Comparative Study on Primary Health Centers in Rural and Urban Areas of Bhavnagar District in Gujarat

By

Harshita Sharma

Dissertation submitted for the partial fulfillment of the

MBA Hospital and Health Management

Academic year, 2015-2017

The IIHMR University, Jaipur

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INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that Harshita Sharma student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at National Health Mission, Gujarat from 1st February to 5th May, 2017.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

Col. (Dr.) Ashok Kaushik
Dean, Academics and Student Affairs
The IIHMR University, Jaipur

Dr. Sandesh Kumar Sharma
Associate Professor
The IIHMR University, Jaipur

જિલ્લા પંચાયત કચેરી

આરોગ્ય શાખા

મોતીબાગ રોડ, ભાવનગર

ફોન/ફેકસ : ૦૨૭૮-૨૪૨૩૬૬૫/૨૫૨૫૬૭૧ Email : cdho.health.bhavnagar@gmail.com

The certificate is awarded to

Ms. Harshita Sharma

In recognition of having successfully completed her

Internship in the department of

Health (Arogya), District Panchayat, Bhavnagar, Gujarat

She has successfully completed her Project on

Comparative Study on Primary Health Care Centres in Rural and Urban Area of Bhavnagar district in Gujarat

Duration: 1st February 2017 to 5th May 2017

Organization- NATIONAL HEALTH MISSION, GUJARAT

She comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning

We wish her all the best for future endeavours

15/17

Additional District Health Officer

District Panchayat, Bhavnagar

Member Secretary (DUHU)
Additional District Health Office.
Bhavnagar.

4-5-17

Chief District Health Officer

District Panchayat, Bhavnagar

Chief District Health Officer
District Panchayat
BHAVNAGAR.

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled '***A Comparative Study on Primary Health Centers of Rural and urban areas of Bhavnagar district, Gujarat'*** is submitted by ***Harshita Sharma*** Enrollment No. **IIHMR-U/01/2015-17/0283** under the supervision of **Dr. Sandesh Kumar Sharma** for award of MBA in Hospital and Health of the University carried out during the period 1st February to 5th May embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

Harshita

Signature

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that all ethical issues have been considered while collecting data for my dissertation titled ***"Comparative study on Primary Health Centers of urban and rural areas of Bhavnagar district, Gujarat"***

Signature of student

ACKNOWLEDGEMENT

It is a matter of honour for me to express my earnest thanks to all those who have helped me for their expert guidance and cooperation during my work.

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Finally yet importantly, I am very much thankful to CDHO/ADHO Bhavnagar, and all the staff at district and block level for their co-operation, without which my study would not have been possible.

Ms. Harshita Sharma

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INTRODUCTION

Primary Health Centre is the initial level of communication of the folks, the personal and the community with the public health system, which brings well-being as adjacent as conceivable to wherever the communal individuals live and work. The knowledge and apprehension in wellbeing expansion and primary health care in India ages back to the Indus-valley civilization. In the modern time, the basis for primary healthcare for all was laid by the suggestions of Bhore committee in 1946. Later, based on the tender of first unified all round progress programme (the communal development programme) primary health centres were established for every block of the district.

As the time passes many modifications were made in Health system of India after Alma Ata declaration (1978), Primary health care for all and later Millennium development goals (MDG) both Central and state government has started providing health services to the poorest by making health accessible and affordable. Many programmes for the improvement of Health has been launched by Ministry of health and family welfare, government of India (GOI) under National Rural Health Mission which has been initiated in 2005 for the welfare and betterment of the people who remain deprived of the health care related services. Schemes like Rashtriya Swasthya Beema Yojana (RSBY), Yashashvini, Vajaaypee Aarogyashree in Karnataka state, Bhamashah Swasthya Beema Yojana, Rajasthan provides financial people to the people who are not able to pay for the treatment and the diagnostic services at all the health centres both in rural and urban areas. Web based monitoring of all the programs made it easier to evaluate and identify the areas of concern.

After successful launch of NRHM for the improvement of Health in rural areas, the GOI came up with a new mission in 2012 i.e. National urban health mission (NUHM) with the purpose to elevate the health status of Urban poor, vulnerable and under privileged population of the society. Under this setup, Government plans to established PHCs in urban areas.

Under this regard, it become crucial to validate the success of existing health centres especially PHCs as they are the link between CHCs and Sub centres and can be termed as first referral units. As the success of PHCs lies in the utilisation of the services by the people, there is a need of intensive research in this field. And, as government is trying to improve health in urban as well as rural areas via different programs, there is a need to

scrutinize is there any differences in the facilities and services provided by health centres in both the areas.

Further, presented literature deep-rooted that several studies were done in availability and service utilisation of health-related services at national as well as at state levels irrespective of type of health centre. However, very rare studies tried to compare the health care facilities and services between rural and urban areas especially in Indian framework; where inequality between rural and urban is a serious issue in all the fields i.e., in development, infrastructure, human resources, quality parameters, availability of drugs and equipment etc. In this background, the present study tried to compare the facilities and services available in rural and urban PHCs by finding substantial factors.

REVIEW OF LITERATURE

Thimmaih N. et. al (2013) The study depicts that PHCs are first place of connection between local people and the organization. The government is trying to expand the health status of urban as well as rural areas by various programs and schemes. Therefore, it is necessary to determine the factors responsible for strengthening the PHCs so that the health for all is achieve and which leads to the better utilisation of the services by local people. The paper addresses the necessity to determine whether there is any difference in the approachability of PHC services by Urban and rural areas through different programs. Different statistical tests were used in the study. It was found that there is no substantial difference in the availability of PHC services in rural and urban areas.

Anargiros Mariolis et. al. (2008) The study was conducted in Greece. Their objective was to assess points of deviation and conjunction between urban and rural PHCs, to highlight challenges faced by the start-up of UHCs in Greece. The study suggested the noteworthy variances concerning PHC facilities utilisation between an urban and a rural people. Citizens in both the areas has dissimilar fitness desires and motives for selecting a PHCs services.

Duggal (1997) concluded that it is ill-fated that the incidence and prevalence of diseases is high in rural areas as compared to urban areas. The people living in rural areas did not get the proper health services. The people in urban have private facilities whereas people living in rural and tribal areas are deprived of minimum health facilities, and wherever services are provided, they are not accessible. The health amenities in urban are provided by numerous hospitals, dispensaries, private practitioners and voluntary organisations. Even PHCs and CHCs are also available at corporation level.

The Eighth Plan jagged out that not only the rural poor but in huge cities, where about 50 per cent of urban residents live in slums are deprived of services and their health status "is is

pathetic in comparison to rural areas. Further, "The setup for primary health care in urban areas barely exists" (VHAI. 1998). The challenges of urban health are discussed below:

	KEY PUBLIC HEALTH CHALLENGES IN URBAN AREAS	POSSIBLE RESPONSES UNDER THE NATIONAL URBAN HEALTH MISSION
1.	Poor households not knowing where to go to meet health need	The biggest challenge is to connect every household to health facilities. The role of the slum level Community Worker (like the Honorary Health Worker in Kolkata slums) is a possible intervention. The Community Worker becomes the first point of contact for any health need. She has the authority to connect households to health facilities. A health facility or health personnel is responsible for a certain number of households.
2.	Weak and dysfunctional public system of outreach	A detailed review of the existing arrangements to identify the causes for dysfunctional/functional systems. The investments under NUHM could be to provide a responsive public system – service guarantees well defined and well recognized by all.
3.	Contaminated water, poor sanitation.	Work towards a possible public health bill that sets standards for provision of basic entitlements like water and sanitation facilities. Provide resources to communities to ensure action at their end to prevent contamination/ maintain cleanliness. Work with urban local bodies to increase access to functional toilets.
4.	Poor environmental health, poor housing	Work with urban local bodies to set standards for environmental sanitation, set up systems of waste disposal, basic housing systems, etc. Work towards a rights and entitlement based approach though a public health bill.
5.	Unregistered practitioners first point of contact – use of irrational and unethical medical practice	Develop systems of accrediting private not fully qualified practitioners if they do basic specially designed courses for them, which gives them some level of acceptable competence. Make them work under the supervision of government doctors. Special thrust on rational drug use and ethical practice. Making local practitioners do more of preventive and promotive health.

6.	Community organizations helpless in health matters	Establish vibrant community organizations at slum level, under the umbrella of the urban local body, wherever feasible. Co-opt community leaders like members of Self Help Groups, women's groups, etc. Provide untied grants to local community organizations to carry out community led action for public health. JNURM is providing the hardware but in the absence of effective community action, the hardware will be of little sustainable use. Community led action for public health encompassing all the wider determinants of health, is needed. (nutrition, water, sanitation, education, housing, women's empowerment, skill development, etc.).
7.	Weak public health planning capacity in urban local bodies	Re-orient existing staff of urban local bodies to understand public health challenges better.
8	Large private sector but poor cannot access them	Develop systems of accrediting private practitioners for public health goals. These could be for a range of services. Need for transparency in developing protocols, and costs. Community organizations to exercise key role in roll-out of such partnerships. Non Governmental Organizations to build capacity in community organizations to handle such partnerships.
9.	Problems of targeting the poor on the basis of BPL card	Many urban poor households do not have BPL card. How to reach every poor household and provide special entitlements at public costs to them for secondary and tertiary care. It will not be possible to provide free cancer treatment for all. Naturally there is a need for identifying the poor. NUHM to develop criteria for such identification on the basis of a wider understanding of poverty as not only income or nutritional poverty.
10.	No convergence among wider determinants of health	Creating common institutional arrangements to ensure that the same community organization, under the umbrella of urban local body, is responsible for all the wider determinants – water, sanitation, nutrition, health care, education, skill development, housing,

11.	No system of counseling and care for adolescents	Adolescents face multiple problems in urban areas. Need to mobilize local youth for community led public health action. Need to attend to special needs of adolescent girls to make them cope with physiological changes.
12.	Over congested secondary and tertiary facilities and under underutilized primary care facilities.	Need to generate awareness through MAS and community workers in every slum so that people know clearly where the house hold has to be sent. Need based referrals are the only way of decongesting.
13.	Problem of drug abuse and alcoholism	Urban life is demanding and leads to living with stress of all kinds. Problems of drugs and alcoholism, tobacco use, etc. need strong public health interventions.
14.	Many slums not having primary health care facility	Creating new public health infrastructure using community buildings, mobile medical units based on fixed schedules where infrastructure cannot be created.
15.	High incidence of domestic violence	Need for Counselors in Bastis to help in many behavior change and gender relation issues.
16.	Multiplicity of urban local bodies, State government, etc. management of health needs of urban people	Need for clarity of responsibilities for urban health. Setting up of an over-arching urban local body level health mission for convergent action.
17.	No norms for urban health facilities.	Need to develop clear norms for primary health care service guarantees for urban areas.
18.	No concerted campaigns for behavior change	Need for concerted campaigns for behavior change to enforce public health thrust. Problem of malaria, dengue, Chikanguniya in urban areas. Counseling services for well-being of households.
19.	Problems of unauthorized settlements	Developing health care facilities in the framework of law for such areas.

METHODOLOGY

RESEARCH QUESTION

How different is the status of primary health centres in urban as compared to that of rural?

HYPOTHESIS

There's no difference in the facility and services given at PHCs and UHCs.

AIM

The study aims at knowing the status of PHCs and UPHCs in terms of infrastructure, HR, services, availability of equipment and essential drugs, quality parameters and other support services.

OBJECTIVES

1. To compare facilities of PHCs and UPHCs.
2. To compare services of PHCs and UPHCs.

METHODOLOGY

Study Design

Cross sectional observational Study/Descriptive

Study Setting

The study would be conducted in Bhavnagar district of Gujarat. It is the fifth largest city of Gujarat. It is divided into ten blocks : Bhavnagar, Shihor, Umarala, Gariyadhar, Palitana, Mahuva, Talaja, Ghogha and Vallbhipur. There are approximately 800 villages in this district. According to the census 2011 it has a population of 2,388,291, roughly equal to the nation of Jamaica or the US state of Kansas.

Duration of Study

The study would be conducted for a period of 90 days (three months), from February 01, 2017, to May 05 2017, till the completion of the desired sample size.

Sample Size

Urban PHCs: All UHCs were selected Mahuva 1, Mahuva 2, Shihor, Palitana, Gariyadhar and Talaja.

For PHCs: six PHCs will be selected from same block where urban PHCs are located.

Sampling Technique

For selection of UPHCs: All UHCs were selected.

For selection of PHCs: Purposive sampling was used.

S.NO.	PHC	UPHC
1	BELAMPAR	MAHUVA 1
2	GUNDARNA	MAHUVA 2
3	SONGADH	SHIHOR
4	VALUKAD	PALITANA
5	MOTIVAVDI	GARIYADHAR
6	MATHAVADA	TALAJA

Data Collection Instrument

The data would be collected using a checklist and observations made during the field visits.

Data Collection Procedure

Data will be collected by visiting the health centers and checking the records. Also if required interacting with health service providers.

Data Analysis Procedure

The data would be checked for partial/incompletely filled information before analysis. The data would be coded, tabulated and analyzed using Microsoft Excel.

RESULT ANALYSIS

Fig.1 Status of PHCs in terms of Physical Infrastructure (fig in %)

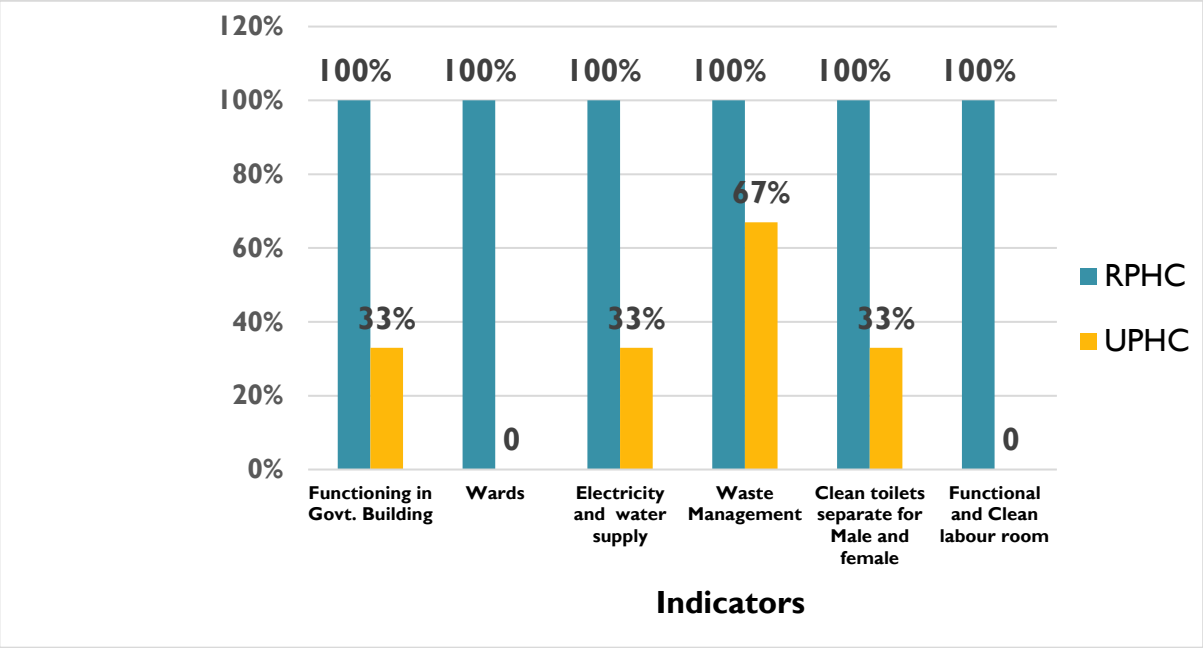


Fig.2 Status of Availability of Human Resources in PHCs and UPHCs (fig in Average number)

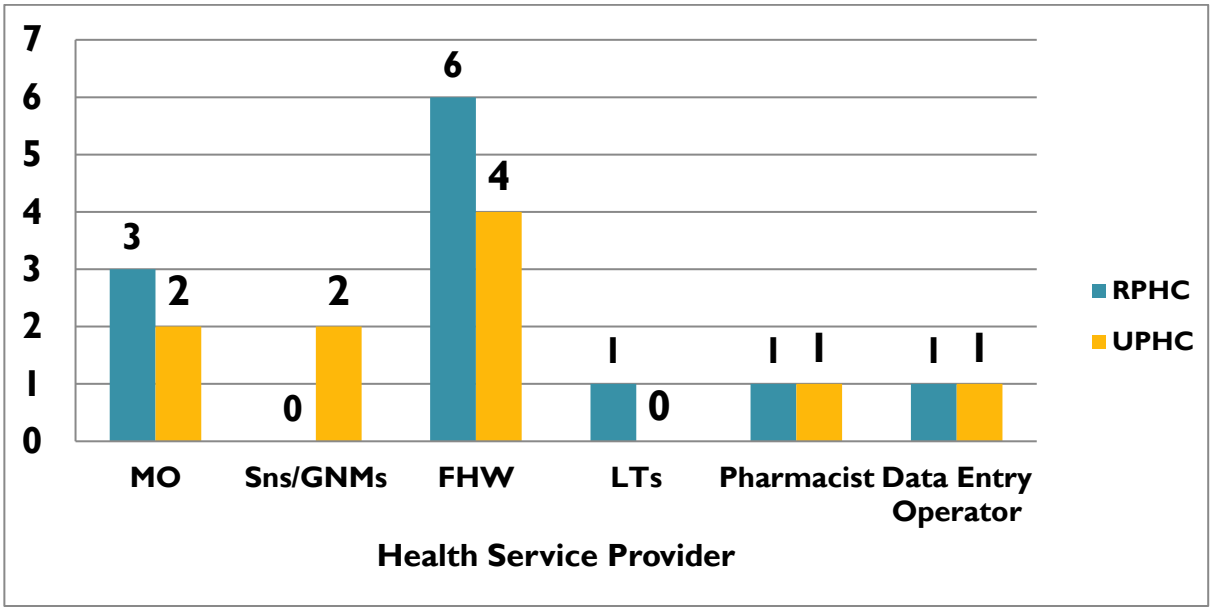


Fig.3 Status of service delivery in health centers (fig in %)

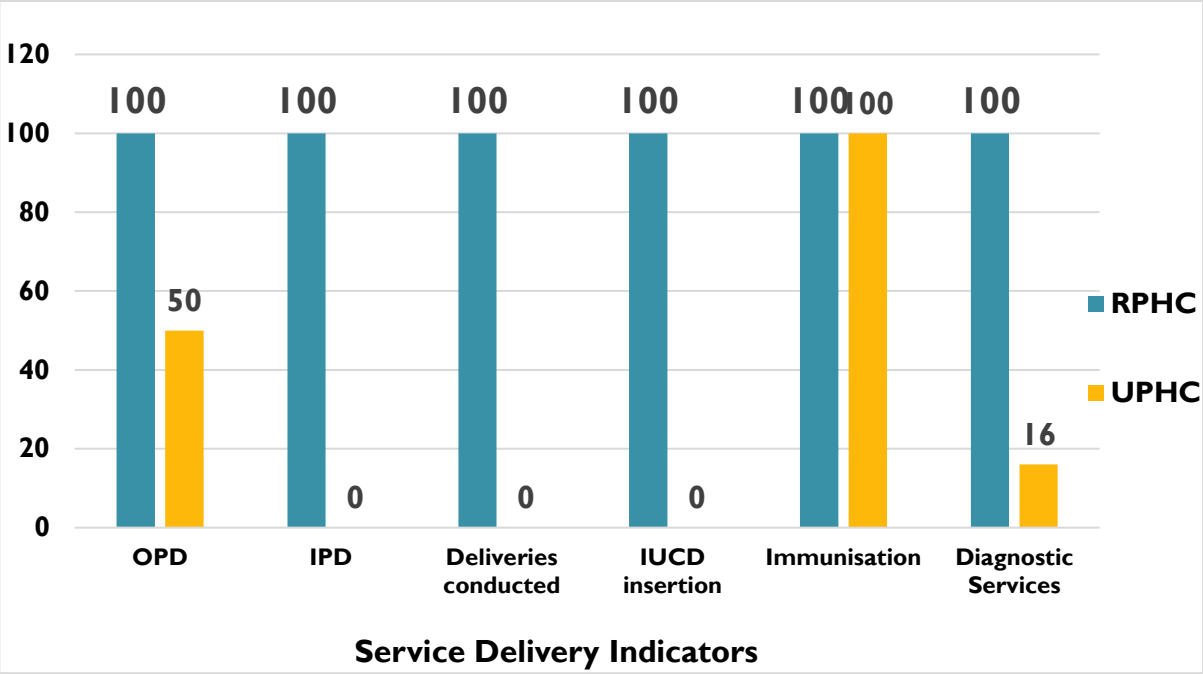


Fig.4 Status of Availability of IEC material(fig in%)

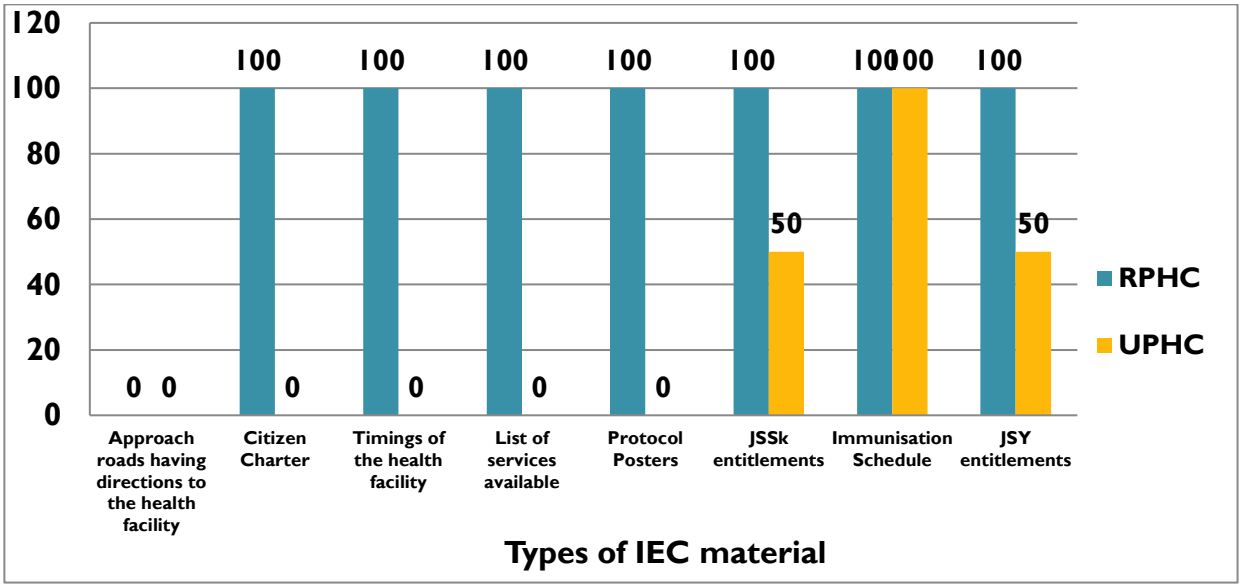


Fig.5 Status of Other support services available at health centers(fig in%)

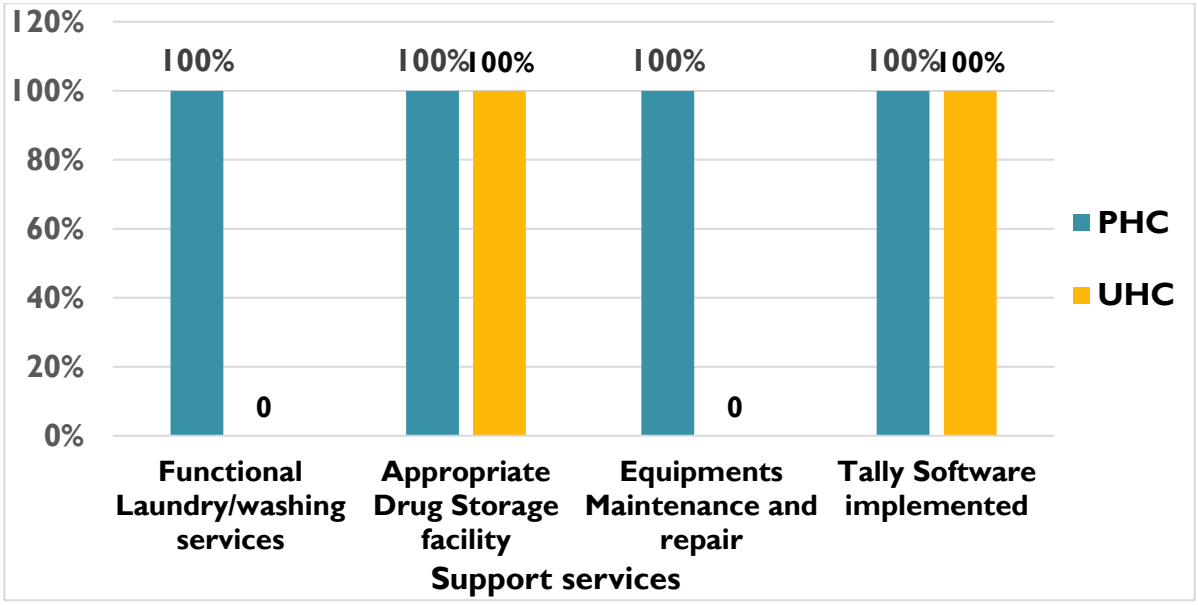
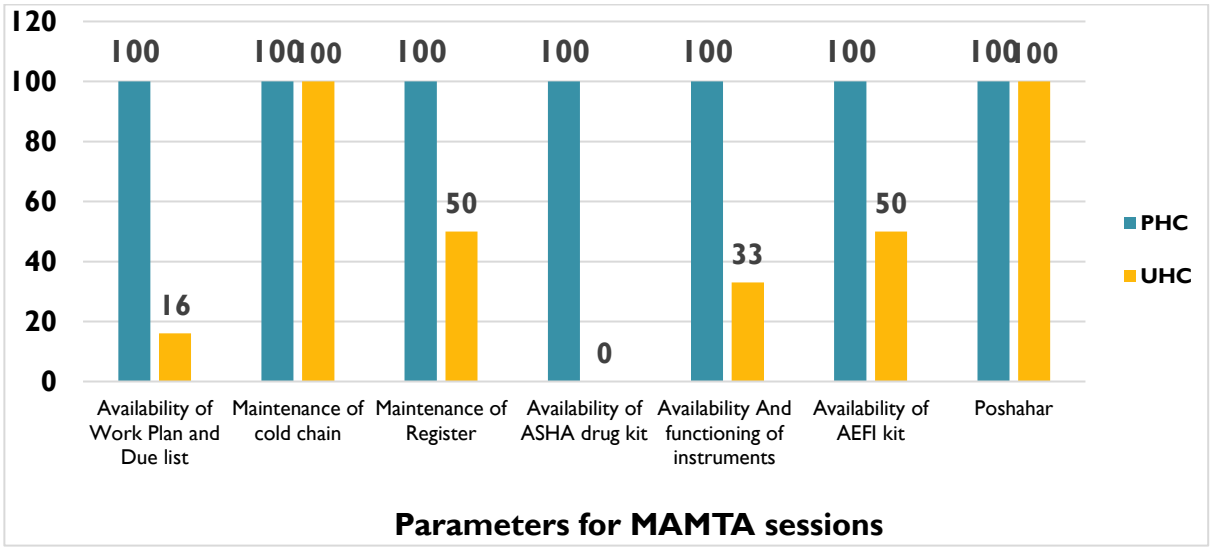


Fig.6 Status of MAMTA Sessions of Rural and Urban Slums(fig in%)



CONCLUSION

- The physical infrastructure of UHCs is inadequate as compared to PHCs as discussed in graph. Lack of wards and Labour room in UHCs affects the service delivery indicator IPD and Deliveries.
- Average Staff at UHC is less than PHCs.
- Only 50% UHCs perform OPD. And no other services are being provided at UHCs in comparison to PHCs where all the services are provided.
- Lack of display of IEC material in UHCs.
- There was appropriate drug storage facility and tally software was implemented in all the PHCs as well as UHCs.
- The status of MAMTA session is inadequate in Urban as compared to Rural.
- Therefore, it is evident from the result that the facilities and services at UHCs is average as compared to rural and they are not efficient enough to Improve health of Urban poor. Hence, there's a need to strengthen UHCs setting the benchmark of PHCs.

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ANNEXURE

PHC/UPHC LEVEL MONITORING CHECKLIST

Name of District: ..... Name of Block: ..... Name of PHC: .....

Catchment Population: ..... Total Villages: .....

Date of last supervisory visit: .....

Date of visit: ..... Name & designation of monitor: .....

Names of staff not available on the day of visit and reason for absence: .....

Section I: Physical Infrastructure:

S.No	Infrastructure	Yes	No	Additional Remarks
1.1	Health facility easily accessible from nearest road head	Y	N	
1.2	Functioning in Govt building	Y	N	
1.3	Building in good condition	Y	N	
1.4	Habitable Staff Quarters for MOs	Y	N	
1.5	Habitable Staff Quarters for SNs	Y	N	
1.6	Habitable Staff Quarters for other categories	Y	N	
1.7	Electricity with functional power back up	Y	N	
1.9	Running 24*7 water supply	Y	N	
1.10	Clean Toilets separate for Male/Female	Y	N	
1.11	Functional and clean labour Room	Y	N	
1.12	Functional and clean toilet attached to labour room	Y	N	
1.13	Functional New born care corner(functional radiant warmer with neo-natal ambu bag)	Y	N	
1.14	Functional Newborn Stabilization Unit	Y	N	
1.15	Clean wards	Y	N	
1.16	Separate Male and Female wards (at least by Partitions)	Y	N	
1.17	Availability of complaint/suggestion box	Y	N	
1.18	Availability of mechanisms for waste management	Y	N	

Section II: Human resource:

S. no	Category	Numbers	Remarks if any
2.1	MO		
2.2	SNs/ GNMs		
2.3	ANM		
2.4	LTs		
2.5	Pharmacist		

ANNEXURE 2

2.6	LHV/PHN	
2.7	Others	

Section III: Training Status of HR

S. no	Training	No. trained	Remarks if any
3.1	BeMOC		
3.2	SBA		
3.3	MTP/MVA		
3.4	NSV		
3.5	IMNCI		
3.6	F- IMNCI		
3.7	NSSK		
3.8	Mini Lap		
3.9	IUD		
3.10	RTI/STI		
3.11	Immunization and cold chain		
3.12	Others		

Section IV: Equipment

S. No	Equipment	Yes	No	Remarks
4.1	Functional BP Instrument and Stethoscope	Y	N	
4.2	Sterilised delivery sets	Y	N	
4.3	Functional neonatal, Paediatric and Adult Resuscitation kit	Y	N	
4.4	Functional Weighing Machine (Adult and infant/newborn)	Y	N	
4.5	Functional Needle Cutter	Y	N	
4.6	Functional Radiant Warmer	Y	N	
4.7	Functional Suction apparatus	Y	N	
4.8	Functional Facility for Oxygen Administration	Y	N	
4.9	Functional Autoclave	Y	N	
4.10	Functional ILR	Y	N	
4.11	Functional Deep Freezer			
4.12	Emergency Tray with emergency injections	Y	N	
4.13	MVA/ EVA Equipment	Y	N	
	Laboratory Equipment	**Yes**	**No**	**Remarks**
4.14	Functional Microscope	Y	N	
4.15	Functional Hemoglobinometer	Y	N	
4.16	Functional Centrifuge,	Y	N	

ANNEXURE 2

4.17	Functional Semi autoanalyzer	Y	N	
4.18	Reagents and Testing Kits	Y	N	

Section V: Essential Drugs and Supplies

S.No	Drugs	Yes	No	Remarks
5.1	EDL available and displayed	Y	N	
5.2	Computerised inventory management	Y	N	
5.3	IFA tablets	Y	N	
5.4	IFA tablets (blue)	Y	N	
5.5	IFA syrup with dispenser	Y	N	
5.6	Vit A syrup	Y	N	
5.7	ORS packets	Y	N	
5.8	Zinc tablets	Y	N	
5.9	Inj Magnesium Sulphate	Y	N	
5.10	Inj Oxytocin	Y	N	
5.11	Misoprostol tablets	Y	N	
5.12	Mifepristone tablets	Y	N	
5.13	Antibiotics	Y	N	
5.14	Labelled emergency tray	Y	N	
5.15	Drugs for hypertension, Diabetes, common ailments e.g PCM, anti-allergic drugs etc.	Y	N	
5.16	Vaccine Stock available	Y	N	
S.No	**Supplies**	**Yes**	**No**	**Remarks**
5.17	Pregnancy testing kits	Y	N	
5.18	Urine albumin and sugar testing kit	Y	N	
5.19	OCPs	Y	N	
5.20	EC pills	Y	N	
5.21	IUCDs	Y	N	
5.22	Sanitary napkins	Y	N	
S.No	**Essential Consumables**	**Yes**	**No**	**Remarks**
5.23	Gloves, Mckintosh, Pads, bandages, and gauze etc.	Y	N	

Note: For all drugs and consumables, availability of at least 2 month stock to be observed and noted

Section VI: Other Services :

S.no	Lab tests being conducted for	Yes	No	Remarks
6.1	Haemoglobin	Y	N	
6.2	CBC	Y	N	
6.3	Urine albumin and Sugar	Y	N	
6.4	Serum Bilirubin test	Y	N	
6.5	Blood Sugar	Y	N	

ANNEXURE 2

6.6	RPR (Rapid Plasma Reagin) test	Y	N
6.7	Malaria (PS or RDT)	Y	N
6.8	T.B (Sputum for AFB)	Y	N
6.9	HIV (RDT)	Y	N
6.10	Others	Y	N

Section VII: Service Delivery in last two quarters:

S.No	Service Utilization Parameter	Q1	Q2	Remarks
7.1	OPD			
7.2	IPD			
7.3	Expected number of pregnancies			
7.4	Percentage of women registered in the first trimester			
7.5	Percentage of women registered in the first trimester			
7.6	Percentage of ANC3 out of total registered			
7.7	Percentage of ANC4 out of total registered			
7.8	Total deliveries conducted			
7.9	Number of obstetric complications managed, pls specify type			
7.10	No. of neonates initiated breast feeding within one hour			
7.11	Number of children screened for Defects at birth under RBSK			
7.12	RTI/STI Treated			
7.13	No of admissions in NBSUs, if available			
7.14	No. of sick children referred			
7.15	No. of pregnant women referred			
7.16	No. of IUCD Insertions			
7.17	No. of Tubectomy			
7.18	No. of Vasectomy			
7.19	No. of Minilap			
7.20	No. of children fully immunized			
7.21	Measles coverage			
7.22	No. of children given ORS + Zinc			
7.23	No. of children given Vitamin A			
7.24	No. of women who accepted post partum FP services			
7.25	No. of MTPs conducted			
7.26	Maternal deaths, if any			
7.27	Still births, if any			
7.28	Neonatal deaths, if any			

ANNEXURE 2

7.29	Infant deaths, if any		

Section VII a: Service delivery in post natal wards:

S.No	Parameters	Yes	No	Remarks
7.1a	All mothers initiated breast feeding within one hr of normal delivery	Y	N	
7.2a	Zero dose BCG, Hepatitis B and OPV given	Y	N	
7.3a	Counseling on IYCF done	Y	N	
7.4a	Counseling on Family Planning done	Y	N	
7.5a	Mothers asked to stay for 48 hrs	Y	N	
7.6a	JSY payment being given before discharge	Y	N	
7.7a	Mode of JSY payment (Cash/ bearer cheque/Account payee cheque/Account Transfer)			
7.8a	Any expenditure incurred by Mothers on travel, drugs or diagnostics(Please give details)	Y	N	
7.9a	Diet being provided free of charge	Y	N	

Section VIII: Quality parameter of the facility

Through probing questions and demonstrations assess does the staff nurses and ANMs know how to...

S.No	Essential knowledge/Skill Set	Knowledge		Skills		Remarks
8.1	Manage high risk pregnancy	Y	N	Y	N	
8.2	Provide essential newborn care(thermoregulation, breastfeeding and asepsis)	Y	N	Y	N	
8.3	Manage sick neonates and infants	Y	N	Y	N	
8.4	Correctly uses partograph	Y	N	Y	N	
8.5	Correctly insert IUCD	Y	N	Y	N	
8.6	Correctly administer vaccines	Y	N	Y	N	
8.7	Alternate Vaccine Delivery (AVD) system functional	Y	N	Y	N	
8.7	Segregate waste in colour coded bins	Y	N	Y	N	
8.8	Adherence to IMEP protocols	Y	N	Y	N	

ANNEXURE 2

Section IX: Record Maintenance:

S. no	Record	Available, Updated and correctly filled	Available but Not maintained	Not Available	Remarks/Timeline for completion
9.1	OPD Register				
9.2	IPD Register				
9.3	ANC Register				
9.4	PNC Register				
9.5	Indoor bed head ticket				
9.6	Line listing of severely anaemic pregnant women				
9.7	Labour room register				
9.8	Partographs				
9.9	OT Register				
9.10	FP Register				
9.11	Immunisation Register				
9.12	Updated Microplan				
9.13	Drug Stock Register				
9.14	Referral Registers (In and Out)				
9.15	Payments under JSY				
9.16	Untied funds expenditure (Check % expenditure)				
9.17	AMG expenditure (Check % expenditure)				
9.18	RKS expenditure (Check % expenditure)				

Section X: Referral linkages in last two quarters:

S. no	JSSK	Mode of Transport (Specify Govt./ pvt)	No. of women transported during ANC/INC/PNC	No. of sick infants transported	No. of children 1-6 years	Free/Paid
10.1	Home to facility					
10.2	Inter facility					
10.3	Facility to Home (drop back)					

ANNEXURE 2

Section XI: IEC Display:

S.No	Material	Yes	No	Remarks
11.1	Approach roads have directions to the health facility	Y	N	
11.2	Citizen Charter	Y	N	
11.3	Timings of the Health Facility	Y	N	
11.4	List of services available	Y	N	
11.5	Essential Drug List	Y	N	
11.6	Protocol Posters	Y	N	
11.7	JSSK entitlements	Y	N	
11.8	Immunization Schedule	Y	N	
11.9	JSY entitlements	Y	N	
11.10	Other related IEC material	Y	N	

Section XII: Additional/Support Services:

Sl. no	Services	Yes	No	Remarks
12.1	Regular sterilisation of Labour room (Check Records)	Y	N	
12.2	Functional laundry/washing services	Y	N	
12.3	Availability of dietary services	Y	N	
12.4	Appropriate drug storage facilities	Y	N	
12.5	Equipment maintenance and repair mechanism	Y	N	
12.6	Grievance redressal mechanisms	Y	N	
12.7	Tally software implemented	Y	N	

Section XIII: Previous supervisory visits:

S. no	Name and Designation of the supervisor	Place of posting of Supervisor	Date of visit
13.1			
13.2			
13.3			
13.4			
13.5			

Note: *Ensure that necessary corrective measures are highlighted and if possible, action taken on the spot. The Monthly report of monitoring visits and action points must be submitted to the appropriate authority for uploading on State MoHFW website*

To be filled by monitor(s) at the end of activity

Key Findings	Actions Taken/Proposed	Person(s) Responsible	Timeline