure, staff & MO must wash hands thoroughly with soap & water.
- Plastic apron, plastic shoe cover, gloves, plastic cap & mask must be discarded in plastic bag. Tie the bag properly & send it for incineration.
- Pajama, shirt, cotton gown should be soaked in sodium hypochlorite solution, washed with water & then sent for autoclaving.

6.10 Penal Provisions & Bhartiya Nyay Sanhita

The Bharatiya Nyaya Sanhita, 2023 (“BNS”) was enacted on December 25, 2023, repealing and replacing the Indian Penal Code, 1860 (“IPC”) as the new penal code of the country. same. The three new Laws Bharatiya Nyaya Sanhita, Bharatiya Nagarik Suraksha Sanhita and the Bharatiya Sakshya Adhiniyam- will come into effect from July 1, 2024, the Ministry of Home Affairs has released notification. The Bharatiya Nyaya Sanhita, 2023 (BNS 2023) represents a significant overhaul of India’s criminal law framework. It aims to replace the 158-year-old Indian Penal Code (IPC) and introduces a modern, rational, and just legal structure to better address contemporary issues and challenges¹. Brief comparison of IPC and BNS 2023 (Refer Annexure 6.2 (Vol. I))

6.11 PCPNDT Act

Pre Conception and Pre Natal Diagnostic Techniques (Prohibition of sex selection) Act amended in 2003. Pre conception and prenatal diagnostic techniques (Prohibition of sex selection) Act Amended in 2003 is an important legal intervention for declining sex ratio of Maharashtra. By this act, detecting sex of baby before birth by any means is legally banned. Various conditions for which these techniques are permissible are defined, similarly authorities are identified at various levels & also punishments for violation of act are given.

Though MO PHC is not directly involved in implementation of act, he/she has very important role in giving information of such places and to generate awareness in the community.

6.11.1 Sex ratio

Sex ratio is the number of females per 1000 males, which indicates social status of women and the degree

of gender discrimination in the community. For Maharashtra state, there is overall decline in sex ratio by 56 points from 1901 (978) to 2001 (922).

Son preference of families leading to prenatal female feticide is one of the important reasons for declining sex ratio. In addition to this, after birth, parents ignore health, nutritional & social needs of a female child, which leads to high morbidity & mortality in females.

6.11.2 Important aspects of act

Implementation of the act started in 1994 as Prenatal Diagnostic Techniques (Regulation & prevention of misuse) Act. It was amended in 2003 and called as “ The Pre-conception & Prenatal Diagnostic Techniques (Prohibition of Sex Selection)”.

Important aspects of the act are as follows -

- No center or no person shall conduct pre-conception & pre-natal diagnostic techniques for sex determination.
- No person shall communicate sex of fetus by words, signs or by any manner.
- No person shall conduct sex selection (i.e. any procedure / technique / test / administration/prescription/provision for increasing or ensuring the probability of a particular sex) on a woman or a man or any tissue, embryo, conceptus, fluid or gametes.

6.11.3 PNDD Centers

- Centers conducting pre-natal diagnostic techniques should be registered and no such techniques should be conducted at un-registered place.
- All the sonography units should be registered to appropriate authorities identified at various levels. All the PNDD centres and sonography units should employ persons having prescribed qualifications.
- Such centres should display a notice in English / in local language expressing that, no pre-conception & prenatal diagnostic techniques are performed for sex determination.
- There is prohibition on sale of USG machines or any other machine, capable of detecting sex of the foetus to persons not registered under act.
- These centres have to keep complete record of use on pregnant women. Doctor has to declare on each report that he has neither detected nor disclosed the sex.
- Pregnant woman has to declare that she does not want to know the sex of foetus.

6.11.4 Appropriate Authority

At State, District/corporation, taluka or ward level Appropriate Authorities have been identified as below.

State Appropriate Authority:	Additional Director (FW), Pune
District Appropriate Authority:	Civil Surgeon/Health officer of corporation
Taluka Appropriate Authority:	Medical Superintendent of Rural Hospital

Important functions of Appropriate Authority are:

- To grant, suspend or cancel registration.
- To investigate complaints & take action
- To take appropriate legal action

6.11.5 Punishment

There are heavy penalties under act for offenders, including doctors, antenatal cases & relatives.

6.11.6 Prenatal diagnostic techniques

No place shall be used for conducting pre-natal diagnostic techniques except in following conditions: ANC having:

- Age > 35 Years
- Undergone 2 or more abortions
- Exposed to teratogenic agents such as drugs, radiation, infection or chemicals
- H/o mental retardation or physical abnormalities in previous birth.

6.11.7 Role of PHC Medical Officer and PHC staff

- Inform all staff working at PHC about provisions in the PNDT Act. They should be aware that, knowing the sex of newborn before birth by any means is legally banned under this act.
- Identify doctors having USG machines / scanners from PHC area & inform their names & other details to the Medical Superintendent of RH or Civil Surgeon.
- Create awareness in the community regarding prohibition of sex determination & sex selection.
- Verify ANC register (R15) of ANMs & identify women with previous one or more female children. Create awareness among them & motivate them not to undergo sex determination.

6.12 Medico-Legal Annexures:

- Provisional Cause of Death Certificate
- Injury Certificate
- Certificate of Drunkenness – Form A
- Format for Detailed Description of A Case of Drunkenness In MLC Register
- Requisition to FSL for Analysis of Sample for Alcohol
- Record of Dying Declaration
- Formats of The Important MLC Registers

(Refer Annexure 6.1 (Vol. I))

Guidelines For Examination of Survivors of SEXUAL ASSAULT

(Reference: MOHFW guidelines vide their Letter no. Z28015/21/2013-H Government Of India Ministry of Health and Family Welfare, Hospital Division, Nirman Bhavan, New Delhi, Date:18 March 2018.) (Refer Annexure 6.3 (Vol. I))

6.12.1 One Page Instructions for Doctors

The examining doctor should carefully read the Guidelines for responding to survivors of sexual violence issued by the MoHFW, and should be well aware of the comprehensive care to be provided.

Informed consent: Doctors shall inform the person being examined about the nature and purpose of examination and in case of child to the child's parent/guardian/person in whom the child reposes trust.

This information should include:

- The medico-legal examination is to assist the investigation, arrest and prosecution of those who committed the sexual offence. This may involve an examination of the mouth, breasts, vagina, anus and rectum.
- To assist investigation, forensic evidence may be collected with the consent of the survivor. This may include removing and isolating clothing, scalp hair, foreign substances from the body, saliva, pubic hair, samples taken from the vagina, anus, rectum, mouth and collecting a blood sample.
- The survivor or in case of child, the parent/guardian/person in whom the child reposes trust, has the right to refuse either a medico-legal examination or collection of evidence or both, but that refusal will not be used to deny treatment to survivor after sexual violence.
- As per the law, the hospital/ examining doctor is required to inform the police about the sexual offence. However, if the survivor does not wish to participate in the police investigation, it will not result in denial of treatment for sexual violence. Informed refusal will be documented in such cases.

Per vaginal examination, commonly referred to by lay persons as 'two-finger test', must not be conducted for establishing an incident of sexual violence and no comment on the size of vaginal introits, elasticity of the vagina or hymen or about past sexual experience or habituation to sexual intercourse should be made as it has no bearing on a case of sexual violence. No comment on shape, size, and/or elasticity of the anal opening or about previous sexual experience or habituation to anal intercourse should be made.

Injury documentation: Examine the body parts for sexual violence related findings (such as injuries, bleeding, swelling, tenderness, discharge). This includes both micro mucosal injuries which may heal within short period to that of severe injuries which would take longer to heal. Please refer to section VI Point 17 of the Guidelines.

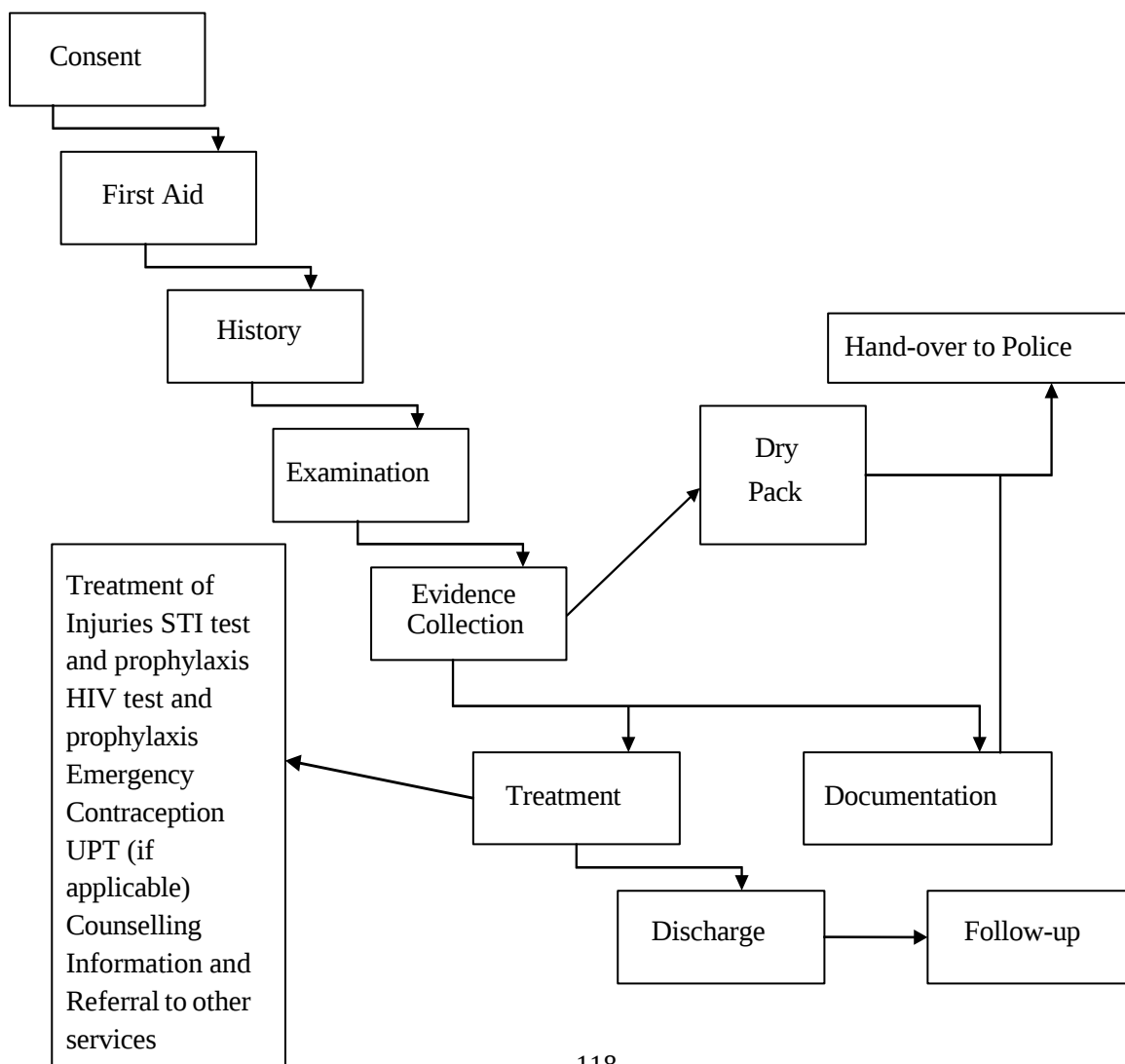
- Injuries must be recorded with details - size, site, shape, colour.
- If a past history of sexual violence is reported, then record relevant findings. Sexual violence is largely perpetrated against females, but it can also be perpetrated against males, transgender and intersex persons.

The nature of forensic evidence collected will be determined by three main factors- nature of sexual violence, time lapsed between incident of sexual violence and examination and whether survivor has bathed or washed herself. Please refer to Section VI Point 21 of Guidelines.

Opinion: The issue of whether an incident of rape/sexual assault occurred is a legal issue and not a medical diagnosis. Consequently, doctors should not, on the basis of the medical examination conclude whether rape/sexual assault had occurred or not. Only findings in relation to medical findings should be recorded in the medical report.

- Drafting of provisional opinion should be done immediately after examination of the survivor on the basis of history and findings of detailed clinical examination of the survivor.
- It should be always kept in mind that normal examination findings neither refute nor confirm sexual violence. Hence circumstantial/other evidence may please be taken into consideration.
- Absence of injuries may be due to:
 - Inability of survivor to offer resistance to the assailant because of intoxication or threats
 - Delay in reporting for examination.

The following are the components of a comprehensive health care response to sexual violence and must be carried out in all cases:



6.12.2 Medico-Legal Examination Report of Sexual Violence

- i. Format- Sexual Assault Survivor
- ii. Report of examination of a male accused in sexual offence (including Potency)

(Refer Annexure 6.4 (Vol. I))

Section 7: National Health Mission

7.1 National Rural Health Mission (NRHM)

The National Rural Health Mission (NRHM): Launched on April 12, 2005 seeks to provide effective health care to the entire rural population in the country with special focus on 18 states, which have weak public health indicators.

Introduction of National Rural Health Mission:

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has launched the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian Systems of Medicine (ISM) to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing Community Health Centers (CHC i.e. Sub-District Hospital & Rural Hospitals) into functional hospitals meeting Indian Public Health Standards (IPHS) in each Block of the Country. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

State of Public Health:

- Public health expenditure in India has declined from 1.3% of GDP in 1990 to 0.9% of GDP in 1999. The Union Budgetary allocation for health is 1.3% while the State's Budgetary allocation is 5.5%.
- Union Government contribution to public health expenditure is 15% while States contribution about 85%
- Vertical Health and Family Welfare Programmes have limited synergisation at operational levels.
- Lack of community ownership of public health programmes impacts levels of efficiency, accountability and effectiveness.
- Lack of integration of sanitation, hygiene, nutrition and drinking water issues.
- There are striking regional inequalities.
- Population Stabilization is still a challenge, especially in States with weak demographic indicators.
- Curative services favour the non-poor.
- Only 10% Indians have some form of health insurance, mostly inadequate one hospitalized Indian spends on an average 58% of their total annual expenditure.
- Over 40% of hospitalized Indians borrow heavily or sell assets to cover expenses.
- Over 25% of hospitalized Indians fall below poverty line because of hospital expenses.

Vision of NRHM:

- The Union government on April 12, 2005 launched NRHM. The NRHM seeks to provide effective health care to the entire rural population in the country with special focus on 18 states, which have weak public health indicators.
- The Mission is an articulation of the commitment of the Government in National Health Policy to rise public spending on Health from 0.9% of GDP to 2-3% of GDP, over the next 5 years.
- It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Program.
- It has as its key components provision of a health activist in each village; a village health plan prepared through a local team headed by the Panchayat representative; strengthening of the rural hospital for effective curative care through Indian Public Health Standards and accountable to the community; integration of vertical Health & Family Welfare Programmes and optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare.
- It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Health Action Plan (DHAP).
- It seeks decentralization of the program for district management of health.

- It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure.
- It aims to promote policies that strengthen public health management and services.
- It shall define time-bound goals and report publicly on their progress.
- Above all, it seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

Goals of NRHM:

- Reduction of Infant Mortality Rate (IMR).
- Reduction of Maternal Mortality Ratio (MMR).
- Universalize access to public health services, such as women's health, child health, sanitation, immunization, nutrition etc.
- To prevent and control both communicable and non-communicable diseases with increased emphasis on locally endemic diseases.
- Provide for integrated comprehensive primary health care.
- Assuring population stabilization, gender and demographic balance.
- Promotion of healthy life styles.

Objectives:

- Provision for a trained and supported Accredited Social Health Activists (ASHA) as village health activist.
- Emphasis on Community Participation by involving panchayats in formulating local health plans.
- Strengthening Sub-Centres (SCs), Primary Health Centres (PHCs) and Community Health Centres by developing Indian Public Health Standards.
- District level Management of Health to be institutionalized and strengthened. Increase utilization of First Referral Units (FRUs).
- Strengthening sound local health traditions and local resource based health practices related to primary health care and public health.

Targets:

- To reduce IMR to 28/1000 live births.
- To reduce MMR to 130/1,00,000 live births.
- To reduce Total Fertility Rate (TFR) to 2.2
- To reduce Malaria mortality rate by 50%
- 100% Reduction of Kala Azar mortality & sustain elimination until.
- Filariasis/Microfilaria reduction 70%, 80% & elimination.
- Dengue mortality to reduce.
- Japanese Encephalitis mortality reduction rate: 50 per cent and sustaining at that level.
- Cataract Operation: to reduce the incidence of blindness, increase activity.
- Leprosy prevalence rate to reduce from 1.8/10,000 to less than 1/10,000 thereafter.
- Tuberculosis DOTS services: Maintain 85 per cent cure rate through entire Mission period.
- Upgrading Community Health Centers to Indian Public Health Standards.
- Increase utilization of First Referral Units from less than 20% to 75%.
- Engaging female Accredited Social Health Activists (ASHA) in tribal/rural areas.

Strategies:

Core Strategies:

- Train and enhance capacity Panchayati Raj Institutions (PRIs) to plan, control and manage public health services;
- Promote access to healthcare to household through the female health activists.
- Every village to have Health plan prepared through Village Health Committee of the Panchayat;
- Strengthening sub-center, Primary Health Centres and Rural Hospitals for improved curative care as per Indian Public Health Standards through a set of define personnel, equipment and management.

- Preparation and implementation of an inter-sectoral District Health Plan including drinking water, sanitation & hygiene and nutrition by the District Health Mission,
- Integrating vertical Health and Family Welfare programmes at National, State, District and Block levels;
- Technical support to National, State and District Health Missions, for Public Health Management;
- Strengthening capacities for data collection, assessment, review for evidence based planning, monitoring and supervision;
- Formulation of transparent policies for deployment and career development of Human Resources for health;
- Developing capacities for preventive and promoting health care at all levels for promoting healthy life styles;
- Reduction in consumption of tobacco and alcohol etc.
- Promoting non-profit sector particularly in under-served areas;
- Communication strategy to encourage health seeking behavior.

Supplementary Strategies:

- Regulation of private sector,
- Promotion of public-private partnerships (PPP),
- Mainstream AYUSH (Ayurveda, Yoga, & naturopathy, Unani, Siddha, Homeopathy),
- Effective and viable risk pooling and social health insurance.

Plan of Action:

Component 1: Accredited Social Health Activists (ASHA):

- Every village/large habitat (1000 population) will have a female community health activist chosen by and accountable to the panchayat and act as the interface between the community and the public healthcare system.
- ASHA must be women resident of the village; married / Widow / Divorced and preferable in the age group of 25-45 years. She should have had formal education up to class 8th. States to choose state specific models.
- ASHA would act as a bridge or catalyst between the ANM and the village.
- ASHA will be an honorary volunteer, receiving performance-based incentives for promoting construction of household toilets, universal immunization, and other healthcare delivery programmes.
- She will facilitate preparation and implementation of the Village Health Plan along with Anganwadi worker, ANM, functionaries of other Departments, and Self help Group members, under the leadership of the Village Health Committee of the Panchayat.
- She will be trained on pedagogy of public health developed and mentored through a Standing Mentoring Group at National level incorporating best practices and implemented through active involvement of community health resource organizations.
- She will be given a Drug Kit containing generic AYUSH and allopathic formulations for common ailments. The drug kit would be replenished from time to time.

Component 2: Strengthening Sub-Centers:

- Each sub-center will have an untied fund for local action up to Rs.10,000 per annum. This fund will be held in joint account of ANM and CHO for HWC sub centers and for non HWC sub centers ANM and Panchayat Sarpanch operated by the ANM, in consultation with the Village Health Committee.
- Supply of essential drugs (allopathic and AYUSH) to the Sub centers.

Component 3: Strengthening Primary Health Centers (PHC):

- Strengthening PHC for quality preventive, promotive, curative, supervisory and outreach services.
- Adequate and regular supply of essential quality drugs and equipment.
- Provision of 24 x 7 service in PHCs by addressing shortage of doctors, especially in high focus States/ districts, through mainstreaming AYUSH manpower.
- Observance of standard treatment guideline & protocols.
- Codification of new Indian Public Health Standards (IPHS), setting norms for infrastructure, staff, equipment, management etc for PHCs.

Component 4: Strengthening CHCs (SDH &RH) for First Referral Care:

- Operationalisation of existing Community Health Centers (30 /50/100 beds) as 24 x 7 First Referral Units, including posting of anesthetists.

- Promotion of Stakeholders' Committees (Rugna Kalyan Samitis) for hospital management.
- Codification of new Indian Public Health Standards (IPHS), setting norms for infrastructure, staff, equipment, management etc for CHCs.
- Developing standards of services and costs in hospital care.
- Display and ensure compliance to Citizen's Charter at CHC/PHC level.

Component 5: District Health Action Plan (DHAP):

- District is the core unit of planning, budgeting and implementation.
- District Health Plan would be a mix of field responses through Village Health Plans, State priorities for Health, Water Supply, Sanitation and Nutrition.
- Centrally Sponsored Schemes could be rationalized/modified accordingly in consultation with States.
- Concept of "funneling" funds to district for effective integration of programmes
- All vertical Health and Family Welfare Programmes at district and state level merge into one common "District Health Mission" at the district level and the "State Health Mission" at the state level.
- Provision of Programme Management Unit (PMU) for all districts, through contractual engagement of MBA, Accountant and Data Entry Operator, for improved management.

Component 6: Converging Sanitation and Hygiene under NRHM:

- The Total Sanitation Campaign (TSC) is proposed to cover all districts. Components of TSC include IEC activities, rural sanitary marts, individual household toilets, women sanitary complex, and School Sanitation Programme.
- The District Health Mission would therefore guide activities of sanitation at district level, and promote joint IEC for public health, sanitation and hygiene, through Village Health & Sanitation Committee, and promote household toilets and School Sanitation Programme. ASHA would be given incentives for promoting household toilets by the Mission.

Component 7: Strengthening Disease Control Programs:

- Strengthening ongoing National Disease Control Programs for Malaria, TB, Kala Azar, Filariasis, Blindness & Iodine Deficiency etc shall be horizontally integrated under the Mission, for improved programme delivery.
- Supply of generic drugs (both Allopathic & AYUSH) for common ailments at village, SC, PHC, CHC level.

Component 8: Public-Private Partnership (PPP) for public health goals, including Regulation of Private Sector:

- Guidelines to be formulated for Public Private Partnership in the health sector.
- Since 75% of health services are being currently provided by the private sector, there is a need to refine transparent and accountable regulation.
- Reform of regulatory bodies/creation where necessary.
- District Institutional Mechanism for Mission must have representation of private sector.

Component 9: New Health Financing Mechanism:

- Task Force to examine new health financing mechanisms.
- Standardization of services: outpatient, inpatient, laboratory, surgical interventions and costs will be done periodically by a committee of experts.
- A National Expert Group to monitor these standards and give suitable advice and guidance on protocols and cost comparisons.
- A district health accounting system to be created to monitor the District Health Fund Management, and take corrective action.
- The Central government will provide subsidies to cover a part of the premiums for the poor, and monitor the schemes.

Component 10: Reorienting Medical Education to support Rural Health issues:

- While district and tertiary hospitals are necessarily located in urban centres, they form an integral part of the referral care chain serving the needs of the rural people.
- Medical and paramedical education facilities need to be created in states, based on need assessment.

Institutional Mechanism:

Formation of following institutions for implementation:

- Village Health, Nutrition, Water Supply & Sanitation Committee (VHNSC) (at village level) consisting of Panchayat Representatives, ANM/MPW, Anganwadi worker, teachers, ASHA, community health volunteers.

- Rugna Kalyan Samiti for community management of public hospitals.
- District Health Mission under the leadership of Zilla Parishad with District Health Head as Convener and all relevant departments, NGOs, private professionals etc represented on it.
- State Health Mission, Chaired by Chief Minister and co-chaired by Health Minister and with the State Health Secretary as Convener, representation of related departments, NGOs, private professionals etc.
- Integration of Departments of Health and Family Welfare, at National and State level and development of National Mission Steering Group consisting Planning Commission. Ministry of Panchayat Raj, Rural Development and Human Resource Development.

7.2 National Urban Health Mission (NUHM)

Rationale:

As per Census 2001 currently 28.6 crores people living in urban areas. It is estimated that the urban population of country will increase to 43.2 crores by 2021. The urban growth has also led to increase in number of urban poor population, especially those living in slums. Despite the supposed proximity of the urban poor to urban health facilities their access to them is severely restricted. This is on account of their being “crowded out” because of the inadequacy of the urban public health delivery system. In order to effectively address the health concerns of the urban poor population, the Ministry proposes to launch a National Urban Health Mission (NUHM). The duration of the Mission would be the remaining period of 11th Five Year Plan (2008-2012). The NUHM would cover all Cities (430 in total) with population above 1 lakh and state capitals during phase I. District Head Quarter towns with population less than one lakh would be covered under Phase II of the Mission.

The NUHM would have high focus on:

- Urban Poor Population living in listed and unlisted slums
- All other vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers, any other temporary migrants.

The National Urban Health Mission therefore aims to address the health concerns of the urban poor through facilitating equitable access to available health facilities by rationalizing and strengthening of the existing capacity of health delivery for improving the health status of the urban poor.

Goal:

The National Urban Health Mission would aim to improve the health status of the urban poor particularly the slum dwellers and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system, partnerships, community based risk pooling and insurance mechanism with the active involvement of the urban local bodies.

Core Strategies:

- Improving the efficiency of public health system in the cities by strengthening, revamping and rationalizing urban primary health structure.
- Partnership with non-government providers for filling up of the health delivery gaps.
- Promotion of access to improved health care at household level through community based groups: Mahila Arogya Samitis.
- Strengthening public health through preventive and promotive action.
- Increased access to health care through risk pooling and community health insurance models.
- IT enabled services (ITES) and e-governance for improving access improved surveillance and monitoring.
- Capacity building of stakeholders.
- Prioritizing the most vulnerable amongst the poor .
- Ensuring quality health care services.

Outcomes:

The NUHM would strive to put in place a sustainable urban health delivery system for addressing the health concerns of the urban poor. Since NUHM would complement the efforts of NRHM, the expected health outcomes of the NRHM would also be applicable for NUHM.

The NUHM would therefore be expected to achieve the following targets in urban areas:

- IMR reduced to 28/1000 live births.
- Maternal Mortality reduced to 100/100,000 live births.
- TFR reduced to 2.2.

- Reduction in Malaria Mortality by 50%.
- 25 % reduction in malaria morbidity and mortality up to 2010, additional 20%.
- Kala Azar Mortality Reduction Rate - 100% by 2010 and sustaining elimination.
- Filaria/Microfilaria Reduction Rate - 70% by 2010, 80% by 2012 and elimination.
- Filariasis: Coverage of more than 80% under MDA
- Reduction in case fatality rate and reduction in number of outbreaks of dengue
- Dengue Mortality Reduction Rate - 50% and sustaining at that level.
- Chikungunya: Reduction in number of outbreaks and morbidity due to Chikungunya by prevention and control strategy
- Leprosy Prevalence Rate- reduced from 1.8 per 10,000 to less than 1 per 10,000 thereafter.
- Tuberculosis DOTS series- maintain 85% cure rate through the entire Mission Period and also sustain planned case detection rate.
- Reduce the prevalence of deafness by 25% (from existing levels)

Urban Social Health Activist (USHA) / (Urban ASHA):

Each slum/community would have a well defined grass root level area covering about 1000-2,500 Population, between 200-500 households based on spatial consideration, preferably co-located at the Anganwadi Centre functional at the slum level, for delivery of services at the door steps. One front-line community worker called USHA on the lines of ASHA under NRHM would remain in charge of each area and serve as an effective and demand-generating link between the health facility (Urban Primary Health Centre) and the urban slum populations. The USHA on the lines of ASHA, would preferably be a woman resident of the slum- married/widowed/ divorced, preferably in the age group of 25 to 45 years. She should also be a literate woman with formal education up to class eight which may be relaxed only if no suitable person with this qualification is available.

The essential services to be rendered by the USHA may be as follows:

- Active promoter of good health practices and enjoying community support.
- Facilitate awareness on essential RCH services, sexuality, and gender equality, age at marriage/pregnancy, motivation on contraception adoption, medical termination of pregnancy, sterilization, spacing methods.
- Facilitate access to health related services available at the Anganwadi/ Urban Primary Health Centres.
- Formation and promotion of Mahila Arogya Samittees (MAS) in her community.
- Carrying out preventive and promotive health activities with AWW/ Mahila Arogya Samiti.
- Provision for a minimum package of curative care empowered with minimum knowledge for timely referrals equipped with an ASHA like drug kit.

In return for the services rendered, she would receive a performance-based incentive.

Mahila Arogya Samittee (MAS):

Will act as community-based peer education group, involved in community monitoring and referral. The MAS may consist of 20-100 households (HH) with an elected Chairperson and a Treasurer, supported by an USHA. This group would focus on preventive and promotive care, facilitating access to identified facilities, risk pooling fund and health insurance.

7.3 National Ayush Mission (NAM)

Introduction:

In India, the traditional systems of medicine are well accepted in the communities and widely used for the treatment of common ailments. Among ancient medical systems Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy have impressive record of safety and efficacy to promote positive health. Now-a-days, practice of Yoga has become a part of everyday life in preventing and mitigating diseases and it has proved to prevent psychosomatic disorders and improves the ability to endure stressful situation of the individual. So Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) have been integrated into the national health delivery system with a network of registered practitioners, research institutions and licensed pharmacies.

Now, Ministry of Ayush launched the Centrally Sponsored Scheme of National AYUSH Mission (NAM) on 15.09.2014 for implementing through States/UTs. The National AYUSH Mission (NAM) was approved for its further continuation till March, 2020 by Cabinet in 2017. As per the Department of Expenditure's O.M. dated 10th January, 2020, the ongoing Schemes were approved for interim extension upto 31.03.2021. Union Cabinet also approved operationalization of 12,500 AYUSH Health and Wellness Centres (AHWCs) component under AYUSHMAN BHARAT for implementation through National AYUSH Mission with a

financial outlay of Rs. 3399.35 Crores for a period of 5 years upto 2023-24. Union Cabinet on 14.07.2021 approved the continuation of National AYUSH Mission (NAM) with financial implication of Rs. 4607.30 crores (Rs. 3000.00 Crore as Central Share and Rs. 1607.30 crores as State Share) with effect from 01.04.2021 to 31.03.2026 excluding AYUSH Health and Wellness Centres (AHWCs) component.

Vision:

- To provide cost effective and equitable AYUSH health care throughout the country by improving access to the services.
- To strengthen preventive and promotive aspects in primary health care.
- To provide services of a holistic wellness model based on AYUSH principles and practices.
- To improve AYUSH educational institutions for imparting quality education.

Objectives:

- To provide AYUSH health care services throughout the country by strengthening and improving AYUSH health care services.
- To establish a holistic wellness model through AYUSH Health and Wellness Centres focusing on preventive and promotive health care based on AYUSH principles and practices, to reduce the disease burden and out of pocket expenditure.
- To provide informed choice to the needy public through co-location of AYUSH facilities at PHCs, CHCs and DHs resulting in medical pluralism.
- To emphasize the role of AYUSH in Public Health as per NHP 2017.
- To enhance and strengthen the infrastructure of AYUSH educational institutions.

Components of the Mission:

- AYUSH Services
- AYUSH Educational Institutions
- Quality Control of ASU & H Drugs
- Medicinal plants
- Flexible Components

AYUSH Services:

Objective

The main objective of AYUSH services is to enhance coverage of health care system through cost effective AYUSH Services by focusing on core competency areas of AYUSH through upgrading AYUSH Hospitals and Dispensaries, co-location of AYUSH facilities at Primary Health Centres (PHCs), Community Health Centres (CHCs), District Hospitals (DHs) and setting up of upto 50 bedded Integrated AYUSH Hospitals.

Components of the AYUSH Services under National AYUSH Mission:

- Co-location of AYUSH facilities at PHCs, CHCs and DHs.
- Upgradation of exclusive / standalone Government AYUSH Hospitals (other than PHCs / CHCs/ DHs)
- Upgradation of Government / Panchayat / Government aided AYUSH Dispensaries
- Setting up of upto 50 bedded integrated AYUSH Hospitals
- Supply of essential drugs to AYUSH Hospitals and Dispensaries
- Public Health Outreach activity
- Behaviour Change Communication (BCC)
- Mobility support
- AYUSH Gram
- School Health Programme through AYUSH

AYUSH Health and Wellness Centre (AHWC):

Services

- Preventive and promotive measures for Self care through healthy lifestyle, food, Yoga and medicinal plants
- Management of common ailments under 12 service delivery framework
- Care in Pregnancy and Child-birth
- Neonatal and Infant Health Care Services
- Childhood and Adolescent Health Care Services
- Reproductive Health Care Services
- Management of Communicable Diseases: National Health Programmes

- General Out-patient Care for Acute, Simple and Minor Ailments
- Screening, Prevention, Control and Management of Non-communicable Diseases
- Care for Common Ophthalmic and ENT Problems
- Basic Oral Health Care
- Elderly and Palliative Health Care Services
- Emergency Medical Services including Burns and Trauma
- Screening and Basic Management of Mental Health Ailments

Educational Institutions:

Objectives:

- To upgrade Government/Government Aided AYUSH UG and PG Educational Institutions
- To provide financial assistance to the states for setting up of new AYUSH educational Institutions in the States where it is not available in Government sector.
- Components of the AYUSH Educational Institutions under National AYUSH Mission:
- Infrastructural development of AYUSH Under-Graduate Institutions
- Infrastructural development of AYUSH Post-Graduate Institutions / add on PG Pharmacy / Para-Medical Courses
- Setting up of new AYUSH Educational Institutions in the States where it is not available in Government sector.

Quality Control of ASU & H Drugs:

Objective

- To strengthen State Govt. ASU&H Pharmacies and Drug Testing Laboratories.
- Strengthening of ASU&H regulatory framework.
- To improve the Quality of ASU&H Drugs to enable their export in International Markets.
- Components of the Quality Control of ASU & H Drugs under National AYUSH Mission:
- Grant in aid to State/Govt. ASU&H Pharmacies/ State Govt. ASU&H Cooperatives, State Govt. ASU&H PSU's.
- Grant in aid to State Drug Testing Laboratories of Ayurveda, Siddha, Unani and Homoeopathy (ASU&H) Drugs.
- Grant-in-aid for strengthening of ASU&H Drug Control Framework.
- Grant in aid to State Licensing Authority of ASU&H Drugs for documentation publication and dissemination of quality control material for States.

Medicinal Plants:

Objectives:

- Support cultivation of medicinal plants which is the key to integrity, quality, efficacy and safety of the AYUSH systems of medicines by integrating medicinal plants in the farming systems, offer an option of crop diversification and enhance incomes of farmers.
- Cultivation following the Good Agricultural and Collection Practices (GACPs) to promote standardization and quality assurance and thereby enhance acceptability of the AYUSH systems globally and increase exports of value added items like herbal extracts, phyto-chemicals, dietary supplements, cosmeceuticals and AYUSH products.
- Support setting up processing clusters through convergence of cultivation, warehousing, value addition and marketing and development of infrastructure for entrepreneurs to set up units in such clusters.
- Implement and support certification mechanism for quality standards, Good Agriculture Practices (GAP), Good Collection Practices (GCP), and Good Storage Practices (GSP).
- Promote partnership, convergence and synergy among stake holders involved in R&D, processing and marketing in the public as well as private sector at national, regional, state and sub state level.

Flexible Components:

- AYUSH Wellness Centres including Yoga & Naturopathy
- Tele-medicine
- Sports Medicine through AYUSH
- Innovations on mainstreaming of AYUSH including PPP
- Reimbursement of Testing charges

- IEC activities
- Research & Development in areas related to Medicinal Plants
- Voluntary certification scheme: Project based.
- Market Promotion, Market intelligence & buy back interventions
- Crop Insurance for Medicinal Plants.

7.4 Maharashtra Emergency Medical Services (MEMS)

“Emergency Medical Service on Call”

Introduction:

Maharashtra Emergency Medical Services (MEMS) project under National Health Mission provides pre-hospital health services to patients through life support ambulances to nearby hospitals for further treatment. This includes patients suffering from Road accidents, all critical diseases, critical pregnant women, Neonates related diseases, Patients suffering from an epidemic, Natural calamities and Man-made Hazards, Critical heart patients, snake bite, all accidents, food poisoning, respiratory diseases, brain diseases etc.

- Financial provision for the project is being made under ‘National Health Mission And ‘Government of Maharashtra’.
- **Toll free number 108** has been assigned for provision under Maharashtra Emergency Medical Services (MEMS).
- Strategy based on “**Golden Hour Theory**” – Patient to be shifted within first hour to nearest hospital is being applied through a dedicated toll-free number 108. These services are available **24 X 7** in a year and offered ‘free of cost’ to the patient.
- Integrated approach to provide emergency response services which includes Computer technology integration, voice logger system, **GIS** (Geographic Information System), **GPS** (Geographic Position System) **AVLT** (Automatic Vehicle Location System) & Mobile Communication System (**MCS**).
- Ambulances procured in the scheme includes well equipped Advance Life Support Ambulances (**ALS**) and Basic Life Support Ambulances (**BLS**).
- The service provider has procured medical equipments for both ALS & BLS ambulances as per list and specifications given in the Tender Document.
- Medical Equipments include Ambulance cot, Scoop Strecher, Bi-Phasic Defibrillator cum Cardiac Monitor with Recorder (For ALS only), Transport Ventilator (For ALS only), Pulse Oximeter (For BLS only), Suction Pump (Manual & Electronic), Oxygen Cylinder Etc.
- Ambulances are being operated through **trained drivers** & trained EMSO’s (Emergency Medical Service Officers) who are **Doctors**.

Goals & Objectives:

- To provide First aid to preserve life, prevent further injury & promote recovery.
- To provide comprehensive 24X7 hours emergency response services by direct calling 108 Toll free number from any network in Maharashtra.
- System to leverage all the stake holders to offer comprehensive range of services in emergencies.
- Expected 20% reduction in mortality & reduce morbidity.

Deployment of Ambulances:

Under Maharashtra Emergency Medical Services (MEMS) project total 937 ambulances are provided phase wise across the State.

Call Centre:

- Central Control Room/Emergency Response Centre (ERC) is established at Chest Hospital, Aundh, Pune.
- Real time location of ambulances using GPS-GPRS technology is being monitored from call center.
- 24X7 trained Call taker & call dispatchers are available for emergency response.
- Daily, weekly & monthly MIS reports can be generated from call center.
- There are about 60 call assistants deployed per shift at ERC, Pune.

Training:

- Comprehensive training for all Doctors has been provided.
- Training for ambulance driver is also provided for emergency response service.
- Training provided to call taker, call dispatcher for operationalization of EMS.

Doctor:

Qualification	B.A.M.S
Training given	ALS (Advance Life Support) BLS (Basic Life Support) Disaster Management etc.

Training program	18 days /batch+5 days work at hospital Casualty
Total doctors	2616 (Approximately)

Driver:

Qualification	As per Gov. rule for driving of heavy vehicle
Training given	Vehicular Safety Checks, Ambulance Driving Techniques, Accident Avoidance & Crash Procedures, Basic Life Support & Disaster Management Protocols
Driver Training	7 days/batch
Total drivers	2456 (Approximately)

Call Assistant:

- Qualification: Any graduate
- Training given:

Communication Officer	Priority Dispatch System & Telecommunication Essentials
Protocol Instruction and Practice & Roles of the Communication Officer	Operations, Legal issues, Dispatch Stress & Quality Improvement
Dispatch Officer	The science of prioritized dispatch & Ethical and Medical Legal issue, Dispatch Life Support.
Call Assistance Training	3 days /batch
Total call assistants	180 (Approximately)

- Also training given to Ambulance Control Officer, Emergency Physicians Online Medical Control, Supervisors & other Administrative Staff.

Current Status:

As on today, all 937 ambulances are operational, out of which 704 are BLS ambulances and 233 are ALS ambulances.

District wise deployment of ambulances is as follows:

District Wise Ambulance Count				
Sr.No.	District	ALS	BLS	Total
1	Ahmednagar	9	31	40
2	Akola	4	11	16
3	Amravati	6	21	29
4	Aurangabad	8	23	31
5	Beed	5	14	19
6	Bhandara	3	8	11
7	Buldhana	5	18	23
8	Chandrapur	5	16	23
9	Dhule	4	13	18
10	Gadchiroli	2	8	10
11	Gondia	3	10	15
12	Hingoli	3	9	12
13	Jalgaon	9	25	35
14	Jalna	4	11	15
15	Kolhapur	8	28	36
16	Latur	5	15	20
17	Mumbai	26	73	93
18	Nagpur	11	31	40
19	Nanded	6	19	25
20	Nandurbar	3	10	14
21	Nashik	11	35	46
22	Osmanabad	4	11	15
23	Palghar	6	23	29
24	Parbhani	4	9	13

25	Pune	24	60	82
26	Raigad	4	18	22
27	Ratnagiri	4	13	17
28	Sangli	5	19	24
29	Satara	6	26	32
30	Sindhudurg	3	9	12
31	Solapur	10	24	35
32	Thane	12	29	40
33	Wardha	3	8	11
34	Washim	3	8	11
35	Yavatmal	5	18	23
Total		233	704	937

7.5 Comprehensive Primary Health Care Through Health & Wellness Centres

Government of India has launched Ayushman Bharat campaign to address critical issue of access to health care. Comprehensive Primary Health Care (CPHC) is essential to avert disease and promote well-being, ensure continuity of care, and enable gate-keeping, so as to reduce the burden on secondary and tertiary level facilities, thus saving costs to system and the individual.

Idea of Health & Wellness Centre:

India has adopted a three tiered system of health care delivery and Sub Health Centre is the peripheral outpost that caters to a population of 5000 in plane areas and 3000 populations in tribal, hilly and desert areas. Currently, the package of services that a sub-centre provides largely relates to outreach RCH care. Owing to the changes in disease profile, with non-communicable diseases and communicable diseases contributing a major part of the disease burden there is a conscious shift in focus from primary care to comprehensive primary care beyond RCH services and communicable diseases and inclusive of Preventive and Promotive care. For provision of comprehensive primary care, the strategy is to re-define the role of the sub-centre and its staffing pattern and strengthen the sub centres into Aayushman Aarogya Mandir (AAM) [Health and Wellness Centres (HWC)].

The HWCs provides Preventive, Promotive, Rehabilitative, Curative and Palliative care for a package of 13 services as below:

- Care in Pregnancy and Child-birth.
- Neonatal and Infant Health Care Services
- Childhood and Adolescent Health Care Services.
- Family Planning, Contraceptive Services and other Reproductive Health Care Services
- Management of Communicable Diseases: National Health Programmes
- General Out-patient Care for Acute Simple Illnesses and Minor Ailments
- Screening, Prevention, Control and Management of Chronic & Non-communicable Communicable Diseases including-TB, Leprosy.
- Care for Common Ophthalmic and ENT Problems
- Basic Oral Health Care
- Elderly and Palliative Health Care Services
- Emergency Medical Services including Burns and Trauma
- Screening and Basic Management of Mental Health Ailments
- Yoga & Ayush

HWC deliver, these set of comprehensive services through team based approach. A primary health care team trained and equipped in a set of skills and redesigned work processes to ensure a continuum of care that places emphasis on preventive and promotive health.

HWCs not only to expand the service package, but also to create a perception in the community, that the facility close to them, offers a platform for preventive and promotive action. Apart from service provision, key interventions envisaged under HWC include Population Enumeration, Creation of Family folders and use of IT platform and to assure continuity of care, through diagnostic services, regular refills of drugs for chronic diseases, and access to Tele-Consultation Services.

The SC-HWCs are to be headed by a Community Health Officer with a primary health care team including ANMs, MPW (M) and ASHAs of the sub center area.

HWC Implementation in Maharashtra State:

To provide CPHC near to the community, State is moving forward with strengthening of all the SCs, PHCs & UPHCs as HWCs along with additional provision of health promotion & wellness activities viz. Yoga. State is committed to transform all 10673 SCs, 1839 PHCs & 651 UPHCs in to Health and Wellness Centers in phase wise manner by Dec' 2022. **State has operationalized total 10398 facilities which includes 8052 SCs, 1831 PHCs and 515 UPHCs as Health & Wellness Centres till date (as per AB-HWC Portal)**

JAS (RKS) Meeting Norms:

Structure	Meetings	Particular
SC- JAS Meeting	Per Month	1 meeting per Month (As per GOI Guideline)

Uses of RKS, AMG, and UF Fund are as Follows:**RKS Fund is utilized for:**

- Purchase of medicine to poor patients
- Laboratory tests outside hospital
- Transportation of patient (Referral Services)
- Cloths to patients/ newborn for delivery patients
- Drinking water facility to patients
- Sitting arrangement for patients
- Solar power heater for patients
- Kitchen /Dharmashala – Construction/ maintenance
- Food facility for patients
- Other innovative schemes.
- Purchase of essential equipment not available in the Hospital

AMG Fund is utilized for:

- Repairs & maintenance of hospital building & quarters
- Repairs & maintenance of water supply & drainage
- Repairs of instruments/equipment/ delivery table etc.
- Repairs of furniture / doors/ windows (Furniture works)
- Payment for cleaning of Sub Centre / hospital building & premises
- Water supply during scarcity
- Maintenance of computers & other office equipment & other maintenance expenses

UF Fund is utilized for:

- Purchase of medicine which is urgently required & not available
- Purchase of lab material
- Purchase of instrument/ equipment
- Purchase of furniture/ curtains/ mattresses
- Purchase of dressing material (bandage/ cotton)
- Transport of emergency patients
- Transport of women in labor
- Transporting of samples in epidemics
- Innovative schemes for work improvement
- Minor Civil works
- Stationary, registers, papers etc.

7.6 Village Health Nutrition Water Supply & Sanitation Committee (VHNSC)**Village Health Nutrition Sanitation Committee****Objective of the VHNSC:**

- To provide an institutional mechanism of the community to be unformatted of health programmers and government initiatives and to participate in the planning and implementation of these programmers, leading to better outcomes.
- To provide platform for convergent action on social determinants and all public service direct to indirect related to health
- To provide an institutional mechanism for the community to voice health needs

- To empower panchayats with the with the understanding and mechanisms required for them to play their role.
- To provide support and facilitation to the community health workers.

Composition of the VHNSC:

- **Number of Members-** VHNSC Should have a minimum of 15 members, it may have more members.
- **Key Principals Governing the Composition of the VHNSC.**
 - Elected members, especially women of panchyati resident in the village should be enabled to lead
 - All those working for health or health related services should be able to participant
 - The voices of services users of health services- especially of mother should find place.
 - There should be representation from all community sub groups, especially from poor and more vulnerable sections.
 - All habitations/ hamlets should have representation
- **Constitution of the VHNSC**
 - Elected Gram Panchayat Members (Sarpanch/ Mahila Sarpanch)
 - ASHA Workers
 - Frontline staff of government health related services- ANM, Anganwadi Workers, School teacher, Volunteers/ Village level workers, Hand pump Mechanical, Field coordinator of MNREGA
 - Community based Organizations: CBOs, SHG Groups, Forest Management Committees, Youth Committees
 - Pre-Existing Committees- Village level separate committees, water, sanitation or Nutrition.
 - Service Users- pregnant women, lactating mother,

Joint Bank Account of VHNSC- Chairperson and ASHA Workers (Member Secretary)

Activities and Out Come of VHSNC:

- Monthly Meeting
- Accounting for the untied village fund
- Management of untied village Health fund
- Record Maintenance
- Monitoring and facilitating access to essential public services
- Organizing local collective action for health promotion
- Facilitating service delivery in the village
- Community of Heath care facilities
- Village Health Planning

Action Points:

- Decentralize Funds. Should be used at Institutional level only.
- Centralized purchasing from district level is banned.
- 1st installment to be released to all the institutions as per time line given.
- Subsequent installments to be given after receiving the SOE of the available amount.
- Amount allocated in the PIP is to be released in III or IV installments to the institutes.
- Conducting 1st GB within 2months of the beginning of the financial year.
- GB to approve plan for entire allocation of funds sanctioned to the institution in the PIP.
- Distribution of funds should be done according to the given timelines.

VHNSC Fund is utilized for:

- Preparation of Village Health Plan
- Organization of Village Health & Nutrition Day
- Gram-Sabha organized for health issues
- Purchases for Organizing Village health day
- Nutritional schemes for malnourished children
- Transporting pregnant women for delivery if not available for government vehicle
- Transporting other patients for treatment
- Organization of Health Awareness activities
- Purchase of TCL for safe water supply (in Kilo)
- Repairs of water supply scheme

7.7 Schemes Under NHM

7.7.1 Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) under the overall umbrella of National Health Mission (NHM) is being proposed by way of modifying the existing National Maternity Benefit Scheme (NMBS). While NMBS is linked to provision of better diet for pregnant women from BPL families, JSY integrates the cash assistance with antenatal care during the pregnancy period, institutional care during delivery and immediate post-partum period in a health centre by establishing a system of coordinated care by field level health worker. The JSY would be a 100 per cent centrally sponsored scheme.

Vision:

- To reduce overall Maternal Mortality Ratio and Infant Mortality Rate.
- To increase institutional deliveries.

Target Group:

All pregnant women belonging to the below poverty line (BPL) and SC/ST households

Strategy:

- Early registration of the beneficiaries with the help of health worker.
- Early identification of complicated cases.
- Providing at least 3 ANC & post delivery visits.
- Provide referral transport to mother.
- Convergence with ICDS worker by way of involving Anganwadi worker.
- Operationalization of 24 * 7 delivery services at PHC level.
- Operationalization of FRUs to provide emergency obstetric care.
- Building partnerships through a process of recognition/accreditation with doctors, hospitals/nursing homes/clinics from the private sector especially in the rural areas to provide obstetric services to the JSY beneficiaries.

Features:

- **Cash Assistance:** The benefit under the scheme would be linked to availing of antenatal check ups, delivery in health centre/ hospital.
- **Tracking** Each Pregnancy: Each beneficiary registered under this Yojana should have a JSY form along with a MCP card. ASHA/AWW/ any other identified link worker under the overall supervision of the ANM and the MO, PHC should prepare a micro-birth plan.

Cash assistance provided under JSY:

Package to mother:

- Rs. 700/- for rural and Rs.600/- for urban institutional delivery and Rs. 500/- for home delivery.

The package for ASHA:

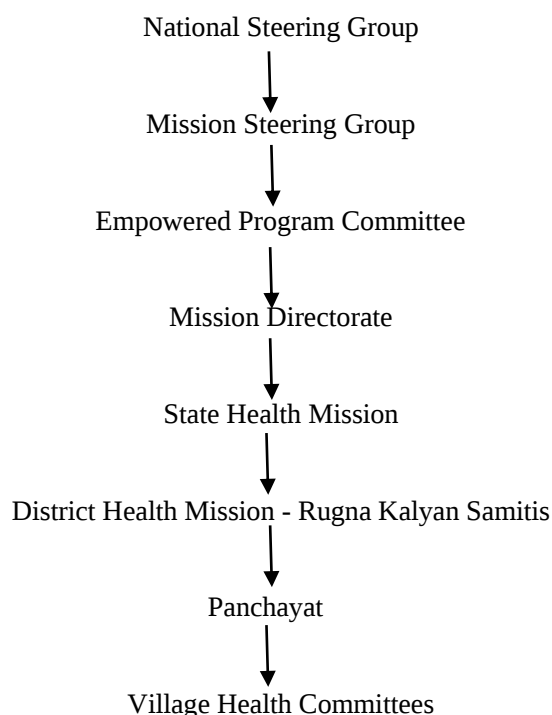
- ASHA will be paid Rs.300/- for giving all expected ANC services to JSY beneficiary.
- She will be paid Rs. 300/- as incentive for escorting and staying with a pregnant woman for delivery to the hospital. The amount will be disbursed after post delivery visit to mother and child and after the baby receives BCG vaccination but within seven days of delivery.
- Incentives for ASHA will be Rs. 200 + Rs. 200 in urban areas.

Assistance for Caesarean Section: FRUs/CHCs would provide emergency obstetric services. Where Government specialists are not available in a health institution, assistance up to Rs. 1500/- per case will be provided for hiring services of private experts to carry out the surgery either in a government medical facility or in accredited Private hospital, nursing home etc.

Convergence under NHM:

- Convergence with all departments that influence outcomes of wider determinants of health is necessary for improved health indicators.
- District level Zilla Parishad framework allows convergent action of all departments under one umbrella.
- State and National level should allow more flexibility and more financial resources to districts for them to forge solidarity of various departments.
- Bringing development functionaries under the control of the district facilitates greater co-ordination in deployment and integration. Need to develop district specific cadres of functionaries.
- Women & Child development, Education and Literacy Department, Panchayati Raj and Rural Development, Water and Sanitation Department, other institutions in health care like HIV/AIDS, AYUSH etc need to be better integrated with interventions for health care.
- Programmatic integration and convergence is easier to effect at district, sub district and block levels.

Organogram Of National Health Mission



7.7.2 Janani Shishu Suraksha Karyakram (JSSK)

In order to reduce the maternal and neonatal deaths, the Govt. of India has announced the Janani Shishu Suraksha Karyakram. As per Govt. of Maharashtra Resolution dated 26th Sept. 2011 Janani Shishu Suraksha Karyakram has been launched from 7th Oct. 2011 in all districts of Maharashtra.

It has been observed that most of the times due to delay in reaching health care facility like FRU, 24x7 PHCs, Secondary or Tertiary centres, mothers and neonates are deprived of emergency care resulting in maternal morbidity and mortality, still birth and neonatal deaths. To prevent all these complications, it is important that mothers and children should be provided quality care free of cost including diet and transport facility on time. Maharashtra is progressive state and is progressing towards achievement of NHM goals.

The important components of the program are as follows:

Entitlement of Pregnant Women:

- Free & zero expense Delivery & Caesarian section.
- Free drugs & consumables.
- Free essential diagnostics (blood, urine tests & Ultra Sonography etc.)
- Free diet during stay in the health institutions (up to 3 days for normal delivery & 7 days for caesarian section)

- Free provision of blood.
- Free transport from Home to Health Institutions, between facilities in case of referral & dropback from institutions to home.
- Exemption from all kinds of user charges.

Entitlement for Sick Neonates till 365 days after birth:

- Free & zero expense treatment.
- Free drugs & consumables.
- Free essential diagnostics
- Free provision of blood.
- Free transport from Home to Health Institutions, between facilities in case of referral & dropback from institutions to home.

Above services are provided through the network of PHCs, RH-SDH, DH, WH and GH under public health department and Govt. Medical Colleges, Hospital.

7.7.3 Referral Transport (Toll Free Call Center 102)

It has been observed that most of the times due to delay in reaching health care facility like FRU, 24x7 PHCs, Secondary or Tertiary centres, mothers are deprived of emergency obstetric care resulting in maternal morbidity and mortality, still birth and neonatal deaths. To prevent all these complications, it is important that mothers should be referred to the health care facility on time.

Considering this, under Janani Shishu Suraksha Karyakram, free transport services are provided to pregnant and delivered mothers upto 45 days (PNC period) and sick neonates up to the age of 365 days. These services include free transport from home to institutions, from institution to institution (in case of 2nd referral) and drop back home. Presently all the health facilities at the level of PHC and above are provided with ambulances. Considering this, one call center has been established at each district. One person is always available round the clock in this call center. Once the call is made by patient/relative, it is the responsibility of call center to arrange the nearest ambulance for free transport of mother or child to nearest appropriate health facility.

Initially, the driver of the PHC of respective area is contacted and informed to attend to caller. In case PHC vehicle is not available due to administrative / technical reasons, Ambulance of nearby PHC/RH/SDH is to be contacted. If no government ambulance is contactable then Block Level Contractual Ambulance driver is to be informed to attend the call. It is expected that contractual ambulance will be available 24x7 as stand by arrangement.

For establishment and functioning of Referral Transport, following activities must be carried out:

Background of Referral Transport Scheme.

This scheme is basically established for providing free transport in time to pregnant women 45 days (PNC period) in labour and to sick neonates up to 365 days. Therefore, pregnant women in labour 45 days (PNC period) and sick neonates (up to 365 days) are to be provided services free of cost.

It is also important to inform all the drivers and Call Center Assistants that this free facility of transporting patients is only to transport to Govt. Health Institute or Hospitals and not for Private Hospitals. Therefore, providing ambulances services for transporting the patients from home to Private Health Facility should not be allowed. Exception to these guidelines will be life threatening conditions which require immediate treatment that is available only in nearby Private Hospital, but on payment basis only with prior permission of Concerned Medical Officers.

Provision of Ambulance services

- **Ambulances to PHC/Hospitals:** All the PHCs and Hospitals are provided ambulances as per bed strength. DHOs and Civil Surgeon to ensure that all the PHC ambulances are on road and repaired. For ambulance repairs, state budget provided should first be utilized. If state budget is not sufficient then NHM Mobility Support budget should be utilized for this purpose. District can also purchase tires and batteries from Mobility Support budget besides repairs. However, do not use NHM budget for painting and cushions of the ambulance. The history sheet of ambulance should clearly mention the source of fund utilized for repairs. Concerned MO should record a certificate about non-availability of state funds while utilizing the NHM funds for repairs.
- **Additional POL to Ambulances:** Ambulances are provided regular POL grant, FW cases grant, Pulse Polio and other similar program grant and also substantial grant under Mobility Support under Mission Flexi pool. In addition to this, yearly grant is provided to each Ambulance for POL to transport the pregnant women for delivery and sick neonates. All these grants should be used to keep the ambulance on road. Distribute the grant to health facilities only after establishment of Call Center in your district.

- For the purpose of drop-back the Concerned Medical Officer should give PHC Ambulance In case of non-availability of both then only he should call vehicles from other nearby PHC where the patient is going for drop-back.

Monitoring of project:

Responsible Persons: In District Level.

Controlling Authority – Civil Surgeon

Implementing Officer in field – M&E Officer, Team Leader In charge Superintendent of Health Institutions.

Record keeping

Following registers will be maintained by the Referral Transport Cell

- **Referral Register:** Should be maintained at PHC level.
- **Register with driver:** One register will be kept with driver of each ambulance. Driver will enter the call receive time, response to call and he will also get signature of doctor/nurse after admission to health facility. This register is maintained by drop back vehicles drivers allotted at DH & WH on monthly basis.

7.8 AYUSH, IPHS and Panchayat RIs

Mainstreaming AYUSH under NHM:

Introduction:

In India, the traditional systems of medicine are well accepted in the communities and widely used for the treatment of common ailments. Among ancient medical systems Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy have impressive record of safety and efficacy to promote positive health. Now-a-days, practice of Yoga has become a part of everyday life in preventing and mitigating diseases and it has proved to prevent psychosomatic disorders and improves the ability to endure stressful situation of the individual. So Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) have been integrated into the national health delivery system with a network of registered practitioners, research institutions and licensed pharmacies.

The NHM seeks to revitalize local health traditions and mainstream AYUSH (including manpower and drugs); to strengthen the Public Health System at all levels. Under NHM, AYUSH medications shall be included in the drug kit of ASHA. The additional supply of generic drugs for common ailments at SC/PHC/CHC levels under the Mission shall also include AYUSH formulations. At the CHC level two rooms shall be provided for AYUSH practitioner and pharmacist under the Indian Public Health Standards (IPHS) model. At the same time, single Doctor PHCs shall be upgraded to two Doctor PHCs by inducting AYUSH practitioner at that level.

Strategies:

- Integrate and mainstream Indian System of Medicine & Health (ISM & H) in health care delivery system including National Programs.
- Encourage and facilitate in setting up of specialty centres and ISM clinics.
- Facilitate and Strengthen Quality Control Laboratory.
- Strengthening the Drug Standardization and Research Activities on AYUSH
- Develop Advocacy for AYUSH.
- Establish Sectoral linkages for AYUSH activities.

Activities for Mainstreaming AYUSH:

- For mainstreaming of AYUSH in NHM, the personnel of AYUSH may work under the same roof of the Health Infrastructure. However, separate space should be allocated exclusively for them in the same building.
- Provision of at least one specialist doctor of any of the AYUSH systems as per the local acceptability assisted by a pharmacist.
- Supply of appropriate medicines pertaining of AYUSH systems.
- The already existing AYUSH infrastructure should be mobilized. AYUSH dispensaries that are not functioning should be merged with the PHC or CHC barring which, displacement of AYUSH clinic is not advised.
- Cross referral between Allopathic and AYUSH streams should be encouraged based on the need for the same.
- Improving the availability of AYUSH treatment facilities and integrating it with the existing Health Care Service Delivery System.
- Integration of AYUSH services in CHC/Block PHC with appointment of contractual AYUSH Doctors.

- Appointment of paramedics where AYUSH Doctors shall be posted.
- Appointment of a Data Assistant to support the ISM&H Directorate.
- Strengthening of AYUSH dispensaries with provision of storage equipments.
- The specific choice of AYUSH system that should be set up in each state should be decided by the State depending on the local preference.
- AYUSH doctors shall be involved in IEC, health promotion and also supervisory activities.
- The IPHS pertaining to AYUSH and also the detailed manpower and other requirements and financial projections for the same will be provided by the Department of AYUSH for further consideration.
- AYUSH doctors to be involved in all National Health Programmes, especially in the priority areas like IMR, MMR, JSY, Control of vector Borne Diseases and other communicable diseases etc.
- Training of AYUSH doctors for Primary Health Care and National Diseases Control Programmes.

Integration of AYUSH with ASHA:

- Training module for ASHA/ANMs has to incorporate information of AYUSH.
- Training & capacity building to be undertaken and necessary training material for the purpose to be modified and provided accordingly.
- Drug kit provided to ASHA will contain one AYUSH preparations.

Drug Management:

- Priority will be given to manufacture drugs in Government Sector Pharmacies.
- Provision of Rs. 25,000/- to supply drugs per AYUSH dispensary.
- Provisions of medicines for District AYUSH wings and Specialty Therapy Centres proposed to be operated in the State.

Special Initiatives for Mainstreaming and Strengthening of AYUSH:

- The drug regulatory mechanism to be strengthened at the state level to improve the quality of drugs used in AYUSH and ensures proper standardization.

Development of Herbariums and crude drug museums:

- Herbarium may be developed in collaboration with the Forest Department in selected Districts of the State.
- The existing Herbal gardens will be strengthened.
- Plant extraction centres in selected areas may be developed for extraction and preservation of the plants for medicinal use.

Strengthening of the State and District Management System of AYUSH:

- It is proposed to create necessary managerial post in the State and District level for effective supervision and implementation of different activities.
- Joint monitoring visits to health centres to be undertaken by both AYUSH and Health Care Officials at the District/State level.

7.9 Indian Public Health Standards (IPHS)

Introduction:

The healthcare system in India has expanded considerably over the last few decades; but due to non-availability of manpower, problems of access, acceptability, lack of community involvement, the quality of services is not up to the mark. Hence, standards are being introduced in order to improve the quality of public health level. The Bureau of Indian Standards already prescribed standards for healthcare facilities, but at present these standards are not achievable as they are very resource-intensive. As India has a developing health system with limited resources, hence a less resource intensive standard is suited to the requirements of the system.

The NHM aims at strengthening hospital care for rural areas. As a first step, requirements for a Minimum Functional Grade of a Community Health Centre, Primary Health Centre and Sub Centre are being prescribed. IPHS are a set of standards envisaged to improve the quality of healthcare delivery in the country. IPHS defining personnel, equipment and management standards, its decentralized administration by a hospital management committee and the provision of adequate funds and powers to enable these committees to reach desired levels.

The main objectives of IPHS are:

- To provide optimal support and comprehensive Primary Health Care.
- To achieve and maintain an acceptable standard of quality of care.
- To make the services sensitive to the needs of the community.

Indian Public Health Standards for Primary Health Centres (PHCs):

In order to provide optimal level of quality health care, a set of standards are being recommended for PHC. The standards prescribed in this document are for a PHC covering 20,000 to 30,000 populations with 6 beds.

Assured Services at the PHCs:

Assured services cover all the essential elements of preventive, promotive, curative and rehabilitative primary healthcare. This implies a wide range of services that include:

- **Medical care:**

- OPD services,
- 24 hours emergency services,
- Referral services,
- In-patient services (6 beds).

MCH Care & FP:

- **Antenatal care & Intra-natal care:**

- Early registration of all pregnancies ideally in the first trimester,
- Minimum 4 ANC checkups,
- Minimum laboratory investigations like hemoglobin, urine albumin, and sugar, RPR test for syphilis,
- Nutrition and health counseling,
- Identification and referral of high-risk pregnancies/ appropriate management,
- Chemo prophylaxis for malaria in high malaria endemic areas as per NVBDCP guidelines,
- Promotion of safe institutional deliveries,
- Management of Pregnancy Induced hypertension,
- Pre-referral management (Obstetric first-aid) in obstetric emergencies that need expert assistance. (Training of staff for emergency management to be ensured).

- **Postnatal Care:**

- A minimum of 6 postpartum home visits, first within 48 hours of delivery, 2nd on 7 day, 3rd on 14th day, 4th on 21st day, 5th on 28th and 6th on 42nd day of delivery through sub-centre staff.
- Initiation of early breast-feeding within half-hour of birth,
- Education on nutrition, hygiene, contraception, essential new born care,
- Others: Provision of facilities under JSY.

- **New Born care:**

- Facilities and care for neonatal resuscitation,
- Management of neonatal hypothermia / jaundice.

- **Care of the child:**

- Emergency care of children including Integrated Management of Neonatal and Childhood Illnesses (IMNCI) and control of routine childhood illness,
- Promotion of exclusive breast-feeding for 6 months,
- Full immunization of all children against vaccine preventable diseases,
- Vitamin A prophylaxis to the children.

- **Family Planning:**

- Education, motivation and counseling to adopt appropriate FP methods,
- Provision of contraceptives,
- Follow up services to the eligible couples adopting permanent methods,
- Counseling and appropriate referral for safe abortion services (MTP) and for couples having infertility.

- **Management of RTIs/STIs:**

- Treatment and health education for prevention of RTI/ STIs,

- **Nutrition Services (coordinated with ICDS):**

- Diagnosis, management and nutritional advice to malnourished children, pregnant women and others,
- Coordination with ICDS.

- **School Health:**

- Regular checkups by RBSK Team, appropriate treatment including de-worming, referral and follow-ups.

- **Adolescent Health Care:**

- Life style education, counseling, appropriate treatment.

- **Promotion of Safe Drinking Water and Basic Sanitation**

- Disease Surveillance and Control of Epidemics & Prevention and control of locally endemic diseases:
- Alertness to detect unusual health events and take appropriate remedial measures.
- **Sanitation and Water Quality:**
 - Disinfections of water sources,
 - Testing of water quality using H2S- Strip Test,
 - Promotion of sanitation including use of toilets and appropriate garbage disposal.
- **Collection and reporting of vital events.**

Behavioral Change Communication.

- **Referral Services:**
 - Appropriate and prompt referral of cases needing specialist care including pre-referral management.
- **Basic Laboratory Services:**
 - Routine urine, stool and blood tests
 - Diagnosis of RTI/ STI with wet mounting, grams stain, etc
 - Sputum testing for tuberculosis
 - Blood smear examination for malaria parasite\
 - RPR test for Syphilis
 - Rapid diagnostic tests for Typhoid (Typhi Dot)
 - Rapid test kit for fecal contamination of water
 - Estimation of chlorine level of water using ortho-toludine reagent & Chloroscope.
- **National Health Programmes:**
- **NTEP:** All PHCs to function as DMC centres and treatment of common complications of TB and side effects of drugs, record and report on NTEP activities.
- **IDSP:** Collect and analyze data from sub-centres and will report information to district surveillance unit. Appropriate preparedness and first level action in out-break situations.
- **NPCB &VI:** Basic services:
 - Diagnosis and treatment of common eye disease,
 - Refraction Services,
 - Detection of cataract cases and referral for cataract surgery.
- **NVBDCP:**
 - Diagnosis of Malaria cases, microscopic confirmation and treatment
 - Cases of suspected JE and Dengue to be provided symptomatic treatment, hospitalization and case management as per the protocols
 - Complete treatment to Kala-Azar cases in endemic areas
 - Complete treatment of microfilaria positive cases with DEC and participation and arrangement of Mass Drug Administration (MDA) along with management of side reactions, if any. Morbidity management of Lymphedema cases
- **National AIDS Control Program:**
 - IEC activities to enhance awareness and preventive measures about RTI / STIs and HIV/AIDS,
 - Prevention of Parents to Child Transmission (PPTCT) services,
 - Screening of persons practicing high-risk behaviour with one rapid test and development of referral linkages with the nearest ICTC at the RH /SDH/ District hospital level for confirmation of HIV status of those found positive at one test stage in the high prevalence states.
 - Risk screening of antenatal mothers with one rapid test for HIV and to establish referral linkages with RH / SDH or District Hospital for PPTCT services,
 - Linkage with Microscopy Centre for HIV-TB coordination,
 - Condom Promotion & distribution of condoms to the high-risk groups,
 - Help and guide patients with HIV/AIDS receiving ART with focus on adherence.
- **Training:**
 - Health workers
 - Initial and periodic Training of paramedics in treatment of minor ailments,
 - Training of ASHAs,
 - Periodic training of doctors through Continuing Medical Education, conferences, skill development training, etc. on emergency obstetric care,
 - Training of ANM and LHV in antenatal care and skilled birth attendance.
- **Monitoring and Supervision:**

- Monitoring and supervision of activities of sub-centre,
 - Monitoring of all National Health Programs,
 - Monitoring activities of ASHAs.
 - **Mainstreaming of AYUSH is the responsibility of PHC:**
 - **Rehabilitation:**
 - Disability prevention, early detection, intervention and referral,
 - **Operation Theatre / Labour Room (Optional):**
 - To facilitate conducting selected surgical procedures (e.g. vasectomy, tubectomy, hydrocelectomy, Cataract surgery camps) and it should have sterilized operating area.
 - **Essential Infrastructure:**
 - The PHC should have a building of its own. The surroundings should be clean. The details are as follows:
 - PHC Building in an easily accessible area with all the basic facilities (registration and record room, drug dispensing room, and waiting area with booklets / leaflets and drinking water supply for patients) with ventilated rooms. The walls should carry the posters imparting health education. Toilets with adequate water supply separate for males and females should be available. A locked complaint / suggestion box should be provided
 - Outpatient Department with separate areas for consultation and examination for privacy
- In PHCs with AYUSH doctors, necessary infrastructure such as consultation room for AYUSH Doctor and AYUSH Drug dispensing should be made available.

Indian Public Health Standards for Sub Centres:

In the public health sector, a sub-centre is the most peripheral and first contact point between the primary health care system and the community. A sub-centre provides all the primary healthcare services such as immunization, antenatal, natal and postnatal care, prevention of malnutrition and common childhood diseases, family planning services and counseling. They also provide elementary drugs for minor ailments such as ARI, diarrhoea, fever, worm infestation etc and carryout community needs assessment and national health and family welfare programs through frontline healthcare workers.

In order to provide Quality Care in these sub centres, IPHS are being prescribed to provide basic primary health care services to the community and achieve and maintain an acceptable standard of quality of care. These standards would help monitor and improve functioning of the sub-centre.

Currently the IPHS for sub-centres has been prepared keeping in view the resources available with respect to functional requirement for sub-centres with minimum standards, such as building, manpower, instruments and equipments, drugs and other facilities etc.

Assured Services to be provided in a Sub-centre:

Sub-centres are expected to provide promotive, preventive and few curative primary health care services as below:

- **Maternal and Child Health:**
 - Antenatal, intra-natal and postnatal care, Child Health, Family Planning and Contraception, Provision of facilities under Janani Suraksha Yojana (JSY).
- Adolescent health care, School Health Services,
- Control of endemic/epidemics, disease surveillance, Water Quality Monitoring, Promotion of sanitation,
- Curative Services,
- Training & Coordination,
- **National Health Programmes:**
 - National AIDS Control Program (NACP), National Vector Borne Disease Control Program (NVBDCP), National Leprosy Eradication Program (NLEP), Integrated Disease Surveillance Projects (IDSP), National Tuberculosis Elimination Program (NTEP), National Blindness Control Program & Vision Impairment (NBCP&VI), Non-communicable Disease (NCD) and Cancer Control Programs
- Record of Vital Events,
- **Physical Infrastructure:**
 - A sub-centre should have its own building, road communication, public transport, telephone, boards showing visiting schedule of ANM in local language, suggestion/complaint boxes, waiting area, waste disposal facility, adequate furniture and equipment for conducting safe deliveries, immunization, and contraceptive services like IUD insertion etc.
- **Supporting Services:**
 - Laboratory services (hemoglobin and urine test), electricity, potable water for patients and staff,

- Monitoring may be made possible by internal mechanisms, supportive supervision and record checking at periodic intervals or by external mechanism i.e. village health and sanitation committee, by an independent external agency, client satisfaction survey etc.

7.10 Panchayati Raj Institutions and NHM

Introduction:

In spite of the progress made, a high proportion of the population, especially in rural areas, continues to suffer from preventable diseases, pregnancy and childbirth related complications as well as malnutrition. In addition to old unresolved problems, the health system in the country is facing emerging threats and challenges. The rural public health care system in many states and regions is in an unsatisfactory state. Even though the Panchayats have historically been an integral part of rural India, the Constitution (73rd Amendment) Act, 1992 has institutionalized the Panchayati Raj Institutions at the Village, Intermediate and the District levels, as the third tier of governance. The aim was to strengthen local government organizations with clear areas of jurisdiction, adequate power, authority and funds commensurate with responsibilities and with an emphasis on reservations for deprived classes of the population in Panchayats including of the leadership positions.

Panchayats have been assigned 29 rural development activities, which are related to health and population stabilization. The XI schedule includes Family Welfare, Health and Sanitation, (including hospitals, Primary Health Centers, and Dispensaries,) and the XII schedule includes Public Health. Thus the possible realm of influence of the Panchayats extends over a significant proportion of public health issues. The Gram Sabha, where empowered has the potential to act as a community level accountability mechanism to ensure that the functions of the village Panchayat in the area of public health and family welfare, actually respond to people's needs.

The NRHM has been launched with a view to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance.

The core strategies of the Mission include train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services and strengthening of existing Sub-Centre through better human resource development, PHCs, CHC under Indian Public Health Standards. PRIs are specific public bodies with adequate funds, functions and functionaries that involve all the governing bodies as stakeholders. PRIs act in a decentralized manner for planning and specific need-based interventions. PRIs help to convergent action and community monitoring at all levels.

Increasingly it is being realized that strategies for achieving low infant, under five and maternal mortality depend on a functioning continuum of high-quality services from community to secondary and sometimes higher levels of care. In addition, community support for such services comes through behavior change to increase utilization as well as demand high quality services. In the RCH phase-2 implementation document, specific mention is made of plans to support PRI (and urban counterparts) in design, implementation, monitoring of RCH related interventions. This is also seen as a potential to address the social determinants of health through engagement with communities and PRI rather than a biomedical approach. It is also expected that PRI involvement will increase community understanding of issues of accountability for quality and reliability of health care services.

Critical Role of Panchayati Raj Institutions in NHM:

The NHM, designed to integrate health and family welfare related interventions and address health from a holistic preventive, promotive and curative viewpoint takes a much more significant view of PRI engagement. The fulcrum of the NRHM program is a social activist (ASHA) at the village level, who will work with the village level resource team in providing preventive and promotive health care services. It is expected that she will be supervised and supported by the panchayats.

Thus, there is opportunity for PRI involvement to address the non technical components of health care seeking, provided all PRI representatives are exposed to a perspective building exercise on health within the framework of gender and equity.

Linkage from the village to Gram Panchayat to Block and District:

- **At the village and Gram Panchayat level:**

The Village Health Committee (VHC) will form the link between the Gram Panchayat and the community. The VHC would be responsible for working with the Gram Panchayat to ensure that the health plan is in

harmony with the overall local plan. It is anticipated that this committee will prepare a Village Health Plan and maintain village level data, supervised by the Gram Panchayat. Engaging the Gram Sabha and other groups in planning and monitoring the Village Health Plan will presumably enforce transparency and accountability.

Under the NHM, untied funds of upto Rs. 10,000 are placed with the ANM to meet unanticipated expenditures and to ensure that lack of drugs and other consumables is not an issue. An account has been opened with the Sarpanch for operationalisation of the activities planned. At the sub-centre level, planning and use of these funds will be supported by the appropriate tier of the panchayat.

- **Block Level:**

At the block level a Block Co-ordination Committee with the Block Nodal Officer /Block Panchayat President as Chairperson and the involvement of PRIs and civil society will be formed for effective functioning and convergence. This will be linked to the Meeting of the Block level Committees under the Sarpanch.

- **District level:**

At the District level the District Health Mission will co-ordinate NHM functions and are under the Zila Parishad President.

- **ASHA and the PRIs:**

The selection of ASHA is the responsibility of the Gram Panchayat where it will be finalized in a meeting of the Gram Sabha. The success of ASHA scheme will depend on how well the scheme is implemented and monitored. It will also depend crucially on the motivational level of various functionaries and the quality of all the processes involved in implementing the scheme.

- At the village level ASHA will receive support from the women's committees (like self help groups or women's health committees), Village Health & Sanitation Committee of the Gram Panchayat, peripheral health workers especially ANMs and Anganwadi workers, the trainers of ASHA and mainly the Panchayat members.
- At the block level, ASHA scheme will have a Block Co-ordination Committee with the Block Nodal Officer /Block Panchayat President as Chairperson and the involvement of PRIs and civil society.
- The Gram Panchayat would lead the ASHA initiative in selection of ASHA, providing regular support in undertaking many health-related tasks through its statutory health committee, developing the village health plan and in the compensation incentive. All ASHAs will be in this Village Health & Sanitation Committee of the Panchayat either as members or as special invitees.

Importance of PRIs:

PRIs can take part in planning, implementation and monitoring of health services to improve the health care delivery by solving the following issues:

- Reaching the health facilities or programs to every household has become a tedious work.
- Poor access of health care and public services.
- Lack of knowledge regarding the health care services.
- Resident, skilled, development workers with high motivation.
- Accountability to Local Governments.
- Crafting Credible Public Systems.

Functions (Critical Role) of PRIs in the success of the NHM:

- PRIs are seen as critical to the planning, implementation, and monitoring of the NHM. Implementation of the NHM in achieving its outcomes is significantly dependent on well functioning gram, block and district level panchayats. At the District level a District Health Mission will coordinate NHM functions.
- Key to NHM success are:
 - Inter-sectoral convergence,
 - Community ownership steered through village level health committees at the level of the Gram Panchayat, and
 - A well functioning public sector health system with support from the private sector.
- ASHA, selected by the Gram Panchayat or the Village Health Committee to strengthen village level service delivery. She will be supported in her work by the AWW, school teacher, community based organizations, such as SHGs, and the VHC.

Enlisting NGO support in building capacity among PRI members to effectively handle development related functions:

- Capacity building of PRI is required in thematic areas and leadership skills, negotiating, monitoring, ability to withstand patronage and political interference. Capacity building processes need to be tailored to literacy levels, sex and circumstances of PRI members.

- Joint orientation and sensitization meetings between PRI and health and medical professionals could help to bridge the gap in education and social strata. Developing Citizen Charter of Rights and Codes of conduct also lay down guidelines for boundaries of operation and accountability.
- NGOs could be involved in PRI strengthening in a variety of ways, including: consciousness raising, provision of technical advice, support in participatory planning, capacity building and facilitating monitoring processes, such as community and social audits to improve accountability.

7.11 Financial Guidelines, Cash Flow and Audits

Jan Aarogya Samiti- JAS (Rugna Kalyan Samiti- RKS)

- In Maharashtra, vide GR dated 30th December 2005 RKS was established in DH/RH/SDH/WH and RKS was established in PHCs vide GR dated 31st January 2007
- RKS has been renamed as JAS vide GR dated 23rd November 2022.
- JAS (RKS) is a registered body under Charity Commissioner Act
- Delegated powers to JAS (RKS) & District Health Societies to plan and implement activities as per their needs.
- Planning and monitoring process of JAS (RKS) should be through Governing body & Executive committee decisions
- JAS (RKS) can raise money through Donations.
- JAS (RKS) is expected to facilitate better service delivery in the institutions.
- Any change in the membership of Governing and Executive Committee members could be done only with the prior approval of Charity Commissioner 's Office.

Activities of JAS (RKS):

- Undertake all activities to improve and expand patient related quality services and welfare activities.
- The Executive Committee will guide and control the activities as per the policy formulated by JAS (RKS) Governing Body.
- Acquiring equipment, furniture, emergency medicines for efficient running of the hospitals as per existing rules and regulations.
- To ensure food, medicines and quality drinking water to the patients and their relatives.
- Improve boarding and lodging arrangements (Kitchen/Dharmashala) for patients and their attendant.
- To provide Referral services to patients.
- Cloths to patients/ newborn for delivery patients.

Jan Aarogya Samiti (JAS) [Rugna Kalyan Samiti (RKS)]:

Sr. No.	Health Institutes	Designation	JAS Committee Body
1	Primary Health Centre	Chairperson	Z.P. member who represents for the Jurisdiction of the PHC
		Member secretary	Medical Officer of the PHC
2	UPHC	Chairperson	CO Municipal Council
		Member secretary	MO UPHC
3	Sub- Centre	Chairperson	Sarpanch GP (by rotation 3 yearly)
		Member secretary	CHO
4	VHSNC	Chairperson	Sarpanch
		Member secretary	ASHA (Senior most)

Annual Maintenance Grant:

- In Maharashtra, vide GR dated 17th January 2007 AMG is distributed in PHC and SC .
- Annual Maintenance Grants are distributed for maintenance of physical infrastructure of health institutions.
- GOI has directed to use the Annual Maintenance grants for regular maintenance of physical structure of health institutions including provision of water, toilets and other maintenance.
- Major part of the Annual Maintenance grant should be spent to do minor repairs and strengthening of the building and then for doing cleanliness activities.

Activities of AMG:

- To ensure/ undertake regular repairs and maintenance of the physical facilities.
- To ensure/undertake cleaning, bio-medical waste management, and other services of the hospital.
- To provide improved facilities in various departments including contract services of technical/other personnel.
- To ensure proper use by timely maintenance and repair of hospital equipment and machinery.
- Repairs and Maintenance of water supply and drainage.
- Payment of Electricity bills and Telephone bills.
- Maintenance of Computers and other office equipment's.
- Any other maintenance expenditure.

Untied Fund

- In Maharashtra, UF is distributed vide GR dated 17th January 2007
- Untied funds have been provided to the institutions up to Village health nutrition sanitation & water supply Committees, Sub Centers, PHCs , PHU and Ayurvedic Dispensaries to promote local health action.
- Necessity of Untied Fund has been felt mainly due to unavailability of funds for undertaking any innovative need-based activity
- Untied Funds will be used only for the common good & not for individual needs,
- Expenditure in the case of referral & transport in emergency situations.
- Untied Funds should not duplicate what can be taken up under other programs
- The Untied grant is to be used for household surveys, health camps, sanitation drives, revolving fund etc.
- Untied Funds shall not be used for any salaries, vehicle purchase & recurring expenditure.

Activities of UF:

- This fund is mainly provided for implementation of innovative schemes.
- Expenditure can be made under untied fund to fill up temporary gaps created in response to short supply of logistics or unexpected change in demand pattern.
- This fund can be used for the purchase of Lab materials, Instruments/Equipment's, Furniture, Curtains, Mattresses etc.
- Transfer of samples during epidemics.
- Transport of emergencies to appropriate referral center.
- Untied fund shall not be used for vehicle purchase, payment of monthly salaries. But can be used to make payments for services rendered.
- Untied fund should not be used for recurring expenditures.
- This fund can also be used for minor purchases like Stationery, Registers, Papers etc.

Village Health Nutrition Water Supply & Sanitation Committee

- Formation of Village Health, Nutrition, Water Supply and Sanitation Committees was sanctioned via GR dated 6th December 2006
- Total 39872 VHNSC established in Revenue Villages
- Chairperson (Sarpanch) & Member secretary (ASHA) holds the Joint Account of VHNSC
- The VHNSC will be the key agency for developing Village Health Plan and the entire planning of Village Panchayat for NHM.
- VHNSC Committee comprises of Panchayat Representatives, ANM, Anganwadi Workers, Teachers, Community Health Volunteers & ASHA.
- VHNSC is provided Untied Fund which is made available for IEC household survey, Preparation of Health Registered, Organization of Meetings at Village Level, Village Health Plan, Health awareness activities, Safe Water Supply etc.

VHNSC Fund is utilized for

- Preparation of Village Health Plan
- Organization of Village Health & Nutrition Day
- Gram-Sabha organized for health issues
- Purchases for Organizing Village health day
- Nutritional schemes for malnourished children
- Transporting pregnant women for delivery

- Transporting other patients for treatment
- No. of breeding places destroyed
- Organization of Health Awareness activities
- Minor repairs of water supply scheme.
- Minor repairs /Civil Works in Anganwadi
- Cleanliness of Common Toilets

Action Points

- Decentralize Funds. Should be used at Institutional level only.
- Centralized purchasing from district level is banned.
- 1st instalment to be released to all the institutions as per time line given.
- Subsequent instalments to be given after receiving the SOE of the available amount.
- Amount allocated in the PIP is to be released in III or IV instalments to the institutes.
- Conducting 1st GB within 2months of the beginning of the financial year.
- GB to approve plan for entire allocation of funds sanctioned to the institution in the PIP.
- Distribution of funds should be done according to the given timelines.

Utilization of JAS (RKS) Funds:

JAS (RKS) Fund is utilized for

- Purchase of medicine to poor patients
- Laboratory tests outside hospital
- Transportation of patient (Referral Services)
- Cloths to patients/ newborn for delivery patients
- Drinking water facility to patients
- Sitting arrangement for patients
- Solar power heater for patients
- Kitchen / Dharmashala – Construction/ maintenance
- Food facility for patients
- Other innovative schemes
- Good practices under JAS (RKS) & VHNSC.
- purchase of essential medicine not available in Hospital
- purchase of essential equipments not available in the Hospital

AMG Fund is utilized for:

- Repairs & maintenance of hospital building & quarters
- Repairs & maintenance of water supply & drainage
- Repairs of instruments/equipments/ delivery table etc
- Repairs of furniture / doors/ windows (carpenter works)
- Payment of cleaning of Sub Centre / hospital building & premises
- Water supply during scarcity
- Electricity bills
- Telephone bills
- Maintenance of computers & other office equipment
- Other maintenance expenses

UF Fund is utilized for

- Purchase of Sub Centre medicine which is urgently require & not available
- Purchase of lab material
- Purchase of instrument/ equipment
- Purchase of furniture/ curtains/ mattresses
- Purchase of dressing material (bandage/ cotton)
- Transport of emergency patients
- Transport of women in labour
- Transporting of samples in epidemics
- Mobile charges to ANMs (regular/Contractual)

- Innovative schemes for SC work improvement
- Civil works
- Stationary, registers, papers etc.
- charges to ANMs (regular/Contractual)
- Innovative schemes for SC work improvement
- Civil works

7.12 वित्तीय व्यवस्थापन विषयक मार्गदर्शक पुस्तिका

दफ्तरी ठेवावयाची लेखा पुस्तके

- राष्ट्रीय आरोग्य अभियान अंतर्गत ठेवण्यात येणारे लेखे डबल एन्ट्री बुककिपिंग पद्धतीने ठेवण्यात यावेत.
- केंद्र शासनाच्या मार्गदर्शक सूचनांस अनुसरून राज्यभरात सर्वस्तरावर लेख्यांमध्ये साम्यता येण्याच्या दृष्टीकोनातून, संगणकीकृत टॅली ईआरपी ९ या कस्टमाईज्ड प्रणालीचा वापर करणे बंधनकारक आहे.
- संगणकीकृत टॅली ईआरपी ९ ही कस्टमाईज्ड प्रणाली जरी वापरात असली तरी हस्तलिखित कॅशबुक अद्यावत स्थितीत दफ्तरी असणे बंधनकारक आहे.
- हस्तलिखित स्वरूपात दफ्तरी अभिप्रेत असलेली लेखा पुस्तके खालील प्रमाणे आहेत:

Books of Accounts / Other Records	Block	JAS PHC	JAS Sub Centres	VHSNC
Cash Book	✓	✓		
Bank Register	✓	✓	✓	✓
Ledger	✓	✓		
Cheque Issue Register / PFMS	✓	✓		
Advance Register	✓	✓		
Salary Register / File	✓	✓	✓	
Fixed Asset Register	✓	✓	✓	
Stock Book	✓	✓	✓	
Bank Pass Book / Bank Statement	✓	✓	✓	✓
Bank Reconciliation Statement	✓	✓	✓	✓
Minutes / Proceedings Register	✓	✓	✓	✓

लेखा पुस्तकांबाबत संक्षिप्त विवरण

इतर रजिस्टर्स

- आवक रजिस्टर
- जावक रजिस्टर
- ईएमडी/बैंक ड्राफ्ट रजिस्टर
- पीएफएमएस रजिस्टर

कॅशबुक

राष्ट्रीय आरोग्य अभियान अंतर्गत ठेवण्यात येणारे लेखे डबल एन्ट्रीबुक किपिंग पद्धतीने ठेवावयाचे असून सर्व स्तरावर लेख्यांमध्ये साम्यता येण्याच्या दृष्टीकोनातून संगणकीकृत टॅली ईआरपी९ या कस्टमाईज्ड प्रणालीचा वापर होणे बंधनकारक आहे. टॅली ईआरपी९ या प्रणाली व्यतिरिक्त नवीन पद्धत अवलंबावयाची झाल्यास तशा सुचना निर्गमित करण्यात येतील. संगणकीकृत टॅली ईआरपी९ ही कस्टमाईज्ड प्रणाली जरी

वापरात असली तरी हस्तलिखित कॅशबुक अदयावत स्थितीत दप्तरी असणे बंधनकारक आहे. कॅशबुक मधील नोंदी रोजच्या रोज अदयावत करण्यात याव्यात तसेच प्रत्येक पानावर अधिकृत अधिका-यांची स्वाक्षरी वशिक्का घेऊन प्रमाणित करण्यात यावे. कॅशबुकमध्ये सुरुवातीची शिल्लक, चालु आर्थिक वर्षात घटकनिहाय प्राप्त निधी, दिलेले अग्रीम आणि खर्चाच्या नोंदी तसेच शेवटची शिल्लक या बाबींच्या नोंदी दररोज करणे बंधनकारक आहे.

बँक रजिस्टर

बँक रजिस्टरमध्ये बँकेच्या खाती ईप्रणालीद्वारे प्राप्त झालेल्या निधी रक्कमांच्या नोंदी तारीखनिहाय करण्यात यावी जेणेकरून वर्षाखेरीस वित्तीय विवरणपत्रांना अंतिम स्वरूप देतेवेळी प्राप्त निधी रक्कमेचा ताळमेळ करणे शक्य होईल.

लेजर बुक

कॅशबुक आणि जरनल मधील नोंदीच्या द्वितीय प्रतिनोंदी (लेजर पोस्टिंग) लेजरबुकमध्ये घेण्यात येतात जेणेकरून वर्षाखेरीस घटकनिहाय किती खर्च झाला, कोणास किती अग्रीम देण्यात आले आहे तसेच किती अग्रीमाचे समायोजन बाकी आहे हे समजते आणि त्या वरून वर्षाखेरीस वित्तीय विवरणपत्रामध्ये घटकनिहाय तसेच वस्तुनिहाय आणि व्यक्तिनिहाय रक्कम येणे अथवा देय बाबतची माहिती मिळणेसहज शक्य होते.

चेक्सड्रशू रजिस्टर/ पीएफएमएस रजिस्टर

या रजिस्टरमध्ये वेळोवेळी काढण्यात आलेल्या धनोदशांच्या नोंदी करणे बंधनकारक आहे. यामध्ये किती तारखेस धनादेश काढला आहे, कोणाच्या नावे काढला आहे, किती रकमेचा काढला आहे, कोणत्या कारणास्तव काढला आहे तसेच धनोदश कोणी लिहिला आहे व त्यावर स्वाक्षरी कोणत्या अधिका-यांनी केल्या आहेत याचा उल्लेख असतो. या रजिस्टरमध्ये चेकबुकच्या अनुक्रमांकनिहाय नोंदी असल्या कारणाने गाहाळ झालेल्या चेकची माहिती सहज मिळते व परिणामी भाविष्यात होणा-या अपहारास आळा बसतो. सदय स्थितीत राष्ट्रीय आरोग्य अभियानांतर्गत पीएफएमएस प्रणालीद्वारे सर्व अदायगी बंधनकारक असल्या कारणाने पीएफएमएस रजिस्टर दप्तरी ठेवणे अधिक उचित ठरेल. जेणेकरून भविष्यात पीएफएमएस द्वारे अदा केलेल्या नोंदीची माहिती एकाच ठिकाणी राहिल तसेच लेखापरिक्षण वेळी लेखापरिक्षकांना सहज सादर करणे शक्य होईल.

अॅडव्हान्स रजिस्टर (कर्मचारी / क्षेत्रीय संस्था)

अॅडव्हान्स रजिस्टरमध्ये संस्था / व्यक्तीनिहाय दिलेल्या अग्रीमाच्या नोंदी होणे आवश्यक आहे. जेणेकरून संबंधित संस्था / व्यक्तीकडे किती दिवसापासून अग्रीमाचे समायोजन प्रलंबित आहे याचा बोध होतो. (Age of advance) व्यक्तीगत रित्या एखाद्या कामानिमित्त अधिकारी / कर्मचा-यास अग्रीम दिल्यास त्याचे समायोजन अग्रीम दिलेल्या तारखेपासून ३० दिवसात होणे बंधनकारक आहे तसेच संस्थेस दिलेल्या अग्रीमाचे समायोजन देखील ३ महिन्यांच्या आत होणे बंधनकारक आहे. अग्रीम रजिस्टर मध्ये नोंदविलेल्या अग्रीमांचे समायोजन न होण्याचा कालावधी पडताळावा व त्या नुसार संबंधित संस्था किंवा व्यक्ति यांना खर्च किंवा खर्चाचे समायोजन न केल्या प्रित्यर्थ विचारणा व्हावी व त्वरित खर्चाचे समायोजन करून घेण्यात यावे. कोणत्याही परिस्थितीत संस्था किंवा व्यक्तीस दिलेले अग्रीम हे खर्चाचे समायोजन होण्यापूर्वी लेख्यांमध्ये खर्ची टाकण्यात येवू नये.

सॅलरी रजिस्टर / फाईल

दरमहा संस्था स्तरावरून कर्मचा-यांना अदा केलेल्या मानधनाचे तक्ते तथा प्रशासकीय मान्यतेच्या प्रती या नस्तीमध्ये दप्तरी जतन करून ठेवाव्यात. जेणेकरून लेखापरिक्षण वेळी लेखापरिक्षकांना सहज सादर करणे शक्य होईल.

स्टॉकबुक / फिक्सअसेट्स रजिस्टर

दप्तरी खरेदी करण्यात आलेल्या औषधे, वैद्यकीय साहित्य उपकरणे तथा इतर वस्तुंच्या नोंदी स्टॉकबुक मध्ये करणे आवश्यक आहे. जेणेकरून अभियानाच्या सुरुवातीपासून अदयापर्यंत वर्षनिहाय किती वस्तुची खरेदी करण्यात आली व आजरोजी त्यातील किती वस्तु निष्काशित करण्यात आल्या आहेत व किती कार्यरत आहेत याची माहिती सहज उपलब्ध होते. तसेच, भविष्यात कार्यालयातून एखादी वस्तु चोरी गेल्यास या रजिस्टरमधील नोंदीचा वापर आवश्यक त्या कार्यवाहीवेळी करणे सहज शक्य होते. यास्तव,

वेळोवेळी खरेदी करण्यात आलेल्या वस्तुंच्या नोंदी सदर साठानोंद वहीमध्ये आणि जंगम मालमत्तेच्या नोंदी फिक्सअसेट्स रजिस्टर वेळोवेळी करणे अत्यावश्यक आहे. या रजिस्टरमध्ये वस्तुनिहाय खाते प्रत्येक पानवर घ्यावयाचे असून त्यामध्ये वस्तुचा खरेदी दिनांक, पुरवठा केलेले नग, किंमत, पुरवठादाराचे नाव इ. बाबींच्या नोंदी या रजिस्टर मध्ये करण्यात येतात.

प्रकल्पांतर्गत प्राप्त होणा-या निधीवर नफा कमविणे हा उद्देश नसल्याने खरेदी केलेल्या फिक्स असेटवर घसारा रक्कम (Depreciation) काढण्यात येऊ नये.

जंगम मालमत्ता (फिक्स असेट्स) खरेदी केल्यानंतर त्यावर अनुक्रमांक व खरेदीचे वर्ष ऑईल पेंटने नमुद करणे आवश्यक आहे.

वित्तीय वर्ष अखेरपूर्वी तसेच चालू आर्थिक वर्षात खरेदी केलेल्या जंगम मालमत्तेचे सुस्थितीत कार्यरत असल्याबाबत व ज्यांच्याकडे त्या वस्तु आहेत त्यांच्या स्वाक्षरीचे प्रमाणपत्र दप्तरी ठेवण्यात यावे.

Fund Received Register :

या रजिस्टरमध्ये वरिष्ठ कार्यालयाकडून घटकनिहाय प्राप्त झालेल्या निधीच्या नोंदी करणे आवश्यक आहे. जेणेकरून वर्षाखेरीस प्रत्येक घटकनिहाय किती निधी प्राप्त झाला याची एकत्रितरित्या माहिती मिळणे सुलभ होते आणि वर्षाखेरीच्या वित्तीय विवरण पत्रांमध्ये नोंदी घेण्यास देखील सहज शक्य होते.

Fund Disbursement Register:

या रजिस्टरमध्ये आपल्या कार्यालयाकडून क्षेत्रीय संस्थांना घटकनिहाय वितरीत केलेल्या निधीच्या नोंदी करणे आवश्यक आहे. जेणेकरून वर्षाखेरीस प्रत्येक घटकनिहाय किती निधी प्राप्त कोणास वितरीत केला या अन्वये संबंधित संस्था निहाय एकुण अग्रीम रक्कमेची एकत्रितरित्या माहिती मिळणे सुलभ होते आणि वर्षाखेरीच्या वित्तीय विवरण पत्रांमध्ये नोंदी घेण्यास देखील सहज शक्य होते.

बँक पासबुक / बँक स्टेटमेंट

प्रत्येक संस्थेस होणारी निधी प्राप्ती ही बँकेच्या खाती जमा होते. तसेच प्राप्त निधीतुन झालेल्या विनियोजनाच्या नोंदी देखील सदर खाती खर्ची पडलेल्या असतात. दप्तरी उपलब्ध असलेल्या कॅश बुक मधील नोंदी तसेच महिना अखेरची शिल्लक याचा ताळमेळ करण्यासाठी बँकेचे पासबुक किंवा स्टेटमेंट वेळोवेळी प्राप्त करून घेणे आवश्यक आहे. अर्थात बँकेकडून प्राप्त असलेल्या स्टेटमेंट वर बँकेचा शिक्का असणे बंधनकारक आहे. अन्यथा विना बँकेचा शिक्का असलेले स्टेटमेंट लेखापरिक्षण वेळी ग्राह्य धरले जात नाही.

बँक रिकन्सिलिएशन स्टेटमेंट

कॅशबुकमधील महिना अखेरची शिल्लक आणि बँक पासबुक किंवा स्टेटमेंट मधील शिल्लक यामधील तफावत शोधून काढण्यास तसेच आपल्या अपरोक्ष बँकेकडून एखादी चुकीची रक्कम खर्ची टाकण्यात आल्यास किंवा एखादी अपहार / अनियमिततेची घटना घडल्यास अशा नोंदी पडताळण्यासाठी बँक रिकन्सिलिएशन स्टेटमेंट दरमहा बनविणे बंधनकारक आहे. साधारणतः बँकेने परस्पर वजावट केलेले बँक चार्जेस तसेच बँकेकडून जमा झालेली व्याज रक्कम अशा रक्कमांची तफावत आढळून येते. परिणामी, बँक रिकन्सिलिएशन बनविल्यानंतर त्यातील नमुद फरकाच्या नोंदी कॅश बुकमध्ये घेणे आवश्यक आहे. संस्थेकडे दप्तरी उपलब्ध असलेली जेवढी बँक खाती अस्तित्वात आहेत तेवढ्या बँकांची रिकन्सिलिएशन स्टेटमेंट बनविणे बंधनकारक आहे.

मिनिट्स बुक / प्रोसिडींग रजिस्टर

जिल्हा / उपजिल्हा / ग्रामीण / स्त्री रुग्णालये तसेच प्राथमिक आरोग्य केंद्र इत्यादी स्तरावर स्थापित रुग्ण कल्याण समित्यांच्या माध्यमातून होणा-या खर्चाबाबत समिती सदस्यांच्या कार्यकारी तसेच नियामक मंडळाच्या बैठकीमध्ये मान्यता घेणे बंधनकारक असते. सदर बैठकीतील घेण्यात आलेल्या ठरावाच्या मिनिट्स बुक / प्रोसिडींग रजिस्टरमध्ये नोंदी घेऊन त्याखाली उपस्थित सदस्यांच्या स्वाक्ष-या घेऊन दप्तरी ठेवणे बंधनकारक आहे. जेणेकरून मंजूर ठरावानुसार रुग्ण कल्याण समिती अंतर्गत झालेल्या खर्चास सर्व सदस्यांची मिळून एकत्रितरित्या संयुक्त मान्यता असल्याने तसेच सर्व समिती सदस्यांना पारदर्शकरित्या आर्थिक व्यवहाराची

माहिती होत असल्याने निधीतुन होणा-या विनियोजनामध्ये अपहार तथा अनियमिततेच्या बाबींना आळा बसण्यास मदत होते.

जननी सुरक्षा योजना व कुटुंब कल्याण कार्यक्रम मोबदला रजिस्टर - जननी सुरक्षा योजनेचा लाभ तालुका आरोग्य अधिकारी कार्यालयातून देण्यात येतो. परंतु लाभार्थ्यांची माहिती रजिस्टर प्राआकेद्र व उपकेंद्रा स्तरावर ठेवण्यात यावीत. तसेच कुटुंब कल्याण कार्यक्रमाचे आर ३ व आर ५ रजिस्टर प्राआकेंद्र स्तरावर ठेवण्यात यावे.

दप्तरी अभिप्रेत असलेल्या फाईल्स

- देयकाची फाईल
- संबंधित खर्चाच्या प्रशासकिय मान्यतेच्या फाईल्स
- शासकिय व वित्तीय मार्गदर्शक सूचनांचे परिपत्रक
- एफएमआर/एस ओ इ फाईल
- महालेखाकार (सी अॅण्ड एजी) ऑडीट फाईल
- वैधानिक (जंजनजवतल) लेखापरिक्षण फाईल
- समवर्ती लेखापरिक्षण(व्दबनततमदज) फाईल
- रुग्ण कल्याण समिती लेखापरिक्षण फाईल (आरकेएस ऑडीट)
- जनरल/ सादील खर्चाच्या फाईल्स
- बँक रिकन्सलेशन स्टेटमेंट
- मिनिटस् बुक
- टीडीएस/आयकर चलन्स/रिटर्न फाईल
- इतर फाईल्स उदा. टीए/डीए, टेलीफोन, इलेक्ट्रीसिटी, कॉन्टीजन्सी फाईल्स इत्यादी.

सर्व साधारण सुचना

- सर्वत्र लेखापुस्तकांमध्ये एकसुत्रता रहावी या दृष्टीकोनातून जिल्हा स्तरावरून विहित नमुन्यातील लेखा पुस्तकांची छपाई करून दिल्यास अधिक सुलभ होईल.
- लेखा पुस्तके वित्तीय वर्ष निहाय ठेवण्यात यावी.
- कॅश व्हाऊचर्स फाईल मधील सर्व व्हाऊचर्स अनुक्रमांक निहाय फाईल करण्यात यावे.
- **PFMS** रजिस्टर सुरक्षित ठिकाणी ठेवण्यात यावे. तसेच केवळ अधिकृत अधिकारी/कर्मचा-यांनी हाताळावेत.
- अभियानांतर्गत होणा-या सर्व अदायगी केवळ च्छडै प्रणाली द्वारेच करण्यात यावी.
- दरमहा कॅशबुक मधील शिल्लक व बँकेतील शिल्लक या रक्कमेचा ताळमेळ होण्यासाठी बँक रिकन्सलेशन स्टेटमेंट बनविण्यात यावे.
- देयकांवर व्हाऊचर क्रमांक नमुद असावा. तसेच देयकांवर प्रदानार्थ मंजुरीस्तव अधिकृत अधिका-यांची सही व शिक्का जॅमक वित्त चॅलउमदजण असावा.
- देयकाची अदायगी झाल्यानंतर देयकावर जॅमक - व्दबनससमकण 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. वैयक्तिक नावाने देयक घेण्यात येऊ नये.
- वेळोवेळी अभियानांतर्गत देण्यात आलेल्या मार्गदर्शक सूचनास अनुसरून आर्थिक व्यवहारांमध्ये संयुक्तरित्या अधिकृत स्वाक्ष-या असणे बंधनकारक आहे.
- कॅशबुक मधील नोंदीमध्ये बदल केल्यास अधिकृत अधिका-याची स्वाक्षरी करून सदर नोंदीस प्रमाणित करावे.
- अधिकृत अधिका-यांनी वेळोवेळी आकस्मिक रित्या तपासणी करावी.
- आपल्या अंतर्गत आरोग्य संस्थांना वितरित झालेल्या अग्रिम रक्कमांच्या समायोजनासाठी सतत पाठपुरावा करावा. दिलेल्या अग्रिमचे ३० दिवसात समायोजन होणे आवश्यक आहे.
- संस्थानिहाय वितरित होणारा निधी व त्यातून झालेला खर्च याबाबी आर्थिक वर्षाच्या मंजुर पीआयपीच्या मर्यादेबाहेर जाणार नाही याची दक्षता घ्यावी.

- एसओई/विनियोजन प्रमाणपत्र (नजपसप्रंजपवद बमतजपपिबंजम) हे निर्देशित केलेल्या विहित नमुन्यात असणे बंधनकारक असून विहीत वेळेत वरिष्ठ कार्यालयास सादर होणे बंधनकारक आहे.
- राज्य आरोग्य सोसायटी मार्फत देण्यात आलेल्या मार्गदर्शन सुचनांस अनुसरून केवळ एकच बँकेचे खाते ठेवण्यात यावे. अनावश्यक बँकेची खाती ठेवण्यात येऊ नये किंबहुना विना वापर असणा-या खात्यांमध्ये निधी शिल्लक ठेवू नये. तसेच कोणतेही बँक खाते परस्पर न उघडता वरिष्ठ कार्यालयाची मान्यता बंधनकारक आहे.
- पल्स पोलिओ तथा लसिकरणासाठी वितरीत केलेल्या निधी पोटी झालेल्या खर्चाचे अहवाल २१ दिवसाच्या आत कार्यालयास प्राप्त करून घ्यावेत व खर्चाच्या नोंदी अदयावात कराव्यात.
- राज्य आरोग्य सोसायटीकडून निधी प्राप्त होताच पुढील ७ दिवसात आपल्या कार्य क्षेत्रातील आरोग्य संस्थांना निधी वितरण होणे बंधनकारक आहे.
- सार्वजनिक बांधकाम विभागस आरोग्य संस्थांच्या बांधकामासाठी वितरीत केलेला निधी विनियोजनेबाबत तसेच कामाच्या पूर्णत्वाबाबत पाठपुरावा करावा. सार्वजनिक बांधकाम विभागस बांधकामासाठी वितरित केलेला निधी हा काम पूर्ण झाल्याचा दाखला प्राप्त होईपर्यंत लेख्यांमध्ये अग्रिम दर्शवावा व काम पूर्णत्वाचा दाखला प्राप्त झाल्यानंतरच खर्ची टाळण्यात यावा. तसेच काम पूर्ण झाल्यानंतर वितरित निधीमधून खर्च वजा जाता उर्वरित शिल्लक रक्कमेच्या परतीसाठी बांधकाम विभागाकडे पाठपुरावा करून रक्कम परत संस्थेच्या बँकेच्या खाती जमा करावी.
- ग्राम आरोग्य पोषक पाणीपुरावठा व स्वच्छता समिती तसेच उपकेंद्र स्तरावरील खर्चाची विवरण पत्रे (SOE)ए वार्षिक विनियोजन प्रमाणपत्रे (UC)तसेच घटकनिहाय खर्चाचे व्हाउचर्स संबंधित आरोग्य संस्थेच्या अखत्यारित ठेवावेत.
- संगणिकृत लेखा प्रणालीचा ठंबानच सुरक्षित राहण्याच्या दृष्टीने कार्यालयीन इमारती शिवाय दुसऱ्या सुरक्षित ठिकाणी ठेवण्यात यावा. इमारतीस दुर्घटना/आग लागल्यास ठंबानच सुरक्षित राहण्याच्या दृष्टीने कार्यवाही करण्यात यावी.
- अशासकिय स्वयंसेवी संस्थांना वितरीत झालेला निधी हा संबंधित संस्थेकडून खर्चाची प्रमाणीत वित्तीय विवरण पत्रे व विनियोजन प्रमाणपत्रे (SOC & UC) प्राप्त होईपर्यंत वितरीत निधी हा अग्रिम समजावा.
- आपल्या स्तरावर स्थायी लेखा परिक्षण समितीची स्थापना करून 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.
- राज्य आरोग्य सोसायटी मार्फत नियुक्त केलेल्या समवर्ती लेखा परिक्षकांकडून आपल्या व कार्यक्षेत्रातील सर्व आरोग्य संस्थांचे १०० टक्के समवर्ती लेखा परिक्षण त्रैमासिक पध्दतीने करून घ्यावे व नमुद त्रुटींचा पुर्तता अहवाल तात्काळ लेखा परिक्षकांस सादर करून लेखापरिच्छेदांचा निपटारा करून घ्यावा व त्यांची प्रत या कार्यालयास सादर करावी.
- समवर्ती लेखा परिक्षणापूर्वी तिमाही अखेरची वित्तीय विवरणपत्रे, संगणिकृत लेखे, ळैइववा, बँकेचे ताळमेळ पत्रक तथा इतर आवश्यक त्या सर्व बाबी अदयावात करून ठेवाव्यात जेणे करून लेखा परिक्षक लेखा परिक्षणासाठी हजर राहिल्या नंतर वेळेचा अपव्यय होणार नाही तसेच त्रुटींचे प्रमाण कमी होण्यास मदत होईल.
- समवर्ती तसेच वैधानिक लेखा परिक्षणासाठी संबंधित लेखा परिक्षकांशी सविस्तर चर्चा करून आपल्या कार्यक्षेत्रातील आरोग्य संस्थांच्या लेखा परिक्षणाबाबतचा दिनांक व संस्थानिहाय कृती आराखडा तयार करून सर्व आरोग्य संस्थांना आगावु स्वरूपात कळवावा जेणे करून सर्व संस्थांना लेखा परिक्षणासाठी अदयावात माहिती विहित वेळेत तयार करणे शक्य होईल.
- समवर्ती लेखा परिक्षकांकडून कर विषयक बाबींच्या अडचणी सोडवून घ्याव्यात व विहित वेळेत तमजनतदे भरण्यात याव्यात.
- आपल्या कार्यक्षेत्रातील सर्व आरोग्य संस्थांचे समवर्ती व वैधानिक लेखा परिक्षण झाले आहे किंवा नाही याची शहानिशा करून घ्यावी व लेखा परिक्षणासाठी हजर न राहणाऱ्या संस्थेबाबत स्थायी लेखा परिक्षण समिती सदस्यांसमक्ष चर्चा करून ही बाबत निर्देशनास आणून दयावीत त्यांच्या विरुद्ध योग्य ती कार्यवाही करावी.

- तालुकास्तरीय लेखापालांनी आपल्या कार्यक्षेत्रातील प्राथमिक आरोग्य केंद्रे व उपकेंद्रांना दर महिन्याला भेटी देणे बंधनकारक असून त्यांनी संबंधित आरोग्य संस्थांना दिलेल्या भेटीचा अहवाल पुढील कार्यवाहीस्तव जिल्हा लेखा व्यवस्थापक व जिल्हा आरोग्य अधिकारी यांचेकडे सादर करावा .
- उपसंचालक स्तरीय विभागीय कार्यक्रम प्रमुखांनी आपल्या कार्यक्षेत्रातील सर्व आरोग्यसंस्थांच्या लेखा परिक्षण अहवालातील तसेच महालेखाकार कार्यालयाकडून होणाऱ्या लेखापरिक्षणातील नमुद त्रुटीच्या पुर्ततेबाबत सतत पाठपुरावा करावा व केलेल्या कार्यवाहीचा अहवाल दरमहा न चुकता राज्य आरोग्य सोसायटीस सादर करावा .
- महालेखापाल मुंबई व नागपुर यांचे कडील प्रलंबित परिच्छेदाचा निपटारा तात्काळ करणे आवश्यक आहे . जिल्ह्यांच्या स्थायी लेखापरिक्षण समितीच्या बैठकीमध्ये प्रलंबित लेखा परिच्छेदांचा आढावा आपल्यास्तरावरून घेण्यात यावा . महालेखापालांना पाठविण्यात आलेले अनुपालनानुसार 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 .
- विज देयके व दुरध्वनी देयके वेळेत अदा करावीत जेणे करून त्यावर विलंब आकार लागणार नाही .
- खरेदी तथा बांधकाम विषयक बाबींमध्ये आवश्यक त्या ठिकाणी अनामत रक्कम (मंदमेज डवदमल कमचवेपज) व सुरक्षा ठेव रक्कम (मवनतपजल कमचवेपज) संबंधित पुरवठादारांकडून घेणे बंधनकारक आहे . याबाबत नियमानुसार कार्यवाही करण्यात यावी .
- वैधानिक लेखापरिक्षण केंद्र शासनाच्या मार्गदर्शक सुचनांस अनुसरून विहित वेळेत पूर्ण होण्याच्या दृष्टीकोणातून सर्व आरोग्य संस्थांतील वित्तीय विवरण पत्रे केंद्र शासनाच्या विहित नमुन्यात ३० एप्रिल पूर्वी तयार होणे आवश्यक आहे .

खरेदी विषयक मार्गदर्शक सुचना

- वेळोवेळी निर्देशित केलेल्या मार्गदर्शक सुचनांस अनुसरून विहित खरेदी पद्धतीचा अवलंब करावा .

• दरपत्रक प्रक्रिया राबवितांना पुढील प्रमाणे कार्यवाही करावी- (नियमपुस्तिका नियम ४.२)

अ)	खरेदीची व्याप्ती, अटी व शर्ती, दरपत्रक सादर करण्यासाठी दिनांक, वेळ व ठिकाण, दरपत्रक उघडण्यासाठी दिनांक, वेळ व ठिकाण, निविदाकारांचे हमीपत्र इत्यादींचा उल्लेख करून आमंत्रणपत्र तयार करावे.
ब)	खरेदीसाठी इष्टतम स्पर्धा होण्यासाठी जास्तीत जास्त विक्रेत्यांपर्यंत खरेदीची नोटीस/आमंत्रणपत्र पोहचण्यासाठी प्रयत्न करावेत. यासाठी खरेदी विभागाच्या संकेतस्थळावर तसेच नोटीस बोर्डावर नोटीस/आमंत्रणपत्र प्रसिध्द करण्यात यावे. तसेच विभागाकडे असलेल्या विक्रेत्यांना ई-मेल/पत्राद्वारे कळविणेत यावे.
क)	नोटीस प्रसिध्द केल्यापासून किमान १ आठवड्याचा कालावधी दरपत्रक सादर करण्यासाठी देण्यात यावा.
ड)	प्रत्येक निविदाकारास फक्त एक दरपत्रक देण्याची परवानगी असेल.
ई)	शक्यतोवर जीएसटी नोंदणीकृत पुरवठादाराकडून दरपत्रके मागविण्यात यावी. जीएसटी क्रमांक लागू नसल्यास तत्सम प्राधिकरणाकडील नोंदणी क्रमांक असलेल्या निविदाकाराच्या लेटरहेडवर दरपत्रक घेण्यात यावे. निविदाकारांना पॅनकार्ड नोंदणी आवश्यक असेल.
फ)	विहित दिनांकास व ठिकाणी वेळेवर दरपत्रके उघडण्यात यावीत. निविदाकारांचे प्रतिनिधी उपस्थित असतील तर त्यांची हजेरी पत्रकावर स्वाक्षरी घेण्यात यावी.
ग)	नोटीसीतील नमुद अटीच्या आधारे निविदाकारांच्या प्राप्त कागदपत्रांची पडताळणी करावी. जे निविदाकार व्याप्ती आणि अटीची पुर्तता करत नसतील त्यांना अपात्र ठरविण्यात यावे. त्याची कारणे नमुद करावी.
ह)	पात्र निविदाकारांनी सादर केलेल्या दरामधील न्युनतम दराचा (एल-१) आधार घेण्यात येईल.

अभियानांतर्गत लेखापरिक्षण पद्धती

प्रकल्पांतर्गत प्राप्त निधीतून होणा-या विनियोजनावर सनियत्रण राहण्याच्या तसेच अंतर्गत वित्तीय व्यवस्थापन बळकटीकरण करण्याच्या दृष्टीकोनातून केंद्र शासनाच्या मार्गदर्शक सुचनानुसार वेळोवेळी लेखापरिक्षण होत असते .

लेखापरिक्षणाचे प्रकार

- दर तिमाहीस समवर्ती लेखापरिक्षण
- अभियानांतर्गत वार्षिक वैधानिक लेखापरिक्षण
- रुग्ण कल्याण समित्यांचे वार्षिक वैधानिक लेखापरिक्षण
- महालेखाकार लेखापरिक्षण पथकाकडून वेळोवेळी होणारे लेखापरिक्षण

समवर्ती लेखापरिक्षण

समवर्ती लेखापरिक्षण हे अभियानांतर्गत वित्तीय व्यवस्थापन बळकटीकरणाचे माध्यम आहे. या लेखापरिक्षणांच्या माध्यमातून लेखे कसे ठेवण्यात यावेत, लेख्यांमध्ये / वित्तीय विवरणपत्रांमध्ये कोणत्या चुका आहेत, कोणत्या खर्चावेळी विहित प्रक्रियेचा अवलंब झालेला नाही इ. बाबी वेळीच निदर्शनास येतात व त्यामध्ये आवश्यकत्या सुधारणा करून भाविण्यात अपहार टाळण्यास मदत होते तसेच, लेखा हाताळणा-या मनुष्यबळास लेखा विषयक बाबींचे प्राथमिक मार्गदर्शन देखील मिळते. यास्तव, समवर्ती लेखापरिक्षणाचे कव्हेरेज जास्तीत जास्त आहे. यासाठी दर तिमाहीस लेखा परिक्षक लेखापरिक्षणासाठी हजार राहण्यापूर्वी सर्व लेखे अदयावात असणे बंधनकारक आहे. समवर्ती लेखापरिक्षण अहवालातील लेखा परिच्छेदांची उत्तरे वेळीच न दिल्यास किंवा निकाली न निघाल्यास त्याची पुनरावृत्ती वैधानिक लेखापरिक्षण अहवालामध्ये होण्याची शक्यता असते. त्यामुळे अहवालातील नमुद त्रुटींचा अनुपालन अहवाल पुढील तिमाहीच्या लेखापरिक्षणवेळी लेखापरिक्षकांना दाखवण्यात येवून नमुद लेखा आक्षेप निकाली काढण्यात यावे. जेणे करून प्रलंबित लेखा परिच्छेदांचे प्रमाण वाढणार नाही.

अभियानांतर्गत वार्षिक वैधानिक लेखापरिक्षण

केंद्र शासनाच्या मार्गदर्शक सुचनांस अनुसरून वार्षिक वैधानिक लेखापरिक्षण करून संपूर्ण राज्याचा एकत्रित वैधानिक लेखापरिक्षण अहवाल केंद्र शासनास सादर करणे बंधनकारक असते. संपूर्ण राज्याकरिता एकाच वैधानिक लेखापरिक्षकांची नियुक्ती होत असल्याकारणाने या लेखापरिक्षणाचे कव्हेरेज केवळ ४० टक्के असते त्यामुळे, राज्यभरातील प्रत्येक संस्थेन समवर्ती लेखापरिक्षणावेळी लेखा तपासणी करून घेणे बंधनकारक करण्यात आलेले आहे. संपूर्ण राज्याचा एकत्रित लेखापरिक्षण अहवाल केंद्र शासनास पाठवावयाचा अंतिम दिनांक ३० जुलै असल्याकारणाने राज्यभरातील प्रत्येक तालुके / जिल्हा शल्य चिकित्सक कार्यालयाची वर्षाअखेरीची वित्तीय विवरणपत्रे ३० एप्रिल पुर्वी पुर्ण होवून जिल्हास्तरावर सादर होणे अपेक्षित आहे. जेणेकरून संपूर्ण जिल्ह्याचा एकत्रित अहवाल २० मे पूर्वी राज्य कार्यालयास प्राप्त होईल आणि राज्यस्तरावरून जिल्हानिहाय वित्तीय विवरणपत्रांचा ताळमेळ करून ३० जुन पुर्वी संपूर्ण राज्याची एकत्रित वित्तीय विवरणपत्रे तयार करून वैधानिक लेखापरिक्षकांना तपासणीस्तव सादर करणे शक्य होईल आणि वैधानिक लेखापरिक्षकांची तपासणी होवून प्रमाणित वित्तीय विवरणपत्रांचा संच केंद्र शासनास ३० जुलै पुर्वी सादर करणे राज्य कार्यालयास शक्य होईल. यासाठी प्रत्येक संस्था स्तरावरून विहित वेळेच्या मर्यादा पाळणे बंधनकारक आहे.

वैधानिक लेखापरिक्षण अहवालातील नमुद त्रुटींचा अनुपालन अहवालत्वरीत लेखापरिक्षकांना सादर करून हे आक्षेप निकाली काढणे देखील तितकेच महत्वाचे आहे. अन्यथा या अहवालातील प्रलंबित लेखा परिच्छेदांची पुनरावृत्ती महालेखाकार लेखापरिक्षण पथकांच्या अहवालामध्ये होण्याची शक्यता असते. यास्तव, वैधानिक लेखापरिक्षण अहवालातील नमुद त्रुटींचा अनुपालन अहवाल त्वरीत सादर करणे व ते निकाली काढून घेणे अनिवार्य आहे.

रुग्ण कल्याण समित्यांचे वार्षिक वैधानिक लेखापरिक्षण

रुग्ण कल्याण समित्यांची स्थापना ही धर्मादाय अधिनियमांतर्गत होत असल्याने रुग्ण कल्याण समितीस आर्थिक वर्षात प्राप्त झालेला निधी व त्यातून केलेल्या विनियोजनाची वर्ष अखेरची वित्तीय विवरणपत्रे सनदी लेखा परिक्षकांकडून प्रमाणित करून घेवून संबंधित जिल्हास्तरीय धर्मादाय आयुक्त कार्यालयास सादर करणे बंधनकारक असते. यासाठी वेळोवेळी सर्व लेखे व वित्तीय विवरणपत्रे अदयावात करून ठेवणे बंधनकारक आहे. जेणेकरून लेखा परिक्षण वेळी त्वरीत उपलब्ध करून देणे सहज शक्य होते. लेखा परिक्षण झाल्यानंतर प्रमाणित अहवालाची प्रत जिल्हास्तरीय धर्मादाय आयुक्त कार्यालयास सादर करावा तसेच अहवालातील नमुद त्रुटींचा अनुपालन अहवाल संबंधित लेखा परिक्षकांस सादर करून आक्षेप निकाली काढून घेण्यात यावेत.

महालेखाकार लेखापरिक्षण पथकाकडून वेळोवेळी होणारे लेखापरिक्षण

प्रकल्पासाठी प्राप्त होणारा निधी हा शासन निधी असल्याकारणाने त्यावर शासनाचे सनियंत्रण राहणे क्रमप्राप्त आहे त्यामुळे केंद्र शासनाकडून **C&AG** पथकामार्फत तसेच राज्य शासनाकडून **AG** पथकामार्फत वेळोवेळी लेखा तपासणी केली जाते. सदरच्या महालेखाकार लेखापरिक्षण पथकाकडून लेखापरिक्षण वेळी उपस्थित केलेल्या **Half Margin** ची उत्तरे त्याच वेळी तात्काळ स्वरूपात देणे बंधनकारक असते. तसेच, पथकाने दिलेल्या **Full Margin** ची उत्तरे पुढील १० ते १५ दिवसात आवश्यक त्या कागदापत्रांसह सादर करणे बंधनकारक असते. जेणेकरून महालेखाकार पथकाकडून सदरचे आक्षेप वेळीच निकाली काढणे सोईचे होते. लेखापरिच्छेदांची उत्तरे वेळेत व आवश्यक त्या कागदपत्रांसह सादर न झाल्यास असे लेखा आक्षेप राज्याच्या लोक लेखा समिती (Public Accounts Committee) पुढे सादर केले जातात. सदर प्रकरणाचे गांभीर्य लक्षात घेवून प्रत्येक संस्थास्तरावरून महालेखाकार लेखापरिक्षण पथकाकडून उपस्थित केलेल्या लेखापरिच्छेदांची उत्तरे त्वरीत सादर करून संबंधित लेखापरिक्षकांकडून मान्य करून / निकाली काढण्यात यावेत.

आर्थिक बाबीचे विविध नमुने (Refer Annexure 7.3 (Vol. I))

7.13 Preparation of Pip and District Health Action Plan

At the end of this Session Participant will be able to learn

- Planning process in NHM
- Levels of planning
- Framework for Dist Health Action plan (DHAP)
- Back ground work required for PIP

District Health Action Plan:

Planning: It is the orderly process of defining community health problems, identifying unmet needs and surveying the resources to meet them. It is necessary for economic utilization of material, manpower and financial resources. Purpose of health planning is to improve the health services. It is the continuous process of gathering data, data analysis, making decisions and forming strategic activities for future action all aimed at achieving programme goals.

It focuses on:

- Effective utilization of resources to achieve desired objectives & goal
- Minimum resources –Maximum output
- Blue print for taking action
- To deliver the comprehensive health services to the community.
- Planning is for tomorrow and Management is for today

Planning Process Identify goals, objectives, the organization

- Formulates strategies to achieve them
- Arrangement of resources
- Identifies SWOT
- Integrating SWOT in strategic interventions
- Implementation, direction, monitoring and evaluation

Planning helps to know: Where we are, where we are going, where we want to go and how we will go.

Resources: It implies manpower, money, materials, skills, knowledge, technologies and time needed or available for the performance or support of action directed towards specified objectives.

Objective: An important element of planning is the setting of clear-cut objectives, targets and goals. It is either achieved or not achieved. Objectives should be

- Precise end result of planning
- Concerned directly with the problem
- Timebound
- Measurable (OVI)
- May or may not be achieved
- Measured by Evaluation of program
- Objectives are the lifeblood of organization
- Give direction to organization

Objectives should be: SMART

- S - Specific
- M - Measurable
- A – Achievable
- R – Realistic
- T –Timebound

Targets: refers to the discrete activity which meets the concept of degree of achievement. Targets are thus concerned with the factors involved in a problem, whereas objectives are concerned directly with the problem itself. It is the tool for monitoring the process/activities

Goal: Ultimate desired state to which objectives & resources are directed.

Programme

- Sequence of activities to achieve defined objectives

Policy

- Guiding Principles, direction, fixing the goal & broad objectives, allocation of funds.

Steps to Prepare District Action Plan:

Step 1: Analysis of the health situation

The first step is analysis of health situation. It involves collection, assessment and interpretation of information in such a way as to provide a clear picture of the health situation. Baseline data needed for preparing of health plan contains

- Demographic profile
- Population structure – age, sex, urban/rural, sex ratio, growth rate, Literacy rate etc.
- Morbidity & mortality statistics- CBR, CDR, Disease specific Mortality ratio, MMR, IMR
- Epidemiology of different diseases --Geographic, population, seasonal distribution (place, person & time)
- Health Care Facilities... Public &private Hospitals, PHCs, SC, Anganwadi.
- Other sectors- PRIs, educational facilities
- Manpower – Technical Author Training status, training centres
- Socio-cultural: Socioeconomic status, customs & taboos, beliefs & practices

This data can be obtained from census results, births, deaths & marriages register, MIS, hospital records, model registration scheme, NFHS, special surveys and epidemiological studies.

Step 2: Identifying the health problems

- This can be done by tabulation and Analysis of the data, Interpretation of data like rates, ratios, incidence, prevalence, disease specific mortality rate, Infrastructure, adequacy of manpower,
- Compare with national, state, other districts
- Identify health problems which have more impact on overall health of community

Step 3: Establishing objectives

Objectives and goal are needed to guide the efforts. Objectives must be established at all the levels. In setting these objectives, time and resources are important factors. These are not only a guide to action, but also a yard stick to measure work after it is done. Objectives must be

- Related To the identified health problem
- Main Objective
- Sub-objectives if any
- When will be achieved

Step 4: Assessment of resources

Resources Implies the manpower, money, materials, skills, knowledge and techniques needed or available for the implementation of the plan. Even if shortage, try to make plan with available resources. Prepare plan to make available the deficit resources.

Step 5: SWOT Analysis

SWOT denotes Strength, Weakness, Opportunities and Threats. Strengths indicate attributes of person or organization or factors that are helpful in achieving the objectives. Weaknesses are the attributes of person or organization or factors that are harmful in achieving the objectives. Opportunities are external conditions, circumstances or situations; those are helpful in achieving the objectives and are conducive to organization's flourishing and growing further. Threats are external conditions which could do damage to the objectives and which may hinder the growth and development of organization.

The analysis involves internal factors like, human resources, their level of dedication, motivation, training etc; availability of material and financial resources; partnership and alliances with other organizations; public image; etc. External factors include the social or cultural environment of operation, attitude towards issues involved, etc.

Step 6: Fixing Priorities

Priorities are fixed in order of gravity of health problems. In fixing priorities attention is given to risk of mortality, magnitude, morbidity, Severity of complication, residual damage, social stigma, risk of epidemics. In respect to resources available, political & community interests.

Step 7: Alternate Plan

Alternate plan should always be prepared. It should be cost effective. It is useful in case the resources are not provided intime. Consider That current available resources will not be available in future; like Manpower: long Leaves, transfers retirement etc. Material: cost may increase in future.

Step 8: Write up formulated plan

Plan must be complete in all respects for the execution of project. Write up Detailed Strategies. Enumerate Various activities. i.e. Who will perform particular activity? Where the activity will be performed, who will supervise? Materials required, when it will be completed? Cost of that activity, how much (target) will be achieved?

Step 9: Programming & Implementation

Once the health plan has been approved by the policy making authorities, programming and implementation are begun. It includes appropriate selection of manpower, training, fixing the job responsibilities, defining roles & tasks, fixing the area, organising extra activities in sensitive, uncovered, underserved areas, unmet needs. Ensure regular supply of materials and enhance efficiency by Motivation, supervision, Communication.

Step 10: Monitoring

It is day today follow-up of activities during their implementation to ensure that they are proceeding as planned and are on schedule. It is continuous process of, recording, reporting & observing (MIS) weekly, monthly as per the case. Define various indicators for monitoring the activities. Observe whether activities proceeding as per plan & schedule, targets being achieved or not. If excessive deviation found, identify the factors to take corrective measures immediately. Apply managerial skills.

Step 11: Evaluation

Evaluation is an important component of planning. It is assessment of the achievement of objectives at appropriate intervals. It is needed to see whether programme is accepted by the community, whether it is cost effective. Evaluation should preferably be done by third party to eliminate Bias. Corrective actions are suggested based on findings in evaluation and suggestions are incorporated. It helps in Re-planning.

Key Strategy or Instrument: District Health Plan Decentralized Action through District Plans
The Planning Process in NRHM

- District Health Plans are to be prepared by an aggregation and consolidation of Village Health Plans. Block Plans will be the basis for the District Plan.
- This requires setting up of planning teams and committees at various levels –Habitation/Village, Gram Panchayat (SHC), PHC (Cluster level), CHC/Block level, District level. At Village, PHC and Block levels, broadly representative committees would perform both planning and ongoing monitoring functions. A similar committee at District level would be involved in reviewing plans, based on drafting by the specialized district planning team. The monitoring and planning committee at State level would be supported by a State health planning cell a similar cell being required at the State and National level to provide support as needed.
- Besides large scale consultations, planning teams have to conduct household surveys, help select ASHAs, organize training for community groups and health functionaries. NGOs have a role in the entire planning process.
- Orientation of planning team and contractual engagement of professionals as per need has to be the starting point for the planning process.
- Village Health Plans are likely to take time and therefore District, Block and Cluster level consultation may have to form the basis for initial District Plans. The Initial plans could be adhoc and for a year. The perspective plans must be on the basis of Village Health Plan. Even then, Block will be the key level for development of decentralized plans.

Levels of planning and the key functionaries

- Village level Health and Sanitation Committee will be responsible for the Village Health Plans. ASHA, the Aanganwadi Sevika, the Panchayat representative, the SHG leader, the PTA/MTA Secretary and local CBO representative will be key 47 persons responsible for the household survey, the Village Health Register and the Village Health Plan.
- The Gram Panchayat Level Health Plans, comprising a group of villages in many states and a single village in a few, will be worked on at the Sub Health Centre Level. The Gram Panchayat Pradhan, the ANM, the MPW, a few Village Health Sanitation Committee representatives will be responsible for the

Gram Panchayat Health Plan. They will also be responsible for over view and support for the household survey, preparation of Village Health Registers and preparation of Village Health Plans- the Gram Panchayat /SHC level would also organize activities like health camps to facilitate the planning process.

- The Cluster level will be led by the PHC/Additional PHC. Ordinarily there will be 1-4 Clusters in a Block. The PHC Health monitoring and planning committee will facilitate planning inputs of Panchayat representatives, along with other inputs from the community to formulate a broad plan. In this context the Medical Officer in charge of PHC will work in close coordination with the Pradhan/s of the Gram Panchayat/s covered in that Cluster. The Cluster level would be responsible for over viewing the work of Gram Panchayat/s and for organizing surveys activities through the SHCs.
- The Block/CHC level monitoring and planning committee will review the Block Health Plan. The Adhyaksha of the Block Panchayat Samiti, the Block Medical Officer, the Block Development Officer, NGO/CBO representative, head of the CHC level Rogi Kalyan Samiti will be key members of this team. Additional social mobilization professionals and planning resource persons will also be contracted at the Block level to develop a good Resource team at that level. The Block level Health Mission Team will finalize the Block Health Plans. The Block Health Teams would also supervise household and health facility surveys. They would also organize public hearings and health camps in order to make the planning process activity intensive.
- The District Level Health Mission will have a Health monitoring and planning committee responsible of providing overall guidance and support to the planning process. A draft plan will be formulated by the District Health Team, and presented for discussion to the broader committee. After relevant discussion and modifications in the committee, the district plan will be finally streamlined by the District health team, which, besides a few existing government functionaries, the District Health Teams will also have NGO representatives and a few professionals specially recruited to meet planning and implementation needs. The District Planning team will be responsible for household Surveys and Health Facility surveys. They would also facilitate organization of health camps and public hearings in order to make the planning process activity intensive. The Zila Parishad Adhyaksha, the District Medical Officer, the District Magistrate will key functionaries of the District Team. Every district health society would be assisted by a technical support agency, which they can choose from a number of options.
- The State Level Health Mission will have a State Health monitoring and planning committee to give overall guidance to the planning process. The State Resource Centre/Planning Cell will propose the draft plans to the Committee. After relevant discussion, the State Resource Centre / Planning Cell will finally streamline the plans as part of its resource support. The Resource Centre/Planning Cell will have to supervise the work of all the District Health Missions by scrutinizing and providing feedback on the plans so that adequate quality of plans and processes are ensured. The State Resource Center will also finalize survey formats and formats for preparation of plans at various levels. It will also finalize with guidance and directives from the ministry, the criteria for prioritization and indication of resources likely to be available for each Block and convey these to the district these details as also help develop the financial norms in conformity with these guidelines and on the basis of inputs from Blocks and Districts.

The basis for Annual Work Plans and Perspective Plans

- The Annual Plan will be based on resource availability and a prioritization exercise.
- As far as possible, States should let districts know by October of the resources likely to be available in the coming financial year.
- The District should dis-aggregate likely budget availability on the basis of needs at village/cluster/block levels by November. The Village, Gram Panchayat, Cluster & Block Plans should come to district based on a prioritization exercise.
- The District Health Mission Society will recommend the Annual Work Plan and Budgets and the Perspective Plan to the State level Health Mission under the Chief Minister.

Essential requirements for preparation for Village, Block, and District Health Plans

- Constitution of planning team and committees with clearly demarcated responsibility at each level.
- Engagement of professionals on contract at State, District and Block level urgently to meet planning needs.
- Broad norms for planning activities. Some idea on what is to be taken up and the space for diversity and innovations.

- Preparation of training modules for planning teams, and finalization of survey format for household survey, Family Health Cards, Village Health Register, mapping of non-governmental providers, and Health facility surveys.
- Survey of non-governmental health providers to assess their possible role in the District Health Plan.
- Organization of large scale activities like health camps, Public hearings to make the planning process activity intensive.
- Involvement of Women's groups and Community based organizations in planning activity.
- Release of untied grants to SHCs/ Gram Panchyats to facilitate activities.
- Recruitment and relevant training of ASHAs/ANMs.
- Orientation of existing health department functionaries on new ways of working.
- Convergent local action along with other departments.

The format for household and facility surveys may be seen at Annexure- 7.1 and 7.2 (Vol. I). As will be evident, these surveys are planning and monitoring instruments and not for any national reporting system. The intention is to use the household and facility surveys to construct a base line and to make annual plan for each health facility with a clear assessment of financial and human resources and clear commitments of service guarantees.

Framework for District Action Planning

The following framework for assessing the present situation is proposed:

- **Resources:** Including Health human power, logistics and supplies; Community resources and Financial resources, Voluntary sector health resources
- **Access to services:** including public and private services and informal health care services; also look at levels of integration of services within public health system
- **Utilisation of services:** including outcomes, continuity of care; factors responsible for possible low utilization of public health system
- **Quality of Care:** including technical competence, interpersonal communication, client satisfaction, client participation in management, accountability and redressal mechanisms
- Community needs, perceptions and economic capacities, PRI involvement in health, existing community organizations and modes of involvement in health
- Socio-epidemiological situation: Local morbidity profile, major communicable diseases and transmission patterns, health needs of special social groups (e.g. adivasis, migrants, very remote hamlets)

Broad outline of Planning process

- District health planning is viewed as an iterative and two-way process, where District planning teams provide overall planning framework and financial parameters, along with arranging training inputs for the Block and Village planning teams. The Village teams would need to develop draft plans to be collated and approved at the Block level. Similarly Block plans would be collated and approved at the district level.
- It is desirable as the ongoing model of planning, for such a process to build upwards as Village health plans - Block health plans - District health plan. However, this would not be possible in a full-fledged manner in the first year, since formation and orientation of planning capable bodies at Village and Block levels will take time.

Background work required for PIP

The starting point of PIP would be the RoP/approvals for current year PIP [Main and supplementary (if any) and progress both physical and financial against the approvals (State as well as district wise). State level Programme Divisions as well as districts should be asked to reassess the approval for current year PIP and list down the changes required in next year PIP. States along with their districts should assess the progress, both physical and financial, made till November every year against the approvals given in current year and fill up the required Annexure in the excel sheets and upload as part of the PIP in the relevant sections. PIP would be a consolidated PIP of districts and the State. The District Health Action Plans (DHAPs) would have to be prepared and uploaded by the districts. The approved DHAPs would be consolidated at the state level and sent to MoHFW. The process of forwarding PIPs to the next level has been explained in the User manual for the PIP software.

PIP

PIP would consist of two types of activities:

- **Continued /Existing Activities**

Based on the feedback of the Programme Divisions and the districts, State may propose the same budget and activities as approved in current year, or propose changes which would fall in three categories:

Discontinuation of an activity: no budget required

- Increase in budget: change would be either be in number of units or cost per unit
- Decrease in budget: changes are likely to be in number of units and in some cases cost per unit. The changes required are to be clearly mentioned in the budget sheet and its explanation is to be provided in the remarks column.

- **New Activities**

For all new activities the norms laid down in manual of PIP of current year would apply. The State should clearly mention new activity' in the comments column and upload the justification sheet in the software. The State should provide a brief description, rationale, data/ background information required to appraise the proposal and budget breakup for each new activity (as shown in exhibit). New activities should also address the priorities set for next year (see below).

JUSTIFICATION SHEET: NEW ACTIVITY

- FMR code:
- Activity Proposed:
- Name of the Activity:
- Justification:
- Deliverables:
- Funding Proposed:

No of Units*	Cost per unit	Total Cost

*Note** - Attach separate sheet for the detail components and tentative cost of each component e.g. if Labour Rooms are to be created - unit cost of the LR should be indicated, however if different components of LR are to be strengthened, then their tentative cost should be annexed.

Priorities of next year

It is expected that next year PIP would apply health systems approach to all activities proposed and ensure both effectiveness and efficiency. The PIP should address the following key priorities such as:

- Roll out of NHM Free Drugs Service Initiative including strengthening of basic lab, drug warehouses, IT systems for drug logistics and supply chain
- Operationalization of FRUs including Blood banks (Blood storage units)
- Quality Assurance Systems
- Kayakalp
- Group/Team based incentives at Sub-Centre/PHC (for primary care)
- Comprehensive primary care including UHC pilots
- Grievance Redressal mechanism
- Haemoglobinopathies
- State level Innovation

Innovation

Upto a maximum of 10% of the health systems strengthening budget (Mission Flexipool and NUHM) may be proposed for innovations. Please note that this is part of the overall budget envelope. The budget for innovation is to be proposed under B.14 for Mission Flexipool and budget head 7 for NUHM. Any activity already budgeted/approved under innovation would continue to be budgeted under these FMR codes and would be included in calculation of 10% innovation funds. It is expected that the States would use the flexibility and budget to come up with innovative and sustainable solutions for state specific /local needs. The innovations/projects should ideally have a baseline and must be independently evaluated after 1 ½ - 2

years' of implementation.

The innovations budget **cannot** be utilized for:

- Purchase of vehicles
- Support / Class 4 staff. Any HR required (service delivery/ Programme management) is to be budgeted under A.8 and A.10 respectively of NRHM & RMNCH+A Flexipool, and under appropriate budget heads of NUHM.
- Any cost already budgeted /covered under some other budget head in NHM (No double budgeting)
- Any activity already disapproved
- Infrastructure exceeding 33% of budget under NHM State must ensure that the activities are budgeted under correct budget heads and F.M.R codes. In case there is more than one F.M.R code with similar activity, a logical decision must be taken to budget the activity under the broad budget head which is closest to it and reflects the actual nature of the activity. Guidance may also be sought from the Director/Deputy or PIP process.

Key points to remember

- Planning process
- Constitution of village, block and dist. Level planning team and committees
- PIP consist two types of activities- continued / existing and new activities
- 10% of mission flexipool may be proposed for new activities

Reference:

1. Constitution of Rugna Kalyan Samiti- (Hospital Management Committee) GRNo. NRHM 2005/ 744/ CR -426/ PH-6 Date- 30th December, 2005
2. Corrigendum No. NRHM 2008/ 744/ CR-426/PH-6 Date- 4th May 2006
3. Government addendum No. NRHM 2005/ 744/ CR-426 / PH6, Date- 9th January 2007
4. Constitution of Rugna Kalyan Samiti- (Hospital Management Committee) In Primary Health Centers GR No. NRHM 2005/ 744/ CR -426/ PH-6 Date- 31st January, 2007
5. RKS Involvement in MLA/ MLS Letter No.राग्राआ २००८/ प्रक्र ९०/ आरोग्य- ७ अ, दि. १ जुलै, २००८
6. RKS Chairperson in GB Block Development Officer- Corrigendum No. NRHM 2007/ CR NO. 44/ PH7A, Date - 28 July 2009.
7. RKS Revised Structure GB (Hospital Management Committee) शासन निर्णय क्र. एनएचएम ११२०/ प्र.क्र ७८/ आरोग्य- ७, दि. २६ ऑगस्ट, २०२०
8. User Charges deposit to RKS Account in Institute level शासन निर्णय क्र. एनएचएम ११२०/ प्र.क्र ८३/ आरोग्य- ७, दि. २८ जुलै, २०२१

PHC Manual Annexure QR Code

Chapter	Topic	Link	QR Code
Volume I			
Section 1 (Vol I): Background (No Annexures)			
Section 2 (Vol I): Scope and Objectives of Primary Health Centre			
Annexure 2.1 (Vol I)	Different Format for Monitoring of PHC Activities	https://drive.google.com/file/d/1BZIAZS8wbCxu0WbqXntI_1ZLIL_EZ1zZC/view?usp=sharing	
Annexure 2.2 (Vol I)	NQAS Certification criteria and checklist refer NHSRC website and other resource material	https://www.nhsrcindia.org/search/node?keys=NQAS	
Annexure 2.3 (Vol I)	Guidelines for Certification of Public Health Facility under NQAS NHSRC website:	https://qps.nhsrcindia.org/sites/default/files/2021-05/Guidelines%20for%20Certification%20of%20Public%20Health%20Facilities%20based%20on%20NQAS%20%281%29_0.pdf	

Annexure 2.4 (Vol I)	Certification Process under NQAS refer NHSRC website:	https://qps.nhsrcindia.org/sites/default/files/2022-09/Certification%20at%20HWC.pdf	
Section 3 (Vol I): PHC Administration			
Annexure 3.1 (Vol I)	Types of Leave	https://drive.google.com/file/d/1pWV2EecyGefOPXiKdQzVLGrAR5LhBA7w/view?usp=sharing	
Annexure 3.2 (Vol I)	Job Responsibilities of PHC functionaries	https://drive.google.com/file/d/1RPj4v72OGjm-50zBCrFxAO0ubLJvneck/view?usp=sharing	
Annexure 3.3 (Vol I)	Registers to be kept at PHC	https://drive.google.com/file/d/1TYaT23dO_5-wixHSesd8vO3yixJnj3rU/view?usp=sharing	
Section 4 (Vol I):: Information Education and Communication (IEC)			

Annexure 4.1 (Vol I)	The list of important health days	https://drive.google.com/file/d/1bIZcFhdphVJ4CaAuxbigF9h0q4TFdFJp/view?usp=sharing	
Section 5 (Vol I): Health Information System			
Annexure 5.1 (Vol I)	Calculation of fertility indicators	https://drive.google.com/file/d/1zTJNhpKMNP8AH-D70Y2Ep7O5wkmbHtRy/view?usp=sharing	
Annexure 5.2 (Vol I)	Calculation of MYP mid-year population	https://drive.google.com/file/d/1F9gVq6h5-LYI5C4NKPQrZmY0E4yoyaoT/view?usp=sharing	
Annexure 5.3 (Vol I)	Important Software	https://drive.google.com/file/d/1XuasKoxWmiG6P_cEc8pKIGCVAp04gdG/view?usp=sharing	

Annexure 5.4 (Vol I)	State Standard Drug List State Consumable list	https://drive.google.com/file/d/1fDPnNBjYE68irpDwtoPC1vEGfSmOE4Yf/view?usp=sharing	
Section 6 (Vol I): Medico Legal Aspects			
Annexure 6.1 (Vol I)	Medico-Legal Certificates & other Formats	https://drive.google.com/file/d/1-t5NjeHbslJbcMwX13zq4aJxSO62IkVG/view?usp=sharing	
Annexure 6.2 (Vol I)	Brief comparison of IPC and BNS 2023	https://drive.google.com/file/d/1yCEJkA0OV0xEOmMeXwx-sxxJdorwFIG2/view?usp=sharing	
Annexure 6.3 (Vol I)	Medico-legal care for survivors victims of Sexual violence	https://drive.google.com/file/d/1Rhp83IZy3-QWshRMQ8AAAnJsYFgJTzPr/view?usp=sharing	

Annexure 6.4 (Vol I)	Medico-Legal Examination Report of Sexual Violence	https://drive.google.com/file/d/1hMKQLkIxdOGTFphYrdKq_m0qLcsEsTS6/view?usp=sharing	
Section 7 (Vol I): National Health Mission			
Annexure 7.1 (Vol I)	Sample Village Health Information Format	https://drive.google.com/file/d/1drV14A3nbzOxxVSo7S5AILgR5tzPKl_X/view?usp=sharing	
Annexure 7.2 (Vol I)	Sample Format for PHC Facility Survey	https://drive.google.com/file/d/1mnpSc42DTdmGgp90sPxmF014mSiGSijn/view?usp=sharing	
Annexure 7.3 (Vol I)	Financial Formats	https://drive.google.com/file/d/1TizdsBHeOtwsNvN_f6EW5n4vQcZJ8a1t/view?usp=sharing	

Abbreviations Vol I

AAA	Asha, Anganwadi Sevika, ANM
AAM	Ayushman Aarogya Mandir
AFHS	Adolescent Friendly Health Services
AHD	Adolescent Health Day
AMTSL	Active Management of Third Stage of Labor
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
APH	Ante Partem Haemorrhage
ARS	Anti-Rabies Serum
ARSH	Adolescent Reproductive and Sexual Health
ART	Assisted Reproductive Techniques
ASHA	Accredited Social Health Activist
ATP	Advanced Tour Program
ATR	Action Taken Report
AV	Audio-Visual
AVSR	Annual Vital Statistical Report
AW	Anganwadi
AWC	Anganwadi Centre
AWH	Anganwadi Helper
AWS	Anganwadi Supervisor
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
BCC	Behaviour Change Communication
BCM	Block Community Mobilizer
BMW	Bio-Medical Waste
BNS	Bhartiya Nyaya Sanhita
BPL	Below Poverty Line
BRS	Bank Reconciliations
CA	Chartered Accountant
CAFO	Chief Accounts and Finance Officer
CBO	Community Based Organisation
CBR	Crude Birth Rate
CC	Conventional Contraceptives
CDPO	Child Development Project Officer
CEO	Chief Executive Officer
CHC	Community Health Centre
CHO	Community Health Officer
CHV	Community Health Volunteer
CL	Casual Leave

CPHC	Comprehensive Primary Health Care
CR	Confidential Report
CRS	Civil Registration System
CS	Civil Surgeon
DBT	Direct Benefit Transfer
DCPS	Defined Contribution Pension Scheme
DDO	Drawing and Disbursing Officer
DEC	Diethyl Carbamazone Citrate
DH	District Hospital
DHAP	District Health Action Plan
DHIS	District Health Information System (Software)
DHO	District Health Officer
DHS	Directorate of Health Services
DMC	Designated Microscopic Centre
DMO	District Malaria Officer
DOT	Direct observation of treatment
DOTS	Directly Observed Treatment Short-course
DPDC	District Planning and Development Committee
DQAC	District Quality Assurance Committee
Dy. CEO	Deputy Chief Executive Officer
EDD	Expected Due Date
EDD	Expected date of delivery
EDTA	Ethylenediamine tetraacetic acid
EL	Earned Leave
ELA	Expected Level of Achievement
EMS	Emergency Medical Services
EPC	Empowered Programme Committee
EPD	Expected Place of Delivery
EPD	Expected Place of delivery
EPR	Emergency police register
EVIN	Electronic Vaccine Intelligence Network
FP	Family Planning
FRU	First Referral Unit
FSL	Forensic Science Laboratory
FW	Family Welfare
GAD	General Administration Department
GIS	Group Insurance Scheme
GNM	General Nursing and Midwifery
GP	Gram Panchayat

GPF	General Provident Fund
GR	Government Resolution
GRR	Gross Reproduction Rate
HA	Health Assistant
HACC	Health Advice Call Centre
HC	Head Constable
HE	Health Education
HMIS	Health Management Information System
HQ	Head Quarter
HRA	House Rent Allowance
HRMS	Human Resource Management System
HWC	Health and Wellness Centre
ICDS	Integrated Child Development Scheme
ICTC	Integrated Counselling and Testing Centre
IDSP	Integrated Disease Surveillance Programme
IFA	Iron Folic Acid
IHIP	Integrated Health Information Platform
ILR	Ice Lined Refrigerator
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
IPC	Interpersonal Communication
IPD	In Patient Department
IPHS	Indian Public Health Standards
ISM	Indian System of Medicine
IU	International Unit
IUD	Intrauterine Device
JAS	Jan Arogya Samiti
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
LBW	Low Birth Weight
LHV	Lady Health Visitor
LPC	Last Pay Certificate
LR	Labour Room
LWP	Leave Without Pay
MAM	Moderate Acute Malnutrition
MAS	Mahila Arogya Samiti
MCCD	Medical certification of cause of death
MCH	Maternal and Child Health
MCPC	Mother and Child Protection Card
MCS	Mobile Communication System
MCSR	Maharashtra Civil Services Rules

MCTFC	Mother and Child Tracking Facilitation Centre
MCTS	Mother and Child Tracking System
MDA	Mass Drug Administration
MDR	Multi-Drug Resistant
MEMS	Maharashtra Emergency Medical Services
MIS	Management Information System
MLC	Medico Legal Case
MLEC	Modified Leprosy Elimination Campaign
MLHP	Mid-Level Health Provider
MMDP	Morbidity management and Disability Prevention
MMP	Mission Mode Project
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MPW	Multi Purpose Worker
MR	Measles-Rubella
MRS	Modal Registration Scheme
MS	Medical Superintendent
MTP	Medical Termination of Pregnancy
MYP	Mid Year Population
NACP	National AIDS Control Programme
NAM	National AYUSH Mission
NBCC	Newborn Care Corner
NFHS	National Family Health Survey
NHM	National Health Mission
NHSRC	National Health Systems Resource Centre
NIC	National Informatics Centre
NLEP	National Leprosy Eradication Program
NPCB	National Program for Control of Blindness
NPCBVI	National Programme for Control of Blindness and Visual Impairment
NPCC	National Programme Coordination Committee
NPCP	National Blindness Control Programme
NPPC	National Programme for Palliative care
NQAS	National Quality Assurance Standards
NRHM	National Rural Health Mission
NRR	Net Reproduction Rate

NTEP	National Tuberculosis Elimination Programme
NUHM	National Urban Health Mission
NVBDCP	National Vector Borne Diseases Control Program
OOPE	Out-of-Pocket Expenditure
OPD	Out Patient Department
ORT	Oral Rehydration Therapy
OT	Operation Theatre
OT Test	Orthotoludine test
PC	Police Constable
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
PF	Provident Fund
PFMS	Public Financial Management System
PH	Public Health
PHD	Public Health Department
PHU	Primary Health Unit
PIP	Programme Implementation Plan
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PNC	Postnatal Care
PNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
POCSO	Protection of Children from Sexual Offences Act
POL	Petrol, Oil, and Lubricants
PPH	Post Partem Haemorrhage
PPI	Pulse Polio Immunization
PPTCT	Prevention of Parent-to-Child Transmission
PRC	Panchayat Raj Committee
PRI	Panchayati Raj Institutions
PS	Panchayat Samiti
PTLA	Part Time Lady Attendant
RBD Act	Registration of Births & Deaths Act
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive and Child Health
RDD	Rural Development Department
RGI	Registrar General of India
RH	Rural Hospital
RIG	Rabies Immunoglobulin
RKS	Rugan Kalyan Samiti
RMNCH+A	Reproductive Maternal Neonatal Child Health & Adolescent Health
RPAD	Registered Post Acknowledgment Due

RPR	Rapid Plasma Reagin
RT	Radical Treatment
SA	Statistical Assistant
SAB	Skilled Attendance at Birth
SABLA	Rajiv Gandhi Scheme For Empowerment Of Adolescent Girls-SABLA Yojana
SAM	Severe Acute Malnutrition
SCD	Survey of Causes of Deaths
SCD-R	Survey of Causes of Death – Rural
SCL	standard Consumable List
SDH	Sub-District Hospital
SDL	State Drug list
SDL	standard Drug List
SHG	Self Help Group
SHTO	State Health Transport Organization
SOAP	Simple Object Access Plan
SRS	Sample Registration System
TA	Travelling Allowance
TCL	Teraphthaloyl Chloride
THO	Taluka Health Officer
UID	Unique Identification
UPHC	Urban Primary Health Centre
URL	Uniform Resource Locator
VAT	Verbal Autopsy Technique
VED	Vital-Essential-Desirable
VHND	Village Health and Nutrition Day
VHNSC	Village Health, Nutrition, and Sanitation Committee
VRS	Vital Rates Scheme
WCD	Women and Child Development Department
WFA	Weight-for-Age
WIFS	Weekly Iron and Folic Acid Supplementation
WMF	Wastage Multiplication Factor
ZP	Zilla Parishad



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