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***Indian Public Health Standard (IPHS)  
Community Health Centres Level***

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***Draft Guidelines***

***Directorate General of Health Services  
Ministry of Health and Family Welfare  
Government of India***

# Index

<b>Executive Summary</b>	<b>2</b>
<b>Introduction</b>	<b>4</b>
<b>Requirements in CHC</b>	<b>8</b>
<b>Quality Assurance in Service Delivery</b>	<b>15</b>
<b>Checklist.</b>	<b>18</b>
<b>Annexures</b>	<b>20</b>

## List of Annexures:

1. Revised National Tuberculosis Control programme
2. National AIDS Control programme
3. National Vector-borne Disease Control programme
4. National Leprosy Eradication Programme
5. National Blindness Control programme
6. Integrated Disease Surveillance Project
7. Referral Transport Model
8. List of Equipment in CHC
9. List of Drugs in CHC
10. GOI Guidelines for Blood Storage
11. GOI Guidelines for Waste Management
12. Charter of Patients' Rights.
13. Composition of Task Group III and Consultation Process

## **Executive Summary**

The Community Health Centres (CHCs) which constitute the secondary level of health care were designed to provide referral as well as specialist health care to the rural population. These centres are however fulfilling the tasks entrusted to them only to a limited extent. The launch of the National Rural Health Mission (NRHM) gives us the opportunity to have a fresh look at their functioning.

**In order to provide *Quality Care in these CHCs* Indian Public Health Standards (IPHS) are being prescribed** to provide optimal expert care to the community and achieve and maintain an acceptable standard of quality of care. These standards would help monitor and improve the functioning of the CHCs.

### **Service Delivery:**

- All “Assured Services” as envisaged in the CHC should be available, which includes routine and emergency care in Surgery, Medicine, Obstetrics and Gynaecology and Paediatrics in addition to all the National Health programmes.
- Appropriate Guidelines for each National Programme for management of routine and emergency cases are being provided to the CHC.
- All the support services to fulfil the above objectives will be strengthened at the CHC level.

### **Minimum requirement for delivery of the above-mentioned services:**

The following requirements are being projected based on an average bed occupancy of 60%. It would be a dynamic process in the sense that if the utilisation goes up, the standards would be further upgraded. As regards manpower, 2 specialists namely **Anaesthetist and Public Health programme Manager will be provided on contractual basis in** addition to the available specialists namely Surgery Medicine, Obstetrics and Gynaecology and Paediatrics.

The support manpower will include a Public health Nurse and ANM in addition to the existing staff. An Ophthalmic Assistant will also be need to be provided in centres where currently there is none.

**Facilities:**

The equipment provided under the CSSM is deemed adequate. Physical Infrastructure will be remodelled or rearranged to make best possible use for optimal utilisation. New constructions will follow the specifications provided in this document.

Drugs will be as per the list provided with the document. All the support services like laboratory, blood storage etc. will be strengthened.

**Human Resource Management:**

Capacity Building will be ensured at all levels by periodic training of all cadres.

**Accountability:**

It is mandatory for every CHC to have “Rogi Kalyan Samiti” to ensure accountability.

Every CHC shall have the Charter of Patients’ Rights displayed prominently at the entrance. A grievance mechanism under the overall supervision of Rogi Kalyan Samitis would also be set up.

**Quality of services:**

Every CHC shall also have the Standard Operating Procedures and Standard Treatment Protocols for common ailments and the National Health Programmes.

Social audit by involvement of the community through Consumer Forum and Rogi Kalyan Samitis is being recommended. To maintain quality of services, external monitoring through Panchayati Raj Institutions and internal monitoring at appropriate intervals will be advocated. Guidelines are being provided for management of routine and emergency cases under the National Health Programmes so as to maintain uniformity in management in tune with the National Policy.

## **Indian Public Health Standard for CHC**

### **Introduction**

Health care delivery in India has been envisaged at three levels namely primary, secondary and tertiary. The secondary level of health care essentially includes Community Health Centres(CHCs), constituting the First Referral Units(FRUs) and the district hospitals. The CHCs were designed to provide referral health care for cases from the primary level and for cases in need of specialist care approaching the centre directly. 4 PHCs are included under each CHC thus catering to approximately 80,000 population in tribal / hilly areas and 1, 20,000 population in plain areas. CHC is a 30-bedded hospital providing specialist care in medicine, Obstetrics and Gynaecology, Surgery and Paediatrics. These centres are however fulfilling the tasks entrusted to them only to a limited extent. The launch of the National Rural Health Mission (NRHM) gives us the opportunity to have a fresh look at their functioning.

NRHM envisages bringing up the CHC services to the level of Indian Public Health Standards. Although there are already existing standards as prescribed by the Bureau of Indian Standards for 30-bedded hospital, these are at present not achievable as they are very resource-intensive. Under the NRHM, the Accredited Social Health Activist (ASHA) is being envisaged in each village to promote the health activities. With ASHA in place, there is bound to be a groundswell of demands for health services and the system needs to be geared to face the challenge. Not only does the system require upgradation to handle higher patient load, but emphasis also needs to be given to quality aspects to increase the level of patient satisfaction. In order to ensure quality of services, the Indian Public Health Standards are being set up for CHCs so as to provide a yardstick to measure the services being provided there. This document provides the requirements for a Minimum Functional Grade of a Community Health Centre.

**Objectives of Indian Public Health Standards (IPHS) for CHCs:**

- To provide optimal expert care to the community
- To achieve and maintain an acceptable standard of quality of care
- To make the services more responsive and sensitive to the needs of the community.

### **Service delivery in CHCs:**

Every CHC has to provide the following services which can be known as the *Assured Services*:

- Care of routine and emergency cases in surgery:
  - This includes Incision and drainage, and surgery for Hernia, hydrocele, Appendicitis, haemorrhoids, fistula, etc.
  - Handling of emergencies like intestinal obstruction, haemorrhage, etc.
- Care of routine and emergency cases in medicine:
  - Specific mention is being made of handling of all emergencies in relation to the National Health Programmes as per guidelines like Dengue Haemorrhagic fever, cerebral malaria, etc. Appropriate guidelines are already available under each programme, which should be compiled in a single manual.
- 24-hour delivery services including normal and assisted deliveries
- Essential and Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions
- Full range of family planning services including Laproscopic Services
- Safe Abortion Services
- New-born Care
- Routine and Emergency Care of sick children
- Other management including nasal packing, tracheostomy, foreign body removal etc.

- All the National Health Programmes (NHP) should be delivered through the CHCs. Integration with the existing programmes like blindness control, Integrated Disease Surveillance Project, is vital to provide comprehensive services. The requirements for the important NHPs are being annexed as separate guidelines with the document.
  - RNTCP: CHCs are expected to provide diagnostic services through the microscopy centres which are already established in the CHCs and treatment services as per the Technical Guidelines and Operational guidelines for Tuberculosis Control.(Annexure 1)
  - HIV/AIDS Control programme: The expected services at the CHC level are being provided with this document which may be suitably implemented.(Annexure 2)
  - National Vector –Borne Disease Control Programme: The CHCs are to provide diagnostic and treatment facilities for routine and complicated cases of malaria, filaria, dengue, Japanese encephalitis and Kala-azar in the respective endemic zones. (Annexure 3)
  - National Leprosy Eradication Programme: The minimum services that are to be available at the CHCs are for diagnosis and treatment of cases and reactions of leprosy along with advice to patient on Prevention of Deformity. (Annexure 4)
  - National Programme for Control of Blindness: The eye care services that should be available at the CHC are diagnosis and treatment of common eye diseases, refraction services and surgical services including cataract by IOL implantation at selected CHCs optionally. 1 eye surgeon is being envisaged for every 5 lakh population. (Annexure 5)
  - Under Integrated Disease Surveillance Project, the related services include services for diagnosis for malaria, Tuberculosis, typhoid and tests for detection of faecal contamination of water and chlorination level. CHC will function as peripheral surveillance unit and collate, analyse and report information to District Surveillance Unit. In outbreak situations, appropriate action will be initiated.(Annexure 6)
- Others:
  - Blood Storage Facility

- Essential Laboratory Services
- Referral (transport) Services: (details given in Annexure 7)



**Minimum requirement for delivery of the above-mentioned services:**

The following requirements are being projected based on the assumption that there will be average bed occupancy of 60%. The strength may be further increased if the occupancy increases with subsequent up gradation.

**Clinical Manpower:**

Personnel	Minimum requirement	Proposed	Desirable qualifications	Justification
General Surgeon	1	1	MS/DNB, (General Surgery)	
Physician	1	1	MD/DNB, (General Medicine)	
Obstetrician/ Gynaecologist	1	1	MD/DNB/DGO (OBG)	
Paediatrics	1	1	MD/DNB/DCh (Paediatrics)	
Anaesthetist	-	1	MD/DNB/DA(Anesthesia)/ Certificate course in Anaesthesia for one year	Essential if there is to be utilization of the surgical specialities. They may be on contractual appointment or hiring of services from private sectors on case-to case basis.
Public Health Programme Manager. He/she will be also designated as Block Surveillance Officer.	-	1	MD/DNB/ DPH/ Social science with public health background/ any other recognized course	Will be responsible for surveillance, coordination of NHPs, management of ASHAs, Training, etc. The appointment will be on contractual basis.
Eye surgeon	-	1	MD/MS/DOMS/DNB/(Ophthal)	For every 5 lakh population as per Vision 2020 approved Plan of Action.
<b>Total</b>	<b>4</b>	<b>6/7</b>		

Certain suggestions for offsetting the deficiencies in the availability of required manpower:

- Anaesthetists:
  - Diploma and MD seats for post graduation in Anesthesia to be increased across the country. However care should be taken to only include institutions with assured quality and able to provide adequate clinical training.
  - Certificate course for one year in Anesthesia by the National Board of Examinations
- Public Health Programme Manager:
  - Diploma and MD seats for post graduation in Public Health to be increased across the country. However care should be taken to only include institutions with assured quality and able to provide adequate field and community-based training.
  - Persons with DNB degrees in Family Medicine, Hospital Administration, Public Health, Maternal and Child health are to be recognized for the post.
  - Persons who have completed the Professional Development Course of 3 months with a 9-month field training in recognized training institute may also be eligible for the same. This may also be seen as a career advancement avenue for Medical Officers serving in PHCs who may be eligible for the post after a stint of 3-4 years in PHC and completion of this course.

### Support manpower:

Personnel	Existing
*Nurse-midwife	7+2
Dresser (certified by Red Cross/ St.Johns Ambulance)	1
Pharmacist/compounder	1
Lab. Technician	1
Radiographer	1
**Ophthalmic Assistant	0-1
Ward boys/ nursing orderly	2
Sweepers	3
Chowkidar	5***
OPD attendant	
Statistical Assistant/Data entry operator	
OT attendant	
Registration clerk	
<b>Total Essential</b>	<b>21/22+2</b>

\*1 ANM and 1 PHN for family welfare will be appointed under the ASHA scheme

\*\* Ophthalmic assistant may be placed wherever it does not exist through redeployment or contract basis.

\*\*\* Flexibility may rest with the state for recruitment of personnel as per needs.

### Equipment:

- The list of equipment provided under the CSSM may be referred to as they are deemed to be adequate for providing all services in the CHC. (Annexure 8). Before ordering new sets, the existing equipment should be properly assessed.
- For ophthalmic equipment wherever the services are available and equipment required under various National Health programmes are given in respective annexure(1,2, 4, 5, 6), and Blood storage Facilities(Annexure-10). Cold chain equipment are supplied under Immunization Programme..
- Maintenance of equipment: It is estimated that 10-15% of the annual budget is necessary for maintenance.
- 2 Refrigerators, one for the ward and one for OT should be available in the CHC. Sharing of Refrigerator with the lab should be possible.
- Appropriate standards for equipments are already available in the Bureau of Indian Standards. If standards for any equipment are not available, technical

specifications for the equipment may be prepared by the technical committee for the process of tendering and procurement.

### **Drugs:**

The list of essential drugs and emergency drugs are provided as annexure 9.

Programme specific drugs are detailed in the Guidelines under each programme.

### **Investigative facilities at the CHC:**

- In addition to the lab facilities in the CHC, ECG should be made available in the CHC with appropriate training to a nursing staff.
- All necessary reagents, glass ware and facilities for collecting and transport of samples should be made available.

### **Physical Infrastructure:**

The CHC should have 30 indoor beds with one Operation theatre, labour room, X-ray facility and laboratory facility. In order to provide these facilities, following are the guidelines:

- **Location of the centre:** To the extent possible, the centre should be located at the centre of the block head quarter in order to improve access to the patients. This may be applicable only to centres that are to be newly established.  
***However, priority is to be given to operationalise the existing CHCs.***

### **The building should have areas/ space marked for the following:**

- Entrance zone:
  - Prominent display boards in local language providing information regarding the services available and the timings of the institute
  - Registration counters
  - Pharmacy for drug dispensing and storage
  - Clean Public utilities separate for males and females
  - Suggestion/ complaint boxes for the patients/ visitors and also information regarding the person responsible for redressal of complaints.
- Outpatient department:
  - Clinics for Various Medical Disciplines – These clinics include general medicine, general surgery, dental (optional), obstetric and gynaecology, paediatrics and family welfare. Separate cubicles for general medicine and

surgery with separate area for internal examination (privacy) can be provided if there are no separate rooms for each. The cubicles for consultation and examination in all clinics should provide for doctor's table, chair, patient's stool, follower's seat, wash basin, examination couch and equipment for examination.

- Room shall have, for the admission of light and air, one or more apertures, such as windows and fan lights, opening directly to the external air or into an open verandah. The windows should be in two opposite walls
  - Family Welfare Clinic – The clinic should provide educative, preventive, diagnostic and curative facilities for maternal, child health, school health and health education. Importance of health education is being increasingly recognized as an effective tool of preventive treatment. People visiting hospital should be informed of environmental hygiene, clean habits, need for taking preventive measures against epidemics, family planning, etc. Treatment room in this clinic should act as operating room for IUCD insertion and investigation, etc. It should be in close proximity to Obst. & Gynae. OPD.
  - Waiting room for patients
  - The Drug Dispensary should be located in an area conveniently accessible from all clinics. The dispensary and compounding room should have two dispensing windows, compounding counters and shelves. The pattern of arranging the counters and shelves shall depend on the size of the room. The medicines which require cold storage and blood required for operations and emergencies should be kept in refrigerators.
  - Emergency Room/ Casualty The emergency cases may be attended by OPD during OPD hours and in inpatient units afterwards.
- Treatment Room:
    - Minor OT
    - Injection Room and Dressing Room
  - Wards: Separate for males and females

- Nursing Station– The nursing station shall be centered such that it serves all the clinics from that place. The nursing station should be spacious enough to accommodate a medicine chest / a work counter for preparing dressings, medicines, sinks, dressing tables with screen in between and pedal operated bins to hold soiled material. It should have provision for:
  - Injections,
  - Dressings,
  - Examination and dressing table,
  - Bins for waste material,
  - Wash basins,
  - Syringe destroyer
  - Needle cutter.
  
- Patient Area:
  - Enough space between beds.
  - Toilets; separate for males and females.
  - Separate space/ room for patients needing isolation
- Ancillary rooms:
  - Nurses rest room
- There should be an area separating OPD and Indoor facility.
  
- Operation theatre/ Labour room:
  - Patient area:
    - Pre-operative and Post-operative(recovery)room
  - Staff area:
    - Changing room separate for males and females
  - Storage area for sterile supplies
  - OT/ Labour room area:
    - Operating room/ labour room
    - Scrub area
    - Instrument sterilization area
    - Disposal area

- Public utilities: Separate for males and females
  
- Physical infrastructure for Support services:
  - CSSD:
    - Sterilization and Sterile storage
  - Laundry:
    - Storage: separate for Dirty linen and clean linen
    - Outsourcing is recommended after appropriate training of washer man regarding separate treatment for infected and non-infected linen.
    - Services: Electricity/ telephones/ water/ civil engineering: May be outsourced. Maintenance of proper sanitation in Toilets and other Public utilities should be given utmost attention. Sufficient funding for this purpose must be kept and the services may be outsourced.
      - Water Supply – Arrangements shall be made to supply 10,000 litres of potable water per day to meet all the requirements (including laundry) except fire fighting. Storage capacity for 2 days requirements should be on the basis of the above consumption. Round the clock water supply shall be made available to all wards and departments of the hospital. Separate reserve emergency overhead tank shall be provided for operation theatre. Necessary water storage overhead tanks with pumping/boosting arrangement shall be made. The laying and distribution of the water supply system shall be according to the provisions of IS: 2065-1983\*. Cold and hot water supply piping should be run in concealed form embedded into wall with full precautions to avoid any seepage. Geyser in O.T. / L.R. and one in ward also should be provided. Wherever feasible solar installations should be promoted.

- Emergency lighting – Emergency portable/fixed light units should also be provided in the wards and departments to serve as alternative source of light in case of power failure. Generator back-up should be available in all facilities. Generator should be of good capacity. Use of solar energy wherever feasible may be used.
- Telephone: minimum two direct lines with intercom facility should be available.
- Administrative zone: Separate rooms should be available for
  - Office:
  - Stores

### **Capacity building:**

- Training of all cadres of worker at periodic intervals is an essential component.
- Multi-skill training for paramedical workers

### **Quality Assurance in Service delivery:**

- Quality of service should be maintained at all levels.

Standard treatment protocol for all national programmes and locally common diseases should be made available at all CHCs. **Standard Treatment protocol:** is the “Heart” of quality and cost of care. All the efforts that are being made to improve “hardware i.e. infrastructure” and “software i.e. human resources” are necessary but NOT sufficient. These need to be guided by Standard Treatment Protocols. Some of the states have already prepared these guidelines.

- Diet: Diet may either be outsourced or adequate space for cooking should be provided in a separate space.
- CSSD:
  - Adequate space and standard procedures for sterilization and sterile storage should be available.
- Laundry:
  - Storage: separate for Dirty linen and clean linen



- Outsourcing is recommended after appropriate training of washerman regarding separate treatment for infected and non-infected linen.
- Services: Electricity/ telephones/ water/ civil engineering: may be outsourced.
- **Blood Storage Units:** The GOI guidelines as given in Annexure may be referred to. (Annexure 10)
- Waste disposal: As per National guidelines on hospital waste management as applicable to 30 bed CHCs (Annexure 11) or may be outsourced to agencies trained in this.
  
- **Charter of Patient Rights:** It is mandatory for every CHC to have the Charter of Patient Rights prominently displayed at the entrance.  
Details are provided in the Annexure 12.
- **Quality Control:**
  - Internal monitoring:
    - Social Audit: through **Rogi Kalyan Samitis/ Panchayati Raj Institution, etc**
    - Medical audit
    - Others like technical audit, economic audit, disaster preparedness audit, etc.
    - Patient care: This shall include:
      - Access to patients
      - Registration and admission procedures
      - Examination
      - Information exchange
      - Treatment
      - Other facilities: waiting, toilets, drinking water
      - Indoor patients:
        - Linen/ beds
        - Staying facilities for relatives
        - Diet and drinking water
        - Toilets

- External Monitoring:
  - Gradation by PRI(Zilla Parishad)/ Rogi Kalyan Samitis
  
- Monitoring of laboratory:
  - Internal Quality Assessment scheme
  - External Quality Assessment scheme

### **Record maintenance**

Computers are to be used for accurate record maintenance.

- Suggested innovations:
  - Water harvesting should be introduced in all new buildings
  - Computerisation is a must and would be essential for record maintenance and surveillance.
  - To maintain the hospital landscaping, a room to store garden implements; seeds, etc, should be provided.

Based on the above minimum requirements, the standards need to be developed by a professional body.

**Checklist for minimum requirement of CHCs**

<b>Services</b>	<b>Existing</b>	<b>Remarks</b>
<b>Population covered</b>		
<b>Specialist services available</b>		
<b>Medicine</b>		
<b>Surgery</b>		
<b>OBG</b>		
<b>Paediatrics</b>		
<b>NHPs</b>		
<b>Emergency services</b>		
<b>Laboratory</b>		
<b>Blood Storage</b>		

<b>Infrastructure (As per specifications)</b>	<b>Existing</b>	<b>Remarks</b>
<b>Area of the Building</b>		
<b>OPD rooms/cubicles</b>		
<b>Waiting room for patients</b>		
<b>No. of beds: Male</b>		
<b>No. of beds: Female</b>		
<b>Operation theatre</b>		
<b>Labour room</b>		
<b>Laboratory</b>		
<b>X-ray Room</b>		
<b>Blood Storage</b>		
<b>Pharmacy</b>		
<b>Water supply</b>		
<b>Electricity</b>		
<b>Garden</b>		
<b>Transport facilities</b>		

### Checklist for Equipment

Equipment (As per list)	Available	Functional	Remarks

### Checklist for Drugs:

Drugs (As per Essential Drug list)	Available	Remarks

### Checklist for Audit:

Particulars	Available	Whether functional as per norms
Patient's charter		
Rogi Kalyan Samiti		
Internal monitoring		
External Monitoring		
Availability of SOPs/STPs*		

\*Standard Operating Procedures/ Standard Treatment Protocols

## Annexure 1

### **Requirements with regard to Revised National TB Control Programme for Indian Public Health Standards at CHC Level.**

#### **Diagnostic services**

- A Microscopy Centre (MC) is established for 1, 00,000 population. For hilly, tribal and difficult areas MC is established for 50,000 populations. The Microscopy Centres are established at PHC, CHC or District Hospital.
- Inputs
  - i. RNTCP has provided inputs to upgrade the infrastructure through minor civil works of the existing laboratories to be able to come up to the minimum standard required to carry out sputum microscopy. At present, about 87% of the country is covered under RNTCP and it is envisaged to cover the entire country by June 2005.
  - ii. Manpower: existing Laboratory Technicians (LTs) are provided training and they function as LTs to carry out sputum microscopy. For up to 20% of the requirements of the LTs at designated Microscopy Centres at the District level, LTs are provided by RNTCP on contractual basis.
  - iii. Equipment: Binocular Microscopes are provided to the Microscopy Centres for sputum microscopy.
  - iv. Laboratory Consumables: Funds are provided to the District TB Control Societies for procurement and supply of all the consumables required to carry out sputum microscopy. The list of laboratory consumables required at MC is enclosed at Annexure-I

#### **Treatment Services**

1. Medical Officers: all Medical Officers are trained in RNTCP to suspect chest symptomatics, refer them for sputum microscopy and be able to categorise the patients and handle side effects of anti TB drugs.
2. DOTS Centres: All sub-centres, PHCs, CHCs and District Hospitals work as DOTS Centres. In addition, the community DOTS providers are also trained to deliver DOT. A room of the CHC is used to function as DOTS centre. Facilities for seating and making available drinking water to the patients for consumption of drugs are provided under the Programme.

3. DOTS Providers: the Multi Purpose Workers (MPWs), Pharmacists and Staff Nurses are trained in to monitor consumption of anti TB drugs by the patients.
4. All the DOTS providers to deliver treatment as per treatment guidelines. All the doctors to categories patients as per treatment guidelines (refer Technical Guidelines).
5. Drugs in patient wise boxes and loose drugs are provided at DOT Centres through District TB Centre (DTC). Details of the drugs given at Annexure-II.
6. Recording and reporting to be done as per Operational Guidelines (refer Operational Guidelines).

### **Treatment of complicated cases**

1. For patients who require admission (Pleural Effusion, Emphysema etc.) drugs are provided in the form of prolongation pouches through District TB Centre for indoor treatment.
2. The common complications of TB can be treated by the Medical Officers/ Specialists at CHC and side effects of drugs can also be handled by the doctors at CHC.

### **Quality Assurance**

1. Diagnosis: The diagnostic services are supervised by Senior TB Laboratory Supervisor (STLS) for all the Microscopy Centres at the sub-district level (5, 00,000 population or 2, 50,000 population in the hilly, difficult and tribal areas).
2. Treatment: All major drugs procured at the Centre through World Bank recommended procedures and provided to the States, thereby assuring quality of the drugs.

**LIST OF ANTI-TB DRUGS PROCURED UNDER NATIONAL TB CONTROL PROGRAMME**

Sl.No	Product Code Number	Product Description	Strength
1.	Product Code-1 Treatment box for Cat-I patient	Treatment box for Cat.I patient. Each treatment box containing 24 combi-packs of Schedule-I in one pouch and 18 multi-blister calendar combi-pack of Schedule-2 in another pouch	Each combi-pack of Schedule-I containing 1 R Cap.of 450mg 2 II Tabs. of 300mg each 2 E Tabs of 600mg each 2 Z Tabs. of 750mg each Each multi-blister calender combi-pack of Schedule-2 containing 3 R Caps.of 450 mg each 6 H Tabs. of 300mg each 4 Pyrioxine Tabs of 5mg each
2.	Product Code-2 Treatment box for Cat-II patient	Treatment box for Cat.II patient. Each treatment box containing 36 combi-packs of Schedule-I in one pouch and 22 multi-blister calendar combi-pack of Schedule-3 in another pouch	Each combi-pack of Schedule-I containing 1 R Cap.of 450mg 2 II Tabs. of 300mg each 2 E Tabs of 600mg each 2 Z Tabs. of 750mg each Each multi-blister calender combi-pack of Schedule-3 containing 3 R Caps.of 450 mg each 6 H Tabs. of 300mg each 6 E Tabs of 600mg each 4 Pyrioxine Tabs of 5mg each
3.	Product Code-3 Treatment box for Cat-III patient	Treatment box for Cat.III patient. Each treatment box containing 24 combi-packs of Schedule-4 in one pouch and 18 multi-blister calendar combi-pack of Schedule-2 in another pouch	Each combi-pack of Schedule-4 containing 1 R Cap.of 450mg 2 H Tabs. of 300mg each 2 Z Tabs. of 750mg each Each multi-blister calender combi-pack of Schedule-2 containing 3 R Caps.of 450 mg each 6 H Tabs. of 300mg each 4 Pyrioxine Tabs of 5mg each
4.	Product Code-4 Treatment box for prolongation of Intensive Phase of	Treatment box for Prolongation of Intensive Phase of Cat.I & Cat.II patient. Each box containing	Each combi-pack of Schedule-I containing 1 R Cap.of 450mg 2 H Tabs. of 300mg each 2 E Tabs of 600mg each

	Cat-I & Cat. II	5 pouches and each pouch containing 12 blister combi-pack of Schedule-1	2 Z Tabs. of 750mg each
Sl.No	Product Code Number	Product Description	Strength
5.	Product Code-5	Loose Packs of Streptomycin Vials	Each vial of 750mg
6.	Product Code-6	Blister strips pack containing	10 Rifampicin Capsule of 150mg each
7.	Product Code-7	Blister strips pack containing	10 INH Tablet of 100mg
8.	Product Code-8	Blister strips pack containing	10 Pyrazinamide Tablets of 500mg
9.	Product Code-10	Blister strips pack or Foil Packs containing	10 E Tabs of 800mg each
10.	Product Code-11	Blister strips pack containing	10 H Tabs of 300mg each
11.	Product Code-12	Blister strips pack containing	10 Rifampicin Capsules of 450 mg each

R= Rifampicin; H= Isoniazid; E= Ethambutol; Z= Pyrazinamide; S.M= Inj. Streptomycin.



**Annexure 2**  
**HIV Guidelines**

At present the preventive and care interventions for the control of HIV/AIDS are being provided below district level through Integrated Health Care System using the available staff. There is also a provision of training of health care providers and generating awareness through intensive IEC campaign. The programme is being further strengthened by converging the activities under NACP with RCH programme, which is underway. The following activities are being proposed to be integrated at CHC level.

S. No	Activities	Proposed
1.	RTI/STD Management services	Expansion of services up to CHC & 24 hours PHC. Basic screening test for RTI?STD to be made available at the CHCs
2.	VCTC & youth information centres	Expansion of services up to CHCs in all States.
3.	Prevention of Parent to Child Transmission(PPTCT)	Services to be provided at all CHCs
4.	Behaviour change communication(BCC)	Joint communication strategy messages & medium development to be done
5.	Condom Promotion	Joint condom procurement & Distribution of Condoms to meet the needs of sexually active women and men as a method of dual protection
6.	Blood Safety	Blood storage centres planned at FRUs will

		procure blood from licensed Blood Banks but will be supported by RCH
7.	Trainings	A specific plan will be developed jointly by both the Departments to train the peripheral staff at CHC
8	Management information system	All facilities to report service performance on RTI/STI, VCTC, PPTCT as a part of routine reporting
9.	Operationalization	A convergence facilitator to be appointed to ensure coordinated inputs between the activities implemented by NACP and RCH

**Annexure 3**  
**NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME**

The National Vector Borne Disease Control Programme (NVBDCP), erstwhile National Anti Malaria Programme (National Anti Malaria Programme) is the country's most comprehensive and multi-faceted public health activity. Directorate of NVBDCP is the nodal agency for prevention and control of major vector borne diseases of public health importance namely Malaria, Filariasis, Japanese Encephalitis (JE), Kala-azar and Dengue.

Following are the strategy for control of these diseases:-

**a) Malaria:**

- Early Diagnosis and prompt treatment of malaria cases
- Integrated vector control
- Early Detection and Containment of malaria outbreak
- Information, Education and Communication (IEC) for personal protection and community involvement for malaria control
- Training and Capacity Building of Medical and Para-medical workers
- Monitoring and evaluation of Efficient Management Information System (MIS)

**b) Dengue:**

- Epidemiological Surveillance of Dengue cases
- Entomological surveillance of *Aedes aegypti* mosquitoes
- Clinical management of reported cases
- Control of mosquitoes through Integrated Vector Management including source reduction, use of larvivorous fishes, impregnated bednets and selective fogging with Pyrethrum
- Behaviour change communication to change behavior of the community about prevention of breeding of mosquitoes

**c) Kala-azar:**

- Early diagnosis & complete treatment through Primary Health Care System
- Interruption of transmission through vector control by undertaking residual insecticidal spraying in affected areas
- Health Education and community participation

**d) Japanese Encephalitis:**

- Vector control by insecticidal spraying with appropriate insecticide for outbreak containment
- Early diagnosis and prompt clinical management to reduce fatality
- Health Education
- Training of Medical Personnel and Professionals

e) **Filariasis:**

**For elimination of Lymphatic Filariasis following are the strategies:-**

- Annual Mass Drug Administration (MDA) with single dose of DEC to all eligible population at risk of Lymphatic Filariasis
- Home based management of Lymphodema cases and
- Hydrocelectomy

To provide the above services under NVBDCP the P H C Medical Officers are the In-charge of P H C. The diagnosis, treatment and examination are performed at C H Cs as per the pattern of P H C. In addition, CHCs are the first referral units for treatment of severe and complicated malaria cases. To provide following services, the CHCs should be equipped with the items as mentioned at Annexure:

1. Diagnosis of malaria cases, microscopic confirmation and treatment
2. Cases of suspected JE and Dengue to be provided symptomatic treatment, hospitalization and case managements.
3. Complete treatment to Kala-azar cases in Kala-azar endemic areas
4. Complete treatment of micro-filaria positive cases with DEC and participation & arrangement of MDA along with preparedness of management of side reactions.

**Standards:**

The CHC Medical Officer should be well-trained in the control programme of the Vector Borne Diseases and should carry out the following activities:-

- a) He will, in consultation with District Malaria Officer and the community, select FTD/DDC holders and Voluntary Link Workers for his PRIMARY HEALTH CARE
- b) He will refer all fever cases to malaria laboratory for blood smear collection and examination before giving final prescription/medicines.
- c) He will supervise all Malaria Clinics and P H C laboratory in his area, see the quality of blood smear collection, staining, efficiency microscopic examination and check whether the stain is filtered daily.
- d) He will also ensure/supervise that all positive cases get radical; treatment within 48 hours of examination.
- e) He will also ensure that sufficient stocks of anti-malarials including Quinine tablets and injectable Quinine and Artemisenine are available in CHC and also PHCs
- f) He will ensure that malaria laboratory is kept in proper condition along with microscope and other equipments.
- g) He will provide referral services to severe cases of malaria
- h) He will refer severe and complicated cases to District Hospital in case of emergency and drug failure.
- i) He will also ensure that Filaria cases are managed at CHC and the Hydrocele cases are operated.

1. **Drugs:**

Chloroquine, Primaquine, Sulphadoxin Pyremethamine Combination, Artemisinin Derivatives, Quinine Injections, Quinine tablets and 5% Dextrose saline And DEC tablets

2. **Equipment :**

Microscope, Slides, Pricking Needles, Cotton, Stains, Staining Jars, Filter paper, Glass marking pencil, Lint cloth and Glasswares for preparation of stains and storage.

3. **IEC Material:**

Display material like posters, banners and permanent hoardings etc.

Distribution material like handbills, pamphlets, booklets display cards etc.

Training Materials like Guidelines on programme strategies, dose-schedule cards etc.

## Annexure 4

### National Leprosy Eradication Programme

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Minimum services to be available at Community Health Centres (CHC) are:

- Diagnosis of Leprosy
- Treatment
- Management of Reactions
- Advise to Patient on POD Care

#### **1. Leprosy Case Diagnosis**

##### **> Manpower required**

- Medical Officer trained in leprosy diagnosis
- Pharmacist to issue medicine and manage MDT Stock
- Health Worker trained to maintain records/ reports

##### **> Methodology**

- By following Standard National Guidelines (Annexure-I).

#### **2. Treatment of Cases**

- CHC should have MDT Blister Packs {MB(A), MB(C), PB(A), PB(C)} atleast 3 months stock against patients under treatment.
- The CHC will classify and treat leprosy which MDT as per National Guidelines

#### **3. Management of Reaction Cases**

- The CHC should have adequate stock of prednisolone tablets for management of reaction cases as per National Guidelines (Annexure-III).

#### **4. Advise to patient for prevention of deformity and Ulcer Care.**

- CHC should have a Medical Officer, Pharmacist, Health Worker properly trained for providing counselling to the patients. (Annexure-IV)

## **Leprosy Case Diagnosis**

### **1 How to Diagnose Leprosy?**

#### **Signs of Leprosy**

A leprosy patient is someone who has a skin patch or patches with a definite loss of sensation and has not completed a full course of treatment with multi-drug therapy.

#### **Leprosy patches:**

Can be pale or reddish or copper-coloured, can be flat or raised, do not itch, usually do not hurt, lack sensation to heat, touch or pain, can appear anywhere.

#### **Other signs of leprosy include:**

Reddish or skin- coloured nodules or smooth, shiny diffuse thickening of the skin without a loss of sensation.

### **2. Which Signs is Not Leprosy?**

Skin patches ....

- Present from birth (i.e. birth marks)
- Where there is normal feelings
- That itch
- That are white, black or dark red
- With scaling or skin
- That appear or disappear suddenly and spread fast

### **3. How to Examine a Patient for Leprosy?**

- Examine the skin in daylight or in a well-lit room
- Examine the whole body, taking care to respect the patient's privacy
- Ask the patient if the patch itches. If so, it cannot be leprosy
- Test only one or two skin patches for sensory loss
- If there is a definite loss of sensation, it is leprosy
- Ask about treatment received in the past
- A person who has completed a full course of MDT very rarely needs further treatment
- Look for any visible disability of eyes, face, hands and feet
- When in doubt about the diagnosis, always send the patient to the nearest referral centre.

### **4. How to Test for Sensory Loss?**

- Take a pointed object such as a pen
- Show the person what you are going to do.

- Lightly touch the skin with the pen
- Ask the person to point to where they felt the pen
- Now ask them to close their eyes so that they cannot see what you are doing
- Lightly touch the centre of the most prominent skin patch and ask them to point to where they felt the pen
- Repeat the procedure on normal skin and on the same patch again.
- If the person feels nothing on the skin patch, it is leprosy. Start treatment immediately.

## 5. How to Classify Leprosy?

Leprosy is classified into Paucibacillary or Multibacillary leprosy based on the number of patches.

> 1-5 patches?

It is Paucibacillary (PB) leprosy.

Treatment: 6 PB Blister Packs

> More than 5 patches?

It is Multibacillary (MB) leprosy.

Treatment: 12 MB Blister Packs

## Treatment of Leprosy Cases

### MDT Regimens

MDT supply in separate blister packs for MB (Adult), MB (Child), PB (Adult) & PB (Child). Each Blister Pack contains treatment for 4 weeks.

#### 1. PB Adult Treatment:

##### *Once a month: 1 Day*

- 2 Capsules of Rifampicin (300 mg X 2)
- 1 Tablet of Dapsone (100 mg)

##### *Once a day: Days 2-28*

- 1 Tablet of Dapsone (100 mg)

#### 2. MB Adult Treatment:

##### *Once a month: 1 Day*

- 2 Capsules of Rifampicin (300 mg X 2)



- 3 Capsules of Clofazimine (100 mg X 3)
- 1 Tablet of Dapsone (100 mg)

***Once a day: Days 2-28***

- 1 Capsule of Clofazimine (50 mg)
- 1 Tablet of Dapsone (100 mg)

**FULL COURSE: 12 MONTHS**

It is crucial that patients understand which drugs they have to take once a month and which every day.

**3. PB Child Treatment (10-14 years):**

***Once a month: 1 Day***

- 2 Capsules of Rifampicin (300 mg + 150 mg)
- 1 Tablet of Dapsone (50 mg)

***Once a day: Days 2-28***

- 1 Tablet of Dapsone (50 mg)

**FULL COURSE: 6 Blister Packs**

For Children younger than 10, the dose must be adjusted according to body weight.

**4. MB Child Treatment (10-14 years):**

***Once a month: 1 Day***

- 2 Capsules of Rifampicin (300 mg + 150 mg)
- 3 Capsules of Clofazimine (50 mg X 3)
- 1 Tablet of Dapsone (50 mg)

***Once a day: Days 2-28***

- 1 Capsule of Cllofazimine every other day (50 mg)
- 1 Tablet of Dapsone (50 mg)

**FULL COURSE: 12 Blister Packs**

For Children younger than 10, the dose must be adjusted according to body weight.

## Information for the Patient – Counselling Points

About leprosy .....

- They will be cured of leprosy if they take the drugs in the blister packs as advised
- They must complete a full course of treatment : 6 Blisters for PB patients and 12 Blisters for MB patients
- The drugs stop the disease from spreading
- Patients can lead normal lives. They can live at home, go to school, work, and play, get married, have children, and participate in social events.

Their treatment .....

- The MDT blister packs are free of charge
- They should keep the blister packs in a dry, safe and shady place and out of the reach of children
- If the drugs are spoiled (changed colour, broken), the health worker will replace them

Possible problems.....

- The medicines will turn their urine red and their skin darker.
- Patients should not worry : both will return to normal once the treatment is completed
- They must go immediately to a health centre if they have any problems (pain, fever, malaise, new lesions, muscle weakness).
- They should return for a check-up after they complete their treatment
- If they already have disabilities, tell them how to protect themselves from injuries

## **Important Points about MDT**

### **Safety**

- MDT is very safe and effective in curing leprosy
- MDT is safe during pregnancy
- MDT is safe for patients being treated for tuberculosis (TB) as well as those who are HIV-Positive
- Rifampicin is common to the treatment of leprosy and TB and must be given in the doses required for TB

### **Treatment**

- Give MDT free of charge to all leprosy patients
- Help ensure that patients complete their treatment
- Give patients enough blister packs to last until their next visit
- Use accompanied MDT for all patients who find it difficult to visit the health centre regularly
- If a person cured of leprosy presents new skin patches with definite loss of sensation, consider this as a case of relapse. Re-treat with appropriate MDT regimen

### **MDT Supplies**

Do not use MDT blister packs

- beyond the expiry date
- if the drugs are damaged, or have changed colour, or if a capsule is broken
- keep MDT blister packs in a cupboard or a wooden box.

## **Management of Reactions Cases**

### **1. Leprosy reactions**

### **2. Managing Reactions**

### **3. Dose of Prednisolone**

**Maximum Dose of prednisolone is 1 mg per kg of body weight**

## ***Prevention of Deformity and Ulcer Care Services***

**Simple measures to prevent disabilities**

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<b>For primary Eye Care &amp; Vision Testing</b>
<b>Eye Ointments</b>
<b>Ophthalmic Drops</b>
<b>Injections</b>
<b>Surgical Accessories</b>

## Annexure 6

*(i) Laboratory services for diagnosis of Malaria, Tuberculosis, Typhoid and tests for detection of faecal contamination of water and chlorination level.*

made available.

<b>Disease</b>	<b>Test</b>
Tuberculosis	Sputum AFB smear
Malaria	Blood smear for Malaria
Typhoid	Rapid Diagnostic test (Typhi Dot)
Water Quality	Kit for chlorination test
Water Quality	Rapid test Kit for fecal contamination

*(ii) Data management:* CHC will function as peripheral surveillance unit and collate, analyse and report information to District Surveillance Unit. In out-break situations, appropriate action will also be initiated.



## (b) Physical Structure for Laboratory at CHC

	<b>Item</b>	<b>No. at CHC level</b>
1	Marble/Stone Table Top for Platform	1
2	Wash-basins (Steel/Porcelain)	1
3	Water Tapes	1
4	Electric Fittings	As per requirement
5	Office Table	1
6	Office Chairs	3
7	Revolving Stools	2
8	Almirah (Steel/Wooden)	1
9	Wooden/Steel Racks	1

## (c) Laboratory Equipment

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<b>Equipments</b>	
1	Binocular Microscope with oil immersion
2.	Lancet
3.	Ice box
4	Stool transport carrier
5.	Test tube rack
6.	Table top centrifuge
7.	Refrigerator
8.	Spirit lamp
9.	Smear transporting box
10.	Sterile leak proof containers

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#### **(d) Laboratory Supplies**

<b>Supplies</b>	
1.	Clean slides
2.	Slide markers
3.	Gloves
6.	Transport medium (Cary Blair)
7.	Sterile test tubes
8.	Plastic vials
9.	Sterile cotton wool swabs
10.	Rapid Diagnostic Kit Typhoid
11.	Rapid test kit for faecal contamination
12.	Blood culture bottles with broth
13.	Zeil Neelsen Acid fast stain
14.	Aluminium Foil
15.	Cotton
16.	Sealing material
17.	<u>Extra plastic vials for transportation of serum</u>

#### **(e) Human Resources: Personnel trained in disease surveillance**

1. Medical Officer
  2. Laboratory Technician
- Medical Record Keeper /Data Entry Operator

### **Annexure 7**

#### **Round the clock functional Ambulance / rural transportation – Harayana model**

1. An advertisement is placed in Local Newspaper for leasing of Ambulance by the CMO Office.
2. Preference is given to Ex-Army Defence / Services personnel.
3. Ambulance is given to the Driver by the CMO Office. No guarantee is required.
4. Charges of transportation are fixed at Rs. 5/km.
5. Driver is on a contract basis
6. Driver is required to deposit 50 paise/km in CMO office a monthly basis. This money is kept for major repair.
7. Driver gets Rs. 4.50/km. This would cover petrol, salary and minor repairs.
8. Driver owns the Ambulance after 5 years.

**Annexure 8**  
**Equipment**

**Standard Surgical Set - I (Instruments) FRU**

1 Tray, instrument/dressing with cover, 310 x 200 x 600 mm-ss 1	1
2 Gloves surgeon, latex sterilizable, size 6 12	12
3 Gloves surgeon, latex sterilizable, 6-1/2 12	12
4 Gloves surgeon, latex sterilizable, size 7 12	12
5 Gloves surgeon, latex sterilizable, 7-1/2 12	12
6 Gloves surgeon, latex sterilizable, 8 12	12
7 Forceps, backhaus towel, 130 mm 4	4
8 Forceps, sponge holding, 228 mm 6	6
9 Forceps, artery, pean straight, 160 mm, stainless steel 4	4
10 Forceps hysterectomy, curved, 22.5 mm 4	4
11 Forceps, hemostatic, halsteads mosquito, straight, 125 mm-ss 6	6
12 Forceps, tissue, all/is 6x7 teeth, straight, 200 mm-ss 6	6
13 Forceps, uterine, tenaculum, 280 mm, stainless steel 1	1
14 Needle holder, mayo, straight, narrow jaw, 175 mm, ss 1	1
15 Knife-handle surgical for minor surgery # 3 1	1
16 Knife-handle surgical for major surgery # 4 1	1
17 Knife-blade surgical, size 11, for minor surgery, pkt of 5 3	3
18 Knife-blade surgical, size 15 for minor surgery, pkt of 5 4	4
19 Knife blade surgical, size 22, for major surgery, pkt of 5 3	3
20 Needles, suture triangular point, 7.3 cm, pkt of 6 2	2
21 Needles, suture, round bodied, 3/8 circle No. 12 pkt of 6 2	2
22 Retractor, abdominal, Deavers, size 3, 2.5 cm x 22.5 cm 1	1
23 Retactor, double-ended abdominal, Beltouis, set of 2 2	2
24 Scissors, operating curved mayo-blunt pointed 170mm 1	1
25 Retractor abdominal, Balfour 3 blade self-retaining 1	1
26 Scissors, operating, straight, blunt point, 170 mm 1	1
27 Scissors, gauze, straight, 230 mm, stainless steel 1	1
28 Suction tube, 225 mm, size 23 F 1	1
29 Clamp intestinal, Doyen, curved, 225 mm, stainless steel 2	2
30 Clamp intestinal, Doyen straight, 225 mm, stainless steel 2	2
31 Forceps, tissue spring type, 160 mm, stainless steel 2	2
32 Forceps , tissue spring type, 250 mm, stainless steel. 1	1

## Standard Surgical Set - II

1. Forceps, tissue, 6 x 7 teeth, Thomas-Allis, 200 mm- ss 1	1
2. Forceps, backhaus towel, 130 mm, stainless steel 4	4
3. Syringe, anaesthetic (control), 10 ml, luer-glass 1	1
4. Syringe, hypodermic, 10 ml glass, spare for item 3 4	4
5. Needles, hypodermic 20G x 1-1/2" box of 12 1	1
6. Forceps, tissue, spring type, 145 mm, stainless steel 1	1
7. Forceps, tissue spring type 1 x 2 teeth, Semkins, 250 mm 1	1
8. Forceps, tissue spring type, 250 mm, stainless steel 1	1
9. Forceps, hemostat curved mosquito halsteads, 130 mm 6	6
10. Forceps, artery, straight pean, 160 mm, stainless steel 3	3
11. Forceps artery, curved pean, 200 mm, stainless steel 1	1
12. Forceps, tissue, Babcock, 195 mm, stainless steel 2	2
13. Knife handle for minor surgery No. 3 1	1
14. Knife blade for minor surgery No. 10, pkt of 5 8	8
15. Needle holder, straight narrow-jaw Mayo–Heger, 175 mm 1	1
16. Needle suture straight, 5.5 mm, triangular point, pkt of 6 2	2
17. Needle, Mayo, ½ circle, taper point, size 6, pkt of 6 2	2
18. Catheter urethral Nelaton solid-tip one-eye 14 Fr 1	1
19. Catheter urethral Nelaton solid-tip one-eye 16 Fr 1	1
20. Catheter urethral Nelaton solid-tip one-eye 18 Fr 1	1
21. Forceps uterine tenaculum duplay dbl-cvd, 280 mm 1	1
22. Uterine elevator (Ranathlbod), stainless steel 1	1
23. Hook, obstetric, Smellie, stainless steel 1	1
24. Proctoscope Mcevedy complete with case 1	1
25. Bowl, sponge, 600 ml, stainless steel 1	1
26. Retractor abdominal Richardson-Eastman, dbl-ended, set 2 1	1
27. Retractor abdominal Deaver, 25 mm x 3 cm, stainless steel 1	1
28. Speculum vaginal bi-valve graves, medium, stainless steel 1	1
29. Scissors ligature, spencer straight, 130 mm, stainless steel	1
30. Scissors operating straight, 140 mm, blunt/blunt ss 1	1
31. Scissors operating curved, 170 mm, blunt/blunt ss 2	2
32. Tray instrument curved, 225 x 125 x 50 mm, stainless steel 1	1

33. Battery cells for item 24 2	2
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## IUD Insertion Kit

1 Setal sterilization tray with cover size 300 x 220 x 70 mm, S/S, Ref IS: 3993 1	1
2 Gloves Surgeon, latex, size 6-1/2 Ref. 4148 6	6
3 Gloves surgeon latex, size 7-1/2 Ref. 4148 6	6
4 Bowl, metal sponge, 600 ml, Ref. IS: 5782 1	1
5 Speculum vaginal bi-valve cusco's graves small ss 1	1
6 Forceps sponge holding, straight 228 MMH Semken 200 mm 1	1
7 Sound uterine simpson, 300 mm graduated UB 20 mm 1	1
8 Forceps uterine tenaculum duplay DBL-CVD, 280 mm 1	1
9 Forceps tissue - 160 mm 1	1
10 Anterior vaginal wall retractor stainless 1	1
11 Torch without batteries 1	1
12 Gloves surgeon, latex, size 7, Ref: 4148 6	6
13 Gloves surgeon, latex size 6 Ref. IS: 4148 6	6
14 Battery dry cell 1.5 V 'D' Type for Item 7G 1	1
15 Speculum vaginal bi-valve cusco's/Grea Ves Medium ss 1	1
16 Forceps artery, straight, Pean, 160 mm 1	1
17 Scissors operating, straight, 145 mm, Blunt/Blunt 1	1
18 Forceps uterine vulsellum curved, Museux, 240 mm 1	1
19 Speculum vaginal double-ended sime size #3 1	1

## CHC Standard Surgical Set - III

Tray, instrument/dressing with cover, 310 x 195 x 63 mm 1	1
Forceps, backhaus towel, 130 mm, stainless steel 4	4
Forceps, hemostat, straight, Kelly, 140 mm, stainless steel 4	4
Forceps, hemostat, curved, Kelly, 125mm, stainless steel 2	2
Forceps, tissue Allis, 150 mm, stainless steel, 4 x 5 teeth 2	2
Knife handle for minor surgery No. 3 1	1
Knife blade for minor surgery, size 11, pkt of 5 10	10
Needle hypodermic, Luer 22G x 11/4", box of 12 1	1

Needle hypodermic, Luer 250G x 3/4", box of 12	1
Needle, suture straight 5.5 cm, triangular point, pkt of 6	2
Needle, suture, Mayo ½ circle, taper point No. 6, pkt of 6	2
Scissors, ligature, angled on flat, 140 mm, stainless steel	1
Syringe anaesthetic control, Luer - 5 ml, glass	4
Syringe 5 ml, spare for item 13	4
Sterilizer, instrument 200 x 100 x 60 mm with burner ss	1
Syringe, hypodermic, Luer 5 ml, glass	4
Forceps, sterilizer, Cheatle, 265 mm, stainless steel	1

### Normal Delivery Kit

Trolley, dressing carriage size 76C, long x 46 cm wide and 84 cm high. Ref. IS 4769/1968	1
Towel, trolley 84 cm x 54 cm	2
Gown, operation, cotton	1
Cap. operation, surgeon's 36 x 46 cm	2
Gauze absorbent non-sterile 200 mm x 6 m as per IS: 171/1985	2
Tray instrument with cover 450 mm (L) x 300 mm (W) x 80 mm (H)	1
Macintosh, operation, plastic	2
Mask, face, surgeon's cap of rear ties: B) Beret type with elastic hem	2
Towel, glove	3
Cotton wool absorbent non-sterilize 500G	2
Drum, sterilizing cylindrical - 275 mm Dia x 132 mm, ss as per IS: 3831/1979	2
2	
Table instrument adjustable type with tray ss	1

## Standard Surgical Set - IV

Vaccum extractor, Malastrom 1	1
Forceps obstetric, Wrigley's, 280 mm, stainless steel 1	1
Forceps, obstetric, Barnes-Neville, with traction, 390mm 1	1
Forceps, sponge holding, straight 228 mm, stainless steel 4	4
Forceps, artery, Spencer-Wells, straight, 180mm-ss 2	2
Forceps, artery, Spencer-Wells, straight, 140mm-ss 2	2
Holder, needle straight, Mayo-Hegar, 175 mm-ss 1	1
Scissors, ligature, Spencer, 130 mm, stainless steel 1	1
<del>Scissors, episiotomy, angular, Braun, 145 mm, stainless steel 1</del>	<del>1</del>
Forceps, tissue, spring-type, 1 x 2 teeth, 160 mm-ss 1	1
Forceps, tissue, spring-type, serrated ups, 160mm-ss 1	1
Catheter, urethral, rubber, Foley's 14 ER 1	1
Catheter, urethral, Nelaton, set of five (Fr 12-20) rubber 1	1
Forceps, backhaus towel -130 mm-ss 4	4
Speculum, vaginal, Sim's, double-ended # 3-ss 1	1
Speculum, vaginal, Hamilton-Bailey 1	1



Holder, needle, Mayo-Hegar, narrow jaw, straight, 175 mm-ss 1	1
Speculum vaginal bi-valve, Cusco-medium, stainless steel 1	1

## Equipment for Neo-natal Resuscitation

Catheter, mucus, rubber, open ended tip, size 14FR 2	2
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Catheter, nasal, rubber, open tip, funnel end, size el end, size el end, size el end, size el end, size el end,2i

- a) ceiling lamp
- b) portable type

Sterilizer

Suction apparatus

Stand with wheel for single basin

Table Operation, hydraulic:

- a) Major
- b) Minor

Trolley for patients

Trolley for instruments

X-ray view box

Wheel chairs

### **Equipment for Labour Room**

Aprons rubber

Cradles baby

Wheel chair,

Cabinet, Instrument

Dressing Drum

Shadowless lamps

Table for:

- a) Obstetric labour
- b) Examination

Trolley for:

- a) Patients
- b) Dressing

Torch (flash light)

Trays

Vacuum extractor

Weighing machine baby

Wheel Chairs

## **Equipment for Radiology**

Aprons Lead rubber

Diagnostic X-ray Unit 200 / 300mA with automatic device

Dark Room accessories

Dark room timer

Film Clips

Lead sheets

X-ray view box

Xray protection screen

X-ray film processing tank

EQUIPMENTS under National Health Programmes ( as listed under each NHP), Cold storage facility under Immunization Programme and Blood storage equipment as at annexure- 10.

**Annexure 9**

**LIST OF ESSENTIAL DRUGS FOR CHC**

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<b>Name of the Drug</b>	<b>Route of administration/ dosage form</b>	<b>Strength</b>
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			80 + 400 mg
		Suspension	40 +200 mg / 5 ml
19	Norfloxacin	Tablet	400 mg

48	Tetracycline Hydrochloride	Ointment	1%
49	Alprozolam	Tab	0.25 mg

50

**Other Injections:**

<b>S. No.</b>	<b>Injections</b>
1.	Cryst. Penicillin
2.	Inj.Procaine Penicillin
3.	Inj.Benzathine Penicillin (1.2)



## **Annexure 10**

### **Extracts from National Guidelines on Blood Storage Facilities at FRUs**

#### **1. Requirements**

*Space* : The area required for setting up the facility is only 10 square meters, well-lighted,

Tooth picks As required

*Reagents:* All the reagents should come from the Mother Blood Bank.

Anti-A 2-vials each per month

Anti-B 2-vials each per month

Anti-AB 2-vials each per month

Anti-D

areas clean. The expiry of the blood is normally 35/42 days depending on the type of blood bags used. The Medical Officer in-charge should ensure that unused blood bags should be returned to the mother center at least 10 days before the expiry of the blood and fresh blood obtained in its place. The blood storage centers are designed to ensure rapid and safe delivery of whole blood in an emergency. The detail of storage of packed cells, fresh frozen plasma and platelets concentrate are therefore not given in these guidelines. In case, however, these are required to be stored, the storage procedures of the mother blood bank should be followed.

#### **4. Issue of blood**

Patients blood grouping and cross matching should invariably be carried out before issue of blood. A proper record of this should be kept.

First In and First Out (FIFO) policy, whereby blood closer to expiry date is used first, should be followed.

#### **5. Disposal**

Since all the blood bags will already be tested by the mother center, disposal of empty blood bags should be done by landfill. Gloves should be cut and put in bleach for at least one hour and then disposed as normal waste.

#### **6. Documentation & records**

The center should maintain proper records for procurement, cross matching and issue of blood and blood components. These records should be kept for at least 5 years.

#### **7. Training**

Training of doctors and technicians, who will be responsible for the Blood Storage Center, should be carried out for 3 days in an identified center as per the guidelines. Training will include :

- Pre-transfusion checking, i.e. patient identity and grouping
- Cross matching
- Compatibility
- Problems in grouping and cross matching
- Troubleshooting

- Issue of blood
- Transfusion reactions and its management
- Disposal of blood bags

The states will have to identify the institutions where training of the staff responsible for

Chamber, counting, glass, double neubauer ruling 2
Pipette, serological glass, 0.05 ml x 0.0125 ml 6
Pipette, serological glass, 1.0 ml x 0.10 ml 6
Counter, differential, blood cells, 6 unit 1
Centrifuge, micro-hematocrit, 6 tubes, 240v 1
Cover glass for counting chamber (item 7), Box of 12 1
Tube, capillary, heparinized, 75 mm x 1.5 mm, vial of 100 10
Lamp, spirit W/screw cap. Metal 60 ml 1
Lancet, blood (Hagedorn needle) 75 mm pack of 10 ss 10
Benedict's reagent qualitative dry components for soln 1
Pipette measuring glass, set of two sizes 10 ml, 20 ml 2
Test tube, w/o rim, heat resistant glass, 100 x 13 mm 24
Clamp, test-tube, nickel plated spring wire, standard type 3
Beaker, HRG glass, low form, set of two sizes, 50 ml, 150 ml 2
Rack, test-tube wooden with 12 x 22 mm dia holes 1

## **Annexure 11:**

### **National Guidelines on Hospital Waste Management based on the Bio-Medical Waste(Management & Handling) Rules, 1998.**

**(Only relevant portions as applicable to a 30 bed CHC need to be taken in to account from this guidelines)**

The Bio-Medical Waste (Management & Handling) Rules, 1998 were notified under the Environment Protection Act, 1986(29 of 1986) by the Ministry of Environment and Forest, Government of India on 20<sup>th</sup> July, 1998. The guidelines have been prepared to enable each hospital to implement the said Rules, by developing comprehensive plan for hospital waste management, in terms of segregation, collection, treatment, transportation and disposal of the hospital waste.

#### **1. Policy on Hospital Waste Management**

The policy statement aims to provide for a system for management of all potentially infectious and hazardous waste in accordance with the Bio-Medical Waste(Management& Handling) rules, 1998(BMW,1998)

#### **2. Definition of Bio-Medical Waste:**

Bio-Medical Waste means any waste, which is generated during the diagnosis, treatment or immunization of human beings or animals or in research activities pertaining thereto or in the production or testing of biologicals, including categories mentioned in the Schedule I of the Bio\_MedicalWaste (Management & Handling) Rules, 1998.

#### **3. Categories of Bio-Medical Waste**

Hazardous, toxic and Bio-Medical waste has been separated in to the following categories for the purpose of its safe transportation to a specific site for specific treatment. Certain categories of infectious waste require specific treatment (disinfection/decontamination) before transportation for disposal. These categories of bio-medical waste are mentioned as below:

Category No. 1 – Human Anatomical Waste

This includes human tissues, organs, body parts.

Category No.2 – Animal Waste

This includes animal tissues, organs, body parts, carcasses, bleeding parts, fluid, blood and experimental animals used in research, waste generated by veterinary hospitals and colleges, discharge from hospitals and animal houses.

#### Category No. 3 - Microbiology & Biotechnology Waste

This includes waste from laboratory cultures, stocks or specimens of micro organisms live or attenuated vaccines, human and animal cell culture used in research and infectious agents from research and industrial laboratories, wastes from production of biological, toxins, dishes and devices used for transfer of culture.

#### Category No. 4 – Waste Sharps

This comprises of needles, syringes, scalpels, blades, glass, etc. that may cause puncture and cuts. This includes both used and unusable sharps.

#### Category No. 5 – Discarded Medicines and Cytotoxic drugs

This includes wastes comprising of outdated, contaminated and discarded medicines.

#### Category No. 6 - Soiled Waste

It comprises of items contaminated with blood, and body fluids including cotton, dressings, soiled plaster casts, linens, beddings, other material contaminated with blood.

#### Category No. 7 – Solid Waste

This includes wastes generated from disposable items, other than the waste sharps, such as tubings, catheters, intravenous sets, etc.

#### Category No. 8 – Liquid Waste

This includes waste generated from laboratory and washing, cleaning, house keeping and disinfecting activities.

#### Category No. 9 – Incineration Ash

This contains of ash from incineration of any bio-medical waste

#### Category No. 10 – Chemical Waste

This contains chemicals used in production of biologicals and chemicals used in disinfection, insecticides etc.

### 4. Segregation of Waste

4.1 It should be done at the site of generation of bio-medical waste, e.g., all patient care activity areas, diagnostic service areas, operation theatres, labour rooms, treatment rooms.

4.2 The responsibility of segregation should be with the generator of bio-medical waste,

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\* Those plastics which contains liquid like blood, urine. Pus, etc, should be put in to red colour bag for microwaving and autoclaving and other items should be put in to blue or white bag after chemical treatment and mutilation/shredding.

5.2 All the items sent to incinerator/deep burial(Cat 1, 2, 3, 6) should be placed in yellow coloured bags.

5.3 All the bio-medical waste to be sent for microwave/ Autoclave treatment should be placed in red coloured bags.(Cat. 3, 6, & 7)

5.4 Any waste which is sent to shredder after autoclaving/ microwaving/chemical treatment is to be packed in blue/white translucent bag.

5.5 Location of containers:

All containers having different coloured plasticbags should be located at the point of generation of waste, i.e., near OT tables, injection rooms, diagnostic service areas, dressing trolleys, injection trolleys, etc.

5.6 Labelling: All the bags/containers must be labelled bio-hazard or cytotoxic with symbols according to the rules(ScheduleIII of bio-medical waste Rules, 1998)

5.7 Bags: It should be ensured that waste bags are filled up to three-fourth capacity, tied securely and removed from the site of the generation to the storage area regularly and timely.

5.8 The categories of waste(Cat. 4, 7, 8,& 10) which require pre-treatment(decontamination/disinfection) at the site of generation such as plastic and sharp materials, etc., should be removed from the site of generation only after treatment.

5.9 The quantity of collection should be documented in a register. The colour plastic bags should be replaced and the garbage bin should be cleaned with disinfectant regularly.

6. Storage of Waste:

Storage refers to the holding of bio-medical waste for a certain period of time at the site of generation till its transit for treatment and final disposal.

6.1. No untreated bio-medical waste shall be kept stored beyond a period of 48 hours.

- 6.2. 6.2 The authorised person must take the permission of the prescribed authority, if for any reason it becomes necessary to store the waste beyond 48 hours.
- 6.3. 6.3. The authorised person should take measures to ensure that the waste does not adversely affect human health and the environment, in case it is kept beyond the prescribed limit.

## 7. Transportation:

### 7.1 Transportation of waste within the hospitals

7.1.1 Within the hospital, waste routes must be designated to avoid the passage of waste through patient care areas as far as possible.

7.1.2 Separate time schedules are prepared for transportation of bio-medical waste and general waste; it will reduce chances of their mix-up.

7.1.3 Dedicated wheeled containers, trolleys or carts with proper label (as per Schedule IV of Rule 6) should be used to transport the waste from the site off storage to the site of treatment.

7.1.4 Trolleys or carts should be thoroughly cleansed and disinfected in the event of any spillage.

7.1.5 The wheeled containers should be designed in such a manner that the waste can be easily loaded, remains secured during transportation, does not have any sharp edges and easy to cleanse and disinfect.

### 7.2 Transportation of waste for disposal outside the hospital:

7.2.1. Notwithstanding anything contained in the motor Vehicles Act. 1988 or rules thereunder, bio-medical waste shall be transported only in such vehicles as may be authorised for the purpose by the competent authority.

7.2.2 The containers for transportation must be labelled as given in Schedule III and IV of BMW, 1998

## 8. Treatment of Hospital Waste (Please see Rule 5, Schedule V & VI)

8.1 General waste (Non-hazardous, non-toxic, non-infectious). The safe disposal of this waste should be ensured by the occupier through Local Municipal Authority.

### 8.2 Bio-Medical Waste

Monitoring of incinerator/autoclave/ microwave shall be carried out once in a month to check the performance of the equipment. One should ensure:

- j) The proper operation & Maintenance of the incinerators/ autoclave/microwave
- ii) Attainment of prescribed temperatures in both the chambers of incinerators while incinerating the waste.
- iii) Not to incinerate plastic materials
- iv) Only skilled persons operate the equipment
- v) Proper record book shall be maintained for the incinerators/autoclave/microwave/shredder. Such record book shall have the entries of period of operation, temperature/pressure attained while treating the waste, quantity for waste treated, etc.
- vi) The scavengers shall not be allowed to sort out the waste
- vii) Proper hygiene shall be maintained at, both the waste treatment plant site as well as the waste storage area.
- viii) Categories 4, 7, 8, and 10 should be treated with chemical disinfectant like 1% hypochlorite solution or any other equivalent chemical reagent to ensure disinfection.

8.2.1 Incineration: The incinerator should be installed and made operational as per specifications under the BMW rules , 1998(Schedule V) and an authorization shall be taken from the prescribed authority for the management and handling of bio-medical waste including installation and operation of treatment facility as per Rule 8 of Bio-Medical Waste(Management & Handling) Rules,1998. Specific requirements regarding the incinerators and norms of combustion efficiency and emission levels,etc. have been defined in the Bio-Medical Waste(Management&Handling) Rules,1998. In case of small hospitals, joint facilities for incineration can be developed depending upon the local policies of the hospital and feasibility. The plastic bags made of chlorinated plastics should not be incinerated.

- 8.2.2 Deep burial: Standard for deep burial are also mentioned in the Bio-Medical Waste(Management&Handling) Rules 1998(Schedule V). The cities having less than 5 lakh population can opt for deep burial for wastes under categories 1 & 2.
- 8.2.3 Autoclave and Microwave treatment: Standards for the autoclaving and Microwaving are also mentioned in the Bio-Medical Waste(Management&Handling) Rules 1998(Schedule V). All equipment installed/shared should meet these specifications. The waste under category 3, 4, 6, and 7 can be treated by these techniques.
- 8.2.4 Shredding: The plastics (IV bottle, IV sets, Syringes, catheters, etc.) sharps (needles, blades, glass, etc.) should be shredded but only after chemical treatment/microwaving/ autoclaving, ensuring disinfection.
- 8.2.5 Needle s destroyers can be used for disposal of needles directly without chemical treatment
- 8.2.6 Secured Landfill: The incinerator ash, discarded medicines, cytotoxic substances and solid chemical waste should be treated by this option(Cat. 5, 9, & 10)
- 8.2.7 It may be noted there are multiple options available for disposal of certain category of waste, the individual hospital can choose the best option, depending upon treatment facilities available.
- 8.2.8 Radioactive waste: The management of the radioactive waste should be undertaken as per guidelines of BARC.
- 8.2.9 Liquid(Cat. 8) & Chemical Waste(Cat. 10)
- i) Chemical waste & Liquid waste from Laboratory: Suitable treatment, dilution or 1% hypochlorite solution as required shall be given before disposal.
  - ii) The effluents generated from the hospital should conform to limits as laid down in the Bio-Medical Waste(Management&Handling) Rules 1998(Schedule V).
  - iii) The liquid and chemical waste should not be used for any other purpose.

- iv) For discharge in to public sewers with terminal facilities, the prescribed standard limits should be ensured.

## 9. Safety Measures:

9.1 Personal protection: Hospitals and health care authorities have to ensure that the following personal protective equipment is provided:

### i) Gloves:

- a) Disposable gloves
- b) Latex surgical gloves
- c) Heavy duty rubber gloves (uptil elbows) for cleaners

ii) Masks: Simple and cheap mask to prevent health care workers against aerosols, splashes and dust.

iii) Protective glasses

iv) Plastic aprons

- v) Special foot wear, e.g. gum boots for hospital waste handler.

9.2 Immunization against Hepatitis B and Tetanus shall be given to all hospital staff

9.3 All the generators of bio-medical waste should adopt universal precautions and appropriate safety measures while doing therapeutic and diagnostic activities and also while handling the bio-medical waste.

9.4 All the sanitation workers engaged in the handling and transporting should be made aware of the risks involved in handling the bio-medical waste.

9.5 Any worker reporting with an accident/injury due to handling of bio-medical waste should be given prompt first aid. Necessary investigations and follow up action as per requirement may be carried out.

### 9.6 Reporting Accident & Spillages

The procedure for reporting accidents (as per Form III of BMW Rules, 1998) should be followed and the records should be kept. The report should include the nature of accidents, when and where it occurred and which staff was directly involved. It should also show type of waste involved and emergency measures taken.

## 10 Training:

10.1 All the medical professional must be made aware of Bio-Medical Waste (Management & Handling) Rules, 1998.

10.2 Each and every hospital must have well planned awareness and training programmes for all categories of personnel including administrators to make them aware about safe hospital waste management practices.

10.3. Training should be conducted category wise and more emphasis should be given in training modules as per category of personnel.

10.4 Training should be conducted in appropriate language/medium and in an acceptable manner

10.5 Wherever possible audio-visual material and experienced trainers should be used. Hand on training about colour coded bags; categorization and chemical disinfections can be given to concerned employees.

10.6 Training should be interactive and should include, demonstration sessions, Behavioural Science approach should be adopted with emphasis on establishing proper practices. Training is a continuous process and will need constant reinforcement.

## 11. Management & Administration

11.1 The head of the Hospital shall form a Waste Management Committee under his chairmanship. The Waste Management Committee shall meet regularly to review the performance of the waste disposal. This Committee should be responsible for making hospital specific action plan for hospital waste management and for its supervision, monitoring, implementation and looking after the safety of the bio-medical waste handlers.

11.2 The heads of each hospital will have to take authorization for generation of waste from appropriate authorities well in time as notified by the concerned state/UT Government and get it renewed as per time schedule laid in the rules. The application is to be made as per format given in form I for grant of authorization.(Please see page 18 of notified BMW Rules)

11.3. The annual reports, accident reporting, as required under BMW rules should be submitted to the concerned authorities as per BMW rules format(Form II and Form III respectively)(Please see pages 19& 20 of BMW Rules)

## 12. Coordination between hospital & Outside Agencies:

12.1 Municipal authorities: as quite a large percentage of waste (up to 90%) generated in Indian hospital belong to general category (non-toxic and non-hazardous), the

hospital authorities should have constant interaction with municipal authorities so that this category of waste is regularly taken out of the hospital premises for further disposal

12.2 Coordinated efforts should be made by health authorities and municipal authorities to involve private sector/NGOs for creation of common facilities for treatment.

12.3 Health authorities in coordination with municipal authorities should facilitate optimal utilization of waste treatment facility in the area.

12.4 Coordination with NGOs and Environmental Groups, for public awareness and education.

12.5 Sharing of facility: Hospital which is not on a possession of their own facility for treatment may get their waste treated in a shared facility. The hospitals having additional capacity may extend their facility to nearby smaller hospital or health care units.

12.6 There should be coordinated agencies to take care of exigencies/disruption of waste treatment equipment in a unit

## **Annexure 12**

### **Model Citizens Charter for CHCs and PHCs**

#### **1. Preamble**

Community Health Centres and Primary Health Centres exist to provide health care to every citizen of India within the allocated resources and available facilities. The Charter seeks to provide a framework which enables citizens to know.

- what services are available?
- the quality of services they are entitled to.
- the means through which complaints regarding denial or poor qualities of services will be addressed.

#### **2. Objectives**

- to make available medical treatment and the related facilities for citizens.
- to provide appropriate advice, treatment and support that would help to cure the ailment to the extent medically possible.
- to ensure that treatment is best on well considered judgment, is timely and comprehensive and with the consent of the citizen being treated.
- to ensure you just awareness of the nature of the ailment, progress of treatment, duration of treatment and impact on their health and lives, and
- to redress any grievances in this regard.

#### **3. Commitments of the Charter**

- to provide access to available facilities without discrimination,
- to provide emergency care, if needed on reaching the CHC/ PHC
- to provide adequate number of notice boards detailing the location of all the facilities.
- to provide written information on diagnosis, treatment being administered.
- to record complaints and designate appropriate officer, who will respond at an appointed time, that may be same day in case of inpatients and the next day in case of out patients.

#### **4. Component of service at CHCs**

- access to CHCs and professional medical care to all
- making provision for emergency care after main treatment hour whenever needed
- informing users about available facilities, costs involved and requirements expected of them with regard to the treatment in clear and simple terms.



- informing users of equipment out of order
- ensuring that users can seek clarifications and assistance in making use of medical treatment and CHC facility.
- Informing users about procedures for reporting in-efficiencies in services or non-availability of facilities.

#### 5. **Grievance redressal**

- grievances that citizens have will be recorded
- there will be a designated officer to respond to the request deemed urgent by the person recording the grievance
- aggrieved user after his/her complaint recorded would be allowed to seek a second opinion within the CHC
- to have a public grievance committee outside the CHC to deal with the grievances that are not resolved within the CHC.

#### 6. **Responsibilities of the users**

- users of CHC would attempt to understand the commitments made in the charter
- user would not insist on service above the standard set in the charter because it could negatively affect the provision of the minimum acceptable level of service to another user.
- instruction of the CHC's personnel would be followed sincerely, and
- in case of grievances, the redressal mechanism machinery would be addressed by users without delay.

#### 7. **Performance audit and review of the charter**

- performance audit may be conducted through a peer review every two or three years after covering the areas where the standards have been specified

## Annexure 13

### Composition of the Task Group III and the Consultation Process

Under the National Rural Health Mission, 8 Task Groups were constituted to deliberate upon various issues concerning the operationalisation of National Rural Health Mission. Task Group III under the chairmanship of DGHS comprised the following members:

1. Dr.S.P.Agarwal, Director General Health Services: Chairperson
2. Dr.Imrana Quader, JNU
3. Mrs.Brinda Karat
4. Mr.Satish Agnihotri, IAS
5. Dr.Ravi Narayan, CHC
6. Mrs.Sheela Rani Chungat, Secretary(Health, Tamil Nadu)
7. Mr.Ram Lubaya, IAS, Govt. of Rajasthan
8. Dr.Mohan Rao, JNU
9. Dr.Mira Shiva, VHAI
10. Dr.Jean Dreze, NAC
11. Mr.P.R.Krishna Kumar
12. Mr.Taradatt, JS,(AYUSH)
13. Dr.I.S.Pal, DG (FW), Uttaranchal
14. Mr.S.R.Mohanty, Madhya Pradesh
15. Dr.Abhay Shukla, CEHAT
16. Dr.S.K.Satpathy, DC (ID), Rapporteur

The first meeting of the Task Group III was held on 10<sup>th</sup> Feb.2005. The Group-III was assigned the task of preparing Status papers on the following four issues:

- Setting up of Indian Public Health Standards for health care delivery in Community Health Centres
- Strengthening Public Institutions for Health Delivery.
- Ensuring availability of doctors in rural areas
- Mainstreaming of AYUSH

As a follow-up to the meeting the DG HS reviewed the progress on a daily basis with some of the members from the Directorate and also experts from outside who were invited to join the process. The 4 papers were prepared and sent to all the members electronically and were also given print copies. The second meeting of the Task Group III was held on 26th Feb.2005, under the Chairmanship of Dr. S.P.Agarwal, DGHS at Nirman Bhawan, New Delhi. Secretary (Health & F.W.) also participated in the discussion briefly. The list of Members /their representatives and various experts who participated in the meeting was as follows:

- Dr.S.P.Agarwal, Director General  
Health Services: Chairperson
- Dr.Imrana Quader, JNU
- Dr.Thelma Narayan, CHC
- Dr. S. Murugan, Director(FW Tamil Nadu)
- Dr.Mohan Rao, JNU
- Dr.Mira Shiva, VHAI
- Mr.S.R.Mohanty, Madhya Pradesh
- Mr. B. Venkatraman, QCI
- Dr.Abhay Shukla, CEHAT
- Mr. B.P. Sharma., JS
- Dr. S.K. Sharma, Adviser, AYUSH
- Dr.C.S.Pandav, AIIMS
- Dr.Ichhpujani (DDG (P)
- Dr.D.C.Jain, DC (CH/T)
- Dr.A.K.Harit, CMO, DGHS
- Dr.A.N.Sinha, CMO (HA)
- Dr.Sadhana Bhagwat, Consultant  
Cancer
- Dr.Praveena Goel, AC (UH)
- Dr.Himanshu Bhushan, AC (MH-II)
- Mrs.Mridula Das ADG (N)
- Mrs.Shubhra Singh, Director (P/RHM)
- Mr.Babu Lal Dir, (ID)
- Dr.S.K.Satpathy DC(ID), Rapporteur

These papers were discussed with the members present. Subsequent to the meeting, inputs from the deliberations were added to the papers. Further consultations were held on a daily basis with the members available at the Directorate and external experts. Another meeting with the various National Health Programme Officers and experts was also held on 7<sup>th</sup> March 2005.

The document on IPHS was prepared initially aiming at setting up Standards for the CHCs. But after discussion with Director (P/RHM), the paper was scaled down to discuss the requirements for minimum functional grading of CHCs with scope for further upgradation. Inputs were taken from the Programme Officers of National Health Programmes, consultants from accreditation agencies and also from Dept. of Community Medicine, AIIMS for preparation of the documents.

## IPHS for CHC At a Glance

The Govt. of India is launching a National Rural Health Mission (2005-2012) through out the country to ensure improved access for Primary Health Care Services through the country specially to the poor women and Children. Codification of Indian Public Health Standards to ensure minimal quality hospital services for every one lakh population is an important strategy under the Mission. This document provides the requirements for a Minimum Functional Grade of Community Health Centre.

◆ Objective of IPHS is to provide optimal

- specialist care in the CHC of acceptable standard.
- “Assured Services” provided at CHC will include routine and emergency care in Surgery, Medicine, Obstetrics and Gynaecology and Paediatrics in addition to all the National Health programmes and Integrated Disease Surveillance Project
- Apart from the existing 4 specialists in Surgery, Medicine, Obstetrics and Gynaecology and Paediatrics, it is proposed to make available the services of an Anaesthetist and a Public Health Programme Manager on contractual basis to ensure optimal utilisation and good quality services.
- Necessary support staff will be as it already exists. Ophthalmic assistant where it does not exist provided under the National Blindness Control programme and a Public Health Nurse and ANM under the ASHA scheme.
- The equipment already provided under the CSSM programme is deemed adequate for provision of all the envisaged *assured services*.
- Infrastructure that already exists will have to be utilised as best as possible with remodelling or rearrangement if necessary. New constructions will follow the specifications spelt out in detail in the document.
- The Essential drug list at the CHC level has been updated to ensure proper treatment.
- Laboratory facilities and other support services will be strengthened. Laundry, diet, referral transport and waste management are proposed to be outsourced after appropriate training.
- Capacity Building will be ensured at all levels by periodic training of all cadres.
- It is mandatory for every CHC to have “Rogi Kalyan Samiti” to ensure accountability.
- Every CHC shall have the “Charter of Patients’ Rights” displayed prominently at the entrance.
- Every CHC shall also have the Standard Operating Procedures and Standard Treatment Protocols for common ailments and the National Health Programmes.
- Social audit by means of involvement of the community through Consumer Forum and Rogi Kalyan Samitis is being recommended.

To maintain quality of services, external monitoring through Panchayati Raj Institutions and internal monitoring at appropriate intervals will be advocated.