INDUCTION TRAINING FOR NEWLY APPOINTED DOCTORS UNDER KARNATAKA HEALTH SYSTEMS DEVELOPMENT PROJECT

READING MATERILS

Conducted By

STATE INSTITUTE OF HEALTH AND FAMILY WELFARE, BANGALORE-23.

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Director
State Institute of Health & Family Welfare

INDUCTION TRAINING TO NEWLY APPOINTED GOVERNMENT DOCTORS

INDUCTION Training is nothing but the Orientation Training to Doctors to make them aware of the Organisational set up of Department at various levels from State Level to Sub-Centre Level and various activities to be carried out including providing of Medical Care, implementation of various National Health and Family Welfare Programmes and Financial and Administrative responsibilities of Medical Officers of PHCs for effective functioning of the PHC/Department. The Induction Training is most needed for newly appointed Doctors for their smooth and effective functioning.

:OBJECTIVES OF TRAINING:

1. To orient the Doctors regarding the Organisational set up amd functions of Health and Family Welfare Department from State level to Sub-Centre level and their role/responsiblities as a Medical Officer of PHC/PHU.

2. To orient the Doctors regarding the Administrative, Financial and Management responsibilities of Medical Officers so as to carry out smoothly the functions of Medical Officer.

3. To orient regarding, planning, implementation and monitoring of National Health and Family Welfare Programmes in the PHC/PHU areas and sub-mission of reports and returns to the higher authorities in this regard.

4. To orient in organising and providing of Medical Care to the sick persons coming to the PHC/PHUs and referral of cases to higher Institutions wherever needed.

5. To orient regarding co-ordination and co-operation of Department activities with NGOs and other Departments in implementation of various Health and Family Welfare Programmes in the PHC area.

6. To orient in procurement of drugs, chemicals etc., required for the PHCs.

Health Status and Epidemiology

Health Indicators - Current Status and Targets to the year 2000

Particulars	Target	India	Karnataka	Punjab	West Bengal
1. Population (Millions)	-	-	47.9	20.3	72.4
2. Crude Birth Rate	21	28.5	22.5	26.3	25.6
3. Crude Death Rate	9	9.2	8.5	7.0	7.3
4. I.M.R.	below 60	74.0	67.0	55.0	58.0
5. Expectation of Life at birth					
(a) Male	64.0	60.6	62.1	66.6	62.0
(b) Female	64.0	61.7	63.3	66.6	61.9
6. Percentage of Eligible couples effectively protected	60.0	45.5	49.0	63.7	37.2
7. Annual Growth Rate of population	1.2	2.1	3.19	2.1	2.2
8. Pregnant Mothers receiving A N Care	100.0	78.1	84.0	51.0	80.0
9. Deliveries by Trained Birth Attendants	100.0	69.8	-	-	70.0
10. Immunisation Status % coverage					
(a)T.T.(for pregnant mothers)	100.0	78.1	70.0	91.3	80.9
(b)D.P.T.(Infants)	100.0	88.8	69.3	90.9	84.9
(c)Polio (-do-)	100.0	89.2	69.5	90.4	85.5
(d)B.C.G.(-do-)	100.0	92.6	73.1	88.2	96.2

* Source Sample Registration Survey.

INDIA POPULATION PROJECTS

Director, S I H F W
Dr. K.B. Makapur
11/7/

The India Population Projects are implemented with financial assistance from Government of India and International Development Agency (IDA). This projects are supportive for the success of Family Welfare and Mother-Child Health Programme to achieve the crude Birth Rateof 21/1000 population by year 2000 AD and also other Health Indicators.

The India Population projects implemented in the State are as follows:-

1) India Population Project-I, implemented from April 1973 to March 1980.

Area benefited - All the Districts of Bangalore Division with the following objectives:

- Expansion of Health infrastructure
- linking the provision of F.P. Services with supplimentary Nutrition Programme
- Creation of population centre to evaluate performance on continual basis and design and operate MIES and evaluate performance.
- Provision of technical assistance.

Infrastructure created:-

I. Buildings:- i) Sub Centre buildings - 694

ii) Other Buildings - 97
(ANMTCs, DH & FW Offices and F.P.Annexure to selected PHCs, Population Centre buildings)

iii) Compound walls constructed to Health Institutio
- 417

II. Water supply:- 784 Buildings

III. Vehicles:- Vehicles provided - 111

IV. Equipments:- Equipmentssupplied of Rs.120 lakhs.

India Population Project-III

The project was implemented in six districts of Northern Karnataka (except Uttar Kannada and Bellary Districts). The project was implemented during 1984-92 with financial assistance of Government of India and International Development Agency(IDA). The cost of project was Rs.77.31 crores.

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Objectives:-

- Generating demand for services,
- Augumenting staff and facilities,
- Improving professional and Technical services,
- Improving Management
- Involvement of community, Voluntary Organisations, Other Government departments and local bodies in Family Welfare Programme.

The Project was implemented by the Project Co-ordinator with support of Health and Family Welfare department and other departments.

Infrastructure created:-

I. Buildings:- i) New buildings constructed - 2344 (Subcentres, secondary Health centres, ANMTCs & LHVTCs, & HFWTCs).

ii) PHC Repaired/Extensions - 83

II. Safe drinking water supply:- 720 Buildings

III. Compound walls constructed:- 654 Buildings

IV. Transport:- i) Four wheeled vehicles - 154

ii) Two wheeled vehicles to MOs/BHEs of PHCs - 512

V. Equipment & Furniture Purchased and supplied to Hospitals/PHCs. -Rs.260 lakhs

VI. Training of Medical Officers and Para Medical Staff PHCs:-

The IPP-III was implemented by construction Wing, An implementing wing and an IEC Wing headed by the Project Co-ordinator cum Ex-officio Additional Secretary to Government.

Lacunae in implementations:-

1) Delay in implementation of Project experienced in both projects, prolonging the project period from five to seven years.
2) Delay in deputation of staff from other government departments and appointments.
3) Delay in construction of building due to making the PWD, Land Army Corporations, Karnataka Construction Corporation responsib. for constructions.
4) For obtaining sanctions from Finance and Planning in addition to approval in P.G.B. due to lack of clarity in theproject management at different levels.
5) Delays due to conflict between project staff and Department Officers implementing the Programmes.

INDIA POPULATION PROJECT - IX(K)

The IPP-IX(K) is implemented in the State from 1994 with assistance of Government of India and I.D.A. The IPP-I was implemented in Bangalore Division Districts and IPP-III in the Districts of Belgaum and Gulbarga Divisions. Both the projects covered almost 70% population of the State and both the projects focussed around health and family welfare though there were some differences in the emphasis on service components.

The IPP-IX(K) is implemented in 13 Districts of the State ie. Districts of Mysore Division, Shimoga and Chitradurga of Bangalore Division, Bellary, Gulbarga of Gulbarga Division and Bijapur, Belgaum, Uttara Kannada of Belgaum Division as for Civil component is concerned, the IEC and Training component is implemented in 20/27 Districts.

The estimated cost of Project is Rs.122.09 crores. The Project period is 1994 to 2001.

Project Objectives:-

The specific objective of the project is to implement a programme sustainable at village level to reduce crude Birth Rate, Infant mortality rate and Maternal Mortality Rate and increase couple protection rate to reach National Target for the year 2000 AD.

	1990	1998
1. Infant Mortality	71	50
2. Maternal Mortality	6	2
3. Crude Birth Rate	28	20
4. Couple Protection Rate	47	60

Strategy adopted for achieving the objectives:-

1. To involve the community in promoting and delivery of family welfare services.
2. To strengthen delivery of services by providing:
   a) Equipment Kits and supplies to TBAs., Subcentres and PHCs.

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b) Make ANMs at subcentre mobile by providing loans (Interest free) for purchase of Two wheelers.

c) Buildings for subcentres with provision of residential accomodation for ANMs.

d) Buildings for PHCs.

e) Residential quarters to M.Os.

f) Construction of Training Centres.

3. Improve the quality of services by providing training to personnel, official and non-official at various levels including TBAs, Community leaders and voluntary agencies.

4. Strengthen monitoring and evaluation by developing and installing MIES from District to State level.

No.of Buildings proposed for construction under the Project:

1. Sub-Centres	-	1039
2. P.H.Cs.	-	94
3. Quarters for M.Os.	-	271
4. Training Centres	-	28

Components of Project:-

1. Strengthening of Service Delivery:-

A. Buildings:-

i) New Subcentres buildings construction

ii) New PHC buildings construction

iii) M.O. Quarters building construction

iv) Rehabilitation of C.H.Cs. P.H.Us. and subcentres.

B. Furnitures:

i) New Subcentres

ii) Other subcentres

C. Equipment:

i) New Subcentres

ii) Other subcentres

iii) Kits for ANMs

iv) Delivery Kits

D. Revolving fund for purchase of Two wheelers for increased mobility of ANM/LHV.

2. Improving Quality Service:-

i) Construction of Training Centres

ii) Sanction of SIHFW and District Training Centres

iii) Rehabilitation of existing training centres

iv) Training of M.Os & Paramedical staff of PHCs for improvement in knowledge and clinical skills.

3. Information, Education and Communication:-

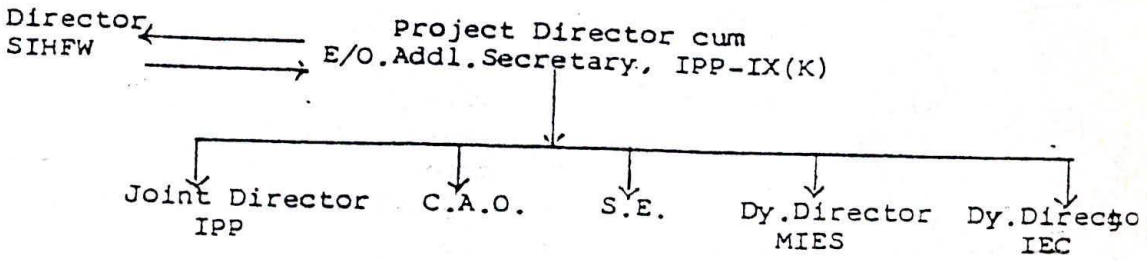
IEC Equipments, Printed materials, films and vehicles etc.

4. MIES:- Computers to be supplied to Districts.

5. Innovative Schemes:-

Implementation of Project:-

The IPP-IX(K) project is implemented from 1994. The Project Director cum Ex-Officio Additional Secretary is responsible for the implementation of project. He is provided the following staff.



ANNEXURE - I : Equipment for ANM Kit

ANNEXURE -II : Furniture and Equipment for Subcentre.

Appended

: ANNEXURE - I :

EQUIPMENT FOR A.N.M . KIT

Sl.No.	Item Description	Quantity
1.	Sphygmomanometer aneroid 300mm with cuff	01
2.	Colour coded weighing scale (baby)	01
3.	Instrument sterilizer SS 222 X 22 X 41 mm	01
4.	Spring type dressing forceps -stainless steel	01
5.	Basin Kidney enamel 825 ml	01
6.	Sponge bowl- stainless steel - 600 ml	02
7.	Urethral catheter (12 fr) runner	01
8.	Sheeting plastic clear vinyl 910 mm wide	02
9.	Enema can with tubing	01
10.	Clinical thermometer oral (dual Celsius/ Fahrenheit scale)	01
11.	Clinical thermometer rectal(dual Celsius/ Fahrenheit scale)	01
12.	Brush surgeon's white nylon bristles	01
13.	Mucus extractor	01
14.	Artery Forceps	02
15.	Cord cutting scissors	01
16.	Cord ties/rubber bandpacket	01
17.	Nail clipper	01
18.	Foethoscope (stethescope Foetal)	01
19.	Surgical scissors straight stainless steel 150 mm	01
20.	Spirit lamp with screw cap: metal (60 ml)	01
21.	Aluminium shield for spirit lamp	01
22.	Poly urethane self sealing bag (125 X 200mm)	12
23.	Arm circumference scale	01
24.	Rack Blood sedimentation Westergen 6-3/4 unit	01
25.	Adhesive zinc oxide tape(25 mm X 0.9 m)roll	01
26.	Tape measure 1.5M/60" wide vinyl coated	01
27.	Flash light pre focused - 2 cell	01
28.	Kit bag	01

: ANNEXURE - II :

FURNITURE AND EQUIPMENT FOR SUB-CENTRES

1. Furniture for new buildings:

Sl. No.	Item Description	Quantity
1.	Examination table	01
2.	Foot step	01
3.	Wash basin with stand	01
4.	Stool	01
5.	Cot with mattress	01
6.	Bench for visitors	02
7.	Cupboards for equipment and supplies	02
8.	Office table	01
9.	Side rack	01
10.	Chairs	02
11.	Container for water storage	01
12.	Bucket with lid	02

2. Equipment for all Sub-centres:

Sl.No.	Item Description	Quantity
1.	Scale Bathroom Metric/Avoirdupois: 120 KG/280 LB	01
2.	Scale infant Metric 16KGs X 20G	01
3.	Colour coded weighing scale (baby)	05
4.	Basin Kidney enamel 825 ml	02
5.	Basin solution deep enamel 6 litres	01
6.	Tray instrument/dressing with cover: 310 X 195 X 631 mm S.S.	01
7.	Sheeting plastic clear vinyl 910 mm wide	02
8.	Brush surgeon's white nylon bristles	02
9.	Lancet (Hedgedorn Needle)straight 75mm	01
10.	Tape measure 1.5 M/60" wide vinyl coated	01
11.	Flash light pre focused - 2 cell	01
12.	Sphygmomanometer aneroid 300 mm with cuff	01
13.	Stethoscope Bianural	01
14.	Forceps dressing spring type 150 mm stainless steel	02
15.	Forceps hemostat straight Kelly 140 mm stainless steel	01
16.	Forceps sterilizer(utility)200 mm Vaughn Crim	01
17.	Jar dressing w/cover 0.945 litre stainless steel	01
18.	Forceps uterine vulsellum straight J and above 250 mm	

P.T.O.

Equipment for all sub-centres (Contd..)

19. Scissors surgical straight 140 mm S/B stainless steel	01
20. Speculum vaginal Bi-valve Cusco's medium stainless steel	01
21. Reagent strips for urine test (albumen and sugar)	100
22. Rack Blood sedimentation Westergren 6-3/4 unit	01
23. Cusco's & Sims vaginal speculum	01
24. Anterior vaginal wall retractor	01
25. Measure 1/2 and 1 litre	01
26. Uterine sound	01
27. Haemoglobinmeter set salti type complete set	01

Overview of Karnataka Health Systems Development Project

- Dr. G.V. Vijayalakshmi*

Karnataka Health Services provide all the health services in the state as elsewhere in India at three levels namely

1. Primary
2. Secondary &
3. Tertiary.

Primary Health Care received considerable attention and resources through the State's own funding and also through external agencies through various IPP projects. So also the tertiary Hospitals are fairly well developed in Karnataka with more than 19 Medical Colleges in the State with their attached Hospitals are being utilized for clinical facilities. Whereas secondary level of heath care hitherto neglected so far has been recognised now by the Govt. Of India and the World Bank authorities & hence the Karnataka Health Systems Development Project aims at improving the infrastructure and modernising in delivering the quality care services by the secondary level hospitals based in rural areas of the Karnataka State.

The Secondary Level Hospitals are of various types and magnitude with marked disparity in the availability of infrastructure and the quality of services provided by these hospitals and it varies in different areas of the State. So the need for the referral network of the Secondary Hospitals which is only an organic extension of the primary health care system. Secondary Health Care is now being recognised all over the world and thus the State Health Systems Development Project 1 & State Health Systems Development Project 2 came into existence. State Health Systems Development Project 1 covers Andhra Pradesh State and State Health Systems Development Project 2 covers Karnataka Punjab & West Bengal States in India.

KHSDP covers 201 rural Hospitals 107 of which are subdivisional Hospitals and 74 are Community Hospitals or CHCs in 4 divisions of Karnataka except the Gulbarga Division which is covered under kfw project.

Land Marks

1. Pre Project Activities — Dec 1994
2. Preliminary Project / Project Plan — Jan 1995
3. Workshop — 28th Feb 1995 to 1st March 1995
   - Project Preparation Committee
   - Norms for Hospital facilities & Services
   - High level Committee

* M.B.B.S., MD, F.I.C.S.,
Consultant, KHSDP, Bangalore

Project Preparation Committee was headed by Mr.Sanjay Kaul, IAS, Additional Secretary for Health with Dr.S.Kantha, Director of medical Education, Dr.M.T.Hema Reddy, Director of Health & FW Services and other various Additional & Joint Directors of the department.

Establishing Norms for Hospital Facilities & Services Committee was formed by various working groups namely,

1. Medical
2. Surgical
3. Diagnostic Groups.

Medical Group was comprised of

a) Physicians - HODs of Medical Colleges and leading Physicians of Private sector.
b) Cardiologists from Jayadeva Institute of Cardiology, Bangalore
c) Neuro Physicians & Psychiatrists from premier Institutes
d) Paediatritians from Medical College Hospitals.
e) Forensic Medicine experts
f) Experts in Preventive Medicine
g) District Surgeons
h) Physiotherapists
i) Chief Nursing faculties.

Surgical Group formed a huge working setup headed by a clinical expert with wide Hospital experience and Administrative Officer supported by

a) General Surgeons
b) Obstetricians & Gynaecologists
c) Orthopaedic Surgeons
d) ENT Surgeons
e) Ophthalmic Surgeons
f) Dental Surgeons
g) Anaesthesiologist

It also included Super Specialists like

a) Urologists
b) Thoracic Surgeons &
c) Neuro Surgeons &
d) Representatives from Operation Theatre Nursing and Nursing Superintendents.

Apart from this it included

a) Bio-Medical Engineers,
b) Health Equipment Specialists &
c) Training experts from ASCI, Hyderabad.

Diagnostic Group which included

a) Pathologists & Bacteriologists.
b) Radiologists & Sonologists.
c) Bio-Chemists
d) Micro Biologists
e) Laboratory service Experts
f) Senior Technicians &
g) Nursing Assistants from Govt. & Private sectors.

Simultaneously different Sub-Committees with various disciplines were formed and the teams visited various Hospitals of different categories in the State for RTNA study (Rapid Training Need Assessment). The teams studied the requirements for training Clinical, Nonclinical, Diagnostics, Pharmacists & Hospital Management Training aspects. Through out the workshop there were observers from the World Bank and Officers from other States of Punjab & West Bengal.

All the Committees submitted their report to the Govt.

Thus the final Project Proposal of KHSDP was submitted to the World Bank in Sept 1995.

Ultimately the "Project Launch Workshop" was inaugurated by the Hon'ble Ex-Prime Minister of India Mr.H.D.Deve Gowda on 27th June 1996 a Red Letter Day for Karnataka State. This was followed by an extensive workshop for 3 days on various aspects of the Project, participated by

1. Health Secretaries from Govt. of India,
2. Health Secretaries from 3 States of Karnataka, Punjab & West Bengal &
3. Health Secretary from Andhra Pradesh to guide the junior Projects.
4. Sri. Pradeep Puri, IAS, Project Administrator of KHSDP & E/o Secretary to Govt.,

The Workshop was also participated by Senior Administrative Heads of Directorate of Health Services of Karnataka, Punjab & West Bengal to discuss the implementation of the project activities in various phases.

Salutations and remembrances to the following Officers & Officials who worked for Pre Project activities & preparation of Project Proposal.

1. Mr.Gautham Basu, Health Secretary to Govt. of Karnataka
2. Mr.Sanjay Kaul, Additional Secretary to Govt. of Karnataka
3. Mr.D.V.N.Sharma of STEM, Govt. of Karnataka
4. Innumerable Officers of various cadres of Clinical, Administration, Statistical sections of Health Dept.

Implementation of the Karnataka Health Systems Development Project (KHSDP)

KHSDP office has been established in the premises of Public Health Institute Building on Seshadri road, KR Circle, Bangalore-1.

To insert Sri. B. Eswarappa, IAS, Secretary to Govt., Health & Family Welfare Dept., Project Administrator & E/O Additional Secretary to the Govt. of Karnataka, Dr.S.Subramanya, IAS. heads the entire Project team. He is assisted by Chief Administrative Officer, Chief Financial Officer, Under Secretary, etc., with their respective teams.

Two Bio-Medical Engineering consultants provide technical assistance in procurement of Hospital equipment and Training programme for the technical assistants for repair & maintenance of equipment through out the State.

Civil wing is headed by the Chief Engineer and assisted by his team of Superintendent Engineers, Executive Engineers, Asst. Executive Engineers, Asst. Engineers, Junior Engineers, etc., along with other ministerial staff.

Deputy Chief Architect heads the team of Architects in preparation of plans, etc., for construction of Hospital Buildings with technical emphasis.

Medical Wing constitute of

1. Additional Director (Strategic Planning Cell) assisted by his team & consultant who evolves Health Sector strategy, coordinates Health Sector planning and conducts research studies.
2. Additional Director (Medical) is supported by the Project Consultant and a team of Joint Director & four Deputy Directors to look after all aspects of infrastructure of 201 Hospitals regarding space norms in planning, Operation Theatre design and Equipment installation, etc.,

   The major component is the training programme which includes clinical training for General Duty Doctors and Specialists in various disciplines to upgrade their clinical skills.

   a. State level training for Trainers of Trainees(TOT) or Master Trainers by the JIPMER, Pondicherry team and St. John's Hospital, Bangalore.
   b. District Level training of the Taluka level Hospitals and CHCs by the TOTs in the District Hospitals.
   c. Specialists' training at super speciality Hospitals under taken at

      i. Jayadeva Institute of Cardiology
      ii. Indira Gandhi Institute of Child Health
      iii. Trauma Care training at HOSMAT & Mallya Hospitals
      iv. Neurology, Neuro Surgery & Psychiatry at NIMHANS
      v. Laparoscopy & Foetal Monitor Tocography at MS Ramaiah Medical College Hospital & Vani Vilas Hospital, Bangalore.

The training programmes will be further extended in other premier institutes for various other disciplines.

Staff Nurses training is undertaken at major District level Hospitals in Govt. and private sector through out the state.

Pharmacists training starts with state level training with the trainers from 29-12-1997 to be followed by District level training of the Pharmacists all over the State.

Laboratory Technicians' training in Bacteriological & Chemical analysis of Water is conducted at Public Health Institute, Bangalore.

Cumulative Status report of various training components are as follows.

KARNATAKA HEALTH SYSTEMS DEVELOPMENT PROJECT, BANGALORE.

Training Status as on 31-03-1997

	Trained
1. Trainers Training at St.John's Medical College, Bangalore (Doctors)	82
2. Masters Trainers Training By JIPMER, Pondicherry Staff (Doctors)	20
3. District Level Training to CHC/ Taluk Level Doctors	11

Training Status as on 31-10-1997

1. Trainers Training at St.John's Medical College, Bangalore (Doctors).	26
2. Masters Trainers Training By JIPMER, Pondicherry Staff (Doctors).	20
3. District Level Training to CHC/ Taluk Level Doctors.	101
4. Sr. Laboratory Technicians Training at PHI in Water testing.	15
5. Nurses Training at Teaching Hospitals.	188
6. Training of Technicians attached to Equipment Maintenance Wing at Hyderabad.	36
7. One day Workshop in Hospital Waste Management.	20
8. Training to Orthopaedicians at Sanjay Gandhi Hospital, Bangalore.	03
9. Training to Pediatricians at Indira Gandhi Institute of Child Health.	12
10. Training to Physicians in ICCU at Sri. Jayadeva Institute of Cardiology.	13

Cumulative Training Status as on 15-11-1997

1. Trainers Training at St.John's Medical College, Bangalore (Doctors).	108
2. Masters Trainers Training By JIPMER, Pondicherry Staff (Doctors).	40
3. District Level Training to CHC/ Taluk Level Doctors.	112
4. Sr. Laboratory Technicians Training at PHI in Water testing.	15
5. Nurses Training at Teaching Hospitals.	249
6. Training of Technicians attached to Equipment Maintenance Wing at Hyderabad.	36
7. One day Workshop in Hospital Waste Management.	20
8. 3 days conference in Trauma Anaesthesia & Critical Care.	20

9. Training to Orthopaedicians at Sanjay Gandhi Hospital, Bangalore.		03
10. Training to Pediatricians at Indira Gandhi Institute of Child Health.		11
11. Training to Physicians in ICCU at Sri. Jayadeva Institute of Cardiology		18
12. Training of OBG specialists		05
13. Training at NIMHANS for Doctors -	Psychiatry	04
	Neuro Surgery	02
	Neurology	02

Status Report on Civil Works as on 10-11-1997.

Total No. of Hospitals included in the Project	201
No. of Hospitals so far assigned to Architects (No. of Architects involved 46)	190
No. of Hospitals for which Preliminary designs are cleared by World Bank	90

Present Stage of these 90 Hospitals

Works awarded after bidding	31
Works taken up under force Account	05
Bids sent to World Bank for Clearance	01
Bids sent to World Bank to clear Re-Bidding	01
Bids under evaluation	12
Bids advertised	03
Bidding documents awaiting approval of World Bank	04
Bidding documents being sent to World Bank for Approval	02
Estimate under finalisation	05
Estimate yet to be received from Architects	26
Total	***90***

Preliminary design cleared by WBA but communication from WBA awaited	01
Preliminary designs reviewed by the World Bank Architect on 10/97 and cleared subject to modifications to be verified by BSC.	26
Preliminary designs reviewed by the World Bank Architect and to be reviewed by him after modifications are carried out.	04
Preliminary Designs under preparation, etc.,	69
No. of Hospitals yet to be assigned to the Architects	11
Grand Total	**201**

Objectives of the Training Programme

Primary objective of the training component is to improve quality and strengthen the services provided at first referral facilities i.e., CHCs.

Main objective of the Hospital Management training is to strengthen management knowledge and Hospital Administrator skills. The intention of the Management training will be to provide practical training to enhance the ability of administrative staff to face day to day problems.

Management training has been focused on

1. Facility Management	
2. Personnel Management	Recruitment procedures Rules and regulations Supervisory Techniques Disciplinary Procedures Motivation Team building Group Dynamics Training & Development
3. Maintenance	Planning for preventive maintenance Maintenance of Buildings House keeping Monitoring of use and abuse Hospital / Medical waste management
4. Finance	Govt. financial procedures Budget Planning Procedures & Practices of Accounting System Budget monitoring and control Internal Audit & Management of User charges
5. Procurement Matters	Procurement procedures, rules & regulations
6. Consumable supplies including Drugs management	Planning for the supplies Procurement Inventory management Usage Monitoring the storage
7. Information System	The use of information to improve Hospital Management Importance of Patient's registration Medical records & Medical reporting

8. General Issues	Role of Secondary level Hospitals in supporting Primary level facilities and referral system Role of advisory committees Relationship of the Hospital with the community

Referral System

Introduction: Health care in 3 levels

Primary	Basic Health Services Preventive & Promotive aspects Family Welfare & MCH Sanitation, etc.
Secondary	CHCs with updated bed strength of 30, taluka and sub divisional Hospitals with updated beds of 50-100 & District Hospitals with beds 250-800. These Hospitals provide Outpatient, Inpatient care & diagnostic facilities. Also carryout various National Health Programmes and these Hospitals come under the control of DH & FW Officer.
Tertiary	Teaching Hospitals with more than 500 beds provide specialised services and these hospitals come under the control of Director of Medical Education.

QUALITY MEDICARE
can be provided only when a
PROPER AND EFFECTIVE REFERRAL SYSTEM
IS FORMULATED AND IMPLEMENTED.

Current Referral System:

No definite system is existing

PHCs	- Inadequate quality of services.
CHCs	- are often bypassed
Tertiary	- are unnecessarily overburdened.

New referral system:

- Renovating and upgrading of Hospital Buildings to provide appropriate space services.
- Upgrading and Updating clinical skills of Medical Officers and Nurses through an effective training programme.
- Providing Ambulances for transporting critical patients. &
- Installing Phone, Fax / Radio communication.

CHCs will become the
Referral Points for Primary Health Care Level

Referral System under KHSDP:

- Provides correct line of treatment with each category of hospital as per the service matrix.
- Patient is encouraged to use Primary and Secondary Hospital facilities before opting for tertiary Hospital.
- A *Referral Card* is used whenever a patient is referred.

Measures contemplated are

- Referral and feedback cards are being introduced
- Referral Guidelines that specify the When & How of implementing the referral system are provided.
- Incentives for patients who follow referral systems is envisaged.
- Linkages & Communications between the First Referral Hospital & primary care facilities through regular training and outreach visits are being established.
- Intensive IEC targeted at providers and the community has been initiated.
- District Health Committees will monitor the implementation of Referral System.

Referral Network:

- Zoning of each District

- Referral Chain - PHC
  ↓
  CHC
  ↓
  TqH / SDH / DH
  ↓
  TH

Referral Maps:

Map 1: Villages, Blocks, Towns & Cities.
Map 2: PHC, CHC, SDH & TH and important NGO unit.
Map 3: Roads, Rivers, Police Station, Post Office, etc.,

Facilities for transport of Patients:

Guidelines:

1. Patients are charged only actual fuel cost.
2. Payment collected by office staff identified by the Medical Officer / Superintendent of referring Hospital.
3. Additionally the driver of the Ambulance will be provided with a receipt for collection of charges if a patient needs further transport if advised by the referred hospital. In such a case the driver should deposit the amount in the original hospital on return.
4. Critically ill and poor patients may be exempted from paying Ambulance fee depending on the situation.
5. Ambulance service to be provided as and when required.
6. Telephone Nos. of Hospitals to be indicated so that during emergencies oral communication can be resorted.

Operationalisation of Referral System: ex. Pilot Chitradurga District Hospital.

Use of Service Matrix - Referral Protocol.

Receiving of the Referred Patients

Place Earmarked

1. Queue Jump / Treated on priority.
2. No OPD ticket. Referral Card itself is used as OPD ticket.
3. Feed Back Card - All information regarding treatment at referred hospital return with follow-up treatment to the referring doctor.
4. Provision of low cost transportation - In emergencies, when no alternative is possible, cost will be reimbursed by KHSDP through the District Surgeon.
5. Accommodation of Patient party in referred hospital in the rest house may be arranged by the Medical Officer if there is any such facility.

Implementation Plan:

Overall responsibility:

- Additional Director (Medical) at State level for necessary Gos, providing funds / cards, procurement, etc.,

- Funds for implementing the Project will be released by the Project Administrator through the District Surgeon.

District Referral Committee: will be setup with

- District Surgeon,
- DH&FWO,
- TMO,
- RMO &
- MOH as members.

The Committee ensures the functioning of referral system as contemplated in service matrix.

Any additional requirement / clarification - may seek the instructions from the Project Administrator, KHSDP.

Referral Training Programme: is organised by District Surgeons for all categories of staff working in all the Hospitals & PHCs in the Districts as per needs.

District Surgeon sends monthly report to the Additional Director (Medical) and Project Administrator of KHSDP.

Any technical suggestions from senior officers of DH&FW may be taken into account by the District Surgeon.

Referral Procedure -

Not Passing the Buck

1. Referral register has to be maintained.
2. State reasons for referral and patient to be informed properly.
3. Stabilize general condition of the patient & transfer when required.

Referral System is only a
Tool to provide best Medicare
and
Not Shirk Responsibilities

4. Non-emergency / cold patients should make own arrangements for transport. But information and broad guidelines are to be given and they are treated in regular OPD hours.

Critically ill patients / emergencies
are attended Round the Clock

On-duty Medical Officers are empowered to make reference to higher hospital following the referral procedure.

Improvement of Access to Health Services for Women - Extended RCH Programme.

Interventions contemplated under *RCH project* mainly relate to maternal health. Recent literature points to the urgent needs to address other aspects of women health which go beyond her role as " Mother ".

Women's low social status and reproductive role expose them to high health risks. Women's health is an important concern as it affects the next generation and her productivity in economic activities.

Special attention is required to reach females during adolescents and reproductive and other life style behaviors set the stage for later life. Hence women's health should be viewed through " Life-cycle Approach " because many problems that affect women's reproductive age and her new born and in her old age - All begin in childhood & adolescence. Towards this end during the project period a range of expanded services under the Extended RCH programme are proposed to be introduced both with and without project interventions.

In the first Phase

1. Promotion of positive health practices such as personal hygiene especially during menstruation, adequate nutrition etc.,

2. Screening for and treatment of reproductive tract interventions and sexually transmitted diseases.

3. Screening and treatment of Gynaecological problems such as

   a) Menstrual irregularities
   b) Fibroid uterus
   c) Ovarian Tumors.
   d) Prolapse Uterus.

   e) Pelvic Infections and other common conditions.

4. Screening & Treatment of Cancer Cervics.

5. Increased policy dialogue and strategic efforts to reduce gender discrimination and violence through " Engendering & Empowerment ".

2nd Phase.

Additional interventions are:

6. Management of problems associated with onset of Menarche and Menopause.
7. Screening and treatment of Breast cancer.
8. Prevention & treatment of infertility.

The above range of services have important health components requiring interventions which are much beyond the scope of the department. Here, the envisages support to the primary health care sector by providing technical services referral services and financial assistance.

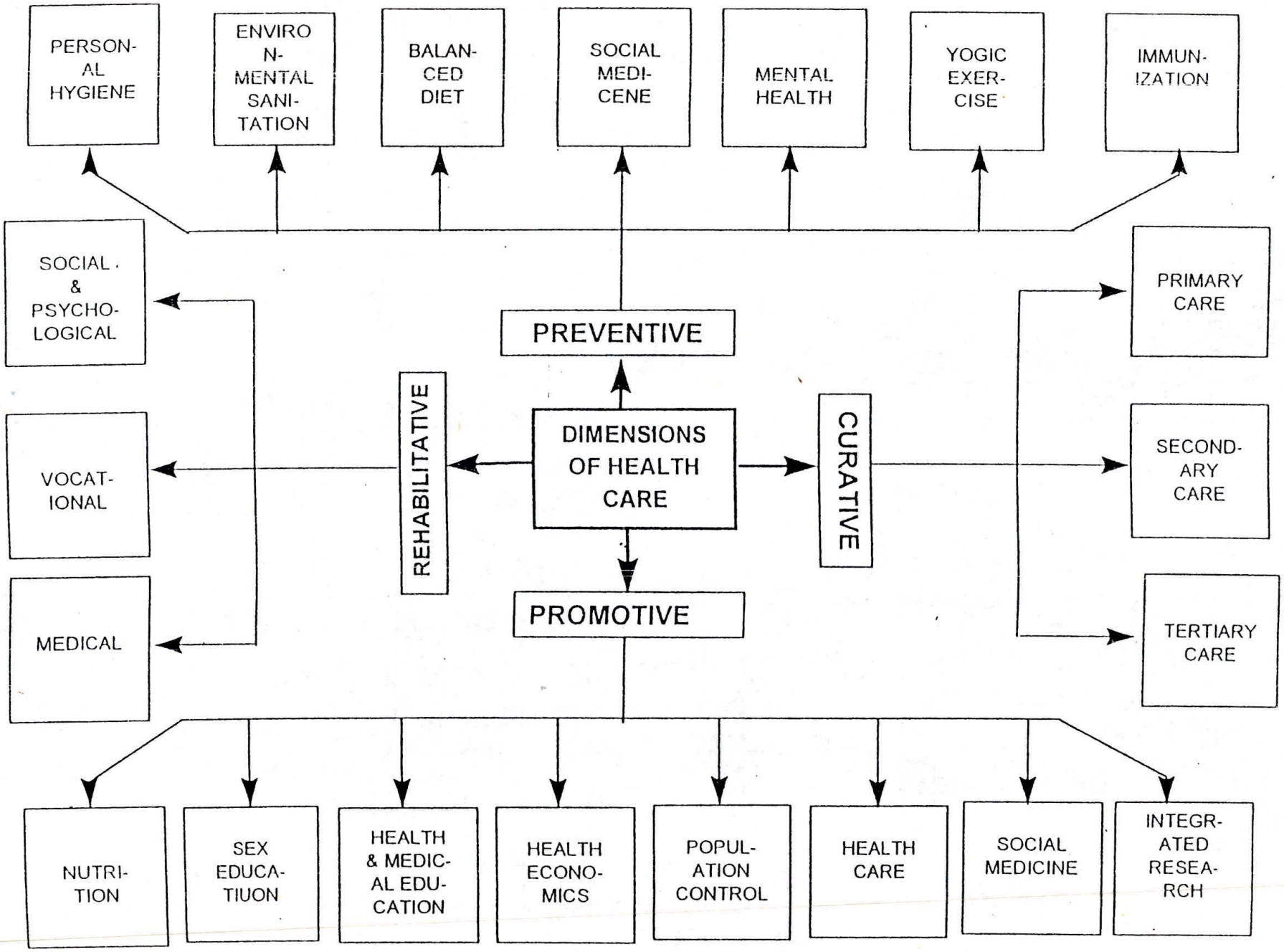
The programme covers all the women from 10 to 60 years. The ANM will identify suspected cases for each type of disorder / disease among the target groups shown in the tables by " Syndrome Approach " and referred to LHV / MO of PHC for detailed checkup and treatment or referral if found necessary.

Role of Doctors in Implementing Project Activities and their responsibilities

- Doctors
- Implementing Project Activities
- Moral Responsibilities

Hospital Quality Indicators (1996-97)

Code	District	Place	Type	Beds				In-Patients		Out-Patients			Deliveries			Emergency		Test	Laboratory Tests Done										Hospital Deaths				Post Oper Casualties		Asst. Reqd		Call attend
				Existing	Paying	Proposed Beds	Proposed Paying	IPD Number	Cumulative Days	OPD New	OPD Old	Maj Surgeries	Normall	High Risk	Caesarean	OPD	IP	X-ray/Ult Snds	Haemetology	Serology	Bio-Chem	Blood Gp	HIV	Stool	Urine	CSF	Post Mortems	Clinical Autopsies	IP	Emergency	Infants	Maternal	Emergency	Planned	Beyond beds	Other	Ambulance
101	Bangalore	Vanivilas	W&C	605		605																														
102	Bangalore	ED Hospital	ED	128		128																														
103	Bangalore	HSIS Bangalore	W&C	120	22	120	50	1912	9560	10217	7712	37	1091	157	161			88	5314	173	267	914	4773	47	4280	0	0	0	0	0	36	0	0	0	46829	0	0
110	Bangalore	Krishnarajapuram	ELH	10		100																														
111	Bangalore	Yellahanka	ELH	9		100																														
112	Bangalore	Anekal	ELH	26		50		537	3743	10961	2543		242					60							1541		91										
201	Bangalore Rura	Chennapatna	ELH	100		100	25	4116	41160	74569	31738	95	695	4	19	1224		1098	8919	151	598	89	0	90	12187		48		69								
202	Bangalore Rura	Devanahalli	ELH	30		30	20	1565	1485	8391	5759		393	13		72	22										13										
203	Bangalore Rura	Doddaballapur	SDH	50		50		1148	1148	47549	9205	368	894	150		177	177	733	1256	8				4	1586		40		23	6							
204	Bangalore Rura	Hoskote	ELH	23		50		340	670	19600	10100		410	11		21	15										60		2	1	2						
205	Bangalore Rura	Kanakapura	ELH	50		50		450	4500	6344	2500		150	1		325	225	200	9372			72		1260	3552		20		6	3	1		1				320
206	Bangalore Rura	Magadi	ELH	30		30		263	526	8278			141	22		63											20		6								
207	Bangalore Rura	Nelamangala	ELH	13		50		1060	3100	27641	8056		287			1800	1200							11	2973		90	0	4	3	3						
208	Bangalore Rura	Ramanagaram	SDH	50		50		1441	10087	40755	37289	0	485			240	200	506	960	492	378	97		558	810	3	40		9	5			2	50		40	4
301	Belgaum	Belgaum	DH	710	11	740		10179	89543	80912	76760	1710	478	232	186	3483	2488	13879	8912			1500	31	301	7583	112	335		112	313	62	7	3	11	37628	119125	11
302	Belgaum	Athani	ELH	28		50		918	459	17770	2332		333			865	343										32										
303	Belgaum	Chikkodi	ELH	13		50		485	373	19866	3617	8	161	11	2	55	55										38		5								
304	Belgaum	Nippani	CHC	10		30		158	340	3314	2142		4			15	6										25						62				
305	Belgaum	Gokak	ELH	10		50		1132	4528	18869	13623		148	2			227	284	1234	36		132		36	2422		60		20	16	2						
306	Belgaum	Hukkeri	ELH	30		30		871	2613	5856	1622		166	11	2	221	351								250											102
307	Belgaum	Khanapur	ELH	28		30		488	1965	10130	5481		246	2		65	29							0	880		30		1	2							
308	Belgaum	Saundatti	ELH	30		50		740	5920	23123	12560	157	723	25	24	31	23	283									29	3	1						1185	12
309	Belgaum	Yargatti	CHC	30		30		416	1395	6115	7925		155			26	51								280		13		4	4	1						
310	Belgaum	Ramdurga	ELH	30		50		549	2957	18222	6504		212	24		48	7								256		63			1	8				434	1
311	Belgaum	Raibagh	ELH	6		30		600	2815	3847	2637		185	25		25	10		100					25	120		45		3								
312	Belgaum	Badhongal	SDH	30		50		633	3165	6146	1918		459	9		174	174							80	160		24		4		3		174	459			3
313	Belgaum	Kittur	CHC	6		30		294	924	4893	782		177	4		32	11		132								38										
401	Bellary	Medical College	DH	512	72	512		6079	57130	108957	106779	1945				2850	1538	13076	504	3211	17839	3913	801	452	38714	562	215	215	427							136325		50
402	Bellary	Bellary	W&C	210		210		5708	0	64181	41459		1156	251	332		1800	2156				1851	212		42561				130	102		28	3				50
404	Bellary	Kurugodu	CHC	6		30		519	3294	16557		344	275			100	39		341						344		5	5		3	3						
405	Bellary	Hadagali	ELH	30	0	50		481	2182	11950			162	5		48	216	295									6		4	6		1		325			12
406	Bellary	Hagaribommanhali		30	0	50		185	555	11061			9			30	38								200		14		8	3							
407	Bellary	Harappanahalli	ELH	14		50		115	115	2652			47			19	19	27									6		1				368				1500
408	Bellary	Hospet	SDH	100		100																														
409	Bellary	Chikajogihalli	CHC	30		50		300	14	19047			20	8	0	281	82	16							515		9		3	3							50
410	Bellary	Kudligi	ELH	6		50		537	3222	9952	319		35	6	11	169	142								2468		30		17	3		21	295		2361	11
411	Bellary	Kottur	CHC	6		30		472	472	10962		396	53	21		249	35	30	297						297		14				1				180	1
412	Bellary	Sandur	ELH	30		50																														
413	Bellary	Siruguppa	ELH	30		50		1397	6985	16876		410	107	22	1	218	462	104							410		31		16	9	2				220	6
501	Bidar	Bidar	DH	285	10	100		6416	0	115472	90578	586	1352	244	144	1820	180	285	12896	727	1190	5509	136	142	22762		91		208	180	1	1	10	15			2500
502	Bidar	Aurad	ELH	30	0	50		1026	6585	5790	3600	0	200	0	0	720	0	120	680	0	0	0	0	0	180	0	30	0	10	10	12	0	0	0	0	0	11
503	Bidar	Basavakalyan	SDH	36	0	50		867	2227	22175	23415	0	206	15	0	122	57	0	505	0	0	0	0	30	850	0	35	0	2	1	2	0	0	0	0	0	11
504	Bidar	Bhalki	ELH	68	0	100		596	17880	5605	23804	0	351	0	0	33	21	0	698	40	0	19	0	0	679	0	14	0	2	2	0	0	0	0	0	0	14
505	Bidar	Humnabad	ELH	50	0	50		801	2112	15643	22705	109	301	49	0	269	52	0	793	0	0	0	0	0	1151	0	30	0	0	0	0	0	0	0	0	0	86
506	Bidar	Chitguppa	CHC	30	0	30		374	0	5489	908		145	2		200	110		124						124		15		2	2	2						88
507	Bidar	Manekanahalli	CHC	30	0	30		107	535	64252	1575	0	180	0	0	155	60	0	100	0	0	0	0	15	150	0	10	0	2	2	0	0	0	0	0	0	0
601	Bijapur	Bijapur	DH	396	5	400	50	7119	11	98256	50535	322	524		123	350	1350		42277	726	1526			917	7151	67	212		180	8		6			2350	10787	228
603	Bijapur	Badami	ELH	30		30		515	3605	20348	8000		282	8													37		9			2	1				
604	Bijapur	Gulcdeuddi	CHC	25		30		669	5352	13039	11619		117		6	5	2	145	786						311		25		0								
605	Bijapur	Bagalkote	SDH	150		150		2845	19356	39081	42813	352	199	36	23	39081	315	1909	2471	710	132				5126		76		106	10		6	23	279		23853	30
606	Bijapur	B Bagewadi	ELH	14		50	15	154	308	4511	1575		96			46	23										7										
607	Bijapur	Bilgi	ELH	10	0	30		263	152	4018	4001		165			32	11								91		11										


PERSON-AL HYGIENE
ENVIRO N-MENTAL SANI-TATION
BALAN-CED DIET
SOCIAL MEDI-CENE
MENTAL HEALTH
YOGIC EXER-CISE
IMMUN-IZATION
SOCIAL & PSYCHO-LOGICAL
VOCAT-IONAL
MEDICAL
REHABILITATIVE
PREVENTIVE
DIMENSIONS OF HEALTH CARE
PROMOTIVE
CURATIVE
PRIMARY CARE
SECOND-ARY CARE
TERTIARY CARE
NUTRI-TION
SEX EDUCA-TIUON
HEALTH & MEDIC-AL EDU-CATION
HEALTH ECONO-MICS
POPUL-ATION CONTROL
HEALTH CARE
SOCIAL MEDICINE
INTEGR-ATED RESEA-RCH

REPRODUCTIVE AND CHILD HEALTH SERVICES

Dr. G.V. Nagaraj*

THE PAST :

For over 30 years Family Welfare Programme was known for its rigid, target based approach in contraceptives. The performance was measured by the reported numbers of the four contraceptive methods-Sterilisation, Intrauterine device, Oral pills and Condoms. This was widely criticised for being a coercive approach.

The 1994 Cairo International Conference on Population and Development (ICPD) formulated a growing International consensus that improving reproductive health and family planning is essential to human welfare and development.

A growing body of evidence and the Cairo consensus suggest ***"Numerical method specific contraceptive target and monetary incentives"*** for providers to be replaced by a broader system of ***"programme performance goals"*** and measures focussed on a range of reproductive health services.

The World Bank report-1995 concludes that, the current contraceptive "Target and Incentive" system gives a demographic planning emphasis to family welfare programme (FWP) which is antithetical to the reproductive and child health (RCH) client centered approach advocated in the GOI-ICPD country statement for the Cairo conference. In particular emphasis on numerical targets is a major reason for the lack of attention to the individual client needs and is detrimental to the quality of services provided.

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Family Welfare Programme to Reproductive Child Health -The paradigm shift :

To date the impact of Family Welfare Programme has been measured in terms of their contribution to increase contraceptive prevalence and to decrease fertility. These indicators are inadequate for measuring the impact of reproductive Health Programme and therefore, new indicators for monitoring reproductive health services and "Service Quality" from the perspective of the client are urgently needed.

Over the past decade there has been a clearer articulation and definition of reproductive health as a concept and some thinking on the ways in which reproductive health problems should be addressed.

Against this background the main recommendations of the World Bank report on the Indian Family Welfare Programme (FWP) is that the programme is to be re-oriented expeditiously to a Reproductive and Child Health approach (RCH). The main objective of which would be to meet individual client health and family planning needs and to provide high quality services.

The principle goal of a reproductive health programme is to ***" Reduce unwanted fertility "*** safely there by responding to the needs of the individuals for ***"High quality health services"*** as well as to the demographic objectives.

The report recommends that the targets be replaced by a broad set of performance goals and greater emphasis on ***"male contraceptive methods"*** especially vasectomy and condoms and greater choice of methods.

" Government goals for family planning should be defined in terms of unmet needs for information and services. Demographic goals should not be imposed in family planning providers in the form of targets or quotas"

-World Bank - 1995

The trend of health programme should change from a "Population Control Approach" of reducing number to an approach that is "Gender Sensitive and Responsive" client based approach of addressing the reproductive health needs of individuals, couples and families.

Reproductive Health Programmes should aim to reduce the burden of unplanned and unwanted child bearing and related morbidity and mortality.

What is reproductive Health ?

The 1994 International Conference on Population and Development at Cairo (ICPD) has indicated a consensus definition as a "State of complete physical, mental and social well being and not merely the absence of disease or infirmity in all matters relating to reproductive system and its function and processes"

Reproductive health approach means that

* People have ability to reproduce and regulate their fertility.

* Women are able to go through pregnancy and child birth safely.

* The outcome of pregnancy is successful in terms of maternal and infant survival and well being and

* Couples are able to have sexual relation free of the fear of pregnancy and of contracting diseases. (Fathallah-1988)

The reproductive health approach believe that it is linked to the subject of reproductive rights and freedom and to women status and empowerment. Thus it extends beyond the narrow confines of family planning to encompass all aspects of human sexuality and reproductive health needs during the various stages of life cycle.

Reproductive health programme is concerned with a set of

* Specific Health Problems
* Identifiable cluster of client groups
* Distrinctive goals and strategies

The programme enable clients:

* To make informed choices
* Receive screening
* Counseling services
* Education for responsible and healthy sexuality
* Access services for prevention of unwanted pregnancy
* Safe abortion
* Maternity care and child survival
* Prevention and management of reproductive morbidity.

Implementing reproductive health services means a change in the existing culture of the programme from one that focuses on achieving targets to one that aim at providing a range of quality services.

Objective of RCH packages are :

1. Meet individual client health and family planning needs.

2. Provide high quality services.

3. Ensure greater service coverage

RCH Policy :

The fundamental policy change is that Instead of remaining responsible for reducing rate of population growth, reproductive health programme would become responsible for reducing burden of unplanned and unwanted child bearing and related morbidity and mortality.

Further the basic assumption is that improvement in service quality will result in client satisfaction and will over long term translate into higher contraceptive prevalence and ultimately fertility regulation. By providing good quality services the programme will be able to achieve the objective of not only reducing fertility but also reducing reproductive morbidity and mortality.

New Signals :

Shifting to reproductive health approach implies changing the implementation signals. :

* Client satisfaction becomes the primary programme goal with demographic impact a secondary though important concern.

* Broadening the service package is necessary

* Improving service quality becomes the top priority.

The new signals for a quiet revolution in the way the programme is planned and managed are :

Primary goal : While still encouraging smaller families help Client meet their own health and F.P. needs.

Priority services : Full range of family planning services

Performance measures : Quality of care, client satisfaction, coverage measures .

Management approach : Decentralised, client-needs driven, gender sensitive

Attitude to client : Listen, assess needs, inform.

Accountability : To the client and community plus health and F.W. staff.

Reproductive Morbidity and Mortality :

* 1/3 of the total disease burden in the developing country of women 15 - 44 years of age is linked to health problems related to pregnancy, child birth, abortion, HIV and Reproductive tract infections (RTI's).
* The heavy load of reproductive morbidity among Indian women is an outcome of their :
  1. Poverty 2. Powerlessness 3. Low social status
  4. Malnutrition 5. Infection 6. High fertility
  7. Lack of access to health care
* India's maternal mortality ratio, usually estimated at 400-500 per 1,00,000 live birth is fifty times higher than that in the developed countries.
* In India a small study has revealed that for every women who dies, an estimated 16 others develop various risks.
* Chronic and debilitating conditions such as vaginal fistulas and uterine prolapse cause terrible suffering.

CHILD SURVIVAL AND SAFE MOTHERHOOD PROGRAMME TO REPRODUCTIVE AND CHILD HEALTH SERVICES

Implementation of a very important, massive and highly credible UIP programme from 1985 to 1991 throughout the country has made a break-through in the improvement of mother and child health services. In spite of this, compared to developed countries, our country is still lagging behind in respect of sensitive indicators such as infant mortality rate and maternal mortality rate.

Looking at the perinatal mortality which contributes 50% of the infant mortality rate and also one mother dying out of 250 pregnancies, it can be concluded that immunization alone is not adequate and will not be able to bring down these death rates.

Hence along with the immunization programme, a package of services named "CHILD SURVIVAL AND SAFE MOTHERHOOD" was implemented with the World Bank assistance from April-1992 to September-1996 in all the states.

The main objectives of CSSM programme are

* Improvement in mother and child health
* Lowering the infant deaths (0 to 1 year) child mortality (1 to 4 years) and maternal deaths.

The package of services under this programme are :

CHILDREN :

1. Essential new born care
2. Immunization (BCG, DPT, Polio and Measles)
3. Appropriate management of diarrhoea cases
4. Appropriate management of ARI
5. Vitamin 'A' prophylaxis

3H
P8-

MOTHERS :

1. Ante-natal care and identification of maternal complications
2. Immunization (against Tetanus)
3. Deliveries by trained personnel
4. Prevention and treatment of anaemia
5. Promotion of Institutional deliveries
6. Management of Emergency Obstetric Care (EmOC)
7. Birth spacing

THE RCH PACKAGE :

During 1995-96, Mandya was identified as Target Free District and the performance was measured by certain quality indicators. Based on the experience, from April 1996 all the districts in Karnataka have adopted "Target Free Approach" and from Sept. 1997 onwards as Community Needs Assessment Approach. The implementation of earlier isolated programmes concentrating on Family Welfare and Mother and Child Health under National Family Welfare Programme will now be implemented as an Integrated Reproductive and Child Health Services which is equivalent to

* Family Planning, to focus on fertility regulation and
* Child Survival and Safe Motherhood Programme and
* Treatment of Reproductive Tract Infections and Sexually Transmitted Infections and prevention of AIDS

Through

1 Client Oriented/Mother-Friendly/ user - specific, Family Welfare Services

2 High quality services

The specific programmes under Reproductive and Child Health services are

1. Prevention and management of unwanted pregnancies
2. Maternal care
   a) Ante-natal services
   b) Natal services
   c) Post-natal services
3. Child Survival
4. Treatment of Reproductive Tract Infections (RTI) and Sexually Transmitted Infections (STI).

Reducing the 'unmet need' increasing 'service coverage' and ensuring 'quality of care' will be the focus of implementation.

The implementation guidelines of these health interventions at various levels are detailed in the annexure.

ESSENTIAL REPRODUCTIVE AND CHILD HEALTH SERVICES AT DIFFERENT LEVELS OF THE HEALTH SERVICES SYSTEM

Health Intervention	Community Level	Subcenter Level	Primary Health Centre Level	First referral Unit/District Hospital Level
1. Prevention and management of unwanted pregnancy	1. Sexuality and gender information education and counseling 2. Community mobilization and education for adolescents, newly married youth, men and women.* 3. Community based contraceptive distribution ** (through panchayats, village Health Guides, Mahila Swathya Sanghas, etc., with follow-up) 4. Motivating referral for sterilization 5. Social marketing of condoms and oral pills through community sources and G.P. (Oral pills to be distributed through health personnel including GPS to women who are starting pills for the first time). 6. Free supplies to health services * to be piloted ** Panchayats to distribute only condoms	No.1 as in community level 2. providing * oral contraceptives (OCS) and condoms. 3. Providing IUD after screening for contraindications. 4. Conseling and early referral for medical termination of pregnancy. 5.Counseling/ management/ referral for side. effects, method related probiems, change of method where indicated. 6. Add other methods to expand choice. 7. Providing treatment for minor aliments and referral for problems. * Social marketing of pills and condoms through HW (M&F) may be explored by permitting her to retain the money.	Nos.1-6 and 7. performing tubal ligation by minilap on fixed dates* 8. Performing vasectomy. 9. Providing first trimester medical termination of pregnancy upto 8 weeks (includes MR) 10. Facilities for Copper 'T' insertion to post natal cases 11. Treatment facilities for all types of referrals. * PHC s should have facilities for tubal ligation and minit lap including OTs and equipments.	Nos. 1-11 and 12. Providing services for medical termination of pregnancy in the first and second trimester (upto 20 weeks) where indicated.

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ESSENTIAL REPRODUCTIVE AND CHILD HEALTH SERVICES AT DIFFERENT LEVELS OF THE HEALTH SERVICES SYSTEM

Health Intervention	Community Level	Subcenter Level	Primary Health Centre Level	First referral Unit/District Hospital Level
2.Maternity care Prenatal Services	1. Early registration of all Pregnant Women 2. Awareness raising for importance of appropriate care during pregnancy & identification of danger signs 3. To mobilise community support for transport, referral and blood donation 4. Counseling education for breast feeding nutrition, family planning, rest, exercise & personal hygiene etc., 5. Early detection and referral of high risk pregnancies 6. Observing five cleans or through Social marketing of disposable delivery kits, Delivery planning as to where? when and from whom? * The need for IEC support and establishment of first Referral facilities	No.1-4 and 5. Three antenatal contacts with women either at the sub-centre or at the outreach village sites during immunisation/MCH sessions. 6. Early detection of high risk factors & maternal complications and prompt referral 7. Referral of high risk women for institutional delivery. 8. Treatment of malaria (facilities including drugs to be made available at subcentres) 9. Treatment for TB and folloup. 10. Preventive measure against all communicable disease	Nos.1-10 and 11. Treatment of T.B. 12. Testing of syphilis for high risk group and treatment where necessary including for RTI's. * training of laboratory technicians, equipment and reagents required	Nos. 1-12 and 13. Diagnosis and treatment of RTIs/STIs. 14. Weakly clincnics for High risk pregnancies.

Health Intervention	Community Level	Subcenter Level	Primary Health Centre Level	First referral Unit/District Hospital Level
Delivery Services	1. Early Recognition of pregnancy and its danger signals (rupture of membranes of more than 12 hours duration, prolapse of the cord, hemorrhage) 2. Conducting clean deliveries with delivery kits by trained personnel. 3. Detection of complications referral for hospital delivery. 4. Providing transport for referral 5. Referral of New born having difficulty in respiration 6. Management of Neonatal hypothermia	Nos.1-4 and 5. Supervising home delivery 6. Prophylaxis and treatment for infection (except sepsis) 7.Routine prophylaxis for gonococci eye infection.	Nos. 1-7 and 8. Modified partograph 9. Delivery services 10. Repair of episiotomy and perennial tears	Nos. 1-9 and 10. Treatment of severe sepsis 11. Delivery of referred cases 12. Treatment of high risk cases 13. Services for obstetrical emergencies anesthesia, cesarean section, blood transfusion through close relatives linkages with blood banks and mobile services.

Health Intervention	Community Level	Subcenter Level	Primary Health Centre Level	First referral Unit/District Hospital Level
Postpartum services	1. Breast -feeding support. 2. Family Planning counseling 3. Nutrition counseling 4. Resuscitation for asphyxia of the newborn 5. Management of neonatal hypothermia 6. Early recognition of post partum sepsis & referral	Nos. 1-6 and 7. Referral for complications 8. Giving inj. Ergometrine after delivery of placenta	Nos. 1-8 and 9. Referral to FRUs for complications after starting an I.V. line and giving initial does of antibiotics and oxytocin when indicated. 10 . Management of asphyxiated new born (equipment to be provided)	Nos.1-10 and 11. Management of referred cases. PHCs and FRUs would require additional equipment and training for management of asphyxiated new boms and hypothermia. These include a resuscitation bag and mask and radiant warmers.

Health Intervention	Community Level	Subcenter Level	Primary Health Centre Level	First referral Unit/District Hospital Level
Child survival	1. Health education for breast feeding nutrition immunization, utilisation of services, etc., 2. Detection and referral of high risk cases such as low birth weight, premature babies, babies with asphyxis, infections, severe dehydration acute respiratory infections (ARI).etc., 3. Help during Immunization by ANM. 4. Help during Vitamin 'A' supplementation by ANM. 5. Detection of pneumonia and seeking, early medical care by community and treatment by ANM. 6. Treatment of diarrhoea cases and ARI cases	Nos 1-6 and 7. Treatment of dehydration and pneumonia and referral of severe cases. 8. First aid for injuries etc., 9. Closing watching on the development of child and creating awareness of cheap and nutritious food.	Nos.1-9and 10. Management of referred cases.	Nos.1-10 and 11. Handling of all paediatric cases including encephalopathy. 12. Identification of certain FRU's to provide specialist services and training

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Health Intervention	Community Level	Subcenter Level	Primary Health Centre Level	First referral Unit/District Hospital Level
Management of RTIs/STIs	1. IEC. counseling for awareness and prevention 2. Condom distribution 3. Creating awareness about usage of sanitary pads by women of reproductive period 4. Creating awareness of about RTI's and Personal hygiene	No.1 and 4 5. Identification and referral for vaginal discharge, lower abdominal pain, genital ulcers in women, and urethra discharge, genital ulcers, swelling in scrotum or groin in men. 6. Diagnosis of RTI/s and STI's by Syndrome approach. 7. Referral of Cases not responding to useval treatment . 8. Partner notification/referral	Nos 1-8 and 9. Treatment of RTIs/STIs 10. Syphilis testing in antenatal women	Nos. 1-9 and 10. Laboratory diagnosis and treatment of RTIs/STIs 11.Syndromic approach to detect and treat STD in Antenatal post-natal and at risk groups

THE PACKAGE OF REPRODUCTIVE AND CHILD HEALTH SERVICES

Reproductive Child Health (RCH) can be defined as a state in which "People have the ability to reproduce and regulate their fertility: women are able to go through pregnancy and child birth safely, the outcome of pregnancy is successful in terms of maternal and infant survival and well being; and couples are able to have sexual relations free of the fear of pregnancy and contracting disease". This means that every couple should be able to have child when they want and, that the pregnancy is uneventful and see, that the safe delivery services are available, that at the end of the pregnancy the mother and the child are safe and well and the contraceptives by choice are available to prevent pregnancy and of contracting disease.

The essential elements of reproductive and child health services at the community and sub-centre level are given below which will help you to understand how the reproductive and child health services are to be provided at the community level. The different services provided under RCH programme are :

I. FOR THE MOTHERS : * TT Immunization * Prevention and treatment of anaemia * Antenatal care and early identification of maternal complications * Deliveries by trained personnel * Promotion of institutional deliveries * Management of Obstetric emergencies * Birth spacing
II. FOR THE CHILDREN * Essential newborn care * Exclusive breast feeding and weaning * Immunization * Appropriate management of diarrhoea * Appropriate management of ARI * Vitamin A prophylaxis * Treatment of Anaemia
III. FOR ELIGIBLE COUPLES * Prevention of pregnancy * Safe abortion
IV. RTI/STD * Prevention and treatment of reproductive tract and sexually transmitted diseases

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IMPLEMENTATION OF RCH PROGRAMME IN KARNATAKA STATE

I) POLICY ISSUES :

* Reproductive & Child Health Programme will be implemented in the State as a 100% Centrally Sponsored Family Welfare Programme during the Ninth Five Year Plan ending by 2000-2002 A.D.
* State Government has principally agreed to implement and a Government Order has been issued to this effect (No.HFW 96 FPR 95 dated 17-6-1998).

According to this

* The funds will flow from Government of India through 'State Finance Department'
* The programme will be implemented as a National component and Sub Project - (Bellary Dist.)
* Posts created under CSSM Programme will be continued under RCH budget.
* The Empowered Committee & a Steering Committee will monitor, guide and solve the problems of implementation of RCH Programme.
* The following posts have been redesignated :

Additional Director (FW&MCH) : **Project Director (RCH**
Joint Director (FW) :**Joint Project Director (RCH)**
District MCH Officer :**Dist. RCH Officer**

* Procurement will be done through Karnataka Health Systems Development Project.
* Minor Civil Works to subcentres, Primary Health Centres, Community Health Centres will be done through IPP-IX.

II) **FUNDING** : A sum of Rs.190.10 crores will be available to Karnataka State during the Ninth Plan as **cash** and **kind** assistance. This includes cash assistance of Rs.15.05 crores exclusively to Bellary Sub-Project.

III) **CATEGORY OF DISTRICTS** : The RCH Programme will be implemented in the State based on differential approach. Inputs in all the districts have not been kept uniform because efficient delivery will depend on the capability of the health system in the district. Therefore basic facilities are proposed to be strengthened and streamlined specially in the weaker districts as the better-off districts already have such facilities and the more sophisticated facilities are proposed for the relatively advanced districts which have acquired capability to make use of them effectively. All the districts have been categorised into : Category 'A'-3 districts, Category 'B'-11 districts, Category 'C'-6 districts.

On the basis of crude birth rate and female literacy rate which reasonably reflect the RCH status of the State the districts will be covered in a phased manner over three years. Category wise phasing of the districts and the facilities to be provided are as follows:

RCH PROJECT - PHASING OF DISTRICTS.

YEAR 1 (9)	CAT 'A' (2)	(A1) Dakshina Kannada	(A3) Mandya	
	CAT 'B' (4)	(B2) Uttara Kannada (B10) Belgaum	(B5) Chikkamagalur	(B11) Dharwad
	CAT 'C' (3)	(C1) Bijapur	(C3 Bidar)	(C4) Gulbarga
YEAR 2 (8)	CAT 'A' (1)	(A2) Kodagu		
	CAT 'B' (4)	(B1) Hassan (B7) Mysore	(B3) Bangalore (R)	(B4) Tumkur
	CAT 'C' (3)	(C2) Bellary **(sub-project)**	(C5) Raichur	(C6) Bangalore
YEAR 3 (3)	CAT 'A' (0)	- -		
	CAT 'B' (3)	(B6) Shimoga	(B8) Kolar	(B9) Chitradurga
	CAT 'C' (0)	- -		

IV) PROGRAMME INPUTS :

I] NATIONAL COMPONENT :

Annual Action Plan For 1998-99 has been prepared

1 CONSULTANTS : Five consultants will be hired one each for IEC, MCH, Administration & Training, Monitoring and Evaluation and Procurement and Finance.

2. COLD CHAIN MAINTENANCE : Budget for minor repairs both by State level and also by District level will be available.

3 CONTRACTUAL STAFF : Staff Nurse will be hired in category 'C' & 'B' districts to the extent of 25% of PHCs in the first year.

4 EMERGENCY OBSTETRIC CARE DRUGS (EmOC) : To bring down the maternal deatlhs, emergency obstetric Care Drugs will be supplied to FRUs wherever cesarean section and other emergency surgical procedures are being conducted.

5 ESSENTIAL OBSTETRIC CARE DRUGS: These drugs will be supplied in the form of kits by Govt. of India during the first year.

6 KITS 'E' TO 'P' : These kits were supplied to 68 FRUs under CSSM programme. Still there are large number of FRUs which are to be equipped during the first year. 2 districts in 'A' category, 4 districts in 'B' category and 3 districts in 'C' category will be supplied with 'E' to 'P' kits.

7 24 HOURS DELIVERY SERVICES AT PHCs : To enhance the institutional deliveries, a scheme will be taken up on a pilot basis in Kolar district wherein an incentive of Rs.200/- to Medical Officer and Rs.150/- to Staff Nurse will be given who attends night deliveries between 7.00 pm to 8.00 a.m.

8 ESSENTIAL NEW BORN CARE EQUIPMENTS : Essential New Born Care Equipments were supplied by Govt. of India through National Neonatology Forum under CSSM programme for few PHCs in Chikkamagalur, Chitradurga and Kolar districts. Realising that the peri-natal mortality rate is responsible for more than 50% of infant deaths, new Born Care Equipments will be supplied to 10 bedded maternity hospitals, FRUs/CHCs and Block Level PHCs where there are facilities such as wards, staff nurse and labour room.

9 IEC ACTIVITIES : A sum of Rs. 15.00 lakhs is available for taking up innovative IEC activities focusing on behavioural changes in addition to enhancing awareness regarding interventions under RCH programme.

10 VEHICLE : Field staff particularly Junior Health Assistant (F) will be supplied two wheelers to improve her mobility, accessibility for service to attend emergency services and also to Improve her Status in public. This facility will be taken up in 7 Non-IPP-IX districts (Tumkur, Kolar, Bangalore (U), Bangalore (R), Dharwad, Raichur & Bidar).

11 MINOR CIVIL WORKS : An amount of Rs.190.00 lakhs has been made available to take up minor civil works particularly in the institutions such as Subcentres, PHCs, FRUs and also training centres.

12 Government of India will be directly releasing the funds to the Deputy Commissioners of the districts to support IEC activities through Zilla Saksharatha Samithis (ZSS). Each proposal costing about Rs.3.00 to Rs.5.00 lakhs will have to be formulated by the ZSS and directly sent to Govt. of India for funding.

13 TRAINING UNDER RCH : The State Institute of Health & FW will be dovetailing the RCH component in the regular IPP-IX training programme. Awareness programme for the State Level Officers as well as District Level Officer will be initiated . Manuals have already been made available at all the districts for undertaking six days RCH training programme for ANM's.

14 IMPROVED MANAGEMENT: Preparation of district plans under Community Needs Assessment Approach as a Decentralized Participatory planning is under way. Training programme has been completed in most of the districts.

II. SUB PROJECT : BELLARY :

Annual Action Plan for 1998-99 has been prepared.

A sum of Rs. 15.05 crores exclusively for Sub Project Bellary has been approved by GoI.

Civil Works	: 5 Sub centres, 5 PHCs & 5 Maternity Hospitals
Equipments	: 174 Subcentres, 10 PHCs, 50 PHUs, 4 maternity Hospitals
Furniture	: 76 Subcentres, 10 PHCs, 11 PHUs
Vehicles	: 15 Ambulance & 2 Jeeps
IEC activities	:CNA: Video-films, flip charts, hand books & hand outs

Baseline Survey :

NGO involvement :

Own Your Telephone

Contractual staff : Staff Nurses & Laboratory Technicians.

PERFORMANCE INDICATORS IN RCH PROGRAMME

OBJECTIVE	INDICATORS	(%)	1997 BASE LINE	1998	1999	2000	2001	2002	DATA SOURCE
I.IMPROVED MANAGEMENT	1.DISTRICT PLANS CNA APPROACH	(%)	20	50	100	100	100	100	RECORDS (D&E CELL)
	2. SC.,PHC's, FRU's, EQUIPPED WITH	(%)	0	25	50	60	75	100	FACILITY SURVEY/RECORDS
	3. INSTITUTIONAL DEVELOPMENT (PLACEMENT OF STAFF)	(%)	0	10	25	50	75	100	FACILITY SURVEY
II. IMPROVED QUALITY, COVERAGE AND EFFECTIVENES	1. SAFE DELIVERIES	(%)	43	50	52	54	56	60	SERVICES STATISTICS
	2. COUPLE PROTECTION RATE	(%)	58	59	60	62	63	65	SURVEY/RECORDS
	3. I NFANT MORTALITY RATE	PER 1000 Lbs	52	50	45	42	40	38	SRS
	4. MATERNAL MORTALITY RATE	PER 1000 Lbs	4.5	4	3.5	30	2.5	2.0	SERVICE STATISTICS
	5. STAFF TRAINED	%	2	10	30	60	75	100	RECORDS
	6. REACHED WITH RTI, HIV/AIDS MESSAGE	%	20	30	60	75	80	85	CLIENT SURVEY
	7. UNMET NEED	%	18	16	14	12	10	8	HOUSE HOLD SURVEY
III. ENAHANCED POPULATION STABILISATION	8. CRUDE BIRTH RATE	PER 1000 POPULA-TION	22	21.5	21	18	15	12	SRS

hdrbdl]

OBSTETRIC EMERGENCIES

Dr. Uma Devi
Prof & H.O.D. OBG
M.S. Ranjah Medical

Identification, management and referral:

INTRODUCTION: In Obstetrics there is an extensive list of potential sudden and unexpected situations which demand prompt action. Non Obstetricians callously characterise obstetrics as 'hours of boredom punctuated by moments of terror'. However, jokingly this has been stated, as Obstetricians we always dread these moments of terror.

In modern Obstetrics, except for a few situations viz., amniotic fluid embolism, we can forearm ourselves by anticipating these complications by early identification of certain warning signals in each and evary catastrophe.

Most of the emergencies can be prevented in a PHC set up by early reference of patients with the high risk factors during the antenatal period to a major institution.

However, certain emergencies arise even in a low risk pregnancy. The PHC obstetricians should be competent enough to identify and manage these emergencies to prevent fatal sequelae.

OBSTETRIC EMERGENCIES CAN BE BROADLY CLASSIFIED AS FOLLOWS:

OBSTETRIC:

ANTENATAL : a. Haemorrhage (Abortion, ectopic gestation and molar pregnancy)
b. Antepartum haemorrhage
c. Septic shock.
d. scar rupture (Classical scar)

Intrapartum:

a. Rupture uterus
b. Shoulder dystocia
c. Third stage complication
   - P P H
   - Adherent placenta
   - Inversion uterus
d. eclampsia

Antenatal & intrapartum & Postpartum: eclampsia [obstetric & Medical]

a. Venous thrombosis and pulmonary embolism
b. Cardiac failure
c. Acute respiratory failure
d. Acute pyelonephritis
e. Diabetic ketocidosis
f. Sickle cell crisis

Others:

a. Cord prolapse

b. Fetal distress
c. Unanticipated breech.

The following emergencies could be anticipated and referred early
Abortion, ectopic gestation and molar pregnancy.

a. Routine first trimester use of ultrasound. (Mole by, blighted ovum missed abortion etc.,)
b. Early suspician of ectopic gestation in patients with abdominal pain and irregular bleeding with or without amenorrhoea and failure to obtain products of conception during a MTP procedures

If not recognised early:
One should be competent to manage & resuscitate a patient with acute massive haemorrhage which would be dealt with later.

Scar rupture:
All patients with a previous Caesarean section should be ~~supervised~~ by an Obstetrician in a hospital where facilities for caesarean section are available within thirty minutes.

Intrapartum Complications
Identification
Rupture uterus
Refer:
a. Prior caesarean section
b. Malpresentations
c. Patients with abnormal progress in labour (Use a partogram)
d. Pregnancy with medical complications
e. Large babies
f. Elderly primis and grand multis.
g. Previous history of shoulder dystocia
h. Previous third stage complications.

Management
However, occassionally complications arise unanticipated as a bolt from the blue. So we should be proficient to tackle them.

ANTEPARTUM HAEMORRHAGE:

PLACENTAL ABRUPTION:

Frequency 1 in 75 to 90 deliveries, perinatal mortality 20 - 35%

ETIOLOGIC FACTORS:

- Maternal hypertension
- Trauma
- Sudden uterine decompression
- Short umbilical cord
- Uterine anomaly
- Uterine tumour
- Pressure by the enlarged uterus on the inferior venacava
- Dietary deficiency
- Cocaine use
- Preterm prematurely ruptured membranes.

RECURRENCE 1 in 10 pregnancies

Signs & symptoms	Frequency%
Vaginal bleeding	78
Uterine tenderness or back pain	66
Fetal distress	60
Abnormal uterine contractions	34
Idropathic preterm labor	22
Dead fetus	15

Complications

Shock

Consumptive coagulopathy

Renal failure

Couvelaire uterus

Management

Blood, crystalloids

Hasten delivery

Amniotomy, Oxytocin, Treatment of coagulation defects FFP, Cryoprecipitate:

Placenta Praevia

Total, Partial Marginal Types I to IV (Browne)

Diagnosis : 1. Clinical picture

2. Placental localization by ultrasound. (TAS - 95% accuracy) false negative - 7%

Phenomenon of migration of low lying placenta. detected in 2nd trimester.

..4..

Management:

Expectant form of management Tocolysis - $MgSo_4$

Caesarean section at fetal maturity.

A placenta previa, whether found fortuitonsly by ultrasound or with the clinical emergency of maternal haemorrhage, carries significant maternal and fetal risk. Accurate diagnosis, judicious expectant management with transfusion as required, and delivery at the time of fetal lung maturation can lead to the most favourable outcome - ~~xxxx~~

Anticipation of hte clinical complications of placenta accreta may avoid some serious consequences. Clinical judgement and skill in the performance of Caesarean sections, dilatation and other forms of uterine invasive techniques may help to keep subsequent incidence of placenta praevia at a reasonably low rate.

RUPTURE UTERUS:

Uterine rupture is a sudden, unforeseable event that carries a high rate of maternal and perinatal mortality. When the dignosis of uterine rupture is suspected, prompt surgical intervention with an experienced pelvic surgeon and blood product replacement should be considered. At the time of uterine rupture, the patinet should be evaluated for possible repair or hystrectomy. Repair is a reasonable consideration. In those patients who have undegone a repair, early delivery by elective Caesarean would appear prudent. In those patients with a prior Caesarean continuous electronic fetal monitoring to detect intrapartum fetal distress would appear prudent. In these patients fetal distress is the most common sign or symptom of uterine rupture and frequently precedes any other clinical manifestations of this complications.

Incidence 0.02% to 0.08%

Definition (Pluche et al)

Complete separation of the wall of the pregnant uterus with or without the expulsion of the foetus.

Clinical Associations

Prior Caesarean section

Oxytocin

Parity ≥ 4

Abruptio placenta

Midforceps delivery

Breech version/extraction

Clinical signs and symptoms

- Fetal distress
- Abdominal pain

- Vaginal bleeding
- Recession of presenting part
- Uterine hypertonus
- Altered uterine contour

MANAGEMENT:

1. Resuscitation
2. Laparotomy - Rent repair
   - Hysterectomy

Shoulder Dystocia

Incidence 0.15-2%

This complication occurs unexpectedly and leads to panic stricken moments. Hence, it is crucial for clinicians to remain familiar with appropriate delivery maneuvers and to organise them into a systematic plan that will provide optimal obstetric care.

Definition: Arrest of spontaneous delivery due to impaction of the anterior shoulder against the symphysis pubis

Diagnosis : head retraction sign or the turtle sign

Prevention:

Anticipation- Antepartum

Is this patients A DOPE?

D : Diabetes
O - Obesity
P - Post term/Prior large baby
E : Excessive wt. gain

Advanced maternal age
Platypelloid or Contracted pelvis

INTRAPARTUM

Prolonged second stage of labour
Oxytocin use
Midpelvic delivery

Management: The shoulder Dystocia drill

The umbilical artery PH declines at the rate of 0.04 PH per minute Hence rapid and well cordinated action is mandatory. The price of error ~~ixxmandatoryxxxThexprice~~ or delay may be high - severe neurologic and skeletal injuries to the infant, as well as uterine rupture or other injury to the mother.

ALL STEPS TO SOLVE A SHOULDER DYSTOCIA SHOULD NOT TAKE MORE THAN 5 MINUTES

STEP: I (PREPARATION)

a. Call for help - anaesthesia, operating room
b. Do not pull the baby head
c. Do not apply fundal pressure.

Step 2 (Diagnosis)

a. Enlarge the episiotomy

b. Explore manually - if bilateral - restitute the baby's head- Caesarean delivery.

Step 3 (MC Robert's maneuver) if unilateral

a. Remove mother's legs from stirrups

b. Abduct her legs and sharply flex them against her abdomen.

Causes : Cephalad rotation of pubic symphysis freeing the anterior shoulder.

c, d, Step 4 step 5, Step 6 (See after Postpartum haemorrhage)

POSPARTUM HAEMORRHAGE:

PRIMARY : Blood loss of 500 ml or more occuring within 24 hrs. of delivery of the baby. Incidence 5%

SECONDARY: Any sudden loss of fresh blood (regardless of volume) from the genital tract occurring after the first 24 hours and within 6 weeks of delivery of the baby.

In developing countries PPH contributes for 28% of maternal deaths. In U.K. 4.33.

CAUSES (Primary PPH)

1. Uterine atony 90%
2. Genital tract trauma 7 %
3. Coagulation disorders
4. Large placenta
5. Abnormal placental site
6. Increased vascularity of the uterus.

PREVENTION

a. Prophylactic oxytocics at the onset of the third stage of labour - Reduction of PPH by 30-40%

b. Active management of the third stage of labour

c. Avoidance of genital tract trauma

CIRCUMSTANCES WHICH INCREASE THE DANGER OF PRIMARY PPH.

a. Anaemia

b. Inadequate access to clinical and laboratory support.

TREATMENT:

a. PPH before placental delivery

b. PPH after placental delivery

c. Massive PPH

BEFORE PLACENTAL DELIVERY

a. Uterine massage

b. administer IV Oxytocics -

c. Venous access , I V infusion (Plasma expandes, Haemaccel, blood)

d. MRP or cord traction

PPH AFTER PLACENTAL DELIVERY

1. Uterine massage
2. IV OXytocic drugs.
3. Venous access
4. Catheterise bladder
5. Explore uterus under G.A. if there is doubt about completeness of placenta or membranes
6. Exclude genital tract trauma when uterus is firm.

MASSIVE PPH:

Extra expereinced Obstetrician midwife, anaesthetist and haematologist involvement would be necessary.

Haematologist: PT, PTT, TT, Fibrinogen level, platelet count and FDP - for identification of a coagulation defect.

Generous supplies of blood.

Anaesthetist:

Further I V line, CVP

Extra midwife - full responsibility to keep up accurate, charts of pulse, BP, fluid, balance C V P, temperature, respiratory and the results of investigations.

Administration of one or several doses of 250 mg carboprost (Deep im) (Prostodin)

Manual compression of uterus, laparotomy - suture of rupture uterus, Internal iliac artery ligation.

MANAGEMENT OF PPH UNRESPONSIVE TO PRELIMINARY MEASURES:

Preoperative management options:

a. Uterine packing
b. Intramyometrial PGF_2 alpha.

Operative measures:

a. Ligation of vessels
   Hypogastic artery
   Uterine artery
   b. Hysterectomy c. Arterial embolization.

Intensive care measures:

Hemodynamic, renal and coagulation surveillance.

CAUSES OF POSTPARTUM COLLAPSE:

1. Haemorrhage
2. Amniotic fluid embolism
3. Pulmonary embolism
4. Acute cardiac failure
5. Pneumonitis
6. Pneumothorax
7. Cerebrovascular accident
8. Ecclampsia
9. Hypoglycemia
10. Septicaemia

RETAINED PLACENTA:

MRP if > 30 mins.

Earlier if patient is bleeding

PLACENTA ACCRETA, INERTIA AND PERCRETA

RISK FACTORS:

Age (Low 30s)

Parity (2-3)

Praevia /Prior caesarean section (35%)

History of curettage (18-60%)

Prior MRP

Prior retained placenta

Infection

Accreta (80%)- Villi attached to myometrium

Increta (15%)-Villi invades the myometrium

Percreta (5%) - villi through the uterine serosa.

Incidence 1 in 2000 to 3570

Diagnosis : a. APH

Antepartum: b. Sudden onset of blood in urine.

c. Abdominal pain with hypotension

d. Sonography - partial or total absence of subplacental lucent zone.

Management : a. Hysterectomy

Conservative: Leaving placenta in situ, localized resection and repair

Oversewing a defect

Blunt dissection/curettage

Methotrexate therapy.

SHOULDER DYSTOCIA: (contd)

c. Assistant to apply suprapulic pressure directed laterally and inferiorly.

d. Apply constant moderate traction on the fetal head for a count of 30. Avoid intermittent pulling.

Step 4: 1. If Mc Robert's manoerbre fouls. attempt to rotate the shoulder by applying pressure on the posterior aspect of the impacted anterior shoulder to move it from the anteroposterior to the oblique diameter of the inlet suprapubic pressure in the same direction should be applied simultaneously. If room under the symphysis pubis insufficient, perform corkscrew manoeuver

b. Apply pressure on the posterior aspect of the posterior shoulder, attempting to rotate it anteriorly under the symphysis (Woods) suprapubic pressure in the opposite direction should be applied simultaneously.

Step 5 (Extraction of the Posterior arm)

The slide your hand in the vagina behind the posterior shoulder and

along the posteri ~ humerus, and sweep the posterior arm of the ~~uterus~~ across the chest keeping the arm flexed at the elbow. Grasp the fetal hand and pull the hand and the arm along the fetal head delivering the posterior arm.

If extraction of the posterior arm is unsuccessful proceed the step 6

Step : 6 (Zavanelli restitution)

Turn the Baby's head to the original position at the time of delivery (usually occipito anterior)

b. Flex the baby's head and apply upward pressure . The fetal head should move easily up into the birth canal.

c. Move the patient to the operating room and perform a caesarean section.

ACUTE PUERPERAL INVERSION OF THE UTERUS:

Uterine inversion may lead to profuse haemorrhage, profound shock and even death. In no obstetric emergency is prompt action more beneficial.

Incidence ranges from 1 in 2000 to 1 in 20,000 deliveries.

There are 3 degrees of inversion.

1. The inverted fundus reaches the cervical os.
2. The whole body is inverted upto the cervical os.
3. The uterus, cervix and vagina are completely inverted.

Etiology: 1. Spontaneous

2. Mismanagement of third stage of labour.

Spontaneous:

1. Fundal placental site
2. Uterine atomy
3. Arcuate or unocornate uterus.

In patients with uterine atomy, the inversions may occur following a cough, sneeze, or any other act causing an increase in intra-abdominal pressure.

Mismanagement of III stage:

1. Cord traction before placental seperation
2. Use of Crede's method when uterus is relaxed
3. MRP when the abdominal band is firmly pressed on the uterus and the vaginal hand is withdrawn to quickly.

PRESENTATION:

1. Complaint of severe lower abdominal pain

2. Feeling of prolapse followed by collapse and haemorrhage.

PREVENTION:

1. Never exert cord traction with relaxed uterus
2. Countertraction should be applied when the uterus finally contracts
3. Crede's manoeuvere should not be employed.

MANAGEMENT:

1. Immediate replacement of uterus & I V bottles of Oxytocins
2. Send to operation theatre for MRP

LATE DETECTION

1. Resuscitate
2. Alleviate pain by vaginal packing
   relieves tension on ligaments.
3. Transfer to pperating theatre.

HYDROSTATIC REPLACEMENT (O'SULLIVAN)

Exclude uterine rupture and infuse warm saline from a container held about 1 m above the patient via a rubber tube into the vagina.

PROTOCOL:

Detected immediately: a. ~~Peel off placenta~~ ??
b. Reinversion by indentation of the center of the fundus
c. Keep the hand in the uterine cavity till it contracts strongly.
d. Antibiotics
e. I V line

Detected after 30 mins. ?? Remove placenta. Be

A. Mobilise full hospital resource
b. Two IV lines
c. Indendation of fundus
d. If it fails Johnson's manoeuvre
e. If it fails huntingdons abnormal operation
f. Removal of placenta of inversion
g. Keep hand inside till uterus firm
h. Antibiotics.

OBSTETRIC SEPTIC SHOCK:

Definition: Infection resulting in peripheral circulatory failure with inadequate tissue perfusion leading to cell dysfunction or death. A high index of suspicious infection based on septic syndrome would serve as a criteria for identifying patients at risk for septic shock.

SEPTIC SYNDROME:

Clinical evidence of infection fever or hypothermia
Tachypnea
Tachycardia
End-organ manifestation
Neurologic changes
Hypoxemia
Elevated plasma lactate
Oliguria
Data from Bone et al

EPIDEMIOLOGY

Sepsis occurs more frequently following gram, negative than gram positive bacteremia.
Mortality in Obstetric septic shock 20.50% of cases.
70% of maternal deaths due to infection are considered to be preventable. Therefore, it is important to recognise the clinical settings in which septic shock is most likely to occur so that early recognition and treatment can be effected.
Pregnancy represents a state of altered immune competence, and is a recognized risk factor for the development of septic shock.

TYPE OF INFECTIONS THAT RESULT IN SEPTIC SHOCK:

Post caesarean section endometrium 15-85% Endometritis follg. vaginal delivery, 1-4% urinary infections 1-6%, Septic abortion -1-2%, Intramniotic infections 1%
Necrotizing fascitis less than1%
Toxic shock syndrome less than 1%

OTHER PREDISPOSING FACTORS:

Prolonged rupture of the amniotic membranes (more than 48 hrs)
Retained products of conception. Any instrumentation of the genitourinary tract.

MICROBIOLOGY:

GRAM NEGATIVE FACULTATIVE ANAEROBES ENTROBACTERIACEAE

Escherichia coli 50%
Klebseilla
serratia 30%
enterobacter species

Gram positive aerobes

Staphylococci
streptococci

GRAM POSITIVE ANAEROBES

- Bacteroides
- Fusobacterium
- Peptostreptococci

Clostridum sordelli - sudden onset of flu like symptoms on the second to sixth day postpartum followed by progressive refractory hypotension and death. These cases were unique in their uniform absence of fever, striking leukemoid reaction and marked vascular 'leakiness'

Common clinical manifestations:

Cardiovascular : Hypotension, Cardiac dysfunction

Pulmonary : ARDS

RENAL : Oliguria
ATN
Interstinal nephritis

Haematologic
- DIC
- Leucocytosis

Neurologic : Mental - status charges
Fever

MANAGEMENT: Initial laboratory tests
CBC
Electrolytes
Glucose
ABG
BUN creatining
Urinalysis
Pt. PTT fibronogen
lactate
Cultures
Blood
urine
Endometrium
Amniotic fluid
Wound episiotomy site
Sputum drains
Chest X-ray, Abdominal X-ray

Drug: vasoactive and Inotropic drues Naloxone
Mechanical ventilation in respiratory failure
Antibiotic therapy
Surgical treatment EURPOC
Debridement
Prompt delivery

ECLAMPSIA

Eclampsia is characterized by generalised tonic, clonic seizures in women with preeclampsia or hypertension aggravated by pregnancy.

INDICATORS OF SEVERITY OF PREGNANCY INDUCED HYPERTENSION:

Diastolic blood pressure 110 mm of Hg
proteinuria 2+ or more
Headache
Visual distnrbances
upper abdominal pain
oliguria
convulsions
Elevated serum creatinine
Thrombocytopenia
Liver enzyme elevation
Fetal growth retardation
Pulmonary edema

Treatment: Control of convulsions with Parkland Hospital $MgSo_4$ Regime.

4G loading dose IV (diluted)
1G per hour - continue 24 hrs after delivery/stoppage of postpartum eclampsia
Monitor: a. Patellae reflex
b. Urinary output hourly
c. Repiratory rate

Control of hypertension:

Hydralazine IV/Nifedepin ~~subsequent~~ Sublingual

Fluid therapy:

Lactated Ringer's 100 ml/hr. If blood loss is more than average earlier transfusion because in PE normal pregnancy induced hypervolemia is attenuated.

DELIVERY: Consider delivery when the convulsion are controlled and the woman is stabilised.

Early detection and hospitalisation in woman with mild preeclampsia may prevent eclampsia.

~~THRO~~ AMNIOTIC AND THROMBOEMBOLISM:

The embolic complications of pregnancy are infrequently seen but command much attention due to the high associated mortality. 80% of patients ~~stricken~~ with amniotic fluid embolus with die, often before intensive monitoring can be instituted.

DVT 3/1000 pregnant patients

Pulemboli - 15-24% of untreated DVT (12-15% mortality)

Causes : 1. Increased concentration of factors X,VIII,V,VII, IX, XII and fibrinogen

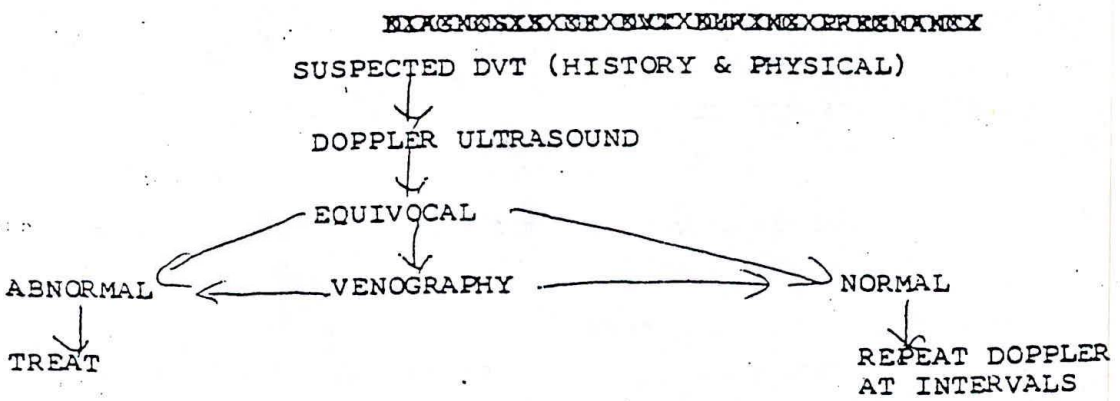
2. Production of fibrinolysis inhibitor by the placenta

3. Venous stasis (Major contributor)

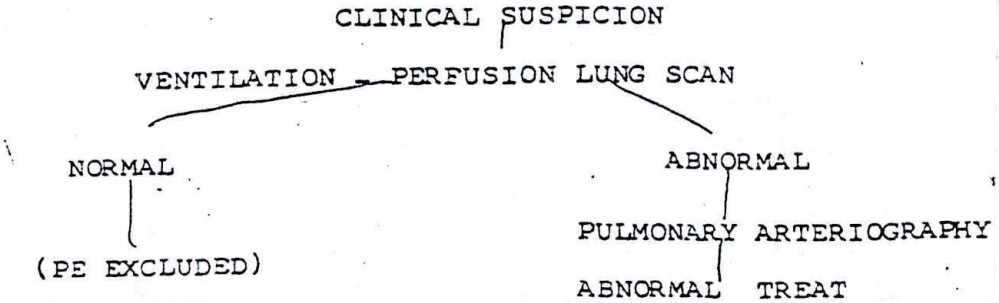
Signs and symptoms of DVT:

Nouspecific, pain, tenderness, positive Homan sign, positive, Lowerberg test, charge in limb color and a palpable cord.

DIAGNOSIS OF DVT DURING PREGNANCY



DIAGNOSIS OF PULMONARY EMBOLUS



TREATMENT OF DEEP VEIN THROMBOSIS

Heparin

Complications of Heparin

-Bleeding

-Thrombocytopenia

-Osteoporosis

HEPARIN PROPHYLAXIS IN SUBSEQUENT PREGNANCY

AMNIOTIC FLUID EMBOLISM:

Hypotension

Hypoxia

Coagulopathy

Mortality - 80%(left - ventricular failure)

Disseminated intravascular coagulation - 40%

AFE -

AFE reported in:

First and second trimester abortion (saline, urea)
Abdominal trauma
Amniocentesis
Vigorous labour and hypertonic uterine contractions
Placental abruptio present in 40%

Treatment:

Mainly supportive

a. Oxygenation
b. Maintenance of cardiac output and blood pressure
c. Combat the severe coagulopathy.

MASSIVE BLOOD LOSS IN OBSTETRICS:

In obstetric practice the threat of massive blood loss should be considered once the patient has lost 1000- 1500 ml.
The fluids used during initial resuscitation depend on clinical circumstances.
Two group of patients can be distinguished.

a. Patients where resuscitation has been delayed - prolonged hypovolemia 30 mins.
- Fluid loss from both circulation & intertitial space
- Lactated Ringers solutions or Isotomic saline (1-2 litres)
- Blood (if not available 1 litre colloid - haemacced)

B. Sudden severe haemorrhage

- Fluid loss from circulation
- First fluid blood or colloid.

After 1-1.5 litres has been infused the situation

a. C V P
b. Arterial pressure
c. Heart rate (from ECG)
d. Hemoglobin & Haematocrit
e. Urine out-put
f- Core-peripheral temperative difference
g. Serum potassium, acid base state, clotting studies.

Practical aspects:

Venous access - 2 lines (14-16 gauge cases)
Blood warmer
Infusers, Microfibration, CVP & arterial line
Metabolic effects.

CONCLUSION:

Thus most of the Obstetric emergencies are connected with massive haemorrhage, be it during pregnancy or labour knowledge and prompt action can save almost all the lives.

Occasionally encountered emergencies like shoulder Dystocia is an Obstetricians nightmare. Rehearse and practise the steps again and again. Display the protocol in the labour rooms. Identify the patients at risk and refer for early Caesarean section.

Emergencies like eclampsia and medical complications should be thoroughly mastered by every PHC medical officer.

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Synopsis (Extended RCH Programme)

Dr. G. V. Vijayalakshmi
Consultant,
K. HSDP

Examination of a Gynaecological patient

- Leucorrhoea - Vaginal Discharge
    - Vaginal swabs for culture
        - For Trichomonas Vaginalis - Kupferberg's or Whittington media.
        - Candidada albicans - Nickerson's or Subouraud's media.
    - Slides - Test for Trichomonas Vaginalis / Candiada albicans
    - Vaginal / Cervical Smear for Exfoliative Cytology

      Indications :

        - Screening Procedure (Down staging of Cancer Cervix)
        - Cytohormonal study and
        - Others

PELVIC INFECTIONS

Causative Organisms - Normal flora of the vagina and cervix.

Exogenous sources - sexually transmitted or following Septic Abortions / Delivery.

I

- Pyogenic - 50%
- Aerobes
  - Gram positive are Staphylococus
  - Gram negative are E. Coli, Pseudomonas, Klebsiella, N. Gonoorhoeae

II STD (Sexually Transmitted Disease)

- N. Gonorrhoeae
- Trachomatis
- Treponema pallidum
- Herpes simplex virus type II
- Human papilloma virus
- Gardnerella vaginalis
- Haemophilus ducreyi
- Donovan bodies
- HIV I or II etc.

III Parasitic - Trichomonas Vaginalis

IV Fungal - Candida albicans

V Viral

- Herpes Simplex virus type II
- Human Papilloma virus
- Condulomata Accuminata

VI Tubercular

- Mycobacterium tuberculosis

Clinical features of Acute Salpingitis, Acute appendicitis and Disturbed Ectopic

Symptoms & Signs	Acute Salpingitis	Acute Appendicitis	Disturbed Ectopic
• Pain	Acute lower abdominal on both sides	Starts near umbilicus but settles to right iiliac fossa	Acute lower abdomen on one side
• Amenorrhoea and bleeding P V	Unrelated	Unrelated	Usually present
• G I symptoms such as nausea, vomiting	Inconsistantly present	Usual	Absent
• General look	Face - flushed	Toxic	Pale
• Tongue	No significant change	Furred	Pale
• Pulse	Rapid but proportionate with temperature	Rapid, out of proportion to temperature	Persistent rise even with normal temperature
• Temperature	More raised	Slightly raised	Not raised
• Tenderness	Lower abdomen on both sides	On McBurney's point. May have music guard	Lower abdomen more on one side
• Per vaginam	Tenderness on both fornices. A mass may be felt	Tenderness on right fornix and hig up	Mass may be felt through one fornix extending to pouch of Douglas.

MODE OF INFECTION

- **Acute Pelvic Infection**
  - Pelvic inflammatory disease (PID)
  - Following delivery and abortion
  - Following gynaecological procedures
  - Following IUCD

- **PID (Pelvic Inflammatory Disease)**
  - Definition
  - Risk factors
  - Protective
  - Microbiology
  - Signs
  - Investigations

- **Clinical Features**
  - Rise of temperature > 38° C
  - Lower abdominal tenderness
  - Tenderness on movement of the cervix
  - Adnexal mass
  - The supportive diagnostic aids are :
  - Blood - Leucocytosis > 10,000 per cu mm
  - Laparoscopic evidence of tubal affection
  - Culdocentesis with purulent fluid having white cell count > 30,000/ml.

- **Differential Diagnosis**

- **Complications**
  - Immediate
  - Late
  - Treatment

OUTPATIENT ANTIBIOTIC THERAPY

- Non-penicillin allergic patient (any one)
  - After 1 gm probenecid orally
  - Amoxycillin 3 gm orally
  - Ampicillin 3.5 gm orally
  - Aqueous procaine penicillin 4.8 mega unit i.m.
- Penicillin allergic patient (any one)
  - Streptomycin 2 gm i.m.
  - Tetracycline 1 gm loading dose
- All patients should receive orally 7-14 days course of (any one)
  - Tetracycline 0.5 gm 4 times a day
  - Doxycycline 0.1 gm twice daily
  - Erythromycin 0.5 gm 4 times a day

INDICATIONS OF INPATIENT ANTIBIOTIC THERAPY

- Adnexal Mass
- Temperature > 38° C
- Uncertain diagnosis
- Unresponsive to outpatient therapy for 48 hours
- Intolerance to oral antibiotics
- Co-existing pregnancy

ACUTE PELVIC INFECTION FOLLOWING DELIVERY OR ABORTION

- **Clinical features**
- **Complicated clinical manifestations**
- **Treatment**
- **Prevention of sepsis**
- **Curative**
  - Hospitalisation
  - Triple swabs for sensitive and Gram stain
  - Bimanual, Vaginal, Rectal expanding
- **Definitive treatment**
  - Supportive therapy
  - Active surgery
  - Late sequelae

ACUTE PELVIC INFECTIONS

- Following Gynaecological procedures
- Clinical features
- Treatment
  - Prophylactic
  - Definitive Treatment

IUCD AND PELVIC INFECTION

With all types more chances in nulliparae

CHRONIC PELVIC INFECTION

- Pyogenic
- Clinical features
- Symptoms
- Important factors for infertility

ON EXAMINATION

- For Abdomen
- For Vagination
- Rectal examination

INVESTIGATIONS

- Blood - WBC
  - TC
  - DC
- Urine examination
  - Routine analysis
  - Culture sensitivity
- Laporoscopy
- Diagnostic Laporoscopy
- Differential Diagnosis
- Management
  - General
  - Specific
  - Surgery

VAGINITIS

- Candida (Moniliasis)
- Chlamydial Vaginitis
- Atrophic
    - Vaginitis
    - Non specific vaginitis
- Toxic shock Syndrome

CEREVICITIS

- Acute
- Chronic
- Endometritis
    - Acute
    - Chronic

ORGANISATIONAL SET UP

OF

HEALTH AND FAMILY WELFARE DEPARTMENT

The health being the State subject under the constitution, the State Governments are responsible for the promotion and protection of Health of their citizens. The health of the people in any area is depended on:

1. Environmental condictions
2. Diseases prevelent in the area
3. Socio-economic status of people
4. Nutrition
5. Availability, accessibility, affordability and acceptability of Health Care Services.

The State Government have, the responsiblity of providing the Health Care Services through the Health Department and other social sectors.

1. Health promotion services
2. Prevention and control of diseases
3. Providing Diagnostic and Curative Services (OPD & IPD)
4. Rehabilitative Health Care Services

To provide above health care services, the Department of Health and Family Welfare has to have an organisation from State Head Quarter to Community Level and to have needed man power, both Medical and Para-Medical and infrastructure facilities by establishing Sub-Centres, PHC CHC and up grading the District Hospitals for providing Health Care Services.

The Health Care Services provided in the State is classified as;

1.Primary Health Care Services	-At Sub-Centres, PHCs
2.Secondary Health care	-CHC, Tq.Level Hospital, Sub-Divisional Hospitals and District Hospitals
3.Tertiary Health Care Services	-Major Hospitals and Super Speciality Hospitals Ex:-Jayadeva Institute of Cardiology, Kidwai Memorial Institute of Oncology NIMHANS etc.,

In addition to above the various National Health and Family Welfare Programmes are to be implemented as per guidelines of Government of India.

Accordingly the Organisation of Health and Family Welfare Department is set up in the State to achieve the above.

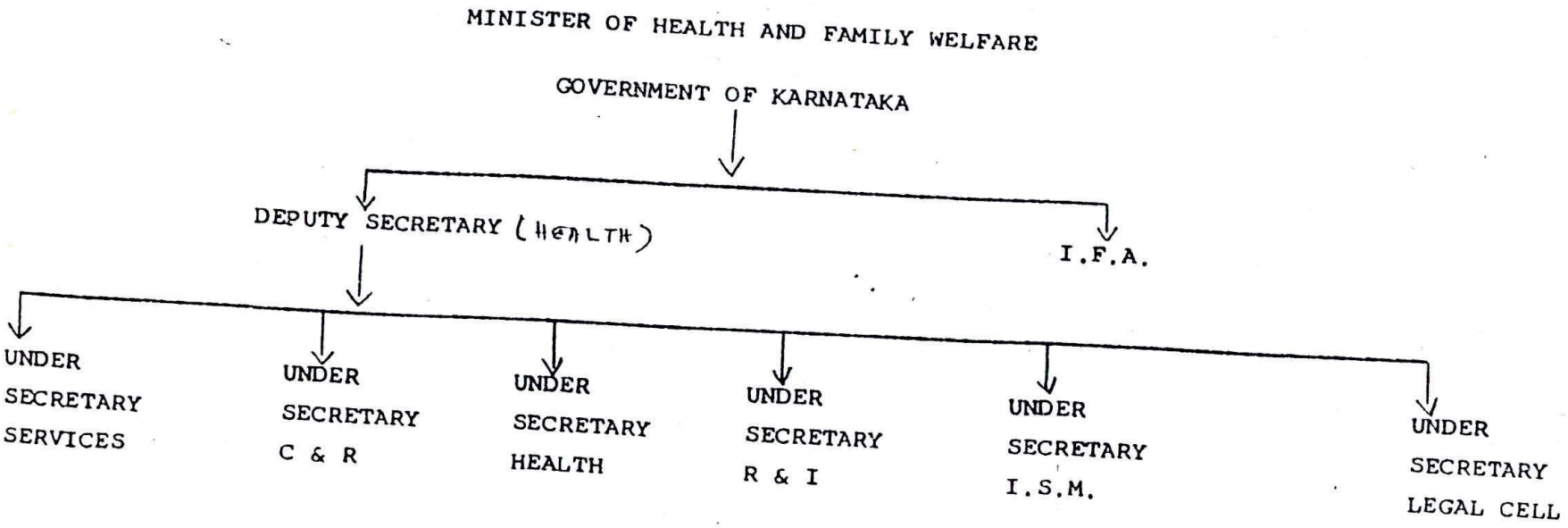
The Organisational set up at different level is enclosed.

ORGANISATIONAL SET UP

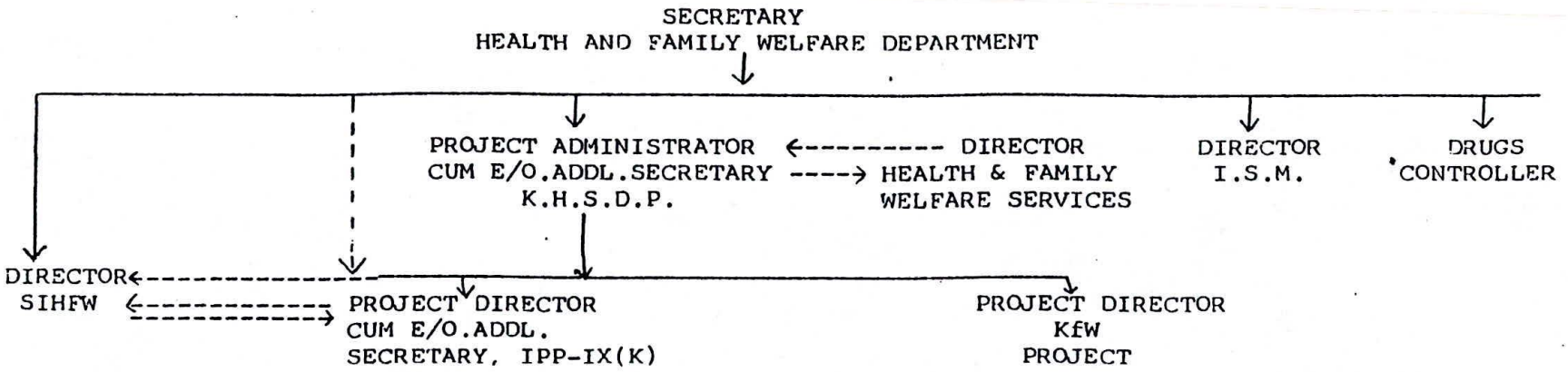
OF

HEALTH AND FAMILY WELFARE DEPARTMENT

SECRETARIAT LEVEL:



STATE LEVEL:


SECRETARY
HEALTH AND FAMILY WELFARE DEPARTMENT
PROJECT ADMINISTRATOR
CUM E/O.ADDL.SECRETARY
K.H.S.D.P.
DIRECTOR
HEALTH & FAMILY
WELFARE SERVICES
DIRECTOR
I.S.M.
DRUGS
CONTROLLER
DIRECTOR
SIHFW
PROJECT DIRECTOR
CUM E/O.ADDL.
SECRETARY, IPP-IX(K)
PROJECT DIRECTOR
KfW
PROJECT

ORGANISATIONAL SETUP OF
HEALTH AND FAMILY WELFARE DEPARTMENT

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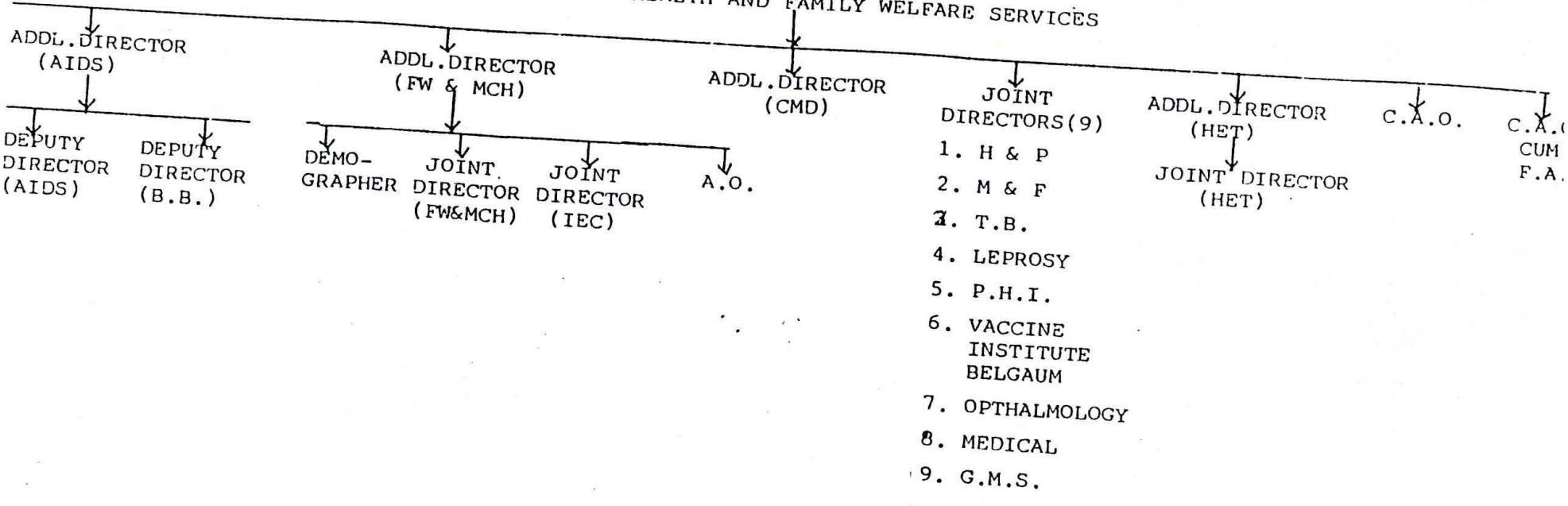
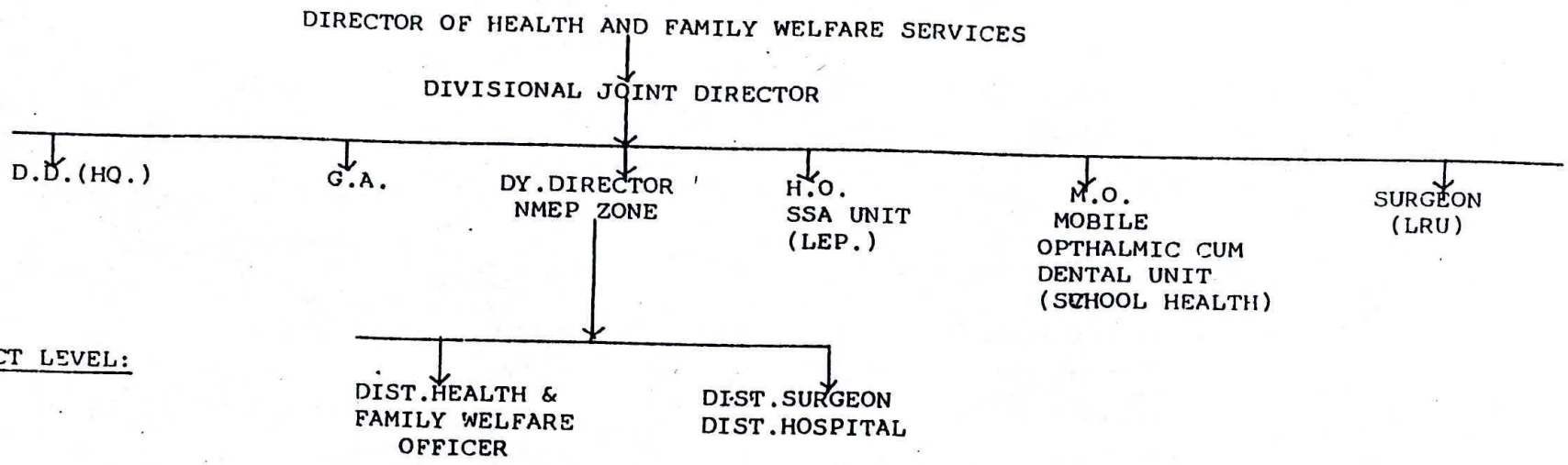
DIRECTORATE LEVEL:



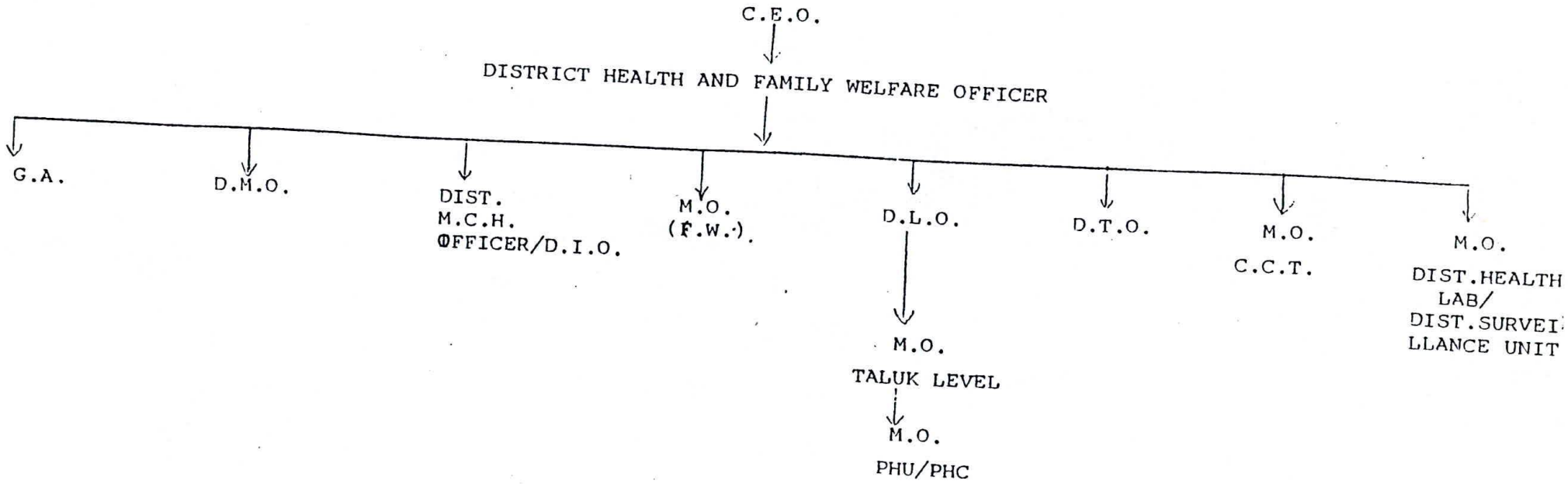
DIVISIONAL LEVEL



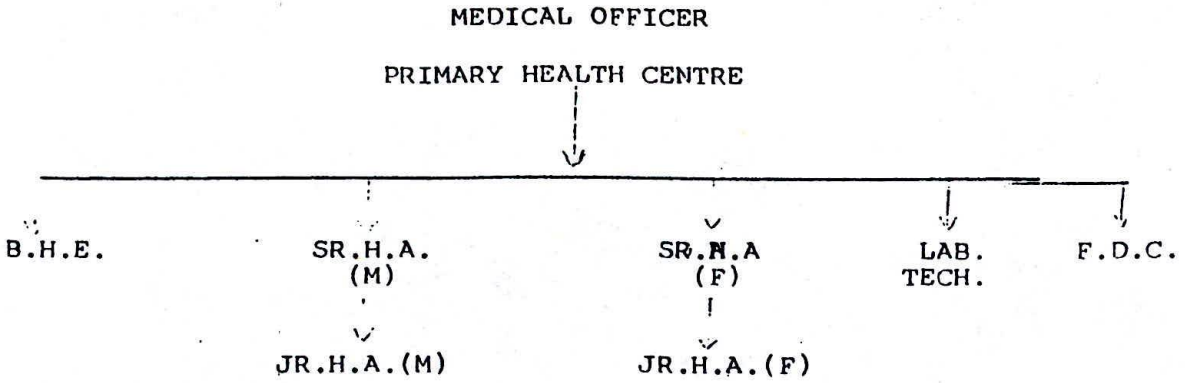
DISTRICT LEVEL:

DISTRICT LEVEL

ZILLA PANCHAYAT



BLOCK LEVEL


MEDICAL OFFICER
PRIMARY HEALTH CENTRE
B.H.E.
SR.H.A. (M)
JR.H.A.(M)
SR.N.A (F)
JR.H.A.(F)
LAB. TECH.
F.D.C.

K A R N A T A K A

Demographic Scene at a Glance:

1.	Karnataka is one of the 8th Major State in India.	
2.	Geographical area	- 1.92 lakhs Sq.Km.
3.	Projected Population	- 5 Crores
4.	No.of Revenue Divisions	- 4
5.	No.of Districts	- 20 + 7 New Districts
6.	Taluks	- 175
7.	Urban Population	- 2.40 Crores
8.	Rural Population	- 3.10 Crores
9.	Male	- 2.30 Crores
10.	Female	- 2.20 Crores
11.	Sex Ratio	- 960 Females/1000 Males.

Health Institutions in Karnataka

1.	Total No.of Health Institutions	- 2336
2.	Total Bed Strength	- 38505
3.	Teaching Hospitals	- 17
4.	No.of District Hospitals	- 20 + 7
5.	No.of Hospitals 50 - 100 Beds	- 52
6.	No.of Community Health Centres	- 242
7.	No.of Primary Health Centres (GOIP 262 + MNP 1332)	- 1601
8.	No.of Primary Health Units	- 589
9.	No.of Sub-centres	- 8143
10.	No.of Maternity Annexes	- 279
11.	Population Bed Ratio	- 1.428/1000 Population.

Demographic Para-meter:

1.	Annual growth rate	- 1.9%
2.	Decimal growth rate	- 21.11%
3.	Birth Rate	- 23
4.	Crude Death rate	- 7.3
5.	I.M.R.	- 53
6.	M.M.R.	- 4.5
7.	Reproductive age group (F)	- 15-29Yr.
8.	Mean age of marriage of girls	- 19.4 yr.
9.	Life Expectancy - Male	- 65-55 Yr.
	-do- - Female	- 66-55 Yr.

P.T.O.

Beds Distributed in Health Institutions:-

District Hospital - 250 to 750 - 2 million
Taluka Hospitals - 30 - 100 & above
Community Health Centres - 30 - 50 beds
Primary Health Centres - 6
Population Bed Ratio - 1.428/1000 Population

Mysore Type of Dispensary/PHU.	Population	Cost
Primary Health Unit - 589	15000	6.00 lakhs

Sanction of Primary Health Units stopped since 1984.

87

ಕರ್ನಾಟಕ ಸರ್ಕಾರ ನಡವಳಿಗಳು :

ವಿಷಯ: ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆಯ ಅಧಿಕಾರಿಗಳಿಗೆ ಪುನರ್ಪರಿಶೀಲಿತ ವಿಶೇಷ ಆರ್ಥಿಕ ಅಧಿಕಾರಗಳನ್ನು ಪ್ರತ್ಯಾಯೋಜಿಸಿ ಆದೇಶ ಹೊರಡಿಸುವ ಬಗ್ಗೆ.

ಸರ್ಕಾರದ ಆದೇಶ ಸಂಖ್ಯೆ:ಹೆಚಿಫಡಬಿಎ:447:ಐಎಫಡಬಿಎ:96 ಬೆಂಗಳೂರು ದಿನಾಂಕ ಏನೇ ಸೆಪ್ಟೆಂಬರ್ 1996

ಓದಲಾಗಿದೆ:— 1) ಸರ್ಕಾರದ ಆದೇಶ ಸಂ:ಹೆಮವಾಯ:21:ಪಿಟಿಡಿ:71 ದಿನಾಂಕ: 14—4—72.
2) —"— ಹೆಮವಾಯ:5:ಪಿಪಿಎಂ:75:28—2—75
3) —"— ಹೆಮವಾಯ:193:ಪಿಟಿಡಿ:75:29—11—76.
4) —"— ಹೆಚಿಎಫಡಬಿಎ:175:ಎಯಿನ್ಸ:76 ದಿ:26—7—75.
5) —"— ಎಫಡಿ:3:ಬಿಇಬಿ:80 ದಿ:7—10—80.
6) ತಿದ್ದುಪಡಿ ಆದೇಶ ಸಂ:ಎಫಡಿ:1:ಬಿಇಪಿ:82 ದಿ:28—4—82.
7) ಸರ್ಕಾರದ ಆದೇಶ ಸಂ:ಎಫಡಿ:3ಕೆಟಿಎನ್ಪಿ:81(1)ದಿ:17—5—82.
8) ನೇರ್ಪಡೆ ಆದೇಶ ಸಂ:ಎಫಡಿ:3:ಟಿಎಫಪಿ:81(2):ದಿ:20—5—82.
9) ಸರ್ಕಾರದ ಆದೇಶ ಸಂ:ಹೆಚಿಎಫಡಬಿಎ:187:ಸಿಜಿಇ:81 ದಿ:20—8—82.
10) ನೇರ್ಪಡೆ ಆದೇಶ ಸಂ:ಹೆಚಿಎಫಡಬಿಎ:187:ಸಿಜಿಇ:81 ದಿ:19—1—83.
11) ನೇರ್ಪಡೆ ಆದೇಶ ಸಂ:ಎಫಡಿ:9:ಬಿಇಪಿ:83 ದಿ:28—7—83.
12) ಸರ್ಕಾರದ ಆದೇಶ ಸಂ:ಹೆಚಿಎಫಡಬಿಎ:17:ಸಿಜಿಇ:83 ದಿ:11—1—1—63.
13) ಸರ್ಕಾರದ ಆದೇಶ ಸಂ:ಹೆಚಿಎಫಡಬಿಎ:131:ಸಿಜಿಇ:85 ದಿ:4—12—86.
14) —"— ಎಫಡಿ:7:ಬಿಎಫಪಿ:91 ದಿ:16—9—91.

— — — —

ಮೇಲೆ ಓದಲಾದ ಸರ್ಕಾರದ ಆದೇಶಗಳಿಂದ ಹೆಚ್ಚಿನ ಸಾಮಾನ್ಯ ವಿಶೇಷ ಆರ್ಥಿಕ ಅಧಿಕಾರಗಳನ್ನು ಇಲಾಖಾ ಮುಖ್ಯಸ್ಥರಿಗೆ ಮತ್ತು ಇಲಾಖೆಯ ಇತರೆ ಅಧಿಕಾರಿಗಳಿಗೆ ಕಾಲಕಾಲಕ್ಕೆ ಪ್ರತ್ಯಾಯೋಜಿಸಲಾಗಿದೆ.

ಇಲಾಖಾ ಮುಖ್ಯಸ್ಥರಿಗೆ ಮತ್ತು ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆಯ ನಿಯಂತ್ರಣದಲ್ಲಿ ಬರುವ ಇತರೆ ಅಧಿಕಾರಿಗಳಿಗೆ ಪ್ರತ್ಯಾಯೋಜಿಸಿರುವ ವಿಶೇಷ ಆರ್ಥಿಕ ಅಧಿಕಾರಗಳನ್ನು ಹೆಚ್ಚಿಸುವ ಪ್ರಸ್ತಾವನೆಯನ್ನು ಕೆಲವಿನಗಳಿಂದಲೂ ಸರ್ಕಾರದ ಪರಿಶೀಲನೆಯಲ್ಲಿತ್ತು. ಆಯಕಟ್ಟಿನ ಎಲ್ಲಾ ಹಂತಗಳಲ್ಲಿ ಕಾರ್ಯಕ್ಷಮ ವಿಧಾನವನ್ನು ಮುನ್ನಡೆಸುವ ನಿಟ್ಟಿನಲ್ಲಿ ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆಯ ಅಧಿಕಾರಿಗಳಿಗೆ ಮೇಲೆ ಕ್ರಮ ಸಂಖ್ಯೆ 13 ರಲ್ಲಿ ಓದಲಾದ ಸರ್ಕಾರದ ಆದೇಶದ ಪ್ರಕಾರ ಪ್ರತ್ಯಾಯೋಜಿಸಲಾದ ಈಗಿರುವ ವಿಶೇಷ ಆರ್ಥಿಕ ಅಧಿಕಾರಗಳನ್ನು ಹೆಚ್ಚಿಸುವುದು ಅವಶ್ಯಕವೆಂದು ಸರ್ಕಾರವು ಭಾವಿಸಿದೆ.

ಆದ್ದರಿಂದ ಇಲಾಖೆಯ ವಿವಿಧ ಅಧಿಕಾರಿಗಳಿಗೆ ವಿಶೇಷ ಆರ್ಥಿಕ ಅಧಿಕಾರಗಳನ್ನು ಪ್ರತ್ಯಾಯೋಜಿಸಿ ಈ ಹಿಂದೆ ಹೊರಡಿಸಿರುವ ಎಲ್ಲಾ ಆದೇಶಗಳನ್ನು ರದ್ದುಪಡಿಸಿ, ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆಯ ಮತ್ತು ವೈದ್ಯಕೀಯ ಶಿಕ್ಷಣ ಇಲಾಖೆಯ ವಿವಿಧ ಅಧಿಕಾರಿಗಳಿಗೆ ಹೆಚ್ಚಿನ ವಿಶೇಷ ಆರ್ಥಿಕ ಅಧಿಕಾರಗಳನ್ನು ಈ ಆದೇಶದಲ್ಲಾಯಿಗೆ ಲಗತ್ತಿಸಿರುವ ಅನುಬಂಧದಲ್ಲಿ ಸೂಚಿಸಿರುವಂತೆ ಪ್ರತ್ಯಾಯೋಜಿಸಲು ಸರ್ಕಾರ ಮಂಜೂರಾತಿಯನ್ನು ನೀಡಿದೆ.

ಈ ಆದೇಶವನ್ನು ಆರ್ಥಿಕ ಇಲಾಖೆಯ ಅನೌಪಚಾರಿಕ ಟಿಪ್ಪಣಿ ಸಂ:ಎಫಡಿ:3:ಬಿಎಫಪಿ: 96 ದಿ:28—2—96 ರಲ್ಲಿ ನೀಡಿರುವ ಸಹಮತಿಗನುಗುಣವಾಗಿ ಹೊರಡಿಸಲಾಗಿದೆ.

ಕರ್ನಾಟಕ ರಾಜ್ಯಪಾಲರ ಆದೇಶಾನುಸಾರ ಮತ್ತು ಅವರ ಹೆಸರಿನಲ್ಲಿ.

(ಜಾಯಪ್ಪ ನಂಜಪ್ಪಯ್ಯ),
ಅಂತರಿಕ ಆರ್ಥಿಕ ಸಲಹಾಗಾರರು
ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ.

ನಂಬಿನೋಡಿ.

ಸಂಖ್ಯೆ : ಎಸಆರಆಅ 19 91—92.

ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ
ಸೇವೆಗಳ ನಿರ್ದೇಶನಾಲಯ,
ಬೆಂಗಳೂರು—9, ದಿನಾಂಕ: 12—4—96.

ಪ್ರತಿಯನ್ನು ಕೆಳಕಂಡವರಿಗೆ ರವಾನಿಸಲಾಗಿದೆ.

1) ಈ ನಿರ್ದೇಶನಾಲಯದಲ್ಲಾಯಿಗೆ ಸ್ಥಿರ ಪತ್ರ ವ್ಯವಹಾರ ನಡೆಸಲಿರುವ ಎಲ್ಲಾ ಪರಿಚಿಕಸ್ಥರಿಗೂ ಸೂಚನೆ ಮಾಹಿತಿಗಾಗಿ.

2) ಈ ನಿರ್ದೇಶನಾಲಯದ ಎಲ್ಲಾ ವಿಭಾಗದ ಪರಿಚಿಕಸ್ಥರಿಗೂ ಮಾಹಿತಿಗಾಗಿ ಮತ್ತು ಸೂಕ್ತ ಕ್ರಮಕ್ಕಾಗಿ.

3) ಕಪ್ಪು : ಕಪ್ಪು.

ನಿರ್ದೇಶಕರ ಪರವಾಗಿ,
ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಸೇವೆಗಳು.

12/4/96.

ಟಿಪ್ಪಣಿ:

ANNEXURE TO GOVT.ORDER NO.HFW 447 IFW 96 BANGALORE, DATED 8TH MARCH 1996

Sl. No.	Description of powers	Director of HFW/DME/ Addl.Director(MCH&FW) Addl.Director (AIDS)/ Addl.Director (Project)/ (CMD)/Addl.Director(KHSDP).	JDS working as Programme Officers in the Directorate/ Divisional JDs/ Principals of Medical/Dental Colleges/Supdt. of teaching Hospitals/ Chief Admn. Officer/Director Minto Regional Inst. of Ophthalmology. JD(CMS)/ JD(Vaccine Inst.)Belgaum/ JD.PHI,Blore, JD.,TB.Blore.	DD/List.HFW Officer/ dist. Surgeon/Dy. CMC/Senior Specialist/ Principal of HFW Training Centres/ College of Nursing/Admn. Officers,DD (PHIT/LD/ Health Officer (SSA UNIT)/ Medical Officer Leprosy Hospital/ Surgeon IRPU/ DD. VBD Shimoga.	Taluk Level Medical Officers/ Sr.Medical Officer/Specialist/Duty Medical Officer Specialist/ Deputy Medical Officer at Taluk Level/ DLC/EMO/DTC/ Medical Officer Dist. Health Laboratory/ Medical Officer(FW&MCH) Medical Officer (EPC) Medical Officer (IITT)/Dist. Training Officer.
1	2	3	4	5	6
1.	To approve the list of candidates for training, Radiographers, Health Inspectors and other categories subject to the Number of candidates and the rates of stipends fixed by government.	Full powers	Full powers	-	-
2.	a. To depute the staff of the Maximum pay of whom is below for Service under local bodies the foreign services rules KCSRs to Commercial under takings (1) in place of Rs.2175/- the current maximum pay of the related post (i.e. class-I Junior Scale Grade in	three years	three years (non-Gazetted)	-	-

1	2	3	4	5	6
5	c. Demmurage and welfare charges provided they are not caused by the negligence of any Government servant.	Full power	Rs.2,500/- each time	Rs.2,000/- each time	Rs.500/- each time
	d. Purchase of X-ray photo films	Full powers	Full power	Full power	Full power
	e. Maintenance of frogs, rabbits, dogs, rats, white rats and other animals required for experiments in Medical Colleges and other Institutions.	nil	Rs.10,000/- each time	Rs.5,000/- each time	-
	f. Supply of shoes to the inmates of Mental Hospital and Leprosy Institutions per year..	- ..	Rs.150/- per each pair of shoes per inmate (Mental Hospital) Rs.200/- to inmate of Leprosy Hospital per case per year	Rs.150/- per each pair of shoes inmate of Mental Hospital and Rs.200/- per inmate of Leprosy Hospital per case per yr.	Rs.150/- per each paid of shoes to inmate of Mental Hospital and Rs.200/- per pair of shoes, to inmates of Leprosy Hospital per case per year.
	g. Measures for control of Plague and other under the following Heads.				
	i) Construction and repairs of segregation camps and Hospitals	full power	Rs.5,000/-	Rs.2,500/-	Rs.1,000/-each time to control plague.
	ii. Purchase and carriage of Medicines	-	-	-	-
	iii. Dietary charges	-	-	-	-

1	2	3	4	5	6
6.	Glassware, Chemicals & Acids, other Laboratory necessaries to Colleges and other Institutions.	Full powers	Rs.25,000/- each time limited to Rs.1/-lakh per annum	Rs.50,000/- each time limited to Rs.1/-lakh per annum	-
7.	To sanction expenditure on fixing replacement of parts and servicing or repairs of				
	a. X-ray, Ultrasound, Endoscopy and other machines.	Full powers	Rs.10/-lakhs per annum	Rs.5/-lakhs per annum	Rs.10,000/- per annum
	b. Sterilisers/Microscopes/ Refrigerators and other equipments.	Full powers	Rs.2/-lakhs per annum	Rs.1/- lakh per annum	Rs.10,000/per annum
	c. Bedding/Clothing/Cots/Lockers and equipments.	Full powers	Rs.5/-lakhs per annum	Rs.1/- lakh per annum	Rs.25,000/- per annum
	d. Urgent repairs of Buildings in respect of Electricals/Sanitation and water supply etc.	Full powers	Rs.2/- lakhs per annum	Rs.1/- lakh per annum	Rs.10,000/- per annum
8.	To accept Gifts and Donations for public or instruments for institutions under the control of the Department.	Full powers	Full powers	Full powers	Full powers
9.	To sanction expenditure out of poor fund of the Hospital	Full powers	Full powers	Rs.500/-each time	Rs.50/- each time
10.	To get forms not supplied by Government Press, printed by Private Presses.	Full powers	nil	Rs.10,000/- each time limited to Rs.1/-lakh per annum.	Rs.10,000/- per annum
11.	To condemn Time-barred Drugs and to order their disposal	Full powers	Full powers to the extent of the powers to purchase these items.	-	-

1	2	3	4	5	6
19.	Purchase and production of film 16 or 35 mm and Video films	Full powers	Rs.3/- lakhs per annum for purchase only.	-	-
20.	Exhibition i.e. Mysore Dasara Major Exhibition Programme	Rs.5/- lakhs each time	Rs.1/- lakh per annum	-	-
21.	Printing of publication reports/ Manual Guidelines.	Full powers.	-	-	-

sd/-x
(JOYCE SURYADEVI)
Internal Financial Adviser,
Health and Family Welfare Deptt.

/COPY/

for Director of Health & FW Services.

12/11/96.

RECRUITMENT

THE KCS (GENERAL RECRUITMENT RULES, 1977)

- Sri. P. Ramanathan*

A) APPLICATION:

APPLICABLE (RULE 1 (3) (A)

1) To all Civil Services and posts to which there are no special rules.
2) Even where there are special rules, where these rules contain an over-riding provision (non-obstatante clause) or where in the special rules there are no specific provision.

NOT APPLICABLE (RULE 1 (3) (B))

1) To All India Services.
2) To Industrial undertakings.
3) To Casual employment.
4) To Work-charged establishment.

B) METHODS OF RECRUITMENT:

This is the core of the rules. The rules give the different methods of recruitment and the incidental provisions.

Basic methods of recruitment	Exceptional methods of recruitment
(1) Direct recruitment (R-3)	1) Re-employment (R-15 (1) (a))
(2) Promotion (R-3)	2) Contract (R-15(1)(b)
(Note: Of the two methods the method to be followed and the qualifications required shall be specified by the C&R Rules).	3) Transfer (R-16) 4) Deputation (R-16)

* Consultant, DPAR.

(1) DIRECT RECRUITMENT:

Definition: Appointment otherwise than by promotion, transfer, re-employment or contract is direct recruitment (Rule 2 (1) (g)).

There are two methods of direct recruitment:-

(i) by competitive examination;
(ii) by selection (Rule 3 (1)).

PROCEDURE OF APPOINTMENT:

If by competitive examination in the order of merit prepared by the selecting authority on the basis of such an examination (Rule 4 (1)(a)).

If by selection, after giving adequate publicity in the order of merit determined by the selecting authorities (Rule 4 (1)(b)).

(2) PROMOTION:-

Definition:- Appointment of a Government Servant from a post/grade/class of service to a higher post/grade/class of the service (Rule 2(1)(m)).

(Manager Sri V. Rangachari AIR 1962 SC 36).

Here also there are two methods:-

(i) Promotion by selection;
(ii) Promotion on the basis of seniority-cum-merit Rule 3(1)

PROCEDURE OF PROMOTION:-

If by selection

(i) On the basis of merit with due regard to seniority (Rule 4 (2)(a))
(ii) merit is determined on the basis of service records - ACRs, APRs, personal dossier and SR.

(iii) Seniority brings within the zone of consideration only (provision to Rule 3(3)(a)).

Union of India -V/s.-Srivatsava - 1979 (2) SLR 116 SC)

Zone of consideration is 2n + 4 where 'n' is the number of vacancies.

(iv) Seniority is not the sole criterion but it counts when two or more persons are of equal merit.

(N.K.Panda - Vs-Union of India - 1977 (2) SLR 589 (Orissa)

(v) This method or provision is limited to the post of Heads of the Departments and Additional Heads of the Departments in equivalent grade - Rule 3(2)(a)

If on the basis of seniority - cum - merit.

(i) If from one cadre or class of posts - on the basis of inter-se seniority - Rule 4 (1) of the Seniority Rules.
(ii) If from several cadres or classes of posts of the same grade by the length of service - Rule 4 (2) of the Seniority Rules.

Note:- This provision prevalis where the C&R rules are silent and does not provide a ratio).

(iii) If from several cadres or classes of posts of different kinds, by the order in which the names are arranged by the appointing authority - Rule 4 (iii) of Seniority rules).
(iv) This method of promotion is applicable to all posts other than HOD and AHODs - Rule 3(2)(b).

(3) **RE-EMPLOYMENT:-**

(1) Restricted to appointment of retired Government servants of the State Government, Central Govt., and other State Governments.
(2) Terms and conditions are unilateral - one sided determined by Government under rules.
(3) Period of re-employment as may be necessary and as determined by the Government. There is no limitation - Rule 15 (1)(a)

(Note:- Extension of service in continuation of service end it cannot be granted beyond 60 years) - Rule (15 (n) of KCS)

(4) **CONTRACT:-**

(1) Slightly different from re-employment.

(5) any eligible and suitable person can be appointed.

(b) duration of the appointment is normally not beyond five years.

(OM No. DPAR 15 SDE 85. Dated 11th June 1985)

(5) **TRANSFER AND DEPUTATION:-**

(i) Government may appoint to a post an Officer of the Defence Service. An All India Service or a Civil Service of the Union or the Civil Service of any other State. This appointment can be either by transfer or deputation. For such transfer or deputation equivalence of grade is not necessary.

(ii) Government may also order transfer or deputation, from one service to other service or one department to other within State Civil Services.

(iii) To effect transfer or deputation from one service to other the following conditions should be satisfied.

(a) Reasons to be recorded in writing.

(b) The post in which the official is working and the post to which he has to be transferred or deputed should be in an equivalent grade.

(c) The official should be capable of discharging the duties of the post to which he is transferred or deputed.

(iv) Government may appoint an official who is permanently incapacitated for the post which he is holding or to another post where his services can be utilised. Such appointments.

(a) cannot be to a lower post unless the official consent to it or

(b) to a higher post unless there is no equivalent post.

Government may similarly appoint an official whose service is temporary incapacitated. Such an appointment can be only for the duration of the temporary incapacitation.

(6) Government may appoint by deputation of a person to any Group-A post in the State Civil Services. If such a person is:-

(a) In the service of any University in India;
(b) In an equivalent grade; and
(c) in possession of speacialised qualification;

Period of deputation - not exceeding five years.

C) MATTERS RELATING TO DIRECT RECRUITMENT

D) DISQUALIFICATION: It is a negative provision. The qualification is, not to possess the disqualifications listed by the rules.

The disqualifications are:-

(1) Not being:-

(a) a citizen of India, or
(b) a subject of Nepal, or
(c) a subject of Bhutan, or
(d) a Tibetian refugee, or
(e) a person of Indian origin migrated from Pakistan, Burma, Sri Lanka and East African Countries of Kenya, Uganda, Tanzania, Zambia, Malawi, Zaire, Ethiopia and Vietnam;

(2) a man having more than one wife living;
(3) a woman married to a man already having a wife;
(Govt. may exempt the operation of this rule in special cases).
(4) Persons attempting extraneous support for appointment;

(5) applicants in Govt. employment not making the application through proper channel (Exception Local Candidates);
(6) for appointment as peon-not passing standard examination and not expressing willingness to serve as Home Guards;
(7) persons associated with unlawful organisation.
(8) Persons associated with activities such as
- subversion of the Constitution;
- Organised breach of law involving violence;
- causing prejudice to the interests of sovereignty, integrity or security of the State;
- promoting disharmony among different sections of the people;

(9) persons dismissed from Central or State Govt. Services;
(10) persons permanently debarred by the UPSC or any State PSC.
(11) persons convicted of an offence involving moral turpitude shall not be appointed unless all the circumstances are reviewed and their suitability tested.
(12) persons temporarily debarred by the UPSC or State PSC's shall not be appointed unless all the circumstances are reviewed and their suitability tested.

- Rule 5.

2) AGE

(1) MINIMUM	MAXIMUM
18	38 - SCs/STs/Category II
	36 - OBCs
	33 - GM

Age to be reckoned with reference to the last date fixed for the receipt of applications or a date specified by the appointing authority.

- Rule 6 (1)

(2) If the C&R rules do not provide for enhanced upper age limits for SCs/STs and other Backward Classes, then these upper age limits will prevail - Rule 6(2)
(3) If the C&R rules provide for lesser upper age limits, then these upper age limits will prevail - Rule 6 (2A)
(4) Relaxation and enhancement in upper age limits.

(a) **Relaxation:-**

In the case of repatriates from East Pakistan (Bangladesh), Burma, Ceylon (Sri Lanka), East African Countries (Kenya, Uganda, Tanzania, Zambia, Malabi, Zaire, Ethiopia and Vietnam, the upper age limit shall be relaxed;

(i) by 3 years for recruitment through competitive examination;
(ii) upto 45 years for all other recruitments;

and

this shall be further relaxed by 5 years for SCs and Sts among them.

(b) **Enhancement:**

(1) by 10 years in the cases of a candidate;

i) who is or was holding a post under the Government or a local authority or a Corporation (if the number of years of service is less than 10 years then by the number of years of service);
ii) who is physically handicapped
iii) who is a widow;
iv) who was a bonded labourer;

(2) by 5 years in the case of a candidate;

i) for appointment to a Group-B post on the personnel establishment of a Minister, Minister of State or a Deputy Minister coterminus with the tenure of the Minister;
ii) who is or was holding a post under the census organisation. (If the number of years of service is less than 5 years then by the number of years of service);

(3) by the number of years of service in the case of a candididate;

i) who is an ex-serviceman + 3 years;
ii) who is a rleased NCC full time Cadet Instructor;
iii) who is or was a Village Group Inspector under Rural Industrialisation scheme;
iv) who is or was a member of the Staff of former Maharaja of Mysore.

(Rule 6 (3)(b))

Application through proper channel:

Persons already in Government service should make the application through the appointing authority.

This condition is not applicable to Local Candidates. (Rule 11)

FEE

i) As prescribed by the PSC or other recruiting agency in consultation with Government in respect of application and examination;
ii) as prescribed by Government in respect of medical examination.

Exemption of fee:

i) Total exemption in respect of SCs/STs/Category-I
ii) This exemption in respect of displaced Goldsmiths;
iii) total exemption in respect of migrants from Bangladesh, Burma and Srilanka for recruitment through PSC only.

(Rule - 13)

Suitability and Character:

i) to be tested by detailed verification int he case of Group A &B;
ii) to be tested on the basis of certificates in the case of Group C&D

(Rule-19)

Physical Fitness:

i) detailed examination by a medical Board in respect of Group A&B
ii) On the basis of a certificate after examination by a Medical Officer not below the rank of an Assistant Surgeon.

(Rule-12)

Joining Time:

i) 15 days from the date of despatch of the appointment order by registered post;
ii) pointing authority may grant such further time as deemed necessary on application made within time;
iii) the name of a candidate who does not assume charge of the post within the prescribed time or extended time shall stand deleted from the select list.

(Rule - 18)

Probation:

All appointments by Direct Recruitment shall be on probation for such period, not being less than two years. (Rule - 19)

Misconduct:

A candidate producing falsified documents or using unfair means in connection with his recruitment is liable to;

i) criminal prosecution;
ii) disciplinary action;
iii) debar permanently or temporarily by the Commission from admission to an examination or interview;
iv) debar from employment by Government.

Ex-servicemen and Physically Handicapped.

Wherever there is an element of direct Recruitment 10% of the vacancies available for such direct recruitment on any occasion shall be earmarked for ex-servicemen, 5% for physically handicapped persons, and 30% for women.

This is a reservation under Article 16 (1) of the Constitution of India. This is called horizontal reservation whereas reservation under Article 16(4) of the Constitution of India is called vertical reservation. The horizontal reservation has to be within the vertical reservation and the overall reservation should not exceed 50%

For this purpose 10% of the vacancies for Ex-servicemen, 5% of the vacancies for physically handicapped and 30% of the vacancies for women shall be set apart in each of the categories of general, merit, scheduled castes, scheduled tribes and in each of the categories among other backward classes identified under Article 16 (4)

(Rule -9 and 3B)

Officiation: - All appointments by promotion shall be on officiating basis.

The period of officiation shall be one year unless otherwise prescribed in the C&R rules.

This period of officiation may be extended by another year by appointing authority. No further extension is permissible.

The period of officiation may be valued if the official has already discharged for the period of one year duties of the post to which he is promoted.

The period of officiation may be reduced by such period not exceeding the period during which the official has already discharged if any, the duties of such post.

On the expiry of the period of officiation either it has to be declared as satisfactorily completed or the official reverted.

After declaration of period of officiation the official may be confirmed at the earliest available opportunity.

INSTRUCTION ON PROMOTION:-

No person retained in service after the date of superannuation shall be promoted to a higher post.

This restriction does not apply to officials who have been retained in service upto the last day of the month in which they have attained the age of superannuation, in accordance with rule 95 (a) of the KCSRs.

COMMON PROVISIONS:

(Rule -7)

1) **Reservation:-** Reservation for Scheduled Castes/Scheduled Tribes and other Backward classes shall be made to such extent and in such manner as may be specified by Govt. under Article 16 (4) of the Constitution. (Rule - 8)

Government have been issuing orders under Article 16 (4) from time to time and at the moment orders issued on 20-6-1995 and connected orders in respect of direct recrutiment and orders issued on 27.4.1978 and the connected orders in respect of promotion

are in force. The policy of reservation is not applicable to other methods of recruitments.

2) Appointment by direct recruitment or by promotion:-

i) a vacancy identified for promotion may be filled up by direct recruitment if no eligible person is available for promotion;

ii) a vacancy identified for direct recruitment may be filled up by promotion when such vacancy is not likely to last for more than one year;

PROBATION/OFFICIATION

No person who has not completed the period of probation or officiation, as the case may be satisfactorily, shall be eligible for promotion.
-Second provision to rule 3 (1)

Seniority

I. Application

The Seniority Rules, 1957 are applicable to all Government servants except to -

(a) local candidates (Rule -1A)

(b) allottees in determining their initial seniority. (Their seniority shall be determined in accordance with section 115 of the State Re-organization Act, 1956 and the orders issued thereof).

II. Principles of Seniority

What is Seniority ?

Persons appointed earlier either by direct recruitment or by promotion in accordance with the rules of recruitment are senior to those appointed subsequently. In other words appointees of one occasion are senior to the appointees of the next or subsequent occasion/s if it is within the frame work of rules of recruitment and this is what is known in service jurisprudence as seniority according to continuous length of service in the cadre or grade.

(G.S. Lamba V/s Union of India)
1985(1) SLR 687 SC)

(1) Appointments can be made on a permanent (substantive) basis or on a temporary (officiating) basis.

(2) Officiating appointment can be made substantive by the process of confirmation. An official can be confirmed when the following conditions are satisfied :

(i) availability of a clear vacancy against a permanent post ;
(ii) the period of probation / officiation of the official is declared to have been completed satisfactorily ;
(iii) the official has passed the prescribed examination, if any, to the cadre / post;
(iv) the official is the senior most eligible person in accordance with the seniority list.

(3) An official appointed on substantive basis is senior to all officials appointed on officiating basis in the same cadre of service or class of posts immaterial of the length of service. Rule 2(a)

(B.N. Nagarajan V/s State of Karnataka)
(197992) SLR 116 SC)

(4) Amongst the officials appointed substantively the interse seniority is to be determined according to the dates of confirmation but if it is the same, on the basis of their interse seniority while officiating in the same grade and if not on the basis of their interse seniority in the lower grade (Rule 2(f)

(5) Amongst the officials appointed on officiating basis their interse seniority is to be determined on the basis of officiation in the same grade and if it is the same, on the basis of officiation in the lower grade. (Rule 2(c)

(N.K. Chauhan V/s State of Gujarat)
(AIR 1977 SC 251)

III. Seniority Between Direct Recruits and Promotees

1. (1) A factor to be taken into account while determining the seniority in accordance with these rules in the proportion or the quota prescribed for direct recruitment and promotion in a cadre in the Cadre and Recruitment Rules.

(2) Direct recruitment and promotion are possible only by the methods and procedure prescribed in the rules of recruitment.

(V.B. Badami V/s State of Karnataka)
(IR 1980 SC 156)

(3) When there is a quota, the quota cannot be altered according to the exigencies of the situation.

(S.C. Jaisingani V/s Union of India
1957(2) SCR 703 SC)

(V.B. Badami V/s State of Karnataka
AIR 1980 SC 156)

(4) Promotions made in excess of promotional quota though not illegal are irregular. The excess promotees have to be absorbed in subsequent vacancies within their quota.

(S.C. Jaisingani V/s Union of India
1957 (2) SCR 703 SC)

(V.B. Badami V/s State of Karnataka
AIR 1980 SC 156)

Similar is the position in respect of direct recruits also.

(5) For the purpose of calculating the quota between the direct recruits and promotees the period which forms a block is the period from the date of Cadre and Recruitment Rules to the date of first direct recruitment. Thereafter from the date of one direct recruitment to the date of next direct recruitment. However, if there is an amendment to the Cadre and Recruitment Rules, the period is from the date of Cadre and Recruitment Rules / recruitment to the date of amendment and then from the date of amendment to the date of next direct recruitment.

(V.B. Badami V/s State of Karnataka
AIR 1980 SC 156)

(2) to (5) above are covered by the Official Memorandum dated 5-7-1976.

(6) The principles evolved in Badami's case have been reiterated in Gonal Bhimappa V/s State of Karnataka

(AIR 1987 SC 2359)

Instructions also have been reiterated by the Government vide Official Memorandum No.DPAR 43 SRR 87 dated 14-12-1987.

Where the date of appointment of promotees and direct recruits is the same, the direct recruits should be ranked senior to the promotees. (Rule 3)

IV. Seniority Among the Promotees

Promotion in one of the methods of appointment.

(Manager, Southern Railway V/s Rangachari)
(AIR 1962 SC 36)

Appointment by promotion is possible by two methods, viz.;

(1) Promotion on the basis of seniority cum-merit ; and
(2) Promotion by selection.

The seniority in these two cases is determined as follows :

(1) Promotion on the basis of seniority-cum-merit at the same time
   a) If promotions are from any one cadre or class of posts, by their seniority interse in the lower cadre or class of posts ; (Rule 4(1)
   b) If promotion are from several cadres or classes of posts of different grades, by the order in which the names are arranged by the appointing authority.

In consultation with the Public Service Commission, where such consultation is necessary, after taking into consideration the order in which promotions are to be made from those cadres or classes of posts. (Rule 4(iii)

(2) Promotion by selection at the same time ;

(Note : Now this is restricted to Heads of Departments and Joint Heads of Departments in the same scale of pay).

Whether promotions are from the name cadre or class of posts or from several cadres or classes of posts, by the order in which the promotees are arranged in the order of merit by the appointing authority, in consultation with the Public Service Commission where such consultation is necessary, subject to any special order of priority in accordance with any special rules of recruitment. (Rule 4A)

(3) Seniority is not the sole criterion. It counts only where two or more persons are of equal merit.

(N.K. Panda V/s Union of India
(1977(2) SLR 589 (Orissa).

Seniority brings the officials within the zone of consideration.

(Union of India V/s Srinivasan
1979 (3) SLR 724 V Delhi)

Zone of consideration is 2X + 4 where X is the number of vacancies.

V. Seniority Among the Direct Recruits

The appointing authority has to determine at the time of first appointment : Rule 5(i)

(i) Where the recruitment is through a competitive examination, in the order of merit. (Rule 5(i) (a))

(ii) When it is by selection it will be in the order of merit in consultation with the selecting agency. (Rule 5(i)(b)

(iii) When successful completion of a course of training is prescribed, on the basis of the order of merit,

(a) at the examination, if an examination is held ;

(b) at the selection for training if no examination is held. (Rule 5(i)(c))

(2) The above principles will apply when the selected candidates assume charge within the specified period under rule 18 of the Karnataka Civil Services (General Recruit) Rules, 1977, otherwise it shall be determined from the date of assumption of the charge of the post. (Rule 5(2)).

(3) Within the specified period date of joining the duty is immaterial for the purpose of determination of seniority and the ranking remains the same.

Syed Shamim Ahmed V/s State of Rajasthan
1981(1) SLR 100 Rajasthan

VI. Seniority on Appointment by Transfer

(1) When a person is appointed by transfer from one class or grade of service to another class or grade of service carrying the same scale of pay, his seniority has to be determined :

(i) if the transfer is in public interest, with reference to his first appointment to the class or grade from which he is transferred :
(ii) if the transfer is at the request of the official, he has to be placed at the bottom of the gradation list of the class or grade of service to which he is transferred, as on the date of transfer.

When determining the seniority of a person transferred in public interest with reference to his first appointment to the class or grade from which he is transferred he has to be placed at the appropriate place among the persons actually holding the posts in the class or grade to which he is transferred as on the date of transfer and the seniority of the persons already promoted cannot be disturbed. (Rule 6)

(2) Transfer does not mean fresh appointment. Transfer in the interest of administration cannot be held as discriminatory.

(S.E.R. V/s M.P. Ranga Reddy
1992 92) SLR 346 Cal).

(3) If the transfer is on request, then seniority has to be assigned as on the date of joining the Head quarters.

(R.N. Dhawan V/s Union of India
1981(1) SLR 855 Delhi).

(4) The seniority of the officers transferred from Defence Service, All India Service, a civil service of the Union or a civil service of any other State to any equivalent class or grade of service in the State Civil Services also has to be determined in accordance with para (1) above. (Rule 6A)

VII. Determination of State-Wise / Division Wise Seniority

Where seniority has to be determined by

(i) preparation of a State wide list consequent upon posts included in the District-wise cadres being included in the State-wide cadre or posts included in the Division-wise cadres being included in the State-wide cadre, or

(ii) preparation of a Division-wise list consequent upon posts included in the District-wise cadres being included in the division-wise cadre :

it has to be done by taking into consideration the total length of continuos service in the district-wise or division-wise cadres, as the case may be. But when the length of continuous service of persons in such cadres is equal then it has to be done by taking into consideration :

(a) where such persons are promoted from a lower cadre, their length of continuous service in the lower cadre;
(b) where such persons are directly recruited to the district-wise/division-wise cadres, on the basis of their relative age, the older in age being considered senior to the younger (Rule 7-A)

VIII. Removal of Difficulties

Cases in which difficulties arise and are not capable of being determined by the application of any of the provisions of these rules have to be determined by the appointing authority himself, in such manner as he deems fit, in consultation with the Karnataka Public Service Commission (Rule 8)

IX. Preparation of Seniority Lists

The seniority list for each cadre of service or class of post has to be prepared in accordance with the provisions mentioned above, every year. (Rule 10(a))

(2) The seniority lists have to be prepared by :

(i) the Government has Gazetted cadres of service or classes of posts.
(ii) the Head of Departments concerned for the non-Gazetted cadres or service or classes of posts. The Government may also prepare the seniority lists for non-Gazetted cadres of service or classes of posts. (Rule 10(2))

(3) (i) Seniority is a condition of service, hence every official has a right to know it. the seniority lists are, therefore, required to be displayed on the notice board of the office or are made available to the officials concerned for reference. If any official desires a copy of the seniority list the same may be supplied to him on payment of a nominal price of fifty paise per copy. They need not be published in the Official Gazette :

(Official Memorandum No.DPAR 62 SRR 76 dt.9-2-76 and
Circular NO.DPAR 25 SRR 85 dated 27-7-85).

(ii) the seniority lists should be invariably prepared as on January first and published immediately.

(Official Memorandum No. DPAR 45 SRR 80 dt. 29-9-1980)

(iii) the seniority lists prepared as on first of January every year should be published before the end of February of the year concerned unless such an action is prevented by orders of stay of courts.

(Official Memorandum No.DPAR 45 SRR 84 dt.22-10-1984)

X. Seniority list for day to day operation in the event of the existing list being quashed by the court :

1. The High Court of Mysore in the case of one Sri. Sunder Murthy (Writ petitions No.25 and 137/1966) passed an order on 8-1-1969 to the effect that the part of ISS list should be remade and until then status-quo should be maintained i.e., persons holding the post will continue to hold and no promotions should be made on the basis of the impugned final ISS list without obtaining the permission of court.

2. Subsequently, the High Court of Mysore in the case of one Sri. Kyathegouda (W.P. No.888 to 891 etc. of 1969) passed an order on 26-8-1970 to the effect that if the final ISS list is quashed either fully or in part the said list should be regarded as available for carrying on day to day administration subject to the conditions that in the event of the final ISS list rectified getting the promotions would be reviewed on the basis of such a rectified final ISS list.

3. On the basis of three directions Government have issued clarifications O.M. No.GAD 156 INS 70 dated 19-2-1971 to the effect that in the event of the final ISS list being quashed it may be followed for carrying day to day administration until rectified final ISS list becomes available whereupon the promotions should be reviewed. Further, the Government have also clarified that in cases where there is a specific directions of the competent court such directions or conditions will have to be strictly complied with before taking any further action and the action taken should be in strict conformity with the directions of the court.

PROBATION

I. (1) Probation:

a) The preliminary time fixed to allow fitness or unfitness to surface;
b) A period of trail.

(2) Probationer:

One who is on trail.

II. The Karnataka Civil Service (Probation) Rules, 1977 Notification Dt:25th June, 1977 Gazettee Dt:7th July, 1977.

(1) 'Appointed on Probation' - appointed on trial - Rule 2 (1)
(2) ' Probationer' - Government Servant on probation Rule 2(2)

III.PERIOD OF PROBATION

1. Not less than two years excluding the extraordinary leave - Rule 3
2. The period of probation gets extended to the extent of extraordinary leave automatically by the operation of Rule 3.
3. If the period of probation prescribed in the Rules of Recruitment is less than two years then the provision in the Probation Rules prevails. - Rule 19(1)
4. If the period of probation prescribed in the Rules of Recruitment is more than two years then the provision in the Rules of Recruitment prevails.

IV.EXTENSION:

1. Reasons for extending the period of probation has to be recorded in writing.
2. Governor/Government may extend by any length of time - Rule 4(1)(I).
3. The appointing authority other than Government may extend by half the prescribed period - Rule 4(1) (ii).
4. If the probationer has appeared for departmental examination during the prescribed or extended period of probation the period of probation is automatically extended by the operation of the provision under rule 4(1).

    I. Until the publication of the results, of examination if he passes ; or
    II. Until the publication of results of the first of the exams in which be fails.

V. REDUCTION:

1) Government alone can reduce not exceeding the period during which the probationer has discharged the duties.

   I. of the post to which he is appointed ; or
   II. of a post the duties of which are similar and equivalent - Rule 4(2)

2) The effect of the above provision is that in respect of Item (1) above, the reduction, in practice, cannot be more than half the prescribed period and in respect of Item (ii) above it can be any period even upto the entire prescribed period.

3) Since the rules provided for extension as well as reduction of the probationary period, the prescribed period of probation cannot be hold to be mandatory - (Ajit Singh V/s State of Punjab - SLR 1983(2) SC(1).

VI. DECLARATION:

At the end of the prescribed/extended/reduced period of probation it is obligatory on the part of the appointing authority to consider the suitability of the probationer to hold the post - Rule 5.

If it is decided that the probationer is suitable, then the period of probation should be declared to have been completed satisfactorily. - Rule 5(1) (a).

Matters which can be taken into consideration for adjudging the suitability:

   I. Work and performance and service records duriing the period of probation;
   II. passing of test/examinations prescribed if any, during the period of probation.

VII. DISCHARGE:

If it is decided that the probationer is not suitable to hold the post, then it may discharge the probationer - Rule 5(1)(b).

Matters which can be taken into consideration for discharging the probationer:

   I. Performance and service records;
   II. not passing the prescribed tests/examination

Matters other than work which can be taken into account to discharge the probationer:

I. Attitude or tendency - example attempts made by a probationer to secure a job with better prospect elsewhere (Case Law, TCM, Pillai V/s Technology Institute, Guindy - AIR 1971 SC 1811).

II. Behavious or conduct - example the conduct which is not in keeping with the status of the Govt., Servants (Case Law: Kumar Chandra V/s State of Karnataka - ILR 1987 KAR 2756);

Mis-conduct which has resulted in punishment - A Producer in All India Radio who committed mis-conduct indulging in loose talk and using filthy abusive language against Station Director. Here the mis-conduct is only a inducing factor for discharge and discharge is not a direct punitive action for that mis-conduct.

VIII. DISCHARGE DURING THE PERIOD OF PROBATION:

A probationer can be discharged even during the period of probation on the grounds arising out of the conditions imposed by rules/orders of appointment or on account of un-suitability - Rule 6.

Orders of appointment may be subject to certain other conditions like; Investigation of antecedents or physical fitness or subject to legal proceedings pending in the Courts. When these conditions are not satisfied by the Probationer he may be discharged during the course of probation.

Unsuitability is another aspect on the basis of which the probationer can be discharged even during the period of probation.

However, when discharging person under rule 6 an appointing authority other then Government should obtain the approval of the next higher authority. This is to avoid prejudice resulting in malafides.

Recourse to rule 6 cannot be had when misconduct is alleged. If misconduct is alleged it amounts to removal or dismissal within the meaning of Article 311 and hence the orders passed have to be in conformity with the Article 311(2) i.e., recourse should be had to CCA Rules and not to rule 6 of the Probation Rules - Ref. Rule 7 and also the Circular No..... Dt:.....).

(Case Law: Anup Jaishwal V/s GOI, SLR 1984 SC 426).

IX. GENERAL ASPECTS OF DECLARATION AND DISCHARGE:

1) Under these rules:

I. Any delay in declaration of probation does not give rise to automatic declaration since there is provision for unlimited extension;

II. Where the rules provide for fixed period of probation and limited provision for extension or no provision at all for extension then after the expiry of such period if the Govt. servent is continued the period of probation is deemed to have been automatically declared.

(Case Law: Kumar Chandra V/s State of Karnataka - ILR 1987 KAR 2756)

III. Discharge of a probationer who was already in Government service prior to appointment as probationer results in his reversion to that earlier service or post (Vide Note below rule 5).

IV. The probitioner discharged under rule 5 or 6 has no right of appeal. That is in other words the order once passed is final - Rule 8.

2) However, this provision in the rules do not bar the judicial serutiny. The affected probationer is not prevented from approaching the Court or the KAT but the scope of interference by the judiciary is limited to verifying whether the discharge is simplicitor or otherwise. Unless there is a prima-facie evidence in the order passed or records leading to the orders that the discharge is other then discharge simplicitor the courts cannot interfere. However, if there is evidence to show on the records to the effect that miscounduct is alleged and stigma attached, however innoouous the working in the final order of discharge the Courts can ask for the production of original records and examining the matter.

(State of Maharashtra V/s Saboji - AIR1980 SC 42)

X. CONFIRMATION

On declaration of satisfactory completion of probation a probationer is entitled to be confirmed at the earliest opportunity in a substantive vaccancy that may exist or arise. - Rule 9.

XI. INCREMENTS AND PAY:

A probationer is entitled to draw all the increments that fall due during the prescribed period of probation. He is not entitled to draw the increments that fall due during the extended period of probation. - Rule 10.

After the expiry iof extended period on declaration of satisfactory completion of probation, as from the date the declaration taken effect,the probationer's pay has to be fixed notionally taking all the increments due to him for the entire service but he is not entitled to any arrears of pay. - Rule 10.

XII. WHERE JUDICIAL PROCEEDINGS ARE PENDING:

Where the appointment of a probationer is questioned and judicial proceedings are pending In a court of law, if the prescribed period of probation is over and if he has otherwise satisfactorily completed the period of probation, the same may be declared and he may be given consequential benefits subject to final disposal of the said proceedings - Rule 11.

by Sri. Vilvaratnam
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RETIREMENT BENEFITS

Every Government employee who enters service has to retire from Service. On retirement an employee governed by the existing pension scheme gets a monthly payment of pension for life and a lumpsum gratuity at the time of his retirement determined with reference to the length of service. In the event of death of the Government Servant, his family gets under certain conditions a monthly Family Pension for life.

To ensure that an employee's family gets all retirement benefits in time, it is essential that employees acquint themselves with rules, and procedures etc. in this behalf.

The determination of pensionary benefits is dependent on the length of qualifying service. This essential piece of information is available in employee's Service Book/Service Record. A Service Book starts as soon as an employee enters service and all important events such as confirmation, promotion, grant of increments, grant of leave etc., sanctioned and the total length of service are recorded in it. The Rules provide for annual verification of entries made in the Service Register by the employee. He should insist on verifying Service Book entries once a year, without fail.

Eligibility for Pension :

A Government employee in a pensionable service, including quasi-permanent or temporary employment, retiring on superannuation after rendering not less than 10 years service is eligible for superannuation pension.

1. The Government servant is required to retire from service on attaining the age of 58 years, which is at present. The retirement actually takes effect from the afternoon of the last day of the month in which he attains the age of 58 years. However, the compulsory retirement of a Government servant whose date of birth falls on the first of day of themonth shall be from the afternoon of the last day of the month preceeding the month in which he attains the age of 58 years. In the case of a Government servant who puts in a qualifying service of not less than 66 completed six monthly periods (33 years), the persion will be calculated at 50 per cent of the employments drawn by him at the time of his retirement. For a

Contd...2

Government servant who at the time of his retirement renders a qualifying service of 20 completed six monthly periods or more but less than 66 completed six monthly periods, the amount of his pension will be in such proportion of the maximum admissible pension. The pension so calculated will be subject to a minimum of Rs.390/- p.m. and maximum of Rs.3450/- p.m.

2.Amount of Gratuity on Retirement:

In the case of a Government servant, who has completed not less than 10 six monthly periods of qualifying service, the amount of retirement gratuity admissible is 1/4 of the documents for each completed six monthly period of qualifying service subject to a maximum of 16 1/2 times the emoluments(subject to a overall maximum of Rs. one lakh).

3. Commutation of pension:

The Government is allowed to commute a portion of his pension not exceeding one thir for a lump payment. As per the existing simplified procedure, the Government servant has to furnish a declaration at the time of retirement regarding his intension or otherwise to commute pension. In cases where no such declaration is made, the Accountant General will presume that the retired Government servant has opted for maximum commutation permissible under the Rules and authorises commutation value alongwith pension and DCRG.

The commuted portion of the pension will be resoted after 15 years from the date of commutation.

4.For Families (a) Death Gratuity:

In the event of death of a Government servant while in service, the Death Gratuity is admissible at the following rates:

Length of Qualifying Service	Rate of Gratuity
Less than One year	Two times of emoluments
One year or more but less than five years.	Six times of emoluments
Five years or more but less than 20 years.	Twelve times of emoluments
Twenty years or more	Half of emoluments for every completed sixmonthly period of qualifying service subject to a maximum of 33 times of emoluments and subject to a maximum of 2.5 lakhs)

Contd..3

5.(b) Family Pension :

Family Pension becomes payable to the widow/widower or minor sons/unmarried minor daughters, from the day following the the date of death of the employee while in service or after retirement. It is payable only to one member of the family at a time. The rates of family pension admissible are as under:

Emoluments	Rate
i) Not exceeding Rs.1500/-p.m.	30% of emoluments subject to a minimum of Rs.390/-p.m
ii) Exceeding Rs.1500 but not exceeding Rs.3000 p.m	20% of emoluments subject to a minimum of Rs.450 p.m.
iii) Exceeding Rs.3000 p.m	15% of emoluments subject to a minimum of Rs.600 p.m and a maximum of Rs.1250 p.m.

In case of Government servant, who dies while in service after having rendered a qualifying service of not less than 7 years the family pension admissible will be at an enhanced rate equal to 50 per cent of the emoluments last drawn or twice the family pension normally admissible, whichever is less, for a period of 7 years or till the date on which the Government servant would have attained the age of 65 years, if he had survived, whichever is earlier.

In the event of death of both the father and mother who were government servants, the family pension payable to minor children is subject to a total of Rs.1250 p.m.

6. Other Types of pension:

a). Compensation Pension: This pension is granted to a Government servant who is discharged from public service on the abolition of his post.

b). Invalid Pension: The pension is granted to a Government servant who is declared by the appropriate medical authority to be permanently incapacitated for further service.

c) Retiring Pension: Retiring Pension is granted to a Government servant who is retires voluntarily or is retired in advance of the age of retirement by giving notice.

d) Extraordinary Pension: This pension is awarded in the form of monthly pension to a widow of a Government servant or a disability pension to a Government servant under the provision of K.C.S.(Extraordinary pension) Rules 1980.

Contd...4

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e) In respect of a Government Servant dismissed or removed for mis-conduct, insolvency or in-effecienty, compassionate allowar not exceeding 2/3 of the pension which would have been admissible had the Government servant retired on medical certificate may be granted in cases deserving special consideration and such an allowance is treated as pension for purposes of commutation.

7. Condition for grant of Pension:

Future good conduct is an implied condition for grant of pension and its continuance: The pension sanctioning authority, may, by order in writing whithold or withdraw pension or part thereof, Whether permanently or for a specified period, if the pensioner is convicted of serious crime or is found guilty of grave misconduct.

8. Time Schedule prescribed for preparation and settlement of pensionary benefit:

i) After completion of 25 years of service, the Head of the office of the Office where the Government servant is working will forward the service book of the Government servant to the Audit Officer for verification and to communicate the qualifying service determined by the Audit Officer.

ii) The Head of the Office will obtain from the retiring Non-Gazetted Government servant the particulars mentioned in the proforma appended herewith one year before the date of his retirement. This proforma and the particulars mentioned therein will be sent along with other pension documents to the Accountant General not later than three months before the date of retirement of the Government Servant. The Gazetted Government servant will submit the proforma one year in advance of his retirement to the Accountant General who will build up his pension records.

9. Documents to accompany Pension papers :

Upon the retirement of the Government servant, the following documents are required to be sent to the Accountant General within a week from the date of retirement:

a) Last Pay certificate duly noting the amount to be recovered from DCRG, such as HBA, MCA and other advances, if any.

b) No due certificate duly noting government dues other than those noted in the LPC which are to be recovered from out of the Gratuity payable to the pensioner.

In order to get pensionary benefits, in time please ensure

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that i) Nomination for DCRG is furnished. ii) Necessary verificati of service is done after completion of 25 years of service. iii) Required particulars in the prescribed proforma are submitted to the Head of Office one year before the date of retirement. iv) The proforma along with particulars mentioned therein are forwarded to the Accountant General by the Head of Office atleast three months before the date of retirement along with N.D.C. v) LPC is sent to Accountant General immediately after retirement.

10. Preparation of Family Pension Papers.

In the case of death of the Government servant, while in service, on receipt of information of the death of the Government servant, the Head of Office will send a letter to the family of the deceased government servant in form C requesting the family to furnish the relevant particulars(both forms appended to this breff) This will enable the family members to get family pension in time.

11. Anticipatory Pension :

Where it is not possible to forward the pension records to the Accountant General, within the prescribed time limit, Head of Office will draw and disburse anticipatry pension at different percentage of last pay with reference to the total number of years of e qualifying service.

Anticipatory Death-cum-Retirement Gratuity can also be paid to the pensioner at the rate of half month's pay for each completed year of qualifying service subject to a maximum of 15 months pay.

12. Voluntary Retirement:

A Government servant may be permitted to retire voluntarily any time on completion of a qualifying service of not less than 15 years. A Government servant may also be permitted to retire voluntarily any time on attaining the age of 50 years. A Government servant who is permitted to retire volunarily any time on com pletio of a qualifying service of not less than 15 years is allowed weightage upto 5 years(Rule 285 (1) (a) of KCSRs). However, the benefit of weightage is not admissible to a Government servant who is permitted to retire volunarily any time on attaining the age of 50 years (rule 285(1)(b)of KCSRs).

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13. Retirement in Public interest:

Government may retire any Government servant, in public interest any time after completion of 25 years qualifying service or after he has attained the age of 50 years in the case of a Government servant holding a Group A or Group B post and case of a government servant holding a Group C or a Group D post.

The pensioners are also entitled to medical attendance and to different classes of accommodation for treatment in Hospitals and Sanatoria as indicated below:-

All General and Special Government Hospitals.

Monthly pension limit	Class of accommodation
1. Not exceeding Rs.500	General Ward
2. Exceeding Rs.500 but not exceeding Rs.750	Rs.5 ward or any ward just below Rs.5
3. Exceeding Rs.750 but not exceeding Rs.1250	Rs.8 ward or any ward just below Rs.8.
4. Exceeding Rs.1250 but not exceeding Rs.1500	Rs.10 ward or any ward just below Rs.10.
5. Exceeding Rs.1500	Rs.20 ward or any ward just below Rs.20.

	P.K. Sanatorium Mysore	Other Sanatoria
1. Not exceeding Rs.500	Narayanaswamy Ward Rs.1	B Class Ward Rs.1
2. Exceeding Rs. 500 but not exceeding Rs.1250	Second class special ward Rs.4 or any ward just below Rs.4	A class ward Rs.2 or any ward just below Rs.2
3. Exceeding Rs.1250	First Class Special ward Rs.6 or any ward just below Rs.6	Special ward Rs.5 or any ward just below Rs.5.

SYNAPTIC NOTES ON TA RULES AND RETIREMENT BENEFITS

BY SRI.VILWANATHAN.
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I. Classification of Government servants for purposes of Travelling Allowance:-

The existing classification of Government servants for purposes of travelling allowance shall be revised as under:-

Category	Pay range (Per month)
I	Rs. 3300 and more
II	Rs. 2150 to Rs.3299
III	Rs. 1520 to Rs.2149
IV	Below Rs.1520

2. Entitlement for Travel By Rail:

The entitlement to railway accommodation of Government servants for journeys on tour or transfer shall be regulated as under:-

Category to which Government servants belongs	Entitlement
I (a) those drawing pay of Rs.4325 or above	I Class/AC
(b) those drawing pay of Rs.3300 or above but below Rs.4325	I Class/AC tow Tier sleeper
II	I Class/AC two tier sleeper
III	I Class/AC Chair Car.
IV	II Class Sleeper

3. Daily Allowance :

For purpose of Daily allowance for halts within the State the revised classification and revised rates as also revised rates of daily allowance for halts outside the State shall be as under:

Contd..2

Category to which Govt. servant belongs	Halts within the State			Halts Outside the State	
	B'lore	Other cities with municipal Corporations	Other Places	Ahemedabad, Bombay Calcutta, Delhi Ghaziabad, Hyderabad. Kanpur, Lucknow, Madras, Mussourie Nagpur, Pune, Simla Srinagar, Goa, Diu and Daman	Other Places
	Rs.	Rs.	Rs.	Rs.	Rs.
I	110	90	70	135	110
II	80	65	55	110	80
III	65	55	45	90	65
IV	45	40	35	65	45

4. Special rates of daily allowance for stay in a Hotel or Other Establishment providing Board and/or Lodging at Scheduled Tariffs:

The Special rates of daily allowance for halts in respect of journeyes on tour outise the State, in a hotel or other registered establishment providing boarding and/or lodging at scheduled tariff shall be revised as under:

Category to which Government Servant belongs	Places of Halt: Ahmedabad, Bombay, Calcutta, Delhi Chaziabad, Hyderabad, Kanpur, Lucknow, Nagpur, Madras, Mussourie, Pune, Simla Srinagar and Goa, Dia & Daman	Other Places Outside the State
	Rs.	Rs.
I	250	200
II	200	150
III	150	125
IV	100	75

5. Journey on tour by Air:

A Government servant drawing a pay of Rs.4325 or above shall be entitled to travel by air for journey on tour outise the State.

A Government servant drawing a pay of Rs.3300 or above shall be entitled to travel by air for journey on tour within the State between the places connected by the Indian Airlines Services, including the Vayudoot Services.

A Government servant drawing a pay of Rs.3300 or above proceeding on duty on tour from Bangalore to any place in Bidar District/Bangalore to Gulbarga and vice-versa is authorised to travel by air via Hyderabad.

6. Journey by Air on transfer :

A Government servant drawing a pay of Rs.4325 or above is entitlement to travel by air(including Vahudoot Services) on transfer and claim one fare for himself and an additional fare for each member of his family.

7. Transfer Grant :

The classification and the rates of transfer grant admissible to a Government servant on transfer in public interest involving change in headquarters, from one station to another station shall be revised as under:

Category to which Govt. Servant belongs	Rate of Transfer grant	
	For transfer within the District	For transfer outside the District
	Rs.	Rs.
I	1200	2000
II	900	1500
III	600	1000
IV	300	500

8. Mileage alloance for journey on transfer by road by owned car or hired taxi:

A Government servant drawing a pay of Rs.2375 or above may on transfer in public interest, undertake journey by owned car or by taxi and may claim single mileage allowance at the rate of Rs.3-00 Per K.M. irrespective of the number of members of his family.

9. Road Journey - Mileage allowance :

The rates of road mileage admissible to Government Servants

Contd..4

In respect of road journeys in owned/hired/borrowed conveyance as laid down in the rule 451 Karnataka Civil Services Rules shall be as follows:-

Category	When journey is performed by			
	Bicycle/ Foot	Motor Cycle/Scooter Tonga Cycle-rickshaw ~~Man-driven rickshaw~~	Full Taxi/ own Car	Auto-rikshaw
I	30 paise per K.M.	Rs.1.00 per K.M.	Rs.3.00per KM	Rs.2.00 per K.M. subject to a minimum Rs.4
II	-do-	-do-	-do-	-do-
III	-do-	-do-	-do-	-do-
IV	-do-	-do-	-do-	-do-

In respect of road marches exceeding 100 K.M.s a day mileage allowance shall be admissible at a uniform rate of Rs.3.00 per K.M. in respect of journeys performed by motor car and Rs.1-00 per K.M. in respect of journey performed by motor cycle/Scooter.

9. Transportation of personal effects on transfer by engaging a whole railway wagon or container service:

A Government servant drawing a pay of Rs.3300 or above may engage a whole railway wagon or avail himself of the facility of the container service provided by the railway service.and

10. Road mileage for transportation of personal effects between places not connected by rail:

A Government Servant on transfer shall be entitled to draw road mileage for transportation of his personal effects of the minimum permissible quantity, between places not connect by railway at the following revised rates:

Category of the Govt. servant	Rate per K.M. Rs. ps.
I	10-00
II	6-00
III	3-00
IV	2-00

11. Incidental Charges:

The computation of daily allowance on tour or transfer shall begin when a Government Servant actually leaves his Headquarter and ends when he actually returns/reaches to the place in which his headquarters are situated whether he halts there or not.

12. Reimbursement of actual cost of transportation of owned conveyance on transfer:

A Government servant on transfer may draw the actual cost of transportation of owner's risk conveyances on the following scales, provided that the distance travelled exceeds 120 Kilometers and that the Government Servant is travelling to join a post in which possession of a conveyance is advantageous from the point of view of his efficiency.

Pay range	Vehicles allowed
Rs.3825 or above	A Motor Car or a Motor Cycle
Rs.1640 or above but below Rs.3025	A Motor cycles/Scooter/ Moped or a Cycle
Below Rs.1640	A Cycle

13. Travel concession to home town :

A Government servant drawing a pay of Rs.3825 or above may after obtaining specific and prior approval of the competent authority, undertake journey in his own car namely, by car registered in his own name for journey to home town between places connected by railway under the scheme of travel concession for journey to home town and claim (a) first class railway fare for himself and the members of his family or (b) single mileage at Rs.3-00 per K.M. by the shortest direct route, irrespective of the number of members of his family, whichever is less.

14. Fixed Travel Allowance:

The fixed Travelling Allowance sanctioned to the following categories of posts shall be contined at the rates indicated against them for a further period of one year from

Contd..6

1-9-1977 or until further orders, whichever is earlier.

1. Junior Health Asst. (Male & Female) . . . . Rs.100/- p.m.

2. Para Medical Workers (Leprosy) ..... Rs.125/- p.m.

The Officers/ Staff who have been provided with Government vehicles for journey on official use will not however be eligible for Fixed Travelling Allowance.

I PENSION

Classification of pensions: (Rule 258 of KCSRs)

1. Compensation pension
2. Invalid pension
3. Retiring pension
4. Superannuation pension.

1. Compensation pension: (Rule 259 of the KCSRs.)

A Government servant selected for discharge from service owing to abolition of a post may:

(a) be appointed to another post, the conditions of which are deemed by the competent authority to be equal to those of the post held by him; or

(b) be given the option of taking any compensation pension or gratuity to which he may be entitled for the service already rendered; or

(c) be given the option of accepting another appointment or transfer to another establishment of lower pay.

2. Invalid pension: (Rule 273 of the KCSRs.)

An invalid pension is awarded to a Government servant who is allowed to retire due to bodily or mental infirmity, which has rendered him permanently incapacitated:

(a) for the public service, or

(b) for the particular branch of it to which he belongs.

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3. Retiring pension: (Rule 285 of the KCSRs)

A Government servant may;

(a) be permitted to retire any time after completion of qualifying service of not less than 15 years;

(b) be permitted to retire any time on attaining the age of 50 years;

(c) be retired in public interest any time after;

(i) completion of 25 years of qualifying service; or

(ii) attaining the age of 50 years in the case of Government servant holding a Group-A or a Group-B post; and 55 years in the case of Government servant holding a Group-C or Group-D post.

4. Superannuation pension: (Rule 95 of the KCSRs)

A Government servant compulsorily retires on the afternoon of the last day of the month in which he attains the age of 58 ~~x~~ years;

Provided that the date of compulsory retirement of a Government servant whose date of birth is first day of the month shall be the afternoon of the last day of the month preceeding the month in which he attains the age of 58 years.

II QUALIFYING SERVICE

(Rule 220, Rule 222 and Rule 224 A of the KCSRs)

(In respect of Government servants whose retirement or death takes place on or after first September 1968)

(1) All services under the Government whether temporary or permanent rendered after attaining the age of 18 years.

(2) The services must be paid for from the consolidated fund of the State Government.

III PERIOD OF SERVICE

(Rule 244 A of the KCSRs)

(In respect of a Government servant whose retirement or death takes place on or after first September 1968)

Time passed on all kinds of leave counts as service under all circumstances;

Provided that the maximum period of leave without allowances to be so counted is restricted to three years in the entire service.

IV SUSPENSION, RESIGNATIONS AND BRAKES IN SERVICE

(Rule 250 and Rule 252 of the KCSRs)

Suspension: (1) Time passed under suspension if on conclusion of the enquiry, Government servant is fully exonerated or if the suspension is held to be wholly

unjustified, counts for pension.

(2) Time passed under suspension in other cases does not count unless the authority competent to pass orders under rule 99 clearly declares that it shall count and it shall count only to such extent as the competent authority may declare..

Resignations: Resignation entails forfeiture of past service;

Provided that resignation with proper permission to take-up another appointment shall not be treated as resignation of public service.

Dismissal or removal:

Dismissal or removal for misconduct, insolvency or inefficiency and not due to age or failure to pass a prescribed examination entails forfeiture of past service.

CALCULATION OF RETIREMENT BENEFITS

1) PENSION

$$\frac{\text{(Last Pay drawn)} \times \text{(Completed six monthly periods of qualifying service)}}{2 \times 66}$$

2) DCRG (Death-cum-retirement gratuity)

$$\frac{\text{(Pay + DA)} \times \text{(Completed six monthly periods of qualifying service)}}{4}$$

3) CVP (Commuted Value of Pension)

(NOTE: Year of purchase as per the table given in rule 380 of the KCSRs)

$$\frac{\text{(Last pay drawn)} \times 12 \times \text{(Commuted value in number of years of purchase)}}{3}$$

4) PEG (Pension equivalent of gratuity)

$$\frac{\text{DCRG}}{12 \times \text{(Commuted value in number of years of purchase Commutation table under rule 380 of KCSRs.)}}$$

5) Encashment of EL

(Pay + DA) X (EL at credit to a maximum of 240 days i.e. 8 months)

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[1][COMMUTATION TABLE

COMMUTATION VALUES FOR A PENSION OF RE 1 PER ANNUM

Age next birthday	Commutation value expressed as number of years' purchase	Age next birthday	Commutation value expressed as number of years' purchase
	Rs. P		Rs. P.
17	19.28	52	12.66
18	19.20	53	12.35
19	19.11	54	12.05
20	19.91	55	11.73
21	18.01	56	11.42
22	18.81	57	11.10
23	18.70	58	10.78
24	18.59	59	10.46
25	18.47	60	10.13
26	18.34	61	9.81
27	18.21	62	9.48
28	18.07	63	9.15
29	17.93	64	8.82
30	17.78	65	8.50
31	17.62	66	8.17
32	17.46	67	7.85
33	17.29	68	7.53
34	17.11	69	7.22
35	16.92	70	6.91
36	16.72	71	6.60

1. Substituted by No. FD 34 SRS 71 dated 14.6.1971 (wef 1.9.1971).

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Age next birthday	Commutation value expressed as number of years' purchase	Age next birthday	Commutation value expressed as number of years' purchase
	Rs. P		Rs. P
37	16.52	72	6.30
38	16.31	73	6.01
39	16.09	74	5.72
40	15.87	75	5.44
41	15.64	76	5.17
42	15.40	77	4.90
43	15.15	78	4.65
44	14.90	79	4.40
45	14.64	80	4.17
46	14.37	81	3.94
47	14.10	82	3.72
48	13.82	83	3.52
49	13.54	84	3.32
50	13.25	85	3.13]
51	12.95		

381. The lumpsum shall be payable at the Treasury or Bank at which the pension is being or is to be drawn.

382. If the pensioner dies on or after the day on which commutation became absolute but before receiving the commutation value, this value shall be paid to his heirs.

383. The following regulations governing procedure for the commutation of pensions are for observance in all cases in which applications for commutation of pension are made under these rules.

Note - For the purpose of commutation of pension, if two different Governments are concerned a Government servant shall

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(3)

EXAMINATION OF INJURED PERSON

Examination of injured person should be conducted in good light.

In every examination of Medico-legal case the written, free and voluntary consent of the injured person should be obtained. If the injured person is below 12 years, consent of the parents or gaurdian should be obtained.

Mention the date, time and place of examination and brief history of the case and the time of assault or Accident and by whom the history is given.

It is necessary to mention two identification Marks on the injured for the purpose of identification of the person in the court of law, along with other particulars like the name, age and the address of the injured.

Describe the injuries found on the body as to the nature of injury, exact location, exact measurement in Cm giving length, breadth and depth if applicable. Mention shape of the injury, and draw a rough sketch if necessary. Colour of the contusion, edges of wounds in case of incised and lacerated and stab wounds. Mention signs of vital reaction, like, bleeding, clot, infiltration, swelling of the edges, sign of inflamation and infection of the wound if any.

Details of General condition of the injured on systemic examination with regards to pulse, blood pressure, pupillary reaction and level of consciousness etc., to be noted down. Any investigation done such as X-ray examination to be mentioned.

Furnish the opinion, with regards to the nature of the injuries found on the body of the injured. Mention the injuries which are simple in nature such as contusions and abrasions, and

(1)

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MEDICO LEGAL AUTOPSIES

Post Mortem report or Autopsy report is an important Medico-legal document in the court of law. Incomplete Autopsy report is legally invalid. If a complete autopsy is not carried out by the Medical Officer, evidence which later may be proof of great Medico-legal importance may be invariably lost and as a result, the course of justice may be impeded. It is therefore essential that in all cases, the autopsy should be a complete one. The responsibility of carrying out a complete autopsy rest soley on the Medical officer.

Rules for Medico-legal autopsies

(1) Medico-legal autopsy should be undertaken only when there is an official order authorising the autopsy from the police or a Magistrate.

(2) The Medical officer should first read the inquest report carefully and findout the apparent cause of Death from the brief history of the case and circumstances of Death. If the same is not furnished in the Inquest report, the investigating officer should be requested to furnish the same.

(3) The Post Mortem examination should be conducted in day light and not in artificial light as far as possible, because colour changes, such as Jaundice, colours of the contusions and Post Mortem stains etc., cannot be appreciated in artificial light. No unauthorised person should be permitted to be present during autopsy.

(4) The Post Mortem should be as through and complete.

(5) Identification of the body is very important, must be identified by the Police constable who accompanies the body and the name and Constable number must be recorded. If the body is unidentified, the marks of identification on the body and the clothings briefly described.

(6) The external examination should be done very carefully from top

...2

of the head to the toes noting down all the injuries, with exact measurements and its size, shape and situations Cyanosis in the finger lips, oedema of the ankle regions, dried blood stains and Post Mortem peeling of cuticle if any, to be mentioned in the Post Mortem report.

The injuries noticed and recorded by the investigating officer should be verified and if there is any discripancies noted on the body, the same should be mentioned in the Post Mortem report.

A brief general discription of the body as to the sex, age, colour of skin, hair, deformities, Injection marks, tattoo marks to be noted in the Post Mortem report, Neck and head specially should be carefully examined for signs of voilence.

Note down the changes that occured due to lapse of time after death such as, extend of rigormortis, post mortem staining in the dependent par t and signs of decomposition if any to be noted down.

Note down all the injuries as to the nature, size, shape, edges of the wound, situation on the body to be described in detail, if possible with diagramatic sketches.

Open the 3 major cavites such as skull, Thorax and Abdomen by classical incision and examine individual organs in detail for the presence of disease, injury, blood clots, pus etc.,

If it is case of suspected poisoning or no cause of death is found on autopsy examination preserve viscera for chemical analysis and tissues for Histopathological examination whenever necessary.

After the examination the organs to be put back into the body cavi ties neatly stiched, washed and handedover to the relatives through the concerned Police.

Furnish the Post Mortem report immediately after the Post Mortem examination and issue the report to the concerned Police in 24 hours as per rules.

4/3/98

(1)

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Department of Forensic Medicine

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Conducting Post Mortems
Writing the autopsy report:

The Post-Mortem examination is a very important piece of evidence in criminal trials and the Medical Officers who are entrusted with this work should do it with the utmost care and attention and should not perform it as a formal duty.

The post mortem report is a permanent record of the findings and is especially vital for Medico legal purposes, when every finding may be questioned in the court of Law after a few years.

The Autopsy report form is a printed proforma in which the various section of the examination and organs are printed, leaving blanck spaces for the insertion of the findings.

The external examination of the body should include length of the body, apparent state of Nutrition, colour of the skin tobe mentioned in the autopsy report.

If the body is unidentified, features which may help to establish identity such as tattoos, scars, deformities, dentures, eye colour, colour of hair tobe noted down.

For estimating the time of death, presence of rigor mortis Hypostasis, signs of Decomposition should be recorded.

Condition of the pupil size, petichial haemorrhages, sub-conjunctival haemorrahges if present to be noted. All external injuries discribed in detail as to the nature, size, shape, situation on the body if possible with sketches.

In the Internal examination record all abnormalities of Thoracic, Abdominal and organs. Describe any abnormilities in the heart like Hypertrophy of the left ventricular wall, thickening and narrowing of the coronary vessels and any pathological defect in the valves of the heart and pathology in large vessels. Examination of the stomach include contents, smell, and condition of the stomach Mucosa tobe noted down.

Examine the brain for any signs of infection such as pus, necrosis and different types of intracranial Hemorrages. Base of the skull to be examined for any hairline fractures etc.

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The ~~descriptive~~ descriptive facts must be recorded at or immediately after the completion of autopsy.

The report may be hand written or typed, when typed, original copy to be retained, any alteration should be initialed.

After the detailed discription of the external and internal appearances, in conclusion

1. Time of death to be recorded from appearance of the postmortum changes in the dead body,
2. Age of the injuries to be mentioned from its appearance,
3. Cause of death to be mentioned to best of knowledge based on facts of pathology or trauma found on the examination of the dead body of the deceased.

6/9/84

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MODEL POST MORTEM

MODEL POST MORTEM REPORT FORM

(Read carefully the instructions at Appendix 'A'

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NAME OF THE INSTITUTION _____

Post Mortem Report No._____ Date _____

Conducted by Dr. _____

Date & Time of receipt of the body
and Inquest papers for Autopsy _____

Date & Time of commencement of Autopsy _____

Time of completion of Autopsy _____

Date & Time of examination of the dead by
at Inquest (as per Inquest Report) _____

Name & Address of the person _____

_____

Videorecording the Autopsy _____

Note : The tape should be duly sealed, signed and dated and sent to the National Human Rights Commission, sardar Patel Bhawan, Sansad Marg, New Delhi.

CASE PARTICULARS :

1. (a) Name of deceased and as entered in the jail or police record. _____

_____

(b) S / O, D / O, W / O _____

(c) Address _____

_____

_____

2. Age (Approx) : _____ Yrs: Sex : Male / Female

3. Body brought by (Name and rank of police officials)

(i) _____

(ii) _____

of police station _____

4. Identified by (Names & Addresses of relatives / persons acquainted)

(i) _____

(ii) _____

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HOSPITAL DEAD BODIES - (Particulars as per hospital records)

Date & Time of Admission in Hospital _____

Date & Time of Death in Hospital _____

Central Registration No. of Hospital _____

SCHEDULE OF OBSERVATIONS

A) GENERAL

1) Height _____cms (2) Weight _____Kgs.

3) Physique - (a) lean / Medium / obese

b) Well built / average built / poor built / emaciated

4) Identification features (if body is, unidentified)

i) _____

ii) _____

iii) Finger prints be taken on seperate sheet and attached by the doctor.

5) Description of clothes worn - important features.

6) Postmortem Changes :

a) As seen during inquest :

...Rigor mortis present _____

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Temperature (Rectal) _____

Others _____

) As seen at Autopsy

) (a) External general appearance

b) State of eyes

c) Natural orifices

)EXTERNAL - INJURIES :

ention Type, Shape, Length X Breadth & Depth of each injury and its relation to important body landmark.
licate which injuries are fresh and which are old and their duration.)

_____

TRUCTIONS :

_____

Injuries to be given serial numbers and mark similarly on the body diagrams attached. (ii) In stab injuries, Mentic state of angles, margins, direction inside body. (iii) In fire arm injuries, mention about effects of fire also. (effects flame)

INTERNAL EXAMINATION

1 HEAD

(a) Scalp findings

(b) Skull (Describe fractures here & show them on body diagram enclosed)

(c) Meninges, meningeal spaces & Cerebral vessels
(Hemorrhage & its locations, abnormal smell etc., be noted)

(d) Brain findings & Wt. (Wt. _____ gms)

(e) Orbital, nasal & aural cavities - findings

2 NECK

- Mouth, Tongue & Pharynx
- Larynx & Vocal Cords :
- Condition of neck tissues
- Thyroid & other cartilage conditions
- Trachea

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- Ribs and Chest wall

- Oesophagus

- Trachea & Bronchial Tree

- Pleural Cavities - R -
  - L -

- Lungs findings & Wt. Rt_____gms & Lt _____gms

- Pericardial Sac

- Heart findings & Wt. _____

- Large blood vessels.

4. **ABDOMEN**

- Condition of abdominal wall

- Peritoneum & Peritoneal cavity

- Stomach (Wall condition, contents & smell) (Weight_____gms).

- Small intestines including appendix

- Large intestines &
  Mesentric Vessels

- Liver including (Wt _____gms)
  gall bladder

- Spleen (Wt_____ gms)

- Pancreas

- Kidneys finding & Wt. - Rt_____gms & Lt_____gms.

- Bladder & urethra

- Pelvic cavity tissues

- Pelvic Bones

- Genital organs (Note the condition of vagina, scrotum, presence of foreign body, presence of fetus, semen or any other fluid, and contusion, abrasion in and around genital organs).

5 SPINAL COLUMN & SPINAL CORD (To be opened where indicated)

OPINION

i) Probable time since death (keep all factors including observations at inquest).

ii) Cause & manner of death - The cause of death to the best of my knowledge and belief is :-

a) Immediate cause

b) Due to

c) Which of the injuries are antemortem / postmortem and duration if antemortem ?

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d) Manner of causation of injuries

e) Whether injuries (individually or collectively) are sufficient to cause death in ordinary course of nature or not ?

iii) .Any other

SPECIMENS COLLECTED & HANDED OVER (Please tick)

a) Viscera (Stomach with contents, small intestine with contents, sample of liver, kidney (one half of each), spleen, sample of blood on gauze piece (dried), any other viscera, preservative used)

b) Clothes

c) Photographs (Video cassettes in case of custody deaths), finger prints etc.,)

d) Foreign body (like bullet, ligature etc.)

e) Sample of preservative in cases of poisoning

f) Sample of seal

g) Inquest papers (mention total number & initial them)

h) Slides from vagina, semen or any other material

PM report in original, _____ inquest papers, dead body, clothings and other articles (mention there) duly sealed (Nos._____) handed over to police official _____

_____ No. _____ of PS

Whose signatures are here with

Signature _____

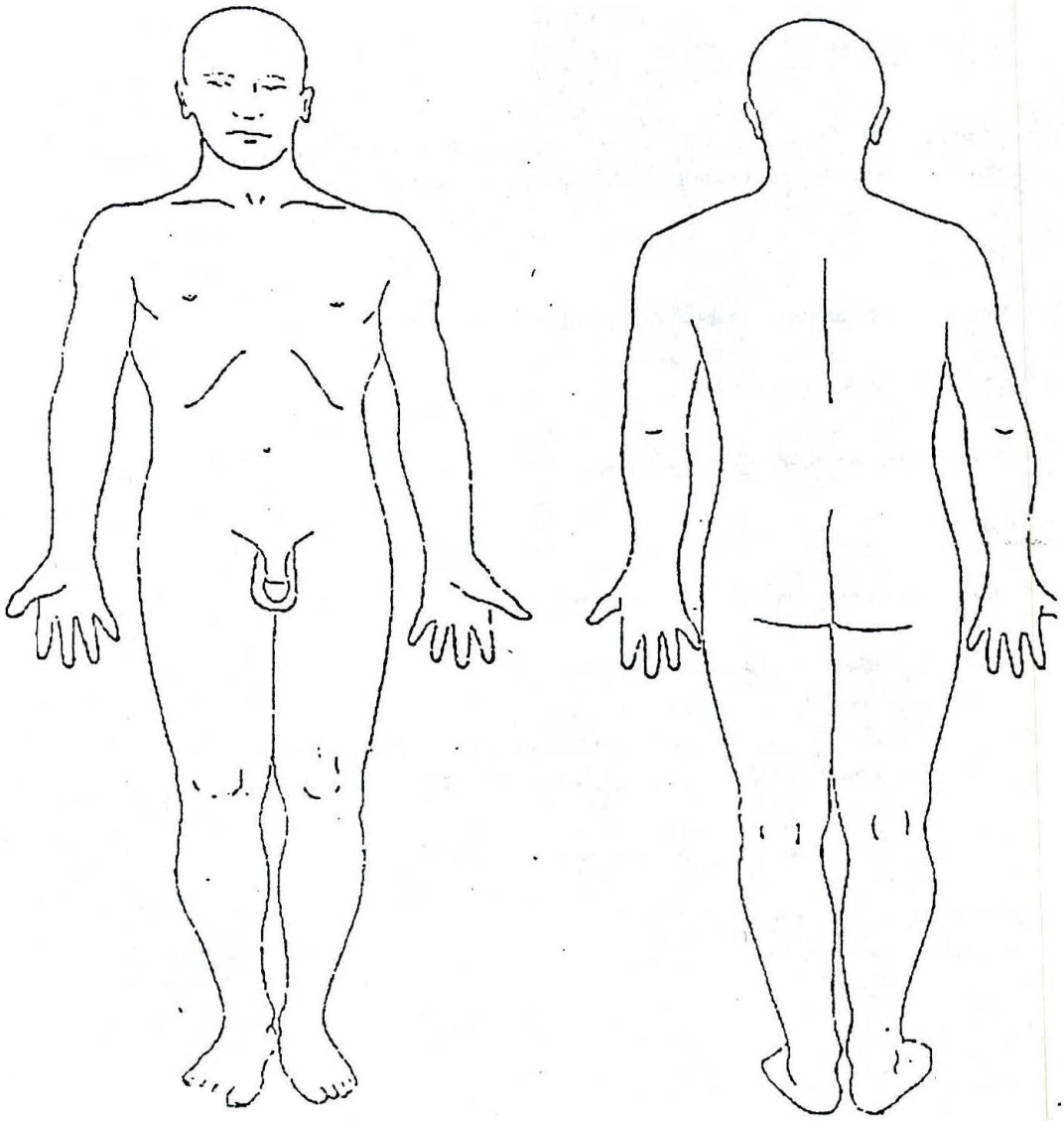
Name of Medical Officer _____

(in block letters) _____

Designation _____

Seal _____

FULL BODY, MALE - ANTERIOR AND POSTERIOR VIEWS (VENTRAL AND DORSAL)



Name _____ Case No. _____

Date : _____

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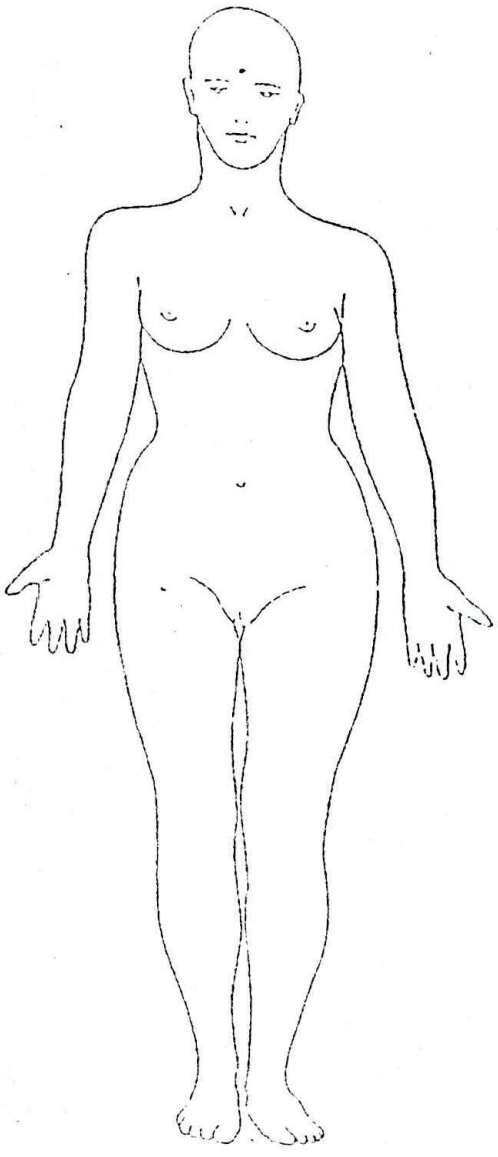
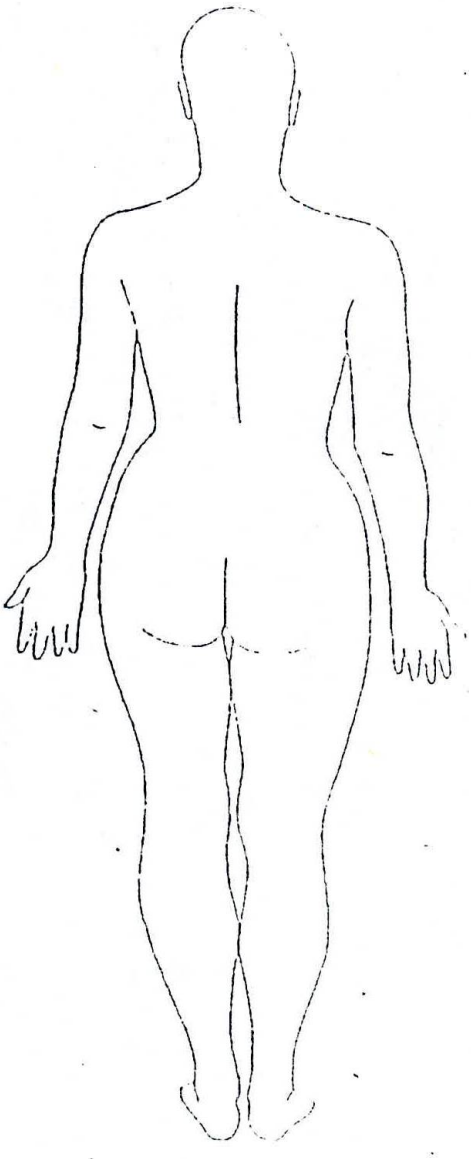
FULL BODY, FEMALE - ANTERIOR AND POSTERIOR VIEWS





Name _____ Case No. _____

Date : _____

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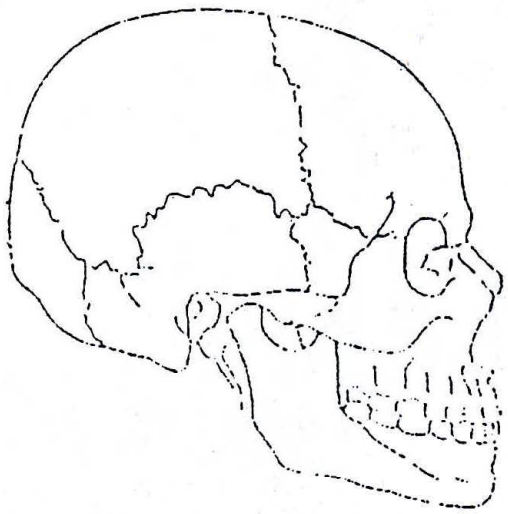
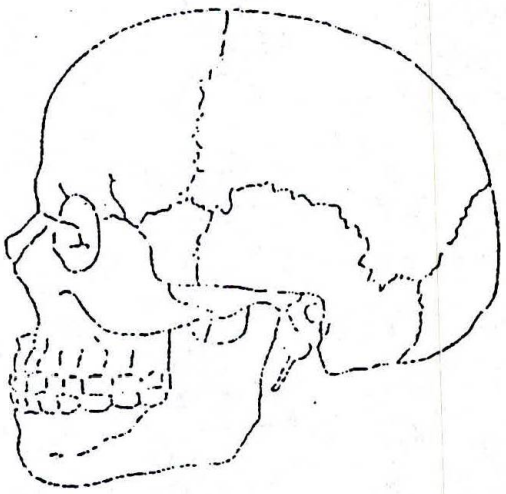
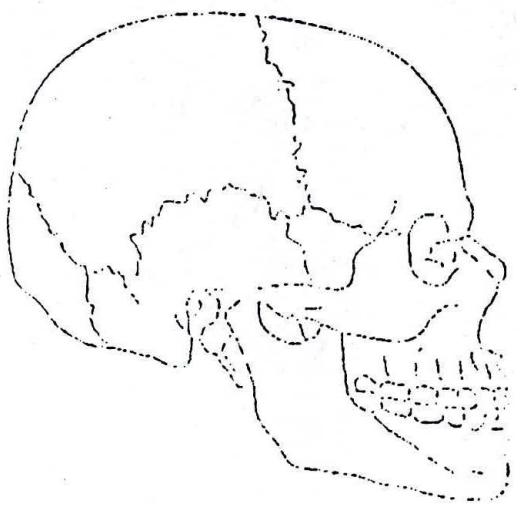
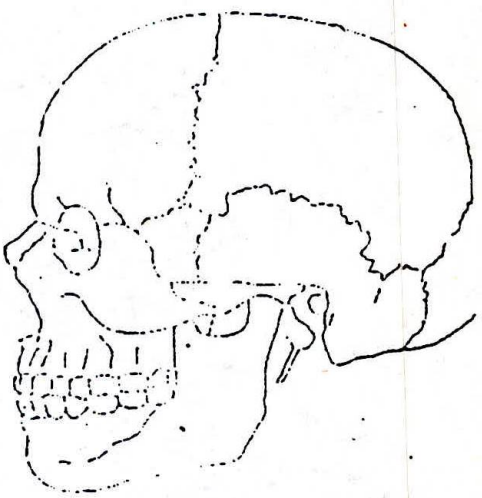
ANATOMY, LATERAL VIEWS



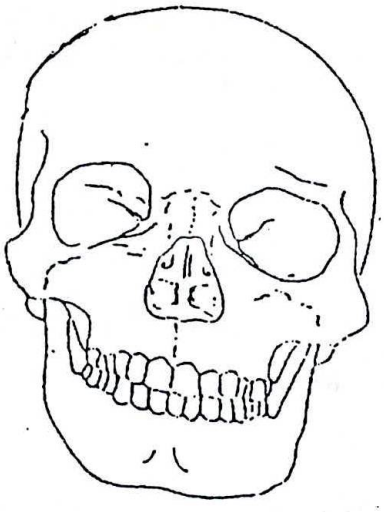


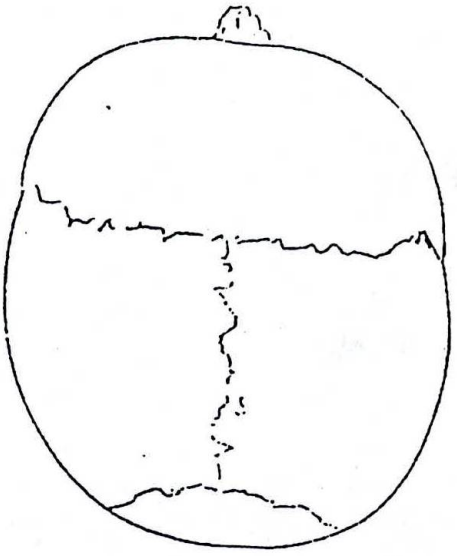


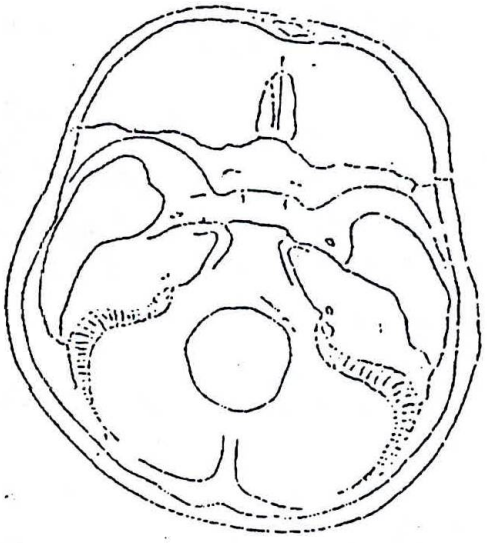


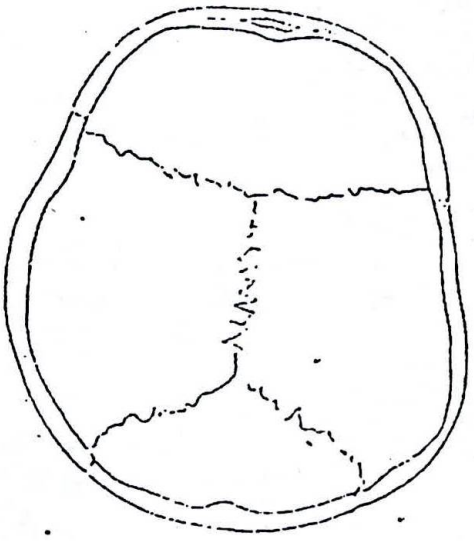
Name _____ Case No. _____

Date : _____









APPENDIX - 'A'

INSTRUCTIONS TO BE FOLLOWED CAREFULLY FOR DETECTION OF TORTURE

(Read carefully the instructions at Appendix 'A'

TORTURE TECHNIQUE	PHYSICAL FINDINGS
ACTING	
1. General	Scars, Bruises, Lacerations, Multiple fractures at different stages of healing, especially in unusual locations, which have not been medically treated.
2. To the soles of the feet, or fractures of the bones of the feet	Haemorrhage in the soft tissues of the soles of the feet and ankles. Aseptic necrosis.
3. With the palms on both ears Simultaneously.	Ruptured or scarred tympanic membranes. Injuries to external ear.
4. On the abdomen, while lying on a table with the upper half of the body unsupported ("operating table").	Bruises on the abdomen, Back injuries. Ruptured abdominal viscera.
5. To the head Haematomas.	Cerebral cortical atrophy, scars, skull fractures. Bruises.
Suspension	
6. By the Wrists	Bruises or scars about the wrists. Joint injuries.
7. By the arms or neck	Bruises or scars at the site of binding, prominent lividity in the lower extremities.,
8. By the ankles	Bruises or scars about the ankles. Joint injuries.
9. Head down, from a horizontal pole placed under the knees with the wrists bound to the "Jack".	Bruises or scars on the anterior forearms and backs of the knees. Marks on the wrists and ankles.
Near suffocation	
10. Forced immersion of head is often contaminated " Wet submarine".	Faecal material or other debris in the mouth, pharynx, trachea, oesophagus or lungs, Intra-thoracic petechiae.
11. Tying of a plastic bag over the head ("dry submarine")	Intra-thoracic petechiae.
Sexual abuse	
12. Sexual abuse	Sexually transmitted diseases. Pregnancy. Injuries to breasts, external genitalia, vagina, anus or rectum.

Posture

13. Prolonged standing — Dependent edema. Petechiae in low extremities.

14. Forced straddling of a bar ("saw horse") — Perineal or scrotal haematomus.

Electric Shock

15. Cattle prod. — **BURNS** : Appearance depends on the age of the injury. Immediately : spots, vesicles, and / or blackexudated within a few weeks : circular, reddish macular scars. At several months small, white, reddish or brown spot resembling telangiectasias.

16. Wires connected to a source of electricity.

17. Heated metal skewer inserted into the anus. — Peri-anal or rectal burns.

Miscellaneous

18. Dehydration — Vitreous humor electrolyte abnormalities.

Animal bites (spiders, insects, rats, mice, dogs.) — Bite marks

22) Drugs Acting on the Uterus
23) Infusion Fluids
24) Minerals,Nutritional Additives
25) Anti-diabetics:- Oral and Parenteral

STORE-STOCK MAINTAINING PROCEDURE.

The following four registers should be maintained in the store.

1) DAY BOOK:- For monitoring the receipt of any item prior to entry in to the stock book.

2)STOCK REGISTER:- Showing the source of procurement and date of receipt, issue and balance on hand.

3)DATE OF EXPIRY REGISTER:-
This sould be maintained compulsarily to keep advance track of the drugs due to expire. This register should be monitored by MOH for every two months.

4)ADVERSE REACTION REGISTER:- MOH , PHC, should record any adverse reaction of any drug either in OPD or in-patient. This matter of adverse reaction should be brought to the notice of TMO /DHO.

BIN-CARD

This will help in knowing on the spot the exact stock position of a particular drug and the pattern of expenditure, Date of expiry of drug , source of procurement.

Details on Bin-Card;-
Date of Expiry of the drug should be written in Red ink. MO should attest the issue and balance columns.

Action taken to dispose of the drugs which are nearing date expiry:-
The Bin-card is like a mirror which gives complete information of a drug.

PROCEDURE FOR DISPOSAL OF NEARING DATE OF EXPIRY DRUGS:-

Any drug which has got six months time before the date of expiry and which is not being utilised in your institutions should be informed to TMO in monthly meetings, so that TMO can take action to redistribute the drug to other needy institutions. This procedure should be adopted regularly in every monthly meeting till the drug is shifted at least 3 months before the date of expiry so that other institution can make use of or replacement can be made.

BUDGET ALLOCATION:-

Know your institutions budget allocation . The total amount ear marked for drugs from G.M.S. and from District Sub-Store should be clearly understood.

(Please see ANNEXURE NO. I.)

CIRCULATION OF AVAILABLE DRUGS IN THE INSTITUTIONS:-

The list of Drugs available in the institution should be circulated among the other Doctors of the Institutions for effective health care delivery system.

STATEMENT SHOWING THE VITAL ESSENTIAL AND DESIRABLE AND LIFE SAVING DRUGS IS AS FOLLOWS.

(Please see ANNEXURE NO.II)

Before concluding it is suggested to have an emergency drug kit which should contain the following :

1) Injection Adrenaline
2) Injection Hydro cortisone/Betamethasone/Dexamethasone
3) Injection Deriphylline/Amino Phylline.
4) Injection Diazepam.
5) Injection C.P.M.
6) Injection Dichlofenac
7) Injection Fortwin
8) I.V. Dextrose 5% /DNS /Linger Lactate.
9) Injection Ranitidine
10) Injection Botropase
11) Injection Atropine.
12) I.V.Manitol
13) Injection P.A.M.
14) Injection ASV
15) Injection baralgan
16) Injection Metachlorpropamide + I.V.Cannula + I.V.Drip set + Scap-vein set.

ANNEXURE NO. I.

BUDGET ALLOTMENT FOR DRUGS AND CHEMICALS

	100%	40%	60%
	Rs	Rs	Rs
1) PHU's	30,000-00(GMS)	—	—
2) PHC's	50,000-00	20,000-00	30,000-00
3) G.H or C.H.C's	3,00,000-00	1,20,000-00	1,80,000-00
4) C.H.C's & Tq.level PHC	2,00,000-00	80,000-00	1,20,000-00
5) SUB-CENTRES each	5,000-00		
6) SET CENTRES Each	4,000-00		
7) Dental Package Each	10,000-00		
8) NLCC	75,000-00	30,000-00	45,000-00
9) MLCU	30,000-00	12,000-00	18,000-00

P.T.O.

All the drugs have to be listed with the help of Store Pharmacist from the Stock registers. All the drugs to be arranged in a descending order of their Annual Consumption Value. On the basis of total cost drugs are to be classified into ABC categories.

TABLE 1. ABC Analysis of the Drugs during 1995-96

Category	Items		Annual Consumption	
	Total number	%of all items	value in Rs.	% of total Consumption
A	86	16	5137533.88	70
B	125	23	1467866.86	20
C	331	61	733933.40	10
Total	542	100	7339334.14	100

But However VED Analysis is better than ABC Analysis. V = Vital, E = Essential , D = Desirable.

Here you can see the top ten items expenditure of a particular Hospital.

TABLE 2. The Description of Top ten items.

Items	Name of the item	Percentage of Total budget
1 - 3	Tab Erythromycin 250 mg Cap ampicillin 250 mg Tab cotrimoxazole Plain	10.7
4 - 6	Tab Baralgan Cap Tetracyclines Tab Nidazest 5 mg (Ethynyl Oestradiol)	6.8
7 - 10	Dextrose 5% Cap amclox Tab desferol Cap Raricap	6.8
	Total	24.3

TABLE NO.3. VED Analysis

Category of Drugs	No. of Drugs	% of total Drugs
V: Vital	116	21
E: Essential	172	32
D: Desirable	254	47

Explain About Lead Time :- Internal & External

EPIDEMIC DISEASES ACT, 1897

- FOR CONTROL OF EPIDEMICS & OUTBREAKS
  - Ex. GE, CHOLERA, FOOD POISONING

- DIST. MAGISTRATE (DC) (THROUGH DHO) IS EMPOWERED TO DECLARE AN AREA EPIDEMIC AFFECTED
- PROVISIONS
  - Sr. HA (MALE) & H.I (URBAN) EMPOWERED TO
    - CLOSURE OF EATING ESTABLISHMENT HOTELS, WAYSIDE EATERIES
    - BAN SALE OF CUTOPEN FRUITS, SWEETS, ETC.
    - IF REQUIRED TO TAKE POLICE HELP FOR ENFORCEMENT.
    - PREVENT CONGREGATION OF PEOPLE Ex. NO FAIRS, FESTIVALS
- DENOTIFICATION OF EPIDEMIC FREE STATUS & RESTORATION OF NORMALCY VIZ. NO CASES FOR TWICE THE KNOWN MAX. INCUBATION PERIOD Ex. 10 DAYS FOR CHOLERA

SUMMARY

- DESCRIBE EPIDEMIOLOGY OF A DISEASE
- EPIDEMIOLOGICAL METHODS
- EPIDEMIC ACT

ENVIRONMENT

- AIR
- WATER
- FOOD
- SOIL
- HEAT
- NOISE
- RADIATION
- LIGHT

* **RELATED FACTORS** : **TIME** & **PLACE**

TIME
- SHORT TERM FLUCTUATION
- LONG TERM TREND

PLACE
URBAN Vs RURAL Vs SLUM
Ex. **SPOT MAPS**
DISTRICT Vs STATE | NATIONS

EPIDEMIOLOGICAL METHODS

OBSERVATIONAL

1. DESCRIPTIVE
2. ANALYTICAL
   - ECOLOGICAL SURVEYS
     Ex. IRRIGATION MALARIA
   - CROSS SECTIONAL SURVEYS
     Ex. DIARH. DIS. SURVEYS
   - CASE CONTROL STUDIES
     Ex. LUNG CANCER Vs SMOKING
   - COHORT STUDIES
     Ex. BHOPAL GAS VICTIMS

EXPERIMENTAL

1. CLINICAL TRIALS
   Ex. VACCINES, DRUGS, PROCEDURES
2. FIELD TRIALS
   Ex. IFA, DECSALT
3. COMMUNITY TRIALS
   Ex. STANFORD 3 COMMUNITY TRIAL
   CRISK FACTOR INT

(c) 15.7.98
IPH(K)

DR. M.K. SUDARSHAN, MD [BHU]
PROFESSOR & HOD OF COMMUNITY MEDICINE
KIMS, BLORE-4 (O) 6679560 (R) 648864

EPIDEMIOLOGY OF DISEASES & EPIDEMIC DISEASES ACT, 1897

- RELATED TASKS OF MO, PHC / PHU
  - DISEASE SURVEYS, OUTBREAK INVESTIGATIONS & REPORTING
    Ex. FEVERS, FOOD POISONING, GE, LAMENESS (POLIO), ETC.

EPIDEMIOLOGY OF DISEASES

AGENT ⟷ HOST ⟷ ENVIRONMENT

AGENT

- MICROBIOLOGY
- SOURCE & RESERVOIR VIZ. ANIMAL OR HUMAN
- ROUTES OF TRANSMISSION
  AIR, WATER, FOOD, CONTACT, ETC.
- INCUBATION PERIOD & PERIOD OF COMMUNICABILITY
- IMMUNITY

HOST

- AGE
- SEX
- SE STATUS
- MARITAL STATUS
- NUTRITIONAL STATUS
- OCCUPATION

RESPONSIBILITY OF DRAWING AND DISBURSING OFFICERS

K. MRUTHYUNJAYASWAMY
Faculty (Financial Management)
A.T.I., Mysore.

and

S. SIDDARAJE GOWDA,
Joint Controller (Retd),
State Accounts Department,
Mysore.

Duties towards Accounts:-

Every Government Servant shall ensure that proper accounts are maintained for all government financial transactions. He should render accurate and proper accounts to the A.G. He must be thoroughly conversant with all the Finance Rules. He should conduct frequent checks to ensure that his subordinates will not commit any fraud, misappropriation or irregularities. He should not rely on his subordinates and should not plead that he was misled by his subordinates (Art. 3 of KFC).

Receipts

1. Amount realised on behalf of government should be paid into government treasury within 2 days since amounts collected should not be kept away from the treasury balance (Art. 4 & 7).

2. Separate accounts should be maintained for government money and non-government money (Art. 4).

3. Government dues paid in the form of cash, cheque, bank drafts, postal orders and money orders should be accepted (Art. 4).

4. Cheques and drafts should be treated as cash and entered in cash book, like other cash transactions.

5. A government officer receiving money on behalf of government must give the payer a receipt in KFC form No. 1. (Art. 6).

6. Heads of offices should keep a complete account of the receipt books that they have received (Art. 6).

7. The money received should be brought to the cash book immediately, the receipt number being noted therein (Art. 6).

8. Any person paying money into government treasury will present with it challan in duplicate in KFC Form No. 2. When money is paid by a private party into a treasury, the copies of the challan should be initialled by the departmental officer (Art. 8).

9. At places where the cash business of the treasuries is conducted by the bank, cheques on local banks may be accepted. When cheque is received, only a preliminary acknowledgement be issued and final receipt be issued after the cheque is cleared (Art. 9).

10. The stamps affixed to documents should promptly be punched. Otherwise it gives scope for fraud and loss of revenue.

11. The drawing and disbursing officers are required to write their cash books independently and not on the basis of treasury schedule and send their monthly accounts/returns to the controlling officers after duly reconciling the departmental figures with that of treasury and furnishing a certificate to that effect. Every departmental controlling officer should obtain regular accounts and return from his subordinates for the amounts realised by them and paid into the treasury and consolidate the figures for all the departments. They should closely watch the progress of the realisations of the revenues under his control and check the recoveries made against the demands.

The controlling authority have to reconcile the accounts with A.G. The DDO's should take prompt action to recover the moneys due to government. The following dates for issue and receipt of the above return are prescribed for adoption.

- Date of despatch from the AG's Office. : 20th of 2nd month following.

- Date of return by the department after verification. : 10th of 3rd month following

- Regarding the yearly accounts ending on March. : Not later than the end of June

The controlling authority should send certificate of reconciliation to A.G. for every month before the 15th of the 3rd following month. This certificate should also be recorded in the pay bill for each month, pertaining to the reconciliation of 3rd previous month (Art. 32).

12. Rents due from government servants occupying government buildings should be recovered regularly by deduction from the salary or establishment bills of such government servant as per the rates and charges intimated by Executive Engineer (Art. 41).

13. If a claim be relinquished the value of the claim shall not be recorded on the expenditure side as a specific loss. Remissions and abandonment of claims to revenue shall be reported to the A.G. in the form of an annual statement with reasons before the 1st June of the next financial year (44-A of KFC).

14. Public money in the custody of government departments shall be kept in strong treasure chests and secured by 2 locks of different patterns. All the keys of one lock should be in the custody of the gazetted government servant who is in charge of cash. All the keys of the other lock should be in the possession of the cashier. This disposition of the keys is for the definite purpose of ensuring that the chest should never be opened or closed without both the custodians being present. When there are no double locking arrangements for the

cash chests the cash should invariably be lodged in the inside drawers, the keys of which should be with the gazetted government servant in charge of cash and the outer keys of the chest with the cashier. When the government servant in charge of cash is on tour or on leave, he should handover the keys of the chest together with the contents to any other responsible government servant. The duplicate keys of cash chests of government offices should be deposited in sealed packets in the Government Treasuries with which the offices transact (Art. 12, 13).

15. Every office should maintain "Register to watch the movement of Cash/Bills/Cheques" and obtain the signature of concerned officials (Art. 345 of KFC).

Expenditure

In essence, every expenditure should be relevant to the objectives of the organisation and it should not be more than the occasion demands.

1. To incur any item of expenditure, there should be competent sanction and budget allotment. The government servant must satisfy the cannons of financial propriety.

(i) Every government servant should exercise the same vigilance in respect of government expenditure as a man of ordinary prudence would exercise in respect of his own money;

(ii) No authority competent to sanction expenditure shall pass an order which will be to his own advantage directly or indirectly;

(iii) The expenditure should not be in favour of a particular person or section of community;

(iv) Expenditure such as T.A., etc., should not be a source of profit to the recepient;

(v) The sanctioning authority should not incur expenditure which at a later date may proved to be beyond his power of sanction; and

(vi) Best possible results should be obtained from public funds keeping in view both economy and efficiency (Art. 15 and 16 of KFC).

2. Delays in payment are opposed to all rules and are highly inconvenient and objectionable. The Heads of Offices should clearly understand that the personal claims of government servants should be discharged with the least possible delay. In any case claims should be settled within one year from the date when it becomes due. If it has to be paid after one year, condonation of delay is necessary (Art. 20).

3. Before, condoning the delay regarding the arrears of payment, the Head of Department should exercise the following checks.

(a) Claims should be got scrutinised by Chief Accounts Officer.

(b) Verification should be done with original records.

(c) The claim should be established beyond doubt.

(d) It should not result in wrong or double payment.

(e) Suitable register to be maintained to watch such sanctions (Art. 20).

4. Regarding payment of arrear claims, to avoid double claims/payments the drawing officer shall make a note of the payment, in acquittance rolls, service registers, office copies of original bills, etc...

5. In the case of payments made out of permanent advances, the amount should be recouped at once and in other cases, the liability discharged at the earliest possible time. Claims preferred within one year (even though they related to previous year) can be settled by the Head of the Office, without higher

sanction. Contingent bills not preferred for recoupment within 3 years should, as a rule not be sanctioned or permitted to be encashed (Art. 21).

6. The right of a government servant to travelling allowance (tour T.A., transfer T.A. and conveyance allowance claims) including daily allowance, is forfeited or deemed to have been relinquished if the claim for it is not preferred to the head of the office or the controlling officer or the A.G. as the case may be, within one year from the date on which it becomes due (Art. 22-A).

7. The LTC/HTC bills should be submitted by concerned government servants within one month, from the date on which it becomes due (Art. 22-A).

8. The Head of an Office may authorise a gazetted government servant serving under him to sign bills, vouchers, and payment orders, for him. But the head of the office continue to be held responsible (Art. 24).

9. The head of the office shall ensure that the payment is made to actual payee only and he should obtain clear acknowledgement (Art. 24).

10. A government servant supplied with funds for expenditure shall be responsible for such funds until an account of them has been rendered to the satisfaction of the audit office. In cases in which the acquittances of the actual payees are not sent for audit, the government servant supplied with funds shall be held personally responsible for seeing that the payments are made to the person entitled to receive them. He shall obtain for every disbursement which he makes on behalf of government including every repayment of moneys which have been deposited with the government a voucher setting forth full and clear particulars of the claim, using as far as possible the particular form if any, prescribed for the purpose and shall obtain at the time of making payment either on the voucher or on a separate paper to be attached to it, an acknowledgement of the payment signed by the payee by hand and ink. For the amount equal to Rs. 500 or exceeding Rs. 500 stamped acknowledgement should be obtained. In exceptional cases, if it is impossible to obtain proper vouchers, the disbursing officer may record the certificate saying that charges are

reasonable and actually paid. When an article is obtained by VPP the value payable cover shall be treated as voucher. Pay order should be recorded on voucher in words and figures with attestation by disbursing officer. Without this order, payment should not be effected (Art. 49, 50).

11. The Head of the Office is personally responsible for all moneys drawn as pay, leave salary, allowance, etc., in an establishment bill signed by him or on his behalf until he has paid them to the person who are entitled to receive them and has obtained their dated acknowledgements, duly stamped where necessary. These acknowledgements shall be taken as a rule on the office copy of the bill. Separate acquittances may be maintained for staff and for private persons. The copies of the bills sent to treasury to be maintained in the form of register (Art. 52).

12. Undisbursed amount may be retained in office for a period not exceeding 3 months. A register to be maintained in KFC Form No. 10 to watch the undisbursed amounts (Art. 52).

13. Sub-vouchers to contingent bills should be cancelled in such a manner that they cannot subsequently be used fraudulently to claim or support a further payment (Art. 58).

14. Every government servant should give proper attention to all objections and orders received from the A.G. without any avoidable delay. A register shall be maintained in each office in KFC Form No. 11 for recording the objections communicated by the Audit Office (Art. 60).

15. Every government servant who draw bills for pay and allowances on contingent expenses is primarily responsible for the correctness of the amount for which each bill is drawn. If any amount is drawn in excess of what is due, the drawing officer will be required to make good the excess amount is drawn (Art. 62).

16. Each head of an office will maintain a register in KFC Form No. 12 for all special advances drawn by him. It is the duty of every government servant to see to the prompt adjustment of advances and items

under objection outstanding against him in the books of the audit office. If, owing to delay in dealing with the matter, any amounts become unadjustable they will be recovered prorata from all the government servants during whose time, they remained under objection (Art. 63).

17. The requisitions of the audit department for supply of information necessary for purposes of audit should be complied with by all departments promptly (Art. 65).

18. Cheque books required by disbursing officers authorised to draw on treasuries like PWD & Forest Departments, etc., should be obtained by them from the treasury officer on a requisition signed by the disbursing officer himself. Cheque book must be kept under lock and key in the personal custody of the drawing officer and when transfer of charge takes place, a note should be recorded in the cash book, over the signature of both the relieved and the relieving officers showing the number of unused cheques and cheque books made over and received in transfer by them. No cheque shall be issued for a sum less than Rs. 10. On the cheque at right angles, the word to be written "under" followed by an amount a little larger than the amount written on cheque. All cheques/drafts on banks for amounts exceeding Rs. 1,000 in each case, other than payment of salary, allowances, premium, etc.,. of government servants should invariably be crossed, with the addition of the words "Account Payee Only". If cheque drawn is lost, before handing it over to the party, the non-payment certificate and stop order to be obtained from bank/and or treasury. Afterwards fresh cheque may be drawn. If a party request for fresh cheque on the pretext that the cheque given to him is lost, the non-payment certificate and stop order to be obtained from bank and /or treasury. Further, the party has to execute an indemnity bond in KFC Form No. 73. Afterwards fresh cheque may be drawn (Art. 66, 72)

19. No government servants may open an account with a private bank for the deposit of moneys by him in his official capacity (Art. 76).

20. Where action for the continuance of temporary posts beyond the period upto which may stand sanctioned has been taken but the competent authority has not accorded sanction, the holders of such temporary

posts may draw provisionally, without any authority from the A.G. their pay and allowances at the same rate as they were drawing in that post for a period of 3 months after the expiry of the period upto which the posts had been sanctioned (Art. 80(A).)

21. Pay, officiating pay, leave salary and other emoluments can be drawn for the day of a government servant's death, the hour at which death takes place does not affect claim. In case of death of government servant, the office head can make payment to the claimant upto Rs. 5,000 without insisting for legal authority. If it exceeds Rs. 5,000, office head has to obtain an indemnity bond in KFC Form No. 13 duly stamped with sureties and also he has to obtain the orders of Head of Department. In case of death of gazetted officers necessary authorisation should be obtained from A.G. (Art. 81).

22. Office heads are responsible for the deduction of income tax at the prescribed rates in respect of non-gazetted staff (Art. 89).

23. It is the duty of the office head receiving the court attachment order. to see that the amount attached is deducted from the pay bill and also that a record is kept of such deduction in KFC Form No. 78. Office heads should not enter into any kind of correspondence with the court and they should not forward the representation of government servants (Art. 90 to 93).

(a). Recoveries are to be effected out of the salary payable and sent to Court or Society as the case may be;

(b). In respect of Court attachment, it has to be shown as a deduction in the Pay Bill. In respect of Society dues it may be disbursed in cash;

(c). The Officer should not enter into correspondence with the Court or forward representations. He has to simply execute provided the money is available;

(d). If the Government Servant does not sign or allows it to be undisbursed, in such cases the Head of the Office in case of Non-Gazetted Officers and the Head of the Department in respect of Gazetted Officers, may draw the pay and pay the warrant amount;

(e). The following are the limits for attachment of pay:

(i) Salary to the extent of first four hundred rupees and two-thirds of the remainder is not liable for attachment towards the execution of pay decree, other than a decree for maintenance.

(ii) All kinds of Travelling Allowances, Conveyance Allowances, Uniform and Ration Allowances, House Rent Allowances, Reimbursement of Medical Allowances and Allowances granted to provide relief against increased cost of living are exempted from attachment.

24. Out of subsistence allowance, taxes, house rent, loans and advances are compulsory deductions. If government servant who under suspension, requests, insurance premium, dues of cooperative societies, recovery of GPF advance may be deducted. The GPF subscriptions, court attachments and recovery of loss should not be made. The rate of recovery out of subsistence allowance should not exceed one-third of the gross subsistence allowance (Art. 94-A).

25. In case where an officer deputed for training does not discharge statutory duties and the handing over of cash or stores is not involved and the total absence from headquarters does not exceed 10 days, the handing over and taking over charge of the post is not required.

26. Every transfer of charge of a gazetted government servant proceeding on leave or on transfer or returning from leave should, without fail be reported by post on the same day to the A.G. in Form No. 18. Every government servant who is responsible for the adjustment of advances and who is transferred to another office before fully accounting for the amounts outstanding against him

should leave for the information and guidance of his successor, a memorandum clearly explaining the state of accounts of each item of advance and noting the action tobe taken for adjusting the outstanding amounts within the time allowed by the sanctioning authority. If he does not do so, his responsibility will not cease and his successor may not be held responsible in respect of the items not brought to the latter's notice. A statement of unadjusted advances and unremedied objections should be given by the relieved to the relieving government servant in KFC Form No. 20 & 21 respectively (Art. 100).

27. The entire salary for the month in which a transfer has been made shall be drawn on the bill of the establishment to which the government servant is transferred, after the close of the month, attaching these to the requisite LPC and not in several bills. In respect of government servants transferred to local funds the joining time allowance and travelling allowance for the forward and return journey shall be borne by local body concerned (Art. 129).

28. Arrear pay shall be drawn on a separate pay bill and not in the original monthly pay bill. The non-drawal certificate on the previous occasion shall be recorded. Only one bill is sufficient for all arrear claims of different months which are drawn at the same time, particulars of claims of different months, being however, shows separately in the bill. All supplemental claims should be noted in the original acquittance rolls. This is necessary to avoid the risk of claiming again. A 'Due and Drawn Statement' in respect of arrears of pay and allowances of a government servant shall be prepared by the drawing and disbursing officers (Art. 132).

29. Travelling allowance of establishment other than permanent or fixed allowances, shall be drawn in KFC Form No. 29 settingforth the details of the journeys and explaining any divergence from the recognised route; ordinarily not more than one bill will have to be preferred for the claims of a particular month in respect of a government servant. The government servant countersigning travelling allowance bills will maintain a register in KFC Form No. 30 in which he will note the bills he countersigns (Art. 137).

and also to prepare an account in Form KFC 62-E (Art. 346).

33. A proper record of personal advances drawn and repaid by non-gazetted government servants should be kept in all offices in a register in the form mentioned under Article 347 of KFC. A separate register for each kind of advance is not necessary but a separate sheet may be allotted in the register for each individual who has drawn any advance (Art. 347).

34. The head of office is responsible for any loss sustained by government through fraud or negligence. He has to take all precautionary steps regarding the movement of cash/bills/cheques/stores, etc., by obtaining adequate security from government servants/contractors/supplier. Particularly he should be cautious regarding the genuineness of bank guarantees, its period vis-a-vis with the fulfillment of terms and conditions by suppliers and/or contractors. He has to follow the procedure laid down in the Articles from 353 to 359 of KFC.

As per Article 332, deficiency found in cash, should be made good at once by the person responsible for it. As per Article 338 when the government servant in charge of cash goes on tour or on leave should handover the keys of cash chest with contents to any other responsible government servant.

If loss takes place, the head of office should send preliminary report to HOD, A.G., Secretary, F.D., through proper channel, explaining the nature and circumstances with extracts of documents. Subsequently, the office head shall conduct detailed investigation and send final report to A.G., H.O.D., and Secretary through proper channel. The detailed report should contain the nature of loss, amount involved, persons responsible, citation of documents and its extracts, modus operandi, recoveries made, disciplinary action/judicial action taken or recommended, defects in system, steps taken to prevention.

35. In all offices, a register of valuabale documents should be maintained and the receipts and disposal noted therein under the initials of a responsible government servant. The documents should be

preserved in safe or other receptacles intended to keep valuables coming into possession of the government servants concerned (Art. 367).

To conclude it is the duty of every Government Servant to observe complete integrity in financial matters and ensure that best results are obtained from the public funds spent by him and strictly guard against any kind of wasteful expenditure. He should not only satisfy himself but also satisfy the requirements of audit.

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PREVENTION AND DETECTION OF FRAUD IN FINANCIAL MANAGEMENT IN GOVERNMENT

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Faculty
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Article 3 of KFC, mentions that, the drawing and disbursing officer (DDO) should keep an adequate check over subordinates in order to avoid financial irregularity. He cannot plead that he was misled or deceived by his subordinates.

Prevention is better than cure. Despite taking lot of precautions, fraud might takes place. Such frauds also to be detected in shorter time and action to be taken on the concerned official's and also action to be taken to prevent it. Therefore DDO has to be extremely cautious.

Negligence or incorrect handling of procedures, or ignorance of financial implications of decisions, will give scope for fraud or it may result in any kind of and financial irregularity. Fraud may takes place in any area of financial management. It may be in the area of receipts, expenditure, deposits and advances. etc.,

The cash inflows to Government takes place in various forms. The responsibility of DDO's is to properly update assessment list, rise the demand in time, collect the amount in time and to see that the amount is actually remitted to the government. For this he has to maintain DCB register and other connected records. The amount will be collected in the office or the parties, will be asked to remit the amount directly to Bank/Treasury and to produce the copy of challan to office. When cash is received in the office, the cash receipt has to be issued in the K.F.C. form No.1. This cash receipt books will be supplied by Government press to heads of departments and im turn Heads of Departments will supply these receipt books to subordinate DDO's. At all the 3 points, the stock register of receipt books will be maintained. DDO and cashier will have to sign the cash receipts and DDo cannot delegate the power of signing the cash receipt to the subordinates. First the cashier should sign the cash receipt and then DDO will sign the cash receipt. The receipt number of the cash receipt has to be entered in the cash book. While signing the cash book DDO must ensure all these aspects.

CASE

After DDO has signed cash receipt for Rs.4,000-00 without an immediate entry in the cash book, the cashier tampered the cash receipt by altering Rs.4,000-00 as Rs.400-00 both in words and figures. He has also made an entry in the cash book for Rs.400-00 only.

The DDO signed the cash book blindly, which resulted in embezzlement of Rs.3600-00. This comes to the notice in audit after a lapse of 2 years. The cashier has remitted only Rs.400-00 into Bank. Even on the remittance book, the power of signing challan and remittance book was blindly signed by DDO, without looking into the tampered cash receipt. Had he followed the procedure, no fraud could have taken place.

Negligence on the part of the DDO's, may end up in much more serious fraud. We, even come across cases where the duplicate cash receipt book has been got printed and that duplicate cash receipts are signed by DDO's. Therefore DDO should be very alert to prevent such kind of fraud.

A few cases are only cited here. It is not possible to predict that fraud will takes place in a particular way. Some times there will be no solutions or guidelines in the rules to prevent fraud. The alertness of mind and Studying of auditors reports and discussion with accountants and auditors will be very useful for the DDO's.

In cases, where, DD's or cheques are received, only the acknowledgement has to be issued and not the cash receipt. When in the Departmental manual, it is mentioned that, cash receipt may also be issued for the receipt of cheque/DD, then the cash receipt may be issued. But the entry to be made in the cash receipt, "This is subject to realisation". The offices with small transactions an entry can be made straight in the cash book with the number of DD/Cheque. The offices having huge transactions,. should maintain the day book in the form of "Cheques received and adjusted". After the encashment only, entries to be made in the cash book. Care should be taken by DDO's for the encashment of cheques within the due date and correct transfer of entries/total of each page/date wise from day book to cash book. Even when there is large cash transactions, the totals of the day book for each day will be transferred to the cash book. Care should be taken by the DDO's to check pagewise totals and verification of carry forwarding of balances, from page to page and from day book to cash book.

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CASE

In the cash day book (receipts), page 6 shows the closing balance of Rs.10,000-00 on a particular date, the Opening Balance on next page (Page-7) shown as Rs.1,800-00.

The page 6 and 7 entries are for particular day only. The total for page 6 and page 7 shown on page 7 as Rs.20,100-00, with a short accounting of Rs.9,000-00. This Rs.9.000-00 entered in the cash book. Both the day book and the cash book are neatly signed by DDO. This is a clear case of failure of supervision.

When cheques/DD's are received, DDO's should see that, it is encashed within the due date of payment to Government. They should also make it clear that, in case of encashment of cheques/DD's after the due date of payment, they are liable for penalties as per the departmental manuals. As far as possible, they should accept the local cheque and DD's payable on local banks. If this is not possible, DDO's should ask the party to remit the amount directly to the Bank/treasury and to produce the copy of challan. Even on copy of challan, should not be acted upon by issuing licences etc., until it is ascertained that the amount is actually remitted to the treasury.

When accepting currency notes from the party, care should be taken, by not accepting fake notes. If fake notes are received, complaint should be lodged with police and the matter should to be reported to the controlling authority.

When large amount is sent to bank/treasury for remittance, sufficient precautionary steps should taken, It should be entrusted to experienced and reliable person. Adequate security should be ensured. Wherever necessary police help may be sought.

It is the responsibility of DDO to see that amount is actually credited to government account. This can be ensured by proper monthly reconciliation of accounts with treasury. The Treasury officer will send the consolidated treasury receipt and DDO to compare the accounts with this schedule. If the receipts accounts appeared in his books and not appeared in treasury receipt accounts, immediately, he should verify in detail and lodge complaint with police and inform the controlling authority. The Departments with small receipts transaction, can depute a clerk to treasury for reconciliation work. The person employed for reconciliation work should not be the same person, employed for reconciliation work should not be the same person, who has taken the amount for remittance to bank or treasury.

CASE

This case pertains to 1972. Earlier in District Hospitals, they used to collect 25 Ps. per patient. Twice in a month, they used to remit this amount to bank. The medical superintendent of Hospital used to send the peon to remit the amount to bank with a challan and remittance book. The investigation proved that, he used to tear the challan and put duplicate bank seal on the remittance book and pocket the cash. No reconciliation work was done for the period from 1972-76. The embezzled amount was around Rs.4.5 lakhs. In such cases detection of fraud is possible only through monthly reconciliation, which the medical superintendent had not done.

Only a few cases are illustrated in the area of receipts management. It is not possible to say specifically how fraud will take place. It is the direct responsibility of the DDO regarding movement of cash from the point of its realisation to its actual remittance to bank/treasury.

Now we will look into precaution to be taken in the area of expenditure management i.e., cash outflow and prevention and detection of fraud.

Funds withdrawal takes place through bills and cheques. Funds will be withdrawn for works, contingencies, establishment expenses like salaries, T.A, medical reimbursement etc. To spend the government money, following are essential rules have to be followed.

1. Budget allotment
2. Competent sanction
3. Financial Propriety
4. Purchase rules
5. Accounting

Finally this will be followed by Audit.

ESTABLISHMENT BILLS

The DDO should be cautious against payments regarding arrears i.e., possibility of double payments, drawal of the leave encashment twice in a single block, non-feeding of retirement date to the computers, drawal on forged bills against the DDO account, discrepancy regarding entries when compared to entries in cash book, tampering the acquittance roll, non-entries of leave accounts in service book, evading the adjustment of advances, wrong pay-fixations, embezzling the undisbursed amount etc., This list is not exhaustive. But the negligence may result any kind frauds.

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Some of the pre-cautionary steps to be taken are as follows.

1. Thorough verification of arrears with reference to acquittance rolls and cash book, to avoid excess or double payment.

2. When signing the leave encashment bills, the entries to be made in the service register.

3. Awareness of the retirement date of the sub-ordinates.

4.Re-conciliation of accounts, to detect the fraudulent encashment of establishment bills and other contingent bills.

5. When signing the cash book every entry in the cash book, has to be verified with acquittance.

6. On every page, total in the acquittance roll to be recorded in words with disbursement certificate. For undisbursed amount, separate register to be maintained.

7. As and when the leave is sanctioned an entry to be made in the service book with attestation.

8. The recovery of advances in installments to be given progressive number and register to be maintained by alloting a page number for each kind of advance name wise for watching it's recovery. On transfer or retirement clear entries are to be noted in LPC by consulting this register

9. Pay-fixation should be done in accordance with relevant rules. In case of doubts, the DDO's may seek the opinion of the Accounts Officers and Treasury officers.

CONTINGENT BILLS

The sub vouchers attached to the bills and sent to treasury or voucher retained in the office should be stamped with "paid and cancelled" immediately after payment to prevent the possibility of double payment. The genuiness of sub vouchers i.e., bills received from the firms should be verified with utmost care. The DDO should see that the amount is actually paid to payee only. Wherever possible, it should be paid by cheque. Clear acknowledgement with date and signature should be obtained from the payee. Wherever thumb impression is obtained it should be got attested by some known persons. It is suggested to issue only the account payee cheques.

When signing the cash book, the entries with reference to sub vouchers and bills wise should be verified.

The expenditure accounts should be got reconciled with treasury on monthly basis. Regarding the accounts not appearing in the DDO's accounts but appearing in the treasury accounts, detailed verification has to be done and if there is any fraud, complaint should be lodged with police and information to be sent to controlling authority.

WORK'S EXPENDITURE

To incur expenditure on works, there should be a technical sanction and administrative sanction with budget allocation. The DDO should see that tender procedure has been followed and the estimates are within the current SR and the procedure regarding the maintenance of muster rolls and MB, Contract ledgers are followed. When paying the bills, particularly running account bills, substantial verification is done. Normally there will be LOC system for payments on works expenditure is concerned. In such cases, the initial accounts will be passed on to A.G. directly by DDO. The amount will be paid by cheques signed by DDO's. This cheque books should be in the personal custody of DDO's.

DDO's should be very careful when signing the cheques by not giving scope to fraud, which may taken place in the form of addition or alterations. Cheque writing machines may also be used. When signing the cheque corresponding entry in the cash book to be entered.

SAFETY OF CASH

The cash should be kept in cash chest with double lock system. One key should be with DDO and the other key should be with cashier. The duplicate keys should be lodged in treasury. Once in a month or as often as required, the cash balance should be verified with the book balance. The cash chest has to be got embeded to the interior walls..

Regarding transportation of cash from Bank//Treasury to office, sufficient care should be taken by employing a reliable government servants. If necessary departmental vehicle may be used, when the amount is large, with police escort.

When the bills sent to treasury is lost, the DDO should obtain non-payment certificate from treasury, by requesting him not to make the payment on the lost bill. Then the duplicate bill may be prepared and sent to treasury.

When the cheque received from treasury is lost, the non-payment certificate has to be obtained from the Bank with a request to bank not to make payment on the lost cheque. Then the duplicate cheque has to be obtained from Treasury.

When the cash received from the Bank is lost/stolen, complaint has to be lodged with police. The information to be sent to Head of the Department to obtain special government order to re draw the amount for disbursement.

When the party approaches the DDO on the pretext that cheque issued to him is lost, the non-payment certificate to be obtained from bank, duplicate cheque to be issued on the lost cheque. The duplicate cheque may be issued to the party by obtaining indemnity bond from him.

During Enquiry in its investigation, it is revealed that, such firms not in existence. Therefore it is suggested to obtain the quotation individually from each firms.

When purchased materials has been procured, it should be compared with the sample or with specification mentioned in the supply order. If this exercise is not done properly, fraud may takes place.

CASE ON FRADULENT ENCASHMENT OF BILLS

In an office, the section superintendent along with cash orderly in collusion with the treasury official managed to obtain the treasury tokens. They prepared the duplicate bills on the DDO account and forged the signature of officer, who used to sign on behalf of DDO. They managed to obtain the cheque from treasury and encashed from bank. This they practiced for years. Even the treasury token number was not verified in treasury office, due to the colusion of treasury officials. This kind of fraud has taken place and the embezzled amount was in terms of few crores. This could have been detected early, if the monthly reconciliation of accounts was done by DDO with treasury, or subsequently this could have been detected through internal audit system. This has not been detected by internal audit system, mainly because the staff borne on the internal audit wing are not professional accountants or auditors.

ROLE OF INTERNAL AUDIT SYSTEM

Role of Internal Audit is to provide the financial date to the management alongwith performance report. It provide advise and also conducts the concurrent audit for all the wings of the organisation. In government departments, following are the few important tips for internal auditors.

1. Comparison of allotment released by Head of the Department to DDO's with the return of expenditure from DDO's on monthly basis.

2. Comparison of accounts return from DDO's to AG's figures.

3. Conducting of rule and propriety audit.

4. Bringing to the notice of HOD about the financial irregularities etc., with suitable suggestions.

5. In consultation with the AG's staff, setting right the misclassifications, verification of voucher and challans for detection of fraud etc., has to be done by internal audit wing.

It is the responsibility of HOD, who is also DDO to see that, the Internal Audit wing staff is filled up by professionals in the area of accounts and audit.

To conclude, the DDO should always keep an eye on the inflow and outflow of cash and materials, so that he can able to detect and/or to prevent the fraud.

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K.H.S.D.P.
HOSPITAL MANAGEMENT TRAINING FOR CHC DOCTORS

Day: 4 : 18-12-1997 12.00 Noon to 1.00 P.M.

Waste Management and Cleanliness of the Hospital

- Dr. Sathyanarayana*

Cleanliness of a health care facility eg. Hospital or clinic, is as important as the health care that the facility offers. Increasing health care activities in hospitals and clinics generate, as a by-product, a large amount of unwanted materials called 'Medical Waste'. Wound dressing, surgery, deliveries, investigations, autopsies and a host of procedures and therapies produce different categories of wastes. These 'biomedical wastes' have proved infections and hazardous. Indiscriminate dumping of these wastes and hazardous. Indiscriminate dumping of these wastes have resulted in a number of nosocomial infections some of which have been fatal.

To-day, the health managers of hospitals and clinics, specially the administrative heads, would like to look around their institution and ponder whether their health care facilities invite or stun away the patients.

Hospital Waste Management or Health Care Waste Management has been a subject ignored so far for a variety of reasons and lack of policy, awareness, commitment, resources. The result rendering a quality health care given by qualified personnel ineffective because of an unpleasant if not filthy environment. The enclosed synopsis on Hospital Waste Management gives an outline of essential facts about hospital Waste and its management. The participants who are not only managers but also trainers would find it useful as a teaching material to train other health workers in their own institution.

* Consultant (STEM), KHSDP.

What is Medical Waste?

Medical Waste is waste generated in diagnosis, treatment, prevention or research of human and animal diseases. The waste can be in the form of solid or liquid waste.

Where is it generated?

Hospitals, health centres, clinics, nursing homes, midwifery, laboratories, research institutes, veterinary clinics as well as from medical care conducted at home.

Why is it important?

1. Medical waste presents occupational health risks to those who generate, handle, treat and dispose of the waste.

2. It may also presents risks to the community or environment if the waste is inappropriately handled, since it can contribute to the spread of diseases. Viral transmission of Hepatitis B, Hepatitis C and HIV through injuries caused by syringes or sharps infected with human blood.

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3. The risk associated with the use of incinerators. The smoke produced by infectious-hazardous incinerators may contain toxic particles that can effect people's health.

Classification

WHO Classification - 1987
WHO simplified classification - 1994 - developing countries
US - EPA classification - 1989
India - classification - 1995

Segregation at the source

Segregation means separation of different categories of wastes by sorting and putting into different containers or bags at the place where waste is produced.

Blue Container	Clinical Waste
Red Container	Infectious Waste
White Container	General Waste

Labeling.

Collection and internal transportation

- Using trolleys or carts.
- Moving waste from one point to another within the facility.

Storage

- A specified area within the hospital or facility's compound, designated exclusively for the storage of medical waste for a short period of time before treatment or disposal.

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Treatment

Process that modifies the waste in some way before it is taken to its final disposal place. Reasons:

- to disinfect or sterilize the waste so that the waste is no longer infectious, after such treatment the waste can be handled more safely with fewer precautions;
- to reduce the bulk volume of the waste in order to reduce the volume before disposing it to the final destination;
- to make surgical waste or body parts unrecognizable so that it will not be unacceptable to the community;

- to make recyclable items, such as needles, become unusable.

Various treatment methods:

Incineration: a process of burning infectious-hazardous waste under controlled combustion, the end product will be sterile residue and emissions.

Regional Incineration: One well-run, state-of-the-art, air pollution-equipped incineration is better than many small incinerators.

Microwaving: the process incorporates shredding, steam spraying and microwave irradiation.

Autoclaving: is a system to sterilize medical waste by using autoclave or steam sterilization.

Chemical Treatment: the process includes preliminary milling and shredding of the waste, washing it with chemical disinfectant, and then going through a de-watering process to limit the moist.

External Transportation

It is the transportation that carries infectious-hazardous waste from health facilities to an outside treatment centre or landfill.

Final Disposal

Final Disposal means to place the waste in its final resting place.

Safety handling

Preventive measures: Hepatitis B vaccination, universa precautions, personal pretective equipment, etc.

Project support:

- State level
- District level
- Facility level

HEALTH MANAGEMENT INFORMATION SYSTEM *

Date : 17-7-98 Jt. Director., Demography Sri Prakasham, D. H & FWS Time : 9 to 10 AM

The MIS varies according to the structure of the system and has to cater to the organisational needs of a) Research b) Planning c) Policy formulation d) System integration and e) Implementation and maintenance.

2. Health is a holistic concept and a confluence of many sub systems. HMIS has to fulfil the following mandate.

1) Describe the level of community health
2) Diagnose community ills and priorities
3) Promotion of legislation
4) Formulation of Programmes(Eg. : AIDS control, RCH)
5) Dissemination of information for Health Education
6) Planning and Evaluation
7) Projections(Eg. : Population)

3. Data/Information is the life blood of Management and is essential at all levels of the organisation

a) for reporting to the next higher authorities and
b) for monitoring and review. It results in action and corrective measures at all levels.

4. Health system in the country - Ministry of Health & Family Welfare (coordination and policy making) →DGHS Technical Wing - Medical Care and Public Health → CBHI(Nodal Agency for HMIS) → State Health & Family Welfare Departments(+ Medical Education) - SBHI - Demographic & Evaluation Cell(FW & MCH) or (RCH)

5. Rural Health set up

- SC - PHC - CHC

6. Information on Medical and Health care is mostly availble for public enterprises only - very little information in respect of private sector in spite of significant contribution(82%). NGOs also are contributing to Public Health Care and Family Welfare activities to a great extent.

7. Health Programmes

a) RCH(FW + CSSM + STI/RTI)
b) Malaria Eradication
c) Tuberculosis
d) Leprocy Eradication
e) Control of Blindness
f) AIDS
g) Nutrition
h) Communicable Diseases

8. NIC - This is a nation wide, satellite-based Computer Communication Network (NICNET) encompassing all districts, State Capitals and the centre, facilitating District Information System(DISNIC) at district level and essential data base for States and the Central Government Departments.

9. Registers to be maintained at PHC level

1. Sub-centre Register - 1 Sub-centre and Village Information
2. Sub-centre Register - 2 Household Information
3. Sub-centre Register - 3 Eligible Couple & Children Information
4. Sub-centre Register - 4 Family Welfare Services
5. Sub-centre Register - 5 Maternal Care Services
6. Sub-centre Register - 6 Child Care & Information Services
7. Sub-centre Register - 7 Tuberculosis & Leprosy Control
8. Sub-centre Register - 8 Malaria Blood Smear & Treatment
9. Sub-centre Register - 9 Home visit Diary
10. Sub-centre Register - 10 Clinic Register
11. Sub-centre Register - 11 Stock & Issue Register
12. Sub-centre Register - 12 Vital events - Births
13. Sub-centre Register - 13 Vital events - Deaths

10. Reports to be sent by the PHC

<u>Family Welfare</u>

1) KDP Report
2) Form-14(Now replaced by 7)
3) OP & CC, IUD Reports
4) Stock position of OP, CC, IUD
5) Quarterly reports - (Socio Demographic Data)
6) Sterilisation death(Quarterly)
7) Conception after Sterilisation(Quarterly)
8) MTP(Monthly)
9) Eligible Couple Analysis
10) Age wise and Children wise Sterilisation Reports(only for sterilisation)

<u>Immunisation (UIP)</u>

1) CSSM reports(Monthly) - Pneumonia, ORT episodes, Diarhhoreal diseases

2) MCH reports - 1) Special report (Deliveries, IFA Tablets) Monthly
2) Infant & Maternal deaths
3) School Health
4) Dais Training

3) Leprosy - 1) Survey reports (Monthly)
2) KDP report
3) Form L1, L2,and L3

4) Malaria - Passive and Active Reports(Monthly)
MF 1-14
Lab report(Weekly /Monthly)

5) TB - Sputum collection and case detection
Stock Position of drugs

NPCB

Cataract Operation, Survey Report(MLY) Total Operations and Refractions

Nutrition

1) ICDS report (Monthly) Project advisors report and sectored advisore report
2) Iodine defeciency - Goitre control programme
3) Vitamin - 'A' report
4) NED(Nutrition, Education and Demonstration)

MEM(IEC reports)

1) Mahila Arogya Sanghas
2) Exhibitions
3) Film Shows
4) Folk media

CMD(MLY)

Indoor and outdoor patients
JE & GE Cases
Dengue fever, Snake Bite, Dog Bite
Morbidity and Mortality report
AIDS

RCH (Reproductive and Child Health services)

Under RCH Programme, the approach to Family Welfare is Community Needs Assessment Approach. Under this, a set of new formats have been prescribed. Accordingly, the Annual Action Plan is to be prepared in Form No. 2. The monthly progress on various services/activities as also the stock position of drugs, vaccines etc., is to be reported in Form No. 7.

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* Prepared by Shri. G. Prakasam, Joint Director(Demography), Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore 560 009.

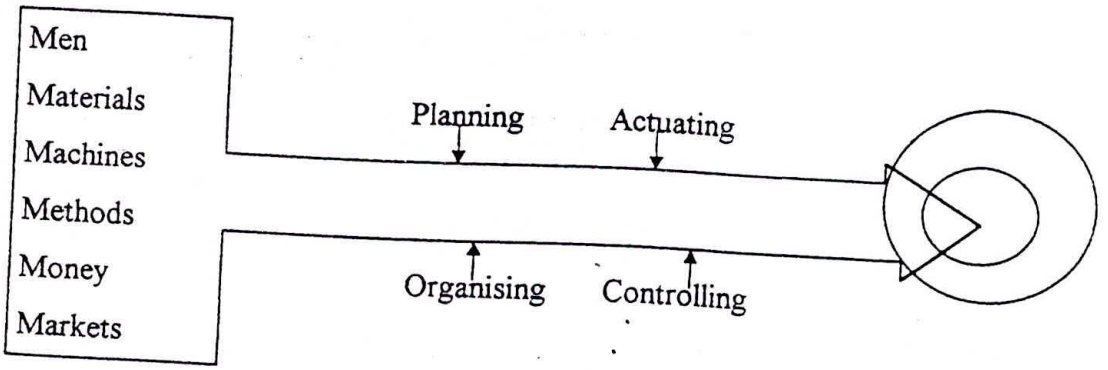
Definition of Management:

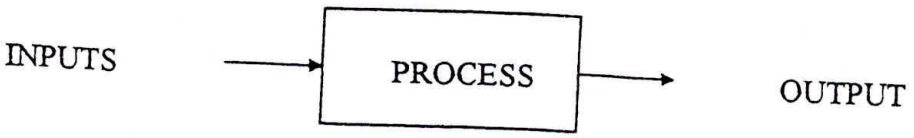
Management is a distinct process consisting of activities of Planning, Actuating and Controlling performed to determine and accomplish stated objectives with the use of human beings and other resources.

Popularly "Getting things done through other people."

Six M's of Management of "basic resources" are subjected to the fundamental functions of management.

Basic Resources	Fundamental Functions	Stated
Objectives		
The 6 M's	The Process of Mgt.	End Results





Management is getting the right things done in rightway in right time by right persons with right amount of resources and with effective use of resources.

Why do you Need Management?

- Human efforts more productive
- Brings better equipment, plants, offices, products and services and human relations to society
- Improvements and progress are the constant watchwords.
- Brings order to endeavours by combining isolated events and disjointed information into meaningful relationships.
- Accomplishment of many social, economic and political goals of any country.

MANAGEMENT

CONCEPTS

PRINCIPLES

FUNCTIONS

APPLICATIONS IN HEALTH MANAGEMENT

Dr. Kishore Murthy

Management : Is it Art or Science?

Management is an ECLECTIC DISCIPLINE with elements of art and science combined.

Body of systematized knowledge accumulated and accepted with reference to understanding of general truths concerning Management.

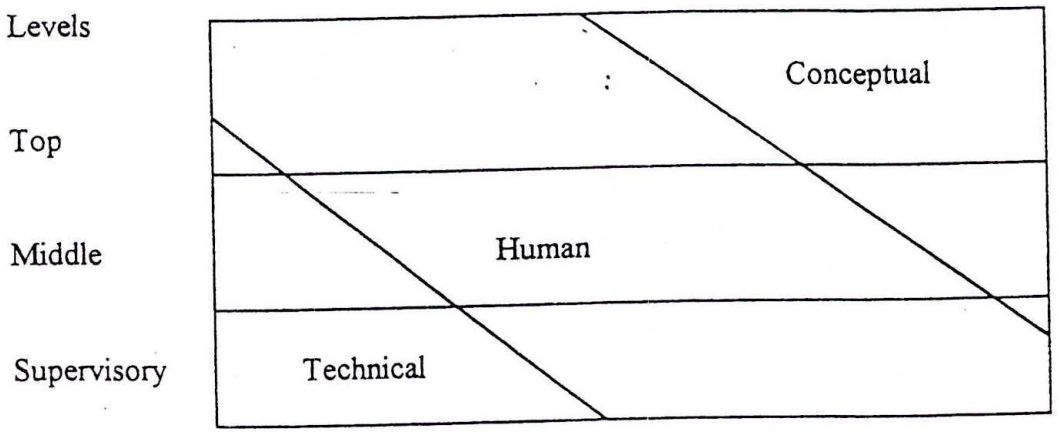
Art of Management is a personal creative power plus skill in performance.

Science teaches one to "know", art teaches one to "do". Management is to know and do things efficiently and effectively to be successful with the proper resources.

Technical, Human and Conceptual Requirements:

Top managerial jobs require more human and conceptual knowledge and skill than technical knowhow.

Lower jobs require more technical and human needs with less emphasis on conceptual work.



Key characteristics to understanding Management:

1. Management is purposeful and Management makes things happen
2. Management is an activity, not jut a person or group of persons
3. Management is accomplished by with and through the efforts of others.
4. Management is usually associated with efforts of a group
5. Management is intangible
6. Management is aided, not replaced by computers.
7. Management is an outstanding means for exerting real impact on human life.

Planning

What is to be done where ? When? How?

Organising

Who is to do what? With what Relationships, What authority, Under what Physical environment ?

Actuating

Getting the Employees to Want to Work willingly with good co-operation

Controlling

Follow up to see that planned work is being properly carried out and if not to apply remedial measures

MANAGEMENT IS DYNAMIC, NOT STATIC

Important activities of each fundamental function of management

Planning	Organizing
Clarify, amplify and determine objectives Forecast Establish the conditions and assumptions under with the work will be done Select and state tasks to accomplish objectives. Establish an overall plan of accomplishment, emphasizing creativity to find new and better means for accomplishing the work. Establish policieies, procedures, standards and methods of accomplishment. Anticipate possible future problems Modify plans in light of control results.	Break down work into operative duties Group operative duties into operative positions Assemble operative positions into manageable and related units. Clarify position requirements Select and place individual on proper job. Utilise and agree upon proper authority for each management member. Provide personnel facilities and other resources. Adjust the organization in light of control results.

Actuating	Controlling
Practice participation by all affected by the decision of act. Lead and challenge others to do their best Motivate members Communicate effectively Develop members to realize full potentials Reward by recognition and pay for work well done. Satisfy needs of employees through their work efforts Revise actuation efforts in light of control of results.	Compare results with plans in general. Appraise results against performance standards. Device effective media for measuring operations. Make known the measuing media Transfer detailed data into form showing comparisons and variances. Suggest corrective actions, if needed Inform responsible members of interpretations. Adjust controlling in light of control results.

The components of results management

1. ESTABLISH OBJECTIVES
   a. Identify key areas
   b. Determine measurement unit

2. PLAN ACTIONS TO BE TAKEN
   a. Decide necessary activities and tasks to be done along with respective purposes and means for accomplishing.
   b. Determine sequence of actions, what resources are needed, time needed to accomplish each task, and who is responsible for it.
   c. Anticipate potential hurdles and decide what might be done to overcome them.

3. CONDUCT PEREIODIC AND ANNUAL APPRIASAL REVIEWS

a. Look over objectives subordinate is responsible for periodically.

b. Review actual results obtained.

c. Evaluate results against performance expectancies as set forth by objectives that were established and establish revised or new objectives.

Management with reference to Medical Officer of Health:

Getting things done by others in a systematic way to achieve the predetermined goals. For eg. given the responsibility of implementing the health programmes, the PHC Medical Officer has to plan various tasks, divide the work among his staff, provide support and supervision so that the ultimate objective or target is achieved. Thus the MOH necessarily acts as a manager in order to get things done through his/her staff.

A medical officer at PHC is both a technical person and a manager. One must be able to differentiate between these two roles. As a technical worker the medical officer is doing some of the following :

1. Diagnosis and treatment
2. Prescribing
3. Follow-up treatment
4. Any other form of treatment
5. Preventive and promotive services
6. Giving clinical knowledge to his staff.

As a manager, the medical officer is doing some of the following:

1. Planning, organising and evaluating the activities of the PHC
2. Supervising the staff
3. Maintaining adequate supplies and equipment
4. Supervising information gathering and recording
5. Managing the PHC vehicles
6. Solving problems

7. Financial administration
8. Motivating the staff and providing leadership
9. Developing staff capabilities through training
10. Developing good relations with community

One of the problems a medical officer faces in being a PHC manager is a sense of frustration that he is not accomplishing as much in his managerial role as he is accomplishing in his technician's role. A few medical officers get so frsutrated with this feeling that they develop a negative attitude towards administrative and managerial functions. Other medical officers tend to ignore management responsibilities and feel comfortable only treating patients. Still, other medical officers delegate all administrative responsibilities to their staff and then forget about them. It is important that medical officers realise that they can influence the PHC's prformance a great deal through appropriate management and thus provide better health care for a community.

Difference between a medical officer's technical and managerial roles:

1. A doctor can observe the results of treatment in a short period of time. Whereas, a manager may have to wait for longer periods of time to see results or improvements.
2. In general, a doctor works alone in his clinical activities, whereas a manager depends upon several other staff and works as a member of a team. For many medical officers it is easier to work alone than to work on a team.
3. The results of performance as a doctor may be more visible and have higher status than the results of performance as a manager.
4. A doctor has a one-to-one relationship with a client and therefore direct control over the client. Whereas manager works through his staff and does not have a one-to-one relation with his client.
5. A doctor may have to face motivational problems as often as a manager, both self-motivation and motivation of staff.

Functions of the MOH

Any organisation is like a pyramid, and at the vertex is the Chief Executive or MOH, whose administrative functions are summed up by Luther Gulick in the word '**POSDCORB**' which stands as follows :

Planning ... Plan the work that needs to be done and the method, how it should be done.

Organizing ... giving the plan some shape and establish the formal structure of authority through which work sub-divisions are arranged.

Staffing ... the whole personnel function of bringing, training and maintain favourable conditions of work.

Directing ... The continuous task of making decision and giving instructions.

Coordinating ... the all-important duty of inter-relating the various parts of the work.

Reporting ... keeping those to whom the executive is responsible informed about the progress and also keeping himself informed through record returns and inspection.

Budgeting ... with all that goes with budgeting in the form of fiscal planning, accounting and control.

Planning:

Planning is selecting information and making assumptions regarding the future to formulate activities necessary to achieve organisational objectives.

Advantages of Planning:

1. Makes for purposeful and orderly activities.
2. Points out need for future changes.
3. Answers "what if" questions
4. Provides a basis for control
5. Encourages achievement
6. Compels visualisation of entirety
7. Increases and balances utilization of facilities
8. Assists manager in gaining status.

Types of Planning:

1. Strategic planning (Long Term Planning)
2. Tactical Planning (Methodology Planning)

Strategic Planning:

1.	Answers :	Where should we be going
2.	Defines:	Enterprise purpose served and its preferances
3.	Analysis:	Environmental factors influencing the operations, constraints and opportunities revealed
4.	Determines:	real abilities of enterprise management, ability, finance, sales, production skills
5.	Selects:	Strategic objectives
6.	Documents:	Strategy

Tactical Planning:

1.	Answers	:	How will we get there
2.	Determines	:	tasks to be done
3.	Establishes	:	who is responsible for what
4.	Allocates	:	resources
5.	Sets	:	quantitative measurements for each task

6. Puts tactical plan in writing
7. Perform planned actions
8. Exercise controls (Monitoring)
9. Evaluate progress

Strategic Planning:

It is the process of deciding on the objectives of the organisation or changes in earlier specified objectives on the resources used to attain these objectives and on the policies that are to govern the acquisition, use of disposition of these resources. Strategic vision accomplishes the organisation goals and objectives, apply criteria to day-to-day operational decisions and involve people to be part of the overall design.

Characteristics:

1. External orientation : Opportunities and Threates
2. Futuristic Action orientation : What is likely to happen and what is possible to make it happen
3. A long term plan
4. Closely tied to the budget.

Steps for Strategic Planning:

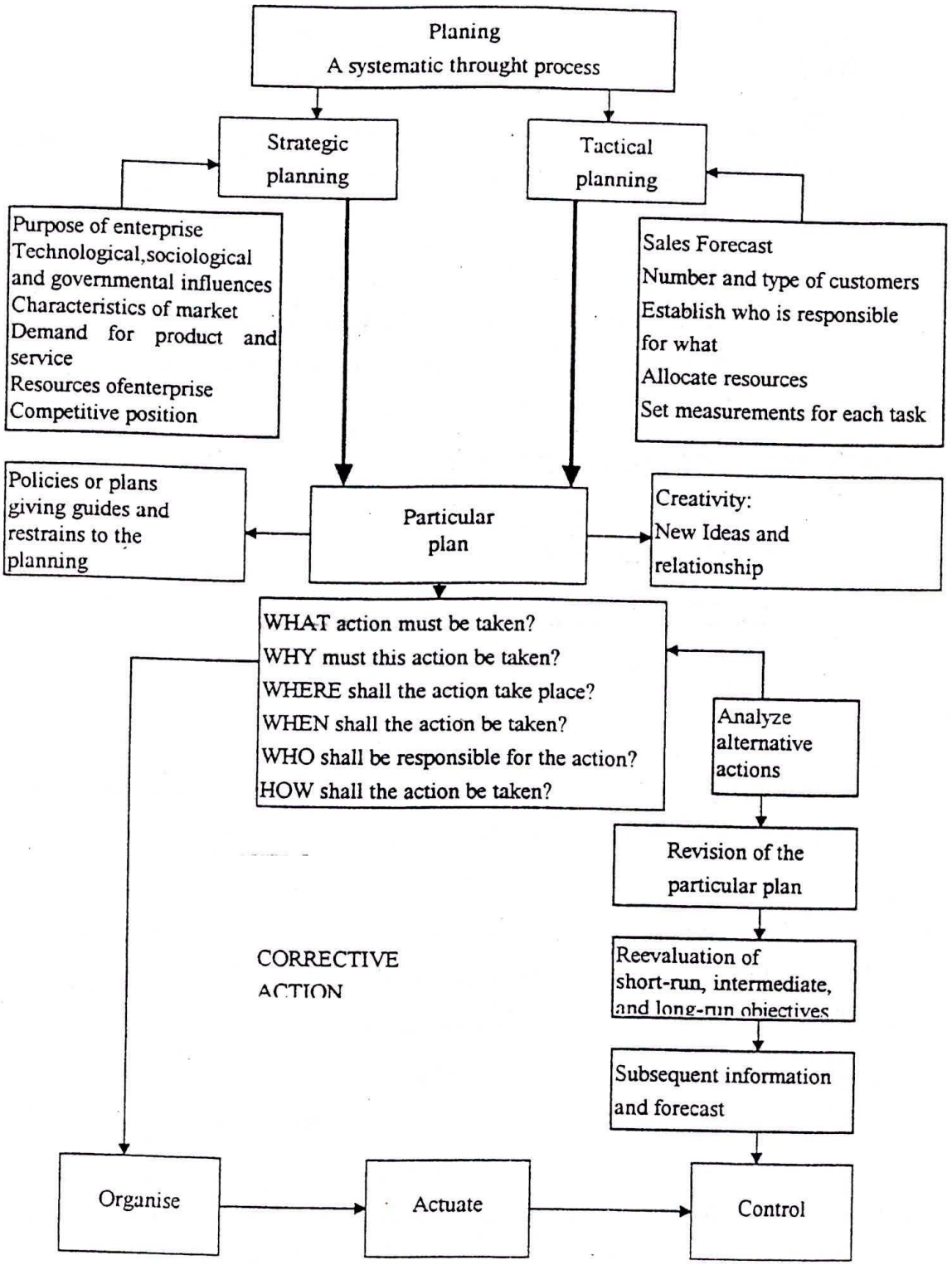
I. Conduct SWOT (Strenghs, Weaknesses, Opportunities & Threats) Analysis
   a. Analyse the external environment
   b. Analyse the internal environment

II. Set objectives in terms of services to be provided, client segments, coverage, channels to reach

Set objectives that are SMART

- Specific : everyone will interpret them in same way
- Measurable to monitor progress/evaluate performance
- Appropriate to your organisational policies, goals
- Realistic given limited resources of money, manpower and materials
- Time bound, so resources can be allocated and activities can be planned to meet the objectives

Overall view of planning and its relationship to the management process



Health Planning may be defined as deciding how the future pattern of health activities would differ from the present, identifying the changes necessary to be accomplished and specifying how those changes should be brough about as to usher in overall health development of the community.

Purpose of Planning:

1. To match limited resources with many problems
2. To eliminate wasteful expenditure or duplication of expenditure
3. To develop the best course of action to accomplish a defined objective.

Purpose of Health Planning in particular:

To improve the :

1. quality of health care
2. efficiency of health care
3. adequacy of health care
4. equity in health care.

Example of Faulty Planning:

In the corridor of a District Headquarter, an unopened crate was lying for more than 2 months now. When enquired as to what is contained, it was found that this was ILR which has been received. As to why it was not being utilised, a M.O. reported that there was no District Immunisation Officer to take charge. Moreover it has been donated by a donor government.

On further inquiry, it was discovered that the ILR had been received but plans for its location were not made and approval for appointing an operator was not secured. This was discovered only when the ILR arrived. The paper work had now been completed but it would be at least 6 more months before all the approvals could be obtained. Clearly failure to plan and take coordinated actions had resulted in non-utilization of the ILR which was badly needed.

Such examples of failures of planning abound. Planning improves performance by :

1. matching services to people's needs
2. efficiently utilizing resources; and

3. coordinating activities to achieve desired results.

But for planning to be effective in improving performance, it should:

a) identify key result areas and prioritize activities,
b) provide sufficient flexibility to respond to local variations,
c) be realisitic and feasible,
d) enable implementers to implement the plan by providing necessary resources, and
e) motivate implementers sufficiently to carry out the plan.

The Planning Process in Health:

The essentials of an effective planning in health lie in answering the following key qeustions:

1. Where are we no	(Situational Analysis)
2. Where do we want to reach	(Goals, objectives, priorities, targets and strategic decisions)
3. How well we get there	(Organisational constraint, resources and organisational structure, functions and managment)
4. How well we have done	Monitoring (evaluation and feedback)
5. What new problems do we have	(Replanning)

The steps for planning in health are no different than that of planning process. These are:

1. Health situation analysis of the area to assess health problems, health resources and opportunities for action by collecting data through available sources and conducting baseline surveys.
2. Establish health priorities of the area
3. Identify key areas for action within national health plan objectives and program objectives.
4. Setting targets for action
5. Identify tasks to be performed

Planning Tasks:

The following table presents Planning Tasks at Different Levels of Management:

Level of Management	Planning for	Planning Tasks
Top	Strategic Outcome	- Developing strategies - Negotiating goals - Allocating resources
Middle	Operational input-output	- Planning for service delivery - Negotiating targets - Logistics support - Mass communication - Coordination with other development departments - Encouraging community participation
Operating	Operational Activities	- Home visits - Follow-up - Field worker activities - Supervision - Clinic/Health Centre Operations - Record keeping

SWOT Analysis:

Assess the external environment to see how it will affect the organisation as well as how the organisation can influence the environment. In other words, identify the constraints (or threats) and the opportunities through systematic scanning of the environment. The external environment may consist of a number of social, political, technological and economic influences.

Assessment of the department's internal strengths and weaknesses, after scanning the environment, one must turn inward to see how the program is performing in

Common problem areas for Managers:

1. Decision making
2. Costs
3. Employee recruitment/selection/training
4. Finances
5. Management Information systems
6. Inventory Records
7. Supervision, morale, motivation
8. Quality control

Possible managerial actions to solve management problems arranged by fundamental functions of the management process :

A. Planning
   1. Objectives of individuals
   2. Objectives of the enterprise
   3. Policies covering authority, prices, attitude toward competition
   4. Procedures - specific means of handling paper and products
   5. Internal programs

B. Organising
   1. Span of authority
   2. Delegation of authority
   3. Use of staff and service groups
   4. Informal groups
   5. Integration of structural activities

C. Actuating
   1. Leading
   2. Developing and evaluating employees.
   3. Fulfilling personal needs through work satisfaction
   4. Job enrichment and enlargement
   5. Supervising.

D. Controlling
   1. Establishing standards of performance
   2. Measuring work performance
   3. Improving rate of return on investment
   4. Developing adequate budgeting
   5. Employing better cost and quality controls.

Managerial problems in Health:

1. Non-achievement of targets for all programmes.
2. Insufficient and irregular supplies including drugs

3. Lack of properly trained health personnel
4. Difficulty in supervising peripheral areas due to terrain on lack of transport
5. Lagging behind the implementation schedule.

Problem Analysis:

At this stage, an important question would be on the process through which one could lay hands to the relevant problem. Table 3.4.2 may help in orienting towards adopting a step by step method for problem analysis.

Incident	-	The situation/ Happending	- What is or is not?
Hypothesis	-	The problem area	- Define and set limits/ boundaries
Data	-	The information, facts and figures	- Calculation and analysis of relevant data.
Qualification	-	Tangible and intangible factors	- Measurement: Values and Weightages-Absolute or Relative
Expectations	-	Objectives/Results	- Musts and Wants
Options	-	Alternative Courses of action	- Identification and Search
Choice	-	Selection of appropriate choice	- Desired result/ satisfaction
Risk	-	Evaluation/ Anticipation	- Expected benefits and costs and adverse future effects

Acord	-	Acceptance by affected group	- Individual vs. group interation
Action	-	Implementation	- Responsibility and Accountability delineation/assigning
Monitor	-	Follow Through	- Constant Review & Direction for Corrective action or strategy

For example you find a situation wherein the district only 40% of the deliveries are ensured to be safe, as those were conducted either by the trained personnel or institutional. You may think of the following causes :

1. Workers are not going for required home visits
2. Health workers (female) do not stay at S.C. beyond their duty hours
3. 30% of the villages do not have trained dais.
4. Community has not been able to perceive the trained dais and Health Worker (F) to be more effective workers than the traditional dais.
5. Community perceives deliveries as natural phenomenon which involves no greater risk to the health of the mother and child and do not consul HW(F).
6. High risk approach and mandatory referral of such cases is not being practiced at any level.
7. There is only one district hospital (women_ and one CHC in the entire district and no obstetrician and gynaecologist is in position at the CHC.
8. Transport and communication facilities are not good in the district
9. Even in the district hospital average length of stay is 8-10 days and 80% of the cases admitted for the delivery are normal ones.

As a district health officer your problem is to increase the coverage of safe deliveries by trained personnel and utilise the hospital and CHC for referreal of high risk and complicated cases. The solution to the problem may be :

a) Strengthening referral services for MCH cases at high risk
b) Training health workers and dais about high risk approach in MCH with an adequate system of supervision.
c) Providing disposable delivery kits and regular replenishment of this for workers so that they can conduct safe deliveries.
d) Organizing IEC activities to inform the community about the facilities, personnel and advantage of getting deliveries conducted by training personnel.
e) Ensure the availability of Health Worker (F) and their supervisors at their work place by making them to stay there beyond working hours.
f) Strengthening the system of preventive ante natal visits at home.
g) Emphasizing on the concurrent visits by the health supervisors (Female)
h) Opening of new CHC, with Junior Specialists in Obst. and Gyne, or at least a lady medical officer.

These solutions indicate that the problems may belong to :

(a) Planning
(b) Direction and supervision
(c) Monitoring and evaluation
(d) Organising and implementation of services.

Therefore the nature of the problem may be determined by the analysis of the situation and feasible solution.

The key points to be noted here are :

i. The problem classification is not done on the basis of symptoms but on alternative courses of action that may be feasible.

ii. Each feasible alternative needs to be evaluated to get an estimate of the likely outcome if the particular alternative is taken for implementation.

iii. For analysis of alternatives one needs a scientific approach.

iv. The analysis should be based on facts and not shrouded by myths/assumptions.

v. The best course of action is chosen after detailed analysis of all the feasible courses of action.

vi. Each one of the above steps must be explicitly governed by the organisational goal being pursued.

NATIONAL AIDS CONTROL PROGRAMME

The National AIDS Control Programme is being implemented in the State as per the Guidelines of National AIDS Control Organisation, Ministry of Health and Family Welfare, Govt. of India. This is a 100% Centrally sponsored Scheme.

The State AIDS Cell is established during May 1992, in the Directorate of Health and F.W.Services, to monitor and supervise the activities under various components of National AIDS Control Programme. The State Level empowered Committee is constituted under the Chairmanship of Health Secretary, Government of Karnataka and Karnataka State AIDS Prevention Society is formed during December 1997.

SURVEILLANCE AND CLINICAL MANAGEMENT

Three(3) AIDS Surveillance Centres are functioning which are taking-up Surveillance and Sentinel Surveillance activities at Victoria Hospital, Bangalore, National Inst. of Mental Health and Neuro-Sciences, Hosur Road, Bangalore; and Kasturba Medical College, Manipal.

BLOOD SAFETY PROGRAMME

Ten(10) Zonal Blood Testing Centres are established and functioning, all the Blood Banks i.e. Government, Private and Voluntary Blood Banks are linked to these Zonal Blood Testing Centres for Screening for HIV to ensure Blood Transfusion Safety. 52 Blood Banks have been Modernised by way of supply of equipments and consumables in a phased manner.

One Blood Component Seperation Facility is sanctioned and established during 1994-95 at Kidwai Memorial Inst. of Oncology, Bangalore.

SEXUALLY TRANSMITTED DISEASE CONTROL PROGRAMME

The service care at the existing 30 STD Clinics attached to major Hospitals and Teaching Hospitals are strengthened by way of supply of equipments, drugs and laboratory supplies.

INFORMATION, EDUCATION and COMMUNICATION

The Information, Education and Communication under AIDS Control Programme is intensified to create awareness among the Community, Television spots and messages on Prevention of AIDS are being telecasted through T.V. and Radio spots are being advertised through All India Radio (AIR). Printed materials like Folders, Posters, Pamplets are being distributed. Audio Cassettes with songs and Dramas on Prevention of AIDS is distributed. Hoardings and Wall-paints in Major Cities and Towns are taken up and Street Plays were conducted.

NON-GOVERNMENT ORGANISATION CO-ORDINATION

Nearly 78 Non-Governmental Organisations are registered out of this 20 are supported Financially, to take up awareness campaign on AIDS.

TRAINING PROGRAMME

Training Programme is being organised for Medical Officers, Para-Medical Staff and Non-Government Organisations.

...2

As on end of 31-3-1998, 386233 Blood Samples have been screened. Out of which 3818 are found HIV positives, 136 AIDS cases and 69 have died (from 1987 to end of March 1998)

Sentinel Surveillance activities were takenup as per the approved protocol of National AIDS Control Organisation at:

1. STD Clinic - Victoria Hospital, Bangalore
2. -do- - Karnataka Medical College Hospital, Hubli
3. ANC Clinic - -do-
4. STD Clinic - C.G. Hospital, Davanagere
5. -do- - Govt. Medical College Hospital, Bellary
6. -do- - District Hospital, Gulbarga
7. -do- - K.R. Hospital, Mysore
8. -do- - District Hospital, Belgaum.

The following category of staff have been trained during the year 1997-98

Sl.No.	Category	No. trained
1	Private Medical Practitioners(Dist. Level)	250
2.	Faculty Members of Private Medical Colleges	140
3.	Laboratory Technicians of Blood Banks	10
4.	Social workers ..	20
5.	Health care providers for Childrens and Non-Governmental Organisations (2 days)	50
6.	Physicians of AIDS Control	20
7.	STD Clinic Doctors	20
8.	Staff Nurses	20
9.	Blood Bank Medical Officers	9
10.	Hospital Administrators	50
11.	DentalSurgeons	240
12.	Key Trainers Training by IMA-2 days	250

FINANCIAL RELEASE BY NATIONAL AIDS CONTROL ORGANISATION
GOVT. OF INDIA

RS. IN LAKHS

YEAR	ALLOCATION	EXPENDITURE
1997-98 upto end of March 1998)	Rs. 417.01 lakhs	Rs. 218.76 lakhs

STATE AIDS CELL

DIRECTORATE OF HEALTH AND FAMILY WELFARE SERVICEES

GOVERNMENT OF KARNATAKA

MONTHLY UPDATE ON HIV INFECTION IN KARNATAKA

(Based on reports received at State AIDS Cell)
(subject to retrospective corrections on receipt of more accurate data from centres)

1. Period of report up to end of : MAY 1998

2. Sero Surveillance Report ;

	From 1987	MAY.1998
	to April 98	
i) Total number of samples screened:	387403	1183
ii) Number confirmed by Second Test ;	3905	68
Cumulative Total HIV +ve :	3973	

iii) Seropositivity rate(per thousand): 10.22

		M	F	Total
iv) AIDS Cases	(a) Karnataka	113	14	127
	(b) Others States	6	2	8
	(c) Foreigners	4	0	4
				139

3. Breakup of sero positives:

a. Hetro sexuals Promiscuent And Others :	1803	45.38
b. Homosexuals :		
c. Blood Donors :	519	13.06
d. Antenatal Mothers :	45	1.13
e. Suspect AIDS/ARC Cases :	1589	40.00
f. Foreigners :	13	0.33
g. I.V. Drug users :	84	8.18
Total :	3973	108.80%

4. Yearwise Blood Samples screened for HIV +ve

Year	Blood Samples	Blood Samples found HIV Positives	AIDS cases (Provisional)	Death due to AIDS
1987	913	-	-	-
1988	2,264	6	2	2
1989	25,928	32	1	1
1990	48,348	58	1	1
1991	66,828	86	1	1
1992	1,02,336	168	2	2
1993	76,237	868	9	9
1994	24,209	425	15	13
1995	11,583	439	12	12
1996	8.877	697	22	7
1997	15,452	847	58	17
MAY 1998	5,611	347	16	6
TOTAL	3,88,586	3,973	139	71

terms of meeting its objectives with present strategy and whether it needs to change strategy. This should involve not only appraising the objectives, but also to its other organizational functions such as administration, education, services, management of financial and human resources and general management.

This type of analysis is called "SWOT" analysis. (It deals with Strength, Weakness, Opportunity and Threat). To illustrate those are described below for a Health Care Organisation:

I. Opportunities:

i. Forthcoming participation from the community and NGOs to the health sector.
ii. Levels of rising awareness of the community towards health care services and facilities.
iii. Involvement of support manpower as potential partners in health care.
iv. Development of integrated rural development services and women and child welfare programmes in the rural areas.
v. Improved provision of safe water into the remote and difficult villages.
vi. Increase in the literacy among women and the population in general.
vii. International collaborations in health.
viii. Opening of large and specialised hospital in the private sector.
ix. Growth of insurance scheme in health care.
x. Adoption of appropriate technology for health care delivery.
xi. In community, growing acceptance of modern system of medicine.

II. Threats:

i. Rate of popultion growth as a whole
ii. Illiteracy and cultural beliefs and traditions.
iii. Shifting priorities of the health programmes.
iv. Decreasing private donor resources particularly in rural areas.
v. Lack of commitment on the part of different political parties to population control measures.
vi. Lack of professionals commitment to the concept of primary health care.

vii. Medical education still continues to be hospital-oriented.

viii. Values system of the village political leaders and elites towards primary health care services.

ix. Inadequate communication and transport channels in remote areas.

III. Strengh:

i. Clearly defined programme policy, objectives and targets.

ii. Integration of MCH and Family Welfare Programmes.

iii. A large network of primary health centres and sub-centres with required manpower and facilities for appropriate health care.

iv. Flexibility in the planning process at the local level

v. Development of a system of Health Information and Monitoring and Evaluation.

IV. Weaknesses:

i. Underutilisation of services

ii. Inadequate organisational leadership

iii. Lack of bottom up planning process

iv. Non-availability of functionaries at the place of duty

v. Poor supplies and logistics support

vi. Undue thrust to selected few programmes only

vii. Too much target completion orientation

viii. Lack of involvement of the functionaries in the decision making process

ix. Inadequate supervisory practices.

Surveillance of communicable diseases : Containment measures and reporting

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REGIONAL OFFICE FOR HEALTH AND F.W.
BANGALORE

Public health surveillance is defined - in it's simplest form - as an on-going, systematic collection of data for action.

There are 5 steps in implementing the surveillance

1) Collection of data
2) Compilation of data
3) Analysis of data
4) Action
5) Feed back

In short surveillance is information for action.

Surveillance of common communicable diseases like malaria, AIDS and Dengue fever have been discussed.

(1) *SURVEILLANCE OPERATIONS* IN NMEP : The surveillance operations aim at an efficient case finding mechanism and adequate treatment. There are two main strategies in surveillance (a) Active surveillance and (b) Passive surveillance.

Active surveillance involves fortnightly visits by the male health worker to each household and collection of blood smears from all current fever cases and those cases who had fever since the previous visit. In problematic areas, and where male health worker posts are vacant, the female health worker also contributes to surveillance.

He will also enquire about any visitors to the house, the place from where they came. He will ask about the movement history of the members of the family since his previous visit. these points are necessary to find about the origion of the positive case or its spread. At the time of taking blood smears it should be ensured that only sterile Hagedorn needles are used to prevent the spread of AIDS. The blood smears are to be sent to the laboratory at the earliest.

Passive surveillance is institutional surveillance whereby all the fever cases attending the outpatient department are screened by taking blood smears. Malaria clinic is a specialized form of surveillance whereby in such institutions where laboratory technician is available and microscope facilities exist, those cases which are clinically strongly suggestive of malaria are screened for malaria and radical treatment is instituted immediately.

Fever treatment depots can be set up in those areas which are remote and not easily accessible. An intelligent person like a Postmaster, school teacher, Anganwadi worker or a community health guide is taught to take blood smears from fever cases and give chloroquine tablets as per a prescribed dosage. Drug distribution centers are similar

centers where the person is not in a position to take blood smears, but only issues chloroquine tablets.

All the blood smears are examined at the primary health centers by the laboratory technician and positive cases are given treatment.

Considering the expected number of fever cases in the community, it is targeted to collect blood smears to the tune of 12% of the population during an year. In passive surveillance about 15% of the new outpatients may be expected to have fever and so the same is set as the target for blood smear collection.

Treatment schedule:

(a) Presumptive treatment: Presuming that any fever case can be malaria, at the time of collection of blood smear, chloroquine is administered to all fever cases as per the following dosage.

Age	Dosage
0 - 1 yr.	½ tab.(75 mg)
1 - 4 yr.	1 tab.(150 mg)
4 - 8 yr.	2 tab.(300 mg)
8 -14 yr.	3 tab.(450 mg)
14 -and above.	4 tab.(600 mg)

Chloroquine should always be administered after food only. With this dosage, the toxicity is minimized. Rarely gastric irritation, nausea, vomiting, headache, pruritus, blurring of vision etc. When chloroquine is taken regularly for months as with chemoprophylaxis for a prolonged period, ocular damage with neuro-retinitis, pigmentation of skin may be seen.

(b) Radical Treatment: To achieve a radical cure of vivax malaria, chloroquine alone is not enough, as the persistent stages of the parasite can cause relapses. In P.falciparum the gametocytes are not killed by chloroquine. Therefore primaquine is also in combination with chloroquine for Radical treatment with the following schedule.

P.vivax: I day - chloroquine - 600 mg.
primaquine - 15 mg.

II day
to - Only primaquine - 15 mg.
V day

P.falciparum: I day - chloroquine - 600 mg.
primaquine - 45 mg.

II day - chloroquine - 600 mg.
III day - chloroquine - 300 mg

The above dosage are for the adult. In children the daily dose of primaquine is as follows:

AGE	DOSAGE
1 - 4 yr.	2.5 mg.
4 - 8 "	5.0 mg.
8 -14 "	10.0 mg.
14 and above.	15.0 mg.

Primaquine should not be administered to infants and pregnant woman. When a pregnant women has malaria, only chloroquine 600 mg is given every week till delivery and full Radical treatment given after delivery.

The drugs should not be given in empty stomach. Rarely anorexia, nausea, epigastric distress, abdominal pain etc. may be seen. In those persons with G-6 PD deficience, primaquine may cause hemolysis which manifests as dark colored urine and cyanosis.

In problematic areas, where large number of cases are encountered, for operational reasons the radical treatment for vivax cases is curtailed to three days with primaquine given in doses of 30 mg., 30 mg., and 15 mg.

For all P.falciparum cases, mass and contact survey is to be done. Also the 7th day follow up smear is to be taken.

To maintain quality control of blood smear examination, 5% of the negative blood smears are to be sent from all the primary health centers to the Central Malaria laboratory (3%) and the Regional Health Office laboratory (2%) for cross-checking.

(2) *Vector Control Operations*: The chief method of vector control in NMEP is by residual spray operations. In all those PHCs where API during the previous three years was 2 or above spray operations are to be done. The main insecticide used is DDT. It should be noted that spray with BHC has been withdrawn. In limited areas where DDT resistance is proven, Malathion spray is undertaken. The Table-1 gives preparation and dosage details for the two insecticides.

Each spray team consists of five daily wage laborers and a supervisor for two pumps. Each pump should cover at least thirty houses in a day.

With increasing problem of mosquitoes developing resistance to the conventional insecticides, more emphasis is being given for source reduction measures in the form of

MANAGERIAL PROBLEMS IN THE DELIVERY OF HEALTH SERVICES

1. PROBLEMS FACED BY MEDICAL OFFICERS

1.1 PLANNING
1.1.1 ABSENCE OF MEDIUM AND SHORT TERM PLANS
1.1.2 LACK OF LABORATORY FACILITIES
1.1.3 SLASHING OF MEDICAL INDENT
1.1.4 NON-AVAILABILITY OF MEDICINES
1.1.5 INADEQUATE FOLLOW-UP OF PATIENTS

1.2 ORGANISING
1.2.2. SHORTAGE OF EQUIPMENTS
1.2.3 LACK OF PHYSICAL FACILITIES
1.2.4 INADEQUATE DELEGATION OF POWER

1.3 STAFFING
1.3.1 SHORTAGE OF DOCTORS
1.3.2 SHORTAGE OF PEONS
1.3.3 LACK OF TRAINING
1.3.4 UNATTRACTIVE TERMS AND CONDITIONS
1.3.5 LACK OF PROMOTIONAL AVENUES
1.3.6 INADEQUATE FRINGE BENEFITS

1.4 DIRECTING
1.4.1 REFUSAL OF DOCTORS TO TAKE RESPONSIBILITY
1.4.2 INTERFERENCE OF CLASS III & IV UNION
1.4.3 NON INVOLVEMENT IN TRANSFER OF STAFF

1.5 COORDINATING
1.5.1 LACK OF COORDINATION BETWEEN VARIOUS SEGMENTS
1.5.2 ATTITUDE OF I.PS

1.6 REPORTING
1.6.1 UNTRAINED STAFF
1.6.2 MORE CLERICAL WORK FOR DOCTORS
1.6.3 DUPLICATING OF WORK

1.7 BUDGETING
1.7.1 NON-INVOLVEMENT
1.7.2 INSUFFICIENT IMPREST MONEY
1.7.3 INADEQUATE FINANCIAL POWERS

1.8 PROBLEMS IN RELATION OF ADEQUATE UTILISATION OF PROFESSIONAL SKILL

2. PROBLEMS FACED BY PARAMEDICAL STAFF

2.1 LHVS/ANMS/DAIS
2.2 PHARMACISTS

2.3 LABORATORY TECHNICIANS
2.4 DRESSERS

3. PROBLEMS FACED BY ADMINISTRATORS

3.1 INSUFFICIENT DELEGATION OF AUTHORITY
3.2 INADEQUATE ADMINISTRATIVE SET-UP
3.3 NON-AVAILABILITY OF STAFF
3.4 ALLOCATION OF DISPENSARY TO I.PS.
3.5 PROCUREMENT OF MEDICINES
3.6 DISTRIBUTION OF MEDICINES
3.7 PILFERAGE OF MEDICINES
3.8 LAX-CERTIFICATION
3.9 FINANCE
3.10 NON-AVAILABILITY OF LAND

4. PROBLEMS FACED BY PATIENTS

4.1 LOCATION
4.2 WORKING HOURS OF STORE
4.3 LONG WAITING TIME
4.4 AMENITIES
4.5 ARRANGEMENTS FOR EXAMINATION IN PRIVACY
4.6 TIME DEVOTED BY DOCTORS
4.7 ATTITUDE AND BEHAVIOUR OF DOCTORS
4.8 AVAILABILITY OF MEDICINES
4.9 DOMICILIARY VISITS
4.10 REIMBURSEMENT FACILITY
4.11 REDRESSAL OF GRIEVANCES

5. PROBLEMS FACED BY PATIENTS AT REFERRAL CENTRE (HOSPITAL)

5.1 LOCATION OF HOSPITAL
5.2 INADEQUATE AMBULANCE SERVICES
5.3 WORKING HOURS OF O.P.D.
5.4 OVER CROWDING
5.5 ATTITUDE AND BEHAVIOUR OF DOCTORS/STAFF
5.6 WAITING TIME
5.7 TIME DEVOTED BY DOCTOR
5.8 PROCEDURE OF ISSUE OF MEDICINES
5.9 ADMISSION IN HOSPITAL

Bioenvironmental control measures. As these measures are possible only with active intersectoral co-ordination between the related sectors like fisheries, irrigation, agriculture, forestry etc., high powered committees have been set up at the State level to oversee operations. The highlights of the strategy include geographical reconnaissance of the area to map out the breeding places, choice of particular antilarval method with emphasis on biological control by larvivorous fishes, engineering methods etc.

(3) Urban Malaria Scheme: Only passive surveillance is undertaken in the scheme. Similarly only antilarval measures in the form of (a) source reduction measures (b) chemical control by abate, baytex, paris green etc. © biological control by larvivorous fishes etc. are undertaken.

SURVEILLANCE IN NATIONAL AIDS CONTROL PROGRAMME

Surveillance as applied to HIV is the collection of epidemiological information of sufficient accuracy and completeness regarding the distribution and spread of HIV infection relevant to the planning ,implementations and monitoring of the control programme.

Let us study the objectives of Surveillance

1) General Objectives :

To establish AIDS case surveillance in all Medical Institutions of the country.

2) Specific Objectives :

a) To Improve identification of AIDS cases among persons approaching for medical aid and reporting.

b) to establish a referral system for suspect AIDS cases

c) To monitor the AIDS epidemic

d) to encourage studies on the sensitivity and specify of the clinical AIDS case definitions.

Types of Surveillance :

The target population for surveillance includes all persons who attend medical institutions for medical aid , be it ambulatory care or admittance for inpatient department. However if the intention is to monitor trends in HIV infection over place and time, cross sectional studies (also known an prevalence studies) have to be undertaken in the population and also repeated serially. Such studies may be conducted based on the general population as a whole or within selected groups within that population. When such groups in the population are selected with the objective of monitoring trends in the

population, they are known as "Sentinel" groups. Sexually separated cross sectional studies in sentinel groups are known as sentinel surveillance.

Sentinel HIV surveillance can be community based or clinic based. It can be undertaken among High Risk groups like Commercial sex workers or low risk groups such as Antenatal cases. Surveys among such low risk groups show prevalence in general population.

Type of Testing :

4 kinds of testing strategies are possible

1) Mandatory Testing : Not possible for testing of persons. But for screening of blood and blood products, organs or tissues.

2) Un linked anonymous Testing : A sample of blood originally collected for other purposes is tested for HIV, after all the information that could identify the source of the blood sample are eliminated from the sample. Only Minimal participation bias results . This is the method of choice.

3) Linked anonymous : An individual agrees to have a HIV test. The sample is given a code and all other identifying date are removed. The individual has the code and can obtain the HIV test result if wanted.

4) Voluntary confidential testing : An individual agrees to have and HIV test. His or her identity and test results are known only to a few selected persons.

(confidentiality is most essential)

Institutions involved ;

At the National Level, the surveillance activities are coordinated by the AIDS case surveillance co-ordinator (ASC). At the state level it is by state PRAM's in corporation with the Deputy Directors.

The Surveillance is conducted at all the Health Institutions. There are divided into two categories :

1) Non-referral Institutions : They can only identify suspect AIDS cases and can make a provisional diagnosis of such case.

2) Referral Institutions : An identified and trained physician will confirm referred suspect cases and prepare technical reports on AIDS patients. In 1992 , there wee only a institutions in India, by phases, more number of institutions have been developed . The aim is to develop all district level hospitals and general city hospitals into the network.

Activities :

Both Non-referral and referral institutions will carry out the following functions :
1.Identify patients suspected for AIDS according to WHO AIDS clinical case definition.
2. Carry out examination by available techniques in order negate or reconfirm " suspect diagnosis "
3. Refer the suspect cases to nearest referral hospital
4. Follow up the confirmed cases for treatment, counseling and home care.
5. Report on the surveillance activities.

The referral hospitals include the following additional activities :
6. Conduct detailed clinical and laboratory examinations to confirm the diagnosis. The PRAM may have to pay visits to the peripheral healths institutions
7. Provide necessary temporary hospital care to the patient
8. Prepare recommendations for treatment, home care and follow up of aids patients through the original medical institutions.
9. Arrange for training and supervisory visits to the institutions within the catchment area of the referral hospital.
10. receive, compile and submit reports.

Activities of the AIDS case surveillance Co-ordinator at the referral Hospital :
1) Co-ordinating with the Medical Superintendent/District Surgeon of the hospital and state ASC in the establishment of the surveillance network in the surveillance activities.
2) Training of medical staff at his own hospital and also medical staff of all health institutions in the area.
3) In case the testing facilities are not available at the hospital where he is working, he is the only authorized person to send blood samples for HIV testing.
4) Arranging for hospitalization, diagnosis and treatment of suspect AID case referred from other institutions.
5) Counseling of cases in the Hospital and developing the counseling services for case in the area.
6) Supervision of the activities in peripheral institutions
7) Monitoring the reporting system.

Dengue surveillance :

In practice, the surveillance of Dengue & Dengue Haemmorhagic Fever(DHF) means collection of data relevant to the occurrence of these illnesses in order to take action to prevent or control them, so that, it no longer would be a public health problem. It should permit immediate actions to prevent or control an epidemic of dengue. The system should be simple in its structure and operation, representative of the population it serves, acceptable to the users, flexible to allow the incorporation of new information, and opportune in data collection and analysis. The system should have adequate sensitivity

and specificity to correctly identify those individuals with the disease and efficiently exclude those without it.

The surveillance system should have both the clinical and entomological perspectives. As DF can be clinically impossible to differentiate from other febrile illnesses, the surveillance must be laboratory based.

Surveillance for Dengue can be either active or passive. The concept of active and passive surveillance differs from that in malaria.

Passive (Reactive surveillance) :

This requires case reports from all health institutions including those in the private sector regarding dengue like illness. Here, the health authorities wait until transmission is recognized by the medical services and detected through the reporting system. Currently DF/DHF is not a notifiable disease. If the passive surveillance system is to succeed in defining trends in dengue transmission, and detect any increase in incidence, the DF/DHF should be made notifiable. This statutory mandate is required for establishing a nationwide surveillance system. Even so, there can be significant under-reporting and poor sensitivity in view of the level of suspicion among medical professionals being low regarding diagnosis of DF/DHF in periods of low transmission. Many patients with milder forms of the illness may not seek medical treatment. Therefore dependance only on the passive system may result in delays in implementation of prevention oriented action.

Active surveillance :

The objective of an active, laboratory based surveillance system is to generate early and precise information on four aspects of increase dengue activity : time, location, virus serotype, and disease severity. Therefore it should be pro-active, in the sense that, it should allow for early detection of dengue cases, improving the capacity of health officials to prevent and control the spread of dengue. The emphasis in active surveillance is on the predictive capability. Analysis of trends of reported cases, the establishment of sentinel clinics, laboratory confirmation suspected dengue cases and the rapid identification of the serotype involved in transmission, provide the necessary information to predict dengue transmission and guide implementation of control measures well in advance of peak transmission period.

In India, the National Institute of Virology with it's field stations and the National Institute of Communicable Diseases have already established a system of testing blood samples for dengue. In addition there are other institutions like medical colleges who also do dengue diagnostic work. Proactive clinical surveillance must be linked to entomological surveillance.

There are vast areas in the country where dengue has not been reported, but which are infested with Aedes aegypti and Aedes albopictus. Except for reports from a

few rural locations, the disease has been reported mainly in the metropolitan areas and other urban areas. However, in all these areas, the risk of major dengue or dengue haemorrhagic fever epidemic exists for much of the population of India. In such areas, dengue surveillance should rely on searching for, and investigating, clusters of nonspecific febrile illness by a **fever alert.** In a fever alert system, trends in rates of febrile illnesses are monitored as an early indicator of possible dengue activity during periods of low level transmission.

Dengue is endemic in a majority of the towns in India. In these places, very few blood samples are sent to the laboratory for dengue testing during the interepidemic periods because of little case identification. At least one major hospital in all the towns should be identified as the sentinel clinics. Criteria for taking blood samples must be expanded to include febrile cases with history of recent travel, and situations where dengue might be causing clusters of fever cases with rash. These hospitals must also maintain communication with the private hospitals/practitioners.

Serological surveys

Community serosurveys, done during and after epidemics define the true incidence of dengue in the population by age, sex, and geographic location. Such surveys provide opportunities to characterize the epidemic, define the populations at highest risk, and identify risk factors for infection. The population based data also can be used to examine the accuracy of the surveillance system, effectiveness of control methods, the cost of the epidemic, and the immune status of the population. They can also be used for descriptive or analytical purposes. Such surveys will use a combination of respondent interviews with blood sampling to provide information on symptoms and the progression of the illness through the community. Blood samples can be collected by finger prick method on filter papers. To measure accurately, the rate of infection in a community, respondents must be bled at least twice(at the beginning and end of epidemic transmission) to test for IgG seroconversion, or sequentially every month to detect all the IgM positive cases.

There are several tests that can be used for routine serologic diagnosis of dengue viruses, including the hemagglutination-inhibition (HI), the complement fixation (CF), the plaque reduction neutralization (N), the IgM-capture ELISA tests and dot blot tests (IgG, IgM). Of all these tests, the MAC ELISA, generally requires only one sample and is a simple, quick test that requires very little sophisticated equipment. Therefore the laboratories should perform IgM capture ELISA test initially to provide rapid results. Virus isolation by inoculation of the C6/36 mosquito cell line is a relatively rapid, sensitive, and economical method that can be set up in most general laboratories. The reference laboratories should be equipped to identify the type of virus which will give an indication of the severity of cases.

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MALARIA - RECENT TRENDS IN PREVENTION ANDCONTROL

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Epidemiological features :

Malaria is one of the major communicable diseases that has been associated with mankind since time immemorial.

It was in 1887, ie. exactly 100 years back, that the causative organism the plasmodium was discovered to be transmitted from one person to another by bite of infected anopheline mosquito, by Sir Ronald Ross a British doctor working in Indian Army Medical service at a place not very far away from here, ie. at Secunderabad.

Even prior to independence, organized malaria control activities were taken up in the project areas, army contonment areas etc. by source reduction measures aimed at mosquito control.

The National Malaria eradication programme launched in 1958 in our country is one of the biggest public health programmes that are in existance.

After the dramatic decline in incidence of malaria seen in the Sixtees, there was resurgence in malaria in most part of the country. The disease was at its peak around 1976 which necessitated radical changes in the NMEP giving rise to the Modified Plan of Operation. This was again followed by very significant decline in malaria incidence all over the country.

From 1983 onwards, the total malaria cases in the country was around two million per annum, touching the lowest incidence of 1.66 million in 1987 and the peak of 2.51 million in 1993. The proportion of P.f. showed gradual and consistant increase from 9.73% in 1977 to 34.5% in 1995 with the peak reaching 43.35% in 1991.

After launching of NMEP, the deaths due to malaria were first recorded during 1974 and the peak 1122 deaths reached in 1994 due to epidemics in Rajastan , Manipur, and Nagaland. The deaths recorded due to malaria were also high reaching the figure of 1012 during 1995.

During the year 1997, about 1.8 lakh cases have been reported in the state. The annual blood examination rate in karnataka is 17 which is one of the highest among the different states of the country. The API for the state is 4.06 and SPR is 2.38. The SFR was 0.64. Though malaria is reported from all the districts, only few districts are

problematic. Districts of Bijapur, Raiochur, Mandya, Kolar, and Bellary are the most problematic which together have contributed 68.2% of malaria incidence.

A study conducted by MRC-ICMR New Delhi has shown that about 190 million cases are being prevented annually in the country due to the malaria control activities. Approximately Rs.76,660 million are being saved every year due to malaria control operations now being implemented in the country. The total expenditure incurred on malaria control in India is around Rs.3468 million. Thus every rupee invested on malaria control has produced a direct return of Rs.22.10.

The estimates of labour days saved come to 1328.75 million man-days per year.

The expenditure per capita per annum being incurred by G.O.I (NMEP) and other organizations works out to Rs. 3.85. To this must be added the expenditure incurred by general community on the treatment of malaria cases. On the basis of MRC estimates of 25 million cases per annum (ten times the incidence recorded by NMEP), the expenditure per capita per annum works out to Rs. 3.33 . Thus the total expenditure incurred on morbidity due to malaria works out to be Rs. 7.18 per capita per annum.

Malaria is a local and focal disease. Accordingly no uniform control strategy can be adopted in all the areas. Efforts have always been made in the programme to undertake area specific control strategies. When MPO was launched, the areas were classified into those with API more than two and those less than two for specific control measures. The indepth evaluation studies that are periodically conducted have stressed that stratification of areas has to be done.

A malariogenic stratification process has been undertaken in Karnataka taking into consideration topography, rainfall, vector prevalance, API, epidemic potential, and vulnerability. The Primary Helth Centres were stratified into strata I to V with I being least problematic and V being the most problematic.

However application of the malariogenic stratification to other areas in the country has not yielded desired results because some of the weightages assigned to parameters require further modification and field testing.

As per the Malaria Action Plan 95, newq criteria are being applied for identification of problematic PHC's (High risk PHC's) based on the SPR and P.f % which are relatively more sensitive and specific indicators. The following are the criteria :

1. Doubling of SPR during last three years provided the SPR in second and third year reaches 4% or more.

2. Where such doubling is not seen but average SPR of last three years is 5% or more.

3. P.f proportion is 30% or more, provided SPR is 3% or more during any of last three years.

About 178 PHC's have been identified as High Risk PHC's out of the current about 1400 PHC's in the state.

Residual insecticidal spray :

Conventionally, DDT has been the main insecticide used for spray. With DDT resistance occuring as a widespread phenomenon, and malaria problem increasing in many areas, alternate insecicides are being sought after. BHC is being phased out and use of Malathion has been very limited because of poor acceptance and resistance problem. A new group of compounds namely synthetic pyrethroids have been introduced into the program. In Karnataka a trial was taken up with Lambdacyhalothrin in two selected PHC's for about three years which has been shown to be remarkably effective. Currently, Deltamethrin and Cyfluthrin are being used in Hassan, Chickamagalore and Tumkur districts. These have proven to be extremely effective and safe.

Bio-environmental control measures :

Residual insecticidal spray cannot be the only vector control measure because of the inevitable resistance problem and the cost involved. Alternatively, trials done in many parts of the country by MRC have conclusively proved the effectiveness of the Bioenvironmental control measures. In Karnataka, the field station of MRC has worked in the Kolar, Chickamagalore and Hassan districts to demonstrate the methodology and train the personnel. The mainstay of this method is detailed Geographical Reconnaisance of all the breeding places and planning suitable larval control measures for each variety of the breeding place. The different methods are :

1) Source reduction measures

2) Use of larvivorous fishes

3) Use of Biocides namely Bacillus thurigensis and Bacillus sphaericus

4) Use of expanded Polysterene beads

Impregnated Bednets :

In different parts of the country, use of bednets impregnated with synthetic pyrethroids have been shown to be very useful.

Malaria Vaccine :

The development of an effective malaria vaccine represents one of the most important strategies for providing a cost-effective addition to currently available malaria control interventions. To

date, relatively few malaria vaccine candidates have progressed to clinical and field trials. Much of the research activity over the past 15 years has focussed on the identification of unmodified parasite antigens to be formulated in traditional adjuvants such as alum. This is now changing as new perspectives to producing modified antigens are developed, together with new strategies such as DNA vaccines and novel adjuvants for human use. In addition, considerable experience has been accumulated in the design and execution of clinical and field trials for malaria vaccines.

Drug Resistance :

In many parts of the country, different levels of chloroquine resistant P. falciparum have been encountered. In Karnataka also, in the districts of Kolar, Gulberga, Bijapur, Raichur, Hassan, Chitradurga and Chickamagalore many foci of such resistance have been seen. However, still there is no indication for change in the drug policy.

Chemotherapy :

In all the High risk areas, with a view to reducing the parasite load in the community at the earliest and thereby interrupting the transmission, changes have been instituted in the presumptive treatment by introducing primaquine along with chloroquine.

Quinine has remained the drug of choice in the treatment of complicated forms of malaria like cerebral malaria. A new group of compounds namely Artemesinine have appeared in the market. While these are yet to be adapted by the NMEP, care has to be taken by the physicians in use of the same.

The need of the hour is to undertake an intergrated vector control strategy. Dependence only on insecticidal spray cannot remain as the intervention measure. Increasing stress on Bioenvironmental control measures is requested.

Apart from malaria, these are various other communicable diseases transimitted by mosquito namely Dengue fiver, Filariasis, Japanese encephalitis etc. whch are becoming increasingly problematic. There fore source reduction measures aimed at oreventing mosquito breeding are a priority. Though for a medical man, the disease transmitted by the mosquitoes are importent for the common man, it is rather the mosquito nuisance that is the control of mosquito nuisance. A brouder strategy aimed at mosquito control is required.

No public healths programme is complete without active community participation. In this respect it has been admitted that the required level of community participates has not been

forth comming in the programme. The aim of the malaria month in to create awareness among the community regarding the different aspects of malaria - the disease and its control, so that the desired participation is acheived.

Similarly the private medical practitioners of different system of medicine have been involved in the programme. They do not lay emphasis on the microscopic diagnosis of malaria and the complete radical treatment of malaria. As the public is in the handy of the private medical practioners, it is our duty to communicate to all these practitioners regarding the different aspects of the NMEP.

DUTIES OF MEDICAL OFFICER, PRIMARY HEALTH CENTRE:

GENERAL:

The Medical Officers of Primary Health Centre will divide the area amongst themselves on a geographical basis and will be responsible for all the activities under Health and Family Welfare Programmes in their respective areas. However, ultimate responsibility will lie with Medical Officer Incharge, PHC/Block M.O. who will be, in addition, administrative head of the Primary Health Centre.

Block M.O./M.O., IC/PHC is responsible for implementing all activities grouped under Health and Family Welfare delivery system in PHC area. He is responsible in his individual capacity, as well as overall incharge. It is not possible to enumerate all his tasks, however, by virtue of his designation, it is implied that he will be solely responsible for the proper functioning of the PHC. He may assign any job to any health functionary in his team, which is deemed essential by him towards achieving National Health goals.

I.CURATIVE WORK:

1. The Medical Officer will organise the dispensary, out-patient department and will allot duties to the ancillary staff to ensure smooth running of the OPD.

2. He will make suitable arrangements for the distribution of work in the treatment of emergency cases which come outside the normal OPD hours.

3. He will organise laboratory services for cases where necessary and within the scope of his laboratory for proper diagnosis of doubtful cases.

4. He will make arrangements for rendering services for the treatment of minor ailments at community level, at the PHC and Sub-Centre level through the Health Assistants and others.

5. He will attend to cases referred to him by Health Assistants, Health Workers, Health Guides, Dais or by the School Teachers.

6. He will screen cases needing specialised medical attention including dental care and nursing care and refer them to referral institutions.

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7. He will provide guidance to the Health Assistants, Health Guides and School Teachers in the treatment of minor ailments.

8. He will cooperate and/or coordinate with other institutions providing medical care services in his area.

9. He will visit each subcentre in his area at least once in a fortnight on a fixed day not only to check the work of the staff but also to provide curative services.

II. PREVENTIVE AND PROMOTIVE WORK:

He will ensure that all the members of his Health Team are fully conversant with the various National Health and Family Welfare Programmes to be implemented in the area allotted to each health functionary. He will further supervise their work periodically both in the clinics and in the community setting to give them the necessary guidance and directions.

He will prepare operational plans and ensure effective implementation of the same to achieve the laid-down targets/ estimates and community needs assessment, under different National Health and Family Welfare Programme. (RCH).

He will keep close liaison with the Taluk Medical Officer and other Officers of Taluk level and his staff, community leaders and various social welfare agencies in his area and involve them to the best adveritage in the promotion of health programmes in the area.

Wherever possible, he will conduct field investigations to delineate local health problems for planning changes in the strategy of the effective delivery of Health and F.W.Services(RCH).

1. R.C.H. Programme:

1.1 He will provide leadership to his tem in the implementation of RCH Programme in the PHC catchment area and PHC should function as a centre of FW & RCH movement.

1.2 He will be responsible for proper and successful implementation of RCH including FW Programme in PHC area, including education, motivation, delivery of services and after care.

1.3 He will be squarely responsible for giving immediate and sustained attention to any complications the acceptor develops due to acceptance of Family Welfare methods and other services under RCH Programme.

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1.4 He will extend motivational advice to all eligible patients he sees in the OPD.

1.5 He will get himself trained in tubectomy, wherever possible, and organise tubectomy camps.

1.6 He will organise and conduct No scalpel vasectomy camps.

1.7 He will seek help from Dist.Health & Family Welfare Officer and other agencies such as other associations/Voluntary Organisations for tubectomy/IUD camps and MTP services.

1.8 He will ensure adequate supplies of equipment, drugs, educational material and contraceptives required for the services/ programmes.

1.9 He will provide leadership and guidance for special programmes such as Family Welfare and Immunisation, STD awareness campaign under RCH, festivals and fairs.

1.10 He will organise regular staff meetings to review the progress made and to discuss the problems and future plans.

1.11 He is expected to train himself in communication techniques so that he can provide leadership and guidance to educational and motivational group talks to eligible couples/community.

1.12 He will develop and maintain cooperative work-relationship with other agencies and opinion leaders in the PHC, in order to generate and sustain Family Welfare as a movement.

1.13 He should encourage and give all help and assistance to private medical practitioners and practitioners of ISM in the implementation of Family Welfare and RCH Programme.

1.14 He will ensure proper and up-to-date maintenance of EC registers through spot checking.

1.15 He will ensure that the block level committee and other committees in catchment area are properly constituted and made operable under the guidance of Taluk level Medical Officer.

1.16 He will provide MCH services such as antenatal, intranatal, and postnatal care of mothers and infants and child care through clinics at the PHC and subcenters.

1.17 He will make estimate of community need assessment of MCH services, immunisation services, new born and child care services and also awarness and medical care of ~~STD~~ RTI / AIDS for his area on the basis of community need assessment done at subcentre area by Health Assistant Male & Female and also for entire PHC area and prepare an action plan for providing other services.

1.18 He will actively involve his health team in the effective implementation of the Nutrition Programme and administration of Vitamin 'A' and Iron & Folic Acid tablets.

1.19 He will plan and implement UIP Immunisation services in line with the latest policy and ensure maximum possible coverage of the estimated beneficiaries in the PHC area.

1.20 He will ensure adequate supplies of vaccines and miscellaneous items required from time to time for the effective implementation of Immunisation Programme.

1.21 He will ensure proper storage of vaccines and maintenance of cold-chain equipment.

1.22 He will arrange for surveillance and reporting of vaccine preventible diseases in his PHC area through the PHC staff on confirmation of the same by investigating himself.

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NATIONAL MALARIA ERADICATION PROGRAMME:

He is the kingpin in early case detection and prompt treatment mechanism in rural areas. He should be well trained and take keen interest in this activity. To fulfill the duties under the Primary Health Care System, he should carry out the following activities:-

1. He will, in consultation with District Malaria Officer and the community, select FTD/DDC holders and Voluntary Link Workers for his PHC.

2. He will also select headquarters of DDCs, FTDs, and Voluntary Link Workers.

3. He will make a fortnightly calendar for house-to-house visit of MPW (Male) in consultation with DMO.

4. He will refer all fever cases to malaria laboratory.

5. He will supervise all Malaria Clinics and PHC laboratory in his area, see the quality of blood smear collection, staining, efficiency of microscopic examination and check whether the stain is filtered daily.

6. He will ensure that the Laboratory Technicians maintain MF-7, 8 and 9 registers and also other charts and graphs showing subcentre-wise and passive agency-wise blood smear collection, examination and positive cases.

7. He will also ensure/supervise that all positive cases get radical treatment within 48 hours of examination.

8. He will also ensure that sufficient stocks of antimalarials including Quinine tablets and injectable Quinine are available in PHC and periphery.

9. He will, while supervising the malaria laboratory (either at PHC or at Malaria Clinic) look into the condition of microscope and other equipment, stains, glass slides, etc.

10. While on tour, he will verify that MPW (Male) and MPW (Female) carryout malaria case detection as laid down in this manual.

11. He will do data analysis for action and prediction of outbreak and also assist in epidemiological investigation.

12. He will provide referral services to severe cases of malaria.

13. He will refer severe and complicated cases to District Hospital, if the treatment facilities are not available at PHC/SHC.

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14. He should monitor the drug failure in malaria cases (failure of response to Chloroquine) and inform the District and State Head Quarters immediately.

15. He will ensure that records of clinically diagnosed cases are maintained.

16. He will ensure that the spray operations are conducted as per schedule and in case of any delay, he will find out the reasons and reschedule the programme with approval of DMO/DH & FWO.

17. He will solve any bottlenecks in spray operations in his area such as turnover of seasonal spray men (field workers), insecticide supplies, shifting of camps, etc.

18. He will see that reports are sent in time.

19. He will contact DMO immediately in case of delay/ suspension of spray programme and solve the problems.

20. He will, during filed visits, inspect spray operations atleast once a week.

CONTROL OF COMMUNICABLE DISEASES:

1. He will ensure that all the steps are being taken for the control of communicable diseases and for the proper maintenance of sanitation in the villages.

2. He will take the necessary action in case of any outbreak of epidemic in his area.

3. He is responsible for inspection of all drinking water sources in each village in his PHC area and take measures for disinfection periodically.

4. He will identify immediately the accurance of epidemic diseases in his area after confirming himself [illegible] and intimate to the Taluka Magistrate, Taluka Medical Officer and District Health and Family Welfare Officer and also take necessary arrangements for [illegible] containment measures with the assistance from the community, Grama Panchayat, and other departments and will send the report of action taken as per guidelines and norms of the department.

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LEPROSY:

1. He will provide facilities for early detection of cases of Leprosy and confirmation of their diagnosis and treatment.

2. He will ensure that all cases of Leprosy take regular and complete treatment.

TUBERCULOSIS:

1. He will provide facilities for early detection of cases of Tuberculosis, confirmation of their diagnosis and treatment.

2. He will ensure that all cases of Tuberculosis take regular and complete treatment.

SEXUALLY TRANSMITTED DISEASES:

1. He will ensure that all the cases of STD/AIDS are diagnosed and properly treated and their contacts are traced for early detection.

2. He will provide facilities for VDRL test for all pregnant women at the PHC.

3. He will arrange awarness campaign on STD/AIDS by extensive IEC Activities and conducting group meeting in the special context and also provide medical care to the cases including the referral if needed. He will also provide medical services to the women suffering from RTI at subcentre level and PHC level including referral if necessary.

SCHOOL HEALTH:

1. He will visit schools in the PHC area at regular intervals and arrange for medical check-ups, immunisation and treatment with proper followup of those students found to have defects.

NATIONAL PROGRAMME FOR PREVENTION OF VISUAL IMPAIRMENT AND CONTROL OF BLINDNESS:

1. He will make arrangements for rendering:

   a)treatment for minor eye ailments and
   b)testing of vision.

2. He will refer cases to the appropriate institutes for specialised treatment.

3. He will extend support to mobile eye-care units.

4. He will organise cataract eye operation camps in his PHC area in consultation with the District Mobile Team by involving Voluntary Organisations, Panchayats and other social workers.

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He will also takeup the followup of the eye camp beneficiaries for any adversory reactions/effects after each eye-camp and report any to the DH & FWO.

DIARRHOEAL DISEASES CONTROL PROGRAMME:

1. He will ensure through his health team early detection of diarrhoea and dehydration.

2. He will arrange for correction of moderate and severe dehydration through appropriate orl/parental fluid therapy.

3. He will arrange for availability of ORS pockets in each village in his area by opening ORS Depots and maintain the list of such depots number of beneficiaries, No.of pockets distributed to the depots by health assistants.

NUTRITION:

IODINE DEFECIENCY DISORDERS: He will takeup awareness programme for consumption of Iodised Salt and also arrange for collection of salt samples for analysis of iodine content and take appropriate measures.

TRAINING:

1. He will organise training programme includingcontinuing education with the assistance of his staff and under the guidance of the District health authorities and Health and FW Training Centres under the MPW Scheme and School Health Services Schemes.

2. He will educate the community as to the selection of Health Guides and will take the necessary steps to train the Health Guides from his area.

3. He will also make arrangements/provide assistance to the Sr.Health Assistant Female and Jr.Health Assistant Female in organizing training programmes for indigenous Dais practising in the area.

ADMINISTRATIVE WORK:

1. He will supervise the work of staff working under him.

2. He will ensure general cleanliness inside and outside the promises of the PHC and also proper maintenance of all the equipment under his charge.

3. He will ensure to keep up-to-date inventory and stock register of all the stores and equipment supplied to him and will be responsible for its correct accounting.

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4. He will get indents prepared timely for drugs, instruments, linen, vaccines, ORS and contraceptives etc. sufficiently in advance and will submit them to the appropriate health authorities.

5. He will check the proper maintenance of the transport given in his charge.

6. He will scrutinize the programmes of his staff and suggest changes if necessary to suit the priority of work.

7. He will get prepared and display charts in his own room to explain clearly the geographical area, location of peripheral health units, morbidity and mortality, health statistics and other important information about his area.

8. He will hold monthly staff meetings with his own staff with a view to evaluating the progress of work and suggesting steps to be taken for further improvements.

9. He will ensure the regular supply of medicines and disbursement of honorarium to Health Guides.

10. He will ensure the maintenance of the prescribed records at PHC level.

11. He will receive reports from the periphery, get them compiled and submit them regularly to the district health authorities.

12. He will keep notes of his visits to the area and submit every month his tour report to the CMO.

13. He will discharge all the financial duties entrusted to him.

14. He will discharge the day-to-day administrative functions pertaining to the PHC.

15. Any other work entrusted by superior officers from District or State level.

I.E.C. ACTIVITIES:

1. He will be responsible for organising IEC Activities for creation of awarness on various health problems of the area and various health programmes implemented to improve the health of the community by organising group meetings, distribution of IEC materials, conducting of film shows and interpersonal contacts etc.

2. He will ensure that proper accounting and utilisation of health education materials and maintenance of the equipments.

Dr. [illegible] Joint Director (Project
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NOTIFICATION OF DISEASES

Usually diseases which are considered to be serious menaces to public health are included in the list of "Notifiable Diseases". Notification system is usually operative through certain legal acts.

Mysore Public Health Act 1944(1-2-1944)

As per this Act Section 63 the notified diseases are:

1. C.S.F.
2. Chicken Pox
3. Cholera
4. Diphtheria.
5. Leprosy.
6. Measeles.
7. Plague
8. Rabies
9. Scarlet Fever
10. Small Pox
11. Typhus

or any other disease which the Government may from time to time by notification declare to be notified disease for the purpose of this part either generally throughout the State or as may be specified in the Notification.

(This Act has not yet amended)

At the International level the diseases are notifiable to WHO in Geneva under the International Health Regulations(IHR)

viz - Cholera, Plague, Yellow Fever.

A few others - Louse-borue, Typhus, Relapsing fever, Polio, Influenza, Malaria, Rabies and Salmonellosis are subject to International Surveillance.

Although the Notification suffers from certain limitations, still it provides valuable information about fluctuations in disease frequency. It also provides early warning about new occurrences or outbreaks of diseaes.

The concept of Notification has been extended to many non-communicable diseases and conditions notably Cancer, Congenital mal- formations, mental illness, stroke and handicapped persons.

REPORTABLE AND EPIDEMIC PRONE DISEASES

I. WATER BORNE DISEASES

1. Cholera
2. Diarrhoea
3. Hepatitis
4. Typhoid fever

II. VECTOR BORNE DISEASES

1. Dengue fever
2. Filariasis
3. Japanese encephalitis
4. Kala azar (visceral leishmaniasis)
5. Plague

III. VACCINE PREVENTABLE DISEASES

1. Diphtheria
2. Measles
3. Pertussis (whooping cough)
4. Poliomyelitis
5. Tetanus

IV. OTHER DISEASES

1. Chicken pox
2. Food Poisoning
3. Guinea Worm
4. Meningitis
5. Yaws

V. OTHER INTERNATIONALLY IMPORTANT AND NEW, EMERGING & RE-EMERGING DISEASES

1. KFD
2. Leptospirosis
3. Plague
4. Yellow fever

CASE DEFINITION OF WATER BORNE DISEASES

Classification	Suspect	Physician confirmed	Laboratory confirmed
Personnel	Lay public/MPWs	Medical officers	Medical officers
Method	History	History + Clinical Investigations	Laboratory Identification
Acute Diarrhoea	• Change in consistency and character of stools • Three or more loose or watery stools • Mother's opinion during infancy	• Change in consistency and character of stools • Three or more loose or watery stools • Mother's opinion during infancy	• None
Cholera	• Acute watery diarrhoea in older children (>5 years) and adults • Profuse painless watery diarrhoea usually with vomiting	• Profuse painless watery diarrhoea usually with vomiting • Signs of severe dehydration in older children (>5 years) and adults • Muscular cramps • Other cases of similar illness reported from the area • Mild cases are clinically indistinguishable from non-specific acute diarrhoea • Decreased urine	• Isolation of V.cholerae O1 or O139 from stool samples
Dysentery	• Bloody diarrhoea	• Bloody diarrhoea • Fever and pain abdoman usually	• Isolation of shigella sp. from stool
Hepatitis (jaundice)	• Fever, fatugue • Yellow colouring of the eyes and skin	• Jaundice • Malaise, anorexia, • Fever at present or preceding jaundice • Hepatomegaly • Right upper quadrant abdominal pain • Pruritis in some cases	• ALT ≥ 8 times of normal • Serum Bilirubin > 2 mg%. • Hepatitis A - IgM HAV +ve • Hepatitis B - IgM Hbc & HBsAg positve • Hepatitis C - anti-HCV positive • Hepatitis E - IgM HEV positive
Persistent diarrhoea	• Symptoms of diarrhoea or dysentery • Lasts more than 14 days	• Symptoms of diarrhoea or dysentery • Associated with weight loss	• None
Typhoid fever	• Sustained fever with gradual onset • Severe headache • Malaise • Loss of appetite	• Onset usually gradual with increase in temperature • Sustained fever • Headache, malaise, bodyache, anorexia, insomnia, thirst • Vague pain or general uneasiness in the abdomen • General apathy • Constipation or diarrhoea • Tongue coated • Non productive cough • Relative Bradycardia • Splenic enlargement • 'Rose spots' on the 7th - 10 day usually on the chest and abdomen, vary in size and shape	• Isolation of S.typhi from blood, stool or other clinical specimens.

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EPIDEMIOLOGICAL PARAMETERS OF EPIDEMIC PRONE WATER BORNE DISEASES

Epidemiological Parameters	Diseases		
	Cholera (El Tor)	Cholera (O139)	Dysentry
Causative Agent	Vibrio cholerae El Tor vibrio	Vibrio cholerae O139	Shigella dysentry-1
Mode of transmission	• Feco-oral • Contamination of water, food, milk, raw fruit	• Feco-oral • Contamination of water, food	• Direct contact • Indirect feco-oral
Reservoir	Human	Human	Human
Incubation Period	3-6 days	3-6 days	1-7 days
Person characteristics	• Children & • Young adults	• All age groups	• All age groups
Case fertality rate	• High (50%) in sever and untreated case • With proper treatment can be brought down to <1%	• High (50%) in sever and untreated case • With proper treatment can be brought down to <1%	High in children & elderly
Seasonality	• Cases increase during late summer, monsoon & post monsoon period • Cases increase following floods	• Cases increase during summer, monsoon & post monsoon period • Cases increase following floods	Through out the year
Geographical distribution	Can occur any where	Can occur any where	• Can occur any where • outbreaks more common during dry summer season
Healthy carriers	Carriers & asymptomatic cases	Carriers can exist	Adults are carriers
Others		Epidemic potential is higher than El tor cholera	• High infectivity (10-100 organism can produce disease) • Secondary cases in house-hold
Control strategy	• Safe drinking water & sanitation • ORS • I.E.C.	• Safe drinking water & sanitation • ORS • I.E.C.	• ORS & effective case management (antibiotic resistance develops quickly) • Safe water and sanitation • I.E.C. for personal hygiene
Miscellaneous			

N.B. In addition to cholera, shigella, norwalk agent, there are several other organisms which can be the cause of outbreak of acute diarrhoea. These are Escherichia coli (several types viz. O157:H7 etc.), Salmonella etc. Other organism responsible for food poisoning are discussed in the training module on food poisoning.

The action to be taken by the district health authorities to control an outbreak of diarrhoeal diseases are similar. The stool samples sent in Carry Blair medium will serve the purpose of isolation of most of enteropathogenic bactena.

It may be re-emphased here that vaccination is not indicated for cholera control.

EPIDEMIOLOGICAL PARAMETERS OF EPIDEMIC PRONE WATER BORNE DISEASES

Epidemiological Parameters	Diseases		
	Typhod fever	Viral hepatitis-E	Acute Diarrhoea (viral)
Causative Agent	Salmonella typhi	H E virus	Norwalk virus
Mode of transmission	Contaminated food, water	Feco-oral	Feco-oral
Reservoir	Human	Human	Human
Incubation Period	7-21 days	40 days	1-2 days
Person characteristics	All age groups	Young adults	<15 years
Case fertality rate	• Improperly managed and non-immune = 10% • Properly managed <1%	• High in pregnant women, <5 year and >50 years	• Nil in properly managed cases. It is mild/moderate disease. More of gastric symptoms.
Seasonality	• Through out the year • Cases increase during monsoon & post monsoon period • Cases increases follows floods	• Endemic:- Through out the year • Epidemic commonly during late summer, rainy & post rainy season	• Through out the year • Can occur in winter season
Geographical distribution	Can occur any where	Outbreaks occur mostly in those areas having defective piped water supply	Can occur any where
Healthy carriers	Chronic carriers	Sub-clinical infection can occur (no chronic carriers)	Can exist, but exact magnitude not known
Others	Point source epidemic mostly in rural areas		Secondary cases occur in the same house-hold or closed community like schools.
Control strategy	• Safe drinking water supply & sanitation • Case management • I.E.C. for personal hygiene • Food hygiene	• Leakage in piped water supply be repaired immediately • Case management • I.E.C. for personal hygiene • Food hygiene • Chlorination does not kill virus, but boiling will kill	• General measures as for feco-oral diseases, • outbreaks are self limiting and of short duration.
Miscellaneous			

N.B. *Viral hepatitis A is also transmitted by feco-oral route, mostly drinking water supply. The disease is endemic, but outbreaks affecting younger age-groups can occur. Control measures are similar to viral hepatitis-E. Chlorination kill the virus. Viral hepatitis B, C, D and G are parentally transmitted. Isolated outbreaks of Viral hepatitis B may occur in small communities like hospitals (same syringe used for several patients in the ward) and in community where private practitioner use unsterilised syringes and needles. Chronic Liver Diseases (CLD) like carcinoma, cirrhosis occur after 30-40 years.

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FACT SHEET

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Fact Sheet N°107
(Revised) January 199[illegible]

CHOLERA

Cholera is an acute intestinal infection caused by the bacterium *Vibrio cholerae*. It has a short incubation period, from less than one day to five days, and produces an enterotoxin that causes a copious, painless, watery diarrhoea that can quickly lead to severe dehydration and death if treatment is not promptly given. Vomiting also occurs in most patients.

Most persons infected with *V. cholerae* do not become ill, although the bacterium is present in their faeces for 7-14 days. When illness does occur, more than 90% of episodes are of mild or moderate severity and are difficult to distinguish clinically from other types of acute diarrhoea. Less than 10% of ill persons develop typical cholera with signs of moderate or severe dehydration.

Background

The vibrio responsible for the seventh pandemic, now in progress, is known as *V. cholerae* O1, biotype El Tor. The current seventh pandemic began in 1961 when the vibrio first appeared as a cause of epidemic cholera in Celebes (Sulawesi), Indonesia. The disease then spread rapidly to other countries of eastern Asia and reached Bangladesh in 1963, India in 1964, and the USSR, Iran and Iraq in 1965-1966.

In 1970 cholera invaded West Africa, which had not experienced the disease for more than 100 years. The disease quickly spread to a number of countries and eventually became endemic in most of the continent. In 1991 cholera struck Latin America, where it had also been absent for more than a century. Within the year it spread to 11 countries, and subsequently throughout the continent.

Until 1992, only *V. cholerae* serogroup O1 caused epidemic cholera. Some other seroq could cause sporadic cases of diarrhoea, but not epidemic cholera. Late that year, howe

large outbreaks of cholera began in India and Bangladesh that were caused by a previ unrecognized serogroup of *V. cholerae*, designated O139, synonym Bengal. Isolation o vibrio has now been reported from 10 countries in South-East Asia. It is still unclear wl *V. cholerae* O139 will extend to other regions, and careful epidemiological monitoring situation is being maintained.

Transmission

Cholera is spread by contaminated water and food. Sudden large outbreaks are u caused by a contaminated water supply. Only rarely is cholera transmitted by direct pe to-person contact. In highly endemic areas, it is mainly a disease of young children, altho breastfeeding infants are rarely affected.

Vibrio cholerae is often found in the aquatic environment and is part of the normal flo brackish water and estuaries. It is often associated with algal blooms (plankton), whic influenced by the temperature of the water. Human beings are also one of the reservo the pathogenic form of *Vibrio cholerae.*

Treatment

When cholera occurs in an unprepared community, case-fatality rates may be as hig 50% -- usually because there are no facilities for treatment, or because treatment is too late. In contrast, a well-organized response in a country with a well establis diarrhoeal disease control programme can limit the case-fatality rate to less than 1%.

Most cases of diarrhoea caused by *V. cholerae* can be treated adequately by givin solution of oral rehydration salts (the WHO/UNICEF standard sachet). During an epidem 80-90% of diarrhoea patients can be treated by oral rehydration alone, but patients become severely dehydrated must be given intravenous fluids.

In severe cases, an effective antibiotic can reduce the volume and duration of diarrhoea the period of vibrio excretion. Tetracycline is the usual antibiotic of choice, but resistar to it is increasing. Other antibiotics that are effective when *V. cholerae* are sensitive to th include cotrimoxazole, erythromycin, doxycycline, chloramphenicol and furazolidone.

Epidemic Control and Preventive Measures

When cholera appears in a community it is essential to ensure three things: hygienic dispo of human faeces, an adequate supply of safe drinking water, and good food hygie Effective food hygiene measures include cooking food thoroughly and eating it while hot; preventing cooked foods from being contaminated by contact with raw foods, includ

water and ice, contaminated surfaces or flies; and avoiding raw fruits or vegetables unless they are first peeled. Washing hands after defecation, and particularly before contact with food or drinking water, is equally important.

Routine treatment of a community with antibiotics, or "mass chemoprophylaxis", has no effect on the spread of cholera, nor does restricting travel and trade between countries or between different regions of a country. Setting up a *cordon sanitaire* at frontiers uses personnel and resources that should be devoted to effective control measures, and hampers collaboration between institutions and countries that should unite their efforts to combat cholera.

The only cholera vaccine that is widely available at present is killed vaccine administered parenterally, which confers only partial protection (50% or less) and for a limited period of time (3-6 months maximum). Use of this vaccine to prevent or control cholera outbreaks is not recommended because it may give a false sense of security to vaccinated subjects and to health authorities, who may then neglect more effective measures.

In 1973 the WHO World Health Assembly deleted from the International Health Regulations the requirement for presentation of a cholera vaccination certificate. Today, no country requires proof of cholera vaccination as a condition for entry, and the International Certificate of Vaccination no longer provides a specific space for recording cholera vaccinations.

Limited stocks of two oral cholera vaccines that provide high-level protection for several months against cholera caused by *V. cholerae* O1 have recently become available in a few countries. Both are suitable for use by travellers but they have not yet been used on a large scale for public health purposes.

NOTIFICATION

Cholera is a notifiable disease locally, Nationally and Internationally. Health functionaries at all levels(particularly those who are closest to the community such as the Junior Health Assistants Male and Female) should be trained to identify and report cases immediately to the Medical Officer.

Under the International Health Regulations, Cholera is notifiable to the WHO within 24 hours of its occurrence by the National Government, the number of cases and deaths are also to be reported daily and weekly till the area is declared free of Cholera. An area is declared free of Cholera when twice the incubation period(i.., 10 days) has elapsed since the death, recovery or isolation of the last case.

Departmental Enquiries

K.R. SRINIVAS
Chief Administrative Officer
K.H.S.D.P.

A departmental enquiry is an enquiry ordered against a Government Servant under the provision of Karnataka Civil Services (C.C.A.) Rules, 1957.

Whenever the authority empowered under the provision of K.C.S. (C.C.A.) Rules is satisfied *prima facie* that a Government Servant has misconducted or acted in a way unbecoming of a Government Servant or has shown dereliction in discharge of Government duties, etc., the Authority can initiate enquiry against Government Servant.

In an enquiry there are two stages:

1. Investigation or Preliminary Enquiry
2. Department enquiry under K.C.S. (C.C.A.) Rules

Whenever it comes to the notice of higher officer, Disciplinary Authority or Government that a Government Servant has committed irregularities in discharge of his duties as Government Servant, before enquiry is ordered under K.C.S. (C.C.A.) rules, the concerned officer or Authority may appoint an officer to investigate into the veracity of the allegations. While conducting investigation, the officer can examine any witness, inspect any site or place and verify any record in order to know the correct position.

Then the Investigating Officer will submit a report to the officer who has ordered investigation. Based on the report of the Investigating Officer, the Disciplinary Authority or the Government as the case may be will decide whether enquiry under K.C.S. (C.C.A.) Rules is necessary or not.

It is not necessary that a departmental enquiry is always preceded by an Investigation. If the Disciplinary Authority or the Appointing Authority is satisfied that *prima facie* a case exists against Government Servant, it can proceed against Government Servant under K.C.S. (C.C.A.) Rules.

Either on the basis of Investigation Report or on the basis of available evidence, charges will have to be framed against Government Servant either under Rule 11 or 12 of the Rules. If two or more officers are involved, a joint enquiry is ordered under Rule 13 of the Rules. If the charges are proved after enquiry, one of the penalties as prescribed under Rule 8 will have to be imposed. If on enquiry if charges are not proved, the Government Servant will be exonerated of charges.

Sometimes Government Servant against whom the enquiry is contemplated will be placed under Suspension as provided under Rule 10 of the Rules. A suspension under Rule 10 is not a punishment. A Government Servant is placed under suspension, when the irregularities appear to be serious and if the Government feels that his

continuance in the post will hamper further investigation etc. During the period of suspension, a subsistence allowance is paid to Government Servant.

A Government Servant who is placed under suspension could be reinstated at any time either before completion of enquiry proceedings or after completion at the discretion of the Disciplinary Authority. If charges are not proved, the period of suspension will be treated as on duty. If the charges are proved and a penalty is imposed, the period of suspension will not be regularised. However at the discretion of Disciplinary Authority, the period may be adjusted against any leave at the credit of Government Servant.

Based on preliminary enquiry (Investigation Report) or on the basis of available evidence, the Disciplinary Authority will frame articles of charges against the Accused Government Servant (AGO/DGO) either under Rule 11 or 12 as the case may be.

If in the opinion of Disciplinary Authority, that irregularities Committee are minor ones, he may initiate enquiry under Rule 12 of the Rules. If enquiry is order under Rule 12, only one of the following minor penalties can be imposed against the A.G.O.

1. fine (for Group 'D' services only)
2. censure
3. withholding of increments
3a. withholding of promotion
4. reduction to a lower stage in the time scale of pay.

If in the opinion of Disciplinary Authority, that the irregularities committed are serious ones, he will initiate enquiry under Rule 11 of C.C.A. Rules. If charges are proved, the Disciplinary Authority may impose any of the following major penalties under Rule 8.

(v) reduction to a lower time scale of pay, grade, post or service.
(vi) compulsory retirement
(vii) removal from service
(viii) dismissal from service

Even when an enquiry is ordered under Rule 11, the Disciplinary Authority can impose any of the minor penalties also. But whenever an enquiry is taken up under Rule 12, no major penalty can be imposed on the A.G.O.

The procedure involved in conducting an enquiry against A.G.O. is to be followed scrupulously otherwise enquiry will vitiate.

On the basis of preliminary investigation report and or on the basis of available evidence, the charges will have to be framed against the A.G.O. The charges should be clear and distinct. There should not be any ambiguity in the charges. The charges ill have to be explained in the form of statement of imputation of misconduct. The documents by which the article of charges are to be sustained and the list of witnesses

to be examined by the Disciplinary Authority in support of charges will have to be listed along with Articles of charges.

The charges along with statement of imputation of misconduct, list of documents listed and the witness to be examined will have to be served on the A.G.O. The A.G.O. should be given a reasonable time with a direction to submit a written statement of his defence and to state Whether he desires to be heard.

On receipt of this statement, the Disciplinary Authority may conduct enquiry himself or appoint an enquiry officer to enquire into such of the articles of charges which are not admitted by the A.G.O. If all articles of charges are admitted by the A.G.O. then there is no need to proceed further. The Disciplinary Authority or the authority competent to impose penalties under the Rules can impose any of the penalties as the case may be.

If the A.G.O. fails to give written statement in his defence, then also Disciplinary Authority may inquire into the charges or appoint an inquiry officer. The Disciplinary Authority may also appoint presenting officer to lead evidence before the presenting officer on behalf of the Disciplinary Authority.

The inquiry officer will issue notices to the A.G.O. to be present before inquiry officer after getting all relevant records from the Disciplinary Authority,. The A.G.O. shall appear in person before the Inquiry Authority. The A.G.O. may also take assistance of another Government Servant or a retired Government Servant who is not a legal practitioner.

The inquiry officer shall ask the A.G.O. whether the A.G.O. is guilty of any of the charges or the A.G.O. wants to defend. This has to be recorded by the Inquiry Officer and take signature of the A.G.O.

If the A.G.O. fails to appear before the Inquiry Officer without valid reason for his absence or refuses to plead, the Inquiry Officer may ask the presenting officer to produce the evidence to prove charges against the A.G.O.

The A.G.O. may be allowed to inspect any of the documents and permit him to take extracts of statements listed in the charge memo. The A.G.O. may be allowed to submit a list of witnesses to be examined on his behalf.

On the date fixed for enquiry the charge witnesses may be examined by P.O. cross examined by the A.G.O. and re-examined by P.O. if necessary. When the examination of witness for Disciplinary Authority is closed. The A.G.O. shall state his defence orally or in initiating. A copy of the defence statement should be given to the P.O.

The A.G.O. may examine himself and also examine the witnesses to be cross examined by P.O. and re-examined by A.G.O. if necessary. The Inquiry Officer can also put questions.

The Inquiry Authority after completion of production of evidence permit the P.O. to address his argument and record the same. The Inquiry Authority may also permit the P.O. to file his written arguments.

After completing enquiry, the Inquiry Authority will draft inquiry report to be submitted to the Disciplinary Authority. In the inquiry report, the Inquiry Officer will have to analyse, each charge on the basis of evidence placed before him and record his findings on each article of charges. These findings will be submitted to the Disciplinary Authority in form of inquiry report along with documents.

The Disciplinary Authority after receipt of inquiry findings will examine the report of the Inquiry Officer and proceed further. If the findings reveal that the gravity of the charges is not serious, the Disciplinary Authority may impose any of the minor penalties under Rule 8. If in the opinion of Disciplinary Authority, the gravity of the charges is so severe that, it warrants a major penalty as specified under Rule 8, the Disciplinary Authority may impose major penalty if he is competent to do so or forward the inquiry report to the Authority competent to impose a major penalty:

If Disciplinary Authority is the Government then before imposing any of the major penalties, the KPSC will have to be consulted. If the Authority subordinate to Government is the Disciplinary Authority, then there is no need to consult KPSC.

Before imposing a major penalty, a second Show Cause Notice to be served on the A.G.O., enclosing copy of the inquiry report. There is no need to intimate the penalty proposed.

Against order of the Disciplinary Authority, the A.G.O. can file an appeal to the Appellate Authority. Appellate Authorities are prescribed for various classes of services as given in the classification.

When an enquiry is ordered under Rule 12, a detailed enquiry may be held in accordance with the procedure laid down in Rule 11, or on the basis of articles of charges, statement of imputation, defence statement, evidences placed, record findings and impose a minor penalty as given in Rule 8.

When two or more Government Servants are involved in a proceedings, the Disciplinary Authority may order joint enquiry under Rule 13. Even in a joint inquiry, the Rule 11 or 12 may be followed depending on the severity of the charges.

The Government can appoint Lokayukta Officers as Inquiry Authority under Rule 11(4) of the Rules. The Inquiry Authority can in such cases modify or alter the articles of charges but they cannot frame the charges on their own.

Special Procedure in certain cases:

The Competent Disciplinary Authority under Rule 14 may without holding any inquiry contemplated under Rule 11, 12 of the Rules, impose any of the penalties specified in Rule 8 on Government Servants.

1. on the ground of conduct which has lead to his conviction in a criminal charge.
2. a) where he has absconded.
   b) where he does not take part in the inquiry
   c) where Government is satisfied that in the interest of security of state, it is not expedite at follow the procedure in C.C.A. Rules.

The important Acts and Rules to be familiar with:

1. K.C.S. (C.C.A.) Rules, 1957
2. K.C.S. (Conduct) Rules, 1966
3. K.C.S. Rules
4. The Karnataka Finance Code
5. The Indian Penal Code

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HOW TO EXPRESS YOUR FEELINGS

DANIEL A. SUGARMAN/ROLAINE HOCHSTEIN

In this brief article the authors attempt to explain some of the major reasons for the many failures in communication and suggest seven principles derived from recent work in human relations that should help to improve your communications with others, both as sender and as receiver. Although the various principles are presented as unqualified directions, they, like most useful principles, should be applied judiciously in response to the specifics of each communication interaction.

Doris: " I really don't care which movie we go to". (She is telling her husban that she is so happy to get out, it doesn't where they actually go).
Phil: "If you'd rather stay home, I can find plenty to do around here." (He thinks she doesn't want to go).

Joan: "I am sorry, but we can't join you Saturday night." (She doesn't enjoy big parties at Mary's country club.)
Mary: " I'am sorry, too." (Mary thinks Joan doesn't like her.)

Betty: "Everything has gone wrong today !" (She wants a little sympathy from her husband.)
Tom: " All you do is complain!" (He thinks she's blaming him.)
Ann: "The Women's Libration movement is the greatest thing since frozen vegetables." (She is glad to see new educational and career opportunities opening up for women.)
Sally: "It's a lot of nonsense." (Her neighbor pictures a group of disheveled activists picketing a men's bar.)

Any of the above dialogues could be the begining of a fight or the end of a friendship. Doris and Joan and Betty and Ann send out one message, but the receiver picks up something entirely different. Each knows what she's telling her husband, friend or neighbor, but the response-or lack of it-indicates that the other person hasn't the faintest idea of what's really on her mind.

Their problems are not unusual. We all have similar difficulties from time to time.

If you have continual misunderstandings with the people close to you, however, you may soon feel isolated, lost, powerless. It is important, therefore, to learn how to get your real feelings across. In recent years scientists concerned with communication and psycholinguistics have learned a lot about how people talk to each other. Some of their findings can help

you to make yourself better understood. First let's examine some of the causes of the flak, fuzz and static that prevent understandi

1. We don't really listen. The average English-speaking person hears more than a billion words a year. Bombarded by so much verbiage, many of erect barriers to screen out much of the talk lest our circuits become overloaded. One woman, for example, described her daily routine with six children, a dog and a parakeet by saying, "If the noise stays about as loud as Niagara Falls, I know everything is all right and I hardly bother to listen. But when it rises to the level of a jet plane taking off, I know it's time to go upstairs and find out what the trouble is....."

2. We assume that words have prcise meanings-and they don't. At bottom, a word is only a symbol-one largely defind by individual experiences. When experiences relating to a word have been different, the receiver "hears" the communication differently.

For example, Alice Grayson grew up in a home relatively stable and free from major strife. Her parents were very warm and affectionate people. Bob Graysnn's childhood home, on the other hand, was characterized by constant bickering. He often witnessed physical assaults upon his mother by an alcoholic, irresponsible father.

When Alice and Bob came to me for marriage counseling, it soon became clear that the word "marriage" conveyed different meanings to each of them. When Alice spoke to Bob about "marriage she implied warmth, intimacy and stability. When Bob spoke to Alice about "marriage", he seemed to be talking about a sort of jail term in which he had to protect himself from criticism and attack.

A word's meaning may also vary with the content in which it is used. We speak, for instance, about a fast runner (meaning sp about going on a fast (not eating) or about a neighbor who leads a fast life.(meaning immoral). Not long ago I was at a social gathering where an animated discussion arose on the subject of women's lib. Listening carefully, I realized that to the original

speaker, women's lib meant that a women should be paid as well as men. To another woman, women's lib connoted an equal sharing of household chores. To a young man, women's lib seemed to suggest that he would stay home and clean the sink while his wife drove a trailer truck and went to communist Party meetings.

b. When people come from different cultures, their problems in exchanging messages are greatly compounded. To someone who grew up in East and is accustomed to carrying groceries in paper bags, it causes momentary alarm to be confronted in Arizona with the prosper of having to carry home a sack. In California people goto the beach on a hot day. In New Jersey they go to the shore.

3. We don't pay enough attention to tone, gesture and other nonverbal forms of communication. Recently a young physician and his wife came to me for help. She complained that he treated her as a little girl. He, on the other hand, spent the session denying the charge in a very intellectual manner. Infact, he said nothing to indicate a patronizing attitude. As they were about to leave at the end of the session, however, he patted her arm in a oondescending fashion and said, " Now that wasn't too bad, was it?" Hisgesture and tone of voice thoroughly corroborated his wife's complaint.

a. Because nonverbal communication often speaks louder than words, the sensitive person must be alert to signals: the smothered yawn of boredom, the swallow of anxiety, the jutting chin of defensiveness, the hair-patting hand of nervousness, the widened eyes of fear, the small smile of disbelief and dozens of other bodily movements that can reveal the hidden agenda of communication patterns.

4. We say what we think we should say instead of what we feel. The meaning of words can be lost in the frequency of their usuage. If you repeat the name of a friend fifty times in rapid succession, an interesting psychological phenomenon will occur. For the first dozen times, the name will bring an image of the friend to mind. After that, the name will become just a sound-and more meaningless with each repetition.

Greetings and social rituals often meet with the same fate. The How-are-you?- I'm-fine routine is probably the most common illustration, and in many ways the saddest. I have known people who were literally suicidal to reply, " I'm fine, thank you. How are you?" when asked how they were feeling.

a. Ironically, some of the most significant occasions in people's lives-such as commemorations of birth, graduation, marriage and death-are often marked by the highest incidence of meaningless, ritualized communications. At weddings and funerals, when people are most deeply moved, they tend to hide their feelings under a cloak of banality.

A woman who had lost her daughter after seven long years of a painful, wasting disease told me that one of the worst ordeals at the funeral was having to shake the hand of person after person who said " I'am sorry" or "What can I say?" At one point, however, a close friend broke away from the ritual and said, "I know it has been terrible; I'am glad for her and for you that it's over." The mother cried then, able at last to express her grief. "It was good to know that at least one person there was generoud enough to share her real feelings with me," she said later.

It is easy to follow the script of conventional comments and responses, but meaningful communication requires that you take the trouble to create original dialogue that expresses your own unique feelings.

In recognition of the critical need for improved understanding among individuals and groups of people, a human relations movement has become a forceful element in American life. Some of the principles and practices ~~and~~ that have been found to work in human relations training may help improve your communications with friends and loved ones.

1. Acknowledge your feelings. The lines of communication often get crossed by our desire to say things that will gain approval-even though they conflict with our true feelings. For example, women conditioned to the traditional female role in our culture generally find it difficult to admit-even to themselves -feelings of anger, boredom, sexual appetite and competitiveness, while men are often inhibited from expressing "weak" emotions such as fear, tenderness, indecision. Mature people are capable of acknowledging all their feelings-even those that are socially taboo.

a. When you are angry, for example, the worst thing you can do is withdraw. A blanket of self-pity or self-righteousness may bring temporary comfort, but it also creates a barrier between you and other people. The best way to deal with anger is through a direct confrontation that balances your feeling with the other person's sensibilities-provided, of course, that you confine your message to the issue and not the personalities involved.

b. Attacks and accusations-"You'are selfish ! !" "You're inconsiderate ! " "You're lazy !" - don't solve any problems. But a specific statement- " I'm angry because you left the bathroom a mess last night and you knew my bridge club was coming over"-defines the issue, leaves room for apology and future correction. If you use a fifty-megaton bomb to get rid of a mosquito of annoyance, your target is apt to erect a protective barrier through which no message can penetrate.

2. Stop, Look and Listen. Sometimes, the habit of tuning out certain types of conversation-Children's prattle, fellow workers' shop talk, a neighbor's gossip-causes us to miss some important messages. As an early step in improving your communications, reassess your listening habits.

a. Learn to catch the cues of nonverbal communication. In recent years psychologists have demonstrated in the laboratory that people broadcast their feelings in a wide variety of nonverbal ways. You need not be a scientist to pick up many nonverbal cues: the glance at a watch that indicates restlessness, the tapping foot of annoyance, the clenched fist of suppressed rage. Arms crossed at the chest may indicate reserve, while pursed lips may signify the desire to say things unpleasant to hear. Learn to watch for revealing signals, to listen objectively and to interpret what you see and hear.

If Doris and Phil Evans had learned to listen with more sensitivity, they could have averted a family quarrel. According to Doris, Phil came home, made the gesture of inviting her out to a movie and then, much to her disappointment, reversed himself. According to Phil, Doris said she didn't want to go, "Doris explained. "What I said was I didn't care which movie we went to. I was so bored with being home with the kids on arainy day that I didn't care where we went."

Recognizing his mistake, Phil admitted, " I guess I took you up wrong. I 'd had a busy day at the office and was really glad to stay home. I guess I heard what I wanted to haar."

Since most of us like to live in anordefly world, we radily allow communications that confirm our desires and prejudices to enter our field of awareness, but we x screen out messages that go agaubst our wishes. The individual who really wants to send and receive clear messages will work at paying objective attention.

3. Explain yourself. When your conversation is sprinkled with such nontalk phrases as "You know what I mean?" it's safe to assume that your meaning is not clear. Lazy talk is the cause of much communication failure. Betty, the woman who greeted her husband with the news that "everything had gone wrong today".

lost the sympathy she wanted because Tom heard an accusation and reacted to defend himself. Her message would have been far more effective if she had been more specific: "Little Tommy fell out of a tree and hurt his arm, the washing machine broke and I forgot to take the meat for dinner out of the freezer."

In busy lives, it's all too easy to generalize, take shortcuts, confuse facts with feelings. The expressions "I feel" or "it seems to me" are valuable tools in avoiding misunderstanding. Your facts may be wrong, but the way you feel cannot be disputed. "I'd prefer less salt in the soup" is a very different statement from "why do you always over-salt everything?" Hasty responses such as "You're wrong" or "don't be silly" are inconsiderate of other people's feelings. Furthermore they invite counterattacks or retreat. If you want an exchange instead of a battle, explanation is more useful than attack. "This is the way I see it" goes further than "You don't know that you are talking about."

All too often a husband will say, "I'm sorry I ever got married." There is not much a wife can do with that except feel wounded and strike back. If the husband said" I'm beginning to feel trapped...." Ar " All these responsibilities get me down sometimes....." the channels of communication would be open. And an honest discussion of the real problems might improve the situation.

Mind-reading is not the responsibility of your loved ones. It is up to you to say what's on your mind-and up to them to respond. By being specific, giving clear instances in straight language, you can make sure that the receiver of your message knows what you're talking about. Calling to tell a friend that you had "a good time" at her house last night doen't mean nearly as much as a specific statement: "The shrimp creole was delicious and the Jacksons were great fun. My husband said he hated to leave. "Such details really get your meaning across.

4. Avoid detours. Some people find it almost impossible to ask a straight question or give a stright answer. Somehow-whether from a need to guard themselves, a mistaken attempt at delicacy or plain fuzzy-mindedness-they get into the habit of indirection.

The Albertsn for example, continually invite the Massons to parties at their country club. The Massons dislike formal dress. Joe Masson doen't dance, and Joan is uncomfortable with the kind of small talk that dominates at the club. Every time Mary Albert invites them, Joan invents a tactful excuse for reusing the invitation. Eventually the Alberts will get annoyed at these rejections and may even drop the friendship.

It would be much better if Joan just said right off: "Look, we enjoy being with you, but we don't enjoy the club. How about doing something else together?"

It's all too easy to get caught up in polite lies, meaningless formalities and convenient evasions. If you want closer connections to the people around you, honesty is a better policy. Start by avoiding the white lies that can destroy trust and confidence. Telling a friend that her prune casserole is delicious when you can barely manage one mouthful doesn't accomplish anything. She'll know your real feelings when she sees the expression on your face when you swallow-or the amount you leave on your plate. And she'll be doubly offended by the obvious lie.

In the long run it's usually wiser to tell the truth-even if it hurts. The consequences of not facing the truth are often more painful than the truth. To communicate unpleasant messages as kindly as possible is a skill worth developing. For example, the hostess who served the offensive prune casserole might be told: "I really admire your creativity with new dishes, and I usually love the results, but this is one time is one time when it just doesn't appeal to me."

5. Offer feedback: When a friend tells you a long story over the phone, you fill in the pauses with sounds of encouragement. "Yes..." "Go on..." "Um-hmh....." If you stop sending this feedback, she soon asks if you're still there.

Face_to-face communication also benefits from feedback-such as eye-to-eye contact, nods of understanding, comments of agreement (or Even disagreement). If the person taling gets the feeling that you are truly interested and accepting, he is encouraged to continue. If he senses disinterest or disapproval, the flow of communication soon stops.

Viola Johnson, a woman with two grown children, told me she was bored with her marriage and considering a divorce. When I asked what she and her husband usually talked about, she snapped, "Engines." since she obviously had no interest in engines, I

asked, "Why don't you change the subject?" Viola was surprised at the question. " A wife is supposed to listen, "she said. But by withholding honest feedback, she failed to let her husband know where he stands.

If Viola really wanted to enjoy his company, she could have asked questions-possibly learning some details of his work that would produce an interest on her part. Or she could ask politely for a change of subject that would give her husband a chance to make himself more interesting. Best of all, she could suggest an activity- a dance class, a painting course, volunteer civic work-that they could do together and talk about to their mutual interest.

a) You should never be afraid to say " I don't understand." It's really a courtesy, for it shows that you think enough of the message and the sender to want to catch the point or see the picture in proper focus. Most people are happy to restate what they have just said in order to clarify it-and they are glad you care enough to ask.

6. Don't label. Nobody really fits into a precast mold, and prejudgement can prevent understanding and limit the possiblities of a relationship.

Ron and Greta Lewis came to me for counselling because of their concern about a sesual problem that began, they said, on their honeymoon about a year before. It seemed that Ron achieved orgasm quickly. While Greta enjoued their sexual relations, it took her longer to reach a climax. On the third day of their honeymoon, Ron kissed Greta and said, " I love you verymuch- even though you are frigid."

Although inexperienced in sexual matters, Greta had read several sex manuals and felt increasingly anxious about her "frigidity." Intercourse soon became a chore to her. She found herself concentrating tensely on mechanics rather than relaxing in the enjoyment of love-making. The more frantically she sought pleasure, the more it eluded her. Finaly, she indeed became unresponsive.

Listening to Ron and Greta, I was convinced that their problem began with Ron's labeling of Greta as "frigid". Frigidity, to most Psychologists,means the lack of pleasure in sexual activity. This was not true of Greta-until anxiety caused her to fulfill the prophecy of Ron's label.

a) In the same way, calling a man" a"drunkard" will likely reinforce his negative self-concept and do nothing to help his drinking problem. But a sympathetic appraach, without labeling-" I am worried about how much you've been drinking lately"- will have a better chance of penetrating the wall of his defensiveness. Much of our achievement depends upon self-image. Children persuaded that they are backward usually perform poorly in school. But when the same children work with a teacher who is convinced they can learn, they often show remarkable improvement in a short time.

b) If your aim is to improve relations-rather than to express feelings of hostility or superiority-don't confine people under sticky labels. "You're stupid, "You're stingy, "You're a tyrant, "You're a bore" are never effective in dealing with a problem. Such labels serve as an effective barrier to any reasonable discussion of grievances.

7. Take off your blinders. Most people resist change. They "don't get" messates that are at odds with their habits and viewpoints. This is the why the wife of a man engaged in an extramarital affair is often the last person to know about it. She doesn't want to know, so she fails to register the obvious evidence.

Protecting oursleves from unpleasant communications that are clearly sent is what psychologists call "the ostrich phenomenon." Ostriches, with their heads stuck in the sand, are extremely vulnerable. So are people who let their blind spots influence their perception of reality. The woman who does not see-because she is really afraid to see-that her child is delinquent, that her husband is dissatisfied, that her friends are exploiting her is not only failing to get a message, she's failing to make the changes that could improve the situation.

a) To avoid the dangers of the "Ostrich phenomenon," you must train yourself to get all messages. Once you understand what another person is trying to tell you, you are in a better position to refute his argument. If you recognize your own prejudices,predilections and fears, you'll be able to listen to divergent viewpoints with an open mind. You can listen without agreeing, but it's important to listen first-then make up your own mind.

Once you understand a communication, you may occasionally find it useful to "tune out" parts of it. I recently worked with an elderly couple who were distressed about having placed their

retarded daughter in an institution because they no longer had the stamina to care for her at home. During the interview, the husband often interrupted his wife with irritable comments. At one point he became frankly abusive, but his wife turned to me and said, " Pay him no mind, Doctor. He's just got to get the pain out somehow." She was a woman who had learned to recive and interpret messages and to share another's feelings.

b) If you truly want to be coser to other people, you can learn to be more expressive and more responsive. The key is wanting to communicate-rather than to win points, make an impression, assert power or reinforce your own attitudes. The point-winner is less interested in understanding other people than he is in putting himself across. Sometimes, in order to put a conversation on a level of honest exhange, it is necessary to say (and mean !): "Look, I'm not tryying to put you down. I only want to understand why you think that way."

If you can't hear another person's story without interrupting to show how much you know or where you have been or how bright your children are, then you're probably more interested in impressing him than in relating to him. If you can't listen to an opposing view point without trying to change it, self-assertion may be more important to you than understanding. If you calm up in the presence of opposition or ideas of which you disapprove, it is likely that you're afraid of the challenge of the new and different. Only when you really listen to another person and try to see things from his point of view are you practicing the art of communication.

c) It's important to keep in mind, though, that not everybody wants intimacy, Not everybody will feel free to open up to you. If you are a friendly, warm, outgoing person, you will probably want to respond to the needs of others who, for one reason or another, may choose to remain aloof and restrict their confidences. If your overture at a party is not welcomed, it's easy to move on to someone more congenial. Sometimes a rejection is very frankly stated: "Steve and I would rather not discuss politics" or " I never talk business at social gatherings." At other times you can tell from downcast eyes or a defensive lift of hand that you are in danger of intruding on delicate ground. A graceful retreat or a change of subject is in order.

d) With intimates, too there may be tender spots on which you should not tread heavily. If your husband feels touchy about his expanding waistline, his receding hairline or his unchanging salary, it is considerate to approach these subjects with discretion-if you mention them at all. It is part of sensitivity to recognize and respect another person's privacy in certain matters.

In short, you may not always succeed, but your efforts to get across will certainly make life a lot easier-for yourself as well as everyone around you.

Dr. K.B. Makapar.

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NATIONAL HEALTH PROGRAMMES, THEIR OBJECTIVES AND IMPLEMENTATION

The National Health Programmes are formulated and launched by the Central or National Government to improve the Health of the people on specific health problems after the independance.

Objectives of National Health Programmes:-

1. To control/Eradicate the Communicable diseases,
2. To improve the environmental sanitation and provide safe drinking water,
3. To improve the Nutrition
4. To Control the population growth and promote the Health of the people, particularly the health of children and Mothers.

Technical and Material Assistance: is provided by International Agencies like, WHO, UNICEF, UNFPA, WORLD BANK and Number of Foreign Agencies like SIDA, DANIDA, NORAD and USAID.

NATIONAL HEALTH PROGRAMMES:

I. 1) National Malaria Eradication Programme:

Malaria was and is one of the major public health problem. In 1950's it was number one Public Health Problem in India. As per 1953 estimates yearly incidance was 75 million cases with 8 lakhs deaths.

The National Government launched National Malaria Control Programme in 1953 as a centrally sponsored programme to reduce the morbidity and mortality due to Malaria. The Malaria incidence was brought down to 2 million cases in 1958 from 75 million cases in 1953. The Central Government upgraded the programme as Malaria Eradication Programme in 1958 due to spectacular success and fear of development of resistance of vectors to DDT. The NMEP had a spectacular success. In 1961 only 50,000 cases were reported and most of the areas entered the maintenance phase by 1965.
of the programme : Due to various problems in maintenance of the programme, again the incidance of malaria started rising in many areas even epidemics were reported. During 1977, a total of 6.4 million cases were reported with few deaths.

....2...

The Government of India implemented modified plan of operation, to prevent deaths due to malaria, to reduce morbidity and mortality due to malaria, and to maintain the development in the field of Agriculture and Industries. To contain the Pf incidence in the North-East region, a special programme viz. plasmodium falcifarum containment programme was launched including the drug resistance problem. The guidelines are changed to contain the spread.

Activities:-1)Attack on the parasite- prompt case detection by Active and passive Surveillance and prompt treatment and reduce the reservoir of infection.

2)Attack on Vector - i)Bioenvironmental method of vector control.
ii)Indoor insecticidal spray with appropriate ~~xxx~~ insecticide as approved by the Central Govt.

3)Awareness campaign regarding the malaria, causation spread, signs and symptoms, diagnosis and treatment and prevention.

The programme is implemented through the following.

State Headquarter:- A cell is established - 1
Divisional level - Deputy Director NMEP Zone - 4
District Malaria Officers - 20 + 7 (New Dists.)
Primary Health Centres - 1601 and
all other health institutions, Drug Distribution Centres and Fever Treatment Depots.

Strategy:-

1) Surveillance - Active - Jr.H.A(M), Jr.H.A(F) & Sr.H.A(M&F)
- Passive - All Medical Institutions
- Mass and Contact.

2)Laboratory Diagnosis at PHCs.

3)Prompt Radical Treatment of cases

4)Indoor insecticidal spray and Bioenvironmental control methods.

5)Operational Research - Vector behaviour and sensitivity to insecticides
- parasite's sensitivity to chloroquine.

The malaria incidence yearwise in the State is given in the Annexure.

....3....

2. National Filariasis Control Programme:-

Filariasis is another public health problem in India. About 304 million people are exposed to the risk of infection and 15 million people with menifest disease and 21 million people are having Micro filaria in their blood as per recent estimates.

The National Filariasis Control Programme is launched in 1955. This programme is integrated with Urban Malaria Control Programme in 1978 to have maximum utilisation of resources.

Activities of NFCP:-

1)Delimitation of problem in the unsurveyed areas,
2)Control in the Urban areas,
i)Recurrent Antilarval measures
ii)Antiparasitic measures with D.E.C.

In Karnataka the problem of filariasis is seen in the Districts of Dakshina Kannada, Uttar Kannada, Bijapur, Gulbarga and Bidar.

The following infrastructure is created for implementation of this programme:

1)Filaria cell in the State HQ. - 1
2)National Filaria Control Units - 8
3)Filaria Night Clinics - 25
4)Filaria Survey cell - 1

The programme is in operation in the problem districts. The Government of India supplies the equipments and materials and rest is met by State Government.

The yearwise achievements is given in Annexure.

3. National Family Welfare Programme:

Government of India recognising the need of population control, launched Family Welfare Programme in 1952 all over the country becoming first country in the World to do so.

....4..

Mile Stones of programme development:-

- Government run Birth Control Clinics started in 1930s in then princely State of Mysore.
- National Family Planning Programme launched during 1952.

  Activities:
  - Establishment of few clinics to provide serv
  - Distribution of education materials
  - Training and Research.
- Change from clinic approach to extension education approach in 3rd five year plan. (1961-66)
  - Motivation of people for acceptance of Small Family Norm.
- Introduction of IUD in the programme - in 1965

  Creation of seperate Family Planing Department in the Health Ministry - 1966.
- Strengthening of F.P. structure (PHC, Subcentre, Urban Family Planning Centres, State and District Bureaues)-1966-
- Top priority programme - During 4th Five Year Plan (1969-74
  - In 1970, the F.P. programme became integral part of MCH Activities of PHCs/Subcentres.
- All India Post Partam Programme in 1972, MTP was introduced.
- Fifth Five Year Plan (1975-80) - Major changes.
- In April 1976 - First National Health Policy framed.
- June 1977 - New population Policy was formed by Janatha Govt. and Ministry was renamed as "Family Welfare".
- Population Control and Family Planning is in the cuncurrent list as per 42nd Amendment to Constitution and provision is made effective from 1977.
- The acceptance of programme is purely on volutary basis.

India is signatory to the Alma Atta declaration to achieve "Health for all by 2000AD" through Primary Health Care. Accordingly National Health Policy was formulated in1982, and same was approved in 1983 by the Parliament and brought into force.

Long Term Demographic Goals set in the population Policy to be achieved by 2000AD:

1) N.R.R. = 1 (2 child Norm)
2) Birth Rate - 21 per 1000 population
3) Death rate - 9 per 1000 population
4) Couple protection Rate - 60 and above per 100
5) I.M.R. -less than 60.

The Family Welfare Programme was a target oriented and timebound programme, but implemented on purely voluntary basis. During 1995-96, the programme was made "Target Free Approach" and there was set back in programme implementation in many State. The same is now renamed as "Community needs assessment approach" where the Jr.H.A.(F) prepares the estimates of the Community needs for each services for her subcentre area. The same is compiled for all subcentres of PHC which will be the community needs estimate for PHCs for the year. The Action Plan will be prepared for PHC accordingly.

Services provided:- Contraceptive Advances & Services
- Terminal methods/permanent F.W.methods
- I.E.C. Activities.

4. Reproductive and Child Health Programme:

The Family Planning Programme was started in 1951 as a purely demographic programme. Subsequently the element of public education and extension wing included to facilitate outcomes under the Family Planning Programme. During the seventies, the Family Planning Programme was focused mainly on terminal methods and Programme received set back due to rigid implementation of a target based approach. The Programme has, however, remained fully voluntary and the main effort of Government has been to provide services on the one hand and to encourage the citizens by information, education and communication on the other hand to use such services. The experiences gained, within the country and outside, had amply established that health of women in the reproductive age group and of small children (upto 5 years of age) is crucial importance for effectively tackling the problem of growth of population which led to change in the approach from Family Planning to Family Welfare. Since the Seventh Plan implemented during 1984-89, the FW programmes have evolved with the focus on the health needs of the women in reproductive age group and of children below the age five years on one hand and on the other hand to provide contraceptives and

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spacing services to the desirous people. The main objective of the Family Welfare Programme for the country has been to stabilise population at a level consistent with the needs of National development.

2. The Universal Immunisation Programme (UIP) aimed at reduction in mortality and morbidity among infants and younger children due to Vaccine Preventable Diseases was started in 1985-86. The Oral Rehydration Therapy (ORT) was also started in view the fact that diarrhoea was a leading cause of deaths among children. Various other programmes under Maternal and Child Health (MCH) were also implemented during the 7th Plan. The objectives of all these programmes were convergent and aimed at improveing the health of the mothers and young children and to provide them facilities for prevention and treatment of major disease conditions. While these programmes did have a beneficial ~~~ impact but the separate identity for each programme was causing problems in its effective management and this was also reducing somewhat the outcomes. Therefore, in 90's in the 8th Plan, these programmes were itegrated under Child Survival and Safe Motherhood (CSSM) Programme and which was implemented from 1992-93.

3. However, the position is not uniform all over the country whereas the State like Kerala, TamilNadu, Goa, Maharashtra and Punjab have achieved a considerable higher level, the States like U.P., M.P., Bihar, Rajasthan, J & K., Assam and Orissa are performing at levels much below the national level. This has been a matter of great concern because these States also happen to be very populous and unless performance in these States improves, the national performance will continue to remain depressed. The results at ground level are influenced by a number of factors like investment for the programme at National/State level, efficiency of the State health system and response of the people. The deficiencies in implementation of the maternal and child health services have been responsible for a high incidence of maternal

mortality and child/infant mortality and low health status of women and children. Poor prospect of health and life of the children is one of the prominent factors leading to birth of more children per family. The present position vis-avis to past levels of various RCH and population indicators is given in the following table:

ACHIEVEMENTS AND GOALS

Indicator	Past levels/achvt.	(NATION) Current level
Infant Mortality Rate	146 (1951-1961)	72 (1996)
Crude Death Rate	25.1 (1951)	8.9 (1996)
Maternal Mortality Rate	NA	4.37(1992-93)*
Total Fertility Rate	6.1(1951)	3.5 (1993)
Life Expectancy at Birth(Years):		
Male	37.1 (1951)	61.5 (1996)
Female	36.1 (1951)	62.1 (1996)
Crude Birth Rate	40.8 (1951)	27.4 (1996)
Effective Couple Protection Rate	10.4 (1970-71)	46.5 (1996)
Immunization Status (% Coverage)		
T.T. (for pregnant women)	40 (1985-86)	76.73 (1996)
Infant (BCG)	29 (1985-86)	93.12 (1996)
Measles	44 (1987-88)	78.91 (1996)

* National Family Health Survey 1992-93.

4. The Approach Paper to the Ninth Plan brought out by the Planning Commission has brought out the inadequacy of the investment made for Family Welfare. This is a severe handicap particularly when it is noted that in almost all respects, the health care system needs upgradation and it needs to reach out to many more people for the national goals to be achieved. While there is a steady improvement due to economic development, spread of education/ literacy and empowerment of citizens, substantial problems in regard to education/literacy particularly among the weak performing States and in regard to empowerment particularly of women, remain.

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5. The process of integration of related programmes initiated with the implementation of the CSSM Programme was taken a step further in 1994 when the International Conference on Population and Development in Cairo recommended that the participant countries should implement unified programmes for Reproductive and Child Health (RCH). The RCH approach has been defined as "People have the ability to reproduce and regulate their fertility, women are able to go through pregnancy and child birth safely, the outcome of pregnancies is successful in terms of maternal and infant survival and well being and couples are able to have sexual relations free of fear of pregnancy and of contracting diseases". This concept is in keeping with the evolution of an integrated approach to the programmes aimed at improving the health status of young women and children which has been going on in the country. It is obviously sensible that integrated RCH Programme would help in reducing the cost of inputs to some extent because overlapping of expenditure would no longer be necessary and integrated implementation would optimise outcomes at the filed level. During the 9th Plan, the RCH Programme, accordingly, integrates all the related programmes of the 8th Plan. The concept of RCH is to provide to the beneficiaries need based client centred demand driven high quality and integrated RCH services. The RRRM RCH Programme is a composite programme incorporating the inputs of the Government of India as well as funding support from external donor agencies including World Bank and the European Commission.

6. It is a legitimate right of the citizens to be able to experience sound Reproductive and Child Health and therefore the RCH Programme will seek to provide relevant services for assuring Reproductive Child Health to all citizens. However, RCH is even more relevant for obtaining the objective of stable population for

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the country. The overall objective since the beginning has been that the population of the country should be stabilized at a level consistent with the requirement of national development. It is now well established that parents keep the family size small if they are assured about the health and longevity of the children and there is no better assurance of good health and longevity of children than health care for the mothers and for young children. Therefore, RCH Programme by ensuring small families also ensures stable population in the medium and long-term though in the short-term population is controlled by use of spacing methods and terminal methods for avoiding unwanted pregnancies. Therefore the overall strategy of the Government of India (Department of Family Welfare) is to simultaneously strive for obtaining Reproductive and Child Health arrangements for the whole of the country's population and to promote and make available contraceptive/terminal methods for desirous couples. It also needs to be observed that the measures through the health system alone do not and cannot assure success in either ensuring Reproductive and Child Health or in controlling population. These objectives are determined concurrently by the following:

i) Policy support expressed publicly by opinion leaders in different sectors the national system and by the community at large. Without this kind of support, the receptivity of the people to make use of even available services cannot be ensured.

ii) Adequate resources for making available Reproductive and Child Health services to all rural and urban communities in the country.

iii) Accountability of performance among the health workers and efficiency of the health system. Without such efficiency the quality of services to citizens or even effective access to health services cannot be ensured.

iv) Literacy among women and educational status of families. Similarly improvement in economic status of families. The educated and economically well-of families can more rationally assess the options before them and acquire capability/willingness to assess consequences of their present actions for future. Therefore, the effort of the Department of Family Welfare is to collaborate with the related departments and Non-Governmental Organisations for seeking support of their Programmes for the Family Welfare Programmes. This in turn will similarly improve the outcomes of related Programmes of those Departments as well.

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The RCH Programme incorporates the components covered under the Child Survival and Safe Motherhood Programme and includes two additional components one relating to sexually transmitted diseases (STD) and other relating to reproductive tract infection (RTI). The main highlights of the RCH Programme are:

i) The Programme integrates all interventions of fertility regulation, maternal and child health with reporudctive health of both men and women.

ii) The services to be provided will be client centred demand driven, high quality and based on the needs of the community arrived at through decentralised participatory planning and the target free approach.

iii) The Programme envisages upgrading of the level of facilities for providing various interventions and quality of care The First Referral Units (FRUs) being set up at sub-district level will provide comprehensive emergency obstetric and new-born care. Similarly RCH facilities in PHCs will be substantially upgraded.

iv) The Programme will improve access of the community to various services which are commonly required. It is proposed to provide facilities for MTP at the PHCs, counselling and IUD insertion at SCs in a phased manner.

v) The Programme aims at improving the out-reach of services particularly for the vulnerable groups of population who have till now substantially been left out of the planning process e.g.

- Special Programmes will be taken up for Urban slums, tribal population and Adolescents.

- Non-Governmental Organisations will be involved in a much larger way to improve out reach and make it people's programme.

- Skills of practitioners of ISM will be upgraded by training and research and & development in ISM will be supported to improve the range of RCH services.

- Panchayati Raj System will have a greater role in planning, implementation and assessment of client satisfaction.

PROGRAMME INTERVENTIONS:

7. The RCH programme will be implemented based on differential approach. Inputs in all the Districts have not been kept uniform because efficient delivery will depend on the capability of the

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health system in the District. Therefore, basic facilities are proposed to be strengthened and streamlined specially in the weaker Districts as the better districts already have such facilities and the more sophisticated facilities are proposed the relatively advanced Districts which have acquired the capability to make use of them effective. All the Districts have been categorised into categories A (58), B (184) and C (265) on the basis of Crude Birth Rate and Female Literacy Rate which reasonably represent the RCH status of the District. The districts will be covered in a phased manner over three years. The nationally uniform and differentiated RCH interventions would be as below:

INTERVENTIONS IN ALL DISTRICTS	INVERVENTIONS IN SELECTED STATES/DISTRICTS
* Child Survival interventions (as available under CSSM Programme)	* Screening and treatment of RTI/STI
* Safe Mother hood interventions (as under CSSM programme)	* Emergency Obstetric Care at selected FRUs by providing Drugs.
* Facilitation for operationalisation of Target Free Approach	* Essential Obstetric Care by providing Drugs and DAI/Staff Nurse at PHCs
* Institutional Development	* Additional ANM at sub-centres in the selected districts for ensuring MCH care
* Integrated training package	
* Modified Management Information System	* Improved delivery services and emergency care by providing Equipment kits, IUD insertions and ANM kits at sub-centres
* IEC activities & counselling on health sexuality & gender	
* Urban & Tribal Areas RCH package	* Rental to contracted PHNs/ANMs not provided Government accommodation
* District Sub-projects under Local Capacity Enhancement	* Facility of Referral transport for pregnant women's.
* RTI/STI Clinics at District Hospitals (Where not available)	
* Facility for Safe abortions at PHCs by providing equipments, contractual Doctors etc.,	
* Enhanced community participation through Panchayats. Women's Groups and NGOs	
* Minor civil works	
* Provision for Lab.Technicians for laboratory diagnosis of RTI/STI & IEC	
* Adolescent health and reproductive hygiene	

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5. National T.B. Control Programme:

Tuberculosis is a major public health problem in India contributing 1/4th of the global burden. 12-14 million people are estimated to be sufferring from active disease of which 3 - 3.5 million are highly infectious . As per the National Survey conducted during 1955-58, by the Indian Council of Medical Research to findout the magnitude of the T.B. problem in the country, it revealed that Tuberculosis is prevalent throughout length and breadth of country equally in urban and rural areas. 2% of the population is suffering from pulmonary Tuberculosis of which 0.4% are sputum positives.

The National T.B. Control Programme was evolved in 1962 on the findings of above study and in Karnataka the programme is in operation from 1962.

Objectives:-

To reduce the Tuberculosis in the community to that level when it ceases to be a public health problem by:

i) Detection of Tuberculosis cases attending the OPD and providing effective treatment.

ii) To reduce morbidity and mortality due to TB.

iii) To break the chain of transmission in the community.

Implementation:- The Joint Director, TB is responsible for implementation of programme in the State. At the District level the District Tuberculosis Officer is responsible for implementation in the District through the network of Health and Medical Institution in the Districts. The infrastructure facilities created under this programme are as follows:

1. District T.B. Centres - 27
2. Addl.Dist.T.B. Centres- 5
3. Microscopic Centres - 805
4. X-Ray Centres - 172
5. Referring Centres - 840

The progress of National T.B. Control Programme for the years 1992-93 to 1997-98 is given in the [illegible].

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6. National Leprosy Eradication Programme:

The Leprosy Control Programme is in operation since 1955 as a centrally aided programme to achieve the control of leprosy through early detection of leprosy cases and DDS monotherapy. During the Fifth Five year plan, it was made as centrally sponsored programme. In 1980, the Government of India resolved to eradicate leprosy by 2000 AD. As per recommendation of working group report of 1982, the National Leprosy Control Programme was redesignated as National Leprosy Eradication Programme with revised strategy based on the Multidrug therapy with goal of eradicating the disease by 2000 AD.

Strategy:-

NLEP operation as a vertical programme in endemic areas and in areas with prevalence of less than 5 per 1000 population it will be provided by the general health services.

The revised strategy is based on:

1. Early detection of cases (By Population Survey, School Surveys, Contact Examination and Voluntary referral).
2. Short term Multidrug therapy.
3. Health Education and rehabilitation activities.

The WHO regrness was adopted for treatment. In Karnataka the Leprosy was evidencies in districts of Gulbarga Division, Belgaum, Dharwad and Bijapur Districts in Belgaum Division. Mysore District in Mysore Division. MDT programme was implemented in the State since 1985-86 onwards.

The infrastructure created under the programme are as follows:

State level programme Officer is the Joint Director (Leprosy)

1. S.L.O. - 1
2. S.S.A. Units - 4
3. D.L.O. - 18
4. L.C.U. - 31
5. S.E.T. - 677

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6. U.L.C. - 49
7. T.H.W. - 22
8. R.S.U. - 6
9. L.R.P.U.- 2 + 1
10. M.L.C.U.- 14
11. M.L.T.U. - 14
12. V.O.L. - 25

The revised objective is to ~~xxxx~~ eliminate the Leprosy by 2000AD by bringdown the prevalance of Leprosy to less than 1 per 10000 population by implementing the revised strategy.

The progress of the programme implementation is given in the Annexure appended.

7. National Programme for Control of Blindness (NPCB):

This programme was launched in 1976, incorporating the earlier Trachome Control Programme which was started in 1968. The National goal is to reduce the blindness in the country from 1.4% to 0.3% by 2000AD and to provide comprehensive Eye Care through Primary Health Care. The catract cases constitute 55% of the total blindness in the country. This programme activities are mainly providing services by organising Eye Camps in the Rural areas for cataract cases. Mobile Opthalmic units are providing the services in the State. All the districts are having these mobile opthalmic units. Danida is providing assistance to this programme. District Blindness Society is functioning in every District under the Chairmanship of Deputy Commissioner which is responsible for organising the services and providing material support.

The Joint Director (Opthalmology) heads the State Opthalmic Cell who is responsible for implementation of programme in the State. This is a 100% Centrally sponsored programme.

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8. Iodine Deficiency Disorders (IDD) Programme:

The Goitre Control programme was started in 1962, based on iodized salt. In Karnataka also the Districts of Chikkamagalur and Kodagu are affected more compared to other districts.

The programme is implemented all over the State. Government has banned sale of non-iodized salt.

9. National AIDS Control Programme:

It is new programme and launched by Government of India with World Bank Assistance being 100% centrally sponsored programme. The State AIDS Cell is responsible for planning, implementing and monitoring of programme activities as per guidelines of NACO. Additional Director (AIDS) is the State level programme officer in the AIDS Cell which has been established during May 1992. The AIDS Surveillance Centre was started at BMC Bangalore in 1987.

Components of the Programme:

1)Programme Management - State Aids Cell
- Empowered Committee

2)Surveilance and Clinical Management

3)Blood Safety - Blood component seperation facility
- Modernisation of Blood Banks
- Zonal Blood Testing Centres

4)STD Control Programme

5)Training Programme

6)I.E.C.

7)NGO Coordination.

Infrastructure:- In addition to State

i)Blood Banks approved for modernisation

ii)Surveillance Centres - 3

iii)Sentinal sites - 4 ANC - 8 STD

iv)Zonal Blood Testing Centres

v)STD Clinics supported - 30

vi)Blood component seperation facilities

vii)NGO Financially supported - 20

Non-financially supported - 15

HIV Infection and AIDS cases reported in Karnataka upto end of May 98.

1. Total No.of samples screened for HIV - 388586
2. No. HIV +ve confirmed - 3973
3. Sero positive rate - 10.22 per 1000 tested.
4. No.of Aids cases reported - 139
   In Karnataka - 127

Diarrhoeal Diseases Control Programme:

During the Sixth Plan, the National Diarrhoeal Diseases Programme was started to bring down the mortality due to diarrhoeal related diseases (including cholera) through promotion of Oral Rehydration Therapy. This programme was intensified during Seventh Plan to reduce the mortality due to diarrhoea by 50% by the year 2000. This programme is integrated with Primary Health Care at village level to District Hospital level. O.R.S. pockets are supplied to subcentres and Village Health Guides. Another important component is Health Education and Health Education materials title "Home Treatment of Diarrhoea" in Local/Regional Language is supplied to PHCs for free distribution.

STD Control Programme:

In 1949 the programme was started as a pilot project for control of venereal diseases. In 1955, the planning commission recommended for establishment of one VD Clinic in every District Hospital and one Headquarter Clinic and Laboratory in every State.

The programme was started in 1957 by settingup of a Central V.D. Organisation in the Directorate General of Health Services for implementing and Co-ordination of programme in the country. Injection Pencillin (PAM) and VDRL Antigen were supplied free to VD clinics. The Government of India discontinued the free supply of drugs to States during 1981-82

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and strategy was focussed on training, teaching and research in the various aspects of S.T.D. Training Centres established are as follows:

1) Institute for study of V.D. Madras, Medical College.
2) STD Training and Demonstration Centre, Safdarjang Hospital, New Delhi and other two centres for remaining areas are at Calcutta & other at Nagpur.

With appearance of AIDS, the problem has changed its dimension. Stress has been given for STD control in the AIDS Control Programme as a component. In Karnataka 30 STD Clinics are functioning. Rupees One lakh drugs are supplied to each for free treatment of S.T.D. cases.

Guinea-Worm Eradication Programme:

The Government of India launched the Guineaworm Eradication Programme in 1983-84 during Sixth Five year Plan after recognising it as a public health problem. This is centrally sponsored programme (50 : 50:). In Independant Appraisal of the programme was made in 1985. As on January 1986, Six States were endemic affecting 7114 villages, in 481 PHCs and 66 Districts in the country. The Tamilnadu State vigorously implemented the programme before National Programme began and no indigeneous cases since 1981.

Programme components/Strategy:-

1) Providing of drinking water sources on priority basis.
2) Vector Control with application of Abate (Temphos) giving concentration of 1mg per litre (IPPM)
3) Health Education including Personal prophylaxis ie., Boiling of drinking Water , Sieving of unprotected water.
4) Supply of Nylon mesh filters.
5) Active Surveillance of cash twice yearly.

This programme is implemented by the Primary Health Care staff. The goal is to eradicate the disease in all affected areas. The programme input was only one cell at Directorate in CMD section to monitor the implimentation and evaluate the activities. The searches were carriedout twice yearly

usually in December and June every year. In Karnataka the Districts of Gulbarga Division Bijapur, Dharwad were affected. Due to implementation of above programme there are no indigeneous cases in these area since last three years. Actions are taken for preparing the areas for WHO Certification. The Award of Rs.100/- to the informer and Rs.500/- for case for treatment purpose. The suspected reported should be investigated reported by PHC Medical Officer and documented for the verification team.

Minimum Needs Programme:

It was introduced in Fifth Five Year Plan. This programme aims for improving the living standards of the people by providing certain basic minimum needs. This is commitment of Government for the Social and Economic Development of people, particularly for under privileged and under served population.

Components:-

1)Rural Health
2)Rural Water Supply
3)Rural Electrification
4)Elementary education
5)Adult Education
6)Nutrition
7)Environmental improvement of slums
8)Houses for landless labourers.

Rural Health: As per objectives of Seventh Five year plan to establish, one PHC for every 30000 population in plain and 20000 population in tribal and hilly areas; one subcentre for every 5000 population in plain areas and 3000 population in tribal and hilly areas and one community health centre for every 1 lakh population by the year 2000AD.

Accordingly the State Government has been establishing the Subcentres, PHCs and CHCs in the State.

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National Diabetic Control Programme:

Objectives:-

1) Identification of high risk subjects at an early stage and imparting appropriate Health education.
2) Early diagnosis and management of cases
3) Prevention, arrest, slowing of acute metabolic as well as chronic cardiovascular complications of diabetics.

The Programme functions at three levels.
1) Subcentre, (2) PHCs and (3) District Hospital.

Government of Karnataka has sanctioned this scheme to Hassan and Dakshina Kannada Districts. Training has been given to Medical and Paramedical staff and Mannuals of the programme is translated in Kannada and printed and supplied to all institutions. The equipments and materials are provided.

Cancer Control Programme:

Government of India has financed the Kidwai Memorial Institute of oncology to takeup the Cancer Control Programme in the State for taking activities.

1) District Cancer Control Programme:

The District Cancer Control Programme is sanctioned to Dharwad and Chikkamagalur Districts in the Eighth Five year plan. The activities carried (1) Survey of cancer cases, diagnosed and treated (2) Health education activities. The programme is sanctioned for five years.

2) Peripheral Cancer Centres:

Peripheral Cancer Centres are sanctioned and established at District Hospital, Gulbarga and Mandya and entirely managed by the Kidwai Memorial Institute of Oncology, Bangalore where diagnostic and treatment facilities are provided.

NATIONAL LEPROSY ERADICATION PROGRAMME

Sl.No.	Year	Cases on hand
1.	1993-94	24542
2.	1994-95	21067
3.	1995-96	18615
4.	1996-97	17766
5.	1997-98	12019

NATIONAL TUBERCULOSIS CONTROL PROGRAMME

Sl.No	Year	Case detected
1.	1993-94	67790
2.	1994-95	76819
3.	1995-96	83244
4.	1996-97	81785
5.	1997-98	79984

DIRECTORATE OF HEALTH AND FAMILY WELFARE SERVICES, BANGALORE

C.M.D. Section

INCIDENCE OF COMMUNICABLE DISEASES in Karnataka State from 1986 to 1997

GASTRO-ENTERITIS		CHOLERA		VIRAL HEPATITIS		TYPHOID		JAPANESE ENCEPHALITIS		K.F.D.		GUINEA WORM		PLAGUE		DENGUE FEVER		LEPTOSPIROSIS	
A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D	A	D
9376	370	1212	59	354	9	-	-	635	185	780	14	2754	-	-	-	-	-	-	-
9845	508	1918	87	945	8	-	-	132	43	228	10	2405	-	-	-	-	-	-	-
14085	645	2263	72	190	8	-	-	81	27	312	6	1909	-	-	-	-	-	-	-
9918	418	767	26	209	10	-	-	49	18	1550	22	896	-	-	-	-	-	-	-
8565	391	448	15	1829	28	-	-	130	43	1309	31	634	-	-	-	-	-	-	-
17465	601	747	15	659	17	-	-	308	114	967	16	226	-	-	-	-	-	-	-
15262	608	402	14	282	17	-	-	58	15	1183	5	167	-	-	-	-	-	-	-
36206	855	424	13	786	7	26047	1	287	67	699	3	29	-	-	-	-	-	-	-
15932	325	304	10	639	3	20349	-	125	47	110	-	10	-	399	51	-	-	-	-
18645	396	532	8	714	1	10250	-	329	102	174	3	-	-	-	-	72	-	-	-
22983	377	657	6	1332	6	22221	12	127	17	140	3	-	-	-	-	93	3	-	-
23665	306	741	10	1714	4	3880	5	407	85	75	4	-	-	-	-	-	-	67	2

EPIDEMIOLOGICAL DATA OF MALARIA, FILARIA, JAPANESE ENCEPHALITIS AND DENGUE FEVER, IN MADHUBANI FROM 1987 to 1998.

MALARIA				FILARIA			J.E.				DENGUE	
Blood Smears Collected & Examined	Malaria cases	P.F. cases	Radical Treatment	Blood Smears Collected & Examined	MF cases detected	MF rate	Suspected A	Suspected B	Confirmed A	Confirmed B	Attacks	Deaths
63,92,165	88,505	29,580	82,948	85,928	2852	3.3%						
68,54,873	1,27,008	37,667	1,17,808	92,247	3077	3.3%						
67,07,559	1,06,260	29,659	1,01,212	1,01,313	2441	2.4%						
66,01,484	74,012	23,209	70,055	97,197	2205	2.2%						
66,45,523	44,565	10,135	43,450	1,02,457	1359	1.3%						
69,28,592	81,057	16,826	63,200	1,19,816	1620	1.3%						
70,38,519	1,96,466	49,246	1,90,644	1,37,606	1520	1.2%	287	67	-	-	375	0
71,20,397	2,66,679	57,789	2,57,558	1,36,823	980	0.7%	125	47	-	-	212	0
71,11,388	2,85,350	39,301	2,79,535	1,22,484	364	0.3%	329	102	13	-	198	0
76,81,302	2,29,198	32,606	2,16,227	1,35,469	1073	0.8%	127	17	44	-	195	5
76,23,013	1,81,450	46,326	1,80,976	2,08,327	1344	0.6%	407	85	32	2	262	1
27,33,364	22,659	5,572	20,960	32,264	355	1.0	20	2	1	-	24	1

- Provisional

CONDUCTION OF TRAINING PROGRAMME AT PHC & SC.

The quality of health care services is directly related to the competencies of the health functionaries in providing these services. their service competencies need to be augmented by Training, to join in the main flow of health services and also to update their knowledge and skill for favourable attitude a nd motivation to perfprm their jobs in an efficient and effective ma nner. So training is essential and vital. It helps in orientation, updating the knowledge and motivating them to become more positive, constructive and productive.

Even after joining the service they are not in touch with acedemic activities. So there are serious ga ps in the knowledge, skills and practices of the health personnels specially in regards to family planning, maternal and child health, nutrition, immunization, control of communicable diseases, environmental sanitation, vital statistics and health education. This has made an urgent need for training of all categories of health personnels now and then during their service.

Training -Give instructions or information or practice to make persons more knowledged and ~~skilled~~ skilled, and it is always reciprocal.

Programme - plan of inteded proceeding

- list of planned events.

(Greek: programma = public notice)

Programme is always a planned one.

Primary Health Centre - place from where the Primary Health Care is provided to the community.

Before Alma-Ata Conference the Primary Health Care means - basic health services

- first contact care

-easily accessible care

- generally provided services.

After Alma-Ata Conference the Primary Health Care means-"Essential health care made universally accessible to all individuals and acceptable to them, through their full participation and at a cost that the community and the country can afford."

Before conduction of training the following points are to be considered in detail as preperation.

I. Category of trainees

- T.B.A.
- V.H.G.
- AWW.
- Medical or Paramedical health personnel.
- M.S.S. members.
- Social workers.
- Link workers.
- School teachers.
- N.G.O.s
- Panchayat raj - members.

II. Objectivesof training

- Update their knowledge, skills & practice.
- Aware of their job responsibilities.
- Regular recording and reporting.
- Prepare them as trainers to community.

III. Types of training - induction / in-service or -yearly / - seasonally / - random

IV. Place of training - Primary Health Centre
- Sub-centre
- Community centre

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There should be feedback,

through- impressions & suggestions
- at the time of tea, lunch
- at the end of training

on- coarse contents
- teaching method
- handouts
- OHP / slide projector
- suggestions to improve.

VI. Curriculum once finalised, should be distributed to teaching faculty and guest speakers well in advance and request to give summery and important handouts to be distributed to the trainees.

VII. All the participants, guest lecturers and field staff where you are giving field training, should be identified, preferabl local or within taluka

Participants and guest lecturers must be informed well in time preferably 4-6 weeks in advance. It should not be too early, so that by the time the training dates approaching it should not be forgotten.

VIII. Training meterials

- Black board & chalk pieces & duster
- Charts & tables
- Diagrams
- VCP with casettes
- O.H.P.
- Slide projector
- Epidiascope
- Demonstration meterials - B.P.apparatus/stethoscope
  - Thermometer
  - Gloves
  - Autoclaver / Pressure cooker
  - Scissor / Blade
  - Delivery kits

V. Curriculum - based on category and contents, should be prepared before training

- Cover all the topics mentioned in the contents of the training.
- Each topic (for example-immunization)
  - what are the facts-important (schedule, cold chain, reactions)
  - how much details should trainee needs (hepatitis vaccine-details etc.)
  - standard of performance.

and also - certain things -must
- useful
- nice

Make sure that the trainees are learning, but not just hearing. For this keep in mind

-Clearity- simple language, community based

-Veriety- makes learning interesting

-Participation - practical demonstration
- hands on practice

(Chinese proverb " if I hear I forget
I see I remember
I do I understand "

So training should be through,

- lectures.
- practical demonstration.
- hands on practice.
- role play, songs.
- group discussion.
- games, problem solving, case study.
- field demonstration.

~~There should be feedback.~~

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IX. Budget.

- T.A. & D.A.
- Contingency
- Guest lecturers/ Speaker's remuneration
- POL

The teamleader(M.O.)may have the diplomacy to mobilise resources

After having prepared all these you are ready to start the training programme. Now it is not possible to remember every thing by the co-odinator of the programme. So it is always better to have the check-list.

Check-list - Arrangements - classroom
- hospital
- field
- Faculty according to timetable - P.H.C.
- Guest speakers
- Training meterials
- Vehicle in good condition with driver & fuel.
- Field staff.

Problems: a)Managerial - accomodation
- food
- faculty members
- Office work
- Copying & distribution of back-ground meterials
- Finance

b)Technical - electricity
- demonstration of instruments
- vehicle

c)Field - acceptability by the community leaders speciall women leaders & family heads at the time of field training.

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