Health Care by Multipurpose Workers at Subcentre Level

Research in District Health Administration Rohtak

(W.H.O./Unicef Assisted Research Project)

BRIEF RESUME OF WORK DONE BY
THE RESEARCH PROJECT
IN BOTH THE PHASES

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INTRODUCTION

1.0 In the overall organisational set-up of the health services in India, the District Health Administration with its responsibility for efficient and effective implementation of both curative and preventive programmes is an important area for careful study to identify those factors that can be modified for the maximumisation of resources particularly with reference to limited material inputs which have neither increased in proportion to demand for service in recent years nor are likely to reduce the gap in the foreseeable future.

1.1 Due to the paucity of material resources, it has been felt that in order to rationalise the health Administration, within the given constraints an experimental approach based on actual feed back from the field may alone give an answer to efficient, effective and optimal functioning of the health administration at the main system and its sub-system within the resources already available. It is almost certain that so long such an approach is not adopted it is difficult to expect any improvement in the existing system. However, since independence, considerable re-organisation and expansion have been undertaken to ascertain whether the existing methodology of delivery of health care is adequate to achieve the objectives of the programme and proper integration of the services. In the absence of such a tested methodology, the validity or practical feasibility of the decisions taken; to determine the organisational structure, the adequacy of staff and funds, the skill required for specific activities, the job description; the work load and the coverage of population etc., remains subjective since these sensitive issues have been decided on hypothetical estimations rather than on objective analysis and actual feed back form of the field situations.

OBJECTIVES OF STUDY

2.0 Against the background stated above, the techno-financial assistance of the WHO and UNICEF enable the NIHAE to undertake a Research Project on the study of District Health Administration in the year 1970 with following objectives :-

(a) To make a comprehensive study of health services at the District level.

(b) To assure most effective and efficient use of resources.

(c) To assure integration of preventive and medical care activities.

(d) To assist in orientation of the above mentioned personnel vis-a-vis (b) and (c).

2.1 From this, it was intended to evolve a methodology for research in the organisation of health services at the district level which could be applied throughout India by the relevant authorities and to formulate recommendations concerning the optimal organisation for district health services.

STUDY PLAN AND RESEARCH METHODOLOGY

3.0 In order to achieve the objectives, referred to above, the research design of the study envisages to conduct the research in two phases. The comprehensive survey of the district health administrations is an answer to the first objective of the study and forms phase-I of the Research Project. This phase has been planned as a diagnostic or descriptive study. The remaining objectives are required to be relevant in phase-II which has been planned basically as a manipulative or experimental study.

3.1 Besides sampling procedure, the phase-I study has been conducted by way of interviews and continuous observations of the personnel working in the organisation of the district health administration. In addition data has been collected from the records maintained at the different levels.

WORK DONE IN PHASE I

4.0 A comprehensive diagnostic study on the working of district health administration with particular reference to (a) Organisation and Administration (b) Utilisation of Manpower and Material Resources and (c) Working of Health Programmes has already been completed in Rohtak district of Haryana State towards the end of 1971. Likewise, a similar kind of rapid study has also been conducted in Patiala District of Punjab in the month of February, 1972. The findings of both the studies have been written in the form of a report and some of the important findings emerging out of the studies are summarised below :

FINDINGS OF PHASE I

5.1 Organisation and Administration

5.1.0 The planning of the programmes is initiated and finalised at the State level on the basis of the past performance and not on anticipations or projections. The district and lower levels have no discretion in determining the policies and the scope of activities.

5.1.1 The organisation of the district health services is designed for integration of curative and preventive services. However, the programmes are still running vertical. Due to vertical organisation of the programmes and uni-purpose working of the peripheral field workers, the meaningful or desired amount of integrations has not been achieved. The Programme Officers of the district as a supervisor, maintain their separate entity and the Medical Officers of the periphery are not playing the role of a co-ordinator or integrator.

5.1.2 Directions and instructions from the State Directorate or the district are non-specific and are not supported by the explanations of on the spot elucidation, guidance or supervision.

5.1.3 The staff working at periphery has not been supplied with a copy of written job description or detailed instructions as how to plan and arrange their daily work.

5.1.4 No systematic orientation for a new entrant to the service is organised. The inservice orientation is planned irregularly.

5.1.5 Coordination at the district level is confined mainly to family planning work. Communication among the programme officers assisting the Chief Medical Officer is unstructured and erratic.

5.1.6 There is not enough decentralisation of administrative and financial powers from the state level to the main system, even for the matters of routine nature. At the district level, all administrative and financial powers are vested with the Chief Medical Officer, resulting in an unnecessary delay in programme operation at the peripheral institutions. This is also resulting in ineffective control by the Programme Officers and the Medical Officers of P.H.Os. over their staff.

5.1.7 The complaints of political interferences are common at all the levels.

5.1.8 Supervision at different level is superficial, unplanned and scanty. The supervisory officers, irrespective of their status or category, pay a casual visit to the field staff just to fulfil the official requirement of the specified number of tours required to be performed by them.

5.1.9 Maintenance of records is poor due to improper designing of some of the records of inadequate understanding thereof by the works. Separate records for each service given are maintained by the workers due to vertical organisation of the programmes. Periodical reports and returns are not scrutinised and evaluated except in the case of family planning achievements. The data on morbidity and vital events are not dependable due to defective recording.

5.2 Utilisation of manpower and Material Resources

5.2.0 The manpower and material resources deployed in achieving the objectives of the programmes, under implementation, are either not properly utilised towards

the given goals in some cases or are under-utilised in other cases due to defective methodology (i.e. single-purpose) of delivery of health care particularly at periphery. The Programme Officers of the district are spending only 52% of their available time in activities and the remaining percentage is utilised in travelling, unoccupied, absent from duty and personal work. At the P. H. C. level, @ the engagement of the staff in actual work relating to job is nearly 33% of the avaliable time and the remaining percentage is utilised in travelling (i.e. only those having itinerant job) and being unoccupied.

@ The table, given below, shows the general trend of time utilisation of some of the officers and other categories working at the main-system and its sub system.

S. No.	Category of Personnel	Percentage break-up of available time		
		Time spent in activities	Time spent in travelling	Time spent otherwise.
A.	**Main System***			
1.	Chief Medical Officer	64.85	18.84	16.31
2.	District F. P. & MCH Officer	48.67	21.86	29.47
3.	District Malaria Officer	42.19	29.71	28.10
B.	**Sub-System****			
1.	Medical Officer	37.53	2.75	59.72
2.	Block Extension Educator	26.30	17.80	55.90
3.	Lady Health Visitor	42.42	21.77	35.81
4.	Health Inspector	41.37	30.00	27.73
5.	Sanitary Inspector	16.77	23.16	60.07
6.	F. P. Field Worker	21.40	18.28	60.32
7.	Basic Health Worker	42.82	12.44	44.74
8.	Auxiliary Nurse Midwife	45.83	13.35	40.82
9.	Vaccinator	20.73	18.02	61.25

* Note :—Observational study on Deputy Chief Medical Officer (Health) could not be conducted because of his non-availability. As regards Deputy Chief Medical Officer (Medical), he being a stationary officer observational study was not considered necessary in his case.

** Note :—Some other categories of personnel like T. B. Multipurpose worker, laboratory technician, dispenser, computor and clerk have not been covered by way of work analysis but have been covered by work sampling.

5.2.1 Some of the factors responsible for inadequate utilisation of manpower as shown above are : (a) Non-availability of job description with functionaries, (b) Lack of orientation to the job and inadequate understanding of the objectives and purpose of the activities, (c) Inadequate supervision and guidance in planning of domiciliary rounds and arrangement of tasks, (d) Lack of discipline, (e) Insufficient motivation and apathy for work, (f) Shortage of equipment and medicines in the case of field workers, (g) Boredom with the monotonous repetition of the activities, (h) absence of encouragement and appreciation, (i) Lack of amenities and social life in the peripheral institutions.

5.2.2 In respect of material resources, the indenting of medicines and equipments at the periphery is not rational. This is not centrally standardised or regulated resulting in shortage at some places and surplus at other units. The instruments and appliances supplied to the PHCs are not put to sufficient use. The physical verification of the stores is seldom done either by the district officers or by the Medical officers of the PHCs. The vehicles provided to the PHCs have been used considerably for transporting cases of sterilisation but have been used very little for the purposes of field supervision of the peripheral field works. Most of the Civil Hospitals are not rendering the role of referral hospitals.

5.3 Working of Health Programmes

5.3.0 The family planning programme has assumed over-whelming importance on the other programmes. As a result, the other programmes have either been neglected or given less attention than what was due in the perspective of an integrated health programme.

5.3.1 **Medical Care :** The facility is available within the vicinity of the PHC or other health institutions falling within the block area. No medical care is available through the sub-centres. Consequently, the benefit is available to a small population and to a limited number of villages in which also the quality is not of a reasonable standard. By and large, the community is depending more on private practitioners of different systems of medicines.

5.3.2 **Malaria Eradication :** The active surveillance appears to be adequate in view of the fulfilment of prescribed targets. However, the number of positive cases is more than the permissible limit for an area to be under maintenance phase. This reflects on the quality of surveillance done. The radical treatment in most of the cases is usually completed within the prescribed time but the focal sprays are generally delayed for want of squad, transport and D.D.T./B.H.C. etc. Passive surveillance is very poor.

5.3.3 **Small-pox Eradication :** The accent is only on primary vaccination and even here the coverage is not assessed against the actual births because the vaccinator is not directly collecting this information. The primary vaccination is given only to those new borns who are recorded in the register of the village-chowkidar. Consequently, a sizeable number of the children between the age group of 1 to 10 years are unprotected in each area. The majority of adults are not re-vaccinated.

5.3.4 **Maternal and Child Health :** This programme has been over-shadowed by the Family Planning Programmes. There is no actual target laid for the coverage. As a result little is achieved under ante-natal care or confinement care. Post-natal and infant care are almost omitted.

5.3.5 **Family Planning :** There is a constant drive to get more and more cases for sterilisation. The survey of the populatian required to be done by the field workers is not up-to-date. As a result there is no way to know, at any point of time, how many couples are under the purview of a single worker and how many of them have adopted family planning. No efforts are made for periodic follow-up of the IUCD cases. With the result, it is not possible to know how many women are still retaining the IUCD. The expelled cases are mostly not recorded. Contraceptives are distributed arbitrarily and indiscriminately without ascertaining whether the recipients are making use of them or not.

5.3.6 **T. B. Control :** T. B. control has been organised only at a very low key and is availed by only those who came to PHC. There is no system of active case-finding. Treatment is possible only in about 50% of the cases held.

5.3.7 **Environmental Sanitation :** Disinfectant of wells and persuation of the people to remove rubbish heaps are the only two activities seen to be done by the Sanitary Inspectors who are the field functionaries for this programme. The chlorination of wells is done crudely and arbitrarily without proper dosing at unspecified periodicity.

5.3.8 **School Health Programme :** The working of this programme is limited to the extent of running a general out-patient clinic for the school children at the district headquarters. No other activities as envisaged under the programme are undertaken by the authorities responsible for this programme.

5.3.9 **Vital Statistics :** The department has no well organised system to collect birth and death information. At the peripheral level, recording of birth and death is the duty assigned to the Basic Health Worker and Auxiliary Nurse Midwife who as a matter of fact give no attention towards this work.

CONCLUSIONS OF PHASE - I STUDY

6.0 The study findings have established it beyond doubts that there is ample scope for reorganisation of the activities in the main system and its sub-system which can help in better utilisation of the resources already available. It has been realised that the effectiveness and efficiency of the main system cannot be assured without introducing procedural changes at the Directorate level at the first instance. However, such changes are beyond the assumptions of the study as the manipulations are required to be introduced within the existing framework of the organisation and administrative procedure. Nevertheless, it has been observed that at the peripheral level a more effective and efficient method of delivery of health care can be assured by introducing changes in the daily routine of activities. Employment of the staff for single purpose programmes has resulted in dissipation of energy in an unmanageable area of population while at the same time giving a chance for the workers to rush through their work and get unoccupied for a major part of the day. Undue stress on Family Planning and targets also gives an excuse to the workers to deviate from a fixed schedule and move about aimlessly. In the light of such findings, it appears that by regrouping the activities of the programmes and by re-distribution of the duties at the peripheral level it should be possible to achieve a better coverage and improved quality of health care. This kind of manipulations or interventions are the theme of Phase II of the Research Project.

PREPARATION FOR PHASE - II

7.0 The initial thinking and responses from Health Authorities of the States of Haryana and Punjab encourages the research team of the Project to plan for Phase-II study in two districts (i.e. Rohtak and Patiala) of these States. However, the subsequent events and the reservations expressed by the Health Authorities of the concerned States reduced the operational area for Phase-II of the Research Project from two districts to a peripheral rural healt unit (i.e. P. H. C. Kiloi of Rohtak district) of a State. The technical preparations for Phase II, undertaken from April, 1972 onwards could not be put into actual practice till September, 1972 even in an area of a P. H. C. because of various considerations of both human and material resources.

THEME OF CHANGES IN PHASE - II

8.0 The main theme of the changes is an integration of the activities to provide an integrated health care programme at the peripheral level through the para medical workers (i.e. both male and female of peripheral and middle level). Broadly, the manipulations introduced are :—

i) To change the delivery of health care from vertical to horizontal functioning at the P.H.C. level and to ensure equal importance to all the health programmes.

ii) To convert the single purpose peripheral field worker and middle level supervisor into an integrated health care worker* with the designations of community health worker and health supervisor, respectively. This would mean that the existing categories of peripheral field workers (i.e. Basic Health worker, Family Planning Field Worker, Vaccinator and Auxiliary Nurse Midwife) will form together a group of workers and will be designated as Community Health Worker. Likewise, the functionaries working at middle level (i.e. Block Extension Educator, Health Inspector, Sanitary Inspector and Lady Health Visitor) would become supervisor of integrated health care over four to five peripheral field workers and would be designated as Health Supervisor.

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* The term multipurpose worker has purposely been avoided because of its vagueness and confusion of terminology. No doubt functioning is, by and large multipurpose but to avoid any confusion the term community health worker has been used.

iii) To delimit the area of operation of the field workers within the radius of three to four kilometers or one to three villages (as the case may be) depending upon the population which must fall within the range of four to six thousands in case of male worker and three to four thousands in the case of female worker.

iv) To ensure the delivery of integrated health care by the peripheral field workers, for the area to be put under their respective charge. They will be attending to all the health programmes in that area. This would mean a new job description for them.

v) To reduce their travel time and to ensure effective utilisation of their working hours.

vi) To simplify recording system and procedure of reporting.

vii) To introduce a programme of minor ailment in the domiciliary visits.

viii) To strengthen the Maternal and Child Health Care Services by providing direct and referral services.

ix) To ensure proper utilization of each category of workers by deploying them in the concerned programme or by assigning additional duties relevant to their qualification, experience and working.

x) To bring about changes in the supervisory techniques by :—

a) Guidance, explanatory instructions and inservice training.

b) Helping in making day to day programme.

c) Demonstration of procedures and techniques.

d) Attending to the problems referred by the worker.

xi) To ensure systematic and regular visits of Medical Officers and Lady Health Visitor/Staff Nurse to the Sub-centres, so that the community may know when to avail the doctor's service through the sub-centres. Likewise, to introduce a similar schedule of work for the middle level supervisors.

xii) To involve the other Rural Health Institutions, such as, Rural Dispensaries, Government Ayurvedic Dispensaries and Civil Dispensaries etc., in the framework of the Primary Health Centre.

xiii) To introduce a proper referral service from field to sub-centre to P.H.C. and P.H.C. to Civil Hospital/Medical College Hospital.

xiv) To evolve a regular system of collecting vital statistics (i.e. birth and death).

xv) To introduce a programme of immunization (i.e. D. P. T., Polio and B. C. G.).

PLAN OF WORK FOR PHASE - II

9.0 In order to implement the proposed strategy, referred to above, the activities of peripheral workers, middle level functionaries and Medical Officers have been regrouped, a systematic schedule of work has been introduced at all the three levels, a meaningful and simplified recording and reporting system have been devised and above all a proper orientation to all the categories involved in the experimentation has been given.

9.1 **Job Description :** A new set of job description for the health functionaries working at the sub-system level has been prepared with an accent on integration of activities or services (Refer Appendix-I).

9.2 **Work Schedule :** Systematic schedules for planning the works at different levels have been introduced so as to ensure a wider coverage of the health care at the required number of intervals (Refer Appendix II to V B for tour programmes).

9.3 **Records and Equipment :** The simplified redesigned records have been introduced with a view to get more dependable and up-to-date information at one place regarding the programmes under implementation. All the Community Health Workers, depending upon their requirements, have been supplied following records :—

a) Village Health Register (Specimen copy at Appendix-VI)
b) Malaria Form in register form (Specimen copy at Appendix-VII)
c) Ante-natal Register—only for female worker (Specimen copy at Appendix VIII)
d) Referral Slips (Specimen copy at Appendix IX)

9 3.0 Besides this, all the C.H.Ws. have been supplied a kit bag in order to carry the required equipments and records for the domiciliary visits. Additional contents of the kit bag are as follows :—

a) Malaria kit-box b) Vaccination kit c) Forceps
d) Towel e) Soap with case f) Brush
g) Plastic container for carrying medicines.

9.3.1 The personnal working at the different levels of the experimental area are submitting the progress report of the services undertaken by them. The proforma for reporting the progress of the work are given at Appendix X and XI.

9.4 **Orientation Training :** As a preparatory work for Phase-II, an orientation training of a week's duration has been given separately to each existing category of the workers for their conversion from unipurpose to integrated health care workers. The curriculum of training broadly covered : (a) Concept of new working methodology, (b) Objectives of the programmes to be enforced, (c) Techniques of undertaking activities under different programmes, (d) Revised job description (i.e. of both the categories viz. Health Supervisor and CHWs), (e) Guidelines to job description, (f) Techniques of supportive supervision, (g) Objective of new recording and reporting system, (h) Maintenance of records, (i) Preparation of daily progress report and (j) Field demonstrations on the points enumerated above.

9.5 **Programmes Undertaken for Implementation :** Based on the analysis of Phase-I findings, the programmes selected for implementation in Phase-II are as follows :—

1. Small Pox
2. Malaria
3. M. C. H.
4. Family Planning
5. Medical Care
   a) Ambulatory
   b) Institutional
   c) Domiciliary
6. Notifiable Diseases
7. Vital statistics
8. Immunization (i.e. D.P.T., Palio and B.C.G.)

9.5.0 Some of the other programmes such as Environmental Sanitation, Health Education, School Health Scheme and Natrition have not been included under the revised methodology. This omission is purposive as it is seen in Phase-I that no attention, whatsover, is given to such programmes.

9.6 **Preliminary Work :** Befor commencing the actual work of proposed strategy for Phase-II, the baseline data in respect of the experimental area has been collected. For this purpose, all the villages/hamlets of the area have undergone the following steps :—

a) Numbering each house in the village.

JOB DESCRIPTION FOR THE PRIMARY HEALTH CENTRE STAFF

A. PERIPHERAL FIELD WORKERS

a) HEALTH WORKER (Male)

The Community Health Worker will be the male paramedical worker at the periphery to provide a basic level of domiciliary health cares. The existing categories of Basic Health Workers, Family Planning Field Workers and Vaccinators will together form the group of Communitty Health Workers. These workers will be responsible to Medical Officer Incharge of Rural Dispensaries and Officers incharge of Govt. Ayurvedic Dispensaries.

Each male Community Health Worker will look after a population ranging between 4,000 to 6,000. He will visit 60 to 80 houses per day and each house will be visited once a fortnight. His daily beat programme will be worked out by taking the media of the following factors :—

a) Population to be covered
b) Number of houses to be visited
c) Distance to be travelled

Duties :

1. Small-Pox Eradication

a) Primary vaccination
b) Re-vaccination
c) Check the Primary Vaccination done during the last visit and repeat, if necessary.

2. Recording of Birth and Deaths

3. Malaria Eradication

a) Detection of fever cases
b) Preparation of blood slides
c) Giving the presumptive treatment
d) Taking follow-up slides of the positive cases.

4. Medical Care

a) Detection of cases of minor ailments and giving them treatment as per guidelines.
b) Referring difficult cases to the middle level Supervisors or sub-centre or Primary Health Centre according to feasibility.

5. Family Planning & MCH

a) Contact eligible couples and motivate them to accept F.P. methods.

b) Distribute contraceptives.

c) Notify to Middle Level Supervisors the cases that have been motivated for sterilization. At least motivated cases should be referred to each worker in a month.

d) Advise the ante-natal mothers to go to Sub-Centre; to report about any problem cases or emergencies to the ANM/LHV.

6. Notifiable Disease Control

a) Report cases of any notifiable diseases to the middle level supervisors or to the main centre without any delay.

b) HEALTH WORKER FEMALE (i.e. ANM)

Population : Each Auxiliary Nurse Midwife will look after a population between 3,000 to 4,000 adjacent to the Primary Health Centre or Sub-centre where she is posted. She will provide basic level health care in the community. She will be responsible to Medical Officer Incharge of the P.H.C. through the Lady Health Visitor. She will visit 30 to 40 houses per day and each house will be visited once a fortnight.

Duties :

1. Small-Pox Eradication

a) Primary vaccination

b) Re-vaccination

c) Check primary vaccination done during the last visit and repeat, if necessary.

2. Recording of Birth and Deaths

3. Malaria Eradication

a) Detection of fever cases

b) Preparation of blood slides

c) Giving the presumptive treatment

d) Taking follow-up slides of the positive cases.

4. Medical Care

a) Conduct an out-patient clinic for an hour on each working day in the afternoon and give treatment for minor ailments to all age groups irrespective of sex.

b) Assist the Medical Officer and L. H. V. on the day of their sub-centre visit in examining the patients.

c) Refer emergencies and difficult cases to the P. H. C. or hospitals according to feasibility.

5. MCH and Family Planning

a) Registration of pregnancies

b) Rendering periodical ante-natal, post-natal care as per guidelines

c) Attending confinements when called upon, directly or by dais.

d) Guide the local dais.

e) Rendering infant and toddler care.

f) Advise the ante-natal mothers for sub-centre attendance and showing them to LHV or MO according to the convenience.

g) Contact eligible couples and motivate them to accept F.P. methods

h) Distribute contraceptives

i) Notify to middle level supervisors the cases that have been motivated for sterilization. Each ANM should refer at least two motivated cases each month.

6. Notifiable Disease Control

Report the cases of any notifiable disease to the middle level supervisors or to the main centre without any delay.

7. Middle level Supervisors

The existing categories of Lady Health Visitor, Health Inspector, Sanitary Inspector and Block Extension Educator will form a group of Health Supervisors.

c) HEALTH SUPERVISOR (Female i.e. L.H.V./Staff Nurse)

The role of the Lady Health Visitor/Staff Nurse will be mainly supervisory. In addition, she will render some services in the community in support of the activities of the Auxiliary Nurse Midwife. All the Auxiliary Nurse Midwives of the Primary Health Centre will be under her direct supervision. Her monthly programme will be chalked out in such a way as to allow her to conduct a clinic once a week at the main centre and twice a month in all the sub-centres.

Duties :

1. In Clinic

1. Examination of ante-natal mother at least twice during the course of pregnancy (2nd and 3rd trimesters) and ensuring examination by the Medical Officer as early as possible.
2. Screening the cases according to ante-natal risks and advice and refer, if necessary.
3. Immunization of ante-natal mothers with tetanus toxoid.
4. Examination of infants and children referred by the ANMs and to take further steps, as necessary.
5. Immunization of infants with D.P.T./Polio.
6. Examination of other cases (Gynaecological, post-natal etc.) referred by ANMs and give necessary treatment or refer to Medical Officer.
7. Selection of cases of IUCD and insertion of IUCD.
8. Motivation of refusal cases in support of the ANMs work.

2. By way of Supervision of the A.N.Ms.

1. Check complete registration of ante-natal mothers, infants and children.
2. Guide the ANMs in the performance of their duties and maintenance of records and give demonstration of the procedures.
3. Arrange periodical supply of medicines, contraceptives, equipments required by the ANMs.
4. Collect blood slides taken by the ANMs to reach the PHC Laboratory.

5. Home visiting for selected cases either referred by the ANMs or to check her work.
6. Arrange for service to the motivated cases of F.P. for sterilization etc. and follow-up.

3. **Dais Training at Primary Health Centre.**

d) HEALTH SUPERVISORS (Male)

Each Health Supervisor (Male) will have to supervise the work of 4 to 5 Community Health Workers. He will be supervising the work of each C.H.W. twice a week. He will ensure consecutive and concurrent supervision over each worker.

Duties :

I Supervision

1. Check the visits, records, number of blood slides taken and quality of blood smear and confirm the presumptive treatment given by the CHWs.
2. Ensure complete coverage of primary vaccination in the area and re-vaccination at required interval.
3. Check Birth/Death records maintained by the CHWs.
4. Guide the CHWs in the performance of their duties.
5. Arrange service to the motivated cases of F.P. ready to under-go sterilization and follow-up.
6. Attend to any problem case referred by the CHWs and give it treatment or refer according to the feasibility.

II Supportive Service

1. Make regular supply of medicines, slides and contraceptives and other equipments to the CHW.
2. Undertake radical treatment measures.
3. Arrange the timely despatch of the blood slides collected by the CHWs.
4. Attend the refusal cases of the primary vaccination and blood slides and ensure action to this effect.
5. Take necessary steps when notifiable diseases are reported.
6. Arrange for improvements of wells and chlorination, installation of smokeless chullahs, installation of latrines pest destruction of stray dogs with the assistance of any auxiliary male staff available for the purpose.

There is a provision of three Medical Officers in each P.H.C., the senior most being the incharge. The remaining two will assist the Medical Officer Incharge in efficient and effective functioning of the P.H.C. The Medical Officers have three areas of work—clinical, administrative and supervisory. Their programmes will be so arranged in such a way that one Medical Officer is available at the Primary Health Centre on each day to conduct the out-patient clinics and to attend the indoor patients and emergencies. The other medical officer will either conduct a clinic at sub-centres or supervise the work of the peripheral workers.

In the case of Lady Medical Officer she will be incharge of the clinics at sub-centres and will supervise and support the services of the LHV/Staff Nurse, ANMs and other female staff.

The male Medical Officer (Incharge or other) will supervise the work of the CHWs and Health Supervisors and deal with administrative matters concerning all the staff of the PHC.

a) Duties of Medical Officer (Incharge)

I Clinical

1. Organising and conducting the out-patients clinics at PHC
2. Organisation of the indoor service
3. Attending emergency cases
4. Attending medico-legal cases
5. Organising the laboratory service at the PHC
6. Referring cases to hospital

II Administrative

1. Guide and check the preparation of tour programmes of field staff
2. All matters relating to management of personnel
3. Reporting the progress of activities under all programmes to the Chief Medical Officer
4. Liaison with other officials and agencies in the block
5. All matters relating to indents, receipts and maintenance of supplies

III Supervisory

1. Check and guide male workers in the field as well as in the main centres.
2. Attend to problem cases referred by field staff and arrange for appropriate services.

b) Duties of IInd Medical Officer (Male)

a) Clinical

1. Organising and conducting the out-patient clinics at PHC
2. Organisation of the indoor service
3. Attending emergency cases
4. Attending medico-legal cases
5. Organising the laboratory service at the PHC
6. Referring cases to hospital

b) Administrative

All work as and when assigned by Medical Officer Incharge.

c) Supervisory

1. Check and guide the male workers in the field as well as in the main centres.
2. Attend to problem cases referred by field staff and arrange for appropriate services.

c) Duties of the Lady Medical Officer

a) Clinical

1. Organise and conduct out-patient clinics at PHC
2. Organisation of indoor service
3. Attending medico-legal cases
4. Referring cases to hospital
5. Attending emergencies

6. Conducting clinics at sub-centres and seeing referred cases and arranging for their treatment.

b) Administrative

1. Guide and check the preparation of your programmes of the female staff.
2. Reporting the progress of activities under all programmes of the female staff to the Medical Officer Incharge.

c) Supervisory

1. Check and guide the ANMs and LHVs in the performance of their duties and maintenance of records.
2. Provide appropriate service to cases referred in the field by the peripheral staff.

Note—In case the services of the Lady Medical Officer are not available, the work of supervising female staff will be decided by the Medical Officer (Incharge).

ANNEXURE III

LIST OF DRUGS TO BE SUPPLIED TO THE A.N.M's.

For Internal Use

1. Tab. Sulphadimidine/Thiazole
2. Tab. Aspirin or A.P.C.
3. Tab. Sulphaguanidine
4. Tab. Sodamint
5. Tab. Unispasmin
6. Tab. Laxative
7. Tab. Vitamin A. and D.
8. Tab. Calcium Lactate
9. Tab. Multivitamin
10. Tab. Vitamin B. Complex
11. Tab. Vitamin C.
12. Tab. Ferrous Sulphate
13. Syrup Ferriphosphate
14. Mist. Alkline
15. Mist. Carminative
16. Mist. Sedative Expectorant
17. Mist. Stimulant
18. Mist. Bismuth Kaolin
19. Mist. Ferriet Ammonium Citrates

For External Use

1. Whitfield's Ointment
2. Calamine Lotion O.I.P.
3. Savlon
4. Eye Drops
5. Eye Ointment
6. Ear Drops
7. Dusting Powder
8. Throat Paint
9. Gentian Violet
10. 10% D.D.T. Powder
11. Tab. Bensoinco
12. Gauze
13. Bandage
14. Cotton
15. Aeroflavene
16. Vaseline
17. Benzyl Benzoate

EQUIPMENT FOR A.N.M's.—For general use

1. Clinical Thermometer
2. Swab Sticks
3. Spatula
4. Tape Measure
5. Weighing Machine
6. Pair of Scissors
7. Pair of Dissecting Forceps
8. Pair of Artery Forceps
9. Bowls for Lotions, Dressing etc.

Ante-natal Care

1. Urine Analysis-Kit
2. Haemoglobin estimation-kit
3. Foetuscope
4. Pelvimeter

Delivery Kit.

APPENDIX IV

MONTHLY FIXED TOUR PROGRAMME OF THE HEALTH SUPERVISOR FEMALE (LHV/STAFF NURSE)

Days of a week	Weeks of a Month			
	1st week	2nd week	3rd week	4th week
Monday	ANM's HQ	S.C.-V	ANM HQ	S.C.-V
Tuesday	S.C.-I	S.C.-VI	S.C.-I	S.C.-VI
Wednesday	S.C.-II	Open Day	S.C.-II	Open Day
Thursday	S.C.-III	S.C.-VII	S.C.-III	S.C.-VII
Friday	Ante-natal Clinic Day H.Q.	Ante-natal Clinic Day H.Q.	Ante-natal Clinic Day H.Q.	Ante-natal Clinic Day H.Q.
Saturday	S.C.-IV	S.C.-VIII	S.C.-IV	S.C.-VIII

Note—Open day is meant for surprise visit or any other work which is required to be done.

APPENDIX VA

MONTHLY TOUR PROGRAMME OF THE MEDICAL OFFICER (INCHARGE) OF P.H.C.

Days of a week	Weeks of a month			
	1st week	2nd week	3rd week	4th week
Monday	P.H.C. Clinical & Administrative work	Open Day	PHC Clinical & Administrative work	H.S.-II
Tuesday	S.C.-VI	S.C.-I	S.C.-VI	S.C.-I
Wednesday	PHC-Clinical & Administrative work	PHC-Clinical & Administrative work	PHC-Clinical & Administrative work	PHC-Clinical & Administrative work
Thursday	S.C.-VII	S.C.-III	S.C.-VII	S.C.-III
Friday	PHC-Clinical & Administrative work	H.S.-I	Open Day	PHC-Clinical & Administrative work
Saturday	PHC-Clinical & Administrative work	PHC-Clinical & Administrative work	PHC-Clinical & Administrative work	PHC-Clinical & Administrative work

Note—Open day is meant for surprise visit or any other work which is required to be done.

S.C.=Sub-centre.

APPENDIX VB

MONTHLY TOUR PROGRAMME OF THE 2nd MEDICAL OFFICER OF PHC

Days of a Week	Weeks of a month			
	1st week	2nd week	3rd week	4th week
Monday	S.C.-V	PHC-Clinical work	S.C.-V	PHC-Clinical work
Tuesday	PHC-Clinical work	PHC-Clinical work	PHC-Clinical work	PHC-Clinical work
Wedensday	H.S.-III	S.C.-II	H.S.-IV	S.C.-II
Thursday	PHC-Clinical work	PHC-Clinical work	PHC-Clinical work	PHC-Clinical work
Friday	Open day	PHC-Clinical wrker	PHC-Clinical work	Open day
Saturday	S.C.-VIII	S.C.-IV	S.C.-VIII	S.C.-IV

Note—Open day is meant for surprise visit or any other work which is required to be done.

APPENDIX IX

Serial No..... Date.....

Surveillance No..... Village.....

Name of Person..... Sex.....Age.....

Natvre of Case	Referred :	Medical Care/FP (Motivated) MCH-Antenatal/complicated labour case/Postnatal/Infant Notifiable disease.
	Refusal :	Blood slide/Primary Vaccination/ Revaccination/F.P. (Hostile)

(Strike out what is not Applicable)

Complaint.....

Service already given.....

Signature of Worker

Referred/PHC/SC/Hospital

APPENDIX X

FORTNIGHTLY PROGRESS REPORT FOR THE MONTH OF.....19

1. Name of Worker		5. H.Q. of Worker
2. Sector/Section No.	3. Name of P.H.C.	6. Name of Supervisor

I. **Dates of Visits**

II. **Name of Village**
(Write vertically)

III. **Houses Visited**
Form S.
To

IV. **Locked Houses**

V. **Birth/Death Regd.**
1. No. of births
2. No. of death
   a) Infant
   b) Maternal
   c) Other

VI. **Small-Pox**
1. P.V. done
2. R.V. done
3. P.V. refused

VII. **Notifiable Disease**
Cases notified

VIII. **Medical Care**
1. Patient treated
   (H. V.)
   (S. C.)
2. Patient referred
   (S. C.)
   * (others)
   *PHC/CH/Medical College,

IX. **Fever Surveillance**

1. Fever cases detected
2. Slides taken
3. Tablets given
4. Refusal cases
5. Follow-up slides collected

X. **Family Planning**

1. E. C. Contacted
2. C. C. Distributed
3. Motivated Cases referred to Supervisor

Dates of Visits

XI. **Mother and Child Health**

A. 1. Antenatal visits
   a) 1st visit
   b) Revisit
   2. Postnatal visits
   3 Infant visits

B. Centre Attendance
   1. Antenatal
   2. Infant

C. Confinements conducted

D. Risk cases referred to PHC/CH/Medical College

XII. **Tests**

1. Urine
2. Haemoglobin

XIII. **T. B. Control**

Slides prepared

Remarks (if any)

(Signature of Supervisor) (Signature of Worker)