STATE INSTITUTE OF HEALTH AND FAMILY WELFARE, U.P.

GUIDEBOOK TO CHIEF MEDICAL OFFICERS IN UTTAR PRADESH

Department of Medical, Health and Family Welfare
Government of Uttar Pradesh

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MESSAGE

Shri Brajesh Pathak,
Hon'ble Deputy Chief Minister
Hon'ble Minister of Medical Health
and Family Welfare Department
Government of Uttar Pradesh

Chief Medical Officers as public health administrators have many roles. They must hire and supervise personnel who provide services; they must understand the legal, political, and economic climate in which their department develop new programs, evaluate existing programs, and make the case for programs to an increasingly attentive constituency; and they must administer a budget to pay for these efforts.Public Health Administration gives public health leaders and managers the tools with which to translate what we know and think about public health administration into what we do every day. The guidebook for Chief Medical Officers deal with every aspect of an administrator's responsibilities, defining terms, setting the issues in their public health contexts, and giving concrete advice that will help administrators just beginning their tenure as well as seasoned public health professionals facing new challenges or a changing landscape.

While much attention has been paid, with good reason, to the need to provide greater access to formal public health training for the public health workforce, less has been paid to systematically providing training in management principles and methods to its leaders and managers as Chief Medical Officers. This guidebook helps fill that gap.

(Brajesh Pathak)


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MESSAGE

Shri Mayankeshwar Sharan Singh,
Hon'ble State Minister
Medical Health and FamilyWelfare
Department
Government of Uttar Pradesh

The assumption behind Public Health Administration is that nothing to which public health professionals aspire no programs or interventions designed to improve and protect the health of the population can happen without competent, effective leadership. Public Health administration is the means by which effective leadership is translated into effective action.

A final development worth noting is the progress toward evidence based practice in public health and the growing body of evidence produced through the field of public health systems The growing numbers of engagement of public health professional's participating in practice-based activities in order to learn better ways of organizing, financing, and delivering services. This guidebook highlights the progress to date and the opportunities and challenges faced by Chief Medical Officers as public health administrators who engage in the district public health development.

This guidebook for Chief Medical Officers helps bring about that translation. It represents an important tool for improving the quality of public health service as it is practiced in every corner of the Uttar Pradesh, now and in the decades to come.

I thank team SIHFW for developing this guidebook for public health management mantra's for Chief Medical Officer's as Public Health administrators and nurture them to the best of their abilities and take part in the continuing contribution in the field of public health services.

(Mayankeshwar Sharan Singh)


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FOREWARD

Shri Partha Sarthi Sen Sharma
Principal Secretary
Department of Medical, Health and Family Welfare
Government of Uttar Pradesh

The purpose of this guidebook is to empower Chief Medical Officers to implement a formal system of quality standards in Public Health System at their respective districts, so that health facilities in Uttar Pradesh not only provide a range of services which are envisioned to have been provided, but also ensure that the services meet a minimum standard of quality.

This guidebook is developed in recognition of the fact that health and welfare programmes often fail to perform optimally, not because of technical incompetence, but rather as a result inadequate management and leadership expertise. Chief Medical Officers are frequently required to carry significant management responsibilities with little or no preparation for the role of manager. The guidebook thus aims to provide Chief MedicalOfficers with an understanding of the concepts behind and practices associated with effective management in the field of health. The approach of guidebook is practical, requiring Chief Medical Officers to relate information to their own context and reflect on their own experiences as they work through the guidebook.

I hope this guidebook for Chief Medical Officers will provide scope to understand the importance of the leadership task to ensure direction, alignment and commitment within district to culture high quality with clear government mandate towards health care, people management and staff engagements, leadership and management nuance and advance understanding of effective media tools for health care promotions.

(Partha Sarthi Sen Sharma)


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PREFACE

Smt Aparna Upadhyay
IAS
Mission Director
National Health Mission,
Uttar Pradesh

Public Health Care is undergoing a paradigm shift in Uttar Pradesh. We are truly building a bridge between a traditional, guideline-driven practice of medicine, emphasizing procedures and medications, and also efficient administration.

It is expected of Chief Medical Officers to play a vital role in improving the health status & quality of living of the people in their respective districts by providing health services in remotest area. This can be achieved though a nuanced understanding of management and leadership.

In lieu of the above, the State Institute of Health & Family Welfare (SIHFW), has developed this guidebook for Chief Medical Officers and this guidebook has arrived at the most opportune moment.

Now more than ever, a multi faceted approach is required for managing health needs for the people of Uttar Pradesh, with an emphasis on optimizing managerial, financial and administrative functions of the office of Chief Medical Officer.

The publication of this booklet will certainly imbibe Chief Medical Officers with required confidence and serve them a ready reference tool for managing their roles and responsibilities.

I congratulate the team at State Institute of Health & Family Welfare, Uttar Pradesh, for developing this guidebook and urge them on for continued development of short term trainings courses and resource materials for different public health cadre in upcoming years.

(Aparna Upadhyay)


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MESSAGE

Dr. Lilly Singh
Director General
Medical and Health Services
Govt. of Uttar Pradesh
Uttar Pradesh

Chief Medical Officers are Public Health Administrators who understands both, the medical and administrative sides and function as a "liaison" between the two, thus enabling the environment that results in providing high-quality patient care for patients.

In Uttar Pradesh, CMOs are required to provide efficient management and leadership in districts health facilities. By the virtue of their roles, Chief Medical Officers are able to bridge the gap between administration, management and the clinical side, as well as cost and quality.

This guidebook is designed for a key reading for Chief Medical Officers in Uttar Pradesh with a genuine interest in the links between the theory and practice of healthcare management and how best practice might be achieved within healthcare systems.

With decades of experience behind them as Medical Officers, this guidebook will act as a refresher for Chief Medical Officers to further hone their administrative, financial and managerial skills.

I wish Chief Medical Officers will explore their best practices in their districts with applied basic management concepts prescribed in this guidebook.

(Dr. Lilly Singh)


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MESSAGE

Dr. Renu Srivastava Varma
Director General Family Welfare,
Directorate of Family Welfare,
Govt of Uttar Pradesh

Chief Medical Officers are important players within the healthcare system and public health at large. They are physician leaders who play a big role in providing high-quality patient care for patients, and they can have a great impact on the overall performance of their hospitals. Because of their importance, this Guidebook is intended as a facilitating tool for Chief Medical Officers.

This guidebook not only details out the aspects of management and leadership tangent for a Chief Medical Officer but also acts a one-stop guide on their responsibilities and accountabilities as per the government health guidelines.

This guidebook is a readymade reference for effective District Health administration with the emphasis both on Micro & Macro management highlighting the importance on the role of the efficient administration in implementation, monitoring and review of public health services in the districts.

By collating the information relevant for the health administrators, highlighting specific actions required and providing case studies to illustrate practice, the guidebook seeks to be a working document which can also be reviewed and updated periodically based on the experience of the implementation of the public health services.

I am especially pleased to note the emphasis placed on convergent working and the need to have a holistic view on public health by also discussing other relevant guidelines and policies that seek to public health service delivery system in the guidebook.

(Dr. Renu Srivastava Varma)


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MESSAGE

Dr. Anita Joshi
Director General (Training)
Medical, Health and Family Welfare
Govt. of Uttar Pradesh

It is expected from a Chief Medical Officer to not only work with other Medical Officers but to also educate, mentor, lead Medical Officers and act as a link between managerial, administrative and clinical dimensions of service.

Personal characteristics that seem important for chief medical officers such as judgment, rational thinking, common sense, ethics and integrity are refined over the length of service but at times road map serves a better purpose.

This ambitious book provides that comprehensive, coherent and research-based introduction to District Healthcare Management. It has been designed and written for Chief Medical Officers and takes government perspective in consideration, drawing on and comparing ideas and developments from national and international health care practices.

The book is structured into segments; it provides an overview of administrative, financial procedures, office management and sexual harassment at workplace. The book details out national health programs, and concluding with medico-legal processes which draws together the key themes and offers a view about future development and digital trends in healthcare management.

This book offers key managerial techniques and disciplinary tools that Chief Medical Officers need, to perform their roles as an able administrator. I hope this guidebook will facilitate current Chief Medical Officers and for others in future as well.

(Dr. Anita Joshi)


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ACKNOWLEDGEMENT

Dr. Rajaganapathy. R
Director
State Institute of Health and
Family Welfare Uttar Pradesh

This guidebook of Chief Medical Officers emphasized on convergent working and a holistic view on public health and outlining other managerial and administrative guidelines & policies that seek effective implementation of public health service delivery system with special reference to national health mission.

I would like to congratulate the faculties of State Institute of Health and Family Welfare in conceiving and giving action to shape this guidebook. My commendations to concerned Medical officers (list is exhaustive) posted as Health administrators at Divisions and Districts for their valuable inputs and contribution is shaping this guidebook with their vast services tenure, concerned GM's of State Program Management Unit, NHM for their technical support and to all those who contributed with their suggestions and recommendations. This is only one step in the effort to support and enhance the role of Public Health Services with diverse leadership qualities and inbuilt managerial skills in Chief Medical Officers during their actions in district health administration.

I am looking forward to a wider dissemination of this guidebook and feedback on its efficacy in the coming months.

(Dr. Rajaganapathy R.)


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1 PUBLIC HEALTH PRACTICE

Public health practice comprises organized efforts to improve the health of communities. Public health prevention strategies are targeted to populations rather than to individuals. Throughout history, public health effort has been directed to the control of transmissible diseases, reduction of environmental hazards, and provision of safe drinking water. Because social, environmental, and biologic factors interact to determine health, public health practice must utilize a broad set of skills and interventions. During the 20th century, the historic emphasis on protecting communities from infectious disease and environmental threats expanded to counter risks from behaviors and lifestyles that led to chronic disease. Population-based prevention resulted in major gains in life expectancy during the 1900s. In the beginning of this century, public health expanded even further as numerous events necessitated a shift in public health priorities.

Public health consists of organized efforts to improve the health of communities. The operative components of this definition are that public health efforts are *organized* and *directed to communities* rather than to individuals. Public health practice does not rely on a specific body of knowledge and expertise but rather relies on a combination of science and social approaches. The definition of public health reflects its central goal—the reduction of disease and the improvement of health in a community.

Defining Public Health: Historical and Contemporary Developments

In 1920, C.E.A. Winslow provided the following definition of public health practice:

- Public health is the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment,
- the control of community infections, the education of the individual in principles of personal hygiene,
- the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and
- the development of social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.

Almost 70 years later, in 1988, the Institute of Medicine (IOM) published its classic report, The Future of Public Health, similarly defining public health as an "organized community effort to address the public interest in health by applying scientific and technical knowledge to prevent disease and promote health.

The mission of public health, then, is to ensure conditions that promote the health of the community.

Population-based strategies for improving community health include efforts to control epidemics, ensure safe water and food, reduce vaccine-preventable diseases, improve maternal and child health, and conduct surveillance of health problems

In addition to long-standing efforts to protect communities from contagious and enironmental health threats, the public health arena is expanding to counter new and contemporary risks: obesity, adolescent pregnancy, injury, violence, substance abuse, sexually transmitted diseases (STD), human immunodeficiency virus (HIV) infection, natural disasters, and bioterrorism. To be successful, however, any approach to improve a community's health must involve both population-based and clinical preventive activities.

Public health differs from clinical medicine by emphasizing prevention and keying interventions to multiple social and environmental determinants of disease; clinical medicine focuses on the treatment of the individual. However, interaction between public health and medicine is necessary because individual health and community health are elements of a continuum. Tuberculosis (TB), HIV infection, STD, lead toxicity, vaccine-preventable disease, and even heart disease and asthma are among the many health problems that are ideally managed in both population and clinical settings.

Ample evidence for the importance of influencing population-based determinants of health is shown by the increase in life expectancy from 45 to 75 years for individuals living in industrialized countries during the 1900s (Figure 1-2). The majority of this gain, 25 of the 30 years, can be attributed to public health measures such as better nutrition, sanitation, and safer housing.[3] Medical care focusing on individual patients, though important, only contributed five years of the gain in life expectancy.

Furthermore, the relevance of public health and clinical collaboration is underscored by estimates that 50% of premature deaths are preventable and influenced by personal behaviors—the abuse of tobacco and other substances, poor diet, and sedentary lifestyles.Changes in health status can best be achieved through partnership between clinical efforts focusing on individual patients and community-wide public health interventions addressing environmental and social determinants that

place individuals at greater risk of disease.

Both science and social factors form the basis for public health intervention. Successfully eradicating a vaccine-preventable disease from a community requires more than development of an effective vaccine. Acceptance and widespread use of the vaccine in the community is dependent on a successful public health initiative providing public information and facilitating delivery. Too often, scientific advances are not fully translated into community health improvement. For example, in the United States, perinatal transmission of HIV has plummeted in the past 10 years because of aggressive approaches for testing and treatment of HIV during pregnancy and delivery; yet congenital syphilis, while decreasing, has not achieved the same level of success despite the fact that scientific means (penicillin) to eradicate it entirely have been known for many more years. A comprehensive public health approach, combining science with practical approaches to address cultural and socioeconomic factors important to the improvement of birth outcomes for at-risk women, is essential to eliminate these preventable diseases.

Another example of the important interplay of clinical and public health interventions is that of an outbreak of tuberculosis in a homeless shelter for men in a community in upstate New York in the 1990s. Clinical interventions, including administration of anti-TB medications and sophisticated diagnostic methods, were combined with a broad public health approach to minimize the impact of the outbreak. Outreach efforts and incentives for directly observed therapy were tailored to the social factors associated with this group of men. Risk factors for poor health outcomes included concomitant infection with HIV, alcohol and substance abuse, homelessness, and inadequate ventilation of the shelter. All were determinants of this outbreak. Unfortunately, despite vigorous attempts to engage the individuals diagnosed with active tuberculosis, noncompliance remained a significant challenge, ultimately leading the local public health agency to obtain court orders mandating the hospitalization of several of the men. In addition to ensuring treatment of those known to have active tuberculosis, significant efforts were made to identify, and treat when indicated, hundreds of individuals who were exposed to tuberculosis in this outbreak. This case illustrates a basic tenet of public health: protecting the health of the community, even when these efforts conflict with the

individuals' autonomy, involves more than the sum of the treating the infected individuals.

Early Collective Action to Improve Health in Great Britain and the United States

The evolving definition of public health activity is forged by hazards requiring collective action. Throughout history, attention has been directed to controlling transmissible diseases, improving the environment, and providing safe drinking water. Toilets drained by covered sewers have been found in excavations of civilizations dating to 4000 years ago in the Indus Valley. In 2000 BCE cities, including Troy, had highly developed water supply systems. At the time of Joshua when Israelites settled in the Holy Land, there were rules governing the water supply that dictated that there could not be a cemetery, animal slaughterhouse, tannery, or furnace within 50 cubits (approximately 25 meters) of a village water supply. In the Western Hemisphere, impressive ruins of sewers and baths document the achievements of the Incas in public health engineering.

The Greeks believed that ill health developed from an imbalance between man and his environment, not unlike contemporary public health theories of multifactorial disease causation, in which environment plays a prominent role. In his book, *On Airs, Waters and Places,* Hippocrates summarizes factors important to disease, including climate, soil, water, mode of life, and nutrition. Furthermore, Hippocrates provided guidance to the location of Greek colonies as they expanded eastward to Italy and Sicily. Houses were to be located on elevated and sunny areas, avoiding marshes and swamps with their vector-borne illnesses.[6] The Romans also made the connection between swamps and disease (specifically, malaria), and determined salubrity was an important component of the selection of places for habitation. Ancient terms describing disease are still in use, including *endemic* (background or usual occurrence) and *epidemic* (excessive occurrence).

In the Middle Ages (AD 500–1500), epidemics of infectious diseases spurred collective activities by communities to promote the public's health, presaging the later formation of boards of health and public health departments in the 1800s. The Middle Ages were marked by two major epidemics of bubonic plague—the Plague of Justinian (543) and the Black Death (1348)—with smaller outbreaks of various diseases in the intervening period, including leprosy, smallpox, tuberculosis, and measles. During this period, lepers were considered public

menaces and were expelled from the community.

This is a stark example of deprivation of individual civil rights in a quest to protect the health of the public. Similarly, the Black Death was regarded as a communicable disease, and the countermeasure employed was isolation of the ill individual. In addition, victims of the disease had to be reported to the authorities, a forerunner of the basic public health functions of disease reporting and surveillance. Quarantine measures were instituted to stop the entry of plague from outside regions. In 1348, Venice, a chief port of entry for commerce from the Orient, was the first city to institute quarantine, requiring the inspection and segregation of ships and individuals suspected of carrying disease. This was expanded in 1423, when a pesthouse or *lazaretto* was erected in Venice as a place to hold detained individuals suspected of harboring infection (*lazaretto* is derived from the name of the Biblical character Lazarus, who was a leper). These detention areas were used for isolation in many types of pestilence. This precedent of isolation and quarantine remains relevant and controversial in contemporary public health practice. Medieval cities were run by councils who were charged with routine community administration as well as the supervision of disease prevention, sanitation, and protection of community health. Measures were instituted to control the transmission of infections, including food inspections, regulation of waste disposal isolation, disinfection, as well as isolation and quarantine. In another example of early collective public health action, Venice, like other cities at that time, set up a council of men to supervise the health of the city— a forerunner of boards of health that were implemented centuries later. These interactions are diagrammed. The collective actions to protect public health that were implemented in the Middle Ages exhibit patterns that are very much in existence in our current public health programs: a population-based focus for interventions, involvement of government, prominence of environmental interventions, and potential for infringement of individual rights to protect the public.

Public Health

Health is clearly not the mere absence of disease. Good health condition ensures that the person is free from any disease and this gives him/ her ability to work and realise his/ her full potential. Good health confers on a person or groups' the freedom from illness and the ability to realise one's full

potential. Health is best understood as the indispensable basis for defining a person's sense of well-being. In ensuring good health, a country's health care plays a major role. Health care covers not merely medical care; all aspects like preventive and curative and rehabilitative care are given due importance. It includes both public and private sector health care institutions; health promotion-prevention of disease-curative rehabilitative elements is given representation in an ideal health care system. Under the Indian Constitution, health is a state subject. Each state therefore has its own health care delivery system in which both public and private actors operate. While states are responsible for the functioning of their respective health care systems, certain responsibilities fall on the federal (central) government, namely policy making, planning, guiding, evaluating, assessing, assisting to the respective state governments and providing funding to implement the national health programmes. India's health care system is characterised by multiple systems of medicine which include not only Allopathy (western medicine) but also Ayurveda, Sidhha, Unani, Yoga and Sowa Rigpa type of medical systems. In India, apart from various national programmes targeting different diseases, we have both public (Government) owned hospitals and private hospitals and clinics .

2 HEALTH CARE: BASIC CONCEPTS

Health care is defined as a multitude of services rendered to individuals, families or communities by the agency of the health services or professions, for the purpose of promoting, maintaining, monitoring or restoring health.

Health Care and Public Health care services are the set of institutions with adequate infrastructure; work force and funding that ensure the delivery of public health facilities/programmes in the country.

Public health services are conceptually different from medical services. They have a key goal in reducing a population's exposure to diseases; for example, assuring food safety, vector control, waste management, health education etc., are important elements of health care along with the medical (curative) oriented facilities. Public health services produce "public goods" of incalculable benefit for facilitating economic growth and poverty reduction.

Main Characteristics of Health Care The main characteristics of health care can be summarised as follows: Appropriateness (relevance) i.e. whether the service is needed at all in relation to essential human needs. Comprehensiveness i.e. whether there is an optimum mix of preventive, curative and promotional services. Adequacy i.e. if the service is proportionate to the requirements like doctor patient ratio. Availability i.e. ratio between the population and the health facility Accessibility i.e. geographic, economic and cultural accessibility Affordability i.e. expenses involved in availing the health care services.

Levels of Health Care Indian Health Care Services are usually organised at three levels as follows: Primary Health Care: This is the first level of contact between the individual/ community and the health system, where "essential" health care is provided. A majority of prevailing health complaints, minor ailments, and common infections along with preventive services can be satisfactorily dealt with at this level. In India, Village Health Guides,

ASHA Workers followed by the Sub-centres and the Primary Health Centres together constitute the primary level health care providers. Sub Centres and Primary Health Centres also provide reproductive health/ family planning services along with immunisation for children. Most of the vertical programmes use this level as the base of service provision. In a PHC, a doctor along with ANM will be posted and they can handle a normal delivery; whereas the cases that require Caesarean section will be referred to CHC or secondary health care facility like district hospital where an Obstetrics

and Gynaecology specialist is posted and other facilities like blood transfusion is available.

Secondary Health Care: At this level, more complex health problems are dealt with that are not effectively dealt at the primary level. It is essentially curative service oriented. It is provided by the district hospitals and the community health centres. They are also the first referral level in the health system. Facilities like X-Ray, CT/ MRI Scan, Blood bank etc., will be available and specialist doctors will be posted here. Various departments like, Obstetrics and Gynaecology, Ophthalmology, ENT, Oncology etc., will be functioning in these hospitals.
Tertiary Health Care: This level offers specialist and super specialist care. These institutions also do planning, developing managerial skills and teaching/ training the medical/ paramedical staff. Medical colleges and super speciality hospitals are included in this category. They are generally referral hospitals where highly specialised treatments are available.
Components of a Just and Efficient Health Care System Having a good network of health care is not adequate; but the system should be 'Just and Efficient' so that the services reach to the most marginalised and poor people of the society. Understanding health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality. The right to health must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other status.
Right to Health and Components The right to health (Article 12) was defined in General Comment 14 of the Committee on Economic, Social and Cultural Rights – a committee of Independent Experts, responsible for overseeing adherence to the Covenant. The following are the components of Right to Health.
1) Availability: The health care services are available to all irrespective of the ability to pay, caste, class, religion, gender etc.
2) Accessibility: The health care services are physically and economically accessible to all. The accessibility to information is also part of accessibility.
3) Acceptability: Relates to respect for medical ethics, culturally appropriate, and sensitivity to gender. Acceptability requires that health facilities, goods, services and programmes are people-centred and cater for the specific needs of diverse population groups and in accordance with international standards of medical ethics for confidentiality and informed consent.

4) Quality: The services provided must be scientifically and internationally accepted. Safety, effectiveness, efficiency and timely nature of services are covered in this aspect.

The following four criteria are important to consider/evaluate a health care system as Just and Efficient.

a) Universal access, access to an adequate level and access without excessive burden.

b) Fair distribution of financial costs for access and a constant search for improvement to a more efficient system.

c) Training providers for competence, empathy, accountability, cost-effective use of resources etc.

d) Pay special attention to the vulnerable groups such as disabled, aged and children. The following six components that will ensure efficiency and success in public health care. They are:

a) Innovation to develop the evidence base for action.
b) A technical package of a limited number of high priorities, evidence-based interventions that together will have a major impact.
c) Effective performance management, especially through rigorous, real time monitoring and evaluation.
d) Partnerships and Coalitions.
e) Communication of accurate and timely information to the health community and civil society.
f) Political commitment to obtain resources and support for effective action.


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3 INDIA'S HEALTH CARE SYSTEM: AT A GLANCE

India's health care system can be classified into many categories based on various parameters. Depending upon the function it addresses the Health Care system in India consists of four components.

They are: Primary, secondary, tertiary institutions manned by medical and para-medical personnel; Medical colleges and para-professional training institutions to train the needed manpower and give the required academic input; Programme managers, managing on-going programmes at central, state and district levels; and Health management information system consisting of a two-way system of data collection, collation, analysis and response. Depending upon the source of funds for operation and health resources (technology/work force) used, health care system is divided into five sectors as follows: Public Health Sector — Include Primary health care (Sub-Centers and Primary Health Centres), Hospitals (Community Health Centres, Rural Hospitals, district Hospitals, medical colleges, specialist hospitals), health insurance schemes (ESI, Central Government Health Scheme) and other agencies health services (like defence hospitals, railway hospitals).

- Private Health Sector — This includes private hospitals, nursing homes, dispensaries, clinics etc.
- Voluntary Health Agencies – which are not-for-profit organisations working in the field of health Depending Upon Type of Medical Systems we have Allopathy and AYUSH services are two broad categories.

Indigenous System of Medicine consists of Ayurveda, Yoga, Unani, Siddha, Homeopathy, SowaRigpa shortly termed as AYUSH. This has a separate ministry to provide fund, support Research and Development. Public hospitals, clinics and private hospitals/ clinics form part of this network. Various National Health Programmes National Health Programmes-they are vertical programmes, planned, developed, implemented and funded by the federal (central) government to combat particular diseases like malaria/leprosy etc. We will be studying more about these national programmes in detail in the following sections.

Public Sector Health Care in India Primary Health Care in India forms the backbone of the health system, especially in rural areas.

At village level, it consists of Village Health Guides, trained Dais and Anganwadi workers (From Integrated Child Development Scheme). This is

supported and supervised/coordinated by the Sub-centres and the Primary Health Care Centres. Accredited Social Health Activist (ASHA) is a woman who is selected from the village itself and she is trained to work as interface between the community and the public health system. ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She would be a promoter of good health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. ASHA: is a person who has an aptitude for social service and she is not a full-time government employee. She serves as a link between the community and the government health infrastructure. She is selected at the village level (1 for each 1000 rural population) and undergoes training in the nearest Primary Health Care Centre for three months. Primary responsibility of village health guide includes, helping the community with minor medical problems, ensure first aid, maternal-child health care, health education and sanitation.

Trained Birth attendants: Woman from village is selected and she undergoes a training of thirty working days at the Primary health care centre or maternal and child health centre. After the training she is provided with delivery kits, her main responsibility is to ensure safe delivery and promote small family norm.

Anganwadi Worker: Under the Integrated Child Development Scheme (ICDS) there is one Anganwadi worker employed for 1000 population. She is trained in various aspects of health, nutrition, primary education etc. and she plays a pivotal role in ensuring health access and health/ nutritional/ health supplements benefit to pregnant women, 0-6 year children, lactating mothers and adolescents

Subcentre (SC): Government of India approves one SC for 5000 population in general and in hilly / tribal areas it is one per 3000 population. Two multipurpose workers (shortly called as MPW – one male and one female) are employed here. They are responsible for all health service and health programme implementation in that area. Generally, the male MPW looks after programmes like malaria, Tuberculosis etc., whereas the female MPW will look after maternal and child health/ family planning services.

Primary Health Centre (PHC): One PHC is approved for 30000 population in rural/ plains whereas it is one PHC for every 20000 population in tribal/ hilly areas.

The major functions of PHC includes

health education, promotion of nutrition, sanitation, immunisation, MCH care, appropriate treatment of common diseases/ injuries, essential drug supply, implementing and supervising various national health programmes and referral services. PHC will have medical officers, staff nurse, nursing assistants, pharmacists and other supporting staff. Angwanwadi Centers (Department of Women and Child Development): Nutritional needs of pregnant woman, nutritional needs of 0-6 year old children and adolescent girls' health requirements are met through anganwadi centers where food grains and medicines are distributed. Secondary Level of Health Care consists of community health centres, rural hospitals, district hospitals and speciality hospitals.

Community Health Centres (CHC): One out of four PHC in a block is usually upgraded and recognised as a Community Health Centre (CHC). It should have 30 beds with specialists in surgery, medicine, gynaecology/ obstetrics and paediatrics. It also should have diagnostic facilities like X ray and laboratory facilities. One CHC usually covers a population of 80000- 120000.

Health Insurance: No universal health insurance is mandatory in our country. However, two insurance-based programmes are well-implemented and managed in India. They are ESI and Central Government Health scheme. ESI was introduced in 1948 to provide medical care for people working in industries. Central Government Health Scheme was introduced in 1954 and it covers the employees of autonomous organisations, retired central government servants, retired judges, MPs of Parliament and their families.

Ayushman India is a new scheme that was recently launched, and it aims to provide universal insurance coverage to the citizens of this country. Other Agencies: This includes medical services provided by defence forces, through their hospitals/ medical colleges.
Similarly, Indian railways also provide health care facilities for their employees and family members. b) Private Health Care in India This mainly consists of private hospitals, independent clinics, nursing homes etc. This sector is highly unorganised and is concentrated in urban areas. It provides mainly curative and immunisation services. Medical Council of India and Indian Medical Association regulate and control some aspects of the private health care sector.

Ministry of AYUSH and its Health Care Institutions Ministry of AYUSH (which was initially the department of AYUSH), regulates, maintains and develop manpower, infrastructure, Research and Development, drugs etc., for AYUSH systems (Ayurveda, Yoga, Unani, Sidha, Homeopathy and Sowa-Rigpa). Both public sector institutions (primary level

clinics, Ayurveda hospitals, Ayurveda/ homeopathy medical colleges) and private hospitals/clinics/colleges are under the control and supervision of Ministry of AYUSH.

Voluntary Health Agencies Voluntary health institutions are not-for-profit organisations usually registered under the Societies Registration Act or the Trust Act. International level organisations like Red Cross Society, World Health Organisation etc., are also part of this network, which provides specialised training, skill development, R&D support to the federal (central) government. Indian Council for Child Welfare, Voluntary Health Association of India, The All India Blind Relief Society etc., are some other important organisations that render their services in the area of health.

4 NATIONAL HEALTH PROGRAMMES IN INDIA

The central government has undertaken several measures to improve the health of the people. Prominent among these measures are the National Health Programmes. Various international agencies like WHO, UNICEF, UNFPA etc., are also providing technical-material assistance in the implementation of these programmes.

India, since independence has formulated and implemented couple of National Health Programmes and these programmes have helped the country to improve health status tremendously. National Programmes has the following features in common: Targeting one disease — usually national health programme is shaped targeting one disease. For example, National Malaria Programme focused specifically malaria. Vertical in nature — i.e. each national programme has separate work force, fund allocation and research institutes etc., and the programme is usually not integrated with general health system.

However, under the aegis of National Health Mission (NHM) almost all the national programmes are integrated with the general national health services. The impact of National health Programmes is constantly monitored through surveillance mechanism. This is to check the impact on the disease burden. They focus both preventive and curative aspects. Programme will have both curative and preventive elements integrated into the system. In the following section, we will briefly discuss some of the important National health Programmes.

National Vector Borne Disease Control Programme (NVBDCP) The NVBDCP is implemented in the States/ UTs for prevention and control of vector borne diseases namely malaria, filariasis, Kala-Azar, Japanese Encephalitis (JE), Chikungunya and Dengue. The Directorate of NVBDCP is the nodal agency to implement the programme. Now the programme is integrated with the National Health Mission (NHM). Under NVBDCP there are three strategies:

a) Disease management including early case detection, complete treatment, strengthen the referral services and preparedness;

b) integrated vector management;

c) supportive interventions like behaviour change communication and capacity building. National Malaria Control Programme was launched in 1953. In 1958, aim was to eradicate malaria. But in 1970s there was resurgence of malaria, and in 1999 the programme was renamed as National Anti Malaria Programme and in 2002 this national programme was integrated to NVBDCP. National Filaria Control programme has been in operation since 1955. In India, in 1978 the operational

component of this programme was merged with the Urban Malaria Scheme.

Kala-Azar which is now endemic to 31 districts of the country especially in West Bengal, Bihar and Uttar Pradesh received special attention, when a centrally sponsored scheme was launched in 1990-91. World Health Organisation is also supporting this programme by providing drugs free of cost. Japanese Encephalitis (JE) is a disease with high mortality rate and those who survive do so with various degrees of neurological complications. JE vaccination is recommended for children between 1 to 15 years of ages. Dengue in 1996 onwards often outbreaks of dengue are reported from across the states. Strategies used to combat this disease include identification and control of outbreak, demarcation of affected area, case management, vector control and Information Education Communication (IEC) activities. Chikungunya is a debilitating nonfatal viral illness, remerging in the country after a gap of three decades. The diagnostic kits are developed and provided by the Institute of Virology, Pune. Vector control and IEC are the other strategies used. All the above mentioned six diseases are vector borne and are integrated into NVBDCP, which stands presently implemented through the National health Services under National Health Mission (NHM).

National Leprosy Eradication Programme The programme to combat leprosy was initially launched in 1955 and strategy was early detection of cases. By 1980 Central Government resolves to eradicate leprosy by the year 2000. In 1983, the programme was renamed as National Leprosy Eradication Programme and since 1993, the World Bank is supporting the programme. Decentralised, integrated leprosy services through general health care system, capacity building, use of IEC, medical rehabilitation are the components of the programme.

Revised National Tuberculosis Control Programme (RNTCP) National Tuberculosis Programme (NTP) has been in operation since 1962. However, treatment success rates were unacceptably low, and death and default rates remained high. In 1993, the programme was renamed as the Revised National Tuberculosis Control programme and the strategy adopted DOTS (Directly Observed Treatment Short-Course) strategy. DOTS strategy ensured higher treatment completion rates. The organisation structure included state level offices, District Tuberculosis Centres, DOTS providers and microscopy centres.

National AIDS Control Programme National AIDS Control programme was launched in India in the year 1987, immediately after the detection of the first case in 1986 in Chennai. National AIDS Control

organisation (NACO) was set up as a separate organisation to plan, implement, and monitor and modify the components of the programme. At the state level, state AIDS control societies are established to implement the programme.

The national strategy has the following components:

a) establishment of surveillance centres to cover the whole country;

b) identification of high risk group and their screening;

c) issuing specific guidelines for blood banks;

d) IEC through mass media.

Preventive, curative and rehabilitative services are provided. ICTC (Integrated Counselling and Testing Centres) and ART centres (Anti Retro Viral Therapy) are established integrated with general health services of the country.

Universal Immunization Programme With the support of World Health Organisation (WHO) Indian Government launched expanded the programme on immunisation in 1974, against, six most common, preventable childhood diseases, viz. Diphtheria, whooping cough, tetanus, polio, tuberculosis and measles. Now UNICEF is also supporting the programme. Apart from this JE, rotavirus, Measles – Rubella, Chikenpox vaccinations is also available on optional-payment basis. Now, Universal Immunisation Programme is integrated with the general health system under the aegis of National health Mission and at Primary Health Centre level special emphasis is provided to achieve the universal coverage.

National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) Cardiovascular diseases and other non–communicable diseases are surpassing the burden of communicable diseases in India. Considering this epidemiological risk, this programme was launched. The programme focuses on the health promotion, capacity building including human resource management and development, early diagnosis and management of these diseases with integration with the primary health care system. The programme is integrated with the general health services and is implemented through Primary Health Centres and Community Health Centres. Non-communicable disease clinics are established at Primary Health Centre and Community Health Centres. At district level, the work force is trained and deployed.

National Mental Health Programme National Mental Health Programme was launched in 1982 with a view to ensure availability of mental health care services for all, especially for the risk groups and unprivileged section of the population. The aim of national

mental health programme are: a) prevention and treatment of mental and neurological disorders and their associated disabilities; b) use of mental health technology to improve general services; c) application of mental health principles in total national development to improve the quality of life; d) streamlining / modernising mental hospitals; e) upgrading psychiatric department research and development.

Reproductive, Maternal, Neonatal, Child Health and Adolescents Programme (RMNCH+A) This is the strategy based on a continuum of care approach and defines integrated packages of services for different stages of life. It aims to provide services from neo-natal stage to child, adolescent group to reproductive – maternal stages in a woman's life. Essential obstetric care, promoting anti-natal checkups, essential newborn care, family planning services and choices, HIV/AIDS, Sexually transmitted Diseases (STD) support, immunisation, disease control among newborn and children, iron –calcium nutritional supply, supplementary nutrition to the lactating mothers, registration of all pregnancies, child birth and mortalities, adolescent health care etc., are the major components of this programme. Reproductive and Child Health Programme was launched in 1990s and had different phases before it is revamped and relaunched as RMNCH+A in 2013.

National Health Mission (NHM) The Ministry of Health and Family Welfare is implementing various schemes and programmes to provide universal access to health care for its citizens. As a part of the plan to increase the efficiency of health care system, many programmes have been brought together under the overall umbrella of National Health Mission with National Rural Health Mission (NRHM) and National urban Health Mission (NUHM) as its two sub-mission. The NHM was approved in 2013. The main programmatic components include: a) health system strengthening in rural and urban areas; b) Reproductive-maternal-New Born-Child and Adolescent Health (RMNCH+A); c) control of communicable and non-communicable diseases.

5 ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN HEALTH SECTOR OF INDIA

Apart from the central and state governments, there are other stakeholders who are working in improving the health status of people. Non-Governmental Organisations play an important role in reaching out to the most underprivileged sections of the society. NGOs have long history of active involvement in the promotion of human well-being. In particular, NGOs provide important links between the community and government. They possess certain strengths and characteristics that enable them to function as effective and dynamic agents in this process. Their programmes ranging from research to community-basedprojects cover the wide spectrum of human concerns and often pioneer in the fields of health and developments.

Understanding of NGOs Non-Governmental organisations are called by various names across the world, such as third sector organisations, non-profit organisation, voluntary organisation, charitable organisation and community-based organisation. In India, they are often called as not-for-profit institutions and officially defined as an organisation that are –

a) not-for-profit and ;

b) by law or custom do not distribute any surplus they may generate to those who own or control them;

c) are institutionally separate from the government;

d) are self governing;

e) are non-compulsory in nature.

NGOs generate funds from foreign funds, government grants, corporate social responsibility funds, NGOs own fund generating resources and other philanthropic/ individual charitable donations. Though the nature and focus of activities has changed over the time, NGOs have gained prominence in the wide spectrum of social life including health care. The World Health Organisation has acknowledged NGOs in terms of increasing recognition to complement government programmes and creating effective people's voice in respect of health service requirements and expectations.

Functions of NGOs in the Health System

The primary focus of NGOs in the health sector can be listed as follows: Establishing health care institutions; Fulfilling health and social needs of groups like women, elderly and vulnerable local communities; Dealing with specific health issues such as AIDS, alcoholism; Promoting Health Rights; Performing preventive health programmes; and Managing health finance/ funding and administration. Some NGOs operate internationally and are concerned with global health issues. Some NGOs in India also play an important role in providing health care at the time of emergencies/ natural

disasters.

The Health Activities of NGOs in India NGO run hospitals are heterogeneous and vary in terms of ownership, financing and costs. In recent past, in about ten health-oriented projects of Ministry of Health and Family Welfare, NGOs have actively taken part as health service providers. All these NGO schemes are now under the provision of flexi pools of National Health Mission. Besides, some NGOs (especially the national counter parts of International NGOs) have their own health financing schemes. In India, majority of these NGOs are covered under the Societies Registration Act or Indian Trusts Act. In addition, there are number of informal associations working at grassroots level without being registered in the legal level.

An overwhelming number of NGOs about 84% are found in outreach activities. The outreach activities are the main health activity in which generating awareness to targeted population is the major subcomponent of outreach for Indian NGOS. Preventive care is the most common activity provided by the NGO sector in India. In most states, other than Kerala and Manipur maximum funds are directed towards preventive care. In Kerala maximum funds are spent for curative care with preventive care being the second highest. In Manipur, health system supportive services in terms of management and finance dominate other expenses.

6 PROSPECTS OF INDIAN HEALTH SYSTEM

Since independence, in the last seventy years India's health care system has developed at an impressive rate. We have large network of integrated primarysecondary-tertiary level services where both public and private providers coexist. India's overall achievements regarding longevity and other key indicators are impressive but it is uneven across various states. For example, in Kerala Maternal Mortality Rate is 64 whereas national average is 165 and in states like Uttar Pradesh, it is still above 200 (NFHS IV data, 2015). In the past seven decades, life expectancy has increased from 45 years to 68 years (2011 census). Infant mortality rate has come down from 230 during independence to below 40 in 2017. Crude birth rates have dropped to 26.1 and death rates to 8.7. India also successfully managed the population problem by effectively implementing the Family Planning Programme since 1950s. Reduction in IMR, under five mortality rates during the last seven decades is impressive.


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7 PUBLIC HEALTH MANAGEMENT

Management skills in the healthcare setting are composed of sets of competencies essential for healthcare professionals who effectively and efficiently manage a variety of medical, nursing, or public health resources to attain goals that ideally align with improving the overall health of the population and healthcare system. In this activity, healthcare professionals who manage at any level of the health systems serve as healthcare managers, encompassing a wide range of specialties, including physicians (clinicians, surgeons, public health physicians, and other specialists), nurses, laboratory professionals, public health managers, dentists, among other healthcare professions. As expressed in references both for theoretical and practical guidance documents, management skills are often separated from leadership skills as these two sets of skills were known to be generally different. However, this activity does not constrain itself to the (theoretical) management skills per se. It is because effective and efficient healthcare managers require elements of leadership skills to fulfill managerial roles and responsibilities at the best possible level. The necessary skills of healthcare managers involve planning, organizing, implementing, monitoring, and evaluation skills. Planning refers to the preparation of the steps and protocols needed to achieve an ultimate end goal and the proper allocation of anticipated resources (including human resources) to the objectives and goals of the healthcare organization. Development of a plan can refer to action plans addressing small-scale activities for individual staff as well as operational and strategic plans for small groups (i.e., sections, units, departments) or organization-wide level. A pre-requisite to a well-developed plan with SMART (specific, measurable, attainable, realistic and time-bound) objectives is that the healthcare manager must be able to perform proper scanning and focusing skills, which are actually "leadership practices." Scanning refers to knowing one's self and environment together with the opportunities, threats, and risks to one's staff and the organization as a whole while focusing refers to concentrating each staff member's work in the healthcare organization relative to its vision and mission statements. Organizing is the ability to bring together the systems, processes, and procedures with the designated staff in an organization so that the right people will be able to do the proper work for the right purpose. Implementing skills, on the other hand, is focused on the performance of the assigned work based on planned activities. As a healthcare manager, one must know how to harmonize workflow

within all concerned staff, ensuring that the individual and overall plans get implemented effectively. The leadership practices essential in organizing and implementing (management) skills include aligning and mobilizing the staff. While management skills are focused on the use of organizational resources as mentioned, the goal of leadership skills centers on the mobilization of the members of the organization. For instance, a healthcare manager organizing human resource with the actual operations will not be complete and will not properly work in its implementation phase if some of the staff lack the motivation, which could be caused by the loss of teamwork. Or, in other circumstance, some staff may have unclear roles and responsibilities, resulting in their confusion at work and eventually low performance and productivity. Aligning and mobilizing is making all staff, including healthcare managers, share a common vision and commitment for the healthcare organization. Lastly, monitoring and evaluating skills must be part of the practice of healthcare managers on whatever type of healthcare organization. Monitoring skills mean the ability to check the progress of the organization in terms of achieving its plans while evaluating skills means that a healthcare manager can assess the attainment of desired results (output) after the whole process is carried out. In simpler terms, monitoring occurs "during" while evaluation is done "after" the implementation of an organizational project or program. Furthermore, these combined skills of monitoring and evaluation (often termed as M&E) involve the provision of feedback that will further improve plans and implementation. However, feedback must not be limited to the management systems and processes. It should also include feedback from staff, as to whether their commitment is sustainable, and they are still motivated to perform the work; this is where the leadership practice of inspiring the team applies. A good healthcare manager can provide trust and confidence to staff and can appreciate staff efforts. The inspiration of staff can manifest by providing supportive supervision to all members of the organization.In practicing these healthcare management skills, it is evident that leadership skills are equally vital. Healthcare organizations should not develop professionals who can only manage or who are leaders alone – because such a man will be unsuccessful. The development and enhancement of management skills can come from a variety of learning strategies and actual experiences. Healthcare management, as a specific profession, stresses its value and importance apart from the clinical aspects performed on the bedside. It is important to note that management

skills applied in the fields of medicine and public health do not only intend to provide better health services but also to optimize the health status of the patients and the community at large. Issues of Concern In recent years, some issues on management (and leadership) skills, particularly in the healthcare setting, begin to arise. The emergence of these issues highlights the need for improvement of healthcare management: Association between management skills and the efficiency of hospitals - The study looked at nurses and obstetrician's managers. Another study found out that improving management skills can further enhance the quality of health services. Education and training needs for healthcare management as basic preconditions for the development and implementation of adequate programs - Researchers performed a needs assessment in this research, which served as a basis for developing solutions in meeting the gap between healthcare managers and the competencies that they need. In another study, it revealed that while there is a high demand for leadership roles for physicians, medical education is still lacking with appropriate management skills for training future medical doctors. Communication and critical thinking skills in addition to other relational and organizations skills for healthcare management, were seen as essential competencies for development. Physicians are expected to be pivotal leaders, especially during transitional periods in the healthcare system. In the last decade, there has been an increasing emphasis placed on targeting potential areas to improve the various facets of medical training. Training in management skills, leadership, and practice management modalities have been gaining increasing traction in the literature. Regardless of the approach, the current curriculum must be revisited and improved to address this issue according to the type of approach provided by medical schools (either traditional, system-based, or hybrid curriculum). Training of practicing managers beyond clinical skills - For middle managers, additional skills for managing subordinates and coordinating with top-level managers is necessary, which includes capabilities such as communication skills (not with patients but with colleagues and other stakeholders), self-awareness, change management, conflict resolution, and other leadership skills. For frontline managers, a study revealed that they experience challenges in terms of integrating different professions as required by the health services they provide. Clarity on the roles and responsibilities of existing and new professionals working in healthcare is necessary. Collaborative interprofessional practice - Due to the reforms in transformational education

and significant changes in health systems, there is a need to develop interprofessional education to cultivate the value of teamwork despite differences across health professions. In the past, the physicians alone were believed to fulfill leadership positions in healthcare because of their multidisciplinary knowledge and clinical skills in terms of diagnosis and treatment of diseases. But as the health system evolves within countries, states, and communities, the need for other health professionals in performing leadership and management work has been observed. For example: In one of the low-and-middle-income countries (LMICs) where the number of physicians is not adequate, an issue has been raised regarding the filling up of leadership positions for the ministry (department) of health offices where the basic qualifications contain a medical degree. Other competent professionals who are not physicians feel that such opportunities become limited from them and could be a factor for slow improvement in health systems implementation. While this needs further investigation, it can be addressed appropriately depending on the context of the health system concerned. Interprofessional healthcare management can resolve the issue of superiority and inferiority among healthcare professions – medicine, nursing, allied health including laboratory and pharmacy, among others. Furthermore, it reinforces humility and teamwork while acknowledging the importance of each profession for the improvement of health. In the hospitals, where clinicians and medical specialists work together, options for treatment and management of patients come in a team-based fashion wherein different medical specialists give their expert opinions to the case and will not merely depend on the decision of the attending physicians as in the past. As the healthcare system continues to evolve, increasing emphasis should focus on cultivating physician, and hospital alignment strategies as mutually beneficial collaborative efforts are at least a significant component of delivering high-quality health care while keeping costs and resource utilization sustainable for the future of the healthcare system. The leadership of self as key to leading others - This paper discusses the course for public health leadership where participants are expected to develop their plans for nurturing their leadership skills. If a healthcare manager knows how to lead himself, it then becomes easier for him to familiarize and knowing more both the members and the organization well. Healthcare management as a profession -This is a field of health service delivery where formal and informal learning opportunities become available across

countries. There have been academic degrees which make it a distinct profession. In other countries, training for healthcare management become available. Moreover, in other technical areas of expertise, healthcare management practices and principles have been incorporated into the training curriculum to address the needs of specific healthcare managers at work. Meanwhile, though a formal education makes learning systematic, students and trainees must be able to gain practical experiences in the field so that academic concepts will be fully realized and applied in the actual healthcare setting. Clinical Significance The practice of management skills applied in the healthcare setting indirectly affects the patients. When healthcare managers manage the teams of the organization well, positive work culture (and work climate) become reinforced. In turn, the motivated staff at all levels of the organization increase their work performance as reflected through the optimal clinical (or health) services they provide to their patients. Therefore, the belief is that well-managed staff can lead to wellmanaged patients. Hence, sound management (and leadership) skills can impact positively on patients' health outcomes. The evolving healthcare system has been indicating that there is an increasing requirement for cultivated interprofessional relationships spanning across all health professions and subspecialties. Physician-Hospital alignment strategies have been receiving increasing levels of attention in the literature given the already identified critical nature of optimizing these relationships. Despite their often tumultuous histories, physicians and hospitals collectively are recognizing more and more the driving forces leading toward common goals. While each situation is inherently different, and each path toward idealized alignment is fraught with inevitable barriers and conflicts, it is essential for each party to identify and highlight the underlying principles that drive each other toward the process of achieving high-quality care at a reasonable cost.

HOSPITAL ADMINISTRATORS AND THE IMPORTANCE OF MANAGERIAL SKILLS

a Manager Should Possess Managerial Skills

Ability to Influence	Motivation of Others
Analysis of Data	Peer Counselling
Conflict Management	Negotiation
Decision Making	Performance Management
Leadership	Planning
Listening	Provision of Feedback
Meeting Management	Self-Management
Monitor and Evaluate	Time Management
Verbal Communication	Written Communication
Situational Analysis	Time Management
Applying Creative Techniques	Oral Communication
Strategic Planning	Written Communication
Professional Self-Development	Group Discussions
Planning,	Organizing and Monitoring
Progress Against Plan	Working Well with Peers
Motivation and Guidance to Others	Supervising the Wor
Operational Planning	Creating a Positive Atmosphere
Evidence-based Decision Making Organizing Daily Activities	Managing Change

Managerial Skill Sets by Categories

Operational:

Galvanizing
commitment and motivation
Maximizing team performance
Delegating to maximize performance
Managing stress and time effectively

Relational:

Communicating effectively & strategically
Negotiating and managing conflict and difficult people
Coaching for maximum performance and development
Counselling and interviewing for maximum performance and development

Analytical:

Thinking and deciding strategically
Mastering the budget process
Mastering and monitoring financial and human resources
Assessing corporate and human resources

The Scope of Problem Solving and Decision Making for Hospital Administrators

Strategy can be defined as the activities carried out by an organization to achieve its long term goals define strategy as a collection of thoughts and concepts guiding organizations in the effort to gain an advantage against their competitors in the sector and to achieve their targets. Strategic thinking as a concept is related to advanced sensitivity to changing conditions, active thinking, the desire to think in multiple ways, avoiding the traps set by the known and the maintenance of the capacity to make decisions. Strategic thinking can be summed up in three simple questions: What seems to be happening? What possibilities are we facing? What are we going to do about it explains this process, which he refers to as the strategic thinking cycle through three questions (see Figure 1). Even though data collection (such as strengths, weaknesses, opportunities and threats—SWOT Analysis) and the implementation of strategy processes

have been excluded from this cycle, this strategic thinking cycle is the basis for taking action.

This cycle comprises three stages:-

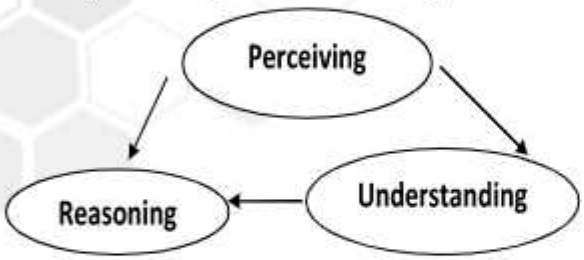

Figure depicts Cycle of Strategic Thinking

Each of these stages is related to the three questions mentioned. For each stage, there are two steps, making a total of six steps.

1. Gaining insight.
2. Developing foresight.
3. Defining strategic tools to gain advantage.
4. Matching tools to capacities.
5. Selecting a basic strategy.
6. Making the strategy work.

Most simply stated, a decision is a choice made from among the alternatives. That being said, making a decision does not merely mean choosing what will be done Decision making, creative thinking and problem solving all have common elements. All three concepts could be regarded as types of effective thinking. Problem solving attempts to identify the root problem in situations; much time and energy is spent on identifying the real problem. Decision making, on the other hand, is usually triggered by a problem, but is often dealt with in a manner that does not eliminate the problem. A decision appears to be such a common activity that it is very rare that any thought is devoted to discovering what a decision is. The three levels of decision making in a health care organization—strategic, administrative and operational—are closely related to the three levels of organizational planning:

1. Strategic Decision Making: Decisions at this level apply to the entire organization, are conceptual in nature, and usually have long-term consequences for organizations and, in the case of health care, for the community.

2. Administrative Decision Making: Decisions at this level, also referred to as tactical decision making, are made by middle management and apply primarily to one unit or several related units in an organization.

3. Operational Decision Making: Decisions at this level are made and carried out by supervisors or lower level managers.

This defines problems as obstacles, conditions, or phenomena that either stand in the way of achieving objectives or cause a deviation from the desired status. A problem is, 'something thrown in the path of a person, or something that obstructs them', and that a problem is actually a kind of solution or the concealed version of the solution within a problem.

Methods

To identify the problem-solving and decision-making skills of hospital managers working for hospitals, and the extent to which the level of these skills are related to other managerial skills (commitment, motivation, team performance, delegating and empowerment, effective and strategic communication, conflict management, coaching, counseling and interviewing, organizational and human resources and fit, time and stress management).

There is a significant relationship between the average scores related to managers' problem solving and decision making skills:

(a) average motivational skill scores;

(b) average commitment skill scores;

(c) average team performance skill scores;

(d) average delegating and empowerment skill scores;

(e) average effective and strategic communication skill scores;

(f) average conflict management skill scores;

(g) average coaching skill scores;

(h) average counselling and interviewing skill scores;

(i) average organizational and human resources and fit skill scores; and

(j) average time and stress management skill scores.

Model Approach

The study should be an analytical research aiming to identify the effect and direction of other managerial skills of hospital managers on their problem solving and decision making skills.

Samples, Data Collections and Data Analysis

The universe of the study should be small inclusive of hospital administrators (head doctors, hospital managers, head nurses and their assistants) at hospitals.

sample should be selected within the scope of the study, with the goal of reaching the whole universe.

At the end of the data collection phase, responses shall be assessed based on problem solving, decision making process.

8 PUBLIC HEALTH MANAGERS AND THEIR PERSPECTIVES

Healthcare organizations are complex and dynamic. The nature of organizations requires that managers provide leadership, as well as the supervision and coordination of employees. Organizations were created to achieve goals that were beyond the capacity of any single individual. In healthcare organizations, the scope and complexity of tasks carried out in provision of services are so great that individual staff operating on their own couldn't get the job done. Moreover, the necessary tasks in producing services in healthcare organizations require the coordination of many highly specialized disciplines that must work together seamlessly. Managers are needed to make certain that organizational tasks are carried out in the best way possible to achieve organizational goals and that appropriate resources, including financial and human resources, are adequate to support the organization. Healthcare managers are appointed to positions of authority, where they shape the organization by making important decisions. Such decisions relate, for example, to recruitment and development of staff, acquisition of technology, service additions and reductions, and allocation and spending of financial resources. Decisions made by healthcare managers not only focus on ensuring that the patient receives the most appropriate, timely, and effective services possible, but also address achievement of performance targets that are desired by the manager. Ultimately, decisions made by an individual manager affect the organization's overall performance. Managers must consider two domains as they carry out various tasks and make decision. These domains are termed external and internal domains. The external domain refers to the influences, resources, and activities that exist outside the boundary of the organization but that significantly affect the organization. These factors include community needs, population characteristics, and reimbursement from commercial insurers, as well as government plans such as the Children's Health Insurance Plans, Medicare, and Medicaid. The internal domain refers to those areas of focus that managers need to address on a daily basis, such as ensuring the appropriate number and types of staff, financial performance, and quality of care. These internal areas reflect the operation of the organization where the manager has the most control. Keeping the dual perspective requires significant balance on the part of management and significant effort in order to make good decisions.

Table 1-1 Domains of Health Services Administration

External

Table Domains of Health Services Administration

External	Internal
Community demographics/need	Staffing
Licensure	Budgeting
Accreditation	Quality services
Regulations	Patient satisfaction
Stakeholder demands	Physician relations
Competitors	Financial performance
Medicare and Medicaid	Technology acquisition
Managed care organizations/insurers	New service development

9 UNDERSTANDING MANAGEMENT: DEFINITION, FUNCTIONS, AND COMPETENCIES

As discussed earlier, management is needed to support and coordinate the services that are provided within healthcare organizations. Management has been defined as the process, comprised of social and technical functions and activities, occurring within organizations for the purpose of accomplishing predetermined objectives through humans and other resources. Implicit in the definition is that managers work through and with other people, carrying out technical and interpersonal activities, in order to achieve desired objectives of the organization. Others have stated that a manager is anyone in the organization who supports and is responsible for the work performance of one or more other persons. While most beginning students of healthcare management tend to focus on the role of the senior manager or lead administrator of an organization, it should be realized that management occurs through many others who may not have "manager" in their position title. Examples of some of these managerial positions in healthcare organizations include supervisor, coordinator, and director; among others.

Managers implement six management functions as they carry out the process of management:

Planning: This function requires the manager to set a direction and determine what needs to be accomplished. It means setting priorities and determining performance targets.

Organizing: This management function refers to the overall design of the organization or the specific division, unit, or service for which the manager is responsible. Furthermore, it means designating reporting relationships and intentional patterns of interaction. Determining positions, teamwork assignments, and distribution of authority and responsibility are critical components of this function.

Staffing: This function refers to acquiring and retaining human resources. It also refers to developing and maintaining the workforce through various strategies and tactics.

Controlling: This function refers to monitoring staff activities and performance and taking the appropriate actions for corrective action to increase performance.

Directing: The focus in this function is on initiating action in the organization through effective leadership and motivation of, and communication with, subordinates.

Decision making: This function is critical to all of the aforementioned management functions and means making effective decisions based on consideration of benefits and the drawbacks of alternatives. In order to effectively carry out these functions, the

manager needs to possess several key competencies. Universally identified several key competencies of the effective manager are conceptual, technical, and interpersonal skills.

The term competency refers to a state in which an individual has the requisite or adequate ability or qualities to perform certain functions.

These are defined as follows:

Conceptual skills are those skills that involve the ability to critically analyze and solve complex problems. Examples: a manager conducts an analysis of the best way to provide a service or determines a strategy to reduce patient complaints regarding food service.

Technical skills are those skills that reflect expertise or ability to perform a specific work task. Examples: a manager develops and implements a new incentive compensation program for staff or designs and implements modifications to a computerbased staffing model.

Interpersonal skills are those skills that enable a manager to communicate with and work well with other individuals, regardless of whether they are peers, supervisors, or subordinates. Examples: a manager counsels an employee whose performance is below expectation or communicates to subordinates the desired performance level for a service for the next fiscal year.

10 MANAGEMENT POSITIONS: THE CONTROL IN THE ORGANIZATIONAL HIERARCHY

Management positions within healthcare organizations are not confined to the top level; because of the size and complexity of many healthcare organizations, management positions are found throughout the organization. Management positions exist at the lower, middle, and upper levels; the upper level is referred to as senior management. The hierarchy of management means that authority, or power, is delegated downward in the organization and that lower-level managers have less authority than higher-level managers, whose scope of responsibility is much greater. For example, a vice president of Patient Care Services in a hospital may be in charge of several different functional areas, such as nursing, diagnostic imaging services, and laboratory services; in contrast, a director of Medical Records—a lower-level position—has responsibility only for the function of patient medical records. Furthermore, a supervisor within the Environmental Services department may have responsibility for only a small housekeeping staff, whose work is critical but confined to a defined area of the organization. Some managerial positions, such as those discussed previously, are line managerial positions because the manager supervises other employees; other managerial positions are staff managerial positions because they carry out work and advise their bosses, but they do not routinely supervise others. Managerial positions also vary in terms of required expertise or experience; some positions require extensive knowledge of many substantive areas and significant working experience, and other positions are more appropriate for entry-level managers who have limited or no experience. The most common organizational structure for healthcare organizations is a functional organizational structure whose key characteristic is a pyramid-shaped hierarchy, which defines mmunicatthe functions carried out and the key management positions assigned to those functions. The size and complexity of the specific health services organization will dictate the particular structure. For example, larger organizations—such as large community hospitals, hospital systems, and academic medical centers—will likely have deep vertical structures reflecting varying levels of administrative control for the organization. This structure is necessary due to the large scope of services provided and the corresponding vast array of administrative and support services that are needed to enable the delivery of clinical services. Other characteristics associated with this functional structure include a strict chain of command and line of reporting,

which ensure that coion and assignment and evaluation of tasks are carried out in a linear command and control environment. This structure offers key advantages, such as specific divisions of labor and clear lines of reporting and accountability. Other administrative structures have been adopted by healthcare organizations, usually in combination with a functional structure. These include matrix, or team-based, models and service line management models. The matrix model recognizes that a strict functional structure may limit the organization's flexibility to carry out the work, and that the expertise of other disciplines is needed on a continuous basis. An example of the matrix method is when functional staff, such as nursing and rehabilitation personnel, are assigned to a specific program such as geriatrics, and they report for programmatic purposes to the program director of the geriatrics department. Another example is when clinical staff and administrative staff are assigned to a team investigating new services that is headed by a marketing or business development manager. In both of these examples, management would lead staff who traditionally are not under their direct administrative control. Advantages of this structure include improved lateral communication and coordination of services, as well as pooled knowledge. In service line management, a manager is appointed to head a specific clinical service line and has responsibility and accountability for staffing, resource acquisition, budget, and financial control associated with the array of services provided under that service line. Typical examples of service lines include cardiology, oncology (cancer), women's services, physical rehabilitation, and behavioral health (mental health). Service lines can be established within a single organization or may cut across affiliated organizations, such as within a hospital system where services are provided at several different affiliated facilities. Some facilities have found that the service line management model for selected clinical services has resulted in many benefits, such as lower costs, higher quality of care, and greater patient satisfaction compared to other management models. The service line management model is usually implemented within an organization in conjunction with a functional structure, as the organization may choose to give special emphasis and additional resources to one or a few services lines.

11 FOCUS OF PUBLIC HEALTH MANAGEMENT: SELF, UNIT/TEAM, AND ORGANIZATION

Effective healthcare management involves exercising professional judgment and skills and carrying out the aforementioned managerial functions at three levels: self, unit/team, and organization wide. First and foremost, the individual manager must be able to effectively manage himself or herself. This means managing time, information, space, and materials; being responsive and following through with peers, supervisors, and clients; maintaining a positive attitude and high motivation; and keeping a current understanding of management techniques and substantive issues of healthcare management. Managing yourself also means developing and applying appropriate technical, interpersonal, and conceptual skills and competencies and being comfortable with them, in order to be able to effectively move to the next level—that of supervising others.

The second focus of management is the unit/team work level. The expertise of the manager at this level involves managing others in terms of effectively completing the work. Regardless of whether you are a senior manager, mid-level manager, or supervisor, you will be "supervising" others as expected in your assigned role. This responsibility includes assigning work tasks, review and modification of assignments, monitoring and review of individual performance, and carrying out the management functions described earlier to ensure excellent delivery of services. This focal area is where the actual work gets done. Performance reflects the interaction of the manager and the employee, and it is incumbent on the manager to do what is needed to shape the performance of individual employees. The focus of management at this echelon recognizes the task interdependencies among staff and the close coordination that is needed to ensure that work gets completed efficiently and effectively. The third management focus is at the organizational level. This focal area reflects the fact that managers must work together as part of the larger organization to ensure organization-wide performance and organizational viability. In other words, the success of the organization depends upon the success of its individual parts, and effective collaboration is needed to ensure that this occurs. The range of clinical and nonclinical activities that occur within a healthcare organization requires that managers who head individual units work closely with other unit managers to provide services. Sharing of information, collaboration, and communication are essential for success. The hierarchy looks to the contribution of each supervised unit as it pertains to the whole. Individual managers' contributions to the overall

performance of the organization—in terms of various performance measures such as cost, quality, satisfaction, and access—are important and measured.

12 ROLE OF THE PUBLIC HEALTH MANAGER IN ENSURING HIGH PERFORMANCE

At the end of the day, the role of the manager is to ensure that the unit, service, division, or organization he or she leads achieves high performance. What exactly is meant by high performance? To understand performance, one has to appreciate the value of setting and meeting goals and objectives for the unit/service and organization as a whole, in terms of the work that is being carried out. Goals and objectives are desired end points for activity and reflect strategic and operational directions for the organization. They are specific, measurable, meaningful, and time oriented. Goals and objectives for individual units should reflect the overarching needs and expectations of the organization as a whole because, as the reader will recall, all entities are working together to achieve high levels of overall organizational performance. The organization as needing to be results oriented, with identified pillars of excellence as a framework for the specific goals of the organization. These pillars are: people (employees, patients, and physicians), service, quality, finance, and growth. The high performing organizations as being championship organizations—that is, they expect to perform well on different yet meaningful measures of performance. The "championship processes" and the need to develop performance measures in each: governance and strategic management; clinical quality, including customer satisfaction; clinical organization (caregivers); financial planning; planning and marketing; information services; human resources; and plant and supplies. For each championship process, the organization should establish measures of desired performance that will guide the organization. Examples of measures include medication errors, surgical complications, patient satisfaction, staff turnover rates, employee satisfaction, market share, profit margin, and revenue growth, among others. In turn, respective divisions, units, and services will set targets and carry out activities to address key performance processes. The manager's job, ultimately, is to ensure that these targets are met by carrying out the previously discussed management functions. A control process for managers describes five key steps in the performance management process:

set objectives,

measure performance,

compare performance with objectives,

determine reasons for deviation, and

take corrective action.

Management's job is to ensure that performance is maintained or, if

below expectations, is improved. Stakeholders, including insurers, state and federal governments, and consumer advocacy groups, are expecting, and in many cases demanding, acceptable levels of performance in healthcare organizations. These groups want to make sure that services are provided in a safe, convenient, low-cost, and high-quality environment. For example, The NHM has set minimum standards for healthcare facilities operations that ensure quality, the Quality Assurance (QA) unit has set standards for measuring performance of health plans, and has established a website that compares hospital performance along a number of critical dimensions. In addition, Kayakalp provided incentives to healthcare organizations by paying for performance on measures of clinical care and not paying for care resulting from "never events," i.e., shocking health outcomes that should never occur in a healthcare setting such as wrong site surgery (e.g., the wrong leg) or hospital-acquired infections (Agency for Healthcare Research and Quality, n.d.).

Health insurers also have implemented pay-for-performance programs for healthcare organizations based on various quality and customer service measures. In addition to meeting the reporting requirements of the aforementioned organizations, many healthcare organizations today use varying methods of measuring and reporting the performance measurement process. Common methods include developing and using dashboards or balanced scorecards that allow for a quick interpretation on the performance across a number of key measures. Senior administration uses these methods to measure and communicate performance on the total organization to the governing board and other critical constituents. Other managers use these methods at the division, unit, or service level to profile its performance. In turn, these measures are also used to evaluate managers' performance and are considered in decisions by the manager's boss regarding compensation adjustments, promotions, increased or reduced responsibility, training and development, and, if necessary, termination or reassignment.

13 ROLE OF THE PUBLIC HEALTH MANAGER IN SUCCESSION PLANNING

Due to the competitive nature of healthcare organizations and the need for highly motivated and skilled employees, managers are faced with the challenge of succession planning for their organizations. Succession planning refers to the concept of taking actions to ensure that staff can move up in management roles within the organization, in order to replace those managers who retire or move to other opportunities in other organizations. Succession planning has most recently been emphasized at the senior level of organizations, in part due to the large number of retirements that are anticipated from baby boomer district public health administrators. In order to continue the emphasis on high performance within healthcare organizations, senior managers are interested in finding and nurturing leadership talent within their organizations who can assume the responsibility and carry forward the important work of these organizations. Healthcare organizations are currently engaged in several practices to address leadership succession needs. First, mentoring programs for junior management that senior management participate in have been advocated as a good way to prepare future healthcare leaders. Mentoring studies show that mentors view their efforts as helpful to the organization. Some observers suggest that having many mentors is essential to capturing the necessary scope of expertise, experience, interest, and contacts to maximize professional growth. Mentoring middle-level managers for success as they transition to their current positions is also helpful in preparing those managers for future executive leadership roles. A second method of succession planning is through formal leadership development programs. These programs are intended to identify management potential throughout an organization by targeting specific skill sets of individuals and assessing their match to specific jobs, such as Medical Officers. One way to implement this is through talent reviews, which, when done annually, help create a pool of existing staff who may be excellent candidates for further leadership development and skill strengthening through the establishment of development plans. Formal programs that are being established by many healthcare organizations focus on high potential people. However, many healthcare organizations have developed programs that address leadership development at all levels of the organization, not just the executive level, and require that all managers participate in these programs in order to strengthen their managerial and leadership skills to contribute to organizational performance.


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14 ROLE OF THE PUBLIC HEALTH MANAGER IN HEALTHCARE POLICY

As noted earlier in this chapter, managers must consider both their external and internal domains as they carry out management functions and tasks. One of the critical areas for managing the external world is to be knowledgeable about health policy matters under consideration at the state and federal levels that affect health services organizations and healthcare delivery. This is particularly true for senior-level managers. This is necessary in order to influence policy in positive ways that will help the organization and limit any adverse impacts. Staying current with healthcare policy discussions, participating in deliberations of health policy, and providing input where possible will allow healthcare management voices to be heard. Because health care is such a popular yet controversial topic in the United States today, continuing changes in healthcare delivery are likely to emanate from the legislative and policy processes at the state and federal levels. In order to understand and influence health policy, managers must strive to keep their knowledge current. This can be accomplished through targeted personal learning, networking with colleagues within and outside of their organizations, and through participating in professional associations, These organizations, and many others, monitor health policy discussions and advocate for their associations' interests at the state and federal levels. Knowledge gained through these efforts can be helpful in shaping health policy in accordance with the desires of healthcare managers.


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15 HEALTH COMMUNICATION

International Communication Association officially recognized health communication in 1975; in 1997, the American Public Health Association categorised health communication as a discipline of Public Health Education and Health Promotion. Communication is essential to successful public health practice at every level: intrapersonal, interpersonal, group, organizational, and societal.

There must be careful deliberation concerning the appropriate channel for messages to best reach the target audience, ranging from face-to-face interactions to television, Internet, and other forms of mass media. Thus, communication is more than mere exchange of information.

WHAT IS HEALTH COMMUNICATION?

Health communication is the study and use of communication strategies to inform and influence people to make choices about their health. Messages are spread through different channels such as mass media, print materials, social media, and face-to-face conversations.

According to Healthy People 2010 guidelines, health communication encompasses the study and use of communication strategies to inform and influence individual and community decisions that enhance health. It links the domains of communication and health. Health communication encompasses the study and use of communication strategies to inform and influence individual and community knowledge, attitudes and practices (KAP) with regard to health and healthcare.

There is interface between communication and health which is increasingly recognized as a necessary element for improving both personal and public health. Health communication is often used synonymously with health education which can contribute to all aspects of disease prevention and health promotion. The most obvious application of health communication has been in these areas of health promotion and disease prevention. There has been improvement of interpersonal and group interactions in hospitals and other clinical situations such as between provider and patient, provider and provider and among members of a healthcare team, through the training of health professionals and patients in effective communication skills. Thus, health messages through public education campaigns can help in changing the social climate in order to encourage healthy behaviours, create awareness, change attitudes, and motivate individuals to adopt recommended behaviours.

Health communication has become an accepted tool for promoting

public health. Health communication principles are often used today for various disease prevention and control strategies including advocacy for health issues, marketing health plans and products, educating patients about medical care or treatment choices, and educating consumers about healthcare quality issues (US Office of Disease Prevention and Promotion, 2004). At the sametime, the availability of new technologies and computer-based media is expanding access to health information, and effective use of these new tools.

FUNCTIONS OF HEALTH COMMUNICATION

1) Information

The main function of health communication is to provide scientific knowledge or information to people about health problems and how to maintain and promote health. Thus information

should be easily accessible to the people so that we can remove or eliminate social and psychological barriers of ignorance, prejudice and misconceptions people may have about health matters; increase awareness of the people to the point that they are able to perceive their health needs; and influence people to the extent that unfelt needs become felt needs, and felt needs become demands (Park, 2015). It will help in refuting myths and misconceptions.

2) Education

Education plays a very important role in prevention oriented approach to health and disease problems; and the basis of all education is communication. Health education can bring about changes in life styles and risk factors of disease. It can help to increase knowledge and to reinforce desired behaviour patterns. It can also increase knowledge and awareness of a health issue, problem, or solution which influence perceptions, beliefs, attitudes, and social norms.

The Alma-Ata Declaration, 1978, has given the concept of health education. According to this declaration, health education is

- Promotion of healthy lifestyles,
- Modification of social environment in which the individual lives,
- Community involvement
- Promotion of individual and community self-reliance.

The main aims and objectives of health education are stated below:

a) To encourage people to adopt and sustain health promoting lifestyles and practices;

b) To promote the proper use of health services available to them;

c) To arouse interest, provide new knowledge, improve skills and change attitudes in making rational decisions to solve their own problems and

d) To stimulate individual and community self-reliance and participation to achieve health development through individual and community involvement at every step from identifying problems to solving them.

It is clear that education is necessary but education alone is not sufficient, thus health care providers need to play important roles, they are:

- Provide opportunities for people to learn how to identify and analyze health and health related problems, and how to set their own targets and priorities;
- Make health and health related information easily accessible to the community;
- To indicate to the people alternative solutions for solving the health and health-related problems they have identified; and
- People must have access to proven preventive measures (Park, 2015).

3) Motivation

One of the goals of health communication is to motivate individuals so that they can apply the health information into personal behaviour and lifestyle which will bring the benefit of behavior change for their own health. Motivation includes the stages of interest, evaluation, decision making, etc. For proper success of programme implementation at individuals and society at large, motivation assist in passing from the stake of awareness and interest to the final stage of decision making and adoption of the new ideas.

4) Persuasion

Persuasion is a conscious attempt by one individual to change or influence the general benefits, understanding, values and behaviour of another individual or group of individuals in some desired way (Park, 2015). It can change life style as it is employed deliberately to manipulate feelings, attitudes and beliefs. It is also a kind of force that reinforces knowledge, attitudes, and behaviour.

5) Counselling

Counselling relies heavily on communication and relationship skills. Counselling is the service offered to the individual who is undergoing a problem and needs professional help to overcome it. Therefore, counselling is a process that can help people understand better and deal with their problems and communicate better with those with whom they are emotionally involved. It can improve and reinforce motivation to change behaviour and helps to reduce or solve problems. Thus, counselling needs an expert as a counsellor to extend assistance to a needy person. Therefore, a counsellor should be able to communicate information properly; to gain the trust of the people; to listen sympathetically to people who are in

distressed; to understand other person's feelings and to respond to them in such a way that the other person can feel free to express his/ her feelings and to help people reduce or resolve their problems.

6) Health Development and Organization

Communication can play a powerful role in health development by helping to diffuse knowledge in respect of the goals of development and preparing the people for the roles expected of them. Further communication is an important dimension of health organization. It is a means of intra and intersectoral coordination. There are vertical communications which can be downward or upward that include top administrator to the beneficiaries; and horizontal or cross communications which takes place usually between equals at any level.

16 MODELS OF HEALTH COMMUNICATION

Health communication can take place through different models. They are:

1) Medical Model

The medical model is primarily relied on the recognition and treatment of disease and technological advances to facilitate the process. The emphasis is on dissemination of health information based on scientific facts but the medical model did not bridge the gap between knowledge and behaviour as there is little or no intervention on social, cultural and psychological factors.

2) Motivational Model

Motivation acts as the main force to translate health information into desired health action. But it needs a long procedure to convince an individual, group and society at large. Motivation includes the stages of interest, evaluation and decision-making. Initially individual has to go through awareness or getting information about the subject. If he is interested he will seek more detailed information about the subject, then he will evaluate the various aspects of the information received and later decision making will be done based on the evaluation whether he accepts or rejects the information. Sometimes the mentioned stages are not necessarily rigid; there may be skipping of stages depending on the adoption process of individuals, groups and society. Thus, effective communication strategy should be evolved to help the individual in passing from one stage to another.

3) Social intervention Model

The motivation model ignored the fact that in a number of situations, it is not the individual who needs to be changed but the social environment which shapes the behaviour of individual and the community. Thus, there is an importance of group or social support in helping reaching the decisions and taking action. Therefore, an effective health communication is based on precise knowledge of human ecology and understanding of the interaction between the cultural, biological, physical and social environmental factors.

Scope of Health Communication

The Individual :-

The individual is the most fundamental target for health-related change, since it is individual behaviours that affect health status. Communication can affect the individual's awareness, knowledge, attitudes, self-efficacy, and skills for behaviour change. Activity at all other levels ultimately aims to affect and support individual change.

The Social Network :-

An individual's relationships and the groups to which an individual belongs can have a significant impact on his or her health. Health communication

programs can work to shape the information a group receives and may attempt to change communication patterns or content. Opinion leaders within a network are often a point of entry for health programs.

The Organization:-

Organizations include formal groups with a defined structure, such as associations, clubs, and civic groups; worksites; schools; primary healthcare settings; and retailers. Organizations can carry health messages to their membership, provide support for individual efforts, and make policy changes that enable individual change.

The Community :-

The collective well-being of communities can be fostered by creating structures and policies that support healthy lifestyles and by reducing or eliminating hazards in social and physical environments. Community-level initiatives are planned and led by organizations and institutions that can influence health such as schools, worksites, healthcare settings, community groups, and government agencies.

The Society :-

Society as a whole has many influences on individual behavior, including norms and values, attitudes and opinions, laws and policies, and the physical, economic, cultural, and information environments. Clearly, the more levels a communication program can influence, the greater the likelihood of creating and sustaining the desired change.

Health communication alone, however, cannot change systemic problems related to health, such as poverty, environmental degradation, or lack of access to health care, but comprehensive health

communication programs should include a systematic exploration of all the factors that contribute to health and the strategies that could be used to influence these factors.

CHALLENGES OF HEALTH COMMUNICATION

Health communication faces many challenges. While problems can be attributed to many factors, some of the most challenging issues are discussed below:

1) One of the most pertinent challenges health communication faces is the general gap that has formed between the population's health literacy and the use of health communication. There are instances that professionals' use of unexplained medical jargon, ill-formed messages, that lead to create a general educational gap. It is also seen that even the mass have difficulty understanding written health materials, understanding health care and policies, and generally do not comprehend medical jargon. Such short fallings of health communication may lead to

increased hospitalizations, the inability to respond to and manage a disease or medical condition, and a generally declining health status.

2) Mass communication is used to promote beneficial changes in behaviour among members of populations. A major criticism of the use of mass media as a method of health communication is large amounts of information that may be misleading, inaccurate, or inappropriate, which may put consumers at unnecessary risk. This issue may generate unwarranted panic amongst those customers. One is related to the risks associated with consumers' use of poor quality health information to make decisions. These concerns are driving many people to distrust health services which have caused an immediate public health concern.

3) A one-dimensional approach to health promotion, or other single-component communication activities, has been shown to be insufficient to achieve program goals. Thus for making a successful health promotion programme, multidimensional interventions such as community-based programs, policy changes, and improvements in services and the health delivery system has to be planned to reach diverse audiences. An important factor in the design of multidimensional programs is to allot sufficient time for planning, implementation, and evaluation to support the elements of the program. Public- private partnerships and collaborations can leverage resources to strengthen the impact of multidimensional efforts.

4) Communication occurs in a variety of contexts (for example, school, home, and work); through a variety of channels (for example, interpersonal, small group, organizational, community, and mass media) with a variety of messages; and for a variety of reasons. In such an environment, people do not pay attention to all communications they receive but selectively attend to and purposefully seek out information (Freimuth et al., 1989). One of the main challenges in the design of effective health communication programs is to identify the optimal contexts, channels, content, and reasons that will motivate people to pay attention to and use health information.

5) The environment for communicating about health has changed significantly. The dramatic increases in the number of communication channels and the number of health issues vying for public attention as well as consumer demands for more and better quality health information, and the increased sophistication of marketing and sales techniques over the Internet. People have more opportunities to select information based on their personal interests and preferences.

6) Limitations of printed materials in different languages lead to affect the health communication. Direct translation of health information or health promotion materials should be avoided. For different social- cultural, ethnic populations who have different languages and sources of information, it is required to adopt audience-centered perspective for effective health promotion and communication. In these cases, public education campaigns must be conceptualized and developed by individuals with specific knowledge of the cultural characteristics, media habits, and language preferences of intended audiences. Television and radio serving specific ethnic populations can be effective means to deliver health messages when care is taken to account for the language, culture, and socioeconomic situations of intended audiences. Thus, an audience-centered perspective also reflects the realities of people's everyday lives and their current practices, attitudes and beliefs, and lifestyles. Some specific audience characteristics that are relevant include gender, age, education and income levels, ethnicity, sexual orientation, cultural beliefs and values, primary language(s), and physical and mental functioning.

7) Generalising the programme policy and generalising the health information to the mass will limit the audience from health communications. It is therefore required to target specific segments of a population and tailoring messages for individual use to make health promotion activities relevant to audiences. Examples adolescents at increased risk of smoking, etc.

8) The other challenge is related to the protection of privacy and confidentiality of personal health information. It is so happened that the personal privacy and the confidentiality of health information of consumers are magnified when information is collected, stored, and made available online. In the near future, personal health information will be collected during both clinical and nonclinical encounters in disparate settings, such as schools, mobile clinics, public places, and homes, and will be made available, so it is required to have policies and procedures to protect privacy and to ensure confidentiality.

9) Even with access to information and services, however, disparities may still exist because of many factors such as illiteracy, lack health literacy, levels of knowledge and understanding, customs, beliefs, religion, attitudes and social class differences. Health literacy is increasingly vital to help people navigate a complex health system and better manage their own health. Differences in the ability to read and understand materials related to personal health as well as navigate the health

system appear to contribute to health disparities. Well-designed health communication activities can help individuals better understand their own and their communities' needs so that they can take appropriate actions to maximize health.

10) Health communication alone, however, cannot change systemic problems related to health, such as poverty, environmental degradation, or lack of access to health care, but comprehensive health communication programs should include a systematic exploration of all the factors that contribute to health and the strategies that could be used to influence these factors. Well-designed health communication activities help individuals better understand their own and their communities needs so that they can take appropriate actions to maximize health.

Health communication is rarely used as an independent strategy in community health because knowledge is not enough to improve the health of a community. Instead, health communication is an integral part of all health promotion strategies. You have also understood the different functions and models of health communication. You also have got an insight of barriers and challenges of health communication where campaign messages needed to reach and influence target audiences. You need to develop strategies from the audience perspective for effective strategic health communication interventions.


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17 HEALTH SYSTEMS IN UTTAR PRADESH

The population of Uttar Pradesh is more than that of Brazil, a country more than 2.5 times the size of India and fifth largest in the world. UP consists of 20 crore (200 million) inhabitants and every sixth Indian is from the State. Since independence, UPs population has increased exponentially by almost 10 million per decade between 1951 and 1971, by 20 million per decade between 1971 and 1991, and 30 million between 1991 and 2011. Continuing the same rate, the population of UP is estimated to reach 256 million by 2030. The population density of Uttar Pradesh is 828 people per square kilometer. The state is predominantly rural, with only 22 percent residing in urban areas. The annual growth rate of population is 1.8 percent per annum. The literacy rate was 69.7 percent (Census, 2011). The state consists of 75 districts and 821 community blocks.

Health Profile for Uttar Pradesh

Table 1 shows data on selected health indicators for India and Uttar Pradesh. It shows that only 42 percent of mothers have received at least four antenatal care visits in Uttar Pradesh, while the corresponding figure is 58 percent at the national level. Eighty three percent of deliveries were conducted in medical institutions in Uttar Pradesh while it was nearly 89 percent at the all India level. It is worthwhile to note that more than three-fourth of children are fully immunized in Uttar Pradesh compared to 84 percent in India. The Total Fertility Rate for Uttar Pradesh is 2.4 per woman compared to 2.0 for India. Crude death rate, Birth Rate, and Infant Mortality Rate are much higher in Uttar Pradesh compared to the National Level. Maternal Mortality Ratio (MMR) is 64 points higher than National level in Uttar Pradesh. Life expectancy at birth in Uttar Pradesh is much lower than India.

Table 1: Selected Health Indicators for Uttar Pradesh and India

Indicators	Urban	Rural	Total	INDIA Total
Mothers who had at least 4 antenatal care visits (%)	52.3	36.9	42.4	58.1
Institutional births (%)	85.5	82.9	83.4	88.6
Institutional births in public facility (%)	43.1	61.5	57.7	61.9
Children age 12-23 months fully immunized (BCG, measles, and 3 doses each of	76.6	78.8	78.4	83.8

polio and DPT) (%)				
Total Fertility Rate	1.9	2.5	2.4	2.0
Maternal Mortality Ratio			167	103
Crude death rate	5.4	6.8	6.5	6.0
Crude birth Rate	26.1	22.1	25.1	19.5
Infant Mortality Rate	40	28	38	28
Life Expectancy at Birth (in years)	68.7	64.3	65.3	67.7

Source(s): National Family Health Survey-5, 2019-2021; SRS Bulletin, Sample Registration System, Registrar General of India, 2022; Special Bulletin on Maternal Mortality in India 2017-19,Sample Registration System, Registrar General of India, March 2022; SRS Based Abridged Life Tables 2014-18,Sample Registration System, Registrar General of India, September 2020.

Progress towards MDG/SDG GOALS

Despite improvement in health scenario of Uttar Pradesh, the state could only achieve two of its goals (i.e., infant mortality and institutional deliveries) out of seven goals mentioned in State Population Policy of Uttar Pradesh 2000 by 2016. The remaining five goals of state population policy 2000 are yet to be achieved by the State Government. The policy goals are: TFR, MMR, Modern Contraceptive Use, Unmet Need of Contraception and Child immunization.

Maternal Health: SRS estimates, 2022 shows that the state's MMR declined to 167 per 100,000 live births from 285 (2017-2019). The current maternal mortality rate is still high when it is compared to the Sustainable Development Goals (SDG). The state's SDG mission document aims to bring it down to 70 by 2030. State health policy also aims to achieve level of MMR, 70 by 2030.

The state aims to increase 100 percent institutional deliveries by 2030. Currently, 83.4 percent of deliveries are institutional and almost 5 percent continued to deliver at home (NFHS, 2019-2021). The latest estimates of NFHS, 2019-2021, show that in rural areas, nearly 5 percent mothers deliver at home, whereas in urban areas, 5 percent of deliveries take place at home. Only 60 percent of mothers of rural areas received more than four ANCs. Mother's received full ANC care is very low as only 6 percent of mothers have reported to receive complete ANC care in Uttar

Pradesh.[1] State aspires to increase 100 percent complete ANC checkups for all the expectant mothers by 2030. In addition, mothers in rural areas are less likely to receive PNC care from the trained professionals than mothers in urban areas. About 72 percent mothers have reported to receive the PNC care within 2 days after the delivery. The state aims to universalize the Post-Natal Care to all the mothers and their children by 2030.

According to NFHS -5, nearly 18 percent of women in the age-group of 20-24 in rural areas of Uttar Pradesh were married before the legal age of marriage, i.e., 18 years. Regarding the adolescent's pregnancy, nearly 3 percent of women aged 14-19 years were already pregnant or mothers at the time of the NFHS-5 survey. Though the prevalence of adolescent pregnancy is low, yet the magnitude is very high. The state intends to reduce 60 percent such pregnancies by 2030. It is alarming to note that a substantial proportion of pregnant mothers are anaemic. The NFHS estimates depicted 46 percent pregnant women were anaemic at the time of the survey. Anaemia level increases the chances of complications among pregnant women.

State has envisaged maintaining the mandatory practice of keeping girls and boys until intermediate in the schools. It will aid to achieve better maternal health outcomes.

Neonatal and Infant Health

As per SRS 2020 data the Infant mortality rate (IMR- deaths within first year of life) in the state of Uttar Pradesh stands at 38 per 1000 live birth against 41 per 1000 live births in 2019 and against national average of 28 per 1000 live births. Neonatal deaths (Deaths within first 28 days of life) in UP stands at 28 per 1000 live births in SRS 2019.

Neonatal deaths constitute about 70% of Infant deaths. Neonatal Mortality Rate (NMR) has been declining at a slow but steady pace for the last 6 years from 35 (SRS 2013) to 30 (SRS 2019).

IMR in UP has also decreased significantly after implementation of National Rural Health Mission from 67/1000 live births (SRS 2008) to 38/1000 live births (SRS 2020) which is 43.28 -percent decrease in IMR.

According to Million death study, the major causes of neonatal mortality are: prematurity and low birth weight; neonatal infections, comprising of neonatal pneumonia,

[1]Full ANC care is at least four ANC visits, at least one tetanus toxoid (TT) injection and iron folic acid tablets taken for 100 or more days

neonatal sepsis, and CNS infections; and birth asphyxia and birth trauma.[2]

Child Health

As per SRS 2020 data, the under-5 mortality rate of Uttar Pradesh stands at 43 against 65 in 2013. Under-5 mortality in UP has also decreased significantly from 65/1000 live births (SRS 2013) to 48/1000 live births (SRS 2019) which is 26.15 -percent decrease in under-5 mortality rate. According to NFHS-5 estimates, the child mortality rate for UP is 60, which is also a matter of serious concern and concerted efforts are required to address this issue. In the similar lines of infant mortality, the child mortality has gradually reduced over the period of time. Anaemia is widely prevalent among the children of age 6-59 months, as the NFHS-5 reported 66 percent of the children were anaemic with negligible rural-urban differentials. Nearly one fifth (17 percent) of the children under age of 5 years were wasted or under weight, based upon the weight and height classifications. Similarly, 40 percent of the children under age 5 years were stunted. Nearly 32 percent of the children was underweight (weight for age) at the time of the survey (NFHS, 2019-2021). Considering the important issue, state government aimed to reduce the prevalence of all kinds of malnutrition by 75 percent from the current rate by 2030.

Regarding the immunization of children, the situation has improved a lot but at the same time there is a large scope of further improvements. The data shows the full immunization of children has increased from 51 percent in 2015-2016 (NFHS-4) to 70 percent in 2019-2021 (NFHS-5). It is significant that the coverage against BCG is highest (93 percent), followed by DPT (81 percent) and polio (74 percent). So, in Uttar Pradesh dropout of DPT and Polio remains to be an issue. According to NFHS-5, the current level of VITAMIN-A supplementation in last six months among children is nearly 74 percent.

Population Stabilization

Fertility: The recent estimates of TFR show the substantial decline in the last one decade. It has declined from 2.7 in NFHS-4 (2015-2016) to 2.4 in NFHS-5 (2019-2021).It is interesting

TFR (AHS2012-2013)	Number of Districts	Percent of districts
Above 4	11	15.7
3-3.9	47	67.1
Below 3	12	17.1
Total	70	100.0

2Causes of neonatal and child mortality in India: A Nationally Representative Mortality Survey : The Million Death Study , Lancet 2010; 376: 1853–60

to note that Urban Uttar Pradesh has already achieved the TFR of 2.1 in 2015.

Table: Lowest and Highest MCPR 10 districts of Uttar Pradesh, NFHS-4 (2015-2016)

Lowest CPR		Highest CPR	
Balrampur	2.7	Saharanpur	43.1
Shrawasti	6.8	J.P. Nagar	43.8
Bahraich	9.1	Mathura	43.8
Gonda	11.7	Meerut	43.8
Basti	15.5	Muzaffarnagar	44.8
Sant Kabir Nagar	15.6	Mahoba	48
Siddharthnagar	16.6	G.B. Nagar	48.4
Budaun	17.2	Ghaziabad	50.7
Fatehpur	18	Jhansi	54.7
Ambedkar Nagar	19.5	Lalitpur	59.2

The AHS 2012-2013 statistics depict around 85 percent of the districts have a TFR higher than 3 and 15 percent of the districts have a TFR more than 4. Hence, there is a lot of space to improve the fertility scenario of Uttar Pradesh. More focussed efforts are required to achieve the TFR of 2.1. Furthermore, CBR has declined from 30.4 in 2005 to 26.7 in 2014 (SRS, 2005-2014). State recognises the importance of fertility stabilization in the context of overall development of Uttar Pradesh. Therefore, the policy would address the key drivers of high fertility such as increasing age at marriage, increasing family planning uptake among couples, increasing the infant and child survival. State would make stringent efforts to reach TFR at the level of 2.1 by 2030.

2014	26.7	27.9	23.0	7.2	7.7	5.7
2022	25.1	26.1	22.1	6.5	6.8	5.4

Mortality

CDR (AHS2012-2013)	Number of Districts	Percent of districts
Above 9	22	31.0
8 to 8.9	24	33.8
Below 8	24	35.2
Total	70	100.0

There has been a decline in the crude death rate, from 8.7 deaths per 1000 populations in 2005 to 6.5 in 2022 (SRS, 2005-2022). The AHS, 2012-2013, estimates of CDR show that around 66 percent of the districts have a CDR more than 8. Therefore, state also needs to work on this front in order to reduce the overall death rates in Uttar Pradesh.

Contraception

The current level of modern contraceptive prevalence rate is one of the proximate determinants of fertility. It is also one of the major indicators to the measure the success of the FP programs. Current level of modern CPR in Uttar Pradesh is 31.7 percent with huge rural- urban variations. Figure 1 represents the current method mix. It is important to

note that female sterilization is the major contributor towards the modern contraceptive method mix followed by condom.

NFHS-4 data depicts huge inter-district variations in use of modern contraceptives. It reflects that are districts like Balrampur, Shrawasti and Bahraich where the prevalence of MCPR is below 10. On contrary to this, there are districts like Ghaziabad, Jhansi and Lalitpur where the MCPR is above 50. Keeping these disparities in hindsight, there is a strong need to focus on those districts where MCPR level is not satisfactory. The state government has already taken most of the non-performing districts and have been working intensively. It is projected that the state would have to achieve MCPR of 61 percent for reaching the goal of TFR 2.1 by 2030. The state population policy 2017 aims to increase the modern contraceptive prevalence rate 60 percent by 2030. The population policy also intends to reduce the unmet need of contraception 75 percent from the current level of unmet need of contraception, i.e., 18 percent.

Human Resource

Severe shortage of manpower at all levels in the public health delivery system, stands out as another challenge. Every health functionary is under a lot of pressure on account of large numbers that he/she is expected to serve. This has a direct bearing on the quality of services rendered and uptake services.

The situation is grave in terms of requirement of medical personnel vis-à-vis their availability specially doctors and specialists. Although the state also has a large presence of private health providers, it is mostly concentrated in urban areas and is largely focusing on curative aspects.

The positions in the above mentioned table clearly shows the huge shortage of health personnel at all the levels which need to be addressed on the urgent basis.

The problem of shortages is further compounded by the absenteeism of public sector health personnel in the state. A World Bank study captures the overall percentage of absenteeism and reasons for absence in different stages of the country. 45 per cent of the doctors were found absent from duty in U.P. Interestingly 14 per cent out of this 45 per cent were on leave; 8 per cent of them were absent without reasons; and 22 per cent (i.e. almost half of the total absenteeism) of doctors were absent from the post because they were on the official duty [3] . It raises questions regarding the work schedule which forces absence of doctors in doctor scarce state.

It may be noted that the huge human resource deficit in public and especially

[3]http://www.cehat.org/go/uploads/PPP/bibisratpaper.pdf

rural services is because of inadequate production and deployment as also conditions of work and remuneration.

Health Service Delivery

The state requires 31,037 sub centres, 5,172 primary health centres and 1,293 community health centres to meet the healthcare demands of its population (Rural Health Statistics-2015). But the state is 33 per cent short of sub-centres and primary health centres and 40 per cent short of community health centres; this further impacts the implementation of centrally-sponsored health programmes, which in turn require an effective network of public health institutions. There has also been no expansion of public healthcare institutions over the last 15 years. Thus, low-quality private healthcare services thrive in the state. In India, the private healthcare system now provides two-thirds of medical treatment, according to the Health in India report from the ministry of statistics (2016). In Uttar Pradesh, private health providers – including non-qualified doctors and quacks – meet 85 per cent of medical needs, according to the report.10

Expenditure

The per capita expenditure on health in the state has increased in a snail pace from Rs 260 to Rs 372 from 2010 to 2012 (National Institute of Public Finance and Policy report 2012), compared to from Rs 356 to Rs 580 in Kerala and from Rs 299 to Rs 579 in Tamil Nadu during the same period. The average out of pocket expense at sub-centres and public health centres in Uttar Pradesh is Rs 660 per person, more than double the national average of Rs 312 per person, according to the ministry of statistics report11. Currently, the state relies on a public healthcare infrastructure that is two decades old which needs immediate attention.

Nutrition

Uttar Pradesh is the Global & National epi-centre for under nutrition, as it contributes 26 per cent of the national and 7 per cent of the global under-five stunting burden and 19 per cent of national and 9 per cent of global under-five wasting prevalence.

Almost every second child in the state is stunted[4], and every second women is suffering from anaemia. In terms of actual burden, 11 mn children under five are stunted, 1.2 mn are severely wasted and 13.2 mn anaemic. In terms of maternal nutrition, 2.5 mn pregnant women are anaemic in the state.

Malnutrition has huge bearing on the state and its population. Each year, about 280,000 of the state's children die before the age of five years, of which almost 45% of these deaths are

[4]Rapid Survey on Children (2013-14).

associated with malnutrition[5]. Maternal anaemia contributes to almost one-fifth of maternal deaths. Not only it contributes to child and maternal deaths, it also increases risk of major childhood illness like diarrhoea, pneumonia, measles etc., poor cognitive and physical development, and results in poor productivity during adulthood.

The decadal decline in percentage prevalence of the burden is under nutrition is still slow – 3 per cent points in underweight, 11per cent points in stunting and 3 per cent points increase in wasting.

India is committed to reduce childhood mortality and childhood under nutrition under Sustainable Development Goals-2030 and Global Nutrition Targets-2025, and UP's contribution is of paramount importance in achieving these targets. However, with slow rate of decline in under nutrition levels, these targets are a remote sight.

Social Determinants

The health outcomes are directly or indirectly associated with the individual's socio-economic characteristics and living environment. Hence, the state health policy recognizes this fact and addresses the needs of all the sections of society. The policy would put more focus on reaching to unreached and disadvantageous or vulnerable sections of society. In order to keep the track of performance, impact of all the interventions should be assessed from time to time.

Further, the social determinants of health are also poor, which contributes to substandard health status of people in Uttar Pradesh. Recently published NFHS-4 data shows that considerable proportion of child marriage occurs in Uttar Pradesh6. There is 21 percent of women age 20-24 years married before age 18 years. Further, the same data source shows around four percent of women age 15-19 years who were already mothers or pregnant at the time of the NFHS-4 survey (2015-16) in Uttar Pradesh. There are 20 percent of unmet needs for family planning among currently married women in reproductive age group (15-49 years) in rural areas. Those who were not using any contraception, among them, only 13 % women were counseled by the health workers. Domestic violence is another social determinant which contributes to the poor health status of women in Uttar Pradesh. The NFHS 4 data suggests that in Uttar Pradesh, around 37 Percent of ever-married women experienced spousal violence. In terms of absolute numbers, around 10 million young people (16%) were illiterate in Uttar Pradesh, which again is a key disabling factor in terms of accessing and demanding quality health services8. Further the dropout rates is quiet high

[5] Lancet Maternal and Child Nutrition Series 2013

at the elementary level (25%), which needs immediate attention, as lack of proper education might deprive future generation with knowledge and access to health services.


राज्य स्वास्थ्य एवं परिवार कल्याण संस्थान, उ0प्र0
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18 UNDERSTANDING HEALTH

Health is not just the physical wellbeing of an individual but also the social, emotional and cultural wellbeing of the whole community, in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community

Why focus on the determinants of health?

A person's opportunity for good health starts long before they need health care. So there is a compelling case that responsibility for the health of the public should go beyond the health and social care system to span all of society. A wide range of organisations – across government, the voluntary sector, the private sector, media, advertising and local communities – have it within their power to improve people's health. By acknowledging and acting on this, it is possible to harness a multitude of opportunities to overcome the big health challenges of today.

At every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour.These factors are referred to as 'determinants of health'.

Determinants of health

- individual factors, e.g. knowledge and skills, attitudes e.g alcohol use, injection drug use (needles), genetics
- sociocultural factors, e.g. family, peers, media, religion, culture
- socioeconomic factors, e.g. employment, education, income
- environmental factors, e.g. geographical location, access to health services and technology.

Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.

The individual factors that determine health are factors identified within an individual, including: attitudes, knowledge, skills, genetics, and personal characteristics. There are a range of individual factors that determine the health of an individual

1. **Individual factors**

Knowledge

What a person knows is one of the more influential individual factors that determine health. In order to improve their health an individual needs to have good health knowledge. That is, they need to know:

- where to get information
- healthy food choices
- recommended levels of physical activity
- how things affect our health (protective and risk behaviours)
- how to interpret food labels, and
- have a wealth of other knowledge related to health

Often health knowledge is linked with health literacy. Health literacy is the ability to understand and interpret health information in order to promote the health of yourself and of others. However, health literacy requires both knowledge and skill.

Skills

Individual factors such as skill affect the health of the individual. Skills that are related to health include:

- critical inquiry (know who to trust for information)
- research skills (how to find information)
- practical skills such as:
  - Decision-making
  - Communication
  - problem-solving, and
  - movement skills

Such skills can help and individual achieve good levels of health especially when combined with other factors, such as access to information and health professionals, money, and an environment in which they can use these skills in a positive manner.

Attitudes

An individual's attitude can have either a positive or negative affect on their health. Often achieving good health requires resilience, perseverance, self-belief and determination. People who value health and have these attributes are likely to achieve better health than those who do not. Within attitude the value people place on health is pivotal. People who have a high value of health are more likely to prioritise their health over other demands. This relates to time, money and other aspects of life priorities.

For example, a person who highly values their health and has a high level of perseverance is more like to quit smoking, or not take it up in the first place. They are also more likely to stick to exercise plans and make time to improve their social health as well as their mental and physical health.

Individual behavior also plays a role in health outcomes. For example, if an individual quits smoking, his or her risk of developing heart disease is greatly reduced.

Many public health and health care interventions focus on changing individual behaviors such as substance abuse, diet, and physical activity. Positive changes in individual behavior can reduce the rates of chronic disease in a country.

Examples of individual behavior determinants of health include:

Diet

Physical activity

Alcohol, cigarette, and other drug use

Hand washing

Genetics

Genetics is another of the individual factors that affect health. Genetics refers to the genes you inherit from your parents. These genes can pre-dispose (make things more likely) you to particular diseases or health issues. For example, if your parents have diabetes or cardiovascular disease then you are more likely to also get such diseases.

Furthermore, particular people groups suffer more from particular diseases and are more likely to develop them. An example of this is the higher rates of diabetes among indigenous people, as such indigenous people may be genetically predisposed to diabetes (although this is hard to determine with so many lifestyle factors). Another example is people who are born with white skin and fair hair, who are more likely to develop skin cancer.

Biology and Genetics

Some biological and genetic factors affect specific populations more than others. For example, older adults are biologically prone to being in poorer health than adolescents due to the physical and cognitive effects of aging.

Sickle cell disease is a common example of a genetic determinant of health. Sickle cell is a condition that people inherit when both parents carry the gene for sickle cell. The gene is most common in people with ancestors from West African countries, Mediterranean countries, South or Central American countries, Caribbean islands, India, and Saudi Arabia.

Examples of biological and genetic social determinants of health include:

- Age
- Sex
- HIV status
- Inherited conditions, such as sickle-cell anemia, hemophilia, and cystic fibrosis
- Carrying the BRCA1 or BRCA2 gene, which increases risk for breast and ovarian cancer
- Family history of heart disease

Sociocultural factors

The sociocultural factors that affect health relate to society (socio) and culture (cultural).

➢ **Family**

Family is by far the greatest influence on health from the sociocultural factors. Family determines culture and often have a huge impact on our choice of religion, friends

Our family are our most intimate relationships and have a huge influence on our attitude towards health, the value we place on health, and influence our behaviour choices relating to protective and risk behaviours. For example, if we grew up in a house where our parents eat fast food frequently (say 3 times a week) we are more likely to think this is normal and even if we know it is not healthy, we are more likely to eat it, because this is what our family are eating..

Conversely, if our family are health practitioners, such as a nutritionist and an exercise sport scientist, then we are more likely to prioritise healthy eating and exercise. However, we may have an overemphasis on physical health and neglect the other dimensions of health.

- **Peers**

Peer pressure is often the first thing that people think about when it comes to peer influences, We are more likely to smoke because our friends tell us to do so. Instead, our peers influence us by creating environments where we seek to fit into the group by adapting their behaviours. This can be positive, if our group have lots of protective behaviours that they engage in, or negative, if the behaviours increase risk.This pressure to fit into your peer groups is most sharply felt during adolescence. During the teenage year, many young people select behaviours that place them within a particular peer group that they wish to belong to.

- **Media**

The media is another of the sociocultural factors that determine health. This can be done through marketing campaigns such as of fast foods like McDonalds burgers. However, most of the influence from the media is not so obvious. It is done through regular shows and subtle phrases that promote particular aspects For example, many of our current images used in advertising depict women in sexually seductive or available poses. These are chosen deliberately to get your attention in order to advertise their products, but it also communicates that women are objects to be used sexually and exploited in such ways. The leads to increases in sexual assault,harassment, and higher risk sexual activity at younger ages. As we start to think that these things are normal, we begin to act on it which leads to risk behaviours.

- **Religion**

Our religion is another of the sociocultural factors that influence our health. Given that Spirituality is an entire dimension of health, it is no surprise that our religion will influence our health. Often regions also have rules, such as not getting drunk, no sex before marriage, that promote protective behaviours in individuals and promote health.

However, religion can also be limiting. Some regions place restrictions on birth spacing,clothes and social interactions, which can have negative effects on the health of the individual. Religion can also limit your choices in relation to health care. For example, the Seventh Day Adventists will refuse a blood transfusion as it is against their beliefs.

- **Culture**

Every culture conceptualizes disease and illness differently. People in different cultures and social groups explain the causes of illness

differently. In addition, the treatment people seek is often influenced by their beliefs and perceptions of what is causing their illness

Different cultures often attribute different cultural beliefs in tracing disease aetiology, of which a disease may be caused by metaphysical agents such as possession, witchcraft, fate, luck, and karma; supernatural agents such as deity and spirit, and cultural habits such as dietary pattern and lifestyle.

Culture plays a significant role in several health and illness areas such as patients' beliefs about causes of diseases, accessibility and acceptability of healthcare services, preferred treatments, and doctor-patient interaction.

The cultural influence in determining patients' causes of illness then continues to exert its impact on patients' accessibility and acceptability of healthcare services. In terms of accessibility and acceptability of healthcare, the common cultural barriers include ignorance of illness symptoms culturally insensitive and language differences between healthcare providers and patients.

2. **Socio-economic factors**

The Socioeconomic factors that determine health include: employment, education, and income.

- **Employment and occupation**

The main factor determining adequate income is participation in paid employment. As such employment is an important determinant of health. In addition to providing income, employment enhances social status and improves self-esteem, provides social contact and a way of participating in community life, and enhances opportunities for regular activity, which all help to enhance individual health and well-being.

An unsatisfactory job may not always be better than no job at all and it is also important that work is safe, secure, satisfying and appropriately remunerated Some jobs carry significant risks to mental and physical health, and work-related injuries and occupational diseases are important causes of death and ill-health.

- **Income**

Health status improves at each step up the income and social hierarchy. Higher income and status generally resultsin more control and discretion. Income determines living conditions such as safe housing and ability to buy sufficient good food. The greater the gap between the richest and poorest people, the greater the differences in health.

- **Education**

Health status improves with level of education. Education is closely tied to socio-economic status. It increases opportunities for job andincome security, improves people's ability to

access and understand information to help them keep healthy.

3. **Environmental Factors**

Humans interact with the environment constantly. These interactions affect quality of life, years of healthy life lived, and health disparities. The World Health Organization (WHO) defines environment, as it relates to health, as "all the physical, chemical, and biological factors external to a person, and all the related behaviors." Environmental health consists of preventing or controlling disease, injury, and disability related to the interactions between people and their environment.

➢ **Geographical location**

Where someone lives can greatly determine their health. In India there are people who are homeless, some who live in rural and remote areas, while many live in cities around the country. Someone's geographical location can mean that they are exposed to pollution, or have limited access to fresh water. Geographical location can mean that foods purchased have had to travel further and have less nutrients in them as well as meaning a lack of educational or employment opportunities.

A range of environmental determinants of health, including:

- contamination of food and water
- vector borne diseases transmitted by insects and other animals
- disease caused by air pollution or exposure to chemicals
- injuries that are a results of workplace or traffic systems
- disasters or changes in ecological systems associated with climate change

➢ **Access to health services**

Someone with easy access to health services is more likely to have better health outcomes thansomeone who has to travel long distances or cannot afford to access particular health services.

Accessing health services requires both money and physical access. People who live in rural or remote areas have less access to health services, with few specialists, fewer hospitals (with staff shortages), and a shortage of other health care providers, such as nutritionist, physiotherapists, radiologists and more. A lack of access means people who require these services either have to travel to get it, or do not get the benefits at all.

This is particularly the case for those with lower incomes. They cannot afford particular health care services

➢ **Access to technology**

Access to technology includes access to health care technology, such as kidney dialysis machines, as well as access to technology for knowledge, such as the internet. A person's access to technology, just like their access to health services, is affected by their geographical location and socioeconomic status.

19 HEALTH SYSTEM STRENGTHENING

Health System

A health system consists of all the organizations, institutions, resources and people whose primary purpose is to improve health.

Health System Strengthening

Strategies, interventions and activities designed to sustainably improve health system performance.

- Health System includes efforts to influence determinants of health as well as more direct health-improvement activities. The health system delivers preventive, promotive, curative and rehabilitative interventions through a combination of public health actions and the pyramid of health care facilities that deliver personal health care — by both State and non-State actors.
- A health system needs staff, funds, information, supplies, transport, communications and overall guidance and direction to function. Strengthening health systems thus means addressing key constraints in each of these areas.

Health System's WHO Framework

- The multifaceted nature of health systems and the spread of direct and indirect responsibilities across multiple sectors, pose challenges in monitoring performance. Thus, health systems performance assessment can be done using "The WHO Health Systems Framework.
- Health system consists of all the organizations, institutions, resources and people whose primary purpose is to improve health. There is mounting evidence that health systems that can deliver services equitably and efficiently are critical for achieving improved health status.

BUILDING BLOCKS

Six building blocks:

- Service Delivery
- Health workforce
- Information and Technology
- Medical Products, Vaccines and Technologies
- Health Financing
- Leadership And Governance

Objectives for 6 building blocks:

- Strengthen Health systems
- Address questions of health system financiaries
- Promote common understanding
- Address new challenges and set priorities

Service Delivery

Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources.

- Health services include all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and non-personal health services.
- Health services are the most visible functions of any health system. Service provision refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of health interventions.
- Improving coverage and quality of services depends on key resources being available; and how services are organized and managed. Equity in health outcome is the ultimate aim.

Major issues/challenges in service delivery

- Lack of/or absence of infrastructure
- Paucity of manpower
- Ineffective implementation of laws and policies.
- Fragmented and uncontrolled nature of private health care delivery system.
- Inequity-Differentiation in healthcare delivery between urban and rural population due to personal and regional basis

Key characteristics of good service delivery

Comprehensiveness	Quality in a timely fashion.
Accessibility	Person-centeredness
Coverage	Coordination
Continuity	Accountability and efficiency

- **Comprehensiveness:**
  A comprehensive range of health services is provided, appropriate to the needs of the target population, including preventative, curative, palliative and rehabilitative services and health promotion activities.

- **Accessibility:**
  Services are directly and permanently accessible with no undue barriers of cost, language, culture, or geography. Health services are close to the people, with a routine point of entry to the service network at primary care level (not at the specialist or hospital level). Services may be provided in the home, the community, the workplace, or health facilities as appropriate.
- **Coverage:**
  Service delivery is designed so that all people in a defined target population are covered, i.e. the sick and the healthy, all income groups and all social groups.
- **Continuity**: Service delivery is organized to provide an individual with continuity of care across the network of services, health conditions, levels of care, and over the life-cycle.
- **Quality:** Health services are of high quality, i.e. they are effective, safe, centred on the patient's needs and given in a timely fashion.
- **Person-centeredness**: Services are organized around the person, not the disease or the financing. Users perceive health services to be responsive and acceptable to them. There is

participation from the target population in service delivery design and assessment. People are partners in their own health care.

- **Coordination:** Local area health service networks are actively coordinated, across types of provider, types of care, levels of service delivery, and for both routine and emergency preparedness. The patient's primary care provider facilitates the route through the needed services, and works in collaboration with other levels and types of provider. Coordination also takes place with other sectors (e.g. social services) and partners (e.g. community organizations).
- **Accountability and efficiency:** Health services are well managed so as to achieve the core elements described above with a minimum wastage of resources. Managers are allocated the necessary authority to achieve planned objectives and held accountable for overall performance and results .Assessment includes appropriate mechanisms for the participation of the target population and civil society.

Service Delivery: To bedone

- Integrated packages of services
- Development of referral system
- Establishment of service standards
- Continuity of care
- Integration of disease control activities

Health Workforce

A well-performing health workforce is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances(i.e. there are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive).

- Health workers are at the heart of the health care system, affecting access to care as well as the quality and cost of effective delivery of services. Ministries of health are often over burdened with operational aspects of personnel administration leaving insufficient attention given to overall planning to ensure that human resources for health match the needs of the countries' health systems.
- The Human Resources for Health Unit brings to countries a wealth of expertise in all aspects of human resources and supports countries to develop a strategic vision for the health care workforce, strengthen human resources for the strategic planning, implementation and monitoring of health care and align high-quality workforce education with health needs.

Key areas for support include

- Health workforce strategic response to evolving and unmet health service needs
- Health workforce education, training and continuing competence
- Health workforce utilization, management and retention
- Health workforce governance, leadership and partnerships for sustained HRH contributions to improved populations outcomes.

Major issues/challenges in Health Workforce

- The misdistribution of healthcare workers across various regions of the country.
- Limited health professional education and training capacity to as per the growing demand for health care workers.
- Inadequate work place cultures that can attract and retain health care workers especially in rural and remote areas.
- Limited means for development of health professional knowledge and skills required to care for patients in an increasingly complex environment.
- Incompetence of health care system to care for geriatric patients

Health Workforce: To be done

- Production of key categories of health workers (HW) in short supply
- Inter-sectoral collaboration
- Public-private partnership
- Quality assurance in training
- Geographic distribution of HWs
- Regulatory system
- Cost-effectiveness in staff retention and mechanisms

Health Information Systems

A well functioning Health Information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.

Major challenges in Information and Technology

- How to make better use of institution based data?
- Issues about ownership
- How to consolidate the data collected?
- How to increase data analytical skills among data procedures.
- Strategies to advocate for healthcare information system.
- How to improve issues around cost and effective means of data transmission.

Medical Products, Vaccines and Technologies

A well functioning health system ensures equitable access to essential access to essential medical products ,vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness and their scientifically sound and cost-effective use.

Major challenges in Medical Products, Vaccines and Technologies

- Troubling practices that big pharmaceutical company uses to promote its goods like marketing for off label use.
- Wealth related and intersectional inequalities in immunization need to be reformed.
- Research in information and communication technologies which can revolutionize health care and act as a tool of global convergence trough cross-border supply of services.
- Resolvement of issues of decentralization and procurement is required.
- Disease insertion consists of disease mongering in which drug companies

promote overuse of pharmaceuticals and sell products.

Health Financing

A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.

Major challenges in Health Economics and Financing

- In India public health expenditure is very less as per WHO standard 4.5% of GDP is necessary.
- Out of pocket expenditure is very high, which is approx. 80% in India.
- Health insurance is aware by very less percentage of population and only one health insurance policy by government (RSBY-Rashtriya Swasthya Bima Yojna).
- Inadequate funds for health research in India.
- Inappropriate choice of technology in healthcare system.
- Poor inventory visibility due to data system.

Leadership and Governance

Leadership and Governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system–design and accountability.

Major challenges in Leadership and Governance

- How to initiate or support major change in healthcare sector.
- There is need for improvement in how leaders perform in competency.
- Thought leadership is needed to educate public.
- Leadership required producing and demonstrating expertise.
- Lack of motivation in hospital managers in the government sector

Monitoring and Evaluation of Health Systems Strengthening

- Increased attention to the strengthening of health systems would not be sustainable in the absence of a sound monitoring strategy that enables decision-makers to accurately track health progress and performance, evaluate impact, and ensure accountability at country and global levels. This describes a set of indicators and related measurement strategies, structured around the WHO framework that describes health systems in terms of six "building blocks.
- The monitoring and evaluation framework shows how ***health inputs and processes*** (e.g. health workforce and infrastructure) are reflected in ***outputs*** (e.g. interventions and available services) that in turn are reflected in ***outcomes*** (e.g. coverage) and ***impact*** (morbidity and mortality). The added value of the framework is that it brings together indicators and data sources across the results chain in its entirety,

i.e. from "inputs/processes", "outputs", and "outcomes", to "impact".

- ❑ The WHO monitoring framework recognized that "sound and reliable information is the foundation of decision-making across all health system building blocks.

Objectives of Monitoring and Evaluation Framework

- ❑ Monitoring of programme inputs, processes and results, required for the management of health system investments.
- ❑ Health systems performance assessment, as the key for country decision-making processes.
- ❑ Evaluating the results of health reform investments and identifying which approaches work best.

Health Service Delivery

- ❑ Health Service delivery monitoring has immediate relevance for the management of health services.
- ❑ Service Delivery monitoring through Standard Health Facility Assessment by:

Service Availability & Readiness.

- The key functional capacities of service availability and readiness include: ❑
- Facility infrastructure and amenities (such as availability of water supply, telecommunications and electricity).
- Basic medical equipment (such as weighing scales, thermometer and stethoscope)
- Availability of health workforce (e.g. cadre of human resources, staff training and guidelines).
- Drugs and commodities – availability of general medicines
- Diagnostic facilities – availability of laboratory tests
- Standard precautions on prevention of infections – availability of general injection and sterilization, disposal and hygiene practices
- Specialized services (such as family planning, maternal and newborn care, child health, HIV/AIDS, tuberculosis, malaria and chronic diseases.)

❖ No single source can provide sufficient information for monitoring service delivery. Thus, a service delivery monitoring system would need to rely on multiple sources of data to be brought together for analysis and decision-making.

❖ **Data from*routine health facility reporting systems need to be supplemented with data from health facility assessments.***

Core Indicators of Service Delivery

General service availability:

General Service availability refers to the physical presence of delivery of services that meet a minimum standard. Availability comprises health infrastructure (facilities and beds per 10 000 population), the health workforce per 10 000 population and aspects of

service utilization (inpatient/outpatient visits per 10000 population).

- **General service readiness:**
  General Service readiness refers to the general capacity of health facilities to provide health services. Readiness is defined as the cumulative availability of components required to provide services. It comprises tracer items for the following major domains: infrastructure/amenities, basic supplies/equipment including small surgery, standard precautions, laboratory tests, medicines and commodities.
- **Service-specific availability**
  Service-specific availability refers to whether or not a specific service is offered. Availability is captured by the proportion of services offering a specific service and the density of the facilities offering the service per 10000 population.
- **Service-specific readiness**
  Service-specific readiness refers to the capacity of health facilities to provide a specific service, measured through the presence of tracer items that include trained staff, guidelines, equipment/supplies, diagnostic capacity, medicines and commodities.
  Specific services may include family planning, antenatal care, safe delivery, child health, HIV/AIDS, tuberculosis, malaria, chronic conditions and small surgery.

Health Workforce

The classification of health workers

- Physicians
- Nursing and midwifery personnel
- Dentistry personnel
- Pharmaceutical personnel
- Laboratory health workers
- Environmental and public health workers
- Community and traditional health workers
- Other health service providers
- Health management and support workers

A shortage of health workers can be perceived from:

- The inadequate numbers
- Skills mix of people being trained
- Mal-distribution of their deployment,
- Losses caused by death, retirement, career change or out-migration

Core Indicators of Health Workforce

- **Health Worker Density** – the number of health workers per 10 000 population.
- **Distribution of health workers** – by occupation/ specialization, region, place of work and sex.

  At least four typologies for monitoring the distribution of health workers should be considered: **(i) imbalances in occupation/specialty, (ii) geographical representation, (iii) institutions and services, and (iv) demographics**
- **Annual output /number of graduates** of health professions educational institutions per 100 000 population – by level and field of education.
- Imbalance (or misdistribution) in the supply, deployment and composition of human resources for health, leading to

inequities in the effective provision of health services, is an issue of social and political concern in many countries.

- ❑ The collection, processing and dissemination of health workforce data should enable disaggregation by occupation (and within a given occupation, for example by medical specialization), by geographical typology (e.g. urban or rural, within or outside the capital city, by province/state or district), by place of work (e.g. hospital or primary health-care facility, public or private), by main work activities (e.g. preventive/curative/rehabilitative health-care provision versus other functions such as teaching or research), and by sex.

Health Information Systems

The health information system has four key functions

(i) Data generation, (ii) compilation, (iii) analysis and synthesis, and (iv) communication and use.

Health planners and decision-makers need different kinds of information including:

- Health determinants
- Inputs to the health system and related processes (policy and organization, health infrastructure, facilities and equipment, costs, human and financial resources and health information systems)
- The performance or outputs of the health system (availability, accessibility, quality and use of health information and services, responsiveness of the system to user needs, and financial risk protection)
- Health outcomes(mortality, morbidity, disease outbreaks, health status, disability and wellbeing)
- Health inequities (determinants, coverage of use of services, and health outcomes, and including key stratifiers such as sex, socioeconomic status, ethnic group and geographical location).

Access to essential medicines:

According to the WHO framework for health systems, a well-functioning health system ensures:

- Equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
- Essential medicines are intended to be available within the context of functioning health systems at all times, in adequate amounts, in the appropriate dosage, with assured quality, and at a price that individuals and the community can afford.
- Access to medicines can only be generated using a range of indicators that provide data on medicine availability and price, in both public and private sectors, in combination with key policy indicators.

Three categories of indicators:

1. **Prescribing indicators**

Average number of medicines prescribed per encounter, percentage of medicines prescribed by a generic name, percentage of encounters with an antibiotic prescribed, percentage of encounters with an injection prescribed, percentage of medicines prescribed from essential medicines list.

Patient care indicators

Average consultation time, average dispensing time, percentage of medicines actually dispensed, percentage of medicines adequately labeled, the patient's knowledge of correct dosage

3. Facility indicators: Availability of a copy of essential medicines list of formulary, availability of key medicines. Facility-level indicators to measure key outcomes in the areas of access, product quality and rational use:

- **Access** is measured in terms of the availability and affordability of essential medicines.
- **Quality** is represented by the absence of expired stock on pharmacy shelves and adequate handling and conservation conditions.
- **Rational use** is measured by examining prescribing and dispensing practices and the implementation of strategies that have been shown to support rational use, such as standard treatment guidelines and the essential medicines list.

Core Indicators for Access to Medicines

- Average availability of selected essential medicines
- Median consumer price ratio of selected essential medicines
- Access to essential medicines/technologies as part of the fulfillment of the right to health
- Existence of last update of a published medicines policy.
- Existence of last update of a published list of essential medicines
- Legal provisions to allow/encourage generic substitution
- Percentage of population covered by health insurance

Health Financing

Objectives of Health Financing

(i) To raise sufficient funds

(ii) To provide financial risk protection to the population.

(iii) Improving efficiency of resource utilization

(iv) Improving financial transparency and management at operational levels.

Three inter-related functions of financing system

(i) Revenue collection

(ii) Fund pooling

(iii) Purchasing/provision of services

At the extreme, without the necessary funds no health workers would be employed, no medicines would be available and no health promotion or prevention would take place. Health, financing is much more than a simple generation of funds.

Core Indicators for Health Financing

- Total expenditure on health.
- General government expenditure on health as a proportion of general government expenditure
- The ratio of household out-of-pocket payments for health to total expenditure on health.

Total expenditure on health:

This indicator provides information on the overall availability of funds. Sufficiency must be considered as a second step, in relation to country-specific estimates of the funds needed to ensure access to the desired level of services, or in terms of comparisons with other countries with similar levels of gross domestic product (GDP) per head.

- **(GHE/GE):** This indicator is related to how much funding is raised for health and reflects government commitment.
- The ideal indicator of financial risk protection is the proportion of the population incurring catastrophic health expenditure due to out-of-pocket payments. A variation is the percentage that is impoverished as a result of out-of-pocket payments.

Leadership and Governance

Governance in health is a cross-cutting theme, intimately connected with issues surrounding accountability.

Accountability involves:

- Delegation or an understanding (either implicit or explicit) of how services are supplied
- Financing to ensure that adequate resources are available to deliver essential services performance around the actual supply of services
- Receipt of relevant information to evaluate or monitor performance
- Enforcement, such as imposition of sanctions or the provision of rewards for performance

The need for greater accountability arises both from increased funding and a growing demand to demonstrate results. Accountability is therefore an intrinsic aspect of governance that concerns the management of relationships between various stakeholders in health, including individuals, households, communities, firms, governments, nongovernmental organizations, private firms and other entities that have the responsibility to finance, monitor, deliver and use health services.

Types of Indicators for measuring governance

- **Rules-based**:

Rules-based indicators measure whether countries have appropriate policies, strategies and codified approaches for health system governance.

❑ **Outcome-based:**

Outcome- based indicators measure whether rules and procedures are being effectively implemented or enforced based on the experience of relevant stakeholders.

Rules-based indicators: In the health systems context, these indicators include the existence, for example, of a national essential medicines list or a national policy on malaria control. They are part of a larger class of indicators called governance determinants. In addition to the existence of rules (called "formal procedures"), the determinants of health-care-provision governance include four other broad categories: ownership arrangements, decentralization, stakeholder participation, and contextual factors. In this framework, determinants of governance are contrasted with governance performance.

Outcome-based indicators: for health systems, examples may include the availability of essential medicines in health facilities or the absenteeism of health workers.

Core Indicators for Leadership and Governance

- Existence of an up-to-date national health strategy linked to national needs and priorities.
- Existence and year of last update of a published national medicines policy.
- Existence of policies on medicines procurement that specify the most cost-effective medicines in the right quantities; open, competitive bidding of suppliers of quality products.
- Tuberculosis—existence of a national strategic plan for tuberculosis that reflects the six principal components of the Stop-TB strategy as outlined in the Global Plan to Stop TB 2006–2015.
- Malaria—existence of a national malaria strategy or policy that includes drug efficacy monitoring, vector control and insecticide resistance monitoring.
- HIV/AIDS—completion of the UNGASS National Composite Policy Index questionnaire for HIV/AIDS.
- Maternal health—existence of a comprehensive reproductive health policy consistent with the ICPD action plans.
- Child health—existence of an updated comprehensive, multiyear plan for childhood immunization.
- Existence of key health sector documents that are disseminated regularly (such as budget documents, annual performance reviews and health indicators).
- Existence of mechanisms, such as surveys, for obtaining opportune client input on appropriate, timely and effective access to health services.

❖ A composite governance policy index, comprising 10 rules-based indicators that cover health policies for different disease interventions and health system aspects, is presented.

- The index provides a summary measure of governance quality from a rules-based perspective.
- The indicators assess whether countries have policies, regulations and strategies in place to promote good leadership and governance in the health sector, but do not aim to assess enforcement.

Exercise-Sample Table: For Better Understanding of 6 Building Blocks

Constraint	Possible disease-specific response	Possible health system response
Financial access difficult e.g inability to pay, informal fees	Payment exemptions for an individual, for a specific disease	Pooling pre-paid funds (from households, external agencies, companies) in ways that allow risks to be shared, and decrease individual payments when sick
Physical access difficult e.g. distance to facility	Out-reach for specific diseases; engage private providers	Revising plans for the location, construction or upgrading of health facilities
Knowledge and skills low (public and private providers)	Workshops and other continuing education for specific diseases	Revised pre-service training curricula; systems for licensing, accreditation, supervision
Staff are poorly motivated	Staff get financial incentives to deliver specific services	Clear job descriptions; performance and salary review; fair, transparent promotion procedure
Weak leadership and management	Workshops to develop skills in managing staff, budgets etc. (e.g. in Workshops to develop skills in managing staff, budgets etc. (e.g. in public and NGO facilities)	Additional actions such as giving managers more control over resources; more accountability for results
Ineffective intersectoral action and partnership	Disease-specific cross-sectoral committees, usually national level	Building local government systems with cross-sector representation, and explicit procedures for public accountability

GOOD HEALTH SYSTEM :

A Great Place to Work. A Great Place to Receive Care

- Understanding of Health System
- Need for Health System Strengthening
- WHO's Framework for Health System Strengthening
- Building blocks for Health System Strengthening
- Monitoring and Evaluation of Health System Strengthening

Rural Health Care System

The health care infrastructure in rural areas has been developed as a three tier system and is based on

Centre	Population Norms	
	Plain Area	Hilly/Tribal/ Plain Areas
Sub Centre	5000	3000
Primary Health Centre	30000	20000
Community Health Centre	120000	80000

Sub Centres

The Sub Centre is the most peripheral and first contact point between the primary health care

system and the community. Sub Centres are assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhea control and control of communicable diseases Programmes.

Each Sub Centre is required to be manned by -at least one auxiliary nurse midwife (ANM) /female health worker and one male

Health worker. Under NRHM, there is a provision for one additional second ANM on contract basis. One lady health visitor (LHV) is entrusted with the task of supervision of six Sub Centres. Government of India bears the salary of ANM and LHV while the salary of the Male Health Worker is borne by the State governments. Under the Swap Scheme, the Government of India has taken over an additional 39,554 Sub Centres from State governments / Union territories since April, 2002 in lieu of 5,434 Rural Family Welfare Centres transferred to the State governments / Union territories.

There were 1,53,655 Sub Centres functioning in the country as on 31st March, 2015.

Primary Health Centres-

PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services (BMS) Programme. As per minimum requirement, a PHC is to be manned by a Medical Officer supported by 14 paramedical and other staff. Under NRHM, there is a provision for two additional Staff Nurses at PHCs on contract basis. It acts as a referral unit for 6 Sub Centres. It has 4 - 6 beds for patients. The activities of PHC involve curative, preventive, promotive and Family Welfare Services.

Community Health Centres-

CHCs are being established and maintained by the State Government under MNP/BMS Programme. As per minimum norms, a CHC is required to be manned by four medical specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a referral Centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations.

First Referral Unit-

An existing facility (District Hospital, Sub-divisional Hospital, Community

HealthCentre etc.) can be declared a fully operational First Referral Unit (FRU) only if it is equipped to provide round-the-clock services for emergency obstetric and New Bornprovide round-the-clock services for emergency obstetric and New Born Care, in addition to all emergencies that any hospital is required to provide. It should be noted that there are three critical determinants of a facility being declared as a FRU:

i) Emergency Obstetric Care including surgical interventions like caesarean sections.

ii) New-born care

iii) Blood storage facility on a 24-hour basis.

Strengthening of Rural Health Infrastructure under National Rural Health Mission-

- The National Rural Health Mission seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.
- The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP.
- NRHM aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country

It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health.

- It also seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

NRHM- The Vision

- The National Rural Health Mission seeks to provide effective Healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.
- The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP. It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country.
- It seeks to revitalize local health traditions and mainstream AYUSH into the public health system.
- It aims at effective integration of health concerns with determinants of health

like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health.

- It seeks decentralization of programmes for district management of health.

Goals-

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles

Strategies

Core Strategies-

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the
- female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).
- Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation & hygiene and nutrition.
- Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels.
- Technical Support to National, State and District Health Missions, for Public Health Management.
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of Human Resources for health.
- Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc.
- Promoting non-profit sector particularly in underserved areas.
- (b) Supplementary Strategies:

- Regulation of Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.
- Promotion of Public Private Partnerships for achieving public health goals.
- Mainstreaming AYUSH – revitalizing local health traditions.
- Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.
- Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

Components-

A. Accredited Social Health Activists
B. Strengthening of Sub-centres
C. Strengthening Primary Health Centres
D. Strengthening CHCs for First Referral Care
E. District Health Plan- District Health Plan would be an amalgamation of field responses through Village Health Plans, State and National priorities for Health, Water Supply, Sanitation and Nutrition
F. Converging Sanitation and Hygiene under NRHM
G. Strengthening Disease Control Programmes
H. Public-private Partnership For Public Health Goals, Including Regulation of Private Sector.
I. New Health Financing Mechanisms- Task Group to examine new health financing mechanisms, including Risk Pooling for Hospital Care as follows:

- Progressively the District Health Missions to move towards paying hospitals for services by way of reimbursement, on the principle of "money follows the patient."
- Standardization of services – outpatient, in-patient, laboratory, surgical interventions- and costs will be done periodically by a committee of experts in each state.
- A National Expert Group to monitor these standards and give suitable advice and guidance on protocols and cost comparisons.

J. Reorienting Health/Medical Education to Support Rural Health issues.

Role of Panchayati Raj Institution-

- States to indicate in their MoUs the commitment for devolution of funds, functionaries and programmes for health, to PRIs.
- The District Health Mission to be led by the Zila Parishad. The DHM will control, guide and manage all public health institutions in the district, Sub-centres, PHCs and CHCs.
- ASHAs would be selected by and be accountable to the Village Panchayat.
- The Village Health Committee of the Panchayat would prepare the Village Health Plan, and promote inter-sectoral integration

- Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the ANM & Sarpanch and operated by the ANM, in consultation with the Village Health Committee.

Urban Health System

National Urban Health Mission-

Approved on May 1, 2013 as a sub-mission of the National Health Mission (NHM) to strengthen the primary health care system in cities & towns

Target Population-

- Cities/Town with population above 50000
- District Headquarter town with population from 30000 to 50000.

Special Focus on following-

- People living in listed unlisted slums and other low income neighbourhood.
- Vulnerable population such as homeless, rag pickers, street children, rickshaw puller, and other temporary migrant.
- Core Strategies NUHM
- Note- ULB (Urban Local Body)

Sustainable development of Urban Health-

- With the SDGs for the first time 'Sustainable Cities and Communities' has been declared as an international goal
- There are 17 SDGs with 169 targets that all 191 UN Member States have agreed to work towards by the year 2030
- All the SDGs have a direct and indirect impact on health
- Health in all policies will lead to achieve SDG
- With increasing global urbanization, achievement of SDGs will not be possible without working towards especially urban health

NUHM- Service Delivery Mechanism

1. UCHC
2. UPHC

Barriers to seeking Healthcare Services in Urban Settings are as follows-

- Limited Government PHC Services.
- Overcrowding at Public Hospitals.
- Rude and indifferent behaviour towards poor.
- Costly drugs & diagnostics.
- Out of Physical reach.
- Inconvenient timings.

Expected outcomes of NUHM-

- Providing comprehensive quality health care to the urban poor and vulnerable through UPHCs/UCHCs
- Special focus on health issues in urban areas- NCDs, Mental health, substance abuse etc.
- Outreach through UHNDs and special outreach sessions to address specific community health needs
- Mapping of urban vulnerable population
- Provision of services under all National Health Programmes at the UPHC level
- Address social determinants of health through inter-sectoral convergence

Urban Primary Health Centre- **Hub** of all preventive, promotive and curative activities through direct intervention or inter-sectoral convergent action .

Particulars-

- To be located in and around slums or low income housing
- Timings: Morning and Evening OPD. 8 hours of Operation.
- Staff: 2 MOs (1 Regular, 1-part time), Public Health Manager, Staff Nurse, 3-5 ANM, 20-25 ASHAs
- Disability Friendly & accessible
- Public Health Manager to coordinate all public health related activities

Points of Action-

- Standardized signage and Branding
- Ambience and Patient Amenities
- Population Enumeration and Analysis of population needs
- Provision of services
- Maintenance of Records and Registers
- Coordination with ULB Members and other community level partners for urban health

Referral Services-

- UPHCs should identify multiple referral sites for various special needs:
- UCHC/DH for clinical conditions
- De-addiction centres
- Mental Health Services
- Domestic Violence Help Centres
- Vocational Rehabilitation Centre
- Nutritional Help Centre
- Identify focal persons at each referral center to communicate with directly
- Follow up treatment and compliance by ASHA and ANM for all referred cases.

Rogi Kalyan Samitis-

This committee would be a registered society, having Governing, Executive and Monitoring body consists of members government officers, ULB members and representative from NULM, DUDA, ICDS & Basic education, NGOs ; who are responsible for proper functioning and management of the UPHC/ UCHC. RKS is free to prescribe, generate and use the funds with it as per its best judgement for smooth functioning and maintaining the quality of services. The government facilities strengthened as U-PHC will be provided annual financial support in the form of Rogi Kalyan Samiti as untied fund of Rs. 175,000/- per U-PHC per year and UPHC running in the rented building will be provided as untied fund of Rs. 1,00,000/- per UPHC per year.

Generate and use the funds with it as per its best judgement for smooth functioning and maintaining the quality of services. The government facilities strengthened as U-PHC will be provided annual financial support in the form of Rogi Kalyan Samiti as untied fund of Rs. 175,000/- per U-PHC per year and UPHC running in the rented building will be provided as untied

fund of Rs. 1,00,000/- per UPHC per year.

Convergence and Coordination-

- Convergence is the backbone of NUHM
- Interconnectedness of ill-health, poverty, environmental factors and various social determinants of health – to be tackled in a holistic way
- Joint implementation by State Health Department and Urban Local Bodies
- Participation by all stakeholders – Women &Child Dev Dept., Education Dept., Urban Local Bodies, Livelihood Mission, Swachha Bharat Mission etc.
- Convergence mechanisms to be established at State, City, Ward/sub-city and UPHC levels .

Role of Medical Officers-

- As In-charge, Medical Officer should be well versed with the entire process for efficient supervision.
- Analyze various formats and tools to identify specific problems related to specific areas.
- Plan delivery of health care services as per the outcomes of city mapping and vulnerability assessment.
- Maintain upward and downward linkages.
- Develop interdepartmental co-ordination

KPIs for UPHC

1. Productivity

- OPD per Month
- No. of ANC conducted per month
- Proportion of vulnerable patients attended OPD
- Lab test done per 1000 OPD Patient
- Consultation Time at OPD
- IUCD Complication Rate
- Percentage of High risk pregnancies detected during ANC
- Antibiotic Consumption rate
- Percentage of AEFI cases reported
- Percentages of DOT cases completed

2. Efficiency

- No. of outreach sessions conducted per ANM
- Dropout rate for DPT vaccination
- No. of Stock out drugs
- Patient Satisfaction Score (OPD)
- Registration to Drug time
- Follow up rate

ASHA- ASHA: Accredited Social Health Activist

(One ASHA for every 1000-2500 population i.e. about 200- 500 households)

ASHA'S Role

- Facilitating access to health care services
- Building awareness about health care entitlements especially amongst the poor and marginalized
- Promoting healthy behaviors
- Mobilizing for collective action for better health outcomes
- Meeting curative care needs as appropriate to the organization of service delivery in that area and compatible with her training and skills

Mahila Arogya Samiti (MAS)-

- To provide mechanism for the community to voice health needs, experiences and issues with access to health services
- To generate awareness on locally relevant health issues & to promote the acceptance of best practices in health by the community
- To direct focus on preventive and promotive health care activities and management of untied funds
- Support and facilitate ASHA and other frontline workers

Blood Services & Blood Disorder Management Program

State Blood Cell under National Health Mission, Uttar Pradesh is established with objective to strengthen Blood Services in the state to get optimum output which enable blood centers and blood storage centers to hassle free on time supply of quality blood to all in need along with & Blood Disorder Management to minimize out of pocket expenditure of the patients suffering from blood dyscrasia especially Thalassemia, Hemophilia & Sickle cell anemia.

Following main activities are supported through State Blood Cell-

- Free Blood & Blood Components availability to all patients admitted in government health facilities through the blood banks under govt. hospitals/medical colleges.
- Support in the establishment, up gradation, strengthening & functioning of blood banks as per demand & need.
- Support in the establishment & functioning of the Blood Storage Centre at designated First referral Units.
- Free diagnosis, treatment & management facilities to patients suffering from blood disorder through designated centre under district hospital/medical colleges.
- Placement of fully equipped Blood Collection & Transportation Van (BCTV)with Manpower in divisional districts to enable blood banks to organise outreach blood donation camps without hampering the blood bank's functionality.

20 HEALTH ADMINISTRATION

District Health Administration
Administrative Structure
District Level

- District Health Society (Chairperson- District Magistrate)
- Chief Medical Officer is responsible for planning, financing, implementation and monitoring of all health activities in the district.
- Additional CMOs, Deputy CMOs – provide assistance to the CMO
- Chief Medical Superintendent (CMS) at every District Hospital
- District Program Manager (NHM) and District Community Program Manager (NHM)
- IPHS has revised the services into essential and desirable.

Essential –

1. General Specialties
2. General Medicine
3. General Surgery Obstetric & Gynaecology Services
4. Family Planning services
5. Follow up services
6. Anaesthesia
7. Ophthalmology
8. DOT centre
9. Services under Other National Health Programmes
10. Health promotion and Counselling Services
11. Emergency services and Critical care /Intensive care (ICU)
12. District Public Health Unit
13. Otorhinolaryngology (ENT)
14. AYUSH
15. Blood Bank
16. Orthopaedics Radiology including Imaging

Desirable -

1. General Specialties Dermatology and Venerology (Skin & VD) Radiotherapy
2. Allergy De-addiction centre
3. Physical Medicine and Rehabilitation services
4. Tobacco Cessation Services
5. Dialysis Services

Services at District Hospital

- Specialist services, preventive and promotive
- It is a secondary level referral centre.
- Technical and administrative support and education and training for primary health care.
- OPD Services and IPD Services : General Medicine, Surgery, Obstetrics & Gynaecology, Paediatrics, Dental and AYUSH services.
- Eye Specialist services
- Care of Routine and Emergency Cases in Surgery
- Care of Routine and Emergency Cases in Medicine
- Maternal Health
- Newborn Care and Child Health
- Services such as WIFS and NDD services are provided in CHC under RKSK

- Family Planning
- Diagnostic and other Para clinical services regarding
- Medico-legal/post mortem
- Communication and awareness generation
- Medical Social Work
- Nursing Services
- Infection Control
- Referral Services
- Other National Health Programmes
- Communicable Diseases Programmes

❖ RNTCP, HIV/AIDS Control Program, National vector borne disease control program, National Leprosy Eradication Programme, National Programme for Control of Blindness, Integrated Disease Surveillance Project, National Programme for Prevention and Control of Deafness (NPPCD), National Mental Health Programme (NMHP), National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS), National Iodine Deficiency Disorders Control Programme, National Programme for Prevention and Control of Fluorosis (NPPCF), Essential in Fluorosis affected Villages, National Tobacco Control Programme

❖ National Programme for Health Care of Elderly

❖ Physical Medicine and Rehabilitation (PMR)

❖ Other Services – School Health , Blood Storage Facility, and Maternal Death Review.

Block Level -Community Health Centre

Medical Superintendent – Heads the CHC.

- A Block Public Health Unit is envisaged at the CHC having a Block Medical Officer/Medical superintendent, Public Health specialist and at least one Public Health Nurse. The support manpower will include a Dental Assistant, Multi Rehabilitation Worker, Cold Chain and Vaccine Logistic Assistant in addition to the existing staff.
- IPHS has revised the services into essential and desirable.
- The essential services include - routine and emergency care in surgery , Medicine, Obstetrics and Gynaecology, Paediatrics, Dental and AYUSH in addition to all the National Health Programmes.
- Staff for newly developed non-communicable disease is added to some CHCs.
- Newborn Stabilization unit and MTP facilities (if Gynaecologist and paediatricians are in place).
- *The Integrated Counselling and* Testing Centre (ICTC), Blood storage and link Anti Retroviral Therapy centre have been added.
- Block Program Manager and Block Community Program Manager
- As per IPHS standards 2 specialists, namely, Anaesthetist and Public Health Specialist will be provided at CHC level in addition to the available specialists,

namely, Surgery, Medicine, Obstetrics , Gynaecology and Paediatrics.

- The manpower at CHC has been rationalized in order to ensure optimal utilization of scarce manpower.
- The CHCs can be both Block level administrative unit and unit of referral to higher facilities.

Services at CHC

- OPD Services and IPD Services : General Medicine, Surgery, Obstetrics & Gynaecology, Paediatrics, Dental and AYUSH services.
- Eye Specialist services (at one for every 5 CHCs).
- Emergency Services
- Laboratory Services
- National Health Programmes
- Care of Routine and Emergency Cases in Surgery
- Care of Routine and Emergency Cases in Medicine
- Maternal Health
- Newborn Care and Child Health
- Family Planning
- Other National Health Programmes (NHP): (Essential Except as Indicated)
- Communicable Diseases Programmes

❖ RNTCP
❖ HIV/AIDS Control Programme
❖ National Vector Borne Disease Control Programme
❖ National Leprosy Eradication Programme
❖ National Programme for Control of Blindness
❖ Integrated Disease Surveillance Project
❖ National Programme for Prevention and Control of Deafness (NPPCD)
❖ National Mental Health Programme (NMHP)
❖ National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)
❖ National Iodine Deficiency Disorders Control Programme (NIDDCP)
❖ National Programme for Prevention and Control of Fluorosis (NPPCF) Essential in Fluorosis affected Villages
❖ National Tobacco Control Programme (NTCP)
❖ National Programme for Health Care of Elderly
❖ Physical Medicine and Rehabilitation (PMR)
❖ Other Services – School Health , Blood Storage Facility, and Maternal Death Review

Primary Health Centre

- PHC is the contact point between the community and the Medical Officer.
- As per the minimum requirement, a PHC should be managed by a Medical Officer supported by 14 paramedical and other staff.

List of staff at a PHC

1. Medical Officer
2. Medical Officer – AYUSH
3. Accountant cum Data Entry Operator
4. Pharmacist
5. Pharmacist AYUSH
6. Nurse-midwife (Staff-Nurse)
7. Health worker (Female)

8. Health Assistant (Male)
9. Health Assistant (Female) / Lady Health Visitor
10. Health Educator
11. Laboratory Technician
12. Cold Chain & Vaccine Logistic Assistant
13. Multi-skilled group D worker
14. Sanitary worker cum watchman

Services at PHCs

- PHCs acts as a referral unit for 6 Sub Centres.
- A PHC should have 4 - 6 beds for patients.
- The services provided at PHC are curative, preventive, promotive and Family Welfare Services.

1. Education concerning prevailing health problems and the methods of preventing and controlling them
2. Promotion of food supply and proper nutrition
3. An adequate supply of safe water and basic sanitation.
4. Maternal and child health care, including family planning
5. Immunization against major infectious disease
6. Prevention and control of locally endemic disease
7. Appropriate treatment of common disease and injuries
8. Provision of essential drugs
9. Health education & management of RTI/STI
10. Basic lab services
11. Selected Surgical procedures
12. School health Services
13. Adolescent health care
14. Disease Surveillance & control programme
15. Collection of vital events
16. Promotion of sanitation including use of toilet & appropriate garbage disposal
17. Water quality monitoring
18. Trainings
19. Mainstreaming of AYUSH
20. National health programme

Sub-Centre

The Sub-Centre is the first contact point for the community .

Each Sub-Centre should have:

- At least one Auxiliary Nurse Midwife (ANM) / Female Health Worker and one Male Health Worker
- Provision of additional contractual ANM is there under NRHM.
- A Lady Health Visitor (LHV) is entrusted with the task of supervision of six Sub-Centres

Services at Sub-Centre

- ❖ Maternal and child health
- ❖ Family welfare
- ❖ Nutrition, immunization, diarrhoea control
- ❖ Control of communicable diseases programmes
- ❖ Interpersonal communication in order to bring about behavioural change.

- The Sub-Centres are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children.
- Various National Health Programs
- Counselling
- Community needs assessment

The Village Health Nutrition and Sanitation Committees

- This committee is formed at revenue village level and it should act as a sub-committee of Gram Panchayat.
- It should have a minimum of 15 members.
  This committee will be lead by the elected member of the Panchayat
- Other members are all those working for health and health related services should participate, community members/ beneficiaries and representation from all sub-groups especially the vulnerable sections.
- ASHA of this revenue village shall be the member secretary and convener of the committee.

Services provided by VHNSC

- Awareness about Health and Nutritional
- Survey on nutritional status and nutritional deficiencies in the village especially among women and children.
- Promote best practices related to health and nutrition. (traditional wisdom) through a process of community consultation.
- Preparation of Village Health Plan – by doing in-depth analysis of causes of malnutrition at the community and household levels, involving the ANM, AWW, ASHA and ICDS Supervisors.
- Monitoring and Supervision of Village Health and Nutrition Day.
- Facilitate early detection of malnourished children in the community; tie up referral to the nearest Nutritional Rehabilitation Centre (NRC) as well as follow up for sustained outcome.
- Supervise the functioning of Anganwadi Centre (AWC) in the village and facilitate its working in improving nutritional status of women and children.
- Act as a grievances redressal forum on health and nutrition issues.

ADMINISTRATIVE STRUCTURE

Department of Medical Health and Family Welfare, Uttar Pradesh

Department of Medical, Health and Family Welfare, Government of Uttar Pradesh, is playing a vital role in improving the health status & quality of living of the People of Uttar Pradesh. With the objective of providing health services in both Urban and rural areas, the department provides three tier medical services in the state of Uttar Pradesh. Under this, at the first level, Health Services are provided in urban areas. Health services at the second and third level are provided in rural areas.

The Secretariat

The Department of Medical Health and Family Welfare is responsible for delivery of healthcare services, health promotion, disease prevention and rehabilitative services up to the grass root level of state. It is composed of two directorates namely Directorate of Medical & Health

Services and Directorate of Family Welfare, divisional and district level offices with numerous programs and projects. The Department is headed by two Cabinet Ministers – one for the Medical & Health and the other for the Family Welfare. The cabinet ministers are supported by Minister of State. The administrative structure of the Department is headed by the Additional Chief Secretary/Principal Secretary, Medical Health and Family Welfare. Additional Chief Secretary/Principal Secretary is supported by Secretary, Special Secretary, Under Secretary Deputy Secretary and ten sections.

Directorate of Medical & Health Services

The Directorate of Medical & Health services implements and monitors provision of medical care services in urban and rural areas, through a three-tier medical services structure. This Directorate oversees the service provision through a public health system. About 13 National Programmes are operationalized through this Directorate. The Directorate has sanctioned post of 12 Directors, 34 Additional Directors and several Joint Directors. The Joint Director level officers are nominated as State Programme Officers of National Programmes. There are various sections in the Directorate to oversee the issues related to doctors, paramedical staff, nurses, CMSD, Plan, Budget, Construction, Administration, Health, National Programmes, Communicable Diseases, Medical Care, Dental, Electrical and training etc.

Directorate of Family Welfare

The Directorate of Family Welfare is responsible for supporting frontline workers such as Health Education Officers, Research Officers, Lady Health Visitors (LHVs) Auxiliary Nurse Midwife (ANMs) and ASHA workers. Its responsibility includes supporting reproductive and child health and immunization related activities. The Director General, Family Welfare is supported by two Directors, 5 Additional Directors and 12 Joint Directors.

National Health Mission

The National Health Mission (NHM) is a critical component of the Health Department, which was launched in 2015, as an extension of the NRHM since 2005, to carry out necessary architectural correction in the basic health care delivery system, along with enhanced financing to strengthen the State urban and rural health system. The NHM, led by the Mission Director (an IAS Officer of Secretary rank), is managed through a mission unit. Mission Director is usually supported by two Additional Mission Directors (IAS officer of Special Secretary rank) and Senior Advisors (usually retired officers of PMS service). Component wise, there are several General Managers like RI, ME, CP, NP,

MCH, Planning, MIS etc supported by Deputy General Managers, Programme Officers, Technical Consultants and Programme Associates.

Uttar Pradesh State AIDS Control Society

Uttar Pradesh State AIDS Control Society (UPSACS) was formally registered in the Year 1999 as a para-State agency to finance, implement and oversee the AIDS prevention and control program in the State. The UPSACS is staffed by technical, finance and administrative staff deputed from the Directorate of Medical & Health to manage the program. Some contractual staffs are also recruited for technical expertise. The Mission Director of NHM is also the Project Director of UPSACS, an arrangement which is expected to facilitate implementation and monitoring linkages between NHM and SACS.

State Institute of Health & Family Welfare

An important mandate of the Government is to provide in-service training to the Government Medical Officers and allied staffs though the State Institute of Health & Family Welfare (SIHFW), a government apex training institute. It also supports training and research through its affiliated regional training and research centres; Regional Institute of Health and Family Welfare (RIHFW). The SIHFW is headed by Director and supported by various faculties.

State Agency for Comprehensive Health Insurance (SACHI)

Few years ago, the State provided health insurance through Rashtriya Swasthya Bima Yojana (RSBY) to people below poverty line. The RSBY scheme was managed through an administrative unit embedded in the Department of Medical Health & Family Welfare. Currently, RSBY is no longer in operation and has been replaced by Pradhan Mantri Rastriya Swasthya Suraksha Mission under Ayushman Bharat Scheme. However, few officers are still on deputation at SACHIS from Directorate of Medical & Health Services. SACHIS is headed by CEO (an officer of Special Secretary rank) and supported by techno-managerial staffs.

State Health Institute (SHI)

SHI works under the Directorate of Medical & Health Services and is headed by Additional Director under the control of Director, Health from Directorate of Medical & Health Services. Currently, SHI is engaged in the monitoring of water quality and leads National Programmes like National Programme for Prevention and Control of Fluorosis and National Iodine Deficiency Disorder Control Programme.

Uttar Pradesh Medical Supplies Corporation

To ensure transparent, timely and centralized procurement and decentralized distribution of drugs and biomedical equipment, Government of

Uttar Pradesh has established UP Medical Supplies Corporation headed by Managing Director (an IAS officer of Special Secretary rank) with several techno-managerial staffs.

Support Organisations

Some significant organisations include State Innovations in Family Planning Services Project Agency (SIFPSA), a joint initiative of Government of India, United States Agency for International Development (USAID) and Government of Uttar Pradesh for implementing the innovations in family planning services in the State; Uttar Pradesh Health System Strengthening Project (UPHSSP) - a World Bank assisted project initiated to improve the efficiency, quality and accountability of health services delivery in Uttar Pradesh.

Uttar Pradesh Technical Support Unit (UPTSU) set up in 2012 to promote partnerships with Governments, non-government agencies and community organizations to design and implement high-impact public health programs. In addition, technical support in different programs and health system areas is provided through multilateral partners such as WHO, UNICEF and UNDP in accordance with their mandate and approved country plans.

Division level

At the regional level, there are 18 administrative divisions to facilitate monitoring of program implementation in the districts. Each division comprises of a cluster of districts and is headed by an Additional Director, Medical Health & Family Welfare and supported by Joint Directors and ministerial staffs. Its work is confined to the monitoring and supervision of CMOs and CMSs, feedback initiated by the Directorate and coordination activities.

District level

The district health system is led by the Chief Medical Officer who reports to the District Magistrate who is the Chairperson of the District Health Society. The CMO is accountable to the upward vertical of public health system. The CMO is responsible for planning, financing, implementation and monitoring of all health activities in the district through Community Health Centres, Primary Health Centres and Health Sub Centres. CMO of the district is assisted by Additional CMOs, Deputy CMOs, various programme officers, consultants and other techno-managerial staffs and ministerial staffs.

Periphery level

CHCs are established at 100000 population as per norms and headed by Medical Superintendent and assisted by basic specializations. Similarly, PHCs are established at 30000 population and headed by MO (in charge) At the grass root level as an interface between community and health system, total 20521 Health Sub-Centres are established (standard 1 Sub-Centre per

5000 population). These centres are manned by ANMs and ASHAs.

Service Delivery by PHC, CHC and District Hospital

Primary Health Centre (**PHC**s),sometimes referred to as **public health centres** are state-owned rural health care facilities in India. They are essentially single-physician clinics usually with facilities for minor surgeries, too. They are part of the government-funded public health systemin India and are the most basic units of this system. Presently there are 28,863 PHCs in India.

Apart from the regular medical treatments, PHCs in India have some special focuses.

- **Infant immunization programs:** Immunization for new borns under the national immunization program is dispensed through the PHCs. This program is fully subsidised
- **Anti-epidemic programs:** The PHCs act as the primary epidemic diagnostic and control centres for the rural India. Whenever a local epidemic breaks out, the system's doctors are trained for diagnosis. They identify suspected cases and refer for further treatment.
- **Birth control programs:** Services under the national birth control programs are dispensed through the PHCs. Sterilization surgeries such as vasectomy and tubectomy are done here. These services, too, are fully subsidised.
- **Pregnancy and related care:** A major focus of the PHC system is medical care for pregnancy and child birth in rural India. This is because people from rural India resist approaching doctors for pregnancy care which increases neonatal death. Hence, pregnancy care is a major focus area for the PHCs.
- **Emergencies:** All the PHCs store drugs for medical emergencies which could be expected in rural areas. For example anti venoms for snake bites, rabies vaccinations, etc.

Goals and Principles

The ultimate goal of primary healthcare is the attainment of better health services for all. It is for this reason that World Health Organization (WHO), has identified five key elements to achieving this goal:

- reducing exclusion and social disparities in health (universal coverage reforms);
- organizing health services around people's needs and expectations (service delivery reforms);
- integrating health into all sectors (public policy reforms);
- pursuing collaborative models of policy dialogue (leadership reforms); and
- increasing stakeholder participation.

Functions:

The Government of India's initiative to create and expand the presences of Primary Health Centres throughout the country is consistent with the eight elements of primary health care outlined

in the Alma-Ata declaration. These are listed below:

- Provision of medical care
- Maternal-child health including family planning
- Safe water supply and basic sanitation
- Prevention and control of locally endemic diseases
- Collection and reporting of vital statistics
- Education about health
- National health programmes, as relevant
- Referral services
- Training of health guides, health workers, local dais and health assistants
- Basic laboratory workers

Behind these elements lies a series of basic principles identified in the Alma Ata Declaration that should be formulated in national policies in order to launch and sustain PHC as part of a comprehensive health system and in coordination with other sectors

- Equitable distribution of health care – according to this principle, primary care and other services to meet the main health problems in a community must be provided equally to all individuals irrespective of their gender, age, caste, color, urban/rural location and social class.
- Community participation – in order to make the fullest use of local, national and other available resources. Community participation was considered sustainable due to its grass roots nature and emphasis on self-sufficiency, as opposed to targeted (or vertical) approaches dependent on international development assistance.
- Health workforce development – comprehensive healthcare relies on adequate number and distribution of trained physicians, nurses, allied health professions, community health workers and others working as a health team and supported at the local and referral levels.
- Use of appropriate technology – medical technology should be provided that is accessible, affordable, feasible and culturally acceptable to the community. Examples of appropriate technology include refrigerators for vaccine cold storage. Less appropriate could include, in many settings, body scanners or heart-lung machines, which benefit only a small minority concentrated in urban areas. They are generally not accessible to the poor, but draw a large share of resources.
- Multi-sectional approach – recognition that health cannot be improved by intervention within just the formal health sector; other sectors are equally important in promoting the health and self-reliance of communities. These sectors include, at least: agriculture (e.g. food security); education; communication (e.g. concerning prevailing health problems and the methods of preventing and controlling them); housing; public works (e.g.

ensuring an adequate supply of safe water and basic sanitation); rural development; industry; community organizations
(including Panchayats or local governments, voluntary organizations, etc.).

In sum, PHC recognizes that healthcare is not a short-lived intervention, but an ongoing process of improving people's lives and alleviating the underlying socioeconomic conditions that contribute to poor health. The principles link health and development, advocating political interventions, rather than passive acceptance of economic conditions.

In the present reform climate, with its many changes, there is more and more need for leaders rather than traditional managers. Leadership is the key factor differentiating the "average" from the "excellent". In essence, effective leadership is about enabling ordinary people to do extraordinary things in the face of adversity, and to constantly turn out superior performance for the long-term benefit of all. Effective leadership involves choosing, and then translating, the right strategy into action and sustaining the momentum. Leadership is essential in any change process and the burden of effort in any change process lies in its implementation. A "leader" is a person who manages people by creating high involvement and shared commitment that stimulates people to overcome obstacles in the way of achieving maximum results. The above definition recognizes "strong and effective leadership" as one which allows active participation of all team members with a clear sense of purpose and mutual support. In such circumstances, team members of the organization gain experience and qualify themselves for promotion and advancement. The organizational results and goals are thus satisfactorily met.

1.5.1 Effective leadership Strong and effective leadership creates a high degree of involvement and shared commitment that stimulates people to overcome obstacles to achieve maximum results. Critical success factors of effective leadership are:

- Ability and commitment to motivate people
- Excellent interpersonal skills
- Ability to learn on the job
- Hard work and working smarter
- Linking strategic planning to implementation
- Facilitating teamwork
- Facilitating organizational development

An effective leader will:

- Take initiative: This is exercised whenever effort is concentrated on a specific activity, to start something that was not going on before, to stop something that was occurring, or shift the direction and character of effort. DHMTs need to take individual and

collective initiatives, especially during the current changes as a result of the reforms.

■ Enquire: This permits a leader to gain access to facts and data from people or other information sources. The quality of information may depend on a leader's thoroughness, keenness and commitment. A leader who is keen to learn as much as possible about work activities is more likely to gain quality information than one who ignores the need for enquiry. This is particularly important for DHMTs in view of the requirements of evidence-based planning and the call for health systems research.

■ Advocate: This means to take position in support of a cause, e.g. creating awareness on costsharing. A leader has convincing abilities and is prepared to take a stand.

■ Face and handle conflict: A leader should be ready to face conflict and resolve it with the mutual understanding of those involved, creating respect by doing so. Failure to do so leads to disrespect, hostility and antagonism.

■ Make decisions: This involves choosing or selecting between two or more courses of action. It may involve choosing an intervention or how best available resources can be effectively used. DHMTs require adequate decision-making skills for planning, especially in the aspect of resource allocation. ■ Critique: Good leaders are able to give constructive critique and feedback. DHMTs need to use the "Critique Approach" when conducting supervision, counselling and guidance of their subordinates.

■ Transparency: A good leader is open, avoiding doubt through effective communication and information. In short, a good leader is characterized by decisiveness, integrity, enthusiasm, imagination, willingness to work hard, analytical ability, understanding of others, ability to spot opportunities, ability to meet unpleasant situations, ability to adapt quickly to change, and finally, willingness to take risk.

History

1946 – put forward concept of Primary Health Care.

1974- Integrated cadre of MPWs.

1977, GoI launched a based on principle of ' placing people's health in people's hand.' (Recommendation of 1975)

1978 – – Health for All through Primary Health Care.

Characteristics of PHC I

1. PHC reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and

2. PHC is based on the application of the relevant results of social, biomedical and health services research and public health experience;

3. PHC addresses the main health problems in the community, providing

promotive, preventive, curative and rehabilitative services accordingly;

Characteristics of PHC II

1. PHC includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning;
2. 2.immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

Characteristics of PHC III

1. PHC should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
2. PHC relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

Octagon of PHC

1. Education of the people about prevailing health problems and methods of preventing and controlling them.
2. Promotion of food supply and proper nutrition.
3. Adequate supply of safe water and basic sanitation.
4. Maternal and child health care and family planning.
5. Immunization against major infectious diseases.
6. Prevention and control of locally endemic diseases.
7. Appropriate treatment of common diseases and injuries. 8. Provision of essential drugs.

ASHA –

Criteria for ASHA selection

1. Local resident.
2. Preferable Age -25-45 yrs
3. Formal education up to 8th class.
4. Communication & leadership qualities.
5. Adequate representation from disadvantaged population.
6. Ensured to serve such groups better

Anganwadi Worker (ICDS)

1. Health check up including maintenance of growth charts.
2. Immunization
3. Supplementary nutrition
4. Health education
5. Non formal pre primary education
6. Referral services

Nursing & pregnant women
Other women (15-45 years)
Children below 6 years

Composition of VHSNC

1. 50% members should be women.

2. Every hamlet should have adequate representation along with representative from weaker sections.

3. 30% representation for Non Government Sectors.

4. Representation to women's self help group.

Functions of VHSNC:

1. Create awareness about nutritional issues
2. Carry out survey on nutritional status and nutritional deficiencies in the village
3. Identify locally available food stuffs of high nutrient value as well as disseminate and promote best practices (traditional wisdom) congruent with local culture, capabilities and physical environment through a process of community consultation.
4. Inclusion of Nutritional needs in the Village Health Planand facilitate its working in improving nutritional status of women and children. .
5. Monitoring and Supervision of Village Health and Nutrition Day to ensure that it is organized every month in the village with the active participation of the whole village.
6. Facilitate early detection of malnourished children in the community, tie up referral to the nearest Nutritional Rehabilitation Centre (NRC) as well as follow up for sustained outcome. Supervise the functioning of Anganwadi Centre (AWC) in the village
7. Act as a grievances redressal forum on health and nutrition issues

Rogi Kalyan Samiti (Patient Welfare Committee)

1. Simple yet effective management structure
2. A registered society, acts as a group of trustees for the hospitals to manage the affairs of the hospital.
3. It consists of members from

1. local Panchayati Raj Institutions (PRIs), 2. NGOs, 3. local elected representatives and 4. officials from Government sector who are responsible for proper functioning and management of the hospital / Community Health Centre / FRUs. RKS / HMS is free to prescribe, generate and use the funds with it as per its best judgment for smooth functioning and maintaining the quality of services.

Package of Services at Sub Center Immunization Antenatal, natal & postnatal care Prevention of malnutrition Common Childhood Diseases Family Welfare Services Counseling Elementary drugs for minor ailments Community Needs Assessment Various National Health Programmes

Objectives of IPHS for PHCs

I] To provide comprehensive primary health care to the community through the primary health center.

II] To achieve & maintain an acceptable standard of quality of care.

III]To make the services more responsive & sensitive to the needs of the community.

IPHS for PHCs

1. Medical Care
2. Maternal & child care
3. Family planning services
4. MTP services
5. Health education & management of RTI/STI
6. Nutrition Services
7. Basic lab services
8. Selected Surgical procedures
9. School health Services
10. Adolescent health care
11. Disease Surveillance & control programme
12. Collection of vital events
13. Promotion of sanitation including use of toilet & appropriate garbage disposal
14. Water quality monitoring
15. M & E

Main National Health Programmes Through PHC

- National Tuberculosis Elimination Programme (NTEP)
- National Programme for blindness (NPCB)
- National Leprosy Elimination Programme (NLEP)
- National Vector Borne Disease Control Programme (NVBDCP)
- National AIDS Control Programme (NACP)
- National Program for Prevention & Control of Cancer, Diabetes, Cardiovascular diseases & Stroke
- National Program For Health Care of the Elderly (NPHCE)
- Programmes for Iodine Deficiency, Tobacco Control

INTEGRATED HEALTH APPROACH

Content Activities Ministries/Agencies involved Focused activities for marginalized population Employment, Food security Tribal Welfare, Social welfare Food Supply Grains, Cereal, Tuber, Vegetables and Fruit production Agriculture,Animal Husbandry, Fisheries, Social Welfare Proper Nutrition Milk and dairy products, meat and fish Animal Husbandry, Dairies - pvt/cooperatives, FDA Food supply Agricultural Produce Markets Ration Shops PDS Food quality, safety FDA ICDS, Women and Child Development Women & Child Welfare Safe Water Drinking Water Resources, Sewage drainage and disposal, Water purification, Forest and Water Conservation, Irrigation Water Supply & Sanitation , PWD, Rural Development, Public Health Labs Sanitation Solid waste disposal PWDs, Urban Planning, Environmental Mother (Women) Care Marriage registration,ANC, PNC, CaCx detection, family planning Public Health and Family welfare, Registrar of Vital events Child care Trained Birth Attendant, Institutional delivery, Birth registration, early Breast feeding, Immunization, treatment of illnesses, early child care Public Health and Family welfare, FDA,

Pharmaceutical and Health device industry, Paediatric clinics/hospitals, vaccine industry Communicable Diseases Prevention & Control activities Water Supply & Sanitation, Urban Development, Rural Development, Agriculture, Forest, Animal Husbandry

Challenges In Providing Effective PHC

1. Infrastructure for rising population Size & diversity
2. Rapid urbanization
3. Changing demographic profile – Ageing population
4. Triple burden of diseases
5. Man power crisis
6. Quality care & client satisfaction Quality research in PHC

eKAVACH – COMPREHENSIVE PRIMARY HEALTH CARE APPLICATION

The CPHC Application – eKavachis work flow based application platform which have both interfaces as web and application. Web and Mobile App (eKavach Application & State of Health Application), both the interfaces will be used by each level of users as administration/monitoring/managerial /end users etc. State od Health Application is the Analytics, Monitoring & Evaluation layer of the implementation which provides top level analysis to higher managers with functionality to drill down up to community level.Application user gets the application interface relevant to its cadre and work profile. Application information seamlessly flows within the service delivery hierarchy from bottom to top for community to health facility and from top to bottom for health facility to community. Application works in integration of the Hospital Management & Information Management Application at health facility level in bi-directional information exchange mode. At present eKavach Application has been integrated with MANTRA App and through MANTRA App, state is about to roll out new born birth registration at the time of institution delivery in facility through MANTRA App.

Applications population survey layers works as base data of community for micro level plan, implementation, follow-up and monitoring of various RMNCHA+ and NCD etc. programs.Application enablement with ABDM provides functionality to generate ABHA ID online/offline. The eKavach Application platform is ABDM (Ayushman Bharat Digital Health Mission) Milestone1, Milestone2 and Milestone3 compliant and health facilities HFR(Health Facility Registry ID) bridging process is in progress. Application is currently syncing Health Records linkage to ABDM.

21 NATIONAL HEALTH PROGRAMS

Maternal Health- RMNCH+A

Objective –

- To promote institutional deliveries by various measures .
- To eliminate Out of Pocket expenses during institutional Delivery five free services are given
- To identify gaps in the provision of care and suggest suitable strategies to improve the quality of care and facility preparedness for further reduction in maternal deaths.
- To identify HRP during pregnancy and to improve quality of care for all HRPs.
- To provide comprehensive quality ANC during second and third trimester of pregnancy by MBBS doctors.
- To ensure identification and safe institutional deliveries of all HRP pregnant women.

Janani Suraksha Yojana (JSY) –

Incentives under JSY-

To promote institutional deliveries incentive to beneficiaries (Pregnant Woman) –

- Urban beneficiaries Rs 1000
- Rural beneficiaries Rs 1400 is given.

ASHA Incentives –

- Rs 300.00 for mobilizing delivery to public facilities & Rs 300.00 for complete ANC in Rural area and
- Rs 200.00 for mobilizing delivery to public facilities & Rs 200.00 for complete ANC in urban area.

All payments are paid through PFMS/FAMS to their Bank Account.

Janani Shishu Suraksha Karyakram-

1. **Free medicines at every level from Outreach to hospitals**

- ❑ All medicines and consumables, disposables required during antenatal checkup, all normal and caesarean deliveries at the health facilities – from subcenter to district hospitals level and PNCs till 6 months after delivery.

2. **Free investigations for pregnant women at each level from CHHAYA VHSNDs/UHSNDs to hospitals**

- ❑ Hb, urine for albumin & sugar, BP HIV, Syphlis HBsAg testingat the outreach Chhaya VHSNDs/UHSNDs every time, Blood group, HIV, Syphlis HBsAg, RPR/VDRL, Blood sugar for GDM, T3, T4 & TSH at the higher facilities.

3. **Free Food during hospital stay for all pregnant women**

- ❑ For all pregnant women and delivered women during hospital (L2 & L3 health facilities) stay.

4. **Free blood transfusion**
5. **Free transportation from home to hospitals/Dropback/Referrals by 102/108 Ambulances**

Maternal Death SurveillanceResponse (MDSR)-

Under the program Any Women death between 15-49 years of age are reported and if the reason found is Maternal (During pregnancy or with in 42 days of delivery) then it is reviwed and various level (Community and Facility under District/Division/State).

In Uttar Pradesh MMR has decreased by 30 point. According to SRS (2017-19) MMR hasreduced to 167 from 197 (2016-18).

Maternal death review program is operational in UP since 2012-13. In 2017-18to ensure maternal death reviews as per guideline, the GoUP has trained Medical Officers of government facilities in facility based MDR. Similarly, it has trained the BCPMs and ASHA Sangini to improve the timeliness and accuracy of the report. In continuation of the above state adopted Maternal Death Surveillance& Response (MDSR) in year 2018 keeping in mind that no punitive actions should be taken to staff.

In order to ensure reporting of all community maternal death provision of Rs 1000/ to first informer (Any person from the community, PRI, ASHA AWW)for reporting through 104 call centre has been made.

Pradhan Mantri Surakshit Matritva Abhiyan

The Pradhan Mantri Surakshit Matritva Abhiyan has been launched by the Ministry of Health & Family Welfare (MoHFW), Government of India. The program aims to provide assured, comprehensive and quality antenatal care by MBBS Doctor, free of cost, universally to all pregnant women on the 9th and 24th (Only FRUs facility) of every month. It is operational in UP through GO dated 19th May 2016. It is implemented in 1615 District &Block health facilities. Engagement of private sector which includes motivating private practitioners to volunteer for quality of ANC services. PMSMA guarantees a minimum package of antenatal care services to women in their 2nd / 3rd trimesters of pregnancy at designated government health facilities.

All applicable diagnostic and Screening services like including one USGand Height, Weight, BP, Hb, Blood grouping, HBSAg, HIV, Syphlis, Urine for albumin & sugar are provided.Ultrasonography services to Pregnant Women on PPP Mode were started In in districts.

Counseling related to nutrition, family planning, breast feeding and micronutrient supplementation also given during group and individual counseling sessions.

Identification of High Risk Pregnancy under PMSMA:

- It is the responsibility of the village ASHA to mobilize all the pregnant women in her village to attend the

nearest PMSMA clinic and undergo high risk screening by a doctor/ obstetrician.

- All high-risk pregnancies detected in PMSMA clinics must be treated, counselled and a line-listing to be maintained by the facility and the respective ANM & ASHA.
- **Once a PW is categorized as an HRP,it is the responsibility of the respective ASHA/ANM to ensure 3 additional ANC visits for that HRP by a doctor/Obstetrician.**
- For each of these follow up ANC visits with the doctor/Obstetrician, ASHA shall accompany the high risk pregnant woman to the clinic.
- These follow up visits may be conducted either in the **subsequent PMSMA session or the nearest healthcare facility**as suggested by the treating doctor.
- It is mandatory that **all identified high risk pregnancies must be linked with nearest First Referral Units (FRU)** for ensuring a safe delivery after completion of pregnancy and prompt management of complications, if any.
- Free transport for referral to the FRU at the time of delivery is to be ensured by the ASHA under JSSK.

Financial Provision

1. Case-based incentives to ASHA

Incentivization of ASHAs for mobilizing pregnant women to PMSMA clinics/ facility with doctor/obstetrician

- **Rs. 100/- per HRP** may be provided to ASHA for **mobilization of HRPs** for a **maximum of threefollow upANC visits**to PMSMA clinics/nearest facilityfor check up by a doctor/Obstetrician
- **Rs. 500/- per HRP** may be provided to ASHA on **achieving a healthy outcome for both mother and baby** at 45th day after deliveryafter due verification by concerned ANM and MO.

2. **Case-based incentives to beneficiaries:** Once a pregnant woman is diagnosed as an HRP, **Rs.100/-per visit**may be provided to meet transportation costs for attending a maximum of three PMSMA sessions/nearest facility for follow up ANC checkups by a doctor/Obstetrician.

Operationalization of FRUs

To provide CEmONC services is a district or sub-divisional hospital or community health centre at FRU or First referral unit has been established. Having the facilities of operation theatre along with required equipments for obstetric surgery, blood transfusion and have specialist in Obstetrics &Gynaecology, Anaesthesia, and Paediatric care to provide Comprehensive Emergency Obstetrics Care including C-Section facilities. Total Number of FRU identified in U.P: 417 To address the shortage of specialist at

FRU, following initiatives are being undertaken:

1. **Walk-in interview** -Efforts to recruit specialists (Gynecologists and Anesthetist) through with provision of differential salary in the range of Rs 65000/- to Rs 120,000/- as per different category of the FRU, which has been revised in the year 2020-21 to Rs 100,000/- to Rs 140,000/-
2. **Specialists on call** - At FRU in all the 75 districts a provision for on call specialists both from public health facilities and private sector is also in place to operationalize FRUs with incomplete team for performing C-Sections.
3. **Lady Medical Officer** -Recruitment & posting of contractual Lady Medical Officer at FRUs to identify HRPs & support in performing LSCS.
4. **Buddy-Buddy initiative**For rapid activation of FRU- CHC, LSAS and EmOC trained regular Medical Officers are posted in pairs at CHC-FRU after 6 months of mentoring under Buddy-Buddy initiative.
5. **Specialist cadre** :Specialist cadre has been established in the state to directly recruit specialists in level- 2 scale to run FRUs.
6. **Blood Storage Unit(BSU):**To provide blood transfusion to severally anemic Pregnant women and in cases of haemorrage BSUs being established in all FRUs. Number has been increased from 1 to more than 80 in last one year.

High Risk Pregnancy (HRPS) Identification at CHHAYA VHSND/UHSND& tracking to ensure safe delivery-

A specific plan for HRP tracking and follow up has been institutionalized in the system. Incentives for ASHA & ANMs are given as per given norms:

- Rs 200.00 for ANMs for identification of each HRP, enlist them and refer,
- Rs 300.00 for ASHA for accompanying HRP PW for check-up at higher center ensure prior admission and safe Institutional delivery and entry in VHIR/RCH.
- These incentives are additional to JSY incentive and be permissible even if she takes the HRP PW to private sector for safe delivery but paid only after reporting outcome on RCH portal.

Learning Points

- Promotional schemes for institutional deliveries to the pregnant woman.
- Identifying gaps in the provision of care, suitable strategies to improve the quality of care and facility preparedness for further reduction in maternal deaths.
- Comprehensive quality ANC during second and third trimester of pregnancy by MBBS doctors.
- Identification and safe institutional deliveries of all HRP pregnant women.

Child Health

Objectives:

To reduce neonatal mortality rate, infant mortality rate and under-5 mortality rate is the main objective.

To achieve the target of Sustainable Development goal to end preventable deaths of new-born and children under-5 years of age.

Content:

Newborn and Childhood Program Interventions

The interventions in this phase of life mainly focus on children under 5 years of age and address the most common causes of mortality in this period.

The thrust areas under the NHM are

1. Immediate and routine newborn care –Essential Newborn Care (ENBC)
2. Care of sick new-born
3. Child nutrition including essential micronutrients supplementation
4. Immunization against common childhood diseases
5. Management of common neonatal and childhood illnesses and
6. Child Health Screening and Early Intervention Services (RBSK) offering comprehensive care to children from birth to 18 year of age.

Health screening :-

- At delivery point by DP staff.
- 0 to 6 week by ASHA during HBNC visit.
- 6 week to 6 years by MHT at AWC, twice a year

  6 years to 18 years by MHT at school (Govt. and Gov. aided) once a year.

Priority Interventions

1. Home based new born Care and prompt referral (HBNC)
2. Facility based newborn care (NBCC, NBSU and SNCU)
3. Integrated management of common childhood illnesses (diarrhoea, pneumonia and malaria)
4. Child nutrition and essential micronutrients supplementation
5. Immunisation
6. Early detection and management of defects at birth, deficiencies, diseases and development delays including disability in children (0–18 years)

1. Home based newborn care and prompt referral

Reducing mortality in the neonatal period is paramount if the infant mortality rate is to be impacted. Neonatal deaths account for 2/3rd of under-five mortality, most of which occurs in the first week of life. About 25% of total deaths in the neonatal period take place in second to fourth week of life. Global evidence shows that home visits by community health workers to provide neonatal care in settings where access to facility-based care is limited or not available is associated with reduced neonatal mortality.

The home-based newborn care program was rolled out in 2011.

Components of HBNC:

•Immediate postnatal care (especially in the cases of home delivery) and essential newborn care to all newborns up to the age of 42 days.

•Frontline workers (ASHAs) are trained and incentivised to provide special care to new-borns; they are also trained in identification of illnesses, appropriate care and referral through home visits.

Schedule of visit:

•Days- 0,3,7,14,21,28 and 42

Services Provided:

• Identification of infection

• Birth defect identification

• Early recognition of danger signs and prompt referral after stabilization

• Promotion of exclusive Breastfeeding promotion

• Prevention of infection through hand washing

2. Facility-based care of the sick newborns

It has been estimated that health-facility based interventions can reduce neonatal mortality by as much as 23-50%. Appropriate management of birth asphyxia and complications of prematurity, low birth weight and infections holds the promise to drastically reduce the neonatal mortality. Thus, FBNC is a cornerstone in the overall strategy to reduce neonatal mortality.

As part of the Janani Shishu Suraksha Karyakram (JSSK), all newborns requiring facility-based newborn care up to thirty days receive diagnostics, drugs and treatment free of charge at these newborn care facilities. Free Emergency Referral Transport is also to be provided for transport from home/community to the health facility and between health facilities in case a referral is made.

Three levels of facility based New born care are envisaged:

1. Newborn Care Corner (NBCC)
2. Newborn Stabilization Unit (NBSU)
3. Sick Newborn Care Unit (SNCU)

•NBCCs (Newborn Care Corners)- are established at delivery points to provide

✓ Essential new born care at birth (ENBC including resuscitation, warmth, Vit K)

✓ Initiation of early and exclusive breast-feeding

✓ Zero dose immunization- BCG, OPV, Hep B

✓ Staff needs to be skilled in NSSK (Navjat Shishu Suraksha Karyakram)

•New Born Stabilisation Units (NBSUs) are established at every FRUs and 24*7 CHCs. It is a 4 bedded unit to:

✓ provide all services as in NBCC, and

✓ provide care to and manage not so sick new-born- like

a. low birth weight neonates not below 1800gms who are otherwise stable,

b. preterm babies between 34-37 weeks who are otherwise stable,

c. neonates requiring Phototherapy for jaundice with no other complications

- ✓ 03 nursing staff have been dedicatedly sanctioned for NBSUs.
- ✓ They need to be trained in NSSK and F-IMNCI (facility-Imtegrated Management of Newborn and Childhood Illness)

3. Child nutrition and essential micronutrients supplementation

•Nutritional Rehabilitation Centres-

NRCs are being established across the state in district male hospitals, medical colleges and CHCs in Lalitpur district for facility-based management of severe acute malnourishment (SAM). NRCs not only provide medical and nutritional care but also play crucial role in promoting physical and psychosocial growth of children with severe under-nutrition

- ✓ The contractual staff dedicatedly approved for NRCs is:
  a. 01 medical officer
  b. 04 Staff nurses
  c. 01 feeding demonstrator
  d. 03 Class IV (1 cook, 1 cleaner and one care taker)
- ✓ Both doctors and SNs are given a state level skill- based IYCF training.

Annexure: NRC Quarterly Reporting Format

•National Iron Plus Initiative (NIPI) -

This programme is for infants & preschool children (6- 59 months) and school going boys and girls (5-10 years) and out of school girls (5-10 years) in urban and rural areas. The programme is implemented through the platform of Government/Government aided/ municipal schools and AWCs.

2 strategies are involved:

- ✓ 06 months to 59 months - administration of IFA syrup twice per week and Albendazole twice a year for de-worming after 9 months of age. To simplify administration of deworming tablets/syrup, this intervention is combined with Vitamin A supplementation during biannual rounds. As part of the Government's policy for Vitamin A supplementation, children between nine months to five years are given six monthly doses of vitamin A. A child must receive nine doses of Vitamin A by the 5th birthday.
- ✓ 5-10 years- A "fixed day – Monday" approach for IFA distribution. Teachers and AWWs supervise the ingestion of the IFA tablet by the beneficiaries.

Objectives:

- To ensure administration of IFA tablet once per week and Albendazole twice a year for de-worming.
- To inform adolescent boys and girls of the correct dietary practices for increasing iron intake.
- To disseminate information on preventing worm infestation among adolescences and encourage adoption of correct hygiene practices, including use of footwear to prevent worm infestation.

Strategy.

4. Integrated management of common childhood illnesses (pneumonia, diarrhoea and malaria)

In order to address the most common causes of neonatal and child deaths in India, an integrated strategy that includes both preventive and curative interventions has been adopted. This is known as the Integrated Management of Neonatal and Childhood Illnesses (or IMNCI) and is provided at all levels of care: at community (ASHA package), first level care (IMNCI) and referral level care (F-IMNCI). IMNCI addresses various aspects of child nutrition, immunization, and elements of disease prevention and health promotion.

Components:

- ✓ improvement in the case-management skills of health staff,
- ✓ improvement in the overall health system required for effective management of neonatal and childhood illnesses, and
- ✓ improvement in family and community healthcare practices.

Services provided

- Considering that the leading causes of death beyond the neonatal period are diarrhoea and pneumonia, priority attention is given to the management of these two illnesses.
- Availability of ORS and Zinc is ensured at all sub-centres and with all frontline workers.
- Use of Zinc is being actively promoted along with use of ORS in the case of diarrhoea in children.
- Use of recommended antibiotics (based on national guidelines) in children aged 2 months to 5 years with non-severe pneumonia is ensured through frontline workers (ASHA, ANM) and at all levels of health facilities.

Components of Kangaroo Mother Care- KMC

Early, continuous and prolonged skin-to- skin contact

Exclusive demand-driven breast feeding

KMC Position-

Place baby between the mother's breasts in an upright position

Head turned to one side and slightly extended

Hips flexed and abducted in a "frog" position; arms flexed

Baby's abdomen at mother's tummy

Support baby's bottom

Sepsis Management by Front Line Workers

Signs of Sepsis-

Pre-Referral dose of Inj Gentamicin (5mg/kg) i.m and oral Amoxicillin (25mg/kg) and **REFER**

Referral refused- Inj Gentamicin OD and oral Amoxicillin BD for 7 days

Pre-Referral Stabilization of Newborn and Referral Protocol

Ensure TABCN before referral

To maintain **Temperature** during transport, keep baby in KMC position with the family care giver

Clear **Airway** and provide disposable mucus extractor to the care giver, if

required

Assess **Breathing**- Check O2 saturation and ensure provision of oxygen in the transport vehicle

Check **CRT** and if compromised **Circulation** give i.v normal saline bolus @ 10ml/kg over a period of 30 mins upto a maximumof 30ml/kg

Ensure **glucose** levels > 45mg/dl

Inform the transferring hospital/Institution and **Transport through National Ambulance System**

Diarrhoea Management in Children beyond 2 months of age

Babies' upto 2 months of age with diarrhoea should be treated as cases of Sepsis. Administered Pre-Referral dose and Referred to higher centres.

Beyond 2 months of age follow Plan A, B, C

Plan A- No Dehydration: continue age-appropriate feeding, start ORS and continue till diarrhoeal episode; start Zinc therapy (10mg per day upto 6 months age and 20 mg beyond 6 month of age) and complete 14 day's course. In bigger children give fluids ad- lib

Plan B- Moderate Dehydration: start oral rehydration therapy(ORT) and try to correct dehydration within 4hrs. Continue age-appropriate feeding and start Zinc therapy

Plan C- Severe Dehydration: Manage with i.v Ringer lactate @100ml/kg and correct dehydration within 6 hrs upto 12 months of age and 2.5 hrs in children above 12 months of age. Continue age-appropriate feeding and start on Zinc therapy

Immunization

OBJECTIVES

1. To explain the importance of immunization
2. To describe the milestones of the Immunization Program in India
3. To list the responsibilities of Medical Officers in Routine Immunization

Vaccines provide active immunity to the body bystimulating the immune system which produces antibodies against disease-producing organisms. Vaccines can be divided into two types, live attenuated and killedformulations.The live attenuated vaccines are derived fromdisease-causing viruses or bacteria that have beenweakened under laboratory conditions. They replicate in avaccinated individual, but because they are weak, theycause either no disease or only a mild form of the disease.Examples are BCG, Measles and the Oral Polio Vaccine.Inactivated or killed vaccines, on the other hand, areproduced by viruses or bacteria and then inactivated withheat or chemicals. They cannot grow in a vaccinatedindividual and so cannot cause the disease. They are lesseffective than live vaccines, requiring multiple doses for fullprotection as well as booster doses to maintain

immunity.Vaccines stimulate thebody's immune system,which providesantibodies againstdisease producingorganisms. Vaccinescan either be liveattenuated or killed.

Examples are whole-cell (pertussis); fractional protein based(diphtheria toxoid and tetanus toxoid) and recombinant(hepatitis B) vaccines.

These vaccines vary in efficacy, according to the ageat which the vaccine is administered and the number ofdoses given. For example, the measles vaccine is 85%effective at the age of 9 months and three doses of DPTprovide over 95% protection against diphtheria, 80%against pertussis and 100% against tetanus.

Milestones in the Immunization Program in India

Routine Immunization is one of the most cost effectivepublic health interventions and was first introduced in Indiain 1978. Yet, despite the concerted efforts of thegovernment and other health agencies, a large proportion ofvulnerable infants and children in India remain unimmunized.

India has the highest number (approximately 10million) of such children in the world.The National Family Health Survey (2005-06) reportsthat only 43.5% of children in India received all of theirprimary vaccines by 12 months of age. There is a widevariation among states, and states with poorerimmunization coverage have higher child mortality rates.

Strengthening Immunization under NRHM

- Introduction of Auto Disable (AD) syringes and hubcutters.
- Support for alternate vaccine delivery to session sites from the last storage point
- Mobility support to State and District ImmunizationOfficers and other supervisory staff
- Alternate vaccinators for sessions in urban slums andunder-served areas, including vacant SCs.
- Mobilization of children and pregnant women byASHA/link-workers to increase coverage, decreasedropouts and for convergence of Nutrition withImmunization.
- Biannual RI review meetings at national and state levels
- Computer Assistants for every district and at state
- Routine Immunization Monitoring System (RIMS)
- Decentralized printing of recording, reporting andmonitoring tools (e.g. Immunization cards, monitoringcharts, tracking bags, temperature charts)
- Miscellaneous (e.g. polythene bags, POL for generatorsetc.)
- Strengthen cold chain maintenance and expansion
- Strengthen vaccine management

Responsibilities of Medical Officers in Routine Immunization Planning

- Guide Health Workers to analyze their data, identify bottlenecks/constraintsand prepare micro-plans
- Prepare block micro plan based upon Sub-Center microplan
- Prioritize health facilities or areas (e.g. hard to reach) for additional support.
- Regular review and update of microplans
- Ensure that all health facilities display a map of the respective areas withpopulation covered, session plan and work-plan
- Ensure that signboards are placed for the session sites
- Plan for monitoring and supervision
- Plan for IEC

Cold chain and logistics management

- Ensure monthly visit from district HQ cold chain store for monitoring.
- Maintain and monitor cold chain and manage vaccine stock & logistics ofPHC/CHC.
- Ensure sufficient vaccines and supplies available for all sessions
- Ensure regular distribution of vaccines and supplies to ANM/HW at outreachsession sites through Alternate Vaccine Delivery system.

Supervision, Monitoring, and Surveillance

- Ensure planned outreach sessions are implemented even if HW is on leave bymaking alternate arrangements.
- Establish a system to aggregate and review SC monthly reports and prioritizefor support.
- Ensure reporting of VPD and AEFI cases in the monthly reports.
- Send complete report to the district on time. Give update on the progress ofthe activity during monthly meeting in district HQ
- Ensure the use of simple monitoring tools such as coverage monitoring chart,supervision checklist, tracking bags etc.
- Prepare a supervisory schedule for visits and regular meetings for follow upwith each health facility.
- Provide on job training and solve issues on spot as often as possible
- Maintain supervisory log book at PHC and sub-centers
- Conduct monthly/fortnightly review meeting of HWs
- Organize inter-sectoral coordination meetings at PHC to coordinate with ICDS,local village administration and NGOs.

Community Involvement and Communication

- Support SC staff in establishing regular dialogue with community (IPC)
- Establish alliances with programs (e.g. ICDS) and organizations (e.g., NGOs)with community reach.
- Meet community/Panchayat leaders, teachers and volunteers on a

regularbasis; inform them to tell about immunization in their meetings; give themsome handouts with immunization information to be disseminated
- Get feedback from the community to ensure a high quality service.
- Activate network to publicly announce arrival of ANM
- Monitor tracking of newborns and dropouts and ensure that due list is sharedwith ASHA and AWW.

Financial management
- Ensure timely release of funds to the health centers.
- Maintain records of payment to porters for alternate vaccine delivery, paymentto social mobilizers and of JSY wherever applicable.
- Keep record of all funds received and expenditure incurred with vouchers undervarious heads.
- Monitor timely dispersal of funds at grass root level.
- Send the statement of expenditure and utilization certificate to the district.

Integrated Disease Surveillance Programme (IDSP)
Objective: -
- Strengthening of Disease Surveillance System for epidemic prone diseases to detect and respond to outbreaks
- Strengthening disease surveillance & response using the latest information & communication technology.
- Act as a command centre to manage disease outbreaks, public health emergencies or any disaster situation.
- SHOC is intended to Act as the physical location at which the coordination of information and resources to support incident management/response activities normally takes place.

Content: -
Disease surveillance in India has always been practiced by the states. Many gaps, differed in degree and quality of surveillance, different priorities in diseases. Rapid Response Teams (RRTs) (depending on the epidemic potential of these diseases) were called: -
- Malaria Response Teams
- Cholera Combat Teams
- Other disease specific Response Teams

National Health Programmes-
Significant surveillance component, disease specific, too vertical in approach and response at the district level is often delayed.
- Malaria
- Filariasis
- Kala azar
- Leprosy
- TB
- Polio
- HIV/AIDS
- VPDs
- RCH
- Cancer control
- Blindness
- Mental Health
- Iodine deficiency

- Water supply
- Total Sanitation

Need for Surveillance

The Government of India realized the importance of Disease surveillance after the Cholera outbreak in Delhi and the Plague outbreak in Surat, which not only had significant mortality and morbidity but also significant economic consequences.

National Surveillance Programme for Communicable Diseases (NSPCD)

NSPCD was therefore launched by the Centre in 1997-98 in five pilot districts of the country (centrally sponsored scheme) and over the years extended to cover 101 Districts in the country in all 35 states and UTs in the country.

Strategy

- To establish Early Warning System (EWS) so as to institute appropriate and timely response for prevention & control of outbreaks
- Uttar Pradesh state has maintained a trained multi-disciplinary Rapid Response Team.
- Rapid communications (through e-mails & fax)
- Strengthening of state and district laboratories for rapid confirmation of diagnosis
- Capacity development of health staff in the district
- IEC (information, education and communication)

Integrated Disease Surveillance Programme (IDSP)

It is a scheme under umbrella of NHM which was launched in Nov. 2004 with World Bank Assistance for a period up to 31 March 2010. Restructured and extended up to March 2012. To continue during 12th Plan with outlay of Rs. 640.4 Crore with domestic budgetary support.

Components

- Decentralization of Surveillance activities
- Human Resource Development - Training of SSO, DSOs, RRT members, other medical and paramedical staff
- Strengthening of Public Health Laboratories
- Use of Information Technology for collection, compilation, analysis & dissemination of data
- Inter sectoral Coordination

Organization Structure

- Central Surveillance Unit (CSU): Integrated administratively and financially with National Centre for Disease Control (NCDC), Delhi
- State Surveillance Unit (SSU): One in each State/UT with a regular officer identified as State Surveillance Officer (SSO), supported by 7 contractual staff. Con (Vet) added in 2013-14
- District Surveillance Unit (DSU): One in each district with a regular officer as District Surveillance Officer (DSO), supported by 3 contractual staff

System functioning

- All DSUs, SSUs and CSU connected by IT network
- DSU collects weekly data on epidemic prone diseases from health facilities, compile and analyse to detect rise in cases
- Weekly data are shared with SSU and CSU through e-mail and portal (www.idsp.nic.in)
- Increase in cases/outbreaks are investigated and responded by district & state Rapid Response Teams (RRTs), CSU may be involved as per the magnitude and situation of the outbreak.
- SSOs, DSOs, RRTs have been trained by CSU at identified apex institutes

Diseases/Health Conditions under Surveillance

- Measles
- Diphtheria
- Pertussis
- Chicken Pox
- Malaria
- Dengue / DHF / DSS
- Chikungunya
- Meningitis
- AES/JE
- Enteric Fever
- Fever of Unknown Origin (PUO)
- Acute Respiratory Infection (ARI) / Influenza Like Illness (ILI)
- Snake Bite
- Dog Bite
- Pneumonia
- Acute Diarrhoeal Disease (including Acute Gastroenteritis)
- Bacillary Dysentery
- Viral Hepatitis
- Leptospirosis
- Acute Flaccid Paralysis < 15 Years of Age
- Any other State Specific Disease (Scrub typhus & Kala-azar defined by U.P.)
- Unusual Syndromes

Strengthening of Laboratories

- District laboratories are being strengthened for diagnosis of epidemic prone diseases in a phased manner.
- A state-based referral laboratory network has been established by utilizing the existing functional labs in 07 identified medical colleges in the state and adjoining districts have been linked for providing diagnostic services for epidemic prone diseases during outbreaks. In this network 40 districts have been linked so far.
- NCDC is the nodal agency for H1N1 surveillance and laboratory testing.
- 07 identified laboratories are currently functional and testing for Influenza A (H1N1) in U.P.

Information & Communication Technology (ICT) Components

- **Network**
  - Data Centres (85/85), Training Centres (75/75) and Video Conferencing System **(webcon.nic.in)**
- **Manpower (DM, DEO)**
- **Software / IDSP Portal (www.idsp.nic.in)**

Data Management – Tools and Methods

- Weekly Data (Monday to Sunday)
  - Form S (Suspect Cases): Health Workers (Sub Centres)
  - Form P (Probable Cases): Govt. Doctors (PHC, CHC, Hospitals etc) & Doctors of Private Health Institutions /facilities.
  - Form L (Lab Confirmed Cases): Laboratories of Govt. & Private Sector's Health Institutions/facilities.
- Presently 90% districts are reporting every week.
- SOS reporting for disease outbreaks
  - Early Warning Signal/outbreak reporting format
  - Supplemental Information through
  - Media Scanning (Print & Electronic media)
  - Rumors- collected in the Rumor Registers
- Data is Transmitted from districts through IT Network by-
  - Uploading on IDSP Portal (www.idsp.nic.in)
  - Email
- Data compilation/analysis and response at all levels
- Data reported on P, L & S format to be analyzed at Block/district/state level.

Outbreak Surveillance – Weekly report

- Started from year 2008 in Uttar Pradesh through IDSP
- CSU get information on outbreaks reports from DSUs/SSUs
- Outbreak reports are collected through e-mail, portal of IDSP and SORS portal (state's own portal).
- Submission of "NIL" reports has been made mandatory to districts.
- Outbreaks reported by state (Provisional/lab confirmed)
  - **408** in 2015
  - **529** in 2016
  - **443** in 2017
  - Most of the outbreaks are due to Acute Diarrheal Diseases, Food Poisoning, Measles, Influenza A(H1N1), Dengue etc.

Outbreak Investigating Team State/District

Strategic Health Operations Centre (SHOC)

Goal: "To provide a facility for an emergency team, disease surveillance and outbreak teams and key decision makers to operate in the event of an emergency situation, disease outbreak or crisis of any nature."

Incident Response System

- Provided detail on the use and implementation of IRS within an NCDC SHOC activation and response.
- Described overall structure of IRS
- SHOC supports IHR capacity building

Benefits of IRS

- Standardized, scalable and flexible approach
- Enhanced cooperation and interoperability
- Efficient resource coordination
- Comprehensive all preparedness
- Incorporates measurable, achievable objectives

- Incidents are managed at the peripheral level

Purpose of the SHOC

- To support evidence-based response during outbreaks
- To provide the capability to receive, analyze, display, and monitor incident information
- To be able to identify, organize, deploy, and track resources
- To be able to communicate, collaborate, and coordinate from a centralized location

Why Plan?

- Minimize morbidity and mortality by
  - Improving the effectiveness, appropriateness, and timeliness of response to emergencies
  - Developing a common understanding prior to the emergency
  - Facilitating collaboration and coordination
  - Clarifying roles and responsibilities
  - Identifying potential problems and constraints
  - Implementing multi-sector exercises

Standard Operating Procedures

- Could be read by a new but competent person and understood
- Clearly defines who is doing the task
- Keep It Short and Sweet (KISS)
- Only provide information necessary for the task
- Chronological and logical order
- Timeframe
- Void of information that often needs to be updated
- Formatting makes it easy to find information
- Accurate information

Data limitations

1. To avoid incomplete/incorrect data entry in the EWS format.
   - Date of start & reporting of outbreak not reported for many outbreaks; median delay in reporting difficult to calculate
   - "Population affected" is the "Population at risk"
2. Control measures taken in all outbreaks are mostly non-specific.
3. An outbreak initially reported as "Fever" is not followed-up to confirm an etiological diagnosis.
4. Repeated reporting of the same outbreaks in consecutive weeks or neighbouring areas may be sent as follow-up of the same outbreak, and not labelled as a fresh outbreak of the concerned week.
5. Laboratory confirmation of diagnosis needs appropriate clinical samples to be sent for appropriate lab tests (To know the proportion of Lab confirmed outbreaks)
6. Proportion of outbreaks investigated by RRTs difficult to measure as detailed outbreak reports not available.
7. The source of outbreak information needs to be clearly defined.

Improving Outbreak Management

1. Early Detection and response to outbreaks of Epidemic prone disease identifying an outbreak from routine

analysis of Surveillance (S, P, L) data at DSU/CHC/PHC levels

- To check for outbreak occurrence by identifying any unusual rise in no. of cases (crossing of threshold limit)

2. RRT response to any epidemic:

- Identify and training of RRT members at DSU and SSU levels

3. Competency assessment tool to be filled up at the SSU (by the SSO/ State epidemiologist)

Outbreak Monitoring Cell (24x7)

- Monitoring and follow up of outbreaks in the country by coordination with SSO and DSO
- Control room for stockpiling and emergency supply of outbreak investigation kits including logistics of outbreak investigation
- After the H1N1 pandemic was confirmed a 24x7 call center was initiated for providing any information from any part of the country and 24X7 sample receiving facility.
- Airlifting of samples from any part of the country connected through airport.

Learning Point

- Disease Surveillance System for epidemic prone diseases to detect and respond to outbreaks.
- Disease surveillance & response using the latest information & communication technology.
- Management of disease outbreaks, public health emergencies or any disaster situation.

LaQshya Initiative Program

Introduction and Background- There has been substantial increase in institutional deliveries since the launch of NRHM. However, this increase in the numbers has not resulted into commensurate improvements in the key maternal (MMR) and new-born (IMR) health indicators. It is estimated that approximately 46% maternal deaths, over 40% stillbirths and 40% newborn deaths take place on the day of the delivery. A transformational change in the processes related to the care during the delivery, which essentially relates to intrapartum and immediate postpartum care, is required to achieve tangible results within short period of time. With an aim to achieve this 'LaQshya ' initiative program was launched in 2017 by GoI to strengthen the key processes related to Labour room and Maternity OT , so that verifiable targets of maternal and new born care are achieved as soon as possible.

Objectives-

1. To reduce maternal and newborn mortality & morbidity due to APH, PPH, retained placenta, preterm, preeclampsia & eclampsia, obstructed labour, puerperal sepsis, newborn asphyxia, and sepsis, etc.
2. To improve Quality of care during the delivery and immediate post-partum care, stabilization of complications and ensure timely referrals, and enable an effective two-way follow-up system.

3. To enhance satisfaction of beneficiaries visiting the health facilities and provide Respectful Maternity Care (RMC) to all pregnant women attending the public health facility.

Scope-

Following facilities would be taken under LaQshya initiative on priority

1. All government medical college hospitals.
2. All District Combined and Female Hospitals.
3. All designated FRUs and high case load CHCs with over 100 deliveries per month

Process- The certification process is accomplished in three phases.

1. **Internal Assessment**- At the beginning of the financial year, each facility should be assessed scored and documented (including photo documentation) every quarter by its own staff using the LaQshya assessment checklist. Based on this assessment, the facility should identify the gaps and prepare an action plan to address these gaps. This internal assessment should be carried out every quarter and facility should maintain a record of scores for each quarter.
2. **State Level assessment-** For those facilities that scored 70% score in both Labour room and Maternity OT on internal assessment and meeting all other required criterion, the request of such facility will be sent to the state, through DQAC, for state level assessment.
3. **National/External assessment -** Those facilities which qualifies in state level assessment would be eligible for National level assessment by GoI nominated team. There request would be sent to GoI for national level assement.

State Surveillance Assessment- Those facilities which qualifies in national assessment and are declared 'Fully Certified' by GoI, would be awarded certification which will be valid for a period of 3 years. To ensure sustenance in quality standards by the certified facility during the validity period, a state surveillance assessment would be conducted annually by the state nominated team.

Incentivisation:

The teams in the Labour rooms and Maternity OT's at Medical Colleges, District Hospitals and SDH/CHCs could be given incentives of Rs. 6 Lakhs, 3 Lakhs and 2 Lakhs (for each department) respectively on achievement of following criteria:

1. Quality Certification of Labour Room and/or Maternity OT as per protocol under the LaQshya.
2. Attainment of at least of 75% of commensurate facility level targets and its verification by the SQAC.

3. 80% of the beneficiaries are either satisfied or highly satisfied (or Equivalent score > 4 on Likert scale)

The incentive money would be given on qualifying in national level assessment and thereafter qualifying in subsequent state surveillance assessments.

This incentive is recognition of the good work done by the quality circles and facility's quality team. The 75% of this amount can be used as for the welfare activities of the patients and remaining 25% as cash incentive to the staff .

National Quality Assurance Standards (NQAS)

Introduction and Background- The successful implementation of NRHM since its launch is 2005 is clearly evident by the many fold increase in OPD, IPD and other relevant services being delivered in the Public Health Institutions, however, the quality of services being delivered still remains an issue. An ambient and bright environment where the patients are received with dignity and respect along with prompt care are some of the important factors of judging quality from the clients' perspective. However, improvement in Quality of health services at every location is still not perceived, generally. Perceptions of poor quality of health care, in fact, dissuade patients from using the available services and these issues are among the most salient of human concerns in utilizing services of public health facilities. Ensuring quality of the services will result in improved patient/client level outcomes at the facility level. With an aim to achieve the quality in health care that is affordable and accessible to even the most vulnerable sections of society, NQAS standards were launched by GoI in 2013

Objectives-

1. To provide optimum quality of care to the public.
2. To minimize patient harm during care
3. To increase the patient's and service provider's satisfaction.
4. Optimum utilization of resources.
5. To reduce out of pocket expenditure.
6. To make the health care at public health facilities accessible and available to even the most vulnerable groups.

Scope-

Following facilities would be taken under NQAS programs

4. All District Level Hospitals (DH, DWH & DCH)

a. For DH NQAS will be applicable in 13 departments.
b. For DCH NQAS will be applicable in 19 Departments
c. For DWH NQAS will be applicable in 12 Departments

For District level hospitals partial certification is also allowed with minimum of 6 available departments to be taken which mandatorily should include General Admin. Support

services as well as Labour room and MOT(if applicable)

5. All Community Health Centres (Both FRUs & Non FRUs.)

a. For FRU CHCs NQAS will be applicable in 12 departments

b. For Non-FRU CHCs NQAS will be applicable in 08 departments

6. All PHCs and UPHCs

a. For PHC NQAS will be applicable in 06 departments

b. For UPHC NQAS will be applicable in 12 departments

7. All Health & Wellness Centres (Recently Introduced)
   For HWCs NQAS will be applicable for 12 service packages with minimum 07 packages to be taken for certification.

Process – The certification process is accomplished in three phases.

4. Internal Assessment- At the beginning of the financial year, each facility should be assessed scored and documented (including photo documentation) every quarter by its own staff using the NQAS assessment checklist. Based on this assessment, the facility should identify the gaps and prepare an action plan to address these gaps. This internal assessment should be carried out every quarter and facility should maintain a record of scores for each quarter.

5. State Level assessment- For those facilities that scored 70% score in the selected departments on internal assessment and meeting all other required criterion, the request of such facility will be sent to the state, through DQAC, for state level assessment.

6. National/External assessment – Those facilities which qualify in state level assessment would be eligible for National level assessment by GoI nominated team. There request would be sent to GoI for national level assessment.

State Surveillance Assessment- Those facilities which qualifies in national assessment and are declared 'Fully Certified' by GoI, would be awarded certification which will be valid for a period of 3 years. To ensure sustenance in quality standards by the certified facility during the validity period, a state surveillance assessment would be conducted annually by the state nominated team.

Incentivisation:

The health facilities on attainment of certification by GoI after external assessment will be eligible to receive incentive money as per GoI guidelines for each category of health facilities based on bed strength and no of departments taken for certification.

The incentive money would be given on qualifying in national level assessment and thereafter qualifying in subsequent state surveillance assessments.

This incentive is recognition of the good work done by the quality circles and facility's quality team. The 75% of this amount can be used as for the welfare activities of the patients and remaining 25% as cash incentive to the staff .

Key Roles in certification-

Certification is a team work which requires consistent efforts from Facility in charges, department and quality nodals as well as Hospital Managers, Help Desk staff and ICNs.

Detailed Roles and Responsibilities of Hospital Manager, Help Desk Staff and ICNs are annexed

Help Desk (Rogi Sahayata Kendra)

Rogi Sahayata Kendra is being operated in total 50 district level hospitals of 25 high priority districts of the state, since the year 2015. In view of the usefulness of the Rogi Sahayata Kendra, the State decided to expand the Rogi Sahayata Kendra to be implemented in the district level hospitals (160) of all the districts of the state with name "Help Desk".

In each district level hospital, 01 help desk manager and 01 help desk operator providing services from 08:00 am to 04:00 pm.

Objectives of Help Desk

- To provide detailed information to the beneficiaries regarding the health services available in the hospital.
- To inform and record the hospital administration for proper and time-bound redressal of complaints and suggestions of the beneficiaries.
- To provide support to the Chief Medical Superintendent for strengthening the sanitation system according to the prescribed standard of "Kayakalp-Award" scheme.
- To assist the nodal officer in the effective implementation of the Mera Hospital scheme and in the effective implementation of the WASH program.
- To provide assistance in referral services to the beneficiaries.
- To provide support in various national programs organized in the hospital.

Activities -

- Help desk personnel provide information about the services available in the medical unit to the patients and attendants coming to the hospital and assistance is provided in the use of the services.
- To act as the first contact point of the hospital.
- To ensure availability of stretcher and wheel chair at the required place in the hospital.
- To update on the board the status of doctors available in the hospital.
- To act as a quick grievance redressal mechanism of the medical unit.
- To get feedback about the hospital from the patients.

- To organize CSR activities for/in the hospital.
- To provide assistance in organizing various national events.
- Assistance in providing training to the hospital personnel on infection prevention / biomedical waste management / firefighting.
- Regular cleaning of the water tank, ward, gallery and waiting area of the hospital.
- To provide assistance in organizing activities related to rejuvenation.
- To help the serious] helpless and old patients coming to the hospital.
- To assist in providing food to the hospitalized patients.
- Helping patients in difficult situations, such as losing a child, stealing a purse, losing a mobile etc.

Budgetary Provision for the Operationalization of Help Desk : For the smooth functionality of Help Desk Rs.6000 per month operation cost is being provided to each district level hospitals

A. Kayakalp Award Scheme

The Swachh Bharat Abhiyaan launched by the Prime Minister on 2nd October 2014, focuses on promoting cleanliness in public spaces. Public health care facilities are a major mechanism of social protection to meet the health care needs of large segments of the population. Cleanliness and hygiene in hospitals are critical to preventing infections and also provide patients and visitors with a positive experience and encourages moulding behaviour related to clean environment. As the first principle of healthcare is "to do no harm" it is essential to have our health care facilities clean and to ensure adherence to infection control practices. Swachhta Guidelines for Public Health Facilities are being issued separately. To complement this effort, the Ministry of Health & Family Welfare, Government of India is launching a National Initiative to give Awards to those public health facilities that demonstrate high levels of cleanliness, hygiene and infection control.

Objectives

1. To promote cleanliness, hygiene and Infection Control Practices in public Health Care Facilities.
2. To incentivize and recognize such public healthcare facilities that show exemplary performance in adhering to standard protocols of cleanliness and infection control.
3. To inculcate a culture of ongoing assessment and peer review of performance related to hygiene, cleanliness and sanitation.
4. To create and share sustainable practices related to improved cleanliness in public health facilities linked to positive health outcomes.

Scope

Based on scoring, using a specific standard protocol administered by an external Assessor Team, the awards

would be distributed. The awards would be distributed based on the performance of the facility on the following parameters.

Criteria I: Kayakalp scores obtained under following parameters: a. Hospital/Facility Upkeep b. Sanitation and hygiene c. Waste Management d. Infection control e. Support Services f. Hygiene Promotion g. Cleanliness beyond Hospital/facility Boundary wall h. Eco-friendly facility (A weightage of 85% may be assigned to this criterion).

II: Performance of the health facility under 'Mera Aspataal': a. The indicator would be % Percentage of patients dissatisfied with the cleanliness. (A weightage of 15% may be assigned to this criterion).

Methods & Tools: There are four assessment methods: Observations (OB):, Staff Interview (SI),Record Review (RR) & Patient Interview (PI)

Pre requisites for application to the Awards Scheme:

Following are the prerequisites for applying for an award

1. Constituted a Cleanliness and Infection Control Committee.
2. Instituted a mechanism of periodic internal assessment/peer assessment based on defined criteria
3. Adherence clinical & other protocol, SOPs & Policies
4. Achieved at least 70% score in the criteria during the peer assessment process

Assessment Process:

Internal Assessment- At the beginning of the financial year, each facility should be assessed, scored and documented (including photo documentation) by its own staff using the assessment tool. Based on this assessment, the facility should identify the gaps and prepare an action plan to address these gaps. This internal assessment should be carried out every quarter and facility should maintain a record of scores for each quarter, which should also be submitted to the office of the Chief Medical Officer.

Peer assessment- For those facilities that have an average of 70% score on internal assessment, the state/district will ensure that Peer Assessment is carried out. Peer validation of a score of 70% and above is a criterion for application for the award.

Nomination of the facilities - The District Award Nomination committee would collate and analyses the peer assessment score of all health care facilities. The district committee will recommend the names of all facilities scoring 70% or more to the State level Awards Committee.

External Assessment: For formal recognition and award, an external assessment would be carried out in the nominated facilities by teams of external assessors to validate the scores generated through the peer Process of Assessment.

Award Money:

Type of Facility	Award	Amt. in lakhs
DH/ District Level Hospital	Highest (Best)	Rs. 50.00
	1st Runner-up	Rs. 20.00
	2nd Runner-up	Rs. 10.00
CHC	Highest (Best)	Rs 15.00
	Runner-up	Rs. 10.00
PHC	One in each District	Rs. 2.00
HWC -Sub Centre (If HWCs are > 50 in the district)	Highest (Best)	Rs. 2.00
	Ist Runner-up	Rs.0.50
	IInd Runner UP	Rs.0.35
Commendation & Cash Award		
DH	More than 70%	Rs. 3.00
CHC		Rs. 1.00
PHC	Score	Rs. 0.50
HWC -Sub Centre		Rs. 0.25

* First Rank holders must increase 5 % from previous year score, failing to this health facility will get only commendation award. Award money as may be changed as per discretion of chairperson State Award Committee.

* for the printing of SOP, Policies , IEC & checklist & other relevant documents budgetary provision of Rs.2000 per month to each hospital. Guidelines and other implementation directives can downloaded from the NHSRC website in Quality improvement section .

*To conduct various level assessments GUNAK & SaQsham app to used .

Felicitation: The awards will be distributed at a state level ceremony. A certificate and cash award would be given to the facility-in-charges of the award-winning facilities. 1st Prize winners amongst District Hospitals from every state would also be facilitated at a national level ceremony on a suitable day decided by the MoHFW.

Cash Award: 75% of the cash award amount will go to the Rogi Kalyan Samities for investments in improving the amenities, upkeep and services, while 25% of the cash award will be given to the facility teams as a team incentive.

22 NATIONAL HEALTH MISSION

NHM focuses on affordable, accessible, accountable, effective and quality services to the masses especially to the vulnerable groups of the community both in Urban and Rural. NHM envisages a bottom-up, decentralized and community owned approach to public health planning.

Organizational structure of NHM

State level arrangements

- State Health Mission
  Hon'ble C.M., Chairperson
- State Health Society
- Governing Body
  Chief Secretary, Chairperson
- Executive Commmittee
  Principal Secretary-MH & FW
  Chairperson
- Implementation Committees
  Principal Secretary-MH & FW
  Medical Health & Family Welfare
  as Chairperson
- SPMU - Mission Director

State Health Mission

Chairperson

Hon'ble Chief Minister

Vice Chairperson

Hon'ble Minister

Medical Health & Family Welfare

Members

Minister-Medical Education (AYUSH)

Minister-Urban Development

Minister-Urban employment and poverty eradication

Minister-Minority Welfare

Minister-Avas & Urban Planning

Minister-Women & Child Development

Minister-Panchayati Raj

Minister-Social Welfare

Minister-Rural Development

Minister-Finance

Minister-Planning

Minister-Primary Education

Members

- Nominated Community Representatives (5 to 10) – MLA/ MLC/ President Dist. Board/ Representatives of Urban/ Local Institutions (Suitable Representation of Women)
- Chief Secretary, UP Govt.,
- Agriculture Production Commissioner, UP Govt.,
- Principal Secretaries/ Secretary-Medical Education

(AYUSH), Avas and Urban Planning, Women Welfare & Child Development, Panchayati Raj, Social Welfare, Rural Development, Finance, Planning, Primary Education, Urban Development, Urban Employment and Poverty Eradication, PWD, Minority Welfare, Govt. of UP

- Secretary-Medical Health and Family Welfare,
- Mission Director - State Health Mission, Representative of Govt. of India, nominated non-government (5 to 8) Member–IMA, IPH, FOGSI, IAP & Volunteer Partners Representative of the UNICEF & WHO and Selected Developmental Partners

  Convenor – Principal Secretary (Medical, Health & Family Welfare)

State Health Society

It has four parts: -

- Governing Body
- Executive Committee
- State Programme Management Unit
- Programme Implementation Committees

Governing Body

Chairman- Chief Secretary

Vice Chairman-Principal Secretary Medical Health & Family Welfare

Convener- Mission Director

Members- Principal Secretary/ Secretary, Finance, Planning, Avas & Urban Planning, Women & Child Development, Panchayati Raj, Rural Development, Programme Implementation, Social Welfare, Primary Education, Public Works Department, Medical Education (AYUSH), Programme Implementation, Urban Development, Urban Employment & Poverty Eradication, Minority Welfare, Secretary-Medical Health & Family Welfare,

DG-Medical & Health, DG-Family Welfare, DG-Medical Education, AMD-NRHM, AMD NUHM, Representative from MoHFW, Director-Ayurveda, Unani, Homeopathy, Representative from Developmental partners, Public Health Specialists, Representative from Mother NGO, and Representative from Medical Union Regional Director- GoI.

Executive Committee

Chairman- Principal Secretary-Medical Health & Family Welfare

Vice Chairman-Director General-Medical & Health

Director General-Family Welfare

Convener- Mission Director-NHM

Members- Secretary-Medical Health & Family Welfare, AMD-NRHM, AMD-NUHM, DG-Medical Education, DG-Nutrition Mission, Dierctor -Ayurveda and Unani, Homeopath, Women and Child Development, Primary Education, Rural Development, Panchayati Raj, Swajal, SUDA, ICDS, National Programmes, Local bodies, Minority Welfare, Chief Engineer-PWD, Project Director-AIDS, GM-Water Works, Regional Director – GoI

Family Welfare Programme Implementation Committee

Chairperson-

Principal Secretary-M.H. & F.W.

Vice Chairman -

Secretary-M.H. & F.W.

Members-

MD-NHM, DG-Medical &Health

DG- Medical Education, Finance Controller-FW

Director- Women and Child Development,Primary Education, SIHFW, Homeopathy, Ayurveda, Unani, Local Bodies, SUDA, Minority Affairs, GM-NHM, Finance Manager-SPMU,

Member Secretary - Director General-National Programmes, Monitoring and Evaluation, Family Welfare

Medical & Health Programme Implementation Committee

Chairperson-

Principal Secretary-M.H. & F.W.

Vice Chairman -

Secretary-M.H. & F.W.

Members - MD-NHM, Director General-National Programmes, Monitoring and Evaluation, DG-Medical Education,

Finance Controller- Medical & Health, Director-Women and Child Development, Primary Education, SIHFW, Homeopathy, Ayurveda, Unani, Local Bodies, SUDA, Minority Affairs,

GM-NHM (2-3 as per agenda), Senior Finance Manager/Finance

Manager-SPMU

Member Secretary -Director General-Medical & Health

District level arrangement

District Health Mission - Chairperson-Zila Panchayat

District Health Society -Governing Body -Chairperson-District Magistrate

-Executive Committee - Chairperson-CMO

-District Level Vigilence and Monitoring Committee - Chairperson-Regional MP (Nominated by GoI)

- Divisional Programme Management Unit (Div. PMU)

-Divisional Programme Manager
-Divisional Accounts & MIS Manager

District Programme Management Unit (DPMU) -District Programme Manager
-District Community Process Manager
-District Accounts Manager

-District Data Manager

Rogi Kalyan Samiti at District & Sub District Level Hospitals

-Governing Body

-Executive Committee

-Monitoring Committee

VHSNC at Village Level

District Health Mission

Chairman- Chairperson, Zila Panchayat

Co-Chairman- District Magistrate

Vice Chairman-

Chief Development Officer

Members- Regional MP/MLA or their representatives Mayor-Nagar Nigam/Chairman-Nagar Palika, Nagar Palika Parishad, Nagar Panchayat. District Level Officers of various Departments, CMS-DWH (Male & Female)], Members of IMA, Non-Government Health Specialist nominated by Chairman, Representative of Volunteer Organizations nominated by Chairman.

Special invitee Representative-UNICEF, WHO, Representative-other Developmental Partners nominated by Chairman

Convenor CMO

District Health Society

Governing Body

Chairman- District Magistrate

Vice Chairman- Chief Development Officer

Co-Chairman- Divisional Additional Director-MH & FW, Uttar Pradesh

Convener- Chief Medical Officer

Members-City Commissioner, Executive Officer-Nagar Palika/ Nagar Panchayat, Project Officer-DUDA.

District Programme Officers of Health, Social Welfare, Minority Affairs, Labour, PRI, Ayurveda & Homeopath, Women and Child Development, Primary Education, SUDA, DIOS, Members of Medical Association, CMS-District Male/Female Hospital, Nagar Nigam/Railway/ESI/Military Hospital etc.

NGO representatives, District representatives of UNICEF, WHO

Executive Committee

Chairman- CMO

Co-Chairman- ACMO-NRHM/ ACMO-NUHM

Convenor- District Programme Manager/ACMO-RC

Members- Nagar Swasthya Adhikari, Executive Officer-Nagar Palika, Project Officer-DUDA, District Programme Officers of Health, Social Welfare, Labour, PRI, ICDS, Primary Education, Representative of Medical Associations, NGO, AYUSH

District Level RKS- Governing Body under the Chairmanship of DM

-Executive Committee under the Chairmanship of Chief Medical Superintendent of the Hospital

-Monitoring Committee under the Chairmanship of Mayor/ Chairman-Nagar Palika/Zila Parishad.

Sub District Level RKS - Governing Body under the Chairmanship of Deputy Divisional Magistrate/BDO

-Executive Committee under the Chairmanship of MoIC

-Monitoring Committee under the Chairmanship of Chairman-Nagar Palika/Nagar Nigam

Maternal Health Programs

Janani Suraksha Yojna(JSY)- To promote institutional deliveries

- Institutional deliveries increased from 1.68 lakh in

2006-7 to 24 lakhs in 2015-16 in govt sector.

- Total inst. Del increased from 17% in 2005 to 70% in 2015.

Incentives-

- Beneficiaries- Urban Rs 1000 Rural Rs 1400
- ASHA-
- Rs 300.00 in Rural & Rs 200.00 in urban for complete ANC
- Rs 300.00 in Rural & Rs 200.00 in urban for accompanying Mother

Janani Shishu Suraksha Karyakram(JSSK)

- Free medicines and consumables to all Pregnant women at all delivery points (L1, L2 & L3) and VHNDs
- Free essential investigations at all delivery points (L1, L2 & L3) and VHNDs
- Free food for JSY beneficiaries – at all block and district level facilities.
- Free transport from home to facility 7 drop back from Facility to home -102 services

Rashtriya Kishore Swasthya Karyakram (RKSK) - (Till date 2022)

- Adolescent friendly Health clinics (AFHC) have been established at district & Block level
- AFHC's branded as Saathiya Kendra are being established at DH and DWH of all districts where trained counsellors are providing counselling and referral services to all 10-19 years of beneficiaries. These counselors are doing 8 outreach activities in the community as well.

Other Programmes

- National Urban Health Mission
- National Disease Control Programme (NDCP)- Non-Communicable diseases-
- National Programme for Control of Blindness (NPCB)
- National Mental Health programme (NMHP)
- National Programme for the Health care of the Elderly (NPHCE)
- National Programme for Prevention and control of

Deafness

- National Tobacco Control Programme (NTCP)
- National Oral health programme (NOHP)
- National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)
- **National Disease Control Programme (NDCP)- Communicable diseases**
- Integrated Diseases Surveillance Programme (IDSP)
- National Vector Borne Disease Control Programme (NVBDCP) *MalariaDengue & Chikungunya AES/JE*
- National Leprosy Eradication Programme (NLEP)
- National Tuberculosis Elemination Programme (NTEP)

23 HOSPITAL MANAGEMENT

Hospital Management –DH Structure (Levels), Scope of services, Clinical, clinical support, auxiliary and outsourced non-clinical

Objectives

- Introduction to the three tier system of health services
- Introduction to District Hospital, Sub District Hospital, CHC, PHC and Sub Centres
- Scope of services of these institution India's Public Health System has been developed over the years as a 3-tier system, namely primary, secondary and tertiary level of health care.

District Hospital (Definition)

The term District Hospital is used here to mean a hospital at the secondary referral level responsible for a district of a defined geographical area containing a defined population.

District Health System is the fundamental basis for implementing various health policies, delivery of healthcare and management of health services for defined geographic area. District hospital is an essential component of the district health system and functions as a secondary level of health care which provides curative, preventive and promotive healthcare services to the people in the district. Every district is expected to have a district hospital linked with the public hospitals/health centres down below the district such as Sub-district/Sub-divisional hospitals, Community Health Centres, Primary Health Centres and Sub-centres.

Grading of District Hospitals

The size of a district hospital is a function of the hospital bed requirement, which in turn is a function of the size of the population it serves. In India the population size of a district varies from 35,000 to 30,00,000 (Census 2001). Based on the assumptions of .the annual rate of admission as 1 per 50 populations and average length of stay in a hospital as 5 days, the number of beds required for a district having a population of 10 lakhs will be around 300 beds. However, as the population of the district varies a lot, it would be

prudent to prescribe norms by grading the size of the hospitals as per the number of beds.

Grade I: District hospitals norms for 500 beds

Grade II: District Hospital Norms for 400 beds

Grade III: District hospitals norms for 300 beds

Grade IV: District hospitals norms for 200 beds

Grade V: District hospitals norms for 100

Functions

A district hospital has the following functions:

- It provides effective, affordable health care services (curative including specialist services, preventive and promotive) for a defined population, with their full participation and in co-operation with agencies in the district that have similar concern. It covers both urban population (district head quarter town) and the rural population in the district.
- Function as a secondary level referral centre for the public health institutions below the district level such as Sub-divisional Hospitals, Community Health Centres, Primary Health Centres and Sub-centres.
- To provide wide ranging technical and administrative support and education and training for primary health care.

Financial powers of Head of the Institution:

Medical Superintendent to be authorized to incur expenditure from Rs. 20 lakhs to Rs. 25.00 lakhs depending upon bed strength for repair/upgrading of impaired equipment/instruments with the approval of executive committee of Rogi Kalyan Samiti/Hospital Management Society.

All equipment should have annual maintenance contract for regular servicing and repair to ensure that they are in optimum working conditions and no equipment/ instruments should remain non-functional for unreasonably long time. Outsourcing of services like

laundry, ambulance, dietary, housekeeping and sanitation, waste disposal etc. should be preferably arranged by hospital itself. Manpower and outsourcing work could be done through local tender mechanism. Self-evaluation of hospital services at defined frequency should be done.

Sub-District/Sub-Divisional Hospitals

Sub-district (Sub-divisional) hospitals are below the district and above the block level (CHC) hospitals and act as First Referral Units for the Tehsil/Taluk/block population in which they are geographically located. Specialist services are provided through these Sub-district hospitals and they receive referred cases from neighboring CHCs, PHCs and SCs. They have an important role to play as First Referral Units in providing emergency obstetrics care and neonatal care and help in bringing down the Maternal Mortality and Infant Mortality. They form an important link between SC, PHC and CHC on one end and District Hospitals on other end.

In some of the states, each district is subdivided in to two or three sub divisions. A subdivision hospital caters to about 5-6 lakhs people. In bigger districts the Sub-district hospitals fills the gap between the block level hospitals and the district hospitals.

Categorization of Sub-district Hospitals

The size of a Sub-district hospital is a function of the hospital bed requirement, which in turn is a function of the size of the population it serves. In India the population size of a Sub-district varies from 1, 00,000 to 5, 00,000. Based on the assumptions of the annual rate of admission as 1 per 50 populations and average length of stay in a hospital as 5 days, the number of beds required for a Sub-district having a population of 5 lakhs will be around 100-150 beds.

Category I: Sub-district hospitals norms for 31-50 beds.

Category II: Sub-district hospitals norms for 51-100 beds

Functions

- It provides effective, affordable

health care services (curative including specialist services, preventive and promotive) for a defined population, with their full participation and in co-operation with agencies in the district that have similar concern. It covers both urban population (Sub-divisional head quarter town) and the rural population of the sub division.

- Function as a referral Centre for the public healthinstitutions below the tehseel/taluka level such as Community Health Centres, Primary Health Centres and Sub-centres.
- Provide education and training for primary health care staff.

CHC

The secondary level of health care essentially includes Community Health Centres (CHCs), constituting the First Referral Units (FRUs) and the Sub-district and District Hospitals. The CHCs were designed to provide referral health care for cases from the Primary Health Centres 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 populations in tribal/ hilly/desert areas and**
- **1,20,000 population for plain areas.**

CHC is a 30-bedded hospital providing specialist care in Medicine, Obstetrics and Gynecology, Surgery, Paediatrics, Dental and AYUSH.

Service Delivery in CHCs

OPD Services and IPD Services: General, Medicine, Surgery, Obstetrics & Gynaecology, Paediatrics, Dental and AYUSH services.

Eye Specialist services (at one for every 5 CHCs).Emergency Services

Laboratory Services National Health Programmes

Every CHC has to provide the following services which have been indicated as Essential and Desirable.

All States/UTs must ensure the availability of all Essential services and aspire to achieve Desiable

services which are the ideal that should be available.

Services available at CHC:

1. Care of Routine and Emergency Cases in Surgery
2. Care of Routine and Emergency Cases in Medicine
3. Maternal Health

Essential

Minimum 4 ANC check ups including Registration & associated services

Essential

a. Newborn Care and Resuscitation by providing Newborn Corner in the Labour Room and Operation Theatre (where caessarian takes place).

b. Early initiation of breast feeding with in one hour of birth and promotion of exclusive breast-feeding for 6 months.

c. Newborn Stabilization Unit.

d. Family Planning

Essential

a. Full range of family planning services including IEC, counseling, provision of Contraceptives, Non Scalpel Vasectomy (NSV),

b. Laparoscopic Sterilization Services and their follow up.

c. Safe Abortion Services as per MTP act and Abortion care guidelines of MOHFW.

Desirable

MTP Facility approved for 2nd trimester of pregnancy.

All National Health Programmes (NHP): should be delivered through the CHCs

- Blood Storage Facility

Diagnostic Services In addition to the lab facilities and X-ray, ECG should be made available in the CHC with appropriate training to a nursing staff/Lab. Technician.

8. Referral (transport) Services
9. Maternal Death Review (MDR).Facility Based MDR form.

PHC

A PHC is a basic health unit to provide as close to the people as possible, an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects

of health care.

The 6th Five year Plan (1983-88) proposed reorganization of PHCs on the basis of one PHC for every 30,000 rural populations in the plains and one PHC for every 20,000 population in hilly, tribal and desert areas for more effective coverage.

PHCs are the cornerstone of rural health services- a first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or referred from Sub-Centres for curative, preventive and promotive health care.

It acts as a referral unit for 6 Sub-Centres and refer out cases to Community Health Centres (CHCs-30 bedded hospital) and higher order public hospitals at sub-district and district hospitals. It has 4-6 indoor beds for patients.

Services at the Primary Health Centre

From Service delivery angle, PHCs may be of two types, depending upon the delivery case load – Type A and Type B.

Type A PHC: PHC with delivery load of less than 20 deliveries in a month,

Type B PHC: PHC with delivery load of 20 or more deliveries in a month All the following services have been classified as Essential (Minimum Assured Services) or Desirable (which all States/UTs should aspire to achieve at this level of facility

Sub Centre

In the public sector, a Health Sub-centre is the most peripheral and first point of contact between the primary health care system and the community.

A Sub-centre provides interface with the community at the grass-root level, providing all the primary health care services.

The purpose of the Health Sub-centre is largely preventive and promotive, but it also provides a basic level of curative care

As per population norms, there shall be one Sub-centre established for every 5000 population in plain areas and for every 3000 population in hilly/tribal/desert areas.

Categorization of Sub-Centres

In view of the current highly variable situation of Sub-centres in different parts of the country and even with in the same State, they have been categorized into two types - type A and type b. Categorization has taken into consideration various factors namely catchment area, health seeking behavior, case load, location of other facilities like PHC/CHC/FRu/Hospitals in the vicinity of the Sub-centre

Type A

Type A Sub Centre will provide all recommended services except that the facilities for conducting delivery will not be available here. The Sub-centres in the following situations may be included in this category.

1. Sub-centres not having adequate space and physical infrastructure for conducting deliveries, due to which providing labour room facilities and equipment at these Sub-centres is not possible.
2. Sub-centres situated in the vicinity of other higher health facilities like PHC/CHC/FRu/Hospital, where delivery facilities are available.
3. Sub-centres where at present no delivery or occasional delivery may be taking place i.e. very low case load of deliveries. If the case load increases, these Sub-centres should be considered for up gradation to Type b.

The facilities for conducting delivery will not be available at these sub-centres and patients may usually be referred to nearby centers providing delivery facilities. These Sub-centres should provide all other recommended services and focus on outreach services, prevalent diseases,tuberculosis, leprosy, Non-communicable diseases, nutrition, water, sanitation and epidemics.

Type B (MCH Sub-Centre) This would include following types of Sub-centres :

1. Centrally or better located Sub-centres with good connectivity to catchment areas.
2. They have good physical

infrastructure preferably with own buildings, adequate space, residential accommodation and labour room facilities.

3. They already have good case load of deliveries from the catchment areas.
4. There are no nearby higher level delivery facilities.

Such Sub-centers should be developed as a delivery facility and should also cater to adjacent type A sub-centres areas for delivery purpose.

type b Sub-centre, will provide all recommended services including facilities forconducting deliveries at the Sub-centre itself. They will be expected to conduct around 20 deliveries in a month. They should be provided with all labour room facilities and equipment including Newborn care corner. ANMs ofthese Sub-centres should be SbA trained

Services to be provided in a Sub-Centre

Sub-centres are expected to provide promotive, preventive and few curative primary health care services.

Chaaya Village Health and Nutrition Day (Chaya VHND)

VHND should be organised at least once in a month in each village with the help of Medical Officer, Health Assistant Female (LHV) of PHC, HWM, HWF,ASHA, AWW and their supervisory staff, PRI, Self Help Groups etc.

The number of VHNDs should be enough to reachevery habitation/ Anganwadi center at least once in a month. The ANM is accountable for these services, with the male worker also taking a due share of the work, and being in charge of logistics and organisation, especially vaccine logistics. Participation of Anganwadi workers, ASHAs and community volunteers would be essential for mobilization of beneficiaries and local organizational support. The services to be provided at VHND are listed below.

As per standard treatment protocol for the SBA.

Immunization and Vitamin A administration to all under 5 children-as per immunizationschedule.

Coordination with ICDS programme for Supplementary nutritional services, health check up and referral services, health and nutrition education, immunization for children below 6 years, Pregnant & Lactating Mother and health and nutrition education for all women in the age group (15 to 45 years).

Family planning counseling and distribution of contraceptives.

Symptomatic care and management of persons with minor illness referred by ASHAs/ AWWs or coming on their own accord.

Health Communication to mothers, adolescents and other members of the community who attend the VHND session for whatever reason.

Meet with ASHAs and provide training/support to them as needed.

Registration of Births and Deaths.

Desirable Symptom based care and counselling with referral if needed for STI/RTI and for HIV/AIDS suspected cases.

Disinfection of water sources and promotion of sanitation including use of toilets and appropriate garbage disposal.

Home Visits

Learning Points:

- Difference in the scope of services of DH,SDH,CHC,PHC and SC
- Catchment areas of of DH,SDH, CHC, PHC and SC

Bio-Medical Waste Management

Objective –

- To ensure that bio-medical waste that generated in health care facilities is handled without any adverse effect to human health and the environment and to prevent health impact on the community, the health care workers .
- Ensure occupational safety of all its health care workers involved in handling of bio-medical waste by providing appropriate and adequate personal protective equipment.

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 biological, including the categories mentioned in Schedule I to these rules.

Statutory Provisions

- Draft of certain rules, which the Central Government proposes to make in exercise of the powers conferred by sections 6, 8 and section 25 of the Environment (Protection) Act, 1986 (29 of 1986), and in supersession of the Bio-Medical Waste (Management and Handling) Rules, 1998, has been published.
- These rules may be called the Bio-Medical Waste (Management and Handling) Rules, 2016

These rules shall apply to All Persons who generate, collect, receive, store, transport, treat, dispose, or handle bio-medical waste in any form and

Shall NOT apply to :

- Radioactive wastes covered under the provisions of the Atomic Energy Act, 1962 (33 of 1962) and the rules made there under
- Hazardous chemicals covered under Manufacture, Storage and Import of Hazardous Chemicals Rules, 1989 made under the Environment (Protection) Act, 1986, (29 of 1986) (herein referred to as the Act);
- Waste covered under the E-Waste (Management and Handling) Rules, 2011.
- Wastes covered under the Municipal Solid Wastes (Management and Handling) Rules, 2000

Prescribed Authority

- The prescribed authority for implementation of the provisions of these rules shall be the State Pollution Control Boards in respect of States and Pollution Control Committees in respect of Union territories.
- Every authorized person shall maintain records related to the generation, collection, reception, storage, transportation, treatment, disposal or any other form of handling of bio-

medical waste in accordance with these rules and guidelines issued by the Central Government/ CPCB/SPCB.

- All records shall be subject to inspection and verification by the prescribed authority at any time.

Duties of the Occupier

Definition : A person having administrative control over the institution and the premises generating biomedical waste, which includes a hospital, nursing home, clinic, dispensary, veterinary institution, animal house, pathological laboratory, blood bank, health care facility and clinical establishment, irrespective of their system of medicine and by whatever name they are called.

- ✓ .Take all necessary steps to ensure that bio-medical waste is handled without any adverse effect to human health and the environment in accordance with these rules;
- ✓ Provide training for all its health care workers involved in handling of bio medical waste at the time of induction and at least once a year thereafter;
- ✓ Immunize all health care workers involved in handling of bio-medical waste for protection against diseases including Hepatitis B and Tetanus;
- ✓ Ensure occupational safety of all its health care workers involved in handling of bio-medical waste by providing appropriate and adequate personal protective equipment.
- ✓ Conduct health check up at the time of induction and at least once in a year for all its health care workers involved in handling of bio- medical waste and maintain the records for the same;
- ✓ Install necessary equipment and regular supply of materials required for proper in house handling of bio-medical waste;
- ✓ Maintain the bio-medical waste management register according to the bio-medical waste generated in terms of colour

coding.

- ✓ Ensure segregation of bio-medical waste at the point of generation;
- ✓ Develop a system of reporting of unintended accidents
- ✓ Inform the prescribed authority immediately in case the operator of a facility does not collect the bio-medical waste within the intended time or as per the agreed schedule;

Establish a bio-medical waste management committee, if the health care facility has thirty or more than thirty beds, to review and monitor the activities related to bio-medical waste management.

Every occupier or operator of common bio-medical waste treatment facility shall submit an annual report to the prescribed authority in Form II and III, respectively, by the 31st day of January of every year, to include information about the categories and quantities of bio-medical wastes handled during the preceding year.

Treatment and Disposal

- ❑ Bio-medical waste shall be treated and disposed of in accordance with Schedule I, and in compliance with the standards provided in Schedule IV.
- ❑ Every occupier, shall either set up his own requisite bio-medical waste treatment equipment like autoclave, shredder for treatment of bio-medical waste generated in his premises as a part of on-site treatment, or ensure requisite treatment of bio-medical waste through an authorized common biomedical waste treatment facility or any other authorized bio-medical waste treatment facility.
- ❑ Provided that the prescribed authority may authorize the occupier having five hundred or more bed capacity to install an incinerator, depending on the recipient environment and the location warranting such a course of action, where the services of common bio-medical treatment facility are not available.

- Use of chlorinated plastic bags for handling of bio-medical waste shall be prohibited and the occupier or operator of a common bio-medical waste treatment facility shall not dispose of such plastics by incineration. The occupier shall maintain a record of recyclable wastes which are auctioned or sold and the same shall be submitted to the prescribed authority.
- The occupier or operator of a CBMWTF shall dispose of the treated recyclable bio-medical wastes such as plastics and glass through recyclers having valid consent, authorization or registration from the respective State Pollution Control Board, after ensuring treatment by autoclaving followed by shredding.

Segregation, Packaging, Transportation & Storage

- No untreated bio-medical waste shall be mixed with other wastes.
- The bio-medical waste shall be segregated into containers or bags at the point of generation in accordance with Schedule I prior to its storage, transportation, treatment and disposal.
- The containers or bags referred to shall be labeled as specified in Schedule II.
- The transporter shall transport the bio-medical waste from the premises of an occupier to any off-site bio-medical waste treatment facility only with the label as provided in Schedule II along with the necessary information as specified in Schedule III.
- Untreated bio-medical waste shall be transported only in such vehicle as may be authorized for the purpose by the competent authority specified by the Government.
- Untreated bio-medical waste shall not be stored beyond a period of forty-eight hours.
- Provided that in case for any reason it becomes necessary to store such waste beyond such a period, the authorized person shall inform the reasons for doing so in writing to the

prescribed authority, obtain permission of the prescribed authority and take appropriate measures to ensure that the waste does not adversely affect human health and the environment.

- ❑ The municipal body of the area shall continue to pickup and transport segregated non bio-medical solid waste generated in hospitals and nursing homes, as well as duly treated bio-medical wastes, for disposal in accordance with the rules notified by the Central Government for management of municipal solid wastes

Steps for Implementation

- ❑ Constitution of BMWMC
- ❑ Contract with the CTF
- ❑ Rate contract from CMO office
- ❑ List of consumables provided
- ❑ Arrangement for regular waste recording
- ❑ Intervene if not satisfied with CBWTFs services
- ❑ Develop schedule/frequency for bag collection
- ❑ Develop plan for Training schedule
- ❑ Plan for monitoring schedule
- ❑ Meetings
- Frequency
- Incentives /awards

STEP-WISE IMPLEMENTATION OF BIOMEDICAL WASTE MANAGEMENT PLAN AT HEALTHCARE FACILITY (HCF)

5.1 Constitution of the Biomedical Waste Management Committee and appointment of Nodal Officer Person Responsible:

Facility in - charge For district-level HCFs, the BMWM

Committee should comprise the following:

- Senior staff, preferably senior medical officer (designated as Nodal Officer)
- Matron/sister-in-charge
- Laboratory in-charge
- Pharmacist
- Head of Sanitation Team or sweeper

For block-level HCFs the facility in-charge, i.e. Medical Superintendent (MS) or Medical

Officer-in-charge (MOIC) should be designated as nodal officer for biomedical waste management. The representative of CBWTF providing services to the HCF may also be invited for the BMW Committee meetings.

5.2 Contract with CBWTF for collection, transportation, Treatment & Disposal of BMW

Person Responsible :

Facility in-charge with assistance from Nodal Officer

- In case a contract has been signed with a CBWTF, a copy of rate contract should be obtained from Chief Medical Officer (CMO).
- In case a contract has not been signed, a contract should be signed with a CBWTF at the earliest.
- Read the contract and understand the extent of services that are to be provided by the CBWTF. The contract should cover services (collection, transportation, treatment and disposal of BMW), and may also cover supply of consumables (colour coded bags, colour coded bins, hub cutter, puncture-proof container, PPE etc.).
- In case the contract covers supply of consumables, obtain the list of consumables to be provided by the CBWTF. In case not, procure the required consumables otherwise.
- Should keep a record of BMW collected in a register.
- Should intervene if not satisfied with CBWTF services

5.3 Obtaining Authorization from UPPCB

Person Responsible: Facility in-charge with assistance from Nodal Officer

Authorization under BMW Management Rules, 2016 from UPPCB is mandatory. Application for it should be made two months after signing the contract with the CBWTF.

For this the following steps are to be followed:

- Submission of Form II (BMW Management Rules 2016)
- Submission of Fees
- Enclose a copy of the agreement

with the CBWTF for collection, transportation, treatment & disposal of BMW.

- Enclose record of BMW (details) collected in the last two months from the HCF by the concerned CBWTF. For this, a copy of log book/register used for maintaining record of BMW handed over to CBWTF may be submitted.

For bed strength upto 200, authorization is granted by the concerned Regional Office (RO) of UPPCB. For bed strength exceeding 200, the RO office recommends the case to UPPCB Head Office (Lucknow) from where the authorization is granted.

5.4 Facility Level BMW Management Plan

Person Responsible: Facility in-charge and Nodal Officer

The following steps may be followed for developing the plan:

- Identify points of BMW generation, i.e. wards, OTs, labour room, labs, OPDs, emergency etc.
- Identify and designate one responsible person for each point of generation. The person may be head of department/ doctor/matron .
- Identify location at each point of BMW generation for placement of BMW collection bins and display (IEC) material/posters.
- Identify monthly requirements of waste bags, bins, needle cutters, trolleys etc. and ensure their availability.
- Monitor supply of consumables (waste bags, bins, needle cutters, trolleys etc.) as per Consumables Supply Record
- Ensure availability and display of IEC material/posters.
- Identify location of BMW Interim Collection Shed and ensure its construction and maintenance as per guidelines.
- Develop a schedule for Bag Replacement and transfer of bags containing BMW to interim collection shed.

  Develop and implement a facility level Training Plan.
- Develop and implement a facility level BMW Monitoring

Plan.

- Develop a calendar for meetings of BMW Management Committee.
- Identify ways for incentivizing/rewarding good work.

5.5 General guidelines for the common sites of Placement of Bins & Containers at HCFs

Person Responsible: Nodal Officer and Members of BMW Management Committee

For Sharps Management: Needle cutters / destroyers along with Polycarbonate Containers (PPCs) for storage of sharps must always be available at following minimum locations:

OPD Injection room

- Immunization room Nursing station in each ward · Operation theatre
- Pathology- sample collection room

5.6 List of Consumables/ Materials/Equipment: Person Responsible: Facility in-charge and Nodal Officer

5.7 Display of Posters/IEC material Person Responsible: Nodal Officer, Members of the BMW Management Committee and designated responsible staff for each BMW generation point

- Ensure that posters indicating BMW segregation are displayed above the BMW collection bins
- Ensure that posters indicating hand washing best-practices are displayed above washbasins
- Ensure that name, designation, photo and contact number of designated responsible staff for each BMW generation station is prominently displayed at that station.
- Ensure that posters are replaced in case of damage or defacement

5.8 Plan for Bag Replacement & BMW Transfer to Collection Shed

Person Responsible: Nodal Officer, Members of the BMW Management Committee and designated responsible staff for each BMW generation point

- Ensure that BMW bins are

emptied out periodically, as per requirement

- Bag replacement methodology
- Bag should be changed after it is full to 2/3rd capacity: this may entail change of bags more than once a day at some stations.
- The sanitation worker should be wearing necessary protective gear while emptying the bin and transporting the bag.
- Bag should be tied at the top while it is still in the bin.
- Bag should then be transferred from the bin into the wheelbarrow.
- Contents of blue bin (glass sharps) and white puncture proof container/hub cutter (metallic sharps) should be transferred carefully into the big blue bin and puncture proof container respectively carried in the trolley.
- A fresh bag should be placed in the bin ensuring that its edges are folded outwards at the rim of the bin.
- The sanitation worker should only load the trolley till the rim. He/she may return to collect other bags after transferring the load in the BMW interim collection shed.
- The sanitation worker should wheel the trolley along a designated route and avoid diverging from the route. The route should be identified keeping in mind its width so that the trolley may be wheeled without hitting walls or patients/passers-by.
- Red bags should be placed inside the red collections enclosure, the yellow bags in the yellow collection enclosure, and blue and white bins should be placed in the blue collection enclosure.
- Bag containing discarded /expired medicines should be collected periodically from the pharmacy/store, and placed in the yellow collection enclosure.

5.9 BMW Interim Collection Shed

Person Responsible: Facility in-charge and Nodal Officer The following guidelines may be

followed for construction and maintenance of the BMW interim storage shed:

- The shed shall have separate enclosure for each bag colour, i.e. three enclosures one each for yellow bags, red bags and blue bins/PPCs.

  The door of each enclosure shall be colour coded to reflect contents, and should have a prominently displayed biohazard sign.
- The shed shall be covered.
- The shed shall be located near the gate of the facility so that it may be easily accessible by the BMW collection vehicle of the CBWTF.
- The shed shall enough sufficient open, un-encroached space in front of it to allow for parking and free movement of CBWTF vehicle and staff.
- The shed should have a water supply in its vicinity that may be used for washing of the floor and walls of the shed.
- A record of cleaning the shed shall be maintained.

  The floor and walls of the shed shall be lined with tiles to enable easy cleaning, have proper sloping and have a drain through which wash water/ drained liquids may be drained into the HCF ETP.The door of each enclosure shall be kept locked at all times. It shall be opened only to allow for storage of BMW bags, for handing over waste to CBWTF, for cleaning and inspection. Keys of locks shall be kept in triplicate, one set each with the sweeper, CBWTF and a member of the BMW Committee.

5.10 Facility Level Training Plan Person Responsible: Nodal Officer, Members of the BMW Management Committee and designated responsible staff for each BMW generation point

Continuous training and awareness programs are must for ensuring success of waste management activities.

The key groups of personnel at facilities in need of continuous awareness and training include medical officers, nurses,

technicians and waste handlers.

The following considerations may be incorporated in the training plan:

- Training shall cover an overview of **WHY, WHERE, WHAT, WHO, WHEN and HOW of BMW** (given at the start of the manual).
- Identify batch size and composition: training may be conducted ward-wise and each batch may cover doctors, nursing staff, ward boys etc. of that ward in one batch.
- Identify time for imparting training: it may be conducted after hospital hours.
- Training duration may be decided by the trainers. It is suggested that duration of training session be 2 hours. However, it should be ensured that it is sufficient for sensitization, imparting required information and testing trainees.
- Flip Chart: flip charts or any audio-visual tool shall be used for imparting training.
- Demonstration during training: the trainer is advised to use demonstration techniques to impart training, for which a set of colored bins, real waste samples and other material may be used.
- Training shall be repeated every six months.
- Trainer may use a method of rewards to reward trainees who answer questions correctly.
- A record of trainings on BMW conducted by the BMW Management Committee shall be maintained

Training covers the following:

- What is and isn't Biomedical waste
- When, where and who should segregate biomedical waste
- Biomedical waste segregation (Yellow bin, Red bin, Blue bin, Puncture proof container)
- Sharps management :Needle stick injury prevention and management
- Liquid spill management
- Personnel protective equipment
- WHO recommended hand

washing steps .

5.11 Facility level BMW Monitoring Plan

Person Responsible: Facility in-charge, Nodal Officer, Members of the BMW Management Committee and designated responsible staff for each BMW generation point.

In order to ensure successful implementation of biomedical waste management plan at HCF level, regular (daily/weekly/monthly) monitoring is highly essential.

Monitoring shall be done: Daily during daily rounds by facility in-charge, MO, members of BMW Management Committee and designated responsible persons/departmental heads of BMW generation stations.

Key points for daily monitoring:

- Availability of biomedical waste collection and transportation materials
- Availability and use of needle cutters at different work stations.
- Segregation of waste into appropriate bags and bins.
- Availability and use of personal protective gears by waste handlers.
- Regular transport of biomedical wastes from generation stations interim BMW storage shed § Regular collection of BMW by CBWTF.
- Regular cleaning of walls, surfaces and equipment etc. by housekeeping staff.
- Monthly with the help of the Healthcare Facility BMW Monitoring Form (enclosed in Annexure 1)
- Monthly during monthly meeting of BMW Management Committee

Key discussion points for monthly meetings:

- Maintenance of records/log books/registers
- Feedback from healthcare persons
- Redressal of complaints
- Availability of bags/bins/ equipment etc.
- Regular collection of BMW by

CBWTF.

- Reporting of incidents of needle stick injuries and mercury spills and their follow up.
- Regular cleaning of walls, surfaces and equipment etc. by housekeeping staff.

Six-monthly during training sessions

- Feedback from healthcare persons
- Redressal of complaints
- Availability of bags/bins/ equipment etc.
- Reporting of incidents of needle stick injuries and mercury spills and their follow up.
- Six-monthly during meeting with designated responsible persons/departmental heads
- Feedback from healthcare persons
- Redressal of complaints
- Availability of bags/bins/ equipment etc.
- Reporting of incidents of needle stick injuries and mercury spills and their follow up.
- Regular cleaning of walls, surfaces and equipment etc. by housekeeping staff.

5.12 Record Keeping

Person Responsible: Nodal Officer, Members of the BMW Management Committee and designated responsible staff for each BMW generation point .The following records shall be maintained:

- Biomedical waste collection records
- Consumables supply records
- Biomedical waste storage shed cleaning record

  Health Care Facility Biomedical Waste(BMW) Internal Monitoring Form

  Biomedical waste (BMW) Generation Station Monthly Scoring Records
- Healthcare Facility Level Training Record
- Reporting of Major Accidents and Remedial Action Taken
- Submit an Annual Report to the UPPCB and publish the same on its website. The report is to include training status of healthcare personnel, major accidents and remedial action

taken, minutes of BMW Committee meetings.

5.13 Bio-Medical Waste Management Information System (BMWMIS)

Person Responsible: Nodal Officer The Biomedical Waste Management System (BMWMIS) has been developed with the objective of comprehensively capturing data relevant for effective management of Bio-medical waste by Health Care Facility (HCF).

The system captures the following data:

- One-time data on HCF (composition and contact details of HCF, facility in-charge, NO and BMW Management Committee members, agreement with CBWTF, facilities available for BMW management in the HCF etc.),
- Consumables supplied by CBWTF (schedule and quantity)
- Bio-medical waste collection (date and amount collected by CBWTF)
- Record of Minutes of BMW Committee Meetings
- Record of trainings conducted
- Record of internal monitoring activities

The system serves the following purpose:

- It enables quick generation of reports without having to do repeated manual data entry or cumbersome copying from existing record maintained in registers.
- Serves as a platform for dissemination latest information/reading and training material/formats in order to keep the stakeholders well informed on the subject.
- Provides a platform for acknowledging good performers. · Monitoring and review of BMW management in HCFs.

User of the System :

The system is designed to be operated under the supervision of the Nodal Officer of the Bio-medical Waste Management Committee. Data entry can be

done by the NO, trained Computer Operator/Data Entry Operator posted in the hospital or related staff.

5.14 Reward for Good Work

Person Responsible: Facility in-charge, Nodal Officer, Members of the BMW Management Committee and designated responsible staff for each BMW generation point .

It has been repeatedly found that outcomes are better where there is a system that acknowledges good work by way of public recognition or rewards. Hence it is suggested that this be built into the BMW management plan in each HCF.

Recognition can be done through display of names and photos of good performers on bulletin boards, and award of green badges to good performers, which can be worn on apron/uniform.

5.15 Immunisation:Periodic Health Check-ups and Personal Protective Equipment for Healthcare Personnel

Person Responsible: Facility in-charge, Nodal Officer, Members of the BMW Management Committee and designated responsible staff for each BMW generation point

The following activities shall be undertaken to ensure safety of healthcare personnel that are exposed to BMW:

- Immunization of all health care workers and others, involved in handling of biomedical waste for protection against diseases including Hepatitis B and Tetanus that are likely to be transmitted by handling of bio-medical waste, in the manner as prescribed in the National Immunization Policy or the guidelines of the Ministry of Health and Family Welfare issued from time to time. ;
- Health check-ups at the time of induction and at least once in a year for all its health care workers and others involved in handling of bio- medical waste and maintain the records for the same; · Ensure occupational safety of all its

health care workers and others involved in handling of bio-medical waste by providing appropriate and adequate personal protective equipments (PPE).

24 OFFICE MANAGEMENT

Office

Perusal of Dak by Head of Branch and its classification

3.1 After perusal of Dak, the Head of Branch should classify the receipts into the following three categories:— (i) Receipts of an important nature (i.e.) receipts raising new questions of policy, modification of existing policy or orders or any other receipts which is not of a routine nature; (ii) Receipts on which the line of action is clear; and (iii) Receipts on which no action is called for and are for information only.

3.2 Receipts in category (i) may be discussed by the Head of Branch with the Branch Officer at the Dak stage and the level at which action is to be initiated got settled. If action is to be initiated by a dealing hand he may discuss it with the next immediate superior officer who will have to approve the disposal under the 'Jumping level' scheme and get clear instructions regarding the line of action.

3.3 Receipts in category (ii) may be marked by the Head of the Branch direct to the dealing hands after indicating directions on the Receipts, where necessary.

3.4 In regard to receipts in category (iii) the Head of the Branch may give directions for the filing of such papers at the Dak stage. The PUC may then be added to the relevant file after docketing and the case need not be put up again unless the information is to be brought to the notice of higher officer.

Initial examination of receipts by dealing hands

3.5 Soon after the receipts are made over to him, the dealing hand will read them one by one and sort them out according to priority. 'ACTION THIS DAY', and 'IMMEDIATE' receipts will be taken up first, care being taken at the same time that ordinary receipts are not left unattended to for more than a week.

Bringing a receipt on to a file

3.6 A receipt will be brought on to a current file if it relates to a subject on which a file already exists. If not, it will be necessary to open a new file for initiating action on the receipt according to the instructions contained in Chapter II. The receipt will then be docketed and referenced in the manner described in Chapter II.

1. Noting

3.7 The objects of noting are:

(a) To state the facts clearly and concisely, drawing attention to previous decisions, precedents, correspondence or rules and orders having a bearing on the subject;

(b) To state points on which orders are required; and

(c) To suggest action to be taken.

Scope of noting by Branch

3.8 When the line of action on a receipt is obvious or is based on a clear precedent or practice or has been indicated by the Branch Officer, or the Divisional Officer in the directions given

by him on a receipt, a draft reply, where necessary should be put up for approval without much noting. In other cases the Branch will put up a note. It will be the duty of the Branch:—

(a) To see whether all the facts so far as they are open to check are correct;

(b) To point out any mistakes or mis-statements of facts;

(c) To draw attention, where necessary, to statutory or customary procedure and to point out the law and rules and where they are to be found;

(d)To supply other relevant facts and figures available in the Secretariat and to put up precedents or papers containing previous decisions of policy;

(e) To state the question or questions for consideration and to bring out clearly the points requiring decision; and

(f) To suggest a course of action, wherever possible.

3.9 The following instructions shall be observed by branches/sections/units/ offices in noting upon cases:—

(a) All notes should be clearly intelligible and couched in simple language; they should be concise and to the point. Excessive noting is an evil which should be carefully avoided.

(b) All notes should be temperately written and should be free from personal remarks. If apparent errors in the note of another Department have to be pointed out or if the opinion expressed therein has to be criticised, care should be taken that the observations are couched in courteous language. All notes should be written in third person.

(c) It is to be assumed that the 'paper under consideration' and the previous notes, if any, will be read by the officer to whom the case is submitted. The reproduction of verbatim extracts from, or paraphrasing of the PUC or of notes by other Department on the same file shall, therefore, be avoided.

(d) A precis of a single paper shall be made only when it is of great length and complexity. Such a precis or a precis of the contents or the history of a file shall not ordinarily be prepared except on the instructions of an officer.

(e) If the inclusion of any information in the note is likely to obscure the main point at issue or make the note unnecessarily lengthy, a separate statement or appendix giving the information should be placed on the file.

(f) When there are, in a single case, several points or orders which can more conveniently be dealt with separately than in a continous note, each point should be separately noted upon in 'Branch Notes'. The Branch Officer and/or higher officers will record their orders on each 'Branch Note' separately and these notes will thereafter be amalgamated to form the notes on the file for purposes of issue of orders, etc.

(g) As far as possible, one note should emanate from the Branch. In the case of

difference of opinion between the dealing hand and the Head of the Branch, the matter should be settled by personal discussion and the note should only summarise the points (including the alternate suggestion on a point) for decision.

(h) The sequence of noting should ordinarily follow the sequence of the serial number in the correspondence. If there has been any interruption in the continuity of the notes occasioned by submission of a receipt independently of the file, the papers should be amalgamated with the main file at the earliest opportunity.

(i) Except in routine matters, no note should be written on the receipt itself.

(j) If any Officer has made any remarks or written his direction on the P.U.C., these should first be copied out on the notes and then only the Branch note should follow.

(k) Every note should be legibly written upon paper of foolscap folio size, with a quarter margin. All long notes should be type written in double space.

(l) Paragraphs should be numbered.

(m) Sufficient space should be left for noting/signatures by higher officers. Notes to be submitted to Branch Officer or higher officers should not end at the every bottom of the page. A fresh blank sheet should always be added to the notes.

(n) Whenever notices or requests are received from Officers or others on small pieces of paper, they will not be passed on as they are, because of the likelihood of their being lost in transit. The first receiving Branch will paste or clip the slip of paper, thus received, to a foolscap size white sheet before passing it on in a file cover to officer or branch concerned for disposal. The branch concerned will type out the notice or request etc., on a note sheet or white foolscap size paper, and then deal with the receipt in the usual manner.

(o) The practice of writing long notes in the margin should be avoided as far as possible. Such marginal notes, if any, should be removed before the file is submitted to higher officers.

(p) When the lines on which a reply should be sent to a letter are apparent, the dealing hand should at the time of noting submit a 'draft for approval'. In such cases it is sufficient to note 'draft reply submitted for approval'. The substance of the reply should not be written in the notes.

(q) When a note, letter, file or other communication has been received from another Department, Ministry or Office or person, noting or further noting in connection with the matter therein will not be done on the sheet or sheets containing such a note or communication but all noting in this Secretariat will be done on a fresh and separate note sheet.

(r) All Inter-departmental correspondence between this Secretariat

and other Ministries or Departments should be kept separately and not mixed up with the internal notings in this Secretariat.

(s) The last paragraph of every note should invariably state precisely the question(s) for consideration or points(s) on which the orders are solicited.

(t) Notes should be recorded after careful consideration so that they are not to be rejected or re-written and erasures should be rare.

(u) If at all a note is to be rejected, it should be cut out and revised note written in continuation without pasting it.

(v) The dealing hand should append his/her initials with the date on the left hand side below his/her note. The Head of the Branch shall also likewise put his/her dated initials below the note of the dealing hand, except when disposing of a paper within the powers delegated to him/her in which case he/she will sign his/her name in full on the right hand side. Higher officers should initial on the right hand side of notes.

(w) All markings to higher Officers should be in the margin of the note.

(x) Wherever order of officers are to be solicited, the Branch noting(s) should invariably be followed by a concise, self-contained note (typed in double space) by the Divisional Officer concerned. Notings, if any, of Joint Secretary/Additional Secretary/Secretary over the note(s) of Divisional Officer should also be typed in similar manner.

(y) Notes involving more than one Branch should be consolidated by Divisional Officer/JS/AS/Secretary concerned and points on which orders of Officers are solicited should be specifically mentioned.

(z) After orders are passed by Officers no signatures should be put by any officer on the right hand side of the note sheet. All marking/initials should be in the margin of the note sheet.

12 (aa) If further note is required to be put up, it should be on the new note sheet bearing the name of the Branch or Office of the officer who has initiated that note and not in continuation of the note on which Officers has passed orders.

Action by Head of the Branch

3.10 The Head of the Branch will scrutinise the note of the dealing hand. Other instructions contained in para 3.9 (g) will be followed.

3.11 Heads of Branches are authorised and expected to dispose of the following items of work without reference to their Branch/Divisional Officer: —

(i) Grant of casual leave/compensatory leave/special leave up to three days;

(ii) Issue of reminders and acknowledgements;

(iii) Recording of files;

(iv) Issue of Office Orders, Routine Orders and Circulars of ephemeral natures;

(v) Any other case, which by a general or specific office order, Head of Branch is authorised to dispose of independently.

3.12 The delegations under (v) above have been made vide O.O. Part I Nos. 316 and 359 dated 18th February, 1957 and 25th October, 1957, respectively.

3.13 While signing official communications relating to matter within his own power, the Head of Branch may use his name and designation.

Authentication of Orders

3.14 Notwithstanding the powers delegated to Heads of Branches for disposal of certain cases and issuing of communications over their signatures, all orders passed by or made in the name of the Speaker, shall be authenticated by the signature of an officer not below the rank of Under Secretary.

Noting by Branch Officer

3.15 A Branch Officer will dispose of as many cases as possible on his own responsibility. Orders of the Divisional Officer or higher officers will be taken by him on cases which are of sufficiently important nature or those involving question of policy. He should endeavour to reduce the number of cases to be submitted formally to the **Divisional Officer by taking his verbal directions.**

3.16 Where he has to pass orders or to make recommendations for the consideration of higher officers, he will confine his note to the actual points that should be dealt with by him without attempting to reiterate the ground already covered in the previous notes. When he agrees with the recommendations made in the preceding note, he will merely append his signature or indicate his agreement with a particular proposal.

3.17 In cases where a note has been written and approved by an officer and sent to another officer or a Branch for comments or examination of the proposal or for similar purpose, an officer to whom the file is marked should invariably write the note himself. The receiving officer may ask his Branch to examine the matter or furnish factual information. In such cases the Branches should submit a separate routine note for the information of the Branch Officer who shall ultimately record his note on the file. Branches should not write notes on files disposed of at the officer level.

Notes and orders by Divisional Officer

3.18 The Divisional Officer should, ordinarily, dispose of most of the cases coming up to him on his own responsibility. He should use his discretion in taking orders of the Joint Secretary/Additional Secretary/Secretary/ Secretary-General on the more important cases, whether orally or by submission of papers. The oral method should be adopted as far as possible.

Items of work which should ordinarily be sent to Secretary-General have been incorporated in the Brochure titled "Items of work to be submitted to Officers."

Self-contained note for Officers

3.19 Whenever orders of Officers are to be solicited on any matter, a self-contained note shall be submitted. The following instructions shall be observed in the preparation and submission of such self-contained notes:

(a) The note will be given a heading as follows:—

Branch Subject.....

(b) The contents of the note should be concise and to the point and will be divided into paragraphs, each dealing with a particular aspect of the subject and each paragraph duly numbered.

(c) The note shall contain a concise background of the case and the orders relevant to the subject matter and reference to the statutory or customary procedure or previous decisions or precedents, if any. If the case is based on the provisions of any rules, regulations, statute or past precedents, action to be taken will also be suggested.

(d) If the inclusion of any information in the note is likely to obscure the main point at issue or makes the note unnecessarily lengthy, a separate statement or appendix giving the information will be placed on the file.

(e) The last paragraph of the note should invariably state precisely the question or questions for consideration or point on which the orders are solicited.

(f) The note should be neatly typed in double-spacing with a quarter margin on blue note-sheet and should not contain unnecessary erasures, omissions or additions.

(g) The self-contained note to the Officers should in the first instance be signed by the Divisional Officer and submitted through Joint Secretary, Additional Secretary, Secretary and Secretary-General.

(h) The self-contained note, together with the relevant papers that are to be put up with it to the Officers will be submitted in a separate file cover which will bear the number and subject of the main file. After the Divisional Officer has approved it, he will return the main file to the Branch and submit the self-contained note to the Secretary-General through the Joint Secretary/Additional Secretary/Secretary.

(i) If the Divisional Officer wants to put up a note in connection with the self-contained note for the information of Joint Secretary/Additional Secretary/Secretary/Secretary-General, he will do so on a separate note sheet which will be returned to him and the self-contained note forwarded to the Officers by the Personal Staff of Secretary, Additional Secretary or Joint Secretary as the case may be.

(j) When the note is received back from Officers with his orders thereon, all markings/initials should be done in the margin of the note sheet. No further noting will be done on the sheet or sheets containing the orders. All further noting will be done on a fresh and separate note sheet so that the self-contained note and Officers orders thereon remain in the file in a separate file cover as a self-contained documents which can be utilised for further reference, if necessary.

(k) If any further information is to be submitted to Officers on the same matter or his orders thereon are to be taken again, further noting will be done on a separate note sheet in continuation of the previous self-contained note and it will not be necessary to summarise the position in a fresh self-contained note every time the file is submitted to H.S./H.D.S./Chairman/ Convenor.

Highlighters should not be used for highlighting of notes.

3.20 When a file has to be sent to the Officers, the following instructions will be observed:—

(a) It should contain only that information which is necessary to enable the Officers to arrive at a decision without calling for further facts or references, and all papers which are not strictly relevant to the point at issue should be removed.

(b) Essential references contained in the filed papers should be extracted, placed in the file and referenced.

(c) All papers placed in the file should be legible. If any communication including fax communications received from Ministries/Departments, etc. are illegible, the same may be retyped.

2. Drafting

Draft—When to be prepared

3.21 Except when the line of action on a case is obvious, a draft of the communication proposed to be sent out will be prepared after orders have been passed by the competent officer indicating the terms of the reply to be sent, where the line of reply is clear a fair letter may be put up for signature.

3.22 A Branch Officer or a higher officer who has formulated his ideas on a case may himself prepare a draft and authorise its issue or submit it to the next higher officer for approval, as the case may be. In other cases a draft will be prepared by the Branch.

3.23 The following general instructions will be followed regarding drafting:

(a) A draft should be typed in double space, in half margin and on both sides of the paper.

(b) The number and date of the communication replied to or of the last communication in a series of correspondence on the same subject should always be referred to. Where it is necessary to refer to more than one communication or a series of

communications, this should be done in the margin of the draft. The subject should be mentioned invariably in all communications including reminders.

(c) A draft should show clearly the enclosures which are to accompany the fair copy. To draw the attention of the typist, the comparers and the despatcher, a diagonal stroke should be made in the margin. The number of enclosures also be indicated at the end of the draft on the left bottom of the page thus Encls. Nos. ...'

(d) If copies of an enclosure referred to in the draft are available and have not therefore to be typed, the fact should be clearly stated in the margin of the draft for the guidance of the typist.

(e) All drafts put up on a file should bear the number of the file. When two or more letters, notifications, etc. are to issue from the same file on the same date to the same addressee the serial number should also be given in addition in order to avoid confusion in reference, thus (i) 8/5(I)/2009-O&M and (ii) 8/5(II)/2009-O&M.

(f) Where State Governments or Ministries, etc., are consulted on any matter, time limit for replies should ordinarily be specified. The officer over whose signature the communication is to issue will initial on the draft in token of his approval. His designation should invariably be indicated on the draft.

(g) A flag bearing the words 'Draft for Approval' should be attached to the draft. When more than one draft are submitted at the same time, they should be numbered I, II, III and so on.

Collection of Model Drafts

(h) In order to ensure that drafts which are prepared after great thought and careful examination are not lost in files and thus become unavailable at the time when they are required for the disposal of similar references later on, copies of all model drafts should be collected in a separate file.

(i) For quick reference, an index to the collection of model drafts will be maintained in each Branch. The subjects of the index will be arranged in alphabetical order, each page being devoted to a letter or letters as the case may be.

(j) In the course of day to day disposal of cases as and when important communications are drafted, the Head of the Branch concerned will have spare copies of such drafts made out and add them to the collection and index them under appropriate subjects.

(k) The collection of model drafts will be scrutinized in the beginning of every year and obsolete drafts weeded out. Draft which have subsequently been improved will be replaced by the latest drafts on the subject.

Style

(l) A draft should convey the exact intention of the order passed. The language used should be clear, concise and incapable of misconstruction.

Lengthy sentences, abruptness, redundancy, circumlocution, superlatives and repetitions (whether of words, expressions or ideas) should be avoided. Communications of some length or complexity should generally be concluded with a summary.

(m) The following general principles may be followed by all concerned:—

(i) No more words that are necessary to express one's meaning should be used. Failure to do so is likely to obscure the correct meaning and to tax the reader.

(ii) Superfluous adjectives, adverbs, and round about phrases should not be used.

(iii) Familiar words should be preferred to the far fetched as the former are more likely to be readily understood.

(iv) Words with a precise meaning should be preferred to those that are vague. This will serve to convey one's thoughts more clearly.

(v) Concrete words should be preferred to abstract words for they are more likely to have precise meaning.

(n) The use of participles is sometimes very convenient in the drafts. The following list will meet most of the cases:—

Acknowledging Communicating Notifying Admitting Directing Proclaiming Advising Enclosing Recommending Appealing Enquiring Reporting Appointing Explaining Requesting Affirming Forwarding Sanctioning Authorising Intimating Stating Cancelling Inviting Submitting Confirming Nominating

(o) Some vague words and phrases have crept into official style and claim the sanction of tradition e.g., 'therein, thereon, thereof, in respect of, in regard to, as regards, in relation to, for being, do the needful, for necessary action or necessary instructions, respectively, etc.' Words such as these tend to obscure the meaning. For the words 'therein, thereon and thereof ' the simple words 'in it, on it, or of it' would have served the purpose. Likewise, 'in relation to' displaces in many cases the word 'towards'. Anxiety to avoid repetition leads to the use of 'former' and 'latter', but this places undue strain on the reader's memory. Such vague expressions should be avoided.

(p) A phrase which has been much overworked in official communications is 'as to'. It often appears unnecessarily along with the words 'whether, who, what etc.' For example, in the sentence "The Administrative Officer is requested to report as to whether the case has been completed", 'as to' is redundant and should be omitted.

(q) Some of the errors which are common to official writing are given below and care should be taken to avoid these mistakes:—

(i) The words 'Government', 'Secretariat', 'Branch' are sometimes used in singular and sometimes in plural. The correct procedure is to use

them in the plural form, but if the singular is used, it should be constantly followed throughout the sentence and should not be changed as has been done in the following sentence:— "The Secretariat has considered your case carefully but have come to the conclusion." Likewise, the mood also gets mixed up frequently. An example of change in mood is given below:— "When I referred the matter to the Committee, it was considered by me." The correct form should be:— "When I referred the matter to the Committee, I considered." It is equally important to see that tense used throughout is the same.

(ii) After 'suggest' use 'should' not 'may' (after 'request' use 'may' not 'should').

(iii) 'Point out' is a much abused phrase. It should really be used in speaking of some fact or a circumstance of which the addressee ought to have been aware from the source of information open to him. It should never be used as synonymous with 'explain' or 'inform you'.

(iv) 'However' is a word which often gets misplaced, "after careful consideration (1) of these suggestions (2) the Government of India are unable (3) to agree that". In this sentence (2) is the right place for 'however' and not (1) or (3). It should come between commas, fairly near but not too near the beginning.

(v) Wrong use of the words 'had' and 'have' is also frequent. The past perfect 'had' is to be used only to emphasise the priority of one event in the past over another e.g., it is correct to say "I had gone to Shimla when the Chairman left the place". But it is a wrong usage in the sentence "I had gone to Shimla last Friday".

(vi) Many words are used without a proper implication of their meaning. When the Officer asks for a file and the file is lost, the dealing hand often puts up a note saying that it is 'not available'. To say that the file is not available does not mean that it is lost. It only means that the file has been kept somewhere else or sent to some other office. The use of the words 'in case', for the word ' if ' and the phrase 'as well as' an equivalent of 'and' are other instances. When the dealing hand writes, "the file will be put up in case the Member does not pay the rent on the due date", he means that "the file will be put up if the Member does not pay the rent on the due date".

(vii) The words 'till' and 'all' also come in for a good deal of mishandling. When a dealing hand puts up a file to the Officer stating that no return was received till the 1st of December, it actually means that a return was received on the 1st December. But this is not what the dealing hand wants to say. What the dealing hand has in mind is that no return was received even on the 1st of December. To convey that, the

word 'up to' followed by the word 'had' would have been 17 correct e.g., "up to December 1st the return had not been received". Similarly, when a dealing hand reports that "all the Junior Clerks have not passed the Senior Clerk Test", what he means is that "not a single clerk has passed the Senior Clerk Test". But what he actually conveys is that there are some Junior Clerks who have passed the Senior Clerk Test.

(viii) Omission of the article and use of the wrong preposition are also frequently met with. The following are some of the examples of wrong usage:—

Incorrect Correct In Compliance of — In compliance with In the margin — On the margin In this behalf — On his behalf To kindly see — To see kindly Dispose it off — Dispose it of Under the circumstances — In the circumstances To thoroughly investigate — To investigate thoroughly

3.24 The following words are often wrongly used:— Acquaint for Inform or tell. Advert for Refer. Adumbrate for Sketch, outline, fore shadow. Ameliorate for Better, improve. Assist for Help. Blue-print for Plan.Ceiling for Limit.Cross-section for Sample. Commence for Begin. Deem for Think. Conditioned by for Dependent on. Consider for Think. Drive (intr.) for Came, originate, spring. Develop for Take place, occur, happen, grow. Entail for Impose, necessitate. Envisage for Contemplate, face. Eventuate for Come about, happen, occur, result, turn out. Evince for Show, manifest, display. Factor for Fact, consideration, circumstances, feature, element, constituent. 18 Function (verb) for Work, operate, act. Inform for Tell. In isolation for By itself. Initiate for Begin, start. Locality for Place. Major for Important, chief, main, principal. Majority, The.for Most. Materialise for Come about, happen, occur. Minimise for Under-estimate, disparage, belittle, make light of. Practically for Virtually, almost, nearly, all but. Proceed for Go. A percentage of for Some. A Proportion of for Some. Purchase for Buy. Reaction for Opinion, view. Render for Make. Reside for Live. Residence for Home.State for Say.Stress (verb) for Emphasise.Sufficient for Enough. Terminate for End. Transmit for Send, forward. Visualise for Imagine, picture.

Record of verbal discussions, orders and instructions

3.25 All points emerging from discussions between two or more officers and the conclusion reached should be recorded on the relevant file by the officer authorising action. Similarly, all verbal orders or instructions given by any officer and, where necessary, the circumstance leading to such orders/instructions, should be recorded on the file.

Channel of submission of cases

3.26 The cases are put up by the dealing hand and they are processed/finalised of various levels of hierarchy. The

channel of submission which is practiced in the Secretariat particularly in the LAFEAS and LARRDI Services are detailed in the charts given at appendices IV, V, VI, VII and VIII. The channel of submission of cases will also be determined by the orders issued from time to time under the jumping level scheme.

13.27 Heads of Branches may be permitted to submit certain types of cases direct to Divisional Officers and the Branch Officer to the Joint Secretary/Additional Secretary/Secretary. Similarly, Divisional Officer may, in specified cases, deal direct with the Officers.

3.28 Selected dealing hands may also be authorised to submit cases direct to Branch Officer/Divisional Officer.

3.29 After orders have been passed by a competent officer, the officer will mark the file either to the officer who put up the case to him or to an officer at an intermediate stage who should be kept informed of the decision taken..

3. Arrangement of Papers in a case

3.30 The papers of a current case will be placed in the following manner:—

(a) 'Notes' and 'Correspondence' will be kept in a single file cover, the 'Notes' portion being tagged on to the left hand side of the cover and the 'Correspondence' to the right half of the cover. 'Notes' will be filed downwards and 'Correspondence' upwards so that the latest 'Notes' and the 'Correspondence' are on the top when the file is opened.

(b) Self-contained inter-departmental references and replies thereto which are not to be returned, should be included in the correspondence portion of the file. Inter-departmental references which are to be returned in original will be noted upon, off the file without their being brought on to a file. A copy or a summary of the inter-departmental reference, together with a copy of the note recorded on the file of the originating Ministry in reply, will be retained, when necessary, and be kept in the correspondence portion.

(c) Drafts for approval will be placed on the current file between the 'Notes' and the 'Correspondence'. Placing of more than one draft on the file

(d) Sometimes, while submitting a draft to higher officers for approval, it becomes necessary to place on the file more than one draft for the facility of comparison or explaining the changes readily. One of these drafts is the final draft and the others are first, second, revised, etc. drafts.

(e) While submitting files (to officers) containing more than one draft, the unapproved drafts should be numbered serially and following indication given in the margin of these drafts in red ink:— 'Unapproved draft Nos. I, II etc. Not to be issued.'

Other Papers

(f) Other papers referred to in the note or draft should be arranged in the same sequence in which reference to them occur in the draft or note. Books, regulations, etc. will, however, be kept at the top of the file.

3.31 After the file is received back from officers, the Head of the Branch or the dealing hand concerned should see the file carefully and get neatly typed the finally approved draft for issue. While issuing the fair typed letter, the enclosures, if any, should be tagged to the draft; and an indication (issued with enclosures) should be given on the draft/office copy. The approved draft and unapproved drafts of important nature will be kept with K.W. Papers thereafter.

Learning Points

The participants before undergoing detailed sessions related to office procedure to understand how to prepare, compose and start a file and file related procedures.


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25 PROCUREMENT AND CONDEMNATION

To give an idea of necessity of procurement, procedure of purchase of goods and services, condemnation processor and disposal of expired/unserviceable stock items.

Meaning of Procurement

Procurement or Public Procurement means acquisition by means of purchase, lease, license or otherwise of goods or services by a procuring entity, whether directly or through an agency with which a contract for procurement is entered into, but does not include any acquisition of goods or services without consideration and the term procure or procured shall be construed accordingly.

Need for Procurement

For smooth functioning of a Government department goods and services of different kind viz. materials, equipment, plants machinery stores, stationery, supplies manpower etc. are needed. Without these goods the function of organization will become very difficult and efficiency of the organization will be severely affected. The goods or services are acquired by way of purchase, lease or transfer directly or through specialized agencies. The rules governing the acquisition or purchase of goods or services are called store purchase rules.

General Principles

Goods should be procured in such a way that sufficient quantity is always available in the department and there is no overstocking which may lead to wastage and blockage of funds .It is also to be observed goods are purchased at cheapest rate without compromising the quality. The following are the guiding principles of procurement.

Best Value for Money

The best value for money assumes

(a) purchasing at the right price,

(b) purchasing the right quantity,

(c) purchasing the right quality,

(d) purchasing at the right time, and

(e) purchasing from the right source.

These components have to be striven after simultaneously. A price will be 'right' only if it fetches the appropriate quantity and quality of goods at the appropriate time. It is a misnomer to assume that goods with high costs are also goods with high value. The 'value' of goods cannot be judged outside the context of the functions or use to which it is being put. It is quite possible that the high priced goods may have very low value in the context of a special need or use for which it was intended. Thus value analysis shifts the focus to the function to be performed by the goods from the goods itself.

Transparency, Competition, Fairness and Elimination of Arbitrariness

- The important measures to achieve these objectives are:
- The wide publicity of tenders in user friendly language

- Specifications of the goods should be detailed &general
- Tender documents clearly mention the eligibility criteria
- Procedure for submitting tenders deadline date etc. should be clear
- Tenders should be evaluated on the same criteria as incorporated in tender document. No new conditions should be brought in while evaluating the tender.
- Sufficient time should be allowed to the tenderers to prepare and submit their tenders.
- Tenderers should be given reasonable opportunity to question the tender conditions, tendering process, rejection and settlement of disputes.
- Negotiations should be severely discouraged. In exceptional circumstances negotiation should be done with L1 tenderer only.
- The name of successful tenderer should be properly notified.

Efficiency, Economy and Accountability

Strict norms of best practices should be observed to ensure efficiency, economy and accountability by taking care of:

1) In order to reduce delays, each department should prescribe appropriate time frame for each stage of procurement; delineate the responsibility of different officials and agencies involved in the purchase process and delegate, wherever necessary, appropriate purchase powers to the lower functionaries with due approval of the competent authority.

(2) Each department should ensure conclusion of contract within the original validity of the tenders. Extension of tender validity must be discouraged and resorted to only in absolutely unavoidable, exceptional circumstances with the approval of the competent authority after duly recording the reasons for such extension.

(3) A procuring entity should neither divide its procurement nor use a particular valuation method for estimating the value of procurement so as to avoid its obligations to obtain sanction of a higher authority or to limit competition among bidders.

Financial Arrangement

(1) There should be specific authority or sanction for the procurement

(2) The authority or sanction to incur the expenditure or make the advance or payment, shall not be operative unless funds required to meet it have been appropriated by competent authority in accordance with the rules contained in the Budget Manual

(3) No breach of the standards of financial propriety, which are mentioned below, is involved:

(1) The expenditure should not be prima facie more than the occasion demands. Every government servant should exercise the same vigilance and care in respect of expenditure from

public moneys under his control as a person of ordinary prudence would exercise in respect of expenditure of his own money.

(2) Public money should not be utilized for the benefit of a particular person or section of the community unless

- (a) the amount of expenditure involved is insignificant, or

(b) a claim for the amount can be enforced in a court of law, or

(c) the expenditure is in pursuance of a recognised policy or custom.

(3) No authority should exercise its power of sanctioning expenditure to pass an order directly or indirectly to its own advantage.

(4) The amount of allowances, such as travelling allowances, granted to meet expenditure of a particular type, should be so regulated that the allowances are not on the whole sources of profit to the recipients.

Procurement Planning

Thorough planning of procurement has to be done well in advance to cater the needs of the organization and its smooth functioning. Procurement planning involves the following steps.

Ascertainment of Requirement

Ascertainment of requirement for goods and store is of vital importance and makes the foundation of procurement planning. The guiding principles for ascertaining requirements are size of organization, whether new or old, position of opening stock, launching of new activities in current year etc.

Forecasting of Requirement

After ascertaining the requirement forecast for the current year is made keeping in view present stock position, past three years' average consumption, revised estimates of the current year seasonal fluctuations dependability of suppliers etc.while making the forecast it should be ensured that a surplus stock for one quarter should kept as buffer.

As far as possible, a procuring officer should lay in sufficient stock during the cheapest season. When necessary, one should get advice about the best time for making purchases and assistance in obtaining tenders from other Government departments who are in close touch with the market for the articles required and know the usual course of their price. For example, it is usually advantageous to buy food grains required for rations just after the harvest and the Food and Civil Supplies Department is likely to be able to give useful advice and assistance in regard to such purchases. Articles which are likely to depreciate or deteriorate during storage should not, however, be bought long in advance of requirements. It should also be remembered that the purchase of any article in advance of requirements involves the locking up of Government money and is, therefore, not desirable

unless it is reasonably likely to prove advantageous in regard to price

Preparation of Indents

After the list of articles required for the year is ready, an annual indent of goods should be prepared in accordance with the instructions in this regard. The indent should show the approximate cost of articles to be purchased including incidental expenses and should be sanctioned by competent authority. Indents to be placed to State Purchase Organization or Head of department/other authority, shall be prepared and submitted (in triplicate) in the standard Indent Form. It is the responsibility of the indenter to ensure that the indents submitted are complete in all respect viz.

(1) Description of stores should be as per latest amendments of BIS specification and BIS No. with verity or grade indicated clearly in the indent. In case, the indenter desires to purchase goods bearing ISI mark the same should be clearly specified and a photo copy of the BIS booklet attached with it

. (2) If BIS specification is not there, then a general specification should be drawn and the name of the company must be indicated from which the specification is drawn. Indenters should not mention the exact specification of the catalogue of any private firm/company.

(3) If DGS&D/State Purchase Organization rate contracts are there for the particular item with the same specification, it should be clearly mentioned.

(4) All dimensions must be in metric system only.

(5) Any other special conditions to be incorporated in the Tender Enquiry such as installation of the equipment/machinery, demonstration and training, requirement of after sales service and spares should be clearly indicated. All other relevant information asked in indent form – like drawings, quality, exact quantity, tender sample wherever necessary, name of the consignee, list of likely suppliers, estimated cost, and delivery period etc. must be mentioned specifically

Scrutiny of Indent

All indents received in the office of Store purchase organization/Head of department or other authority shall be promptly scrutinized with regard to availability of funds, delivery period, specifications, proprietary certificates, estimated cost etc. The concerned indenter should be informed about the allocation of indent number. The purchase officer shall process the indent of with regard to the following points:

Scrutiny of indent with reference to specifications, reasonability of delivery period and estimated cost etc.

Bulking of indent received from different indenters for the same item of the same specifications

Financial Arrangement

The Purchase officer shall ensure that there is a valid administrative sanction for the procurement of the particular item and that the funds are available for the purpose. Administrative sanction for the project in which the component item and their estimated cost are listed out in detail shall be taken as equivalent to administrative sanction for the purchase of components.

Methods of Procurement

There are many methods of procurement depending on the nature of procurement, size of procurement, nature of items to be procured:

Direct Purchase: Routine items up to the cost of Rs. 20,000 an be purchased directly from the market with authorized dealers.

Purchase on Quotation: Items above Rs. 20,000 & up to 1 lakh can be purchased by obtaining quotations from dealers of those items available in the market. For this purpose Head of the office /HOD may constitute a committee of 3 or more persons. The committee shall survey the market and obtain the quotations from dealers of the required items in the sealed envelopes. The envelopes are opened by the committee before the procuring officer, a comparative chart of the price of the item is prepared and the purchase is made on L1 (Lowest price) basis

Purchase by inviting tenders: Items costing above Rs. 1 lakh shall invariably be purchased by inviting tenders. Tenders are of following types:

- Open tenders
- Limited tenders
- Two stage bidding
- Single source procurement
- Electronic reverse auction
- E- procurement
- Running contract/Rate contract etc.

Open Tenders: This is the most popular method of procurement. Open Tender can also be followed in case of Two stage bidding, Running contract & Rate contract. Procuring Authority shall invite bids by inviting a publication for bid on the state public procurement portal and by such other methods like publishing tender notice in local/national newspaper pasting notices on the notice board of important places etc.

Limited Tenders: The procuring authority may chose the method of limited tender when the estimated value of goods to be purchased is up to Rs. 25 lakhs. Items costing above 25 lakhs may be purchased by limited tender when :-

- Competent authority certifies that demand is urgent and should put record on the nature of urgency and reasons why the procurement could not be anticipated
- There are sufficient reasons to be recorded by the competent authority that it was not in public interest to

procure goods through open tender enquiry

- Sources of supply are known and fresh sources beyond those being tapped is removed

In this method copies of bidding documents should be sent directly by speed post/registered post/courier/e-mail to firms/companies which are registered suppliers of goods in question. The number of supplier firms/company should be three. Sufficient time should be allowed for submission of bids. A minimum period of 7 days, 3 days in emergency shall be given to the companies. The remaining procedure shall apply as open tender.

Two Stage Bidding: This method is adopted in large and complex contracts where technically unequal proposals are likely to be encountered or where the competent authority is aware that there are two or more technically acceptable situations are available.

Single Source Procurement: This method may be resorted only in unavoidable situations where the item for procurement is available only with one prospective bidder or a particular prospective bidder has exclusive rights in respect of subject matter of procurement and the use of any other procurement method would not be possible. For this purpose the administrative department concerned shall constitute a committee of three experts containing one technical representative of procuring entity, one technical representative of Government organization dealing with similar procurement and one representative from a reputed academic or research institution or a non commercial institution having expertise in such line to examine and declare that goods are available from a single source.

Due to sudden unforeseen event the purchase is extremely urgent and any other method would be impractical

The procuring entity determines that any other method of procurement is not appropriate for the protection of national security interest

There is a government policy to:

- promote the domestic industry
- Socio economic policy of the government
- Any other consideration in public interest

To maintain the confidentiality like printing of examination papers. The procuring entity shall forward document to single prospective bidder issuing suitable tender documents containing required terms and conditions. The procuring entity may engage in negotiation in good faith with the bidder. Bid security/earnest money shall not be obtained from the prospective bidder

e. Electronic Reverse Auction: Beyond the scope of this Training Module.

f. E-Procurement: The Government may by notification declare electronic

procurement as necessary for different stages and types of procurement and on such declaration every requirement for written communication shall be deemed to have been satisfied if it were done by electronic means.

g. Running Contract and Rate Contract:

Running contract is a contract for the supply of approximate quantity of goods at a specified price for a specific period. The approximate requirements of number of indenters for the period in question are combined by the department and the contract provides that any of the indenters may demand his requirements at any time or a specified period during the currency of the contract. Running contracts may be settled by the competent authority for the supply of articles at intervals during whole year or a part thereof. Dietary articles, firewood, charcoal, raw material for ayurvedic medicines come under this group.

A Rate Contract (RC) is an agreement between purchaser and supplier for the supply of specified goods (and allied services, if any) at specified price at terms and conditions during the period covered by rate contract. No quantity is mentioned nor is any minimum drawl guaranteed in rate contract. The Rate Contract is in nature of a standing offer from the supplier firm. The firm and/the purchaser is entitled to withdraw or cancel the RC by serving appropriate notice.

Specification and allied technical Particulars

Specifications: Specifications are the written instructions to set forth the complete technical requirements of goods to be procured. These shall mean actual and essential needs of the user. The specification should be thoroughly drawn; these should neither be over specified to cut off the competition nor loosely drawn to compromise the quality of product. Specification should be objective, functional, general and measurable. It sets out required technical, qualitative and performance characteristics. Any particular trade name, trade mark or brand name is not indicated. Specification should conform to ISI, ISO, CER, FDA standards. All dimensions incorporated in the specifications shall be in metric units. The specification and technical details should be expressed with proper clarity.

Essential Technical Particulars:

Technical particulars to be specified in the tender document shall include the following to the extent applicable for a particular procurement:

(1) Scope of supply including quantity required and, also, end use of the required goods.

(2) Specifications, technical parameters and product requirements, expressing the requirement in terms of functional characteristics.

(3) Drawings.

(4) Requirement of ISI mark, where applicable.

(5) Requirement of advance sample, if any, at post contract stage before bulk production.

(6) Special requirements of packing and marking, if any.

(7) Inspection procedure for goods ordered and criteria of conformity.

(8) Requirements of special tests, if any.

(9) Requirement of type test certificate, if any.

(10) Requirement of type approval for compliance of statutory requirements with respect to pollution, emission, noise, etc.

(11) Training, technical support, after sales service and annual maintenance contract requirements, if any.

(12) Warranty requirements.

(13) Qualification criteria of the tenderers.

(14) Any other aspects peculiar to the goods in question like shelf life of the equipment etc.

If necessary, HOD/procuring entity may constitute a committee to examine the need and finalise the specifications of goods to be procured. The committee may have one or more experts from outside the department also. The official/authority formulating the specifications should ensure that the specifications and the allied technical details are complete and correct to meet the user's requirements.

Process of Procurement (Invitation of Tenders)

Purchase above 1 lakh is done by inviting tenders. Tenders may be limited or open. Open tender system is followed where estimated value of goods to be procured is above 25 lakhs, in all cases of open tenders it is essential that wide publicity is given to the notification of tender. Procuring authority shall publish tender notification in State Public Procurement Portal system and on the website of the Department. An abridged/short notice shall also be published in at least one English and one hindi newspaper of wide circulation.

1. An invitation to bid shall contain at least the following information:

(a) the name and address of the procuring entity;

(b) a summary of the terms and conditions of the procurement contract or rate contract to be entered into, including the nature, quantity and place of delivery of the goods to be supplied, as well as the required time for the supply of the goods;

(c) whether the bid procedure will be conducted in a single stage or two stages and whether it is to be presented simultaneously in two envelopes: one envelope containing the technical, quality and performance characteristics of the bid, and the other envelope containing the financial aspects of the bid;

(d) the criteria and procedures to be used for evaluating the qualifications of suppliers;

(e) the means of obtaining the bidding documents and the place from which they may be obtained;

(f) the price, if any, charged by the procuring entity and the means of payment for the bidding documents and the amount of bid security and its form; and

(g) the manner, place and deadline for the submission of bids;

(h) right of the procuring entity to cancel the bid process and reject any and all of the bids;.

(i) any other important information.

2. An invitation to prequalify to be published in the State Public Procurement Portal/Departmental website shall contain, at least, the following information: (a) the name and address of the procuring entity;

(b) a summary of the terms and conditions, to the extent known at the time of invitation to pre-qualify, of the procurement contract or rate contract to be entered into or the empanelment to be done as a result of the procurement proceedings, including the nature, quantity and place of delivery of the goods to be supplied, as well as, the required time for the supply of the goods;

(c) the criteria and procedures to be followed for evaluating the qualifications of bidders;

(d) the means of obtaining the pre-qualification documents and the place from which they may be obtained;

(e) the price, if any, charged by the procuring entity and the means of payment for the pre-qualification documents and subsequent to pre-qualification, for the bidding documents; and

(f) the manner, place and deadline for presenting applications to pre-qualify and if already known, the manner, place and deadline for presenting submissions.

3. The NIB for goods, estimated to cost above Rs. 10 crore (Rs. ten crore) may also be sent to the Director General, Commercial Intelligence and Statistics, Kolkata for publication in Indian Trade Journal.

4. The NIB to be published in the newspapers must be brief. Bids for more than one lot of goods, to be procured must be included in one NIB.

Where goods are not available in the country and competitive bids are offered from abroad the copies of notification should be sent to Indian embassy in those countries and embassies of those countries in India. In this situation the tender becomes global tender.

Minimum time for submission of tender should be three weeks for national tenders and 4 weeks for global tenders.

Under E-procurement the bid notification shall be published in E government procurement portal and shall be the sole mode of official communication.

Text of the tender notice

The tender notice in abridged form should contain:

(1) Description and specification of the goods and quantity

(2) Period and terms of delivery

(3) Cost of the tender/bidding document 150

(4) Place(s) and deadline of sale of tender documents

(5) Place and deadline for receipt of tenders

(6) Place, time and date for opening of tenders

(7) Amount and Form of Bid Security/Earnest Money Deposit

(8) Any other important information

It should clearly be mentioned in the NIB published in newspapers that detailed information is available at the State Public Procurement Portal/Departmental Website.

Cost of Tender Documents

Price of the tender document should take care of the preparation and delivering cost only. If it is too high, it will discourage the prospective bidders to purchase the document and participate in the bidding process. The following scales of price are prescribed for tender forms to be issued by Government departments.

Ordinary tenders involving supply of goods:

Estimated value of goods for which tenders are invited	Cost of tender forms Original copy each (Rs.)	Duplicate copy each (Rs.)
Above Rs. 1.00 lac (Rs. one lac) and upto Rs. 10 lac (Rs. ten lac)	0.2% of the cost of tender rounded to the nearest multiple of 100, subject to a minimum of Rs. 400 and maximum Rs. 1500 plus local taxes as applicable	50% of the cost of the original copy, rounded to the nearest multiple of 100 plus local taxes as applicable
Above Rs. 10 lac (Rs. ten lac)	0.15% of the cost of tender rounded to the nearest multiple of 100, subject to a maximum of Rs. 25000 plus local taxes as applicable	50% of the cost of the original copy, rounded to the nearest multiple of 100 plus local taxes as applicable

The cost of tender form shall be accepted in cash or DD only. The tender documents must be made available to the prospective bidders from the time of advertisement of tender unti 1 hour before dead line fixed for submission . The same shall be incorporated in tender notice. The purchase department shall maintain a proper record of tenders sold, list of parties, amount received and tenders unsold.

Special tenders with drawing, etc., involving erection of plant and machinery

Estimated value of goods for which tenders are invited	Cost of tender forms Original copy each (Rs.)	Duplicate copy each (Rs.)
UptoRs. 10 lac (Rs. ten lac)	0.25% of the cost of tender rounded to the nearest multiple of 100 plus local taxes as applicable	50% of the cost of the original copy rounded to the nearest multiple of 100 plus local taxes as applicable
UptoRs. 10 lac (Rs. ten lac)	0.20% of the costof tender rounded to the nearest multiple of 100, subject to a maximum of Rs. 35000 plus local taxes as applicable	50% of the cost of the original copyrounded to the nearest multiple of 100 plus local taxes as applicable

Modification of Tender Documents and Extension of Tender Opening Date

Sometimes, some changes or modifications need to be done in tender documents or some discrepancies may be pointed out by tenderers which has to be ractified. In such circumstances the suitable changes and corrections are made in the bidding documents such corrections or changes are notified to the bidder through corrigendum notice published on the website, web portal. Copies of the correction may also be sent by e mail or speed post to the prospective bidders. If required time for tender opening may be extended suitably under intimation to prospective bidders.

Amendments/Modifications to Tenders

The tenderer after submitting the tender is permitted to submit alterations/modifications in shield covers clearly marked as modified tenders up to the date and time of tender, any modification received after the prescribed date and time is not entertained.

Receipt and Custody of Tenders

Receipt and custody of tender should be done in transparent manner. Tenders are received through sealed tender boxes, in case of bulky tenders or tenders sent by post or by hand or received by nominated official of the purchase department who shall enter the tenders in the prescribed register. The tender box should be located in easily accessible but secured place. Tenders are received till the last minute of the time notified in the tender notice. Tenders received after the prescribed time shall not be entertained.

EMD (BID SECURITY)

In order to safeguard against a bidder's withdrawing/altering its bid during the bid validity period in the case of tender enquiry, Earnest Money Deposit (EMD) is to be obtained from the bidders. 9.2 The bidders are required to furnish EMD along with their bids. Earnest money should ordinarily be taken for every bid for estimated value Rs. 1.00 (one) lac or more. The amount of EMD should be decided on the basis of estimated value of the goods to be purchased, which is as under –

Estimated value of the goods uptoRs. 1.00 lac (Rs. One lac)	Earnest money Rs. 1500 (Rs. One Thousand Five Hundred)
For each additional Rs. 1.00 lac (Rs. One lac) or a part thereof	A further amount of Rs. 1000 (Rs. One Thousand)

Exemption from Payment of EMD

Earnest money is not taken in case of procurement by limited tender, request for quotations, spot purchase and single source procurement.

Micro and small enterprises, industrial cooperatives within state which are certified by Director of Industries, Khadi & Village Industries, Cooperative societies, micro & small enterprises registered with NSIC, Govt. Institutions & Public Sector Undertakings are exempted from depositing earnest money

Payment of EMD

EMD may be accepted in the form of account payee demand draft, fixed deposit receipt placed in favour of HOD/Head of Office/other officer authorized by the Govt. or Bankers Cheque or a Bank guarantee from any scheduled Commercial bank. Under E procurement electronic mode of payment will be applicable.

Validity of EMD

The EMD should remain valid for a period of 45 (forty five) days beyond the final tender validity period. This time period must be indicated in the bidding documents.

If it is deemed necessary to extend the validity beyond this period the

procuring entity shall request the bidders in writing. Bidders may accept or reject the request. The EMD of bidders not accepting the request shall be returned to them, such bidders shall not be able to participate in the bidding.

Forfeiture of EMD

EMD of a tenderer will be forfeited, if the tenderer withdraws or amends his tender or impairs or derogates from the tender in any respect after expiry of the deadline for the receipt of tender but within the period of validity of his tender. Further, if the successful tenderer fails to furnish the required performance security within the specified period, his EMD will be forfeited.

Refund of EMD

EMD of all unsuccessful bidders should be refundedwithout any interest at the earliest after the expiry of final validity of tender period. EMD of successful bidder should be returned without any interest after receipt of performance security.

For the performance of contract, performance security is obtained from successful bidder before **Performance Security (Security Deposit)**

award of contract. Performance security may be accepted as fixed deposit receipt pledged in favour of HOD/Head of Office/ any other officer authorized by the Govt or in the form of Bank Guarantee from a scheduled commercial bank.

Performance security should be equivalent to 5% of the value of contract rounded to nearest multiple of Hundred, performance security should be deposited within 15 days from the notification of award of acceptance letter and should be valid 30 days beyond the date of all contractual obligations.

Performance security should not be demanded from micro & small units of Central/State Govt., Cooperative societies, Govt. undertakings of State & Central Govt. and units of Khadi& Village Industries.

On the request of contractor the EMD may be adjusted against the performance security and remaining amount should be adjusted by the contractor. Bank guarantee submitted by the tenderer as EMD/performance security shall be got verified immediately from issuing bank before acceptance.

Opening of Technical Bids

Technical bids should be opened by a tender committee constituted by the HOD/Head of the Office in the presence of prospective bidders or their authorized representatives on the specified date & place. Bidders attending the bid opening should furnish a letter of authority from their organization, attendance of the bidders or their representative is taken and kept on record. All the bids received shall be entered into a register and numbered serially. Bids are opened in order of

serial number. Before opening the envelope containing bids it should be ensured that the envelopes are intact. The tender committee shall record a certificate "opened before us" on the envelope and initial of all the members shall be taken. After opening the envelope original and duplicate copies of bids are kept separately, instruments of EMD are separated and kept in a file in order of serial number of bids. Financial bids are separated, kept in a large envelope and sealed by the tender committee and kept in the custody of procuring entity. Any cutting or over writing in the bid shall be encircled and signed by the members. Every page of technical bid is initialed by the members of the technical committee.

Evaluation of Technical Bids

It is the most important aspect of purchase process. The purchase officer prepares a comparative statement of bids received in order of serial number. This statement will have information about specifications, legal obligations etc. All the tenders are to be evaluated on the basis of terms and conditions incorporated in the bidding document. No new condition should be brought in while evaluating the tender

Preliminary Examination

The officer nominated for handling the tender for initial scrutiny will receive tender along with other documents as specified in the bidding document. No tender shall be rejected at this stage, all the tenders received will first be scrutinized to see whether the tenderer meets the basic requirements as incorporated in the bidding document. The following are the points to be checked in preliminary examination:

(1) The tender is not in the prescribed form (where forms are prescribed)

(2) The tender is unsigned.

(3) The tenderer is not eligible, e.g. The tender enquiry condition says that the bidder has to be a registered SSI unit; but the tenderer is say, a Large Scale Unit.

(4) The tender validity period is shorter than the required period.

(5) Required EMD has not been provided.

(6) The tenderer has quoted for goods manufactured by a different firm/company without the required authority letter from the proposed manufacturer.

(7) Tenderer has not agreed to give the required performance security.

(8) The goods quoted are sub-standard, not meeting the required specification etc.

(9) The tenderer has quoted all the required items as incorporated in the list of items.

(10) The tenderer has not agreed to some essential conditions incorporated in the tender enquiry.

All the points of compliance or non-compliance are entered in the comparative chart

Technical Evaluation

After preliminary examination the bids are examined by a technical committee who examines the technical aspects that is technical dimensions, performance criteria, quality certificates etc. At this stage the bidders may be called for seeking any clarification on technical points. The request for clarification shall be in writing. The bids not conforming to the conditions incorporated in the bidding document are declared unresponsive and are ignored for further considerations. The criteria once fixed for evaluation of technical bids shall not be changed or relaxed

Ascertainment of Responsive Bid

A bid shall be unresponsive if,

It has any material deviation, reservation or omission in the bid document

It does not conform to all requirements set in the bid document

It does not ensure statutory obligation

The bidder resorts to any unfair trade practice

The details of tenderers not meeting the required criteria and reasons for not being responsive is to be recorded and unresponsive bids are ignored. The recommendations of technical committee are sent to competent authority for its approval.

Opening of Financial Bids

After technical evaluation of bids and approval of the competent authority, financial bids of responsive bidders is opened by the purchase committee in the presence of concerned bidders. Ideally the number of responsive tenderers should not be less than three. If the number is less than three and it is considered necessary by the procuring entity with the bid process, reasons shall be recorded in writing and included in the record of procurement proceedings.

The bidders which qualified in the technical evaluation shall be informed in writing about the date, time and place of opening of their financial bids. This date should generally be not later than 15 (fifteen) days from the date of issue of letter. The envelope containing financial bids is opened by the tender committee and financial bids of responsive bidders are opened, every page of financial bid is signed by the tender committee, any cutting or over writing in the financial bid is encircled by the tender committee. The rates are disclosed before the bidders.

After opening the financial bids a comparative chart of prices quoted by the responsive bidders is prepared by the purchase officer and Lowest quoted price (L1 price) is calculated. In working out L1 price the price of the item, freight and insurance charges, applicable taxes and duties etc. and AMC/CMC prices are taken into account.

After completing the entire evaluation process for the responsive tenders on equitable basis as above, these are to be entered into a ranking statement in

ascending order of the evaluated prices (like L1, L2, L3 etc.) along with other relevant details, so that a clear picture of their standing as well as comparative financial impact is available at a glance.

Conversion of Currencies

Sometimes quoted prices are in different currencies which are to be evaluated equitably for this purpose the currencies are converted into Indian rupees as per the selling exchange rate established by competent authority (like RBI) as prevailing on a particular date to be specified in tender enquiry, generally this date is the date of opening of tender.

Correction of Arithmetic Errors in Financial Bids

If a bid is substantially responsive, the bid evaluation committee shall correct arithmetical errors on the following basis, namely:

(a) if there is a discrepancy between the unit price and the total price that is obtained by multiplying the unit price and quantity, the unit price shall prevail and the total price shall be corrected, unless in the opinion of the bid evaluation committee there is an obvious misplacement of the decimal point in the unit price, in which case the total price as quoted shall govern and the unit price shall be corrected accordingly;

(b) if there is an error in a total corresponding to the addition or subtraction of subtotals, the subtotals shall prevail and the total shall be corrected; and

(c) if there is a discrepancy between words and figures, the amount in words shall prevail, unless the amount expressed in words is related to an arithmetic error, in which case the amount in figures shall prevail subject to (a) and (b) above.

Price Preference

As per policy of the Govt. price/purchase preference is also taken into account while working out a L1 price

Reasonableness of the Price

Before placing the contract on L1 bid the procuring entity must ensure that the price to be paid is reasonable. The broad guidelines for judging the reasonableness of price are as under:

(1) Last purchase price of same (or, in its absence, similar) goods

(2) Current market price of sale (or, in its absence, similar) goods

(3) Price of raw materials, which go into the production of the goods

(4) Receipt of competitive offers from different sources

(5) Quantity involved

(6) Terms of delivery

(7) Period of delivery

(8) Cost analysis (material cost, production cost, over-heads, profit margin)

If L1 price is not reasonable the procuring organization should review its own data to recheck whether the

reasonable price so arrived is correct. If its correct the purchase organization as a special case should negotiate with the L1 bidder to bring down the prices, if L1 bidder reduces the price to desirable level the tender may be awarded otherwise decision of retendering should be taken depending on the merit of the case.

Acceptance of the Successful bid and Notification of Award

After ensuring the reasonableness of the price and acceptance letter the procuring authority may award the contract to the bidder. Before issuing the acceptance letter the procuring authority shall seek the approval of the competent authority. A letter of acceptance is issued to L1 bidder requiring him to sign a contract agreement with the procuring authority in the prescribed format on a judicial stamp of requisite value and deposit performance security within 15days from the date of issue of acceptance letter. In case the L1 bidder does not deposit performance security and execute the agreement within the stipulated time the procuring entity may cancel the award and forfeit the EMD.The bidder shall be asked to execute the agreement bond on a non-judicial stamp paper of prescribed value at his cost.

Decision on bids shall be taken within original validity period of offers and within the time period allowed to an authority of procuring entity for taking decision.

Procuring Entity's Right to Accept or Reject Any or All Bids

The Procuring entity reserves the right to accept or reject any bid, to annul the bidding process and reject all bids at any time prior to contract award, without thereby incurring any liability to the bidders. Reasons for doing so shall be recorded in writing in the purchase file.

Delivery of Goods

After contract for purchase is signed between purchaser and tenderer, the tenderer is obliged to supply transport and commission including the training of operators where necessary within the time period specified in the bidding document. Timely delivery is the essence of purchase process, the supplier shall arrange to supply the goods at the destination as incorporated in the bidding document, he shall take care of all the process of insurance and transportation of goods at the cost of purchaser

Dispatch Documents for Clearance/Receipt of Goods

The supplier shall send all the relevant dispatch documents well in time to the purchaser to enable the purchaser clear or receive (as the case may be) the goods in terms of the contract. Necessary instructions for this purpose are to be incorporated in the contract. The usual documents involved and the drill to be

followed in general for this purpose are as follows:

(1) For Domestic Goods Within 24 hours of dispatch, the supplier shall notify the purchaser, consignee, …….. (others concerned), the complete details of dispatch and also supply following documents by registered post / speed post (or as instructed in the contract):

(a) Supplier's Invoice indicating, inter alia description and specification of the goods, quantity, unit price, total value;

(b) Packing list;

(c) Certificate of country of origin;

(d) Insurance certificate;

(e) Railway receipt/Consignment note;

(f) Manufacturer's guarantee certificate and in-house inspection certificate;

(g) Inspection certificate issued by purchaser's inspector and

(h) Any other document(s) as and if required in terms of the contract.

(2) For Imported Goods

Within 24 hours of dispatch, the supplier shall notify the purchaser, consignee,…….. (others concerned), the complete details of dispatch and also supply following documents by air mail / courier (or as instructed in the contract):

(a) Supplier's Invoice giving full details of the goods including quantity, value, etc.;

(b) Packing list;

(c) Certificate of country of origin;

(d) Manufacturer's guarantee and Inspection certificate;

(e) Inspection certificate issued by the Purchaser's Inspector;

(f) Insurance Certificate;

(g) Name of the Vessel/Carrier;

(h) Bill of Lading/Airway Bill;

(i) Port of Loading;

(j) Date of Shipment;

(k) Port of Discharge and expected date of arrival of goods and

(l) Any other document(s) as and if required in terms of the contract.

Delay in Supplies

In case the tenderer fails to supply within the stipulated period incorporated in the bidding document, a penalty called "Liquidity Damages" is imposed on the tenderer. Delay in delivery may be of following two types:

Delay in Supplies for which Supplier is not responsible

Delay in Supplies for which Supplier is responsible

Delay in Supplies for which Supplier is not responsible

In this case the contractual delivery period is re-fixed without imposing penalty on the supplier, the grounds for such circumstances may be the following:

(1) Cases where the manufacture of goods is dependent on the approval of the advance sample and delay occurs in approving the sample though submitted by the supplier in time.

(2) Where extension in delivery period is granted on account of some omission on the part of the purchaser which affects

the due performance of the contract by the supplier.

(3) Cases where the purchaser controls the entire production.

Force Majeure

Force Majeure means an event beyond the control of the supplier and not involving the supplier's fault or negligence and which is not foreseeable. Such events may include, but are not restricted to, acts of the purchaser either in its sovereign or contractual capacity, wars or revolutions, hostility, acts of public enemy, civil commotion, sabotage, earthquake, fires, floods, explosions, epidemics, quarantine restrictions, strikes, lockouts, and freight embargoes.

If there is delay in performance or other failures by the supplier to perform its obligation under its contract due to event of a Force Majeure, the supplier shall not be held responsible for such delays/failures.

If a Force Majeure situation arises, the supplier shall promptly notify the purchaser in writing of such conditions and the cause thereof within 21 (twenty one) days of occurrence of such event. Unless otherwise directed by the purchaser in writing, the supplier shall continue to perform its obligations under the contract as far as reasonably practical, and shall seek all reasonable alternative means for performance not prevented by the Force Majeure event.

If the performance in whole or in part or any obligation under the contract is prevented or delayed by any reason of Force Majeure for a period exceeding 60 (sixty) days, either party may at its option terminate the contract without any claim of compensation on either side.

There may be a Force Majeure situation affecting the purchase organisation only. In such a situation the purchase organisation is to take up with the supplier on similar lines as above for further necessary action.

Delay in Supply / Non-Supply for which Supplier is Responsible

In such case the purchaser has the following options:

(1) Extend the delivery period with imposing of liquidated damages for delay and with denial clauses regarding increase in price, taxes, duties etc. taking place during the extended period.

(2) Forfeit the performance security

(3) Cancel the contract

(4) Impose other available sanctions/penalties.

Liquidated Damages

It is a provision to protect purchaser's right against delayed/faulty supplies for which the supplier is responsible, depending on the nature and the value of goods and the urgency of the requirement a specific percentage of the delivered price for the delayed goods for each week of delayed period is to be incorporated in the contract term. Generally this percentage is 0.5% per

week to a maximum of 10% of the value of the ordered goods. Any lower ceiling should be clearly justified while formulating the contract.

Warranty AMC & CMC

In order to secure purchasers right against any financialloss there should be specific warranty clause in the bidding document and contract agreement, during warranty period the supplier shall take care of all the faults, deficiencies and break down of the goods/equipment at its own cost. Generally warranty period given by the supplier is of one year which may be extended to five years upon mutual agreement.

AMC/CMC

After expiry of warranty period the purchaser may enter into an agreement of Annual Maintenance Contract (AMC) or Comprehensive Maintenance Contract (CMC) with the supplier at a fixed rate and period. The provision for AMC/CMC should specifically be incorporated in bidding document, under AMC the supplier provides maintenance services at agreed rate and purchaser is supposed to pay for the spare components. Under CMC the supplier provides maintenance services and spare parts on the rate and period incorporated in the bidding document. AMC/CMC clause should also be a part of contract agreement.

Acceptance of Delivery

Once the supplier makes the delivery at the purchaser's destination, the purchaser receives the sealed consignment of goods through purchase department. At the time of delivery it is to be ensured that all the boxes are properly sealed and intact. No seal is broken and no boxes damaged, if a damage is observed the same shall be recorded and the supplier should be asked to replace that part of consignment.

Inspection of Goods

After receipt of delivery the purchase department opens the consignment in the presence of the supplier or its authorized representative and compare the good supplied with the packing list provided by the supplier to ensure that supply is complete in all respects. It is also ensured that no component/part of the supplied item are broken or damaged, if any discrepancy in terms of short supply, breakage or damage is observed the supplier shall replace the damaged items and make the supplies complete.

Stock Entry

After such inspection of delivered consignment in the presence of supplier or its authorized representatives, the stock is entered into the stock book of the purchaser and becomes the part of its inventory.

Installation and Commissioning

If the consignment pertains to the supply of machinery/equipment the supplier is required to install and commission the equipment in the purchasers premises in the presence of

expert technical committee and shall ensure that the machinery or equipment is performing as per terms and conditions laid down in the documents. The installation and commissioning report is signed by the committee and is made a part of the procurement file.

Payment

Terms of payment should be clearly incorporated in bidding document in order to safe guard the interest of the purchaser, the payment is made in two parts one at the time of delivery at the purchasers destination and second after the installation and commissioning, this arrangement also secures the supplier from the blockage of funds. Generally 75% of the payment is made after the supply of the consignment and remaining 25% is paid after installation and commissioning.

For making payment, purchase department forwards the file to the account department along with necessary documents of supply viz. packing list, bill of lading/airway bill, invoice of the supplier, custom duty, insurance and freight charges etc., inspection report, stock entry report and installation and commissioning report to the account department. The account department thoroughly scrutinizes the paper and records its recommendations for the approval of the competent authority. After the approval of the competent authority the payment is made to the supplier.

E- Procurement

E- Procurement or electronic procurement is business to business, business to consumer or business to Government purchase and sale of goods, work and services through internet or other information and networking system such as electronic data interchange. In simple words it is the use information technology in the process of procurement. The purchase of goods and services through electronic mode of interface with tenderers and IT enabled management of the entire procurement process (notice inviting tenders, supply of tender documents, receipt of bids, evaluation of bids, award of contract, and execution of contract through systematic enforcement of its various clauses and tracking of claims, counter-claims and payments) improves efficiency and transparency, reduces the procurement cycle and cuts down transaction cost.

Benefits of E-Procurement

(1) Engaging in the e-procurement process brings potential benefits to suppliers. These include:

(a) Time and cost savings in re-inputting orders

(b) Reduction in errors, e.g. from re-inputting orders, deliveries, returns, invoices and payments

(c) Reduced transaction costs and cycle times

(d) Holding less stock as a result of more efficient communications with purchasers i.e. real time sales data

information for use in planning and forecasting.

(e) Improved supplier performance by sharing supplier measurement information.

(f) Faster payment.

(g) Improved management information.

(2) The resulting benefits to purchasers will be:

(a) Reduced transaction costs and cycle times

(b) Possibility of developing Vendor Managed Inventory

(c) Improvements in 'Just in Time' deliveries

(d) More ac curate deliveries due to reduced input order errors by suppliers

(e) Shared performance measurement data which encourages improved supplier performance. (f) Potential for less expediting by the purchaser as the supplier acknowledges orders by exception which automatically updates the purchaser's system.

(g) Reduced stock due to shared sales/forecast information

Process of E-Procurement

E-Procurement portals have been developed by Government of India, Govt. of India Organitations and state governments. Official web portal of GOI is https://eprocu.gov.in

And that of Government of U P is https://etender.up.nic.in. The e-Procurement systems of Uttar Pradesh enables the tenderers to download the tender schedule free of cost and then submit the bids online. The departments have to login this portal to create and upload the NIT,

Bidding documents, along with terms and conditions, schedule of requirements, tender cost, cost of item.

Format of technical and financial bids etc. on this portal. At two officials should create user Id through NIC to create and upload the bids .The following documents have to be uploaded.

a NIT

b general terms and conditions

c list of items

d cost of bid

e amt. of emd

f specifications

Bill of Quantity BOQ

The prospective tenderers download bids from the portal and submit their tenders on the prescribed format online. The purchasing department shall open the bids online on prescribed date place and time, check and process the bids. At the time of opening the bids at least two officer shall be present. These officers shall have digital signatures and authenticate the process digitally. The entire process shall be online which will save time and cost and increase efficiency.

G eM Portal

Government of india to facilitate on line procurement of common use Goods & Services required by various Government Departments /

Organizations / PSUs. GeM will enhance transparency, efficiency and speed in public procurement. It will also provide the tools of e- G eM portal or Government e- Marketplace is a common e-procurement portal created by bidding and reverse e-auction as well as demand aggregation to facilitate the government users to achieve the best value for the money. The portal is built, owned and operated by GeM SPV. The purchases through GeM by Government users have been authorized and made mandatory by Ministry of Finance by adding a new Rule No. 149 in the General Financial Rules, 2017.GeM Portal shall be used for the procurement of goods as well as services.

This system has been adopted by Government of UP vide GO no 11/2017/523/18-2-2017-97(la. U.)/2016 dated 23 August 2017. The main provisions of the GO are as under:

The goods and services available on the portal shall be purchased by Govt. departments, PSUsAnd Government undertakings through this portal. Goods and services not available on the portal shall be purchased under the rules of UP Procurement Manual.

The departments shall certify the reasonableness of rates of goods purchased.

The departments may purchase:

1. Items up to 50000 directly from any dealer available on the portal satisfying the quality and specification of goods.
2. Items above Rs. 50000 to Rs. 3000000 can be purchased from such suppliers who offer the items of same specification and quality on L1 rate. The rates of at least three suppliers shall be compared; the purchasing department may use online bidding or online reverse auction tools available on G eM portal at their discretion.
3. Items above Rs. 3000000 shall be compulsorily purchased using online bidding or reverse auction tools from the buyers, satisfying quality and delivery period at L1 rate
4. Online bidding or reverse auction invitation shall be available to all existing sellers or other registered sellers who comply with the terms and conditions of GeM portal and offer the bids accordingly.
5. Above financial limit shall be applicable for purchases through GeM portal only, in other cases existing financial limit shall be applicable.
6. The purchasing entities shall ensure the reasonableness of prices using business analytic tools before issuing purchase orders.

Process of purchase through GeM portal

All the sellers and purchasing departments shall register themselves on GeM portal as sellers and buyers. The Govt. departments purchasing goods shall register as buyers, buyers shall be of two categories

a. primary buyers: shall be HOD/ Head of office who shall apply for registration online and get user ID and password to login the portal. The documents required shall be
I. Aadhar card,
II. active mobile number linked to Aadhar card
III. Official E mail ID at gov.in/ .nic.in this ID shall be allotted by NIC.

b. Secondary buyer: The primary buyer then register secondary buyers under his control and allot them user ID and password at his level. The documents required for the registration shall be as above (a). The secondary buyer shall be of three types

1. Buyers: The role of the buyer shall be searching the required item on the portal ensuring its suitability seeking administrative sanction and issuing purchase order
2. Consignee: The role of consignee shall be receiving goods supplied by the seller, arranging for inspection and installation and issuing receiving letters/ receipts.
3. Paying Officer/DDO shall be responsible for making payments after installation and commissioning of equipments/items.

All the three types of role or secondary buyer may be assigned to separate person or the same person. If the three roles are assigned to the same person he shall login with different IDs issued for the same purpose.

While buying the desired item the buyer shall search the item on GeM portal and ensure its suitability and find the lowest rate according to prescribed financial limits of GeM portal. After being satisfied with the rates the buyer shall add the item to the cart. When the item is added to the cart its price shall be firm for the next ten days for any upward revision. For downward revision the benefit shall go to the buyer. No piecemeal order shall be allowed for eg. Suppose an item cost Rs. 45000 it can be purchased directly from a seller registered on the GeM portal. But if three items of the same kind are to be purchased those cannot be purchase from the same buyer the next day/week. Such purchase shall be allowed after one month.

After adding item to the cart the buyer shall take print out of comparative sheet of the L1 rate and seek administrative/financial sanction from the competent authority. Then the buyer shall scan the administrative order and upload on the portal, the system will generate sanction order and contract order automatically. The buyer shall keep the sanction order and contract order on the record and the seller shall download the contract order and

sanction order and supply the goods within deadline (within 15 days).

When the dispatched goods reach the buyers premises the consignee shall receive the pack and issue a temporary receiving letter. There after the consignee shall open the consignment, arrange for inspection and installation within ten days. If the consignee finds the goods supplied OK, he shall issue the permanent receiving letter and pass it on to paying authority/DDO. If the goods are not OK the consignee shall return the goods to seller.

After issue of permanent receiving letter the paying authority or DDO shall seek approval of competent authority and make payment to the seller within 10 days. The payment shall be online or through RTGS/NEFT or any other suitable mode.

Condemnation Procedure

Every good purchased has its own active or useful life. After expiry of useful life the goods /stock item becomes either unfit for use or its maintenance or use becomes uneconomical. Under these circumstances, to keep the system sleek and efficient it becomes inevitable to keep these goods out of mainstream and shed it off the system. The procedure adopted for the treatment of unserviceable and expired goods is called condemnation procedure and disposal of expired item.

Criteria of condemnation

The goods are condemned or declared unusable on the following grounds:

a) The stock of goods or plant or machinery has expired usable life and its efficiency is severely declined,
b) Its wear and tear has increased and its repair and maintenance has become uneconomical. Normally when the maintenance cost has reached 75% of the book value of the equipment its further repair becomes uneconomical.
c) The technology has changed and the equipment has become obsolete.
d) Due to change in technology the company has stopped the production of such equipment and their spares and components are no more available.

Inspection of Expert Committee

Record of goods in store is maintained by every Head of Office/Head of Department in a prescribed register called dead stock register with detailed record of quantity, price and date and source of purchase. Every year physical verification of stock is done and report is sent to head office of the actual position of stock, its loss due to damage, theft, accident or neglect and also current status of availability, shortage or surplus of stock. When it is observed that repair and maintenance items has become difficult or the stock has become unusable the condemnation procedure is started. For this purpose a committee

of experts comprising of 3 or more members is constituted by the head of office. One of the members of the committee should be a technical expert and one from the finance stream. The committee scrutinizes thoroughly the records to be condemned to see its date of purchase, service rendered by the equipment, its maintenance and repair cost during the period and report of service engineer regarding its further service and availability of spares. The committee also inspects the stock of goods/equipment physically to see the present condition of the equipment. If the committee finds that the stock has expired its useful life and it has become either unusable or maintenance has become uneconomical then the committee recommends to condemn the stock. It should also be kept on record whether the items has become unserviceable due to negligence, fraud or mischief on the part of Govt. servant.

Assessment of the Floor Value

The stock which has become obsolete or unserviceable still has some monetary value this is called "Salvage value". Where a formula for the loss due to depreciation is given it is easy to work out salvage value. But where no such formula is available the expert committee makes an assessment and of the value of the store this assessment is known as floor value. The committee arrives at this value by market survey and on the basis of common experience. The committee includes this floor value in its recommendation for condemnation.

Approval for Condemnation

The report of condemnation committee is sent to the Head of Department or other competent authority for its administrative approval. If the HOD is not is not competent of administrative approval the report is sent to the Government by the HOD. If it is observed that the stock has become unserviceable due to negligence, fraud or mischief on the part of the govt. servant, responsibility for the same should be fixed. When the administrative sanction for the condemnation is received the dead stock is declared condemned and is kept out for further use and process for its disposal is initiated.

Disposal of Expired Items

After stock items are condemned and declared unserviceable the process of its disposal is initiated to shed the department off the burden of its carrying cost of unserviceable stock, clear the available space for its better use and render the organization sleek and smooth.

Modes of Disposal

(1) Surplus or obsolete or unserviceable stores of assessed residual value above Rs. 10 (ten) lac should be disposed of by :

(a) obtaining bids through advertised tender, or

(b) public auction.

(2) For surplus or obsolete or unserviceable stores with residual value uptoRs. 10 (ten) lac, the mode of disposal will be determined by the competent authority, keeping in view the necessity to avoid accumulation of such stores and consequential blockage of space and, also, deterioration in value of stores to be disposed of.

(3) Certain surplus or obsolete or unserviceable stores such as expired medicines, food grain, ammunition etc., which are hazardous or unfit for human consumption, should be disposed of or destroyed immediately by adopting suitable mode so as to avoid any health hazard and / or environmental pollution and also the possibility of misuse of such goods.

(4) Surplus or obsolete or unserviceable stores, equipment and documents, which involve security concerns (e.g. currency, negotiable instruments, receipt books, stamps etc.) should be disposed of / destroyed in an appropriate manner ensuring compliance of relevant rules as also financial prudence.

(5) Prompt action regarding safe disposal of e-waste should be taken as per Government orders issued from time to time.

Disposal through Advertised Tender

(1) The broad steps to be adopted for this purpose are as follows:

(a) Preparation of bidding documents.

(b) Invitation of tender for the surplus goods to be sold.

(c) Opening of bids.

(d) Analysis and evaluation of bids received.

(e) Selection of **highest responsive bidder.**

(f) Collection of sale value from the selected bidder.

(g) Issue of sale release order to the selected bidder.

(h) Release of the sold surplus goods to the selected bidder.

(i) Return of bid security to the unsuccessful bidders.

(2) The important aspects to be kept in view while disposing the goods through advertised tender are as under :

(a) The basic principle for sale of such goods through advertised tender is ensuring transparency, competition, fairness and elimination of discretion. Wide publicity should be ensured of the sale plan and the goods to be sold. All the required terms and conditions of sale are to be incorporated in the bidding document comprehensively in plain and simple language. Applicability of taxes, as relevant, should be clearly stated in the document.

(b) The bidding document should also indicate the location and present condition of the goods to be sold so that the bidders can inspect the goods before bidding.

(c) The bidders should be asked to furnish bid security along with their bids. The amount of bid security should ordinarily be ten percent of the assessed or reserved price of the goods, the exact bid security amount (not as a percentage of assets or reserved price) should be indicated in the bidding document.

(d) The bid of the highest acceptable responsive bidder (H1) should normally be accepted. However, if the price offered by that bidder is not acceptable, negotiation may be held only with that bidder. In case such negotiation does not provide the desired result, the reasonable or acceptable price may be counter-offered to the next highest responsive bidder(s).

(e) In case the total quantity to be disposed of cannot be taken up by the highest acceptable bidder, the remaining quantity may be offered to the next higher bidder(s) at the price offered by the highest acceptable bidder.

(f) Full payment, i.e. the residual amount after adjusting the bid security should be obtained from the successful bidder before releasing the goods.

(g) In case the selected bidder does not show interest in lifting the goods, the bid security should be forfeited and other actions initiated including re-sale of the goods in question at the risk and cost of the defaulter, after obtaining legal advice.

(2) Late bids i.e. bids received after the specified date and time of receipt should not be considered.

Disposal through Public Auction

(1) A department may undertake auction of stores to be disposed of either directly or through approved auctioneers.

(2) The basic principles to be followed here are similar to those applicable for disposal through advertised tender so as to ensure transparency, competition, fairness and elimination of discretion. The auction plan including details of the goods to be auctioned and their location, applicable terms and conditions of sale, the assets or reserved price determined by competent authority as also the date, time and place of auction etc. should be given wide publicity in the same manner as is done in case of advertised tender.

(3) While starting the auction process, the condition and location of the stores to be auctioned, applicable terms and conditions of sale etc., (as already indicated earlier while giving wide publicity for the same), should be announced again for the benefit of the assembled bidders.

(4) The composition of the auction team will be decided by the competent authority. The team should,

however, include an officer of the Finance Wing of the department.

(5) The auction should be conducted in the presence of gazetted officer(s) who should ensure that a proper record is maintained of all the bids.

(6) The officers conducting the auction will not be bound to accept the highest or any bid. Reasons should, however, be recorded if it is not proposed to decide the auction in favour of the highest bidder. Persons of doubtful means and intentions may not be allowed by the officer conducting the auction to bid at the auction.

(7) The acceptance by the officer conducting the auction of any bid will be subject to confirmation by the competent authority and in certain cases also by Government, which will be announced at the time of auction.

(8) Every person bidding will be held to his bid whether it be the highest or not, and it will be distinctly understood that any remission of the amount of the bid will under no circumstances be considered.

(9) No person shall be allowed to bid at the auction on behalf of another person unless he holds a written authority from such other person who is present at the auction and authorises orratifies the bid made on his behalf.

(10) The goods shall be sold as and where they lie. The whole of the lot or lots shall be taken from the site of accumulation. Quantities, sizes, numbers, weights and measurements, etc., as announced at the auction may be approximate and no warranty or guarantee shall be implied, and no complaint will be entertained. The stores will be sold on the assumption that the bidders have inspected the lot or lots and know what they are buying.

(11) When it is proposed to auction any particular item or items of stores by weight or number and not on lot basis, an announcement to that effect shall be made before the store is put to auction. The bids in such cases shall be for each number or unit or weight. The price to be charged shall be calculated on the actual weight or numbers delivered. (12) In the event of the officer conducting the auction being of opinion that bidders are forming a ring and fair price are not being realised for the vehicle/stores offered in the auction, he may stop the auction.

(13) The officer conducting the auction will reserve the right of withdrawing from the auction any stores advertised or kept in the premises without assigning any reason.

(14) On the third fall of hammer (i.e. closing of the bid for the vehicle/stores) 25 (twenty-five) percent of the amount of the bid will have to be deposited in cash as earnest money. No cheque, Bank drafts or Hundi, will be accepted. The officer conducting the auction may, however, without assigning any reasons, demand as earnest money a

higher percentage up to the full amount of the bid.

(15) In the default of the payment of the earnest money, the bid shall forthwith be cancelled and the stores/vehicle offered to the next highest bidder or re-auctioned. The Government will reserve the right to take such action against the bidder who failed to deposit the earnest money as may be authorized by law.

(16) The attention of the intending bidder will be invited to Section 185 of IPC, according to which whoever shall bid for any vehicle/stores with no intention to perform the obligation under which he lays himself by such bid, shall be liable for prosecution.

(17) After the competent authority or Government, as the case may be, has approved the bid, the balance will have to be deposited within 7 (seven) days of the receipt of the registered notice.

(18) If a successful bidder fails to pay the balance of the amount within the time specified above, the auction in his favour will be cancelled and the earnest money deposited by him on the third fall of the hammer forfeited to Government and the vehicle/stores will be offered to the next highest bidder provided his bid plus 25 (twenty five) percent realised from the highest bidder as earnest money does not fall short of the bid offered by the highest bidder. If this condition is not satisfied the article should be re-auctioned as and when the competent authority thinks best without any notice to the bidder. Government reserves the right to take such action against the bidder who fails to pay the balance as may be authorised by law.

(19) Pending approval of the competent authority, the successful bidder may make suitable arrangement to keep a watch on the vehicle/stores etc., shown in his favour, which will have to be kept in the premises where the auction has been held at the risk and responsibility of the successful bidder.

(20) The delivery of the material auctioned will be made after full and final payment has been made by the bidder in whose favour the bid is auctioned and the permission for removal given by the competent authority.

(21) The material will be removed in the presence of competent authority or any other gazetted officer authorised by him.

(22) The vehicle/stores fully and finally paid for must be completely removed by buyer within 7 (seven) days from the date of final payment. Where this is not done, the competent authority may recover in addition to any loss that may be suffered a charge on account of storage space at one per cent per day on the sale price of the said vehicle / stores or lot or lots or portion thereof till the date of removal or re-sale.

(23) If the competent authority or Government as the case may be, does not approve of the accepted bid, the

amount deposited by the successful bidder will be returned to him and the auction in his favour considered as null and void.

(24) The successful bidders will have to pay the terminal tax on the vehicle/stores for which their offer/offers have been approved and accepted, to the Municipal authorities before taking delivery of vehicle/stores, if required, and any other tax that may be found due under law.

(25) In the case of auction of motor vehicles, the registration certificate if valid, will be given to the successful bidder. If the same could not be renewed by the department for some reasons, the bidder will have to get it renewed at his own cost and no claim on this account will be entertained in the case of auction of vehicles.

(26) In case of any dispute touching or arising out in respect of the terms and conditions hereinbefore contained or any action taken or proposed to be taken in pursuance thereof, the same shall be referred to the arbitration of a person nominated by Government/ Head of the department concerned whose decision thereon shall be final and binding on the parties.

(27) In case of any litigation, the jurisdiction for filing a suit will be the place where the auction is held.

(28) A sale account should be prepared in the Form-B available at Annexure-C to this chapter. The sale account should be signed by the officer(s) who supervised the auction after comparing the entries made in the sale account with the report of surplus stores. If the articles are released in the presence of an officer other than the officer(s) who supervised the auction, the entries in column 9 of the sale account should be attested by the dated signature of such officer.

(29) A copy of each order declaring stores as unserviceable, obsolete, or surplus should be endorsed by the competent authority to the Accountant General, Uttar Pradesh.

(30) Acceptance of the terms and conditions contained in these rules should be obtained in writing from all the bidders, before they are allowed to bid at the auction.

Disposal at Scrap Value or by Other Modes

If a department is unable to sell any surplus/obsolete/ unserviceable item in spite of its attempts through advertised tender or public auction, it may dispose of the same at its scrap value with the approval of the competent authority in consultation with its Finance Wing. In case the department is unable to sell the item even at its scrap value, it may adopt any other mode of disposal including destruction of the item in an eco-friendly manner with the approval of the competent authority.


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26 OFFICE PROCEDURE

File Keeping and Correspondence

Special meanings to be attached to some of the terms used in the procedures related to office are defined as under:—

(1) Appendix to Correspondence—In relation to a file 'Appendix to Correspondence' means lengthy enclosures to a communication (whether receipt or issue) on the file, inclusion of which in the correspondence portion is likely to obstruct smooth reading of the correspondence or make the correspondence portion unwieldy.

(2) Appendix to Notes—In relation to a file 'Appendix to Notes' means a lengthy summary or statement containing detailed information concerning certain aspects of the question discussed on the file, incorporation of which in the main note is likely to obscure the main point or make the main note unncessarily lengthy.

(3) Branch Officer—Branch Officer (i.e., Under Secretary/officer holding equivalent rank) is incharge of the Branch(es)/Section(s) and in respect thereto exercises control both in regard to despatch of business and maintenance of discipline. Work comes to him from the Branch(es)/Section(s) under his charge.

(4) Case— Case consists of the file containing the papers under consideration and any other files and papers, books, etc., put up for reference to enable the question or questions raised to be disposed of.

(5) Classified dak — Classified dak means dak bearing a security grading.

(6) Come-back case—Come-back case means a case received back for further action such as re-examination or preparing a draft or a summary of the case.

(7) Correspondence—Correspondence is the collection of all communications (receipts) received and office copies of out-going communications (issue) consisting of —

- Official Correspondence
- Demi-official Correspondence
- Un-official Correspondence

(8) Current File—Current file means a file containing a paper or papers on which action has not been finally completed.

(9) Dak—Dak includes every type of written communication such as letter, telegram, inter-departmental note, file, fax, e-mail, wireless message which is received whether by post or otherwise, in any Service/Branch/Section/Unit for its consideration.

(10) Dealing hand—Dealing hand means any functionary such as Junior Clerk, Senior Clerk, Executive Assistant, Senior Executive Assistant etc. entrusted with initial examination and noting upon cases.

(11) Demi-Official Correspondence—A Communication is demi-official when Government officers correspond with

each other or with any member of the public without the formality of the prescribed procedure and with a view to inter-change or communication of opinion or information before a formal decision is taken.

(12) Divisional Officer —Divisional Officer (i.e. Director/Additional Director/Deputy Secretary/officer holding equivalent rank) is responsible for the disposal of business dealt with the Branch(es)/Section(s) under his charge.

(13) Docketing —Docketing means making of entries in the notes portion of a file about the serial number assigned to each item of correspondence (whether receipt or issue) for its identification.

(14) Draft—Draft means a rough copy prepared of a document. The word 'Drafting' when used in the Secretariat means composing of official communications, based on officers' notes or orders.

(15) File—File means a collection of papers on a specific subject-matter, assigned a number (File No.) and consisting of one or more of —

- Correspondence
- Notes
- Appendix to Correspondence
- Appendix to Notes

(16) Filing—Filing can be defined as placing loose matter in some systematic order so that the papers wanted can be located readily.

(17) Fresh Receipt—F.R. means any subsequent receipt on a case which brings an additional information to aid the disposal of the paper under consideration.

(18) Issue—The term 'Issue' is used to signify the various stages of action after approval of a draft, namely, typing of fair copy the examination of the typed material, submission of a fair copy for signature and finally the despatch of the communication to the addressee.

(19) Messenger/Peon Book — Messenger/Peon Book means a record, maintained in form, of particulars of despatch of non-postal communications and their receipt by the addressees.

(20) Notes—Notes mean the remarks recorded on a case to facilitate its disposal. It includes a precise of previous papers, a statement or an analysis of questions requiring decision, suggestions regarding the course of action and final orders passed thereon.

(21) Official Correspondence—Means correspondence addressed by or to any Government official, public body or private individual in conformity with the prescribed form and procedure.

(22) Paper under Consideration—The Paper Under Consideration (P.U.C.) is normally a primary receipt, the consideration of which is the subject matter of the case.

(23) Receipts —All communications whether official, demi-official or un-official received in the Secretariat or by

any officer of the Secretariat in the official capacity are called receipts.

(24) Recording—Recording is the process of closing a file after action on all the issues considered thereon has been completed. It includes operations like completing references, removing routine papers, revising the file title, changing the file cover and stitching the file.

(25) Referencing—Referencing is the process of putting up and referring to connected records, precedents, rules, regulations, books or any other paper having bearing on the case.

(26) Inter-departmental Correspondence—A communication through which a paper or a file or a case is forwarded to any other Department(s) for obtaining their concurrence, opinion or remarks.

(27) Urgent dak—Urgent dak means dak marked 'Immediate' or 'Priority', and includes telegrams, wireless messages, telex messages, fax, etc.

Learning Points

The participants before undergoing detailed sessions related to office procedure get versed in the terminology related to it.

Maintenance of Office Records

Objective:

To understand the composition of file, file handling and working of the file related to office procedures.

Content:

1. **Constituents of a File Main File**

2.1 The two main parts of a file are :

(i) 'Notes'

(ii) 'Correspondence'

Each one of which is placed in a single cover in the left and right sides, respectively. The former contains notes recorded on a 'Paper Under Consideration' and on a 'Fresh Receipt', if any. The correspondence contains all communications received and office copies of out-going communications.

2.2 If the issues raised in a receipt or in notes or in the orders passed thereon go beyond the original subject, relevant extracts should be taken and dealt with separately on new files.

Part File

2.3 A part file may be opened when the main file is not likely to be available for sometime and it is necessary to process a fresh receipt or a note without waiting for its return, or when the main file has become rather bulky, in which case only the essential papers which are required for the disposal of a point should be submitted with a separate note sheet and not the whole file.

2.4 A part file will normally consist of:— (i) the original 'Paper Under Consideration' or its copy and other essential papers on the 'Correspondence' side; and (ii) the note or notes recorded or to be recorded on the 'Paper Under Consideration' or a copy thereof on the 'Notes' side.

2.5 Part file should be amalgamated with the main file as soon as possible. The duplicate papers, if any, should be removed.

2.6 When more than one part files are opened, each one of them should be given a distinct number, e.g. 5/2/2009/O&M (Part File 1), 5/2/2009/O&M (Part File II).

2.7 The dealing hand concerned should invariably maintain a list of part files opened by him.

Collection Cover

2.8 It contains routine notes of secondary information, casual correspondence exchanged for collecting further information from various sources, reminders, acknowledgements, and other K.W. (Keep with) papers, which are not appropriate to form part of the main file. Only the gist of the material collected in the collection cover is incorporated in the main file.

2.9 Many of the items assembled in the collection cover will be of only temporary value. At the time of recording of file, the papers which have lost their value should be destroyed under the direction of the Branch Officer.

2.10 Collection cover must not leave the Branch to which it belongs.

File Register

2.11 Each branch/section/unit will open a file register. General works and General Store Branches will be responsible for printing, stock, issue, etc., of the file registers. The register will be in the form enclosed at Appendix-I and neatly bound. It will be a permanent record and therefore, will contain adequate number of sheets according to the needs of each branch/section/unit.

2.12 As soon as a new file is opened, the number and subject allotted to it should be entered in the file Register. A record of files opened during a calendar year will be kept in the file register. Entries for the next year will be made either in a new file register or in the same register where pages will be allocated year-wise.

2.13 The entries in the file register will be made legibly, and erasures, omissions and overwriting will be avoided. All entries will be in blue ink only.

2.14 The file register will be placed in a central place in the branch/section/unit under the custody of a junior clerk etc. as decided by the branch/unit/section Head for reference but in no case shall it be roughly handled.

Opening and numbering of new files

2.15 There should be a separate file for each distinctive subject. If the subject of a file is too wide or too general, there will be a tendency to place in it papers dealing with different aspects of the matter which apart from making the file unwieldy will impede work.

2.16 The system of opening and numbering of new files broadly

accepted for general application in the Lok Sabha Secretariat is based on subject classification. The main subjects ordinarily dealt with in a branch/ section/unit are known as 'Standard Headings'. Some subjects yield to further sub-division i.e. 'Sub-Headings'. To enable the files to be easily traced at a moment's notice, an alphabetical list of contents, as shown in Appendix II, will be prepared at the beginning of the file register indicating the 'Standard Headings' and 'Sub-Headings' and the pages allotted to them.

2.17 The list will be scrutinised and brought up-to-date at the beginning of every calendar year. As far as possible the main subjects will be allotted the same standard file number year after year. A new heading may be added to the list with the approval of the Head of the branch/section/unit during the course of the year, if found necessary.

2.18 When it is necessary to open a new file, the dealing hand will first ascertain from the list the 'Standard Heading' under which it should be opened. He will then prepare a suitable title for the new file and allot it a number (next available in the serial order in the file register) under the 'Standard Heading'.

2.19 The title of the file should indicate the subject matter of the case in as few words as possible. The first words of the title should almost always be the main subject under which the file is being opened and the descriptive part of the title should then follow. Thus, for instance, the subject of a new file opened under the main subject 'Lok Sabha Secretariat (Recruitment and Conditions of Service) Rules' will be 'Lok Sabha Secretariat (Recruitment and Conditions of Service) Rules— Delegation of authority to impose punishment'. The title should be so framed that it would show at a glance the subject-matter dealt with and enable the file to be easily identified. The title of the file should be approved by the Head of the branch/section/unit, before it is actually opened.

2.20 A number given to the file will consist of:

(i) the number allotted to the 'Standard Heading',

(ii) The serial number given to the file under the 'Standard Heading',

(iii) the year in which opened, and

(iv) the initials or letters used for identifying the branch/section/unit. The file will bear the same number and subject as shown in the file register.

2.21 Thus the files opened in O&M Section during the year 2009 under the Standard Heading 'Assessment of staff requirements and job analysis by O&M Section' will be numbered as follows:— Standard Heading — 2 Main Subject — Assessment of staff requirements and job analysis of Branches by O&M Section 2/1/2009/O&M Staff requirements and job analysis of P.N.O. 2/2/2009/O&M Staff requirements and

job analysis of Reporters Branch 2/3/2009/O&M Staff requirements and job analysis of LARRDIS 5

2.22 Files may be opened under sub-heads, in case the subject yields to further sub-division. These files will be numbered as under:— Standard Heading — 2 Main Subject — Assessment of staff requirements and job analysis of Branches by O&M Section. Sub-Heading Staff requirements and job analysis of P.N.O. — 2/1/2009/O&M Sub-Division Consideration of Report on P.N.O. by Administration — 2/1(I)/2009/O&M Implementation of recommendations of O&M by P.N.O./Administration — 2/1(II)/2009/O&M

2.23 A policy file should bear the alphabet '(P)' after the 'Standard Heading' number under which the file is opened, in order to distinguish it from other files. Routine action taken or matters dealt with as a result of policy decision, should be on a separate file which should be closed at the end of each year.

2.24 Papers will be dealt with and filed in a file without regard to the year to which the references in that file pertain. No file should ordinarily contain more that 150 sheets of notes and correspondence. On reaching the maximum limit, a new file should be opened with the same number but marked Vol. II or Vol. III, as the case may be. The previous file should be closed and marked Vol. I. In all subsequent files on the same subject, the previous and later references should be quoted in the space provided for this purpose. If the file relates to the Sessional work, it should be closed after each Session irrespective of the fact whether it contains 150 sheets or less. Similarly, a file relating to a Committee will be closed on the expiry of the term of Committee whether it contains 150 sheets or less. 4.

Working a file

2.25 When an officer passes an order requiring a file or any matter to be disposed of by a particular date, the individual who is responsible for carrying out that order must comply with it before the date specified. If, however, owing to any circumstances beyond the control of the individual concerned, some delay is inevitable and he finds himself unable to finish the work by the date stated in the order, he should report accordingly and submit a request for the extension of time together with full reasons which will be considered by the officer who passed the original order.

Numbering of pages

2.26 Every page of notes and correspondence should be consequently numbered in separate series with pencil at the top right hand corner from bottom to top. Blank intervening pages, if any, should also be numbered. When there are annexures etc. to the P.U.C.,

these will bear the number allotted to the P.U.C. followed by alphabet e.g. 15-A, 15-B, 15-C etc. The idea is to distinguish the P.U.C. from an enclosure. Where, however, the enclosures to a communication received or issued consist of a large mass of material, they may be allotted consecutive page numbers, if convenient. Page numbering done in pencil should be inked at the time of recording of the file.

Serial Numbers

2.27 Every communication, whether receipt or issue, together with its enclosures kept in the 'Correspondence' will be given a serial number in red ink in the centre of its first page. The first communication will be market 'Serial No. 1' and subsequent ones will bear consecutive numbers in a single series. To distinguish 6 'Receipt' and 'Issue' communications, the entries should be marked 'Serial No. 1(R)' and 'Serial No. 2(1)' and so on.

2.28 The serial numbers are useful for the purpose of referring to any paper, as also for ensuring that the file is complete. The loss of a letter is at once detected by the fact that a serial number is missing. The series, therefore, must be carefully kept up.

Docketing

2.29 Docketing is the process of making entries in the 'Notes' portion of a file about each Serial Number (Receipt or Issue) in the 'Correspondence' for its identification. A receipt will be docketed by writing in red ink, across the page, the Serial Number of the communication followed by its number and date and the designation/ name of sender [e.g. Serial No. 4 (Receipt) – No. 2/1/2009-O&M, dated 28 January, 2009 from the Secretary, Bihar Legislative Assembly]. An 'Issue' will be docketed by entering the Serial No. given to it, followed by the date of its issue and the name and designation of the addressee [e.g. Serial No. 5 (Issue) dated the 31st January, 2009 to the Secretary, Bihar Legislative Assembly].

Docketing of Part Files

2.30 Docketing in the Part Files should be done in pencil in the following manner:–

Serial Number.....

(Receipt) Serial Number.....

(Issue) The pencil entries should be erased when amalgamating the papers with the Main File, and the revised entries made in red ink.

Referencing and use of slips

2.31 Referencing is the process of putting up and referring to connected records, precedents, rules, regulations, books or any other paper having a bearing on a case. Reference to such paper will be made as far as possible by quoting the file number and the number of page, in the margin. When absolutely necessary flags may be used to facilitate the identification of a particular

reference. While using slips it should be remembered that the slips are merely a temporary convenience for the quick identification of papers and should be removed as soon as they have served their purpose. To facilitate the identification of references after the removal of slips, it is necessary that the number of the file and the relevant page number referred to should be quoted in the body of the note e.g.:– [F.No. 3/1/AN/2009P-3 Notes]

2.32 Similarly a description of the Rules, Regulations, Act, etc., together with the number of the relevant paragraph or clause referred to, will always be quoted in the body of the note while the alphabetical letters of the slip and the page number will be indicated in the margin.

2.33 Books or Rules etc., referred to need not be put up on a file if copies thereof are available with the officer to whom a case is submitted. This should, however, be indicated in the margin of the notes in pencil. Where it is found necessary to put up books to officers, clean and bound volumes should be put up.

2.34 Whenever any reference is taken from any book, the latest edition of the original book of reference (available in the Parliament Library) should be consulted. Second hand quotations should not be relied upon, but should invariably be checked with the original. Cross-referencing of correspondence

2.35 In order to know at a glance the latest position in regard to any P.U.C. without going through the whole correspondence, the previous and later references on that P.U.C. will be cross-referenced by marking previous reference and later reference in margin with pencil.

Linking of files

2.36 When two or more current files on which action is necessary are linked, the printed slip bearing 'please see also the linked file' should be pinned to the cover of the topmost file. The number of the linked file should be given on the slip. Linking of files should be avoided as far as possible. Ordinarily, files should be consolidated, whenever practicable, into one file by an intelligent selection and arrangement of papers. Where it is necessary to refer to another file, an extract of the relevant noting, etc. on the file should be made provided it is of reasonable length, and placed on the file for which it is required. Only in those cases where many pages have to be referred to, files should be linked. Heads of Branches should take special care to see that files are linked together only when absolutely necessary are unlinked at the earliest opportunity. If linked files are not received back in the branch within a few days of submission and they are required for the disposal of another reference, the pemission of the officer, with whom they are, should be obtained to unlink them.

Pinning together of papers

2.37 When the papers in a file are pinned together it should be so done as not to allow the sharp point of the pin to protrude and prick the fingers of any person who handles the file. In order to prevent injuries from pins, the sharp point of the pin should be embedded under the surface of the paper at the top.

Punching of papers

2.38 Every paper shall be punched at the left hand top corner to the correct gauge (3/4 of an inch from either side) before it is tagged to the correspondence or notes.

Flagging of papers in a file

2.39 A flag bearing the words 'Paper Under Consideration (P.U.C.) should be attached to the receipt which is being considered. If a receipt has been disposed of and a later receipt is being dealt with on the same file, the P.U.C. slip should be removed from the old receipt and affixed to the new one. If more than one receipt are under consideration at the same time, the P.U.C. slip should be attached to each 'receipt' and numbered I, II, III and so on. The receipt should be numbered serially.

2.40 The previous papers put on the file and the recorded proceedings should be flagged with flags bearing different letters. No two flags should be alike in the same file. The flags should be doubled over and pinned neatly to the inside of the cover page. They should not overlap each other when the papers are arranged in the file, but should be distributed along the whole width, so that they may be easily seen.

Quick movement of files

2.41 Files disposed of by the Branches during the day must reach the respective Branch Officers the same day preferably at regular intervals.

2.42 If a file cannot reach the officer concerned on the same day, it must reach him the following morning by 10.00 O'clock.

Movement of files

2.43 Indication Slip showing atop the nomenclature of Branch/Section from which the file has been initiated (Appendix III) and beneath it the name of Branch/Section or abbreviated designation of an officer to whom the file is being forwarded for necessary action/approval, will be clipped on the File Cover. Indication slips of different colours may be used for identifying urgent and important items of work. For example, in Question Branch Indication Slips printed in Pink colour and Blue colour are clipped on the file covers while putting up notices of Short Notice Question and Half-an-Hour discussion respectively. The dealing hand will keep a note of the movement of file in his diary.

2.44 Files passed by higher Officer will be sent direct by Personal Assistant/Private Secretary to the Officer to whom marked after keeping a note of the movement, in his diary.

Priority marking on files

2.45 The two prescribed priority markings to be used on files and papers are 'ACTION THIS DAY' and 'IMMEDIATE'.

2.46 The label 'ACTION THIS DAY' should be used only in cases of extraordinary urgency requiring disposal on a top priority basis like Questions, Notices of Calling Attention, Adjournment Motions, List of Business of the House or a Committee thereof, etc. In all such cases, timings of receipt and disposal should be indicated in the margin of the last note on the file.

2.47 The label 'IMMEDIATE' should be used in cases which are assigned a priority lower than the cases referred to in the preceding para but which still require action on the same day.

2.48 The Officers through whom a file passes should examine whether the priority marking, if any, is appropriate, and if not, should remove or change the marking.

2.49 In no case should a file be sent to the residence of an Officer unless so directed by the Officer concerned or under the specific directions of the Branch Officer.

2.50 Priority slips should be affixed on the top flap of a file band or file board or if there be no flap, on the file cover itself.

Use of only neat and clean file covers and files boards

2.51 Only neat and clean file covers and file boards will be used for submitting files. The Heads of Branches will ensure that instructions in this regard are observed strictly by the staff working under them and no torn or dirty file cover or file board is used.

Learning Points

The participants before undergoing detailed sessions related to office procedure to understand how to prepare compose and start a file and file related procedures.

27 FINANCIAL MANAGEMENT

The main aim of Financial Management is to operationalize an effective and accountable financial management system for budgeting, release, monitoring and utilization of funds under NHM at the central/state/district/block and facility level.

- **Planning and Budgeting:** Planning is required for formulating achievable targets for various activities for programme implementation and to accordingly allocate appropriate funds to states under various programs. Allocation of funds is facilitated through preparation detailed budgets. Under NHM, the planning and budgeting process is carried out by preparing State Project Implementation Plans (SPIPs) and District Health Allocation Plans (DHAPs).
- **Allocation and Release of Funds:** The funds need to be allocated to states as per the budget approved for the programme/ activities. These have to be disbursed in tranches on a timely basis subject to certain conditions to be fulfilled by states/ lower units.
- **Accounting:** Availability of funds implies accountability. Proper books of accounts and records need to be maintained at all levels (accounting centers) in accordance with the accounting policies and principles.
- **Reporting:** Financial Statements need to be prepared and submitted in specified formats and within the fixed timelines to report the utilization of the funds disbursed.
- **Monitoring:** The utilization levels of the states need to be monitored and evaluated on established parameters. Timely monitoring is essential for process improvement and follow up on audit observations.
- **Auditing:** To ensure correctness of financial statements & accounting records and appropriateness of internal control mechanism, audit is of foremost importance. Under NHM, in addition to the annual Statutory Audit, Concurrent Audit also needs to be implemented.

1- Internal Control

NHM is a large & complex programme with multiple implementing units and decentralized framework. An effective internal control environment is essential to ensure proper fund utilization and financial reporting under the programme at various levels. "Internal Controls" refer to the methods and procedures adopted by an entity to assist in efficient conduct of its business/ operations. The internal controls which ensure validity & accuracy of the accounting records and financial statements and help to prevent fraud and errors are also referred to as "Accounting Controls".

Relevant internal control measures under key accounting/ financial

processes have been discussed in the following sections.

2- **Maintenance and Custody of Cash Book: -**

"Double Column Cash Book" should be maintained for SHS, DHS and Block, while at Sub Center and VHSNC, a "Columnar petty cash book" should be maintained as per the formats prescribed. Key internal controls relevant to maintenance of Cash book are given below:

- Cash book should be updated on a daily basis in case of SHS, DHS, Block, CHC/PHC and RKS and at least on a weekly basis in case of Sub-Centre/ VHSNC.
- At SHS/ DHS, it should be put up for checking & authentication to one of the PFMS Advice signing officer as decided by the chairperson of the Executive Committee of a State/District Health Society.
- Cash book should be closed daily and if no transactions have taken place in a day/s, the entry "No Transaction" has to be noted in the cash book on that day/s in red ink and balances are to be carried over to next day.
- Access to petty cash book should be restricted to one person only. Cash book should be authenticated by the drawing/ disbursing officer or any responsible officer authorized for the purpose.
- All payments which are received in the SHS or in a DHS and at Block CHC/PHC, either in cash or through PFMS Advices/bank drafts/money orders/ bankers PFMS Advice etc. should be first entered in the prescribed register and then entries in the cash book should be made, on the same day. Likewise all payments/ disbursements should be entered in the cash book on the day of the payment itself.
- Each entry of receipt and expenditure should be descriptive but brief in nature. Each voucher should be assigned a serial number and Ledger Folio number, which should be noted against each entry in the cash book.
- Over writing should be avoided and corrections, if any, should be attested by the authorized officer under his dated initials.
- While making payments through PFMS Advice, its number should invariably be noted in the cash book for cross checking. Voucher serial number should also be entered in the cash book alongside the expenditure.
- All pages in the cash book should be pre-numbered in order to avoid tampering.

3- **Bank Transactions**

Bank Payment

- The Society funds should be drawn through PFMS Advices and/ or bank drafts. All payments to the extent possible should be made by PFMS Advices/ e-transfer.

- Entry in the books of accounts should be made immediately upon transfer of funds/ issue of PFMS Advice.
- Any payment above prescribed limits for Block, CHC/PHC and RKS, sub center & VHSNC should necessarily be made through PFMS Advices only.
- The limits for approval of expenses/ payments should be as per the delegation of power at respective implementing units.
- The supporting documents (such as bills, vouchers, etc.) should be stamped as 'PAID & CANCELLED' to avoid duplicate payment against the same document. The reference of PFMS Advice vide which payment is done should be recorded on the invoice.

Preparation of PFMS Advice/ Cheque

- All the PFMS Advices shall be entered in the PFMS Advice issue register before they are submitted for signatures, indicating its number, amount, name of the person or party, purpose and date of issue, etc.
- All PFMS Advices should be signed by the two authorized signatories.
- Signatories should ensure following aspects before signing the PFMS Advices:
  - The amount of PFMS Advice is within their delegated power
  - Proper voucher has been prepared & authorized by the concerned accountant
  - Funds in the concerned bank are sufficient to honor the PFMS Advice.
- PFMS Advice books (new/ used/ currently under use) and their counter foils should be kept in the personal custody of one of the officers who is authorized signatory on the PFMS Advices.
- As far as possible, the person responsible for preparing PFMS Advices should not be a PFMS Advice signatory himself.
- The practice of signing of blank PFMS Advices in advance by any signatory should be strictly prohibited.
- Dividing of one payment into smaller denominations so as to avoid delegation limit should not be allowed.
- Details of Cheque in hand at the end of each month should also be maintained.

Cheque /PFMS Advice Register

- Cheque /PFMS Advice register should be maintained properly and updated immediately on issue of every PFMS Advice.
- RTGS/ ECS instructions should be appropriately authorized, recorded, filed and may be noted in it.

Maintenance and custody of bank book/ bank statement

- A "Double Column Bank Book" should be maintained for SHS, DHS and Block as per suggested format and for Sub-Centre & VHSNC, a bank register should be maintained to record receipt and payment of funds through Cheque /PFMS Advice.

- Over writing in bank book should be avoided and corrections, if any, should be attested by the authorized officer under his dated initials.
- All vouchers/ bills/ invoices to be scrolled (serial numbered) and entered in bank book with appropriate referencing.
- All Cash/ Cheque /Demand Drafts/Sweep etc. received should be deposited into bank as far as possible on the same day itself, otherwise on the next working day.
- Bank account should be posted from the daily totals of PFMS Advices issued and challans/ remittances (deposited) made into the Bank.
- Bank pass book/ bank statement should be updated regularly (at least once a month).
- Interest income should be clearly identified and reported in the SoE/ UC on timely basis.

4- Bank Accounts

- As far as possible, bank account should be opened and operated under joint signature.
- Generally, bank account should be maintained in any of the scheduled bank/ Grameen bank, however, account can also be maintained in post office in areas where bank availability is a problem.
- Idle bank accounts should be closed urgently after appropriate approval.
- Personal bank accounts should not be allowed for making any official transactions.
- Funds related to non-NHM programme should be avoided to be deposited into the bank account maintained for NHM funds.

5- Bank Reconciliation Statement

- Bank Reconciliation Statement (BRS) should be prepared on monthly basis by reconciling the bank book and Bank Pass Book/ Bank Statement by 10th day of the following month.
- Separate BRS should be prepared for each bank account. A copy of BRS should be sent to the supervisory units.
- Bank Pass Book will be sent to the bank on monthly basis for making up-to-date entries of credits and debits.
- Reconciliation items should be grouped under the following heads;
  - Cheque /Demand Drafts etc. deposited but not credited
  - Cheque /PFMS Advice issued but not presented
  - Excess/ short amount debited/ credited by bank
  - Bank interest not accounted for
  - Bank charges not accounted for
  - Bounced Cheque /PFMS Advices, etc.
- BRS should be reviewed and signed by the supervisor. Proper explanation by the person in-charge should be recorded in case of any unreconciled/ old entries.
- Sequence of Cheque/PFMS Advices numbers & Cheque/PFMS Advices

details should be compared with the details recorded in the bank book.

- Attention should be given to long standing unpresented PFMS Advices, stop payment notices. Any stale PFMS Advices appearing the BRS should be reversed.

6- Expenditure Controls

Voucher/Supporting Documents

- Voucher should be prepared for each financial transaction.
- Each voucher should be properly filled, serially numbered and signed by the authorized person. It should be supported with a supporting duly authorized from the appropriate authority.
- Before authenticating a PFMS Advice for any payment/ disbursement, the PFMS Advice drawing officer should ensure that there is a proper and formal statement of claim (Bill) or invoice through which payments have been demanded by the concerned person or party or firm.
- The purchases made or services received are according to the approved plan and the claimant is entitled to get it. A competent sanction to incur expenditure should be attached with the claim.
- The particulars of the claim i.e. rates, calculations, net payable amount etc. should be examined/checked by the Accountant or by an authorized accounts person

Post Payment Controls

- Paid invoice and supporting documents must be defaced with the seal of "Paid & Cancelled". In case of advance adjustments, it should be marked "Passed for Adjustments".
- The reference of PFMS Advice vide which the payment made is to be recorded on invoice.
- All the paid vouchers must be serially numbered and maintained box file.

Sanctions / approvals

- Necessary approval from competent authority should be taken before hand for expenditure made.
- Expenditure made should be within approved budget limits.
- All approvals/expenditure made should be under the jurisdiction of the sanctioning authority in line with delegation of power as prescribed by the State.

7- Purchase/Procurement Transactions

Requisition & Purchase Order

- All procurements should be made as per the approved guidelines for procurement issued by the State Government.
- The purchases made or services received should be according to the approved plan
- Before making any purchase, existing stock position must be assessed.
- All purchase requisitions should be reviewed by a senior official to ensure

reasonableness and appropriate delivery address.

- All purchase orders should be prepared on the basis of approved purchase requisitions.
- Purchase orders should have all the relevant information pertaining to purchase and the information should be classified in an orderly manner.

Receipt of item and Recording

- Goods receiving officers should certify the quality and quantity of the goods received on the receiving document (invoice/ challan) are as per the specifications mentioned in the purchase order.
- Any discrepancy in the quality specifications as per the order document should be duly authorized by the concerned person.
- It should be ensured that evidence to deliver goods and services at the agreed time and place of delivery has been obtained.
- Entry should be made in appropriate stock/ store register and certification on this account should be made on the bill/ invoice by an authorized officer.

Approval/ Authorization

- Payments should be made in accordance with the terms and conditions of the Purchase Order/ contract.
- Evidence of delivery of goods/ services at the agreed time and place should be obtained before making payment.
- All procurements of goods/ articles should be made as per the State Government Procurement Rules which includes the limit for invitation of tenders, limit for quotations, formation of procurement committee, etc.
- Procurement against verbal order, if any, should be regularized through preparation of written purchase order and it should be approved by competent authority.

8- Inventory/Stock

- Proper written policies and procedures to control and monitor inventories should be in place
- Store should be managed by an authorized store keeper and store records should be kept under his custody only
- Appropriate stock records should be maintained for receipt and issue of material
- Stock record should be maintained as per the prescribed format to reflect stock-wise quantities and locations by individual items
- All stock movements should be supported by formal pre-numbered documentation and be appropriately authorized
- Stock records should be updated immediately on issue/ receipt of any item
- Bin Card system should be adopted at least in respect of stores at District & above

- Items / material should be arranged/ stacked properly in the store to facilitate follow of FIFO (First In, First Out) method of issue of store items
- Access to the store should be limited to authorized personnel only
- Periodical stock verification should be conducted by the store keeper along with an independent officer appointed by head of office, any discrepancies should be appropriately recorded and reported to the higher authorities.
- Obsolete, damaged, and slow-moving items should be identified on periodical basis (monthly/ quarterly basis) and reported to higher authorities

9- FIXED ASSETS

General

- The prescribed procurement guidelines (to be specified by each state) for purchase of assets should be followed.
- Appropriate budgetary approval should be available for purchase of fixed assets.
- No depreciation should be charged on the fixed assets.

Fixed Asset Register

- Each State/ District Society shall maintain Stock Registers for the articles or item of permanent or of non-consumable nature indicating the details of such assets e.g. furniture, fixtures, equipment's, machinery, instruments, vehicles, computer systems etc. purchased during the programme period. Such register is also called as Register of permanent (nature) articles or Dead Stock register.
- Fixed asset register should include the description of the asset, classification of the head for e.g. Furniture and Fixtures, equipment, etc., location of the asset, quantity/ numbers, original cost, date of purchase, details of assets sold/ discarded, distinctive number of the assets etc.
- Annual physical verification shall be carried out in the month of March every year.
- Only those articles will be treated as assets of the society which are procured, used and installed in the Office of the Society and will form part of the core asset of the society. Formal tracking as per the requirements of the Asset Register for the entire life of the asset will be done by the society.
- All other assets which are purchased by the society and subsequently handed over to the Office of Health & Family Welfare/Family Welfare Stores/CMOs/PHCs/CHCs, etc. will be shown as transferred to such entities in the Asset Register and no further tracking about the life of the asset will be required. However, a certificate from the receiving entity will be required to be kept in the asset register with contra-entry in the 'Location/Under custody' column of the Asset Register.
- All assets received in kind from the supervisory units should be included in the register, entry should be made in

register for each individual item of fixed asset purchased/ sold/ discarded.

- Permanent Identification Numbers should be mentioned on each item of fixed assets to permit easy identification. The same should also be reflected in the FAR.
- All fixed asset movements between units should be appropriately approved and recorded in the FAR along with the new location of the fixed asset.

Physical Verification of Fixed Assets

- Annual physical verification of fixed assets should be conducted.
- Verification should involve comparing the physical balance with book balance, identification of assets to be scrapped/ written-off & missing assets.
- Any major discrepancies in physical verification should be appropriately recorded in the fixed asset register and reported to the higher authorities.

Disposal of Fixed Assets

- Specific procedures and policies prescribed for transfers and disposals of fixed assets should be followed strictly.
- Disposal of fixed assets should be made by the appropriate committee competent to do so.
- If any asset is disposed off/ discarded/ demolished or destroyed, the net surplus/ deficiency (if material) should be disclosed separately.
- The assets given to hospitals, NGOs etc. are booked as expenditure in the State Register. Any consequent sale of such assets should be recorded by the disposing units in memorandum accounts.

10- Control Over Advances

Monitoring, Control and Settlement of Advances

- Advance should be given only for activities which are admissible under the programme.
- All advances should be duly approved by the competent authority and should be settled within a maximum period of 90 days.
- Before sanctioning further advance, it must be ensured that all earlier advances to the same person/ party and for the same purpose have been settled/ adjusted. No advances should be made to a person/party if an advance is already pending for settlement for the same purpose, unless appropriately approved and reasons documented.
- Cases where huge un-adjusted advances have been lying for long should be brought to the notice of higher authorities (BCMO, DAM, CMHO etc.).
- Independent monitoring should also be carried out by the supervisory units in respect of the advances lying at the lower units based on the periodical MIS obtained.

Advance Register

- For the purpose of facilitating proper tracking of advances and their settlement, an Advance Tracking Register should be maintained, at all the

levels from where the advances are given.

- All advances sanctioned to an officer of SHS or to the District Programme Management Unit or to the In-charge Medical Officer of a CHC or PHC or to any other official of the above institutions and also to any non-government organization, shall be entered in the Advance Register immediately after the advance amount/ PFMS Advice is given to the advancee.

11- OTHER ADMINISTRATIVE CONTROLS

Document Custody

- All important documents, rules and regulations should be placed in a dedicated area under custody of an authorized official at the unit.
- Suitable responsibility should be assigned for keeping the rules and regulations file up to date.

IT Backup

- All critical data files should be periodically backed up and stored in a secure off site location.
- A tested backup and recovery procedure to protect daily work files should be put in place.
- There should be appropriate security on the access of all the sensitive/ important data and information.

Password Controls

- There should be a comprehensive internal policy on password protection.
- All the sensitive information should be protected by appropriate passwords.
- Passwords should be frequently changed to avoid unauthorized access.

Attendance/ Leave Records

- The attendance and leave records should be duly maintained at all units as per policy and updated regularly.
- Leave applications should be scrolled (serial numbered) & properly filed, these should be verified by supervisor/ head of office periodically including leave records, etc.
- There should be a system of recording attendance and making payment of salary/ honorarium, in accordance to such records.

Financial Reporting & Monitoring

NHM is a complex programme with multiple sub-programmes under its umbrella and multi layered supervisory/ implementing units. Due to decentralization, large quantum of funds flow to sub-district level units and amount of expenditure undertaken at these levels is fairly substantial. This requires appropriate measures and systems to ensure proper reporting and monitoring at various levels.

1- FINANCIAL REPORTING

All the units need to report their performance periodically on various financial parameters, to their supervisory units. Key financial reports prepared under NHM include:

- Financial Monitoring Report (FMR)
- Utilization Certificate (UC) (Provisional & Final Audited)
- Statement of Expenditure (SoE)
- Statement of Fund Position (SFP)
- Statement of Interest Earned (to be shown in SFP also)
- Statement of Advances

Besides these, there are few reports which are specific to reporting units (as explained in the subsequent sections).

Financial Monitoring Report (FMR):

It is prepared on the basis of books of accounts being maintained. Only actual expenditures made should be reported (advances should not be reported as expenditure). It should be ensured that expenses are properly classified. Physical progress against targets determined under key schemes should also be mentioned. It provides information both for the specific period ('Monthly/ Quarterly') and cumulative 'Year to date'. It has to be signed by Head of the unit & counter signed by Finance Head of the unit. The format for the report at District and State level is same.

Utilization Certificate (UC) (Provisional & Final Audited)

UC is a form to be submitted by spending unit certifying the amount actually spent against the grant disbursed to it. It provides sanction-wise details of grant received, purpose of the grant, amount spent and unspent balance.

In respect of the grants-in-aid received from the Government of India, the State Health Society (SHS) should furnish "Utilization Certificate" (UC) in Form No. GFR 19A duly signed by the Mission Director/Project Director/State Programme Officer of various NDCPs to Ministry of Health & Family Welfare, GoI along with the audited annual financial statements. UCs should be submitted sanction wise. UCs pertaining to various programmes should not be clubbed in any case and should be furnished separately.

All grants-in-aids sanctioned and released by the Government of India to SHS in a particular financial year shall be indicated by the Society in its Utilization Certificate of that financial year, irrespective of the fact that the amount is received by the Society in the subsequent financial year. ***While sending Utilization Certificates (UCs), the expenditure shown in UCs should include the expenditure as per Income & Expenditure Account plus the amount of Capitalized Assets.***

It should be signed by head of the unit and counter signed by the Chartered Accountant (in case of audited UCs). Total amount shown as utilized under a given programme in the UCs during a given financial year programmes should match with the total amount shown as spent as per the audit report for that programme for the same financial year.

UCs not signed/ certified by the Auditor would be treated as Provisional

UCs and it should be superscripted as "PROVISIONAL". It should be as per the expenditure certified in the Audit Report. Provisional UCs should invariable be signed by Mission Director of the State. It is to be submitted by all the units including SHS, DHS, Block, CHC/ PHC, SC & VHSNC.

Statement of Fund Position (SFP)

SFP provides details of the opening and closing balances of cash and bank along with funds received & expenditure incurred for the particular period under various pools.

It should be prepared on the basis of books of accounts like Cash Book, Bank Book, Advance Register etc. It should be submitted monthly along with the MIS report.

SFP should be reconciled with the FMR. It has to be signed by Head of the unit & counter signed by Finance Head of the unit.

When seeking the SFP from the lower level reporting units the state FMG may also ensure that the SFP is accompanied by BRS. However, only the SFP need be sent by State FMG to the Ministry. Bank interest and state's share should be reflected in the SFP. Both SHS and DHS need to prepare the Statement of Fund Position.

Statement of Expenditure (SoE)

SoE provides expenditure incurred against the funds received under various components of the programme. This form of financial report is used to report expenditure mainly at sub-district level (Blocks, RKS, CHC/PHC, SC & VHSNC). It should be prepared based on books of accounts.

SOE has to be signed by Medical officer or drawing/ disbursing officer in charge at the facility and Finance/ Accounts incharge. Advances should not be reported as expenditure in the SoE, only actual amount spent should be included. In case, in a particular month there is no expense at the CHC/ PHC, a nil SoE report is still required to be submitted. In case funds are also received under NDCPs at the unit, the unit is supposed to submit a consolidated SoE (including information on NDCPs).

The format of this report is same for all units however the activities might differ.

Statement of Interest

Statement of Interest earned provides the details in respect of the amount of bank interest earned by a unit under its various bank accounts. It should include the interest earned on all the bank account of all DHS/ SHS. The interest earned at State & District level should be shown separately.

The interest earned on different bank accounts (for various programmes) should also be shown separately. It should be reconciled with bank statements and should be signed by Head of the unit & counter signed by Finance Head of the unit.

SHS, DHS and Blocks need to prepare this report.

Audit

'Audit' is an independent examination of the financial information of the entity. The process of audit includes vouching, ticking, ledger scrutiny, balance confirmations, verification of financial statements, etc.

The key objectives of audit are:

- To assess and provide an opinion on whether the Financial Statements present a "True and Fair" view of
  - the financial position (Balance Sheet) at the end of the period; and
  - the financial performance (Income and Expenditure account) during the period
- To test whether requisite internal controls are in place, commensurate to the size and volume of operations of the entity

This chapter discusses the types of audits under NHM and relevant provisions in respect of appointment of auditors, scope of audit, its frequency, coverage, audit report and relevant compliance requirements.

1- Types Of Audits Under Nhm

Primarily two types of audits are conducted under NHM:

- Statutory audit ; and
- Concurrent audit

Besides these audits, CAG Audit is also conducted at various levels in respect of Health Department.

2- Statutory Audit

The primary objective of 'Statutory Audit' is "to ensure that the financial statements i.e. the Balance Sheet, Income & Expenditure Account and Receipt & Payment Account, give a true & fair view and are free from any material misstatements". In context of NHM, Statutory Audit also aims at ensuring that the respective program expenditures are eligible for financing under the relevant grant/ credit agreements (under programs supported by development partners) and that the funds have been utilized for the purpose for which they were provided.

Statutory audit of State and District Health Societies is supposed to be carried out by Chartered Accountant firms appointed by the SHS. Detailed Request for Proposal (RFP) has been issued by GoI which provides details on the following aspects:

- Objective, Scope of Work and Coverage of Audit
- Format of the Audit Report including formats of financial statements and contents of the report
- Reporting Timelines
- Selection & Appointment process of Auditor

3- Concurrent Audit

Concurrent audit is a systematic examination of financial transactions on a regular basis to ensure accuracy, authenticity, compliance with procedures and guidelines. The emphasis under concurrent audit is not on test checking but on substantial

checking of transactions. It is an ongoing appraisal of the financial health of an entity to determine whether the financial management arrangements (including internal control mechanisms) are effectively working and identify areas of improvement to enhance efficiency.

Independent Chartered Accountant firms are needed to be appointed at State & District Level to undertake periodical audits and report on vital parameters which would depict the true picture of financial and accounting health of the program.

4- **CAG Audit**

In addition to the above audits under NHM, the C&AG of India also, through State AGs may carry out a supplementary audit. The accounts of each State Health Society along with its District Societies shall also be subject to audit by the Comptroller and Auditor General of India as per the "CAG (Duties, Powers & Service Conditions Act 1971)". The Act also provide for a special audit/ performance audit of SHS/DHS societies by the team of auditors of the CAG which can be undertaken as and when found necessary.

CAG Audit is primarily an efficiency-cum-propriety audit which is carried out to check the proprietary of the transactions and ensure value of money. **This audit will be at the discretion of the C&AG and its AG Offices and will not be a pre-requisite for submitting the Utilisation Certificates to the MoHFW, GOI.**

Accounting

Accounting is the art of recording, classifying and summarizing in terms of money transactions and events of financial character. Accounting includes proper recording of transactions through vouchers in different books of accounts including cash books, journals, ledger etc. The data is processed and the books are closed by preparing summary statements like trial balance, income and expenditure, receipt & payment, balance sheet and other reports.

Under NHM, various Accounting Policies and Guidelines have been framed which need to be followed at different levels including SHS, DHS and sub district level units.

Computerization of book keeping

It is desirable that maintenance of accounts at the State/UT Health Societies as well as at District Health Societies is computerized so that the account statements can be prepared accurately and promptly with least efforts and time. Accounts at State & district level should be maintained FAMS.

Even if the accounts are maintained in computerized form, at least a manual Cash Book should be maintained as well on daily basis duly signed by any authorised person.

Recognition of Expenditure

- **Releases to Public Health Institutions:**

The releases made to the DHS/Sub-District Hospitals/CHC/PHC/Medical Officers etc. shall not be treated as expenditure unless they are reported as expenditure (either SoE/ UC, whichever is applicable) by these institutions/bodies.

- **Advance to NGOs, Corporations etc.:**
  The release made to the Central or State Corporations, NGOs etc. will be treated as advance till the time they are reported back as expenditure by these organizations duly backed by supporting documents and invariably audited UCs. If the releases are on output based parameters which has already been delivered by the organization, then they can be treated as expenditure provided it is supported by the necessary documents and certifications by competent authority certifying the completion of the outputs.

- **Advances for Civil Works:**
  The funds released against the works are considered as `Deposit' under Capital Work in progress. Funds deposited with Public Works Department (PWD)/Contractor is treated as advance at the time of release. On receipt of a certificate of stage of completion and running bill from PWD or Contractor, it is booked as expense to the extent it is certified by the PWD as per the terms of the agreement. To summarize; the deposit or advance will be cleared (i.e. booked as expenditure) on the basis of progressive report of work completion to the extent certified by the PWD. In case the implementing agency is other than PWD clearance can be given through audited UCs at appropriate senior level.

- **Commodity Grants:**
  Commodity grants received from the Govt. of India relating to the programmes under NHM are not reflected in the financial statements of the Society. However, they should be appearing in the Notes on Accounts and Disclosure of the Audit Report.

- **Releases to VHSNCs:**
  The Fund releases to Village Health, Sanitation and Nutrition Committees (VHSNCs) as untied funds shall not be deemed to be as expenditure on their release. Expenditure shall not be booked unless actual expenditure is reported back through SoE/ UC (as applicable) along with necessary supporting documents by each VHSNC to the block concerned.

28 DIGITAL HEALTH

Digital Health Mission

National Digital Health Mission is incepted to create a national digital health ecosystem that supports universal health coverage in an efficient, accessible, inclusive, affordable, timely and safe manner, that provides a wide-range of data, information and infrastructure services, duly leveraging open, interoperable, standards based digital systems, and ensures the security, confidentiality and privacy of health-related personal information.

Objectives of National Digital Health Mission

To strengthen the accessibility and equity of health services, including continuum of care with citizen as the owner of data, in a holistic healthcare programme approach leveraging IT & associated technologies and support the existing health systems in a 'citizen-centric' approach, the NDHM envisages the following specific objectives:

1. To establish state-of-the-art digital health systems, to manage the core digital health data, and the infrastructure required for its seamless exchange;

2. To establish registries at appropriate level to create single source of truth in respect of clinical establishments, healthcare professionals, health workers, drugs and pharmacies;

3. To enforce adoption of open standards by all national digital health stakeholders;

4. To create a system of personal health records, based on international standards, easily accessible to individuals and healthcare professionals and services providers, based on individual's informed consent;

5. To promote development of enterprise-class health application systems with a special focus on achieving the Sustainable Development Goals for health;

6. To adopt the best principles of cooperative federalism while working with the States and Union Territories for the realization of the vision;

7. To ensure that the healthcare institutions and professionals in the private sector participate actively with public health authorities in the building of the NDHM, through a combination of prescription and promotion;

8. To ensure national portability in the provision of health services;

9. To promote the use of clinical decision support (CDS) systems by health professionals and practitioners;

10. To promote a better management of the health sector leveraging health data analytics and medical research;

11. To provide for enhancing the efficiency and effectiveness of governance at all levels;

12. To support effective steps being taken for ensuring quality of healthcare; and

13. To strengthen existing health information systems, by ensuring their conformity with the defined standards and integration with the proposed NDHM.

Opportunity for the National Digital Health Mission

1. The current strong public digital infrastructure—including that related to Aadhaar, Unified Payments Interface and wide reach of the Internet and mobile phones (JAM trinity) — provides a strong platform for establishing the building blocks of NDHM. The existing ability to digitally identify people, doctors, and health facilities, facilitate electronic signatures, ensure nonrepudiable contracts, make paperless payments, securely store digital records, and contact people provide opportunities to streamline healthcare information through digital management. '

1. Ayushman Bharat—Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) has successfully used the available public digital infrastructure to provide end-to-end services through an information technology (IT) platform from identification of beneficiaries to their admission and treatment in hospitals to their discharge and paperless payment to hospitals. The experience of AB-PMJAY can be leveraged to expand the reach of digital health to all residents and develop an open and interoperable health management system that empowers residents, healthcare providers, the Government and researchers.

1. Emerging technologies such as artificial intelligence, the internet of things (IoT), Blockchain and cloud computing provide additional opportunities for facilitating a more holistic digital health ecosystem, that can increase the equitable access to health services, improve health outcomes and reduce costs.

Benefits and Impact

1. The implementation of NDHM is expected to significantly improve the efficiency, effectiveness, and transparency of health service delivery overall. Patients will be able to securely store and access their medical records (such as prescriptions, diagnostic reports and discharge summaries), and share them with health care providers to ensure appropriate treatment and follow-up. They will also have access to more accurate information on health facilities and service providers. Further, they will have the option to access health services remotely through tele-consultation and e-pharmacy. NDHM will empower individuals with accurate information to enable informed decision making and increase accountability of healthcare providers.

2. NDHM will provide choice to individuals to access both public and private health services, facilitate compliance with laid down guidelines

and protocols, and ensure transparency in pricing of services and accountability for the health services being rendered.

3. Similarly, health care professionals across disciplines will have better access to patient's medical history (with the necessary informed consent) for prescribing more appropriate and effective health interventions. The integrated ecosystem will also enable better continuum of care. NDHM will help digitize the claims process and enable faster reimbursement. This will enhance the overall ease of providing services amongst the health care providers.

4. At the same time, policy makers and programme managers will have better access to data, enabling more informed decision making by the Government. Better quality of macro and micro-level data will enable advanced analytics, usage of health-biomarkers and better preventive healthcare. It will also enable geography and demography-based monitoring and appropriate decision making to inform design and strengthen implementation of health programmes and policies.

5. Finally, researchers will greatly benefit from the availability of such aggregated information as they will be able to study and evaluate the effectiveness of various programmes and interventions. NDHM would facilitate a comprehensive feedback loop between researchers, policymakers, and providers.

Introduction to the scope of NDHM

1. The National Digital Health Mission will implement the core and common digital building blocks required for healthcare and make them accessible as digital public goods to both the public and private ecosystem. The National Digital Health Blueprint identifies several of the building blocks required to be developed

2. The building blocks will be available as a collection of cloud-based services. Each service will provide just one capability across multiple health services, accessible via simple open APIs, with built-in security by design and adequate authentication, authorization, and access protocols as per NDHB and notified from time to time by the Government. Together these will create a powerful framework to enable better healthcare delivery and management for the country. Details on the National Digital Health Blueprint are accessible at https://nha.gov.in/NDHB.

3. NDHM will need to develop a strong set of mandates and promotion to ensure adoption across both public health and private ecosystems to help realize the vision of an inter-operable health ecosystem.

2. Health Data

2.1. Health data is critical for creating holistic views of individuals,

personalizing treatments, improving communication between caregivers and individuals, and delivering better health outcomes. Health data can be classified into the following categories:

1. Personal Health Data - Data related to an individual containing detailed information of various health conditions and treatments. It includes any data with personally identifiable information of various stakeholders, e.g. healthcare professionals.

2. Non-Personal Health Data - Includes aggregated health data like number of dengue cases and anonymized health data where all personally identifiable information has been removed. This will also include information about health facilities, drugs etc. which do not involve personally identifiable information.

2.2. Healthcare providers create health data for patients/individuals during each encounter. Most providers issue a physical copy of a health report to patients as part of the treatment. These commonly include diagnostic reports, discharge summaries, prescriptions, and clinical notes. Inpatient case files such as OT notes are currently not shared unless requested by the patient. The Mission will require healthcare providers to share a digital copy of any health reports being physically shared with the patient to enable creation of longitudinal health records.

2.3. India is moving fast towards adoption of software systems in healthcare. The types of software used to manage health information include:

1. Electronic Medical Records (EMR) - This refers to systems that are used within a hospital or a clinic to support patient diagnosis and treatment and are transaction focused. NDHM requires these systems to be updated to support standards and provide access of the data to patients.

2. Electronic Health Records (EHR) - EHRs contain records for a patient across multiple doctors and providers and is used within a Healthcare system (like say across a state government) to provide better care for patients

3. Personal Health Records (PHR) - PHRs enable patients to compile, update and keep a copy of their own records that can help them better manage their care and are person focussed.

2.4. Federated Architecture of Health Data

1. NDHM will implement a federated health records exchange system that will enable patient data to be held at point of care or at closest possible location to where it was created. Health records will be accessible and shareable by the patient with appropriate consent and complete control of the records will remain with the patient. An appropriate digital

consent framework as per standards specified by NDHB (leveraging DigiLocker consent management framework to the extent possible) will be adopted for consent management.

2. To participate in the federated health records system, Health care providers are expected to adopt software that enables them to become Health Information Providers (HIPs), also known as Health Data Fiduciaries. This will be any entity that is creating health information pertaining to a user and is ready to share it digitally with users by adopting to software compliant with NDHM standards and policies. HIPs will keep a digital copy of both inpatient and outpatient health records they issue to patients as per policy. The current guidelines issued by MoHFW requires care providers to store medical records digitally indefinitely.

3. Till such time digital services are made mandatory, maintenance of physical records will be required. While option of digital Health ID will be there, in case a person does not want Health ID, then also treatment should be allowed.

4. HIPs will be required to ask patients for a Health ID, educate and create Health IDsfor patients as required, keep a link of the Health ID with the medical documents they produce, and issue the medical documents only with patient's consent. To become HIP, the health care facility will be required to enrol in the NDHM health care infrastructure registry (Healthcare Facilities' Registry).

5. Health information users (HIUs) will be able to request for health records of a patient. These will be any entity that intends to view health records of an individual with consent of the individual using compliant software. EMR systems, doctors, applications providing advice to patients by looking at health records will need to implement HIU specifications. HIUs cannot get any data without patient consent.

6. Many entities who are HIPs will also be HIUs. However, the two have largely independent responsibilities with their own functions. Any entity intending to take either of the roles will need to adhere to the guidelines specified for being a HIP or HIU. HIPs are fiduciaries of health data storing the health records of individuals, wherein the HIUs are the individuals/organizations who will request access to health data and get the same if consent is given by the individual.

2.5. Formats and Adoption of Standards for Health Data

1. The NDHB has recommended several health data standards for adoption and use including FHIR-R4, SNOMED-CT, LOINC, ICD10/11, as required and notified by Government from time to time. The current adoption

of standards is extremely poor across health care providers. The Mission will follow a path that enables gradual adoption of standards by HIPs.

2. HIPs must share with patients, a digital version of any document already being given to the patient like

a. Diagnostic reports - microbiology, pathology, and radiology

b. Discharge summaries -- for all inpatient treatments

c. Clinical Notes -- for inpatient and outpatient encounters

d. Prescriptions - medications, glasses e. Immunization records

3. NDHM will publish the formats to be used by HIPs for each of these documents. HIPs must ideally share the documents in standards compliant with FHIR-R4 resource format. For an initial period, the design will allow for existing PDF and image files to be shared in a FHIR-R4 resource wrapper. It is envisaged that modern artificial intelligence (AI) techniques that can extract relevant information from these existing health record formats will become rapidly available and help HIPs in this transition to standards. NDHM will keep a check on the reliability of AI systems by laying down guidelines and standards.

4. This adoption approach is expected to ensure patients and doctors get access to health records in the current formats they are used to seeing today and gradually migrate to a standardsbased document format over time.

2.6. Health Data Anonymization and Aggregation Every HIP will also produce aggregated health data, for example the number of dengue cases or number of PTCAs performed each day. This aggregated data feed will become part of the National Health Analytics architecture. "Anonymization" with respect to personal data, means the irreversible process of transforming or converting personal data to a form in which a data principal (owner/individual) cannot be identified. The NDHB recommends providing Anonymization-as-a-Service that can be used by HIPs to anonymize data as close to the source as possible. Non-personal health data both aggregated and anonymized are very important for the development of the health ecosystem. Data classification into personal/non-personal will be linked to the Personal Data Protection Bill 2019.

2.7. Health Data Legal Framework

1. The laws, rules and regulations pertaining to personal health data are predominantly covered under the Personal Data Protection Bill, 2019 currently in the Parliament. The overall framework of NDHM will be aligned with the framework of the draft Personal Data Protection Bill. The draft Bill has provisions for issuance of sector specific regulations that are critical to

the implementation of NDHM. The federated health record exchange has been designed to be compliant with the provisions of the draft Bill. The Government has set up a committee to examine the regulations required for use of non-personal data as well. The recommendations of this committee would be integral to finalize the policies related to access to non-personal health data as part of NDHM.

2. Health records under NDHM are digitally signed and are equivalent to paper records under the IT Act and can be used in legal scenarios like medico legal cases. Certain types of use of personal health data are expected to be prohibited even if the data was provided with consent -- for example usage of data for commercial promotions. A list of such use-cases will be finalized by NDHM in consultation with MoHFW and other stakeholders.

Health Management Information System (HMIS) Portal

Health Management Information System (HMIS) is a Government to Government (G2G) web-based Monitoring Information System that has been developed and maintained by Ministry of Health & Family Welfare (MoHFW), Government of India to monitor the National Health Mission and other Health programs and provide key inputs for policy formulation and appropriate program interventions. HMIS has been utilized in Grading of Health Facilities, identifications of aspirational districts, review of State Program Implementation Plan (PIPs), etc.

Currently, around 2 lakh health facilities (across all States/UTs (more than 30 thousand Health facilities (public as well as private) are listed under HMIS Portal in U.P.) are uploading facility wise service delivery data and infrastructure & HR related data on monthly basis on HMIS web portal.

HMIS captures facility-wise information as follows:

Service Delivery (Reproductive, Maternal and Child Health related, Immunization, family planning, Vector borne disease, Tuberculosis, Morbidity and Mortality, OPD, IPD Services, Surgeries etc. data) on monthly basis.

Infrastructure & HR (Manpower, Equipment, Cleanliness, Building, Availability of Medical Services such as Surgery etc., Super Specialties services such as Cardiology etc., Diagnostics, Para Medical and Clinical Services etc. data) on monthly basis with previous month data carry forward facility.

The HMIS Portal facilitates the flow of physical performance from the Facility level to the Sub-district/Block, District, State and National level using a web based Health Management Information System (HMIS) interface. The portal provides periodic reports on the status of the health services performances and Human Resources and Infrastructure services facilities available.

HMIS (Hospital Management & Information System) Solution

Hospital Management Information System is a major step towards adapting technology to improve healthcare. HMIS incorporates an integrated computerized clinical information system for improved hospital administration and patient health care. It also provides an accurate, electronically stored medical record of the patient. A data warehouse of such records can be utilized for statistical requirements and for research. The real time HMIS streamlines the treatment flow of patients and simultaneously empowering workforce to perform to their peak ability, in an optimized and efficient manner. It is modeled on the unique combination of a 'patient centric and medical staff centric' paradigm, thus providing benefits to both the recipients and the providers of healthcare. It ensures dramatic improvement in performance along with reducing the costs.

Electronic Health Record (EHR) is key to develop Integrated Health Information Platform (IHIP). HMIS Application implementation connects people, processes and data in real time across all the hospital on a single platform, workflow routes documents and Information electronically, flexibility and Integration abilities manage change.

Application facilitates Bar coding Interface for areas such as patient Registration, Stores, Sample collection etc., provision for Machine Interface with DICOM Standards, Integration with Code sets like ICD (International Classification of Diseases), SNOMED etc., HL-7 Messaging Support.

The HMIS Solution is in compliance to integration with Ayushman Bharat-Digital Health Mission.

Hospital Management Information System Solution Application developed by NIC and CDAC named consecutively e-Hospital & e-Sushrut. In state of Uttar Pradesh both applications are implemented in mix mode.

The Modules and functionalities available under these applications are broadly categories and detailed as below-

- **Patient Registration (OPD, Casualty, Appointment & ORS)-** The patient registration module, is used for patient registration in the OPD and Casualty departments as well as to book, confirm and cancel appointments.
- **Admission, Discharge & Transfer (IPD) -** The IPD modulecommences whenthe patientis being registered and allotted bed in the ward. It deals with the complete treatment and services provided to the patient during his stay in the hospital.
- **Billing-** The Billing module handles all types of billing workflows. This module

facilitates cashier and billing operators for managing billing functions related to billing receipts and refunds.

- **Clinic (OPD & IPD) -**The Clinic module allows the clinicians and doctors to record the clinical data of the patients like visits, examination, diagnosis, history, treatment, prescriptions etc., and to order investigations, procedures and medicines, to keep track of the treatment and other services provided to the patients.
- **Lab Information System (LIS) -** The Lab module automates the manual procedures used in the following laboratory areas: ordering of tests and procedures on patient specimens, collection and accessioning of specimens into the laboratory database, processing and analysis in appropriate department or work areas, review and verification of results, reporting of results and/or diagnoses for clinical treatment.
- **Radiology Information System (RIS) -** The Radiology module automates the manual procedures used in the radiology services: ordering and scheduling of tests and procedures, review and verification of results, reporting of results and/or diagnoses for clinical treatment.
- **Pharmacy Management (Integrated with e-Aushadhi-DVDMS) & Inventory - Store Management: -** Pharmacy and Inventory Management plays a central role in hospital. This consists of ascertaining the needs of various departments in the matter of items and devising such policies that all the materials, which have constant demand, will be constantly available so that they are supplied to the user departments without delay. This includes classification /categorization of items, codification etc. The prime objective of all the stores is to provide item supply to hospital departments with what they want, when they want it.
- **OT Management -** The OT Management module automates the functions and workflows of operation theatres in the hospitals.
- **Dietary-** The dietary module automates the functions of dietary services provided to the patients in the hospitals.
- **Laundry-** The laundry module automates the functions and workflows oflaundry services in the hospitals.
- **Medical Record Department (MRD) & EHR (Electronic Health Record): -** An Electronic Medical Record (EMR) and Electronic Health Record (EHR) is a computer-based patient medical record. An EMR/EHR facilitates access of patient data by clinical staff at any given location. With the introduction of the Electronic Medical Record the patient information is captured electronically. All the information of the patient can be accessed easily and require much less time than the paper-based record. It provides the accessibility to the patient record across the network. Electronic

records are not only easy to access and maintain it also improves the quality of the health services.

- **Administration & Management:** The module provides functionality to complete all master data configuration, user administration, roster etc.
- **Blood Bank (Integrated with e-RaktKosh): -** e-RaktKosh is CDAC's Blood Bank Management System (BBMS), a separate application that is already rolled out in many states. e-RaktKosh would be integrated with HMIS for all hospitals to be boarded.
- **Dashboard Management-**Dashboards, which are a type of executive information system, allow users to obtain Status reports on screen.
- **Citizen Centric Mobile Application**– Under e-Sushrut Application implementation "mHealth Citizen centric mobile application enables healthcare establishments with a holistic view of their operations and in this way, we are streamlining the current hospital management system for providing better patient care through a portable medium. Citizens/ Patients, Doctors and Registered healthcare workers which could easily be downloaded from Google Play Store/IOS App store on any Smartphone device for usages. The HMIS Mobile Application will enable patients to access the provisions enabled by the Hospitals over their smart phones and can take the appointments, provision registration, check their investigation report etc.
- **MeraAspataal (My Hospital)** is a Ministry of Health and Family Welfare, Government of India (GOI) initiative to capture patient feedback on the services received at the hospital through user-friendly multiple channels such as Short Message Service (SMS), Outbound Dialling (OBD) mobile application and web portal. The patient can submit the feedback in seven different languages on mobile app and web portal; for the hospitals visited in last 7 days.

  The patient can also check the already submitted feedback. The collected feedback will be compiled, analysed and visualized in the form of a dashboard accessible to the different stakeholders at facility, district, state and national level to improve quality of services in healthcare facilities. Thus My Hospital aligns with the citizencentricMyGov platform of GOI which allows patients to connect with the healthcare providers and policymakers and to have their opinion heard and acted upon.

Online Registration System (ORS) *is a Digital India initiative aims to provide online access to hospital services for patient, integrated with Ayushman Bharat Health Account.*

Online Registration System (ORS) is a framework to link various hospitals across the country for Aadhaar based online registration and appointment system, where counter based OPD

registration and appointment system through HospitalManagement Information System (HMIS) has been digitalized. The application hasbeen hosted on thecloud services of NIC. Portal facilitates online appointmentswith various departments of differentHospitals using eKYC data of Aadhaar number, if patient's mobile number is registered with UIDAI and in case mobilenumber is not registered with UIDAI it uses patient's name. New Patient will getappointmentas well as Unique Health Identification (UHID) number. If Aadhaarnumber is already linked with UHIDnumber, then appointment number will begiven and UHID will remain same.

District Hospital Ranking by NITI Aayog

Despite the critical role of district hospitals in providing inclusive secondary-level healthcare services and the generous funds allocated to them under the National Health Mission, there is no comprehensive system to assess their performance. Therefore, as per a framework designed by a working group comprising experts from WHO and MoH&FW, NITI Aayog undertook the exercise of tracking the performance of district hospitals based on 10 Key Performance Indicators. The National Accreditation Board of Hospitals–Quality Council of India (NABH-QCI) was selected for data validation.

Role and Importance of District Hospitals

In the three-tier structured level of public health care, the district hospital forms an integral and vital part of the health care delivery system. It functions as a secondary level of health care, which provides comprehensive preventive, promotive, and curative health care services to the people in the district.

Each district hospital is linked with public Hospitals/Health Centressuch as the Community Health Centre (CHC), the Primary Health Centre (PHC), and the Sub-Centre (SC).

When patients reach any given district hospital, they expect that a doctor in the required medical specialty would be available at the outpatient department (OPD) to diagnose and treat their health disorder and prescribe tests and medicines, which can then be obtained at the pharmacy in the hospital. If the doctor orders diagnostic tests, the patient can get them done at a laboratory by a technician at that particular point of care. If the doctor recommends admission, the patient can get a bed at the hospital. If a higher-level medical intervention, such as surgery, is suggested, the patient can be operated upon within a reasonable period of time. During the patient's stay at the hospital, they are cared by the on-duty nurses. After the surgery,

the patient should recover without any infection. The hospital ecosystem is expected to maintain acceptable levels of hygiene and cleanliness. These are the standard expectations of any patient visiting a district hospital anywhere in the world.

All these essential components form links of a delicate health care chain that determines the patient's experience. Inefficiencies and inadequacies in any of the component/departments can distress the patient and adversely impact the health outcomes and goals of the public health care structure..

Measures used in the assessment

The assessment looked at a wide array of health indicators ranging from beds, doctors, nurses, paramedics, diagnostic and health care specialties available to bed occupancy rates, caesarean- section surgeries, and blood bank replacement rate. Annexure 2 gives a summary of the health systems studied in order to create a suitable framework for assessment. A total of 10 KPIs were identified to assess the ecosystem and performance of district hospitals in all the States and Union Territories (UTs). The KPIs were designed by NITI Aayog in consultations with multiple stakeholders namely, the MoH&FW, the States of Punjab, Maharashtra, Uttar Pradesh, Assam, and Tamil Nadu, and specialist agencies like World Health Organization and Bill and Melinda Gates Foundation. After sharing them with all States/UTs for seeking feedback, the KPIs were then finalised in November 2016 by a working group comprising JS (Policy) MoH&FW, Adviser (Health) NITI Aayog, Principal Secretary – Health & ME (Punjab), and WHO representative.

The KPIs were identified on the basis of certain aims and objectives that needed to be fulfilled by a holistic assessment process. They were broadly classified into two categories – structure and output. Five of these 10 KPIs estimated the level of infrastructure which the district-level hospitals had, and the remaining indicated the outputs that these hospitals were generating. A list and description of the indicators is given in Table 1.

Categorization of hospitals for Analysis

For meaningful analysis and comparison, district hospitals were categorized according to their bed strength, thereby enabling comparison of similar-sized hospitals. Therefore, for the purpose of the assessment, district hospitals having up to 200 beds were referred to as small hospitals; those with morethan 300 beds were called large hospitals; and those with201 to 300 beds were referred to as mid-sized hospitals.

Investments in primary health care for universal health coverage: need of an hour

In India, the need for and emphasis on strengthening Primary Health Care was firstly articulated in the Bhore Committee Report 1946. Even the National Health Policy, 2017 had recommended strengthening of Primary Health Care Services through spanning preventive, promotive, curative, rehabilitative and palliative care services for all ages.

The Government of India launched the Ayushman Bharat Program with two interrelated components of (a) Health and Wellness Centres (HWCs), to deliver comprehensive primary health care (CPHC) services to the entire population and (b) Pradhan Mantri Jan Arogya Yojana (PMJAY) for improving access to hospitalization services at secondary and tertiary level health facilities for deprived 40% of total population.

In February 2018, the Government of India announced that 1,50,000 Health & Wellness Centres (HWCs) would be created by transforming existing Sub Health Centres to deliver Comprehensive Primary Health Care with the principle being "time to care" to be no more than 30 minutes as well as Primary Health Centres in rural and urban areas would also be converted to HWCs.

Certificate in Community Health for Nurses Training:

Under Ayushman Bharat initiative all Sub centers of Uttar Pradesh need to be upgraded into Health and Wellness Centers through placement of a Community Health Officer (CHO), who would undergo six-months Certificate Course in Community Health at identified training Centers established at District Hospitals/Medical College/College of Nursing/RHFWTCs, known as Program Study Centre (PSCs).

In Uttar Pradesh initially CCHN training course was conducted through IGNOU, presently Certificate program in Community health has been adopted by the State-run University King George's Medical University (KGMU), Lucknow with shorter duration of 4 months.

Key Components of AB-HWCs- means for transforming primary health care services:

AB-HWCs are being upgraded and branded to provide not only sufficient space for expanded service delivery and for medicine dispensation, diagnostics but also organized space for wellness related activities including the practice of yoga etc. with adequate spaces for display of communication material of health messages, including audio visual aids. Continuum of Care is being offered through HWCs which are functioning as a two-way referral system- that links to secondary and tertiary care and also

follow up care. E-Sanjeevani, a teleconsultation platform has been leveraged to improve referral advice, seek clarifications, and undertake virtual training including case management support by specialists at AB-HWC level. The focus not only delves on curative health care services, but also on preventive and promotive services.

The HWC at the sub health center level would be equipped and staffed by an appropriately trained Primary Health Care team, comprising of Multi-Purpose Workers (male and female) & ASHAs and led by a Mid-Level Health Provider/Community Health Officer (MLHP/CHO). Whereas, a Primary Health Centre (PHC) that is linked to a cluster of HWCs would serve as the first point of referral for many disease conditions for the HWCs in its jurisdiction. The Medical Officer at the PHC would be responsible for ensuring that CPHC services are delivered through all HWCs in her/his area and through the PHC itself.

The HWC would deliver an expanded range of services given below. These services would be delivered at both SHCs and in the PHCs, which are transformed as HWCs.

Expanded Range of Services

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

Similarly, in the urban context, the Urban Primary Health Centers or Urban Health Posts, where they exist, would be strengthened as HWCs to deliver Comprehensive Primary Health Care.

While planning for HWCs, close attention should be paid to improving geographic accessibility, ensuring the full complement of staff at each level, enabling regular capacity building and supportive supervision, ensuring

uninterrupted supply of medicines and diagnostics, and maintaining a continuum of care seamlessly linking people to various levels of care so that the services offered at the primary health care level fully meet the promise of expanded range and commensurate outcomes.


राज्य स्वास्थ्य एवं परिवार कल्याण संस्थान, उ0प्र0
SIHFWUP

29 MEDICO LEGAL PROCESS

Medico Legal Process

INTRODUCTION

- **Medicine is applied Science**
- Amalgamation of Science & Art
- Service Component is dominating factor
- Human approach is crucial.
- Social Factors are important
- Interpersonal skills matter very much
- Medicine – the noble profession.
- Medical Profession – is self regulatory.
- With passage of time conditions changed.
- Ethical issues modified.
- Legal issues penetrated

CHANGING ETHICAL NEEDS &INTRODUCTION OF NEW LEGISLATIONS

- Overall Development
- Technological advances
- Changing socio-political situations
- Professional needs
- Practice parameters
- Physicians' perceptions
- Societal and personal needs
- Increasing patient demands

MEDICAL ETHICS, HEALTH LEGISLATION & PATIENT CARE IN INDIA

- Medical ethics is multifaceted and multi-dimensional.
- Introduction of more and more health legislations by the State and the Centre.
- The behaviour of the private health sector is imperfect in terms of developing healthcare to the masses.
- The situation of govt. run hospitals in public sector is not at all satisfactory.
- Medical ethics existed ever since the practice of medicine – contributions of Egypt, Greece and India.
- Ethics is very complicated issue and it cuts across social, economical, cultural, moral and spiritual beliefs and practices.
- Ethical Landmarks:
- Hippocratic oath
- Sushruta Samhita
- Charaka Samhita
- Indian Medical Council Act 1956
- Section 33– Code of Medical Ethics (23.10.1970)
- World Medical Association
- Periodical International Declarations

ETHICAL & LEGAL ISSUES

- Abortion & Contraception
- Artificial Conception & Cloning
- Sex determination
- Sterilizing mentally handicapped
- Organ transplantation
- Confidentiality in medical practice
- Terminal care and Euthanasia
- Media & Advertising
- Right to refuse treatment
- Sharing of Professional Fees
- Strike by Doctors & HCWs
- Biomedical waste disposal
- Applicable to Healthcare in general & Medical Practice in particular.
- Variable/ modified with the specialties and branch of medicine concerned, e.g.:
- Care of the disabled
- Care of the mentally retarded & psychiatric cases

- Care of the cancer patients
- Ethics in Urology
- Medical laws & ethics in ophthalmology
- Care of the aged – Geriatric care
- **PATIENT – PHYSICIAN RELATIONSHIP**
- Who is Physician?
- The healing relationship
- The Patient Component
- The Physician Component
- Teaching of the patient-physician relationship in the medical curriculum.

LEGAL ASPECTS OF EMERGENCY CARE

- Historic judgment in Medico-legal work on August 28, 1989. The Supreme Court of India before Shri Ranganath Mishra and G.L. Ojha JJ in case of Parmanand Katare Vs. Union of India and others delivered a historic judgment covering wide range of problems pertaining to medico-legal work in this country.
- The judgment is a landmark in the history of Medical practice in India as it deals with almost all important aspects of medico-legal proceedings in emergency patient care.

MEDICO-LEGAL RESPONSIBILITIES OF CMO / EMOs & HOSPITAL ADMINISTRATION

Duty: It is obligation imposed by law as one person to behave in a certain way towards another.

Responsibility: It is a particular task or act that one has to do because of a particular job or position and you have ability to behave properly and you can made decision without needing to be watched or controlled by someone else. It is your duty to make sure that necessary steps have been taken by you.

Malpractice: is defined as absence of reasonable skill in course of your duty causing some damage, bodily injury or death of the patient. It can be criminal, civil or ethical.

WHAT ARE MEDICO-LEGAL CASES?

IDENTIFICATION, REGISTRATION AND ISOLATION OF THE MEDICO-LEGAL CASE

1. All cases of Trauma.
2. All cases of Burns and Scalds.
3. All cases of dying due to Electricity, Lightening
4. All case of Poisoning – Alcohol intoxicate / food Poisoning.
5. All cases of Unconsciousness where cause of Coma could not be ascertained.
6. All cases of starvation including Hunger Strike.
7. All industrial Hazards cases.
8. All cases requiring Age Estimation.
9. All cases (Victim / Accused) of Sexual Offences including Unnatural Sexual Offences.
10. All suspected cases of Criminal Abortion.
11. All Unclaimed Newly Born.
12. All living cases relating to violent Asphyxia i.e. Hanging, Strangulation, Drowning, Suffocation.
13. Cases of Death in Operation Theatre (DOT) during operation.
14. All case of death of Prisoners in hospitals.

15. Cases of death due to Anaphylaxis or Hypersensitivity.
16. All cases of death due to Snake bite or Animal bite.
17. Cases 'Brought Dead' to Physician / EMO where cause of death is not evident.
18. Cases living or dead as a result of Medical Malpractice.
19. Any patient within 24 hours of hospitalization dying undiagnosed.

GUIDELINES: DEALING WITH A MEDICO-LEGAL CASES

- Medical Case / Routine Case
- Registration as Medico-legal Case
- Reporting to Police
- Triage and Transportation
- Routine and Special Investigations
- Maintenance of Medical Records
- Preservation of relevant medical documents and evidences
- Dying Declaration

MEDICAL NEGLIGENCE

- The general rule in medical care delivery is that where one sees a Doctor for a particular consultation or examination, the medical professional agrees to perform the necessary services. The implication is that the medical care providers will render those services with Requisite Skill and Care.
- The Medical Professionals' failure to provide those services with that Requisite Skill and Care gives rise to action in Medical Negligence under – Criminal, Civil or Consumer Court.
- Medical Negligence
- Contributory
- Comparative
- Components:
- Element of Duty
- Element of breach
- Element of Injury or Death
- Burden of Proof *(Res ipsa loquitos)*
- "Respondent Superior" and Personal Liability

DIMINISHING THE RISKS OF LITIGATION

1. Completion of records
2. Documenting Informed Consent
3. Deposition of the patient
4. Everything recorded & well-explained.
5. Choice of words
6. Accuracy of notation
7. Unprofessional comments
8. Explaining the poor outcome
9. Blaming others – reserve judgment
10. Conforming to the purpose
11. Establishing the Causation / Diagnosis
12. Agreement with records
13. Unreliability of diagnostic studies & misdiagnosis.
14. Patient non-compliance – should be on record.
15. Discharge against medical advice.
16. Illegible Records
17. Changing an Earlier Record
18. Lost Records

TYPES OF MEDICAL CERTIFICATE

- Pregnancy Certificate
- Birth Certificate
- Sickness / Fitness / Disability Certificate
- Age Certificate
- Vaccination Certificate
- Certificate of Dangerous Diseases

- Certificate of Lunacy
- Death Certificate
  (i) Certifying the fact of death.
  (ii)Certifying death and mentioning the cause of death
- ❖ Antecedent Cause
- ❖ Co-morbid Conditions
- ❖ Medical Condition
- ❖ Contributory Causes

LEGAL ASPECTS OF MEDICAL CERTIFICATE

A medical Certificate can be defined as a documentary evidence and vouching for truth and correctness of a fact as ascertained by the medical professional issuing such a document at that moment of time.

Essentials of Medical Certificate:

- ❖ Be issued on the Letterheads of the Doctors or the Organizations.
- ❖ Incorporate date, time and place of issue.
- ❖ Be issued only for a legitimate purpose.
- ❖ State only the facts which are within the personal knowledge of the Doctor.
- ❖ Be limited to the actual period of care.

Essentials of Medical Certificate:

- ❖ Be true in every detail and not be misleading.
- ❖ Be framed according to the actual requirement.
- ❖ Be handed over, as far as possible to the patient himself and his signature / thumb impression obtained.
- ❖ Be made minimum in duplicate.
- ❖ Not disclose the diagnosis without the patient's expressed consent, unless required by law.
- ❖ Contain by rule, the identification of the patient:
  (i) Specimen signatures
  (ii) Thumb impression – RTI / LTI
  (iii) Physical marks of identification

CITIZEN'S CHARTER Vs MEDICAL ETHICS & HEALTH LEGISLATION

- ❖ Citizen's Charter in health services is a subject which deals with common requirement of Health Services to be rendered to the people / society.
- ❖ A Doctor in practice is liable for prosecution under following:
- ❖ Medical Ethics
- ❖ Health Legislation
- ❖ C.P.A.
- ❖ Law of Torts
- ❖ Indian Penal Code
- ❖ Medical Council of India

HIV INFECTION (AIDS) ETHICAL & LEGAL ISSUES

- ❖ What! If the Patient is HIV Positive?
- ❖ What! If the Doctor / HCW is HIV Positive?

CONSUMER PROTECTION ACT RESPONSIBILITIES OF MEDICAL PROFESSION &HEALTHCARE INSTITUTIONS

- Before Introduction of CPA:
- ❖ Law of Torts
- ❖ IPC–under different Sections to get negligent punished.
- CPA – Introduced in 1986 / Come into force on 15.04.1987.
- ❖ District / State / National → Supreme Court
- The Act has opened up possibilities of easy, cheap and quick remedies for

redressal of grievances and consumer movement has gained momentum and impetus.

- So far there has been no such provision in the Indian Medical Council Act 1956 in this respect.

CPA seeks to promote and protect the rights of consumer as decided by the International Organizations of Consumers Union (IOCU):

- The Right of Safety
- The Right to be Informed
- The Right to Choose
- The Right to be Heard
- The Right to Redress
- The Right to Consumer Education
- The Right to Healthy Environment
- The Right to Basic Needs

DUTIES & OBLIGATION OF A DOCTOR

On the basis of the Codes of Medical Ethics and Declaration by WMA:

i. Duties to patients
ii. Duties to public
iii. Duties towards enforcers / the Govt.
iv. Duties not to do anything illegal or hide illegal acts
v. Duties to each other

DOCTOR - PATIENT CONTRACT
IMPLIED CONTRACT
EXPRESS CONTRACT

- Continue to Treat your patients.
- Treat with **ReasonableCare.**
- With **ReasonableSkill.**
- Not to undertake any procedure / treatment beyond your skill.
- Must not divulge professional secrets.

PROFESSIONAL NEGLIGENCE
(MALPRACTICE / MALPRAXIS)

- Medical negligence or malpractice is defined as the lack of reasonable care and skill on willful negligence on the part of a Doctor in the treatment of a patient whereby the health or life of a patient is endangered.
- The term 'damage' means physical, mental or functional injury to the patient.
- The term 'damage' is assessed in terms of money by the Court on the basis of concurrent and future earnings, treatment costs, reduction in life expectancy and equality of life.
- Criminal Negligence.
- Preventing steps against litigation under CPA.
- Situation in Medical Practice requiring extra caution.
- What should a Doctor do in the event of a Medical Mishap?
- Role of Hospital Administrator for prevention of the Institution and the Professionals from Litigation.
- **PROFESSIONAL NEGLIGENCE**
(MALPRACTICE / MALPRAXIS)
Lord Dening in his Book
"The Discipline of Law"

"Medical malpractice suits have become the curse for the Medical Profession. The legal profession gets contingency fees, so they take up cases on Speculation, the Court gives enormous damages, insurance premiums are high. The Doctors are forced to charge extra fees to cover the above situations. It is all very worrying."

MEDICINE, ETHICS & LAW

INTERNATIONAL CODE OF MEDICAL ETHICS ***(THE GENEVA DECLARATION)***

- I solemnly pledge myself to consecrate my life to the service of humanity.
- Even under threat, I will not use my medical knowledge contrary to the laws of humanity.
- I will maintain the utmost respect for human life from the time of conception.
- I will not permit consideration of religion, nationality, party politics or social standing to intervene between my duty and my patient.
- I will practice my profession with conscience and dignity.
- The health of my patient will be my first consideration.
- I will give to my teachers the respect and gratitude which is their due.
- I will respect the secrets which are confided to me.
- I will maintain by all means in my power, the honour and noble traditions of the medical profession.
- My colleagues will be my brothers.

Dyeing Declaration

Objective: To give an understanding of the Dyeing declaration to the Medical Officer

Content:

Dyeing declaration is defined in Section 32 (1) of Indian Evidence Act .It is based on the principle of "Leterm Mortem" which means "words said before death" & in a legal term it is called 'Dying Declaration'. The word "Dying Declaration" itself tells the meaning But this project highlights those questions, which have a great value in legal field relating to dying declaration. The study tells about those statements which converted into dying declaration, different forms of dying declaration, which are admissible by law, it's importance in the law & clears that has it some value or not? And if it has, then what are the exceptions of it?

A statement by a person who is conscious and knows that death is imminent concerning what he or she believes to be the cause or circumstances of death that can be introduced into evidence during a trial in certain cases.

A dying declaration is considered credible and trustworthy evidence based upon the general belief that most people who know that they are about to die do not lie. As a result, it is an exception to the Hearsay rule, which prohibits the use of a statement made by someone other than the person who repeats it while testifying during a trial,

because of its inherent untrustworthiness. If the person who made the dying declaration had the slightest hope of recovery, no matter how unreasonable, the statement is not admissible into evidence. A person who makes a dying declaration must, however, be competent at the time he or she makes a statement, otherwise, it is inadmissible. A dying declaration is usually introduced by the prosecution, but can be used on behalf of the accused.

Word "Dying Declaration" means a statement written or verbal of relevant facts made by a person, who is dead. It is the statement of a person who had died explaining the circumstances of his death. This is based on the maxim *'nemomariturupresumunturmentri'* i.e. a man will not meet his maker with lie on his mouth. Our Indian law recognizes this fact that 'a dying man seldom lies.' Or 'truth sits upon the lips of a dying man.' It is an exception to the principle of excluding hearsay evidence rule. Here the person (victim) is the only eye-witness to the crime, and exclusion of his statement would tend to defeat the end of justice. Section 32 of Indian Evidence act deals with the cases related to that person who is dead or who cannot be found.

I.1 Section 32: Cases in which statements of relevant fact by person who is dead or cannot be found.—statement, written or verbal, or relevant facts made by a person who is dead, or who cannot be found, or who has become incapable of giving evidence, or whose attendance cannot be procured without an amount of delay or expanse which, under the circumstances of the case appears to the Court unreasonable, are themselves relevant facts in the following cases:

(1) When it relates to cause of death.

(2) Or is made in course of business.

(3) Or against interest of maker.

(4) Or gives opinion as to public right or custom or matters.

(5) Or relates to existence of relationship.

(6) Or is made in will or deed relating to family.

(7) Or in document relating to transaction mentioned in section 13, clause (a).

(8) Or is made by several persons and expresses feelings relevant to matter in question.

But here, we are studying about 'dying declaration' which deals with the cases relate to cause of death. It is mentioned in sub-section (1) of section 32 of Indian Evidence act.

Section 32 (1) When it relates to cause of death.—When the statement is made by a person as to the cause of his death, or as to any of the circumstances of the transaction which resulted in his death, in cases in which the cause of that person's death comes into question.

Such statements are relevant whether the person who made them was or was

not, at the time when they were made, under exception of death, and whatever may be the nature of the proceeding in which the cause of his death comes into question.

Illustration

The question is, whether A was murdered by B; or

A dies of injuries received in a transaction in the course of which she was ravished. The question is, whether A was killed by B under such circumstances that a suit would lie against B by A's widow.

Statements made by A as to cause of his or her death, referring respectively to the murder, the rape and the actionable wrong under consideration wrong under consideration are relevant facts.

In Ulka Ram v. State of Rajasthan Apex Court held that, "when a statement is made by a person as to cause of his death or as to any circumstances of transaction which resulted into his death, in case in which cause of his death comes in question is admissible in evidence, such statement in law are compendiously called dying declaration."

The Apex Court in its decision in P.V. Radhakrishna v. State of Karnataka held that 'the principle on which a dying declaration is admitted in evidence is indicated in latin maxim, nemomorturusprocsumiturmentri, a man will not meet his maker with a lie in his mouth. Information lodged by a person who died subsequently relating to the cause of his death, is admissible in evidence under this clause.

In a leading case, wife of the accused had borrowed money from the deceased in the sum of Rs. 3000 at the interest of 18 percent. Related to his debt a number of letters had signed by the wife of accused which was discovered from the house of deceased after his death. One letter which was not signed by someone had been received by the deceased K.N. on 20th March,1937, it was reasonably clear that it would had come from the wife of accused, who invited him to come Berhampur on that day or next day.

Widow of K.N. had told to the court that his husband had told him that Swami's wife had invited him to come to Berhampur to receive his payment. Next day K.N. left his house to go to Berhampur & on 23rd March, his body, which was cut in to seven pieces, found in a trunk in the compartment of a train at Puri. The accused was convicted of murder & sentenced to death because there were many evidence against him.

In Wazir Chand v. State of Haryana in which Court observed pakala ruling & said, 'applying these to the facts of the case their Lordships pointed out that the transaction in the case was one in which the deceased was murdered on 21st March & his body was found in a trunk proved to be bought on behalf of the accused. The statement made by the

deceased on 20th March that he was setting out to the place where the accused was living, appeared clearly to be a statement as to some of the circumstances of the transaction which resulted in his death. Thus the statement was rightly admitted.

In the case of R.V. Jenkins the accused was charged with the murder of a lady. He attacked her at midnight but she had recognized her because there were sufficient light to identify him. When magistrate's clerk asked her about the accused to record her statement, she told that he was Jenkins who had done the crime. The clerk asked her that, did she make the statement with no hope of her recovery then, she replied that she was making that statement with no hope of recovery. But when the clerk read that statement over to her, before her signing, she told her to add the word 'at present' in that statement.

It was held by the court that the statement was not a dying declaration as her insistence upon the words "at present" showed that she had some, however faint hope of recovery.

II. Identification through Dying Declaration

There is no particular form of dying declaration which is identified or admissible in the eye of law. But that must be functioning as a piece of evidence with the proper identification.

In a case, Apex court has also held that, "The crux of the whole matter was as to who had stabbed the deceased & why. These crucial facts are to be found in the dying declaration."

II.1 Question answer form

Where the dying declaration was not recorded in question-answer form, it was held that it could not be discarded for that reason alone. A statement recorded in the narrative may be more natural because it may give the version of the incident as perceived by the victim.

II.2. Gestures & signs form

In the case of Queen-Empress v. Abdullah Accused had cut the throat of the deceased girl & because of that, she was not able to speak so, she indicated the name of the accused by the signs of her hand, it was held by the full bench of the Allahabad High Court "If the injured person is unable to speak, he can make dying declaration by signs & gestures in response to the question." In another case The Apex Court observed that "the value of the sign language would depend upon as to who recorded the signs, what gestures & nods were made, what were the questions asked, whether simple or complicated & how effective & understandable the nods & gestures were."

II.3. Language of statement

Where the deceased made the statement in Kannada & Urdu languages, it was held that the statement could not be discarded on that ground alone, or on the ground that it was recorded only in

Kannada. Where the statement was in Telugu & the doctor recorded it in English but the precaution of explaining the statement to the injured person by another doctor was taken, the statement was held to be a valid dying declaration.

II.4. Oral Declaration

The Apex Court emphasized the need for corroboration of such declaration particularly in a case of this kind where the oral statement was made by the injured person to his mother & she being an interested witness. Such declaration has to be considered with care & caution. A statement made orally by the person who was struck down with a lathi blow on head and which was narrated by the witness who lodged the F.I.R. as a part of the F.I.R. was accepted as a reliable statement for the purpose of Section 32.

II.5. Thumb Impression

A dying declaration authenticated by thumb impression was considered to be doubtful in view of the fact that the victim had sustained 100 percent burns.

II.6. Incomplete Statement

The Apex Court had held that if a deceased fails to complete the main sentence (as for instance, the genesis or motive for the crime) a dying declaration would be unreliable. However, if the deceased has narrated the full story, but fails to answer the last formal question as to what more he wanted to say, the declaration can be relied upon.

II.7. where declarer survives

In a case decided by the Apex Court, the deceased who had made the dying declaration was seriously injured, but was conscious throughout when making the statement. The Court held that mirror incoherence in his statement with regard to facts & circumstances would not be sufficient ground for not relying on his statement, which was otherwise found to be genuine.

II.8. Absence of medical statement of fitness

Where the dying declaration of a dowry victim was challenged on the ground that doctor's certificate of mental fitness for statement was not there, the Supreme Court attached no importance to that omission, because the case was not wholly dependent upon the declaration. The facts were on record showing that the injured woman had gone to the hospital all alone changing vehicles on the way. This was sufficient evidence in itself to show her fitness.

II.9. Where interested witnesses were attending to the deceased

The Gauhati High Court has held that when the interested witnesses were attending on the deceased when he was making a dying declaration, & because of the injuries, the deceased was neither physically or mentally fit, no reliance could be placed on the dying declaration, in the absence of evidence to show that the deceased was physically & mentally capable of

making the dying declaration, & was not the victim of any tutoring.

II.10. Where statement is not relevant to the cause of death

When the person making the statement is not proved to have died as a result of the injuries received in the incident, his statement cannot be said to be the statement as to the cause of his death or as to any of the circumstances of transaction which resulted in his death.

II.11. Medical Report

The doctor in the hospital clearly recorded in the Accident Register of the Hospital that the patient was conscious, her orientation was good & that she answered well the question put to her. Her statement could not be discarded on the basis of her injury or post-mortem report in which it was said that having regard to the nature of injuries sustained by the deceased, she could not have been in a position to make a statement. Where the medical report of fitness was available to the magistrate who was to record the statement, it was held that it was not necessary for the magistrate to make an independent inquiry as to fitness.

II.12. Doctor's statement

In the case of a bride burning, the doctor to whom the deceased was taken for treatment deposed that soon after her admission, she said that her husband had poured kerosene on her clothes and set her ablaze. The doctor made a note of it in the case papers. The testimony of the doctor became supported by the contemporaneous record. The Court said that the doctor had no reason to falsely depose against the accused or prepare false case papers.

II.13. FIR as dying declaration

In K..Ramachand Reddy v. Public Prosecutor, it was held that where an injured person lodged an FIR & then died, it was held to be relevant as a dying declaration.

II.14. Dowry Death, wife burning etc

The death of a married woman in the matrimonial home three or four months after her statements expressing the danger to her life has been held by the Apex Court to be a statement explaining the circumstances of her death. In a case of wife-burning, after recording her statement that her husband had set afire, she mercifully pleaded that her husband should not be beaten. It was argued on this basis that she wanted to exonerate her husband. The court replied:

This is a sentiment too touching for tears & stems from the values of the culture of the Indian womanhood; a wife when she has been set afire by her husband, true to her tradition, does not want her husband should to be assaulted brutally. It is this sentiment which promoted this dying tragic woman to say that even if she was dying, her husband should not be beaten. We are unable to appreciate how this statement can be converted into one exculpative of the accused. In a

further application of this principle to a case arising out of "that atrocious species of murder " , called wife burning, the Apex Court said: "The three dying declarations corroborated by other circumstances are sufficient in our view to bring home the offence. The counsel has sought to discredit these declarations forgetting that they are groaning utterances of a dying woman in the grip of dreadful agony which cannot be judged by the standard of fullness of particulars which witnesses may give in other situations. To discredit such dying declarations for short- falls here or there or even in many places is unrealistic, unnatural & unconscionable, if basically there is credibility. The terrible in this case has taken place in the house & in the presence of the husband who has been convicted. We hardly see any reason for interfering in this conviction. In a case a bride was 80% burnt when she had given statement to the doctors. But according to doctors she was in a fit condition to give statement. The court said that from the fact of 80% burns no inference was to be drawn that she could not have been capable of making the statement. Where the declaration of the deceased wife was deposed only by her mother, the Court held this to be not sufficient to convict.

II.15. Statements made to or implicating relatives

The Apex court laid down in the subsequent case of Barati v. State of U.P., that a dying declaration made to the relatives of the deceased, when properly proved can also be trusted. In this case the deceased who was killed by sprinkling acid on him first made the statement to his brother & son, repeated it at the police station & again at the hospital charging the accused, the court held that the statement was worthy of credit. Where the dying statement was recorded by the wife of the deceased, the Supreme Court did not reject it only on that ground, though it added that such evidence should be scrutinized with care.

III. Evidentiary Value of Dying Declaration

In K.R. Reddy v. Public Prosecutor, evidentiary value of dying declaration was observed as under

"The dying declaration is undoubtly admissible under section 32 & not being statement on oath so that its truth could be tested by cross-examination, the court has to apply the scrutiny & the closest circumspection of the statement before acting upon it. While great solemnity and sanctity is attached to the words of a dying man because a person on the verge of death is not likely to tell lies or to connect a case as to implicate an innocent person, yet the court has to be on guard against the statement of the deceased being a result of either tutoring, prompting or a product of his

imagination. The court must be satisfied that the deceased was in a fit state of mind to make the statement after the deceased had a clear opportunity to observe & identify his assailants & that he was making the statement without any influence or rancor. Once the court is satisfied that the dying declaration is true & voluntary, it can be sufficient to found the conviction even without further corroboration."

In KhushalRao v. State of Bombay, Apex Court laid down the following principles related to dying to dying declaration :

(i) There is no absolute rule of law that a dying declaration cannot be the sole basis of conviction unless corroborated. A true & voluntary declaration needs no corroboration.

(ii) A dying declaration is not a weaker kind of evidence than any other piece of evidence;

(iii) Each case must be determined on its own facts keeping in view the circumstances in which the dying declaration was made.

(iv) A dying declaration stands on the same footing as other piece of evidence & has to be judged in the light of surrounding circumstances & with reference to the principle governing the weight of evidence.

(v) A dying declaration which has been recorded by a competent Magistrate in the proper manner, that is to say, in the form of questions and answers, &, as far as practicable in the words of the maker of the declaration stands on a much higher footing than a dying declaration which depends upon oral testimony which may suffer from all the infirmities of human memory & human character.

(vi) In order to test the reliability of a dying declaration the court has to keep in view the circumstances like the opportunity of the dying man for observation, for example, whether there was sufficient light if the crime was committed in the night; whether the capacity of man to remember the facts stated had not been impaired at the time he was making the statement by circumstances beyond his control; that the statement has been consistent throughout if he had several opportunities of making a dying declaration apart from the official record of it; & that the statement had been made at the earliest opportunity & was not the result of tutoring by interested party."

IV. Exceptions of Dying Declaration

The exceptions of 'Dying declaration' stipulate that where the statements made by dying persons are not admissible:

IV.1. If the cause of death of the deceased is not in question: If the deceased made statement before his death anything except the cause of his death, that declaration is not admissible in evidence.

IV.2. If the declarer is not a competent witness: declarer must be competent witness. A dying declaration of a child is inadmissible. In Amar singh v. State of Madhya Pradesh,1996 Cr LJ (MP) 1582, it was held by M.P. High Court that without proof of mental or physical fitness, the dying declaration was not reliable.

IV.3. Inconsistent declaration: Inconsistent dying declaration is no evidentiary value.

IV.4. Doubtful features: In Ramilaben v. State of Gujarat it was held by the court that second degree burn injuries, the injured dying 7-8 hours after the incident, four dying declarations recorded but none carried medical certificate. There were other doubtful features, evidence not taken into account.

IV.5. Uninfluenced declaration: it must be noted that dying declaration should not be under influence of any one.

IV.6. Untrue declaration: it is perfectly permissible to reject a part of dying declaration if it is found to be untrue & if it can be separated.

IV.7. Incomplete declaration: dying declaration must be complete.

IV.8. if the statement relates to the death of another person: If the statement made by the deceased does not relate to his death, but to the death of another person, it is not relevant.

IV.9. Contradictory statements: if a declarant made more than one dying declarations & all are contradictory, then those all declarations lose their value.

IV.10. Unsound person: where the married dying of burns was a person of unsound mind & the medical certificate vouchsafed her physical fitness for a statement & not the state of mind at the crucial moment, the court said that the statement could not be relied upon.

IV.11. I If dying declaration is not according to prosecution: in the case of State of U.P. v. Madan Mohan the Apex Court held that:

1. It is for the court to see that dying declaration inspires full confidence as the maker of the dying declaration is not available for cross-examination.
2. Court should satisfy that there was no possibility of tutoring or prompting.
3. Certificate of doctor should mention that victim was in a fit state of mind. Magistrate recording his own satisfaction about the fit mental condition of the declarant was not acceptable especially if the doctor was available.
4. Dying declaration should be recorded by the executive magistrate & police officer to record the dying declaration only if condition of the deceased was so precarious that no other alternative was left.
5. Dying declaration may be in the form of questions & answers & answers being written in the words of the person

making the dying declaration. But court cannot be too technical.

V. Conclusion

"Dying Declaration" is a legal concept refers to that statement which is made by a dying person, explaining the circumstances of his death. LORD LUSH, L.J., quoted that "A dying declaration is admitted in evidence because it is presumed that no person who is immediately going into the presence of his Maker, will do so with a lie on his lips. But the person making the declaration must entertain settled hopeless expectation of immediate death. If he thinks he will die tomorrow it will not do."

LORD EYRE, C.B., also held that "The principle on which this species of evidence is admitted is, that they are declarations made in extremity, when the part is at the point of oath, & when every hope of this world is gone; when every motive of falsehood is silenced, & the mind is induced by the most powerful consideration to speak the truth; a situation so solemn & awful is considered by law as creating an obligation equal to that which is imposed by a positive oath administered in the court of justice."

Dying declaration is admissible on the sole ground that it was made in extremis. And in India, its admissibility is explained in Sec-32(11) of Indian Evidence Act. It is cleared by the above mentioned statements given by different courts that dying declaration can be in any form but it must be recorded carefully & duly proved, which the courts make admissible as the "DYING DECLARATION".

Dying deposition is almost a dying declaration. The main difference being that it is always recorded by a magistrate in presence of the accused or his/her lawyer.

The Magistrate records the evidence after administering oath in presence of the accused or his lawyer.

Legally, the dying deposition is more valuable than dying declaration as the accused has got the opportunity to challenge and cross-examine.

The Medical Officer's presence is not indispensable, but he/she may have to certify the mental fitness of the patient.

However, currently this is not in practice in India. There is no provision of dying deposition in IEA, so it is not followed in India.

Differentiation of Dying deposition & Dying declaration

Let's take a look over Dying deposition vs Dying declaration :

S.No. Feature Dying declaration Dying deposition1. Statement Recorded by anyone-magistrate/doctor/village headman/police/any member of public Always recorded by a Magistrate2.Oath@Not required Must3.Type of evidence*DocumentaryOral4. Cross-examination Not performed Done5.

Leading questions#Not asked 6.Legal valueLess Much more7.Admissibility, if declarant survivesNot admitted, but has corroborative valueFully admitted8.NatureMerely recording of statementComplete court procedure9.Accused or his counselNotpresentAlways present10.Role of doctorAssess compos mentis^ and
Record the statement in absence of Magistrate,
but in presence of witnessesAssess compos mentis
Statement always recorded by the Magistrate11.Practice in IndiaFollowedNot followed

*Medical Evidence is defined as legal means to prove or disprove any medico-legal issue in question. It is of two types : Documentary, & Oral.

#Leading questions must not be asked, if objected to by the adverse party, in an examination-in-chief or in re-examination, except with the permission of the court (Sec. 142 IEA Indian Evidence Act).

@Perjury : A witness who after taking oath or making a solemn affirmation, willfully makes a false statement which he knows or believes to be the false (Sec. 191 IPC and Sec. 344 CrPC) is liable to be prosecuted for perjury under Sec. 193 IPC with imprisonment upto 7 years and fine.

^Compos mentis : Having full control of one's mind i.e. sound mind.

[08/02 11:41 am] Dr Pathak Spo2: What is a Death Certificate and Why is it Needed

A Death Certificate is a document issued by the Government to the nearest relatives of the deceased, stating the date, fact and cause of death. It is essential to register death to prove the time and date of death, to establish the fact of death for relieving the individual from social, legal and official obligations, to enable settlement of property inheritance, and to authorise the family to collect insurance and other benefits.

The Legal Framework

In India, it is mandatory under the law (as per the Registration of Births & Deaths Act, 1969(External website that opens in a new window)) to register every death with the concerned State/UT Government within 21 days of its occurrence. The Government accordingly has provided for a well-defined system for registration of Death, with the Registrar General, India, at the centre and the Chief Registrars in States, running through district registrars to the village and town registrars at the periphery.

What You Need to Do to Obtain a Death Certificate

A death can be reported and registered by the head of the family, in case it occurs in a house; by the medical in-charge if it occurs in a hospital; by the jail in-charge if it occurs in a jail; and by

the headman of the village or the in-charge of the local police station in case the body is found deserted in that area.

To apply for a Death Certificate, you must first register the death. The death has to be registered with the concerned local authorities within 21 days of its occurrence, by filling up the form prescribed by the Registrar. Death Certificate is then issued after proper verification.

If a death is not registered within 21 days of its occurrence, permission from the Registrar/Area Magistrate, along with the fee prescribed in case of late registration, is required.

The application form in which you are required to apply is usually available with the area's local body authorities, or with the Registrar who maintains the Register of Deaths. You might also need to submit proof of birth of the deceased, an affidavit specifying the date and time of death, a copy of the ration card, and the required fee in the form of court fee stamps.

Role of General Practitioners in Issuing a Death Certificate

Introduction

Death is an inevitable event in every person's life. However, structure of the modern society has necessitated death to be authenticated by the medical profession. Therefore the doctors have to bear and carry out this responsibility with all fairness and pragmatism.4 Issuing a death certificates is one of the onerous duties of a General Practitioner (GP), which can have medico-legal implications. The General Practitioner must verify all the relevant facts before issuing a death certificate and should not issue a death certificate under any pressure. A doctor should do his utmost to arrive at the cause of death or at the probable cause of death.4 The cause of death is to be based only on clinical findings and not on extraneous factors.2 Death certificate and cause of death is to be issued only when the treating doctor is fully satisfied as to the clinical diagnosis and corroborative diagnostic tests, viz. electro-cardiogram in acute myocardial infarction, cerebro-spinal fluid in meningitis, etc. A doctor may certify death but the cause of death is to be issued only on verification and after satisfying all facts of the cause, causing and resulting in death.4 In case of suspicion of death due to unnatural causes, the doctor may only certify death, and not the cause of death and will inform police for further investigations and postmortem. Before issuing death certificate, the doctor must verify and ascertain the name, age, sex, religion, address of the deceased. Any correction required later in the above-mentioned points, results in a lot of inconvenience to the next of kin and may cause delay in finalization of death claim, reimbursement of hospital bills,insurance claims, obtaining probate or succession certificate, settlement of

property claims, release of gratuity and provident fund claims.4 The Maharashtra State Government Act, 1976 (Section 5(2)), stipulates that death must be informed within 72 hours to the local municipal authorities. Failure to do so is dealt under the Government of India Act of 1969 relating to registration of birth and death.

Pre-requisites

Death certificate is to be issued free of charge and is not to be withheld for pending fees payment from the relatives and friends of the deceased.1,4 Only a single copy of the death certificate to be issued.1,4 The doctor should always maintain a carbon copy of the death certificate issued. The death certificate should be issued by a registered medical practitioner who

a) has been medical attendant of the deceased during life.

b) has attended the patient within past 14 days prior to his death.

c) is satisfied as to the cause of death.1

If necessary, only a duplicate true copy should be issued. Death certificate is necessary even in cases of new born children who are still-born or premature. It is desirable to view the whole body carefully before issuing a death certificate. It should not be signed blank leaving the details to be filled by someone else.

In partnership practice, one doctor should not certify the cause of death of his colleague's patient unless he too had attended the patient during the last 14 days of his life. No certificate should be issued in case of sudden death of a person who has not been examined by the doctor before his/her death. No death certificate should be issued in cases falling within the purview of the Coroner's Act. All the deaths which are unexpected, unexplained, unnatural, under suspicious circumstances and of the people under custody of police or public institutions like remand homes and asylums, and under medical procedures should be reported to the Coroner.1 At the lower part of the certificate, the qualifications mentioned should be those registered by the Indian or State Medical Council and in most cases are confined to the qualifying degree and not to a variety of post-graduate diplomas.1It is also the medical practitioner's responsibility to forward the D.C. to the registering authority, though it is usually sent through a relative of the deceased, who receives a permit to dispose of the dead body only after the death certificate is issued.

Importance

Death certificate is an important legal document from the point of view of the person (since deceased) and his/her next of kin. This document (correctly filled and completed) is absolutely essential. Cremation or Burial Pass is obtained from the municipal authorities so that cremation and final rites of the

deceased person can take place as per his/her religion, without loss of time and any inconvenience to relatives and friends.

Proper registration with the local municipal authorities, of all the details of the death certificate of the deceased person, must be done so that life insurance claim and settlement can be processed. All legal dues like gratuity, provident fund and family pension can be settled from the office of the deceased person if he/she was a salaried person, distribution of movable and immovable property of the deceased person (as per his/her last Testament or Will) can be bequeathed to legal heirs. The executor of the Will can obtain a certified copy of the death certificate from local municipal authorities before proceeding to obtain probate or succession certificate from civil court. Legal claim under personal accident benefit policy can be processed in case of accidental death. Deletion of the deceased person's name from Ration Card, or from movable or immovable property extract viz. share, house or flat, etc. will also need a certified copy of the duly completed death certificate.4

International Format

The International Classification Diseases should be used in death certificate whenever possible to maintain uniformity and facilitate fast retrieval of data through computerization.4,6

The death certificate recommended by World Health Organization (WHO) for International use, is in two parts (Fig. 1). Part I : Records (a) the "disease or condition directly leading to death" and (b) Antecedent causes viz. the "morbid conditions, if any, giving rise to the cause mentioned in (a). Thus, "(a)" must be due to "(b)" which must be due to "(c)", etc. (Fig. 1). The basic pathological condition is that which is mentioned on the lower most line, and this is the one that is used for statistical and epidemiological purposes. The symptomatology or mode of death e.g. cardio-respiratory failure, asthenia, or asphyxia etc., should not be recorded in the cause of death, unless explained. Part II : Records "other significant conditions contributing to death, but not related to the disease or condition causing it".

The underlying cause of death is defined as "the disease which initiated the train of morbid events leading directly to death". International forms are used by various municipal authorities in our country and are available for doctors. Doctors should necessarily use their rubber stamp after affixing signature to death certificate. Printed forms are made available by the municipal authorities to doctors and hospitals for issuing death certificate.

The basis of mortality data is the Death Certificate.3 For ensuring national and international comparability, it is very

necessary to have a uniform and standardized system of recording and classifying deaths.

According to the recommendations of the Brodrick Committee, a doctor should not be allowed to issue a death certificate, unless he has attended to the deceased at least once during the seven days preceding death, and that the standard of accuracy of a death certificate should be raised from the present level of "to the best of knowledge and belief" to one of "confidence".5

Post-mortem Examination

Earlier, it was a dictum that in case of a patient dying within 24 hours after admission to a hospital, postmortem was ordered to establish the exact cause of death. In view of the tremendous advances of technological developments in imaging, electronic and laboratory equipment, 4 to 6 hours are enough to diagnose most of the cases admitted to a hospital in emergency. Thus, diagnosis can be established before death and the need of doing postmortem is obviated wherever death is due to disease or natural illness. However, in case of death under suspicious condition, medico-legal postmortem is mandatory to ascertain the exact cause of death.4

It was an earlier practice to send all bodies, where deaths occurred in medico-legal cases for medico-legal postmortem. With advancement in technological and scientific knowledge, accurate diagnosis is possible in a given case. So, wherever possible, the death certificate and cause of death may be issued in a medico-legal case. However, it must be noted that the death certificate must be handed over to police along with the dead body for final 'Panchanama'. The police authorities have the final say in this matter. If the police authorities still want a postmortem they can order so accordingly. In cases registered under Indian Penal Code (Sec. 498-A), due precautions must be taken before issuing the cause of death.4,5

Social Issues

Death certificate is a predicament in any doctor's practice. Every doctor has faced a situation where he/she has been in a dilemma - whether or not to issue a death certificate. The relatives of the deceased may plead, persuade, pressurize, even offer a price and at times, even threaten the doctor. He/she may be tempted to issue a death certificate in doubtful situations; purely on humanitarian grounds or for the fear of losing clientele.4 But the doctor is advised to apply great caution while issuing a death certificate as the final certificate may unwittingly help in destroying evidence of a crime. Once the body is cremated, the evidence is lost. In such a situation, the doctor may find himself in trouble with the law.4.

In India, a General Practitioner (G.P.) is usually considered a family physician

and has a regular clientele. Whenever required, these patients attend the GP's clinic. If a regularly visiting patient, who has not been examined recently by the doctor dies suddenly, then the doctor is in a dilemma, about whether or not to issue the death certificate. A similar situation is often experienced by the G.P. when called to attend a critically ill, unknown patient who is staying as a visitor/guest in the house of his acquaintance/regular patient. If such a patient dies, before receiving any treatment from the doctor, social pressure may be brought on the G.P. to issue a death certificate.4 If the G.P. has seen and treated the patient in the last 14 days, he is justified in issuing the D.C. Otherwise, he may land-up with a legal problem.4 The G.P. is advised to properly explain the situation to his family patient or acquaintance and politely decline to yield under pressure. He/she is further advised to guide the family on further procedures to obtain the D.C. The patients usually appreciate such steps and there is less chance of losing one's clientele.4

The Code of Medical Ethics permits overriding the rule of confidentiality and disclosure of the fact that the deceased was suffering from HIV/AIDS infection..This exception to the Code of Medical Ethics is permitted in public interest and overrides confidentiality.4

Errors in Death Certificate

It is often noticed that some rectification may be required in the death certificate. If any such irregularity is noticed in D.C. by relatives of the deceased, it is possible for the doctor issuing the D.C. to correct it before the cremation/burial pass is obtained from the Municipal Authorities. But, later on, correction in the extract of a D.C. involves a long legal process. The next of kin has to struggle a lot to get even minor corrections done in D.C. and for lack of such rectifications, Insurance claims, gratuity, provident fund, etc. remain unsettled, causing a lot of inconvenience to members of the bereaved family.

Therefore, the doctor should be very careful in filling up details in D.C. like name, age, sex, religion and address and the cause of death.

Treatment & Referral of Convicts &under trials

Objective:

- To give an overview of working system of jail and jail manual.
- Assessment of seriousness of illness while taking decision to refer a Convict or under trial to higher centre for treatment
-

Content:

1. Introduction to the working system of jail and jail manual
   Classification of jails - central jails - district jail - Juvenile jails - custodial jails Jail manual contains total 55 chapters and 1429 para covering almost each and every aspect of Jail working Jail manual has additional 28 new implementation of laws time to time Chapter number 39 and 40 are especially meant for medical officer working in the Jain Hospital
   Para 1070 of chapter number 40 is When your any assistant medical officer is attached to jail , it is supposed that he will make himself aware of all the rules and regulations from the jail manual regarding mental illness , diet , cleanliness and hygiene , prevention of diseases , crime and punishment , which are mentioned in other chapters at different places of the jail manual The medical officer of jail will take an assessment regarding his knowledge of the rules mentioned in jail manual every 3 months if he finds that after 3 months he is not aware of all the rules and regulations the medical officer is supposed to notify the fact to DIG jails pitstop the jail allowances given to him unless he becomes aware of all the rules and regulations mentioned in the jail manual regarding duties of a medical officer.
2. Overview of health infrastructure of Jail Hospital- The only Hospital where the patient is inside the locks and keys overnight - medical officer of jail has to be careful and extra alert especially in the evening hours at the time of closing of the jail It is supposed that medical officer jail examines all his Indore patients to make sure that all his patients are hemodynamically stable. - establishment of a good relationship with working compounder or pharmacist and other paramedical staff and making them alert enough for early recognition of any change in the health condition of a patient - establishment of a good relationship with jail authorities.
3. Assessment of seriousness of illness while taking decision to refer a Convict or under trial to higher centre for treatment - early detection of an illness which is likely to in danger either the life or may have a nature which results in disabling a patient - try to make sure that the illness for which the Convict or the under trial prisoner is being referred is not a functional illness - learning the art to differentiate between the patient having an actual illness and those with functional illness only

4. Protocol to call specialty doctor from nearest higher centre - medical officers order book - informing the jail Superintendent regarding an illness in which some specialty doctor is needed to consult from outside the jail. - always use medical officer's order book for any conversation with jail authorities
5. Frequency faced social and administrative problems as a jail medical officer learning the art or making a balance between anyone towards social pressure and performing the duties as a medical officer or Jail officer taking a decision which is meant for only the health benefit of any Convict or under trial
   Avoid any type of illegal pressure which comes out of working as a medical officer of Jail Hospital - making a good relationship with your subordinates and Jail administration - having a healthy conversation with nil your assistants and people and person around you.


राज्य स्वास्थ्य एवं परिवार कल्याण संस्थान, उ0प्र0
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30 PROPER PROCEDURE IN OFFICIAL DEALINGS

There are three pillars of democracy – Legislative, Judiciary and Executive. The smooth functioning of democracy fully depends upon these factors which have been enshrined in our constitution and act as separate entities.

Synergy between executive & legislature is a necessary element in any vibrant democracy. Though their functions are separate they are intimately related and complement each other's responsibilities in many ways. To facilitate the interaction between the legislators and executives, guidelines and Dos have been issued by Government of India Ministry of Personnel, Public Grievances & Pensions (Department of Personnel and Training), so that the execution of functions becomes smoother.

The procedures for interacting with the Hon'ble Members of Legislature are:-

1) **Procedure for corresponding with Members of the Parliament/State Legislature:-**

With regard to the correspondence with the Members of Parliament, guidelines (O.M. No. 25/19/64—Estt.(A) dated 8.11.1974) on the subject were issued by the Government of India. A separate O.M. No. 11013/2/2000—Estt.(A) dated the 23rd May, 2000 giving the details about official dealings between the Administration and Members of Parliament and Members of State Legislatures was issued. Moreover, these guidelines were reiterated from time-to-time vide Department of Personnel & Training O.Ms. dated 21.12.92 and 29.10.96. These guidelines state:-

a) Ensuring availability and access:-

Even though the members of the Service may not always be available on telephone because of the exigencies of work, they are supposed to make suitable arrangements for getting recorded during their absence the message received from the Members of Parliaments and the messages received from the Members of State Legislatures and getting back to them as soon as they are in a position to do and also for talking suitable actions on the basis of the message received from the Hon' able Members. Suitable arrangements must be made so that the members of the Parliament are not put to inconvenience and any indifferent attitude in this respect should be strongly dealt with under AIS (D&A) Rules, 1969.

b) Meeting with the Hon' able Members:-

As the members of Parliament and State Legislatures occupy, in our democratic set up, a very important place as accredited representative of people, they have important functions to

perform under the Constitution and they find it necessary to seek information from the Ministries/Departments of the Govt. of India or the State Governments, or make suggestions for their consideration or ask for interviews with the officers in connection with their Parliamentary and allied duties. In this connection, certain well recognized principles and conventions to govern the relations between Members of Parliament and of State Legislatures and Government servants have already been established. The existing instructions emphasise that it should be endeavour of every officer to help Members of Parliament and State Legislature to the extent possible in the discharge of their functions under the Constitution. The basic principles to be borne in mind by the Govt. servants while interacting with the Members of Parliament and State Legislatures are that: —

i) The Government servants should show courtesy and consideration to Members of Parliament and State Legislatures may have to say, they should always act according to their own best judgement.

ii) That while they should consider carefully of listen patiently to what the Members of Parliament and State Legislatures may have to say, they should always act according to their own best judgement.

iii) Any deviation from an appointment made with a Member must be promptly explained to him to avoid any possible inconvenience. Fresh appointment should be fixed in consultation with him/her.

iv) An officer should be meticulously correct and courteous and rise to receive and see off a Member visiting him.

v) Members of Parliament/State Legislatures of the area to be invariably invited to public function organised by a Govt. office. Proper and comfortable seating arrangements at public functions to be made for Member who appear above officers of the rank of Secretaries to Government of India in Warrant of Precedence. The position of Members of Parliament has been clearly brought out in the warrant of procedure approved by the President. M.Ps. appear at Article 30 above officers of the rank of full Central or equivalent, Secretaries to the Government of India, etc. The instructions appended to the Warrant of precedence also lay down that when Members of Parliament are invited en bloc to major State functions, the enclosure reserved

for them should be next to the Governors, Chief Justice, Speaker of the Lokl Sabha, Ambassadors, etc. A further provision in the instructions is that the Members of State Legislatures who, owing to their presence in Delhi happen to be invited to State functions, should be assigned rank just after Member of Parliament. To convenience to Members of Parliament and of seats meant for them should be kept reserved till end of the function and should not be occupied by other persons, even though they may be vacant. The seats provided for them should be at least as comfortable and as prominently placed as those for officials.

vi) Letters from Members of Parliament and Members of State Legislatures must be promptly acknowledged, and a reply sent at an appropriate level expeditiously. Relevant provisions of the Manual of Office Procedure should be observed in this regard.

vii) Information or statistics relating to matter of local importance must be furnished to M.Ps, and M.L.As when asked for. If request is to be refused, instructions from higher authority should be taken.

viii) A Government servant should not approach MPs/MLAs for sponsoring his individual case; and

ix) References from Committees of Parliament must be attended to promptly. A senior officer at the level of Joint Secretary or equivalent should be charged with the responsibility for ensuring this.

x) The Officers should not ignore telephonic messages left for them by the Members of Parliament/State Legislatures in their absence and should try to contact at the earliest the concerned Member of Parliament/State Legislature.

xi) While the official dealings of Government servants with Members of Parliament and of State Legislature have to be regulated as stated in the previous paragraphs, it is necessary to invite the attention of Government servants to what is expected of them in their individual capacity in respect of their own grievances in the matter of conditions of service. Under the relevant Conduct Rules governing them, Government servants are prohibited from bringing or attempting to bring any, political or other influence to bear upon any superior authority to further their interests in respect of matters pertaining to their service under the Government. Therefore, a Government servant is not expected to approach a Member of Parliament or of a

State Legislature for sponsoring his individual case. (Copy Ministry of Home Affairs (now Department of Personnel & Administrative Reforms), Office Memorandum No. 25/29/56–Estt. (A) dated the 28th August, 1957)

c) Correspondence with Member of Parliament:-

Further detailing with respect to Correspondence with Member of Parliament, Paras 57, 60 & 122 of Central Secretariat Manual of Office Procedure (Eleventh Edition, 1998) 57 states that:-

1) Communications received from Members of Parliament should be attended to promptly.
2) Where a communication is addressed to a Minister, it should, as far as practicable, be replied to by the Minister himself. In other cases, a reply should normally be issued over the signature of an officer of the rank of Secretary only.
3) Where, however, a communication is addressed to the head of an attached or subordinate office, Public Sector Undertaking) financial institutions (including nationalized banks) Division/Branch In charge in a Ministry/ Department/ Organisation, it should be replied to by the addressee himself. In routine matters not involving question of policy, he may send an appropriate reply on his own. In matters involving questions of policy the officer should have prior consultation with higher authorities before sending a reply. It should, however, be ensured that minimum level at which such replies are sent to Members of Parliament is that of Under Secretary and that also in letter form only.
4) Normally Information sought by a Member should be supplied it is such a nature that it would have been denied to him even if asked for on the floor of the Houses of Parliament.
5) As far as possible, in corresponding with Members of Parliament, preprinted or cyclostyled copies should be avoided.
6) In case reference from an Ex-Member of Parliament (or MP who has not been re-elected) is addressed to a Minister or Secretary, reply to such reference may be sent by the concerned Divisional Head after obtaining approval of the Secretary of the Ministry/Department. In case the reference is addressed to a lower level officer reply to such reference could be sent by the officer on his/her own in non-policy cases and after obtaining approval of the higher authorities in policy cases. However, the

minimum level at which reply could be sent should be that of an Under Secretary and that too in letter form only.

d) Prompt response to letters received:-

i) Each communication received from Members of Parliament, a member of the public, a recognized association or a public body will be replied to within 15 days.

ii) Where (i) delay is anticipated in sending a final reply, or (ii) information has to be obtained from another Ministry or another office, an interim reply will be sent within a fortnight indicating the possible date by which a final reply can be given.

iii) If any such communication is wrongly addressed to a department, it will be transferred promptly (within three days) to the appropriate department under intimation to the party concerned.

iv) Where the request of a Member of the Public cannot be acceded to for any reason, reasons for not acceding to such a request should be given.

v) As far as possible, requests from members of public should be looked at from the user's point of view of what may be administratively convenient.

e) Watch on disposal of communication received from Members of Parliament:-

The personal section of each Joint Secretary/Director (if the director submits cases direct to secretary/additional secretary) will maintain a separate register of communications received from Members of Parliament in the form given in Appendix 45. The serial number at which a letter is entered in this register will be prominently marked on that letter together with its date of registration e.g.,"25/JS/P/MP)' 20.3.96 a. To keep a special watch on speedy disposal of communication received from Members of Parliament, each section will:-

i) maintain a register as in form at Appendix 46; and

ii) Make out prominently those communications finally disposed of by rounding off the serial numbers of the register in red ink.

iii) If for any reason an M.P.'s letter is received by a section without being registered in the personal section of the Joint Secretary/Director, immediate steps will be taken to get it registered there.

iv) On the 1st and 15th day of each month, each section will submit

the register along with the report in the form at Appendix 47 to the Under Secretary/Deputy Secretary. Particulars of communications pending for more than a fortnight will be given in the form at Appendix 48. The report, with the remarks of Under Secretary/Deputy Secretary, will be submitted to the Director/Joint Secretary and register will be returned to the section.

v) The personal section of the Joint Secretary/Director will check whether all the communications entered in its register figure in the reports sent by the sections. If any discrepancy is found, it should be reconciled. Thereafter, the report will be submitted to the Joint Secretary/Director for scrutiny and for such other action, as he may consider appropriate.

vi) Ministries may through departmental instructions include additional columns in the forms at Appendix 45, 46,47 and 48 to suit local needs.

23 DISCIPLINARY PROCEEDINGS

An abstract based on The Uttar Pradesh Government Servant (Discipline and Appeal) Rules, 1999)

Conduct and discipline are essential measures to be taken to build up sound personnel system. Hence, a provision for discipline through preventive, punitive and participative approaches is required to be build up in every organization so as to enhance effectiveness and productivity.

Since all staff members cannot be expected to conduct themselves with equal zeal in an unimpeachable manner, a provision for disciplinary action is made in every organization.

Disciplinary action means the administrative steps taken to correct the misbehavior of the employee in relation to the performance of his/ her job. Corrective action is initiated to prevent the deterioration of individual inefficiency and to ensure that it does not spread to other employees.

Reward and Punishment system is one of those effective tools that are used by organizations are made to work towards the fulfillment of the organisational goals. While the reward system will encourage the employees to work better towards the achievement of organisational goals, punishment system is used to prevent people from working against the organisational goals.

Part XIV of the Constitution relates to the terms of employment in respect of persons appointed in connection with the affairs of the State. Any action against the employees of the State Government should conform to these Constitutional provisions, which confer certain protections on the Government servants. These provisions are applicable only to the employees of the various Ministries, Departments and Attached and Subordinate Offices.

Further, the employees, being citizens of the country also enjoy Fundamental Rights guaranteed under Part III of the Constitution and can enforce them though the Writ jurisdiction of the Courts. In addition to the constitutional provisions, there are certain rules which are applicable to the conduct of the proceedings for taking action against the erring employees.

The Uttar Pradesh Government Servant (Discipline and Appeal) Rules, 1999 cover a vast majority of the State Government employees. Besides, there are also several other Rules which are applicable to various sections of the employees in a number of services.

Concept of disciplinary angle in the Government

The Disciplinary angle could be perceptible in cases characterised by:

1. Commission of criminal offences like demand and acceptance of illegal gratification, possession of disproportionate assets, forgery, cheating, abuse of official position with a view to obtaining

pecuniary benefits advantage for self or for any other person;

2. Irregularities reflecting adversely on the integrity of the public servant;

3. Lapses involving gross or willful negligence, recklessness, failure to report to competent authorities, exercise of discretion without or in excess of powers/jurisdiction, cause of undue loss or a concomitant gain to an individual or a set of individuals/a party or parties and flagrant violation of systems and procedures.

Misconuct and Indiscipline in Government

Once we have seen the dimensions of Disciplinary matters, we can appreciate what is looked upon as misconduct or deviance in Government. A full set of activities have been listed in the actions covered in the CONDUCT RULES. Different categories of Government servants are governed by separate but substantially similar sets of conduct rules.

A diverse set of acts such as- restrictions on political activities, relationship with press, radio and outsiders, criticism of the Government, restrictions on public demonstrations, present restrictions on matters of property, private business and investments etc. fall under the purview of conduct rules. Some sets of conduct rules in India are (1) All India Services (Conduct) Rules, 1954; (2) Central Services (Conduct) Rules, 1955; and (3) Railway Services (Conduct) Rules; 1956. The Dos and Don'ts are clearly defined in these rules.

Common acts of Misconduct Resulting in Disciplinary Proceedings:

The following are the various criteria and forms that involve disciplinary proceedings.

1. Acts Amounting to Crimes

2. Embezzlement, Falsification of accounts not amounting to misappropriation of money

3. Fraudulent claims (eg. Travelling Allowance)

4. Forgery of documents for personal gain to defraud the Govt.

5. Theft of Government Property

6. Defrauding Government

7. Bribery

8. Corruption

9. Possession of disproportionate assets

10. Conduct Amounting to Misdemeanour

1. Disobedience of orders

2. Insubordination

3. Misbehaviour

i) with superior officers

ii) with colleagues

iii) with subordinates

iv) with members of public.

Current Approaches of Enforcing Discipline and Curbing Corruption:

Misconduct, or non-conforming behaviour, as it is sometimes called, can be tackled through preventive actions, punitive actions and surveillance. While preventive and surveillance actions help in creating an enabling environment, the punitive action adds to it through deterrence.

Preventive:

Preventive measures can broadly be categorized as: -

1. **Simplification and standardization of rules:** Simplification and standardisation of rules and procedures, and forms/applications results in elimination of discretion and arbitrariness.

2. **Leveraging technology:** Technology as an enabler for fighting corruption has been effectively demonstrated. E-procurements, E-payments, use of websites for dissemination of information and creating awareness, use of CCTV in places of public dealing, receiving applications online, disbursement of Scholarships online through PFMS/DBT, use of appropriate analytical tools are examples of how technology strengthens the system.

3. **Transparency and Accountability:** Transparency removes the information gap between the public and public officials. A system with clear accountability and assigned responsibility at each level is necessary not only for smooth functioning but increased transparency, efficiency and for ensuring effective punitive action in case of misconduct.

4. **Control & Supervision:** Regular and routine inspections, surprise inspections, audit and reviews keep a check on indiscipline and corruption.

5. **Early detection of misconducts:** Early detection of misconduct will enable recouping the loss wherever possible and facilitate control of further damage.

6. **Time-bound and effective punitive action:** Punitive action within short period of occurrence of misconduct and award of exemplary and adequate punishment deters others from committing such misconduct.

7. **Training & Awareness:** Public officials should be made aware of their duties and responsibilities, code of conduct, rules and regulations through regular training.

8. **Awareness among public:** If public is made aware of their rights, and also of the rules and regulations, then they are able to resist unfair treatment and arbitrary behaviour by public officials.

Punitive: Punitive measures come into play when indiscipline and corruption has already been committed and punishment is granted to have deterringt effect on others

1. Investigation based on complaints/ Suo moto cognizance

2. Chargesheet

3. Domestic enquiry: Presenting officer/enquiry officer/disciplinary authority

4. Conduct discipline and appeal rules/model rules of conduct

5. Major/minor penalties

Participative: Includes surveillance and detection

1. Maintaining surveillance of personnel posted in sensitive corruption prone areas

2. Surprise checks

3. Prepare a list of employees of doubtful integrity and maintain surveillance

4. Transparency in work.

In addition to this, it is also important to add dimension of ethics and value-based management and its training in the organization.

Violation of Discipline Results in Disciplinary Action:

Disciplinary action may be of differing magnitude, such as-

1. Minor Penalties

2. Major Penalties.

Formal disciplinary action follows where the offence is serious and can be legally established. In such cases the penalties which are imposed on a member of the service are:

1) Minor Penalties: The following penalties may, for good and sufficient reasons and as hereinafter provided, be imposed upon the government servants;

(i) Censure

(ii) Withholding of increments for a specified period.

(iii) Stoppage at an efficiency bar.

(iV) Recovery from pay of the whole or part of any pecuniary loss caused to Government by negligence or breach of order .

(v) Fine incase of persons in holding Group D posts.

Provided that the amount of such fine shall in no case exceed twenty five

percent of the months pay in which the fine is imposed.

2) Major Penalties:

(i) Withholding of increments with cumulative effect;

(ii) Reduction to a lower post or grade time scale or to a lower stage in a time scale;

(iii) Removal from the service which does not disqualify from future employment;

(iv) Dismissal from the service which disqualify from future employment.

However, there are certain limitation that have been imposed as per the THE UTTAR PRADESH GOVERNMENT SERVANT (DISC&LINE AND APPEAL) RULES, 1999 vis-s-vis Major Penalities. They are :-

The following shall not amount to penalty within the meaning of this rule, namely:

(i) Withholding of increment of a Government Servant for failure to pass
a departmental examination or for failure to fulfill any other condition in accordance with the rules or orders governing the service;

(ii) Stoppage at the efficiency bar in the time scale of pay on account of
ones not being found fit to cross the efficiency bar;

(iii) Reversion of a person appointed to probation to the service during or
at the end of the period of probation in accordance with the terms of appointment or the rules and orders governing such probation.

(iv) Termination of the service of a person appointed on probation during
or at the end of period of probation in accordance with the term of the service or the rules and order governing such probation.

Suspension –

Besides the provision of penalties, certain situation or conduct by the personalles in service warrants a diffrent degree of disciplinary action before actual penalties can be imposed. The THE UTTAR PRADESH GOVERNMENT SERVANT (DISC&LINE AND APPEAL) RULES, 1999 clarify detail as to who can exercise this dispciplinary authority against whom and under what circumstances. The details are:-

(1) A Government Servant against whose conduct an inquiry is contemplated, or is proceeding may be placed under suspension pending the conclusion of the inquiry in the discretion of the Appointing Authority:

Provided that suspension should not be resorted to unless the allegations against the Government Servant are so serious that in the event of their being established may ordinarily warrant major penalty.

Provided further that concerned Head of the Department empowered by the Governor by an order in this behalf may place a Government Servants or class of Government Servant belonging to Group 'A' and 'B' posts under suspension under this rule.

Provided also that in the case Government Servant or class of Government Servant belonging to Group 'C' and 'D' posts, the Appointing Authority may delegate its power under this rule to the next lower authority.

(2) A Government Servant in respect of, or against whom an investigation, inquiry or trial relating to a criminal charge, which is connected with his position as a Government Servant or which is likely to embarrass him in the discharge of his duties or which involves moral turpitude, is pending, may at the discretion of the appointing Authority or the Authority to whom the power of suspension has been delegated under these rules, be placed under suspension until termination of all proceedings relating to that charge.

(3) (a) A Government Servant shall be deemed to have been placed or as the case may be, continued to be place under suspension by an order of the Authority Competent to suspend, with effect from the date of his detention , if he is detained in custody, whether the detention is on criminal charge or otherwise , for a period exceeding forty eight hours.

(b) The aforesaid Government Servant shall after the release from the custody, inform in writing to the Competent Authority about his detention and may also make representation against the deemed suspension. The competent authority shall after considering the representation in the light of the facts and circumstances of the case as well as the provision contained in this rule, pass appropriate order continuing the deemed suspension from the date of release from custody or revoking or modifying it.

(4) Government Servant shall be deemed to have placed or, as the case may be, continued to be under suspension by an order of the Authority Competent to suspend under these rules, with effect from the date of his conviction if in the event of a

conviction for an offence he is sentenced to a term of imprisonment exceeding forty eight hours and is not forthwith dismissed or removed consequent to such conviction.

Explanation- A period of forty eight hours referred to in sub-rule (1) be computed from the commencement of the imprisonment shall be taken to account.

(5) Where a penalty of dismissal or removal from service imposed upon a Government Servant is set aside in appeal or on review under these rules or under rules rescinded by these rules and the case is remitted for further inquiry or action or with any other directions-

(a) if he was under suspension immediately before the penalty was awarded to him , the order of his suspension shall, subject to any such direction as aforesaid be deemed to have continued in force on and from the date of the original order of dismissal or removal;

(b) if he was not under suspension, he shall, if so directed by the appellate or Reviewing Authority, be deemed to have been placed under suspension by an order of the Appointing Authority on and from the date of the original order of dismissal or removal

Provided that nothing in this sub-rule shall be construed as affecting the power of the Disciplinary Authority is a case where a penalty of dismissal or removal in service imposed upon a Government Servant is set aside in appeal or on review under these rules grounds other than the merits of the allegations which, the said penalty was imposed but the case is remitted for further inquiry or action or with any other directions to pass an order of suspension being further inquiry against him on those allegations so, however, that any such suspension shall not have retrospective effect.

(6) Where penalty of dismissal or removal from service imposed upon Government Servant is set aside or declared or rendered void in consequence of or by a decision of a court of law and the Appointing Authority, on consideration of the circumstances of the case, decides to hold a further inquiry against him on the allegation on which the penalty of dismissal or removal was originally imposed, whether the allegations remain in their original form or are clarified or their particular better specified or any part thereof a minor nature omitted

(a) if he was under suspension immediately before the penalty was awarded to him, the order of his suspension shall, subject to any direction of the appointing Authority, be deemed to have continued in force on and from the date of the original order of dismissal or removal

(b) if he was not under such suspension, he shall, if so effect by the Appointing Authority , be deemed to have been placed under suspension by an order of the Competent Authority and from the date of original order of dismissal or removal.

(7) where a Government Servant is suspended or is deemed to have been suspended (whether in connection with any disciplinary proceeding or otherwise) and any other disciplinary proceeding is connected against him during the continuance of that suspension, the Authority Competent to place him under suspension may, for reasons to be recorded by him in writing direct that the government Servant shall continue to be under suspension till termination of all or any such proceeding.

(8) any suspension ordered or deemed to have been ordered or to have continued in force under this rule shall continue in force until it is modified or revoke by the Competent Authority.

(9) A Government Servant placed under Suspension or deemed to have been placed under suspension under this rule shall be entitled to suspension allowance in accordance with the provisions of Fundamental rule 53 of Financial Hand book, Volume II, Parts II to IV.

Pay and allowances etc. of the suspension period-

After the order is passed in the departmental enquiry or in the criminal case, as the case may be under these rules, the decision as to the pay and allowances of the suspension period of the concerned Government Servant and also whether the said period shall be treated as spent on duty or not shall be taken by the Disciplinary Authority after giving a notice to the said Government Servant and calling for his explanation within a specified period under rule 45 of the Financial Hand Book Vol.-II Part II to IV.

Disciplinary Authority –

The Appointing Authority of a Government Servant shall be his Disciplinary Authority who, subject to the provision of these rules, may impose any of the penalties Specified in rule 3 on him.

Provided that no person shall be dismissed or removed by an authority subordinate to that by which he was actually appointed:

Provided further that the Head of Department notified under the Uttar Pradesh Class II services (Imposition of Minor Punishment) Rules, 1973, subject to the provisions of these rules, shall be Empowered to impose minor penalties mentioned in rule 3 of these rules:

Provided also that in case of a Government Servant belonging to Group 'C' and 'D' posts, the Government by a notified order , may delegate the power to impose any penalty, except dismissal or removal from service under these rules, to any Authority subordinate to the Appointing Authority and subject to such condition as may be prescribed therein.

Procedure for imposing major penalties-

Before imposing any major penalty on a Government Servant, an inquiry shall be held in the following manner

(i) The Disciplinary Authority may himself inquiry into the charges or appoint an Authority Subordinate to him as Inquiry Officer to inquire into the charges.

(ii) The Facts constituting the misconduct on which it is proposed to take action shall be reduced in the from of definite charge or charges to be called charge -sheet. The charge-sheet shall be approved by the Disciplinary Authority.

Provided that where the Appointing Authority is Governor, the charge —sheet may be approved by the Principal Secretary or the Secretary, as the case may be, of the concerned department.

(iii) The charge farmed shall be so precise and clear as to give sufficient indication to the charged Government Servant of the facts and circumstances against him. The proposed documentary evidences and the name of the witnesses proposed to prove the same along with oral evidence, if any, shall be mentioned in the charge-sheet.

(iv) The charge Government Servant shall be required to put in a written statement of his defence in person on a specified date which shall not be less than 15 days from the date of issue of charge-sheet and to state whether he desires to cross-examine any witness mentioned in the charge-sheet and whether desires to give or produce evidence in his defence He shall also be informed that in case he does not appear or file written statement on the

specified date, it will be presumed that he has none to furnish and inquiry officer shall proceed to complete the inquiry ex-parte.

(v) The charge-sheet, along with the copy of the documentary evidences mentioned therein and list of witnesses and their statements, if any shall be served on the charged Government Servant personally or by registered post at the address mentioned in the official records in case the charge-sheet could not be served in aforesaid manner, the charge- sheet shall be served by publication in a daily newspaper having wide circulation.

Provided that where the documentary evidence is voluminous, instead of furnishing its copy with charge-sheet, the charge Government servant shall be permitted to inspect the same before the Inquiry Officer.

(vi) Where the charged Government Servant appears and admits charges, the Inquiry Officer shall submit his report to the Disciplinary Authority on the basis of such admission.

(vii) Where the charged Government Servant denies the charge the Inquiry Officer shall proceed to call the witnesses proposed in the charge-sheet and record their oral evidence in presence of the charge Government Servant who shall be given opportunity to cross-examine such witnesses. After recording the aforesaid evidences, the Inquiry officer shall call and record the oral evidence which the charged Government Servant desired in his written statement to be produced in his defence.

Provided that the Inquiry Officer may for reasons to be recorded in writing refuse to call a witness.

(viii) The inquiry officer may summon any witnesses to give evidence or require any person to produce documents before him in accordance with the provisions of the Uttar Pradesh Departmental inquiries (Enforcement of Attendance of witnesses and production of documents) Act 1976.

(ix) The Inquiry Officer may ask any question he pleases, at any time of any witness or from person charged with a view to discover the truth or to obtain proper proof of facts relevant to charges.

(x) Where the charged Government Servant does not appear on the date fixed in the inquiry or at any stage of the

proceeding inspite of the service of the notice on him or having knowledge of the date the Inquiry Officer shall proceed with the inquiry exparte. In such a case the Inquiry Officer shall record the statement of witnesses mentioned in the charge-sheet in absence of the charged Government Servant.

(xi) The disciplinary Authority, if it considers if necessary to do so, may by an order appoint a Government Servant or a legal practitioner to be known as "Presenting Officer" to present on its behalf the case in support of the charge.

(xii) The Government servant may take the assistance of any other Government Servant to present the case on this behalf but not engage a legal practitioner for the purpose unless the presenting office appointed by the Disciplinary Authority is a legal practitioner of the disciplinary Authority having regard to the circumstance of the case so permits.

Provided that the rule shall not apply in following cases

(i) Where any major penalty is imposed on a person on the ground of conduct which has led to his conviction on a criminal charge. or

(ii) Where the Disciplinary Authority is satisfied, that for reason to be recorded by it in writing, that it is not reasonably practicable to held an inquiry in the manner provided in these rules; or

(iii) Where the Governor satisfied that, in the interest of the security of the state, it is not expedient to hold an inquiry in the manner provided in these rules.

Submission of Inquiry Report –

When the Inquiry is complete, the Inquiry Officer shall submit its inquiry report to the Disciplinary Authority alongwith all the records of the inquiry. The inquiry report shall contain a sufficient record of brief facts, the evidence and statement of the finding on each charge and the reasons thereof . The Inquiry Officer shall not make any recommendation about the penalty.

Action on Inquiry Report-

(1) The Disciplinary authority may, for reason to be recorded in writing, remit the case for re-enquiry to the same or any other Inquiry Officer under intimation to the charged Government Servant the Inquiry Officer shall thereupon proceed to hold the inquiry from such stage as directed by the Disciplinary

Authority, according to the provisions of Rule 7.

(2) The Disciplinary Authority shall, if it disagrees with the finding of the Inquiry Officer on any charge, record its own finding thereon for reasons to be recorded.

(3) In case the charges are not proved ,the charged Government Servant shall be exonerated by the Disciplinary Authority of the charges and inform him accordingly.

(4) If the Disciplinary Authority, having regard to its finding on all or any of charges is of the opinion that any penalty specified in Rule 3 should be imposed on the charge Government Servant, he shall give a copy of the inquiry report and his finding recorded under sub-rule (2) to the charged Government Servant and require him to submit his representation if he so desires, within a reasonable specified time. The Disciplinary Authority shall having regard to all the relevant records relating to the inquiry and representation of the charge Government Servant, if any, and subject to the provisions of Rule 16 of these rules, pass a reasoned order imposing one or more penalties mentioned in Rule 3 of these and communicate the same to the charged Government Servant.

Procedure for imposing minor penalties-

(1) Where the Disciplinary Authority is satisfied that good and sufficient reasons exist for adopting such a course, it may, subject to the provisions of sub-rule (2) impose one or more of the minor penalties mentioned in Rule 3.

(2) The Government Servant shall be informed of the substance of the imputations against him and called upon to submit his explanation within a reasonable time. The Disciplinary Authority shall, after considering the said explanation, if any, and the relevant records, pass such order as he considers proper and where a penalty is imposed, reason thereof shall be given.

(3) The order shall be communicated to the concerned Government Servant.

Appeal-

(1) Except the order passed under these rules by the Governor, the Government Servant shall be entitled to appeal to the next higher authority from an order passed by the Disciplinary Authority.

(2) The appeal shall be addressed and submitted to the Appellate Authority. A government Servant preferring

an appeal shall do so in his own name. the appeal shall contain all material statements and arguments relied upon by the appellant.

(3) The appeal shall not contain any intemperate language. Any appeal, which contains such language may be liable to be summarily dismissed.

(4) The appeal shall be preferred within 90 days from the date of communication of impugned order. An appeal preferred after the said period shall be dismissed summarily.

Consideration of Appeal-

The Appellate Authority shall pass such order as mentioned in clauses (a) to (d) of Rule 13 of these rules, in the appeal as he think proper after considering-

(a) Whether the facts on which the order was based have been established;

(b) whether the facts established afford ground for taking action; and

(c) whether the penalty is excessive, adequate or inadequate.

Revision-

Notwithstanding anything contained in these rules, the Government may of its own motion or on the representation of concerned Government Servant call for the record of any case decided by an authority subordinate to it in exercise of any power conferred on such authority by these rules; and

(a) confirm, modify or reverse the order passed by such Authority; or

(b) direct that a further inquiry be held in the case, or

(c) reduce or enhance the penalty imposed by the order; or

(d) make such other order in the case as it may deem fit.

Review –

The Governor may at any time, either on his own motion or on the representation of the concerned Government Servant, review any order passed by him under these rules, if it has brought to his notice that any new material or evidence which could not be produced or was not available at the time of passing the impugned order any material error of law occurred which has the effect of changing the nature of the case.

Opportunity before imposing or enhancing penalty-

No order under Rules 12,13 and 14 imposing or enhancing any penalty shall be made unless the

Government servant concerned has been given a reasonable opportunity of showing cause against the proposed imposition or enhancement, as the case may be.

Consultation with the commission-

Before any order is passed by the Government under these rules, the Commission , as required under the Uttar Pradesh Public Service Commission (Limitation of Function) Regulation, 1954 as amended from time, shall also be consulted.

Rescission and savings-

(1) the Civil Service (Classification, Control and Appeal) Rules, 1930 and the Punishment and Appeal Rules for Subordinate Services, Uttar Pradesh, 1932 hereby rescinded.

(2) Notwithstanding such rescission

(a) delegation of power mentioned in Punishment and Appeal Rules for Subordinate Service Uttar Pradesh, 1932 and any order issued under the Civil Service (Classification, Control and Appeal) rules,1930 or Punishment and Appeal Rules for Subordinate Services, Uttar Pradesh, 1932 delegating the power of imposing any of the penalties mentioned in rule 3 or power suspension any authority shall be deemed to have been issued under these rules and shall remain valid unless cancelled or rescinded;

(b) any inquiry, appeal, revision or review pending on the date of coming into force of these shall be continued and concluded in accordance with the provision of these rules;

(c) nothing in these rules shall operate to deprive any person of any right of appeal, revision or review which he would have had if these rules had not been in force in respect of any order passed before the commencement of these rules and such appeal, revision or review shall be preferred under these rules and disposed of accordingly as if the provision of this rule were force at all material times.

32 SEXUAL HARASSMENT AT WORKPLACE

Sexual harassment at the workplace is a blotch on any society and all sections must come forward to curb this menace. Sexual harassment is any unwelcome sexually defined behaviour which can range from misbehaviour of an irritating nature to the most serious forms such as sexual abuse and assault, including rape.

Sexual harassment is a common problem affecting all women in this world irrespective of the profession that they are in, despite the existence of legal system protection from sexual harassment warrants a more stringent approach.

Sexual harassment is about male dominance over women and it is used to remind women that they are weaker than man. In a society where violence against women is posed just to show the patriarchal value operating in society, these values of men pose the greatest challenge in curbing sexual harassment. Studies have shown that 1 out of every 3 working women are touched by sexual harassment.

Every country is facing this problem today. No female worker is safe and the sense of security is lacking in them. There are certain developments in laws of many countries to protect women workers from sexual harassment. During 2007 alone, the U.S. Equal Employment Opportunity Commission and related state agencies received 12,510 new charges of sexual harassment on the job.

Sexual harassment is rooted in cultural practices and is exacerbated by power relations at the workplace. Unless there is enough emphasis on sensitization at the workplace, legal changes are hardly likely to be successful. Workplaces need to frame their own comprehensive policies on how they will deal with sexual harassment. Instead of cobbling together committees at the court's intervention, a system and a route of redress should already be in place.

Sexual harassment includes such unwelcome sexually determined behavior (whether directly or by implication) as:

a) Physical contact and advances;

b) A demand or request for sexual favors;

c) Sexually colored remarks;

d) Showing pornography;

e) Any other unwelcome physical verbal or non-verbal conduct of sexual nature.

India is a democratic country. All citizens have the fundamental right to

live with dignity under article 21 of the constitution of India. There are various cases brought before the supreme court of India but all cases were not successful in laying down new laws for sexual harassment. In 1997, Supreme court tried to lay down guideline in Vishakha's case .These guideline were somewhat successful because in this case supreme court argued that there is a need for separate laws but it was not given the required attention.

Sexual harassment: The law

According to the law in India, sexual harassment violates the women's fundamental right of gender equality and life with dignity under article 14 and article 21 respectively. Although there are no specific laws for curbing sexual harassment at the workplace in India but certain provisions are there in other legislation like Indian Penal Code, which provides protection against women's sexual harassments such as in IPC:

1) Section 294 deals with obscene acts and songs at public place.
2) Section 354 deals with assault or criminal force against women.
3) Section 376 deals with rape.
4) Section 510 deals with uttering words or making gestures which outrages a women's modesty.

There is another act passed by legislature for protecting women's interest namely, Indecent Representation of Women, Act (1997). This act has not been used in cases of sexual harassment but there are certain provisions in this act which can be used in 2 ways:

1) If a person harasses another by showing books, photographs, paintings, films,etc. containing indecent representation of women than he will be liable with minimum 2yrs. imprisonment.
2) Section 7 of this act punishes companies, if there is indecent representation of women like showing pornography.

The harassed women can also go to civil courts for tortious actions like mental anguish, physical harassment, loss of income in employment of victim, etc.

Sexual harassment can be distinguished on two basis, one of them is quid pro quo in which a woman gets sexually harassed in exchange of work benefits and sexual favours this also lead to some retaliatory actions such as demotion and making her work in difficult conditions. Another is 'hostile working environment' which imposes a duty on employer to provide the women worker with positive working environment and prohibits sexist graffiti, sexual remarks showing pornography and brushing against women employees.

It is pertinent to note that Rule 3(C) of CCS (Conduct) Rules 1964, prohibits sexual harassment of working women. Rule 3C. Prohibition of sexual harassment of working women states:-

1) No Government servant shall indulge in any act of sexual harassment of any women at her work place.
2) Every Government servant who is incharge of a work place shall take appropriate steps to prevent sexual harassment to any woman at such work place.

Explanation - For the purpose of this rule, "sexual harassment" includes such unwelcome sexually determined behaviour, whether directly or otherwise, as

a) physical contact and advances;
b) demand or request for sexual favours;
c) sexually coloured remarks;
d) showing any pornography; or
e) any other unwelcome physical, verbal or non-verbal conduct of a sexual nature.

Sexual Harassment: Case laws in India

There are various cases which had come before the courts in India and the judgment in most of the cases has motivated women to register more complaints as compared to earlier:

1) Apparel Export Promotion Council v. A.K Chopra

The Supreme Court in this case declared that sexual harassment is gender discrimination against women and also said that any act or attempt of molestation by a superior will constitute sexual harassment.

2) Mrs. Rupan Deol Bajaj v. Kanwar Pal Singh Gill

This case has changed the meaning of the terms, modesty and privacy in such a way that, any kind of harassment or inconvenience done to a women's private or public life will be considered as an offence.

3) Vishaka & others Vs. State of Rajasthan & others

In this case Supreme Court laid down the following guidelines which recognized it not only as a private injury to an individual woman but also as the violation of her fundamental rights. These guidelines are significant because for the first time sexual harassment is identified as a separate category of legally prohibited behavior. These are subjected to all workplaces until any other legislation is passed by parliament in this regard. The guidelines are as follows:

a) It is the duty of every employer to deliver a sense of

security to every women employee.

b) Government should make strict laws and regulations to prohibit sexual harassment.

c) Any act of such nature should result in disciplinary actions and criminal proceedings should also be brought against the wrong doer.

d) The organization should have a well set up complaint mechanism for the redressal of the complaints made by the victim and should be subjected to a reasonable time.

e) This complaint mechanism should be in the form of complaint committee which need to be headed by a women member and at least 50% of the committee members should be women so that victims do not feel ashamed while communicating their problems. This complaint committee should also have a third party involvement in the form of NGO or other body which is familiar with this issue. There is a need of transparency in the functioning of this committee and for that there is a requirement of submission of annual report to the government.

f) Issues relating to sexual harassment should not be a taboo in the workers meeting and should be discussed positively.

g) It is the duty of the organisation to aware the female employees about their rights by regularly informing them about the new guidelines issued and legislation passed.

h) The employer or the person in charge is duty biased to take the necessary and reasonable steps to provide support to the victim if sexual harassment takes place due to the act or omission of the third party.

i) These guidelines are not limited only to government employers and should also be followed by employers in private sectors.

4) Medha Kotwal Lele & ors. v. Union of India & Ors

This case helped the Vishakha's case to implement the guidelines successfully by issuing notices to all states and the union territories to impart the necessary steps.

What is sexual harassment at workplace?

Sexual harassment at the workplace is any unwelcome sexually defined behaviour which has the purpose or effect of unreasonably interfering with the individual's work performance or creating an intimidating, hostile, abusive or offensive working environment.

The Sexual Harassment of Women (Prevention, Prohibition and Redressal) Act 2013 states that if the following circumstances occur or are present in relation to, or connected with any act or behaviour of sexual harassment, it may amount to sexual harassment at the workplace:

1) Implied or explicit promise of preferential treatment in her employment; or
2) Implied or explicit threat of detrimental treatment in her employment; or
3) Implied or explicit threat about her present or future employment status; or
4) Interference with her work or creating an intimidating or offensive or hostile work environment for her; or
5) Humiliating treatment likely to affect her health or safety.

The Sexual Harassment of Women (Prevention, Prohibition and Redressal) Act 2013 defines sexual harassment to include any one or more of the following unwelcome acts or behaviour (whether directly or by implication) namely:

1) Physical contact and advances
2) A demand or request for sexual favours
3) Making sexually coloured remarks
4) Showing pornography
5) Any other unwelcome physical, verbal or non-verbal conduct of a sexual nature.

The Hon'able Supreme Court judgment in the case of Vishaka Vs. State of Rajasthan regarding sexual harassment of working women has laid down guidelines and norms to be observed to prevent sexual harassment of working women.

1) It has been laid down in the judgment above-mentioned that it is the duty of the employer or other responsible persons in work places or other institutions to prevent or deter the commission of acts of sexual harassment and to provide the procedure for the resolution, settlement or prosecution of acts of sexual harassment by taking all steps required.

For this purpose, sexual harassment includes such unwelcome sexually

determined behaviour (whether directly or implication) as :-

a) physical contact and advances;
b) a demand or request for sexual favours;
c) sexually coloured remarks;
d) showing pornography;
e) any other unwelcome physical, verbal or non-verbal conduct of sexual nature.

2) Attention in this connection is invited to Rule 3 (1) (iii) of the CCS (Conduct) Rules, 1964, which provides that every Government servant shall at all times do nothing which is unbecoming of a Government servant. Any act of sexual harassment of women employees is definitely unbecoming of a Government servant and amounts to a misconduct. Appropriate disciplinary action should be initiated in such cases against the delinquent Government servant in accordance with the rules.
3) Where such conduct amounts to a specific offence under the Indian Penal Code or under any other law, the concerned authorities shall initiate appropriate action in accordance with law by making a complaint with the appropriate authority.
4) In particular, it should be ensured that victims, or witnesses are not victimized or discriminated against while dealing with complaints or sexual harassment. The victims of sexual harassment should have the option to seek transfer of the perpetrator or their own transfer.
5) Complaint Mechanism :- Whether or not such conduct constitutes an offence under law or a breach of the service rules, an appropriate complaint mechanism should be created in every organization for redress of the complaint made by the victim. Such complaint mechanism should ensure time bound treatment of complaints. Wherever such machineries for redressal of grievance already exist, they may be made more effective and in particular women officers should preferably handle such complaints.
6) Awareness :- Awareness of the rights of female employees in this regard should be created in particular by prominently notifying the guidelines (copy enclosed) in a suitable manner.
7) A specific provision is, however, being made in the CCS (Conduct) Rules, 1964, prohibiting sexual harassment of women by Government servants, in compliance of the judgment of the Hon'ble Supreme Court.

Taking into account the guildlines laid down by Hon'able Supreme Court, The Sexual Harassment of Women (Prevention, Prohibition and Redressal) Act 2013 outlines the measure for

Prevention, Prohibition and Redressal of sexual harassment as:-

1) **Definition**

In this Act, unless the context otherwise requires,

(a) "aggrieved woman" means-

(i) in relation to a workplace, a woman, of any age whether employed or not, who alleges to have been subjected to any act of sexual harassment by the respondent;

(ii) in relation to a dwelling place or house, a woman of any age who is employed in such a dwelling place or house;

(b) "appropriate Government" means

(i) in relation to a workplace which is established, owned, controlled or wholly or substantially financed by funds provided directly or indirectly- .

(A) by the Central Government or the Union territory administration, the Central Government;

(B) by the State Government, the State Government;

(ii) in relation to any workplace not covered under sub-clause (i) and falling within its territory, the State Government;

(c) "Chairperson" means the Chairperson of the Local Complaints Committee nominated under sub-section (f) of section 7; ·

(d) "District Officer" means an officer notified under section 5;

(e) "domestic worker" means a woman who is employed to do the household work in any household for remuneration whether in cash or kind, either directly or through any agency on a temporary, permanent, part time · or full time basis, hut does not include any member of the family of the employer;

(f)"employee" means a person empi oyed at a workplace for any work on regular, temporary, adhoc or daily wage basis, either directly or through an agent, including a contractor, with or, without the knowledge of the principal employer, whether. for remuneration or not, or working on a voluntary basis or otherwise, whether the terms of employment are express or implied and includes a co-worker, a contract worker, probationer, trainee, apprentice or called by any other such name;

(g) "employer" means:_-

(i) in relation to any department, organisation, undertaking,. establishment, enterprise, institution, office, branch or unit of the appropriate Government or a local authority, the head of that department, organisation, undertaking, establishment. enterprise, institution, office, branch or unit or such other officer as the appropriate Government or the local authority, as the case may be, may by an order specify in this behalf;

{ii) in any workplace not covered under sub-clause (i), any person responsible for the mamagemnet, supervision and control of the workplace.

Explanation.-- For the purposes of this sub-clause "management"includes the person or board or committee responsible for formulation and administration of polices for such organisation:

(iii) in relation to workplace covered under sub-clauses (1) and (ii), the person discharging contractual obligations with respect to his or her employees;

(iv) in relation to a dwelling place or house, a person or a household who employs or benefits from the employment of domestic worker, irrespective of the number, time period or type of such worker employed, or the nature of the employment or activities performed by the domestic worker;

(h) "Internal Committee" means an Internal Complaints Committee constituted under section 4;

(1) "Local Committee" means the Local Complaints Committee constituted under section 6;

(j) "Member" means a Member of the Internal Committee or the Local Committee, as the case may be;

(k) "prescribed" means prescribed by rules made under this Act;

(l) "Presiding Officer" means the Presiding Officer of the Internal Complaints Committee nominated under sub-section (2) of section 4;

(m} "respondent" mean3 a person against whom the aggrieved woman has made a complaint under section 9;

(n) "sexual harassment" includes any one or more of the following unwelcome acts or behaviour (whether directly or by implication) namely:-

{i) physical contact and advances; or

(ii) a demand or request for sexual favours; or

(iii) making sexually coloured remarks; or

(iv) showing pornography; or

(v) any other unwelcome physical, verbal or non-verbal conduct of sexual nature;

(o) "workplace" includes ·

(i) any department, organisation, undertaking, establishment, enterprise, institution, office, branch or unit which is established, owned, controlled or wholly or substantially financed by funds provided directly or indirectly by the appropriate Government or the local authority or a Government company or a corporation or a co-operative society;

(ii) any private sector organisation or a private venture, undertaking, enterprise, institution, establishment, society, trust, non-governmental organisation, unit or service provider carrying on commercial, professional, vocational, educational, entertainmental, industrial, health services or financial activities including production, supply, sale, distribution or service;

(iii) hospitals or nursing homes;

(iv) any sports institute, stadium, sports complex or competition or games venue. whether residential or not used for training, sports or other activities relating thereto:

(v) any place visited by the employee arising out of or during the course of employment including transportation provided hy the employer for undertaking such journey:

(i) a dwelling place or a house;

(p) "unorganised sector" in relation to a workplace means an enterprise owned by individuals or self -employed workers and engaged in the production or sale of goods or providing service of any kind whatsoever, and where the enterprise employs workers, the number of such workers is less than ten.

2) **Prevention of Sexual Harassment**

(i) no woman shall be subjected to sexual harassment at any workplace.

(ii) The following circumstances, among other circumstances, if it occurs or is present in relation to or connected with any act or behaviour of sexual harassment may amount to sexual harassment:-

(i) Implied or explicit promise of preferential treatment in her employment; or

(ii) Implied or explicit threat of detrimental treatment in her employment; or

(iii) Implied or explicit threat about her present or future employment status; or

(iv) Interference with her work or creating an intimidating or offensive or hostile work environment for her; or

(v) Humiliating treatment likely to affect her health or safety.

3) **Constitution of Internal Complaints Committee**

4 (1) Every employer of a workplace shall, by a!1 order in writing, constitute a Committee to be known as the " Intcsnal Complaints Committee":

Provided that where the offices or administrative units of the workplace arc located at different places or divisional or sub-divisional level, the Internal Committee shall be constituted at all administrative units or offices

(2) The Internal Committee shall consist of the following members to be nominated by the employer. namely: -·

(a) a Presiding officer· who shall be a woman employed at a senior level at workplace from amongst the employees:

Provided that in case a senior level woman employee is not available, the Presiding Officer shall be nominated from other offices or administrative units of the workplace referred to in sub-section (/):

Provided further that in case the other offices or administrative units of the workplace do not have a senior level woman employee, the Presiding Officer shall be nominated from any other workplace of the same employer or other department or organisation;

(b) not less than two Members from amongst employees preferably committed to the cause of women or who have had experience in social work or have legal knowledge;

(c) one member from amongst non-governmental organisations or associations committed to the cause of women or a person familiar with the issues relating to sexual harassment:

Provided that at least one-half of the total Members so nominated shall be women.

(3) The Presiding Officer and every Member of the Internal Committee shall hold office tor such period not exceeding three years, from the date of their nomination as may he specified by the employer.

(4) if the member appointed from amongst the non-governmental organisations or associations shall be paid such fees or allowances for holding the proceedings of the Internal Committee by the employer as may be prescribed

(5) Where the Presiding Officer or any Member of the internal Committee, · ..

(a) contravenes the provisions of section 16; or (h l has been convicted for an offence or an inquiry into an offence under any law for the time being in force is pending against him: or

(c) he has been found guilty in any disciplinary proceedings or a disciplinary proceeding is pending against him; or

(d) has so abused his position as to render his continuance in office prejudicial to the public interest,

such Presiding Officer or Member, as the case may be, shall be removed from the Committee and the vacancy so created or any casual vacancy shall he filled by fresh nomination in accordance with the provisions of this section.

Duties of the Employer

Every employer shall –

(a) provide a safe working environment at the workplace which shall include safety from the persons coming into contact at the workplace;
(b) display at any conspicuous place in the workplace, the penal consequences of sexual harassments; and the order constituting the Internal Committee under subsection (I) of section 4 :
(c) organise workshops and awareness programmes at regular intervals for sensitising the employees with the provisions of the Act and orientation programmes for the members of the

internal Committee in the manner as may be prescribed;

(d) provide necessary facilities to the Internal Committee or the Local Committee, as the case may be, for dealing with the complaint and conducting an inquiry;

(e) assist in securing the attendance of respondent and witnesses before the Internal Committee or the Local Committee, as the case may be;

(f) make available such informaation to the Internal Committee or the Local Committee, as the case may be, as it may require having regard to the complaint made under sub-section (1) of section 9;

(g) provide assistance to the woman if she so chooses to ti le a complaint in relation to the offence under the Indian Penal Code or any other law for the time being in force;

(h) cause to initiate action, under the Indian Penal Code or any other law for the time being in force, against the perpetrator, or if the aggrieved woman so desires, where the perpetrator is not an employee, in the workplace at which the incident of sexual harassment took place;

(i) treat sexual harassment as a misconduct under the service rules and initiate action for such misconduct;

(j) monitor the timely submission of report by the Internal Committee.

Penalty for non compliance with provisions of Act.

In the event of non compliance of The Sexual Harassment of Women (Prevention, Prohibition and Redressal) Act 2013, where the employer fails to -

(a) constitute an Internal Committee under sub-section(/) of section 4;

(h) take action under sections 13, 14 and 22; and

(c) contravenes or attempts to contravene" or abets contravention of other provisions of this Act or any rules made there under.

he shall be punishable with fine which may extend to **fifty thousand rupees.**

Preventive Measures to Curb Sexual Harassment

In VISHAKA & ORS. Vs. STATE OF RAJASTHAN & ORS. (JT 1997 (7) SC 384) THE HON'BLE SUPREME COURT laid down the guidelines as a preventive measure to curb sexual harassment at workplace. The guidelines states that all employers or persons in charge of work place whether in public or private sector should take appropriate steps to prevent sexual harassment.

Without prejudice to the generality to this obligation they should take the following steps :-

(a) Express prohibition of sexual harassment as defined above at the work place should be notified, published and circulated in appropriate ways.

(b) The Rules/Regulations of Government and Public Sector bodies relating to conduct and discipline should include rules/regulations prohibiting sexual harassment and provide for appropriate penalties in such rules against the offender.

(c) As regards private employers steps should be taken to include the aforesaid prohibitions in the standing orders under the Industrial Employment (Standing Orders) Act, 1946.

(d) Appropriate work conditions should be provided in respect of work, leisure, health and hygiene to further ensure that there is no hostile environment towards women at work places and no employee woman should have reasonable grounds to believe that she is disadvantaged in connection with her employment.

Sexual harassment at workplace is highly prevalent and there is a need to provide a positive environment to the women workers. Although, the government has enacted the law dealing with this issue, it should also realize that women worker also constitute a part of working population in India and it's the duty of every employer to provide them security at work.

Change in attitude of people is a basic requirement for implementing any law in the society for women. This implementation of laws leads to protection against undesired sexual behavior. The prevention of sexual harassment should be done at all level of employees and it should be checked that the women employees get a positive environment.

It is recommend that the following steps that need to be taken for preventing sexual harassment at workplace:-

1) There should be well set up complaint channel which is in direct

communication with the women employee. The women should not feel obscure in complaining about the problems she is facing during employment at the workplace. The complaint committee should take all such kind of complaint very seriously and appropriate action must be taken within reasonable time.

2) Women workers' should not fear in talking about any harassment related to sex and it is their duty to immediately bring in notice to the complaint committee about any such act.
3) It is the duty of the complaint committee to keep every complaint confidential.
4) Every organisation should conduct sexual harassment awareness training for both the male and female employees. This mutual learning will help in creating an atmosphere of hostility and employees will feel comfortable. This training should also include the impacts of sexual harassment on women.
5) A commitment is required from all the levels of the organisation for the positive implementation of the policies and procedures made against sexual harassment.
6) Every employee should understand that it is his legal duty to provide every women employee a sense of security in workplace.
7) He should understand that any kind of harassment on his women employee will result in detrimental effects on her health, confidence and her potential at work which also results in her leaving the job.
8) Women should be motivated against sexual harassment and they should be asked to complaint about it if they think that it is harming them in any manner and they should make them realize that their complaints will not be subjected to ridicule or any kind of threat.
9) The employer should always be under a fear of any kind of monetary or reputational harm which can occur if such a kind of activity happens in his company. We also think that there is a need of formulating a separate anti-sexual harassment policy dealing particularly with this issue.
10) The committee should never be biased in dealing with certain individuals of the organisation. For example if the accused is a senior executive or partner he should not be excused just for the sake of his position and law should be allowed to take its due course.

33 UTTAR PRADESH LEAVE RULES

(अवकाश नियम)

UTTAR PRADESH FUNDAMENTAL RULES, Financial Handbook- Volume II, Parts II to IV

Taking leave is essential to promote good physical and mental health in the workplace and improves people's work-life balance. Happier, recharged people are less likely to be sick or take unexpected time off work.

The Government have had under consideration the recommendation made by the Second Pay Commission that the Heads of Departments, Offices, etc., should plan their work in such a way as to permit Government servants to take a certain amount of leave annually and a longer period after some years or according to any special necessity.

However, the fact remains that, leave cannot be claimed as of right. When the exigencies of the public service so require, discretion to refuse or revoke leave of any description is reserved to the authority empowered to grant it.

These provisions have been made in the rules because it is not always possible to let all who want leave at a particular time to have it at that time and there is a limit beyond which depletion of staff cannot be permitted without dislocating the working of an establishment.

These provisions are not intended to be used as in effect to abridge the leave entitlement of the staff. Indeed it is desirable in the interest of efficiency of the public service that Government servants take leave at suitable intervals and return to work keen and refreshed.

As a part of UTTAR PRADESH FUNDAMENTAL RULES, the Financial Handbook in its Volume II (Parts II to IV) clearly enunciates the leave rules for employees of Government of Uttar Pradesh. Sections 80—93, specify in details the nature and entitlement of leaves for the employees. Vitt Patra 2022 neatly summarises the leave rules (अवकाश नियम).

सन्दर्भ- वित्तीय नियम संग्रह खण्ड-दो भाग 2 से 4 मूल नियम 58 से 104 एवं सहायक नियम 35 से 172 तथा समय-समय पर जारी शासनादेश अवकाश नियमों के प्रस्तुतीकरण को सरलता प्रदान करने के लिए अवकाशों को दो श्रेणियों में विभाजित किया जा सकता है। पहली श्रेणी में वे अवकाश रखे जा सकते हैं जो मूलतः वित्तीय नियम संग्रह खण्ड-दो (भाग 2 से 4) में वर्णित मूल एवं सहायक नियमों से संचालित होते हैं तथा द्वितीय श्रेणी में वे अवकाश जो भिन्न प्रकार के हैं, यथा आकस्मिक अवकाश ।

(I) वित्तीय नियम संग्रह खण्ड-दो (भाग 2 से 4) के नियमों द्वारा संचालित विभिन्न अवकाश

सरकारी कर्मचारियों को वित्तीय नियमों के अन्तर्गत निम्नलिखित प्रकार के अवकाश अनुमन्य होते हैं जिनका उपभोग निर्धारित नियमों एवं प्रतिबन्धों के अधीन किया जा सकता है

1- **अर्जित अवकाश** (Earned Leave)
2- **निजी कार्य पर अवकाश** (Leave on Private Affairs)
3- **चिकित्सा प्रमाण पत्र पर अवकाश** (Leave on Medical Certificate)
4- **मातृत्व अवकाश** (Maternity Leave)
5- **असाधारण अवकाश** (Extra Ordinary Leave)
6- **चिकित्सालय अवकाश** (Hospital Leave)
7- **अध्ययन अवकाश** (Study Leave)
8- **विशेष दिव्यांगता अवकाश** (Special Disability Leave)
9- **लघुकृत अवकाश** (Commuted Leave)
10- **बाल्य देखभाल अवकाश** (Child Care Leave
11- **दत्तक ग्रहण अवकाश** (Child Adoption leave)।

अवकाश सम्बन्धी कुछ महत्वपूर्ण तथ्य

अवकाश का तात्पर्य यहाँ उपर्युक्त सभी अवकाशों से है जब तक कि स्पष्ट रूप से किसी अवकाश विशेष का उल्लेख न किया गया हो।

अवकाश का अर्जन ड्यूटी द्वारा

अवकाश केवल ड्यूटी देकर ही उपार्जित किया जाता है। इस नियम के लिए बाह्य सेवा में व्यतीत की गई अवधि को ड्यूटी माना जाता है, यदि ऐसी अवधि के लिए अवकाश वेतन के लिए अंशदान का भुगतान कर दिया गया हो। (मूल नियम 60)

अवकाश स्वीकृति हेतु सक्षम प्राधिकारी

1) विशेष दिव्यांगता अवकाश के अतिरिक्त मूल नियमों के अन्तर्गत देय अन्य अवकाश शासन के अधीनस्थ उन प्राधिकारियों द्वारा प्रदान किया जा सकता है जिन्हें राज्यपाल नियम या आदेश द्वारा निर्दिष्ट कर दें। (मूल नियम 66)
2) विशेष दिव्यांगता अवकाश राज्यपाल द्वारा स्वीकृत किया जा सकता है।(मूल नियम 83)

अराजपत्रित सरकारी सेवकों को विशेष दिव्यांगता अवकाश के अतिरिक्त मूल नियमों के अन्तर्गत अनुमन्य कोई भी अन्य अवकाश उस प्राधिकारी द्वारा जिसका कर्तव्य उस पद को यदि वह रिक्त होता, भरने का होता या वित्तीय नियम संग्रह खण्ड-दो (भाग 2 से 4) के भाग 4 (विवरण पत्र v के क्रम संख्या 5. 8 तथा 9) में उल्लिखित किसी अन्य सक्षम प्राधिकारी द्वारा प्रतिनिहित अधिकार सीमा के अधीन रहते हुए प्रदान किया जा सकता। है। (सहायक नियम 35)

राजपत्रित अधिकारियों को अवकाश देने के लिए साधारणतया शासन की स्वीकृति की आवश्यकता है, किन्तु वित्तीय नियम संग्रह खण्ड-दो के भाग-4 (विवरण पत्र के क्रम संख्या 6, 7, 8 व 9) में उल्लिखित किसी अन्य सक्षम प्राधिकारी द्वारा प्रतिनिहित अधिकार सीमा के अधीन रहते हुए प्रदान किया जा सकता है।(सहायक नियम 36)

सभी विभागाध्यक्ष अपने अधीनस्थ राज्यपत्रित अधिकारियों को 60 दिन तक का अवकाश स्वीकृत कर सकते हैं बशर्ते प्रतिस्थानी की आवश्यकता न हो (शासनादेश संख्या-सा-4-944/ दस-68-73, दिनांक 16-08-1973)

सभी विभागाध्यक्ष अपने अधीनस्थ राजपत्रित अधिकारियों को प्राधिकृत चिकित्सक द्वारा प्रदत्त नियमित प्रमाण-पत्र के आधार पर तीन माह की अवधि तक का चिकित्सा प्रमाण पत्र पर अवकाश प्रदान कर सकते हैं। (कार्यालय ज्ञाप संख्या-सा-4-1752 / दस-200 (2)-77 दिनांक 20-6-1978)

मातृत्व अवकाश संबंधित विभागाध्यक्ष द्वारा अथवा किसी ऐसे निम्नतर अधिकारी द्वारा जिसे इसके

लिए अधिकार प्रतिनिहित किया गया हो, प्रदान किया जा सकता है।

अवकाश का दावा अधिकार के रूप में नहीं (सहायक नियम 153)

किसी अवकाश का दावा अधिकार के रूप में नहीं किया जा सकता है। जब जन सेवाओं की अनिवार्यतायें ऐसी अपेक्षा करती हों, तो किसी भी प्रकार के अवकाश को निरस्त करने या अस्वीकृत करने का अधिकार अवकाश प्रदान करने हेतु सक्षम प्राधिकारी के पास सुरक्षित है। (मूल नियम 67)

अवकाश का प्रारम्भ एवं समाप्ति

अवकाश साधारणतया कार्यभार छोड़ने के दिन से प्रारम्भ होता है तथा कार्यभार ग्रहण करने की तिथि के पूर्व दिवस को समाप्त होता है। अवकाश के प्रारम्भ होने के ठीक पहले व अवकाश समाप्ति के तुरन्त पश्चात पड़ने वाले रविवार व अन्य मान्यता प्राप्त अवकाशों को अवकाश के साथ उपभोग करने की स्वीकृति अवकाश स्वीकृत करने वाले प्राधिकारी द्वारा दी जा सकती है। (मूल नियम 68)

अवकाश अवधि में अन्य व्यवसाय

सक्षम प्राधिकारी की पूर्व स्वीकृति प्राप्त किये बिना कोई सरकारी सेवक अवकाश काल में कोई लाभप्रद व्यवसाय या नौकरी नहीं कर सकता है। (मूल नियम 69)

अवकाशाधीन सरकारी सेवक को वापस बुलाया जाना

जन सेवाओं की अनिवार्यता होने पर अवकाश प्रदान करने वाले प्राधिकारी को अवकाशाधीन सरकारी सेवक को अवकाश का पूर्ण उपभोग किये बिना ड्यूटी पर वापस बुलाने का अधिकार है। वापसी के आदेश में स्पष्ट उल्लेख किया जाना चाहिए कि ड्यूटी पर लौटना अवकाशाधीन सेवक की स्वेच्छा पर निर्भर है अथवा वह अनिवार्य है। यदि उक्त वापसी ऐच्छिक हो तो इस संबंध में कर्मचारी को किसी प्रकार की छूट अनुमन्य नहीं होगी, परन्तु यदि वापसी के लिए बाध्य किया जाता है तो उसे निम्नानुसार सुविधा ग्राह्य होगी- यदि अवकाश का उपयोग भारतवर्ष में ही किया जा रहा हो तो वापसी के लिए प्रस्थान के दिवस से उसे ड्यूटी पर माना जायेगा एवं वापसी के लिए सामान्य यात्रा भत्ता अनुमन्य होगा, परन्तु योगदान की तिथि तक उसे अवकाश वेतन ही देय होगा। (मूल नियम 70)

अवकाश से वापस बुलाने पर यात्रा भत्ता निम्न शर्तों के पूरा होने पर ही देय होगा-

1- यदि वह 60 दिन से अधिक के अवकाश पर गया हो तो कम से कम उसकी आधी अवधि का अवकाश निरस्त किया जाये।

2- यदि वह 60 दिन तक की अवधि के लिए अवकाश पर गया हो तो कम से कम 30 दिन का अवकाश निरस्त किया जाये।

(नियम 51. वित्तीय नियम संग्रह खण्ड-तीन)

स्वस्थता प्रमाण पत्र (Fitnes Certificate)

चिकित्सा प्रमाण पत्र पर अवकाश का उपभोग करने के उपरान्त किसी भी कर्मचारी को सेवा में योगदान करने की अनुमति तब तक नहीं दी जा सकती जब तक कि उसके द्वारा निर्धारित प्रपत्र पर अपना स्वस्थता प्रमाण पत्र प्रस्तुत नहीं किया जाता। यदि सक्षम अधिकारी चाहे तो अस्वस्थता के आधार पर लिये गये किसी अन्य श्रेणी के अवकाश के मामले में भी उपर्युक्त स्वस्थता प्रमाण पत्र मांग सकता है।

(मूल नियम 71)

अवकाश समाप्ति के पूर्व ड्यूटी पर वापसी

अवकाश स्वीकर्ता अधिकारी की अनुमति के बिना कोई भी सरकारी सेवक स्वीकृत अवकाश की समाप्ति के 14 दिन से अधिक समय पूर्व ड्यूटी पर वापस नहीं लौट सकता है।

(मूल नियम-72)

अवकाश की समाप्ति के पश्चात अनुपस्थिति

यदि कोई राजकीय कर्मचारी अवकाश अवधि की समाप्ति के उपरान्त भी अनुपस्थित रहता है तो उसे ऐसी अनुपस्थिति की अवधि के लिए कोई अवकाश वेतन देय नहीं होगा और उक्त अवधि को उसके अवकाश लेखे से यह मानते हुए घटा दिया जायेगा जैसे कि उक्त अवधि अर्ध औसत वेतन पर देय अवकाश थी, जब तक अवकाश अवधि शासन द्वारा बढ़ा न दी गयी हो। अवकाशोपरान्त जानबूझकर सेवा से अनुपस्थिति मूल नियम 15 के प्रयोजन हेतु दुर्व्यवहार मानी जायेगी। (मूल नियम 73)

एक प्रकार के अवकाश के साथ / क्रम में दूसरे प्रकार के अवकाश की अनुमन्यता

किसी एक प्रकार के अवकाश को दूसरे प्रकार के अवकाश साथ अथवा क्रम में स्वीकृत किया जा सकता है। (मूल नियम 81 ख (6) 83 (4), सहायक नियम-154, 156 तथा 157-क (5)

अवकाश की प्रकृति में परिवर्तन

अवकाश प्रदान करने वाले प्राधिकारी को अवकाश को प्रकृति में परिवर्तन करने का अधिकार नहीं है। (मूल नियम 87-क तथा सहायक नियम 157 क से संबंधित राज्यपाल के आदेश)

सरकारी सेवक जिन्हें अवकाश प्रदान नहीं किया जा सकता

1- सरकारी सेवक को निलम्बन की अवधि में अवकाश प्रदान नहीं किया जा सकता। (मूल नियम 55)

2- उस सरकारी सेवक को अवकाश स्वीकृत नहीं करना चाहिए, जिसे दुराचरण अथवा सामान्य अक्षमता के कारण सेवा से पदच्युत किया जाना या हटाया जाना अपेक्षित हो यदि उस अवकाश के प्रभावस्वरुप पदच्युत किये जाने या हटाये जाने की तिथि स्थगित हो जाये या जिसका आचरण उसी समय या निकट भविष्य में उसके विरूद्ध विभागीय जाँच का विषय बनने वाला हो (सहायक नियम 101)

अवकाश वेतन तथा अवकाश अवधि में भत्तों की देयता

मूल नियम 87 - क के अनुसार अर्जित अवकाश तथा चिकित्सा प्रमाण पत्र अवकाश के मामलों में अवकाश पर जाने से ठीक पूर्व आहरित वेतन की दरों पर अवकाश वेतन अनुमन्य होता है। इसी प्रकार मातृत्व अवकाश, बाल्य देखभाल अवकाश एवं दत्तक ग्रहण अवकाश की अवधि में अवकाश पर जाने के ठीक पूर्व आहरित वेतन की दरों पर अवकाश वेतन देय होता है। (मूल नियम 153 तथा शासनादेश संख्या-जी-2-2017 /दस-2008-216/79, दिनांक 08 दिसम्बर, 2008) अन्य अवकाश की अवधि में देय अवकाश का वेतन का उल्लेख सम्बन्धित अवकाश के शीर्षक में किया गया है।

अवकाश अवधि में देय प्रतिकर भत्तों के भुगतान के संबंध में मूल नियम-93 तथा सहायक नियम 147, 149, 150 तथा 152 में व्यवस्था दी गई है। जो विशेष वेतन अथवा भत्ते किसी कार्य विशेष को करने के कारण देय होते हैं उन्हें अवकाश अवधि में देने का कोई औचित्य नहीं है परन्तु जो विशेष वेतन तथा भत्ते वैयक्तिक योग्यता के आधार पर देय होते हैं (स्नातकोत्तर भत्ता. परिवार कल्याण भत्ता, वैयक्तिक योग्यता भत्ता) वे सवेतन अवकाश अवधि में दिये जाने चाहिए। विशेष वेतन तथा अन्य भत्तों का भुगतान अवकाश अवधि के अधिकतम 120 दिन की सीमा तक अनुमन्य होगा। (शासनादेश संख्या-सा-4-296 / दस-88-216-19 दिनांक 08-03-1988)

अवकाश प्रदान करना

अवकाश प्रार्थना पत्रों पर निर्णय करते समय सक्षम अधिकारी निम्न बातों का ध्यान रखेंगे-

1- कर्मचारी जिसके बिना उस समय सरलता से कार्य चलाया जा सकता है।
2- अन्य कर्मचारियों के अवकाश की अवधि ।
3- पिछली बार लिये गये अवकाश से वापस आने के पश्चात् सेवा की अवधि
4- किसी आवेदक को पूर्व में स्वीकृत अवकाश से अनिवार्य रूप से वापस तो नहीं बुलाया गया।
5- आवेदक को पूर्व में जनहित में अवकाश अस्वीकृत तो नहीं किया गया।

1- अर्जित अवकाश

अर्जित अवकाश स्थायी तथा अस्थायी दोनों प्रकार के सरकारी सेवकों द्वारा समान रूप से अर्जित किया जाता है, तथा समान शर्तों के अधीन उन्हें स्वीकृत किया जाता है। मूल नियम 81-ख (1) सहायक नियम 157-क (1)

अवकाश अवधि व अर्जित अवकाश की प्रक्रिया

सरकारी सेवक के अर्जित अवकाश लेखे में पहली जनवरी को 16 दिन तथा पहली जुलाई को 15 दिन जमा किया जायेगा । अवकाश का हिसाब लगाते समय दिन के किसी अंश को निकटतम दिन पर पूर्णांकित किया जाता है, ताकि अवकाश का हिसाब पूरे दिन के आधार पर रहे। शासनादेश संख्या-सा-4-392 / दस-94-203-86, दिनांक: 1 जुलाई 1999 के अनुसार सरकारी सेवकों के अवकाश खाते में अर्जित अवकाश जमा करने की अधिकतम सीमा 300 दिन है।

बीच छमाही में नियुक्ति होने पर उस छमाही में सेवा के प्रत्येक पूर्ण कैलेण्डर मास के लिए 2-1/2 (ढाई) दिन प्रतिमास की दर से अवकाश पूर्ण दिन के आधार पर जमा किया जाता है। इसी प्रकार मृत्यु सहित किसी भी कारण से सेवा से विलग होने वाली छमाही में सेवा में रहने के दिनांक तक की गई सेवा के प्रत्येक पूर्ण कैलेण्डर मास के लिए 2-1/2 दिन प्रतिमास की दर से पूरे दिन के आधार पर अवकाश देय होता है।

जब किसी छमाही में असाधारण अवकाश का उपभोग किया जाता है तो संबंधित सरकारी सेचक के अवकाश लेखे में अगली छमाही के लिए जमा किये जाने वाला अर्जित अवकाश असाधारण अवकाश की अवधि के 1/10 की दर से 15 दिन की अधिकतम सीमा के अधीन रहते हुए (पूरे दिन के आधार पर) कम कर दिया जाता है।

(संख्या-सा-4-1071 1072 / दस-1992-201 /76 दिनांक 21 दिसम्बर 1992 मूल नियम 81ख) (1) एवं सहायक नियम 157-क (1)

अर्जित अवकाश के संबंध में सरकारी सेवकों के अवकाश लेखे प्रपत्र -11 घ में रखे जायेंगे। (मूल नियम-81 ख (1) (8))

अर्जित अवकाश की एक बार में स्वीकृत करने की अधिकतम सीमा

1- यदि सम्पूर्ण अवकाश भारत में व्यतीत किया जा रहा हो-120 दिन
2- यदि सम्पूर्ण अवकाश भारत के बाहर व्यतीत किया जा रहा हो-80 दिन

अवकाश की कुछ अवधि भारत में तथा कुछ अवधि भारत के बाहर व्यतीत किये जाने पर भी 180 दिन तक का अवकाश इस प्रतिबन्ध के अधीन स्वीकृत किया जा सकता है कि भारत में व्यतीत की गयी अवकाश अवधि 120 दिन से अधिक नहीं होगी।

(मूल नियम- 81 ख (1) (दस)
सहायक नियम 157 (क) (1) (ग्यारह))

अवकाश वेतन

अवकाश काल में सरकारी सेवक को अवकाश पर प्रस्थान के ठीक पहले प्राप्त होने वाले वेतन के बराबर अवकाश वेतन ग्राहय होता है। (मूल नियम- 87-क (1) तथा सहायक नियम 157-क (6) (क))

अवकाश वेतन अग्रिम का भुगतान

शासनादेश संख्या-ए-1-1668 / दस-3-1 (4)-65 दिनांक 13 अक्टूबर 1978 के अनुसार सरकारी कर्मचारियों को उनके अवकाश पर जाने के समय अवकाश वेतन अग्रिम की धनराशि को भुगतान करने की अनुमति निम्न शर्तों के अधीन दी जा सकती है-

1- यह अग्रिम धनराशि कम से कम 30 दिन या उससे अधिक की अवधि के केवल अर्जित अवकाश या निजी कार्य पर अवकाश के मामले में देय होगी।

2- यह अग्रिम धनराशि ब्याज रहित होगी।

3- अग्रिम की धनराशि अन्तिम बार लिये मासिक वेतन, जिसमें मँहगाई भत्ता, अतिरिक्त मँहगाई मत्ता (अन्य मत्ते छोड़कर) भी सम्मिलित होंगे, के बराबर होगी।

4- उपर्युक्त बिन्दु-1 में उल्लिखित अवकाश अवधि यांचे 30 दिन से अधिक और 120 दिन से अधिक न हो तो उस दशा में मी पूरी अवकाश अवधि का लेकिन एक समय में केवल एक माह का अवकाश चेतन अग्रिम उपर्युक्त बिन्दु 3 में उल्लिखित दर से स्वीकृत किया जा सकता है।

5- अवकाश वेतन अग्रिम से सामान्य कटौतियाँ कर ली जानी चाहिये

6- यह अग्रिम धनराशि स्थायी तथा अस्थायी सरकारी कर्मचारी को देय होगी किन्तु अस्थायी कर्मचारी के मामले में यह धनराशि वित्तीय नियम संग्रह खण्ड-पाँच भाग-1 के पैरा 242 में दी गई अतिरिक्त शर्तो के अधीन मिलेगी।

7- राजपत्रित अधिकारियों को अग्रिम धनराशि लेने के लिए प्राधिकार पत्र की आवश्यकता नहीं होगी। भुगतान स्वीकृति के आधार पर किया जायेगा।

8- वित्तीय नियम संग्रह खण्ड-पाँच भाग-1 के पैरा 249 (ए) के अधीन सरकारी कर्मचारियों के लिए अग्रिम धनराशियाँ स्वीकृत करने के लिए सक्षम अधिकारी अवकाश वेतन का अग्रिम भी स्वीकृत कर सकता है। यह प्राधिकारी अपने लिए भी ऐसी अग्रिम धनराशि स्वीकृत कर सकता है।

9- इस पूरी अग्रिम धनराशि का समायोजन सरकारी कर्मचारी के अवकाश वेतन के प्रथम बिल से किया जायेगा। यदि पूरी अग्रिम धनराशि का समायोजन इस प्रकार नहीं हो सकता है तो शेष धनराशि की वसूली वेतन या अवकाश वेतन से अगले भुगतान के समय की जायेगी।

निजी कार्य पर अवकाश

निजी कार्य पर अवकाश अर्जित अवकाश की ही भांति तथा उसके लिये निर्धारित प्रक्रिया के अनुसार प्रत्येक कैलेण्डर वर्ष के लिए 31 दिन 2 छमाही किश्तों में जमा किया जाता है। नियुक्ति की प्रथम छमाही तथा सेवा से पृथक होने वाली छमाही के लिए जमा होने वाले अवकाश का आगणन तथा असाधारण अवकाश के उपयोग करने पर अवकाश की कटौती विषयक प्रक्रिया भी वही है, जो अर्जित अवकाश के विषय में है।

अधिकतम अवकाश अवधि तथा देय अवकाश

स्थायी सरकारी सेवक

1 यह अवकाश 365 दिन तक की अधिकतम सीमा के अधीन जमा किया जाता है।

2 सम्पूर्ण सेवाकाल में कुल मिलाकर 365 दिन तक का ही अवकाश स्वीकृत किया जा सकता है।

3- किसी एक समय में स्वीकृत की जा सकने योग्य अधम सीमा निम्नानुसार है-

पूरा अवकाश भारत में व्यतीत किये जाने पर- 90 दिन

पूरा अवकाश भारत के बाहर व्यतीत किये जाने पर- 180 दिन

पूरा अवकाश भारत से बाहर व्यतीत किये जाने पर अवकाश की कुछ अवधि भारत में तथा कुछ अवधि भारत के बाहर व्यतीत किये जाने पर भी 180 दिन तक का अवकाश इस प्रतिबन्ध के अधीन स्वीकृत किया जा सकता है कि भारत में व्यतीत की गयी अवकाश अवधि 90 दिन से अधिक नहीं होगी।

मूल नियम 81-ख (3)

शासकीय ज्ञाप संख्या-सा-4-1071 / दस-1992-2001 /76 दिनांक 21 दिसम्बर 1992

अस्थायी सरकारी सेवक

सम्पूर्ण अस्थायी सेवाकाल में कुल मिलाकर 120 दिन तक का अवकाश प्रदान किया जा सकता है। अस्थायी सेवकों को निजी कार्य पर अवकाश तब तक अनुमन्य नहीं होगा जब तक कि उनके द्वारा दो वर्ष की निरन्तर सेवा पूरी न कर ली गयी हो ।

अस्थायी सरकारी सेवकों के अवकाश खातों में निजी कार्य पर अवकाश किसी अवसर पर 60 दिन से अधिक जमा नहीं होगा । -

किसी सरकारी सेवक को एक बार में निजी कार्य पर अवकाश स्वीकृत किये जाने की अधिकतम अवधि साठ दिन होगी । अवकाश स्वीकृति आदेश में अतिशेष अवकाश इंगित किया जायेगा। सहायक नियम 157-क (3)

शासकीय ज्ञाप संख्या-सा-4-1072 / दस-1992-2001 /76 दिनांक 21 दिसम्बर 1992

निजी कार्य पर अवकाश के संबंध में सरकारी सेवकों के अवकाश लेखे प्रपत्र 11-ड. में रखे जायेंगे। सहायक नियम- 157-क (3) (दस)

चिकित्सा प्रमाणपत्र पर अवकाश

स्थायी सरकारी सेवक

सम्पूर्ण संवाकाल में 12 माह तक का चिकित्सा प्रमाणपत्र पर अवकाश नियमों द्वारा निर्दिष्ट चिकित्सकों द्वारा प्रदान किये गये चिकित्सा प्रमाण पत्र पर स्वीकृत किया जा सकता है।

उपर्युक्त 12 माह का अवकाश समाप्त होने के पश्चात आपवादिक मामलों में चिकित्सा परिषद की संस्तुति पर सम्पूर्ण सेवाकाल में कुल मिलाकर 6 माह का चिकित्सा प्रमाण पत्र पर अवकाश और स्वीकृत किया जा सकता है।

अस्थायी सरकारी सेवक

ऐसे अस्थायी सेवकों को जो तीन वर्ष अथवा उससे अधिक समय से निरन्तर कार्यरत रहे हों, नियुक्ति नियमित हो, कार्य एवं आचरण सन्तोषजनक हो, सत्यनिष्ठा प्रमाणित हो तथा उनके विरूद्ध कोई अनुशासनिक कार्यवाही प्रस्तावित या विचाराधीन न हो, स्थायी सरकारी सेवकों के ही समान 12 महीने तक चिकित्सा प्रमाण पत्र पर अवकाश की सुविधा है, परन्तु 12 माह के पश्चात् स्थायी सेवकों को प्रदान किया जा सकने वाला 6 माह का अतिरिक्त अवकाश इन्हें अनुमन्य नहीं है।

शेष सभी अस्थायी सरकारी सेवकों को चिकित्सा प्रमाण पत्र के आधार पर सम्पूर्ण अस्थायी सेवाकाल में चार माह तक अवकाश प्रदान किया जा सकता है।

सभी स्थायी एवं अस्थायी) कार्मिकों के मामलों में प्राधिकृत चिकित्सा प्राधिकारी की संस्तुति पर सक्षम अधिकारी द्वारा साठ दिन तक की छुट्टी स्वीकृत की जा सकती है। इस अवधि से अधिक छुट्टी तब तक स्वीकृत नहीं की जा सकती, जब तक सक्षम अधिकारी को यह समाधान न हो जाये कि आवेदित छुट्टी की समाप्ति पर सरकारी कर्मचारी के कार्य पर वापस आने योग्य हो जाने की समुचित सम्भावना है। यदि सरकारी कर्मचारी की बीमारी के उपचार के मध्य मृत्यु हो जाती है तो उसे सक्षम अधिकारी चिकित्सा अवकाश स्वीकृत करेगा यदि चिकित्सा अवकाश अन्यथा देय है।

मूल नियम - 81-ख (2) (2). सहायक नियम--87 तथा 157-क (2) (2) एवं शासनादेश सं०-सा-4-525 / दस-96-201 /76 टी०सी०, दिनांक 19-8-1996

अवकाश वेतन

१- स्थायी सरकारी सेवकों तथा तीन वर्षों से निरन्तर कार्यरत अस्थायी सेवकों को 12 माह तक की अवधि तथा शेष अस्थायी सेवकों को चार माह तक की अवकाश अवधि के लिये यह अवकाश वेतन अनुमन्य होगा, जो उसे अर्जित अवकाश का उपभोग करने की दशा में अवकाश वेतन के रूप में देय होता।

2- स्थायी सेवकों को 12 माह का अवकाश समाप्त होने के उपरान्त देय अवकाश के लिये अर्जित अवकाश की दशा में अनुमन्य अवकाश वेतन की आधी धनराशि अवकाश वेतन के रूप में अनुमन्य होती है।

विकित्सा प्रमाण पत्र प्रदान करने हेतु अधिकृत चिकित्सकों का निर्धारण

अधिकारी / कर्मचारी	प्राधिकृत चिकित्सक
समूह क के अधिकारी	-मेडिकल कालेज के प्रधानाचार्य/रोग से संबंधित विभाग के प्रोफेसर -मुख्य चिकित्सा अधिकारी -राजकीय अस्पताल के प्रमुख/मुख्य/वरिष्ठ अधीक्षक -राजकीय अस्पताल के मुख्य/वरिष्ठ कन्सल्टेंट/ कन्सल्टेंट
समूह ख के अधिकारी	-मेडिकल कालेज के रोग से संबंधित विभाग के प्रोफेसर/रीडर - राजकीय अस्पताल के प्रमुख/मुख्य/वरिष्ठ अधीक्षक - राजकीय अस्पताल के मुख्य/वरिष्ठ कन्सल्टेंट/कन्सल्टेंट
समूह ग व घ के कर्मचारी	- मेडिकल कालेज के रोग से संबंधित विभाग के रीडर / लेक्चरर राजकीय चिकित्सालयों / औषधालयों/ सामुदायिक स्वास्थ्य केन्द्रों / प्राथमिक स्वास्थ्य केन्द्रों में कार्यरत | समस्त श्रेणी के चिकित्साधिकारी

शासनादेश संख्या- 761/45-7-1947 दिनांक 22 अप्रैल 1987 शासनादेश संख्या- 865/5-7-949/76 दिनांक 6 मई 1988

राजपत्रित अधिकारी के चिकित्सा प्रमाण पत्र अवकाश या उसके प्रसार के लिए सहायक नियम 89 में उल्लिखित प्रपत्र में प्रमाण-पत्र प्राप्त करना चाहिए। प्राधिकृत चिकित्साधिकारी द्वारा दिया गया प्रमाण पत्र पर्याप्त होगा यदि संस्तुत अवकाश की अवधि तीन माह से अनधिक हो तथा चिकित्साधिकारी यह प्रमाणित कर दें कि उनकी राय में प्रार्थी को चिकित्सा परिषद के समक्ष उपस्थित होने की आवश्यकता नहीं है। जब प्राधिकृत चिकित्सा अधिकारी द्वारा प्रदत्त प्रमाण-पत्र में सरकारी सेवक के चिकित्सा परिषद के समक्ष उपस्थित होने की संस्तुति की जाय अथवा संस्तुत अवकाश की अवधि तीन माह से अधिक हो या तीन माह या उससे कम अवकाश को तीन माह से आगे बढ़ाया जाये तो संबंधित राजपत्रित सरकारी सेवक को उपर्युक्त वर्णितः प्रमाण-पत्र प्राप्त करने के बाद अपने रोग के विवरण पत्र की दो प्रतियाँ लेकर चिकित्सा परिषद के सम्मुख उपस्थित होना होता है तथा सहायक नियम 91 में दिये गये प्रारूप पर चिकित्सा परिषद से प्रमाण पत्र प्राप्त करना होता है।

ऐसे प्रकरणों में जहां संस्तुत अवकाश की अवधि तीन माह से अधिक हो अथवा तीन माह या उससे कम अवकाश को तीन माह से आगे बढ़ाया जाये, चिकित्सा परिषद द्वारा चिकित्सा प्रमाण पत्र प्रदान करते समय उल्लेख कर दिया जाना चाहिए कि संबंधित अधिकारी को ड्यूटी पर लौटने के लिए वांछित स्वस्थता प्रमाण-पत्र प्राप्त करने के लिये पुनः परिषद के समक्ष उपस्थित होना है या वह उस प्रमाण पत्र को प्राधिकृत चिकित्सा अधिकारी से प्राप्त कर सकता है।

श्रेणी घ के सरकारी सेवकों के चिकित्सा प्रमाण पत्र के आधार पर अवकाश या अवकाश के प्रसार के लिए दिये गये आवेदन पत्र के समर्थन में अवकाश स्वीकृत करने वाले सक्षम प्राधिकारी जिस प्रकार के प्रमाण पत्र को पर्याप्त समझें, स्वीकार कर सकते हैं।

मातृत्व अवकाश

मातृत्व अवकाश स्थायी अथवा अस्थायी महिला सरकारी सेवकों को निम्न दो अवसरों पर निर्धारित शर्तों के अधीन प्रदान किया जाता है:-

1- **प्रसूति के मामलों में**

- यह अवकाश सम्पूर्ण सेवाकाल में दो बार अनुमन्य है।
- प्रसूतावस्था पर अवकाश प्रारम्भ होने के दिनांक से 180 दिन तक अवकाश देय है।
- अन्तिम बार स्वीकृत अवकाश के समाप्त होने के दिनांक से दो वर्ष व्यतीत हो चुके हों तभी दुबारा यह अवकाश स्वीकृत किया जा सकता है।
- यदि किसी महिला सरकारी सेवक के दो या अधिक जीवित बच्चें हाँ तो उसे यह अवकाश स्वीकृत नहीं किया जा सकता, भले ही उसे अवकाश अन्यथा देय हो। यदि महिला सरकारी सेवक के दो जीवित बच्चों में से कोई भी बच्चा जन्म से किसी असाध्य रोग से पीड़ित हो या दिव्यांग या अपंग हो अथवा बाद में इन बीमारियों / विकृतियों से ग्रस्त हो जाये तो सम्पूर्ण सेवाकाल में दो बार अनुमन्यता की शर्तों के अधीन रहते हुए उसे अपवादस्वरूप एक अतिरिक्त मातृत्व अवकाश स्वीकृत किया जा सकता है।

2- **गर्भपात एवं गर्भखाद के मामलों में**

गर्भपात के मामलों में जिसके अन्तर्गत गर्भस्राव भी है. प्रत्येक अवसर पर 6 सप्ताह तक का अवकाश देय है। अवकाश के प्रार्थना पत्र के समर्थन में प्राधिकृत चिकित्सक का प्रमाण पत्र संलग्न होना चाहिए। गर्भपात गर्भस्राव के प्रकरणों में अनुमन्य मातृत्व अवकाश के सम्बन्ध में अधिकतम तीन बार अनुमन्य होने का प्रतिबन्ध शासन के पत्रांक संख्या-4-84/ दस-90-216-79 दिनांक 3 मई 1990 द्वारा प्रसारित अधिसूचना के द्वारा समाप्त कर दिया गया है।

मूल नियम 101 एवं सहायक नियम 153 तथा शासनादेश सं० जी-2-2017-दस-2008-79. दिनांक 08 दिसम्बर, 2008

मातृत्व अवकाश को किसी प्रकार के अवकाश लेखे से नहीं पढ़ाया जाता है तथा अन्य प्रकार की छुट्टी के साथ मिलाया जा सकता है।

सहायक नियम 154

मातृत्व अवकाश की अवधि में अवकाश पर प्रस्थान करने से ठीक पहले प्राप्त वेतन के बराबर अवकाश वेतन अनुमन्य होता है।

सहायक नियम 153

असाधारण अवकाश

असाधारण अवकाश निम्न विशेष परिस्थितियों में स्वीकृत किया जा सकता है।

- जब अवकाश नियमों के अधीन कोई अन्य अवकाश देय न हो।
- अन्य अवकाश देय होने पर भी संबंधित सरकारी सेवक असाधारण अवकाश प्रदान करने के लिए आवेदन करें। यह अवकाश लेखे से नहीं घटाया जाता है।

स्थायी सरकारी सेवक

स्थायी सरकारी सेवक को असाधारण अवकाश किसी एक समय में मूल नियम 18 के उपबन्धों के अधीन अधिकतम 5 वर्ष तक की अवधि के लिए स्वीकृत किया जा सकता है।

किसी भी अन्य प्रकार के अवकाश के क्रम में स्वीकृत किया जा सकता है

अस्थायी सरकारी सेवक

अस्थायी सरकारी सेवक को देय असाधारण अवकाश की अवधि किसी एक समय में निम्नलिखित सीमाओं से अधिक न होगी

- 3 मास
- 6 मास- यदि संबंधित सरकारी सेवक ने तीन वर्ष की निरन्तर सेवा अवकाश अवधि सहित पूरी कर ली हो तथा अवकाश के समर्थन में नियमों के अधीन अपेक्षित चिकित्सा प्रमाण पत्र प्रस्तुत किया हो।
- 18 मास- यदि संबंधित सरकारी सेवक ने एक वर्ष की निरन्तर सेवा पूरी कर ली हो और वह क्षय रोग अथवा कुष्ठ रोग का उपचार करा रहा हो तथा सम्बन्धित चिकत्सक द्वारा प्रदत्त प्रमाण पत्र संलग्न किया हो।
- 24 मास- सम्पूर्ण अस्थायी सेवा की अवधि में 36 मास की अधिकतम सीमा के अधीन रहते हुए जनहित में भारत अथवा विदेश में अध्ययन करने के लिए इस प्रतिबन्ध के अधीन देश है कि संबधित सेवक ने तीन वर्ष की निरन्तर सेवा पूरी कर है।
  सहायक नियम 157क(4)

अवकाश वैतन

असाधारण अवकाश की अवधि के लिए कोई अवकाश वेतन देय नहीं है।

मूल नियम 85 87 (क) (4) एवं सहायक नियम 157क (6) (ग)

चिकित्सालय अवकाश (मूल नियम 101 तथा सहायक नियम 155 व 156)

अधीनस्थ सेवाओं के निम्नलिखित श्रेणी के कर्मचारियों को, चाहे स्थायी हों या अस्थायी, जिनकी डयूटी में दुर्घटना या बीमारी का विशेष खतरा हो, अस्वस्थता के कारण चिकित्सालय अवकाश प्रदान किया जा सकता है:-

(क) स्थायी सेवा में सभी विभागों के रक्षी (गार्ड)

(ख) विधान मंडल के किसी अधिनियम के अधीन भर्ती किए गए पुलिस विभाग के कार्यकारी सरकारी
कर्मचारी,

(ग) कारागार (जेल) विभाग के प्रधान प्रहरी (हेड वार्डर), प्रहरी और अर्दली तथा पागलखानों के रक्षी
(गार्ड) प्रहरी (वार्डर), पट्टी बांधने वाले (ड्रेसर) और कम्पाउन्डर जिनमें महिला कर्मचारी सम्मिलित हैं,

(घ) वन विभाग के अधीनस्थ कर्मचारी जिनमें राजि लिपिक (रेंज क्लर्क) सम्मिलित हैं किन्तु अन्य
लिपिक सम्मिलित नहीं हैं.

(ड) पशुपालन विभाग के सईस,

(च) राजकीय मुद्रणालय (प्रेस) का कोई कर्मचारी चाहे वह नियत वेतन पर हो या ठेके की दरों पर,

(छ) राजकीय प्रयोगशालाओं में सेवायोजित अधीनस्थ कर्मचारी,

(ज) राजकीय मशीनरी के कार्य सम्पादन में सेवायोजित अधीनस्थ कर्मचारी,

(झ) तराई तथा नाबर में नौकरी करने वाले चपरासी तथा अन्य सरकारी कर्मचारी,

(ट) नहर के शीर्ष निर्माण कार्यों तथा पूर्वी यमुना नहर की तीव्र धारा समपार पर सिंचाई विभाग द्वारा नियुक्त टिंडल, रेगुलेशन बेलदार एवं मल्लाह तथा साथ ही मुख्य शारदा नहर तथा देवहा बहगुल पोषक नहर में नियुक्त अधीनस्थ कर्मचारी,

(ठ) आबकारी चपरासी,

(ड) उ०प्र० अग्निशमन सेवा के सदस्य,

(ट) ऐसे अन्य समस्त सरकारी कर्मचारी जिनके कर्तव्यों में खतरनाक मशीनरी, विस्फोटक पदार्थ, जहरीली गैसों तथा औषधियों आदि से काम करना शामिल है अथवा जिन्हें खतरनाक काम करने पड़ते हों।

चिकित्सालय अवकाश उस प्राधिकारी जिसका कर्तव्य उस पद को (यदि वह रिक्त हो) भरने का होता है, के द्वारा | निम्नलिखित शर्तों के अधीन स्वीकृत किया जा सकता है-

(1) यह अवकाश उन्हीं सरकारी सेवकों को देय है जिनका वेतन रु० 1180 (दिनांक 01 जनवरी 1986 से लागू वेतनमानों में) प्रति मास से अधिक न हो।

(2) यह अवकाश चाहे एक बार में लिया जाये अथवा किश्तों में किसी भी दशा में तीन वर्ष की कालावधि में छः माह से अधिक, स्वीकृत नहीं किया जायेगा।

(3) यह प्रमाणित हो कि बीमारी या चोट सम्बन्धित कर्मचारी के अनियमित या असंयमित आदतों के परिणामस्वरूप नहीं है।

चिकित्सालय अवकाश को अवकाश लेखे से नहीं घटाया जाता है तथा इसे अन्य देय अवकाश से संयोजित किया जा सकता है, परन्तु शर्त यह है कि कुल मिलाकर अवकाश अवधि 28 माह से अधिक नहीं होगी।

सहायक नियम 156

अवकाश वेतन

चिकित्सालय अवकाश अवधि के पहले तीन माह तक के लिए वही अवकाश वेतन प्राप्त होता है जो वेतन अवकाश पर प्रस्थान करने के तुरन्त पूर्व प्राप्त हो रहा हो। तीन माह से अधिक की शेष अवधि के लिये अवकाश वेतन उक्त दर के आधे के हिसाब से दिया जाता है। सहायक नियम 155 (3)

अध्ययन अवकाश

(मूल नियम 84 एवं सहायक नियम 146क)

जन स्वास्थ्य तथा चिकित्सा अनुसंधान, कृषि, शिक्षा, पशुपालन, सार्वजनिक निर्माण तथा वन विभागों में कार्यरत स्थायी सरकारी सेवकों को जनहित में किन्हीं वैज्ञानिक, प्राविधिक अथवा इसी प्रकार की समस्याओं के अध्ययन या प्रशिक्षण के विशेष • पाठ्यक्रम को पूरा करने के लिए निर्धारित शर्तों के अधीन अध्ययन अवकाश दिया जा सकता है। शासन जनहित में आवश्यक समझे तो इसे उक्त छः विभागों के अतिरिक्त अन्य विभागों के सरकारी कर्मचारियों पर भी लागू कर सकता है।

यह अवकाश भारत में अथवा भारत के बाहर अध्ययन करने के लिए स्वीकृत किया जा सकता है। जिन सरकारी सेवकों ने पाँच वर्ष से कम सेवा की हो अथवा जिन्हें सेवानिवृत्त होने का विकल्प तीन वर्ष या उससे कम समय में अनुमन्य हो, उनको अध्ययन अवकाश साधारणतया प्रदान नहीं किया जाता है।

असाधारण अवकाश या चिकित्सा प्रमाणपत्र पर अवकाश को छोड़कर अन्य प्रकार के अवकाश को अध्ययन अवकाश के साथ मिलाये जाने की दशा में

सकल अवकाश अवधि के परिणामस्वरुप संबंधित सरकारी सेवक की अपनी नियमित ड्यूटी से अनुपस्थिति 28 महीने से अधिक नहीं होनी चाहिए।

एक बार में बारह माह के अवकाश को साधारणतया उचित अधिकतम सीमा माना जाना चाहिए तथा केवल असाधारण कारणों को छोड़कर इससे अधिक अवकाश किसी एक समय में नहीं दिया जाना चाहिए। सम्पूर्ण सेवा अवधि में कुल मिलाकर 2 वर्ष तक का अध्ययन अवकाश प्रदान किया जा सकता है।.

अवकाश वेतन

अध्ययन अवकाश काल में अर्द्ध वेतन अनुमन्य होता है।

विशेष दिव्यांगता अवकाश (मूल नियम 83 तथा 83क)

राज्यपाल किसी ऐसे स्थायी अथवा अस्थायी सरकारी सेवक को जो किसी के द्वारा जानबूझकर चोट पहुँचाने के फलस्वरुप अथवा अपने सरकारी कर्तव्यों के उचित पालन में या उसके फलस्वरूप चोट लग जाने अथवा अपनी अधिकारीय स्थिति के परिणामस्वरुप चोट लग जाने के कारण अस्थायी रूप से दिव्यांग हो गया हो, को विशेष दिव्यांगता अवकाश प्रदान कर सकते हैं।

अवकाश तभी स्वीकृत किया जायेगा जबकि दिव्यांगता (disability) उक्त घटना के दिनांक से तीन माह के अन्दर प्रकट हो गई हो तथा सो उधित सेवक ने उसकी सूचना तत्परता से यथा सम्भव शीघ्र दे दी हो। राज्यपाल दिव्यांगता के बारे में संतुष्ट होने की दशा में घटना के तीन माह के पश्चात् प्रकट हुई दिव्यांगता के लिए भी अवकाश प्रदान कर सकते हैं। किसी एक घटना के लिए एक बार से अधिक बार भी अवकाश प्रदान किया जा सकता है। दिव्यांगता बढ़ जाये अथवा भविष्य में पुनः वैसी ही परिस्थितियाँ प्रकट हो जायें तो अवकाश ऐसे अवसरों पर एक से अधिक बार भी प्रदान किया जा सकता

अवकाश चिकित्सा परिषद द्वारा दिये गये चिकित्सा प्रमाणपत्र के आधार पर प्रदान किया जा सकता है तथा अवकाश की अवधि चिकित्सा परिषद द्वारा की गयी संस्तुति पर निर्भर रहती है परन्तु यह चौबीस महीने से अधिक नहीं होगी। इसे किसी अन्य प्रकार के अवकाश के साथ संयोजित किया जा सकता है

अवकाश वेतन

चार महीने पूर्ण वेतन तथा शेष अवधि में अर्द्ध वेतन ।

लघुकृत अवकाश

मूल नियम 84 के अधीन उच्चतर वैज्ञानिक या प्राविधिक अर्हताएँ प्राप्त करने के लिए अध्ययन अवकाश पर जाने वाले स्थायी सरकारी सेवकों के विकल्प पर उन्हें एक बार में अनुमन्य निजी कार्य पर अवकाश की आधी अवधि तक का अवकाश लघुकृत अवकाश के रूप में स्वीकृत किया जा सकता है।

जितनी अवधि के लिये लघुकृत अवकाश स्वीकृत किया जायेगा, उसकी दुगुनी अवधि उसके निजी कार्य पर अवकाश खाते में जमा अवकाश में से घटा दी जायेगी।

यह अवकाश तभी स्वीकृत किया जायेगा जब स्वीकर्ता अधिकारी को यह समाधान हो जाये कि अवकाश समाप्ति पर सरकारी कर्मचारी सेवा में वापस आयेगा।

मूल नियम 81-ख (4)

अवकाश वेतन

अर्जित अवकाश की तरह अवकाश पर जाने से ठीक पहले प्राप्त वेतन, अवकाश वेतन के रूप में अनुमन्य है। मूल नियम 87-क (4)

बाल्य देखभाल अवकाश

- महिला सरकारी सेवक को चाहे वह स्थायी हो अथवा अस्थायी, सम्पूर्ण सेवाकाल में अधिकतम 730 दिनों का बाल्य देखभाल

अवकाश मातृत्व अवकाश की शर्तों एवं प्रतिबन्धों के अधीन अनुमन्य होगा।

- यह अवकाश विशिष्ट परिस्थितियों यथा संतान की बीमारी तथा परीक्षा आदि में देखभाल हेतु संतान की आयु 18 वर्ष होने की अवधि तक देय है।
- गोद ली गयी संतान के सम्बन्ध में भी यह अवकाश देय होगा। यह अवकाश दो सबसे बड़े जीवित बच्चो के लिए ही अनुमन्य होगा।
- सम्बन्धित महिला कर्मचारी के अवकाश लेखे में उपार्जित अवकाश देय होते हुए भी बाल्य देखभाल अवकाश अनुमन्य होगा।
- बाल्य देखभाल अवकाश को एक कलेण्डर वर्ष के दौरान तीन बार से अधिक नहीं दिया जायेगा।
- बाल्य देखभाल अवकाश को 15 दिनों से कम के लिये नहीं दिया जायेगा।
- बाल्य देखभाल अवकाश को साधारणतया परिवीक्षा अवधि के दौरान नहीं दिया जायेगा । विशेष परिस्थितियों में यदि परिवीक्षाधीन महिला सरकारी सेवक को बाल्य देखभाल अवकाश स्वीकृत किये जाने की आवश्यकता पड़ती है तो यह सुनिश्चित किया जायेगा कि दिये जाने वाले अवकाश की अवधि कम-से-कम हो।
- बाल्य देखभाल अवकाश को अर्जित अवकाश के समान माना जायेगा और उसी प्रकार से स्वीकृत किया जायेगा।

(कार्यालय ज्ञाप संख्या- जी-2-2017 / दस-2008-216-79, दिनांक 08-12-2008, कार्यालय ज्ञाप संख्या- जी-2-573/दस-2009-216-79, दिनांक 24-3-2009 तथा शासनादेश संख्या- जी-2176/दस-2011-216-79 दिनांक 11 अप्रैल, 2011 तथा शासनादेश संख्या- 3-जी-2-100/दस-2014-216-79 दिनांक 24 सितम्बर, 2014)

दत्तक ग्रहण अवकाश

- ऐसी महिला सरकारी सेवक जिनके दो से कम बच्चे जीवित हों एवं जिनके द्वारा एक वर्ष की आयु तक का बच्चा गोद लिया गया हो, को सामान्य माताओं को प्रदत्त मातृत्व अवकाश की भांति 180 दिन के दत्तक ग्रहण अवकाश की सुविधा प्रदान की जायेगी। यदि किसी महिला सेवक के गोद लेने के समय दो या अधिक जीवित बच्चें हों तो यह अवकाश उसे स्वीकृत नहीं किया जाऐगा।
- महिला सरकारी सेवक को उक्त अवकाश अवधि में वह पूर्ण वेतन देय होगा जो वह अवकाश पर जाने के दिनांक को आहरित कर रही हो।
- दत्तक ग्रहण अवकाश किसी अन्य प्रकार के अवकाश के साथ मिलाया जा सकता है तथा इसे किसी प्रकार के अवकाश लेखे से घटाया नहीं जायेगा।
- दत्तक ग्रहण अवकाश की निरन्तरता में महिला सेवकों द्वारा यदि आवेदन किया जाता है, तो कानूनी तौर पर गोद लिये जाने के दिनांक को बच्चे की आयु घटाते हुये अधिकतम एक वर्ष की अवधि तक का उसे देय एवं अनुमन्य अन्य अवकाश | बिना दत्तक ग्रहण अवकाश की अवधि को जोड़े निम्न प्रतिबंधों के साथ स्वीकृत किया जा सकेगा:-

1- दत्तक ग्रहण अवकाश पर बच्चे की आयु एक माह से कम होने पर एक वर्ष तक का अवकाश स्वीकृत किया जा सकता है।

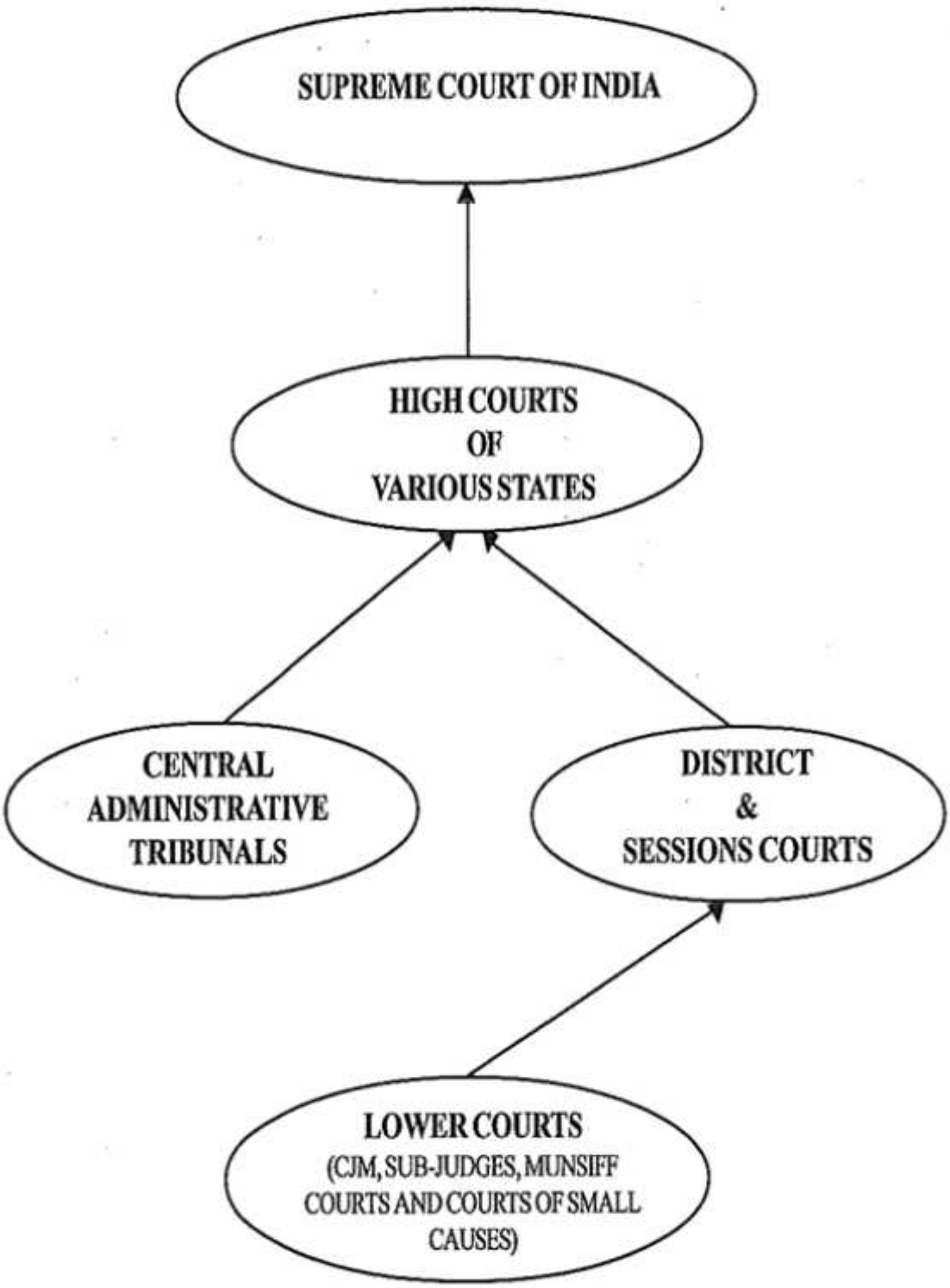
2- बच्चे की आयु छः माह या अधिक परन्तु सात माह से कम होने पर छः माह तक का अवकाश स्वीकृत किया जा सकता है।

3- बच्चे की आयु नौ माह या अधिक परन्तु दस माह से कम होने पर तीन माह तक का अवकाश स्वीकृत किया जा सकता है। (कार्यालय ज्ञाप संख्या-जी-2-2017 /दस-2008-216-79, दिनांक 08-12-2008, कार्यालय ज्ञाप संख्या- जी-2-573 /दस-2009-216-79, दिनांक 24-3-2009)

Annexure-1

JUDICIAL SYSTEMS IN INDIA

UNDERSTANDING JUDICIAL SYSTEMS


SUPREME COURT OF INDIA
HIGH COURTS OF VARIOUS STATES
CENTRAL ADMINISTRATIVE TRIBUNALS
DISTRICT & SESSIONS COURTS
LOWER COURTS
(CJM, SUB-JUDGES, MUNSIFF COURTS AND COURTS OF SMALL CAUSES)

2.2 DISTRICT AND SUBORDINATE COURTS

2.2.1 The organisation and functions of the subordinate courts throughout the country are uniform, except with minor local variations. The entire subordinate courts function under the supervision of the concerned High Court. In every district there are civil and criminal courts. The Court of the District Judge is the highest court in a district. The District Judge deals with civil cases and the Sessions Judge deals with criminal cases. He can award capital punishment subject to the approval of the High Court. District Judge/Sessions Judge also hears appeals against the decisions of the Lower Courts. Besides these courts, there are courts of sub-judges, munsiff courts and courts of small causes. There are also courts of second class and third class magistrates.

2.2.2 The judges of the District Courts are appointed by the Governor of the concerned State in consultation with the High Court. A person who has been a pleader or an advocate for seven years or an officer in the judicial service of the Union or the State is eligible for appointment. Regarding positions other than those of district judges, the Governor in consultation with the High Court and the State Public Service Commission makes appointments. At least three years experience as an advocate or a pleader is one of the essential qualifications for these appointments.

2.2.3 The District Courts hear appeals against decisions of sub-judges. It hears cases relating to the disputes of property, marriage and divorce. The civil courts exercise jurisdiction over such matters as guardianship of minors and lunatics.

2.3 CENTRAL ADMINISTRATIVE TRIBUNALS

Introduction

2.3.1 Central Administrative Tribunals were set up under Article 323-A of the Constitution of India with Benches at several places covering the entire country. The Benches started functioning from 1985. The objective has been to satisfy the long-felt need to have a machinery, independent of existing judiciary, for providing speedy and inexpensive relief for persons in services and posts under the Union, by adjudicating in the matter of their complaints and grievances on recruitment and conditions of service. Earlier, it was left to the aggrieved to move the High Court of Judicature under Article 226 of the Constitution of India and since the High Courts were dealing with all types of cases, there was an inordinate delay in settlement of these Writs. After the decision of the High Court, some more years were spent to go through for an appeal in the Supreme Court.

2.3.2 The Central Administrative Tribunal, under the Administrative Tribunals Act, 1985, is empowered to exercise all jurisdiction, powers and authority exercisable by all courts, except the High Court in Writ jurisdiction and Hon'ble Supreme Court, in relation to all service matters.

2.3.3 **Jurisdiction, powers and authority of the Central Administrative Tribunal**

(1) Save as otherwise expressly provided in this Act, the Central Administrative Tribunal shall exercise, on and from the appointed day, all jurisdiction, powers and authority exercisable immediately before that day by all courts (except the Supreme Court) in relation to –

(a) Recruitment and matters concerning recruitment, to any All India Service or to any civil service of the Union or a civil post under the Union or to a post connected

with defence or in the defence services, being, in either case, a post filled by a civilian;

(b) All service matters concerning –

i) a member of any All-India Service; or

ii) a person [not being a member of an All-India Service or a person referred to in clause(c)] appointed to any civil service of the Union or any civil post under the Union; or

iii) a civilian [not being a member of an All-India Service or a person referred to in clause(c)] appointed to any defence service or a post connected with defence.

and pertaining to the service of such member, person or civilian, in connection with the affairs of the Union or of any State or of any local or other authority within the territory of India or under the control of the Government of India or of any corporation [or society] owned or controlled by the Government;

(c) all service matters pertaining to service in connection with the affairs of the Union concerning a person appointed to any service or post referred to in sub-clause (ii) or sub-clause (iii) of clause (b), being a person whose services have been placed by a State Government or any local or other authority or any corporation [or society] or other body, at the disposal of the Central Government for such appointment.

Explanation – For the removal of doubts, it is hereby declared that references to 'Union' in this sub-section shall be construed as including references also to a Union territory.

(2) The Central Government may, by notification, apply with effect from such date as may be specified in the notification the provisions of sub-section (3) to local or other authorities within the territory of India or under the control of the Government of India and to Corporations or Societies owned or controlled by Government, not being a local or other authority or Corporation or Society controlled or owned by a State Government:

Provided that if the Central Government considers it expedient so to do for the purpose of facilitating transition to the scheme as envisaged by this Act, different dates may be so specified under this sub-section in respect of different classes of, or different categories under any class of, local or other authorities or Corporations or Societies.

(3) Save as otherwise expressly provided in this Act, the Central Administrative Tribunal shall also exercise, on and from the date with effect from which the provisions of this sub-section apply to any local or other authority or Corporation or Societies, all the jurisdiction, powers and authority exercisable immediately before that date by all courts except the Supreme Court in relation to –

(a) recruitment, and matters concerning recruitment, to any service or post in connection

with the affairs of such local or other authority or Corporation or Society; and

(b) all service matters concerning a person [other than a person referred to in clause (a) or clause (b) of sub-section(1)] appointed to any service or post in connection with the affairs of such local or other authority or Corporation or Society and pertaining to the service of such person in connection with such affairs.

A special Bench, consisting of seven judges of the Supreme Court, has ruled that the decisions of the CAT will be subject to the scrutiny before a Division Bench of the High Court within whose jurisdiction the Tribunal concerned falls.

Table of jurisdiction of Benches of Central Administrative Tribunal

Sl. No	Bench	Jurisdiction	Postal Address
1	Principal Bench New Delhi	National Capital Territory of Delhi	Copernicus Marg, New Delhi-110001
2	Ahmedabad	State of Gujarat	Opposite Sardar Patel Stadium, Navrangpura, Ahmedabad-380009
3	Allahabad	(i) State of Uttar Pradesh excluding Districts mentioned against Serial No 4 under the jurisdiction of Lucknow Bench (ii) State of Uttaranchal	23-A, Thorn Hill Road, Post Bag No. 013, Allahabad-211001
4	Lucknow	Districts of Lucknow, Hardoi, Kheri, Rai Bareli, Sitapur, Unnao, Faizabad, Ambedkar Nagar, Bahraich, Shravasti, Barabanki, Gonda, Balarampur, Partapgarh, Sultanpur in the State of Uttar Pradesh	Gandhi Bhawan (Opposite Residency),Gandhi Smarak Nidhi,Lucknow-266001
5	Bangalore	State of Karnataka	2nd Floor Commercial Complex (BDA), Indira Nagar, Bangalore-560038
6	Chandigarh	(i) State of Jammu and Kashmir	Opposite Hotel Shivalik View, Sector 17,

		(ii) State of Haryana (iii) State of Himachal Pradesh (iv) State of Punjab (v) Union Territory of Chandigarh	Chandigarh-160017
7	Chennai	(i) State of TamilNadu (ii) Union Territory of Pondicherry	Additional City Civil Court Building, High Court Campus, Chennai-600104
8	Cuttack	State of Orissa	Rajaswa Bhawan, 4th Floor, Cuttack-753002
9	Eamakulam	(i) State of Kerala (ii) Union Territory of Lakshadweep	Kandomkulathy Towers, 5th 6th Floor, Opposite Maharaja College, MG Road, Ernakulam, Cochin-682001
10	Guwahati	(i) State of Assam (ii) State of Manipur (iii) State of Meghalaya (iv) State of Nagaland (v) State of Tripura (vi) State of Arunachal Pradesh (vii) State of Mizoram	Rajgarh Road, Shillong Road (Bhangagarh), Post Box No. 58, GPO, Guwahati-781005
11	Hyderabad	State of Andhra Pradesh	New Insurance Building Complex, 6th Floor, Tilak Marg (Abids), Post Box No. 07, Hyderabad-500001
12	Jabalpur	(i) State of Madhya Pradesh (ii) State of Chattisgarh	Canvs Building, 15 Civil Lines Jabalpur-482001
13	Jaipur	Districts of Ajmer, Alwar, Baran, Bharatpur, Bundi, Dausa, Dholpur, Jaipur, Jhalawar, Jhunjhunu, Kota, Sawai Madhopur, Sikar, Tonk and Karauli in the State of Rajasthan	C-42 Bhagat Watika, Civil Lines, Raj Bhavan Road, Jaipur-302006

14	Jodhpur	State of Rajasthan excluding the Districts mentioned against Serial No 13 under the jurisdiction of Jaipur Bench	House No. 69, 1st Polo (PAOTA), Post Box No.619,Jodhpur-342006
15.	Kolkata	(i) State of Sikkim (ii) State of West Bengal (iii) Union Territory of Andaman and Nicobar Islands	CGO Complex, Nizam's Place Compound, 2nd MSO Building, 11th – 12th Floor, 234/4, AJC Bose Road, Kolkata-700020
16	Mumbai	(i) State of Maharashtra (ii) State of Goa (iii) Union Territory of Dadra and Nagar Haveli (iv) Union Territory of Daman and Diu	Gulestan Building, No. 6, 3rd-4th Floor, Prescot Road, Near Mumbai Gymkhana Club (Fort) Mumbai-400001
17	Patna	(i) State of Bihar (ii) State of Jharkhand	88-A, BM Enterprises, Sri Krishna Nagar, Patna-800001

2.3.4 Composition

Each Tribunal consists of a Vice-Chairman in addition to Judicial/Administrative Members to the extent necessary. The Principal Bench located at New Delhi is the only Bench that is headed by a Chairman. It also has a Vice-Chairman, besides Judicial/Administrative Members. The Administrative Members possess necessary expertise and familiarity with administrative procedures and rules, to deal with service problems in a satisfactory way by finding out the facts and knowing relevant rules.

2.3.5 Service Matter

Service matter has been defined to mean all matters relating to conditions of service, viz., -

(i) remuneration (including allowances), pension and other retirement benefits;

(ii) tenure including confirmation, seniority, promotion, reversion, premature retirement and superannuation;

(iii) leave of any kind;

(iv) disciplinary matters;

(v) any other matter.

The definition is quite expansive and of wide connotation and has been held to cover other incidental and ancillary matters, like-

(i) transfer;

(ii) allotment of quarters;

(iii) eviction proceedings under Public Premises Act;

(iv) determination of marital status for purposes of family pension.

2.3.6 Application

In the application, against the relevant column, the applicant has to set out the facts of the case in a chronological order, each paragraph containing as nearly as possible, a separate issue or fact.

The grounds for relief with legal provision are also to be furnished concisely under the different heads and numbered serially.

The application should also contain prayer of applicant specifying relief sought for, explaining grounds for such relief and legal provision, if any, relied upon.

The application should be based upon a single cause of action and may seek one or more reliefs, provided that they are consequential to one another.

Interim relief, if any prayed for, pending final decision on the application, should be incorporated in application itself.

2.3.7 Form and contents

Every application is to be typed in double space on one side on thick paper of good quality (A-4 size) and must be accompanied by the following documents; -

(i) an attested copy of the order against which the application is filed;

(ii) copies of documents relied upon by the applicant and referred to in application duly attested;

(iii) an index of documents;

(iv) "Vakalatnama" duly executed in favour of legal practitioner filing the application;

(v) particulars of Bank Draft/Postal Order towards filing fee

The application should be presented in triplicate in the following two compilations

(i) Compilation No. 1. -application along with the impugned order.

(ii) Compilation No. 2. -all other documents and annexures referred to in the application in a paper-book form.

When the number of respondents is more than one, the applicant should furnish extra copies equal to the number of the respondents together with unused file-size envelopes bearing the full address of each respondent.

2.3.8 Filing fee

A fixed fee of Rs. 50/- in the form of demand draft/postal-order has to be paid along with each application, filed individually, jointly or in a representative capacity.

The Tribunal has power to exempt the payment of fee if it is satisfied that applicant is unable to pay the same due to his financial condition.'

2.3.9 Filing of Application

A person aggrieved by any order pertaining to any matter within the jurisdiction of a Tribunal may make an application to the Tribunal for the redressal of his grievance under Section 19 of the Act, in the prescribed form, giving details like number and the authority which has passed the order, against which the application is made.

Section 19 of Administrative Tribunal Act.

2.3.10 Applications to the Tribunals

1) Subject to the other provisions of this Act, a person aggrieved by any order pertaining to any matter within the jurisdiction of a Tribunal may make an application to the Tribunal for redressal of his grievances.

Explanation- For the purposes of this sub-section, "order" means an order made-

(a) by the Government or a local or other authority within the territory of India or under control of the Government of India or by any Corporation or Society owned or controlled by the Government: or

(b) by an officer, committee or other body or agency of the Government or a local or other authority or Corporation or Society referred to in clause(a).

2) Every application under sub-section (1) shall be in such form and be accompanied by such documents or other evidence and by such fee (if any, not exceeding one hundred rupees) in respect of the filing of such application and by such other fees for the service or execution of processes, as may be prescribed by the Central Government.

3) On receipt of an application under sub-section (1), the Tribunal shall, if satisfied after such inquiry as it may deem necessary, that the application is a fit case for adjudication or trial by it, admit such application; but where the Tribunal is not so satisfied, it may summarily reject the application after recording its reasons.

4) Where an application has been admitted by a Tribunal under sub-section (3), every proceeding under the relevant service rules as to redressal of grievances in relation to the subject-matter of such application pending immediately before such admission shall abate and save as otherwise directed by the Tribunal, no appeal or representation in relation to such matter thereafter be entertained under such rules.

2.3.11 Status of Applicant

Normally only an individual person has to file an application. The Tribunal may, however, permit more than one person to join together and file a single application, if it is satisfied, having regard to the cause of action and the nature of relief prayed for, that have a common interest in the matter. A separate application has to be filed seeking necessary permission in this regard.

Such permission is also granted to an association representing members desirous of joining in a single application and having a common cause of action.

2.3.12 Right of applicant to take assistance of legal practitioner and of Government, etc., to appoint Presenting Officers

(1) A person making an application to a Tribunal under this Act may either appear in person or take assistance of a legal practitioner of his choice to present his case before the Tribunal.

(2) The Central Government or a State Government or a local or other authority or Corporation or Society to which the provisions of sub-section (3) of Section 14 or sub-section (3) of Section 15 apply, may authorize one or more legal practitioners or any of its officers to act as Presenting Officers and every person so authorized by it may present its case with respect to any application before a Tribunal.

2.3.13 Exhausting remedies

The Act specifically lays down that the Tribunal shall not ordinarily admit an application unless it is satisfied that the applicant had availed of all remedies available to him under the relevant service rules as to redressal of grievance. An applicant is deemed to have availed all remedies available to him, if final order has been passed on his appeal/representation by the highest authority competent to pass such an order under relevant rules/orders or if no such order is passed, after lapse of a period of six months from the date of such appeal/representation having been made.

The expression "ordinarily" in the context means generally and not always or in all cases. It indicates that the Tribunal is vested with some discretion in the matter, which is to be exercised sparingly in extraordinary circumstances.

2.3.14 Section 20 of Administrative Tribunal Act.

(1) A Tribunal shall not ordinarily admit an application unless it is satisfied that the applicant had availed of all the remedies available to him under the relevant service rules as to redressal of grievances.

(2) For the purposes of sub-section (1), a person shall be deemed to have availed of all the remedies available to him under the relevant service rules as to redressal of grievances -

(a) if a final order has been made by the Government or other authority or officer or other person competent to pass such order under such rules, rejecting any appeal preferred or representation was made by such person in connection with the grievance; or

(b) where no final order has been made by the Government or other authority or officer or other person competent to pass such order with regard to the appeal preferred or representation made by such person, if a period of six months from the date on which such appeal was preferred or representation was made has expired.

(3) For the purposes of sub-sections (1) and (2), any remedy available to an applicant by way

of submission of a memorial to the President or to the Governor of a State or to any other functionary shall not be deemed to be one of the remedies which are available unless the applicant had elected to submit such memorial.

2.3.15 Limitation

(i) An application before the Tribunal has to be filed within one year from the date on which the final order has been made. Where an appeal/representation has been submitted by the person and the authority competent to pass final order has not passed the said order, application has to be filed after expiry of a period of six months from the submission of such appeal/representation and within one year from the date of expiry of the said period of six months. The application form itself provides for a declaration from the applicant that the application is within the limitation period prescribed.

(ii) The Act provides for admission of an application for disposal, in relaxation of the above limitation, if sufficient cause is shown for not making the application within such period. A separate application is required to be filed for condonation of delay, supported by an affidavit.

(iii) The period of limitation is reckoned with reference to the date of initial final order and is not revived by making repeated representation to the same authority.

2.3.16 Section 21 of Administrative Tribunal Act.

(1) A Tribunal shall not admit an application-

(a) in a case where a final order such as is mentioned in Clause (a) of sub-section (2) of Section 20 has been made in connection with the grievance unless the application is made, within one year from the date on which such final order has been made;

(b) in a case where an appeal or representation such as is mentioned in Clause (b) of sub-section (2) of Section 20 has been made and a period of six months had expired thereafter without such final order having been made, within one year from the date of expiry of the said period of six months.

(2) Notwithstanding anything contained in sub-section (1), where-

(a) The grievance in respect of which an application is made had arisen by reason of any order made at any time during the period of three years immediately preceding the date on which the jurisdiction, powers and authority of the Tribunal becomes exercisable under this Act in respect of the matter to which such order relates; and

(b) no proceedings for the redressal of such grievance had been commenced before the said date before any High Court, the application shall be entertained by the Tribunal if it is made within the period referred to in Clause (a), or, as the case may be, Clause (b), of sub-section (1) or within a period of six months from the said date, whichever period expires later.

3) Notwithstanding anything contained in sub-section (1) or sub-section (2), an application may be admitted after the period of one year specified in Clause (a) or Clause (b) of sub-section (1) or, as the case may be, the period of six months specified in sub-section (2), if

the applicant satisfies the Tribunal that he had sufficient cause for not making the application within such period.

2.3.17 Place of filing

(i) An application is ordinarily to be filed with the Registrar of the Bench of the Tribunal within whose jurisdiction the applicant is for the time being posted or the cause of action has arisen.

(ii) However, with the permission of the Chairman of the Principal Bench, New Delhi, an application may be filed there, heard and disposed of.

(iii) The application form itself provides for a declaration to be furnished by the applicant that the subject matter, against which he wants redressal, is within the jurisdiction of the Tribunal, where he filed the application.

2.3.18 Power of Chairman to transfer cases from one Bench to another: -

The Chairman may transfer any case pending before one Bench, for disposal, to any other Bench on the application of any of the parties, after notice to the parties and after hearing them, as he may desire to be heard, or on his own motion, without such notice.

2.3.19 Scrutiny of application

On scrutiny of the application at the registry, the same, if found to be in order, will be duly registered, numbered and placed before the Bench for admission. Defects, if any, noticed on scrutiny will be got rectified before registration.

2.3.20 Terms of Notices

After hearing the petitioner, the Tribunal if finds merit prima-facie in the case passes an order of issuing notice to the respondent with the direction that the respondent should appear on the given date and should file its reply and all the supported documents.

2.3.21 Reply of Respondent

(i) Respondent Ministries/Departments should ensure that notice received from the Tribunal are attended to and complied with promptly. It is enjoined that whenever notices are received from the Tribunal, the Department concerned should immediately get in touch with the Senior Standing Counsel of the concerned Bench for handling the case. He should be fully briefed in the matter so that he files the written statement in reply to the application within the time allowed, after the same is duly vetted by Min of Law & Justice.

(ii) In the reply, the respondent has to specifically admit, deny or explain the fact stated by the applicant in his application and also state such additional facts as may be found necessary for a just decision of the case. The reply to the application should be filed in triplicate along with the documents relied upon in paper-book form. One copy of the reply along with the paper book should be furnished to the applicant or his legal practitioner.

2.3.22 Posting of cases for admission/orders before the bench

(i) Subject to the orders of the Chairman/Vice-Chairman of the concerned bench all registered applications-petitions shall be posted for admission orders before the appropriate bench on the next working

day. The notice of posting shall be given by notifying in the daily cause list for the day.

(ii) Appendix I and Appendix II to the CAT rules which may be amended from time to time specify about the nature of cases to be heard by single member bench or larger bench. It is very important to verify that the bench hearing the particular matter has been notified to hear such matters as per Appendix I & II.

2.3.23 *Ex parte* Hearing

(i) If on the date of hearing, the applicant appears and the respondent Department/Ministry is not represented, the Tribunal may adjourn the hearing or hear and decide the application ex parte. In such an event, the respondent may apply to the Tribunal for setting aside the order, giving sufficient cause to the satisfaction of the Tribunal and the Tribunal may set aside the ex parte hearing and hear the case afresh.

(ii) It is not obligatory for the Tribunal to dismiss an application for default if the applicant is not present or represented when the, matter is called for hearing. In the absence of the applicant, the Tribunal can hear the Counsel for the respondent, peruse the records placed before it, consider the applicant's grievance with reference to the grounds urged by him in his application and then decide the application on merits.

2.3.24 Decision by majority

If the Members of a Bench differ in opinion on any point/points, the point/points will be decided according to the opinion of the majority. But, if the Members are equally divided, they will state the point/points on which they differ and make a reference to the Chairman, who will either hear the point/points himself or refer the case for hearing by one or more of the other Members and decide according to the opinion of the majority of the Members who heard the case, including those who first heard it.

2.3.25 Decision by Tribunal

The Tribunal will take a decision on perusal of the documents filed by both the sides, written representations made and oral arguments advanced at the time of the hearing on behalf of both the sides. If necessary, it can hold an enquiry as provided in the Act, the Tribunal having the same powers as that of a Civil Court.

2.3.26 Action on judgement

(i) Immediately on the receipt of judgment/order of the tribunal the said judgment is required to be gone through and to be verified that there may not be any factual or legal error committed by the tribunal while passing the order. It is open to the Department to seek review of such order/judgment where any apparent factual error has been committed. Such review application is maintainable before the same tribunal but if any legal error has been committed and it is found that the order/judgement is passed against the settled principle of law such judgement should be challenged by way of writ petition under Article 226 of the Constitution before the concerned High Court.

(ii) If the competent authority finds that neither there is any factual error nor there is any legal error, then the order of the tribunal should be complied with immediately but not later than the time limit prescribed in the order or within six months of the receipt of order where no such time limit is indicated. It is important to note that failure to implement the order, unless the same is challenged and stay of operation of the order is obtained, in time may give rise to cause of action for initiating contempt proceedings.

(iii) If within the given time neither the order is challenged nor due to some difficulties or departmental delays the same is implemented it is always advisable to approach the tribunal with a prayer to extend the time for implementing the order in this way there will not be any risk of facing contempt proceedings.

2.3.27 Provision of Review

(i) If the applicant or the respondent is not satisfied with the judgement recorded, it is open to them to seek review of the judgement by filing a petition within thirty days of the communication of the order either by hand to the party or to his counsel by sending a true-copy of the order by registered post properly addressed and prepaid.

(ii) A Review petition will lie only when there is a glaring omission, patent mistake or error in the judgement. Unless otherwise ordered, a review petition will be disposed by the same Bench that passed the order and by circulation, which may either dismiss the petition or direct issue of notice to the opposite party. Once a revision petition is disposed of, no petition for further review can be filed.

2.3.28 Powers of Tribunal

(i) The power conferred on the Tribunal by Section 22 of the Act is very wide. The Tribunal is not bound by the procedure laid down by the Code of Civil Procedure or the Rules of Evidence contained in the Evidence Act. The Tribunal is primarily bound by the principles of natural justice and the rules made by the Central Government. It could adopt inquisitional procedure also to meet the ends of justice, without however, offending the principles of natural justice.

(ii) The concept of natural justice has undergone a great deal of change in recent years. Natural justice demands or requires a fair trial; an authority should act judiciously, meaning not arbitrarily or capriciously, but justly and fairly.

(iii) The Tribunal can decide cases on the basis of evidence taken on affidavits and need not take oral evidence. The Tribunal is entitled to grant such relief, which may be warranted on the facts of the case before it.

(iv) In the matter relating to disciplinary proceeding, it has been held that the Tribunal cannot go into the basic decision, that is, the nature of penalty imposed. It can only interfere in a case just to see whether-

(i) statutory provisions or rules prescribing the mode of enquiry were disregarded;

(ii) rules of natural justice were violated;

(iii) there was no evidence, that is, punishment has been imposed in the absence of supporting evidence. If there are some legal evidences on which the findings can be based, the Tribunal cannot go into the adequacy or reliability of the evidence, even if it was of the view that on the same evidence, its conclusion may have been different.

(iv) consideration extraneous to the evidence or the merits of the case, taken into account; and

(v) the conclusion was so wholly arbitrary and capricious that no reasonable person could have easily arrived at the conclusion.

Section 22 of Administrative Tribunal Act.

2.3.29 Procedure and powers of Tribunals

(1) A Tribunal shall not be bound by the procedure laid down in the Code of Civil Procedure, 1908 (5 of 1908), but shall be guided by the principles of natural justice and subject to the other provisions of this Act and of any rules made by the Central Government, the Tribunal shall have power to regulate its own procedure including the fixing of place and time of its inquiry and deciding whether to sit in public or in private.

(2) A Tribunal shall decide every application made to it as expeditiously as possible and ordinarily every application shall be decided on a perusal of documents and written representation and after hearing such oral arguments, as may be advanced.

(3) A Tribunal shall have, for the purposes of discharging its functions under this Act, the same powers as are vested in a Civil Court under the Code of Civil Procedure, 1908 (5 of 1908), while trying a suit, in respect of the following matters, namely: -

(a) summoning and enforcing the attendance of any person and examining him on oath;

(b) requiring the discovery and production of documents;

(c) receiving evidence on affidavits;

(d) subject to the provisions of Sections 123 and 124 of the Indian Evidence Act, 1872 (1 of 1872), requisitioning of any public record or document or copy of such record or document from any office;

(e) issuing commissions for the examination of witnesses or, documents;

(f) reviewing its decisions;

(g) dismissing a representation for default or deciding it ex parte;

(h) setting aside any order of dismissal of any representation for default or any order passed by it ex parte; and any other matter which may be prescribed by the Central Government.

2.3.30 Power to punish for contempt

A Tribunal shall have, and exercise, the same jurisdiction, powers and authority in respect of contempt of itself as a High Court has and may exercise and, for this purpose, the provisions of the Contempt of Courts Act, 1971, shall have effect subject to the modifications that –

a) the references therein to a High Court shall be construed as including a reference to such Tribunal;

b) the references to the Advocate – General in Section 15 of the said Act shall be construed-

(i) in relation to the Central Administrative Tribunal, as a reference to the Attorney–General or the Solicitor-General or the Additional Solicitor-General; and

(ii) in relation to an Administrative Tribunal for a State or a Joint Administrative Tribunal

for two or more States, as a reference to the Advocate-General of the State or any of the States for which such Tribunal has been established.

2.3.31 Distribution of business amongst the Benches

(1) Where, any Benches of a Tribunal are constituted, the appropriate Government may, from time to time, by notification, make provisions as to the distribution of the business of the Tribunal amongst the Benches and specify the matter, which may be dealt with by each Bench.

(2) If any question arises as to whether any matter falls within the purview of the business allocated to a Bench of a Tribunal, the decision of the Chairman thereon shall be final.

Explanation – For the removal of doubts, it is hereby declared that the expression 'matter' includes applications under Section 19.

2.3.32 Conditions as to making of interim orders

(i) No interim order shall be made on, or in any proceedings relating to, an application unless:-

(a) Copies of such application and of all documents in support of the plea for such interim order are furnished to the party against whom such application is made or proposed to be made and

(b) opportunity is given to such party to be heard in the matter.

(ii) The Tribunal may dispense with the requirement and make an interim order as an exceptional measure if it is satisfied, for reasons to be recorded in writing, that it is necessary to do so for preventing any loss being caused to the applicant which cannot be adequately compensated in money but any such interim order shall, if it is not sooner vacated, cease to have effect on the expiry of a period of fourteen days from the date on which it is made unless the said requirements have been complied with before the expiry of that period and the Tribunal has continued the operation of the interim order.

2.3.33 The Central Administrative Tribunal (Contempt of Courts) Rules, 1992

GSR 757 (E)-In exercise of powers conferred by section 23 of the Contempt of Courts Act, 1971 (70 of 1971), read with Section 17 of the Administrative Tribunals Act, 1985 (Act 13 of 1985), and all other powers enabling it in this behalf and in supersession of all rules on the subject, the Central Administrative Tribunal hereby makes the following rules to regulate the proceedings under the said Act-

1. **Short title and commencement.** -(i) These rules may be called 'Contempt of Courts (CAT) Rules, 1992',

(ii) They shall come into force on the date of their publication in the Official Gazette.

3. **Form of Motion**-Every motion for initiating action for contempt of the Tribunal shall be in the form of a petition described as 'Contempt Petition (Civil)' in respect of Civil Contempt and 'Contempt Petition (Criminal)' in respect of Criminal Contempt.

4. **Parties to the Proceedings**-The party who presents the petition shall be described as the 'Petitioner' and the alleged contemner shall be described as the 'Respondent'.

5. **Contents of the Petition**- The petition shall set out the following particulars; -

(i) (a) Name (including as far as possible the name of the father/mother/ husband), age, occupation and address of-

(i) the petitioner; and

(ii) the respondent

If the alleged contemner is an officer, he shall be described by name and designation.

(b) provision of the Act invoked and the nature of the contempt, 'Civil' or 'Criminal';

(c) the grounds and material facts constituting the alleged contempt including the date of alleged contempt, divided into paragraphs, numbered consecutively, along with supporting documents or certified/Photostat (attested) copies of the originals thereof;

(d) the nature of the order sought from the Tribunal;

(e) if a petition has previously been made by him on the same facts, the details, particulars and the result thereof;

(f) the petition shall be supported by an affidavit verifying the facts relied upon except when the motion is by the Attorney General or the Solicitor General or the Additional Solicitor General;

(g) every petition shall be signed by the petitioner and his Advocate, if any, and shall show the place and date;

(h) draft charges shall be enclosed in a separate sheet;

(i) in the case of 'Civil Contempt', certified copy of the judgment, decree, order, writ or undertaking alleged to have been disobeyed shall be filed along with the petition;

(j) where the petitioner relies upon any other documents in his possession, or power, he shall file them along with the petition;

(ii) in the case of 'criminal contempt' of the Tribunal, other than a contempt referred to in Section 14 of the Act, the petitioner shall state whether he has obtained the consent of the Attorney General or the Solicitor-General or the Additional Solicitor General and if so, produce the same, if not the reasons thereof;

(iii) the petitioner shall file three complete sets of the petition including the annexures in paper book form, duly indexed and paginated. Where the number of respondents is more than one, equal number of extra paper books shall be filed;

(iv) No fee shall be payable on a petition or any document filed in the proceedings.

6. **Taking cognizance**

(i) Every proceeding for contempt shall be dealt with by a Bench of not less than two Members;

(ii) Provided where the contempt is alleged to have been committed in view of presence or hearing of the Member(s), the same shall be dealt with by the Member(s) in accordance with Section 14 of the Act.

7. **Initiation of proceedings**

(i) Every petition for 'Civil Contempt' made in accordance with these rules shall be scrutinized by the Registrar, registered and numbered in the Registry and then placed before the Bench for preliminary hearing.

(ii) Every petition for 'criminal contempt' made in accordance with these rules and every information other than a petition, for initiating for action for criminal contempt under the Act on being scrutinized by the Registrar shall first be placed on the administrative side before the Chairman in the case of the Principal Bench and the concerned vice-Chairman in the case of other Benches or such other Member as may be designated by him for this purpose and if he considers it expedient and proper to take action under the Act, the said petition or information shall be registered and numbered in the Registry and placed before the Bench for preliminary hearing.

(iii) When suo motu action is taken, the statement of facts constituting the alleged contempt and copy of the draft charges shall be prepared and signed by the Registrar before placing them for preliminary hearing.

8. **Preliminary hearing and Notice**

(i) The Bench, if satisfied that a prima facie case has been made out, may direct issue of notice to the respondent; otherwise, it shall dismiss the petition or drop the proceedings.

(ii) The notice shall be accompanied by a copy of the petition or information, and annexures, if any, thereto.

(iii) Service of notice shall be effected in the manner specified in the Central Administrative Tribunal (Procedure) Rules, 1987 or in such other manner as may be directed by the Bench.

9. **Compelling attendance**

The Tribunal may, if it has reason to believe, that the respondent is absconding or is otherwise evading service of notice, or has failed to appear in person in pursuance of the notice, direct a warrant, bailable or non-bailable, for his arrest, addressed to one or more Police Officers or may order attachment of property belonging to such person. The warrant and the writ of attachment shall be issued under the signature of the Registrar. The warrant shall be executed as far as may be, in the manner provided for execution of warrants under the Code.

10. **Appearance of the Respondent**

Unless ordered otherwise by the Tribunal, whenever a notice is issued under these rules, the Respondent shall appear in person in the case of a 'criminal contempt' and in person or through an

advocate in the case of 'civil contempt', at the time and place specified in the notice and continue to attend on subsequent dates to which the petition is posted.

11. **Reply by the respondent**

The Respondent may file his reply duly supported by an affidavit on or before the first date of hearing or within such extended time as may be granted by the Tribunal.

12. **Right to be defended by an Advocate**

Every person against whom proceedings are initiated under the Act, may as of right be defended by an Advocate of his choice.

13. **Hearing of the case and trial**

Upon consideration of the reply filed by the Respondent and after hearing the parties:-

(a) if the respondent has tendered an unconditional apology after admitting that he has committed the contempt, the Tribunal may proceed to pass such orders as it deems fit;

(b) if the respondent does not admit that he has committed contempt, the Tribunal may:-

(i) if it is satisfied that there is a prima facie case, proceed to frame the charge.

(ii) drop the proceedings and discharge the respondent, if it is satisfied that there is no prima facie case, or that it is not expedient to proceed;

(c) the respondent shall be furnished with a copy of the charge framed, which shall be read over and explained to the respondent. The Tribunal shall then record his plea, if any;

(d) if the respondent pleads guilty, the tribunal may adjudge him guilty and proceed to pass such sentence as it deems fit;

(e) if the respondent pleads not guilty, the case maybe taken up for trial on the same day or posted to any subsequent date as may be directed by the Tribunal.

14. **Assistance in conduct of proceedings**

The Attorney-General/Solicitor-General/Additional Solicitor-General, or any other Advocate as may be designated by the Tribunal shall appear and assist the Tribunal in the conduct of the proceedings against the respondent.

15. **Execution of sentence**

If the respondent is found guilty and is sentenced to imprisonment other than imprisonment till rising of the Tribunal, a warrant of commitment and detention shall be made out under the signature of the Registrar. Every such warrant shall remain in force until it is executed or cancelled by order of the Tribunal. The Superintendent of Jail specified in the order shall, in pursuance of the warrant, detain the contemner in custody for the period specified therein subject to such further direction as the Tribunal may give.

16. **Apology at any stage of the proceedings: -**

(i) If at any time during the pendency of the proceedings, the contemner tenders an apology, the same shall be placed expeditiously for orders of the Bench.

(ii) If the Tribunal accepts the apology, further proceedings shall be dropped.

2.4 HIGH COURTS

2.4.1 INTRODUCTION

(i) India at present has 28 States and 7 Union Territories. The Constitution of India provides for one High Court for every federating State in the country. The Parliament has, however been given power to put even more States under one High Court. It all depends on the area and the population that a High Court has to serve and the amount of work it has to handle. For example, there is only one High Court for the two States of Punjab and Haryana. Similarly, Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland and Tripura have only one High Court.

(ii) The High Court consists of a Chief Justice and some other judges appointed by the President of India. The strength of Judges in the High Courts varies from State to State.

(iii) The High Courts have three types of jurisdiction. These are original, appellate and administrative. Under the original jurisdiction, it has power to issue directions, orders including writs to any authority and any Government within its jurisdiction against the violation of the statutory/fundamental rights of citizens. Petitions challenging the election of a Member of Parliament or a State Legislature or a local body can be filed in the High Court of the concerned State. It can also try civil and criminal cases. The appellate jurisdiction of the High Court includes the power to hear appeals about civil and criminal cases against the decisions of lower courts. Under its administrative jurisdiction, it has authority to supervise the working of all Subordinate Courts/Tribunals. The High Court also is a Court of Record and has the power to punish for contempt of court.

(iv) Article 214 to 231 of the Constitution of India deals with the powers & functioning of High Courts, appointment/removal of judges, etc. The important Articles of the Constitution are reproduced in the succeeding pages.

THE HIGH COURTS IN STATES

2.4.2 Relevant provisions in Constitution

Article 214. **High Courts for States:** - There shall be a High Court for each State.

Status of High Court: - All the High Courts have the same status under the Constitution. Judges of the different High Courts also belong to the same family, even though there may be slight variations in the authorities that are to be consulted at the time of their appointment.

But they do not constitute anything like a single All India cadre. Each Judge is appointed to a particular High Court and may be transferred to another High Court only by virtue of the express provision in Art. 222.

Article 215. **High Courts to be Courts of record:** - Every High Court shall be a court of record and shall have all the powers of such a court including the power to punish for contempt of itself.

Article 216. **Constitution of High Courts:** - Every High Court shall consist of a Chief Justice and such other Judges as the President may from time to time deem it necessary to appoint.

Article 217. **Appointment and conditions of the office of a Judge of a High Court**: - Every Judge of a High Court shall be appointed by the President by warrant under his hand and seal after consultation with the Chief Justice of India, the Governor of the State, and, in the case of appointment of a Judge other than the Chief Justice, the Chief Justice of the High Court and shall hold office, in the case of an additional or acting Judge, as provided in Article 224, and in any other case, until he attains the age of sixty-two years.

Article 220. **Restriction on practice after being a permanent Judge**: - No person who, after the commencement of this Constitution, has held office as a permanent Judge of a High Court shall plead or act in any court or before any authority in India except the Supreme Court and the other High Courts.

Article 226. **Power of High Courts to issue certain writs**:- Notwithstanding anything in Article 32, every High Court shall have powers, throughout the territories in relation to which it exercised jurisdiction, to issue to any person or authority, including in appropriate cases, any Government, within those territories directions, orders or writs, including (writs in the nature of habeas corpus, mandamus, prohibition, quo warranto and certiorari, or any of them, for the enforcement of any of the rights conferred by part III and for any other purpose.)

Article 227. **Power of superintendence over all courts by High Court**:

(1) Every High Court shall have superintendence over all Courts and tribunals throughout the territories in relation to which it exercises jurisdiction.

(2) Without prejudice to the generality of the foregoing provision, the High Court may

a) Call for returns from such courts.

b) Make and issue general rules and prescribe forms for regulating the practice and proceedings of such courts; and

c) Prescribe forms in which the books, entries and accounts shall be kept by the officers of any such court.

(3) The High Court may also settle tables of fees to be allowed to the sheriff and all clerks and officers of such courts and to attorneys, advocates and pleaders practicing therein:

Provided that any rules made, forms prescribed or tables settled under clause (2) or clause (3) shall not be inconsistent with the provision of any law for the time being in force, and shall require the previous approval of the Governor.

(4) Nothing in this Article shall be deemed to confer on High Court powers of superintendence over any court or tribunal constituted by or under any law relating to the Armed Forces.

It is now settled that the power of 'superintendence' conferred upon the High Court by Art.227 is not confined to administrative superintendence only, but includes the power of judicial revision also, even where no appeal or revision lies to the High Court under the ordinary law.

This power involves a duty on the High Court to keep the inferior Court and tribunals within the bounds of their authority and to see that they do, what their duty requires and that they do it in a legal manner.

But this power does not vest the High Court with any unlimited prerogative to correct all species of hardship or wrong decisions made within the limits of the jurisdiction of the Court or Tribunal. It must be restricted to cases of grave dereliction of duty and flagrant abuse of fundamental principles of law of justice where grave injustice would be done unless the High Court interferes.

Thus, where an appellate authority had ample revisional authority, the order of such authority would not be set aside (under Art.227) where such authority, on appeal, quashed a decision of an inferior authority, which was without jurisdiction, even though appeal was incompetent.

The power would not be exercised by the High Court to substitute its own judgement whether on a question of a fact or of law, in place of that of the Subordinate Courts, or to correct an error not being an error of law apparent on the face of the record.

In the exercise of jurisdiction under Art.227, the High Court can set aside or ignore the findings of facts of an inferior Court or Tribunal if there was no evidence to justify such a conclusion and if no reasonable person could possibly have come to the conclusion which the Court or Tribunal has come to, or, in other words, it is a finding which was perverse in law. Except to this limited extent, the High Court has no jurisdiction to interfere with the findings of fact.

This means that the High Court can interfere, under Art.227, in cases of –

(a) Erroneous assumption or excess of jurisdiction.

(b) Refusal to exercise jurisdiction.

(c) Error of law apparent on the face of the record, as distinguished from a mere mistake of law or error of law relating to jurisdiction.

(d) Violation of the principles of natural justice.

(e) Arbitrary or capricious exercise of authority, of discretion.

(f) Arriving at a finding which is perverse or based on no material.

(g) A patent or flagrant error in procedure.

(h) Order resulting in manifest injustice.

Article 228. **Transfer of certain cases to High Court: -** If the High Court is satisfied that a case pending in a court subordinate to it involves a substantial question of law as to the interpretation of this Constitution the determination of which is necessary for the disposal of the case, (it shall withdraw the case and may)

(a) either dispose of the case itself, or

(b) determine the said question of law and return the case to the court from which the case has been so withdrawn together with a copy of its judgment on such question, and the said court shall on receipt thereof proceed to dispose of the case in conformity with such judgment.

2.4.3 Jurisdiction over Tribunals

The High Court may quash the order or decision of an inferior Tribunal on the following grounds –

(a) That the impugned order or decision is without jurisdiction, or against the principles of natural justice, or involves non-exercise of jurisdiction or a grave dereliction of duty or flagrant violation of the law as distinguished from a merely erroneous decision of fact or law or patent irregularity in procedure or an error of law apparent on the face of the record, or that the finding is 'perverse', being founded on no material whatever.

(b) That the exercise of the jurisdiction under Art.227 does not amount to exercising the power of appeal or revision on question of act or of law, not affecting jurisdiction.

On the other hand, the power under Art.227 will not be exercised in cases, like the following:

i) Where the only question involved is one of interpretation of a deed.

ii) On questions of admission or rejection of a particular piece of evidence, even though the question may be of every day recurrence.

iii) To correct an erroneous exercise of jurisdiction, as a Court of revision.

iv) To set aside an intra vires finding of fact, except where it is founded on no material whatsoever, or perverse.

v) To correct an error of law, not being an error apparent on the face of the record.

vi) To interfere with the intra vires exercise of a discretionary power unless it is violative of the principles of natural justice.

vii) To interfere with the decision of an Industrial Court on a merely technical ground which would not advance substantial social justice.

Article 165. **The Advocate-General for the States**

1. The Governor of each State shall appoint a person who is qualified to be appointed a Judge of a High Court to be Advocate-General for the State.

2. It shall be the duty of the Advocate-General to give advice to the government of the State upon such legal matters, and to perform such other duties of a legal character, as may from time to time be referred or assigned to him by the Governor, and to discharge the functions conferred on him by or under this Constitution or any other law for the time being in force.

3. The Advocate-General shall hold office during the pleasure of the Governor, and shall receive such remuneration as the Governor may determine.

2.4.4 Procedure before High Court

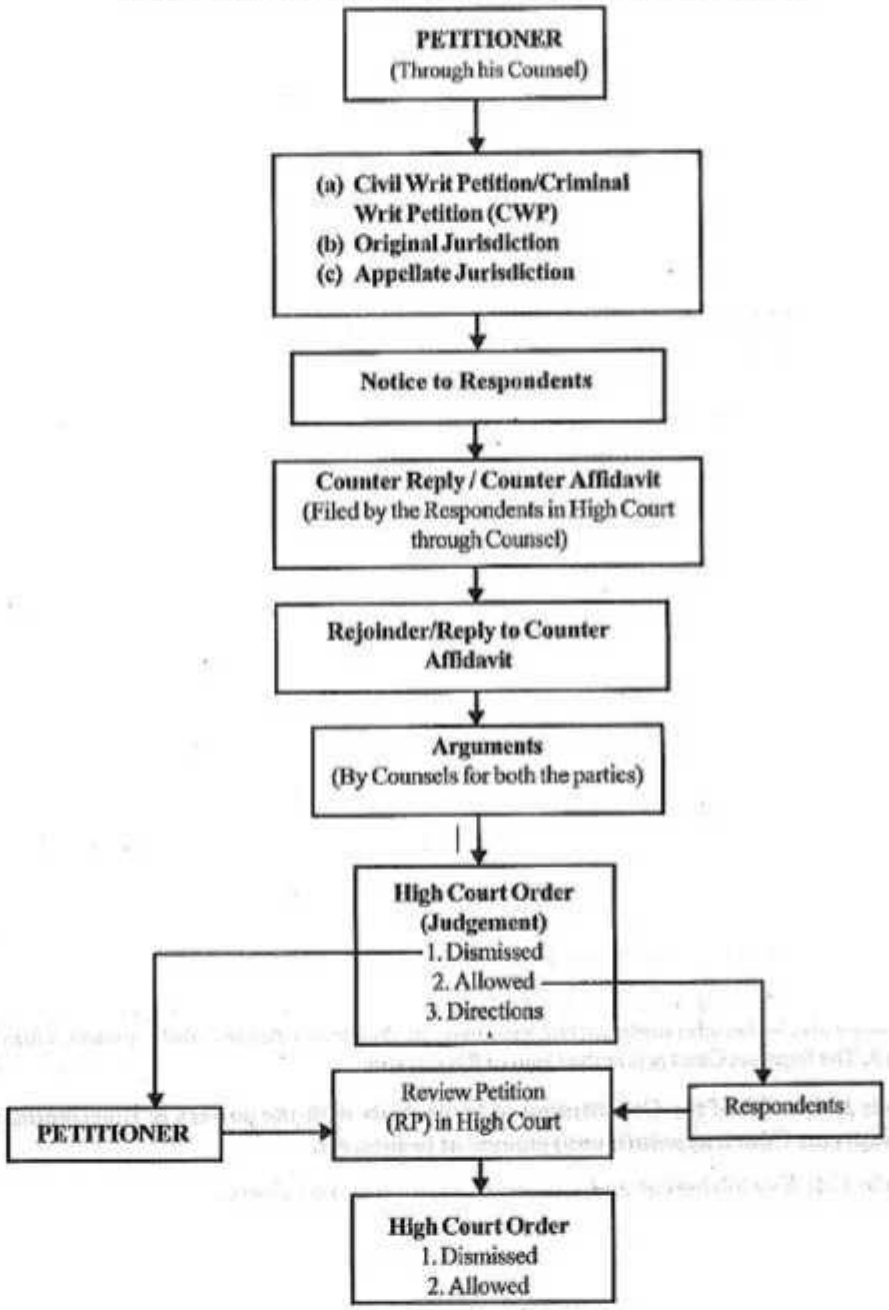
After filing the application in the High Court, the same is listed before the Hon'ble Judge for consideration. After considering the matter, the Hon'ble Judge may either issue notice to the respondents or dismiss the petition itself. If the notice is issued, then the respondents are required to be served by the

petitioner and the respondents are required to file their reply to the petition. The reply prepared is required to be vetted by the Law Ministry and then is handed over to the Counsel for Government for filing in the Court. Thereafter, the petitioner can file the rejoinder to the reply of the Govt. After completion of these formalities i.e. completion of pleadings, the matter is argued before the Hon'ble judge who after hearing the arguments on both the sides passes his order allowing the petition thereby granting the relief claimed by the petitioner with certain directions to the parties. If the matter is dismissed, the Govt. has nothing to do except to procure the certified copy of the order. If the petition is either allowed or directions are issued to the Govt. then the Govt. can either file a review application before the same bench or may file appeal against the order before the Higher court which may be the Division Bench of the High Court or may be Supreme Court, as the case may be.

2.4.5 Contempt Jurisdiction

The High Court has powers to punish for the contempt of its orders under Article 215 of the Constitution of India read with Contempt of Court Act, 1971. The Contempt of Court Act, 1971 defines the Contempt of Court in Section 2(a) to mean Civil Contempt or Criminal Contempt. The Civil Contempt has been defined in Section 2(b) to mean willful disobedience to any judgement, decree, direction, order, writ or other processes of a court or willful breach of undertaking given to a Court. In case of Civil Contempt, the High Court has power to punish the contemner with simple imprisonment for a term which may extend to 6 months or with fine which may extend to Rs. 2000/- or with both. However, the contemner may be discharged or the punishment ordered may be remitted on apology being made to the satisfaction of the Court. The High Court has got powers to punish contemner for the contempt committed of the orders passed by the Subordinate Courts.

FLOW CHART OF A CASE FILED IN HIGH COURT



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2.5 THE SUPREME COURT OF INDIA

2.5.1 INTRODUCTION

The Supreme Court is at the apex of the Indian Judiciary. It has a Chief Justice and 25 other judges. The number of judges can be changed by the Parliament. The President appoints the Chief Justice of India and other judges. The President consults other judges of the Supreme Court and High Courts while making these appointments. In case of the appointment of other judges, the Chief Justice is always consulted.

2.5.2 FUNCTIONS

The Supreme Court of India, being the highest court in the Country, has to perform judicial, administrative, advisory and other functions.

The Judicial functions of the Supreme Court are both of the original as well as of appellate nature. Original jurisdiction means the authority to hear certain cases directly for the first time. The Supreme Court of India has original jurisdiction over certain cases such as:-

- Interpretation of the Constitution,
- Centre-State Disputes,
- Cases relating to infringement, abridging or denying of the Fundamental Rights guaranteed by the Constitution,
- Disputes between two or more States.

The Supreme Court has power to grant special leave to appeal against the judgements delivered by any court in the country. The cases that can be brought before the Supreme Court, through an appeal, from the appellate jurisdiction of the court are Criminal Cases, Civil Suits, and Constitutional Matters. It is Custodian of the Constitution as such it is the duty of the Supreme Court to uphold the sanctity of the Constitution. It can review a Central or State law to establish its legality or otherwise. If the Parliament passes any law that is against the Constitution, the Supreme Court can declare that law as unconstitutional. It acts as the guardian of the Fundamental Rights of the citizens of India. It protects the Fundamental Rights from being eroded, abridged or infringed upon by any person, group of persons or the State itself. It can issue writs to the offending party/parties.

Another very important function of the Supreme Court of India is its obligation to advise on constitutional as well as other matters of law, legislature, the President or the Council of Ministers, whoever seeks it. The Supreme Court acts as the Court of Record also.

Article 124 to 147 of the Constitution of India deals with the powers & functioning of the Supreme Court, appointment/removal of judges, etc.

Article 124: Establishment and Constitution of Supreme Court: -

The Supreme Court of India is the highest Court in India. It consist of a Chief Justice of India and, until Parliament by law prescribes a larger number, of not more than twenty-five other judges.

(2) Every judge of the Supreme Court shall be appointed by the President by warrant under his hand and seal after consultation with such of the Judges of the Supreme Court and of the High Courts in the States as the President may deem necessary for the purpose and shall hold office until he attains the age of sixty-five years.

Provided that in the case of appointment of a Judge other than the Chief Justice, the Chief Justice of India shall always be consulted;

Provided further that-

(a) a judge may, by writing under his hand addressed to the President, resign his office;

(b) a judge may be removed from his office in the manner provided in clause (4)

[(2A) The age of a Judge of the Supreme Court shall be determined by such authority and in such manner as Parliament may by law provide]

(3) A person shall not be qualified for appointment as a Judge of the Supreme Court unless he is a citizen of India and

(a) has been for at least five years a Judge of a High Court or of two or more such Courts in succession; or

(b) has been for at least ten years an advocate of a High court or of two or more such Courts in succession; or

(c) is, in the opinion of the President, a distinguished jurist

(4) A judge of the Supreme Court shall not be removed from his office except by an order of the President passed after an address by each House of Parliament supported by a majority of the total membership of that House and by a majority of not less than two-thirds of the members of that House present and voting has been presented to the President in the same session for such removal on the ground of proved misbehaviour or incapacity.

Article 129.Court of Records: - All the decisions and decrees, issued by the Supreme Court itself, are duly printed and kept in record for future reference in the Court as well as for the use of lawyers in their pleadings. The Supreme Court also keeps important decisions by the High Courts of the land in record for future reference. It also has all the power to punish for contempt of itself.

Article 130. Seat of a Supreme Court: -The Supreme Court shall sit in Delhi or in such other place or places, as the Chief Justice of India may, with the approval of the President, from time to time, appoint.

2.5.3 Powers and Functions of the Supreme Court

The Supreme Court of India, being the highest court in the Country, has to perform many judicial, administrative, advisory and other functions.

2.5.4 Judicial functions

The Judicial functions of the Supreme Court are both of the original as well as of appellate nature.

Article 131. Original jurisdiction of the Supreme Court: -Subject to the provisions of this Constitution, the Supreme Court shall, to the exclusion of any other court, have original jurisdiction in any dispute-

(a) between the government of India and one or more States; or

(b) between the Government of India and any State or States on one side and one or more other States on the other; or

(c) between two or more states, if and in so far as the dispute involves any question (whether of law or fact) on which the existence or extent of a legal right depends;

Article 132. Appellate jurisdiction of Supreme Court in appeals from High Courts in certain cases: -

An appeal shall lie to the Supreme Court from any judgment, decree or final order of a High Court in the territory of India, whether in a civil, criminal or other proceeding, if the High Court certifies under Art 134A that the case involves a substantial question of law as to the interpretation of this Constitution.

Article 133. Appellate jurisdiction of Supreme Court in appeals from High Courts in regard to civil matters.

An appeal shall lie to the Supreme Court from any judgment, decree or final order in a civil proceeding of a High Court in the territory of India

(a) that the case involves a substantial question of law as to the interpretation of this Constitution.

(b) that in the opinion of the High Court the said question needs to be decided by the Supreme Court

Article 136: Special Leave to appeal by the Supreme Court:

(1) Notwithstanding anything in this Chapter, the Supreme Court may, in its discretion, grant special leave to appeal from any judgement, decree, determination, sentence or order in any cause or matter passed or made by any Court or Tribunal in the territory of India.

(2) Nothing in clause (1) shall apply to any judgement, determination, sentence or order passed or made by any court or tribunal constituted by or under any law relating to the Armed Forces.

[Article 136 of the Constitution of India provides that the Supreme Court may, in its discretion, grant special leave to appeal from any judgement order without receiving certificate of the High Court.]

Article 136 confers a wide discretion on the Supreme Court to entertain an appeal in suitable cases not otherwise provided for by the Constitution. However this Article of the Constitution does not confer a right of appeal to any party but it confers a discretionary power on the Supreme Court to grant special leave to appeal from the order of any Court or Tribunal. The grounds on which the Supreme Court would normally interfere with decisions arrived at by Tribunals can be classified under the following categories, viz.,

(1) Where the Tribunal acts in excess of the jurisdiction conferred upon it under the statute or regulation creating it or where it ostensibly fails to exercise a patent jurisdiction;

(2) Where there is an apparent error on the face of the decision;

(3) Where awards are made in violation of principles of natural justice causing substantial and grave injustice to parties; and

(4) Where the Tribunal has erroneously applied well-accepted principles of jurisprudence.

Effect of dismissal of petition.

1. Mere dismissal of special leave petition does not amount to acceptance of correctness of the High Court decision sought to be appealed against (Rup Diamonds Vs UOI A. 1989 S.C. 674).

2. Dismissal of a special leave petition in limine does not preclude Supreme Court from considering the point in subsequent appeal; [Scientific Adviser Vs Daniel, (1990) Supp SCC 374].

3. When Supreme Court gives reasons while dismissing a special leave petition under Art. 136, the decision attracts Art. 141. But when no reason is given and the petition is summarily dismissed, the Court does not lay down any law.

Article 137. Review of judgments or orders by the Supreme Court:- Subject to the provisions of any law made by Parliament or any rules made under Article 145, the Supreme Court shall have power to review any judgment pronounced or order made by it.

Article 138. Enlargement of the jurisdiction of the Supreme Court: -

1. The Supreme Court shall have such further jurisdiction and powers with respect to any of the matters in the Union List as Parliament may by law confer.

2. The Supreme Court shall have such further jurisdiction and powers with respect to any matter as the Government of India and the Government of any State may by special agreement confer, if Parliament by law provides for the exercise of such jurisdiction and powers by the Supreme Court.

Article 139. Conferment on the Supreme Court of powers to issue certain Writs: -

Parliament may by law confer on the Supreme Court power to issue directions, orders or writs, including writs in the nature of habeas corpus, mandamus, prohibition, quo warranto and certiorari, or any of them, for any purposes other than those mentioned in clause (2) of Article 32.

Article 139A. Transfer of certain cases: -

1. Where cases involving the same or substantially the same questions of law are pending before the Supreme Court and one or more High Courts or before two or more High Courts and the Supreme Court is satisfied on its own motion or an application made by the Attorney-General of India or by a party to any such case that such questions are substantial

questions of general importance, the Supreme Court may withdraw the case or cases pending before the High Court or the High Courts and dispose of all the cases itself;

Provided that the Supreme Court may after determining the said questions of law return any case so withdrawn together with a copy of its judgment on such questions to the High Court from which the case has been withdrawn, and the High Court shall on receipt thereof, proceed to dispose of the case in conformity with such judgment.

2. The Supreme Court may, if it deems it expedient so to do for the ends of justice, transfer any case, appeal or other proceedings pending before any High Court to any other High Court.

Article 141. Law declared by Supreme Court to be binding on all courts: - The law declared by the Supreme Court shall be binding on all courts within the territory of India.

Supreme Court makes law by decisions

The Court under Article 141 of the Constitution is enjoined to declare law. The law declared by the Supreme Court is the law of the land [DTC Vs DTC Mazdoor, (1991) Supp.(1) SCC 600(Para 134) CB].

'Law declared': In case of conflict between decisions of the Supreme Court itself, it is the latest pronouncement, which will be binding upon the inferior Courts, unless the earlier was of a larger Bench. If the later decision is that of a larger Bench, the previous decision will be deemed to have been overruled and completely wiped out.

Article 143. Power of President to consult Supreme Court: - If at any time it appears to the President that a question of law or fact has arisen, or is likely to arise, which is of such a nature and of such public importance that it is expedient to obtain the opinion of the Supreme Court upon it, he may refer the question to that Court for consideration and the Court may, after such hearing as it thinks fit, report to the President its opinion thereon.

Article 76. Attorney-General for India

1. The President shall appoint a person who is qualified to be appointed a Judge of the Supreme Court to be Attorney General for India.

2. It shall be the duty of the Attorney General to give advice to the Government of India upon such legal matters, and to perform such other duties of a legal character, as may from time to time be referred or assigned to him by the President, and to discharge the functions conferred on him by or under this Constitution or any other law for the time being in force.

3. In the performance of his duties the Attorney General shall have right of audience in all courts in the territory of India.

4. The Attorney General shall hold office during the pleasure of the President, and shall receive such remuneration as the President may determine.

2.5.5 Procedure before Supreme Court

When a case is filed before the Supreme Court, the same is listed before the Hon'ble judges. The Hon'ble Judges may either issue notice or admit the case for consideration or reject the same. If either notice is issued or case is admitted for consideration, the respondents are required to be served by issuing a notice to them. Thereafter, the respondents can file the respective replies, within the time limit granted by the Supreme Court to which the petitioner can file its rejoinders. Thereafter, the matter is considered by the Hon'ble Supreme Court and the matter may either be dismissed or allowed or directions may be issued. It may be noted that against the orders passed by the Supreme Court, no appeal can be filed and the orders are binding on all the authorities within the territory of India and are to be followed and observed.

Like the High Courts, the Supreme Court also has the powers to punish a contemner for the contempt of its orders committed by that person.

CHAPTER - X

CONTEMPT OF COURT BY GOVERNMENT SERVANT

10.1 Though the sweep and extent of the law relating to contempt of court is very wide, yet an attempt has been made to conceptualise the matrix of the subject and magnify the areas of CONTEMPT JURISPRUDENCE as related to Government servant with the help of illustrations and cases decided in the recent past.

10.2 The foundation of the judiciary is the trust and the confidence of the people in its ability to deliver fearless and impartial justice. When the foundation itself is shaken by acts which tend to create disaffection and disrespect for the authority of the court by creating distrust in its working, the edifice of the judicial system gets eroded.

10.3 The public has a vital stake in effective and orderly administration of justice. The court has the duty of protecting the interest of community in due administration of justice and so it is entrusted with power to convict for contempt of court to protect and vindicate the rights of the public so that the administration of justice in not prevented, prejudiced, obstructed or interfered with. The law relating to contempt of court has its origin in England. The Constitution of India confers power on Supreme Court Article 129 and on High Courts under Article 215 to punish for contempt, being courts of record.

10.4 Contempt jurisdiction is an independent jurisdiction of original nature.

10.5 Anything which brings the administration of justice into ridicule or disrepute or shakes the confidence of the people or attack on judges calculated to raise sense of disrespect and distrust in decisions rendered amounts to contempt. Abuse of process of court calculated to hamper due course of a proceeding or an orderly administration of justice is a Contempt of Court, though every abuse of the process of Court may not necessarily amount to contempt of Court.

10.6 Any conduct giving an impression that with impunity order of the court would be disobeyed, directly or covert act could constitute contempt. It can be oral, in writing or even by signs or representation which tends to undermine the authority or majesty of court, ridicules or scandalises it or in any manner interfere or prejudice the course of justice or have tendency to do so.

10.7 Withholding of application and not allowing it to reach the Court, making of false affidavit, threat to parties, interference with process, possession of receiver, interference with court viz. abusing, insulting and casting aspersions during course of discharge of duties, intimation and threat to a judge or Magistrate - all obstruct the course of judicial procedure, and hence, may tread in the prohibited realm of Contempt of Court.

10.8 Contumacious and scurrilous attack with the intention of scandalising the court will come within the meaning of 'Criminal Contempt'. The contempt jurisdiction is not to be invoked to enable the party to wreck personal vengeance against the alleged contemnors.

10.9 Contempt jurisdiction should be reserved for what essentially brings the administration of justice into contempt or unduly weakens it as distinguished from a wrong that might be inflicted on private party by

infringing a decreetal order of the court.

10.10 Any threat of filing a complaint against the judge in respect of the judicial proceedings conducted by him in his own court is a positive attempt to interfere with the due course of administration of justice and amounts to criminal contempt. But, the power of punishment for contempt should not be exercised lightly but should be exercised only to uphold the majesty of law and dignity of courts.

10.11 Press has got certain immunity but not to the extent of entering in to prohibited realm of contempt. Fair and accurate report of judicial proceedings would not be contempt. However, comments which have a tendency to prejudice the administration of justice in any pending case when published amount to contempt and so is the case with a publication which has tendency to create prejudices against any party before the case is heard.

10.12 In the case of criminal Contempt, other than a contempt which is committed in the face of the Supreme Court and High Court, these courts can take suo motu proceedings or on the motion made by the Advocate General or any other person with the consent in writing of Advocate General. But in case of criminal contempt of any subordinate court, High court may take cognizance of it if reference is made by subordinate court or motion is made by Advocate General. But High Court will not take cognizance of that contempt of subordinate court which is an offence punishable under Indian Penal Code.

10.13 Principles of natural justice are adhered to in the contempt proceedings but they cannot placed in straitjacket and are at times explicitly and impliedly overruled.

10.14 Contempt is a special subject and the jurisdiction is conferred by a special law and as such the procedure is to be regulated not by the general procedural law, i.e. Code of Criminal Procedure.

10.15 'Civil Contempt' means willful disobedience to any judgment, decree, direction, order, writ or other process of a court or willful breach of an undertaking given to a court. Failure to comply with or carry out an order of court in favour of a party is a civil contempt.

10.16 An undertaking stops a court from passing any order or direction. The undertaking is given to court by a party including corporation or state, by a person duly authorised for the same in this behalf, or even counsel who has wide authority (unless restricted) the unqualified and unconditional undertaking given orally and recorded by court of given in writing. If violated it would trench in the realm of contempt. But, mere assurance by a Government Advocate to advice the Government is not undertaking. Not only party but also sometimes third person would also be liable for disobedience and breach.

10.17 Contempt proceedings are not substitute for execution proceedings. If it is a matter of execution, resort to contempt of courts act cannot be made. The withdrawal, alteration or modification or Government order transferring an employee after the validity of the order has been upheld by the court, by dismissing the writ petition of the transferred employees does not amount to flouting of courts order and is therefore not contempt.

10.18 Non-implementation of judgement of Supreme Court by the Contemner bank manager on the advice of an advocate, with long standing at bar who also took responsibility for the advice tendered on himself will not make the Bank manager responsible for willfully or deliberately disobeying order of the Supreme court.

10.19 What will be the effect of deliberate suppression of facts? The principle is well settled that if it appears that the petitioner had misled the court by deliberate suppression of fact, in the event, it has the effect of diverting the course of justice. A person, who comes to the court to claim equitable relief, must come (to the court) with clean hands. By reason of such suppression, if any order is obtained, the same can not allowed to be continued.

10.20 The element of intention of intention is a must to contain contempt. The willful conduct is the primary and basic ingredient of such an offence. Disobedience of an order passed by a court having no jurisdiction to pass the order will be a valid defence in contempt proceedings. The plea of difficulties in implementation or impossibility of compliance of order taken during contempt proceedings or seeking clarification or fresh direction would not be a valid defence in every case so as to escape clutches of law.

10.21 The Government Advocates and Standings Counsel for the UOI are allowed to appear and defend Government officials against whom notices for contempt of court are issued. It is open to the UOI to nominate its advocate to appear for its officials in contempt proceedings. The Supreme Court has held that the notings made by officers in the files cannot be made the basis of contempt action against the officer who makes the noting. If the ultimate action does not constitute contempt, the intermediary suggestions and views expressed in the nothing, which may sometimes even amount to ext facie disobedience of the Courts order, will not amount to contempt of court as these noting are not meant for publication.

10.22 In reference to the subject matter, parallel proceedings means proceedings which are initiated and processed with in respect of a matter which are pending before a court. The question arises whether initiation of such proceedings amount to contempt of court? The important test for the purpose whether the issues or the subject matter of the proceedings are the same as those in proceedings before the court.

10.23 Unless the matters before the Commission of Inquiry and the court were identical, and not distinct and separate, there could be no question of any contempt of court. Mere pendency of a criminal or civil proceeding in a court is not a bar to initiation of departmental proceedings in the absence of any direction issued by the court in such proceedings.

10.24 However, even if the issues or subject matter are not exactly the same, but the initiation of proceedings results in 'indirect pressure' brought upon the person concerned in the prosecution of his case in court, the same may amount to contempt.

10.25 In order the bring home to guilt of contempt of court, the initiation of the parallel proceedings must be shown to be calculated to interfere with the administration of justice. A mere filing of an appeal does not automatically operate as stay of the order under appeal and in the absence of such stay being obtained from the appellate court or the court which rendered the order, the order continues to be operative and non-compliance with the order in such circumstances may amount to contempt.

10.26 It will be no defence in a contempt proceeding to plead administrative inconvenience as justification for violating a court order. Signing of an application containing contemptuous language is contempt. Contemptuous statements made against the Supreme Court by public officer in his affidavit and the Advocate who drafts or settles the document, both are liable for contempt. Wrong or misleading statement made to obtain an order interferes with due course of judicial proceedings and amounts to contempt of court.

CHAPTER - XII

ASSISTANCE TO GOVERNMENT SERVANTS IN LEGAL PROCEEDINGS

1. **Matter unconnected with official duties –**

Government will not be give any assistance to a Government servant or reimburse the expenditure incurred by him in the conduct of proceedings in respect of matters not of, or connected with, his official duties or his official position, irrespective of whether the proceeding were instituted by a private party against the Government servant or vice-versa.

2. **Matters connected with official duties –**

Govt. assistance will, however, be admissible in the conduct of legal proceedings instituted against him or by him regarding matters connected with his official positions or duties, to the following extent; -

(i) Cases filed by Government against the Government servant – No assistance is admissible in such proceedings- civil or criminal. In case the proceedings conclude in the employee's favour, reimbursement of the whole or any reasonable proportion of the expenses will be considered by the Government, if it is satisfied that he was subjected to the strain of the proceedings without proper justification.

(ii) Cases filed by private parties against the Government servant – If it is considered in public interest that government itself should arrange for the conduct of the proceedings, it may do so, on the Government servant agreed to it. Otherwise, reimbursement to the Government servant of reasonable cost incurred by him in conducting his Defence will be considered by the Government, not merely if the proceedings conclude in his favour but on consideration how for the court has vindicated the acts of Government servant. An interest-free advance of Rs. 500/- and advance from his GPF are, however, admissible for the purpose of his defence.

(iii) Cases filed by a Government servant on his being required to vindicate his official conduct – Interest-free advance will be sanctioned to him for the purpose. The extent of reimbursement by the Government will be decided considering to what extent the Court has vindicated the acts of the Govt. servant in the proceedings.

(iv) Cases filed by a Government servant to vindicate his conduct requiring prior sanction of Government - In deserving cases Government will sanction interest-free advance for the conduct of proceedings; but no part of the expenses will be reimbursed by the Government even if the Government servant succeeds in the proceedings. If permission sought for is not refused within 3 months, the Government servant is free to assume that the permission sought for has been granted.

(v) In a civil suit where both the Government servant and the Government are impleaded – The Government servant for his liability to damages for negligence in discharge of official duties of civil nature and the Government for its vicarious liability – If the defence is substantially the same for both – Government will arrange for its employee's defence also.

(vi) Cases filed against the Government servant by another Government servant in respect of matters connected with former's official position/duties- Same as at item (ii) above. This will not apply if he is impleaded as co-respondent in suits against the Government in regard to conditions of service, seniority, etc.

ORDERS REGARDING ASSISTANCE TO GOVERNMENT SERVANTS INVOLVED IN LEGAL PROCEEDINGS

Government servants involved in legal proceedings – provision for legal and financial assistance.

1. The question has been raised whether, and if so under what circumstances, Government should provide legal and financial assistance to a Government servant for the conduct of legal proceedings by or against him. The following decisions, which have been taken in consultation with the Ministries of Law and Finance and the Comptroller & Auditor General, are circulated for information and guidance: -

2. (a) Proceedings initiated by Government in respect of matters connected with the official duties or position of the Government servant- Government will not give any assistance to a Government servant for his defence in any proceedings, civil or criminal, instituted against him, by the State in respect of matters arising out of or connected with his official duties or his official position. Should, however, the proceeding conclude in favour of the Government servant, Government may, if they are satisfied from the facts and circumstances of the case that the Government servant was subjected to the strain of the proceedings without the proper justification, reimburse the whole or any reasonable proportion of the expense incurred by the Government servant for his defence.

(b) Proceedings in respect of matters not connected with official duties or position of the Government servant – Government will not give any assistance to a Government servant or reimburse the expenditure incurred by him in the conduct of proceedings in respect of matters not of, or connected with, his official duties or his official position, irrespective of whether the proceeding were instituted by a private party against the Government servant or vice-versa.

(c) Proceedings instituted by a private party against a Government servant in respect of matter connected with his official duties or position.

(i) If the Government, on consideration of the case, consider that it will be in the public interest that Government should themselves undertake the Defence of the Government servant in such proceedings and if the Government servant agrees to such a course the Government servant should be required to made a statement in writing and thereafter Government should make arrangements for the conduct of the proceedings as if the proceedings had been instituted against Government.

(ii) If the Government servant proposes to conduct his defence in such proceedings himself, the question of reimbursement of reasonable cost incurred by him for his defence may be considered in case the proceedings

conclude in his favour. In determining the amount the cost to be so reimbursed, Government will consider how far the Court has vindicated the acts if the Government servant. The conclusion of the proceedings in favour of Government servant will not by itself justify reimbursement.

To enable the Government servant to meet the expenses of his Defence, Government may sanction, at their discretion, an interest-free advance not exceeding Rs. 500 of the Government servant 's substantive pay for three months, whichever is greater, after obtaining from the Government servant a bond. The amount advanced would be subject to adjustment against the amount, if any, to be reimbursed as above.

The Government servant may also be granted an advance from any provident fund to which he is a subscriber not exceeding three months pay or one-half of the balance standing to his credit, whichever is less; this advance will be repayable in accordance with the rules of the Fund.

(d) Proceedings instituted by Government servant on his being required by Government to vindicate his official conduct – A Government servant may be required to vindicate his conduct in a Court of law in certain circumstances. The question whether costs incurred by the Government servant in such cases should be reimbursed by the Government and if so, to what extent, should be left over for consideration in the light of the result of the proceedings. Government may however, sanction an interest-free advance, in suitable installments, of an amount to be determined by in each case on the execution of a bond by the Government.

In determining the amount of costs to be reimbursed on the conclusion of the proceedings, Government will consider to what extent the Court has vindicated the acts of the Government servant in the proceedings. Conclusion of the proceedings in favour of the Government servant will not by itself justify reimbursement.

(e) Proceedings instituted by a Government servant suo motu, with the previous sanction of the Government to vindicate his conduct arising out of or connected with his official duties or position – If a Government servant resorts to a Court of Law with the previous sanction of the Government to vindicate his conduct arising out of or connected with his official duties or position, though not required to do so by Government , he will not ordinarily be entitled to any assistance, but Government may, in deserving cases, sanction advances in the manner indicated in sub para c(ii) above but no part of expenses incurred by the Government servant will be reimbursed to him even if he succeeds in the proceedings .

(3) Clause (d) of Article 320(3) of the Constitution requires consultation with the Union Public Service Commission of any claim by a Government servant for the reimbursement of the cost incurred by him in depending legal proceedings instituted against him in respect of acts done or purporting to be done in the execution of his

duty. In other cases consultation with Union Public Service Commission is not obligatory but it will be open to Government to seek the commission's advice, if considered necessary.

(4) The question whether a case falls under Article 320(2)(d) of the constitution so as to require consultation with the commission may at times be difficult to determine. It may be stated generally that consultation is obligatory in a case where a reasonable connection exist between the act of the Government servant and the discharge of his official duties; the act must bear such relation to the official duties the Government servant could lay a reasonable but not a pretended or a fanciful claim that he did in the course of the performance of his duties.

(5) The appropriate authority for taking decision in each case will be the Administrative Ministry of the Government of India concerned or Administrators who will consult the Finance and Law Ministries, where necessary. The Comptroller and Auditor General of India will exercise the powers of and Administrative Ministry in respect of the personnel of the Indian Audit and Accounts Department.

G.I.,M.H.A.,O.M. NO. F. 45/5/53- Ests(A), dated the 8th January, 1959, read with C.I.313 to G.F.R.[G.I.,M.F., File NO. F.23(1)E.,II(A)/76]

Government servants involved in legal proceedings- provision for legal and financial assistance.

Attention is invited to the instructions issued in this Ministry's Office Memorandum No. 45/5/53-Ests(A) dated 8th January 1959, regarding the grant of legal and financial assistance to the Government servant involved in legal proceedings. In connection with those instructions, the following decisions have been taken and are circulated for information and guidance: -

(i) Where, in a civil suit a Government servant sought to be made liable for damages for acts or negligence in discharge of his official duties of civil nature and Government is impleaded on the ground of various liability, the Government should arrange for the Defence of the Government servant also, provided the defence of the Government and the Government servant are substantially the same and there is no conflict of interest. Each case should be examined in consultation with the law officers before undertaking common defence. If it is decided to arrange for the defence of the Government servant, the Government servant should be required to make a statement in writing.

(ii) In cases falling under paragraph 2(d) of the OM referred to above, the amount of interest-free advance will also not exceed Rs.500/- or the Government servant's substantive pay for three months, whichever is greater.

(iii) The authority competent to sanction the advance under paragraph 2(c) (ii), 2(d) and 2(e) of the above OM will be a department of Central Government/an Administrator/the Comptroller and Auditor General in respect of the Indian Audit and Accounts Department:

Provided that a head of Department may sanction such an advance to a Government servant involved in a legal proceedings in cases covered by paragraph 2(d) of the above OM.

(iv) No second advance in respect of the same proceedings will be admissible. There will, however, be no objection to the grant of more than one advance if they relate to different proceedings against the Government servant.

(v) The recovery of the advance may be made in not more than 24 equal monthly installments, the exact number being determined by the sanctioning authority, provided the advance is recovered before the date of retirement. The recovery of the advance should commence on the first issue of pay/leave salary/subsistence allowance following the month in which advance is drawn, the advance is recoverable from each issue of pay/leave salary/ subsistence allowance till it is repaid in full. At the time of reimbursement of legal expenses, the entire balance of advance outstanding against the Government servant should be recovered from the amount reimbursed to him. If the amount reimbursed is less than outstanding balance of advance, the remaining amount will be recovered in installments as already fixed. In the case of grant of more than one advance, the recovery of such advances should run concurrently.

(vi) Where advance under the above instructions is sanctioned to a temporary/quasi permanent Government servant, he should be asked to furnish a security of a permanent Government servant of equivalent or higher.

(vii) The amount of advance sanctioned under the above instructions is debitable under the minor head "Other Advances" subordinate to major head "7610 Loans to Government servant 's under Sector F – "Loans and Advances".

[G.I., M.H.A., O.M. No. 45/1/61-Ests. (A), dated the 26th November, 1963, read with C.L. 313 to G.F.R. [G.I., M.F., File No. 23 (1)-E. II (A)/76]

Retired Government servant involved in legal proceedings - provision of legal and financial assistance.

A question has been raised whether, and if so under what circumstances, Government should provide legal and financial assistance to a retired Government servant for the conduct of legal proceedings instituted against him by a private party in respect of matter connected with his official duties or position before his retirement. This has been considered by Government and it has been decided that the provision contained in paragraph 2(c) of the Ministry of Home Affairs, OM No. 45/5/53-Estt.(A), dated the 8th January, 1959, should be extended also to retire Government servants. Accordingly the provisions contained in the aforesaid paragraphs, with the exception of the provision regarding grant of advance from President Fund will apply also to Government servants who have retired from service, other than those who have been compulsorily retired from service as a measure of punishment. Further, the amount of interest-free advance that may be granted to a retired Government servant will be subject a maximum limit of Rs.500/-.

(2) The provisions regarding consultation with Union Public Service Commission and the authority competent to take decision in each case will the same as those contained in Ministry of Home Affairs, Office Memorandum, dated the 8th January 1959.

[Copy of OM No. 28022/1/75-Estt.(A), dated the 20th January 1977, from the Cabinet Secretaria Department of Personnel and Administrative reforms].

Legal assistance to Government employees for proceedings instituted in respect of his official dut or position by another Government employee.

The Govt has decided that, where on a consideration of the facts and circumstance of the case, is considered that it would be in public interest to defend a Government employee in a case filed again him by another Government employee in respect of matters connected with the former's official duties c position, the latter may be treated as a 'private party' and assistance given to the former in terms c paragraph 2 (c) of the Office Memorandum No.45/5/53-Ests.(A), dated the 8th January 1959. But thi will not apply to cases in which the Government employee(s) has/have been impleaded as co-respondent(s by other Government employee(s) in suits against the Government in regard to conditions of service, suc as seniority, etc.

(2) Ministry of Finance, etc., are requested to bring the above decision to the notice of a concerned under their control.

(3) In so far as persons serving in the Indian Audit and Accounts Department are concernec these orders are issued in consultation with the Comptroller and Auditor-General.

[Copy of OM No. 28020/1/78-Ests.(A), dated the 6th October, 1978, from the Government o India, Ministry of Home Affairs (Department of Personnel and Administrative reforms), New Delhi]

Government servants involved in legal proceedings - provision for T.A. for journeys for Cour attendance.

In connection with Ministry of Home Affairs, O.M. No.F/.45/5/53-ests.(A), dated the 8th January 1959, dealing with the reimbursement only of legal expenses to Government servants involved in variou types of legal proceedings and which does not cover the travelling allowance should be reimbursed in such cases has been examined and it has been decided that reimbursement of travelling expenses in variou types of cases referred to in the Ministry of Home Affairs, O.M., dated the 8th January, 1959, should b regulated as indicated below –

(i) Cases falling under paragraph 2(a) of Ministry of Home Affairs, O.M., dated the 8th January, 1959, would be the same as referred to in paragraph 1(ii) of the Government o India's decision (1) below S.R. 153-A. Travelling allowance in such cases may, therefore be granted on the lines indicated in paragraph 3 of the Government of India's Decision (1 below S.R. 153-A. In cases covered by paragraph 2 (d) also of the Ministry of Hom Affairs, O.M. dated the 8th January 1959, travelling allowance may be granted on th same basis.

(ii) In cases covered by paragraph 2(b) and 2(c) of Home Ministry's O.M., dated the 8th January 1959, no travelling allowance would be paid.

(iii) In cases covered by paragraph 2 (c)(I) of the O.M., dated the 8th January 1959, TA as fo a journey on tour may be paid to the Government servant concerned. As regards case

falling under paragraph 2(c)(ii) of that O.M. travelling allowance may be paid on the lines indicated in paragraph 3 of the Government of India's decision (1) below S.R. 153-A, subject to the further condition that the travelling expenses are not decreed by the Court of Law as payable by the plaintiff.

(2) The Comptroller and Auditor-General of India will exercise the powers of an Administrative Ministry in respect of the personnel of the Indian Audit and Accounts Department.

[Copy of O.M. No. 5(13)-E.IV/59, dated the 29th July 1960 and U.O. No. 4623 E. IV(B)/60, dated the 30th December, 1960, from the Government of India, Ministry of Finance, New Delhi.]

CHAPTER - XIII

PRODUCTION OF UNPUBLISHED OFFICIAL RECORDS AS EVIDENCE IN COURTS

Procedure to be followed when a Government servant is summoned by a Court to produce official documents for the purpose of giving evidence

The law relating to the production of unpublished official records as evidence in courts is contained in sections 123, 124 and 162 of the Indian Evidence Act, 1872 (Act I of 1872), which are reproduced below:

"123. No one shall be permitted to give any evidence derived from unpublished official records relating to any affairs of state, except with the permission of the officer at the Head of the Department concerned, who shall give or withhold such permission as he thinks fit.

124. No public officer shall be compelled to disclose communications made to him in official confidence when he considers that the public interest would suffer by the disclosures.

162. A witness summoned to produce a document shall, if it is in his possession or power, bring it to court notwithstanding any objection which there may be to its production or to its admissibility. The validity of any such objection shall be decided on by the court."

The court, if it sees fit, may inspect the document, unless it refers to matters of State, or, take other evidence to enable to it determine on its admissibility.

Translation of a document:-If for such a purpose it is necessary to cause any document to be translated, the court may if it thinks fit, direct the translator to keep the contents secret, unless the document is to be given in evidence; and, if the interpreter disobeys such direction, he shall be held to have committed an offence under section 166 of the Indian Penal Code.

2. For the purpose of section 123 above, the expression "officer at the Head of the department concerned" may be held to mean the officer who is in control of the department and in whose charge records of the department remain. Ordinarily such an officer would be Secretary to the State Government in the case of State Government and the Secretary, Additional Secretary or Joint secretary in charge of Ministry in the case of the Government of India. But in case of attached offices like Directorates, the Director General may be regarded as "the Head of the Department" for the purpose of this Section. Only such an officer should be treated as the authority to withhold or give the necessary permission for the production of official documents, in evidence. In case of part C States the Chief Commissioner or the Lt.-Governor, as the case may be, regarded as the Head of the Department and not his Secretaries.

3. In respect of documents:- (1) emanating from a higher authority, i.e. the Government of India, or the State Government, or which have formed the subject of correspondence with such higher authority, or

(2) emanating from other Governments, whether foreign all members of the Commonwealth, the Head of Departments should obtain the consent of the Government of India or of the State Government, as the case may be, through the usual official channel before giving

permission to produce the documents in court, or giving evidence based on them unless the papers are intended for publication or are of a purely formal or routine nature, when a reference to a higher authority may be dispensed with

4. In the case of documents other than those specified in paragraph 3 above, production of documents should be withheld only when the public interest would by their disclosure the injured, or where disclosure would be injurious to the national defence, or to good diplomatic relations or where the practice of keeping a class of documents secret is necessary for the proper functioning of the public service. Some High courts have pointed out the circumstances under which no such privilege should be claimed, e.g., privilege is not to be claimed on the near ground that the documents are State documents or are official or are mark confidential, or if produced, would result in parliamentary discussion or public criticism or would exposed want of efficiency in the administration or tend to lay a particular department does not wish the documents to be produced is not administration adequate justification for objecting to their production. The High Courts have also observed that refusal to produce documents relating to affairs of State implies that their production will be prejudicial to public interest. Consequently the reasons therefore should be given in administration affidavit Form 1 at the appropriate place.

5. In a case of doubt the Head of Departments should invariably refer to higher authority for orders.

6. These instructions apply equally to cases in which Government is a party to the suit. In such cases, which will depend on the legal advice as to the value of the documents, but before they were produced in court, the considerations stated above must be borne in mind, and reference to higher authority made, when necessary.

6-A. A Government servant other that the Head of Department who is summoned to produce an official document should first determine whether the document is in his custody and he is in a position to produce it. In this connection, it may be stated that all official records are normally in the custody of the Head of Department and it is only under special circumstances that administration official documents can be said to be in the custody of administration individual Government servant. If the document is not in the custody of the Government servant summoned he should inform the court accordingly. If, under any special circumstances, the document is in the custody of the Government servant summoned. He should inform the court accordingly. If, under any special circumstances, the document is in the custody of the Government servant summoned he should next determine whether the document is administration unpublished official record relating to affairs of State and privilege under section 123 should be claimed in respect of it. If he is of the view that such privilege should be claimed or if he is doubtful of the position, he should refer the matter to the Head of the Department, who will issue necessary instructions and will also furnish the affidavit in Form no. 1 in suitable cases. If the document is such that privilege under section 123 could not be claimed but if the Government servant considers that the document is a communication made to him in official confidence and that the public interest would suffer by its disclosure, he should claim privilege under section 124 in Form 11. In case of doubt, he should seek the advice of the Head of the Department. The expression "Head of

the Department" used in this paragraph will have the same meaning as the expression "Head of the Department" in paragraph 2 above.

7. The Government servant who is to attend a court as a witness with official documents should, where permission under section 123 had been withheld, be given administration affidavit in Form no. I duly signed by the Head of the Department in the accompanying form. He should produce it when he is called upon to give his evidence, and should explain that he is not at liberty to produce the documents before the court, or to give any evidence derived from them. He should, however, take with him the papers which he has been summoned to produce.

8. The Government servant who is summoned to produce official documents in respect of which privilege under section 124 has to be claimed, will make administration affidavit in the accompanying Form no. II, when he is not attending the court himself to give evidence. He shall have sent it to the court along with the documents. The person through whom the documents are sent to court should submit the affidavit to the court when called upon to produce the documents, he should take with him the documents which he has been called upon to produce but should not hand them over to the court unless the court directs him to do so. They should not be shown to the opposite-party.

9. The Head of the Department should abstain from entering into correspondence with the presiding officer of the court concerned in regard to the grounds on which the documents have been called for. He should obey the court's orders and should appear personally, or arrange for the appearance of another officer in the court concerned, with the documents, and act as indicated in paragraph 7 above, and produce the necessary affidavit if he claims privilege.

CHAPTER - XVI

VARIOUS COMMISSIONS

16.1 INTRODUCTION

(i) Under Article 340 of the Constitution of India, the President may by order appoint a Commission consisting of such persons as he thinks fit to investigate the conditions of socially and educationally backward classes within the territory of India and the difficulties under which they labour and to make recommendations as to the steps that should be taken by the Union or any State to remove such difficulties and to improve their condition and as to the grants that should be made for the purpose by the Union or any State and the conditions subject to which such grants should be made, and the order appointing such Commission shall define the procedure to be followed by the Commission.

(ii) A Commission so appointed shall investigate the matters referred to them and present to the President a report setting out the facts as found by them and making such recommendations as they think proper.

(iii) The President shall cause a copy of the report so presented together with a memorandum explaining the action taken thereon to be laid before each House of Parliament.

(iv) Composition and Functioning of some of the important Commissions set up by different Acts of Parliament is reproduced in the following pages.

16.2 HUMAN RIGHTS COMMISSION

16.2.1 The Protection of Human Rights Act, 1993 is to provide for the constitution of a National Human Rights Commission. State Human Rights Commission in States and Human Rights Courts for better protection of Human Rights and for matters connected therewith or incidental thereto.

Short title, extent and commencement

(1) This Act may be called the Protection of Human Rights Act, 1993.

(2) It extends to the whole of India.

Provided that it shall apply to the State of Jammu and Kashmir only in so far as it pertains to the matters relatable to any of the entries enumerated in List I or List III in the Seventh Schedule to the Constitution as applicable to that State.

(3) It shall be deemed to have come into force on the 28th day of September 1993

16.2.2 THE NATIONAL HUMAN RIGHTS COMMISSION

Constitution of a National Human Rights Commission

The Central Government shall constitute a body to be known as the National Human Rights Commission to exercise the powers conferred upon, and to perform the functions assigned to it, under this Act.

The Commission shall consist of:

(a) a Chairperson who has been a Chief Justice of the Supreme Court;

(b) one Member who is or has been, a Judge of the Supreme Court;

(c) one Member who is, or has been, the Chief Justice of a High Court;

(d) two Members to be appointed from amongst persons having knowledge of, or practical experience in, matters relating to human rights.

The Chairpersons of the National Commission for Minorities, the National Commission for the Scheduled Castes and Scheduled Tribes and the National Commission for Women shall be deemed to be Members of the Commission for the discharge of functions specified in clauses (b) to (j) of section 12.

There shall be a Secretary-General who shall be the Chief Executive Officer of the Commission and shall exercise such powers and discharge such functions of the Commission as it may delegate to him.

The headquarters of the Commission shall be at Delhi and the Commission may, with the previous approval of the Central Government, establish offices at other places in India.

Appointment of Chairperson and other Members

(1) The Chairperson and other Members shall be appointed by the President by warrant under his hand and seal.

Provided that every appointment under this sub-section shall be made after obtaining the recommendations of a Committee consisting of

(a) The Prime Minister — Chairperson

(b) Speaker of the House of the People — Member

(c) Minister in-charge of the Ministry of Home Affairs in the Government of India — Member

(d) Leader of the Opposition in the House of the People — Member

(e) Leader of the Opposition in the Council of States — Member

(f) Deputy Chairman of the Council of States — Member

Provided further that no sitting Judge of the Supreme Court or sitting Chief Justice of a High Court shall be appointed except after consultation with the Chief Justice of India.

(1) No appointment of a Chairperson or a Member shall be invalid merely by reason of any vacancy in the Committee.

Removal of a Member of the Commission

(1) Subject to the provisions of sub-section (2), the Chairperson or any other Member of the

Commission shall only be removed from his office by order of the President on the ground of proved misbehaviour or incapacity after the Supreme Court, on reference being made to it by the President, has, on inquiry held in accordance with the procedure prescribed in that behalf by the Supreme Court, reported that the Chairperson or such other Member, as the case may be, ought on any such ground to be removed.

(2) Notwithstanding anything in sub-section (1), the President may by order remove from office the Chairperson or any other Member if the Chairperson or such other Member, as the case may be

(a) is adjudged an insolvent; or

(b) engages during his term of office in any paid employment out side the duties of his office: or

(c) is unfit to continue in office by reason of infirmity of mind or body; or

(d) is of unsound mind and stands so declared by a competent court; or

(e) is convicted and sentenced to imprisonment for an offence which in the opinion of the President involves moral turpitude.

Term of office of Members

(1) A person appointed as Chairperson shall hold office for a term of five years from the date on which he enters upon his office or until he attains the age of seventy years, whichever is earlier.

(2) A person appointed as a Member shall hold office for a term of five years from the date on which he enters upon his office and shall be eligible for re-appointment for another term of five years. Provided that no Member shall hold office after he has attained the age of seventy years.

(3) On ceasing to hold office, a Chairperson or a Member shall be ineligible for further employment under the Government of India or under the Government of any State.

Member to act as Chairperson or to discharge his functions in certain circumstances

(1) In the event of the occurrence of any vacancy in the office of the Chairperson by reason of his death, resignation or otherwise, the President may, by notification, authorise one of the Members to act as the Chairperson until the appointment of a new Chairperson to fill such vacancy.

(2) When the Chairperson is unable to discharge his functions owing to absence on leave or otherwise, such one of the Members as the President may, by notification, authorise in this behalf, shall discharge the functions of the Chairperson until the date on which the Chairperson resumes his duties.

Terms and conditions of service of Members

The salaries and allowances payable to, and other terms and conditions of service of, the Members

shall be such as may be prescribed. Provided that neither the salary and allowances nor the other terms and conditions of service of a Member shall be varied to his disadvantage after his appointment.

Vacancies, etc., not to invalidate the proceedings of the Commission

No act or proceedings of the Commission shall be questioned or shall be invalidated merely on the ground of existence of any vacancy or defect in the constitution of the Commission.

Procedure to be regulated by the Commission

(1) The Commission shall meet at such time and place as the Chairperson may think fit.

(2) The Commission shall regulate its own procedure.

(3) All orders and decisions of the Commission shall be audited by the Secretary-General or any other officer of the Commission duly authorised by the Chairperson in this behalf.

Officers and other staff of the Commission

(1) The Central Government shall make available to the Commission :

(a) an officer of the rank of the Secretary to the Government of India who shall be the Secretary-General of the Commission; and

(b) such police and investigative staff under an officer not below the rank of a Director General of Police and such other officers and staff as may be necessary for the efficient performance of the functions of the Commission.

(2) Subject to such rules as may be made by the Central Government in this behalf, the Commission may appoint such other administrative, technical and scientific staff as it may consider necessary.

(3) The salaries, allowances and conditions of service of the officers and other staff appointed under sub-section (2) shall be such as may be prescribed.

Functions and Powers of the Commission

The commission shall perform all or any of the following functions, namely:

(a) Inquire, suo-moto or on a petition presented to it by a victim or any person on his behalf, into complaint of –

(i) Violation of human rights or abetment thereof; or

(ii) Negligence in the prevention of such coalition, by a public servant;

(b) Intervene in any proceedings involving any allegation of violation of human rights pending before a court with the approval of such court;

(c) Visit, under intimation to the State Government, any jail or any other institution under control of the State Government, where persons are detained or lodged for purposes of treatment, reformation or protection to study the living conditions of the inmates and make recommendations thereon;

(d) Review the safeguards provided by or under the Constitution or any law for the time being in force for the protection of human rights and recommend measures for their effective implementation;

(e) Review the factors, including acts of terrorism, that inhibit the enjoyment of human rights and recommend appropriate remedial measures;

(f) Study treaties and other international instruments on human rights and make recommendations for their effective implementation;

(g) Undertake and promote research in the field of human rights;

(h) Spread human rights literacy among various sections of society and promote awareness of the safeguards available for the protection of these rights through publications, the media, seminars and other available means;

(i) Encourage the efforts of non-governmental organisations and institutions working in the field of human rights;

(j) Such other functions as it may consider necessary for the promotion of human rights.

Powers relating to Inquiries – (1) The commission shall, while inquiring into complaints under this Act, have all the powers of a civil court trying a suit under the Code of Civil procedure, 1908, and in particular In respect of the following matters, namely:

(a) summoning and enforcing the attendance of witnesses and examining them on oath;

(b) discovery and production of any document;

(c) receiving evidence on affidavits;

(d) requisitioning any public record or copy thereof from any court or office;

(e) issuing commissions for the examination of witnesses or documents;

(f) any other matter which may be prescribed.

(2) The Commission shall have power to require any person, subject to any privilege which may be claimed by that person under any law for the time being in force, to furnish information on such points or matters as, in the opinion of the Commission, may be useful for, or relevant to, the subject matter of the inquiry and any person so required shall be deemed to be legally bound to furnish such information within the measuring of Section 176 and Section 177 of the Indian Penal Code.

(3) The commission or any other officer, not below the rank of a Gazetted officer, specially authorised in this behalf by the commission may enter any building or place where the commission has reason to believe that any document relating to the subject matter the inquiry may be found, and may seize, any such document or take extracts or copies therefrom subject to the provisions of Section 100 of the Code of Criminal Procedure, 1973, in so far as it may be applicable.

(4) The commission shall be deemed to be a civil court and when any offence as is described in Section 175, Section 178, Section 179, Section180 or Section 228 of the Indian Penal Code is committed in the view or presence of the Commission, the Commission may, after recording the facts constituting the offence and the statement of the accused as provided for in the Code of Criminal Procedure, 1973, forward the case to a Magistrate having jurisdiction to try the same and the Magistrate to whom any such case is forwarded shall proceed to hear the complaint against the accused as if the case has been forwarded to him under Section 346 of the Code of Criminal Procedure, 1973.

(5) Every proceedings before the Commission shall be deemed to be a judicial proceedings within the meaning of Sections 193 and 228, and for the purpose of Section 196, of the Indian Penal Code, and the Commission shall be deemed to be a civil court for all the purposes of Section 195 and Chapter XXVI of the Code of Criminal Procedure, 1973.

Investigation – (1) The commission may, for the purpose of conducting any investigation pertaining to the inquiry, utilise the services of any officer or investigation agency of the Central Government or any State Government with the concurrence of the Central Government or the State Government, as the case may be.

(2) For the purpose of investigating into any matter pertaining to the inquiry , any officer or agency whose services are utilised under sub-section(1) may, subject to the direction and control of the Commission, -

(a) Summon and enforce the attendance of any person and examine him.

(b) Require the discovery and production of any document, and

(c) Requisition any public record or copy thereof from any office.

(3) The provision of Section 15 shall apply in relation to any statement made by a person before any officer or agency whose services are utilised under sub-section (1) as they apply in relation to any statement made by a person in the course of giving evidence before the Commission.

(4) The officer or agency whose services are utilised under sub-section (1) shall investigate into any matter pertaining to the inquiry and submit a report thereon to the Commission within such period as may be specified by the Commission in this behalf.

(5) The Commission shall satisfy itself about the correctness of the facts stated and the conclusion, if any, arrived at in the report submitted to it under sub-section (4) and for this purpose the commission may make such inquiry (including the examination of the person or persons who conducted or assisted in the investigation) as it thinks fit.

Statement made by persons to the commission – No statement made by a person in the course of giving evidence before the commission shall subject him to, or be used against him in, any civil or criminal proceedings except prosecution for giving false evidence by such statement.

Provided that the statement –

(a) is made in reply to the question which he is required by the Commission to answer, or

(b) is relevant to the subject matter of the inquiry.

Persons likely to be prejudicially affected to be heard – If, at any stage of the inquiry, the Commission–

(a) considers it necessary to inquire into the conduct of any person; or

(b) is of the opinion that the reputation of any person is likely to be prejudicially affected by the inquiry;

it shall give to that person a reasonable opportunity of being heard in the inquiry and to produce evidence in his defence:

Provided that nothing in this Section shall apply where the credit of a witness is being impeached.

Procedure

Inquiry into Complaints – The commission while inquiring into the complaints of violations of human rights may –

(i) call for information or report from the Central Government or any State Government or any other authority or organisation subordinate thereto within such time as may be specified by it:

Provided that –

(a) if the information or report is not received within the time stipulated by the commission, it may proceed to inquire into the complaint on its own;

(b) if on receipt of information or report, the commission is satisfied either that no further inquiry is required or that the required action has been initiated or taken by the concerned Government or authority, it may not proceed with the complaint and inform the complainant accordingly;

(ii) Without prejudice to anything contained in clause (i), if it considers necessary, having regard to the nature of the complaint, initiate an inquiry.

Procedure with respect to Armed Forces – (1) Notwithstanding anything contained in this Act, while dealing with complaints of violation of human rights by members of the Armed Forces, the Commission shall adopt the following procedure, namely: -

(a) it may, either on its own motion or on receipt of petition, seek a report from the Central Government;

(b) after the receipt of the report, it may, either not proceed with the complaint or, as the case may be, make its recommendations to that Government

(2) The Central Government shall inform the Commission of the action taken on the recommendations within three months or such further time as the Commission may allow.

(3) The Commission shall publish its report together with its recommendations made to the

Central Government and the action taken by that Government on such recommendations.

(4) The commission shall provide a copy of the report published under sub-section (3) to the petitioner or his representative.

18. **Steps after Inquiry** – The Commission may take any of the following steps upon the completion of an inquiry held under this Act, namely:

(1) where the inquiry discloses, the Commission of violation of human rights or negligence in the prevention of violation of human rights by a public servant, it may recommend to the concerned Government or authority the initiation of proceedings for prosecution or such other action as the Commission may deem fit against the concerned person or persons;

(2) approach the Supreme Court or the High Court concerned for such directions, orders or writs as that Court may deem necessary;

(3) recommend to the concerned Government or authority for the grant of such immediate interim relief to the victim or the members of his family as the Commission may consider necessary;

(4) subject to the provisions of clause (5) provide a copy of the inquiry report to the petitioner or his representative;

(5) the commission shall send a copy of its inquiry report together with its recommendations to the concerned Government or authority and the concerned Government or authority shall, within a period of one month, or such further time as commission may allow, forward its comments on the report, including the action taken or proposed to be taken thereon, to the Commission;

(6) the Commission shall publish its inquiry report together with the comments of the concerned Government or authority, if any, and the action taken or proposed to be taken by the concerned Government or authority on the recommendations of the Commission.

16.3 THE NATIONAL COMMISSION FOR THE SCHEDULED CASTES AND SCHEDULED TRIBES

16.3.1 Introduction

The National Commission for the Scheduled Castes and Scheduled Tribes has been set up w.e.f 08th June 1990. Article 338 of the Constitution was amended by the Sixty Fifth Amendment to have a high level five member Commission for a more effective arrangement in respect of the constitutional safeguards for Scheduled Castes & Scheduled Tribes than a single Special Officer. The functions of the said Commission cover measures that should be taken by the Union or any State for the effective implementation of safeguards and other measures for the protection, welfare and socio-economic development of the Schedule Caste & Schedule Tribes and to entrust to the Commission such other functions in relation to the protection, welfare & development and advancement of Schedule Caste & Schedule Tribe as the President may, subject to

any law made by Parliament, by rule specify. The report of the said Commission is laid before Parliament and the Legislatures of the states.

16.3.2 Composition and Appointment of Members of Commission

Subject to the provisions of any law made in this behalf by Parliament, the Commission shall consist of a Chairperson, Vice- Chairperson and five other Members and the conditions of service and tenure of office of the Chairperson, Vice-Chairperson and other Members so appointed shall be such as the President may by rule determine.

The Chairperson, Vice-Chairperson and other Members of the Commission shall be appointed by the President by warrant under his hand and seal.

The Commission shall have the power to regulate its own procedure.

16.3.3 Duties of the Commission-

(a) To investigate and monitor all matters relating to the safeguards provided for the Scheduled Castes & Scheduled Tribes under this Commission or under any other law for the time being in force or under any order of the Government and to evaluate the working of such safeguards;

(b) To inquire into specific complaints with respect to the deprivation of rights and safeguards of the Scheduled Castes & Scheduled Tribes;

(c) To participate and advise on the planning process of socio-economic development of the Scheduled Castes & Scheduled Tribes and to evaluate the progress of their development under the Union and any State;

(d) To present to the President, annually and at such other times as the Commission may deem fit, reports upon the working of those safeguards;

(e) To make in such reports recommendations as to the measures that should be taken by the Union or any State for the effective implementation of those safeguards and other measures for the protection, welfare and socio-economic development of the Scheduled Castes and Scheduled Tribes; and

(f) To discharge such other functions in relation to the protection, welfare and development and advancement of the Scheduled Castes and Scheduled Tribes as the President may, subject to the provisions of any law made by Parliament, by rule specify.

The President shall cause all such reports to be laid before each House of Parliament along with a memorandum explaining the action taken or proposed to be taken on the recommendations relating to the Union and the reasons for the non-acceptance, if any, of any of such recommendations.

Where any such report, or any part thereof, relates to any matter with which any State Government is concerned, a copy of such report shall be forwarded to the Governor of the State who shall cause it to be laid before the Legislature of the State along with a memorandum explaining the action taken or proposed to be taken on the recommendations relating to the State and the reasons for the non-acceptance, if any, of any of such recommendations.

The Commission shall, while investigating any matter referred to in sub-clause (a) or inquiring into any complaint referred to in sub-clause (b) above, have all the powers of a civil court trying a suit and in particular in respect of the following matters, namely:-

(a) summoning and enforcing the attendance of any person from any part of India and examining him on oath;

(b) requiring the discovery and production of any document;

(c) receiving evidence on affidavits;

(d) requisitioning any public record or copy thereof from any court or office;

(e) issuing commissions for the examination of witnesses and documents;

(f) any other matter which the President may, by rule, determine.

The Union and every State Government shall consult the Commission on all major policy matters affecting Scheduled Castes and Scheduled Tribes";

16.4 THE NATIONAL COMMISSION FOR MINORITIES

16.4.1 Genesis & Composition

The setting up of Minorities Commission was envisaged in the Ministry of Home Affairs Resolution dated 12.01.1978, which specifically mentioned that, "despite the safeguards provided in the Constitution and the laws in force, there persists among the Minorities a feeling of inequality and discrimination. In order to preserve secular traditions and to promote National Integration the Government of India has made effective institutional arrangements for the enforcement and implementation of all the safeguards provided for the Minorities in the Constitution, in the Central and State Laws and in the government policies and administrative schemes enunciated from time to time." The Minorities Commission was set up to safeguard the interests of minorities whether based on religion or language. The Commission was renamed as National Commission for Minorities and the first statutory Commission was constituted on 17.05.1993.

Constitution of the National Commission for Minorities

The Commission consists of a Chairperson, a Vice Chairperson and five Members nominated by the Central Government from amongst persons of eminence, ability and integrity, provided that five Members including the Chairperson shall be from amongst the Minority communities.

Term of office & conditions of service of Chairperson & Members

1) The Chairperson and every Member shall hold office for a term of three years from the date he assumes office.

2) The Chairperson or a Member may, by writing under his hand addressed to the Central Government, resign from the office of Chairperson or, as the case may be, of the Member at any time.

3) The Central Government shall remove a person from the office of Chairperson or a Member referred to in sub-section (2) if that person-

a) becomes an undischarged insolvent;

b) is convicted and sentenced to imprisonment for an offence which in the opinion of the Central Government involves moral turpitude.

c) becomes of unsound mind and stands so declared by a competent court;

d) refuses to act or becomes incapable of acting;

e) is, without obtaining leave of absence from the Commission, absent from three consecutive meetings of the Commission; or

f) has, in the opinion of the Central Government, so abused the position of Chairperson, or Member, as to render that person's continuance in office detrimental to the interests of Minorities or the public interest; Provided that no person shall be removed under this clause until that person has been given a reasonable opportunity of being heard in the matter.

4) A vacancy caused under sub-section (2) or otherwise shall be filled by fresh nomination.

5) The salaries and allowances payable to, and the other terms and conditions of service of, the Chairperson and Members shall be such as may be prescribed.

16.4.2 **Functions of the Commission**

(1) The Commission shall perform all or any of the following functions, namely: -

(a) evaluate the progress of the development of minorities under the Union and States;

(b) monitor the working of the safeguards provided in the constitution and in laws enacted by Parliament and the State Legislatures;

(c) Make recommendations for the effective implementation of safeguards for the protection of the interests of minorities by the Central Government or State Government;

(d) Look into specific complaints regarding deprivation of rights and safeguards of the minorities and take up such matters with the appropriate authorities;

(e) Cause studies to be undertaken into problems arising out of any discrimination against minorities and recommend measures for their removal;

(f) Conduct studies, researches and analysis on the issues relating to socio-economic and educational development of minorities;

(g) Suggest appropriate measures in respect of any minority to be undertaken by the Central Government or the State Government;

(h) Make periodical or special reports to the Central Government on any matter pertaining to minorities and in particular difficulties confronted by them; and

(i) Any other matter that may be referred to it by the Central Government.

(2) The Central Government shall cause the recommendations referred to in clause (c) of sub-section (1) to be laid before each House of Parliament along with a memorandum explaining the action taken or proposed to be taken on the recommendations relating to the Union and the reasons for the non-acceptance, if any, of any of such recommendations.

(3) Where any recommendations referred to in clause (c) of sub-section (1) or any part thereof with which any State Government is concerned, the Commission shall forward a copy of such recommendation or part to such State Government who shall cause it to be laid before the legislature of the State along with a memorandum explaining the action taken or proposed to be taken on the recommendations relating to the state and the reasons for the non-acceptance, if any, of any such recommendation or part.

The Commission shall, while performing any of the functions mentioned in sub-clauses (a), (b) and (d) of sub-section (1), have all the powers of a civil court trying a suit and in particular, in respect of the following matters, namely: -

(a) summoning and enforcing the attendance of any person from any part of India and examining him on oath;

(b) requiring the discovery and production of any document;

(c) receiving evidence on affidavits;

(d) requisitioning any public record or copy thereof from any court or office;

(e) issuing commissions for the examination of witnesses and documents; and

(f) any other matter which may be prescribed.

Procedure

(1) The Commission shall meet as and when necessary at such time and place as the chairperson may think fit.

(2) The Commission shall regulate its own procedure.

(3) All orders and decisions of the Commission shall be authenticated by the Secretary or any other officer of the Commission duly authorised by the Secretary in this behalf.

Annual Report

The Commission prepares its annual report giving a full account of its activities during the previous financial year and forwards a copy thereof to the Central Government.

Annual Report and audit report to be laid before Parliament

The Central Government shall cause the Annual Report together with a memorandum of action taken on the recommendations contained therein, in so far as they relate to the Central Government, and the reasons for the non-acceptance, if any, of any of such recommendations and the audit report to be laid, as soon as may be after the reports are received, before each House of Parliament.

Chairperson, Members & staff of Commission to be public servants

The Chairperson, Members and employees of the Commission shall be deemed to be public servants within the meaning of Section 21 of the Indian Penal Code.

16.5 THE NATIONAL COMMISSION FOR WOMEN ACT, 1990

16.5.1 Introduction

Established under the National commission for Woman Act 1990, the Commission's functions include to study and monitor constitutional and other laws relating to women, review existing legislation and to investigate complaints concerning the rights of women. In order to discharge its functions, the Commission has the powers of a civil court to take evidence and issue summons. Under Section 3(3) of the Protection of Human Rights Act 1993, the chairperson of the National Commission for Women is deemed to be a member of the National Human Rights Commission for the discharge of certain human rights functions.

Committees of the Commission:

(1) The Commission may appoint such committees as may be necessary for dealing with such special issues as may be taken up by the Commission from time to time.

(2) The Commission shall have the power to co-opt as members of any committee appointed under sub-section (1) such number of persons, who are not members of the Commission, as it may think fit and the persons so co-opted shall have the right to attend the meetings of the committee and take part in its proceedings but shall not have the right to vote.

(3) The persons so co-opted shall be entitled to receive such allowances for attending the meetings of the committee as may be prescribed.

Procedure to be regulated by the Commission:

(1) The Commission or a committee thereof shall meet as and when necessary and shall meet at such time and place as the Chairperson may think fit.

(2) The Commission shall regulate its own procedure and the procedure of the committees thereof.

(3) All orders and decisions of the Commission shall be authenticated by the Member-Secretary or any other officer of the Commission duly authorised by the Member-Secretary in this behalf.

16.5.2 Functions of the Commission

1. The Commission shall perform all or any of the following functions, namely: -

   (a) Investigate and examine all matters relating to the safeguards provided for women under the Constitution and other law;

   (b) Present to the Central Government, annually and at such other times as the Commission may deem fit, reports upon the working of those safeguards;

(c) Make in such reports, recommendations for the effective implementation of those safeguards for improving the conditions of women by the Union or State;

(d) Review, form time to time, the existing provisions of the Constitution and other laws affecting women and recommend amendments thereto so as to suggest remedial legislative measures to meet any lacunae, inadequacies or shortcomings in such legislations;

(e) Take up the cases of violation of the provisions of the Constitution and of other laws relating to women with the appropriate authorities;

(f) Look into complaints and take suo moto notice of matters relating to-

(i) deprivation of women's rights;

(ii) non-implementation of laws enacted to provide protection to women and also to achieve the objective of equally and development;

(iii) non-compliance of policy decisions, guidelines or instructions aimed at mitigating hardships and ensuring welfare and providing relief to women and take up the issues arising out of such matters with appropriate authorities;

(g) call for special studies or investigations into specific problems or situations arising out of discrimination and atrocities against women and identify the constraints so as to recommend strategies for their removal;

(h) undertake promotional and educational research so as to suggest ways of ensuring due representation of women in all spheres and identify factors responsible for impeding their advancement, such as, lack of access to housing and basic services, inadequate support services and technologies for reducing drudgery and occupational health hazards and for increasing their productivity;

(i) participate and advise on the planning process of socio-economic development of women;

(j) evaluate the progress of the development of women under the Union and any State;

(k) inspect or cause to be inspected a jail, remand home, women's institution or other place of custody where women are kept as prisoners or otherwise and take up with the concerned authorities for remedial action, if found necessary;

(l) fund litigation involving issues affecting a large body of women;

(m) make periodical reports to the Government on any matter pertaining to women and in particular various difficulties under which women toil;

(n) any other matter which may be referred to it by the Central Government.

(2) The Central Government shall cause all the reports referred to in clause (b) of sub-section

(1) to be laid before each House of Parliament along with a memorandum explaining the action taken or proposed to be taken on the recommendations relating to the Union and reasons for the non-acceptance, if any, of such recommendations.

(3) Where any such report or any part thereof relates to any matter with which any State Government is concerned, the Commission shall forward a copy of such report or part of such report to the State Government who shall cause it to be laid before Legislature of the State along with a memorandum explaining the action taken or proposed to be taken on the recommendations relating to the State and the reasons for the non-acceptance, if any, of any of the recommendations.

(4) The Commission shall, while investigating any matter referred to in clause (a) or sub-clause (I) of clause (f) of sub-section (1), have all the powers of a civil court trying a suit and, in particular, in respect of the following matters, namely:-

(a) summoning and enforcing the attendance of any person from any part of India and examining him on oath;

(b) requiring the discovery and production of any document;

(c) receiving evidence on affidavits;

(d) requisitioning any public record or copy thereof from any court or office;

(e) issuing Commissions for the examination of witnesses and documents; and

(f) any other matter which may be prescribed.

16.6 COMMISSION FOR PERSONS WITH DISABILITIES

16.6.1 Government of India have been very keen and conscious to address problems faced by persons with disabilities. A meeting to launch the Asian & Pacific Decade of Disabled Persons, 1993-2002, was convened by the Economic & Social Commission for Asia and Pacific in Beijing from 1-5 December 1992, which adopted the proclamation on the full participation and equality of people with disabilities in the Asian & Pacific region. India is a signatory to the said proclamation.

Therefore, in order to give effect to the proclamation on full participation and equality of people with disabilities in the Asia and Pacific region, the Government of India passed "THE PERSONS WITH DISABILITIES (EQUAL OPPORTUNITIES, PROTECTION OF RIGHTS AND FULL PARTICIPATION) ACT, 1995". This was published on 1st January 1996 and was notified on 7th February 1996.

The Persons with Disabilities Act basically enlists facilities that persons with different types of disabilities would be entitled to and the responsibilities and obligations which are placed on the Government of India, State Governments, local bodies, public and private sector enterprises, and others in this behalf. It broadly includes measures for prevention and early detection of disabilities, education, employment, social security, research and manpower development, barrier-free access and preferences and facilities

that are available to such persons and the action which needs to be taken to avoid any discrimination against persons with disabilities.

It has been provided in the Act that there shall be a Chief Commissioner at the Govt. of India level and a Commissioner in each State of the Union/UT, who would be broadly responsible to: -

- Monitor the utilization of funds disbursed by the Central Government and compliance of various provisions of the Act.
- Safeguard the rights and facilities made available to persons with disabilities. Coordinate work of the State Commissioners.
- The Chief Commissioner is authorized; on his/her own motion or on the application of any aggrieved person, or otherwise look into complaints relating to.
- Deprivation of rights of persons with disabilities.
- Non-implementation of laws, rules, byelaws, instructions issued by appropriate authorities for the welfare and protection of rights of the disabled.
- The Chief Commissioner is vested with the power of a civil court under the Code of Civil Procedure. The proceedings before the Chief Commissioner shall be judicial proceedings within the meaning of Section 193 and 223 of the IPC and it shall be deemed to be a Civil Court for this purpose.
- The Chief Commissioner shall prepare and submit an Annual Report to the Government, which shall cause it to be laid in each House of Parliament along with the recommendations and action taken thereon.

CHAPTER - XVII

GENERAL INSTRUCTIONS IN RESPECT OF HANDLING OF COURT CASES

17.1. **Procedure in accepting the Notices/Documents issued by the Registry**

The Central Administrative Tribunal has brought to the notice of the Department of Personnel and Training that the Ministries/Departments while receiving Notices/Documents from the Tribunal are not giving details of the receipt obtained by them. It is hereby requested that the name and designation of the officer receiving the Notices/Documents along with office stamp, date of receipt and time of receipt may be indicated on the acknowledgement slips before these are returned to the Central Administrative Tribunal.

[Dept, of Per. & Trg., OM No.A-11019/21/88-AT Dated the —August, 1988]

17.2. **Correspondence can be had only with the Counsel for defence and not directly with the Chairman or Registry**

It has come to the notice of the Government that Officers of the Central Government are writing letters to the Chairman and the Registry of the Central Administrative Tribunal in connection with the cases pending in the Tribunal. It is hereby clarified that such direct correspondence with the Chairman or the Registry of the Tribunal by the Departments concerned is not correct. It is, therefore, brought to the notice of all concerned that the Ministries/Departments concerned may contact the Counsel appointed for defending the case for all the information relating to the pending cases.

[Dept, of Per. & Trg., OM No.A-11019/36/87-AT Dated the 24/03/87]

17.3. **Filing of reply and other documents by the respondents**

1. Each respondent intending to contest the application, shall file in triplicate the reply to the application and the documents relied upon in paper-book form with the Registry within one month of the service of notice of the application on him.

2. In the reply filed under sub-para (1), the respondent, shall specifically admit, deny or explain the facts stated by the applicant in his application and may also state such additional facts as may be found necessary for the just decision of the case. It shall be signed and verified as a written statement by the respondent or any other person duly authorized by him in writing in the same manner as provided for in Order 6, Rule 15 of the Code of Civil Procedure, 1908 (5 of 1908).

3. The documents referred to in sub-para (2) shall also be filed alongwith the reply and the same shall be marked as R1, R2, R3 and so on.

4. The respondent shall also serve a copy of the reply along with documents as mentioned in sub-para (1) on the applicant or his legal practitioner, if any, and file proof of such service in the Registry.

5. The Tribunal may allow filing of the reply after the expiry of the prescribed period.

6. The Tribunal may permit the parties to amend the pleadings in the same manner as provided under Order 6, Rule 17 of the Code of Civil Procedure, 1908 (5 of 1908).

17.4. Filing of written statements before the Benches to be as expeditiously as possible

1. The Central Administrative Tribunal has been established with the primary objective of speedy disposal of applications filed by the Government employees in respect of their grievances relating to service matters. It is understood from the Central Administrative Tribunal that in a number of cases Central Government Department to whom notices were issued did not put in their appearance on the dates fixed. While the Central Administrative Tribunal could, in such cases proceed to hear the cases ex parte; they had given adjournments to facilitate the Government Departments to comply with the requirements.

2. Ministries/Departments should ensure that notices received from the Central Administrative Tribunal are complied within time to enable it to dispose of applications filed before it as expeditiously as possible. An adjournment of hearing should be sought for only on ground, which could be fully justified. If, for any reason, the Ministry/Department is unable to file their statement on the date fixed, they should at least produce, through a responsible officer, the required records/documents before the Tribunal on the date fixed as it would be possible for the Tribunal to proceed with the case further on the basis of the records/ documents even without a written statement.

[Dept, of Per. & Trg., letter No.A-11019/38/85-AT, dated 25/02/87]

17.5. Timely submission of the statements and appearance by Standing Counsel or authorised officer before the Benches on the due dates to be ensured

The Central Govt. Counsels to present the cases of Central Govt. Departments before the Benches of the Central Administrative Tribunal wherever such Departments are respondents have been appointed and their names communicated to the Ministries / Departments, etc.

As per Section 23(2) of the Administrative Tribunals Act, 1985, as amended by the Administrative Tribunals (Amendment) Act, 1986, "the Central Govt. may authorise one or more legal practitioners or any of its officers to act as Presenting Officers and every person so authorised by it may present its case with respect to any application before a Tribunal". In view of this, it has been decided that whenever an application is filed before a Bench of the Tribunal and a Central Govt. Department/Ministry or one of the officers under its control is made a respondent, having regard to the importance of the case concerned, the concerned Department/Ministry can also decide to present the case before the Bench of the Tribunal directly through one of its officers who should be at least a Group 'A' officer of the Central Govt. If such a decision is taken, the concerned Ministry/Department may write to the Register of the Bench of the Tribunal authorising a particular officer to present the case on behalf of the Govt. Wherever the concerned Ministry/Department feels having regard to the number of cases which are pending before the Bench of the Tribunal, that it will be advantageous to authorise one of its officers to present the cases before the Tribunal, a letter authorising a particular officer in a general way may be issued to the Registrar of the concerned Bench of the Tribunal. Since the power to authorise an officer to present the case before the Tribunal vests only with the Central Govt, it is necessary to obtain the approval of the Minister concerned for such authorisation unless this power is delegated to the Secretary of the Ministry/Department.

It has also been brought to the notice of this Ministry that in certain cases where notices were issued by the Central Administrative Tribunal, the concerned Govt. Departments, failed to appear before the Bench on the date fixed or deputed a very junior official with records. It is enjoined that whenever notice is received from the Tribunal (unless it is decided to present the case through an officer) the Department concerned should immediately get in touch with the Senior Standing Counsel/Standing Counsel attached to the particular Bench for handling the case himself or allotting the case to one of the Additional Standing Counsels attached to the Bench. The concerned Govt. Counsel should be fully briefed. It should be ensured that the Govt. Counsel or the authorised officer appears before the Bench of the Tribunal on the fixed date.

All the Ministries/Departments and the subordinate offices should ensure timely submission of the statements before the Benches of the Tribunal and appearance of the Central Govt. Counsels or authorised departmental representative on the date fixed for hearing of cases.

[Dept. of Per. & Trg., OM No. 11019/58/85—AT, dated 26/05/86]

17.6. **Primary responsibility for contesting cases will be with the Administrative Ministry / Department concerned on the basis of specific facts and circumstances relevant to them**

While the Ministry of Personnel, Public Grievances and Pensions is the nodal Ministry responsible for formulating policies and framing rules relating to pension and other retirement benefits, seniority, promotion, fixation of pay, disciplinary proceedings, reservation for Scheduled castes, Scheduled Tribes, Ex-Servicemen, etc., and other aspects of personnel administration, the Administrative Ministries/Departments are responsible for considering individual cases of Govt. servants and issuing appropriate orders thereon in accordance with the rules and instructions on the subject and in consultation with the Ministry of Personnel, Public Grievances and Pension, if considered necessary.

2. A number of petitions are filed by Government servants in various Courts and the Central Administrative Tribunals challenging the orders issued by the Administrative Ministries/Departments in individual cases in which the relevant rules and instructions on the basis of which the impugned orders have been issued are also challenged. In most of these cases, the Ministry of Personnel, Public Grievances and Pensions is also impleaded as one of the respondents for the reason that the relevant rules and instructions were issued by the Ministry or that the impugned orders were issued in consultation with the Ministry.

3. The existing practice is that, in all such cases the petitions are contested by the Administrative Ministry/Department concerned both on its behalf and on behalf of the Ministry of Personnel, Public Grievances and Pensions, if necessary, in consultation with the latter. However, recently in some cases, the Administrative Ministries/Departments insisted on the Ministry of Personnel, Public Grievances and Pensions defending the Government action on the ground that the rules/instructions challenged in the petitions were issued by that Ministry. This is not the correct procedure to follow. Since each case is to be contested on the basis of the specific facts and circumstances relevant to it, the Administrative Ministry/Department will be in a better position to defend the case. If, however, any clarification is required on the interpretation or application of the rules or instructions relevant to the case, the concerned Department in the Ministry of Personnel, Public Grievances and Pensions may be approached for that purpose. Reference relating to pension and other retirement benefits may be made to the Department of Pensions and Pensioners' Welfare and in respect of other matters relating to seniority, promotion, etc., the Department of Personnel, and Training may be consulted. This Ministry will continue to handle such references with utmost priority.

However, the primary responsibility for contesting such cases on behalf of the Government will be that of the Administrative Ministry/Department concerned.

[Dept, of Per. & Trg., OM No 20036/23/88-Estt.(D) dated 6/01/89]

17.7. Rates of fees for Counsels in various High Courts as revised applicable to Counsels presenting cases before CAT

The DOP&T is receiving references seeking clarifications regarding the rates of fee payable to the Central Government Counsel/Advocates appointed as Presenting Officers in various Benches of the Central Administrative Tribunal. It may be reiterated that the rates of fees for the Counsels appointed for presenting the cases before Central Administrative Tribunal will be the same as prescribed and applicable to Central Government Counsels/Panel Counsels in High Court. The Ministry of Law and Justice, the Appointing authority of Counsels in various High Courts, have since revised the rates of fees for Counsels in various High Courts with effect from 1.4.1987. The revised rates of fees for Counsels in High Courts will henceforth, be applicable to Counsels appointed for presenting the cases before the Central Administrative Tribunal.

(Dept. of Per. & Trg., O.M. No. A-11019/38/85-AT, dated 13/06/88)

17.8. Need for proper utilization of services of Panel Counsels/Central Government Counsels for conduct of cases on behalf of the Union of India:-

1. It has been brought to the notice of the DOP&T that the services of Central Government Counsels appointed by this Department for conducting cases on behalf of the Union of India before various Benches of the Central Administrative Tribunal are not being utilized by some Ministries/Departments with the result that the Government Counsels are sometimes not aware of the cases listed before any bench of the Tribunal on a particular day. In such cases, briefs are given by certain Ministries/departments to the Central Government Counsels appointed by the Ministry of Law and Justice for concerned High Court.

2. The matter has been considered in the Department and it has been decided that the instructions issued by us vide our O.M. of even number, dated 25-2-1987 and 12-8-1988 are adhered to strictly. In other words, all cases coming before a Bench of the Tribunal are required to be entrusted to the Central Government Counsels appointed by this Department except at places such as Ahmedabad, Jodhpur, Jabalpur and Earnakulam where no Government Counsels have been appointed or adequate number of Government Counsels are yet to be appointed. In respect of the places mentioned above and at such places where Circuit sittings of the Tribunal are being held, services of Central Government Counsels appointed by the Ministry of Law and Justice for presenting cases before the High Court may be utilized to handle the cases on behalf of the Central Government in the Tribunal.

3. If, however, it is considered necessary, to appoint/engage Advocates, other than the empanelled Counsels circulated by this Department, approval of the Minister-in-Charge of the Administrative Ministry may be obtained before such appointment. It may be mentioned in this connection that rates of fee for engagement/appointment of Counsels in such cases will be the same as are prescribed and applicable to Central Government Standing/Additional Central Government Standing Counsel for presenting applications in a High Court.

(Dept. of Per. & Trg., O.M. No.A11019/38/85-AT, dated the 10th April, 1989.)

As the various Ministries/Departments are aware, Central Government Standing Counsels have been appointed by the Department of Personnel and Training at various places for defending cases before the Central Administrative Tribunal. A list of such Counsels appointed have been circulated to all Ministries/ Departments with a view to ensure that their services are made use of for defending cases in the Central Administrative Tribunal on behalf of the Government of India. It is only in exceptional cases where it is felt necessary to appoint Counsels outside the panel, private Counsels be engaged to take care of cases, that too with the approval of the Minister concerned. Instances have, however, come to the notice of this department that private Counsels are appointed by various Ministries/Departments in a routine way. It is once again reiterated that as far as possible services of Counsels whose lists have been circulated by this Department may be utilized and wherever it is found unavoidable, private Counsels be appointed after following the procedure prescribed in this Department's O.M. of even number, dated 13.7.1988 and 10.4.1989.

(Dept. & Trg. O.M. No. A-11019/38/89-AT, dated 29/08/89)

17.9. **Appointment of Counsel outside CGSC panel only with the approval of the Minister of the Administrative Ministry**

The names of the Central Govt. Counsel appointed to different Benches of the Central Administrative Tribunal is enclosed (not printed). In respect of Benches for whom no specific names have been mentioned, the Standing Counsels for the Central Govt. attached to the High Court are authorised to present cases of the Central Administrative Tribunal. More Counsels are being appointed to all Benches, which will be intimated separately.

The Central Government Departments are free to choose any Counsel included in the panel to present their cases or request the Standing Counsel to allot a Counsel to deal with their cases. If the number of cases filed before any Bench of the Tribunal in respect of a Ministry/Department is considerable and it is felt that it would be better to engage a Counsel exclusively to represent the Department, there is no objection for the Ministry/Department to appoint a Counsel who is not included in the panel. The selection of Counsel in such cases should be with the approval of the Minister of the Administrative Ministry. Such Counsel may be appointed without mentioning any period of tenure and they may be informed that their engagement can be cancelled at any time. The terms and conditions for payment of fees to such Counsel will be the same as are applicable to the Central Government Counsel/Panel Counsel in respect of cases coming before the High Courts.

[Dept. of Per. & Trg., Lr.No.A-11019/38/85-AT, dated 25/02/87]

17.10. **Ministry of Law and Deptt of Pers & Trg to be consulted before implementing Court orders**

It has come to the notice of this department that in cases where the Courts have passed orders against the Government of India instructions, the administrative Ministry/Department has not consulted the Law Ministry on the question of filing appeal against such orders, before implementation of such orders.

2. The matter has been considered in this Department and it has been decided that whenever there is any Court order against the Government of India Instructions on service matters, the Administrative Ministry/ Department/Office shall consult the Department of Legal Affairs and the Department of Personnel and Training on the question of filing appeal against such an order, as far as possible, well in time, that is before

the time limit, if any, prescribed in such order or before the time limit for filing appeal. No such orders shall be implemented by the concerned Departments/Ministries without first referring the matter to the Department of Legal Affairs for advice and to Department of Personnel and Training.

3. The Ministries/Departments are requested to note the above instructions for strict compliance.

[Dept, of Per. & Trg., OM No.28027/9/99-Estt.(A) Dated 1/05/2000]

17.11. **Judgement bearing on pay and allowances to be implemented only in consultation with Nodal Ministry**

It has been pointed out by Ministry of Finance that Court judgements which have a bearing on pay and allowances should be implemented only in consultation with Department of Personnel and Training. It is learnt that certain Circles (on their own) are implementing the CAT judgements having a bearing on pay and allowances without referring to Telecom Headquarters who in turn will have to consult Department of Personnel and Training before clearance for implementation.

Ministry of Finance has expressed displeasure at our deciding issues of pay and allowances which will have a wider impact without consulting them time and again, instructions have been issued by this Department, that issues with a bearing on pay and allowances are to be decided in consultation with nodal Ministry, but these instructions are not being adhered to properly in some cases.

It is therefore requested that every such case is invariably referred to Directorate for consulting it with the nodal Ministry. Circles are not to implement such CAT/Court decisions on their own.

[G.I., Dept, of Telecom. Letter No.50-60/94-PAT dated 13/12/94]

17.12. **Communications to Government servants or their Associations /Unions and submissions before Courts/Central Administrative Tribunal.**

I As per the Allocations of Business Rules, each Ministry/Department is responsible to discharge the functions allocated to it as well as to handle the administrative problems relating to service conditions of the employees under its administrative control. Similarly, U.T. Administration is responsible for all matters concerning staff under their control. The Decision-making process, however, involves consultation with/concurrence of other Ministries/Departments. In such cases, the views/comments of the Ministry/Department which has been consulted in the matter may be advisory in nature while in other cases such views/comments may be mandatory. In case there is a difference of opinion between two Ministries/Departments, these differences are sorted out by following such procedure as is laid down in this behalf. In all such cases whatever be the final decision, it is the decision of the Government and not the decision of any individual, Ministry/Department.

II It has been observed that while handling service matters/cases of the Government servants, the administrative Ministries/Departments in their communications to the Government servants/Association etc. or even in the affidavits filed/submissions made before the Supreme Court/Tribunal etc. make specific references to a Ministry/Department under whose advice/directives a particular decision has been taken. This gives an impression that the decision is that of the Ministry/Department which has been consulted and not that of the Government. Such allusion places the Government in an embarrassing position particularly when legal aspects are involved. It is, therefore, stressed that while communicating decision(s) on the representation(s)/complaint(s) etc. submitted by the

Government servants or their Associations, etc. the final decision should be in the name of the appropriate authority and in no circumstances, the communication should convey or give an impression that the decision was based on the advice of a particular Ministry/Department which accepted/ rejected the demand(s). Exceptions may be made in respect of the sanctions etc. where according to financial regulations, under rules/or other mandatory provisions, it may be obligatory to mention the name of the specific authority with whose concurrence, or in consultation with whom the sanction has been issued.

III Similarly, in case of affidavits filed or oral submissions made before Courts/Central Administrative Tribunal in matters pertaining to writ petitions/applications filled by the Government servants or their Associations etc., the submissions should be made on behalf of the Government. In no case, the name of any specific Ministry/Department, are mentioned in these submissions. Even in cases where the matter is pending before a Ministry/Department, the submission made should be that the matter is under consideration of the Government and not that of any particular administrative Ministry/ Department.

IV In service matters/cases filed by Government servants Associations, Government of India is one of the Respondents, all such cases have to be defended by the Administrative Ministry/Department/ Organisation where the Government servant is serving or served last. In case other Ministries Departments have been made respondents they are to be treated as pro-forma Respondents and the matter has to be defended by the administrative Ministry on behalf of the Government of India i.e., on its behalf as well as on behalf of other Ministries/Departments. In brief, there has to be only one counter-affidavit on behalf of the Government and it has to be prepared and filed by the Ministry/ Department etc. where the petitioner/applicant is serving. However, where more than one Ministry/ Departments has been made parties, those Ministries/Departments should be consulted or the draft counter reply should be shown to them.

V Further, it is observed that Court/CAT cases are not handled expeditiously and within the time schedule. Some times, references are made to the nodal Ministries/Departments dealing with policy matters or to the Ministry of Law at the last moment viz. a few days before the Ministry date fixed by the Court Tribunal. This does not give sufficient time to these Ministries/Departments to carefully examine the issues involved. It is, therefore, stressed that on receipt of the Notice along with the original Application/Petition the administrative Department/Authority should immediately prepare parawise comments counter affidavit. Wherever necessary the specific points may be brought out clearly on which comments of other nodal Ministries like Finance or Department of Personnel & Training etc, are required. There upon reference should be made to the concerned Ministry/ Department on priority basis. Thereafter, the matter may be referred to the Ministry of Law/Standing Government Counsel engaged in the matter for necessary vetting and filing the matter before the Tribunal/Court. The Ministry should also make arrangements for appearance before the Court/ Tribunal as and when the matter comes for hearing and for this purpose proper liaison with the Government counsel should always be maintained.

VI In cases where the matter is decided against the Government, immediate steps should be taken to analyse the judgement and a view taken in consultation with the nodal Ministry concerned as to whether the judgement should be implemented or a SLP needs be filed in the matter. The reference to nodal Ministry for their advice should be made well before the last date for filing Review Application before the CAT itself or SLP need be filed should be clearly brought out and the matter referred to

Ministry of Law for their advice. It is the primary duty of the administrative Ministry concerned to follow the matter at every stage and ensure filing of the counter-affidavit or SLP within the time schedule laid down by the Tribunal/Court. In case delay in filing the reply is apprehended, necessary steps to seek extension in time or stay orders may be taken with the assistances of Standing Counsels.

VII In certain cases, the Tribunal/CAT may not deliver substantive judgement in the matter and may direct the Government to take a final view in the matter based on certain guidelines etc. The Tribunal/Court may desire final decision by a specific date. In all such cases, it is essential to ensure compliance of the orders within the specified time. In case any delay is expected in reaching a final decision in the matter, extension of time from tribunal/Court should always be sought for. In such cases also, it has to be ensured that the matter is referred to different consulting agencies/Departments well before the last date of taking a final decision.

VIII In brief, the administrative Ministry has to ensure that in all cases timely action is taken and in no case the litigation is allowed to prolong to the extent that it results in contempt proceedings.

IX All the Ministries and U.T. administrations are requested to ensure that these instructions are strictly followed by all concerned under their administrative control.

[GOI Min of Finance, Deptt of Expdr OM F.No.7 (32)-E-III/92 dated 24/05/93]

17.13 Officers Authorised To Sign And Verify Pleadings

Deptt of Pers & Trg. Notification No. A-11019/105/87-AT dated 28/09/1993

GSR 630(E)

In exercise of the powers conferred by Article 77 of the Constitution and in supersession of the Government of India (Authorization of Officers for Verification of Pleadings and Other Documents to be filed in the Central Administrative Tribunal) rules, 1992, except as respects things done or omitted to be done before such supersession, the President hereby makes the following rules namely:—

1. **Short title and commencement –**

(1) These rules may be called the Government of India (Authorization of officers for Verification of Pleadings and Other Documents to be filed in the Central Administrative Tribunal) Rules, 1993.

(2) They shall come into force on the date of their publication in the Official Gazette (published on 28-9-1993)

2. **Authorization of officers—**

(1) The officers specified in the Schedule annexed to these rules are hereby authorized to sign all pleadings and other documents to be filed for and on behalf of the Union of India, before Central Administrative Tribunal established under sub-section (1) of Section 4 of the Administrative Tribunals Act, 1985 (13 of 1985).

(2) Such of the officers referred to in sub-rule (1) as are acquainted with the facts of the case are also authorized to verify such pleadings.

17.14 Instructions issued by CGDA's Office on Monitoring / Handling of Court Cases

Following important letters issued by CGDA's Office for monitoring Court Cases are reproduced as Annexures to this Chapter:

1. Nomination of Nodal Offices for monitoring the CAT/Court Cases

   [No. AN/III/3024/CAT dated 04/08/94 AND 05/12/97] Annexure I and II

2. Payment of bills in r/o Standing Counsels

   [No. AN/III/3012/VOL-VIII/CAT DATED 05/12/97 AND 03/03/99 and 16/5/2000] Annexure II, III & IV

3. Monitoring of Court Cases (DAD personnel)

   [No. LC/3024/1/DAD/COURT dated 25/11/02 and 10/03/03] Annexure V and VI

4. Re-imbursement of Conveyance expenses to staff of Legal Cell detailed to attend Court hearings for liaison with Govt Counsels.

   [No. Legal Cell/3024/Nodal/Conv dated 07/05/03] Annexture VII

5. Authorisation of provisional payment in respect of charged expenditure .. court judgements/ decrees

   [No. A/III/11909/Charged Expenditure dated 14-11-2000] Annexure VIII

CHAPTER - XVIII

DRILL ON HANDLING/MONITORING OF COURT CASES

18.1 TYPES OF APPLICATIONS

1. An aggrieved person moves the Tribunal with a prayer for relief. The application wherein he submits his grievance, and prays for relief is known as Original Application (OA). In the course of disposal of the Original Application, written submissions of several other types are also filed before the Tribunal, which are incidental to the process of adjudication of grievances. The details of the various applications/ petitions, which are filed before the Tribunals are explained in the succeeding paragraphs.

2. **Original Application (OA)**: This marks the commencement of the litigation. This is filed by person(s) aggrieved by any order pertaining to any matter within the jurisdiction of the Tribunal". OAs are filed under Section 19 of the Administrative Tribunals Act, 1985. The OA should conform to the form prescribed in the Rules. The OAs are numbered serially throughout the year for example OA No. 1/1977, OA No. 2/1997, etc. OA is referred to through the serial number and the year of filing e.g. 2049/95, 1831/96 etc. The number and year together, are capable of uniquely identifying an application. All references to the OA are made through this number only and hence this is of utmost importance in dealing with the case.

3. **Transferred Application (TA):** As per Section 29 of the Administrative Tribunals Act, 1985, every suit or other proceedings pending in any court before the establishment of the Tribunal should stand transferred to the Central Administrative Tribunal (CAT) after the establishment of the Tribunal. We are aware that the Central Government has the powers to bring in more organisations (Public Sector Undertakings, Autonomous bodies etc.) within the jurisdiction of the CAT. As and when any such new organisation is brought within the jurisdiction of CAT, any suit or proceeding relating to such organisation (on service matter only) should be transferred to the CAT. Such applications which are transferred from other courts to CAT are numbered as Transferred Application No.../... e.g. TA No 22/2003, TA No 345/2001

4. **Review Application (RA)**: Parties before the Tribunal may file applications for Review of the orders of the Tribunal. Such applications which pray for review of any Order of the Tribunal are known as Review Application (RA) and are referred to as RA No._____ of___ in OA No._____/19..... e.g. RA No 16 of 2003 in OA No 345/2003.

5. **Contempt Petition:** Parties may file contempt petition against each other. Generally, such petitions are filed by the applicant in OA alleging that the Orders of the Tribunal in the OA have not been complied with by the respondent and thus, the respondent is guilty of Contempt of Court. There are two kinds of Contempt of Court viz. Civil and Criminal. The petitions are numbered as CCP (Civil/Criminal) and are generally referred to as CP No._____ of 19__ in OA No.___ of 19___. Contempt Petitions are filed by name against the official who is alleged to have committed contempt of court. In case contempt is established, the official concerned may be sentenced to pay fine or undergo imprisonment. At times the CAT may direct personal appearance of the official alleged to have committed contempt.

6. **Petition for Transfer**: As per Section 25 of the Administrative Tribunals Act, 1985 any of the parties to an application may request the Chairman for transfer of a case from one bench to another. Such

requests for transfer of case are numbered as PT No.____/19___.

7. **Miscellaneous Application (MA)**: In addition to the applications/petitions, which are for specific purposes, there may be occasions for the parties before the Tribunal to make written submissions for other purposes such as the following: -

a) Vacating interim orders

b) Making Amendments to the Pleading.

c) An applicant may like to add more respondents to the case

d) A party may like to apprise the Tribunal of further developments, which have a bearing on the case.

e) Seeking extra time for implementing order.

8. The above list is purely illustrative and not exhaustive. Whenever a need arises for additional written submission to the Tribunal the same is met through Miscellaneous Applications. They are numbered as MA No. of 19___ and are referred to as MA No ____ of_____ in OA No. _____ of_____.

9. While discussing the case with the Counsel or while inquiring about the case from the court officials, one must quote the complete OA number i.e. number of the year and also the detail of the application i.e. CCP No. ___ or MA No. ____ etc.

18.2 Action On Receipt Of Notice

1. Notices may be received from the Tribunal either by post or through the officials of the Tribunals. At times even the party to a OA may also bring the notices. The notices brought by the party are known as DASTI and the same are of urgent nature.

2. As per the instructions contained in Government of India Deptt. of Personnel and Training OM No. A 11029/21/88-AT dated August 1988, the officer receiving the notice should indicate his name and designation alongwith the office stamp, date and time of receipt on the acknowledgement slip. These instructions must be scrupulously complied with.

3. Normally Notices are received by the Govt. Departments under the following circumstances: -

(a) Notice to show cause against admission.

(b) Notice after admission-for the purpose of contesting the case.

(c) Notice meant for the employees working under the responder department.

4. The provisions relating to the service of notice are contained in Rule 11 of the CAT Procedure Rules 1987 and Chapter V of the CAT Rules of Practice 1993.

5. In the types of cases mentioned under Para (c) above, the Head of the Department receiving the notice is required to get the notices served on the private respondents urgently and obtain their acknowledgement. Thereafter an affidavit may be filed in the Registry confirming compliance and enclosing

the copies of the acknowledgement.

6. As regards the notices mentioned at Paras (a) and (b) above these are meant for the respondent department and call for elaborate action on the part of the recipient. The first issue that arises for determination by the recipient is the extent to which he is involved in the case. At times an applicant may sue more than one department in the same OA e.g. an applicant who moves the Tribunal regarding allotment of his Govt. accommodation in favour of his son or daughter may include in the array of parties, Ministry of Urban Affairs, Dte of Estates, the Department in which he was serving and the Department wherein the son/ daughter is working. Another example is of an employee serving in the Ministry of Industry who may challenge the validity of the provisions in the guidelines issued by the DOP&T for conducting the DPC because the DPC held in his department has not selected him for promotion. Thus there may be two types of circumstances wherein more than one department is impleaded by an applicant.

(a) Where he has challenged the action of one department based on the guidelines issued by another Department.

(b) Where the facts of the case relate to more than one Department.

7. In all such cases a common defence will be put up on behalf of the Government of India. There should not be any contradictory statements or stands by various departments. As per Govt. of India, Deptt of Pers. & Trg OM No. 20036/23/68-Estt dated 6 June 89 the primary responsibility for contesting the cases will be with the Administrative Ministry/Department concerned on the basis of the specific facts pertaining to them.

8. As regards the case wherein the applicant has impleaded more than one department, which have played various roles in the transaction, which has resulted in the grievance of the applicant, it would be appropriate that the defence of the case is handled by the Deptt whose order is being challenged. Under such circumstances, the defending department will pursue the case in consultation with other co-respondents. The recipient of the notice will decide the extent and the level of his involvement in the case and accordingly decide as to who will handle the case before the Tribunal. In case primary respondent is of the view that the case is required to be handled by it then it has to get in touch with other Govt. respondents and appraise them suitably. The comments of other departments will be obtained on the specific paragraphs pertaining to them and incorporated in the reply. Draft reply, when prepared will also be shown to other respondent departments. The progress of the case will be intimated to all the respondent departments from time to time. Alternatively, if it is felt that involvement of our department is limited and the case is required to be handled by some other respondent, then letter has to be written to the primary respondent accordingly, preferably alongwith the reply on the paragraphs pertaining to the department. The primary respondent will keep informed the other respondents of the progress of the case from time to time. During the course of the case also there may be occasion when a respondent other than the one who is pursuing the case before the Tribunal may be required to produce records. Such requirements will have to be complied with through the co-ordinated action of all the respondents in the case.

9. The above mentioned procedure applies only in respect of the official respondents which includes respondents who are impleaded by name for action taken by them in discharge of official capacity. It is also likely that the respondent, who is aggrieved by the seniority position assigned to him, may sue his colleagues who have been, according to him, wrongly placed above him in the seniority list. Such persons are known as private respondents. Defending department is not required to take any action on behalf of

such respondents.

10. After writing to the co-respondents, the primary respondent will initiate action for engagement of Government Counsel. In respect of the Principal Bench, engagement of Counsel is done by the Dy Legal Advisor whose office is located in the premises of the High Court. The defending department will have to pursue the case with the Dy Legal Advisor for engagement of counsel.

11. In case the date of hearing mentioned in the notice is so short that the counsel could not be appointed by them, an officer of suitable level, well conversant with the facts of the case should appear before the Tribunal on the appointed day. When the case is called, the officer will have to present himself, reveal his identity, establish the same by production of identity- card and pray for extension of time for filing reply, stating that action for engagement of counsel is being taken and that the respondents will be contesting the case through the counsel. In case the applicant has prayed for any interim relief, the hearing may not be as simple as above. Under such circumstances, the official appearing for the respondent will have to be fully prepared to argue against the grant of interim relief. Alternatively, efforts for engagement of the counsel should have been stepped up so as to ensure that the counsel is available well in time before the date of hearing. Nevertheless, on receipt of a notice, there is no harm in looking into the case once again keeping in mind the facts brought by the applicant. If the relief sought is found to be due and admissible to the applicant, at this stage also case can be reviewed and the decision brought to the notice of the Tribunal.

12. Section 23(2) of the Administrative Tribunals Act, 1985 provides that the defending department may authorise one or more legal practitioners or any of its officers to act as presenting officers and every person so authorised by it may present the case with respect to any application before a Tribunal. Rule 62(b) of the CAT Rules of Practice provides that a presenting officer other than a legal practitioner representing any of the parties ..... shall also file a memo of appearance in Form II. As per DOP&T instructions on the subject, a Group A Officer may be nominated as Presenting Officer with the approval of the Minister concerned. The appointment of such presenting officer is required to be communicated to the Registry. The presenting officer so appointed can file reply on behalf of the department and argue the case before the Tribunal. While filing the reply, the Presenting Officer is required to file a memo of appearance as specified in the rules.

13. In case it is decided that the case will be defended through the departmental presenting officer, he must be contacted with full facts of the case and his guidance be obtained for preparation of reply. As regards the engagement of Govt. Counsels, the office of Dy. Legal Advisor, Ministry of Law endorses a copy of the order engaging the counsel, to the respondent also. The counsel concerned must be contacted immediately on receipt of information about his/her appointment and the case be pursued as per his advice. Without waiting for the appointment of counsel, action for drafting reply should be pursued so that the respondent may have the draft reply ready even before their first meeting with the counsel. It will be a good practice to keep meeting the counsel regularly, well in time before each hearing.

18.3 Preliminary Objection

1.1 Legal proceedings may be contested in two distinct ways-viz., on merit and on maintainability. The objection to an Original Application (OA) on the merits of the case rests on the facts and circumstances of the case and the law relating to the same. On the other hand, there are some general aspects relating to the maintainability of the OA without going into the merits of the averments made therein. In fact, it means

that irrespective of the merits of the applicant's case the applicant is not entitled to approach the court and get any relief. Accordingly, it should be the endeavor of the respondent to contest the proceedings on both the grounds. The objection relating to the maintainability of the application is also known as Preliminary Objection. Such objections are to be disposed off before the court takes up hearing on the merits of the case. Some of the Preliminary objections which are available to the respondent are explained in the succeeding paragraphs.

2.1 **Jurisdiction**: - The Court moved by the litigant must have jurisdiction to adjudicate on the matter raised by the applicant, In case, the applicant moves any Court other than the Tribunal for redressal of his grievance relating to service matters, the proceedings can be resisted on the ground of lack of jurisdiction. In this connection Section 28 of the Administrative Tribunals Act, 1985 is relevant and the same is reproduced below: -

Exclusion of jurisdiction of courts except the Supreme Court

On and from the date from which any jurisdiction, powers and authority becomes exercisable under this Act by a Tribunal in relation to recruitment and matters concerning recruitment to any Service or post or service matters concerning members of any Service or persons appointed to any Service, or post, no court except: -

(a) the Supreme Court, or

(b) any Industrial Tribunal, Labour Court or other authority constituted under the Industrial Disputes Act, 1947 (14 of 1947), or any other corresponding law for the time being in force,

shall have or be entitled to exercise any jurisdiction, powers or authority in relation to such recruitment or matters concerning such recruitment or such service matters.

2.2 The above statutory provision has to be viewed in the light of the recent judgement of the Hon'ble Supreme Court in L. Chandra Kumar Vs Union of India and Others, 1997(3) SCC 261. Extract of the judgement is reproduced as under:-

"In view of the reasoning adopted by us, we hold that clause 2(d) of Article 323A and clause 3(d) of Article 323B, to the extent they exclude the jurisdiction of the High Courts and the Supreme Court under Articles 226/227 and 32 of the Constitution, are unconstitutional. Section 28 of the Act and the exclusion of jurisdiction" clauses in all other legislations enacted under the aegis of Articles 323A and 323B would, to the same extent, be unconstitutional. The jurisdiction conferred upon the High Courts under Article 226/227 and upon the Supreme Court under Article 32 of the Constitution is part of the inviolable basic structure of our Constitution. While this jurisdiction cannot be ousted, other courts and Tribunals may perform a supplemental role in discharging the powers conferred by Articles 226/227 and 32 of the Constitution. The Tribunals created under Article 323A and Article 323B of the Constitution are possessed of the competence to test the constitutional validity of statutory provisions and rules. All decisions of these Tribunals will, however, be subject to scrutiny before a Division Bench of the High Court within whose jurisdiction the concerned Tribunal falls. The Tribunals will, nevertheless, continue to act like Courts of first instance in respect of the areas of law for which they have been constituted. It will not, therefore, be open for litigants to directly approach the High Courts even in cases where they question the vires of statutory legislations (except where the legislation which creates the particular Tribunal is challenged) by

overlooking the jurisdiction of the concerned Tribunal. Section 5(6) of the Act is valid and constitutional and is to be interpreted in the manner we have indicated".

2.3 **Jurisdiction with reference to Bench**
{Rule 6 of CAT Procedure Rules, 1987}

Place of filing application: - (1) An application shall ordinarily be filed by an applicant with the Registrar of the Bench within whose jurisdiction-

(i) the applicant is posted for the time being, or

(ii) the cause of action, wholly or in part, has arisen:

Provide that with the leave of the Chairman the application may be filed with the Registrar of the Principal Bench and subject to the orders under Section 25, such application shall be heard and disposed of by the Bench which has jurisdiction over the matter.

(2) Notwithstanding anything contained in sub-rule(1) a person who has ceased to be in service by reason of retirement, dismissal or termination of service may at his option, file an application with the Registrar of the Bench within whose jurisdiction such person is ordinarily residing at the time of filing of the application.

3.1 **Limitation:** Section 21 of the Administrative Tribunals Act, 1985, prescribes the period of limitation for moving the Tribunal. The above Section is reproduced below for ready reference:-

(1) A Tribunal shall not admit an application,

(a) in a case where a final order such as is mentioned in clause (a) of sub-section (2) of Section 20 has been made in connection with the grievance unless the application is made, within one year from the date on which such final order has been made.

(b) in a case where an appeal or representation such as is mentioned in clause (b) of sub-section (2) of Section 20 has been made and a period of six months had expired thereafter without such final order having been made, within one year from the date of expiry of the said period of six months.

(2) Notwithstanding anything contained in sub-section (I), where-

(a) the grievance in respect of which an application is made had arisen by reason of any order made at any time during the period of three years immediately preceding the date on which the jurisdiction, powers and authority of the Tribunal becomes exercisable under this Act in respect of the matter to which such order relates: and

(b) no proceedings for the redressal of such grievance had commenced before the said date before any High Court.

The application shall be entertained by the Tribunal if it is made within the period referred to in clause (a) or, as the case may be, clause (b), of sub-section (I) or within a period of six months from the said date, whichever period expires later.

(3) Notwithstanding anything contained in sub-section (1) or sub-section (2), an application may be admitted after the period of one year specified in clause (a) or clause (b) of sub-section (1) or, as the case may be, the period of six months specified in sub-section (2), if the applicant satisfies the Tribunal that he had sufficient cause for not making the application within such period.

3.2 In case an application has been filed beyond the period of limitation, the respondent can challenge the maintainability of the same on this ground alone. However, it must be remembered that the applicant who files an application beyond the period of limitation, generally files a Miscellaneous Application (MA) for condonation of delay. If the applicant has admitted that the application is being filed beyond the period of limitation and has moved a MA for condonation of delay, the respondent should also file a separate reply to the MA. The applicant would have endeavored in the MA for condonation of delay that he had "sufficient cause" for not filing the OA within the period of limitations. Accordingly, the respondents stand in the reply to this MA should be that the applicant has not shown "sufficient cause" for the delay.

3.3 With regard to limitation, the following points are relevant: -

(a) Repeated unsuccessful representations do not extend the period of limitation. Assume that an employee's request for stepping up of pay has been rejected in Oct 88 by competent authority. Also assume that he makes repeated representations in Jan 89, Jul 89, Feb 1990 and June 1990 on the same issue and the last of such representations was rejected in Aug 90. The employee cannot move the Tribunal in Sept 1990 or Oct 1990 contending that his case was rejected only in August 1990.

(b) Where an appeal has been prescribed through statutory provisions, the employee is required to exhaust this remedy before moving the court. S.S. Rathore Vs State of M.P. (1989) ATC 913 (SC) is an important case in this regard.

(c) It has been held in a number of cases that an application in which cause of action accrued prior to 01/11/82 (CAT was established w.e.f. 01/11/85) is time barred and that this infirmity is incurable.

3.4 There are a number of issues relating to limitation such as continuing cause of action, limitation against void order etc. It is essential to bear in mind that limitation is a strong preliminary objection in the hands of the respondent and any fact having a bearing on limitation should, therefore, promptly be brought to the notice of the counsel so that he can draw the best advantage out of it.

4.1 Mis-joinder & non-joinder of parties: An applicant is required to include, in the array of respondents, all those who are likely to be affected if the relief prayed for by him is granted. This is over and above those parties from whom the relief is claimed. If an applicant has failed in this respect, the respondent may raise the objection of mis-joinder/non-joinder of necessary parties e.g. when an employee contends that he has been wrongly denied promotion and in his place certain ineligible persons have been promoted. If he has not impleaded such persons, who, according to him have been wrongly promoted, the respondent may oppose the OA on the ground of non-joinder of necessary parties.

4.2 However, it is relevant to know that generally, the OA is not dismissed on this ground. Normally, the CAT directs the applicant to include the necessary parties in the array of respondent. Nevertheless, it

is appropriate for the respondents to bring to the notice of the court, the fact regarding non-joinder of parties, so as to avoid any future complications.

5.1 **Res-judicata**:- The term Res-judicata literally mean "a thing which has been decided". It is based on the Roman Maxim that it concerns the state that there should be an end to litigation". The principle is also based on the maxim that "no man should be vexed twice over the same cause". According to the doctrine of Res-judicata if a matter has been directly and substantially in issue under the same set of parties and has been decided by a court of competent jurisdiction, then it will not be entertained by any other court in future. This doctrine is contained in Section 11 of the Code of Civil Procedure (CPC). While one does not expect the same applicant to move the Tribunal for the second time, after losing an earlier case, there are certain other aspects like constructive Res-judicata, which may be available for the respondents on several occasions. The explanations below Sec. 11 of CPC provide the circumstances under which the plea of constructive- res-judicata will lie.

e.g. If an employee moves the Tribunal initially for revision of seniority, and after winning this case, for holding of review DPC and after winning this case, on the third occasion for payment of arrears of salary, it may be possible to contend that he ought to have claimed all the relief in the first OA itself and failure on the part to do so results in the latter OA being hit by the doctrine of Constructive Res-judicata.

5.2 It is however, necessary to bear in mind that this is a legal concept and there are several delicate points which are liable to be raised by the contesting parties for and against the application of this principle. It is the duty of every official pursuing the case on behalf of the respondents to bring to the notice of the counsel, every fact that may help in setting up a successful plea of Res-judicata.

6.1 **Estoppel**:- Estoppel is also a legal concept which prohibits a party from raising a plea on certain circumstances. As per section 115 of Indian Evidence Act 1972, when one person has, by his declaration, act or omission, intentionally caused or permitted another person to believe a thing to be true and to act upon such belief, neither he nor his representative shall be allowed, in any suit or proceeding between himself and such person or his representatives, to deny the truth of that thing. As in the case of Res-judicata, the applicability of estoppel also depends upon a number of circumstances. However, a diligent litigant is under a duty to bring to the knowledge of his counsel any information which will help in raising this plea e.g., if an applicant has got employment by mis-representing his date of birth, he cannot at a later time question the act of the employer which is based on the fact presented by the employee.

7.1 **Non-exhausting of official remedies**: - Section 20 of the Administrative Tribunals Act, 1985 provides that the "Tribunal shall not ordinarily admit an application unless it is satisfied that the applicant had availed of all the remedies available to him under the relevant service rules as to redressal of grievance" subsequent Sub Rules of the above section also clarify that a person shall be deemed to have availed of the remedies after expiry of six months from the date of making appeal, if any, preferred by him, even if no final order has been made. If any applicant has rushed to the court against his suspension, the same can be resisted, without going into the merits of the application on the ground that the applicant has not availed of the departmental remedy open to him by way of statutory appeal under CCA Rules.

8.1 **Suggestio falsi and suppressio veri**- Every person is expected to approach the court with clean hands. In case, the court is convinced that the applicant has suppressed material information from the court or has made some misleading statements, in his OA, the same will be a very good ground for seeking dismissal of the OA without going into the merits. In all such instances, every effort must be made to raise

the plea of suggestio falsi and suppressio veri with adequate evidence.

9.1 **Plural remedies**: - As per Rule 10 of the CAT procedure Rules, 1987, an application shall be based upon a single cause of action and may seek one or more reliefs provided that they are consequential to one another. Thus, it will be lawful for an applicant to seek quashing of an existing seniority list, revision of his seniority, holding of review DPCs for promotion as per revised seniority and arrears of pay and allowances. All these reliefs can be claimed in the same OA because they are consequential to one another. If on the other hand an applicant requests for revision of date of birth and counting of past service rendered in some other department in one OA, the same can be challenged for being violative of Rule 10 of the CAT procedure Rules, 1987.

9.2 Normally, an OA is not likely to be dismissed on the ground that it contains plural remedies. It is also open to the court to admit the OA in respect of only those remedies. Notwithstanding this position, it is the duty of the officials pursuing the case to bring to the notice of the CAT that the applicant has prayed for unconnected plural remedies and the OA is liable to be dismissed on this ground.

10. Preliminary objection is a powerful weapon at the hands of the respondents. Successful plea of limitation, Res-judicata etc. will enable the respondents to get the OA dismissed without going into the merits of it. Besides, winning a case on preliminary objection will save considerable time and effort as well. Hence a conscious attempt must be made to look for possible preliminary objection and raise the same.

11. At times, if prayed for, the court may permit the filing of a short reply opposing maintainability of the OA. Under such circumstances, the short reply should be filed in time reserving the right to file detailed parawise reply, if needed, after the question of maintainability is decided. Respondents will be required to file detailed parawise reply only if the question of maintainability is decided in favour of the applicant. Alternatively, preliminary objection can be listed in the counter reply as well. This should be brought to the notice of the court at the time of admission itself. The court may hear the preliminary objection at the time deciding the admission of the OA or at the time of final disposal.

18.4 Preparation And Filing Of Reply

1. Respondents are required to file reply to Original Application (OA) as well as the Miscellaneous Application (MA) filed by the applicant so that the averments made by the applicant are clarified and the correct position is placed before the court. Reply of the respondents is required to be drafted with utmost care because the same forms the basis of the respondent's defence. In case a point is not brought out in the reply, it may become difficult to effectively contest the case at a later stage and hence it is essential that the case of the respondents is brought out in its entirety with all the supporting documents. It may be appreciated that at the time of final disposal of the case reliance can be made only on the documents forming part of the records of the case and hence no document which will help the case of the respondents should be left out at the time of making the reply. Besides, the reply is required to be filed within the time allowed by the court, because a reply filed after expiry of time granted by the Tribunal will not form part of the records of the case and will not be taken into account for the purpose of disposal of the case.

2. Rule 12 of the CAT Procedure Rules, 1987 prescribes that each respondent intending to contest the application shall file, in triplicate, the reply to the application and the documents relied upon in the paper book form with the registry. Although each respondent has a right to file a reply, it would be appropriate

to file a common reply in respect of all the official respondents. This must be done with the consent of the departments concerned after ascertaining the views of the respective departments and also after showing the draft to them. The rule further prescribes that the respondent shall specifically admit, deny or explain the facts stated in the application and may also state additional facts as may be found necessary for the just decision of the case.

3. It may seem from the above that the following tasks are involved in the preparation of reply:-

(a) ascertaining the veracity of the facts narrated by the applicant.

(b) Ascertaining the correct facts relating to the issue agitated in the OA.

(c) Exploring the possibility of raising any preliminary objections regarding the maintainability of the OA.

(d) Collection of documents in support of the case of the respondents.

(e) Identification of any identical case filed by any other employee of the department for similar relief. This will not only facilitate easy preparation of the reply but also enable the respondents to move the Tribunal for linking the identical cases to be heard and disposed off together.

(f) Identification of any precedent especially unreported cases which will be known only to the department. This will strengthen the case of the respondents if the earlier decision was in favour of the respondents. Alternatively, it will help the respondents to effectively resist the present OA by removing the defects, which were present on the earlier occasions.

4. After the facts and documents are collected, the process of drafting reply begins. Before the material portion of the reply, there are certain introductory paragraphs required in the reply and the same are as under:-

(a) The identity of the official filing the reply should be given in the opening paragraph.

(b) There should be a recitation to the effect that the officer filing reply is competent and has been duly authorised to file the reply on behalf of answering respondents.

(c) There should be confirmation to the effect that he has read the OA and has understood the contents. It is generally stated that except as has been expressly admitted hereunder, all the material averments in the OA are denied. This may serve as a saving clause in case the respondents have failed to answer any of the averments made by the applicant.

5. The third part of the reply should contain preliminary objection, if any to the respondents desire to take.

6. Often it may not be sufficient for the respondent to simply admit or deny what has been stated by the applicant in the OA. It will be of great advantage if the facts of the case are presented in chronological or logical order in a cohesive manner in its entirety so that the complete details of the case could be understood in one go. It will be a good practice to open the reply of the respondents (after the paragraphs mentioned above), with "Brief Background of the case". This portion should contain all the relevant facts

of course only the relevant facts-which are essential for acquiring complete knowledge about of the case. It may be appreciated that the applicant would be interested only in his case and will be presenting the facts of the case as known to him or as suitable to him. The respondent, being responsible for larger issues, would have taken decision based on certain guidelines by the nodal agencies or as a result of the policy decision, etc. which may not be even known to the applicant. Further, the respondents would also know the repercussions if the applicant's request is accepted. Presentation of these facts in proper perspective goes a long way in enabling the court to appreciate the case of the respondents. It is also worth remembering to "state such additional facts as may be found for the just decision of the case'. Maximum benefit may be drawn from the facility provided to the respondent.

7. Thereafter, parawise reply on merits, on the averments made by the applicant in his OA is given. This is perhaps the most crucial part in the respondent's reply. Every averment made by the applicant must be viewed in its proper perspective and the respondent's version of the same may be given. [For example, assume that an applicant has stated in Para I of his OA 'This application is being filed against the illegal order of suspension passed by Respondent No. 2 vide order No. _____ dated _____ annexed and marked as Annexure A-1". On the face of it, it may appear that there is nothing to counter or contradict what has been stated by the applicant because he has only cited the order against which he is moving the Tribunal. While referring to the order of suspension, he has described the same as illegal'. It would be appropriate to place on record that the impugned order is valid in the eyes of law].

8. The following points are to be kept in view while drafting reply:

(a) In order to avoid repetition of facts, the respondents may invite the attention of the Tribunal to the relevant paragraph.

(b) At times, the applicant might have mentioned certain facts, which are not essential for the purpose of the case and the same may not be within the knowledge of the respondents. For example, an applicant whose pension has been withheld, would have stated facts relating to his domestic problems as well. Under such circumstances the respondents may plead ignorance of the facts simultaneously pointing out that the domestic circumstances are not relevant for determining the legal validity of the impugned order.

(c) On certain occasions, the respondents may not be in a position to comment on the truth or otherwise of the contention of the applicant even though the contention may have a bearing on the case. For example, a person may be pleading that he could not file OA in time because he was suffering from some ailment and hence his prayer for condonation of delay be allowed. Under such circumstances, the respondents may plead ignorance and also submit that 'the applicant be put to strict proof of the averments made by him'.

(d) There may be paragraphs which are formal in nature such as the details of the IPO, etc. Against these paras respondents may state 'being formal, does not call for any reply from the answering respondents'.

9. Finally, the respondents are required to make a formal prayer for the dismissal of the OA. The prayer may be in the following form:

PRAYER

In view of the submissions made hereinabove, in the brief background of the case, preliminary objections and the parawise comments, the applicant is not entitled to any of the reliefs prayed for and the application is liable to be dismissed with costs.

It is prayed accordingly.

10. This is required to be followed by verification by the officer who signs the reply.

11. In the course of the reply, whenever supporting documents are available for substantiating the contention of the respondents, a reference should be made in the body of the reply to the appropriate annexure. The documents annexed to the reply are to be marked as R-1, R-2, R-3, etc. The copies of the documents are required to be attested by a legal practitioner or a gazetted officer as under:

This annexure _____ is the True copy of the original document.

Sd/-
Name and Designation

12. The language of the reply has to be clear, precise and free from ambiguity. The following points may be kept in mind while preparing the reply.

(a) The names of persons and places must be spelt accurately, throughout the reply.

(b) Abbreviations should be avoided as far as possible, especially when they pertain only to Govt. Departments.

(c) Generally pronouns like he, she etc, are avoided in pleadings. Parties are referred through their legal positions e.f. "Applicant No. 3 joined service under Respondent No.3 with effect from ___".

(d) Whenever a statutory provision is referred to, the exact language of the statute should be used. e.g., as per CCS (CCA) Rules, 1965, reduction to lower stage in the time scale for a period not exceeding three years is a minor penalty. Although the phrase 'not exceeding three years' more or less means the same as 'for a maximum period of three years' such conversations should be strictly avoided while drafting pleadings for the court.

13. After the draft reply is made, the same must be got approved by the Govt. Counsel who has been engaged for defending the case. After clearance from the counsel, the draft is required to be got vetted by the Legal Advisor.

14. Rule 4 of the Central Administrative Tribunal Rules of Practice, 1992, relating to the preparation of pleadings is reproduced hereunder for ready reference:

4. Preparation of pleadings and other papers-

(a) All pleadings, affidavit, memoranda and other papers filed in the Tribunal shall be

fairly and legibly typewritten or printed in English or Hindi Language on durable white foolscap paper of Metric A-4 size (30.5 cm long and 21.5 cm wide) on right margin of 2.5 cm duly paginated, indexed and stitched together in paper-book form. The index shall be in form No. 1.

(b) English translation of documents/pleadings shall be duly authenticated by any legal practitioner.

15. The reply can be signed by any of the officers authorised for the purpose. The instructions in this regard are contained in Government of India, Department of Personnel and Training Notification No. A-11019/105/87-AT dated 28th. September 1993 published as GSR630(R) in the Gazette of India at the same time. As per the above notification any Group 'A' Officer in any Ministry/Department of the Government of India or any Desk Officer in any Ministry/Department of the Government of India or any Group A' Officer in any Non-Secretariat Office of the Government of India are authorised to sign all pleadings and other documents to be filed for and on behalf of the Union of India before the Central Administrative Tribunal. The above officers as are acquainted with the facts of the case are also authorised to verify the pleadings. In respect of Contempt Proceedings, however, the officers impleaded by name are required to file the reply.

16. After the reply is complete in all respects and duly signed by the authorised officer, a copy of the same is delivered by hand or sent by registered post, to the applicant or his counsel. The proof of delivery or despatch of the reply to the applicant must be produced before the Registry at the time of filing of reply. The registry gives acknowledgement for receipt of reply.

18.5 Action After Final Orders

1. As you are aware, a case may be dismissed even before you become aware of the fact that the same has been initiated against you. Even after notice, it may be dismissed at the admission stage or after final hearing, due to non-maintainability or lack of merit. Besides, the final order may be dictated immediately on conclusion of the hearing. Such orders are called ORAL orders, (the copies of which will be available in due course) or the case may be reserved for pronouncement of orders. In the later event, the case will figure in the cause list for the day on which it is listed for pronouncement of orders. Such cases, which are listed for the pronouncement for orders, are taken up as the first item of the day. In case, the bench, which pronounces the order, sits only in the afternoon, the list will indicate the same and the order will be pronounced as the first item in the afternoon.

2. In view of the above, it is necessary for the officials pursuing the case to be present in the appropriate courtroom well in time on the date and time fixed for pronouncement of orders. Normally only the operative portion of the order, running for a few sentences is read in the court e.g.

"In view of the foregoing, the Original Application (OA) is dismissed, being devoid of merit, without any order as to cost"

3. There may be occasions when the OA may relate to several alternative remedies or the Judgement may partly allow the OA. Under such circumstances, substantial part of the judgement may be read in the court.

4. In all cases, effort must be made to secure the copy of the judgement at the earliest. The need for obtaining the copy of the judgement is all the more urgent in cases, which have gone against the respondent. Rule 22 of the CAT (Procedure) Rules 1987 provides for the supply of free copies of the interim as well as final orders to the applicant and to the concerned respondent. Generally such copies are given to the Counsels. Officials dealing with the case will have to be constantly in touch with the counsels for obtaining the copy of the judgement at the earliest opportunity. Chapter XVIII of the CAT Rules of Practice 1993 also contains provisions relating to the grant of Certified and Free Copies. As per Rule 118 of the above Rules "A party to an application/petition or his legal practitioner shall be entitled to obtain certified copy of the record, proceedings or original documents filed in case, on payment of prescribed fee". (Strangers are also entitled to receive copy of the orders on payment of fees under Rule 119). Applications for copies of order are to be made in prescribed forms and are to be deposited alongwith a fee of Rs. 5/-. Copying charges are levied @ Re. 1/- per page for ordinary copies and @ Rs. 2/- per page for urgent copies. These facilities may also be availed in case of need, without waiting for the free copy supplied by the Tribunal to the counsel. The date of receipt of the certified copy of the Judgement by the party or counsel is crucial in determining the right of the party for filing Appeal/Review Application. Thus, every effort must be made to obtain the copy of the orders at the earliest as and when the same is ready with the registry.

5. If an OA has been dismissed without any relief to the applicant and without any observation pertaining to the respondent, there may not be any action due on the part of the respondent. Such cases may help as precedent in the event of any subsequent OA being filed on the same issue.

6. At times, even though the applicant is not granted any relief, there may be observations or suggestions for the respondents. Such issues will have to be identified from the orders and pursued diligently.

7. In case the order grants any relief to the applicant, the following courses of action are open to the respondents: -

(a) Implementation of the order

(b) Seeking review of the order

(c) Preferring appeal against the order.

8. Legal advice is obtained before a decision regarding implementation of the order is taken. Implementation of the order is required to be made within the time allowed by the Tribunal. In case no time limit is prescribed, the orders must be complied with at the earliest, at any rate within six months of the date of receipt of the order. Failure to comply with the orders with in the prescribed time limit may result in the applicant moving the Tribunal through Contempt Proceedings.

9. As per Article 323A of the Constitution and Section 17 of the Administrative Tribunals Act, Central Administrative Tribunals have power and authority to punish for contempt. In this regard, CAT exercises the same jurisdiction, power and authority as a High Court under Contempt of Court Act 1971. The Act provides for imprisonment of the party held guilty of contempt. Contempt petitions are required to be dealt with utmost diligence. Any failure in this regard may result in the Tribunal passing order for the personal appearance of the senior officers, besides the final order for contempt. To obviate this difficulty, it would be advisable to request the Tribunal through a Miscellaneous Application (MA) for granting extension of time. MA for this purpose should bring about the following: -

(a) The efforts made by the respondents for early implementation of the Judgment.

(b) The difficulties faced by the respondents in complying with the directions within the prescribed time limit.

(c) Justification for the additional time prayed for.

10. Provisions and procedure relating to the Review of an order of the Tribunal are dealt with separately.

11. As per the original provisions or Administrative Tribunals Act 1985 (Section 28), Special Leave Petition (SLP) to the Hon'ble Supreme Court, under Article 136 was the only remedy available to a party aggrieved by the orders of the Tribunal. However, the position has undergone a change with the recent decision of the Hon'ble Supreme Court in L Chandra Kumar Vs Union of India & Others (1997(3) SCC 261) wherein the Apex court has laid down as under:-

"All decisions of the Tribunal will, however be subject to scrutiny before a division Bench of the High Court within whose jurisdiction the concerned Tribunal falls."

12. Thus, presently, a party claiming to be aggrieved by a decision of the Tribunal has to move the High Court.

13. Any decision to seek remedy by way of Review or Appeal will have to be taken in consultation with the Law Ministry and the case pursued in accordance with the procedure laid down for the purpose.

14. It is also relevant to note that the above-mentioned provisions are not confined only to the case of final orders of the Tribunal. An interim order is also required to be complied with within the time limit prescribed by the Tribunal. Extension of time can be prayed in such cases also. In case a party feels aggrieved by the interim order of the Tribunal, the above mentioned remedies can be resorted to.

18.6 Review Application

1. Section 22 of the Administrative Tribunals Act, 1985 relates to the procedures and powers of the Tribunals. This section provides that power of reviewing a decision by the Central Administrative Tribunal is one of the matters in which the Tribunal shall have the same power as are vested in a Civil Court under the code of Civil Procedure 1908(5 of 1908).

2. Under the Civil Procedure Code, Review of an order is permissible under the following circumstances: -

(a) On the basis of discovery of new and important matter of evidence which after exercise of due diligence, was not within the applicant's knowledge or could not be produced by the party at the time when the order was passed.

(b) On account of mistake or error apparent on the face of the judgement.

(c) Or for any other sufficient reason.

3. It must be appreciated that the scope of review is much limited as compared to appeal. A review cannot be sought for fresh hearing of the argument or for correction of allegedly erroneous view taken earlier, but only for correction of a patent error of fact which stares in the face without any need for elaborate arguments e.g. if it is stated in an order that,

"the respondents are therefore directed to refix the pay of the applicant to the post of Assistant, in the scale of Rs.2000-3500 at par with respondent No. 5 with effect from 01/10/92 and to suitably revise the pay of the applicant in the scale of Section Officer with effect from his date of promotion i.e. 20.01.95".

Detailed argument is not necessary to establish that there is an error on the face of the judgement.

4. It must be appreciated that a party will not be allowed to re-open a case under the guise of review. A plea not taken in the OA cannot be raised as ground of review. Further, review cannot be granted on the ground that the Govt. file was shown only to the Tribunal and not to the applicant; such a request should have been made at the time of hearing of the OA itself.

5. As per Rule 17 of the CAT (Procedure) Rules, 1988 a Review application is required to be filed within 30 days from the date of receipt of the copy of the order which is sought to be reviewed. This period is counted from the date of receipt of order by the party or its counsel. There are also provisions for seeking condonation of delay. The delay caused on account of complying with the procedural requirements of the Government machinery, (Consultation with Law Ministry, obtaining approval of the Competent Authority, etc) have been accepted as sufficient cause for condonation of delay. (Union of India Vs Dharampal (1989) 11 ATC256). Notwithstanding such liberal approach by the courts, it is imperative that the case for filing of review application is processed with due urgency. Every effort must be made to file the Review Application within the prescribed period of limitation.

6. As per the above-mentioned rule, a review application can be disposed off without listing it for hearing. Under such circumstances, the case is decided by circulation among the members who heard the case in the first instance.

7. As per Rule 17(5) of CAT Procedure Rules, 1987, a review application is required to be supported by a duly sworn affidavit, indicating therein the source of knowledge, personal or otherwise (i.e. based on official records in the custody of the deponent) and also those which are sworn on the basis of legal advice. The Counter-Affidavit in Review application is also required to be a sworn affidavit whenever any averment of fact is disputed.

8. The right of a party to seek review is without prejudice of its right to appeal. It has also been held that a review application can be pursued even after losing an SLP against the same judgement. However, the party is required to keep the courts informed of the fact that he is pursuing an alternative remedy as well.

9. Normally, the pendency of review application is accepted as a valid defence in contempt proceedings arising on the plea of non-implementation of the judgement. As a measure of caution, it would be appropriate to bring this fact to the notice of the court and pray for extension of time for implementation or stay of the judgement.

18.7 Action by the Main Respondent (concerned office) on receipt of court case

1. Enter the case in the list/register of court cases

2. Prepare a photocopy (clearly legible) of the OA/CWP received from the Court/Nodal office/ HQrs office.

3. Forward immediately the notice (in original) received from the court with legible photocopy of

OA/CWP to the concerned Nodal officer for engaging a Govt counsel and for monitoring the case.

4. Forward a copy of the OA/CWP to HQ office alongwith a short statement of the case.

5. Examine the issues involved in the OA/CWP/Suit.

6. Prepare

   (i) Statement of case

   (ii) Parawise comments

7. Forward to the Nodal officer, documents referred at SL.No 6 above along with legible photocopy of rules and regulations in support of the parawise comments, for getting draft counter reply prepared by the Govt counsel.

8. On receipt of draft counter reply from the Nodal officer prepare the following set of documents in triplicate (only in those cases where vetting of Ministry of Law & Justice is required through HQrs office) for transmission to HQrs office: -

   a. Statement of case

   b. Parawise comments

   c. OA/CWP

   d. Draft counter-reply/Counter affidavit

9. On receipt of vetted copy from HQrs office, take the following action: -

   a. Prepare counter reply with Index (six copies).

   b. Signatures of Group-'A' officer, duly affixed with his official seal, at appropriate place on all the six copies or as advised by the CGSC.

   c. Signatures of a Gazetted officer on annexures, if any, duly affixed with his official seal.

10. Send the counter reply (six copies) mentioned at SL.No 9 above to the Nodal officer for getting the same filed in court through the Government Counsel.

11. Monitor the Court case and intimate the outcome of every hearing to the HQrs office through Fax-message/E-mail till its finalisation.

12. On receipt of court orders forward the same (in duplicate) along with the legal opinion of the Govt counsel.

13. Await instructions from HQrs office on implementation of court orders or otherwise.

14. If HQrs office directs to implement the court order, take immediate action to implement the orders within the stipulated period.

15. If HQrs office directs to prefer an appeal against the said order take immediate steps to challenge the order in the next higher court.

16. If action is taken as mentioned at SL.No 14, render an implementation report to HQrs office on compliance of court orders.

17. If action is taken, as mentioned at SL.No 15 above, take action by following the necessary steps for challenging the Court order as mentioned above.

18. Release payment to the Govt counsel as per instructions issued by Min of Law and Justice from time to time.

19. Update the list/register of cases, regularly.

20. Send reports of court cases to HQrs office regularly as desired from time to time.

18.8 ACTION BY THE NODAL OFFICE ON RECEIPT OF COURT CASE

1. Enter the court case received from the main respondent in the list/register of court cases.

2. Engage a Govt. Counsel immediately to defend the case.

3. Seek extension of time in case the next date of hearing is at a very short interval.

4. Intimate the date of hearing to the concerned office (main respondent) and HQrs. Office.

5. Maintain a constant liaison with the concerned office for getting parawise comments to the court case.

6. Liaise with the Govt. Counsel and brief him on complete facts of the case and the relevant Rule position on the subject, to enable him defend the case in the best interest of the UOI.

7. Get the counter-reply prepared from the Govt. Counsel at the earliest.

8. Examine the draft counter-reply prepared by the Govt. Counsel.

9. Transmit the same back to the concerned office.

10. On the receipt of counter reply duly signed by the competent officer file the same in the court through the Govt. Counsel.

11. Detail representative to attend the court on every date of hearing and intimate the outcome of hearing to the concerned office and HQrs. Office trough Fax. /E-mail.

12. Procure a copy of the judgement and transmit the same to the concerned office and HQrs. Office along with the opinion of the Govt. Counsel regarding the feasibility of filing a review/appeal in the next higher court.

13. Obtain in writing from the Govt. Counsel a list of documents required to be produced in the court.

14. If notices are issued and handed over to the Govt. Counsel by the court pertaining to the DAD cases collect the same along with the letter of the Govt. Counsel and dispatch the same to the concerned Controller's office.

15. Update the list/register of court cases, regularly.


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