ANNEXURE

IN SUPPORT OF

SERIAL NO. - 1

Indian Association of Preventive & Social Medicine
UP UK Chapter
Head Office: Department of Community Medicine,
Muzaffarnagar Medical College, Muzaffarnagar
Mobile: +91-9759585668, +91-9411311561, Fax : 01396-252703
Email: secretaryiapsmupuk@gmail.com ; Website: www.iapsmupuk.org

AGENDA & MINUTES

GENERAL COUNCIL MEETING OF IAPSM UPUK - BAREILLY

Department of Community Medicine, SRMS IMS, Bareilly.
(15th Oct' 2016; 05:00 PM to 06:30 PM)

1. Welcome to all the members of General Council by Secretary.
2. **Tribute to -**
   - **a)** (Late) Prof. V. P. Shrotriya Sir
   - **b)** (Late) Dr. Harshvardhan (PG-II), SNMC Agra

3. IAPSM Flag Salutation and IAPSM Prayer : Held before GBM.
4. Confirmation of the minutes of the Governing Council Meeting (ECM) held at SRMS, Bareilly, U.P. on 15th May' 2016. **PASSED**
5. Confirmation of the minutes of Third Mid Term Governing Council Meeting (ECM) held at MMC, Muzaffarnagar, U.P. on 8th May' 2016. **PASSED**
6. Confirmation of the minutes of last General Council Meeting (GBM) held at BRD Medical College, Gorakhpur, U.P. on 9th Oct' 2015. **PASSED**
7. IJCH & Head Quarters' account Audited Report. **PASSED**
8. Status of transfer of fund of Rs 10,000 towards the contribution to IAPSM UPUK HEAD QUARTER from the host of IAPSM UPUK CON-2013 held at MLB Medical College, **Jhansi.**

   - **It was decided unanimously that PROF. V. K SRIVASTAVA will talk to Dr. B. P. Mathur (Organizing Secretary of IAPSM UPUK CON held at Jhansi) in this regard to settle the issue. Dr. V. K. Srivastava also agreed and consented to settle the 4-year-old issue.** **PASSED**

9. **JOURNAL RELATED:** Letter of reconsideration of our earlier demand to the newly elected National President & Secretary General of IAPSM & request them to make way for minute amendment in the national constitution of IAPSM for endorsement of IJCH as its one of the official journal incorporating that "IJCH is one of the official journal of IAPSM & the responsibility of its publication is being given to IAPSM UPUK". **PASSED**

10. **HOST OF NEXT CONFERENCE:** Only one application was received by the Secretary and that was from **Dr. Pankaj Jain (Prof. & Head) Department of Community Medicine, UPRIMS & R Saifai.** This application was forwarded and recommended by their Director too. His application was approved by all present over there. Dr. Pankaj Jain thanked the Governing & General Council for giving this opportunity and showing trust on him. **PASSED**

11. **ELECTION NOMINATIONS & CONFERENCE PROPOSAL: 2018 – 2019.**
It was decided that the last date for submission of the following be fixed –

(1) Letter of proposal for hosting the next conference in 2018 &
(2) Elections for the various vacant post of Governing Council - IAPSM UPUK

Last date of receiving such proposal/ nominations = 31st August 2017
Last date of withdrawal = 10th Sept 2017

PASSED

12. **ANY OTHER MATTER WITH THE PERMISSION OF THE CHAIR:**
Prof. Uday Mohan raised an issue with the permission of the Chair that there should be election for the post of President every year like that of the National President.

- In response to this issue house was initially divided. The Secretary of IAPSM UPUK and President emphasized and cleared their views on the need of current rule to be continued as mentioned in the constitution of IAPSM UPUK. The Chairman of the IAPSM UPUK's constitution committee Prof. J. V. Singh also laid down his view as to why the Organizing Secretary or any member from the Organizing Committee of the conference be nominated as the President by default. Later on after thorough discussion it was decided by the majority that the current rule should persist as per the constitution of IAPSM UPUK and the proposal was disapproved. **PASSED**

13. DECISION OF THE CHIEF ELECTION OFFICER:

Prof. J. V. Singh (Chief Election Officer) announced the status/ result of the screening/ elections held on various post of Governing Council. He informed the house about the number of nominations and their status after scrutiny and finally the result of the Newly Elected Governing Council for the next tenure as per the constitution of IAPSM UPUK. **PASSED**

Newly Elected Governing Council (1st April 2017 – 31st March 2018)			
Sl. No.	**Name**	**Designation**	**Institute**
1	Dr. S. B. Gupta	President	SRMSIMS, Bareilly
2	Dr. Manish K Singh	IPP	BRDMC, Gorakhpur
3	Dr. Pankaj Jain	Vice- President	UPIMS & R, Saifai
4	Dr. Khursheed Muzammil (IInd Consecutive Term)	Secretary (01/04/17 to 31/03/2020)	MMC Muzaffarnagar
5	Dr. Shaili Vyas	Joint Secretary (01/04/17 to 31/03/2020)	HIMS, Dehradun
6	Dr. Ashok Srivastava	Treasurer (01/04/17 to 31/03/2020)	HIMS, Dehradun
7	Dr. Pradeep Aggarwal (IInd Consecutive Term)	Chief Editor (01/04/17 to 31/03/2020)	HIMS, Dehradun
UTTAR PRADESH			
1	Dr. Harsh Mahajan	EC Member	SMSR, SU, Greater Noida
2	Dr. Sumit Saxena	EC Member	SRMSIMS, Bareilly
3	Dr. Ali Jafar Abedi	EC Member	JNMCH, AMU Aligarh
4	Dr. Arun Singh	EC Member	RMCH, Bareilly
5	Dr. Shalini Srivastav	EC Member	SMSR, SU, Greater Noida
6	Dr. Rashmi Katyal	EC Member	RMCH, Bareilly
UTTARAKHAND			
7	Dr. Richa Sinha	EC Member	GDMC Dehradun
8	Dr. Mehar Bano	EC Member	GMC Haldwani
9	Dr. Deep Shikha	EC Member	HIMS Dehradun

(**Note:** It was proposed by Chief Election Officer that Dr. Renu Agarwal - SNMC Agra and Dr. Ajay K. Agarwal – RMCH bareilly may be considered for

the election of EC member next year as the nomination process was completed after the dead line – **GBM approved it.)** **PASSED**

14. Vote of thanks by the Secretary:

A total of 30 General Council Members were present in the meeting (Attendance list is attached). Meeting ended at 06:30 PM. All the members present over there appreciated the target accomplished by the Governing Council set during the Mid-Term Governing Council held at MMC Muzaffarnagar on 08th May 2016. The Secretary with the help of inputs from President & Chief Editor – IJCH finally prepared the minutes to keep it in the record. The minutes of the meeting were later on verified by the President and uploaded by Chief Editor – IJCH on official website of IAPSM UPUK (**www.iapsmupuk.org**) and sent for publication in December issue of IJCH for wider circulation.

21-1-2017

President
IAPSM - UP UK

20/01/17

Secretary
IAPSM - UP UK

ANNEXURE

IN SUPPORT OF

SERIAL NO. - 2

SRMS
Institute of
Medical
Sciences, Bareilly

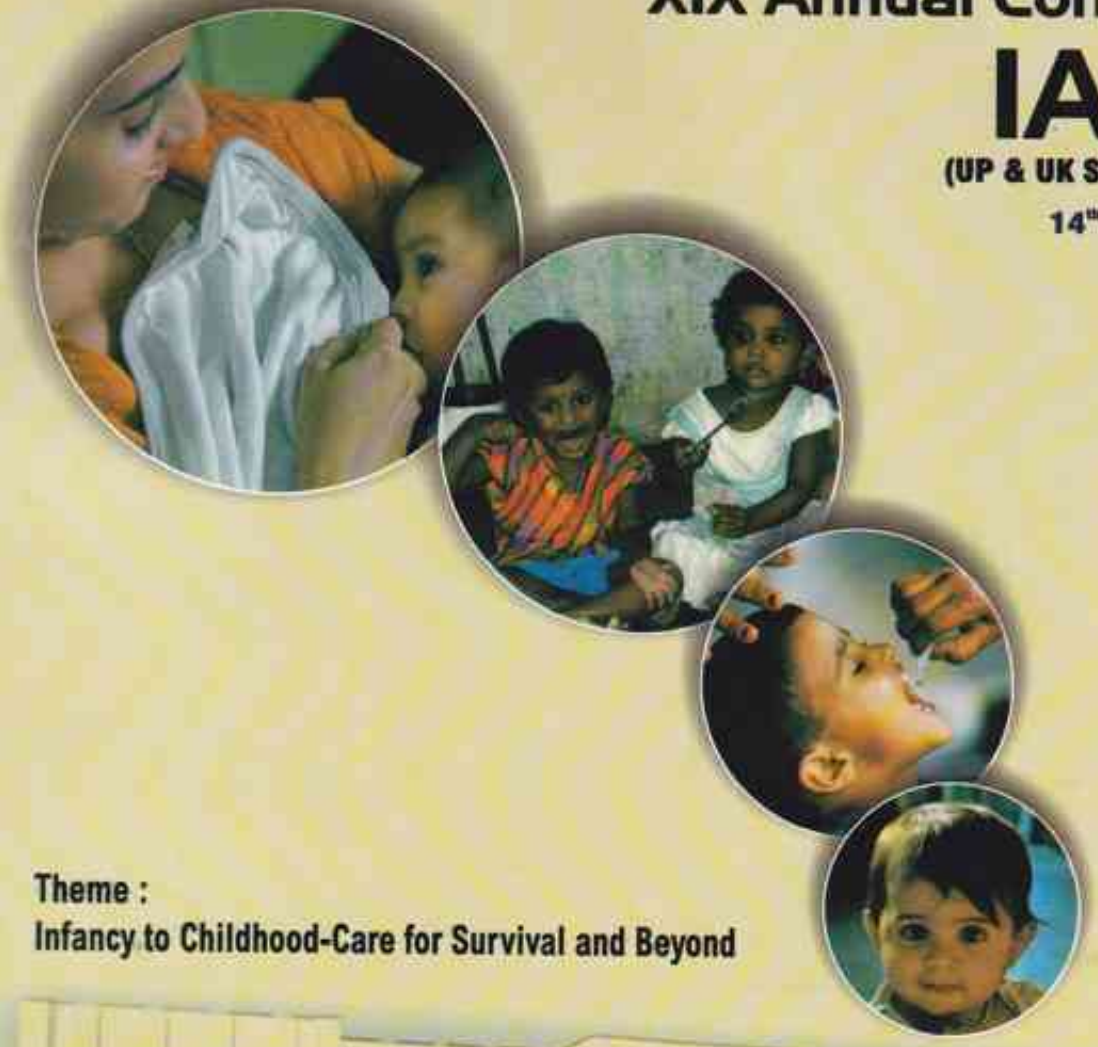
unicef
unite for children

XIX Annual Conference of

IAPSM

(UP & UK STATE CHAPTER-2016)

14th - 16th October, 2016



Theme :
Infancy to Childhood-Care for Survival and Beyond

Organised by :

Department of Community Medicine
Shri Ram Murti Smarak Institute of Medical Sciences
Bareilly (U.P.) INDIA

SOUVENIR


IAPSMCON UP & UK-2016
Annual Conference of IAPSM
UP & UK STATE CHAPTER
"Infancy to Childhood-Care for Survival and Beyond"
Department of Community Medicine
Shri Ram Murti Smarak
Institute of Medical Sciences, Bareilly (U.P.)


SRMS
Institute of
Medical
Sciences, Bareilly
IAPSMCON UP & UK-
XIX Annual Conference of IA
(UP & UK STATE CHAPTER)
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"Infancy to Childhood-Care for Survival and
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Department of Community Medicine
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Institute of Medical Sciences, Bareil


SRMS
unicef
IAPSMCON UP & UK-2016
XIX Annual Conference of IAPSM
(UP & UK STATE CHAPTER)
14th - 16th October, 2016
"Infancy to Childhood-Care for Survival and Beyond"

XVIII
Annual Conference
IAPSM UP & UK State Chapter

9th - 10th October, 2015

unicef

Being Born ... To Giving Birth

Strategies & Challenges

SOUVENIR

Organised by

Department of Community Medicine

BRD Medical College, Gorakhpur, UP


XVIII
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IAPSM UP &
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9th - 10th October, 2015
Being Born ...
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Star Night
Star Nig

XVII[th] Annual Conference of

IAPSM

UP UK State Chapter

7[th] - 8[th] November 2014

Theme

Newborn Survival : Challenges & Strategies

Souvenir

Organised by

Department of Social & Preventive Medicine

S. N. Medical College, Agra


unicef
XVII Annual Conference of IAPSM - UP & UK Chapter 2014
7th & 8th November 2014
Newborn Survival: Challenges and Strategies
Organised by:
Department of Social and Preventive Medicine, S. N. Medical College, Agra
Supported by:
UNICEF, Uttar Prade


Annual Conference of IAPSM - UP & UK Chapte
7th & 8th November 2014
Survival: Challenges and Strategies
Organised by:
Supported by:
UNICEF, Uttar Pradesh


unicef
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7th & 8th November 2014
lewborn Survival: Challenges and Strategies


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Organised by:
Preventive Medicine, S. N. Medical College, Agra
Supported by:
UNICEF, Uttar Pradesh

ANNEXURE

IN SUPPORT OF

SERIAL NO. - 3

Indian Association of Preventive & Social Medicine
UP UK Chapter
Head Office: Department of Community Medicine,
Muzaffarnagar Medical College, Muzaffarnagar
Mobile: +91-9759585668, +91-9411311561, Fax : 01396-252703
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AGENDA & MINUTES

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9. **JOURNAL RELATED:** Letter of reconsideration of our earlier demand to the newly elected National President & Secretary General of IAPSM & request them to make way for minute amendment in the national constitution of IAPSM for endorsement of IJCH as its one of the official journal incorporating that "IJCH is one of the official journal of IAPSM & the responsibility of its publication is being given to IAPSM UPUK". **PASSED**

10. **HOST OF NEXT CONFERENCE:** Only one application was received by the Secretary and that was from **Dr. Pankaj Jain (Prof. & Head) Department of Community Medicine, UPRIMS & R Saifai.** This application was forwarded and recommended by their Director too. His application was approved by all present over there. Dr. Pankaj Jain thanked the Governing & General Council for giving this opportunity and showing trust on him. **PASSED**

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Last date of withdrawal = 10th Sept 2017

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- In response to this issue house was initially divided. The Secretary of IAPSM UPUK and President emphasized and cleared their views on the need of current rule to be continued as mentioned in the constitution of IAPSM UPUK. The Chairman of the IAPSM UPUK's constitution committee Prof. J. V. Singh also laid down his view as to why the Organizing Secretary or any member from the Organizing Committee of the conference be nominated as the President by default. Later on after thorough discussion it was decided by the majority that the current rule should persist as per the constitution of IAPSM UPUK and the proposal was disapproved. **PASSED**

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5	Dr. Shaili Vyas	Joint Secretary (01/04/17 to 31/03/2020)	HIMS, Dehradun
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(**Note:** It was proposed by Chief Election Officer that Dr. Renu Agarwal - SNMC Agra and Dr. Ajay K. Agarwal – RMCH bareilly may be considered for

the election of EC member next year as the nomination process was completed after the dead line – **GBM approved it.**) **PASSED**

14.Vote of thanks by the Secretary:

A total of 30 General Council Members were present in the meeting (Attendance list is attached). Meeting ended at 06:30 PM. All the members present over there appreciated the target accomplished by the Governing Council set during the Mid-Term Governing Council held at MMC Muzaffarnagar on 08th May 2016. The Secretary with the help of inputs from President & Chief Editor – IJCH finally prepared the minutes to keep it in the record. The minutes of the meeting were later on verified by the President and uploaded by Chief Editor – IJCH on official website of IAPSM UPUK (**www.iapsmupuk.org**) and sent for publication in December issue of IJCH for wider circulation.

21-1-2017

President
IAPSM - UP UK

20/01/17

Secretary
IAPSM - UP UK

(3)

Indian Association of Preventive & Social Medicine

UP UK Chapter

Head Office: Department of Community Medicine, Muzaffarnagar Medical College, Muzaffarnagar

Mobile: +91-9759585668, +91-9411311561, Fax: 01396-252703

Email: secretaryiapsmupuk@gmail.com ; Website: www.iapsmupuk.org

ATTENDEES Of The General Council Meeting of IAPSM UPUK

Department of Community Medicine, SRMS Medical College, Bareilly (15th Oct 2016 at 05:00 PM onwards)

S. No.	Name of the participants	Designation	Institute	E-mail ID	Whats App No./ Mobile No.
1	Dr Jai Prakash Singh	Assistant Prof.	SRMS IMS, Bareilly	[illegible]@rediffmail.com	9458701813
2	DR. S. K. Garg	Prof & Head	LLRM MC, Meerut	drgargfam@rediffmail.com	9412837112
3	Dr V. K. Srivastava	Prof & Head	Com Med, HIMS Lko	vinods5[illegible]@hotmail.c	9415101085
4	Dr Shiv Prakash	Prof & Head	MLNMC Allahabad	[illegible]@gmail.com	8004158839
5	Dr R. P. Sharma	Prof & Head	GSVM Med College, Kanpur	dr_sharmarp@yahoo.in	9839074338
6	Dr Arun Kumar	Associate Prof	LLRM Medical College, Meerut		
7	JAI VIR SINGH	Professor	MZN Med College, Muzaffarnagar	drjaivir[illegible]@gmail.com	9411093573
8	SANJEEV KUMAR	A P	LLRM MC Meerut	9412663094	
9	Dr Mukesh Sharma	Assoc Prof	TMMC & RC, Moradabad	[illegible]@gmail.com	9458410031
10	Dr SK Singh	Professor	KGMU, Lko	[illegible]@gmail.com	9412705107
11	Dr. M. A. Hassan	Professor	MRA Medical college Ambedkar Nagar	hassan_aminul@rediffmail.com	9415206073 9415816929
12	Dr Ratan K. Srivastava	Professor	IMS, BHU, Varanasi	ratanpsm@gmail.com	9889665528
13	Dr Harivansh Chopra	Professor	LLRM MC, Meerut	harichopra@gmail.com	9412529800
14	Dr [illegible] Jain	[illegible]	UPUMS Saifai	DrPankaj[illegible]@yahoo.com	9756[illegible]47[illegible]
15	Dr SK Gupta	Professor	UPUMS Saifai	sham.gupta@yahoo.com	7055605104
16	Dr. Peeyush Kariwal	Asst Prof.	UPUMS Saifai	peeyushkariwal@yahoo.com	9639990876
17	Dr. Aravind Kumar Singh	Asst Prof.	MRA Med. College, Ambedkar Nagar	[illegible]aravind2000@gmail.com	9412705129
18	Dr Pawan Kumar Goel	Professor	SHKM Govt. Medical college Mewat	drpkgoelbobby@rediffmail.com	8059505853
19	Dr Anurag Srivastava	Professor	TMMC & RC, Moradabad	dranurag[illegible]@yahoo.co	9415061563
20	DR. Nadeem Ahmad	Prof & HOD	IIMSR, Integral Univ. LKO	drnadeem[illegible]1976@gmail.com	8125909970

21	Dr. Shaili Vyas	Assoc prof	HIMS Dehradun	Shailivyas7@gmail.com	9758130862
22	Dr RAKESH KAKKAR	PROFESSOR	— " —	drrakesh75@rediffmail.com	9927343064
23	Dr JAYANTI SEMWAL	PROFESSOR & HEAD	HIMS, Dehradun	Semwal@hotmail.com	94120087[illegible]
24	Dr C.P. Mishra	Professor	Deptt of Community Medicine, IMS, BHU.	drcpmishra	8004764981
25	Dr Shalini Srivastava	Assoc. Prof.	Dept. of Community Medicine	shalini.srivastava@sharda.ac.in SMSR, Sharda University	9599790219
26	Dr Harsh Mahajan	Asst Prof	SMSR Sharda University	harsh2709@gmail.com	9971215210
27	Dr S.B. Gupta	Prof & Head	Deptt of C.M, SRMS IMS	dr_sbgupta@rediffmail	9415030071
28	Dr Uday Mohan	Prof	Com Med, KGMU, Bareilly	drudaymohan@yahoo.com	9415408926
29	Dr S C Gupta	Professor	Comm Med FH Medical College Tundla	scguptaspm@gmail.com	9917611110
30	Dr Pradeep Aggarwal	Assoc Prof	HIMS Dehradun	drpradeep.aggarwal@hotmail	9837215757
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PRESIDENT (IAPSM UPUK)

SECRETARY (IAPSM UPUK)

Indian Association of Preventive & Social Medicine
UP UK Chapter
Head Office: Department of Community Medicine,
Muzaffarnagar Medical College, Muzaffarnagar
Mobile: +91-9759585668, +91-9411311561, Fax : 01396-252703
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AGENDA & MINUTES

GOVERNING COUNCIL MEETING OF IAPSM UPUK - BAREILLY

Deparment of Community Medicine, SRMS IMS, Bareilly.
(15th Oct' 2016; 03:00 to 04:00 PM)

1. Welcome to all the members of General Council by Secretary.
2. **Tribute to -**
   - **a)** (Late) Prof. V. P. Shrotriya Sir
   - **b)** (Late) Dr. Harshvardhan (PG-II), SNMC Agra
3. Confirmation of the minutes of last General Council Meeting (GBM) held at BRD Medical College, Gorakhpur, U.P. on 9th Oct' 2015. **PASSED**
4. Confirmation of the minutes of Third Mid Term Governing Council Meeting (ECM) held at MMC, Muzaffarnagar, U.P. on 8th May' 2016. **PASSED**
5. Our Head Quarters' account balance status & Audited Report.
   In the absence of Treasurer Dr. Khursheed (Secretary) presented the report including details of the account balance and expenditure. **PASSED**
6. IJCH account balance status & Audited Report. Dr. Pradeep Aggarwal (Chief Editor – IJCH) presented the report including details of the account balance and expenditure). **PASSED**
7. Status of transfer of fund of Rs 10,000 towards the contribution to IAPSM UPUK HEAD QUARTER from the host of IAPSM UPUK CON-2013 held at MLB Medical College, **Jhansi.**

   - **It was decided that some senior member should be given the responsibility to talk to Dr. B. P. Mathur (Organizing Secretary of IAPSM UPUK CON held at Jhansi) to settle the issue.**

   PASSED

8. **JOURNAL RELATED:** Letter of reconsideration of our earlier demand to the newly elected National President & Secretary General of IAPSM & request them to make way for minute amendment in the national constitution of IAPSM for endorsement of IJCH as its one of the official journal incorporating that "IJCH is one of the official journal of IAPSM & the responsibility of its publication is being given to IAPSM UPUK". **PASSED**

9. **NEXT CONFERENCE:** Only one application was received by the Secretary and that was from Dr. Pankaj Jain (Prof. & Head) Department of Community Medicine, UPRIMS & R Saifai. This application was forwarded and recommended by their Director too. His application was approved by all present in the Governing Council Meeting and forwarded to GBM for approval. **PASSED**

10. **ELECTION NOMINATIONS & CONFERENCE PROPOSAL: 2018 – 2019**

It was decided that the last date for submission of the following be fixed –

(1) Letter of proposal for hosting the next conference in 2018 &
(2) Elections for the various vacant post of Governing Council - IAPSM UPUK

Last date of receiving such proposal/ nominations = 31st August 2017
Last date of withdrawal = 10th Sept 2017 **PASSED**

11. **CERTIFICATE OF APPRECIATION:**

The nodal person of all the colleges for various health event observations in 2016 were appreciated for their efforts/ contribution and a certificate of appreciation has to be given to them. **PASSED**

12. **ANY OTHER MATTER WITH THE PERMISSION OF THE CHAIR:**

Dr. Anurag Srvastava (Joint Secretary) suggested to have a committee named Health Promotion Committee to work for Health Promotion related activities. It was decided unanimously to constitute the same as follows - **Health Promotion Committee:** (5 members)

- **Chairman (HPC)**: Dr. Manish Singh
- **Secretary (HPC)**: Dr. Anurag Srivastava
- **Members (HPC)**: Dr. H. S. Joshi, Dr. Pradeep Aggarwal, Dr. Khursheed

PASSED

13. Vote of thanks by the Secretary.

A total of 08 Governing Council Members were present in the meeting namely Dr. Manish Singh (President), Dr. H. S. Joshi (Vice-President), Dr. Khursheed Muzammil (Secretary), Dr. Anurag Srivastava (Joint Secretary), Dr. Pradeep Aggarwal (Chief Editor), Dr. Mukesh Sharma (EC Member), Dr. J. P. Singh (EC Member) and Dr Shaili Vyas (EC Member). Dr. Ajay Agarwal was observing the meeting that went smoothly. Dr. Ruch Juyal (Treasurer) informed the Secretary through e-mail about his inability to attend the meeting due to personal reasons. Meeting ended at 04:00 PM. Those who were present in the meeting were anxious on the poor attendance of the Executive Members. The Secretary with the help of inputs from President & Chief Editor – IJCH finally prepared the minutes to keep it in the record. The minutes of the meeting were later on verified by the President and uploaded by Chief Editor – IJCH on official website of IAPSM UPUK (**www.iapsmupuk.org**) and sent for publication in December issue of IJCH for wider circulation.

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Department of Community Medicine, SRMS Medical College, Bareilly (15th Oct 2016 at 02:30 PM onwards)

S. No.	Name of the participants	Designation	Institute	e-mail ID	Mobile No.
1	Dr. Shaili Vyas	Assoc. Professor.	HIMS Dehradun	shailivyas7@gmail.com	9759135362
2	Dr Pradeep Aggarwal	Assoc Professor	HIMS Dehradun	drpradeep aggarwal@hotmail.com	9837215757
3	Dr H.S. Joshi	Prof & Head	RMCH Bareilly	drjoshiharish@rediffmail.com	9415833751
4	Dr Anurag Srivastava	Prof. & Head	TMMC&RC Moradabad	dranurag73@yahoo.co.in	9415061563
5	Dr Mukesh Sharma	Assoc. Professor	TMMC & RC Moradabad	sharma.mukesh[illegible]@gmail.com	9927051107
6	Dr J.P. Singh	Assistant Prof.	SRMS IMS Bareilly	drjpsingh0001@rediffmail.com	9458701813
7	Dr Ajay Kumar Agarwal	Assistant Prof	R.M.C.H. Bareilly	drajayagarwal0@[illegible]mail.com	9412603109
8	Dr Manish Kumar Singh	Asst. Prof	B.R.D Medical College	drmanishsc hmc@yahoo.co.in	9005435789
9	Dr. Khursheed [illegible] Tyagi	~~Asstt~~ Prof	MMC MZN	[illegible]25@yahoo.com	9759585668.
10					
11					
12					
13					
14					
15					
16					
17					
18					

Total = 09

PRESIDENT
IAPSM UPUK

SECRETARY
IAPSM UPUK

Indian Association of Preventive & Social Medicine
UP UK Chapter
Head Office: Department of Community Medicine,
Muzaffarnagar Medical College, Muzaffarnagar
Mobile: +91-9719585668, +91-9411111561, Fax: 01396-252701
Email: [illegible] Website: www.iapsmupuk.org

MINUTES

THIRD MID-TERM GOVERNING COUNCIL MEETING OF IAPSM UPUK - MUZAFFARNAGAR

Department of Community Medicine, MMC, Muzaffarnagar

(8th May 2016; 02:00 PM – 04:30 PM)

1. Welcome to all the members of Governing Council by Secretary.
2. Tribute to **(Late) Prof. Ved Prakash Shrotriya (L-0078)**
3. Confirmation of the minutes of last General Council Meeting (GBM) held at BRD Medical College, Gorakhpur, U.P. on 9th Oct' 2015. - **PASSED**
4. Our Head Quarters' account balance status. - **PASSED**
5. Status of transfer of fund from the host of IAPSM UPUK CON-2013 held at MLB Medical College, **Jhansi** and IAPSM UPUK CON-2015 at **Agra.** - **First reminder to be sent requesting for the transfer of Rs. 10,000 as part of their contribution towards IAPSM UPUK as per the constitution of IAPSM UPUK and in case of a negative balance audited report of the conference be sought.** **PASSED**

Dr. Manish Kumar Singh (President)

Dr. Khursheed Muzammil (Secretary)

6. **Journal Related:** Letter to be sent to the newly elected National President & Secretary General of IAPSM, requesting them to make way for minute amendment in the national constitution of IAPSM for endorsement of IJCH as its one of the official journal incorporating that "IJCH is one of the official journal of IAPSM & the responsibility of its publication is being given to IAPSM UPUK". - **PASSED**

7. Election Related (For 2017-2018): Nominations to be invited for **Secretary/VP/ ECM/ Chief Editor as per our constitution**: Last date of nominations and date of withdrawal be fixed.
   Last date of nomination is 30th August 2016.
   Last date for withdrawal of nomination is 10th September 2016.
   All election related communications (nomination/withdrawal) will be made at - secretaryiapsmupuk@gmail.com **PASSED**

8. Nomination of **Chief Election Officer** for smooth conduction of election process. - **Dr. (Prof.) J. V. Singh (Muzaffarnagar) will be the Chief Election Officer and is entrusted to build his team. Decision of the Chief Election Officer will be final.** **PASSED**

9. **Conference Related:** Last date for submission of letter of proposal as per norms for hosting the next conference in 2017 be fixed.
   Last date of submission of letter of proposal for hosting the next conference in 2017 is 30th August 2016. **PASSED**

10. Finalization of nominations for 02 **Prof. Deoki Nandan Life Time Achievement Award** as per norms.

    a) **(Late) Prof. Ved Prakash Shrotriya (L-0078)** **PASSED**
    b) **Prof. Zulfia Khan (L-0534)** **PASSED**

Dr. Manish Kumar Singh (President)

Dr. Khursheed Muzammil (Secretary)

11. Finalization of **Prof. B. G. Prasad Oration Award.**

Prof. V. K. Srivastava **PASSED**

12. Place, Dates and Registration Fee for next IAPSMCON UP & UK IN 2017:

1) It was decided that the expression of interest for hosting the IAPSM CON 2017 be collected as per the existing norms. The **last date for receiving such nominations** has been fixed as the **30th August 2016 & the last date of withdrawal will be 10th Sept 2016.** **PASSED**

2) The **Registration Fee** has been fixed as follows- **PASSED**

REGISTRATION DETAILS	
CATEGORY	AMOUNT (INR)
Preconference Workshop	1000
CONFERENCE (EARLY BIRD)	
IAPSM LIFE MEMBERS	2500
IAPSM NON MEMBERS	3000
PG STUDENT	2000
ACCOMPANYING PERSON	1500
CONFERENCE (AFTER THE LAST DATE OF EARLY BIRD)	
IAPSM LIFE MEMBERS	2700
IAPSM NON MEMBERS	3200
PG STUDENT	2200
ACCOMPANYING PERSON	1500
CONFERENCE (SPOT REGISTRATION)	
IAPSM LIFE MEMBERS	3000
IAPSM NON MEMBERS	3500
PG STUDENT	2500
ACCOMPANYING PERSON	1500

13. To establish from now onwards a corpus fund for academic activities: It had already been suggested and passed by all the Governing Council members during the Mid Term Meeting at Bareilly and subsequently passed in the GBM at Gorakhpur that a sum of **INR 100 per conference registration** in addition to the already existing norms of minimum INR 10,000/- be deposited to the associations account by the organizing secretary of the conference within 3 months of the conference.

INR 100 per registration has to be deposited to the Secretary/Treasurer of IAPSM UPUK before conduction of GBM on day-1 of the conference and

Dr. Manish Kumar Singh (President) Dr. Khursheed Muzammil (Secretary)

their contribution of INR 10, 000/- towards IAPSM UPUK has to be deposited within 03 months of the conference.

PASSED

14. Any other matter with the permission of the President.

A. **Celebration of Health Days especially –**

a) World TB day
b) World Rabies Day
c) World Breast Feeding Week
d) World AIDS Day
e) World Health Day **PASSED**

B. **Online Courses Commencement** – Dr. Manish Kumar Singh (President) will look into the matter in its design and modalities and will build the team to coordinate it. **PASSED**

C. **Manual Committee** – to have a uniform practical manual in all the Departments of Community Medicine in IAPSM UPUK Chapter. Dr. Manish Singh – President, will be the Chairman of this committee & will select the members of the committee to have this agenda accomplished. **PASSED**

D. **Website Updation Committee –**

a) Dr. Pradeep Aggarwal (Chairman)
b) Dr. Rakesh Kakkar
c) Dr. Manish Kumar Singh
d) Dr. Arvind Kumar Singh
e) Dr. Khursheed Muzammil **PASSED**

E. **Indexing of IJCH:** PubMed indexing related matter – Chief Editor & Editor to speed up the matter and complete the process. **PASSED**

F. **Best Thesis Award:** Mechanism to be developed to award "Best Thesis Award" for all the thesis work in Community Medicine submitted in a particular year. Secretary to develop such mechanism to have maximum transparency. **PASSED**

Dr. Manish Kumar Singh (President)

Dr. Khursheed Muzammil (Secretary)

15. Vote of thanks by the Secretary.

The meeting started under the chairmanship of our President Dr. Manish Kumar Singh at 02:00 pm and ultimately ended at 04:30 p.m. with vote of thanks by the Secretary to all the members for attending the 3rd Mid Term Governing Council Meeting in a cordial manner. Everyone appreciated the hospitality provided by Dr. J. V. Singh (HOD, Community Medicine, MMC Muzaffarnagar). Out of the 16 Governing Council Members, a total of 05 members were present in the meeting namely - **Dr. Manish Kumar Singh (President), Dr. Khursheed Muzammil (Secretary), Dr. Anurag Srivastava (Joint Secretary), Dr. Pradeep Aggarwal (Chief Editor) and Dr. Mukesh Sharma (EC Member).** The remaining 11 Governing Council members could not attend the meeting because of their some personal problems. They all informed the Secretary well before the start of the meeting by e-mail.
The proposal of contribution of worth INR 15000/- by Chief Editor/ IJCH Team for encouraging the Finalist of the State Level Quiz was appreciated by all the Governing Council Members present in the meeting. Their proposal was already accepted by President/ Secretary beforehand. A Cheque of Rs. 2000/ head for the winning team and Rs. 1000/ head for the rest of the team members was handed over to the team members during the Prize distribution ceremony along with a Play card of the Cheque. The Secretary finally prepared the minutes to keep it in the record. The minutes of the meeting have been verified by the President.

President
IAPSM - UP UK

Dr. Manish Kumar Singh (President)

Secretary
IAPSM - UP UK

Dr. Khursheed Muzammil (Secretary)

ANNEXURE

IN SUPPORT OF

SERIAL NO. - 4

IAPSM-WHD-QUIZ : 2016

State/Zone Summary Report : Form No. 2

Name of the State/zone: **IAPSM UPUK STATE CHAPTER**

Total number of Medical Colleges in the State/zone: __**33**__ **(Functional)**

Total Number of Medical College where event held: __**21** __

Sr. No.	Name of the Institute	Form no. 1 received Yes/No	Photo received Yes/No	Brief narrative Report received. Yes/No
1.	BRD MEDICAL COLLEGE GORAKHPUR, U.P.	**NO**	**YES**	**NO**
2.	IMS, BHU, VARANASI, U.P.	**YES**	**YES**	**YES**
3.	MLN MEDICAL COLLEGE, ALLAHABAD, U.P.	**YES**	**YES**	**YES**
4.	MAGMC, AMBEDKAR NAGAR , U.P.	**YES**	**YES**	**YES**
5.	FHMCH, TUNDLA, U.P.	**YES**	**YES**	**YES**
6.	JNMCH, AMU, ALIGARH, U.P.	**YES**	**YES**	**YES**
7.	LLRM MEDICAL COLLEGE, MEERUT, U.P.	**YES**	**YES**	**YES**
8.	SMSR, SHARDA UNIVERSITY, GREATER NOIDA, U.P.	**YES**	**YES**	**YES**
9.	MMC, MUZAFFARNAGAR, U.P.	**YES**	**YES**	**YES**
10.	TM MEDICAL COLLEGE, MORADABAD, U.P.	**YES**	**YES**	**YES**
11.	RUHELKHAND MEDICAL COLLEGE, BAREILLY, U.P.	**YES**	**YES**	**YES**
12.	SRMSIMS, BAREILLY, U.P.	**YES**	**YES**	**YES**
13.	GSVM MEDICAL COLLEGE, KANPUR, U.P.	**YES**	**YES**	**YES**
14.	HIMS, JOLLY GRANT, DEHRADUN, UTTARAKHAND.	**YES**	**YES**	**YES**
15.	VCSGGMS&RI SRINAGAR, UTTARAKHAND.	**YES**	**YES**	**YES**
16.	GOVT. MEDICAL COLLEGE, HALDWANI UKD.	**YES**	**YES**	**YES**
17.	SMC, GHAZIABAD, U.P.	**YES**	**YES**	**YES**
18.	HIMS, BARABANKI, U.P.	**AWAITED**	**YES**	**AWAITED**
19.	INTEGRAL MEDICAL COLLEGE, LUCKNOW, U.P.	**AWAITED**	**YES**	**AWAITED**
20.	UPRIMS & R SAIFAI, ETAWAH, U.P.	**AWAITED**	**YES**	**AWAITED**
21.	AIIMS, RISHIKESH, UTTARAKHAND.	**AWAITED**	**YES**	**AWAITED**

Name of the State Coordinator: __**Dr. (Prof.) Khursheed Muzammil**__

Note: Please save the photos and report in the one folder with name **"Name of State _name of Institute_IAPSM_WHD_Report"** and share in one folder.

Please also share your qualitative feedbacks separately in "What were good", "What needs to be improved" based on lessons learnt from the experiences to make IAPSM-WHD-QUIZ better next time.

FEEDBACK FROM HEAD QUARTER OF IAPSM UPUK

What happened ?

Head Quarter of IAPSM with tremendous effort of the President- Prof. Ashok Mishra, Secretary General- Prof. A M Kadri, Dr. Bannerjee and the entire Quiz Team designed the whole event and ultimately got success in its implementation. They appointed the state level nodal coordinators for ease in dissemination of informations/ quiz related questions etc at college level. The college level nodal person/ HOD ultimately got the task done.

In our chapter i.e., IAPSM UPUK, we moved a step further and come up with a state champion team. For that we conducted online elimination round in all the 21 medical colleges participated in the college level champion round. Firstly, a trial round was conducted on 25th April to get accustomed with the online system and was very successful. A total 16 medical colleges ultimately participated on 30th April 2016 in 25 minutes online round containing 40 MCQs designed with the help of Dr. Bannrjee & Dr. A. M. Kadri. A competent team was formed to undergo this online elimination round under the able guidance of Dr. Rakesh Kakkar including the web designer of IAPSM UPUK- Shri Santosh Budhakoti. At last Final Round in its original Pattern was conducted at the State Head Quarter at MMC Muzaffarnagar with the Secretary itself being the Quiz Master. Out of the following four teams selected in the online elimination round, HIMS Dehradun ultimately declared as **STATE CHAMPION TEAM** –

1. BRD Medical College, Gorakhpur
2. GSVM Medical College, Kanpur
3. TMC Medical College, Moradabad
4. **HIMS, Jolly Grant, Dehradun.**

At the end, Prizes/ Trophies & Certificates were distributed to all the 12 finalist of the 04 teams. The State Champion team members were also honoured with a huge trophy and cheque worth INR 2000/- each and rest of the 09 participants with INR 1000/- each. This amount of INR 15000/- was sponsored

by the IJCH Editorial Team for which the Governing Council is thankful to them for their generous support.

So what ?

This was a wonderful experience as we had such activity for the very first time at All India level. Everybody concerned was very happy to have such PAN India level activity by IAPSM National Body under the able Guidance of Dr. Ashok Mishar (President) and Dr. A. M. Kadri (Secretary General) with technical expertise of Dr. Bannerjee & team. All the HODs/ Nodal Coordinators cooperated to the best of their capabilities. All the members realized that by undertaking such events we can strengthen our association many fold and can explore the leadership qualities of young faculty members.

What next ?

We should have similar activity for some other important health days also from now onwards. Conduction of such event will not only give our fraternity a recognition to NGOs but also develop a sense of trust which was lacking for too many years in fact. We should try to have State level championship and at last come up with National Champions. All the winners must be given free registration, TA/DA to attend our National Conferences and honoured in the inaugural ceremony of the conference. By doing all these we will generate enthusiasm among the students to do much better and opt our speciality as their career too. If possible some uniform IEC material or a token monitory aid be given to all those medical colleges/ concerned HODs/ Nodal Coordinators to affiliate the National Body/ Head Quarter directly with the event. This will create more realistic approach during the dialogue with the college administration. Time to time review of such events and feedback be taken to improve ourselves further. The best performing college in a state/ chapter and a best forming state/ chapter be given due recognition for healthy competition and increased enthusiasm.

DR. KHURSHEED MUZAMMIL
STATE COORDINATOR - WHD
&
SECRETARY – IAPSM UPUK

ANNEXURE

IN SUPPORT OF

SERIAL NO. - 5

IAPSM-WHD-QUIZ : 2016

STATE LEVEL WHD QUIZ - 2016

BRIEF REPORT

IAPSM took the initiative to organize a national level Quiz at college level on the occasion of World Health Day – 2016 for the first time in the history of our association. IAPSM UPUK moved a step further to have a state level quiz also to come up with a state champion team. In this regard, after the successful completion of the preliminary and online secondary screening round, a total of 04 teams ultimately entered the final. These teams were from –

1. **HIMS, Dehradun (STATE CHAMPION)**
2. **BRD Medical College, Gorakhpur**
3. **GSVM, Kanpur &**
4. **TMC Moradabad**

The state level quiz final was held at IAPSM UPUK HEAD QUARTER, MMC MUZAFFARNAGAR on 8th May 2016. **The winner team was from HIMS Dehradun**. All the finalist were awarded with certificates of appreciation and participation as the case may be. Prizes were distributed to the winners and runner ups. Cheques of handsome amount were also handed over to the winners from IJCH office bearers to motivate the students. It was a successful event and concluded by having the Third Mid term Governing Council Meeting.

DR. KHURSHEED MUZAMMIL
STATE COORDINATOR - WHD
&
SECRETARY – IAPSM UPUK

Dated: 10/05/2016

ANNEXURE

IN SUPPORT OF

SERIAL NO. - 6

Gmail **Secretary Iapsmupuk <secretaryiapsmupuk@gmail.com>**

BEST OBSERVATION OF WORLD AIDS DAY 2016

1 message

Dr Manish Kumar Singh <drmanishscbmc@yahoo.co.in> Fri, Jan 6, 2017 at 7:06 PM
Reply-To: Dr Manish Kumar Singh <drmanishscbmc@yahoo.co.in>
To: Jayanti Semwal <semwal@hotmail.com>, "drd.shikha@yahoo.co.in" <drd.shikha@yahoo.co.in>, Shri Prakash Singh <drspsingh1953@gmail.com>, Shri Prakash <drspsingh_vns@yahoo.com>, Ratan Srivastava <ratanpsm@gmail.com>, Dr Santosh Verma <drsantoshvermaspm@gmail.com>, "malhotra.anil_kumar" <malhotra.anil_kumar@yahoo.co.in>, "malhotra.anilkumar@yahoo.co.in" <malhotra.anilkumar@yahoo.co.in>, "conscious.richa@gmail.com" <conscious.richa@gmail.com>, "DR. Shiv Prakash" <shivprakashspm@gmail.com>, "Dr H. S. Joshi" <drjoshiharish@rediffmail.com>, Arun Singh <arunspm@gmail.com>, Jp Singh <jpsingh0001@rediffmail.com>, "Dr.S.B.Gupta(Prof)" <dr_sbgupta@rediffmail.com>, "Dr.Venkatashiva reddy.B" <dr.shiva222@gmail.com>, "hodpsmvcsg@rediffmail.com" <hodpsmvcsg@rediffmail.com>, Jp Srivastava <jp_srivastava07@rediffmail.com>, Mrinal Srivastava <dr.mrinal.srivastava@gmail.com>, Iqbal Mohammad <driqbalmkhan@gmail.com>, Seema Nigam <drseemagsvm@yahoo.co.in>, RP Sharma <dr_sharmarp@yahoo.in>, Amirul Hassan <hassan_amirul@rediffmail.com>, Arvind Singh <iamarvind2000@gmail.com>, Sadhana Awasthi <drsadhna1810@yahoo.com>, "shobha chaturvedi (Jaunpur)" <chaturvedirajesh@yahoo.com>, Shailendra Pratap Singh <shailup02@gmail.com>, Pradip Kharya <drpradipkharya@gmail.com>, Dinesh Singh Martolia <dr.martolia10@gmail.com>, Deepak Chopra <drdeepakchoprakgmu17@gmail.com>, Nadeem Ahmad <nadeemarman@rediffmail.com>, Ali Jafar Abedi <alijafarabedi@gmail.com>, Najam Khalique <najam_km@yahoo.com>, "Dr J. V. Singh Lucknow" <jvsingh510@rediffmail.com>, Prof JV Singh <jvsingh510@yahoo.com>, DR Reema Kumari <reema_tua05@yahoo.co.in>, Sanjeev Kumar <drsanjeev_cm@rediffmail.com>, Sunil Kumar Garg <drgargfam@rediffmail.com>, Khursheed Muzammil <drkmb25@yahoo.com>, Secretary Iapsmupuk <secretaryiapsmupuk@gmail.com>, Narendra Singh <narendra.singhv@gmail.com>, Amit Pawaiya <amtyyash@gmail.com>, Nagesh Seetharamiah <prof.nagesh@gmail.com>, Ranjana Singh <dr.ranjanaabhi@gmail.com>, "dr_kajal_jain@yahoo.ie" <dr_kajal_jain@yahoo.ie>, Sudhir Gupta <sudhirsarthak@rediffmail.com>, Anurag Srivastava <dranurag77@yahoo.com>, Mukesh Sharma <sharma.mukesh40@gmail.com>, Dr Pankaj Jain <drpankajjain@yahoo.com>, Vidya Rani <vidyarims@gmail.com>, Rahul Bansal <drrahulbansalzp@gmail.com>, "dr_varsha25@yahoo.co.in" <dr_varsha25@yahoo.co.in>, "J. V. Singh Sir Senior Head" <doctorjaivir@yahoo.co.in>, Pradeep Aggarwal <drpradeep_aggarwal@hotmail.com>, Sunil Misra <misrasunil66@gmail.com>, Suneel Kaushal <dr.suneel31@rediffmail.com>

Respected Sir / Madam

IAPSM & Health Education Committee- IAPSM is extremely grateful to you for your wholehearted support in the nationwide observance of World AIDS Day 2016.
The World AIDS Day was observed in about 215 medical colleges all across India.

As a part of the World AIDS Day 2016, 3 competitions were held for UG/ PG/Interns. This year there
was also a "Best Observation of World AIDS Day " Award for the college observing the World AIDS
day.

A total of 28 colleges from across UP and Uttarakhand observed the World AIDS Day 2016. From the
reports received 7 colleges are being awarded for the " Best Observation of World AIDS Day"

Please find as attachment the list of colleges that observed the World AIDS Day & the winners of the "Best Observation of World AIDS Day 2016". Also attached is the list of winners for "IAPSM UP & UK" of the 3 competitions.

Thanking you

With regards

Dr Manish Kumar Singh
President-IAPSM (UP & Uttarakhand)
Secretary -Health Education Committee-IAPSM

2 attachments

BEST OBSERVATION OF WORLD AIDS DAY 2016 FINAL.pdf
482K

WINNERS IAPSM UPUK.pdf
270K

WORLD AIDS DAY 2016
IAPSM UP & UK
"BEST OBSERVATION AWARD"

S. No	Name of College (Alphabetical Order)	Nodal Person	Head of Department, Community Medicine
1	Himalayan Institute of Medical Sciences, Dehradun	Dr Deepshikha	Dr Jayanti Semwal
2	IMS BHU, Varanasi	Dr Ratan Srivastava	Dr SP Singh
3	MLB Medical College, Jhansi	Dr Santosh Verma	Dr AK Malhotra
4	MLN Medical College, Allahabad	Dr Richa Mishra	Dr Shiv Prakash
5	Rohilkhand Medical College & Hospital, Bareilly	Dr Arun Singh	Dr HS Joshi
6	Sri Ram Murti Smarak Institute of Medical Sciences, Bareilly	Dr JP Singh	Dr SB Gupta
7	VCSGGIMS & R, Srinagar, Garhwal	Dr Venkat Shiva Reddy	Dr Amit Singh

(Dr Manish Kumar Singh)

President IAPSM UP UK

"WORLD AIDS DAY 2016"
IAPSM UP & UK
PARTICIPATING COLLEGES

S. No	Name of College (Alphabetical Order)	Nodal Person	Head of Department, Community Medicine
1	ERA'S Medical College, Lucknow	Dr Mrinal Srivastava	Dr JP Srivastava
2	FH Medical College, Tundla	Dr Panchsheel Sharma	Dr Mohd Iqbal Khan
3	GSVM Medical College, Kanpur	Dr Seema Nigam	Dr RP Sharma
4	Government Medical College, Ambedkarnagar	Dr Arvind Kumar Singh	Dr Amirul Hasan
5	Government Medical College, Haldwani	Dr RK Singh	Dr Sadhna Awasthi
6	Government Medical College, Jalaun	Dr Shailendra Pratap Singh	Dr Shobha Chaturvedi
7	Government Medical College, Kannauj	Dr Pradip Khariya	Dr DS Martolia
8	Himalayan Institute of Medical Sciences, Dehradun	Dr Deepshikha	Dr Jayanti Semwal
9	Institute of Medical Sciences, BHU, Varanasi	Dr Ratan Srivastava	Dr SP Singh
10	Integral Institute of Medical Science & Research, Lucknow	Dr Deepak Chopra	Dr Nadeem Ahmad
11	JNMC, AMU, Aligarh	Dr Ali Jafar Abdi	Dr Najam Khalique
12	King George Medical University, Lucknow	Dr Reema Kumari	Dr JV Singh
13	Lala Lajpat Rai Memorial Medical College, Meerut	Dr Sanjeev Kumar Singh	Dr SK Garg
14	MLB Medical College, Jhansi	Dr Santosh Verma	Dr AK Malhotra
15	MLN Medical College, Allahabad	Dr Richa Mishra	Dr Shiv Prakash
16	Muzaffarnagar Medical College, Muzaffarnagar	Dr Khursheed Muzammil	Dr JV Singh
17	Rama Medical College & Research Centre, Kanpur	----------	Dr Anju Gehlot
18	Rohilkhand Medical College & Hospital, Bareilly	Dr Arun Singh	Dr HS Joshi
19	Santosh Medical College, Ghaziabad	----------	Dr Narendra Singh
20	School of Medical Sciences and Research, Sharda University, Noida	Dr Amit Pawaiya	Dr S. Nagesh

"WORLD AIDS DAY 2016"
IAPSM UP & UK
PARTICIPATING COLLEGES

S. No	Name of College (Alphabetical Order)	Nodal Person	Head of Department, Community Medicine
21	Saraswati Institute of Medical Sciences, Hapur	----------	Dr Ranjana Singh
22	SGRR Institute Of Medical & Health Sciences, Dehradoon	Dr Kajal Jain	Dr Sudhir Gupta
23	Sri Ram Murti Smarak Institute of Medical Sciences, Bareilly	Dr JP Singh	Dr SB Gupta
24	Subharti Medical College, Meerut	Dr Varsha	Dr Rahul Bansal
25	Teerthankar Mahaveer Medical College, Moradabad	Dr Mukesh Sharma	Dr Anurag Srivastava
26	UP University of Medical Sciences, Saifai	Dr Vidya Rani	Dr PK Jain
27	Varun Arjun Medical College, Shahjahanpur	----------	Dr RK Pal
28	VCSGGIMS & R, Srinagar, Garhwal	Dr Venkat Shiva Reddy	Dr Amit Singh

(Dr Manish Kumar Singh)

President IAPSM UP UK

WINNERS IAPSM UP & UK

Activity	Winner Details	1st Prize	2nd Prize	3rd Prize
Essay Writing	Name	**Dr Kritika Tiwari**	**Dr Kriti Dwiwedi**	**Ms Prachi Tamta**
	MBBS Semester/ Intern/ PG YEAR INSTITUTE	PG RESIDENT (3rd Year) **Himalayan Institute of Medical Sciences, Dehradoon**	PG RESIDENT **MLN Medical College, Allahabad**	MBBS (2013-14 Batch) **Government Medical College Haldwani**
Poster Making	Name	**Ms Neha Bisht**	**Ms Vani Yadav**	**Ms Almas Fatima**
	MBBS Semester/ Intern/ PG YEAR INSTITUTE	MBBS (2015-16 Batch) **Government Medical College Haldwani**	MBBS (2013 Batch) **Himalayan Institute of Medical Sciences, Dehradoon**	MBBS (2013 Batch) **GSVM Medical College, Kanpur**
Slogan Writing	Name	**Arya Ankit**	**Rajeev Kumar**	**Mohd. Ziyauddin Ali Ansari**
	MBBS Semester/ Intern/ PG YEAR INSTITUTE	MBBS (2016 Batch) **Government Medical College Kannauj**	MBBS (2013 Batch) **MLN Medical College, Allahabad**	MBBS (2014 Batch) **Government Medical College, Jallaun**

(Dr Manish Kumar Singh)

President IAPSM UP UK

ANNEXURE

IN SUPPORT OF

SERIAL NO. - 7

SYMPOSIUM

ON

RECENT UPDATES ON LIFE STYLE FACTORS FOR PREVENTING NCDs


SYMPOSIUM
RECENT UPDATES ON LIFE STYLE
FACTORS FOR PREVENTING NCD'S
Date : 1st Aug' 2015
Time : 8 am - 5 pm
venue
Council Hall, SMC, Meerut


SYMPOSIUM
CENT UPDATES ON LIF STYL
FACTORS FOR PREVENTIN NCD
st Aug' 2015 Time pm
venue
ouncil Hall, SMC,
Organizer
artment of Com
i Medical Colle with
UP/UK/IAPSM


SYMPOSIUM
RECENT UPDATES ON LIFE STYLE
FACTORS FOR PREVENTING NCD'S
Date : 1st Aug' 2015
Time : 8 am - 5 pm
venue
Council Hall, SMC, Meerut


PHYSIOLOGY
SYMPOSIUM
RECENT UPDATES ON LIFE STYLE
FACTORS FOR PREVENTING NCD'S
Date : 1st Aug' 2015
Time : 8 am - 5 pm
venue
Council Hall, SMC, Meerut
Organized by
Department of Community Medicine
Subharti Medical College in association with
UP/UK/IAPSM State Branch
Registration Counter
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FACULTY
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REGISTRATIONS

WORKSHOP

ON

CRITICAL APPRAISAL OF PUBLISHED MEDICAL EVIDENCE: READING BETWEEN THE LINES

Registration Form

Name : ______________________________

Designation : ______________________________

College : ______________________________

Payment details : ______________________________

DD/Cheque/NEFT/Cash ______________________________

DD/Cheque No. : ______________________________

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WORKSHOP

Critical appraisal of published medical Evidence : Reading between the lines

Date : 16/10/14 **Time : 9 am - 4 pm**

Venue

Council Hall, SMC, Meerut

Organized by

Department of Community Medicine
Subharti Medical College
with
State Chapter IAPSM-UP/UK

Subhartipuram, N.H. 58, Delhi-Haridwar
Bypass road, Meerut - 250005
Ph. : 0121-2439056, 3058034 ext. 2142
mcsubms2006@gmail.com

Invitation

Dear Friends,

It is always challenging to read and interpret the results published in the medical journals. There has been a growing tendency among big pharma companies to publish their results of RCT's in such a way that the drug looks very effective though it may not be. Therefore post graduate students should be good at sifting the 'truth' from the 'half truth'. The workshop will be done under the guidance of one of the well known statistician Dr. R.M. Pandey (Prof. & Head, Department of Biostatistics, AIIMS, New Delhi) of our country. It will enlighten the participants to read between the lines and grasp the real worth of the statistical results being published in the medical journals. We welcome you to come to Subharti Medical College and have an academic feast.

Dr. Bhawna Pant
Ph. : 8057618841

Dr. Rahul Bansal
Ph. : 9837277055

ORGANIZING COMMITTEE

Patrons

Dr. A.K. Asthana
Principal, SMC, Meerut

Dr. C.M.S. Rawat
President IAPSM, UP/UK Chapter

Chairperson
Dr. Rahul Bansal

Organizing Secretary
Dr. Bhawna Pant

Joint Secretary
Dr. Amit Mohan Varshney
Dr. Arvind Kumar Shukla

Treasurer
Dr. Monika Gupta

Who should attend
PG/Junior Faculty of Community Medicine
PG/SR/Faculty of Clinical/Paraclinical Department

Registration Fee

Resident	400 Rs. till 15/10/14	500 Rs. Spot Registration
Faculty	500 Rs. till 10/10/14	600 Rs. Spot Registration

Programme

Registration	8:30 - 9:00 AM
Inaugural	9:05 - 9:30 AM
Keynote address : Dr. R.M. Pandey*	9:35 - 11:00 AM
** Rise and why of common tests used for medical evidence*	
Tea Break	11:05 - 11:15 AM
Keynote address : Dr. P.P. Khosla#	10:20 - 12:00 AM
# How Pharma Companies turn and twist the Medical evidence	
Hands on exercises : Group work	12:10 - 1:10 PM
Working Lunch	1:15 - 2:00 PM
Presentations of Group work	2:05 - 3:00 PM
Valedictory & Tea	3:00 - 4:00 PM

Bank details for DD/Cheque/NEFT

Bank Name : OBC, SMC, Meerut
Account No : 52282011017823 IFSC Code : ORBC0105228
Account Name : IAPSMCONUPUK2011

Organizing Committee

Chief Patron
Shri Dev Murti

Patron
Mr. Aditya Murti
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Dr. S.B. Gupta

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Dr. Danish Imtiaz

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Dr Sumit Saxena

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Dr. Sunil Kumar Misra

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About the institute

Shri Ram Murti Smarak Institute of Medical Sciences, Bareilly, a mission conceptualized in year 2002 is the most modern 950 bedded multi super speciality and tertiary care hospital and a recognized medical college, catering for health needs in a radius of 250 kms of Bareilly zone reaching up to farthest border towns of Uttarakhand & Nepal. The medical college (recognized by ministry of health, Govt. of India and approved by Medical council of India, New-delhi) offers undergraduate (M.B.B.S) and postgraduate (M.D./M.S.) courses in 21 departments.

About the Department

The department of Community Medicine is established and has teaching facilities for training the undergraduate & postgraduate students in order to enable them provide comprehensive and promotive, preventive and curative services to society. The department also has well equipped Rural Health Centre & Urban Health Centre with all modern facility for primary health care including facilities for X-Ray, ECG, Blood investigations, physiotherapy, O.T. & ambulance. These centers also working as e-health centers and RHTC as 24X7 health centre. We have well developed Public Health Research Lab having facility for Water analysis, Milk & Food Adulteration analysis. The department is actively involved in field & operational research. A total of 27 research papers have been published in national & international journals during the last 3 years. Research projects from ICMR, Government of U.P. and UNICEF are being undertaken in the department.

Hands-on Workshop on Thesis Writing

8th & 9th August 2015

Venue :
Medical College Building
Seminar Hall, Second Floor

Organized by

Department of Community Medicine
Shri Ram Murti Smarak
Institute of Medical Sciences, Bareilly (U.P.)
In association with IAPSM UP-UK Chapter

Workshop Invitation

Dear colleagues,

In continuation of the tradition of Shri Ram Murti Smarak Institute of Medical Sciences, Bareilly in encouraging research in medical field and inspiration from our chairman Shri Dev Murti ji and support of our director administration Shri Aditya Murti ji, Department of Community Medicine is pleased to announce a 'Hands-on Workshop on Thesis Writing' under the auspices of IAPSM-UPUK chapter on 8th and 9th August 2015. The workshop will be facilitated by renowned faculty from ICMR and other institutes of repute.

Every Post Graduate is expected to know clearly about the different steps in writing a thesis right from selection of research question to conclusion and recommendation through data handling and analysis. We are optimistic that this workshop will serve its objective of benefitting the PG students and young faculty members who are going to be the future guides for the research.

We welcome your participation in the workshop.

Dr. V. P. Shrotriya
Patron

Dr. S. B. Gupta
Organizing Chairperson

Programme

DAY - 1

8 August 2015		Saturday
Registration & Breakfast	**09:00 to 10:00 am**	
Scientific Session-I		
Introductory remark	10:00 to 10:15 am	Dr. V.P. Shrotriya
Selection of topic & framing research question	10:15 to 11:00 am	Dr Piyush Kumar
Inauguration & Tea	**11: 00 to 12:00 pm**	
Scientific Session-II		
Ethical issues in Medical Research	12:00 to 12:30 pm	Dr. Renu
Literature search (Thesis Vs research protocol)	12:30 to 01:30 pm	Dr. Smita Asthana Dr. L. Satyanarayana
Framing the objectives	01:30 to 02:00 pm	Dr. S.K. Misra
Lunch	**02:00 to 02:30 pm**	
Scientific Session-III		
Study designs & understanding research findings	02:30 to 03:30 pm	Dr. L. Satyanarayana
Sampling technique, sampling procedure, Sample size & dummy exercises on sample size calculation	03:30 to 05:00 pm	Dr. Smita Asthana Dr. L. Satyanarayana Mrs. Sonam Maheshwari Dr. Huma Khan
Evening Tea	**05:00 to 05:15 pm**	
Developing study tools	05:15 to 06:00 pm	Dr. Smita Asthana

DAY - 2

9 August 2015		Sunday
Breakfast	**08:00 to 09:00 am**	
Scientific Session-I		
Type of Data & Data Analysis	09:00 to 10:00 am	Dr. B. L. Verma
Practical work on data handling (Hands on Training) and writing of results	10:00 to 11:00 am	Dr. L. Satyanarayana Dr. Smita Asthana Dr. B.L. Verma
Tea Break	**11:00 to 11:15 pm**	
Scientific Session-II		
Introduction of statistical software (like Epi info, SPSS)	11:15 to 12:00 pm	Dr. Smita Asthana
Hands on training in SPSS software	12:00 to 01:00 pm	Dr. L Satyanarayana Dr Smita Asthana
Biostatistical Fallacies in Medical research: from data collection to report writing	01:00 to 02:00 pm	Dr. B. L. Verma
Lunch	**02:00 to 03:00 pm**	
Scientific Session-III		
Reference Writing	03:00 to 03:30 pm	Dr. Rakesh Kakkar
Question &Answer + Discussion	03:30 to 04:00 pm	Dr. L. Satyanarayana Dr. Smita Asthana Dr. Huma Khan Mrs. SonamMaheshwari
Valedictory Function	04:00 to 05:00 pm	

Registration Form

Name (in capital letters) _____

Institution _____

Address _____

_____

City _____ Pin _____ State _____

Phone _____ Email _____

Registration Details

Registration fee - Rs. 750 (for in-station delegates)
Rs. 1000 (for out station delegates) *
Rs. 1200 (Spot registration)

*This includes one night stay. Please register early & inform beforehand so that accommodation can be arranged.

Details of Payment

- Demand Draft of Rs. _____ in words _____
  Demand Draft no _____ Date _____
  Drawn on Bank _____ in favour of
  "SRMSIMS" payable at Bareilly.
- Online cash payment: Account No. 52241010000010
  IFSC code : ORBC0105224 Bank: Oriental Bank of Commerce
  (Details available on website)
- Please mention transaction receipt no. _____ Date _____
  Online registration: srmsims.ac.in. details available on website: www.srmsims.ac.in

Please mail tthis form, Bank Draft/Transaction Receipt No. to

Dr. Sumit Saxena
Joint Organizing Secretary
Shri Ram Murti Smarak Institute of Medical Sciences
13 km., Bareilly- Nanital road, Bareilly-243202 (U.P.) India.
Email: iapsmsrms2015@gmail.com
Mobile no: 9458705020

Gmail

Secretary Iapsmupuk <secretaryiapsmupuk@gmail.com>

Invitation

2 messages

SECRETARY IAPSMUPUK <secretaryiapsmupuk@gmail.com> Fri, Aug 7, 2015 at 1:35 AM
To: drcpmishra@gmail.com, doibale@gmail.com
Cc: drpradeep_aggarwal@hotmail.com, chiefeditor@iapsmupuk.org, drrakesh75@rediffmail.com

Dear Sir,

It gives me immense pleasure to inform you that the Deptt of Community Medicine, SRMS, Bareilly on request of IAPSM UPUK

is jointly organizing a workshop on thesis writing on 8th & 9th August 2015.

On 1st August 2015, the Deptt of Community Medicine, SMC Meerut in close collaboration with IAPSM UPUK has already conducted

a Symposium on NCDs.

You are requested to kindly grace the Inaugural Function as Special Invitee on 8th August 2015 at SRMS Bareilly, UP and boost up the moral

of our young faculty members and PGs participating in it.

Hope to see you there.

Regards,

SECRETARY

IAPSM UPUK

2014 - 2017

DR.MOHAN DOIBALE <doibale@gmail.com> Fri, Aug 7, 2015 at 8:37 AM
To: SECRETARY IAPSMUPUK <secretaryiapsmupuk@gmail.com>

Dear Dr Khurshid,
Thanks
All the Best !
Regards
Mohan Doibale
[Quoted text hidden]
--

Prof. Dr. Mohan K. Doibale
Professor & HOD,Community Medicine
***Dy. Dean,*Govt. Medical College,**
AURANGABAD-431001 *Maharashtra India*
Cell- 94222 03393
National President Elect: IAPSM (2015-16)
President Elect: IAPSM Maharashtra Chapter
Member-Governing Council IPHA Maharashtra
MUHS: Ph.D. Research Guide (Com.Med.)
B.O.S./Faculty of Medicine/31(5)Committee
Life Member-
IAPSM, IPHA, IRCS,ISMS,Env. Research Foundation
International Epidemiological Association-Mentor

Indian Association of Preventive & Social Medicine
UP UK Chapter
Head Office: Department of Community Medicine,
Muzaffarnagar Medical College, Muzaffarnagar
Mobile: +91-9759585668, +91-9411311561, Fax : 01396-252703
Email: secretaryiapsmupuk@gmail.com ; Website : www.iapsmupuk.org

Dated: 22/01/2017

SPSS WORKSHOP

IAPSM UPUK in association with SPSS South Asia Pvt. Ltd., has organized two workshops at Rohilkhand Medical College, Bareilly and another at TMC Moradabad and another is scheduled to be held on 3rd & 4th February 2017 on the following topic –

"SPSS Training Workshop For Data Analysis In Research For Medical Professionals"

Colleges having this 02 days workshop so far are:-

1. Rohilkhand Medical College, Bareilly
2. TMC Moradabad
3. MMC Muzaffarnagar

Many more Medical Colleges of our Chapter are in queue and probably after the inspection we will take positive steps to have this workshop in more than 75 % colleges of IAPSM UPUK.

DR. KHURSHEED MUZAMMIL

SECRETARY – IAPSM UPUK

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SPSS Online Training Portal

for Medical Statistics

Uniqueness of the SPSS Online Training Portal

- The Portal includes the most Common number of Real life topics or Cases.
- Coverage on theories and concepts of Statistical techniques.
- Each technique has been explained by use of a Medical case.
- Guidance on interpreting results and drawing conclusions.
- Completely process driven training with prompted steps
- Simulated User Interface as if one is working on SPSS Software
- Virtual Interactive Session will be conducted 2 to 3 times during the training Program.
- Duration of the Training is for 6 months
- Small datasets would be made available in the SOTP for working on SPSS Software.
- Institute to be provided with a question bank for them to conduct a test after 6 months
- Certificates of participation will be issued to each students

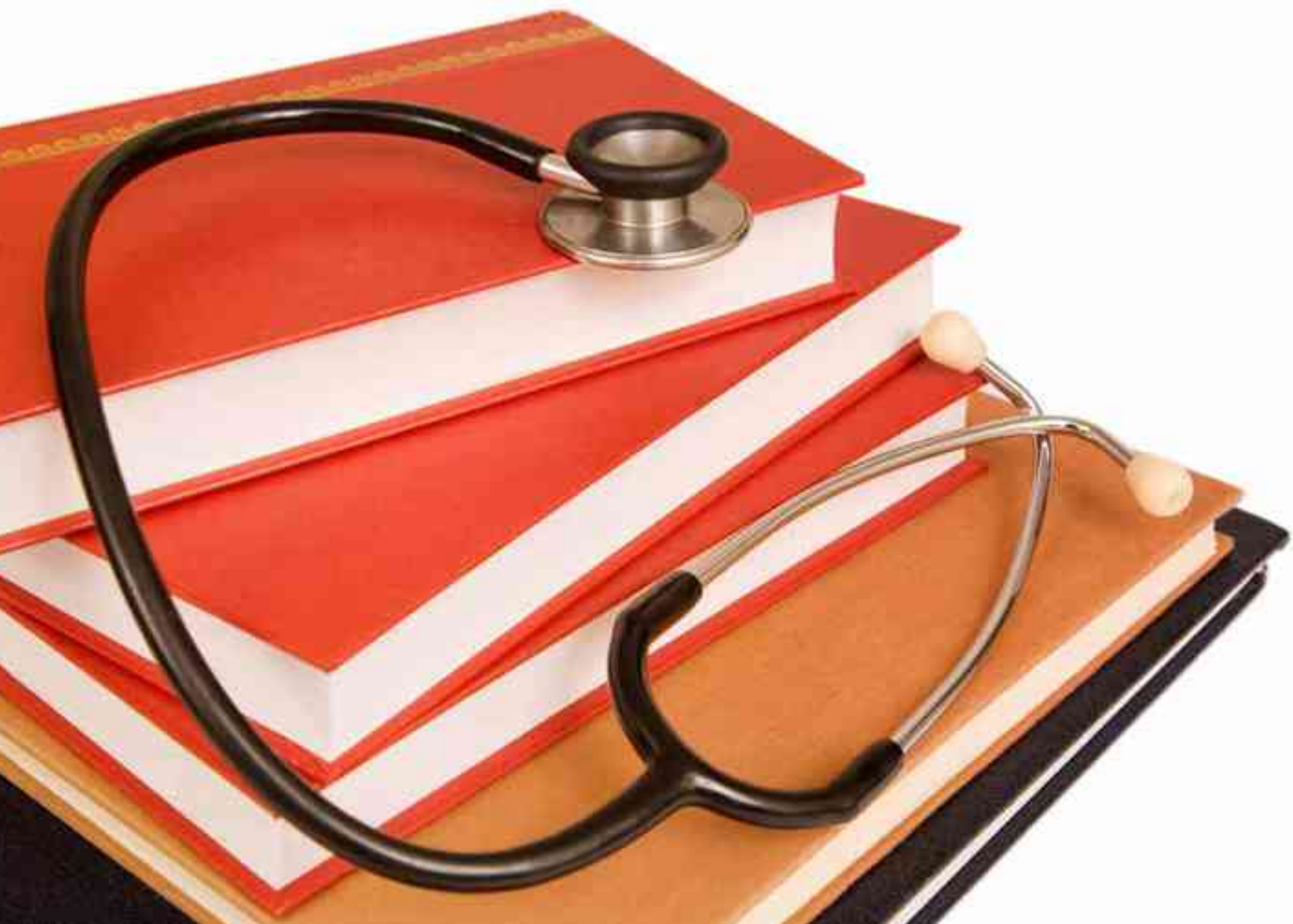
You can login to and register at http://learnspss.in/demo/register.php to evaluate the portal.

www.learnspss.in
training@spss.co.in, 08040117300

SPSS

Online Training on SPSS for Medical Professionals

STATISTICS FOR MEDICAL PRACTITIONERS



But HOW?

Turn Insights Into Action With Medical Statistics

With the welfare of the public as the ultimate goal, and with the uncertainty that is inherent in all health and medical related decisions, statistical sciences can play an important role in solving problems of human health & disease. Evidence Based Medicine (EBM) requires medical practitioners to carefully consider all evidence on whether a particular line of treatment works, in turn requiring evidential data to be objectively analysed. An application of statistical techniques is required to achieve this data.

Medical statistics is the science of analyzing and interpreting data in medical practice in order to locate associations and test hypothesis, while taking into account the variability inherent in biological processes. It provides an objective and formal framework for communicating findings and evidences to medical practitioners, for them to decide on a method of treatment.

Do More With Less

SPSS Licenses are expensive, and as much as possible they should be put to use for analytical work: for project reports, theses and research papers. Yet, to first pick up the analysis skills, it becomes inevitable to spend more time on the software learning it, than is spent actually getting productive work out of it. This makes it very difficult for education administrators to allocate adequate software time to a large body of students to both train as well as produce results.

The simulated environment of the SPSS Online Training course, along with statistical concepts as well as guidelines on interpreting results, makes students adept at using SPSS. So that when they are given access to SPSS they use it for producing results, not learn it. This of course helps the institute manage a bigger load of students with an optimal number of licenses.

Free Up Resources With Asynchronous Learning

In a learning institution time and space are two of the most valuable resources that need to be put to the best productive use. This includes using them to impart learning on core subject areas that are mandatory for the students with respect to their course specialisation.

SPSS, when taught as an added skill or as a part of the repertoire of tools that a doctor must acquire, is best delivered in an asynchronous mode over the web, so that it does not consume the vital resources of time and space, leaving them available for focus areas of learning.

Standardise The Training Delivery

Teaching a subject like data analysis with SPSS in a Medical course, where it needs to be taught as a skill set for future doctors rather than as a primary subject, sometimes faces a challenge when it comes to managing the need for adequate coverage while avoiding too much of technicality. And it is often left to the individual trainer to strike the right balance between these two necessities. The problem becomes further compounded as both the number of students as well as the geographic dispersion increases. SPSS online training ensures that all students undergo the same training regardless of their number or geographic location.

WHAT'S in the training ?

In Line With Doctors' Needs

This training is meant for medical researchers. Researchers who will need to learn on how to apply statistics and SPSS to solve medical problems, rather than attempt to become statisticians or data scientists.

The training focuses therefore, on just what is needed by medical professionals while avoiding what is not.

Statistical Concepts

Trying to analyse data in SPSS without understanding the statistical concepts that underlie the techniques is not advisable. For it can often lead the researcher to either apply an incorrect technique or draw the wrong conclusions. Each section in the training therefore first explains a statistical concept before exposing the learner to the running of the analysis itself.

Simulated User Interface

A primary objective of the training is to give the learner a hands-on feel of the environment that she would encounter while working on SPSS itself. The training does provide a simulated environment, guiding the learner step by step through the analysis process, and preparing them to become completely familiar with the workings of the actual software itself.

Interpretation Of Results

Running an analysis on the data is just the beginning. Ultimately the doctor has to draw conclusions from the results SPSS produces. The training explains the SPSS output, with a variety of examples, guiding the learner through the findings the results show up. The examples are created using health related data, giving the learners an opportunity to learn the techniques in a data environment familiar to them.

What's in the Content?

Data
- Data Measurement
- Data Type
- Data Documentation
- Visual Binning
- Data Selection

Descriptive Statistics
- Frequencies
- Measures of Central Tendency
- Measures of Position
- Measures of Dispersion
- Measures of Distribution

Graphical representation of Data
- Univariate Graphs
- Bivariate Graphs
- Multivariate Graphs
- Comparing Categories in the Same Variable
- Multiple Variable Comparisons

Tabular Representation of Data
- Comparing Categories
- Comparing Multiple Variables

Data Reports
- Olap Cubes
- Case Summaries

Relationship between variables
- Correlation
- Regression

Classification
- Hierarchical Clustering
- K Means Clustering
- Discriminant Analysis

Data Reduction
- Factor Analysis

Logistic Regression
- Binary Logistic Regression
- Multinomial Logistic Regression

Comparing Populations
- Chi Square Test
- T Test

Analysis of Variance
- One Way ANOVA
- Two Way ANOVA
- MANOVA

Non Parametric Tests
- Mann Whitney U Test
- Wilcoxon's Signed Rank Test
- Kruskal Wallis Test
- Friedman's Test

Survival Analysis
- Life Tables
- Kaplan Meier
- Cox Regression
- Time Dependent Cox Regression

Diagnostic Study
- ROC Curve

SPSS South Asia Pvt Ltd.
No.2353/1-4, 'Dolphin', 4th Floor, Hennur Main Road, Opp. Harmony Apartments, Kacharakanahalli, Bangalore - 560043
+91-80-41123945 - 947 +91-80-41323618 training@spss.co.in

To,

Dr. Khursheed Muzammil
Community Medicine
Muzaffarnagar Medical College

19th November 2016

Sub: SPSS Training Workshop for Data Analysis in Research for Medical Professionals

Today's Medical decision making requires enhanced capabilities in communication as well as Data analysis. The Medical Council of India has also acknowledged that Medical Professionals need to use the data and interpret it statistically on a daily basis. This has led to increase the importance of Bio-Statistics/ Medical Statistics.

And SPSS (Statistical Package for Social Sciences) is a popular Tool or Software for a Medical Data analysis and interpreting it. However, a key Challenge the Medical Professionals face is learning SPSS thoroughly before they actually start work on it.

We from SPSS South Asia Pvt. Ltd. have launched **SPSS Online Training Portal content for Medical professions called "Medstat"** covering wide ranging Statistical and analytical techniques for The medical professionals who would be able to get benefits out of the same.

Together with SPSS Software & SOTP portal one can easily equip to take up the challenge of "***Data Analytics***". In order to provide a structured overview on both SPSS Software & SOTP we from SPSS would like to propose a SPSS Training Workshop for Medical Professionals.

Please find enclosed, the proposal for "***SPSS Training Workshop For Data Analysis in Research for Medical Professionals*** ".

Please find the enclosed the following:

1. List of Topics and the durations schedule for the same
2. List of Deliverables for the Workshop
3. Terms and Conditions for the Payment.

SPSS TRAINING WORKSHOP FOR DATA ANALYSIS IN RESEARCH FOR MEDICAL PROFESSIONALS

Organized by: SPSS South Asia Pvt. Ltd. – Bangalore

Day 1

TOPIC	SPEAKER	TIME
Welcome address	SPSS South Asia Pvt. Ltd.	9- 9:30AM
Introduction to Bio-Statistics and SPSS	SPSS South Asia Pvt. Ltd.	9.30-9.45AM
Starting SPSS, Creating Variables, Data and its types, Importing Data into SPSS from Excel, Visual Binning	SPSS South Asia Pvt. Ltd.	9.45AM-10.45AM
SOTP –Medstat	SPSS South Asia Pvt. Ltd.	10.45AM-11.00AM
TEA BREAK 11.00 AM – 11:15AM.		
Frequency, Crosstabs, Graphs & Charts (Bar, Pie, Line), heat map, scatter diagram. Descriptive Statistics: Measure of central tendency, Measure of variability. Measure of distribution	SPSS South Asia Pvt. Ltd.	11.15-11:45AM
SOTP –Medstat	SPSS South Asia Pvt. Ltd.	11:45-12:00PM
Correlation, Regression: Simple , Multiple regression	SPSS South Asia Pvt. Ltd.	12:00-1:00PM
LUNCH BREAK: 1:00 – 1:30PM		
Binary Logistic regression and multinomial logistic regression	SPSS South Asia Pvt. Ltd.	1:30-2:30AM
SOTP–Medstat	SPSS South Asia Pvt. Ltd.	2.30-3.00PM
TEA BREAK 3:00 – 3:15PM.		
Introduction: Testing of hypothesis	SPSS South Asia Pvt. Ltd.	3:15-4:00PM

Day 2

TOPIC	SPEAKER	TIME
Parametric test : independent sample 't' – test ,Paired sample 't'-test,	SPSS South Asia Pvt. Ltd.	9- 10AM
SOTP–Medstat	SPSS South Asia Pvt. Ltd.	10.00-10.15 AM
Parametric test : ANOVA (one-way classification and two way Classification)	SPSS South Asia Pvt. Ltd.	10.15 AM-11.00AM
SOTP –Medstat	SPSS South Asia Pvt. Ltd.	11.00-11.15AM
TEA BREAK 11.15 AM – 11:30 AM.		
Non-parametric test: Mann Whitney 'U' – test, Wilcox on sign rank test.	SPSS South Asia Pvt. Ltd.	11.30-12.00pM
Non parametric test : Kruskal Wallis test, chi square test(χ2 TEST)	SPSS South Asia Pvt. Ltd.	12.00-12:30PM
SOTP–Medstat	SPSS South Asia Pvt. Ltd.	12.30PM-1 PM
LUNCH BREAK: 1:00 – 1:30PM		
Survival analysis :Kaplan Meier analysis	SPSS South Asia Pvt. Ltd.	1:30-2.45PM
SOTP –Medstat	SPSS South Asia Pvt. Ltd.	2.45-3PM
TEA BREAK 3:00 – 3:15PM.		
Discussion regarding research and data analysis	SPSS South Asia Pvt. Ltd.	3:15-4:00PM

Deliverables:

1. **SPSS 14 days Evaluation license CD**
2. **SPSS & SOTP Brochure**
3. **Two days Workshop Certificate after 7 days of Workshop**
4. **SOTP Login details for 6 months**
5. **SOTP Completion Certificate at the end of 6 months**

Uniqueness of the Classroom Training on SPSS

- The Course is aimed at everyone who intends to understand application of Biostatistics in research with the help of SPSS Software and online Training.
- SPSS course is ideal for the ones, who are willing to learn and perform the Data analysis more quickly and effectively.
- It helps you to make the Statistical data analysis for Thesis completion, Project report and Paper publications by yourself
- Certificates for Training Workshop will be provided after 7 days of Completion of Program.

Uniqueness of the SPSS Online Training Portal (SOTP)

- The Portal includes the most Common number of Real life topics or Cases.
- Curriculum designed after due Consultation with medical professionals.
- Coverage on theories and concept of Statistical techniques.
- Each technique has been explained by use of a Medical case.
- Guidance on interpreting results and drawing conclusions.
- Completely process driven training with prompted steps
- Simulated User Interface as if one is working on SPSS Software.
- Duration of the Training is for 6 months
- Certificates of participation will be issued to each student after completion of program.

TERMS & CONDITIONS FOR THE PAYMENT

Order	Kindly mention our Quotation Reference number in your Purchase Order. Your order should include the name, email id & phone number of the participants along with Demand Draft for training workshop for all participants.
Payment	Payment should reach us 7 days before the Training Workshop date & Payment for ***SPSS SOTP*** will be raised on **: *Ms/ SPSS South Asia (P) Ltd, 2353/1-4, 4th Floor, Hennur Main Road, Kacharakanahalli, Bangalore – 560 043***
Payment	**Registration Price Slab for the Workshop:** **Two days – Rs. 2,300/-(Inclusive of Taxes)** **50% advance along with your Purchase Order and remaining 50% after completion of the Workshop.**
Delivery	Login ID and Password will be issued within 7 working days after receiving 100% payment in Advance and Original Purchase Order. **Login IDs are valid for 180 days.**
Disputes	All disputes at Bangalore Jurisdiction.
Cancellation Policy	Order once invoiced will not be cancelled.
SOTP Query Support	All SOTP Queries should be marked to trainingsupport@spss.co.in
SOTP Login	For 2 Days Training Workshop duration – 6 months SOTP login will be provided
Note :* *Minimum number of 40 to 50 Participants should attend this SPSS Training Workshop	

We look forward to getting a positive response from you along with suitable dates well in advance before 2 to 3 weeks.

Regards,

Shruthi R K
SPSS South Asia Pvt.Ltd.
Email Id: shruthi@spss.co.in
Ph No. 080 40117300
Mob. No. 8970811571

WORKSHOPS UNDERTAKEN BY IAPSM UPUK

1. "Workshop for "Application of Bio-Statistical methods in epidemiological study designs" on 20th October, 2015 Venue: **HIMS, Department of Community Medicine, Dehradun, Uttarakhand**

2. "Hands on Workshop on Thesis Writing" on 8th & 9th August, 2015, Venue: **Medical College Building Seminar Hall, Second Floor.**

3. "Workshop on Recent updates in life style factors for preventing NCD's on 1st August, 2015 Venue: **Council Hall, SMC, Meerut, U.P.**

4. "Workshop on Health Economics on 6th-7th April, 2014 Venue: **M.L.B. Medical College, Jhansi, U.P.**

5. "Hands on Workshop on Qualitative Research Methodology" on 7th September, 2013 Venue: **Subharti Medical College, Meerut**.

6. "Workshop on Data e-Compiling, analysis and Presentation" on 10th-11th August, 2013 Venue: **M.L.B. Medical College**.

7. "Workshop on Post Disaster Management on 3rd August, 2013 Venue: **HIMS, Dehradun**.

DR. KHURSHEED MUZAMMIL

SECRETARY – IAPSM UPUK

9759585668

ANNEXURE

IN SUPPORT OF

SERIAL NO. – 8 & 9

PROJECT UNDER IAPSM UPUK

INPEN: Rapid Assessment of Essential New born Care Services and Needs in NRHM Priority States of India. *

This project was sponsored by UNICEF to the members of IAPSM UPUK based on the proposals submitted on the related theme and the investigator teams were selected on merit by a core team taking consideration of the technical issues and feasibility of the project proposal.

The result was announced during the valedictory function of IAPSM UPUK CON 2014 held at SNMC AGRA, UP. This project was allocated to PGs as well as to young faculty members. As a whole this project was worth INR more than 10 lac and individually INR 1 Lac (approx.) was allocated.

DR. KHURSHEED MUZAMMIL

SECRETARY – IAPSM UPUK

9759585668

ANNEXURE

IN SUPPORT OF

SERIAL NO. - 10

OFFICIAL WEBSITE OF IAPSM UPUK

www.iapsmupuk.org


Events: Qualitative Research
Uttar Pradesh
Uttarakhand
Indian Association of Preventive and Social Medicine State Chapter
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Minutes of Meeting
1. 2016 ECM Minutes
2. 2015 GBM Minutes
3. 2015 ECM Minutes (Signature)
4. 2014 GBM Minutes
5. 2014 Second ECM Minutes
6. 2014 Mid Term ECM Minutes
7. 2013 GBM Minutes


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Journal Archives
1. Vol.7 No.3 Sep - Dec 1983 (IJCM)
2. Vol.3 No.1 Jan - Apr 1987
3. Vol.6 No.3 Sep - Dec 1990
4. Vol. 13 No 1 Jan - Jun 2003
5. Vol.16 No.1 Jan - Jun 2004
6. Vol.16 No.2 Jul - Dec 2004

ANNEXURE

IN SUPPORT OF

SERIAL NO. - 11

CONSTITUTION

Passed on: 18- 09 - 2013

(Constitution of the IAPSM UPUK State Chapter officially approved by General Council of the IAPSMUPUK State Chapter & to be implemented from 18th October 2013 itself.)

Indian Association of Preventive and Social Medicine, Uttar Pradesh and Uttarakhand State Chapter

1. NAME

The name of the association is "Indian Association of Preventive and Social Medicine, Uttar Pradesh and Uttarakhand State Chapter" hereafter called the IAPSMUPUK State Chapter: Preventive and Social Medicine is to be considered synonymous with Social and Preventive Medicine/ Community Medicine/ Community Health/ Public Health.

2. OFFICE

The Headquarter of the IAPSMUPUK State Chapter shall be located in a Medical College/ Institution. The location of the IAPSMUPUK State Chapter Headquarters would be decided by the highest number of single non-transferable votes of the members of IAPSMUPUK State Chapter through a voting and its approval by the Governing Council and the General Council. Its term shall be ordinarily of three years.

The Professor and Head or any other teacher of the Department of Preventive and Social Medicine of the said College/ Institution, after election by the highest number of single non-transferable votes of the members of IAPSMUPUK State Chapter on the approval of the General Council will be the Secretary for the duration the headquarters remain in that Medical College/ Institution. He /She shall be a member of the Governing Council of the IAPSMUPUK State Chapter.

3. OBJECTIVES

The Aims of the Society

With the realization of the immense value of the science and art of Preventive and Social Medicine for Medical Students, Researchers, Practitioners, Public and State and in view of the fact that Preventive and Social Medicine forms the basis for the practice of all clinical specialties, the following are the aims to achieve the objectives of IAPSMUPUK State Chapter:

1. To improve the teaching standards of Preventive and Social Medicine at all levels.
2. To promote research in the specialty of Preventive and Social Medicine, and the effective application of the knowledge acquired in teaching, training, research and services.
3. To facilitate co-ordination amongst the Departments of Preventive and Social Medicine and other departments, medical colleges / institutions and health agencies / organization.
4. To develop co-operation in teaching, training, research and service between the Departments of Preventive and Social Medicine of various medical colleges / institutions in the country.
5. To promote welfare of the teachers of the Preventive and Social Medicine.
6. To publish a journal – INDIAN JOURNAL OF COMMUNITY HEALTH (IJCH - Journal) which will be furtherance of these aims and will be the official organ of IAPSMUPUK State Chapter.

President Chairman Secretary

4. JOURNAL'S OFFICE

The official journal of the IAPSMUPUK State Chapter shall be called the "Indian Journal of Community Health," hereafter called the IJCH.

The office of the IJCH - Journal shall be located at the Medical College/ Institution which will be elected by the highest number of single non-transferable votes of the members of IAPSMUPUK State Chapter through a voting and approved by the Governing Council and the General Council of the IAPSMUPUK State Chapter. Its term shall be for a period of three years.

The Professor and Head or any other teacher of department of Preventive and Social Medicine of the said college/ institution will be elected as the Chief Editor of the IJCH - Journal by the highest number of single non-transferable votes of the members of IAPSMUPUK State Chapter on the approval of the General Council. His/her term shall be for a period of three years. He /She shall be a member of the Governing Council of the IAPSMUPUK State Chapter.

5. RULES & REGULATIONS OF THE IAPSMUPUK STATE CHAPTER

The IAPSMUPUK State Chapter shall consist of the members whose names are on the Register of Members of the IAPSMUPUK State Chapter, when these rules come into operation, and of such persons who subsequently adopt these rules and take the membership of the IAPSMUPUK State Chapter.

5.1. Register of Members

There will be a register of all the members of IAPSMUPUK State Chapter that will be maintained at the headquarter of IAPSMUPUK State Chapter. The details viz - name, date of birth, qualifications, designation, name of the serving institution, contact numbers, e-mail IDs, official address, permanent address, address for communication, IAPSM membership number etc of all the members of IAPSMUPUK State Chapter shall be entered in the register.

5.1.1. Eligibility for Membership

The following persons are eligible to take up the membership of the IAPSMUPUK State Chapter:-

i. Present and past teachers of Preventive and Social Medicine.
ii. Present & Past teachers of the disciplines allied to Preventive and Social Medicine.
iii. Those having or pursuing post-graduation in the specialty of Preventive and Social Medicine.
iv. Those having interest in fulfilling the aims and objectives of the IAPSMUPUK State Chapter.

5.1.2. Enrolment of Members: Procedure

Those desirous of taking the Life membership of IAPSMUPUK State Chapter shall apply on the prescribed form (Annexure-I) to the Secretary of the IAPSMUPUK State Chapter along with the prescribed membership fee. Annual Membership has been discontinued since April 2008. The application will be scrutinized by the Secretary and after his/her approval; the name will be entered in the Register of Members. However, membership under 5.1.1.(iv) shall be entered in the register of members after approval of the Governing Council of the IAPSMUPUK State Chapter.

President Chairman Secretary

5.1.3. Membership Fee

All the Life Membership holders of IAPSM belonging to Uttar Pradesh or Uttarakhand are entitled to become member of IAPSMUPUK State Chapter without any extra fee.

5.1.4. Termination of Membership

5.1.4.1. Resignation

Any member of IAPSMUPUK State Chapter can resign his/her membership by writing to this effect to the Secretary. Such a member shall pay all outstanding dues of the IAPSMUPUK State Chapter along with his resignation.

5.1.4.2. Termination

If the conduct of a member is deemed to be prejudicial to the interests of the IAPSMUPUK State Chapter, he/she would be served a notice by the Secretary on the instructions of the Governing Council to explain his/her conduct within 30 days, informing him/her of the proposed action. The Secretary shall put the member's explanation or its absence before the General Council for decision. The General Council can terminate a membership by the vote of not less than 2/3rd of the members present, the vote being taken by a method deemed as appropriate by the General Council. On termination of the membership, he/she can again apply as a new applicant for membership after a lapse of two years, which may be accepted on the approval of the Governing Council of the IAPSMUPUK State Chapter.

5.1.5. Constitutional Bodies Of The Society

a) **Governing Council:** It includes all the office bearers.

b) **General Council:** It includes all categories of members of the association.

5.2. Office Bearers Of The Governing Council

The Governing Council of the IAPSMUPUK State Chapter shall comprise of 19 members on different post as under:-

i.	President	-	One
ii.	Immediate Past President (IPP)	-	One
iii.	Vice President	-	One
iv	Secretary	-	One
v.	Joint Secretary	-	One
vi.	Treasurer		One
vii.	Chief Editor	-	One
viii.	Executive Members	-	One
			Nine

Members of the IAPSMUPUK State Chapter shall vote to elect Six Executive Members; with equal representation of executive members from Uttar Pradesh and Uttarakhand state.

President

Chairman

Secretary

5.2.1. Term/Tenure

The Secretary, the headquarter of the IAPSMUPUK State Chapter, the office of the IJCP, and the Chief Editor of IJCH would be elected for a term of three years and can be re elected as continuation only for one more term of three years.

The Secretary (along with the location of the headquarter) and the Chief Editor (along with the office of the IJCH) would be appointed for a term of three years on the approval of the General Council of the IAPSMUPUK State Chapter by means of the proposals made by the Governing Council of the IAPSMUPUK State Chapter on the basis of the application received by the current President/ Secretary of IAPSMUPUK State Chapter from the interested Department of Community Medicine of respective Medical Colleges/ Institutes. The Immediate Past President will be a member of the Governing Council and the Immediate Past Chief Editor (IPCE) will be a member of the Editorial Board of the IJCH for a period of one year after their term is over.

The President, the Immediate Past President (IPP), the Vice-President, and the six Executive Members shall hold office until the new Governing Council is formed which would be at the time of ensuing the annual conference of the IAPSMUPUK State Chapter.

The President can seek re-election only after five years. No Executive Member shall hold this office for more than two consecutive years and can seek re-election only after a lapse of one year.

If a vacancy on the post of President/ Secretary or the Chief Editor occurs in the mid of a term, the Governing Council may elect a new President/ Secretary /Chief Editor from amongst the members of the Governing Council of the IAPSMUPUK State Chapter or from the Editorial Board of the IJCH till the next election is held.

5.2.2. Election

The President, the Vice-President and the six Executive Members shall be elected annually by the highest number of single, non-transferable votes of the members of IAPSMUPUK State Chapter Executive members must have minimum qualifying experience of 3 years as Member of IAPSMUPUK State Chapter and have attended at least two Annual Conferences of IAPSMUPUK State Chapter.

The Secretary & the office of the headquarter, the Chief Editor & the office of the IJCH shall be elected once in every three years by the highest number of single non transferable votes of the members of IAPSMUPUK State Chapter.

The Organizing Secretary or nominee of the Organizing Committee of the IAPSMUPUK State Chapter Conference – subject to eligibility as per IAPSMUPUK State Chapter constitution- will be the President of the IAPSMUPUK State Chapter for the next tenure (starting from 1st April to 31st March) Elections for Head Office of the IAPSMUPUK State Chapter, Head Office of the IJCH, the post of Vice-President and 6 Members of the Governing Council (equal representation from Uttar Pradesh and Uttarakhand) will be held by voting at the Annual General Council Meeting held during the Annual Conference of the IAPSMUPUK State Chapter.

For the post of Vice-President, only those members of the IAPSMUPUK State Chapter who fulfil all the following three criteria shall be eligible:-

i. Must be a life member of the IAPSMUPUK State Chapter for the preceding three years.
ii. Must be a teacher in the specialty of Preventive and Social Medicine for 10 years.
iii. Must have participated in at least 03 Annual Conferences of the IAPSMUPUK State Chapter.

President Chairman Secretary

5.2.3. Duties Of The Office Bearers

5.2.3.1. President

i. He/ She shall preside over the meetings of the Governing Council and General Council of the IAPSMUPUK State Chapter.
ii. He/ She shall represent the IAPSMUPUK State Chapter at State/ National & International Forums.
iii. He/ She may sanction an expenditure of more than Rs 20,000 at one time on the request of the Secretary.
iv. He/ She may approve expenditure out of the Reserve Funds of the IAPSMUPUK State Chapter.
v. He/ She can take a decision, within the objectives of the IAPSMUPUK State Chapter in consultation with at least three members of the Governing Council, and later put it before the General Council for ratification.

5.2.3.2. Vice-President

He/ She shall assist the President in carrying out his/ her duties, and will undertake the duties of the President in his/ her temporary absence.

5.2.3.3. Secretary

i. He/ She shall be responsible for the upkeep of the permanent record/ articles of the IAPSMUPUK State Chapter, and up-to-date maintenance of the Register of Members.
ii. He/ She shall conduct all correspondence on behalf of the IAPSMUPUK State Chapter.
iii. He/ She shall accept Donations received for the IAPSMUPUK State Chapter.
iv. He/ She shall prepare the budget and get it approved by the Governing Council for expenditure of the IAPSMUPUK State Chapter during the ensuing year.
v. He/ She shall maintain and keep the accounts of the IAPSMUPUK State Chapter and shall place before the General Council duly audited Statement of Accounts of the year.
vi. He/ She shall be authorized to make expenditure up to Rupees 20,000 at one time, and Rupees 20,000 with the approval of President and more than this with approval of Governing Council.
vii. He/ She shall appoint Auditors each year in consultation with the President of the IAPSMUPUK State Chapter.
viii. He/ She shall convene the Governing Council/ General Council/ Requisitioned-Governing Council/ General Council Meetings.
ix. He/ She shall keep the minutes of the meetings and after getting concurrence of the President, get these confirmed at the next meeting.
x. He/ She shall be responsible to take action/ implement the resolutions passed by the Governing Council/ General Council of the IAPSMUPUK State Chapter.
xi. He/ She shall receive nominations for the election of the Office Bearers/ Members of the Governing Council, Office of the Headquarters of IAPSMUPUK State Chapter, Office of the UCH and make necessary arrangements for the voting.
xii. He/ She shall nominate a Joint Secretary and Treasurer from amongst the members of the IAPSMUPUK State Chapter. The Joint Secretary shall assist the Secretary in performing his/her duties and in the temporary absence of the Secretary, the Joint Secretary shall undertake his/her duties. The Treasurer shall assist the Secretary in preparing the budget and maintenance of accounts of the IAPSMUPUK State Chapter. The tenure of the Joint

President Chairman Secretary

Secretary and Treasurer will be of three years along with the tenure of the Secretary whichever is earlier.

xii. He/ She shall consult the President on all important matters.

xiii. At the end of the tenure he/ she should co-operate and handover all the documents related with the association and its bank account also to the next Secretary for uninterrupted and smooth functioning of the association.

5.2.3.4. Chief Editor

i. He/ She shall ensure the timely publication and circulation of the IJCH.

ii. He/ She shall nominate Editor, Managing Editor and Assistant Editor from amongst the members of the IAPSMUPUK State Chapter.

iii. He/ She shall function on the advice of the Editorial Board of IJCH in democratic way.

iv. He/ She shall open and operate the Accounts of the IJCH in a bank.

v. He/ She shall place annually the report of the IJCH, and duly Audited Statement of Accounts of the IJCH before the General Council of the IAPSMUPUK State Chapter.

vi. At the end of the tenure he/ she should co-operate and handover all the documents related with the publication of IJCH and its bank account also to the next Chief Editor for uninterrupted and smooth publication of IJCH in the interest of the association.

5.2.4. The Governing Council

5.2.4.1. Functions

The Governing Council shall be the main Executive of the IAPSMUPUK State Chapter, and will carry out the following functions:-

i. It will manage the affairs of the IAPSMUPUK State Chapter.

ii. It will finalize resolutions to be placed before the General Council.

iii. It will propose the place for Holding the Annual Conference of the IAPSMUPUK State Chapter on the basis of receiving application from the interested colleges/ institutes.

iv. It will sanction the expenditures exceeding Rs 20,000 at one time.

v. It will advise and guide the Secretary regarding implementation of the resolutions passed by the General Council.

vi. It may pass a resolution within the objectives of the IAPSMUPUK State Chapter, and get it ratified later by the General Council.

5.2.4.2. Meetings

The Secretary shall notify the members of the Governing Council the place, date and time for the meetings of the Governing Council. There should preferably be two meetings in a year, but one meeting must be held every year. A requisitioned meeting of the Governing Council may be called by the Secretary on receipt of such requisition duly signed by minimum five members out of the 13 members of the Governing Council.

The Quorum of the Governing Council Meeting shall be of 07 (50 %) members of the Governing Council. If 07 members are not present, the meeting shall be adjourned, and may be called again by the President after 15 minutes and shall be held with the members present.

President — Chairman — Secretary

If the President is absent then in such case the Vice-President shall preside over the meeting of the Governing Council. In case of the absence of both President and Vice-President, the Governing Council may elect any of its members to preside over the meeting.

5.2.5. The General Council

All members, whose names are on the Register of the IAPSMUPUK State Chapter, shall constitute the General Council of the IAPSMUPUK State Chapter.

5.2.5.1. Meetings

There will be at least one meeting of the General Council every year. The Secretary shall notify the place, date and time of the General Council meeting by 2.00 p.m. on the first day of the Annual Conference of the IAPSMUPUK State Chapter.

The Quorum of the meeting shall be of 25 members. If 25 members are not present, then the meeting shall be adjourned and may be called again by the President after 15 minutes and shall be held with the members present.

Any member of the IAPSMUPUK State Chapter desirous of moving a resolution shall send it to the Secretary in writing so as to reach him/ her latest by 2.00 p.m. on the first day of the Annual Conference of IAPSMUPUK State Chapter. The resolution excepting those pertaining to the amendment in the constitution may be passed by the General Council by a majority vote.

For passing constitutional amendments, two third votes of the members present are necessary. All resolutions and decisions of the Governing Council shall be placed before the General Council by the Secretary for the approval.

5.3. Reserve Fund

A Reserve Fund shall be created in the name of the IAPSMUPUK State Chapter at it's headquarter. It will be operated jointly by any two from amongst the President, Secretary, Joint Secretary and Treasurer of the IAPSMUPUK State Chapter.

The amount of the fund shall be invested in a fixed deposit in a nationalized bank to the extent and for the time approved by the Governing Council of the IAPSMUPUK State Chapter. The Life Membership Fee will be credited to this Fund.

5.3. Source of the Reserve Fund

i. From voluntary donations.
ii. 1/5th of the interest on the membership fee of the national body of IAPSM received from the candidates of UP & UK state.

5.4. Journal's Management & Publication

The Editorial Board besides the Chief Editor shall consist of Editor, Managing Editor, Assistant Editor and 21 members (along with IPCE- Immediate Past Chief Editor).

President Chairman Secretary

The Secretary of IAPSMUPUK state chapter will be an ex-officio member of the Editorial Board of IJCH and Chief Editor of the IJCH will be the ex-officio member the Governing Council of IAPSMUPUK State Chapter. Chief Editor will ensure at least one meeting of the Editorial Board in six months.

The name of the members of the Editorial Board of IJCH shall be proposed to the Governing Council by the Chief Editor of IJCH and will finally be selected after the approval of the General Council for a period of three years. As far as possible, the members of the Editorial Board should be proposed in such a manner by the Chief Editor that they represent various sub-specialties of Preventive and Social Medicine as well as different regions of Uttar Pradesh and Uttarakhand state. If a vacancy arises on the Editorial Board in the middle of a term, the Governing Council on the advice of the Chief Editor may nominate any other member of the IAPSMUPUK State Chapter to fill up the vacancy for the remaining term.

The official journal of IAPSMUPUK State Chapter i.e., IJCH shall be published quarterly (i.e., in January, April, July and October) and as far as possible all the issues of IJCH shall be sent to all the members quarterly every year. All the members whose names are mentioned on the Register of the Members of the Society available at the headquarter on the day of the dispatch of a particular issue of IJCH shall be sent a copy of journal by the office of the IJCH - Journal without any cost.

5.4.1. Source of Journals' Fund

i. The subscription charges of IJCH for non-members/ Institutions as deemed fit and fixed by the Chief Editor of IJCH.

ii. The account of the IJCH shall be credited 3/5th of the interest of the reserved fund of IAPSMUPUK State Chapter comprising of Life Membership Fee and Fellowship Registration Fee by the Secretary of the IAPSMUPUK State Chapter.

iii. Charges of the ethical advertisements in IJCH or official website (www.iapsmupuk.org) of the IAPSMUPUK state chapter if any.

iv. Processing charges of Rupees 1500 per article in to-to.

v. The Organizing Secretary of every Annual Conference of the IAPSMUPUK State Chapter shall contribute a minimum of Rupees 10,000/- to the accounts of the Journal for incurring IJCH and official website (www.iapsmupuk.org) related expenses and dues if any.

6. AMENDMENT IN THE CONSTITUTION

Any member desirous of alteration in this constitution should give his/her resolution, after obtaining the consent of at least two or more members to the Secretary, which should reach him/her at least two weeks prior to the conduction of Annual Conference of IAPSMUPUK State Chapter. The Secretary shall place all such resolutions before the General Council of the IAPSMUPUK State Chapter. The General Council may pass such a resolution with 2/3rd members present in the meeting favouring the resolution. The quorum for amendment in the constitution - alteration or addition shall be of twenty five members of the IAPSMUPUK State Chapter.

President
IAPSMUPUK State Chapter
Dr. Bhakt Prakash Mathur

Chairman
(Constitutional Committee)
Dr. Jai Vir Singh

Secretary
IAPSMUPUK State Chapter
Dr. Shivendra Kumar Singh

Indian Association of Preventive and Social Medicine

UP UK State Chapter

Minutes of the Governing Council / EC Meeting

(Held on 18-10-2013)

16th IAPSMUPUK State Chapter Annual Conference (18th & 19th October' 13)

Department of Community Medicine, Govt. Medical College, Haldwani, Nainital, UKD

1. Confirmation of Minutes of the General Council (GBM) dated 24.12.2012 held at MLB Medical College Jhansi, U.P. - **Passed**

   - The last point in agenda no-4 of the minutes of the Governing Council/ EC Meeting held at Jhansi i.e., the Draft Constitution of IAPSM UP UK State Chapter which was updated last on 17-09-2013 by Dr. J. V. Singh, Prof. & Head, Department of Community Medicine, MMCH, Muzaffarnagar, U.P. has been approved unanimously with slight modification in number of Executive Members i.e., total 09 (06 from U.P. & 03 from Uttarakhand) - **Passed**
   - In line with the constitution of the national body of IAPSM, the newly formulated constitution of the State Chapter would be implemented with immediate effect i.e., from 18th October 2013 onwards if passed by the General Council / GBM also - **Passed**

2. **Holding of next chapter conference** – Proposal of Dr. S. K. Mishra, Prof. & Head, Department of Community Medicine, S.N. Medical College, Agra, U.P. along with the consent letter of the Principal for holding next conference has been **passed.**

3. **Election of Chief Editor of the IJCH:** Following four nominations were received and was decided to put up the matter in the General Council Meeting / GBM scheduled to be held on the same day to elect the Chief Editor of IJCH for the next tenure starting from 1st April 2014 to 31st March 2017.

   a) Prof J. V. Singh, Prof. & Head, Department of Community Medicine, MMCH, Muzaffarnagar, U.P.
   b) Prof. J. V. Singh, Director, UPRIMS & R, Saifai, Etawa, U.P.
   c) Dr. C. M. Singh, Additional Professor, Department of Community Medicine, AIIMS, Patna, Bihar.
   d) Dr. Pradeep Aggarwal, Associate Professor, Department of Community Medicine, HIMS, HIHT University, Jolly Grant, Dehradun, Uttarakhand.

President

Secretary

4. Election of the Governing Council / EC of the state chapter: For next tenure as required -

1)	President	-	Prof. C.M.S. Rawat (Org. Sec. of the Conference)
2)	Immediate Past President (IPP)	-	Prof. B.P. Mathur (Current President)
3)	Vice President	-	Prof. S.B. Gupta (Proposed by Governing Council / EC)
4)	Secretary	-	Dr. Khursheed Muzammil (Unopposed)
5)	Joint Secretary	-	One } To be nominated by the Secretary
6)	Treasurer	-	One }
7)	Chief Editor	-	One (To be elected by General Council / GBM)
8)	Executive Members	-	09 members (06 from U.P & 03 from Uttarakhand)

[To be elected by General Council/ GBM]

5. Any other matter with the permission of the chair.

a) Life Time Achievement Award - 2014 to be awarded to two eminent persons of our fraternity -
   - Prof. J. V. Singh (Muzaffarnagar)
   - Prof. B. M. Gupta (Varanasi)

b) Prof. B. G. Prasad Oration Award for 2014: To be awarded to -
   - Prof. J. V. Singh (Director-UPRIMS & R, Saifai, U.P.)

c) Constitution of a committee to frame the criteria to be adopted from 2015 onwards for –
   - Prof. B. G. Prasad Oration Award &
   - Life Time Achievement Award

d) Mid-term Governing Council / EC Meeting between the two conferences is mandatory to be held preferably at the venue of next conference or at a place suitable to all the concerned. Only hospitability will be provided for the members attending the same. No travelling allowance will be given to the members attending such meeting.

e) E-newsletter related to Departmental & Association related activities is to be published online on the official website of the association on quarterly basis.

f) Workshops to be held at Khajuraho & Bareilly under the able guidance of Prof. B. P. Mathur before 31st March 2014.

g) Workshop on Research Methodology in Remote and Rural Medical Colleges: Proposal to be sent Prof. Deoki Nandan for funding & related matters etc.

h) Chair of the Secretary to be included and placed on the stage in the inaugural ceremony and valedictory function as a Protocol and in every conference from now onwards.

i) Audited reports of the accounts of the Journal and Association are to be produced and read by the Chief Editor and Treasurer of the association respectively during the Governing Council / EC Meeting.

j) Following members were present in the Governing Council / EC Meeting –
   1) Prof. B. P. Mathur (President)
   2) Prof. Rahul Bansal (Immediate Past President: IPP)

President

Secretary

3) Dr. S. K. Singh (Secretary)
4) Dr. Khursheed Muzammil (Joint Secretary)
5) Prof. S. K. Misra (EC Member)
6) Dr. A. K. Srivastava (EC Member)
7) Dr. Vidya Rani (EC Member)
8) Dr. C. P Mishra
9) Dr. V. M. Gupta
10) Dr. Rakesh kakkar
11) Dr. Pradeep Aggarwal
12) Prof H. Chopra
13) Prof. S. K. Garg
14) Prof. J. V. Singh
15) Prof. S. B. Gupta
16) Prof. Deoki Nandan
17) Dr. C. M. Singh
18) Prof. S. C. Gupta

i) The meeting was chaired by Prof. B. P. Mathur (President: 2013-14).

6. **Vote of thanks: Delivered by Secretary** – Dr. Shivendra Kumar Singh

.....	.....
(Signature)	(Signature)
Prof. B. P. Mathur	**Dr. Shivendra Kumar Singh**
President - IAPSMUPUK State Chapter	**Secretary - IAPSMUPUK State Chapter**
Professor and Head	Associate Professor
Department of Community Medicine	Department of Community Medicine
MLB Medical College	K G Medical University
Jhansi, U.P.	Lucknow, U.P.

Indian Association of Preventive and Social Medicine

UP UK State Chapter

Minutes of the General Council / GBM

(Held on 18-10-2013)

16th IAPSMUPUK State Chapter Annual Conference (18th - 19th Oct' 13)

Deptt. of Community Medicine, Govt. Medical College, Haldwani, Nainital, UKD

The General Council / General Body Meeting of IAPSM UP and UK State Chapter was held on 18th October, 2013 during 16th Annual Conference of UP and UK Chapter at Department of Community Medicine, Govt. Medical College, Haldwani, Nainital, UKD.

The following 60 members were present:-

S.N.	Name of member	S.N.	Name of member	S.N.	Name of member
1	Dr. Uday Mohan	23	Dr. Huma Khan	45	Dr. Vandana
2	Dr. S. B. Gupta	24	Dr. Ruchi Juyal	46	Dr. Neha Goyal
3	Dr. R. P. Sharma	25	Dr. Jayanti Semwal	47	Dr. Mradula Doha
4	Dr. S. C. Gupta	26	Dr. Rahul Bansal	48	Dr. Pradeep Aggarwal
5	Dr. S. K. Kaushal	27	Dr. H. Chopra	49	Dr. Mohd Haroon Khan
6	Dr. Anurag Srivastava	28	Dr. Deoki Nandan	50	Dr. Shantanu Aggarwal
7	Dr. Naresh Pal Singh	29	Dr. Bhola Nath	51	Dr. Anish Khanna
8	Dr. Dhiraj Srivastava	30	Dr. Nipun Agarwal	52	Dr. Naim Ahmad
9	Dr. Vidya Rani	31	Dr. Sumit Saxena	53	Dr. Dr. M. K. Manar
10	Dr. Santosh Kumar	32	Dr. Gagan Garg	54	Dr. Janki Bartwal
11	Dr. Sadhna Awasthi	33	Dr. Sujit K Singh	55	Dr. C. M. Singh
12	Dr. Pooja Chaudhary	34	Dr. Shailendra Kumar	56	Dr. B. P Mathur
13	Dr. Madhavi	35	Dr. J. V. Singh	57	Dr. C. M. S. Rawat
14	Dr. Gagandeep Kaur	36	Dr. Pallavi Shukla	58	Dr. V. M. Gupta
15	Dr. Rajesh K Singh	37	Dr. Pawan Pandey	59	Dr. S. K. Misra
16	Dr. Amandeep Kaur	38	Dr. Ashish Chauhan	60	Dr. Khursheed Muzammil
17	Dr. Mehar Bano	39	Dr. Ravi Kant		
18	Dr. Nirankar Singh	40	Dr. Ashish Srivastava		
19	Dr. Pawal Goel	41	Dr. A. Gupta		
20	Dr. Sudhir K Gupta	42	Dr. Anupama Arya		
21	Dr. A. K. Srivastava	43	Dr. Saurabh Shukla		
22	Dr. Rakesh Kakkar	44	Dr. Sunil		

The meeting was chaired by Dr. B. P. Mathur (President: IAPSMUPUK - 2013-2014.

President

Secretary.

Agenda No.1: Confirmation of the Minutes of the General Council / GBM held at Jhansi.

The minutes of the last General Council / General Body Meeting held at MLB Medical College on 24-12-2012 were read by Dr. S. K. Singh, Secretary, IAPSMUPUK and were **passed.**

- The last point in agenda no-4 of the minutes of the Governing Council/ EC Meeting held at Jhansi i.e., the Draft Constitution of IAPSM UP UK State Chapter which was updated last on 17-09-2013 by Dr. J. V. Singh, Prof. & Head, Department of Community Medicine, MMCH, Muzaffarnagar, U.P. has been approved unanimously with slight modification in number of Executive Members i.e., total 09 (06 from U.P. & 03 from Uttarakhand) - **Passed**
- In line with the constitution of the national body of IAPSM, the newly formulated constitution of the State Chapter would be implemented with immediate effect i.e., from 18th October 2013 onwards if passed by the General Council / GBM also - **Passed**
- For publication of alphabetical Directory a sum of Rs. 5000/- was sanctioned.
- Minutes of the Governing Council / EC meeting held on 18th October 2013 at Haldwani around 02:00 PM were read by Dr. Shivendra Kumar Singh (Secretary IAPSM UPUK State Chapter) and **passed** by the General Council / GBM.

Agenda No.2: Holding of the next Annual Conference of IAPSMUPUK State Chapter:

Proposal of Dr. S. K. Mishra, Prof. & Head, Department of Community Medicine, S.N. Medical College, Agra, U.P. along with the consent letter of the Principal for holding next conference has been **passed.**

Agenda No.3: Election of the Chief Editor of IJCH as required: After thorough discussion by the members and the applicants it was decided that Dr. Pradeep Aggarwal will be the Chief Editor of IJCH for the next tenure of three years that is from 1st April 2014 to 31st March 2017. He will constitute his Editorial Team as per the constitution in force keeping Dr. C. M. Singh (Immediate Past Chief Editor) as the Chief Advisor for the next tenure of three yearss.

Agenda No.3: Election of Governing Council / EC of the State Chapter as required:

Election was required for all the posts of the Governing Council / EC. Following were elected on different posts by the General Council / GBM:-

1) President - Prof. C.M.S. Rawat (1st April 14 - 31st Mar 15)
2) Immediate Past President (IPP) - Prof. B.P. Mathur (1st April 14 - 31st Mar 15)
3) Vice-President - Prof. S. B. Gupta (1st April 14 - 31st Mar 15)
4) Secretary - Dr. Khursheed Muzammil (3 yrs from 1/4/14)
5) Joint Secretary - One
6) Treasurer - One
   To be nominated by the Secretary
7) Chief Editor - Dr. Pradeep Aggarwal
8) Executive Members - 09 members (06 from U.P. & 03 from UKD)

President

Secretary

I. Prof. R. P. Sharma (GSVM Medical College, Kanpur)
II. Dr. Peeyush Kariwal (SRMSIMS, Bareilly)
III. Dr. MoniKa Agarwal (KGMU, Lucknow)
IV. Dr. Sanjeev Kumar (LLRM, Meerut)
V. Dr. P. K. Jain (UPRIMS & R, Saifai)
VI. Dr. Sunil (SNMC, Agra)

} From U.P.

VII. Prof. Jayanti Semwal (HIHT, Dehradun, UKD)
VIII. Dr. Bhola Nath (Shrinagar, UKD)
IX. Dr. Sadhna Awasthi (GMC, Haldwani, UKD)

} From UKD

- The office of the Headquarter of IAPSM UPUK State Chapter will be located at Department of Community Medicine, Muzaffarnagar Medical College, Muzaffarnagar from 1st April 2014 to 31st March 2017.

- Dr. Khursheed Muzammil (Newly Elected Secretary) nominated and announced -
  1. **Prof. Anurag Srivastava (as Joint Secretary)**
  2. **Dr. Ruchi Juyal (as Treasurer)**

Agenda No.4: Any other matter with the permission of the Chair (President):

a) Dr. S. K. Gupta was requested to take the responsibility of preparing a list of Chair Holders since the inception of our State Chapter Association and the same is to be uploaded on the official website of IAPSM UPUK State Chapter (www.iapsmupuk.org).

b) Mid-term Governing Council / EC Meeting before 31st March of every year was made mandatory to be held preferably at the venue of next conference or at a place suitable to all the concerned. Only hospitability will be provided to the members attending the same and no travelling allowance will be given.

c) Constitution of a committee to frame the criteria to be adopted and implemented from 2015 onwards for –
   - Prof. B. G. Prasad Oration Award &
   - Life Time Achievement Award

d) The mid-term meeting of the Governing Council / EC of the current session after necessary correction or modification will finalize and approve the criteria as suggested by the committee constituted for Life Time Achievement Awards and Prof. B. G. Prasad Oration Award from 2015 onwards.

e) Office of the Headquarter along with Bank Account details, all the necessary registers, documents, files, previous & current audited reports and important papers are to be handed over by the outgoing Secretary to the forth coming Secretary in the Mid-term meeting of the Governing Council / EC amicably.

f) Office of the IJCH along with Bank Account details, all the articles, hard and soft copies of the important documents, previous & current audited reports, bills, files and required papers are to be handed over by the outgoing Chief Editor to the

President

Secretary

forth coming Chief Editor in the Mid-term meeting of the Governing Council / EC amicably.

g) Dr. Pradeep Aggarwal (Elected Chief Editor) was entrusted to contact Medknow authorities for publication of IJCH and to ensure indexing of IJCH with PubMed.

h) Life Time Achievement Award for 2014 to beawarded to two eminent persons of our fraternity -
   - Prof. J. V. Singh (Muzaffarnagar)
   - Prof. B. M. Gupta (Varanasi)

i) Prof. B. G. Prasad Oration Award for 2014: To be awarded to –
   - Prof. J. V. Singh (Director-UPRIMS & R, Saifai, U.P.)

j) E-newsletter related to Departmental & Association related activities is to be published online on the official website of the association on quarterly basis.

k) Workshops to be held at Khajuraho & Bareilly under the able guidance of Prof. B. P. Mathur before 31st March 2014.

l) Workshop on Research Methodology in Remote and Rural Medical Colleges: Proposal to be sent Prof. Deoki Nandan for funding & related matters etc.

m) Chair of the Secretary to be included and placed on the stage in the inaugural ceremony and valedictory function as a Protocol in every conference from now onwards.

n) Audited reports of the accounts of the Journal and Association are to be produced and read by the Chief Editor and Treasurer of the association respectively during the Governing Council / EC Meeting.

The Meeting ended with Vote of Thanks to the Chair and all members present over there by Dr. Shivendra Kumar Singh, Secretary, IAPSM UPUK State Chapter.

Dr. B. P. Mathur
President- IAPSM
UPUK State Chapter

Dr. S. K. Singh
Secretary- IAPSM
UPUK State Chapter

Membership Directory
IAPSM UPUK

Indian Association of Preventive & Social Medicine UPUK

Dedicated

To

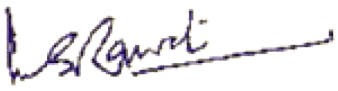
(Late) Prof. Deoki Nandan

Message

The first edition of the membership directory of Indian Association of Preventive and Social Medicine UP Chapter was published in the year 1991 which was the first effort of its kind by the then Secretary of IAPSM UP Chapter (Late) Prof. Deoki Nandan. It's a matter of great pleasure that after a gap of 24 years we have been able to publish the long awaited second edition of membership directory of IAPSM UPUK with the constant guidance and encouragement from eminent professors. But this time, the current directory will include not only the basic information & contact details of the IAPSM members from Uttar Pradesh but also from Uttarakhand which was officially added up in the UP Chapter in the year 2010.

I hope this directory will be useful and of immense help for all the members of IAPSM especially from UP & UK. The basic informations given in this directory have been collected from the national data base of IAPSM for its members as on 15th Sep' 2015. I am thankful to Prof. B. P. Mathur (Jhansi) & Prof. J. V. Singh (Muzaffarnagar) for their valuable suggestions in the making of this directory. I must also thank Dr. Pradeep Aggarwal to incorporate relevant informations and the most recent contact details of the members of IAPSM UPUK. Despite all the best possible efforts at one place or the other some information may be incomplete due to lack of timely response from our respected members and for that I may be forgiven.

LONG LIVE IAPSM UP-UK!



Prof. C. M. S. Rawat
President
IAPSM UPUK
2013 – 2014

Dr. Khursheed Muzammil
Secretary
IAPSM UPUK
2014 – 2017

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ABEDI ALI JAFAR
L-2275
MEDICAL OFFICER T-7, AZIM ESTATE, NEW SIR SYED NAGAR ALIGARH UTTAR PRADESH
alijafarabedi@gmail.com
9219510553

AGARTANIA MAMTA
L-1724
D/O SHRI B.R. AGARTANIA, H.NO. 242-243 SADAR BAZAR, AZAD MOHALLA BAREILLY CANTT, BAREILLY UTTAR PRADESH

AGARWAL ARCHANA
L-0164
C/O MOHAN HOTEL, CHARBGH, LUCKNOW UTTAR PRADESH

AGARWAL DISHA
L-3283
FLAT NO. 105, GANPATI APARTMENTS, KENDRIYA HINDI SANSATHAN ROAD,KHANDARI, BYE PASS ROAD, AGRA, UP – 282005
agarwaldisha04@yahoo.com
9412155991

NAME					
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AGARWAL K. L.
L-0046
DEPTT. OF PSM, GSVM MEDICAL COLLEGE, KANPUR UTTAR PRADESH

AGARWAL MEDHAVI
L-3169
28 – D EXECUTIVE, SUN CITY VISTAR, BAREILLY, UTTAR PRADESH – 243001
dr.medhaviagarwal@gmail.com

AGARWAL RENU
L-1723
C/O MR R. S. SHARMA, 33, GAJANAN NAGAR, KOTHI MEENA BAZAR, NEAR SHAHGANJ, AGRA UTTAR PRADESH
renua13@gmail.com
9897133888

AGARWAL RICHA
L-1903
4/278-B, CHHAYA, VISHNUPURI KANPUR UTTAR PRADESH
richatandon1979@gmail.com
9919331981

NAME					
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AGARWAL SIDHARTH RAJ
L-1419
A-1, KANT KUNJ, 62, SAKET MEERUT UTTAR PRADESH

AGGARWAL D. K.
L-0332
NEW E-10, JODHPUR COLONY, B.H.U., VARANASI
UTTAR PRADESH 227005

AGGARWAL MONIKA
L-1309
H.NO. 12, SECTOR-14, INDIRA NAGAR LUCKNOW
UTTAR PRADESH
monicaag51@gmail.com
9794999270

AGGARWAL PRADEEP
L-1981
DEPTT. OF COMMUNITY MEDICINE, HIMS SWAMI
RAM NAGAR, DOIWALA, DEHRADUN UTTARANCHAL
drpradeep_aggarwal@hotmail.com
9837215747

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AGRAWAL NIPUN
L-3292
232, MADHO BARI, BAREILLY, UTTAR PRADESH – 243005
nipun.agrawal@gmail.com

AHMAD SHAMSHAD
L-2752
MARRIED DOCTOR'S FLAT – 06, BHU, VARANASI
UTTAR PRADESH – 221005

AHMAD SIRAJ
L-1461
23, ALIG APARTMENTS, SHAMSHAD MARKET
ALIGARH UTTAR PRADESH 202002
tosiraj@hotmail.com
9879249668

AHMED MALIK SHANAWAZ
L-3210
JUNIOR RESIDENT, DEPTT. OF COMMUNITY MEDICINE, JNMCH, AMU, ALIGARH, UTTAR PRADESH – 202002
maliks_03@yahoo.com
9307085992

NAME					
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AHMED NAIM
L-2204
ASSTT. PROFESSOR 1, LA PLACE COLONY SHAH NAJAF ROAD LUCKNOW UTTAR PRADESH

AHMED UWES
L-0598
42/317, BILLOCH PURA, LOHA MANDI AGRA UTTAR PRADESH

AHUJA PRAKASH CHANDRA
L-0117
MOH CUM LECTURER DEPTT. OF SPM, KG'S MEDICAL COLLEGE LUCKNOW UTTAR PRADESH

ALI S. MANAZIE
L-0485
C/O ER. AGHA MUBARAK HUSAIN, AB-50 MEDICAL COLONY, AMU ALIGARH UTTAR PRADESH

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ALOK KUMAR
L-2256
58/11-SBH MLB MEDICAL COLLEGE, JHANSI UTTAR PRADESH

ARUN ABHISHEK
L-3536
C487/D, VATSALYTA, INDIRA NAGAR, UP
dr.abhishekarun@gmail.com
9455388302

ARYA RAVI KANT
L-0330
S/O DR. OM PRAKASH ARYA, 46, HAPUR, GHAZIABAD UTTAR PRADESH 245101
rkarya2311@gmail.com
9411056285

ARYA VIMAL
L-3148
S/O DR. V.V. ARYA,315- C.P. MISSION COMPOUND, CIVIL LINE, JHANSI, UP –284003
drvimalarya@gmail.com

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ASHOK KUMAR
L-0603
MEDICAL OFFICER QUODEEM, DISTT. SAHARANPUR
UTTAR PRADESH

ASIF RASHMI
L-0697
C/O MR. N. L. SHARMA, 3/49 JANAK PURI, ALIGARH
UTTAR PRADESH 202001
rashmi.asif@jhpiego.org
9810095449

ASTHANA SMITA
L-3329
132, CITY VIEW APTS. SECT. – 35, NOIDA, UTTAR
PRADESH – 201301
smitasanjay97@yahoo.com
9810622149

AWASTHI SADHNA
L-1398
DEPTT. OF COMMUNITY MEDICINE, UTTARANCHAL
FOREST HOSP. TRUST MED. COL., HALDWANI,
NANITAL UTTARANCHAL
drsadhna1810@yahoo.com
9319928622

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BAJPAI PUSHPA
L-0956
160, BAJPAI NAGAR, BHARTHANA, ETAWAH UTTAR PRADESH

BAKSHI RAVLEEN KAUR
L-3206
drravleen01@gmail.com

BALDEO RAJ
L-0249
PROFESSOR AND HEAD DEPTT. OF SPM, MLN MEDICAL COLLEGE, ALLAHABAD UTTAR PRADESH

BANDOPADHYAY PRASHANTA
L-0813
BEHIND MALARIA OFFICE, KATRA, BASTI, BASTI UTTAR PRADESH 272001

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BANO MEHAR
L-3491
D/O MR. SAEED AHAMAD, COLONY, MAJRA, PHASE – I, DEHRADUN, UTTARAKHAND – 248171
meharbano1204@gmail.com
9918047513

BANO TANVEER
L-0890
1, DR. CARALLI ROAD, BEGUM BRIDGE MEERUT UTTAR PRADESH
tanveerbano@hotmail.com
9927065121

BANSAL RAHUL
L-0687
PROFESSOR AND HEAD, DEPTT, OF SUBHARATIPURAM, MEERUT UTTAR PRADESH 250027
drrahulbansalzp@gmail.com
9837277055

BANSAL RAKESH KUMAR
L-0628
A-193, SHASTRI NAGAR MEERUT UTTAR PRADESH

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BARDHAN HARSH
L-3149
A-304, KRESENT APARTMENT, PRATAP VIHAR,
SECTOR – 11, GHAZIABAD, UTTAR PRADESH – 201010
9911622440

BARMAN SANTOSH KUMAR
L-1840
JUNIOR RESIDENT DEPTT NI MEDICINE, KGMU,
LUCKNOW UTTAR PRADESH

BARTWAL JANKI
L-3411
jankibartwal@yahoo.in

BENARA SUDHIR KUMAR
L-0347
DEPUTY DIRECTOR(MED.) D-2/24/4, DLF DILSHAD
PLAZA DILSHAD EXT.-2, BHOPARA, UTTAR PRADESH
201005

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BETTAPPA PRASHANTHA
L-2644
JR, ROOM NO. 6, NEW NEHRU HOSTEL, INSIDE CSMMU CAMPUS, CHOWK, LUCKNOW, UTTAR PRADESH – 226003

BHARDWAJ PANKAJ
L-2122
C/O MR. M. P. ASTHANA, E – 1674/1 RAJAJIPURAM, LUCKNOW, UTTAR PRADESH – 17

BHATNAGAR J. K.
L-0107
B-133, SECTOR-C, MAHANAGAR LUCKNOW UTTAR PRADESH

BHATNAGAR MANJUL
L-0075
64-65, PREM PRAYAG, GARG ROAD, MEERUT UTTAR PRADESH
drmanjulbhatnagar@yahoo.com

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BHATTACHARYA RITA
L-0418
B-21/109-D, VINAIKA, KMACHA VARANASI UTTAR PRADESH

BINA NILARATHNA
L-0337
A-15, JUDGES COMPUND AGRA UTTAR PRADESH

BUTT ARINDAM
L-2486
C/O, HIRANMOY CHAKROBORTY NIRAMOY, M.J.N ROAD (OPPOSITE TO FORWARD BLOCK PARTY OFFICE)
buttarindam@gmail.com
9434037982

CHAND RAJESH HUKAM
L-2016
DEPTT. OF COMMUNITY MEDICINE, GOVT. MEDICAL COLLEGE, AMRITSAR, PUNJAB

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CHANDRA PRAKASH
L-0617
PG STUDENT DEPTT. OF PSM, LLRM MEDICAL COLLEGE, MEERUT UTTAR PRADESH

CHANDRA RAMESH
L-0154
PROFESSOR AND HEAD KALIGANJ, LUCKNOW UTTAR PRADESH

CHANDRA SURESH
L-0622
DEPTT. OF PSM, GSVM MEDICAL COLLEGE KANPUR UTTAR PRADESH
drsureshchandra10@gmail.com
9450937555

CHATTERJEE ANAMIKA
L-2497
PGT. IN COMMUNITY MEDICINE 105/2, B.K. STREET, UTTARPARA HOOGHLY – 712258, WEST BENGAL

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CHATURVEDI AVM ASHOK (RETD.)
L-0557
ADDL. DG AFMS (MR) ROAD), LUCKNOW UTTAR PRADESH 226001

CHATURVEDI MANISH
L-1722
1/119, CHOBE JI KA KATRA, KINARI BAZAR, AGRA UTTAR PRADESH
dr.manish.chaturvedi@gmail.com
9818643177

Chaudhary Anjuman
L-3538
1377/2A, Near Saraswati Vidya Mandir School, Vivekanand Nagar, Sultanpur-228001 (UP)
nutan237@gmail.com

CHAUDHARY CHINTU
L-2799
41C/2, RAJPUR ROAD, DEHRADUN UTTARAKHAND – 248001
chaudharychintu@gmail.com ;
chintu.chaudhary@yahoo.com

NAME					
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CHAUDHARY POOJA
L-3241
3/37 SHRADHAPURI, KANKER KHERA, MEERUT,
UTTAR PRADESH – 250001
drpoojachaudhary@gmail.com
9457033680

CHAUDHARY SHAILENDRA SINGH
L-3104
LECTURER, DEPTT. OF SOCIAL AND PREVENTIVE MEDICINE, S.N. MEDICAL COLLEGE, UTTAR PRADESH – 282002
drshailen321@yahoo.co.in
9458429778

CHAUDHARY VARSHA
L-3266
60, SANT VIHAR TRANSPORT NAGAR, MEERUT,
UTTAR PRADESH – 250002
mahichaudhaery25@gmail.com
9897694695

CHAUHAN ANJU
L-0522
ASSTT. PROFESSOR RAMA MED. COLLEGE & RESEARCH CENTER, RAMA EDUCATIONAL CITY, G.T. ROAD UTTAR PRADESH – 209217
dranjugahlot@gmail.com
9792266664

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CHOPRA HARIVANSH
L-0497
Professor, Deptt. of Community Medicine, LLRM, Meerut; R/O: 7-A, PATEL NAGAR MEERUT UTTAR PRADESH
harichop@gmail.com
9412529800

D. S. MARTOLIA
L-1845
Prof. & Head, DEPARTMENT OF COMMUNITY MEDICINE, Govt. Medical College, Kannauj, UTTAR PRADESH
dr.martolia10@gmail.com

DABRAL MADHAV
L-0380
READER DEPTT. OF SPM, MLB MEDICAL COLLEGE JHANSI UTTAR PRADESH

DABRAL S. B.
L-0099
65, NESHVILLA ROAD DEHRADUN UTTARANCHAL

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DEEP SHIKHA
L-3460
C/O DR. VIJAY PAL 3/144, VIDHYA NAGAR COLONY,
ALIGARH, UTTAR PRADESH -202001
drd.shikha@yahoo.co.in
9837006962

DEEPA RUWALI
L-1306
49, ASHUTOSH NAGAR, KRISHNA NAGAR LUCKNOW
UTTAR PRADESH 226023

DEVESH KUMAR
L-0817
BUNGLOW NO. 349, RAILWAY STADIUM CNY.
GORAKHPUR UTTAR PRADESH

DHALARIA PRITU
L-0909
1504, PARK VIEW APPTTS., SECTOR – 29 NEAR
BHARAMHAPUTRA MARKET, NOIDA, UTTAR
PRADESH– 201301

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DHINGRA NEERAJ
L-0325
59,RAIL VIHAR, SECTOR 30,NOIDA UTTAR PRADESH 201301

DIXIT ANAND MOHAN
L-1725
DEPTT. OF SPM,S. N. MEDICAL COLLEGE, AGRA UTTAR PRADESH
dixitam@rediffmail.com
9414956772

DIXIT SUMEET
L-2545
H.NO. 5/246,GULSHAN PARK BANNA DEVI, ALIGARH, UTTAR PRADESH – 202001
docdixit30@gmail.com
9012047473

DUBE SWAPNIL
L-2915
ASSOCIATE CONSULTA NT LIMITED, 126-C, SECTOR – III, DEFENCE COLONY, DEHRADUN, UTTARAKHAND – 248005
swapnildube@rediffmail.com , swapnildube@amsindia.org

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DUBEY BHARAT
L-1844
S/O SH. RAJEEV DUBEY, 288/167, ARYA NAGAR
LUCKNOW UTTAR PRADESH 226004

DUTTA SHRIHARI
L-1026
H.NO. 11, C-LANE, STREET NO.1, ROAD, DEHRADUN
UTTARANCHAL 248001
sdutta@unicef.org
9560198557

DWIVEDI RADHA RAMAN
L-0208
8, SHIVPURI COLONY, NAGWA VARANASI UTTAR
PRADESH

DWIVEDI RANJANA
L-3287
JUNIOR RESIDENT – II,.DEPTT.OF M., S. N. MEDICAL
COLLEGE, AGRA, UTTAR PRADESH – 282002
dr.ranjanaabhi@gmail.com
9369541394

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DWIVEDI SHRADDHA
L-0668
Ex- Professor & Head, Deptt. of Community Medicine MLN Medical College, Allahabad, R/O: G-110, Sanjay Gandhi Puram, Lucknow, U.P.
shraddha.dwivedi@gmail.com
9415347536

FAHEEM AHMED
L-3499
PG 1ST YEAR, DEPTT. OF COMMUNITY MEDICINE, SCIENCES, BAREILLY, NAINITAL ROAD, BHOJIPURA, BAREILLY, UTTAR PRADESH – 243202
drfam2009@gmail.com

FAIZI NAFIS
L-2835
B-8, 2ND FLOOR, SAMI APARTMENT, DODHPUR, ALIGARH, UTTAR PRADESH – 202002
nafisfaizi@gmail.com
9897107815

GARG CHHAYA
L-2518
C/O SH. A.S. MITTAL OPPOSITE TELEPHONE EXCHANGE, RAJENDRA NAGAR, MODI NAGAR UTTAR PRADESH –
dr_chhaya04@yahoo.co.in

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Garg Gagan
L-3578
S/o. Sri Arvind Kumar, H. No. 106, Joshiwara,
Deoband, Saharanpur-247554 (UP)
drgagan14@gmail.com
9634522363

GARG S. K.
L-0074
PROF. & HEAD, DEPTT OF COMMUNITY MEDICINE,
LLRM MEDICAL COLLEGE, MEERUT, UTTAR PRADESH
drgargfam@rediffmail.com
9412837112

GARG SUNEELA
L-0627
C17/SEC-19, NOIDA UTTAR PRADESH

GAUR S.D.
L-0151
7/11 KABIR NAGAR COLONY VARANASI UTTAR
PRADESH

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GEORGE CAROLIN ELIZABETH
L-3089
PG STUDENT – 3RD YEAR. DEPTT. OF SPM, L.L.R.M. MEDICAL COLLEGE, MEERUT, UTTAR PRADESH – 250004
9012534732

GOEL KAPIL
L-2813
H.NO.-A-422, DEFENCE ENCLAVE SARDHANA ROAD, MEERUT, UTTAR PRADESH – 250001
drkapil123@gmail.com
9410276076

GOEL NEETA
L-0835
DEPTT. OF SPM, SN MEDICAL COLLEGE AGRA UTTAR PRADESH

GOEL PAWAN KUMAR
L-2625
ASSOCIATE PROFESSOR, DEPTT. OF COMMUNITY MEDICINE, SHKMM Govt. Medical College, Nuh, Nalhar, Mewat, Haryana; Email: drpkgoelbobby@rediffmail.com Mobile: 09412655800
drpkgoelbobby@rediffmail.com
9412655800

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GOEL SELESH KUMAR
L-0891
H.NO. 120, AFGANAN STREET, DELHI GATE
GHAZIABAD UTTAR PRADESH

GOPAL KRISHAN
L-0125
PROFESSOR DEPTT. OF S.P.M.,G.S.V.M. MEDICAL COLLEGE, KANPUR UTTAR PRADESH
gkrishna1942@gmail.com
9451877987

GOVIL MANJU
L-0386
DEPTT. OF SPM, M.L.B. MEDICAL COLLEGE, JHANSI UTTAR PRADESH

GUPTA B. N.
L-0629
PROFESSOR ROAD, LUCKNOW UTTAR PRADESH
226001

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GUPTA BINOD KUMAR
L-1054
S/O SH. PASHUPATI RAM GUPTA, NAGAR, BALLIA
UTTAR PRADESH 277001

GUPTA DHARMENDRA KUMAR
L-3267
PG STUDENT, DEPTT. OF COMMUNITY MEDICINE,
ROHILKHAND MEDICAL COLLEGE & HOSPITAL,
BAREILLY, UTTAR PRADESH – 243006
dharmendrashivani25@gmail.com

GUPTA GAJENDRA KUMAR
L-0837
G-281, GOVINDPURAM GHAZIABAD UTTAR PRADESH
gajendrakgupta@gmail.com
9868459936

GUPTA GAURAV
L-3065
L-657, SHASTRI NAGAR, MEERUT, UTTAR PRADESH –
250004
drgg11@gmail.com

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GUPTA MANISHA
L-1032
C/O RISHI KUMAR GUPTA, NAGAR, SAHARANPUR
UTTAR PRADESH 247001

GUPTA MONIKA
L-2743
D-9, DEV PARK OPP. MILLENIUM PUBLIC SCHOOL,
BAGHPAT ROAD, MEERUT, UP – 250002
dr_monikagupta81@yahoo.co.in
9410862264

GUPTA NAVEEN
L-2248
FLAT NO. C-2, PLOT NO. 1/9, 5, RAJENDRA NAGAR,
SAHIHABAD UTTAR PRADESH

GUPTA NEETU
L-1590
G-2, Royal Nirmal, Crown Apartment, Khandari Road,
Agra, U.P.
neetugupta@dps.ac.in
9412022225

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GUPTA PRATHIBA
L-1843
JR-I, DEPTT. OF COMMUNITY MEDICINE KGMU, LUCKNOW UTTAR PRADESH

GUPTA R.K.
L-0005
120/200 LAJPAT NAGAR KANPUR UTTAR PRADESH 208006
Expired

GUPTA RAKESH KUMAR
L-3513
H.NO. 210 – C, SHIV KATRA, INDIRA GANDHI CHORAHA,HARJENDRA NAGAR, KANPUR,UP – 208007
drguptarakeshknp@gmail.com ;
drrekhacgupta@gmail.com

GUPTA S. C.
L-0258
PROFESSOR AND HEAD DEPTT. OF SPM, S.N. MEDICAL COLLEGE, AGRA, UTTAR PRADESH Mobile: 09917691110 , 0562-2605020
scgupta_spm@rediffmail.com
9917691110

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GUPTA S. C.
L-1057
22, SB HOSTEL, MLB MEDICAL COLLEGE JHANSI
UTTAR PRADESH

GUPTA SANJAY
L-0615
H.N. 1/228, PEEPAL MANDI AGRA UTTAR PRADESH
sanjay.gupta@impacrpartner.org.in
9818181600

GUPTA SANJAY
L-1302
MAHESH TEA COMPANY, JAWALAPUR, HARDWAR
UTTAR PRADESH 249407

GUPTA SATISH CHANDER
L-0833
EX-PRINCIPAL SNMC, I-3, LAWYERS COLONY, BYE
PASS ROAD UTTAR PRADESH

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GUPTA SHIPRA
L-2692
W/O MR. PRATEEK KACKERD-4031, GAUR GREEN CITY,INDIRAPURAM, GHAZIABAD,UP – 201010
shipragupta10@gmail.com

GUPTA SHYAM BIHARI
L-0381
LECTURER DEPTT. OF PSM, MLB MEDICAL COLLEGE, JHANSI UTTAR PRADESH
dr_sbgupta@rediffmail.com
9415030071

GUPTA SUDHIR KUMAR
L-1728
DEPTT. OF COMMUNITY MEDICINE, GRANT, DEHRADUN UTTARANCHAL 248140
sudhirsarthak@rediffmail.com
9410527979

GUPTA SURESH CHAND
L-1028
ASSOCIATE PROFESSOR DEPTT.OF COMMUNITY MEDICINE, GSVM MED.COLLEGE, UTTAR PRADESH 208001

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GUPTA V. K.
L-1634
KOTHI NO. 1-5, AZAD ROAD NEAR LOD HAPUR BUS STAND MEERUT CITY, MEERUT UTTAR PRADESH

GUPTA VIKRAM
L-2414
NPSP-WHO OFFICE,35- E/2, GOPI HOSPITAL,OPP. VIKAS BHAWAN, RAMPUR GARDEN,BAREILLY, UP– 243001

GUPTA VIRENDER MOHAN
L-0214
DEPTT. OF PSM, INST. OF MED. SCIENCES BANARAS HINDU UNIVERSITY, VARANASI UTTAR PRADESH

GUPTA VIRENDRA MOHAN
L-0204
READER DEPTT. OF PSM, INSTITUTE OF MEDICAL SCIENCES BANARAS HINDU UNIVERSITY, VARANASI UTTAR PRADESH 221005

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HARI SHANKAR
L-1457
SENIOR RESIDENT, DEPTT, OF BHU, VARANASI UTTAR PRADESH

HASAN SYED BADRUL
L-0210
Ex-MEDICAL SUPERINTENDENT, JNMCH, AMU, ALIGARH, UTTAR PRADESH
9897198825

JAIN JYOTI JOSHI
L-1212
C-602, STELLAR KINGS COURT APTT., SECTOR 50, NOIDA UTTAR PRADESH 201305

JAIN KAJAL
L-1942
60, RAJA ROAD DEHRADUN, UTTARANCHAL 248001
dr_kajal_jain@yahoo.ie
9837180006

NAME					
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JAIN MANISH
L-1675
C/O SH. S.K. AGGARWAL 53-6 CNY, AGRA UTTAR PRADESH
Drmjain2gmail.com
9670764000

JAIN SEEMA
L-0892
W/O DR. PARDEEP JAIN,. SHIV COLLEGE, MEERUT UTTAR PRADESH
drseemajain11@gmail.com
9837126575

JAIN TIMSI
L-1553
C-10, PG GIRL'S HOSTEL, LLRM MC, MEERUT UTTAR PRADESH

JHA SANJAY KUMAR
L-2629
ASSISTANT PROFESSOR DEPTT. OF COMMUNITY MEDICINE, UFHT MEDICAL COLLEGE,HALDWANI,NAINITAL, UTTARAKHAND – 263139
drsanjaykumarjha@gmail.com,
drsanjaykumarjha@yahoo.com

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JOSHI DINESH CHANDRA
L-0506
8/130, INDRA NAGAR LUCKNOW UTTAR PRADESH

JOSHI HARI SHANKER
L-1612
S/O EX. CAPT. P. D. JOSHI, VILLAGE DAHARIA PO MANPUR WEST HALDWANI DIST.NAINITAL UTTARANCHAL 263139
drjoshiharish@rediffmail.com
9415833751

JUNEJA KHUSHBOO
L-3511
C/O MR. ASHWANI KUMAR JUNEJA, MANDIR, SOOT MILL, G.T. ROAD, ALIGARH, UTTAR PRADESH – 202001
dhushboojuneja22@gmail.com
8439025056

JUYAL RUCHI
L-1589
ASSOC. PROF., DEPTT. OF COMMUNITY MEDICINE HIMS, SRH UNIVERSITY, SWAMI RAM NAGAR, DIOWALA, DEHRADUN, UTTARAKHAND
aniruchi08@gmail.com
9458913505

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KAKKAR RAKESH
L-2471
PROFESSOR, DEPTT. OF COMMUNITY MEDICINE, JOLLY GRANTS, SWAMI RAM NAGAR, DEHRADUN (UTTARAKHAND) – 248140
drrakesh75@rediffmail.com

KAMAL KISHORE REMY
L-0421
DEPTT. OF SPM, MLB MEDICAL COLLEGE JHANSI UTTAR PRADESH

KAMBOJ AMIT KUMAR
L-1304
S/O SH. B. D. KAMBOJ, 3-IIND FLOOR, KANHAIYA VAATIKA OPP. KAILASH HOSP., BAGHPAT ROAD, MEERUT UTTAR PRADESH

KANDPAL SUNIL D.
L-1439
B-31, HIMALAYAN INSTITUTE CAMPUS GRANT, DEHRADUN UTTARAKHAND
dr_sdk_hiht@yahoo.com
9411311571

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KANSAL AMRITA
L-1591
DEPTT. OF COMMUNITY MEDICINE, HIMS, SWAMIRAM NAGAR, DIOWALA DEHRADUN UTTARANCHAL
amritakansal@gmail.com
9958898464

KANSAL SANGEETA
L-1384
KP-73, NEW KAVI NAGAR GHAZIABAD UTTAR PRADESH

KANUNGO SRIKANTA
L-3202
PG STUDENT, DEPTT. OF COMMUNITY MEDICINE, JN MEDICAL COLLEGE, ALIGARH MUSLIM UNIVERSITY, ALIGARH,UP –202002
srikantak109@gmail.com
8307932643

KAPOOR RACHNA R.
L-1267
C/O DR. POWAR TAPSAVI, D-15, MODELTOWN, MISSION COMPOUND, SAHARANPUR UTTAR PRADESH

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KAR SONALI
L-1836
ROOM NO. 28, IST FLOOR, PG HOSTEL, HIMALAYAN INST. OF MED. SCI., GRANT, DEHRADUN UTTARANCHAL
sonsam72@yahoo.co.uk
9438423273

KARAN BIR SINGH
L-0487
F-3, SECTOR -41 NOIDA UTTAR PRADESH

KARIWAL PEEYUSH
L-2225
JR-II, ROOM NO. 135, SENIOR BOYS HOSTEL M. L COLLEGE, JHANSI UTTAR PRADESH 284128
peeyushkariwal@yahoo.com
9453176216

KATARIYA T. R.
L-0607
B-314, NEW RAJA MANDI COLONY AGRA UTTAR PRADESH

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KATYAL RASHMI
L-2742
1ST YR. PG, DEPTT. OF PSM COLLEGE, DELHI HARIDWAR BY PASS ROAD, MEERUT, UTTAR PRADESH – 250002
rashmikatyal@gmail.com
9897373850

Kaur Amandeep
L-3575
D/o. Dr. G.S. Sandhu, Barelley Road, Naee Sunehri Kiccha Dist. Udham Singh Nagar-263148 (Uttarakhand)
amansmailbox82@gmail.com

KAUR PARAMJIT
L-0068
NEW D-7, BANARAS HINDU UNIVERSITY VARANASI UTTAR PRADESH 221006

KAUSHAL SUNEEL KUMAR
L-1853
AT POST-BIDOKHAR, DIST. HAMIRPUR UTTAR PRADESH
dr.suneel31@rediffmail.com
9458060463

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KAUSHIK AMIT
L-2932
LECTURER, COMMUNITY MEDICINE, UP RIMS & R, SIAFAI, ETAWAH, UTTAR PRADESH - 206301
dramitkaushik@gmail.com
9456033030

KESARWANI PRIYANKA
L-3132
CK-64/70A, HIRAPURA, KABIRCHAURA, VARANASI, UTTAR PRADESH – 221001
drpriyankakesarwani@gmail.com
9839350744

KHAN AMIR MAROOF
L-1818
ASSTT. PROFESSOR DEPTT. OF COMMUNITY MEDICINE, UCMS, New Delhi
khanamirmaroof@yahoo.com
9711914361

Khan Huma
L-3572
C/o. Mr. Ashutosh Gupta, 324, Kanoon Goyan, Opp. Prem Nagar Post Office, Bareilly-263005 (UP)
humakgupta@gmail.com

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KHAN MOHAMMAD SHIBLY
L-3452
JUNIOR RESIDENT, DEPTT. OF COMMUNITY MEDICINE,J.N. MEDICAL COLLEGE, AMU,
shibly001@gmail.com
9997688376

KHAN MOHD. HAROON
L-3211
E – 5, ABDULLAH APARTMENT, ROAD, CIVIL LINE ALIGARH, UTTAR PRADESH – 202002
drharoonkhan99@yahoo.com

Khan Samreen
L-3713
Flat B-2Sabal Appartment, Shah Bagh Sulaiman Hall, Anupshahar Road, Aligarh, UP-202002
drsamreen2k4@gmail.com
9557458237

KHAN SWATI
L-1333
HOUSE NO. 116, UDYAN, MAHANAGAR, PHASE – TWO, PILIBHIT BYPASS ROAD, BAREILLY, UTTAR PRADESH – 243001
s_khan87902@hotmail.com
9411471500

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KHAN ZULFIA
L-0534
SAMAN ZAAR, L.B. SHASTRI MARG, ALIGARH-202002, UTTAR PRADESH
zulfiakhan1@gmail.com
9456064849

KHANNA ANISH
L-1286
ASHIRWAD,5A, BISHOP ROCKEY ST. FAIZABAD ROAD, NEAR IT COLLEGE, LUCKNOW UTTAR PRADESH

KHANNA D. K.
L-0394
24 ED, AF AIR FORCE STATION MANAURI, ALLAHABAD UTTAR PRADESH 212212

KHARYA PRADIP
L-3121
C/O MR. BRAJ BIHARI KHARYA,963 – ALYAI, NEAR CHANDRA SHEKHAR STATUE, MAURANIPUR, JHANSI, UP – 284204
drpradipkharya@gmail.com
8800263819

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KHILNANI PARUL SHARMA
L-2701
Assistant Professor, DEPTT. OF COMMUNITY MEDICINE, D Y Patil Medical College, Pune
dr.parulkhilnani@gmail.com

KHURSHID PARVEEN
L-1491
LECTURER DEPTT. OF COMMUNITY MEDICINE M.L.N. MEDICAL COLLEGE, UTTAR PRADESH
drkparveen2007@yahoo.com
9452102609

KISHORE SUREKHA
L-0886
PROFESSOR & HEAD, DEPTT OF COMMUNITY MEDICINE, AIIMS, RISHIKESH, UTTARAKHAND
surekhakishore@rediffmail.com

KULKARNI SANKET V.
L-2211
SMO, WHO-NPSP OFFICE E-35/2, GOPI HOSPITAL, OPP. VIKAS BHAWAN, RAMPUR GARDEN, BAREILLY, UTTAR PRADESH - 243001

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Kumar Ajay
L-3585
H. No. 169, Chowk Mohalla, Kanker Khera, Meerut-250001 UP
ajaykumar1969@gmail.com

Kumar Anupama
L-3764
B-147, Mehdauri Colony, Teliarganj, Allahabad, UP_211004
anupamakumar2@gmail.com

KUMAR ARUN
L-1935
H.NO. 60, NEW SHIV LOK KHERA, MEERUT CANTT. UTTAR PRADESH

KUMAR ARUN
L-1936
DEPTT. OF COMMUNITY MEDICINE COLLEGE, MEERUT UTTAR PRADESH 250004

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KUMAR DEEPAK
L-1941
DEPTT. OF COMMUNITY MEDICINE COLLEGE, MEERUT UTTAR PRADESH
deepak_aditya16@yahoo.com
9412782210

KUMAR GURESH
L-2700
B-902, JAGDAMBE APTT., C-58/25, SECTOR-62, NOIDA, UTTAR PRADESH – 201307
chibbegk@hotmail.com
9818559049

Kumar Madhu Rendra
L-3793
Hostel Ruiya Annexie, Room No. 67, BHU, Varanasi-221005
msk.bhu@gmail.com

KUMAR SANDIP
L-1477
S/O MR. RAM SHANKAR GUPTA, SIRSAGANJ, DISTT. FIROZABAD UTTAR PRADESH 205151

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KUMAR SANJIV
L-1535
DEPTT. OF COMMUNITY MEDICINE, CSM MEDICAL UNIVERSITY(UPGRADED KG HC) CHOEK. LUCKNOW UTTAR PRADESH 226003

KUMAR SATISH
L-0445
L 7/76, SHASTRI NAGAR, SIGRU VARANASI UTTAR PRADESH

KUMAR SHAILENDRA
L-1938
D-28, LLRM MEDICAL COLLEGE MEERUT UTTAR PRADESH
drsdr73@gmail.com
9411950716

Kumar Vijay
L-3704
Upgraded Dept. of Community Medicine, KGMU, Lucknow-226003
drvksingh05@gmail.com

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KUMAR VIKAS
L-2791
JUNIOR RESIDENT, SPM DEPTT., S.N. MEDICAL COLLEGE, AGRA, UTTAR PRADESH – 282002
drvikaspsm@gmail.com
8826474002

KUMARI RANJEETA
L-1842
124A/186, BLOCK NO. 11, GOVIND NAGAR, KANPUR, UTTAR PRADESH
rkaiims2012@gmail.com

KUMARI REEMA
L-1582
36-A, LAXMAN PURI COLONYFAIZABAD ROAD, LUCKNOW UTTAR PRADESH

LABANI SATYANARAYANA LABANI
L-3328
321, CITY VIEW APTS, SECT – 35, NOIDA, UTTAR PRADESH – 201301
satyanarayanalabani@yahoo.com
9899008191

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LAL BHAIYA
L-1479
DEPTT. OF SPM, M.L.B. MEDICAL COLLEGE JHANSI
UTTAR PRADESH 284128

LAMBA RATANDEEP
L-3288
HOUSE NO. D-4, GEETA NAGARI, BIJNOR – 246701,
UTTAR PRADESH
drrdlamba@gmail.com

LARI AHMAD NADEEM
L-2643
JUNIOR RESIDENT,DED DEPTUPGRADED DEPTT
DEPTT. MEDICINE,, C.S.M.M.U. CHOWK, LUCKNOW,
UTTAR PRADESH - 226003

LENKA SATYA RANJAN
L-1854
UPSACS, A-BLOCK, 4TH FLOOR, PICKUP BHAWAN
VIBHUTI KHAND, GOMTI NAGAR, LUCKNOW UTTAR
PRADESH 26010
dr_satyalenka@rediffmail.com
9918001363

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LUTHRA MEGHA
L-1299
58, CHAKRATA ROAD DEHRADUN UTTARAKHAND - 248001
drmeghaluthra@gmail.com
9997779588

M. A. HAQUE
L-0834
FLAT NO.-B1(5)=11 APARTMENTS, 32- SAROJINI NAIDU MARG, ALLAHABAD, UTTAR PRADESH - 211001
mahaquedr@yahoo.com
9415209786

M. A. HASSAN
L-1281
Prof & Head, DEPTT. OF P.S.M., Manyawar Kanshi Ram Ji Govt. Allopathic MEDICAL COLLEGE, Ambedkar Nagar, UTTAR PRADESH
hassan_amirul@rediffmail.com
9415816929

M. ATHAR ANSARI
L-1784
PROFESSOR, DEPTT OF COMMUNITY MEDICINE, J.N. MED. COL., ALIGARH MUSLIM UNIVERSITY, ALIGARH UTTAR PRADESH 202002
atharansari777@rediffmail.com
9897267621

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Madhu Priya
L-3794
Dept. of Community Medicine, IMS, BHU, Varanasi-221005
mdhpry03@yahoo.co.in

MAHAJAN DHIRAJ KUMAR
L-2220
S/O HUKUM CHAND MAHAJAN, 151, PURA, JHANSI UTTAR PRADESH

MAHESHWARI B. B.
L-0709
36, SULABH VIHAR GALANA ROAD, AGRA UTTAR PRADESH

MARWAH S. M.
L-0011
174-B, BRIJ ENCLAVE ,VARANASI UTTAR PRADESH, 221005

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MASOOD JAMAL
L-1364
1/69 VISHWAS KHAND, GOMTINAGAR LUCKNOW
UTTAR PRADESH

MATHUR BHAKT PRAKASH
L-0309
PROFESSOR DEPTT. OF SPM, M.L.B. MEDICAL COLLEGE JHANSI UTTAR PRADESH
mathurbp@gmail.com
9935084481

MATHUR J. S.
L-0019
Ex-PRINCIPAL & PROFESSOR DEPTT. OF SPM LLRM MEDICAL COLLEGE, MEERUT UTTAR PRADESH

MATHUR KUSH PRASAD
L-2276
ASSOCIATE PROFESSOR APARTMENT, 7A, LUCKNOW
UTTAR PRADESH 226001

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MATHUR VANESH
L-2192
50, HIG ADA FLATS, MUMFORDGUNJ ALLAHABAD
UTTAR PRADESH

MEHNAZ SAIRA
L-2282
LECTURER NAGAR, ALIGARH UTTAR PRADESH 202002
drsairamehnaz@gmail.com
9927016936

MEHROTRA AJIT KUMAR
L-0710
C/3, JUDGES COMPOUND, NEHRU NAGAR AGRA
UTTAR PRADESH

MEHROTRA S. K.
L-0010
C/O DR. U. S. MISHRA,1/2 VIJAY KHAND, GOMTI NAGAR, LUCKNOW UTTAR PRADESH 10

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MIDHA TANU
L-2410
120/133, LAJPAT NAGAR KANPUR - 208005 UTTAR PRADESH
Tanumidha2001@gmail.com
9336818435

MISHRA ALOKE
L-1029
DEPTT. OF SPM, GSVM MEDICAL COLLEGE KANPUR UTTAR PRADESH 208001
kgnaloke@gmail.com
9415041353

MISHRA BRIJENDRA
L-0905
CENTRAL JALMA INSTITUTE FOR LEPROSY PO. 101, BOX GANJ, AGRA UTTAR PRADESH 1

MISHRA CHANDRA PATI
L-0341
READER DEPTT. OF COMMUNITY MEDICINE INST. OF MED. SCI., BHU UTTAR PRADESH 221005
drcpmishra@gmail.com
9451885964

NAME					
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MISHRA RAGHUNATH
L-0938
83, SHIBTALA STREET, UTTARPARA DISTT. HOOGHLY
WEST BENGAL

MISHRA RICHA
L-2750
JUNIOR RESIDENT-II,,(DEPTT OF PSM, M.L.N.
MEDICAL COLLEGE, ALLAHABAD, UTTAR PRADESH
dr.richamishra@gmail.com
9415287926

MISHRA SUNIL KUMAR
L-0606
PROFESSOR & HEAD, III GANJ, AGRA UTTAR PRADESH
misrasunil66@gmail.com
9997816020

MISHRA VIRENDRA NATH
L-0109
PROF. & HEAD, SPM DEPTT. COLLEGE, MEERUT
UTTAR PRADESH 250102

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MITTAL ANJU
L-1974
KE-24, KAMLA NAGAR EXT. AGRA UTTAR PRADESH

MOHAMAD ZAFAR IDRIS
L-0196
PROFESSOR, UPGRADED DEPTT. OF COM. MED.(SPM) COL., LUCKNOW UTTAR PRADESH 226003
idrismz05@gmail.com
9415157520

MOHAMMAD YUNUS KHAN
L-0708
4/1376, SIR SYED NAGAR ALIGARH UTTAR PRADESH
mmkhandr@gmail.com/mohammadkhan592002@yahoo.com
9219071389

MOHAN UDAY
L-0371
PROFESSOR, B-1306, OCR COMPLEX, VIDHAN SABHA MARG LUCKNOW UTTAR PRADESH 226001
drudaymohan@yahoo.co.in
9415007727

NAME					
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MOHAPATRA ARCHISMAN
L-3181
DEPTT. OF COMMUNITY MEDICINE, SCIENCES, BANARAS HINDU UNIVERSITY, VARANASI, UTTAR PRADESH – 221005
archimn@gmail.com
9250568511

MOHAPATRA S. C.
L-0317
PROFESSOR AND HEAD. DEPTT OF COMMUNITY MEDICINE, IMS, B.H.U., VARANASI UTTAR PRADESH 221005
vishwamegh@gmail.com
9415302540

MUKHERJEE AMIYA BHUSHAN
L-1152
PROFESSOR FLAT E, 1ST FLOOR, 168, NETAJI SUBHASH ROAD, PO. UTTARPARA,

MUSHFIQ SAKEENA
L-3510

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MUZAMMIL KHURSHEED
L-2417
C/O PROF. MOHD. ZAHID KABIR COLONY, JAMALPUR
ALIGARH (U.P.) -202002
drkmb25@yahoo.com

NAGAONKAR S.N.
L-0022
PROF. & H.O.D. COMMUNITY MEDICINE, VEER CHANDRA G G M S, & RESEARCH INSTITUTE, SRICOT, SHIRINAGAR, UTTARAKHAND - 246174

NAGARGOJE MANISHA
L-3097
C/O DR. SHAILENDRA SINGH CHAUDHARY 120, BALAGIPURAM, ALBATIA ROAD, SHAHGANJ, AGRA, UTTAR PRADESH – 282010
drmanishan@rediffmail.com

NANDAN DEOKI (LATE)
L-0006
31, ASHOK NAGAR AGRA UTTAR PRADESH
dnandan51@yahoo.com
9971104666

NAME					
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NATH BHOLA
L-1841
C/O PREM WATCH CO. SHOP NO. 28-29, KAUSHALPURI, GUMTI NO.5, KANPUR, UTTAR PRADESH
bholanath75@yahoo.co.in
9451802690

NAVEEN K. H.
L-2193
JR. RESIDENT DEPTT . MEDICINE, MOTI LAL NEHRU MEDICAL COLLEGE, ALLAHABAD UTTAR PRADESH

NAWAB TABASSUM
L-2969
JUNIOR RESIDENT, DEPTT OF MEDICINE, JNMCH, A.M.U., ALIGARH, UTTAR PRADESH – 202002
tabassumnawab@yahoo.com

NEGI KAMAL SINGH
L-1979
PROFESSOR (BIOSTATISTICS), DEPTT. OF COMMUNITY MEDICINE, SGRRIMHS, DEHRADUN, UTTARAKHAND
ksnhims@gmail.com
9758358664

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NEYAZ ARSLAN
L-3455
JUNIOR RESIDENT – II, DEPTT OF MEDICINE, JNMCH, AMU, ALIGARH, UTTAR PRADESH – 202002
arslanneyaz2002@yahoo.com
9634723161

NIGAM SEEMA
L-1291
H-1/19, KRISHANA PURAM, G.T. ROAD KANPUR UTTAR PRADESH
drseemagsvm@yahoo.co.in
9450334897

PAL ANJALI
L-1232
C/O PROF. RAMESH CHANDRA, UPGRADED DEPTT. OF KGMC, LUCKNOW UTTAR PRADESH

PALIWAL GYAN CHANDRA
L-0600
49, S.B. HOSTEL, SN MEDICAL COLLEGE AGRA UTTAR PRADESH
dr.g.paliwal@gmail.com
971998726

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PANDEY SANJAY
L-2030
Assoc. Professor, DEPTT. OF COMMUNITY & FAMILY MEDICINE, AIIMS, PATNA, BIHAR
drsanjayp@aiimspatna.org, drsanjayp69@gmail.com
9412087622

PANT BHAWNA
L-1241
W/O DR. DEEPAK PANT, JAGRATIVIHAR, MEERUT UTTAR PRADESH 250004
drbpant2007@rediffmail.com
9457032830

PANT CHHAVI
L-1405
D/O V.S. PANTA-198 INDIRA NAGAR, LUCKNOW UTTAR PRADESH

PARASHAR PAWAN
L-2197
ADDITIONAL PROFESSOR, (Deptt. of Community Medicine-SMC) WARES, MEERUT UTTAR PRADESH 250002
drpparashar@rediffmail.com
9927013538

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PARVEEN SHAHIDA
L-2543
PG STUDENT, DEPTT. OF SPM, S.N. MEDICAL COLLEGE, AGRA, UTTAR PRADESH – 282002
dr.shaida@gmail.com
9368094196

PARVEZ ASHIB
L-3212
HOUSE NO. 91, LOHARPURA, G.T. ROAD, GHAZIABAD, UTTAR PRADESH – 201009
ashib81@gmail.com

PATEL S. P.
L-0677
ASSTT. PROFESSOR RURAL HEALTH TRG. CENTRE, SAROJINI NAGAR, UTTAR PRADESH 8
patelkgmclko@gmail.com
9415784571

PRASOT RAM MILAN
L-2639
JUNIOR RESIDENT, UPGRADED DEPTT OF COMMUNITY MEDICINE & PUBLIC HEALTH, C.S.M.M.U. CHOWK, LUCKNOW, UTTAR PRADESH - 226003

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RAJ PUROHIT AMBESH CHANDRA
L-2720
A-1658, SECTOR – I, LDA COLONY, LUCKNOW UTTAR PRADESH
rajpurohitambesh21@gmail.com
9454363371

RANI VIDYA
L-2371
LECTURER H, L.D.A.COLONY, P. O. SECT. 'G', KANPUR ROAD, LUCKNOW UTTAR PRADESH

RANJAN ROOCHIKA
L-1269
B-073, SURYA NAGAR, GHAZIABAD UTTAR PRADESH

RAO TIRUMALA
L-1792
SMO, WHO-NPSP, ROOM NO. -8, T.B. CLINIC, DISTT. HOSPITAL, HARDOI, UTTAR PRADESH – 241021
9415417348

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RASANIA SANJEEV KUMAR
L-0550
J/172, PATEL NAGAR-I GHAZIABAD UTTAR PRADESH
skrasania@indiatimes.com

RASTOGI ANIL KUMAR
L-0364
LECTURER R., H. T PHC, ALLAHABAD UTTAR PRADESH

RASTOGI SANJAY KUMAR
L-0922
SENIOR DMO HOSPITAL, ALLAHABAD UTTAR PRADESH 211001

RASTOGI SWARNA
L-3382
C-12, Sector-III, Ansal Sushant City, Ved Vyas Puri Yojana, Delhi-Dehradun Bypass, NH-58, MEERUT, UTTAR PRADESH – 250005
dr.swarnarastogi@gmail.com

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RATHORE A. S.
L-0363
93-AK-I, INDRAPURAM GHAZIABAD UTTAR PRADESH

RAVANAN PIRABU
L-2641
JUNIOR RESIDENT, MEDICINE, C.S.M.M.U. CHOWK, LUCKNOW, UTTAR PRADESH - 226003

RAWAT CMS
L-1303
PROFESSOR & HEAD, DEPTT OF COMMUNITY MEDICINE, HALDWANI, NAINITAL- 263139, UTTARAKHAND
drcms2000@rediffmail.com
9412085617

RAWAT RANU
L-3142
D/O SH. A. S. RAWAT, HOUSE NO. – 8, 'VEERALAYA', LANE – B, ST. – 1, SHASTRI NAGAR, HARDWAR ROAD, UTTARAKHAND – 248001
drranurawat09@gmail.com
9410539532

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RIA
L-2267
30, TAGORE TOWN ALLAHABAD UTTAR PRADESH

RIZVI ANDLEEB
L-2642
TALAT VILLA, 450/128/33, FRIEND'S COLONY, MUFTIGANJ –II, LUCKNOW, UTTAR PRADESH – 226003
9935671124

ROY DEBABRATA
L-2890
droy97@rediffmail.com
9761376270

ROY NIRAJ KUMAR
L-2790
JUNIOR RESIDENT, SPM DEPTT., S.N. MEDICAL COLLEGE, AGRA, UTTAR PRADESH – 282002
niraj8roy@yahoo.com
9971572990

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ROY RAMAPRASAD
L-1228
DEPTT. OF COMMUNITY MEDICINE, COLLEGE,
KOLKATA UTTAR PRADESH 14

SABARWAL MANISH
L-0614
H.N. 1/228, PEEPAL MANDI AGRA UTTAR PRADESH
manish.sabharwal@impactpartner.org.in
9818137204

SACHAN BEENA
L-2645
D/O SHRI RAMKRISHNA SACHAN, INFRONT OF DR. UMASINGH, RAILWAY STATION CORNER, KANPUR, UTTAR PRADESH – 209206
sachan_beena@yahoo.com
9473960543

SAHA SIDDHARTHA
L-3269
4/5, GULMOHAR ROAD, SHIPRA SUN CITY INDIRAPURAM, GHAZIABAD, UTTAR PRADESH – 201014
mailtodrsaha@gmail.com

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SAHOO UMESH CHANDRA
L-2638
JUNIOR RESIDENT,DED DEPTUPGRADED DEPTT
DEPTT. MEDICINE,, C.S.M.M.U. CHOWK, LUCKNOW,
UTTAR PRADESH - 226003

SAINI NARENDER K.
L-0871
FLAT NO. 6, PLOT NO. 99A, RAMPURI, GHAZIABAD
UTTAR PRADESH

SAVINDER KAUR
L-1810
32 B/6, PURA PHTEH MUHAMMAD NAINI,
ALLAHABAD UTTAR PRADESH 211008

SAXENA HARISH CHANDRA
L-0343
READER WARDEN Q.NO.4, RUIYA HOSTEL, BHU
VARANASI UTTAR PRADESH

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SAXENA POOJA
L-1397
307, SIDHARTH APARTMENTS,CIVIL COURT COMPOUND, NEERAJ TALKIES, AGRA UTTAR PRADESH

SAXENA S. C.
L-0168
#475, VAYU VIHAR, SUGANDHA NURSING HOME, HAIJINDER NAGAR, UTTAR PRADESH 208008
scsaxena1982@yahoo.co.in
9415074933

SAXENA SUMIT
L-3291
POST GRADUATE – 1ST YEAR, DEPTT OF MEDICINE, SRMSIMS, BHOJIPURA, BAREILLY, UTTAR PRADESH – 243202
drsumitsaxena22@gmail.com
9458705020

SAXENA VARTIKA
L-1069
ASSICIATE PROFESSOR DEPTT. OF COMMUNITY MEDICINE, HIMALYAN INSTITUTE OF HOSPITAL TRUST, UTTARAKHAND – 248140
dr_vsaxena@rediffmail.com
9458344247

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SEN PRITHVIRAJ
L-1362
POST BOX NO. 5021, UNIVERSITY, VARANASI UTTAR PRADESH 221005

SHAH MOHAMMAD SALMAN
L-2536
SENIOR RESIDENT DEPTT. OF COMMUNITY MEDICINE J.N. MEDICAL COLLEGE ALIGARH, UTTAR PRADESH – 202002
salmanshah78@gmail.com,
salmanshah123@yahoo.com
9457254273

SHAMA SHAIKH
L-2798
164/3, NEAR COLONEL GANJ INTER COLLEGE, TAGORE TOWN, ALLAHABAD, UTTAR PRADESH – 211001
shama_2rhyme@yahoo.co.in

SHANKAR MATTA
L-1177
G-426, SECTOR 30, RAM VIHAR NOIDA UTTAR PRADESH

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SHANKAR RAVI
L-1475
ASSOCIATE PROFESSOR, DEPTT. OF COMMUNITY MEDICINE, IMS, BHU, VARANASI, UP
drrshankar1@gmail.com
9454352721

SHARMA DIPAK KUMAR
L-2308
SURVEILLANCE MEDICAL OFFICER, GOMTINAGAR, LUCKNOW-226010, UTTAR PRADESH

SHARMA PANCHSHEEL
L-3448
20, BALLABH JI VIHAR, DAYAL BAGH AGRA, AGRA, UTTAR PRADESH – 282005
drpanchsheelsharma@yahoo.co.in
9823234477

SHARMA RAM PRAVESH
L-0621
LECTURER DEPTT. OF SPM, GSVM MEDICAL COLLEGE KANPUR UTTAR PRADESH
dr_sharmarp@yahoo.co.in
9839074338

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SHARMA S. N.
L-0713
L-17, MEDICAL COLLEGE CAMPUS KANPUR UTTAR PRADESH
Expired

SHARMA SANJEEV KUMAR
L-3198
C – 9, DOCTOR'S QUARTER, SRMS, IMS, BHOJIPURA, BAREILLY, UTTAR PRADESH – 243003
sharma.drsanjiv@gmail.com
9457113271

SHAROTIYA VED
L-0078
29, KHANDARI ROAD AGRA UTTAR PRADESH
dean@srmsims.ac.in

SHRIVASTAVA ASHOK KUMAR
L-1729
DEPTT. OF COMMUNITY MEDICINE, HIMS, SRH UNIVERSITY, SWAMI RAM NAGAR, DOIWALA, DEHRADUN-248140, UTTARAKHAND
drsrivastava_ak123@rediffmail.com
9837338696

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SHRIVASTAVA SUYESH
L-3207
PG STUDENT, DEPTT.OF COMMUNITY MEDICINE, J N MEDICAL COLLEGE, AMU, ALIGARH, UTTAR PRADESH – 202002
ssuyesh@gmail.com
8307932643

SHRIVASTVA ANURAG
L-1847
G-48, SANJAY GANDHI PURAM, FAIZABAD ROAD
UTTAR PRADESH 226006
dranurag77@yahoo.com
9415061563

Shukla Mukesh
L-3771
96-HA, Vihar Panigaon, Indiranagar, Lucknow-226016, UP
drmukeshshukla@gmail.com

Shyam Subhajit
L-3579
Subuarti Medical College, Meerut (UP)
catchsubhajit@hotmail.com

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SIDDIQUI ARSHIYA MASOOD
L-2152
C/O DR. MOHD ASLAM, SENIOR LECTURER IN PHYSIOLOGY,C-51, MEDICAL COLONY, AMU, ALIGARH UTTAR PRADESH
kashishrabbi@gmail.com
9760036213

SINGH ABHISHEK
L-2800

SINGH AMIT KUMAR
L-2572
ASSISTANT PROFESSOR VEER CHANDRA SINGH GARHWALI GOVT. MEDICAL SCIENCE & RESEARCH, UTTARAKHAND – 246174
singh120377@yahoo.co.in
9410392588

SINGH ANIL KUMAR
L-1937
C/O SR. DHARAM SINGH, 645/90A/14J/I, BAJPAYI ROAD, ALLAPUR, BAGHAMBARI GADDI, UTTAR PRADESH

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SINGH ANIRUDH KUMAR
L-0597
KOTHI AGHA SAHIB, MAHARAJ NAGAR LAKHIMPUR-KHERI UTTAR PRADESH 262701

SINGH ARUN
L-2586
ASSTT. PROFESSOR DEPTT. OF COMMUNITY MEDICINE, ROHILKHAND MEDICAL COLLEGE, UTTAR PRADESH – 243006
arunspm@gmail.com, drarunsingh1977@yahoo.com

SINGH ARVIND KUMAR
L-1943
LECTURER, H.NO. C/119/845, JATEPUR SOUTH, POKHRA, GORAKHPUR UTTAR PRADESH 273001
iamarvind2000@gmail.com
9412705129

SINGH ASHOO
L-2524
C-74, NAR VIHAR PART – I SECTOR – 34, NOIDA UTTAR PRADESH – 201301
ashoojs@yahoo.com
9968776282

NAME					
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SINGH ATUL KUMAR
L-2748
VILL+POST: RAMPUR KALAN DISTT.- RAIBARELI
UTTAR PRADESH – 229216
docaks37@gmail.com
9455150191

SINGH CHANDRAMANI
L-2299
ASSTT. PROF. RSAIFAI, ETAWAH UTTAR PRADESH
drcmsingh@yahoo.co.in
9931733280

SINGH DHARMENDER
L-0836
DEPTT. OF SPM, SN MEDICAL COLLEGE AGRA
UTTAR PRADESH

SINGH GEETU
L-3466
85, KALINDI PURAM, MAU ROAD, KHANDARI, AGRA,
UTTAR PRADESH – 282005
geetu.singh1701@gmail.com
7376043771

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SINGH GYANENDRA
L-0167
PROFESSOR AND HEAD DEPTT. OF SPM, MLN MEDICAL COLLEGE, ALLAHABAD UTTAR PRADESH

SINGH INDRA VIR
L-0595
VILL. & PO. NARAICH, DISTT. AGRA UTTAR PRADESH

SINGH J. V.
L-0159
PROFESSOR AND HEAD, DEPTT. OF MEDICINE, MUZAFFARNAGAR MEDICAL COLLEGE, MUZAFFAR NAGAR-251203, UTTAR PRADESH
doctorjaivir@yahoo.co.in
9412663844

SINGH J. V.
L-0396
PROFESSOR ROAD, LUCKNOW UTTAR PRADESH 226003
jvsingh510@rediffmail.com
9335299804

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SINGH JAYANTI
L-1191
31- ANAND CHOWK, DEHRADUN UTTAR PRADESH
semwal@hotmail.com
9412008770

SINGH MANISH KUMAR
L-2533
Type-4/51, Faculty Residences, BRD Medical College, Gorakhpur-273013
drmanishscbmc@yahoo.co.in
9005435789

SINGH NARENDRA
L-1601
COMMANDING OFFICER ORGANIZATION, JHANSI UTTAR PRADESH - 284001

SINGH NARESH PAL
L-1852
S/O SH. PATI RAM, 36/34R/P22, RADHA. KUNJ ROAD, AGRA CANTT. UTTAR PRADESH 282001
nareshpalsingh@gmail.com
9897843136

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SINGH NEELAM KUMARI
L-3110
C/O MR. J. S. CHAUHAN,. A TOWNSHIP, FAIZAABAD ROAD, LUCKNOW, UTTAR PRADESH – 16
neelamkumari0809@gmail.com
9415514286

SINGH O. P.
L-1583
DEPTT. OF COMMUNITY MEDICINE K. G COLLEGE, LUCKNOW UTTAR PRADESH

SINGH PARDAL MANINDER PAL
L-1321
COMMANDING OFFICER ORGANISATION, BAREILLY CONTONMENT, BAREILLY, UTTAR PRADESH – 243001
ltcolpmpsingh@yahoo.com

SINGH PREM PAL
L-0596
RESIDENT DEPTT. OF PSM, ROOM N. C-13 PG HOSTEL, SN MEDICAL COLLEGE, UTTAR PRADESH

NAME					
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SINGH RANJNA
L-1058
D/O DR. S. R. SINGH, MIG-116 SHAHEED NAGAR, AGRA-I UTTAR PRADESH
sranjana@rediffmail.com
9654873085

SINGH RITA
L-1189
C/O SH. MANBIR SINGH, 406, COLONY, MEERUT, UTTAR PRADESH 250001

SINGH RITESH
L-2129
6A, FIRST BYE LANE, SECTOR 2, SARADAPALLY, P.O. MAKHLA, DIST.-HOOGHLY, UTTARPARA, WEST BENGAL - 712245
drriteshsingh@yahoo.com
9836444242

SINGH S. J.
L-0980
N-84, SHIVALIK NAGAR HARIDWAR UTTAR PRADESH

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SINGH SHAILENDRA PRATAP
L-3284
VILL.-LARONI, POST-SIJARI, DISTT.- JHANSI, UTTAR PRADESH – 284204
dr_spsingh02@rediffmail.com
9559644756

SINGH SHIVENDRA KUMAR
L-1488
158, BABUGANJ, FAIZABAD ROAD LUCKNOW UTTAR PRADESH
shivmymail0522@gmail.com
9415086073

SINGH SHRI PRAKASH
L-0647
N8/180A-122, RAJENDRA VIHAR COLONY, NEWADA, SUNDERPUR, VARANASI UTTAR PRADESH – 221005
drspsingh1953@gmail.com
9415166351

SINGH VED PAL
L-1478
DEPTT. OF SPM, M.L.B. MEDICAL COLLEGE JHANSI UTTAR PRADESH 284128

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SINGH VINAY KUMAR
L-0618
D-35, SHASTRI NAGAR MEERUT UTTAR PRADESH

SINGHAL ARUN KUMAR
L-2221
JR-I, DEPTT. OF COMMUNITY MEDICINE, MOTI LAL NEHRU MEDICAL COLLEGE, ALLAHABAD UTTAR PRADESH

SINGHAL PRERNA
L-3492
568/6, SHASTRI NAGAR, MEERUT, UTTAR PRADESH – 250004
drguptaprerna@gmail.com

SINGHAL SAMEER
L-2205
S/O SHRI SHOBHA RAM SINGHAL LAXMI NIKETAN MATIA MAHAL, SAHARANPUR UTTAR PRADESH

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SINHA RICHA
L-3459
PG STUDENT, DEPTT. OF COMMUNITY MEDICINE, HIMS, DEHRADUN, UTTARAKHAND – 248140
richaparmarth@gmail.com
9536733191

SINHA S. N.
L-0209
D-33, NIRALA NAGAR, SCHOOL, LUCKNOW - 226020 UTTAR PRADESH PHONE: 0522-2787520

SRIVASTAV SHALINI
L-3345
ASSISTANT PROFESSOR, UNIVERSITY, GAUTAM BUDH NAGAR, UTTAR PRADESH
gud009@gmail.com
8285662039

SRIVASTAVA AJIT KUMAR
L-2400
C-208 ARAWALI MARG INDIRA NAGAR, LUCKNOW UTTAR PRADESH-226076

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SRIVASTAVA ANUPAMA
L-1108
DEPTT. OF SPM, S.N. MEDICAL COLLEGE AGRA UTTAR PRADESH

SRIVASTAVA DHIRENDRA KUMAR
L-0698
ASSTT. PROFESSOR DEPTT ST MEDICINE, BRD MEDICAL COLLEGE, GORAKHPUR UTTAR PRADESH
dkspoonam@gmail.com
9839473140

SRIVASTAVA JYOTI PRAKASH
L-0711
PROFESSOR & HEAD, DEPTT OF COMMUNITY MEDICINE, ERA'S LUCKNOW MEDICAL COLLEGE, LUCKNOW, UTTAR PRADESH
jp_srivastava07@rediffmail.com

SRIVASTAVA KAJAL
L-2517
C/O SH. AJAY SIHNA (ADVOCATE) III-B/4 NEHRU NAGAR GHAZIABAD, UTTAR PRADESH – 201001
kajal.shrivastava@gmail.com
9319029781

NAME					
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SRIVASTAVA MAJ VP
L-2719
66, L –IV, SEC.- 'M' ALIGANJ, LUCKNOW UTTAR PRADESH – 226024
vinayp.99@hotmail.com
9415011740

SRIVASTAVA RATTAN K.
L-0383
PO BOX NO. 22, POST OFFICE NAMNPURA SURAT, GUJARAT, 395001
ratanpsm@gmail.com
9415543467

SRIVASTAVA SHIKHA
L-1290
C/O MR. P. D. LAL, B-14, AWAS VIKAS CNY. TIWARIPUR, GORAKHPURA UTTAR PRADESH

SRIVASTAVA VINOD KUMAR
L-0620
DEPTT. OF SPM, COLLEGE, KANPUR UTTAR PRADESH

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SRIVASTVA VINOD K.
L-0181
HAR-NIWAS, 10, HAVELOCK ROAD LUCKNOW UTTAR PRADESH
vinods51@hotmail.com
9415101095

SUMAN SHAILESH KUMAR
L-2512
DEPTT. OF COMMUNITY MEDICINE B R D MEDICAL COLLEGE GORAKHPUR, UTTAR PRADESH – 273013
drsks15c@gmail.com
9236101005

SURYA BALI
L-1791
ASSOCIATE PROFESSOR, AIIMS, BHOPAL, M.P.
drsuryabali@yahoo.com
8004794067

SUSHIL DOHARA
L-1220
B-136, SECTOR-19 NOIDA UTTAR PRADESH

NAME					
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TANDON JANNAVI
L-0342
25, RAVINDRA PURI EXTENSION VARANASI UTTAR PRADESH

THAKKAR HEMABEN KANUBHAI
L-2542
PG STUDENT, DEPTT. OF SPM, S.N. MEDICAL COLLEGE, AGRA, UTTAR PRADESH – 282002
dr.hema123@yahoo.com
dr.hema123@yahoo.com

Tiwari Harish Chandra
L-3565
Vill. Kushaha, Post. Mahmdepur (Gorwara), Distt. Pratapgarh-230502 (UP)
dr.harishchandratiwati@gmail.com

TIWARI R. S.
L-0633
DIRECTOR 37, NOIDA UTTAR PRADESH 201303

NAME					
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TRIPATHI BHUPENDRA
L-2224
C/O SRI MP TRIPATHI, ADVOCATE, OPP. COURT CAMPUS, P.O. MAN-CHITRAKOOT UTTAR PRADESH 210209

TRIPATHI SURABHI
L-1443
2/165 VIKAS NAGAR LUCKNOW UTTAR PRADESH

UPADHYAY ASHOK KR.
L-0712
ASSTT. PROFESSOR DEPTT. OF SPM, BRD MEDICAL COLLEGE GORAKHPUR UTTAR PRADESH

UPADHYAYA SANJEEV
L-1031
A-27, SECTOR 34, NOIDA UTTAR PRADESH

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URFI
L-2914
JUNIOR RESIDENT, DEPTT OF MEDICINE,
JAWAHARLAL NEHRU MEDICAL COLLEGE, A.M.U.,
ALIGARH, UTTAR PRADESH – 202002
urfiislam@yahoo.com

VADHERA KEWAL KRISHAN
L-0312
H.NO. 1431, SECTOR 37, ARUN VIHAR NOIDA, DISTT.
GHAZIABAD UTTAR PRADESH

VARID MALA
L-1285
C/O SHRI M.L. JAIN, PO INTIYATHOK GONDA UTTAR
PRADESH

VARSHNEY AMIT MOHAN
L-3117
ASSTT. PROF, DEPTT. OF COMMUNITY MEDICINE,
SMC MEERUT

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VERMA BABU LAL
L-3087
PROFESSOR OF BIOSTATISTICS & IN – CHARGE DIVISION OF BIOSTATISTICS & EPIDEMIOLOGY DEPTT. OF SOCIAL & PREVENTIVE MEDICINE, JHANSI, UTTAR PRADESH – 284128
blverma49@gmail.com
9415030170

VERMA KAMAL KISHORE
L-2792
A BLOCK, B1-5, KALINDI VIHAR, 100 FEET ROAD, AGRA UTTAR PRADESH – 282006
kamal.verma81@gmail.com

VERMA PREETI
L-3285
C/O- SRI DR. S.K. SINGH, 35/294, NAUBASTA, LOHAMANDI, AGRA, UTTAR PRADESH – 282002
dr.preetivermakgmc2002@gmail.com

Verma Santosh Kumar
L-3649
Dept. of Community Medicine, MLB Medical College, Jhansi-284128
drsantoshvermaspm@gmail.com

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VERTIKA
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VRINDAVAN AROGYA DEEP ATALBAN VRINDAVAN
UTTAR PRADESH

VIBHA KUMAR
L-0849
PVNR, MEDICAL COLLEGE, JOLLY GRANT DEHRADUN
UTTAR PRADESH

VIRENDERA KUMAR PURI
L-0116
LECTURER. DEPTT COLLEGE, LUCKNOW UTTAR
PRADESH

VYAS SHAILI
L-2699
F-29, DOCTOR'S HOSTEL, SRMS-IMS, NAINITAL ROAD,
BAREILLY, UTTAR PRADESH
shailivyas7@gmail.com
9454593210

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YADAV ARUN KUMAR
L-2446
28-B, SWAROOP PARK, SAHIBABAD, GHAZIABAD – 201005 UTTAR PRADESH

YADAV ASHISH
L-3088
S/O MR. I.D.S. YADAV 628/9A, SHAKTI NAGAR, NEAR RAJAT GIRLS INTER COLLEGE, UTTAR PRADESH – 226016
ashmedico@gmail.com

Yadav Manoj
L-3763
Kot East Near Ramitla Ground, Sanbhal, Moradabad, UP-244302
manoj.yadav23@yahoo.co.in

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Website: www.iapsmupuk.org E – Mail: chiefeditor@iapsmupuk.org
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10th WORLD RABIES DAY SEPTEMBER 28

RABIES

Educate • Vaccinate • Eliminate

28TH SEPTEMBER 2016
WORLD RABIES DAY CELEBRATIONS

World Rabies Day 2016 was celebrated across 23 medical colleges of Uttar Pradesh & Uttarakhand under the aegis of IAPSM UP & Uttarakhand. The events comprised of a half day CME on Rabies Prevention & Management. Other events comprised Health talks, Seminars, Poster competitions, Quiz and Nukkad Natak etc. The Consortium Against Rabies was our partner in this year's World Rabies Day Celebrations

Rabies is a vaccine preventable infectious viral disease almost always fatal following onset of clinical signs. Rabies elimination is feasible

In up to 99% of human rabies deaths, the rabies virus is transmitted by domestic dogs

About 36% of the world's rabies deaths occur in India each year

40% of people bitten by suspect rabid animals are children under 15 years of age.

Deaths are scattered and never amount to the kind of crisis that get epidemics top billing and hence the disease is neglected

INDIAN ASSOCIATION OF PREVENTIVE AND SOCIAL MEDICINE UTTAR PRADESH AND UTTARAKHAND

SECRETARIAT -
Department of Community Medicine,
Muzaffarnagar Medical College,
Muzaffarnagar (U.P.)

http://iapsmupuk.org
secretaryiapsmupuk@gmail.com

WORLD RABIES DAY 2016

IAPSM UTTAR PRADESH & UTTARAKHAND

World Rabies Day is celebrated annually on 28 September (anniversary of Louis Pasteur's death, the French chemist and microbiologist, who developed the first Rabies vaccine) to raise awareness about rabies prevention and to highlight progress in defeating this fatal disease. The theme for this year's World Rabies Day was 'Educate, Vaccinate, Eliminate' that highlights two crucial actions that communities need to undertake to prevent rabies. It also reflects the global target to eliminate all human deaths from dog mediated rabies by 2030.

As part of our continuous efforts to raise awareness among the community and medical fraternity on important public health issues, the executive committee IAPSM UP UK decided to observe the World Rabies Day 2016. Human mortality due to Rabies is highest in Asia, with highest incidence and deaths reported from India. Deaths are scattered and never amount to the kind of crisis that get epidemics top billing and hence the disease is neglected. Estimates of burden uncertain due to absence of reliable data and this is where IAPSM can contribute in a big way.

As chief coordinator for the World Rabies Day Celebrations 2016, I express my sincere gratitude to the Head of Departments, Community Medicine of the 23 participating Medical Colleges across UP & Uttarakhand for lending us their active support for successful organisation of this event. We are also thankful to the Faculty/ Nodal officers of the participating medical colleges for organising the event at their respective colleges and sharing the reports with us.

This year we partnered with the Consortium Against Rabies for the World Rabies Day Celebrations. I am extremely thankful to the office bearers Dr AT Kannan (President), Dr Anurag Agarwal (Secretary General) and Dr Khan Amir Maroof (Secretary) for their technical support and help.

Dr Manish Kumar Singh

President, IAPSM UP UK (2016-17)

Participating Colleges

A total of 23 medical colleges across Uttar Pradesh and Uttarakhand participated in this noble endeavor:

- Baba Raghav Das Medical College, Gorakhpur
- Government Medical College, Kannauj
- Government Medical College, Jalaun
- Government Medical College, Ambedkarnagar
- Himalayan Institute of Medical Sciences, Dehradun
- Hind Institute of Medical Sciences, Barabanki
- Institute of Medical Sciences, BHU, Varanasi
- Integral Institute of Medical Science & Research, Lucknow
- King George Medical University, Lucknow
- Lala Lajpat Rai Memorial Medical College, Meerut
- Moti Lal Nehru Medical College, Allahabad
- Muzaffarnagar Medical College, Muzaffarnagar
- Rama Medical College & Research Centre, Kanpur
- Rohilkhand Medical College & Hospital, Bareily
- SRMS Institute of Medical Sciences & Research, Bareily
- SGRR Institute Of Medical & Health Sciences, Dehradoon
- School of Medical Sciences and Research, Sharda University, Noida
- SN Medical College, Agra
- Santosh Medical College, Ghaziabad
- Subharti Medical College, Meerut
- Teerthankar Mahaveer Medidical College, Moradabad
- UP University of Medical Sciences, Saifai
- V.C.S.G.G.M.S. & R.I. Govt. Med. College, Srinagar

28TH SEPTEMBER 2016

WORLD RABIES DAY CELEBRATIONS

IAPSM UPUK Rocks !!! The zeal, the enthusiasm and the team spirit is great ! Congratulations to team IAPSM UP UK & to all the colleges, on celebrating the World Rabies day with such fervour.

Dr Khan Amir Maroof
UCMS,New Delhi

Many of our colleagues have taken the pain to organize this event inspite of prior engagements and NEET counselling going on. Thanks a lot to all our HOD and dedicated IAPSM members.

Dr Manish Kumar Singh
President IAPSM UP UK

Health education camp ... question answer session was held at UHTC. We also invited pet owners in the group... Awesome experience....

De Seema Jain,
LLRM, Meerut

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Dr AM Kadri,
Secretary General IAPSM

.....
.....

Dr Ashok Mishra
President IAPSM

INDIAN ASSOCIATION OF PREVENTIVE AND SOCIAL MEDICINE UTTAR PRADESH AND UTTARAKHAND
SECRETARIAT -
Department of Community Medicine,
Muzaffarnagar Medical College,
Muzaffarnagar (U.P.)
http://iapsmupuk.org
secretaryiapsmupuk@gmail.com

28TH SEPTEMBER 2016. WORLD RABIES DAY

HEALTH AWARENESS ACTIVITIES AT RHTC/UHTC

BRD MEDICAL COLLEGE, GORAKHPUR, UP

HIMALAYAN INSTITUTE OF MEDICAL SCIENCES, DEHRADOON

28TH SEPTEMBER 2016. WORLD RABIES DAY

TMMC, MORADABAD

SGRRIMHS, DEHRADOON

MLN MEDICAL COLLEGE, ALLAHABAD

LLRM MEDICAL COLLEGE, MERUT

28TH SEPTEMBER 2016. WORLD RABIES DAY

CME FOR STUDENTS / FACULTY

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GMC AMBEDKARNAGAR

GMC JALLAUN

28TH SEPTEMBER 2016. WORLD RABIES DAY

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HIND INSTITUTE OF MEDICAL SCIENCES, BARABANKI

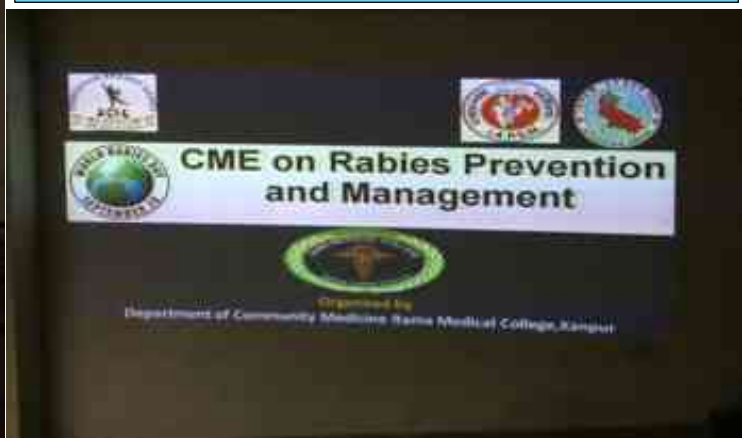
Muzaffarnagar Medical College, Muzaffarnagar

Integral Institute of Medical Sciences & Research, Lucknow

28TH SEPTEMBER 2016. WORLD RABIES DAY

KGMU, LUCKNOW

RAMA MEDICAL COLLEGE, KANPUR



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28TH SEPTEMBER 2016. WORLD RABIES DAY

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28TH SEPTEMBER 2016. WORLD RABIES DAY

SRMSIMS & R, BAREILY

IMS, BANARAS HINDU UNIVERSITY, VARANASI

28TH SEPTEMBER 2016. WORLD RABIES DAY

SGRRIM&HS, DEHRADOON

V.C.S.G.G.M.S. & R.I. Govt. Med. College, Srinagar

UPUMS, SAIFAI

LLRM MEDICAL COLLEGE, MEERUT

28TH SEPTEMBER 2016. WORLD RABIES DAY

ROLE PLAY

ROHILKHAND MEDICAL COLLEGE, BAREILY

SUBHARTI MEDICAL COLLEGE, MEERUT

28TH SEPTEMBER 2016. WORLD RABIES DAY

POSTERS & IEC MATERIALS

IIMSR, LUCKNOW

V.C.S.G.G.M.S. & R.I. Govt.

LLRM MEDICAL COLLEGE, MEERUT

28TH SEPTEMBER 2016. WORLD RABIES DAY

CONTRIBUTIONS.....

Dr JV Singh, Professor & Head, Community Medicine, MMC, Muzaffarnagar

Dr SP Singh, Professor & Head, Community Medicine, IMS BHU, Varanasi

Dr JV Singh, Professor & Head, Community Medicine, KGMU, Lucknow

Dr SK Garg, Professor & Head, Community Medicine, LLRM Medical College, Meerut

Dr VK Srivastava, Professor & Head, Community Medicine, HIND Institute of Medical Sciences

Dr Ratan Srivastava, Professor, Community Medicine, IMS BHU, Varanasi

Dr CP Mishra, Professor, Community Medicine, IMS BHU, Varanasi

Dr SB Gupta, Professor & Head, Community Medicine, SRMSIMS& R, Bareilly

Dr SK Mishra, Professor & Head, Community Medicine, SN Medical College, Agra

Dr Rahul Bansal, Professor & Head, Community Medicine, Subharti Medical College, Meerut

Dr HS Joshi, Professor & Head, Community Medicine, RMCH, Bareilly

Dr Jayanti Semwal, Professor & Head, Community Medicine, HIMS Dehradoon

Dr Amirul Hasan, Professor & Head, Community Medicine , GMC, Ambedkarnagar

Dr Sobha Chaturvedi, Professor & Head, Community Medicine , GMC Jallaun

Dr DS Martolia, Professor & Head, Community Medicine, GMC Kannauj

Dr Sudhir Gupta, Professor & Head, Community Medicine, GRRIMS, Dehradoon

Dr Shiv Prakash, Professor & Head, Community Medicine, MLN Medical College, Allahabad

Dr. S.Nagesh. Professor & Head, Head, Community Medicine , SMSR Sharda University.

Dr Amit Singh, Professor & Head, Head, Community Medicine, V.C.S.G.G.M.S. & R.I. GMC, Srinagar

Dr Nadeem Ahmed, Professor & Head, Community Medicine, IIMS& R, Lucknow

Dr PK Jain, Professor & Head, Community Medicine, UPUMS, Saifai

Dr Anurag Agarwal, Professor & Head, Community Medicine, TMC Moradabad

Dr PK Mahajan, Professor & Head, Community Medicine, RAMA Medical College, Kanpur

Dr Monika Agarwal, Professor, Community Medicine, KGMU, Lucknow

Dr Seema Jain, Professor, LLRM Medical College, Meerut

Dr Ruchi Juyal, Professor, Community Medicine, HIMS Dehradoon

Dr Narendra Singh, Professor, Community Medicine, Santosh Medical College, Ghaziabad

Dr Arun Singh, Professor, Community Medicine, RMCH, Bareilly

Dr Renu Agarwal, Professor, Community Medicine, SN Medical College, Agra

Dr Khursheed Muzammil, Professor, Community Medicine, MMC Muzaffarnagar

28TH SEPTEMBER 2016. WORLD RABIES DAY

CONTRIBUTIONS.....

Dr Megha Luthra, Professor, Community Medicine, GRRIMS, Dehradoon

Dr Anand Mohan Dixit, Associate Professor, Community Medicine, UPUMS, Saifai

Dr Mukesh Sharma, Associate Professor, Community Medicine, TMC Moradabad

Dr Arun Tandon, Associate Professor, Community Medicine, LLRM Medical College, Meerut

Dr Khursheed Parveen, Associate Professor, Community Medicine, MLN Medical College, Allahabad

Dr Varsha Chaudhary, Associate Professor, Community Medicine, Subharti Medical College, Meerut

Dr.Medhavi Agarwal, Assistant Professor, Community Medicine, RMCH, Bareilly

Dr Manushi Srivastava, Assistant Professor, Community Medicine, IMS BHU, Varanasi

Dr Manish Kumar Singh, Assistant Professor, Community Medicine BRD Medical College, Gorakhpur

Dr Arvind Kumar Singh, Assistant Professor, Community Medicine, GMC Ambedkar Nagar

Dr. Sanjeev Kumar, Assistant Professor, Community Medicine, LLRM Medical College, Meerut

Dr. Swarna Rastogi, Assistant professor, Community Medicine, MMC Muzaffarnagar

Dr Anshu Singh, Assistant Professor, Community Medicine, SMSR,Sharda University

Dr Anees Saif, Assistant professor, Community Medicine, RAMA Medical College, Kanpur

Dr Harish Chandra Tiwari, Lecturer, Community Medicine, BRD Medical College, Gorakhpur

Dr Shailendra Pratap Singh, Lecturer, Community Medicine, GMC Jallaun

For Consortium Against Rabies

Dr Khan Amir Maroof, Associate Professor, Community Medicine, UCMS, New Delhi (Secretary)

Dr Anurag Agarwal, Assistant Professor, Pediatrics, MAMC, Delhi (Gen. Secretary)

Coordinator for World Rabies Day 2016 (IAPSM UP & Uttarakhand)

&

Report Preparation

Dr Manish Kumar Singh

Assistant Professor, Community Medicine, BRD Medical College, Gorakhpur

President, IAPSM UP & Uttarakhand (2016-17)

WORLD BREASTFEEDING WEEK – 2016: IAPSM UP UK

A short video report summarizing the event can be viewed and downloaded from : WORLDBREASTFEEDING WEEK 2016 IAPSM UP UK

Link is --

https://www.youtube.com/watch?v=0ZMbFqUQxqk&feature=youtu.be

WORLD BREASTFEEDING WEEK 2016

BREASTFEEDING

A KEY TO SUSTAINABLE DEVELOPMENT

World Breastfeeding Week in Uttar Pradesh & Uttarakhand

Year 2016

Report on various activities carried out by Department of Community Medicine, in Medical Colleges across Uttar Pradesh & Uttarakhand (INDIA) during the World Breastfeeding Week (August 1st – 7th 2016) under the banner of IAPSM-UP & UK

Indian Association of Preventive and Social Medicine Uttar Pradesh and Uttarakhand [IAPSM-UP UK]

President +91-9005435789
Secretary +91-9759585668

SECRETARIAT -
Department of Community Medicine,
Muzaffarnagar Medical College,
Muzaffarnagar (U.P.)

http://iapsmupuk.org
secretaryiapsmupuk@gmail.com

Contents

"It's a new beginning, we have much more to achieve. Together we can surely make a difference. But the work isn't finished yet……..."

Dr Manish Kumar Singh, President

"World Breastfeeding Week celebrations in medical colleges of UP UK have once again proved to be a successful one. Everybody involved in it have taken IAPSM UPUK to zenith. Its our strength indeed which will prove one day as the best chapter of IAPSM"

Dr Khursheed Muzammil, Secretary

To Our Members

"An empowered organization is one in which individuals have the knowledge, skill, desire, and opportunity to personally succeed in a way that leads to collective organizational success"

– M Shawn Covey

An organization is like the human body – thinking, feeding, acting, balancing and so many roles to play. Nevertheless, it becomes handicapped once the parts stop functioning. On the positive note, if all parts function in synchrony, there is no goal that is unattainable. IAPSM-UPUK is growing stronger day by day as we, the members, are working hard to make its presence felt through our actions. This year's commitment was celebration of 5 events across both states. We started with the celebration of World Health Day this year. Most of the colleges participated in celebration of the one-day event that was highly appreciated one and all. However, the full strength of our organization was evident during a week-long World Breastfeeding Week celebrations 2016. Observed between August 1st and August 7th, 2016, through WBW-2016 celebrations, IAPSM-UPUK has been able to touch the lives of tens of thousands of beneficiaries through the team of dedicated members spread across 22 medical colleges across the states of Uttar Pradesh and Uttarakhand.

Touching lives of mothers and infants

"Breastfeeding is 90% determination and 10% milk production" *-Anonymous*

Fortunately, India is a country where traditionally breastfeeding has never been looked down. Not even the bait set up by the commercial baby food industry could shake the roots of this powerful tradition much. However there have been some lacunae – the fear of not enough milk, the lure of pre-lacteal feeds or even mixed feeding, and many more. While the developed countries have been striving hard to popularize breastfeeding and removing the fad that extended breastfeeding a child for 2 years and beyond does not count *incest (!!!!),* India's struggle is way too different. There is the 'Attitude' and 'Practice', only a gap in 'Knowledge' exists. Our primary aim was to fill that gap, to instigate self-confidence in mothers that each mother – weak or strong, rich or poor, with singleton or twins – is naturally capable to breastfeed her child/ children through scientifically tested and approved methods. We might have been able to reach only a small fraction of such beneficiaries, but we believe that 'Right Knowledge' is like a rolling snowball – won't stop growing and won't stop moving.

“It gives a great pleasure to see all the posts related to breastfeeding week celebrations in various institutions…… …. Nevertheless we are on right track……”

Dr Naresh Pal Singh,UPUMS, Saifai

“…… appreciation….. These are our best motivators”

Dr Anurag Srivastava, TMU, Moradabad

“……unity is strength. Leadership is the key to achieve that”

Dr Shama Sheikh, MLN Medical

Participating Colleges

A total of 22 medical colleges spread across Uttar Pradesh and Uttarakhand participated in this noble endeavor:

- **Baba Raghav Das Medical College, Gorakhpur**
- **Era's Medical College & Hospital, Lucknow**
- **FH Medical College, Tundla**
- **Ganesh Shankar Vidyarthi Memorial Medical College, Kanpur**
- **Government Medical College, Haldwani**
- **Himalayan Institute of Medical Sciences, Dehradun**
- **Institute of Medical Sciences, BHU, Varanasi**
- **Integral Institute of Medical Sciences and Research, Lucknow**
- **Jawarhar Lal Nehru Medical College, AMU, Aligarh**
- **King George Medical University, Lucknow**
- **Lala Lajpat Rai Memorial Medical College, Meerut**
- **Moti Lal Nehru Medical College, Allahabad**
- **Muzaffarnagar Medical College, Muzaffarnagar**
- **Maharani Lakshmi Bai Medical College, Jhansi**
- **Rohilkhand Medical College & Hospital, Bareilly**
- **Rama Medical College Hospital & Research Centre, Kanpur**
- **Sarojani Naidu Medical College, Agra**
- **Shri Guru Ram Rai Institute of Medical & Health Sciences, Dehradun**
- **Sri Ram Murti Smarak Institute of Medical Sciences and Research, Bareilly**
- **Subharti Medical College, Meerut**
- **Teerthankar Mahaveer Medical College, Moradabad**
- **UP University of Medical Sciences, Saifai**

OUR ACTIVITIES – Poster Competition

A poster presentation is *"an experimental learning activity that stimulates curiosity and interest, encourages exploration and integration of concepts and provides students with a novel way of demonstrating understanding"*

- *Handron, 1994*

Posters were used to generate interest on breastfeeding among the medical students. Coupled with an urge to excel in the competition, this activity generated curiosity and innovation on *What, How, When, Where and Which* on various topics related to breastfeeding. This gave them an insight into details of breastfeeding. The task didn't end here – the next mammoth task was decorating the selected topic on a sheet of paper such that it generated curiosity and interest of the viewers, while giving them the required information.

Poster competitions were carried out at most of the medical institutions across both states. Later these posters were used at Rural and Urban Health Training Centres for display to beneficiaries and also as visual tool for counselling pregnant & lactating mothers.

World Breast Feeding Week - 2016

IAPSM UP UK

OUR ACTIVITIES – Poster Competition

World Breast Feeding Week - 2016

IAPSM UP UK

OUR ACTIVITIES – Seminars, Presentations & Panel Discussion

Seminars, Presentations and Panel discussion were also held. These served the function of bringing together the medical fraternity from various disciplines focusing on the importance of spreading awareness regarding breastfeeding among public and updating their knowledge related to the topic by providing scientific, evidence based knowledge. This medium served in empowering the health care providers, who were motivated to participate actively in these activities. While the senior members could discuss, debate over and question the readings, the junior members had the opportunity to learn a lot from their wide experiences.

World Breast Feeding Week - 2016

IAPSM UP UK

OUR ACTIVITIES – Seminars, Presentations & Panel Discussion

World Breast Feeding Week - 2016

IAPSM UP UK

OUR ACTIVITIES – Seminars, Presentations & Panel Discussion

World Breast Feeding Week - 2016

IAPSM UP UK

OUR ACTIVITIES – SENSITIZATION OF PREGNANT & LACTATING WOMEN

Health talks provided an opportunity to share reliable information about issues related to breastfeeding, by sharing people's real life experiences. Depending upon the agreement made, other people could watch them sharing their own stories – stories of success and failure, stories of desire and apathy, stories of myths and facts. With a subject expert listening to the talk, others could see them making decisions, talking with family members and the impact on their work; which in turn enabled them to make decisions at their end.

World Breast Feeding Week - 2016

IAPSM UP UK

OUR ACTIVITIES – Radio Talk

Radio talks an excellent means of reaching public *en masse.*

World Breast Feeding Week - 2016

IAPSM UP UK

OUR ACTIVITIES – *Nukkad Natak*

World Breast Feeding Week - 2016

IAPSM UP UK

OUR ACTIVITIES –Sensitization of ASHA, ANM & Anganwadi Workers

World Breast Feeding Week - 2016

IAPSM UP UK

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World Breast Feeding Week - 2016

IAPSM UP UK

OUR ACTIVITIES – Sensitization of Adolescent Girls

World Breast Feeding Week - 2016

IAPSM UP UK

OUR ACTIVITIES – Sensitization of Adolescent Girls

Dr Shiv Prakash, Professor & Head, Community Medicine, MLN Medical College, Allahabad

Dr JV Singh, Professor & Head, Community Medicine, KGMU, Lucknow

Dr Monika Agarwal, Professor, Community Medicine, KGMU, Lucknow

Dr JP Srivastava, Professor & Head, Community Medicine, Eras Medical College, Lucknow

Dr Pratibha Gupta, Professor, Community Medicine, Eras Medical College, Lucknow

Dr Nadeem Ahmed, Professor & Head, Community Medicine, IIMS& R, Lucknow

Dr SP Singh, Professor & Head, Community Medicine, IMS BHU, Varanasi

Dr RP Sharma, Professor & Head, Community Medicine, GSVM Medical College, Kanpur

Dr Seema Nigam, Professor, Community Medicine, GSVM Medical College, Kanpur

Dr AK Malhotra, Professor & Head, Community Medicine, MLB Medical College, Jhansi

Dr Santosh Verma, Assistant Professor, Community Medicine, MLB Medical College Jhansi

Dr PK Jain, Professor & Head, Community Medicine, UPUMS, Saifai

Dr Anand Mohan Dixit, Associate Professor, Community Medicine, UPUMS, Saifai

Dr Anurag Agarwal, Professor & Head, Community Medicine, TMC Moradabad

Dr SB Gupta, Professor & Head, Community Medicine, SRMSIMS& R, Bareilly

Dr JP Singh, Assistant Professor, Community Medicine, SRMSIMS& R, Bareilly

Dr HS Joshi, Professor & Head, Community Medicine, RMCH, Bareilly

Dr Deepak Upadhayay, Assistant Professor, Community Medicine, RMCH, Bareilly

Dr.Medhavi Agarwal, Assistant Professor, Community Medicine, RMCH, Bareilly

Dr Rahul Bansal, Subharti Institute of Medical Sciences, Meerut

Dr SK Garg, Professor & Head, Community Medicine, LLRM Medical College, Meerut

Dr Arun Tandon, Associate Professor, Community Medicine, LLRM Medical College, Meerut

Dr SK Mishra, Professor & Head, Community Medicine, SN Medical College, Agra

World Breast Feeding Week - 2016

IAPSM UP UK

OUR ACTIVITIES – Sensitization of Adolescent Girls

World Breast Feeding Week - 2016

IAPSM UP UK

Dr Renu Agarwal, Professor, Community Medicine, SN Medical College, Agra

Dr JV Singh, Professor & Head, Community Medicine, MMC, Muzaffarnagar

Dr Khursheed Muzammil, Professor, MMC Muzaffarnagar

Dr Jayanti Semwal, Professor & Head, Community Medicine, HIMS Dehradoon

Dr Shaili Vyas, Assistant Professor, Community Medicine, HIMS Dehradoon

Dr Vivek Pandey, Resident , Community Medicine, HIMS Dehradoon

Dr Iqbal Mohammad Khan, Professor & Head, Community Medicine, FHMC, Tundla

Dr Harish Chandra Tiwari, Lecturer, Community Medicine, BRD Medical College, Gorakhpur

Dr Najam Khalique, Professor & Head, Community Medicine, JNMC, AMU, Aligarh

Dr PK Mahajan, Professor & Head, Community Medicine, RAMA Medical College, Kanpur

Dr CMS Rawat, Professor & Head, Community Medicine, GMC Haldwani

Dr Sadhna Awasthi, Professor, Community Medicine, GMC Haldwani

Dr Sudhir Gupta, Professor & Head, Community Medicine, GRRIMS, Dehradoon

Dr Megha Luthra, Professor, Community Medicine, GRRIMS, Dehradoon

Suggestions

Dr JV Singh, Dr VK Srivastava, Dr Harivansh Chopra, Dr Seema Jain, Dr Renu Agarwal, Dr Manish Chaturvedi, Dr Rakesh Kakkar, Dr AK Srivastava, Dr Khursheed Muzammil, Dr Arvind Kumar Singh & Dr Manish Kumar Singh.

Coordinator for WBW 2016 (IAPSM UP & Uttarakhand)

Dr Manish Kumar Singh

Assistant Professor, Community Medicine, BRD Medical College, Gorakhpur

President, IAPSM UP & Uttarakhand (2016-17)

Report compilation

Dr Arvind Kumar Singh, Assistant Professor, Community Medicine, GMC Ambedkar Nagar

Gmail **Secretary Iapsmupuk <secretaryiapsmupuk@gmail.com>**

BEST OBSERVATION OF WORLD AIDS DAY 2016

1 message

Dr Manish Kumar Singh <drmanishscbmc@yahoo.co.in> Fri, Jan 6, 2017 at 7:06 PM
Reply-To: Dr Manish Kumar Singh <drmanishscbmc@yahoo.co.in>
To: Jayanti Semwal <semwal@hotmail.com>, "drd.shikha@yahoo.co.in" <drd.shikha@yahoo.co.in>, Shri Prakash Singh <drspsingh1953@gmail.com>, Shri Prakash <drspsingh_vns@yahoo.com>, Ratan Srivastava <ratanpsm@gmail.com>, Dr Santosh Verma <drsantoshvermaspm@gmail.com>, "malhotra.anil_kumar" <malhotra.anil_kumar@yahoo.co.in>, "malhotra.anilkumar@yahoo.co.in" <malhotra.anilkumar@yahoo.co.in>, "conscious.richa@gmail.com" <conscious.richa@gmail.com>, "DR. Shiv Prakash" <shivprakashspm@gmail.com>, "Dr H. S. Joshi" <drjoshiharish@rediffmail.com>, Arun Singh <arunspm@gmail.com>, Jp Singh <jpsingh0001@rediffmail.com>, "Dr.S.B.Gupta(Prof)" <dr_sbgupta@rediffmail.com>, "Dr.Venkatashiva reddy.B" <dr.shiva222@gmail.com>, "hodpsmvcsg@rediffmail.com" <hodpsmvcsg@rediffmail.com>, Jp Srivastava <jp_srivastava07@rediffmail.com>, Mrinal Srivastava <dr.mrinal.srivastava@gmail.com>, Iqbal Mohammad <driqbalmkhan@gmail.com>, Seema Nigam <drseemagsvm@yahoo.co.in>, RP Sharma <dr_sharmarp@yahoo.in>, Amirul Hassan <hassan_amirul@rediffmail.com>, Arvind Singh <iamarvind2000@gmail.com>, Sadhana Awasthi <drsadhna1810@yahoo.com>, "shobha chaturvedi (Jaunpur)" <chaturvedirajesh@yahoo.com>, Shailendra Pratap Singh <shailup02@gmail.com>, Pradip Kharya <drpradipkharya@gmail.com>, Dinesh Singh Martolia <dr.martolia10@gmail.com>, Deepak Chopra <drdeepakchoprakgmu17@gmail.com>, Nadeem Ahmad <nadeemarman@rediffmail.com>, Ali Jafar Abedi <alijafarabedi@gmail.com>, Najam Khalique <najam_km@yahoo.com>, "Dr J. V. Singh Lucknow" <jvsingh510@rediffmail.com>, Prof JV Singh <jvsingh510@yahoo.com>, DR Reema Kumari <reema_tua05@yahoo.co.in>, Sanjeev Kumar <drsanjeev_cm@rediffmail.com>, Sunil Kumar Garg <drgargfam@rediffmail.com>, Khursheed Muzammil <drkmb25@yahoo.com>, Secretary Iapsmupuk <secretaryiapsmupuk@gmail.com>, Narendra Singh <narendra.singhv@gmail.com>, Amit Pawaiya <amtyyash@gmail.com>, Nagesh Seetharamiah <prof.nagesh@gmail.com>, Ranjana Singh <dr.ranjanaabhi@gmail.com>, "dr_kajal_jain@yahoo.ie" <dr_kajal_jain@yahoo.ie>, Sudhir Gupta <sudhirsarthak@rediffmail.com>, Anurag Srivastava <dranurag77@yahoo.com>, Mukesh Sharma <sharma.mukesh40@gmail.com>, Dr Pankaj Jain <drpankajjain@yahoo.com>, Vidya Rani <vidyarims@gmail.com>, Rahul Bansal <drrahulbansalzp@gmail.com>, "dr_varsha25@yahoo.co.in" <dr_varsha25@yahoo.co.in>, "J. V. Singh Sir Senior Head" <doctorjaivir@yahoo.co.in>, Pradeep Aggarwal <drpradeep_aggarwal@hotmail.com>, Sunil Misra <misrasunil66@gmail.com>, Suneel Kaushal <dr.suneel31@rediffmail.com>

Respected Sir / Madam

IAPSM & Health Education Committee- IAPSM is extremely grateful to you for your wholehearted support in the nationwide observance of World AIDS Day 2016.
The World AIDS Day was observed in about 215 medical colleges all across India.

As a part of the World AIDS Day 2016, 3 competitions were held for UG/ PG/Interns. This year there
was also a "Best Observation of World AIDS Day " Award for the college observing the World AIDS
day.

A total of 28 colleges from across UP and Uttarakhand observed the World AIDS Day 2016. From the
reports received 7 colleges are being awarded for the " Best Observation of World AIDS Day"

Please find as attachment the list of colleges that observed the World AIDS Day & the winners of the "Best Observation of World AIDS Day 2016". Also attached is the list of winners for "IAPSM UP & UK" of the 3 competitions.

Thanking you

With regards

Dr Manish Kumar Singh
President-IAPSM (UP & Uttarakhand)
Secretary -Health Education Committee-IAPSM

2 attachments

BEST OBSERVATION OF WORLD AIDS DAY 2016 FINAL.pdf
482K

WINNERS IAPSM UPUK.pdf
270K

WORLD AIDS DAY 2016
IAPSM UP & UK
"BEST OBSERVATION AWARD"

S. No	Name of College (Alphabetical Order)	Nodal Person	Head of Department, Community Medicine
1	Himalayan Institute of Medical Sciences, Dehradun	Dr Deepshikha	Dr Jayanti Semwal
2	IMS BHU, Varanasi	Dr Ratan Srivastava	Dr SP Singh
3	MLB Medical College, Jhansi	Dr Santosh Verma	Dr AK Malhotra
4	MLN Medical College, Allahabad	Dr Richa Mishra	Dr Shiv Prakash
5	Rohilkhand Medical College & Hospital, Bareilly	Dr Arun Singh	Dr HS Joshi
6	Sri Ram Murti Smarak Institute of Medical Sciences, Bareilly	Dr JP Singh	Dr SB Gupta
7	VCSGGIMS & R, Srinagar, Garhwal	Dr Venkat Shiva Reddy	Dr Amit Singh

(Dr Manish Kumar Singh)

President IAPSM UP UK

"WORLD AIDS DAY 2016"
IAPSM UP & UK
PARTICIPATING COLLEGES

S. No	Name of College (Alphabetical Order)	Nodal Person	Head of Department, Community Medicine
1	ERA'S Medical College, Lucknow	Dr Mrinal Srivastava	Dr JP Srivastava
2	FH Medical College, Tundla	Dr Panchsheel Sharma	Dr Mohd Iqbal Khan
3	GSVM Medical College, Kanpur	Dr Seema Nigam	Dr RP Sharma
4	Government Medical College, Ambedkarnagar	Dr Arvind Kumar Singh	Dr Amirul Hasan
5	Government Medical College, Haldwani	Dr RK Singh	Dr Sadhna Awasthi
6	Government Medical College, Jalaun	Dr Shailendra Pratap Singh	Dr Shobha Chaturvedi
7	Government Medical College, Kannauj	Dr Pradip Khariya	Dr DS Martolia
8	Himalayan Institute of Medical Sciences, Dehradun	Dr Deepshikha	Dr Jayanti Semwal
9	Institute of Medical Sciences, BHU, Varanasi	Dr Ratan Srivastava	Dr SP Singh
10	Integral Institute of Medical Science & Research, Lucknow	Dr Deepak Chopra	Dr Nadeem Ahmad
11	JNMC, AMU, Aligarh	Dr Ali Jafar Abdi	Dr Najam Khalique
12	King George Medical University, Lucknow	Dr Reema Kumari	Dr JV Singh
13	Lala Lajpat Rai Memorial Medical College, Meerut	Dr Sanjeev Kumar Singh	Dr SK Garg
14	MLB Medical College, Jhansi	Dr Santosh Verma	Dr AK Malhotra
15	MLN Medical College, Allahabad	Dr Richa Mishra	Dr Shiv Prakash
16	Muzaffarnagar Medical College, Muzaffarnagar	Dr Khursheed Muzammil	Dr JV Singh
17	Rama Medical College & Research Centre, Kanpur	----------	Dr Anju Gehlot
18	Rohilkhand Medical College & Hospital, Bareilly	Dr Arun Singh	Dr HS Joshi
19	Santosh Medical College, Ghaziabad	----------	Dr Narendra Singh
20	School of Medical Sciences and Research, Sharda University, Noida	Dr Amit Pawaiya	Dr S. Nagesh

"WORLD AIDS DAY 2016"
IAPSM UP & UK
PARTICIPATING COLLEGES

S. No	Name of College (Alphabetical Order)	Nodal Person	Head of Department, Community Medicine
21	Saraswati Institute of Medical Sciences, Hapur	----------	Dr Ranjana Singh
22	SGRR Institute Of Medical & Health Sciences, Dehradoon	Dr Kajal Jain	Dr Sudhir Gupta
23	Sri Ram Murti Smarak Institute of Medical Sciences, Bareilly	Dr JP Singh	Dr SB Gupta
24	Subharti Medical College, Meerut	Dr Varsha	Dr Rahul Bansal
25	Teerthankar Mahaveer Medical College, Moradabad	Dr Mukesh Sharma	Dr Anurag Srivastava
26	UP University of Medical Sciences, Saifai	Dr Vidya Rani	Dr PK Jain
27	Varun Arjun Medical College, Shahjahanpur	----------	Dr RK Pal
28	VCSGGIMS & R, Srinagar, Garhwal	Dr Venkat Shiva Reddy	Dr Amit Singh

(Dr Manish Kumar Singh)

President IAPSM UP UK

WINNERS IAPSM UP & UK

Activity	Winner Details	1st Prize	2nd Prize	3rd Prize
Essay Writing	Name	**Dr Kritika Tiwari**	**Dr Kriti Dwiwedi**	**Ms Prachi Tamta**
	MBBS Semester/ Intern/ PG YEAR INSTITUTE	PG RESIDENT (3rd Year) **Himalayan Institute of Medical Sciences, Dehradoon**	PG RESIDENT **MLN Medical College, Allahabad**	MBBS (2013-14 Batch) **Government Medical College Haldwani**
Poster Making	Name	**Ms Neha Bisht**	**Ms Vani Yadav**	**Ms Almas Fatima**
	MBBS Semester/ Intern/ PG YEAR INSTITUTE	MBBS (2015-16 Batch) **Government Medical College Haldwani**	MBBS (2013 Batch) **Himalayan Institute of Medical Sciences, Dehradoon**	MBBS (2013 Batch) **GSVM Medical College, Kanpur**
Slogan Writing	Name	**Arya Ankit**	**Rajeev Kumar**	**Mohd. Ziyauddin Ali Ansari**
	MBBS Semester/ Intern/ PG YEAR INSTITUTE	MBBS (2016 Batch) **Government Medical College Kannauj**	MBBS (2013 Batch) **MLN Medical College, Allahabad**	MBBS (2014 Batch) **Government Medical College, Jallaun**

(Dr Manish Kumar Singh)

President IAPSM UP UK

IAPSM-WHD-QUIZ : 2016

State/Zone Summary Report : Form No. 2

Name of the State/zone: **IAPSM UPUK STATE CHAPTER**

Total number of Medical Colleges in the State/zone: __**33**__ **(Functional)**

Total Number of Medical College where event held: __**21** __

Sr. No.	Name of the Institute	Form no. 1 received Yes/No	Photo received Yes/No	Brief narrative Report received. Yes/No
1.	BRD MEDICAL COLLEGE GORAKHPUR, U.P.	**NO**	**YES**	**NO**
2.	IMS, BHU, VARANASI, U.P.	**YES**	**YES**	**YES**
3.	MLN MEDICAL COLLEGE, ALLAHABAD, U.P.	**YES**	**YES**	**YES**
4.	MAGMC, AMBEDKAR NAGAR , U.P.	**YES**	**YES**	**YES**
5.	FHMCH, TUNDLA, U.P.	**YES**	**YES**	**YES**
6.	JNMCH, AMU, ALIGARH, U.P.	**YES**	**YES**	**YES**
7.	LLRM MEDICAL COLLEGE, MEERUT, U.P.	**YES**	**YES**	**YES**
8.	SMSR, SHARDA UNIVERSITY, GREATER NOIDA, U.P.	**YES**	**YES**	**YES**
9.	MMC, MUZAFFARNAGAR, U.P.	**YES**	**YES**	**YES**
10.	TM MEDICAL COLLEGE, MORADABAD, U.P.	**YES**	**YES**	**YES**
11.	RUHELKHAND MEDICAL COLLEGE, BAREILLY, U.P.	**YES**	**YES**	**YES**
12.	SRMSIMS, BAREILLY, U.P.	**YES**	**YES**	**YES**
13.	GSVM MEDICAL COLLEGE, KANPUR, U.P.	**YES**	**YES**	**YES**
14.	HIMS, JOLLY GRANT, DEHRADUN, UTTARAKHAND.	**YES**	**YES**	**YES**
15.	VCSGGMS&RI SRINAGAR, UTTARAKHAND.	**YES**	**YES**	**YES**
16.	GOVT. MEDICAL COLLEGE, HALDWANI UKD.	**YES**	**YES**	**YES**
17.	SMC, GHAZIABAD, U.P.	**YES**	**YES**	**YES**
18.	HIMS, BARABANKI, U.P.	**AWAITED**	**YES**	**AWAITED**
19.	INTEGRAL MEDICAL COLLEGE, LUCKNOW, U.P.	**AWAITED**	**YES**	**AWAITED**
20.	UPRIMS & R SAIFAI, ETAWAH, U.P.	**AWAITED**	**YES**	**AWAITED**
21.	AIIMS, RISHIKESH, UTTARAKHAND.	**AWAITED**	**YES**	**AWAITED**

Name of the State Coordinator: __**Dr. (Prof.) Khursheed Muzammil**__

Note: Please save the photos and report in the one folder with name **"Name of State _name of Institute_IAPSM_WHD_Report"** and share in one folder.

Please also share your qualitative feedbacks separately in "What were good", "What needs to be improved" based on lessons learnt from the experiences to make IAPSM-WHD-QUIZ better next time.

FEEDBACK FROM HEAD QUARTER OF IAPSM UPUK

What happened ?

Head Quarter of IAPSM with tremendous effort of the President- Prof. Ashok Mishra, Secretary General- Prof. A M Kadri, Dr. Bannerjee and the entire Quiz Team designed the whole event and ultimately got success in its implementation. They appointed the state level nodal coordinators for ease in dissemination of informations/ quiz related questions etc at college level. The college level nodal person/ HOD ultimately got the task done.

In our chapter i.e., IAPSM UPUK, we moved a step further and come up with a state champion team. For that we conducted online elimination round in all the 21 medical colleges participated in the college level champion round. Firstly, a trial round was conducted on 25th April to get accustomed with the online system and was very successful. A total 16 medical colleges ultimately participated on 30th April 2016 in 25 minutes online round containing 40 MCQs designed with the help of Dr. Bannrjee & Dr. A. M. Kadri. A competent team was formed to undergo this online elimination round under the able guidance of Dr. Rakesh Kakkar including the web designer of IAPSM UPUK- Shri Santosh Budhakoti. At last Final Round in its original Pattern was conducted at the State Head Quarter at MMC Muzaffarnagar with the Secretary itself being the Quiz Master. Out of the following four teams selected in the online elimination round, HIMS Dehradun ultimately declared as **STATE CHAMPION TEAM** –

1. BRD Medical College, Gorakhpur
2. GSVM Medical College, Kanpur
3. TMC Medical College, Moradabad
4. **HIMS, Jolly Grant, Dehradun.**

At the end, Prizes/ Trophies & Certificates were distributed to all the 12 finalist of the 04 teams. The State Champion team members were also honoured with a huge trophy and cheque worth INR 2000/- each and rest of the 09 participants with INR 1000/- each. This amount of INR 15000/- was sponsored

by the IJCH Editorial Team for which the Governing Council is thankful to them for their generous support.

So what ?

This was a wonderful experience as we had such activity for the very first time at All India level. Everybody concerned was very happy to have such PAN India level activity by IAPSM National Body under the able Guidance of Dr. Ashok Mishar (President) and Dr. A. M. Kadri (Secretary General) with technical expertise of Dr. Bannerjee & team. All the HODs/ Nodal Coordinators cooperated to the best of their capabilities. All the members realized that by undertaking such events we can strengthen our association many fold and can explore the leadership qualities of young faculty members.

What next ?

We should have similar activity for some other important health days also from now onwards. Conduction of such event will not only give our fraternity a recognition to NGOs but also develop a sense of trust which was lacking for too many years in fact. We should try to have State level championship and at last come up with National Champions. All the winners must be given free registration, TA/DA to attend our National Conferences and honoured in the inaugural ceremony of the conference. By doing all these we will generate enthusiasm among the students to do much better and opt our speciality as their career too. If possible some uniform IEC material or a token monitory aid be given to all those medical colleges/ concerned HODs/ Nodal Coordinators to affiliate the National Body/ Head Quarter directly with the event. This will create more realistic approach during the dialogue with the college administration. Time to time review of such events and feedback be taken to improve ourselves further. The best performing college in a state/ chapter and a best forming state/ chapter be given due recognition for healthy competition and increased enthusiasm.

DR. KHURSHEED MUZAMMIL
STATE COORDINATOR - WHD
&
SECRETARY – IAPSM UPUK

IAPSM-WHD-QUIZ : 2016

STATE LEVEL WHD QUIZ - 2016

BRIEF REPORT

IAPSM took the initiative to organize a national level Quiz at college level on the occasion of World Health Day – 2016 for the first time in the history of our association. IAPSM UPUK moved a step further to have a state level quiz also to come up with a state champion team. In this regard, after the successful completion of the preliminary and online secondary screening round, a total of 04 teams ultimately entered the final. These teams were from –

1. **HIMS, Dehradun (STATE CHAMPION)**
2. **BRD Medical College, Gorakhpur**
3. **GSVM, Kanpur &**
4. **TMC Moradabad**

The state level quiz final was held at IAPSM UPUK HEAD QUARTER, MMC MUZAFFARNAGAR on 8th May 2016. **The winner team was from HIMS Dehradun**. All the finalist were awarded with certificates of appreciation and participation as the case may be. Prizes were distributed to the winners and runner ups. Cheques of handsome amount were also handed over to the winners from IJCH office bearers to motivate the students. It was a successful event and concluded by having the Third Mid term Governing Council Meeting.

DR. KHURSHEED MUZAMMIL
STATE COORDINATOR - WHD
&
SECRETARY – IAPSM UPUK

Dated: 10/05/2016

INDIAN ASSOCIATION OF PREVENTIVE & SOCIAL MEDICINE UP & UK STATE CHAPTER

IAPSM UPUK STATE CHAPTER IS HEREBY PLEASED TO CONFER

BEST PAPER PUBLICATION AWARD – 2016

TO

DR. RUDRA P. DAS

LIFE MEMBERSHIP NO: L-

Post Graduate Student, Department of Community Medicine and Public Health, KGMC, Lucknow.

This award is being conferred to him on 15th Oct 2016 during XIXth Annual Conference of IAPSM UPUK State Chapter at SRMS Medical College, Bareilly, for the publication of original research work in IJCH entitled –

"Perception of caregivers regarding danger signs of childhood diarrhea and attitude towards its management in rural Lucknow, UP, India."

Co-authored by –Shietal Prasad Patel, Monika Agarwal, Om Prakash Singh, Vijay Kumar Singh.

Indian Journal of Community Health, [S.l.], v. 28, n. 2, p. 196-201, jun. 2016. ISSN 2248-9509

Dr. Manish Singh	Dr. Pradeep Aggarwal	Dr. Rakesh Kakkar	Dr. Khursheed Muzammil
President	Chief Editor	Editor	Secretary

APPLICATION FOR THE BEST THESIS AWARD

INDIAN ASSOCIATION OF PREVENTIVE & SOCIAL MEDICINE UPUK STATE CHAPTER

Note: After filling this format and getting all the signatures, scan this format and send to the following e-mail ID along with the soft copy of your thesis:- secretaryiapsmupuk@gmail.com
(Last date is 30th Sep'2016)

1. Name of the PG resident (In Capital Letters): RATNESH
2. Provisional/ Permanent Membership Number of IAPSM: 4293
3. Affiliated College/ Institute: SHRI RAM MURTI SMARAK INSTITUTE OF MEDICAL SCIENCES
4. Period of completion of thesis work: From 2014 to 2016
5. Name of the Chief Thesis Guide/ Chief supervisor: DR. SHYAM BIHARI GUPTA
6. Name of the Co-guide/s: DR ATUL KUMAR SINGH, DR LALIT SINGH, DR DHARMENDRA KUMAR GUPTA
7. Title of the Thesis: STUDY OF DEFAULT AND ITS DETERMINANTS AMONGST TB PATIENTS UNDER RNTCP IN BAREILLY DISTRICT OF UP
8. Thesis work has been completed as per the THESIS PROTOCOL: YES/ NO
9. Thesis work has been completed within the stipulated time: YES/ NO
10. We declare that the information given above is correct to the best of our knowledge and match with the departmental/ institutional records.

Dated: 27/09/2016

Signature (HOD)	Signature (Chief Guide)	Signature (Applicant - PG Resident)

Countersignature of the Principal / Dean
(SEAL)

Principal
SRMS Institute of Medical Sciences
Bareilly - 243 202 (U.P.) India

प्रेषक,

संयुक्त निदेशक (क्षय)/
राज्य क्षय नियंत्रण कार्यक्रम अधिकारी,
चिकित्सा एवं स्वास्थ्य सेवाएं,
उत्तर प्रदेश, लखनऊ।

सेवा में,

1. मुख्य चिकित्सा अधिकारी, लखनऊ।
2. मुख्य चिकित्सा अधिकारी, बरेली।

पत्रांक:–एसटीसीएस/158/2011/628 लखनऊ, दिनांक: 3 मार्च 2015

विषय: पुनरीक्षित राष्ट्रीय क्षय नियंत्रण कार्यक्रम के अर्न्तगत स्टेट आपरेशनल रिसर्च कमेटी द्वारा अनुमोदित थिसिस प्रस्तावों हेतु मेडिकल कालेज मद में उपलब्ध धनराशि से आवश्यक धनराशि सम्बन्धित अभ्यर्थी/मेडिकल कालेज को उपलब्ध कराये जाने के सम्बन्ध में।

महोदय,

उपरोक्त विषय के सम्बन्ध में कृपया प्रो0 अमिता जैन, अध्यक्षा, स्टेट आपरेशनल रिसर्च कमेटी उ0 प्र0/प्रभारी आई0आर0एल0, के0जी0एम0यू0 लखनऊ के संलग्न ई–मेल दिनांक–18 दिसम्बर 2014 का सन्दर्भ ग्रहण करने का कष्ट करें।

उक्त ई–मेल के माध्यम से अवगत कराया गया है कि स्टेट आपरेशनल रिसर्च कमेटी उ0 प्र0 की बैठक दिनांक–15.12.2014 में मेडिकल कालेज बरेली एवं लखनऊ से प्राप्त कुल 4 थिसिस प्रस्तावों का अनुमोदन करते हुए बजट उपलब्ध कराये जाने की संस्तुति की है। अवगत कराना है कि पुनरीक्षित राष्ट्रीय क्षय नियंत्रण कार्यक्रम हेतु भारत सरकार द्वारा निर्धारित गाइडलाइन में स्टेट आपरेशनल रिसर्च कमेटी द्वारा थिसिस का अनुमोदन किये जाने पर 80 प्रतिशत बजट तथा थिसीस प्रस्तुत किये जाने पर शेष 20 प्रतिशत धनराशि सम्बन्धित मेडिकल कालेज कालेज को उपलब्ध कराये जाने का प्राविधान है। एक थिसीस पर कुल व्यय रू0 30000.00 निर्धारित है।

अतः कार्यक्रम हित में आपसे अनुरोध है कि आपके जनपद में मानक मद "मेडिकल कालेज" मद में उपलब्ध धनराशि को जिला स्वास्थ्य समिति का अनुमोदन प्राप्त कर नियमानुसार सम्बन्धित अभ्यर्थी/मेडिकल कालेज को निम्न विवरण के अनुसार तत्काल उपलब्ध कराने का कष्ट करें।

क्रम सं0	थिसिस प्रस्ताव प्रस्तुत करने वाले मेडिकल कालेज, विभाग एवं अभ्यर्थी का नाम	थिसिस की प्रस्तावित धनराशि	थिसीस हेतु अग्रिम के रूप में 80 प्रतिशत धनराशि का आवंटन	थिसीस पूर्ण होकर प्राप्त होने पर शेष 20 प्रतिशत का भुगतान
1	माइक्रोबायोलाजी विभाग, के0जी0एम0यू0, लखनऊ (डा0 सरिता)	30000.00	24000.00	6000.00
2	कम्यूनिटी मेडिसिन विभाग, श्री राममूर्ति स्मारक विभाग, बरेली (डा0 रत्नेश)	30000.00	24000.00	6000.00
3	रूहेलखण्ड मेडिकल कालेज एण्ड हास्पिटल, बरेली (डा0 ऋषी कुमार सैनी)	30000.00	24000.00	6000.00
4	रूहेलखण्ड मेडिकल कालेज एण्ड हास्पिटल, बरेली (डा0 राजन शुक्ला)	30000.00	24000.00	6000.00

संलग्नक–उपरोक्तानुसार।

भवदीय

(आलोक रंजन) 2/3/15
संयुक्त निदेशक (क्षय)/
राज्य क्षय नियंत्रण कार्यक्रम अधिकारी

पृष्ठांकन–एसटीसीएस / 158 / 2011 / 629–33 तद्दिनांक।

प्रतिलिपि निम्नलिखित को सूचनार्थ एवं आवश्यक कार्यवाही हेतु प्रेषित–

1. मिशन निदेशक, राष्ट्रीय स्वास्थ्य मिशन उ0 प्र0, एस0पी0एम0यू0, लखनऊ।
2. प्रो0 अमिता जैन, अध्यक्ष, स्टेट आपरेशनल रिसर्च कमेटी उ0 प्र0 / प्रभारी आई0आर0एल0, माइकोबायोलाजी विभाग, के0जी0एम0यू0 लखनऊ।
3. महाप्रबन्धक (राष्ट्रीय कार्यक्रम), राष्ट्रीय स्वास्थ्य मिशन उ0 प्र0, एस0पी0एम0यू0, लखनऊ।
4. जिला क्षय रोग अधिकारी, लखनऊ एवं बरेली।
5. चेयरमैन स्टेट टास्क फोर्स उ0प्र0।

(आलोक रंजन) 3/3/15
संयुक्त निदेशक (क्षय) /
राज्य क्षय नियंत्रण कार्यक्रम अधिकारी

Director Cmpl
3.3.15

STUDY OF DEFAULT AND ITS DETERMINANTS AMONGST TB PATIENTS UNDER RNTCP IN BAREILLY DISTRICT OF UP

Mahatma Jyotiba Phule Rohilkhand University, Bareilly (U.P.)

Thesis For

DOCTOR OF MEDICINE

(COMMUNITY MEDICINE)

2014-2017

By: Dr. Ratnesh

M.B.B.S.

DEPARTMENT OF COMMUNITY MEDICINE

SHRI RAM MURTI SMARAK

INSTITUTE OF MEDICAL SCIENCES BAREILLY (U.P.)

प्रेषक,

संयुक्त निदेशक (क्षय)/
राज्य क्षय नियंत्रण कार्यक्रम अधिकारी,
चिकित्सा एवं स्वास्थ्य सेवाएं,
उत्तर प्रदेश, लखनऊ।

सेवा में,

1. मुख्य चिकित्सा अधिकारी, लखनऊ।
2. मुख्य चिकित्सा अधिकारी, बरेली।

पत्रांक–एसटीसीएस/158/2011/628 लखनऊ, दिनांक 3 मार्च 2015

विषयः **पुनरीक्षित राष्ट्रीय क्षय नियंत्रण कार्यक्रम के अर्न्तगत स्टेट आपरेशनल रिर्सच कमेटी द्वारा अनुमोदित थिसिस प्रस्तावों हेतु मेडिकल कालेज मद में उपलब्ध धनराशि से आवश्यक धनराशि सम्बन्धित अभ्यर्थी/मेडिकल कालेज को उपलब्ध कराये जाने के सम्बन्ध में।**

महोदय,

उपरोक्त विषय के सम्बन्ध में कृपया प्रो0 अनिता जैन, अध्यक्षा, स्टेट आपरेशनल रिसर्च कमेटी उ0 प्र0/प्रभारी आई0आर0एल0, के0जी0एम0यू0 लखनऊ के संलग्न ई–मेल दिनांक–18 दिसम्बर 2014 का सन्दर्भ ग्रहण करने का कष्ट करें।

उक्त ई–मेल के माध्यम से अवगत कराया गया है कि स्टेट आपरेशनल रिसर्च कमेटी उ0 प्र0 की बैठक दिनांक–15.12.2014 में मेडिकल कालेज बरेली एवं लखनऊ से प्राप्त कुल 4 थिसिस प्रस्तावों का अनुमोदन करते हुए बजट उपलब्ध कराये जाने की संस्तुति की है। अवगत कराना है कि पुनरीक्षित राष्ट्रीय क्षय नियंत्रण कार्यक्रम हेतु भारत सरकार द्वारा निर्धारित गाइडलाइन में स्टेट आपरेशनल रिसर्च कमेटी द्वारा थिसिस का अनुमोदन किये जाने पर 80 प्रतिशत बजट तथा थिसीस प्रस्तुत किये जाने पर शेष 20 प्रतिशत धनराशि सम्बन्धित मेडिकल कालेज कालेज को उपलब्ध कराये जाने का प्राविधान है। एक थिसीस पर कुल व्यय रू0 30000.00 निर्धारित है।

अतः कार्यक्रम हित में आपसे अनुरोध है कि आपके जनपद में मानक मद "मेडिकल कालेज" मद में उपलब्ध धनराशि को जिला स्वास्थ्य समिति का अनुमोदन प्राप्त कर नियमानुसार सम्बन्धित अभ्यर्थी/मेडिकल कालेज को निम्न विवरण के अनुसार तत्काल उपलब्ध कराने का कष्ट करें।

क्रम सं0	थिसिस प्रस्ताव प्रस्तुत करने वाले मेडिकल कालेज, विभाग एवं अभ्यर्थी का नाम	थिसिस की प्रस्तावित धनराशि	थिसीस हेतु अग्रिम के रूप में 80 प्रतिशत धनराशि का आवंटन	थिसीस पूर्ण होकर प्राप्त होने पर शेष 20 प्रतिशत का भुगतान
1	माइक्रोबायोलाजी विभाग, के0जी0एम0यू0, लखनऊ (डा0 संरिता)	30000.00	24000.00	6000.00
2	कम्यूनिटी मेडिसिन विभाग, श्री राममूर्ति स्मारक विभाग, बरेली (डा0 रत्नेश)	30000.00	24000.00	6000.00
3	रूहेलखण्ड मेडिकल कालेज एण्ड हास्पिटल, बरेली (डा0 ऋषी कुमार सैनी)	30000.00	24000.00	6000.00
4	रूहेलखण्ड मेडिकल कालेज एण्ड हास्पिटल, बरेली (डा0 राजन शुक्ला)	30000.00	24000.00	6000.00

संलग्नक–उपरोक्तानुसार।

भवदीय

(आलोक रंजन) 3/3/15

संयुक्त निदेशक (क्षय)/
राज्य क्षय नियंत्रण कार्यक्रम अधिकारी

Department of Community Medicine

Shri Ram Murti Smarak Institute of Medical Sciences, Bareilly

CERTIFICATE

This is to certify that the thesis entitled "**Study of Default and its Determinants amongst TB Patients under RNTCP in Bareilly District of UP**" is a bonafide work of **Dr. Ratnesh** under the guidance of **Dr. Shyam Bihari Gupta** in partial fulfilment of the MCI regulations for the award of the degree of **Doctor of Medicine in Community Medicine**

I am satisfied regarding the authenticity of the research methodology and results being presented which confirm to the standard of **Mahatma Jyotiba Phule Rohilkhand University, Bareilly** and contributory to the existing knowledge on the subject.

(Dr. Shyam Bihari Gupta)

Prof.& Head

Department of Community Medicine

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(Dr. Shyam Bihari Gupta)
Guide
Professor & Head
Community Medicine

(Dr. Atul Kumar Singh)
Co-Guide
Associate Professor
Community Medicine

(Dr.Lalit Singh)
Co-guide
Professor
Pulmonary Medicine

(Dr. Dharmendra Kumar Gupta)
Co-guide
Assistant Professor
Community Medicine

DECLARATION

I, **Dr. Ratnesh,** hereby declare that the thesis entitled "**Study of Default and its Determinants amongst TB Patients under RNTCP in Bareilly District of UP"** is the original work carried out by me under the guidance of my guide Dr Shyam Bihari Gupta and co-guide Dr Atul Kumar Singh, Dr Lalit Singh and Dr Dharmendra Kumar Gupta in the Department of Community Medicine, Shri Ram Murti Smarak Institute of Medical Sciences, Bareilly (U.P.)

I certify that the contents of the thesis have not been submitted earlier for the candidature for my degree. I hereby give consent for my availability of thesis for photocopying and interlibrary loan to other institutions.

DR RATNESH
P.G. Final year
MD Community Medicine
Department of Community Medicine,
Shri Ram Murti Smarak Institute of Medical Sciences,
Bareilly (UP)

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Dedicated to my

Late

Grandfathers

Dr R.P. Sinha

and

Dr S.P. Verma

LIST OF ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ATT	Anti – Tubercular Treatment
BCG	Bacillus Calmette Guerin
CHC	Community Health Centre
DMC	Designated Microscopy Centre
DOTS	Directly Observed Treatment Short – Course
DTC	District Tuberculosis Centre
DTP	District Tuberculosis Programme
HBC	High Burden Countries
HIV	Human Immuno-deficiency Virus
ISTC	International Standards for Tuberculosis
MDG	Millennium Development Goals
NTI	National Tuberculosis Institute
NTP	National Tuberculosis Control Programme
PTB	Pulmonary Tuberculosis
RNTCP	Revised National Tuberculosis Control Programme
SDG	Sustainable Development Goals

TB	Tuberculosis
TU	Tuberculosis Unit
WHA	World Health Assembly
WHO	World Health Organization

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"You're only as Safe as the Air you Breathe..

Protect Yourself from Tuberculosis"

TB anywhere is TB everywhere

1. INTRODUCTION

Tuberculosis (TB) continues to intimidate the human race since time immemorial not only due to its effects as a medical malady but also by its impact as a social & economical tragedy. At the dawn of the new millennium, we are still mute witness to the silent yet efficient march of this sagacious disease, its myriad manifestations and above all its unequalled vicious killing power.[1]

TB is caused by Mycobacterium tuberculosis. It primarily affects lungs and causes Pulmonary TB (PTB). It can also affect intestine, meninges, bones and joints, lymph glands, skin and other tissues. It is usually chronic with cardinal features like persistent cough with or without expectoration, intermittent fever, loss of appetite, weight loss, chest pain and haemoptysis.[2]

TB is transmitted mainly by droplet nuclei generated by sputum-positive patients with PTB.[3]

TB is one of the three primary diseases of poverty along with AIDS and malaria.[4]

The risk for developing TB is higher in persons with diabetes, other chronic debilitating disease leading to immune-compromise, poor living conditions and smokers etc.

In 2014, globally there were an estimated 9.6 million new TB cases: 5.4 million men, 3.2 million women and 1.0 million children, including 1.2 million people living with HIV. One and half million people died from TB, including 0.4 million people who were HIV-positive.[5]

Most of the estimated number of cases in 2014 occurred in Asia (58%) and the African Region (28%); smaller proportions of cases occurred in the Eastern Mediterranean Region (8%), the European Region (3%) and the Region of the Americas (3%). The six countries with largest number of cases were India, Indonesia, China, Nigeria, Pakistan and South Africa. India, Indonesia and China alone accounted for a combined total of 43% of global cases.[5]

Though India is the second-most populous country in the world one fourth of the global incident TB cases occur in India annually.

TB kills more women in reproductive age group than all causes of maternal mortality combined. Nearly one-third of female infertility in India is caused by TB. The indirect impact of TB on children is considerable, as nearly 3 lakhs children of TB patients, either leave the school or take up employment to help and support their families.[6]

A patient of TB takes an average of three to four months to recuperate, losing that much income. The loss is disastrous for those struggling against poverty. The vast majority (more than 90%) of the economic burden of TB in India is caused by the loss of life rather than morbidity.

To combat TB, Government of India had launched National Tuberculosis control Programme (NTP) in 1962 which evolved as Revised National Tuberculosis Control Programme (RNTCP) in 1992 to overcome the lacunae's of NTP. RNTCP adopted Directly Observed Treatment Short-course (DOTS) for the treatment of TB.

In India under RNTCP, TB prevalence per lakh population has reduced from 465 in year 1990 to 195 in 2013. There is 55% reduction in TB prevalence rate by 2014 as compared to 1990 level and also, the incidence is on declining trend. TB incidence per lakh population has reduced from 216 in year 1990 to 167 in 2014. TB mortality per lakh population has reduced from 38 in year 1990 to 17 in 2012. There is 58% reduction in TB mortality rate by 2014 as compared to 1990 level.[7]

Despite these achievements in the field of TB control, the end (TB elimination) is nowhere in sight, still one-third cases of TB remains undetected in India and poor treatment adherence. Poor treatment adherence increases the risk of drug resistance, treatment failures, relapses, deaths and prolonged infectiousness, which is a hurdle to the success of TB programmes.[8-10]

According to Annual RNTCP report 2016 the prevalence of default in new smear positive cases is 6% and 5% in Uttar Pradesh and India. Default rate in new smear negative is 7% and 6% in Uttar Pradesh and India while in new extra pulmonary cases default rate is 3% both in Uttar Pradesh and India. In retreatment cases i.e. Category II cases default rate in relapse was 12% and 10% in Uttar Pradesh and India, in failure cases it was 14% and 13% in Uttar Pradesh and India while in treatment after default it was 14% and 16% in Uttar Pradesh and India respectively.[7]

Defaulter is a patient who has not taken anti-TB drugs for 2 months or more consecutively after starting treatment.[11]

Default is one of the unfavourable outcomes for patients on DOTS and represents an important challenge for the control program.[12]

Studies in India and other developing countries have focused on various causes and risk factors for default. Gender, alcoholism, treatment after default, poor knowledge of TB, irregular treatment and socioeconomic status are some of the factors which have been found to be associated with higher default rates.[13-16]

The other risk factors which play a vital role in treatment interruption is age and its related factors, overcrowding in urban area and distance factor in rural area are also a major factor for defaults. TB patients are more in slums and places with poor living condition.

The implementation of DOTS as a strategy under RNTCP aims at minimal defaulter rate. With present HIV epidemic and the emergence of multi drug resistance TB, there is a further urgent need to prevent the patient default. Further, corrective measures can be taken to prevent the patient from defaulting. Ultimately, the higher cure rate can be achieved which in turn will enhance the efficiency of the program.

Very few studies done in India have given comprehensive description of various causes of default. Moreover, there may be regional variations in the default rate and causes of default.

Very little is known about the basic profile of the defaulters, the timing of default and the extent of program efforts to retrieve defaulters.

Keeping in view of the above mentioned facts, the present study has been done to find out prevalence and various factors that influence to default TB patients under DOTS in RNTCP in district Bareilly, Uttar Pradesh.

AIM AND OBJECTIVES

2.1 AIM

- To find the burden of defaults and its determinants among TB patients registered under RNTCP in Bareilly district.

2.2 OBJECTIVES

- To estimate the default rate among the TB patients registered under RNTCP.
- To find out the reasons for treatment interruptions among defaulters.
- To recommend measures to improve compliance among TB patients.

3. REVIEW OF LITERATURE

The “captain of all these men of death”, TB has been a scourge of the humankind from time immemorial. Till date, no other disease in history matches the sheer magnitude of the misery inflicted by TB on the human race in terms of morbidity and mortality. The social and economic consequences of TB have had a profound effect on human existence.

Historically, even though several other diseases like smallpox and plague have killed millions of people, their reign has been relatively short-lived; TB has been ever present. The inexorable march of time has witnessed the changing face of TB: from an incurable disease to the hype and hope of being an eminently curable one. However, even today TB remains as a formidable foe threatening to annihilate the human race.[17]

3.1 Evolution of TB control

TB has coevolved with humans for many thousands of years and perhaps for several million years. The oldest known human remains showing signs of tuberculosis infection are 9,000 years old.

Since ancient times, there have been references to TB or illnesses resembling TB from several parts of the world from many civilizations. The earliest references to TB can be found in the language Samskritam (Sanskrit). In the ancient Indian scriptures, the Vedas, TB was referred to as Yakshma (meaning wasting disease).[18-20]

Phthisis is a Greek term for tuberculosis, around 460 BC, Hippocrates identified phthisis as the most widespread disease of the times involving coughing up blood and fever, which was almost always fatal.[21]

In English literature, the word “consumption” (derived from the Latin word consumer) has also been used to describe TB. The word “tuberculosis” appears to have been derived from the Latin word tubercula (meaning “a small lump”).[22-23]

TB is also called Koch's disease, after the scientist Robert Koch who announced the discovery of the tubercle bacillus during the monthly evening meeting of the Berlin Physiological Society on 24th March 1882. On this day, after thousands of years, Mycobacterium tuberculosis, the organism causing TB finally revealed itself to humans. Commemorating the centenary of this event, since 1982, 24th March is being celebrated as “World TB Day” world over.[24]

The first genuine success in immunizing against tuberculosis was developed from attenuated bovine-strain tuberculosis by Albert Calmette and Camille Guerin in 1906. It was called "BCG" (Bacillus Calmette Guerin).[25]

During the 1950s and 1960s, significant research on TB was undertaken in India and in 1959 the Government of India set up the National TB Institute (NTI) at Bangalore to suggest a realistic and economically feasible TB control programme for the country and to train workers in the methodology involved in it. The District TB programme (DTP) was evolved by the institute in 1962 as the basic unit of NTP.

NTP is being in operation since 1962 and in 1964, WHO recommended the following as priorities in TB control programme – case finding, chemotherapy, BCG vaccination, health education, case holding and record keeping.[26]

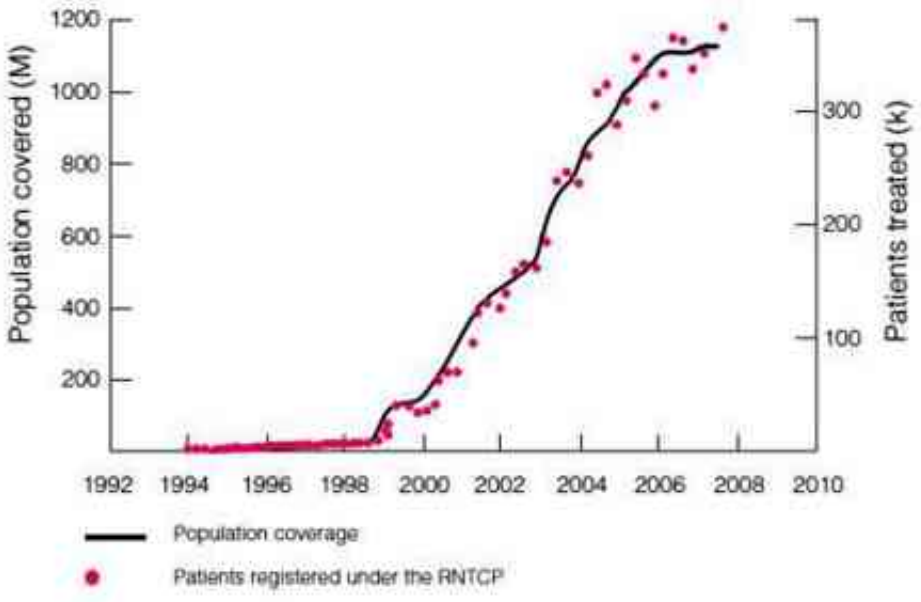
In 1991, the World Health Assembly (WHA) resolution recognised TB as a major global public health problem[27] and suggested two targets for National Tuberculosis Programmes, of detecting 70% of new smear positive patients and curing 85% of such cases by the year 2000 in an attempt to rejuvenate global TB control.

Government of India, World health Organization and World Bank together reviewed the NTP in the year 1992. Based on the findings from that review a revised strategy for NTP was evolved into RNTCP in 1993.

Difference between NTP and RNTCP	
NTP	**RNTCP**
No target for case detection and treatment	70% case detection and 85% cure rate
Irregular drug supply	Patient wise boxes for uninterrupted supply of drugs
Patients not categorised for treatment	Categorization of treatment
Chemotherapy was not supervised	Chemotherapy supervised
Case detection rate and success rate less than 50%	Case detection rate and success rate more than 85%.
Over reliance on clinical and radiological diagnosis	Case detection by quality sputum microscopy
Lack of systematic information on treatment outcome	Evaluation of treatment outcome by health worker

RNTCP expanded it in phased manner to cover half the country's population by 2002 and the entire country by 2005.

Trends DOTS population coverage (black line) and patients registered under the RNTCP (pink dots), 1994 – 2009 [28]



The goal of RNTCP is to decrease the mortality and morbidity due to tuberculosis and cut down the chain of transmission of infection until TB ceases to be a public health problem. The goal is achieved through the following objectives[29]:

To achieve and maintain:

- Cure rate of at least 85% among newly detected smear-positive (infectious) pulmonary tuberculosis cases; and
- Case detection of at least 70% of the expected new smear positive PTB cases in a community.

A fundamental principle of the DOTS strategy includes:

1. Political and administrative commitment
2. Good quality diagnosis, primarily by sputum smear microscopy
3. Uninterrupted supply of quality drugs
4. Directly observed treatment (DOT)
5. Systematic monitoring and accountability

The Stop TB Partnership was developed as a Global Plan to Stop Tuberculosis that aims to save 14 million lives between 2006 and 2015.[30]

The observation that TB is still plaguing us even after 50 years of availability of effective anti-tuberculosis drugs is an ample testimony to the fact mere availability of drugs is not adequate for ensuring control and elimination of this scourge. DOTS to ensure treatment compliance have been found to yield promising results.[31] Similarly, the efforts to involve NGOs, and private sector (public private mix DOTS), use of Paramedical persons such as Anganwadi workers to promote treatment adherence has proved to be effective in the field setting in India.[12] The International Standards for Tuberculosis Care (ISTC)[32] also provides insight into what is expected as the best possible care to patients with TB who get treated outside the National Tuberculosis Control Programs.

Another effort worth mentioning is the involvement of Medical Schools in TB control that has been tried in India. For the first time in the annals of history of any disease has an association between the academicians and the public health experts been so fruitful.[33-35] This venture has been tremendously successful in bridging the gap between what is practiced and what is preached.

For the past decade, the focus has been on progress towards 2015 global targets for reductions in TB disease burden set in the context of the Millennium Development Goals (MDGs). The targets are that TB incidence should be falling (MDG Target 6.c) and that TB prevalence and mortality rates should be halved compared with their 1990 levels. The Stop TB Strategy, developed for the period 2006–2015, has been WHO's recommended approach to achieving these targets.

With 2015 marking the MDG and global TB target deadline, the special emphasis and most important topic of this 2015 global TB report is an assessment of whether the 2015 targets have been achieved. This assessment is made for the world, for the six WHO regions and for the 22 high-burden countries that collectively account for 80% of TB cases.

Since the end of 2015 also marks the end of the MDG and Stop TB Strategy eras and the start of a post-2015 development framework (2016–2030) of Sustainable Development Goals (SDGs) and an associated post-2015 global TB strategy.[5]

Though the achievements in the field of TB control are gratifying, the march ahead is long and the end (TB elimination) is nowhere in sight. It is time to sustain the all pronged onslaught against this ancient foe. Any let down in the guard and slackening of the commitment in this battle is likely to have disastrous consequences and the dreadful prospect of return to the era of untreatable TB.

Annual RNTCP 2016 Report [7]

Treatment Outcome of New TB cases for 2014

Type of New TB case	New Smear Positive		New Smear Negative		New Extra Pulmonary	
	India	UP	India	UP	India	UP
No. registered	627710	124904	296627	55176	239396	30892
Defaulted	5%	6%	6%	7%	3%	3%

Outcome of Smear Positive Retreatment cases for India 2014

Type of retreatment case	Relapse		Failure		Treatment after default	
	India	UP	India	UP	India	UP
No. registered	103799	17005	12638	1412	61729	10909
Defaulted	10%	12%	13%	14%	16%	14%

3.2 Prevalence of Default

Babu BS et al conducted a study in **2007** from Andhra Pradesh to evaluate reasons for treatment non-initiation in smear-positive PTB patients in which the proportion of reported initial defaulters was 8.5%.[36]

In **Bhardwaj AK et al** study, among new sputum smear positive tuberculosis patients in **2011** from Himachal Pradesh only 1.5% patients had defaulted.[37]

Chadha SL et al did a study in **1998** to evaluate treatment outcome in tuberculosis patients under DOTS in New Delhi in which defaulter rate was 7.7%. [38]

Chaudhri S et al study in **2009** from Kanpur on two groups revealed that in Group A (DOTS therapy along with psychiatric intervention) and group B (only DOTS therapy) in which the default rate came to be 13.6% and 33.4% respectively.[39]

Dolma KG et al conducted a study in **2010** on retreatment TB patients' attending the DOTS centre in Sikkim in which default rate was 4.3%. [40]

Gopi PG et al conducted a study in **2005** from Tiruvallur district of Tamil Nadu to know the reasons for initial defaulters, in which 23.5% and 14.9% were diagnosed initial defaulter in a community survey and health facility respectively. [41]

In **Gorityala SB et al** study on assessment of treatment interruption among pulmonary tuberculosis patients from a Government hospital from Hanamkonda, Tamil Nadu in which 107 defaulters were identified out of 956 TB patients.[42]

Gupta S et al conducted a study in **2007** from New Delhi to know the reasons of treatment interruption, in which 13.51% had interrupted the treatment.[43]

Jaggarajamma K et al study in **2006** from Tiruvallar district, Tamil Nadu conducted a study to find the reasons for non-compliance among TB patients under RNTCP in which default rate came to be 20%. [44]

Study done by **Jaggarajamma K et al** in **2001** from Tiruvallar district, Tamil Nadu to find out the significance of migration as a leading factor for default in RNTCP, reported a default rate of 20%. [45]

In 2006, **Jha UM et al** conducted study to find the reasons of risk factors for Treatment Default among Re-Treatment Tuberculosis Patients in India In 2006, in which among new cases 7% and re-treatment cases, 15.3% were reported to have defaulted.[46]

Karanjekar VD et al study in **2008** from Aurangabad was done to find the Treatment Outcome and Follow-up of Tuberculosis Patients Put on Directly Observed Treatment Short-course under Rural Health Training Center in which Defaulters were 18.3% and 25% among Category I and Category II respectively.[47]

Katiyar SK et al conducted a study in **2005** from various centers mainly from eastern and north-eastern parts of Uttar Pradesh for an analysis of Failure of Category II DOTS Therapy in which default rate was 31.5%. [48]

Kulkarni PY et al study in **2012** from e ward of Mumbai Municipal Corporation was done to find the reasons of Non-Adherence of New Pulmonary Tuberculosis Patients to Anti-Tuberculosis Treatment, in which it was observed that 50% patients defaulted out of 156 patient's treated.[49]

Roy N et al did a study in **2011** from Darjeeling, West Bengal to find out the Risk factors associated with default among tuberculosis patients, in which default rates were 6% among NSP cases; 7% among new smear negative (NSN) cases; 4% among new extra pulmonary cases; 11% among relapse

cases; 15% among treatment failure cases; and 23% among treatment after default cases, respectively.[50]

Santha T et al study in **2000** from Tiruvallur district, Tamil Nadu was done to find out the risk factors associated with default, failure and death among tuberculosis patients treated in a DOTS programme, in which it was observed that 17% patients had defaulted from the DOTS.[15]

Study done by **Sarpal SS et al** conducted a study in **2011** from Chandigarh was to find Treatment Outcome among the Retreatment TB Patients under RNTCP, in which it was observed that the default rate in the study came out to be 5.9%. [51]

Satti SBR et al conducted a study in **2015** from Nalgonda district, Telangana to know the Risk Factors for DOTS Treatment Default among New HIV-TB Co-infected Patients, default rate came out to be 7%. [52]

Sharma SK et al study from New Delhi revealed the clinical profile & predictors of poor outcome of adult HIV-tuberculosis patients in a tertiary care centre in which default rate came out to be 8.1%. [53]

Varshney AM et al conducted a study in **2010** from district Anand, Gujarat on sources of previous ATB drug exposure for patients registered in RNTCP as retreatment cases in which 37% were defaulters during initial treatment.[54]

Vasudevan K et al study in **2011** from Puducherry was to find out the smear conversion, treatment outcomes and the time of default in registered tuberculosis patients on RNTCP DOTS in which it was observed that default rate in category I and II came out to be 5.9% and 13.7% respectively.[55]

Verma AK et al conducted a study in **2007** from Kanpur revealed the outcome of cases under RNTCP designated microscopy centre of a tertiary level hospital in which the default rate came out to be 8.1%, 18%, 15%, 5%, 10% 14.3% and 23.1% in new smear positive, new smear negative & extra pulmonary, retreatment, relapse, treatment after default, treatment failure and others respectively.[56]

Vijay S et al conducted a study in **2000** from Bangalore to find defaults among tuberculosis patients treated under DOTS in which it was observed that defaults were 25% and 45% in CAT I & CAT II respectively.[57]

Vijay S et al study in **2001** from Bangalore reports the re -treatment outcome of smear positive tuberculosis cases under DOTS, in which a high proportion of 'defaults' (43.8%) were found.[58]

Vijay S et al in **2006** study to know the risk factors associated with default among new smear positive TB patients treated under DOTS in India shows the default rate of 6.4%. [59]

3.3 Socio Demographic Profile of TB patients

Bhardwaj AK et al in **2011** from Andhra Pradesh in which total 1607 patients were enrolled in which patients were largely from rural (80.0%) area, male (67.9%), and of 15– 44 years (62.3%) of age group. Almost half of the patients had joint family of middle socioeconomic class (65.5%) with more than three members (86.5%) in the family.[37]

Chaddha SL et al conducted a study in **1998** which shows age and sex distribution of 693 patients: 432 were male (67.6%) and 207 were female

(32.4%); 415 patients were in the age group 21-40 years (58.8%); 569 (82%) were from low socio-economic status and 39% were illiterate while just 3% had college education. Regarding occupational status, 392 patients (61.3%) were unskilled and 103 (26.1%) were skilled and the rest were semi-skilled workers.[38]

Chaudhri S et al study in **2009** from Kanpur showed that 56% of patients were males and the mean age of study subjects was 27.53 ± 0.9 years. About 62% of patients were from rural area and 73.5% belonged to low socioeconomic status. Thirty-nine percent of patients were illiterates.[39]

Chennaveerappa PK et al also conducted a study in **2011** from Karnataka in which it was reported that in their study 68% were male cases and 32% were females.[60]

Gopi PG et al conducted a study in **2005** from Tiruvallur district of Tamil Nadu in which the initial default among males and females were 24.4% and 17.6% respectively and the difference was not statistically significant (P=0.5). The initial default rates were also similar in the two age groups i.e. 15-44 and 45 years or more (22.8% vs 23.5%).[41]

In **Gorityala SB et al** study, 91.5% were males and 8.41% were females. 72.89% of the patients were in the age group between 35 and 60 years, 67.28% were illiterates, 49.53% were daily wage labour.[42]

In **Gupta S et al** study in **2007** from New Delhi, among the 201 patients interviewed, 156 (77.61%) were males and 45 were females. The highest number of treatment interrupters were in the age group 25 to 44 years (n=116),

constituting nearly 57% of all the patients studied, while only 1.49% were below 15 years of age. 42 (20.9%) were unmarried, 145 (72.14%) were married, 12 were widowed, while two were divorced. 58 (28.86%) patients had a family history of TB. 92 (45.77%) patients were residents of urban areas, while the other 109 (54.23%) patients used to reside in rural areas.[43]

In **Jaggarajamma K et al** study in **2006** out of 938 patients, 186 defaulters in which 167 males & 19 females; 85 were less than 45 years of age & 101 were more than 45 years; 75 defaulters gave a positive history of alcoholism; 62 illiterate; and 37 were unemployed.[44]

Jha UM et al conducted study in **2006**, in 1,141 defaulters 79.5% were male, 20.5% were female; and 28.1%, 23.4% and 19.4% were from 35-44yrs, 25-34yrs and 45-54yrs age group respectively.[46]

Karanjekar VD et al study in **2008** shows that the tendency for defaulting was high among males 23.0% (18/78) as compared with females. The percentage of treatment completion among the patients below 34 years and above 54 years was observed to be 45.4% (15/33) and 47% (8/20) respectively. As age advanced, percentage of defaulters was found to be increased. The proportion of defaulters was low 14.3% (2/14) in patients having education more than high school as compared with the illiterates and those having education below high school (17.5% [7/40] and 22.5% [16/71] respectively).[47]

Katiyar SK et al conducted a study in **2005**, there were 95 cases in the study out of which 60 (63.2%) were from rural areas and 35 (36.8%) from urban areas. The average monthly income of the earning member of the patient's family in rural areas was Rs. 1512 and in urban areas was Rs. 3452. The

majority of the patients (80%) were in the economically productive age group (15-44 years). Around 60% of them were illiterate or could write their name only.[48]

Khalil S et al reported from Aligarh in **2011** that there were 61.4% male and 38.6% female cases.[61]

In **Kulkarni PY et al** in **2012**, total 156 NSP TB patients were recruited 156 patients in the study. 67.30% (105/156) were males and 32.70% (51/156) were females. Average age of patients recruited was 32.99 years. 66.66% (104/156) were in the age group of 20-49 years.[49]

A study conducted by **Mukherjee A et al** in **2012** from West Bengal showed that 69.3% cases were male and 30.7% were females.[62]

Pandit N et al in **2006** from Gujarat reported that majority of study population (85%) was in the age group of 15-55 years and that almost 63% were male cases and 37% were female cases in their study.[63]

Roy N et al conducted a study in **2011**, in which about 63.29% of the study population consisted of males; 27.84% were within 25-35 years of age group; followed by 45-55 years and 55-65 years (18.99% each); mean age was 38.22 years; median age was 40.08 years; 29.11% were from hilly area and 70.89% were from plain area. As per the educational status concerned; 42.41% were illiterate; 9.49% read up to primary level; 28.48% secondary passed; 14.57% higher secondary passed; graduate and post graduate were 3.79% and 1.26%, respectively. Occupational distribution showed that 3.67% were unemployed; 11.39% were unskilled labourers; 29.12% were skilled labourers; 6.96% were

housewives; 7.59% had business; and 1.26% had service. About 81.64% had Per Capita Monthly Income (PCMI) below Rs. 3000/; followed by 12.03% (between Rs. 3000/and 5000/); 4.43% (between Rs. 5000/and 10000/); 1.27% (between Rs. 10,000/and 15,000/); and 0.63% (more than Rs. 15,000/), respectively.[50]

In **Santha T et al** study in **2000** revealed that the median age of cases was 44 years (range 14–87 years); 75% were men, 55% literate, and 73% employed.[15]

Sarpal SS et al conducted a study in **2011**, in which the study included 348(63.9%) males and 197(36.1%) female patients registered under category II. The mean age of patients was 35.92 ± 15.42 (p = 0.928). Maximum patients belonged to age group of 25-34 years (25.3%). Maximum patients were in service 149(27.3%), followed by housewives 109 (20%), 95(17.4%) were labourers. In the present study 73(13.4%) of the patients were Illiterate, followed by 150 (27.5%) went to middle school while 111(20.4%) did primary schooling.[51]

Satti SBR et al in **2015**, reported by his study that the 85.84% defaulters belonged to the economically productive age group (16-45 years). A smaller proportion of study population 34 (14.16%) were in the older-than-46 years age group. The mean age was 36.5 ± 9 years and range was 18-60 years. In the study population, 144 were males (the majority at 60%) and 96 were females (40%). The proportion of DOTS defaulters [85 (70.83%)] with primary education was found to be high when compared to controls [52 (43.33%)]. The proportion of unskilled workers was higher among DOTS treatment defaulters [85 (70.83%)] as compared to controls [62 (51.67%)]. More individuals of lower

socioeconomic status discontinued DOTS treatment [110 (91.67%)] as compared to controls [85 (70.83%)]. A higher proportion of cases [100 (83.33%)] had small family size compared to controls [46 (38.33%)]. A higher proportion of patients who defaulted had lived for less than 2 years in the treatment area [47 (39.17%)] as compared to controls [23 (19.17%)]. Extra pulmonary TB prompted more patients to default 28 (23.33%) as compared to controls [10 (8.33%)]. As expected, a higher proportion of DOTS defaulters [49 (40.83%)] were of separated or disrupted marital status as compared to controls [20 (16.67%)].[52]

In the study of **Sukumaran P et al** in **2002** from Kottayam, Kerala, age group distribution of cases showed that 9% were in the age group of 11-20 years, 4% were in 21-30 years, 23% were in 31-40 years, 20% were in 41-50 years, 175 were in 51-60 years, 25% were in 61-70 years and 2% were of more than 70 years; 76% were male cases and 24% were females. [64]

Study done by **Sumer C et al** in Nagpur in **2012** showed that patients registered under different age groups were 6.38%, 26.95%, 15.60%, & 4.97% in age group of 5-15,16-24 35-44, 45-59 and 55 -64 respectively.[65]

Varshney AM et al conducted a study in **2010** in which the mean age was 42 (39.4 – 44.4) years, 65% male, 53% illiterate, 81% married, 74% Hindu, 21% unemployed, 55% unskilled worker, 69% having monthly per capita income less than Rs 2500. [54]

Vasudevan K et al study in **2011** reported that the study population consisted of 31.2% females and 68.8% males.[55]

Verma AK et al conducted a study in **2007** showed that most of the patients were in the 31-40 years age group (62/ 233; 26.6%). There were 130 (55.8%) males. According to modified Kuppuswamy scale,5,6 39% patients belonged to socio-economic class IV (upper lower) followed by Class V (lower) (32%); 81 (34.8%) were illiterate.[56]

Vidhani M et al in **2012** from Gujarat reported that 61.4% cases were male and 38.6 % were female.[66]

Yadav SP et al informed from Jodhpur, Rajasthan in **2006** that majority of the respondents (79.3%) were in the age group 20-39 years and there were 95.5% males.[67]

3.4 Determinants for Default

Babu BS et al in **2007** from Andhra Pradesh reported the results of the retrieval efforts of the district staff, in which out of 685 patients retrieval effort was taken for 633 (92%) of the 'confirmed initial defaulters' as no data was available for the rest 52 initial defaulters. Among 633 patients, 350 (51%) patients could not be contacted due to insufficient or inaccurate recording of address, or change of address; 152 (22%) patients had died, while 38 (5.5%) patients were taking anti-tuberculosis treatment from sources other than RNTCP, including private practitioners; 28 patients refused treatment; 19 were follow up cases not for diagnosis; 24 were chronic cases and 22 were out of the district without documentation.[36]

Bhardwaj AK et al in **2011** from Andhra Pradesh in which total 1607 patients were enrolled majority reported alcohol (56.9%) consumption and smoking

(54.4%) at the time of interview. Most of patients (76.0%) thought that TB and its treatment affect their work performance, 56.0% hid their disease status from others, and 52.0% did not disclose their disease status to their family members. Despite this, 96.0% of defaulted patients were aware of the curable nature of disease and 84.0% knew about the duration of available treatment.

Significantly early (within 30 day) contact to health facility was observed among patients of upper socioeconomic status (RR: 1.80; CI: 1.72–1.88), nuclear family (RR: 1.27; CI: 1.04–1.55) with family size of 3–5 (RR: 1.22; CI: 1.00– 1.49), and of rural area (RR: 1.55; CI: 1.20–2.00). Early contact was observed less among patients of urban area (RR: 0.64; CI: 0.48–0.83). When analysed for patient related factors, it was found that significantly more patients contacted health facility early, who felt ashamed about their disease status (RR: 1.41; CI: 1.15–1.74), but, ready to disclose their disease status (RR: 1.63; CI: 1.33–1.98), thought that treatment would be costly (RR: 2.08; CI: 1.40–3.09), and they knew disease is curable (RR: 1.96; CI: 2.43–2.69) and could be prevented by vaccine (RR: 1.29; CI: 1.05–1.59). Significantly fewer patients contacted early who wished to hide the disease from others (RR; 0.80; CI: 0.65–0.97). [37]

Chaddha SL et al conducted a study in **1998** in which two thirds of male patient were regular smokers while none of the female patients smoked. History of contact with a tuberculosis patient was present in 40%, and of diabetes and pleurisy in 3% and 4.5% respectively.[38]

Chandrasekaran V et al, studied default and its associated risk factors during the intensive phase of the treatment among new sputum positive patients

registered under a DOTS programme in Thiruvallur district, Tamil Nadu, 84% attributed their default to drug related problems, 32% to work related problem, 23% each to alcoholism and being symptom free followed by domestic problems and taking treatment from outside.[68]

Study done by **Chaudhri S et al** in **2009** from Kanpur revealed that 66% of patients were tobacco chewers, 52% were smokers, and 24% were alcoholics.[39]

In the study by **Chatterjee P et al**, comparative evaluation of factors and reasons for defaulting in tuberculosis treatment in the states of West Bengal, Jharkhand and Arunachal Pradesh was assessed, reasons for default included distance from treatment 36.5 %, due to improvement 24.5 – 60 %, lack of motivation 15 %, intolerance to drugs 9 %, temporary illness 9 % and others 6 %. In this study defaulting was found to start at the 3rd month, rise upto 4th month and then decline subsequently.[69]

Gopi PG et al study in **2005** from Tiruvallur district of Tamil Nadu reported the reasons given by the patients by community survey for initial default included (i) unwillingness (refusal or not interested) for initiation of treatment; (ii) symptoms too mild to warrant treatment followed by (iii) too sick/old; and (iv) work related problems. More men than women were unwilling for the initiation of treatment.

The reasons (multiple) for default given by the patients of health facility were (i) personal problems like loss of wages, social engagements, etc; (ii) dissatisfaction with health services; and (iii) disease related problems like felt better or too sick. Reasons reported by males were mostly personal and health service problems.[41]

In **Gorityala SB et al** study the most common reason for the treatment interruptions were felt well with TB treatment (29.53%) followed by side effects (16.06%), lack of money (8.29%), workload (7.25%), alcohol (7.25%), did not feel well with treatment (6.73%) etc.[42]

In **Gupta S et al** study in **2007** from New Delhi, out of 201 patients, there where smokers among which 56.03% (n=65) had a smoking index of < 300, 12.93% (n=15) had a smoking index between 300 – 400 and 36 patients (31.03%) had a smoking index of >400. Almost half [49.25% (n=99)] of the patients interviewed had a history of alcohol intake. 179 of the patients interviewed had no comorbidities. Among the remaining, nine had Diabetes, two had co-existing Hypertension and other comorbidities were present in 11 patients (8.29%).

The most common reason stated was a feeling of early improvement (30.05%), followed by high cost of treatment (16.39%) and ATT-induced side effects (12.84%). Among the various ATT-induced side effects (n=47), the most commonly reported side effect was nausea and vomiting (53.19%), followed by restlessness (14.89%), next being ATT-induced skin rash (n=6), drug-induced hepatitis (n=5); hearing loss (n=2), nephrotoxicity (n=1) and seizures (n=1).

Fifty-nine (16.12%) patients cited other reasons to be responsible for their treatment interruption. Other reasons being lack of faith in treatment (n=10); DOTS – related (n=27); and personal or family reasons (n=22). [43]

In **Jaggarajamma K et al** study in **2006** reasons for default given by the patients were: drug related problems like nausea, vomiting, giddiness 59 (42%), migration 41 (29%), relief from symptoms 28 (20%), work related problems 21 (15%), consumption of alcohol 21 (15%), treatment from other private or public

health facility 19 (13%), domestic problems 11 (8%), stigma 4 (2%), too ill to attend 6 (4%). Old age, other illnesses, inconvenient DOT and dissatisfaction with treatment centre and DOT provider were included as other reasons given by 22 (16%) patients. Majority of patients gave multiple reasons for default.

The DOT providers attributed the defaults to the drug related problems 46 (34%), migration 41 (31%), relief from symptoms 21 (16%), work related problems 14 (10%), alcohol consumption 28 (21%), treatment from other private or other public health facility 6 (4%), domestic problems 11 (8%), stigma related 1 (1%) and too ill 5 (4%). Others reasons like indifferent behaviour of patients, old age and other concurrent illnesses were mentioned for 13 (10%). The DOT providers also gave multiple reasons.[44]

In **Jaggarajamma K et al** study in **2001**, of the 104 defaulters, 21 (20%) were reported to have died at a later date after their outcome was declared as default; addresses could not be traced for 2 (2%) and 7 (6%) had completed treatment and were wrongly documented as default. Migration was one of the reasons for default among 25 (24%) of patients. Of the 49 patients who were interviewed, drug related problems such as bulk of tablets and side effects were reported by 37 (76%), alcohol consumption by 18 (37%), symptom free by 23 (47%), taking treatment from private practitioner or other government facility by 11 (22%) and work related problems such as inconvenient timings/going out stations on work by 8 (16%) and stigma by 4 (8%). (Patients had given multiple reasons for default).[45]

Jha UM et al conducted study in **2006** amongst these 735 patients, the most commonly cited reasons were migration 246 (21.6%), refusal 177 (15.5%),

treatment from private sector 101 (8.9%), side effects 110 (9.6%) and others (social, HIV, pregnancy) 77 (6.7%). [46]

Karanjekar VD et al conducted a study in **2008**, out of total 125 patients, 93% opinioned that laboratory diagnosis, treatment as well as the services provided by DOTS provider was good. 5 (4%) defaulted because of feeling of well-being. 2 (1.6%) left treatment because of side effects of oral drugs. Five patients had shown lack of trust on treatment provided by government health center. [47]

In **Katiyar SK et al** study in **2005**, about half of the cases had the history of smoking (>1 year), one fifth had alcohol intake and about 5% had drug abuse history. The most important causes of interruption were the lack of relief of symptoms (37%), intolerance/toxicity (17%), inability to come for drug administration during intensive phase due to loss of earning and poor general condition (15%) and migration (14%).

Another important factor was non-willingness to come thrice weekly for the drug administration (9%) during the intensive phase.[48]

Kulkarni PY et al conducted a study in **2012**, majority of the patients (27 out of 40) left the treatment because they started to feel better. Thirteen out of these 40 patients knew that duration of treatment was only 2 months and all were non-adherent at completion of IP.

19.2% non-adherence was due to forgetfulness of patients to go to DOTS clinic and take medicine. Other 19.2% non-adherence was due to timing at occupational site of the worker. Out of 156 patients, we had 50 smokers. Majority of them (60%) were non-adherent to the treatment.[49]

Roy N et al conducted a study in **2011**, in which most commonly cited reasons for default were alcohol consumption (29.1%), adverse effects of anti-TB drugs (25.32%), long distance of DOT center from residence (21.52%), temporary vocational migration (12.66%), poor patient provider interaction (6.33%), and social stigma (5.06%). [50]

Santha T et al study in **2000** revealed that a higher likelihood of default was associated with irregular drug intake, being male, having a history of previous treatment, being alcoholic, and being diagnosed by community survey.[15]

Satti SBR et al study in **2015** shows that a higher proportion of DOTS defaulters [79 (65.83%)] were not satisfied with the conduct of health personnel in DOTS centers as compared to controls [22 (18.33%)]. Among DOTS defaulters, a higher proportion of cases [76 (63.33%)] were alcohol abusers compared to controls [30 (25%)]. Likewise, 68 (57%) were smokers compared to 20 (17%) controls. Among the cases, 90 (75%) HIV-TB coinfected and DOTS defaulters had experienced drug side effects compared to 60 (50%) controls. Among the cases, 60% had poor knowledge scores compared to 17 (14%) controls.

Multiple logistic regression analysis revealed that the following risk factors had strong and significant association with DOTS defaulting: Unskilled occupation, Living alone (single/divorced/widowed), Small family size, Not being satisfied with the conduct of health personnel, Smoking, Drug side effects, and Poor knowledge score.[52]

Singh G et al, studied defaulters and non-defaulters numbering 150 each, showed that the reasons for default were family problems 74 (49.3 %), financial

difficulty 46 (30.7 %) and there was no reason in 8 (5.3 %). Certain individual characteristics of the defaulters such as age, sex and religion did not show any significant association with drug default in this study.[61]

In **Varshney AM et al** study in **2010** shows that patients who defaulted, 47% of them had a history of smoking & 18% had a habit of chewing tobacco.[54]

Verma AK et al conducted a study in **2007**, in which history of close contact with known case of pulmonary TB was present in 30.5% cases. The prevalence of diabetes mellitus among patients taking treatment at our DOT Centre was 3.3%. Four patients were human immunodeficiency virus (HIV) seropositive. All of them were males; 3 had pulmonary and 1 patient had extra-pulmonary TB. A large number (73.8%) of patients were addicted to one or more intoxicants. Tobacco abuse (tobacco chewers 74%; tobacco smokers 69%) was the most common of these. During treatment, most common side effect was gastro-intestinal upset observed in 16.3% cases.

During the intensive phase of treatment, 24 (10.3%) patients had defaulted. Of these, 8 (3.43%) patients could be brought back to treatment by defaulter action while 16 (6.9%) patients could not. A majority of patients who interrupted the treatment [51 (89.5%)] attributed a "feel good sensation" as the prime cause. 45% patients lost faith in treatment; adverse effects were responsible in 31.6% cases; and 35.1% patients defaulted treatment because they were moving out of their place of domicile.[56]

Vijay S et al in **2006** conducted a study in which literacy rate was significantly lower among patients in defaulted in comparison with completed group in plain ($p = 0.01$) and MC strata ($p = 0.03$). Though alcoholics were higher among

defaulted in all the strata, the association of alcoholism with default was significant only in coastal [OR-3.2, CI (1.5–6.8)], plain [OR -1.8, CI (1.1–2.9)] and MC [OR-2.3,CI(1.3–4.2)] strata. Important commitments like weddings / functions, festivals, work etc., during treatment period was also associated with default among patients in coastal [OR-3.2,CI(1.0–10.2)], plain [OR-2.1,CI(1.2–3.9)], tribal [OR-3.8,CI(1.5–9.4)] and MC [OR-4.6,CI(2.2–9.4)] strata. Association of Smoking with default was observed in coastal [OR-3.1, CI (1.4–6.6)] and MC [OR-2.0, CI (1.1–3.6)] strata. Proportion of patients employed and having nuclear families though not significant were higher among the completed group in all the strata.[59]

3.5 Timing of Default

Chandrasekaran V et al. studied default and its associated risk factors during the intensive phase of the treatment among new sputum positive patients registered under a DOTS programme in Thiruvallur district, Tamil Nadu. A total of 1406 (96%) patients formed the study group, of 208 (15%) defaulted. Out of 208 defaulters, 117 (56%) defaulted during first two months and another 33(16%) during the extension period of treatment in the intensive phase, in all 150 (72%) defaulted by the end of intensive phase. Among the 208 patients defaulters 31(15%) defaulted by the end of first month (12 doses) and 68 (33%) patients in the last two weeks of the (19-24 doses) the intensive phase. Another 33 (16%) defaulted in the extension phase of treatment.[68]

In the study by **Chatterjee P et al**, comparative evaluation of factors and reasons for defaulting in tuberculosis treatment in the states of West Bengal, Jharkhand and Arunachal Pradesh was assessed, the timing of defaulting was

similar in all the institutions starting at the third month increasing up to fourth month & declining subsequently, 3rd month 27, 40 29.5, 33 % respectively, 4th month 32, 40, 33.5 % respectively, 5th month 23.0, 20.0, 13.5 % and only in TB centre Roing it was 67.0 % in 5th & 6th months.[69]

In **Gupta S et al** study in **2007** from New Delhi, 72% patients had interrupted treatment by the end of third month; and maximum (30.28%) interruptions were found to occur between second and third months.[43]

In **Jaggarajamma K** et al study in **2006**, Fifty-three of 74 (72%) smear positive patients from CAT-I had defaulted during intensive phase of treatment (IP). Most of the defaults occurred between 18-24 doses of the treatment (at the end of the IP).[44]

Jha UM et al conducted study in **2006**, the median duration of treatment prior to default was 81 days (inter-quartile range 44–117 days). Of 1,141 defaulters, 720 (63%) defaulted within 90 days of treatment, prior to completion of 36 doses in IP; another 281 (25%) patients defaulted after completion of IP but before starting CP, and 140 (12%) patients defaulted during CP.[46]

Kulkarni PY et al conducted a study in **2012**, overall 50% (78/156) were non-adherent to ATT that is they interrupted treatment for ≥1 month. 50% (78/156) were treatment adherent till final outcome of RNTCP. 42.3% (33/78) of non-adherent patients interrupted ATT during CP for ≥1 month and 6.5% (5/78) interrupted ATT for ≥1 month for 2 times during the course of the treatment.[49]

Roy N et al study in **2011** revealed that about 75% of the default occurred in the intensive phase i.e., within 0–2 months (34% between 0 and 1 month and

41% between 1 and 2 months, respectively); rest 25% default occurred within 2–4 months (20% between 2 and 3 months and 5% between 3 and 4 months, respectively).[50]

Santha T et al conducted a study in **2000**, of the 127 (19%) patients who defaulted from treatment, 76% did so by the end of the intensive phase; the median duration from the onset of treatment to default was 66 days. The default rate ranged from 7% to 30% in the 17 health facilities.[15]

Satti SBR et al conducted a study in **2015**, in which most of the patients (23.3%) defaulted from treatment during the second month, 22.5% defaulted in the first month, and 17.5% defaulted in the third month of treatment, followed by 14.2% in the fourth month, 12.5% in the fifth, and 10% in the sixth month.[52]

Vasudevan K et al study in **2011** showed that maximum default is seen in the second month of treatment in category I, i.e., 1.5%; and in fourth month of treatment in category II, i.e. 5.8%. [55]

3.6 Miscellaneous

3.6.1 First Contact with the Health system

Grover A et al, found that many of the chronic chest symptomatics persisted with home remedies / self-medication for some period of time before switching over to a health care provider. 33% had contacted a health care provider on their own and 66% were persuaded by their relatives or neighbours / friends. 30% had changed the health care provider agencies 3 to 10 times. No relief from symptoms or recurrence of symptoms was the major factor in changing the health care agency in 55.6% of cases, other reasons were transfer of

doctor, referral by the doctor (13.6%), lack of money (7.4%), long distance from place of residence (2.5%) and attitude of the doctor (5.9%). [70]

Nair D et al, in their study noted that, during the first two months of symptoms most patients either did nothing or took home remedies. When symptoms continued, private practitioners were the first source of allopathic treatment. They were generally unable to correctly diagnose the disease. Respondents shifted to Government and NGO health services when private treatment became unaffordable. 80% of the respondents had visited private medical practitioner during the course of their illness. Government facilities were not preferred initially because of fixed days of service, inconvenient and fixed timings, and lack of personal attention by the staff.[71]

In the study by **Rajeshwari R et al**, 98% presented with a complaint of cough of more than 2 weeks duration. Patients first consulted private practitioners more frequently than government providers (54% vs. 27%; $p<0.001$). Most patients resorted to self-medication (61%) or pharmacies (7%).Only 20% were diagnosed at the health facility where thy first sought care; the others shopped around for care at various health facilities before a diagnosis of tuberculosis was made. Nearly half of all the patients had to visit three or more health facility before a diagnosis of tuberculosis was made. No significant gender or residential influence observed in care seeking pattern.[72]

Sudha G et al, in their study highlighted that private health care facilities were the first and preferred point of contact for 57% of urban and 48% of rural participants, the major reason were proximity to residence and their perception that good quality care would be available there and shifted to another if they

were dissatisfied . 33% of urban and 21% of rural chest symptomatic opted for self-medication. 57% of urban chest symptomatic consulted more than one health care provider during the course of their illness. Unaffordability was the commonest reason given for shifting from Private to Government facility, while the main reasons given for switching from a government to a private facility were dissatisfaction with the services and the location of the health facility being far from their residence.[73]

Suganthi P et al, in their study in Bangalore slums found that 72% first approached private health facilities. 87% visited two or more facilities before initiating treatment. The choice of first health facility depended primarily on distance from residence and faith in the health care services. Predominant reasons for subsequent visits to other health facilities were persistence of symptoms and referral.[74]

3.6.2 Delays in starting the treatment

Balasubramanian R et al (2004) in their study on 566 new smear positive TB patients at Tiruvallur district, Tamil Nadu found that the Median Patient Delay was 14 days and Health System Delay 31 days and Total Delays 45 days.[13]

Chakraborthy AK et al (2001), in a cross sectional study interviewed 147 new smear positive pulmonary patients, 83 in district under NTP and 64 in districts under RNTCP put on treatment over 2-3 months prior to study. Only 3.4% of patient took first action within 0-4 moths and remaining 96.6% had done so after 4 months and beyond. The mean Patient Delay, Health System and Total Delay observed were 8.9, 1.8, 10.7 months (Area 1) and 9.0, 0.7, 9.6 months

(Area 2) respectively. Of the 147 respondents, only 34% were diagnosed at their first health facility.[75]

Dingra VK et al (2002) conducted study on patients attending an urban TB clinic in Delhi. Overall Median delay was 2.69 weeks. The delay in health seeking did not show any significant difference according to sex, income, literacy status, source of referral and sputum status.[76]

Nair SS et al (2002), in their cross sectional studies found that, proportion of patients who sought care within 7 days were 40%, within 15 days were 67%, within 30 days were 81.9%. Private medical practitioners were preferred for first contact by 65% of cases. Government institutions were visited by 15.29% reasons cited were proximity in 59% of patients, advice by friends / relatives in 23% and perception of free and quality care in 14% of patients.[77]

In the study conducted by **Rajeshwari R et al**, in **2002** on 531 patients in Tamil Nadu, they found the Median Patient, Health System and Total Delays was 20,23 and 60 days respectively. Twenty nine percent of patients delayed seeking care for more than one month. Health System Delay was more than 7 days among 69% of patients.[72]

Study conducted by **Selvam JM et al, (2003)** in Districts of Tamil Nadu, found that 65% contacted a provider within 28 days. Median Total, Patient and Provider Delays were 62, 28 and 28 days respectively. 65% of patients were diagnosed after 14 days.[78]

3.6.3 Treatment Start by the TB patients

Bhardwaj AK et al in **2011** from Andhra Pradesh Since appearance of symptoms, patients were put on DOTS after median (mean: 49 days; mode: 33 days) duration of 33 days. Treatment was started after more than 30 days among 55.6% of patients. Once patient contacted the health facility, treatment was started within 2.4 day. Most of the patients (62.1%) first contacted government health facility for care.[37]

Verma AK et al conducted a study in **2007**, in which only 17.7% patients sought medical attention within 1 week of onset of symptoms; 32% patients took action in 1-3 weeks; 28.4% took 3 weeks to 3 months; while 22% patients took medical help after three months. There was no gender difference in this respect. Only 71.7% of patients in the present study consulted health care providers within 1 week of onset of symptoms. The time lag between onset of symptoms and consulting health care providers was lesser in urban patients (7.95 ± 9.4) compared with rural patients (9.9 ±11.4).[56]

3.6.4 Results of retrieval action taken on Defaulters

Babu BS et al in **2007** from Andhra Pradesh reported the results of the retrieval efforts of the district staff, in which out of 685 retrieval effort was taken for 633 (92%) of the 'confirmed initial defaulters' as no data was available for the rest 52 initial defaulters. Among 633 patients, 350 (51%) patients could not be contacted due to insufficient or inaccurate recording of address, or change of address; 152 (22%) patients had died, while 38 (5.5%) patients were taking anti-tuberculosis treatment from sources other than RNTCP, including private practitioners.[42]

Jha UM et al conducted study in **2006** out of 1,141 defaulters, at least 1 retrieval action was documented in 726 (64%) patients. Relative to the last dose taken, the 1st retrieval action was taken within 1 week in only 328 (45%) of defaulters; an additional 87 (12%) patients had retrieval actions during the second week. Out of 726 patients who had any documented retrieval actions, 492 (68%) actions were taken by TB programme staff (senior treatment supervisor or tuberculosis health visitor], and 154 (21%) were done by staff from the general health system. In only 11 (2%) instances was any retrieval action by medical officers (physicians) documented.[46]

Karanjekar VD et al study in **2008** reported that during follow-up visits of the TB patients; it was observed that out of 125 patients, 103 were alive while 22 were dead. 18 deaths were related with TB and its sequel. Out of total 125 TB patients, 4 were dead on record and during follow-up 23 patients could not be traced due to death and migration.[47]

Roy N et al conducted a study in **2011**, in which zero retrieval action was not documented, retrieval was not delayed by more than 1 week in IP and 11 days in CP. Almost one third of the documented retrieval actions were undertaken by medical officers and cent per cent by the contractual TB program staffs. [50]

4. MATERIAL AND METHODS

The present study entitled "**Study of default and it's determinants amongst TB patients under RNTCP in Bareilly district of UP**" was planned to find out the prevalence of defaulters, understand the factors for default among TB patients undergoing DOTS in district Bareilly and recommend measures to improve the compliance among TB patients.

Study design	Cross sectional study
Study period	2014 – 2016
Study tool	Predesigned, pretested semi-structured questionnaire
Study area	Bareilly
Study population	TB patients registered under RNTCP in Bareilly
Sample size	2010 TB patients
Sampling technique	Two stage random sampling

4.1 Study Design: Cross Sectional Study

4.2 Study Period: Total study period was of two year from 1st August 2014 to 31st July 2016. The break-up of the study period is as follows:

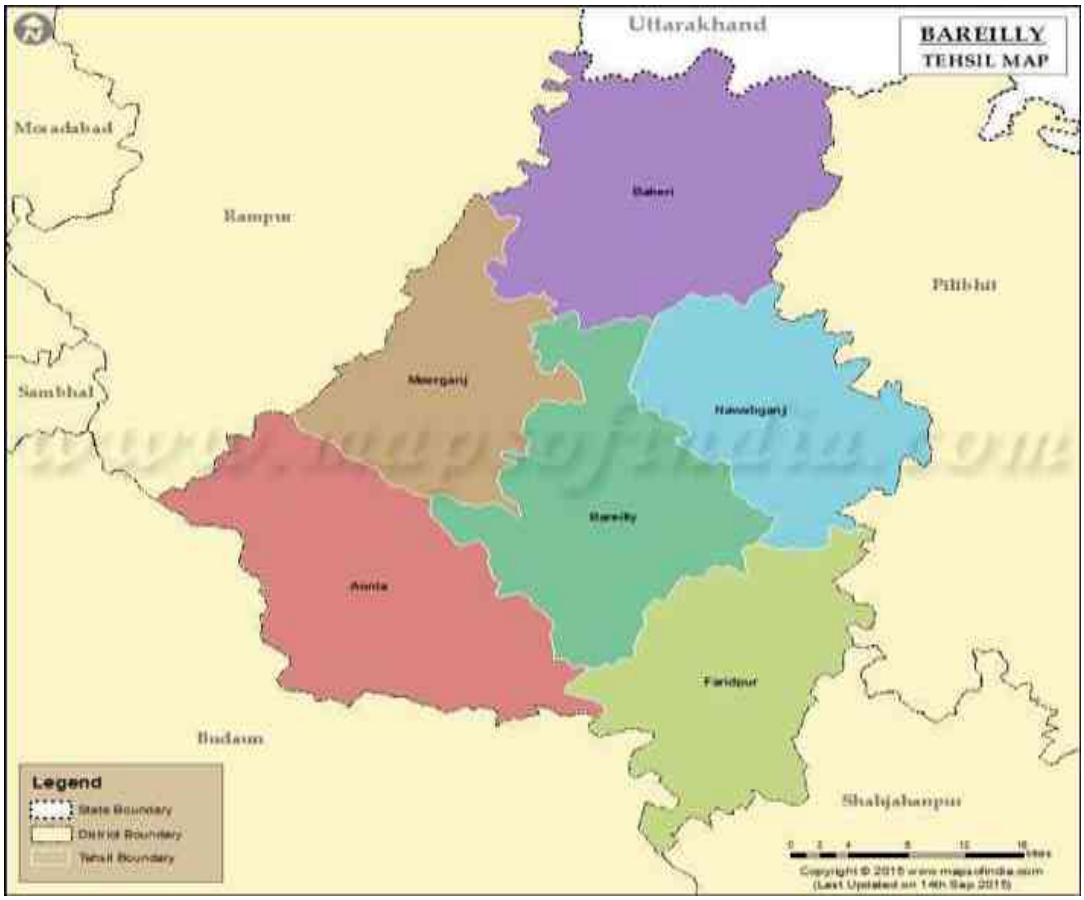
- **1st August 2014 to 31st September 2014 –** Thesis topic was selected and synopsis was prepared.
- **1st October 2014 to 31st April 2015 –** Review of literature was collected and methodology was developed.
- **1st May 2015 to 31st August 2015 –** Questionnaire was developed and Pilot study was done.
- **1st September 2015 to 31st March 2016 –** Data Collection and compilation.
- **1st April 2016 to 31st July 2016 –** Data analysis and thesis writing.

4.3 Study Tool: A predesigned, pretested semi-structured questionnaire comprising questions about demographic data, history of disease, treatment seeking behaviour, compliance and adherence to RNTCP-DOTS was prepared in english language after reviewing the available literature; however questions were asked into local language at the time of interview.

4.4 Study Area: The present cross sectional study was done in district Bareilly. Bareilly is a prominent city in the northern Indian state of Uttar Pradesh, standing on the Ramganga river, headquarter of Bareilly division and the geographical region of Rohilkhand.

The Bareilly district administers 4,120 square kilometres of area, consisting of one District Hospital, 15 Community Health Centres and 65 Primary Health Centres.

There are total 20 Tuberculosis Units (TUs), 45 designated microscopy centres (DMCs) and 649 DOTS centre in Bareilly district. The District TB Centre (DTC) is located nearby Ghantaghar, Bareilly.



Demographic data of Bareilly	
Total population Rural population Urban population Total male population Total female population	4,448,359 2,879,950 1,568,409 2,357,665 1,934,119
Population density	1080 square kilometre
Sex ratio (per 1000 male)	887
Literacy rate Male literacy rate Female literacy rate	58.49% 67.5% 48.3%

4.5 Study Population: TB patients registered under RNTCP for DOTS in Bareilly district.

a. Inclusion Criteria of the study subjects:

1. The TB patients registered for treatment under RNTCP for DOTS in Bareilly from 1st April 2014 to 31st March 2016.
2. Patients willing to participate in study and ready to give verbal consent.

b. Exclusion Criteria of the study subjects:

1. Patients who are not willing to give consent.
2. Patients who have moved out of the geographical area.
3. Patients who are not available for interview on two subsequent visits.
4. Those who are unable to understand or answer the questions (like deaf, mentally retarded or having any psychotic disorders)

4.6 Sampling Methodology

a) **Sample Size:** Sample size was calculated by using the formula

$n = 3.84pq/d^2$

n = sample size

p = prevalence of default

q = 100 - p

d = Relative allowable error= 20 % of p

By using default rates of TB patients as 5% for the cohort of patients registered in 2011, Annual RNTCP 2013 Report, the sample size came out to be 1825 TB patients registered on DOTS with 20% relative allowable error.

$n = (3.84 * 5 * 95)/(5*20/100)^2 = 1825$

Keeping the 10% dropouts and non-respondents in consideration, the sample size was increased to 2008 TB patients. Based on this a total of 2010 TB patients sample size was taken for the study.

b) **Sampling Technique:** A two-stage sampling design with random approach has been used.

I. **First stage: Selection of DMC**

There are 45 DMCs in Bareilly district, on reviewing the registers of DMCs it was presumed that to achieve the sample size 10 DMCs were sufficient for the data collection. Out of these DMCs, 10 DMCs were selected randomly by using lottery method. The names of DMCs were written on paper and 10 pieces of paper were picked up randomly.

II. **Second Stage: Selection of TB patients**

All patients who were registered during 1st April 2014 to 31st March 2016 have been included in the study. Interview of the TB patients were taken at the health facility or by making home visits for the selected patients who were not able to come to health facility.

4.7 Study Variables: Socio-demographic variables (age, gender, area of residence, religion, caste, marital status, education, occupation, socioeconomic status, family type), variants & category of TB, symptoms of diseases, treatment seeking behaviour (type of first contact with the health system, suspicion of TB by whom, place of diagnosis, treatment interruptions), history of contact, personal and medical history, recorded information about prior to TB treatment, (source, how long ago), DOTS provider, adherence, timing and reasons of default.

4.8 Pilot Study: Pilot study was done in month of August 2015 in the DMC at CHC Bhojipura, where face to face interview were taken from 50 TB patients. After the pilot study, necessary modifications were done in the study tools.

4.9 Methodology of Data Collection: The selected TB patients were contacted at DMC, DOTS centre or at their home. A verbal consent was obtained from the patients before taking face to face interview and those who gave consent were recruited for the study. After collecting relevant information about demographic parameters, subjects were interviewed for the history of disease, treatment seeking behaviour, adherence, timing and reasons of default.

Compliance at the time of interview was assessed on the basis of entry made on the treatment card of the case. Data regarding outcome of the disease were obtained from the TB register.

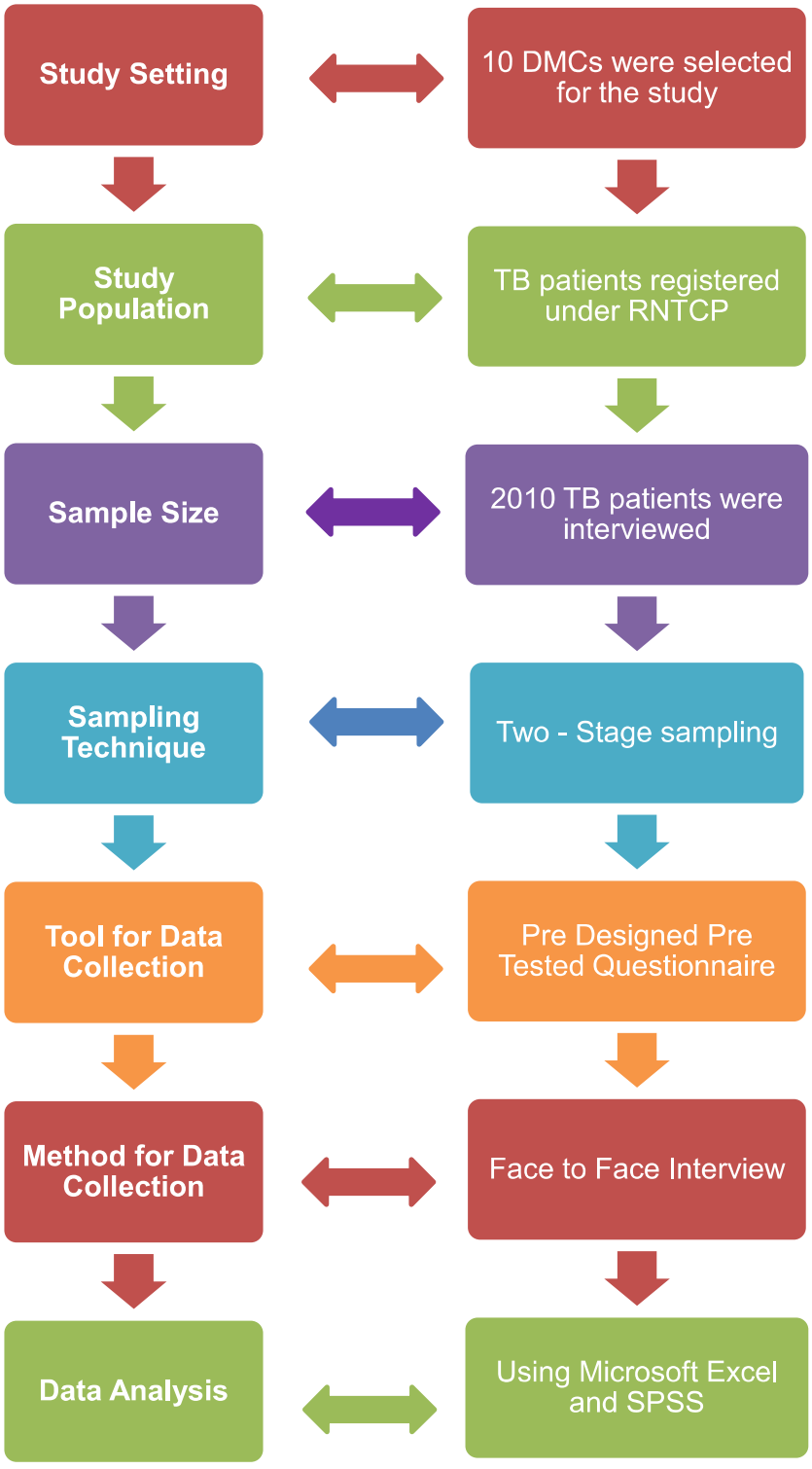
4.10 Data Management and Statistical Analysis:

The information collected was tabulated and analysed using standard statistical software (Microsoft Excel 2010 and SPSS Version 23). Chi-Square test and Logistic Regression were applied to find out the association and their strength between the variables to validate the findings of the study.

4.11 Ethical considerations

The study was started after obtaining approval from ethical committee of SRMS Institute of Medical Sciences, Bareilly. Prior verbal permission was sought from the TB Medical Officer in-charge before taking interview of patients at the respective health facility.

Schematic Representation of Research Design



5. RESULTS

In this cross-sectional study, a total of 2010 TB patients registered under RNTCP were interviewed after taking verbal consent from them by using a predesigned, pretested semi-structured questionnaire. After the collection and compilation of data, analysis was done by using Microsoft Excel 2010 and SPSS Version 23 from which the following results were obtained.

Table 1: Distribution of TB cases according to their socio-demographic characteristics

Characteristics	Frequency (N=2010)	Percentage
Age		
<20 Years	489	24.3
20 - 29 Years	371	18.5
30 -39 Years	332	16.5
40 - 49 Years	359	17.9
50 - 59 Years	206	10.2
> 60 Years	253	12.6
Gender		
Male	1119	55.7
Female	891	44.3
Locality		
Urban	1050	52.2
Rural	960	47.8
Religion		
Hindu	1123	55.9
Muslim	887	44.1
Caste		
General	483	24
OBC	1403	69.8
SC	124	6.2

Table 1 continued

Characteristics	Frequency (N=2010)	Percentage
Marital Status		
Married	1358	67.6
Unmarried	652	32.4
Education		
Illiterate	365	18.2
Able to Read	133	6.6
Primary School	704	35
Middle School	245	12.2
High School	225	11.2
Intermediate	226	11.2
Graduate or Above	112	5.6
Occupation		
Professional	50	2.5
Skilled Worker	21	1.0
Unskilled Worker	769	38.3
Housewife	514	25.6
Student	487	24.2
Unemployed	169	8.4
Socio Economic Status		
Class I	20	1.0
Class II	59	2.9
Class III	343	17.1
Class IV	1318	65.6
Class V	270	13.4
Family Type		
Nuclear Family	777	38.7
Joint Family	748	37.2
Three Generation Family	485	24.1

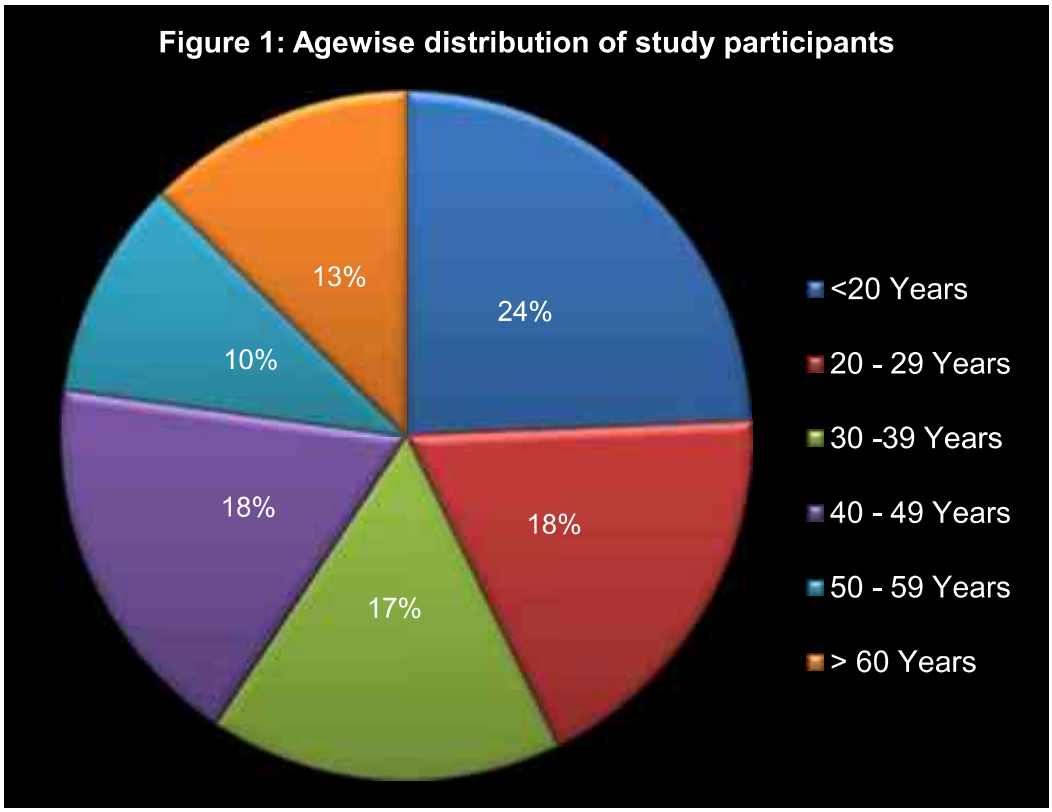


Figure 1: Agewise distribution of study participants
24%
18%
17%
18%
10%
13%
<20 Years
20 - 29 Years
30 -39 Years
40 - 49 Years
50 - 59 Years
> 60 Years

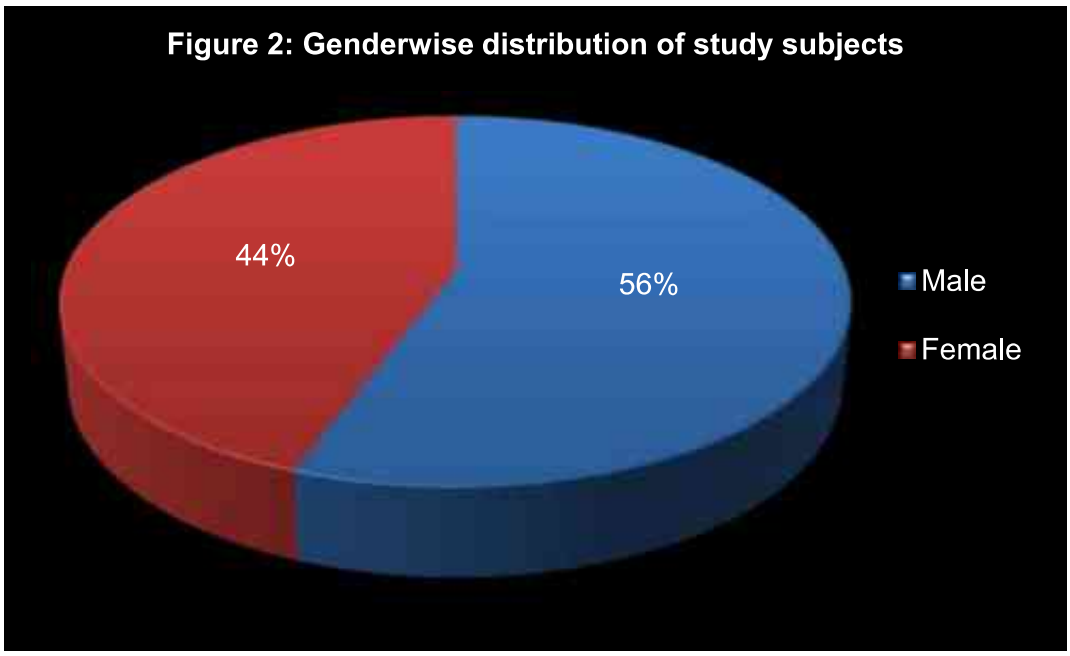


Figure 2: Genderwise distribution of study subjects
44%
56%
Male
Female

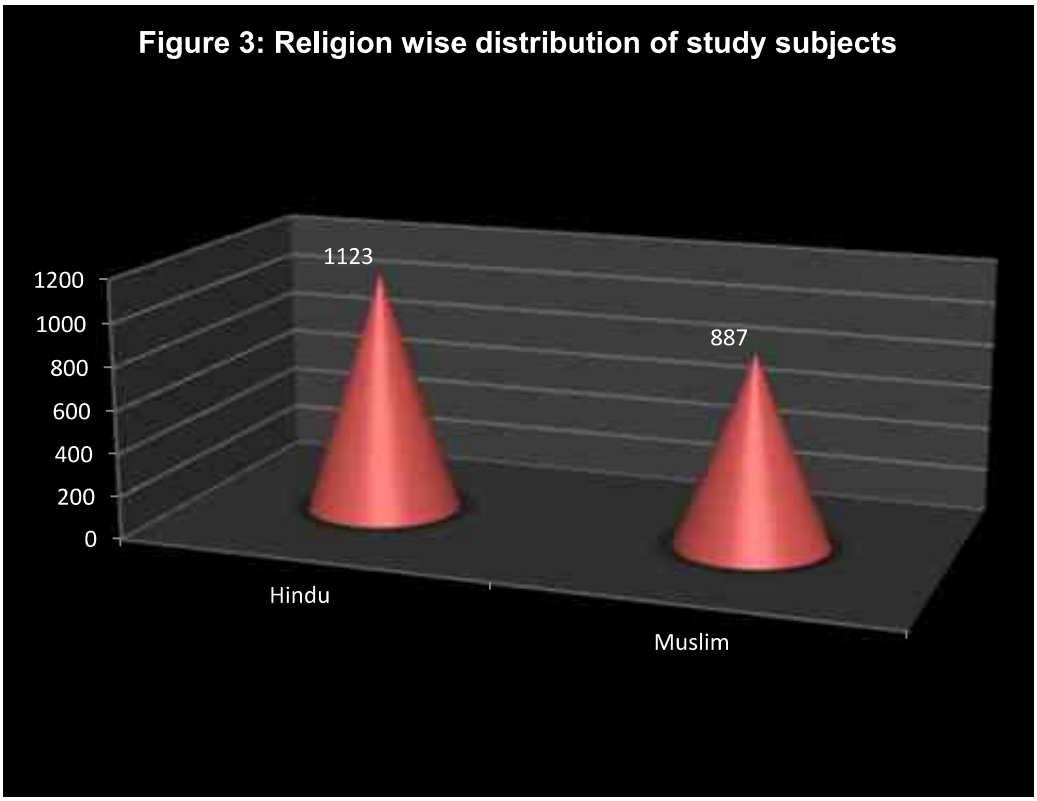


Figure 3: Religion wise distribution of study subjects
1200
1000
800
600
400
200
0
1123
887
Hindu
Muslim

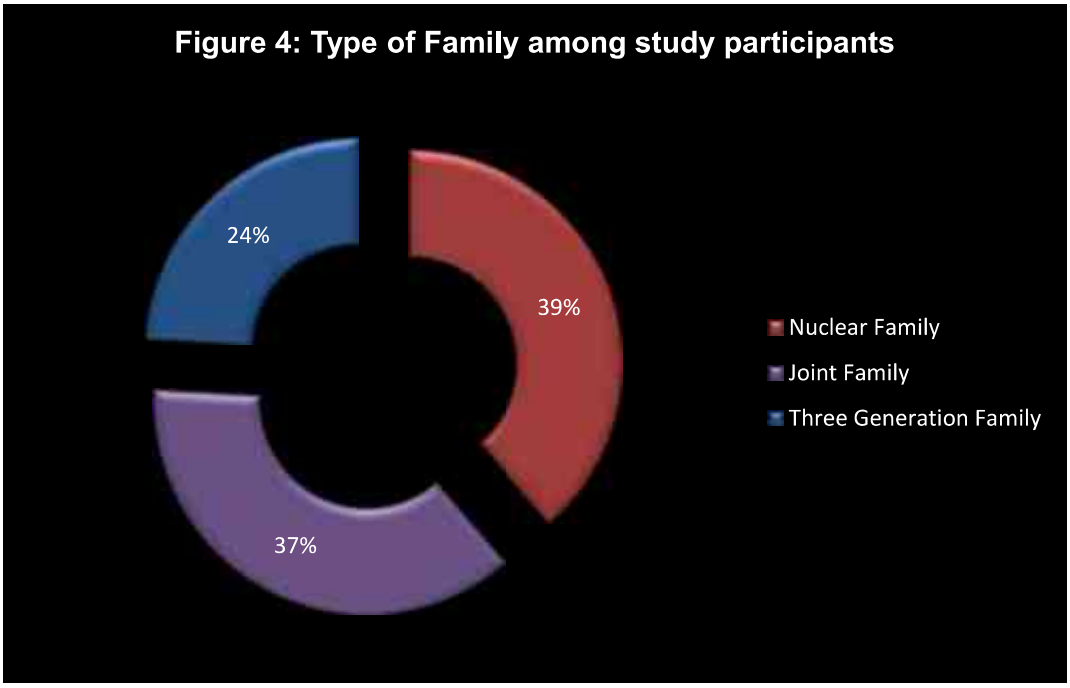


Figure 4: Type of Family among study participants
24%
39%
37%
Nuclear Family
Joint Family
Three Generation Family

Table – 1 shows the socio-demographic characteristics of 2010 subjects who participated in the study in which the age distribution revealed that maximum subjects (24.3%) were in the age group of < 20 years followed by 18.5% belonging to 20 – 29 years, 17.9% belonging to 40 – 49 years, 16.5% belonging to 30 – 39 years, 12.6% belonging to > 60 years and 10.2% belonging to 50 – 59 years age group (Figure 1).

Male cases contributed 55.7% of the study population while 33.6% were females. More than half of the study population that is 52.2% was from urban background and rest (47.8%) were from rural area (Figure 2).

More than half of the study subjects (55.9%) belonged to Hindu religion while rest of them (44.1%) were Muslims (Figure 3). Majority of the cases (69.8%) belonged to the other backward class (OBC) while general and scheduled caste compromised 24% and 6.2% respectively.

More than two third of the study population that is 67.6% were married and the rest (32.4%) were unmarried.

Educational profile showed that 35% were educated upto primary level, 18.2% were illiterate, 12.2% studied upto middle school level, 11.2% were educated upto high school level, 11.2% got their education upto intermediate level, 6.6% were able to read and only 5.2% had an education level of graduate or above.

Majority of the study population that is 65.6% belonged to socioeconomic status class IV according to modified BG Prasad scale followed by 17.1% in category III, 13.4% in category IV, 2.9% in category II and 1% in category I.

Maximum number of study subjects (38.7%) was from nuclear families while 37.2% and 24.1% were from joint families and three generation families respectively (Figure 4).

Table 2: Distribution of TB cases according to their type and category

	Frequency (N=2010)	Percentage
Site of Involvement		
Pulmonary TB	1699	84.5
Extra Pulmonary TB	311	15.5
Smear Status		
Smear Positive	1398	69.5
Smear Negative	301	15
Not Applicable*	311	15.5
Category of Treatment		
Category I	1670	83.1
Category II	340	16.9

* Extra Pulmonary TB cases

Table – 2 reveals that more than four fifth (83.1%) showed pulmonary site of involvement while rest (15.5%) had extra pulmonary site of involvement (Figure 5).

Majority of the cases that is 69.5% was sputum smear positive while 15% was sputum smear negative and in 15.5% cases sputum examination was not done as they were extra pulmonary cases.

More than two third (83.1%) of the cases was taking treatment in category I while the rest (16.9%) was undergoing treatment of category II (Figure 6).

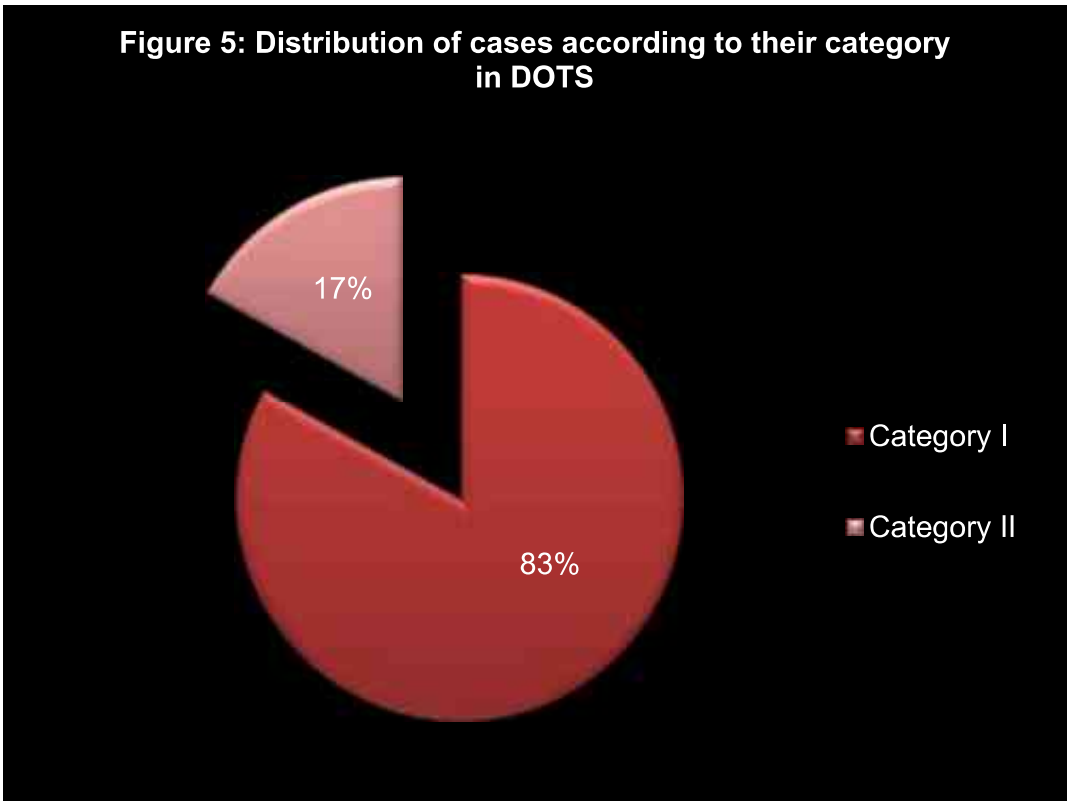


Figure 5: Distribution of cases according to their category in DOTS
17%
83%
Category I
Category II

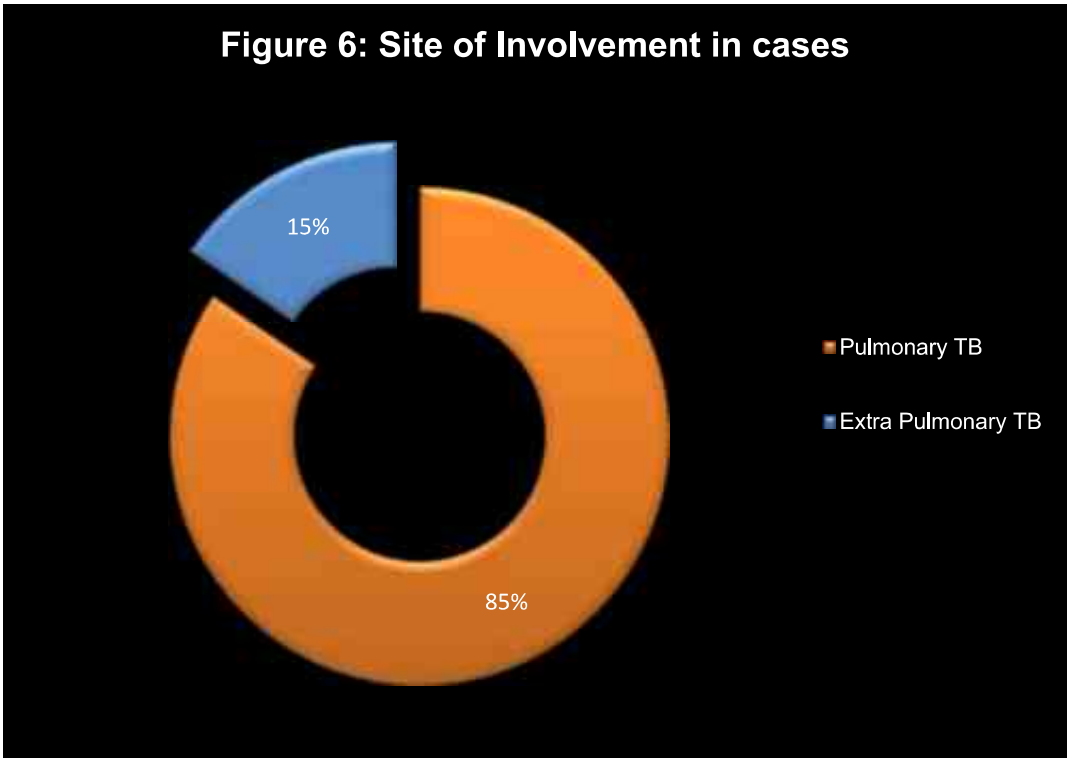


Figure 6: Site of Involvement in cases
15%
85%
Pulmonary TB
Extra Pulmonary TB

Table 3: Distribution of TB cases on the basis of presenting symptoms

Symptoms*	Frequency (N=2010)	Percentage
Cough	1687	83.93
Fever	1608	80
Breathlessness	744	37.01
Weight Loss	655	32.59
Loss of Appetite	460	22.89
Chest Pain	163	8.11
Blood in Sputum	125	6.22

* Multiple responses

Table – 3 shows the most common presenting symptoms was cough reported by 83.93% cases followed by fever in 80% cases, breathlessness in 37.01% cases, weight loss in 32.59% cases and loss of appetite in 22.89% cases. Other presenting symptoms such as chest pain and blood in sputum accounted for 8.11% and 6.22% respectively (Figure 7).

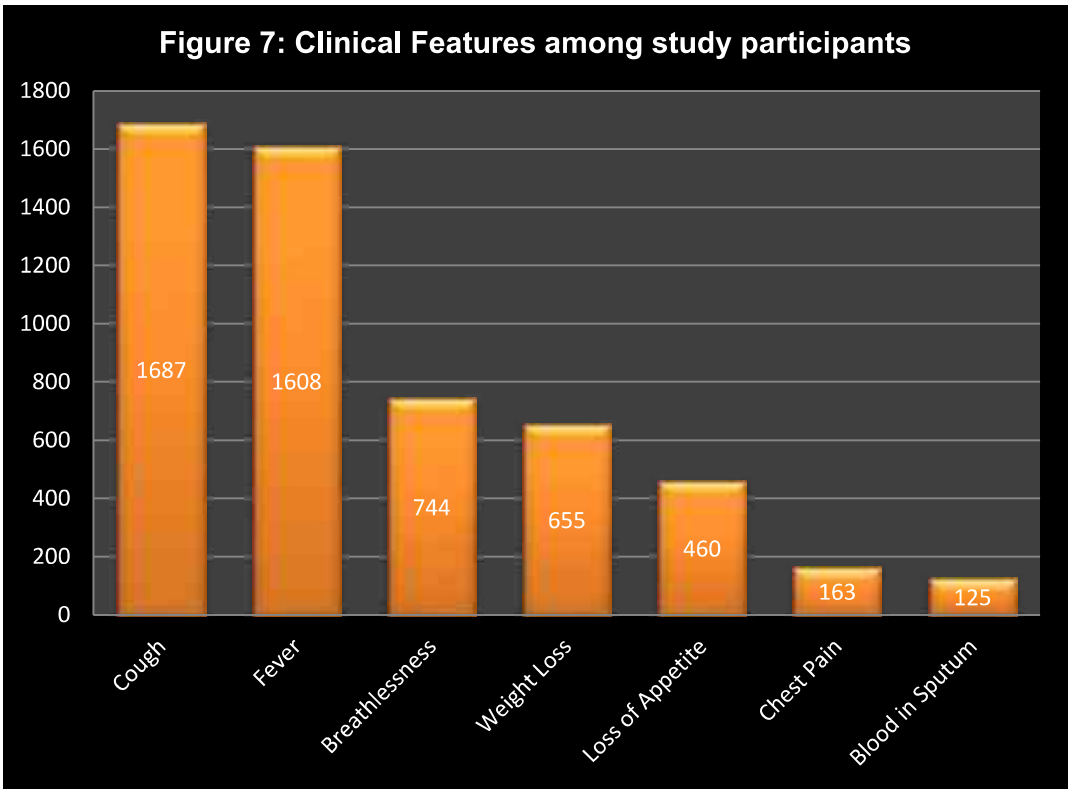


Figure 7: Clinical Features among study participants
1800
1600
1400
1200
1000
800
600
400
200
0
1687
1608
744
655
460
163
125
Cough
Fever
Breathlessness
Weight Loss
Loss of Appetite
Chest Pain
Blood in Sputum

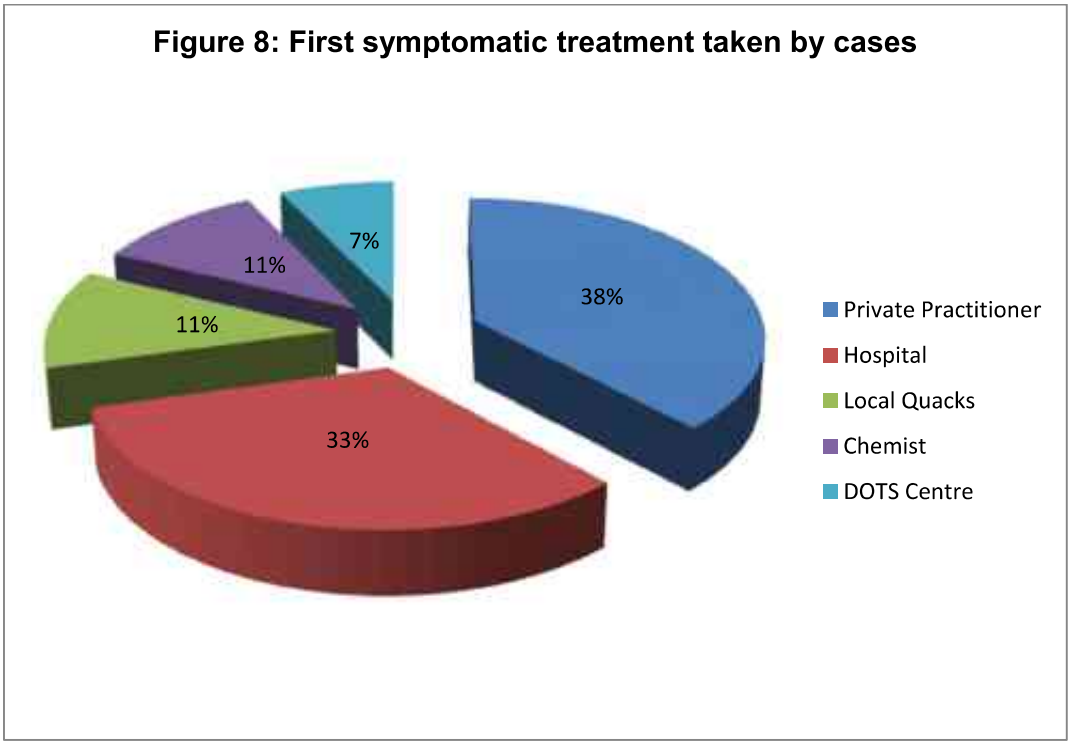


Figure 8: First symptomatic treatment taken by cases
38%
33%
11%
11%
7%
Private Practitioner
Hospital
Local Quacks
Chemist
DOTS Centre

Table 4: Distribution of TB cases according to their treatment seeking behaviour

	Frequency (N=2010)	Percentage
First symptomatic treatment was taken from		
Private Practitioner	765	38.1
Hospital	656	32.6
Local Quacks	230	11.4
Chemist	214	10.6
DOTS Centre	145	7.2
Suspicion aroused by		
Suggested by Doctor	1465	72.9
Self-Perception	279	13.9
Suggested by Health Worker	187	9.3
Suggested by Peer Group	34	1.7
Effect of Awareness Campaign	29	1.4
Effect of Media	16	0.8
Place of Diagnosis		
DOTS Centre	808	40.2
Government Health Centre	681	33.9
Private Clinic	521	25.9
Time Taken for treatment to start after the diagnosing TB		
< 2 Weeks	1890	94.0
> 2 Weeks	120	6.0
History of treatment interruption		
Yes	562	28
No	1448	72

Table – 4 shows the distribution of cases according to their first contact to the health system by the cases on the onset of their symptoms which revealed that 765 (38.1%) study subjects took their first symptomatic treatment from private practitioner followed by 32.6% individuals who went to hospitals, 11.4% cases took treatment from local quacks, 10.6% cases took treatment from chemist while only 7.2% cases went to DOTS centre for their treatment (Figure 8).

The biggest source of suspicion of tuberculosis was suggested by doctor (72.9%), followed by self-perception (13.9%), suggestion by health worker (9.3%), an effect of awareness campaign (1.4%) and only 0.8% cases had an effect of media.

Maximum number of cases that is 40.2% was diagnosed tuberculosis at DOTS centre while 33.9% and 25.9% were diagnosed at other government hospitals and private clinics respectively.

Almost all the cases (94%) started their DOTS treatment within the 2 weeks of time period while only 6% of the cases showed delay in treatment more than 2 weeks.

Majority of the patients (72%) did not break their continuity for the treatment while approximately one fourth of the cases (28%) showed interruption in their treatment.

Table 5: Distribution of TB cases according to history of contact

History of Contact	Frequency (N=2010)	Percentage
No history of contact	1481	73.7
Family Members	317	15.8
Friends	100	5.0
Neighbours	82	4.1
Colleague's	30	1.5

Table – 5 shows that majority (73.7%) of cases had no history of contact with any tuberculosis patients, while 15.8%, 5%, 4.1% and 1.5% had contact history from family members, friends, neighbours and colleagues respectively.

Table 6: Distribution of TB cases with respect to medical history

Illness	Frequency (N=2010)	Percentage
Diabetes	540	26.9
Any Chronic Respiratory Disease	400	19.9
HIV	13	0.6
None of the above mentioned diseases	1057	52.6

Table – 6 shows that 26.9% cases had history of diabetes while 19.9% and 0.6% had chronic respiratory disease and HIV respectively. Majority (52.6%) of the case didn't have any of the given three diseases.

Table 7: Distribution of TB cases according to smoking history

History of Smoking	Frequency (N=2010)	Percentage
Non Smoker	1494	74.3
Current Smoker	264	13.1
Past Smoker	252	12.5

Table – 7 shows that more than two third (74.3%) of cases were non-smoker while only 13.1% and 12.5% cases were current smoker and past smoker.

Table 8: Distribution of TB cases according to alcohol consumption history

Alcohol Consumption History	Frequency (N=2010)	Percentage
Non Alcoholic	1916	95.3
Past Alcoholic	57	2.8
Current Alcoholic	37	1.8

Table – 8 shows that almost all of the cases that is 95.3% were non-alcoholic while only 2.8% and 1.8% were past alcoholic and current alcoholic.

Table 9: Distribution of TB cases according to knowledge of patients regarding TB

	Frequency (%)	
	Yes (%)	**No (%)**
TB is a serious disease	1928 (95.92)	82 (4.08)
TB is curable	1954 (97.21)	56 (2.79)
Illness of TB kept secret	446 (22.19)	1564 (77.81)

It is evident from table – 9 that majority of the cases (95.92%) knew that TB is a serious disease while only 4.08% thought that TB is not a serious disease.

Almost all cases (97.21%) cases were aware that TB is curable only 2.79% thought that TB is not curable.

More than two third of the cases (77.81%) kept their family and friends informed about their disease while 22.19% did not want to share or disclose about their illness.

Table 10: Default Rate among study participants according to their Socio-Demographic characteristics

	Total TB Patients	Defaulters	Default Rate
Study Participants	2010	188	9.35
Age			
<20 Years	489	33	6.75
20 - 29 Years	371	46	12.40
30 -39 Years	332	38	11.45
40 - 49 Years	359	30	8.36
50 - 59 Years	206	25	12.14
> 60 Years	253	16	6.32
Chi-Square Value = 14.727; df = 5; p-Value = .012			
Gender			
Male	1119	116	10.37
Female	891	72	8.08
Chi-Square Value = 3.056; df = 1; p-Value = .047			
Locality			
Urban	1050	125	11.90
Rural	960	63	6.56
Chi-Square Value = 16.881; df = 1; p-Value = < .001			
Religion			
Hindu	1123	123	10.95
Muslim	887	65	7.33
Chi-Square Value = 7.680; df = 1; p-Value = .003			
Caste			
General	483	63	13.04
OBC	1403	99	7.05
SC	124	26	20.97
Chi-Square Value = 36.218; df = 2; p-Value = < .001			

Table 10 continued

	Total TB Patients	Defaulters	Default Rate
Marital Status			
Married	125	125	9.20
Unmarried	652	63	9.66
Chi-Square Value = .109; df = 1; p-Value = .399			
Education			
Illiterate	365	34	9.32
Able to Read	133	13	9.77
Primary School	704	61	8.66
Middle School	245	12	4.90
High School	225	30	13.33
Intermediate	226	29	12.83
Graduate & Above	112	9	8.04
Chi-Square Value = 13.817; df = 6; p-Value = .032			
Occupation			
Professional	50	9	18.00
Skilled Worker	21	4	19.05
Unskilled Worker	769	96	12.48
Housewife	514	25	4.86
Student	487	37	7.60
Unemployed	169	17	10.06
Chi-Square Value = 29.715; df = 5; p-Value = < .001			
Socio Economic Status			
Class I	20	0	0.00
Class II	59	0	0.00
Class III	343	43	12.54
Class IV	1318	128	9.71
Class V	270	17	6.30
Chi-Square Value = 15.426; df = 4; p-Value = .004			
Type of Family			
Nuclear Family	777	75	9.65
Joint Family	748	80	10.70
Three Generation Family	485	33	6.80
Chi-Square Value = 5.388; df = 2; p-Value = .068			

It is evident from table – 10 that the prevalence of defaulters in the study subjects came out to be 9.35% (Figure 9).

Age group of 20 – 29 years showed highest default rate (12.4%) followed by 50 – 59 years of age group in which default rate came out to be 12.14% and 11.45% in 30 – 39 years of age group while 8.36%, 6.75% and 6.32% default rate were seen in 40 – 49 years, < 20 years and > 60 years of age group respectively. The association was found to be statistically significant between defaulters and age

A little higher default rate is seen in males (10.37%) as compared to females (8.08%). The value came out to be statistically significant.

Similarly default rate is higher in urban population (11.9%) as in rural population default rate is 6.56%. The association came out to be highly significant with the place of residence.

In Hindu patients default rate came out to be 10.95% and in Muslims it came out to be 7.33%. The results were found to be statistically significant.

A high default rate was seen in scheduled caste (20.97%) while in general and other backward classes default rate came out to be 13.04% and 7.05%. The association was found to be statistically significant between the defaulters and caste.

A very little difference of default rate was seen in unmarried (9.66%) and married (9.20%) cases. The association was not statistically significant.

A slight high default rate was seen in high school and intermediate level of education, 13.33% and 12.83% respectively as compared to education level in

study group of able to read (9.77%), illiterate (9.32%), primary school (8.66%), graduate & above (8.04%) and middle school (4.90%). The association came out to be statistically significant.

In occupation, skilled worker and professional group has shown high default rate of 19.05% and 18.00%, followed by unskilled worker, unemployed, student and least in housewife in which default rate came out to be 12.48%, 10.06%, 7.60% and 4.86% respectively. The value came out to be statistically significant.

According to Revised BG Prasad classification, class III showed a default rate of 12.54%, class IV had 9.71% defaulters and class V had 6.30% default rate while class I and II had reported no defaulters. The association came out to be statistically significant.

Default rate in joint family (10.70%) was slightly higher as compared to nuclear family (9.65%) and three generation family (6.80%). The association came out to be statistically insignificant.

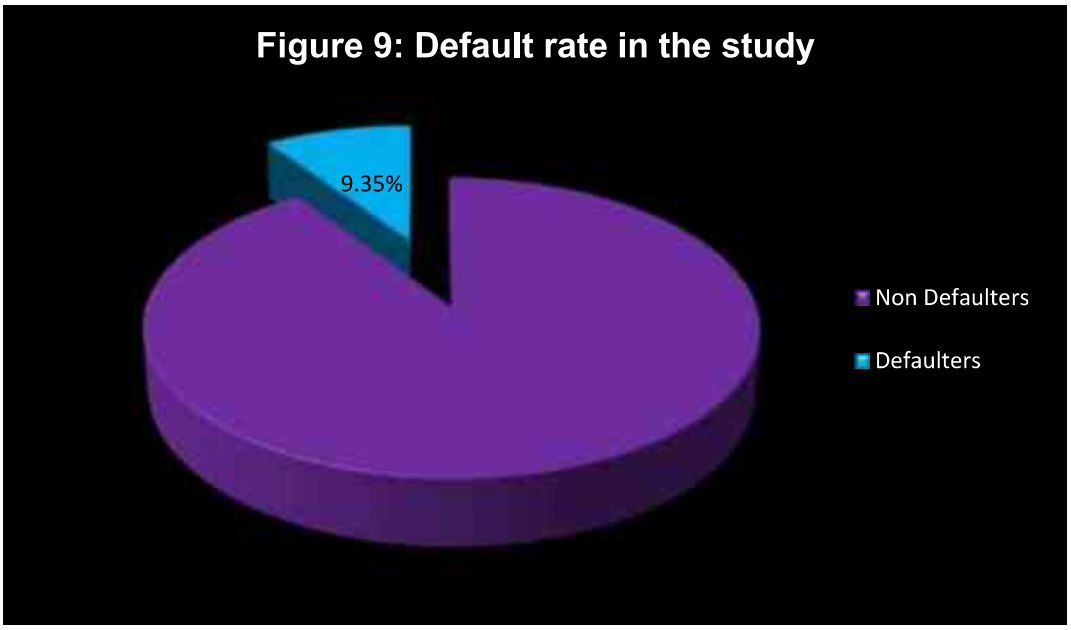


Figure 9: Default rate in the study
9.35%
Non Defaulters
Defaulters

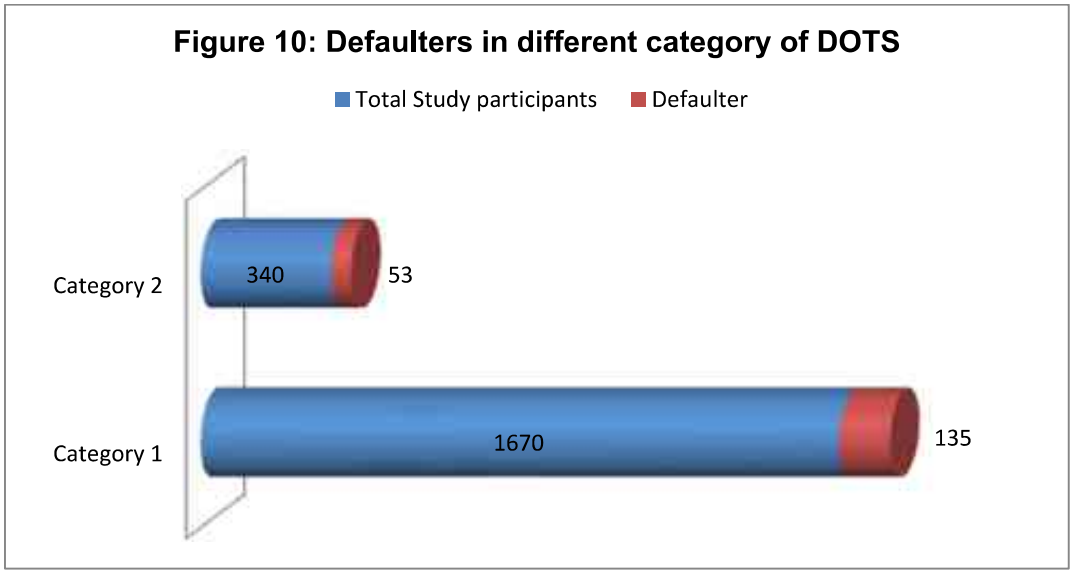


Figure 10: Defaulters in different category of DOTS
Total Study participants
Defaulter
Category 2
340
53
Category 1
1670
135

Table 11: Default rate in different variants of TB

	Total TB Patients	Defaulters	Default Rate
Site of Involvement			
Pulmonary TB	1699	179	10.54
Extra Pulmonary TB	311	9	2.89
Chi-Square Value = 18.106; df = 2; p-Value = < .001			
Smear Status			
Smear Positive	1398	137	9.80
Smear Negative	301	42	13.95
Not Applicable*	311	9	2.89
Chi-Square Value = 23.146; df = 3; p-Value = < .001			
Category of Treatment			
Category I	1670	135	8.08
Category II	340	53	15.59
Chi-Square Value = 18.764; df = 2; p-Value = < .001			

* Extra Pulmonary TB cases

Table – 11 shows that pulmonary TB cases showed a higher default rate (10.54%) as compared to extra pulmonary TB cases (2.89%). Default rate is high in sputum smear negative cases (13.95%) followed by sputum positive cases (9.80%) and then in cases in which sputum examination was not done (2.89%) as they were of extra pulmonary cases. A higher default rate is seen in category II patients (15.59%) as compared to category I patients (8.08%). The association came out to be statistically significant (Figure 10).

Table 12: Default rate in association with any medical illness

Illness	Total TB Patients	Defaulters	Default Rate
Any Chronic Respiratory Disease	400	61	15.25
Diabetes	540	24	4.44
HIV	13	0	0.00
None of the above mentioned diseases	1057	103	9.74
Chi-Square Value = 33.284; df = 3; p-Value = < .001			

High default rate (15.25%) was seen in cases having past history of chronic respiratory diseases while people having diabetes showed a low default rate (4.44%). No defaulters were found in patients having HIV, while default rate came out to be 9.74% in cases who had none of the given three diseases. The association came out to be statistically significant.

Table 13: Default rate in association with history of smoking

History of Smoking	Total TB Patients	Defaulters	Default Rate
Non Smoker	1494	147	9.84
Current Smoker	264	29	10.98
Past Smoker	252	12	4.76
Chi-Square value = 7.511; df = 2; p-Value = .023			

Table – 13 shows that cases who were current smoker had default rate of 10.98% followed by non-smoker having default rate of 9.84.It was seen that past smoker had a low default rate (4.76%). The association came out to be statistically significant.

Table 14: Default rate in association with history of alcohol consumption

Alcohol Consumption History	Total TB Patients	Defaulters	Default Rate
Non Alcoholic	1916	181	9.45
Past Alcoholic	57	0	0.00
Current Alcoholic	37	7	18.92
Chi-Square value = 64.372; df = 2; p-Value = < .001			

Table – 14 shows that default rate is almost double in current alcoholics (18.92%) as compared to non-alcoholics (9.45%) while no defaulters were seen in past alcoholics. The association came out to be statistically significant.

Table 15: Default rate according to the history of treatment interruption

History of treatment interruption	Total TB Patients	Defaulters	Default Rate
Yes	562	131	23.3
No	1448	57	3.93
Chi-Square value = 179.233; df = 1; p-Value = < .001			

It is evident from table – 15 that cases who had history of treatment interruption had a very high default rate that is 23.3% while cases who didn't interrupted their treatment had a low default rate of 3.93%. The association came out to be statistically significant.

Table 16: Timing of default in TB patients

Stopped treatment after	Frequency (n = 188)	Percentage (%)
< 1 month	51	27.13
1 – 2 months	35	18.62
2 – 3 months	57	30.32
3 – 4 months	32	17.02
> 4 months	13	6.91
Total	188	100

Table – 16 shows that maximum cases (30.32%) defaulted from their treatment between 2 -3 month of their treatment, followed by 27.13% in less than one month of treatment duration, 18.62% in 1 – 2 month of treatment duration, 17.02% in 3 – 4 months of their treatment duration and 6.91% defaulted after completing the treatment of 4 months.

Table 17: Risk of defaulting from treatment according to the socio-demographic characteristics of cases by applying logistic regression

Characteristics	Defaulter	Non Defaulter	Odds Ratio	Confidence Interval (95%)		p-value
				Lower limit	Upper limit	
Age						
<20 Years	33	456	Reference	-	-	-
20 - 29 Years	46	325	1.956	1.223	3.127	**.005**
30 -39 Years	38	294	1.786	1.095	2.912	**.020**
40 - 49 Years	30	329	1.260	0.753	2.107	.378
50 - 59 Years	25	181	1.909	1.104	3.300	**.021**
> 60 Years	16	237	.933	0.503	1.730	.825
Gender						
Male	116	1003	1.316	0.967	1.790	.081
Female	72	819	Reference	-	-	-
Locality						
Urban	125	925	1.924	1.402	2.640	**< .001**
Rural	63	897	Reference	-	-	-
Religion						
Hindu	123	1000	Reference	-	-	-
Muslim	65	822	0.643	0.469	0.880	**.006**
Caste						
General	63	420	Reference	-	-	-
OBC	75	990	.506	.362	.707	**< .001**
SC	26	98	1.769	1.065	2.937	**.027**
Marital Status						
Married	125	1233	.948	.689	1.303	.741
Unmarried	63	589	Reference	-	-	-

Table 17 continued

Characteristics	Defaulter	Non Defaulter	Odds Ratio	Confidence Interval (95%)		p-value
				Lower limit	Upper limit	
Education						
Illiterate	34	331	Reference	-	-	-
Able to Read	13	120	1.055	.538	2.066	.877
Primary School	61	643	.924	.595	1.434	.723
Middle School	12	233	.501	.254	.989	**.046**
High School	30	195	1.498	.889	2.524	.129
Intermediate	29	197	1.433	.847	2.425	.180
Graduate & Above	9	103	.851	.395	1.832	.679
Occupation						
Professional	9	41	Reference	-	-	-
Skilled Worker	4	17	1.072	.290	3.959	.917
Unskilled Worker	96	673	.650	.306	1.379	.262
Housewife	25	489	.233	.102	.532	**.001**
Student	37	450	.375	.169	.830	**.016**
Unemployed	17	152	.510	.212	1.227	.132
Socio Economic Status						
Class I	0	20	NA	-	-	-
Class II	0	59	NA	-	-	-
Class III	43	300	2.133	1.187	3.832	**.011**
Class IV	128	1190	1.601	.948	2.703	.078
Class V	17	253	Reference	-	-	-
Type of Family						
Nuclear Family	75	702	1.463	.956	2.241	.080
Joint Family	80	668	1.640	1.075	2.503	**.022**
Three Generation Family	33	452	Reference	-	-	-

Applying logistic regression on the socio-demographic factors regarding the risk for default, results were as follows:

Age group less than 20 years of the study participants were taken as reference category. While applying regression, in the age group 20 – 29 years of study participants have 95% more chance of defaulting from treatment. Study participants of age group 30 -39 years have a chance of 78% for defaulting from the treatment. Study participants belonging to the age group of 40 – 49 years have a 26% chance of defaulting from treatment. 90% chance of defaulting is there in age group of 50 – 59 years whereas in more than 60 years of age group there is 7% less chances of defaulting from treatment as compare to study participants in age group less than 20 years.

In the gender, Females were taken as reference category. In the study it was found that in Males there is 31% risk of more defaulting as compared to females.

In the area of residence, Rural area was considered as reference category. The study revealed that Urban area cases have 92% more chance of defaulting from the treatment as compared to Rural area cases.

In the religion, Hindu religion was taken as reference category. In the study it was found that in Muslim religion participants have 36% less chances for defaulting from the treatment as compared to participants in Hindu religion.

In the caste, General caste was considered as reference category. In the study it was found that OBC category have 50% less chances of defaulting

from the treatment and SC caste had 76% more chance of defaulting the treatment as compared to General caste in study population.

In marital status, unmarried cases were taken as reference group. In the study it was found that married cases had 5% less risk of defaulting from the treatment.

In the education category, illiterate was taken as reference category. Among able to read cases, 5% more chances of defaulting from the treatment was found. While in primary level educated cases had a 8% less chance of defaulting from the treatment, in middle level educated cases there was 50% less chance of default, while in high level educated cases there is 50% more risk of defaulting from the treatment, in intermediate level educated cases it was seen that they have 43% more chance of defaulting from the treatment and in graduate &/or above educated cases there was 15% less chance of defaulting from the treatment as compared to illiterate cases.

In the occupation category, professional employees were taken as reference category. In skilled worker category, they had a 7% chance of more from the defaulting the treatment, but unskilled worker had 35% less chance of defaulting from the treatment, while housewife's had 77% less chances of defaulting the treatment, student category showed 63% less chances of defaulting from the treatment and unemployed category had 49% less chances of defaulting from treatment as compared to professional category.

In socioeconomic status, class I and II were not considered as there was no default cases found in them. Class V was taken as reference category. On regression analysis, it was found that class III had two times more chances of

defaulting and class IV had 60% more chances of defaulting from the treatment as compared to class V category cases.

Three generation family was taken as reference category, where it was found that cases belonging to nuclear family had 46% more chance of default and joint family showed 64% risk of default as compared to three generation family.

Table 18: Risk of defaulting from treatment according to the distribution of category of treatment for cases according to RNTCP by applying logistic regression

	Defaulter	Non Defaulter	Odds Ratio	Confidence Interval (95%)		p-value
Category of Treatment				**Lower limit**	**Upper limit**	
Category I	135	1535	Reference	-	-	-
Category II	53	287	2.086	1.482	2.936	**< .001**
Smear Status						
Smear Positive	137	1261	3.645	1.835	7.239	**< .001**
Smear Negative	42	259	5.441	2.599	11.391	**< .001**
Not Applicable*	9	302	Reference	-	-	-
Site of Involvement						
Pulmonary TB	179	1520	3.951	2.003	7.806	**< .001**
Extra Pulmonary TB	9	302	Reference	-	-	-

***** Extra Pulmonary TB cases

Out of 2010 patients taken in the study, 1670 patients were in category I of RNTCP in which 179 patients have defaulted and 340 patients in category II in which 53 defaulted. On applying logistic regression by keeping category I patients as reference it was seen that category II patients had twice the risk of defaulting as compared to category I.

In sputum smear status, by keeping the extra pulmonary cases as reference in which sputum examination was not done, it was seen that in smear positive cases it was than three times the risk of default and in sputum negative cases it was almost five times the risk of default.

According to site of involvement in TB, extra pulmonary TB patients were kept as reference. In the study it showed that patients having pulmonary involvement had almost four times the risk of defaulting from the treatment.

Table 19: Risk of defaulting from treatment according to their personal medical history by applying logistic regression

Illness	Defaulter	Non Defaulter	Odds Ratio	Confidence Interval (95%)		p-value
				Lower limit	Upper limit	
Diabetes	24	516	Reference	-	-	-
Any Chronic Respiratory Disease	61	339	3.869	2.366	6.326	**< .001**
HIV	0	13	NA	-	-	-
None of the above diseases	103	954	2.321	1.470	3.666	**< .001**

By applying logistic regression on medical history of the patients following results were seen:

By keeping diabetes as reference group, study revealed that patients having any chronic respiratory disease had almost four times of chances for defaulting from treatment and patients having none of the mentioned diseases had twice the chance of defaulting from the treatment as compared to patients having diabetes. No association was found for patients having HIV as there were no defaulters found in this category.

Table 20: Risk of defaulting from treatment according to their history of smoking by applying logistic regression

History of Smoking	Defaulter	Non Defaulter	Odds Ratio	Confidence Interval (95%)		p-value
				Lower limit	Upper limit	
Non Smoker	147	1347	Reference	-	-	-
Current Smoker	29	235	1.131	.742	1.725	**.046**
Past Smoker	12	240	.458	.250	.838	**.011**

On applying logistic regression on history of smoking and keeping non-smokers in reference category it was seen that there was 13% more chance of defaulting in smokers and 55% less chance of defaulting in past smokers as compared to non-smokers.

Table 21: Risk of defaulting from treatment according to their history of consumption of alcohol by applying logistic regression

History of Consumption of Alcohol	Defaulter	Non Defaulter	Odds Ratio	Confidence Interval (95%)		p-value
				Lower limit	Upper limit	
Non Alcoholic	181	1735	Reference	-	-	-
Current Alcoholic	7	30	8.674	4.459	16.873	**< .001**

By using logistic regression and keeping non alcoholics as reference group it was observed that current alcoholics had more than eight times of defaulting as compared to non-alcoholics.

Table 22: Risk of defaulting from treatment according to the attitude of health care worker towards the patients by applying logistic regression

Attitude of HCW	Defaulter	Non Defaulter	Odds Ratio	Confidence Interval (95%)		p-value
				Lower limit	Upper limit	
Non Supportive	18	44	4.306	2.432	7.612	**< .001**
Supportive	170	1778	Reference	-	-	-

On applying logistic regression to know the risk of default among TB patients by the attitude of health care worker providing ATT and keeping supportive attitude as reference category, study revealed that risk of default was four times more in the non-supportive group.

Table 23: Risk of defaulting from treatment according to the knowledge of the patients regarding the disease by applying logistic regression

Attitude of Patient	Defaulter	Non Defaulter	Odds Ratio	Confidence Interval (95%)		p-value
				Lower limit	Upper limit	
TB is curable						
Yes	184	1810	Reference	-	-	-
No	4	12	3.279	1.046	10.270	**0.041**
Illness of TB should be kept secret						
Yes	72	374	2.403	1.753	3.292	**0.001**
No	116	1448	Reference	-	-	-
Patient needed permission from anyone in family to go to DOTS centre						
Yes	38	412	.867	.597	1.258	0.452
No	150	1410	Reference	-	-	-

By applying binary logistic regression, on the knowledge of patients regarding the disease, following results were observed:

By keeping yes as reference category for the response whether TB is curable or not, it was seen that patients who responded by telling no had almost three times more risk of default from the treatment as compared to patients who responded yes, TB is curable.

On keeping the illness of TB secret, people who were favour for keeping it as secret had twice the risk of default from treatment as compared to patients who responded by answering ‘no’ to the question.

Patients who needed permission from any family members had 14% less chance of default from the treatment as compared to people who needed permission.

Table 24: Risk of defaulting from treatment according to the history of treatment interruption by applying logistic regression

History of treatment interruption	Defaulter	Non Defaulter	Odds Ratio	Confidence Interval (95%)		p-value
				Lower limit	Upper limit	
Yes	131	431	7.417	5.336	10.309	**.001**
No	57	1391	Reference	-	-	-

In table – 24, logistic regression was applied on the history of treatment interruption, by keeping patients who didn't have any treatment interruption history in reference category it was observed that people who had a positive history for treatment interruption had seven times more risk of becoming a defaulter.

Table 25: Reasons for default

Reasons*	Frequency (n = 188)	Percentage (%)
Personal Reasons		
Work is getting affected	145	77.1
Non-compliant attitude	116	61.7
Advice by someone	64	34.0
Financial constraints	61	32.4
Permission to go to DOTS centre	34	18.9
Smoked during the treatment	29	15.43
Migration/Travelling	8	4.3
Consumed alcohol during the treatment	7	3.72
Treatment related		
Lack of faith in treatment	124	66
Tired of alternate day treatment	117	62.2
Didn't know the duration of treatment	62	33
Took medicines empty stomach	13	6.9
Side effects	112	59.57
Gastritis	103	54.8
Joint pain	61	32.4
Red colour urine	37	19.7
Symptomatic relief after taking ATT for	67	35.6
< 1 month	9	13.43
1 -2 month	20	29.85
2 - 3 month	34	50.75
>3 month	4	5.97

* Multiple responses

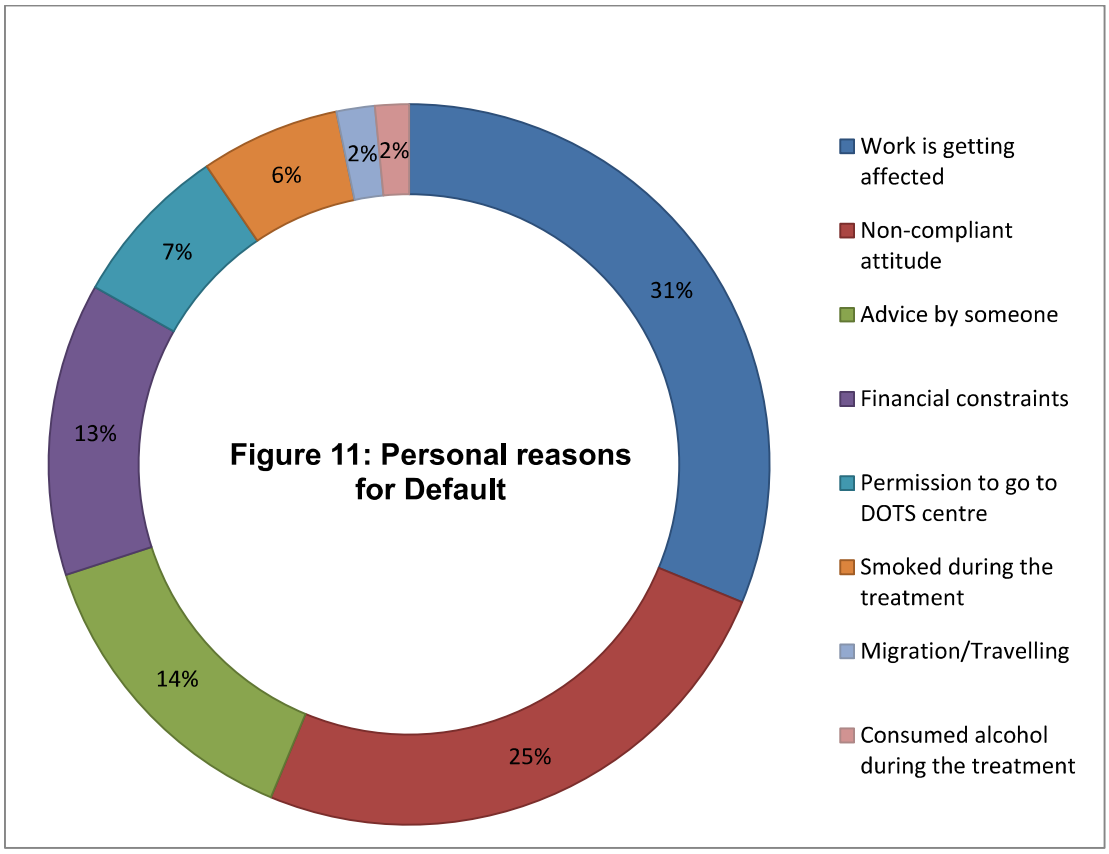


Figure 11: Personal reasons for Default

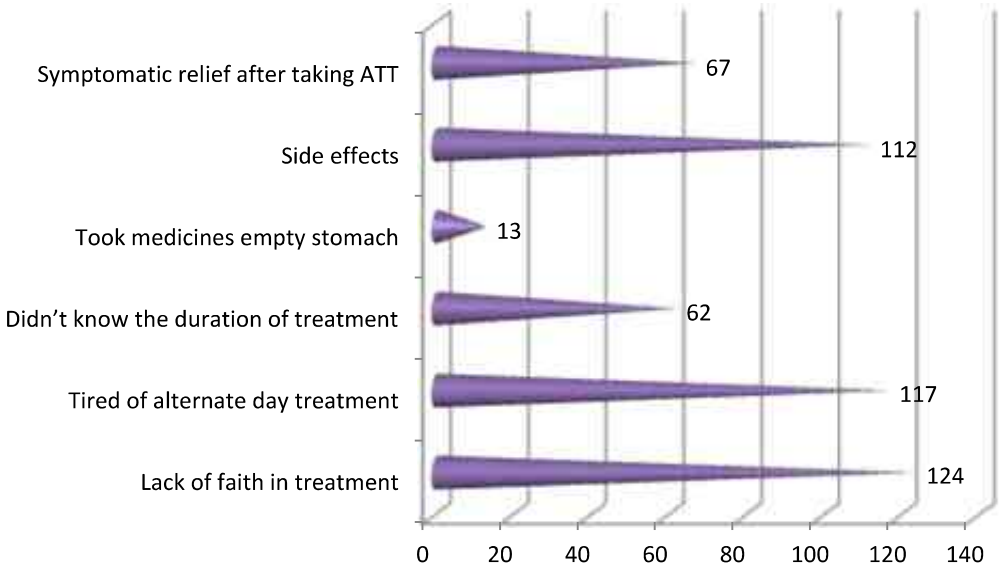


Figure 12: Treatment related reasons for Default

In table – 25, reasons for default were asked by the TB patients who became defaulters. Reasons given by them were classified into personal and treatment related reasons for default.

In personal reasons (Figure 11), maximum defaulters (77.1%) revealed that they left treatment because their work is getting affected, while 61.7% had non-compliant attitude, 34% left treatment because of advice by family members and friends that there is no benefit in taking treatment for such a long time, 32.4% gave reasons of financial constraints, 18.9% needed permission from any family members to go to DOTS centre, 15.43% smoked during their treatment, 4.3% were travelling during the treatment period and 3.72% were consuming alcohol during the treatment.

In treatment related reasons (Figure 12), 124 (66%) defaulters had lack of faith in treatment, 62.2% were tired of coming to DOTS centre for taking drug alternate day, 33% of defaulters didn't knew the duration of treatment. side effects were reported by 112 (59.57%) patients in which most common side effect was seen is gastritis (54.8%) followed by joint pain and red colour urine in 32.4% and 19.7% respectively. Symptomatic relief was seen in 67 (35.6%) cases, in which most of the patient (50.75%) reported relief from symptoms after taking treatment for 2 – 3 months, followed by treatment of 1 – 2 month in 20 (29.85%) defaulters, 9 (13.43%) in less than 1 month of treatment and only 4 (5.97%) had symptomatic relief after taking treatment for more than 3 months.

6. DISCUSSION

The present study entitled "**Study of default and it's determinants amongst TB patients under RNTCP in Bareilly district of UP**" was planned to find out the prevalence of defaulters, understand the factors for default among TB patients undergoing DOTS in district Bareilly, and how to improve the capacity of the RNTCP programme to find and recover defaulters for treatment.

The discussion of the study is been covered under the following headings:

6.1 Socio-demographic characteristics of the TB cases

6.2 Clinical symptoms and treatment seeking behaviour of the TB cases

6.3 Medical illness and Personal history of the TB cases

6.4 Prevalence of Default among the study participants

6.5 Timing and Reasons for Default by defaulters

6.1 Socio-demographic characteristics of the TB cases:

There were total 2010 TB cases interviewed in the present study. Nearly one fourth of the TB cases i.e. 489 (24.3%) were from the age group less than 20 years of age.

The findings of this study are similar to the findings of **Sumer C et al (2012)**[65] where most of the TB patients were in the age group of 16 – 24 years (26.95%). Whereas study done by **Roy N et al (2011)**[50] the 27.84% of study population was in age group of 25 – 35 years.

In the present study out of 2010 TB patients, 1119 (55.7%) of the study participants were male, 1050 (52.2%) of urban area, 1123 (55.9%) Hindu by religion and 1403 (69.8%) OBC by caste, and 1358 (67.6%) were married,

The above finding is similar to **Verma AK et al (2007)**[56] where out of 130 participants 55.8% were male. And in the study conducted by **Gupta S et al (2007)**[43] 45.77% of patients were residents of Urban area and 145 (72.14%) were married. Whereas study done by **Varshney AM et al (2010)**[54] 74% of the study participants were Hindu by religion.

In the present study it was noticed that 365 (18.2%) cases were illiterate, 769 (38.3%) were unskilled worker, 514 (25.6%) were housewives and 777 (38.7%) were from nuclear family. Nearly two-third of the TB cases i.e. 1318 (65.6%) belonged to Class IV socioeconomic status according to Modified B.G. Prasad Classification April 2016.

The findings of this study are similar to the findings of **Sarpal SSS et al (2011)**[51] where 73 (13.4%) patients were illiterates and 109 (20%) were housewives. On the contrary, **Varshney AM et al (2010)**[54] study shows that 55% were unskilled workers and 69% having monthly income less than Rs 2500.

6.2 Clinical symptoms and treatment seeking behaviour of the TB cases:

In the present study most common presenting symptom was cough reported by 1687 (83.93%) of the study participants followed by fever in 1608 (80%) of the study participants and 655 (32.59%) cases had complaints of weight loss. In 2010 TB cases, 765 (38.1%) cases took their first symptomatic treatment from private practitioner; Suspicion of TB was aroused by Doctor in 1465 (72.9%) cases; most of the cases i.e. was diagnosed TB in DOTS centre and almost all the TB patients i.e. 1890 (94%) started their treatment within two weeks after

getting diagnosed for TB while only 562 (28%) gave a history of treatment of interruption.

The findings of this study is similar to the findings of **Varshney AM et al (2010)**[54] in which 72% of the study participants had cough, 69% of the participants presented with fever and 24% of the participants had loss of weight. It also reported that 52% of the study participants had first time consulted private practitioner for their illness and 48% from Government physician.

Sudha G et al[73] in their study highlighted that private health care facilities were the first and preferred point of contact for 57% of urban and 48% of rural participants. Chest symptomatic opted for self-medication in urban and rural 33% and 21% respectively. More than half i.e. 57% of urban chest symptomatic consulted more than one health care provider during the course of their illness. Unaffordability was the commonest reason given for shifting from Private to Government facility, while the main reasons given for switching from a government to a private facility were dissatisfaction with the services and the location of the health facility being far from their residence.

Grover A et al[70] found that many of the chronic chest symptomatic persisted with home remedies / self-medication for some period of time before switching over to a health care provider. 33% had contacted a health care provider on their own and 66% were persuaded by their relatives or neighbours / friends. Nearly one-third i.e. 30% cases had changed the health care provider agencies 3 to 10 times. No relief from symptoms or recurrence of symptoms was the major factor in changing the health care agency in 55.6% of cases,

other reasons were transfer of doctor, referral by the doctor (13.6%), lack of money (7.4%), long distance from place of residence (2.5%) and attitude of the doctor (5.9%).

Suganthi P et al[74] in their study in Bangalore slums found that 72% first approached private health facilities. Most (87%) of the cases visited two or more facilities before initiating treatment. The choice of first health facility depended primarily on distance from residence and faith in the health care services. Predominant reasons for subsequent visits to other health facilities were persistence of symptoms and referral.

Nair D et al[71] in their study noted that, during the first two months of symptoms most patients either did nothing or took home remedies. When symptoms continued, private practitioners were the first source of allopathic treatment. They were generally unable to correctly diagnose the disease. Respondents shifted to Government and NGO health services when private treatment became unaffordable. Majority i.e. 80% of the respondents had visited private medical practitioner during the course of their illness. Government facilities were not preferred initially because of fixed days of service, inconvenient and fixed timings, and lack of personal attention by the staff.

In the study by **Rajeshwari R et al**[72] 98% presented with a complaint of cough of more than 2 weeks duration. Patients first consulted private practitioners more frequently than government providers (54% vs. 27%; $p<0.001$). Most patients resorted to self-medication (61%) or pharmacies (7%).Only 20% were diagnosed at the health facility where thy first sought care;

the others shopped around for care at various health facilities before a diagnosis of tuberculosis was made. Nearly half of all the patients had to visit three or more health facility before a diagnosis of tuberculosis was made. No significant gender or residential influence observed in care seeking pattern.

6.3 Medical illness and Personal history of the TB cases:

In the present study, 529 (26.3%) study participants had history of contact with TB patients, 540 (26.9%) were having diabetes, 516 (25.7%) were having history of smoking and 94 (4.7%) were having history of alcohol consumption.

Similar findings were seen in different studies, in the study done by **Gupta S et al (2007)**[43], 58 (28.86%) of the patients had a positive history of contact with TB patients, 56.03% were current smokers, 49.25% had a history of alcohol intake and 4.48% had diabetes.

In **Bhardwaj AK et al (2011)**[37] study 56.9% and 54.4% of the study participants reported alcohol consumption and smoking at the time of the interview.

Chaddha SL et al (1998)[38] study showed that two third of the male patient were regular smokers, 40% had history of contact with TB patients and diabetes was present in 3% of the study participants.

In **Katiyar SK et al (2005)**[48] study, about 50% of the cases had the history of smoking for more than 1 year and 20% had history of alcohol intake while study done by **Verma AK et al (2007)**[56] reported 30.5% cases having history of close contact with known case of pulmonary TB and prevalence of diabetes mellitus among patients taking treatment at DOT centre was 3.3%.

6.4 Prevalence of Default among the study participants:

In the present study overall prevalence of default in the study subjects was found to be 9.35%. Default rate in Category I and II cases were found to be 8.08% and 15.59% respectively, while default rate in Pulmonary TB cases and Extra-pulmonary TB cases came out to be 10.54% and 2.89% respectively. Default rate in sputum smear positive cases was 9.80 but in sputum smear negative cases it was 13.95%.

Almost similar type of prevalence is reported in the **Annual RNTCP report (2016)**[7] in which prevalence of default in new smear positive cases is 6% and 5% in Uttar Pradesh and India. Default rate in new smear negative is 7% and 6% in Uttar Pradesh and India while in new extra pulmonary cases default rate is 3% both in Uttar Pradesh and India. In retreatment cases i.e. Category II cases default rate in relapse was 12% and 10% in Uttar Pradesh and India, in failure cases it was 14% and 13% in Uttar Pradesh and India while in treatment after default it was 14% and 16% in Uttar Pradesh and India respectively.

Roy N et al (2011)[50] conducted a study in Darjeeling in which default rates were 6% among new smear positive cases; 7% among new smear negative cases; 4% among new extra pulmonary cases; 11% among relapse cases; 15% among treatment failure cases and 23% among treatment after default case respectively.

Vasudevan K et al (2011)[55] also reported a prevalence of default rate of 5.9% and 13.7% in Category I and II cases in Puducherry.

Verma AK et al (2007)[56] conducted a study in Kanpur in which default rate came out to be 8.1%, 18%, 15%, 5%, 10%, and 14.3% in new smear positive, new smear negative, new extra pulmonary, retreatment, relapse, treatment after default and treatment failure respectively.

Jha UM et al (2006)[46] reported default rate of 7% and 15.3% in new and re-treatment cases in India.

Vijay S et al (2006)[59] conducted a study in which default rate came out to be 6.4% of India.

6.5 Timing and Reasons for Default by defaulters:

In the present study maximum cases i.e. 57 (30.32%) cases defaulted from their treatment between 2 -3 month of their treatment, followed by 51 (27.13%) cases defaulted in less than one month of treatment duration, 35 (18.62%) cases in 1 – 2 month of treatment duration, 32 (17.02%) cases in 3 – 4 months of their treatment duration and 13 (6.91%) cases defaulted after completing the treatment of 4 months.

In **Gupta S et al (2007)**[43]study, 72% patients had interrupted treatment by the end of third month; and maximum (30.28%) interruptions were found to occur between second and third months.

In **Jaggarajamma K et al (2006)**[44] study, 53 of 74 (72%) smear positive patients from CAT-I had defaulted during intensive phase of treatment (IP). Most of the defaults occurred between 18-24 doses of the treatment (at the end of the IP).

Jha UM et al (2006)[46] conducted study, the median duration of treatment prior to default was 81 days (inter-quartile range 44–117 days). Of 1,141 defaulters, 720 (63%) defaulted within 90 days of treatment, prior to completion of 36 doses in IP; another 281 (25%) patients defaulted after completion of IP but before starting CP, and 140 (12%) patients defaulted during CP.

Roy N et al (2011)[50] conducted a study in which about 75% of the default occurred in the intensive phase i.e., within 0–2 months (34% between 0 and 1 month and 41% between 1 and 2 months, respectively); rest 25% default occurred within 2–4 months (20% between 2 and 3 months and 5% between 3 and 4 months, respectively).

Santha T et al (2000)[15] conducted a study, 127 (19%) patients who defaulted from treatment, 76% did so by the end of the intensive phase; the median duration from the onset of treatment to default was 66 days.

Satti SBR et al (2015)[52] conducted a study in which most of the patients (23.3%) defaulted from treatment during the second month, 22.5% defaulted in the first month, and 17.5% defaulted in the third month of treatment, followed by 14.2% in the fourth month, 12.5% in the fifth, and 10% in the sixth month.

Vasudevan K et al (2011)[55] study showed that maximum default is seen in the second month of treatment in category I, i.e., 1.5%; and in fourth month of treatment in category II, i.e. 5.8%.

In the study by **Chatterjee P et al**[69], comparative evaluation of factors and reasons for defaulting in tuberculosis treatment in the states of West

Bengal, Jharkhand and Arunachal Pradesh was assessed, the timing of defaulting was similar in all the institutions starting at the third month increasing up to fourth month & declining subsequently, 3rd month 27, 40 29.5, 33 % respectively, 4th month 32, 40, 33.5 % respectively, 5th month 23.0, 20.0, 13.5 % and only in TB centre Roing it was 67.0 % in 5th & 6th months.

In the present study, reasons for default were classified into personal and treatment related reasons for default. In personal reasons, majority of the defaulters (77.1%) revealed that they left treatment because their work is getting affected, while 61.7% had non-compliant attitude, 34% left treatment because of advice by family members and friends that there is no benefit in taking treatment for such a long time, 32.4% gave reasons of financial constraints, 18.9% didn't get permission from family members to go to DOTS centre and 4.3% were travelling during the treatment period.

In treatment related reasons, most of the defaulters (66%) had lack of faith in treatment, 62.2% were tired of coming to DOTS centre for taking drug alternate day, 33% of defaulters didn't knew the duration of treatment. side effects were reported by 112 (59.57%) patients in which most common Total 59.57% defaulters reported side effects due to ATT, in which the most common side effect presented as gastritis (54.8%) followed by joint pain and red colour urine in 32.4% and 19.7% respectively.

Symptomatic relief was seen in 67 (35.6%) cases, in which majority of the patient (50.75%) reported relief from symptoms after taking treatment for 2–3 months, followed by treatment of 1–2 month in 20 (29.85%) defaulters, 9

(13.43%) in less than 1 month of treatment and only 4 (5.97%) had symptomatic relief after taking treatment for more than 3 months.

Gopi PG et al (2005)[41] reported the reasons given by the patients of community survey for initial default included (i) unwillingness (refusal or not interested) for initiation of treatment; (ii) symptoms too mild to warrant treatment followed by (iii) too sick/old; and (iv) work related problems. More men than women were unwilling for the initiation of treatment. The reasons (multiple) for default given by the patients of health facility were (i) personal problems like loss of wages, social engagements etc; (ii) dissatisfaction with health services; and (iii) disease related problems like felt better or too sick. Reasons reported by males were mostly personal and health service problems.

In **Gorityala SB et al**[42] study, the most common reason for the treatment interruptions were felt well with TB treatment (29.53%) followed by side effects (16.06%), lack of money (8.29%), workload (7.25%), alcohol (7.25%), did not feel well with treatment (6.73%) etc.

In **Gupta S et al (2007)**[43] study, the most common reason stated was a feeling of early improvement (30.05%), followed by high cost of treatment (16.39%) and ATT-induced side effects (12.84%). Among the various ATT-induced side effects (n=47), the most commonly reported side effect was nausea and vomiting (53.19%), followed by restlessness (14.89%), next being ATT-induced skin rash (n=6), drug-induced hepatitis (n=5); hearing loss (n=2), nephrotoxicity (n=1) and seizures (n=1). Fifty-nine (16.12%) patients cited other reasons to be responsible for their treatment interruption. Other reasons being

lack of faith in treatment (n=10); DOTS – related (n=27); and personal or family reasons (n=22).

In **Jaggarajamma K et al (2006)**[45] study reasons for default given by the patients were: drug related problems like nausea, vomiting, giddiness 59 (42%), migration 41 (29%), relief from symptoms 28 (20%), work related problems 21 (15%), consumption of alcohol 21 (15%), treatment from other private or public health facility 19 (13%), domestic problems 11 (8%), stigma 4 (2%), too ill to attend 6 (4%). Old age, other illnesses, inconvenient DOT and dissatisfaction with treatment centre and DOT provider were included as other reasons given by 22 (16%) patients. Majority of patients gave multiple reasons for default.

Jha UM et al (2006)[46] study the most commonly cited reasons were migration 246 (21.6%), refusal 177 (15.5%), treatment from private sector 101 (8.9%), side effects 110 (9.6%), substance abuse 24 (2.1%), and others (social, HIV, pregnancy) 77 (6.7%).

In **Katiyar SK et al (2005)**[48] study the most important causes of interruption were the lack of relief of symptoms (37%), intolerance/toxicity (17%), inability to come for drug administration during intensive phase due to loss of earning and poor general condition (15%) and migration (14%). Another important factor was non-willingness to come thrice weekly for the drug administration (9%) during the intensive phase.

Kulkarni PY et al (2012)[49] conducted a study in which majority of the patients (27 out of 40) left the treatment because they started to feel better. Thirteen out of these 40 patients knew that duration of treatment was only 2 months and all were non-adherent at completion of IP. 19.2% non-adherence

was due to forgetfulness of patients to go to DOTS clinic and take medicine. Other 19.2% non-adherence was due to timing at occupational site of the worker.

Roy N et al (2011)[50] conducted a study in which most commonly cited reasons for default were alcohol consumption (29.1%), adverse effects of anti-TB drugs (25.32%), long distance of DOT centre from residence (21.52%), temporary vocational migration (12.66%), poor patient provider interaction (6.33%), and social stigma (5.06%).

Verma AK et al (2007)[51] conducted a study in which majority of patients who interrupted the treatment [51 (89.5%)] attributed a "feel good sensation" as the prime cause. 45% patients lost faith in treatment; adverse effects were responsible in 31.6% cases; and 35.1% patients defaulted treatment because they were moving out of their place of domicile.

In the study by **Chatterjee P et al**[29] reasons for default included distance from treatment 36.5 %, due to improvement in their condition 24.5 %, lack of motivation 15 %, intolerance to drugs 9 % and temporary illness 9 %.

7. CONCLUSION

In spite of patients being treated under RNTCP there have been cases of default. Default is one of the unfavourable outcomes of ATT. It is one of the most important contributory factors for drug resistance, treatment failures, relapses, deaths and prolonged infectiousness.

- In the present study the default rate came out to be 9.35% among TB patients registered under RNTCP in district Bareilly, Uttar Pradesh.
- Default rate in Category I and II cases were found to be 8.08% and 15.59% respectively.
- Default rate in sputum smear positive cases was 9.80 but in sputum smear negative cases it was 13.95%.
- Default burden was more i.e. 12.4% in the age group of 20 – 29 years, 11.9% in urban residents, 10.95% in cases of Hindu by religion and 20.97% in scheduled caste.
- It was interesting to note that defaulters were more in cases having high school (13.33%) and intermediate (12.83%) level of education.
- Chi Square test shows significant association for high default rate was seen in cases that were associated with history of any chronic respiratory disease (15.25%), smokers (10.98%), alcoholics (18.92%) and treatment interruptions (23.3%).
- Logistic Regression revealed that chances of defaulting from treatment was more in PTB (four times as compared to EPTB), current smokers (13% as compared to non-smokers), current alcoholics (8.6 times as compared to

non-alcoholics) and cases having history of treatment interruption (7.4 times as compared to those giving no history of treatment interruption).

- Maximum cases i.e. 57 (30.32%) defaulted from their treatment between 2 - 3 month of their treatment
- Reasons for default were classified into personal and treatment related reasons. In personal reasons, majority of the defaulters i.e. 145 (77.1%) revealed that they left treatment because their work was getting affected, while 116 (61.7%) had non-compliant attitude, 64 (34%) left treatment because of advice by family members and friends that there is no benefit in taking treatment for such a long time, 61 (32.4%) gave reasons of financial constraints, 34 (18.9%) didn't get permission from family members to go to DOTS centre and 8 (4.3%) were travelling during the treatment period.
- In treatment related reasons, most of the defaulters i.e. 124 (66%) had lack of faith in treatment, 117 (62.2%) were tired of coming to DOTS centre for taking drug alternate day, 62 (33%) of defaulters didn't knew the duration of treatment.
- Total 112 (59.57%) defaulters reported side effects due to ATT, in which the most common side effect presented as gastritis in 103 (54.8%) cases followed by joint pain and red colour urine in 61 (32.4%) and 37 (19.7%) respectively.
- Symptomatic relief after taking the ATT was seen in 67 (35.6%) cases, in which maximum patients (50.75%) reported relief from symptoms after taking treatment for 2–3 months, followed by treatment of 1–2 months in 20 (29.85%), 9 (13.43%) in less than 1 month of treatment and only 4 (5.97%) had symptomatic relief after taking treatment for more than 3 months.

8. SUMMARY

TB is an infectious disease caused predominantly by Mycobacterium tuberculosis. It spreads from one person to another; it has a devastating impact on the economic wellbeing of individual, their families and the entire community

To combat TB, Government of India had launched NTP in 1962 which evolved as RNTCP in 1992 to overcome the lacunae of NTP. RNTCP adopted DOTS for the treatment of TB.

Default is one of the unfavourable outcomes for patients on DOTS and represents an important challenge for the control program.

Defaulter is a patient who has not taken anti-TB drugs for 2 months or more consecutively after starting treatment.

The present study was undertaken with the objective to find out the prevalence of defaulters, understand the factors for default among TB patients undergoing DOTS in district Bareilly and recommend the measures to improve the compliance among TB patients.

- In the present cross-sectional study, total 2010 TB patients were interviewed, in which maximum number i.e. 489 (24.3%) of the study subjects belonged to the age group of less than 20 years, 1119 (55.7%) were male, 1050 (55.9%) were from urban population, Hindu by religion 1123 (55.9%), OBC caste 1403 (69.8%), married 1358 (67.6%), educated up to primary class 704 (35%), unskilled worker 769 (38.3%) and 777 (38.7%) were from nuclear family.

- More than three fourth (83.1%) of the cases were taking treatment of category I while the rest (16.9%) of cases were undergoing treatment of category II.
- Multiple responses were told on asking about the presenting symptoms of the patient. Most of cases i.e.1687 (83.93%) reported that they had persistent cough followed by fever in 1608 (80.0%) cases, breathlessness in 744 (37.01%) cases, weight loss in 655 (32.59%) cases, loss of appetite 460 (22.89%) cases, chest pain 163 (8.11%) and blood in sputum was reported in 125 (6.22%) cases.
- Almost one third of the cases (38.1%) took their first symptomatic treatment from private practitioners followed by hospitals (32.6%). The suspicion of TB was raised on the suggestion by doctor in 1465 (72.9%) cases. More than one third of the cases (40.2%) got their TB diagnosed at DOTS centre.
- Most of the study participants 1481 (73.7%) had no history of contact with any TB patients.
- In the present study regarding history of chronic diseases, the history of DM, chronic respiratory disease and history of HIV has only been taken. Almost one fourth (26.9%) cases had diabetes, 400 (19.9%) cases had a history of chronic respiratory disease, 13 (0.6%) had HIV while 1057 (52.6%) cases had none of the above mentioned medical illnesses.
- Almost three fourth (74.3%) cases were non-smoker and most of the cases (95.3%) were non-alcoholic in the present study.
- Maximum patients (95.92%) considered TB as a serious disease, while 97.21% knew that TB is curable and 22.19% wanted to keep illness of TB as a secret.

- The overall prevalence of defaulters in the present study was found to be 9.35%. Default rates in Category I and II cases were found to be 8.08% and 15.59% respectively.
- Highest default rate (12.40%) was seen in age group of 20 – 29 years of age group.
- In the present study male cases (10.37%) had a little higher default rate as compared to female cases (8.08%). In urban population default rate was 11.9% but in rural population it was low 6.56%.
- By religion default rate in cases Hindu was 10.95% and Muslim was 7.33%; and by caste it was highest in OBC caste 20.97% followed by general caste 13.04% and other backward classes 7.05%.
- In the present study the default rate in married and unmarried cases were almost same i.e. 9.20% and 9.66% respectively.
- Patients with high school level of education had the highest level of default rate (13.33%). A high default rate (19.05%) was seen among skilled workers. Cases belonging to socio-economic class III had a high default rate of 12.54%.
- Prevalence of default was highest in patients who belonged to joint family (10.70%) followed by patients belonging to nuclear family (9.65%) and three generation family (6.80%).
- In the present study, default rate (15.55%) was seen in patients who had a medical history of chronic respiratory disease. Cases that had no history of any chronic respiratory disease, diabetes or HIV showed a default rate of 9.74%.

- Cases who smoked during treatment had a high default rate of 10.98% while current alcoholic had a default rate of 18.92%. Patients having history of treatment interruption showed a default rate of 23.3% while who didn't have a history of treatment interruption had a default rate of 3.93%.
- By applying Chi Square test, significant association of default was seen with age, gender, place of residence, religion, caste, education, occupation, socio economic status, site of involvement in TB, smear status of the patient, category of treatment undergoing in DOTS, history of medical illness, smoking, alcohol and treatment interruption.
- By Logistic Regression, the strength of association of default was seen more in 20 – 29 years of age group, urban resident cases, Hindu cases, SC caste, joint family, sputum smear negative cases, pulmonary TB cases, having a history of chronic respiratory disease, current smokers, current alcoholics, patients having history of treatment of interruption and patients belonging to category II in DOTS.
- In the present study, maximum number of defaulters i.e. 57 (30.32%) defaulted after taking treatment for 2 – 3 months.
- Multiple responses were given by the defaulters on asking for the reasons for default. Out of 188 defaulters, in personal reasons, the common reasons for defaulting were that their work was getting affected by 145 (77.1%) followed by non-compliant attitude in 116 (61.7%).
- In treatment related reasons, 124 (66%) had lack of faith in treatment, 117 (62.2%) were tired of alternate day treatment of DOTS, side effects were the reasons for defaulting was given by 112 (59.57%) and defaulting because of symptomatic relief was reported by 67 (35.6%) cases.

9. Recommendations

- A positive attitude and moral support from family members can help in maintaining compliance for ATT which otherwise is usually stopped once symptoms disappear or some side effects appear after initiating the drug therapy for a short period.
- Health education on TB and its treatment is most crucial which has profound influence on treatment seeking behaviour and compliance to treatment. The patients along with the family members must be provided with adequate information regarding tuberculosis.
- Periodic monitoring of the DOT providers by the health staff is important to minimize default.
- Factors related to non-compliance to ATT needs to be looked into thoroughly as on many occasions patient find it hard to make a decision regarding to choose between receiving ATT drugs from DOTS provider or to go to their job because of fixed timing of some of the health facilities providing DOTS services.
- The medical staff and community health workers should encourage and motivate the patients to complete the treatment.
- Provision of free supportive medicines to manage the side effects caused by drugs used in ATT.

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11. Annexures

Annexure 1

Proforma – I

Questionnaire for "Study of Default and its Determinants amongst Tuberculosis Patients registered under RNTCP in Bareilly District"

Date: _____ **Respondent No:** _____

Information Given By:

1. Name:
2. Father's/Husband's name:
3. Address:_____
   _____
4. Locality: Urban/Rural
5. DMC Name:_____
6. Registration No._____
7. Age: _____years
8. Gender: Male / Female
9. Religion:_____
   a. Hindu b. Muslim c. Others
10. Caste:_____
    a. General b. OBC c. SC
11. Marital status:
    a. Married b. Unmarried c. Widowed/Divorcee
12. Education:_____
    a. Illiterate d. Middle school g. Graduate
    b. Able to read e. High school h. Post Graduate
    c. Primary f. Intermediate
13. Occupation:_____
    a. Professional c. Unskilled worker e. Student
    b. Skilled worker d. Housewife f. Unemployed
14. Monthly Family Income : Rs_____
15. Total number of family members : _____
16. Per capita Income: Rs_____
17. Socio-economic status :_____ (Revised BG Prasad Classification)
18. Type of Family :
    a. Nuclear b. Joint c. Three generation

19. Category I / II / IV (_____)

20. Smear status + / - ve / Unknown

21. Type of T.B. Pulmonary / Extra-Pulmonary

22. Symptoms

a. Cough > 2 weeks
b. Breathlessness
c. Fever
d. Chest pain
e. Loss of appetite
f. Weight loss
g. Blood in sputum
h. Other

23. From where the first symptomatic treatment taken

a. Chemist
b. Local Quacks
c. Private Practitioner
d. DOTS
e. Hospital
f. Others(specify

24. How the suspicion of TB was raised

a. Self-perception
b. Effect of media
c. Effect of awareness campaign
d. Suggested by peer group
e. Suggested by health worker
f. Suggested by doctor

25. Place where the TB was diagnosed

a. Private clinic
b. Govt. Health centre
c. DOTS centre
d. Others(specify)

26. Time taken for starting of treatment after the diagnosis of TB? a. < 2 weeks b. ≥ 2 weeks

27. Any interruption in treatment? a. Yes b. No

28. Any history of contact with any TB patients

a. No
b. Family members
c. Friends
d. Neighbours
e. Colleague's
f. Others(Specify)

29. History of any associated chronic illness

a. Diabetes
b. HIV
c. Any chronic respiratory disease
d. Other(Specify)

30. Do you Smoke?

a. Current smoker
b. Past smoker
c. Non smoker

31. Do you drink Alcohol?

a. Current alcoholic
b. Past alcoholic
c. Non alcoholic

32. Did HCW motivate you to take complete course of treatment? a. Yes b. No

33. TB is a serious disease? a. Yes b. No

34. TB is curable? a. Yes b. No

35. TB cases should keep their illness a secret? a. Yes b. No

36. Do you need permission from anyone in the family to access DOTS centre? a. Yes b. No

Proforma – II Reasons for Default by defaulters

Name: _____ **Respondent No:** _____

1. **Personal reasons**
   i. Smoked during treatment
   ii. Consumed alcohol during treatment
   iii. Financial constraints
   iv. Migration/Travelling
   v. Non-Compliant attitude
   vi. Work is getting affected
   vii. Advice by someone that no benefit will happen with this treatment

2. **Treatment related**

a. Do you know the approximated duration of treatment?

b. Lack of faith in treatment?

c. Tired of having alternate/daily drug consumption

d. Adverse reactions

   1. Gastritis
   2. Red colour urine
   3. Rashes
   4. Joint pain
   5. Others(specify)

f. Irregular supply of drugs

g. Symptomatic relief after taking ATT

   i. Yes ii. No

   If yes, then after how many days of treatment: _____

h. No improvement or deteriotion in health or symptoms

i. Medicines/ blister packs given to take home during intensive phase?

j. Have to wait for long time in DOTS centre for taking medicines?

k. Too much time taken to travel between your house and DOTS centre

l. Unusual timings of DOTS centre for giving medications

3. **After how many days you stopped taking treatment?** _____

For Category II patients

How many times you have discontinued the treatment in past & after how much time?

_____
_____
_____

Annexure 2 - Operational Definitions

- **Case of TB**: A TB case is defined as
    i. A bacteriologically confirmed TB case is one from whom a biological specimen is positive by smear microscopy, culture or WRD (such as Xpert MTB/RIF). All such cases should be notified, regardless of whether TB treatment has started.
    ii. A clinically diagnosed TB case is one who does not fulfil the criteria for bacteriological confirmation but has been diagnosed with active TB by a clinician or other medical practitioner who has decided to give the patient a full course of TB treatment. This definition includes cases diagnosed on the basis of X-ray abnormalities or suggestive histology and extrapulmonary cases without laboratory confirmation.
- **New or Category I Patients**: Patients who have never been treated for TB or have taken anti-TB drugs for less than 1 month.
- **Old Case or Category II or Previously treated patients**: Patients who received 1 month or more of anti-TB drugs in the past.
- **Defaulter or Lost to follow-up**: A TB patient who did not start treatment or whose treatment was interrupted for 2 consecutive months or more.
- **Pulmonary tuberculosis (PTB)**: refers to any bacteriologically confirmed or clinically diagnosed case of TB involving the lung parenchyma or the tracheobronchial tree. Miliary TB is classified as PTB because there are lesions in the lungs.

  A patient with both pulmonary and extra pulmonary TB should be classified as a case of PTB.

- **Extra pulmonary tuberculosis (EPTB):** refers to any bacteriologically confirmed or clinically diagnosed case of TB involving organs other than the lungs, e.g. pleura, lymph nodes, abdomen, genitourinary tract, skin, joints and bones, meninges.
- **Smear Positive PTB**: A patient with one or two smears being positive for AFB out of the two sputum specimens subjected for smear examination by direct microscopy is diagnosed as having smear positive PTB.
- **Smear Negative PTB**: A patient with symptoms suggestive of TB with two smear examination negative for AFB, with evidence of pulmonary TB by microbiological methods (culture positive or by other approved molecular methods) or Chest X-ray is classified as having smear negative PTB.
- **Current Smoker**: A person who is smoking for more than 6 months.
- **Non Smoker**: A person who has never smoked.
- **Past Smoker**: A person who has stopped smoking for more than 6 months.
- **Current Alcoholic**: A person who is drinking alcohol for more than 6 months.
- **Non Alcoholic**: A person who has never consumed alcohol
- **Past Alcoholic**: A person who has stopped drinking alcohol for more than 6 months.

Annexure 3 – List of DMCs selected for the study

S.No	DMC Name
1	Bharei
2	Bhojipura
3	District T.B. centre
4	District hospital
5	Jagatpur
6	Kareli
7	Mental hospital
8	Military hospital
9	Railway hospital
10	Shri Ram Murti Medical College

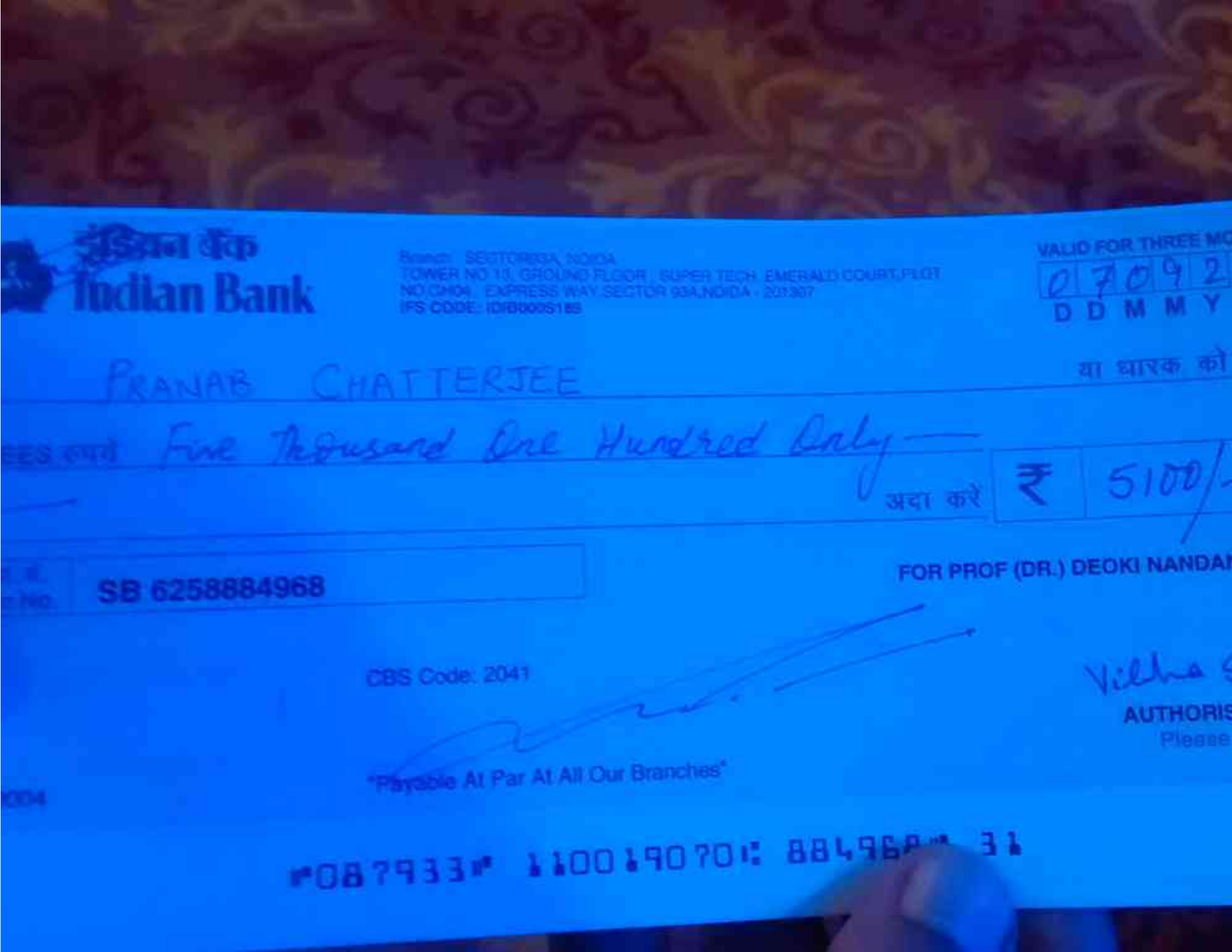
Annexure 4 – Modified B.G. Prasad Social Classification

Derivation of modified B.G. Prasad classification: Prasad's classification (1961) based on the per capita monthly income has been widely in use in India. It is computed as:

Per capita monthly income = Total monthly income of the family/Total members of family.

The advantage with Prasad's classification is that it takes into consideration only the income as a variable and it is simple to calculate. B.G. Prasad gave social classification in the year 1961, the value of which after multiplying with Multiplication Factor (M.F.) 4.93 (based on All India Consumer Price Index 1980) gives the applicable value in 1980. In the next stage, this value is further multiplied by M.F. of 1255 (based on AICPI April 2016, base year 1980) the obtained grand M.F. is 0.0493x1255 = 61.86 Approx. By applying M.F. of 61.86 to B.G. Prasad income criteria given in year 1960 will give the applicable income criteria in April 2016, the year of our study. According to modified B.G. Prasad classification, applicable in April 2016, based on AICPI, the derived M.F. 61.86 the income strata so derived for various social class as follows:

Social Class	**Per capita income per month**	
	1960	**April 2016**
	No M.F.	**M.F. = 61.86**
Class I (upper)	Rs ≥ 100	Rs ≥ 6186
Class II (upper middle)	Rs 50 -99	Rs 3093 – 6185
Class III (middle)	Rs 30 -49	Rs 1856 – 3092
Class IV (upper lower)	Rs 15 – 29	Rs 925 – 1855
Class V (lower)	Rs < 15	Rs < 927



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TO

(LATE) PROF. V. P. SHROTRIYA

LIFE MEMBERSHIP NO: L-0078

This award was conferred on 15th Oct' 2016 during XIXth Annual Conference of IAPSM UPUK State Chapter at SRMS Medical College, Bareilly.

Dr. Manish Singh
President

Dr. Khursheed Muzammil
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LIFE TIME ACHIEVEMENT AWARD – 2016

TO

PROF. ZULFIA KHAN

LIFE MEMBERSHIP NO: L-0534

This award was conferred on 15th Oct' 2016 during XIXth Annual Conference of IAPSM UPUK State Chapter at SRMS Medical College, Bareilly.

Dr. Manish Singh
President

Dr. Khursheed Muzammil
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IN THE SPECIALITY OF COMMUNITY MEDICINE
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PROF. B. G. PRASAD ORATION AWARD – 2016

TO

PROF. VINOD K. SRIVASTAVA

LIFE MEMBERSHIP NO: L-0181

Head of the Department, HIMS, Barabanki.

This Oration was delivered on 15th Oct' 2016 during XIXth
Annual Conference of IAPSM UPUK State Chapter
at SRMS Medical College, Bareilly. Subject of this Oration was –

" Infancy to Childhood-Care for Survival & Beyond"

Dr. Manish Singh
President

Khursheed

Dr. Khursheed Muzammil
Secretary

Reforms in Medical Education

National Consultative Meet

on

Defining Norms for RHTC and UHTC of Medical Colleges

at

King George's Medical University, Lucknow, UP

12- 14 October, 2016

Convenors:

Indian Association of Preventive & Social Medicine

King George's Medical University, Lucknow

National Health Systems Resource Centre

National Consultative Meet

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Defining Norms for RHTC and UHTC of Medical Colleges

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12- 14 October, 2016

Draft Document

1. **Preamble:**

   RHTC and UHC are integral part of department of Community Medicine of a medical college and provide learning opportunity to medical students, interns and postgraduates. The MCI documents provide a working guideline for its functioning but do not clearly define its organizational infrastructure and functioning. The Assessment Form used by the Assessors during MCI inspection, focuses on a number of parameters which do not go with the ongoing activities and causes lot of problem to the college and may even become cause of de-recognition.

2. **Need for consultation/Background:**

   Lack of clarity in guidelines for physical establishment of RHTC/UHC

   Lack of clarity in relationship between RHTC and PHC

   Lack of clarity in the services to be delivered – Clinic Vs Family care

   Lack of clarity on quantum of work load of the RHTC/UHC Vs staff available

   Lack of clarity in the prescribed qualifications of paramedical staff

   Lack of clarity in the prescribed services Vs data being recorded in the Assessment Form

   Lack of clarity on the residential requirement of Staff/students/Interns/PGs at RHTC/UHC

   Lack of clarity as how to avoid overlap of preventive services being delivered by RHTC/UHC Vs Health staff of State Govt.

   Lack of clarity on need of 3 PHCs to be adopted as RHTC is only at one PHC

   Lack of clarity on the ownership of RHTC/UHC

   Lack of clarity in area/population to be covered

3. **Objectives:**

To review the existing MCI guidelines

To review the existing set up of RHTC/UHC in various colleges and their functioning

To review the need for 3 PHCs

To review the justification of the information being collected by Assessors.

To debate on the areas lacking clarity, and

To come out with realistic recommendations on establishment of infrastructure, staff and functioning of RHTC/UHTC.

4. **Members of the Consultative Group:**

Chairperson:

Vice Chancellor, KGMU

Members:

IAPSM Governing Council/ Other Members
MCI Representatives
MCI Assessor
Ministry of Health & Family Welfare, Govt. of India
NHSRC- representative
State Health/ Medical Education Officials
Representatives from Govt. & Private Medical Colleges
All India Institute of Hygiene & Public Health, Kolkata
All India Institute of Medical Sciences, New Delhi
Select HODs of Community Medicine/ Deans of Medical Colleges in India

Convenors:

1. Indian Association of Preventive & Social Medicine – National Body through its UP/UK Chapter
2. King George's Medical University, Lucknow
3. National Health Systems Resource Centre

Local Organizing Committee Members:

Dr VK Srivastava, Past President, IAPSM & Prof. & Head, Comm. Med., HIMS
Dr Uday Mohan, Past Vice President & Professor of SPM, KGMU
Dr Ajit Sahai, Consultant (Research), KGMU
Dr. K Muzammil, Secretary, UP/UK- IAPSM
Dr. SK Singh, Professor, SPM, KGMU

5. **Background Documents:**

Standard requirements for the setting up of College/ Dept. of Community Medicine

Requirements as prescribed in LOP/Renewal of colleges

MCI guidelines on functioning

MCI Standard Assessment Forms – UG/PG

Paper publication by Dr Pradeep Kumar, Gujrat

6. **Group Work:**

7. **Presentations by the groups and Discussion:**

8. **Preparing a Report on the Recommendations:**

The recommendations of this Consultative Meet will be drafted and subsequently shared by the members of the group to make it final and to be submitted to the Govt. of India/MCI for approval and adaptation. The NHSRC will help in drafting of the minutes of the meeting and getting it printed.

9. **Budgetary requirement:**

The organizers will provide local hospitality viz. stay arrangement, food, local transportation, venue etc. for all the participants. The organizers will also bear the travel expenses of participants other than the Central/State Govt. officials. It is suggested that the Midterm meeting of the Governing Council of IAPSM may be convened at Lucknow along with this meeting so that their travel cost is covered in it.