

PLS NOTE:

- Objective of this document: discussion the parts of MCQs and provide reference for updating the knowledge of physicians and medical students.
- The Questions Discussed here are on recall bases and do not intend to testify the examination or its contents.
- The question stem and options may have been altered for confidentiality and the explanations are indicative of the topics in the question.
- For any queries, please feel free to mail me at mukhmohit.psmsimplified@gmail.com

**What is the Numerator in perinatal mortality rate?**

- a. Still birth more than 500 grams
- b. Still births after 28 weeks
- c. Post neonatal death < 2500 grams
- d. neonatal deaths up till 28 days

Ans: B.

reference:

1. Chapter: Preventive Pediatrics, Conceptual review of PSM 2ed (pb 2019).
2. Parks textbook of PSM, 25<sup>th</sup> Edn. Pg 618

**Perinatal Mortality Rate (PNMR)**

Perinatal mortality includes *late foetal deaths, live births* and *early neonatal deaths* with:

- Minimum birthweight of 1000 g (equivalent to 28 weeks of gestation) - Preferred criterion
- If the birthweight is not available, a gestational age of at least 28 weeks
- If both birthweight and gestational age are not available, body length (crown to heel) of at least 35 cm.

Formula for perinatal mortality rate:

$$\text{Perinatal mortality rate} = \frac{\text{late foetal deaths (28 weeks gestation or more)} + \text{early neonatal deaths (within 7 days of life) in one year}}{\text{live births} + \text{late foetal deaths}}$$

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Note: there is a difference in the denominator (and NOT in numerator) for developed countries and that given by WHO (more for countries with less established vital recording systems) The WHO definition, which suits the less developed recording systems, takes into account ONLY Live births in the denominator

**Assertion: Typhoid vaccine is used in endemic areas in disaster management**

**Reasoning: Vaccine is cost-effective way to deal with disease prevention in endemic area**

- a. Both Assertion and Reasons are independently true / correct statements and the Reason is the correct explanation for the Assertion
- b. Both Assertion and Reasons are independently true / correct statements, but the Reason is not the correct explanation for the Assertion
- c. Assertion is independently a true / correct statement, but the Reasons is independently a false / incorrect statement
- d. Assertion is independently a false / incorrect statement, but the Reasons is independently a true / correct statement
- e. Both Assertion and Reasons are independently false / incorrect statements

Ans: D.

Assertion is independently a false / incorrect statement, but the Reasons is independently a true / correct statement

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Reference:

1. Park Pg 260, 25<sup>th</sup> edn
2. Communicable disease, Conceptual review of PSM, 2<sup>nd</sup> Edn.

Typhoid vaccine features:

- Complementary approach to prevention, with highest benefit for money spent
- Decrease incidence and seriousness of infection
- Special recommendation for high risk cases as:
  - people in endemic areas
  - household contacts
  - groups at risk of infection school children or hospital staff
  - travelers to endemic zones, large religious gatherings

Two types of vaccine are available:

- Vi (capsular) polysaccharide
  - after age of 2 years
  - dose – 25 microgram, single dose is required, which provides effective immunity after 7 days of injection
  - revaccination is required every 3 years
- Ty21a (oral, live) vaccine

**A and R**

**Assertion: Malathion used in dengue control as anti-adult in ULV fogging**

**Reasoning: Malathion has residual effect as an insecticide**

- Both Assertion and Reasons are independently true / correct statements and the Reason is the correct explanation for the Assertion
- Both Assertion and Reasons are independently true / correct statements, but the Reason is not the correct explanation for the Assertion
- Assertion is independently a true / correct statement, but the Reasons is independently a false / incorrect statement
- Assertion is independently a false / incorrect statement, but the Reasons is independently a true / correct statement
- Both Assertion and Reasons are independently false / incorrect statements

Correct ans. Option A. (Revised)

Both Assertion and Reasons are independently true / correct statements and the Reason is the correct explanation for the Assertion

Source:

Park, Pg 833, 25<sup>th</sup> edn

[https://www.who.int/water\\_sanitation\\_health/resources/vector357to384.pdf](https://www.who.int/water_sanitation_health/resources/vector357to384.pdf)

ULV Fogging is ultra-low volume fogging. Most extensively used insecticides are malathion and fenitrothion

Most residual sprays are – DDT, lindane, Malathion, OMS 33  
widely used space spray is Pyrethrum or pyrethrum extracts / pyrethroids

**Malathion**

This has become one of the most commonly used residual insecticides, following the development of resistance to DDT in many countries. It is classified as slightly hazardous. The absorption of particles by spray workers through inhalation, ingestion or contact with the skin reduces the activity of the enzyme cholinesterase in the nervous tissue. Signs of severe poisoning are muscle twitching and weakness followed by fits and convulsions. Spray personnel should not work with malathion for more than five hours a day, nor for more than five days a week. If the insecticide is stored for long periods in hot areas, impurities may develop which make the product more toxic to humans. Malathion is the least expensive organophosphorus insecticide and the safest when manufactured according to WHO specifications. It is commonly used as a residual spray in the control of malaria and Chagas disease. Acceptability to house owners is sometimes a problem because of its unpleasant smell.

*Commonly available formulations:* 50% water-dispersible powder and 50% emulsifiable concentrate.

*Dosage:* 1 or 2 g/m<sup>2</sup>.

*Residual effectiveness:* at the higher dose it may last up to six months on thatch or wood but only 1–3 months on mud and plaster surfaces. Mud surfaces with a high alkali content (minerals) tend to break down the malathion most rapidly.

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**Assertion: lead poisoning produces eosinophilia**

**Reason: Lead inhibits ALA dehydratase in heme synthesis**

- a. Both Assertion and Reasons are independently true / correct statements and the Reason is the correct explanation for the Assertion
- b. Both Assertion and Reasons are independently true / correct statements, but the Reason is not the correct explanation for the Assertion
- c. Assertion is independently a true / correct statement, but the Reasons is independently a false / incorrect statement
- d. Assertion is independently a false / incorrect statement, but the Reasons is independently a true / correct statement
- e. Both Assertion and Reasons are independently false / incorrect statements

Ans: Option D.

Assertion is independently a false / incorrect statement, but the Reasons is independently a true / correct statement

Lead inhibits TWO enzymes:

- a. ferrochelatase
- b. ALA dehydratase

Hence: protoporphyrin and ALA levels may be raised in lead toxicity – Plumbism

Laboratory: Lead toxicity causes a hypochromic microcytic anemia and basophilic stippling of red blood cells. Lead is a surface-acting poison and may produce increased RBC fragility and acute hemolytic anemia. Lead toxicity is not known to lead to eosinophilia.

multiple options correct:

**Causes of Death may be assessed by**

- a. Medical death certificate
- b. Census
- c. Death reporting
- d. SRS

- (1) If a, b, c are correct
- (2) If a and c are correct
- (3) If b and d are correct
- (4) If all four (a, b, c, & d) are correct

Ans. 2. If a and c are correct

Causes of death are assessed by:

1. Verbal autopsy – using death reporting and review of causes
2. RHIME (routine, representative, re-sampled household interview of mortality with medical evaluation) has helped enhance the quality of information on the causes of death
3. Death certificate

In the above MCQ, considering option C, death reporting may be regarded as method for evaluation of cause of death because, it is involved in verbal autopsy.

\*Note: SRS (sample registration system) provides reliable estimates for the MMR, CBR, IMR... and some reports may also mention RHIME for understanding causes of maternal mortality (which is through an indirect activity and hence, we do not mark SRS in the MCQ stated above)

**Match the following with color coded bins:**

Waste material	Color coded bins
1) Expired medicine	a. Red
2) Catheter	b. yellow
3) Discarded lab report form	c. blue
4) Antibiotic bottle	d. green
	e. black

Ans.

1 – B

2 – a

3 – e

4 – c

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A lot of discussion is already done on this... for more information – pls visit our Youtube channel - [https://youtu.be/JEk91L3gg\\_k](https://youtu.be/JEk91L3gg_k) or visit the FB discussion forum – Mukhmohit's community and medicine Discussions.

**A study is to be designed to understand the correct technique for injection by a health care professional. The best way to assess will be:**

- a. In depth interview with the patient
- b. using CCTV
- c. In depth interview with the health care professional
- d. questionnaire based with checklist

Ans: D

Option	Discussion
In depth interview with the patient	Not a very good modality, as the patient may be biased towards health care professional or maybe influenced by subjective feeling towards injection process
Using CCTV	Not very good, as costly, and not proper visualization. maybe subjective to positioning and environmental factors
In depth interview with the health care professional	Not reliable
Questionnaire based with checklist	Better method for analysis of technique or atleast may also have a small element of influencing the HCP towards proper technique and its evaluation process as well

HCP = health care professional

**Which of the following is not true about influenza?**

- a. Virus shedding is present before symptoms begins
- b. Secondary attack rate is 5-15%
- c. Aquatic birds act as reservoir
- d. 1-5 years is the highest risk group

Ans. D. 1-5 years is the highest risk group

Ref: Park Pg 170, 25<sup>th</sup> Edn.

OPTION	DISCUSSION
Virus shedding is present before symptoms begins	Yes, the period of infectivity is from 1-2 days before and 1-2 days after onset of symptoms  PSM Simplified By Dr Mukhmohit <a href="http://www.mukhmohit.com">www.mukhmohit.com</a>
Secondary attack rate is 5-15%	Yes, Park Textbook: the attack rates are 5-10 % for adults and 20-30% for children Other sources: Source: WHO influenza review of literature... <a href="https://www.who.int/influenza/preparedness/pandemic/PIRM_update_052017.pdf">https://www.who.int/influenza/preparedness/pandemic/PIRM_update_052017.pdf</a> <a href="https://academic.oup.com/cid/article/50/11/1462/505636">https://academic.oup.com/cid/article/50/11/1462/505636</a>  Keeping in view different review of literature... the attack rates are 5-10 % for adults and 20-30% for children. some studies have shown low attack rates of 5% and maximum even upto 70%. so this option may or may not be true... but is NOT the false one...!
Aquatic birds act as reservoir	Major reservoirs are animals and birds, especially the aquatic birds... (source WHO Fact sheet on Influenza)  PSM Simplified By Dr Mukhmohit <a href="http://www.mukhmohit.com">www.mukhmohit.com</a>
1-5 years is the highest risk group	No, influenza affects all age groups and gender. certain high-risk groups are there which includes infants and children under 18 months (or under 2 years) Source: 1. NICD, influenza guidelines, April 2018, 2. <a href="https://www.cdc.gov/flu/highrisk/index.htm">https://www.cdc.gov/flu/highrisk/index.htm</a>

So, technically speaking, the High-risk groups for severe influenza infection are:

- 1. Infants and young children < 2 years
- 2. Pregnant females
- 3. Persons with preexisting COPD
- 4. Persons with preexisting cardiac disease
- 5. Persons with preexisting metabolic syndrome and/or morbid obesity
- 6. Persons with preexisting renal, liver, neurological or immunosuppressive disease
- 7. Children receiving chronic aspirin therapy
- 8. Person age > 65 years

This is a doubtful MCQ... keeping in view the given options... 1-5 years is the best possible answer.

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*simplest one...*

**Pneumococcal vaccine will be most beneficial for which of the following groups:**

- a. Cystic fibrosis patient
- b. Sickle cell anemia
- c. Recurrent otitis and sinusitis
- d. Child less than 2 years

Ans. B.

Ref: Park Pg. 186, 25<sup>th</sup> Edn.

Indications of PPV are:

- Chronic cardiac disease
- Chronic lung disease and/or liver kidney
- Sickle cell disease
- Post splenectomy
- DM, alcoholism, malignancy, organ transplants (immune-suppressive condition)

#### **In-detail indications for PPV**

The Advisory committee on immunization practices (ACIP) and WHO recommendations are:

1. PPV 23 is NOT recommended for healthy adults age 19-64 years
2. PPV23 is recommended for:
  - a. Chronic heart disease, such as heart failure and cardiomyopathy (excluding hypertension alone)
  - b. Chronic lung disease, such as asthma and chronic obstructive pulmonary disease
  - c. Chronic liver disease
  - d. Poorly controlled diabetes mellitus
  - e. Current cigarette smoking
  - f. Alcohol use disorder
3. Chronic renal disease – probably because of hypogammaglobulinemia at are thus at increased risk of invasive pneumococcal disease, esp. people suffering from protein loosing nephropathies, nephrotic syndrome.
4. Persons at risk of meningitis – Vaccination with both PCV13 and PPSV23 is indicated for individuals who are at increased risk of meningitis as:
  - i. due to structural abnormalities that allow communication with the subarachnoid space – CSF leaks or cochlear implant placements
  - ii. who have previously had pneumococcal meningitis
5. Impaired splenic function:
  - a. Anatomic asplenia or congenital hyposplenism
  - b. Sickle cell disease or other hemoglobinopathy
  - c. Functional asplenia or hyposplenism
6. Immuno-suppressive state:
  - a. HIV infection, organ transplant, immunodeficiency syndrome
  - b. generalized malignancy or hematologic malignancy
7. On case to case basis for age > 65 years

**A 5-year-old boy presents to emergency with bleeding wound from bite of his pet dog which was fully vaccinated. He previously had complete anti rabies immunization on December 2018. The next course of management is:**

- A. No ARV required
- B. Single site 2 doses - days 0 and 3
- C. Single site 4 doses – 0,3,7,28 days
- D. RIG and 4 dose regime

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Ans. option B – 2 doses 0,3 with wound washing...[www.mukhmohit.com](http://www.mukhmohit.com)

Now, In this MCQ, the Options and the MCQ statement may have some element of recall error, but anyways, lets learn the concept using the above recalled options only.

On review of literature, a few previous guidelines do mention as NO PEP required, if the dog is properly vaccinated and the efficacy of the vaccine is confirmed by laboratory evidence... but the recent WHO 2018 position does not have a mention on the same.

**Basically the previous immunization status of animal should not necessarily be the deciding factor for ARV in India... This information is particularly true where pet animal laws are strictly adhered and regulated as in developed countries.**

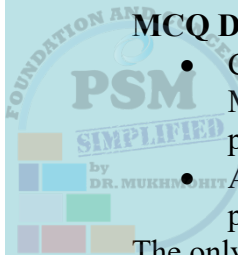
This is a point of discussion as far as Indian settings is concerned..

In my personal perception: **The main factor for consideration is the case fatality rate of rabies and risk involved on the background of knowledge of sporadic rabies cases (and some areas as rabies endemic) in our country.**

#### MCQ Discussion:

- Considering 2 chances of animal bites within 5 years of age of child (as mentioned in MCQ)– is scary..! This animal should be strictly observed and sent for examination if possible. Also search that why this child gets bitten by dogs every now and then...!!
- Although the child has taken immunization last year, and now AGAIN an animal bite practically should give you some reasonable thoughts about giving ARV.

The only reasonable option I would be marking is 0,3 days – Re-Exposure guideline.



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**Dengue hemorrhagic fever discharge criteria is**

- A. After 24 hours fever controlled on paracetamol
- B. After return of appetite
- C. Urine output 200ml/day
- D. 24 hrs after control of shock

Ans. is B.

Reference: National Guidelines for Clinical Management of Dengue Fever, NVBDCP, MoHFW

Criteria for discharge of patients

- Absence of fever for at least 24 hours without the use of anti-fever therapy
- No respiratory distress from pleural effusion or ascites
- Platelet count > 50 000/mm<sup>3</sup>
- Return of appetite
- Good urine output
- Minimum of 2 to 3 days after recovery from shock
- Visible clinical improvement.

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**Indicator for vector burden on humans in malaria is:**

- a. Man biting rate
- b. Inoculation rate
- c. slide positivity rate
- d. human blood index

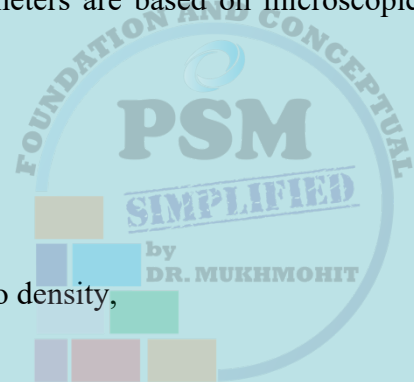
Ans. A.

Vector burden for humans may be denoted by the term – anthrophilism

Human blood index	It is the proportion of freshly fed female Anopheline mosquitoes whose stomach contains human blood. It indicates the degree of anthrophilism
Sporozoite rate	It is the percentage of female anopheles with sporozoites in their salivary glands.
Mosquito density:	It is usually expressed as the number of mosquitoes per man-hour-catch.
Man-biting rate (biting density)	It is defined as the average incidence of anopheline bites per day per person. It is determined by standardized vector cache on human bait.
Inoculation rate:	The man-biting rate multiplied by the infective sporozoite rate is called the inoculation rate.

Remember:

1. **Pre eradication era Malarimetric Indicators** -parameters are based on clinical diagnosis (Spleen Rate, Average enlarged spleen, Parasite rate, Parasite density index, Infant parasite rate and proportional case rate).
2. **Eradication era Malarimetric Indicators** - parameters are based on microscopic diagnosis of malaria
  - a. Annual parasite incidence,
  - b. Annual blood examination rate
  - c. Annual falciparum incidence
  - d. Slide positivity rate
  - e. Slide falciparum rate
3. **Vector Indices** are
  - a. Human blood index, Sporozoite rate, mosquito density,
  - b. man biting rate and inoculation rate



Indicator	High yield Point to remember
Spleen rate	endemicity of malaria in a community
Infant parasite rate	the most sensitive index of recent transmission of malaria in a locality.
Annual parasite incidence	sophisticated measure of malaria incidence and burden of disease in a community.
Annual Blood Examination Rate	index of operational efficiency.
Human Blood Index	indicates the degree of anthrophilism.

**Intensified malaria control under the national framework for malaria elimination is defined as**

- A) States with  $API \geq 1$
- B) Zero incidence of malaria
- C) No longer a health problem
- D) 3 consecutive years no local transmission in the state

Ans. A

the objectives of the national framework for malaria elimination are:

1. by 2022, by all 26 states that were in cat 1,2 in year 2014
  - a. interrupt transmission of malaria
  - b. zero indigenous cases
2. by 2024 → incidence of malaria to be less than 1 per 1000 population in all states in India
3. by 2027 → indigenous transmission to be interrupted in all states in India
4. by 2030 → malaria to be eliminated and re-establishment prevented

Technically the NVBDCP divides the country into 4 categories based on the malaria burden:

Category	Definition	Naming
category 0	Zero indigenous cases of malaria	Prevention of re-establishment phase
category 1	States with $API < 1$ and all districts with $API < 1$	Elimination phase
category 2	States with $API < 1$ and few districts with $API > 1$	Pre-elimination phase
category 3	States with $API \geq 1$	Intensified Control Phase

Option	Discussion
A) States with $API \geq 1$	Yes, this is the technically right definition for intensified malaria control in an area.
B) Zero incidence of malaria	No, the incidence is to be reduced to less than 1/1000 cases by 2024
C) No longer a health problem	This has already been accomplished
D) 3 consecutive years no local transmission in the state	Probably, may be correct, but the criteria of 3 years is not true for malaria control. NVBDCP just provides fixed years for achieving the targets in districts and states in India



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### Hand washing steps (Arrange sequentially)

- Back of hand
- Back of fingers
- Fingernails
- Palm to palm

Sequence – D → A → B → C

refence:

Hand Hygiene: Why, How & When? online resource:

[https://www.who.int/gpsc/5may/Hand\\_Hygiene\\_Why\\_How\\_and\\_When\\_Brochure.pdf](https://www.who.int/gpsc/5may/Hand_Hygiene_Why_How_and_When_Brochure.pdf)

<https://www.cdc.gov/handwashing/when-how-handwashing.html>

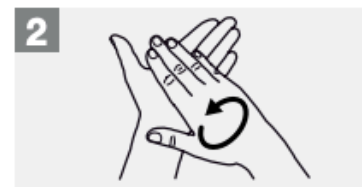
### Duration of the entire procedure: 40-60 seconds



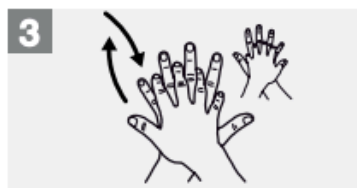
Wet hands with water;



Apply enough soap to cover all hand surfaces;



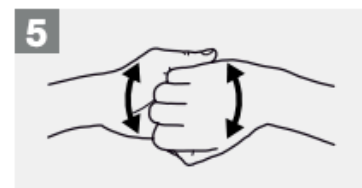
Rub hands palm to palm;



Right palm over left dorsum with interlaced fingers and vice versa;



Palm to palm with fingers interlaced;



Backs of fingers to opposing palms with fingers interlocked;



Rotational rubbing of left thumb clasped in right palm and vice versa;



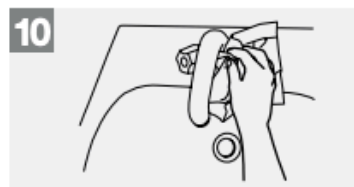
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



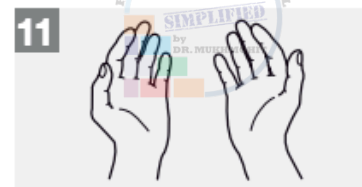
Rinse hands with water;



Dry hands thoroughly with a single use towel;



Use towel to turn off faucet;



Your hands are now safe.

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**Which of the following is not a primary prevention?**

- A. giving pentavalent vaccine to children
- B. health education about hand washing
- C. addition of iron to wheat flour
- D. Ribavirin to close contact of meningitis patient

Ans. B. health education about hand washing

Option	Discussion
A. giving pentavalent vaccine to children	Primary prevention
B. health education about hand washing	Usually primordial prevention
C. addition of iron to wheat flour	Specific protection and primary prevention
D. Ribavirin to close contact of meningitis patient	Chemoprophylaxis and primary prevention

**Which of the following is true regarding new management protocol for Paucibacillary leprosy?**

- e. 2 drug combination for 6 months
- f. 3 drug combination for 6 months
- g. 2 drug combination for 12 months
- h. 3 drug combination for 12 months

Ans. B. 3 Drug combination for 6 months

Reference: Guidelines for the Diagnosis, Treatment and Prevention of Leprosy, WHO 2018

Revised WHO recommended Leprosy treatment regime:

Age group	Drug	Dosage and frequency	Duration	
			MB	PB
Adult	Rifampicin	600 mg once a month	12 months	6 months
	Clofazimine	300 mg once a month and 50 mg daily		
	Dapsone	100 mg daily		
Children (10–14 years)	Rifampicin	450 mg once a month	12 months	6 months
	Clofazimine	150 mg once a month, 50 mg daily		
	Dapsone	50 mg daily		
Children <10 years old or <40 kg	Rifampicin	10 mg/kg once month	12 months	6 months
	Clofazimine	6 mg/kg once a month and 1 mg/kg daily		
	Dapsone	2 mg/kg daily		

*Note: The treatment for children with body weight below 40 kg requires single formulation medications since no MDT combination blister packs are available. For children between 20 and 40 kg, it would be possible to follow the instructions of the Operational Manual, Global Leprosy Strategy 2016–2020 on how to partly use (MB-Child) blister packs for treatment (60).*



**Mass drug administration done for all except**

- A. Filariasis
- B. Worm infestation
- C. Vit A
- D. scabies

Ans. C. Vit A

Ref:

DK de Souza, PC Dorlo. *Safe mass drug administration for neglected tropical diseases*. Lancet, vol 6 (10) ; Oct 2018

[https://www.who.int/lymphatic\\_filariasis/resources/mass\\_drug\\_administration/en/](https://www.who.int/lymphatic_filariasis/resources/mass_drug_administration/en/)

Mass drug administration – is a term used for administration of drug to en-mass to control a particular disease. It is generally given for mass treatment of some disease

Mass drug administration for neglected tropical diseases gained particular prominence in the 1990s. Diseases such as onchocerciasis, lymphatic filariasis, trachoma, schistosomiasis, and soil-transmitted helminths are amenable to mass treatment and control as a result of the availability of safe and affordable drugs. MDA has also been tried for trachoma and scabies in various review of literature.

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Vitamin A prophylaxis is a program by MoHFW for providing specific protection for vit a as cause of blindness in a specified category of 6 m to 59 months age group children in India the Program is being implemented using the ICDS facility and primary health care system of our country.

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