Study on Gap Assessment of RMNCH+A Strategy in High Priority District of Barabanki Uttar Pradesh

By

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Dissertation submitted for the partial fulfillment of the

MBA Hospital and Health Management

Academic year, 2014-2016

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TO WHOMSOEVER MAY CONCERN

This is to certify that **Vikash Kumar** student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone dissertation training at **India Health Action Trust, Uttar Pradesh** from February 8th, 2016 to May 8th, 2016.

The Candidate has successfully carried out the study designated to his during dissertation training and his approach to the study has been sincere, scientific and analytical. This training is in fulfillment of the course requirements.

I wish him all success in all future endeavors.

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This is to certify that **VIKAS KUMAR**, District Technical Specialist, Sitapur, UP has done his dissertation and summer internship in India Health Action Trust, Uttar Pradesh Technical Support Unit from 08-2-2016 to 08-5-2016. He has worked on the topic **A Study on gap assessment of RMNCH+A strategy in high priority district of U.P. (Barabanki).**

He is hard working, sincere and a committed student and we wish him very best for all his future endeavors.

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **A study on gap assessment of RMNCH+A strategy in high priority of Barabanki district.(U.P)** and submitted by Vikash Kumar under the supervision of Prof. Dr.J.P Singh for award of MBA in Hospital and Health Management of the University carried out during the period from 8st February 2016 to 18th May 2016 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.

Signature

PREFACE

The MBA (hospital and health management) course is well structured and integrated course of business studies. The main objectives of practical training at MBA level are to develop skill in students by supplement to the theoretical study of business management in general. Professors give us theoretical knowledge of various subjects in the institute. But we are practically exposed of such subjects when we get the training in the organization. It is the training through which we come to know that what an organization is and how it works. During this whole training I got a lot of experience and came to know about management practices in real that how it differs from those of theoretical knowledge and the practically in the real life.

It's very beneficial to learn health care delivery system at various levels. I observed the implementation of various National Health Programs at National/State/District levels; I understood various functions of health systems by interactions with key stakeholders, policy makers, program managers, academicians and researchers.

During my training period I had an overview of various programs undertaken By Uttar Pradesh Technical Support Unit including the current status of the program I also carried out a small study on-
A study on gap assessment of RMNCH+A strategy in high priority district of Barabanki (Uttar Pradesh)

I have tried to put my best effort to complete this task on the basis of skill that I have achieved during my studies in the institute.

Acknowledgements

The internship was started with a vision to be able to learn about the practical aspects of healthcare delivery system in a detailed manner. I hereby take this opportunity to express my deep sense of gratitude to all those who have been instrumental in the successful completion of my internship. Any accomplishment requires efforts of various individuals and this work is no exception

Firstly, I would like to thank Dr. S.D. Gupta, Director - Institute of Health Management Research, Jaipur, and all the faculties, for the education imparted which has made me the person I am today, and IHAT UP-TSU for believing in my abilities.

This project would not have been completed without the tremendous contribution of my Guide, Dr.J.PSingh right from the onset lending a helping hand at every step.

Dr. Sanjeev Kumar (State Team Leader)-Technical deserves gratitude for always guiding me through difficulties.

Dr.AshishTiwari (Zonal Technical Specialist), my Supervisor and guide at IHAT UP-TSU has been supportive all along my tenure in the organization and allowed me the freedom to express myself.

I would like to express my sincere thanks to Dr.GirishMathur (District Technical Specialist) Barabanki district and Dr.AshiashBhat(DM&E) for their kind support.

I would also like to specially thank all of my study participants (ANMs ,ASHA and Staff Nurse of Barabanki district) who have been co operative in participating and responding well during the assesment.

Finally, and most importantly, I would like to thank God for allowing me to complete my project, my beloved parentsfor their blessings and my friends for their help and wishes for the successful completion of this internship.

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ABSTRACT

BACKGROUND

Health (RCH), healthcare infrastructure and workforce as also the expansion of programme management capacity since the launch of NRHM in 2005 provide an important opportunity to consolidate all our efforts. As we inch closer to 2015, there is an opportunity to further accelerate progress towards MDG and redefine the national agenda to come up with a coordinated approach to maternal and child health in the next five years.The most common direct medical causes of maternal death as per SRS (2001–03) are haemorrhage, mainly postpartum (37%), sepsis because of infection during pregnancy, labour and postpartum period (11%), unsafe abortions (8%), hypertensive disorders (5%) and obstructed labour (5%). These conditions are largely preventable and once detected, they are treatable. Among children who die before their fifth birthday, almost one third of them die of infectious causes, nearly all of which are preventable.

Objectives

1. To assess the availability of drugs and equipment's coverage for RMNCH+A
2. To identify gaps in services delivery of RMNCH+A

Methodology

A Descriptive cross sectional study was carried out in Barabanki district of Uttar Pradesh from February2016 to May 2016.Random sampling was done for PHCs and SC and one district women hospital. The sample design was Quota study design and sample size was 21 health facilities. In the data collection tools Government of India Supportive supervision was used. The data or information is compiled using MS Excel. Data is enter manually into the application and analyzed. Graphs and charts are being made using MS Excel package.

Results

Average referral among all facilities was 213 it shows that there was not proper handling of cases is being done. Quarterly IPD average load was 2208 and OPD average load was 220603.Availability of drugs at maternal care basically if we talk about injetablesMgSO4 is only available was 60%. The availability of drugs and essentials of new born health, the bag and mask is only present is 61% which is very low indicator for managing the Asphyxia in new born. If we see in Adolescent health Dicyclomine availability is very poor at facility only 32%. The vaccine supplies at L1 faclity HEPB supply is only 45% followed by 27% vitamin syrup and Measles Vaccine is 36%. At L2 also Hep B availability is only 60% followed by in L3 HEP B, Measles and Syrup Vitamin supply is 80% only. If we see the overall availability HEP B is 67%, syrup Vitamin 71% is available only.For the infection prevention quarterly data shows that color coded bins are only 43% which shows very poor facility of Bio medical waste management apart from this bleaching powder availability is only 57%. In TSU blocks Fetal Heart Rate recorded at time of admission is 100%, partograph is filled is 100%, utertonic drugs use is 100%. The basic difference is that mother temperature recorded at time of admission is 77% in L1 and in L2 and L3 IS 100%. But in non TSU block it is not recorded in L1 and L2 only in one FRU which is L3 it is done. AntenatalCorticosteroids used at all level L1 was 50%, L2 was 67% and in L3 100% But in non TSU block L1 is 14%, L2 (50%).

Essential New Born care and new born Resuscitation equipped NBCC is available at L2 facility (57%). The services delivery at community level by ASHA and ANM .The status of menstrual hygiene is only 52%. The referral at NRC was done only 76% because they are unaware to detect the SAM child.

Organization Background

UTTAR PRADESH TECHNICAL SUPPORT UNIT
INDIA HEALTH ACTION TRUST, UTTAR RADESH

BACKGROUND

A Technical Support Unit (TSU) is established for the Government of Uttar Pradesh (Go UP),with the **goal** of providing techno-managerial support to the Go UP to improve the efficiency, effectiveness and equity of delivery of key RMNCHA interventions. This will be accomplished by supporting the state in the implementation of the nationally launched NRHM RMNCH+A strategy, and in the scale-up of agriculture and financial inclusion services.

The TSU's activities will be focused on the twenty-five most underserved districts in the state, where the aim is to improve RMNCHN service delivery and outcomes within 100 priority blocks. These districts have been selected and agreed upon jointly by GOI, Go UP and the foundation.

The India Health Action Trust (IHAT) will have overall responsibility for executing the TSU project in Uttar Pradesh. The University of Manitoba (UM) will provide key technical and managerial support to all RMNCH+A areas, and financial inclusion/agriculture. John Snow International Research & Training Institute Inc. (JSI) will provide technical inputs in the areas of strategic planning and donor/stakeholder coordination, supply/cold chain management, new born care, and immunization. The JSI will also facilitate linkages and alignment of project activities to the Government of India (GoI) policies by providing support at national level.

ORIGIN AND HISTORY

Uttar Pradesh is India's most populous state, with approximately 200 million people, and with weak health infrastructure and poor health outcomes. There is a tremendous opportunity to improve the state execution capacity to enhance the efficiency, effectiveness and equity in health and development. This is the basis upon which the Bill & Melinda Gates Foundation (the foundation) has collaborated to provide techno-managerial assistance to the Government of Uttar Pradesh (Go UP) and this proposed to set up a Technical Support Unit (TSU) to execute against the Memorandum of Cooperation (MoC) signed by the foundation and Go UP in December 2012. The Government of India (GoI) has launched a renewed campaign to improve RMNCH+A performance across India, and the Go UP has followed up the national launch with its own show of commitment through the state RMNCH+A effort.

VISION

To reduce the adverse health and development outcomes to families, mothers, new-borns and children by achieving high reach, coverage and quality of effective interventions and services for health (reproductive, maternal, neonatal and child health and nutrition in communities and at health facilities), agriculture and financial inclusion

MISSION

The mission of the TSU is to support the government, not to implement on its own. Building the capacity of the health system to execute according to its own mandate, with strong political, bureaucratic and administrative ownership

OBJECTIVES:

The key **objectives** of the project are to:

- Support the Go UP to improve the quality and quantity of FLW interactions at the community level and within households to drive the eight priority RMNCHN behaviors
- Support GoUP in improving its RMNCHN related primary care services at facilities.
- Support GoUP to improve strategies and systems required to deliver improved FLW capabilities and service delivery at primary care facilities
- Support the GoUP in improving its capacity to fund, contract, and regulate/ mandate private providers
- Support the GoUP in improving the scale and quality of community accountability mechanisms

CORE VALUES:

The four core values to address the major barriers like poor accountability, poor focus on outcomes, lack of skillful planning and poor policies are as follows:

1. Efforts to improve leadership and outcome-focus by ensuring bureaucratic ownership of innovations, strong political will under the foundation-GoUP MOU.
2. Strengthening of internal and external accountability mechanisms through developing strong coaching, mentoring and supervisory systems within NRHM and the Directorate of Health/Family Welfare in the GoUP and by creating concurrent monitoring systems using data, dashboards and feedback loops to effect mid-course corrections.
3. Improving the skills and capabilities for FLW and primary care performance by ensuring trainings are conducted with high quality by GoUP and the skills and practices are enhanced through appropriate supportive supervision mechanisms and use of Information Communication Technology (ICT) based solutions to improve FLW and facility performance.
4. Improving policy, planning and coordination by improving private sector stewardship, funding and contracting processes (such as providers for family planning services, developing new incentive schemes and contracting more management capacity out to the private sector for issues like accreditation), supply chain and G2P (Government to person) payment improvements, select human resource and infrastructure improvements at the field level, better annual planning and fund flow mechanisms.

STRATEGIES

Six structural components which define the *modus operandi* of the TSU have been identified as follows:

1. Strengthen FLW skills/capabilities: Strengthen FLW skills/capabilities through supportive supervision and job-aids to improve quality and quantity of interactions in households, at VHNDs and facilities, to increase service access and improve the eight key behaviors around MNCH, nutrition, and FP.
2. Build skills/capabilities of providers at facilities: Improve availability of services and quality of care at first level facilities (e.g., block PHCs) and referral facilities by offering improved training and on-site skills building (e.g., nurse mentors and skills labs) combined with improved case sheets, checklists and workflow management tools.
3. Improve health system management capabilities to support efficient and effective execution to support the above two areas.
    - Ensure robust project planning and funds flow (e.g., PIP processes)
    - Establish appropriate roles and responsibilities for supportive supervision at the block, district and state levels
    - Leverage ICT to improve data, dis-intermediation, demand and to drive performance efficiencies, especially among FLWs and facilities
    - Create robust systems for data collection, analysis, and planning to improve management of the program (e.g., MCTS, HMIS)
    - Create robust concurrent monitoring systems to validate data collection by the system and feedback information for immediate and mid-course correction
    - Assist the government to execute existing incentive schemes at scale by improving data management, planning and streamlining payment systems
4. Support critical infrastructure improvements at the health system level in collaboration with other DPs: support select cross-cutting areas of the health system that act as critical bottlenecks to the first two areas listed above

- Improve supply chain and cold chain management to minimize stock out of essential drugs
- In our role as the state lead partner, ensure alignment with donor/partner efforts in the state; coordinate with other 'units' to catalyze the overall response especially around creating critical infrastructure (e.g. PHCs, FRUs) and HR (staff nurses, supervisors, etc.)

5. Improve the government's ability to be better stewards of the private sector, through better management and contracting approaches:

- Assist the government with devising and executing schemes and contracts to outsource select provision to the private sector (e.g., ORS/Zinc scheme to improve distribution, institutional deliveries, clinical services for FP, 'outsourced' management of FRU staff through 'mother NGOs')
- Assist with improving accreditation and payment systems to enable private providers to be paid by the government to increase coverage – e.g., contracting of agencies (such as Public Private Interface Agencies) to oversee accreditation processes and to streamline their function.
- Explore potential options for a primary care pilot involving government and private providers under a capitation-based model
- Work with the World Bank, UNICEF and other partners to ensure harmonization of efforts with other public private partnership (PPP) efforts in the state

6. Enable accountability measures to provide feedback on quality of services, improve external accountability and hence drive program change.

- The NRHM construct includes an external accountability framework that includes social audits and involvement of democratic grass root institutions (Panchayati Raj Institutions) and grievance redressal mechanisms. While progress has been slow, senior politicians and bureaucrats are committed to this vision.
- We would support government to strengthen the functioning of existing government-mandated accountability structures such as Village Health and Sanitation Committees (VHSCs), RKS (RogiKalyanSamiti) and grievance redressal mechanisms, where beneficiaries can directly register/log their complaints. Our grants would provide state level technical assistance for the state government to contract NGOs to build VHSC capabilities as has been done in other states.

ABBREVIATIONS

AEFI Adverse Events Following Immunization
AHS Annual Health Survey
ANC Ante Natal Care
ANM Auxiliary Nurse Midwife
ART Anti Retro-viral Therapy
AWC Anganwadi Centre
AWW Anganwadi Worker
BCC Behaviour Change Communication
CAC Comprehensive Abortion Care
CHERG Child Health Expert Review Group
DH District Hospital
DLHS District Level Household Survey
EAG Empowered Action Group
EMOC Emergency Obstetric Care
FP Family Planning
FRU First Referral Unit
GNM General Nursing Midwives
GOI Government of India
HIV Human Immunodeficiency Virus
HMIS Health Management & Information System
HR Human Resource
ICDS Integrated Child Development Services Scheme
IMNCIIntegrated Management of Neonatal and Childhood Illnesses
IPC Inter Personal Communication
IPHS Indian Public Health Standards
IUCD Intra Uterine Contraceptive Device
LBW Low Birth Weight
LHV Lady Health Visitor
LSASLife Saving Anaesthesia Skills
MCH Maternal and Child Health
MCISMulti Cluster Indicator Survey
MCTS Mother and Child Tracking System
MMU Mobile Medical Unit
MO Medical Officer
MTPMedical Termination of Pregnancy
MWCD Ministry of Women and Child Development
NBSU New Born Stabilisation Unit
NFHSNational Family Health Survey
NRC Nutrition Rehabilitation Centre
NRHMNational Rural Health Mission
NSSK NavjaatShishuSurakshaKaryakram
OCPOral Contraceptive Pills
ORS Oral Rehydration Solution
OT Operation Theatre
PCPNDT Pre-Conception & Pre-Natal Diagnostic Test
PHCPrimary Health Centre
PIP Programme Implementation Plan
PHNPublic Health Nurse
PPIUCD Post Partum Intra Uterine Contraceptive Device

PPS Post-Partum Sterilisation
PPTCT Prevention of Parent to Child Transmission
PRI Panchayati Raj Institution
RCH Reproductive Child Health
RGI Registrar General of India
RKS RogiKalyanSamiti
RPR Rapid Plasma Reagin
RMNCH+A Reproductive, Maternal,Newborn, Child Health plus Adolescents
RTI Reproductive Tract Infection
SBA Skill Birth Attendant
SHC Sub Health Centre
SNCU Special Newborn Care Unit
SRSSample Registration System
STI Sexually Transmitted Infection
TFR Total Fertility Rate
UT Union Territory
U5M Under Five Mortality
VHND Village Health & Nutrition Day
VHNSC Village Health Nutrition and Sanitation Committees
WHOWorld Health Organisation

INTRODUCTION

In the past seven years, innovative strategies evolved under the national programme to deliver evidence-based interventions to various population groups.

A substantial increase in the availability of financial resources for Reproductive and Child Health (RCH), healthcare infrastructure and workforce as also the expansion of programme management capacity since the launch of NRHM in 2005 provides an important opportunity to consolidate all our efforts. As we inch closer to 2015, there is an opportunity to further accelerate progress towards MDG and redefine the national agenda to come up with a coordinated approach to maternal and child health in the next five years.

In order to bring greater impact through the RCH programme, it is important to recognise that reproductive, maternal and child health cannot be addressed in isolation as these are closely linked to the health status of the population in various stages of life cycle. The health of an adolescent girl impacts pregnancy while the health of a pregnant woman impacts the health of the new-born and the child. As such, interventions may be required at various stages of life cycle, which should be mutually linked. The reasons for adopting such a strategy can be understood when the available data is taken into account and the close inter-linkages between different stages of life cycle are recognised. Birth weight is an important risk factor for child survival as children with low birth weight (LBW) are more likely to have impaired growth, higher mortality and risk of chronic adult diseases. The LBW is also a strong predictor for size in later life as most of these babies have intrauterine growth retardation, and they seldom catch-up with normal size during childhood. In India, 22% babies born each year have LBW, which has been linked to maternal under-nutrition and anaemia among other causes. The mother's condition before pregnancy is a key determinant of its outcome; half of adolescents (boys and girls) have below normal body mass index (BMI) and almost 56% of adolescent girls aged 15–19 years have anaemia.

Therefore, the nutritional status of adolescent girls and young women is inextricably linked to the birth weight of their children and subsequently to child survival. There is evidence to show that adolescent mothers are vulnerable to problems related to pregnancy and childbearing. Of all mothers, adolescent mothers are more likely to have preterm births. According to national surveys, adolescents (15–19 years) contribute about 16% of total fertility in the country and 15–25 years age group contributes 45% of total maternal mortality. With substantial unmet need of contraception – about 27% among married adolescents (15–19 years) – and low condom use by adolescents in general, adolescent girls are at a high risk of contracting sexually transmitted infections, HIV and unintended and unplanned pregnancies. This in turn contributes to maternal morbidity and mortality due to unsafe abortions and infections.

High maternal and child mortality in adolescent mothers and a smaller but significant contribution of adolescents to total fertility brings the focus back on the need to address adolescents as an integral part of the strategy so as to improve maternal and child health. Another compelling reason to invest in an integrated strategy across life stages is the well-known link between maternal and child survival, and the use of family planning methods. There is evidence to show that in developing countries, the risk of premature delivery and LBW doubles when conception occurs within six months of a previous birth. The use of contraceptive has the potential to improve perinatal outcomes andchild survival by widening the interval between successive pregnancies. Increased contraceptive usecan also reduce the number of maternal deaths by reducing unintended pregnancies and thereby abating the number of times women face the hazards of pregnancy. Especially in areas with poor health infrastructure, family planning is a cost-effective and feasible way to reduce maternal and

child deaths as it does not rely on complex technology. It is estimated that if the current unmet need for family planning could be fulfilled within the next five years, India can avert 35,000 maternal deaths and 12 lakh infant deaths while saving more than 4,450 crore of Indian currency. If safe abortion services are coupled with increase in family planning services, the savings made to the country could be to the tune of Rs 6,500 crore.

Just as different stages in the life cycle are interdependent so are the aspects of where and how healthcare is provided. Household or community education contributes to preventing health complications, quality care provided at the community level helps avoid the need for hospitalisation, and sound referral systems at primary care level support early identification of risks and better treatment for acute and complicated conditions. Essential interventions to improve the health of women and children therefore need to take place at all levels in the health system, that is, from the home to the community level and through all the health facilities.

Thus, there are two dimensions to healthcare:

(1) Stages of the life cycle and

(2) Places where the care is provided. These together constitute the 'Continuum of Care.'

This Continuum of Care approach of defining and implementing evidence-based packages of services for different stages of the lifecycle, at various levels in the health system, has been adopted under the national health programme. This strategic approach to Reproductive, Maternal, New-born, Child plus Adolescent Health (RMNCH+A) is described further in the document. The 'Plus' in the strategic approach denotes the

(1) Inclusionof adolescence as a distinct 'life stage' in the overall strategy;

(2) Linking of maternal and child health to reproductive health and other components (like family planning, adolescent health, HIV, gender and Preconception and Prenatal Diagnostic Techniques (PC&PNDT); and

(3) Linking of community and facility-based care as well as referrals between various levels of health care system to create a continuous care pathway.

Literature Review

Globally, an estimated 287,000 maternal deaths occurred in 2010, when the global maternal mortality ratio was 210 maternal deaths per 100,000 live births. Sub-Saharan Africa (56%) and Southern Asia(29%) accounted for 85% (or 245,000 in numbers) of the global burden of maternal deaths in 2010.At the country level, India accounted for 19% (56,000 in numbers) of all global maternal deaths. In terms of child mortality, globally 76 lakh children died in 2010 before reaching their fifth birthday.

Five countries – India, Nigeria, Democratic Republic of the Congo, Pakistan and China – collectively accounted for half or nearly 37.5 lakh of all global deaths in children younger than five years. India presently accounts for nearly 20% of the world's child deaths. In terms of numbers, it is the largest number of child deaths (approximately 15.8 lakh) under the age of five years in any country. The reasons for this are a large birth cohort (2.6 crore) and child population (15.8 crore in the age group 0–6 years) and a relatively high child mortality rate (59 per 1,000 live births).Despite India being amongst the top five countries in terms of absolute numbers of maternal and child deaths, encouraging progress has been made in terms of reducing maternal and child mortality rates. In 1990, when the global under five mortality rate was 88 per 1,000 live births, India carried a much higher burden of child mortality at 115 per 1,000 live births. In 2010, India's child mortality rate (59 per 1,000 live births) almost equals the global average of 57. As per the report of Maternal

Mortality Estimation Inter-Agency Group, maternal mortality has shown an annual decline of 5.7%between the years 2005 and 2010.

At the national level, maternal mortality ratio (MMR) declined from 254 (SRS 2005) to 212 (SRS2007–09) – a decline of about 14 points per year on an 'All India' basis. In terms of numbers, there are still 56,000 maternal deaths each year. About two-thirds of maternal deaths occur in just a few states – Assam, Uttar Pradesh(including Uttarakhand), Rajasthan, Madhya Pradesh (including Chhattisgarh), Bihar (including Jharkhand) and Odisha. However, these states have also shown the most notable drop in MMR (between Sample Registration System(SRS) 2004–06 and SRS 2007–09) during the initial years of NRHM: Assam (90 points), Uttar Pradesh including Uttarakhand (81points), Rajasthan (70 points), Madhya Pradesh and Chhattisgarh (66 points). It is likely that more of this success will be evident as and when data from the current period becomes available.

The mortality rate in children below five years is 59 per 1,000 live births (SRS 2010), which translates into 15.8 lakhs deaths in the country per year. Of these, 8.8 lakh (56%) children die in the first month of life; 12.5 lakh (79%) children die in the first year, including the neonatal period. The neonatal mortality rate has remained stagnant, constituting an even larger proportion of the total child deaths (0–5 years) in 2010. A rural-urban differential in under-five mortality is evident and stands at 28 points; however, the encouraging trend is that the decline in rural child mortality has been fasterthan the urban. There is also a gender differential of 9 points in the under-five category (female:

64; male: 55), underlining the need to address social determinants of health, including the status of women and the girl child, female literacy, and women's economic and social empowerment. Looking at the national and state averages as the measures of progress can very often mask the inequities in progress in various regions and districts of a large country like India. The Annual Health Survey carried out in eight Empowered Action Group (EAG) states and Assam in 2010–11 provides amore accurate picture of the RCH status within the states with a high burden of maternal and child mortality. Analysis of data from 284 districts across these nine states shows that there is a wide inter-district variation. For example, Madhya Pradesh, a state with high under-five mortality rate has an inter-district variation of 89 points between Indore (51) and Panna (140) while Uttar Pradesh has a 90 point variation

between the two districts of Kanpur Nagar (52) and Shrawasti (140).Therefore, it is clear that the implementation focus has to shift to geographical areas of greatest concern and populations that carry the highest burden of illness and mortality. This must also include a focus on the urban disadvantaged population (the 'urban poor') where barriers to utilization of health services, often due to inequitable distribution of service availability, are well documented.

One of the key indicators of good reproductive health of the community is the Total Fertility Rate (TFR). As described earlier, TFR is linked to maternal health and child survival. The TFR is defined as the average number of children that would be born to a woman over her reproductive life span's TFR decreases, maternal mortality rate also declines. Low TFR impacts child survival by bringing optimum spacing between successive pregnancies. Currently India's TFR is 2.5 (SRS 2010). Although India has not achieved the replacement level of fertility (i.e. 2.1), the rate of decline in TFR has accelerated since the implementation of the NRHM and this trend is expected to continue further. Currently, twenty-one states/union territories have already achieved the replacement level of fertility (i.e. 2.1) or less, while seven more states are on the verge of achieving replacement level fertility. Concern remains with seven high focus states, which have the TFR of 3.0 or more as these are (predictably so) also the states with the highest burden of maternal and child mortality. Before the change can be seen in terms of programme impact (maternal and child mortality, total fertility), intermediate outcomes or results may become evident. These could be in terms of services made available, change in community knowledge and behaviour, adoption of safe practices or utilisation of available health services.

Goals & Targets

Taking into account the progress made so far in maternal and child health, it is pertinent to establishthe goals and targets for the implementation phase 2012–2017, after considering the main reasonsfor mortality and interventions proven to have an impact on them.

The 12th Five Year Plan has defined the national health outcomes and the three goals that arerelevant to RMNCH+A strategic approach as follows:

Health Outcome Goals established in the 12th Fiver Year Plan

- Reduction of Infant Mortality Rate (IMR) to 25 per 1,000 live births by 2017
- Reduction in Maternal Mortality Ratio (MMR) to 100 per 100,000 live births by 2017
- Reduction in Total Fertility Rate (TFR) to 2.1 by 2017

Coverage targets for key RMNCH+A interventions for 2017

- Increase facilities equipped for perinatal care (designated as 'delivery points') by 100%
- Increase proportion of all births in government and accredited private institutions at annualrate of 5.6 % from the baseline of 61% (SRS 2010)
- Increase proportion of pregnant women receiving antenatal care at annual rate of 6% fromthe baseline of 53% (CES 2009)
- Increase proportion of mothers and new-borns receiving postnatal care at annual rate of 7.5% from the baseline of 45% (CES 2009)
- Increase proportion of deliveries conducted by skilled birth attendants at annual rate of 2%from the baseline of 76% (CES 2009)

In order to achieve these goals, that are ambitious, yet potentially feasible Lives Saved Tool (List),a computer based application was used to estimate the coverage targets for key child healthinterventions. A sub-committee and an expert group were constituted to review the application ofLIST in Indian context. The expert group ensured that the inputs to List are adapted to the IndianContext and by undertaking an in-depth review of the impact of various

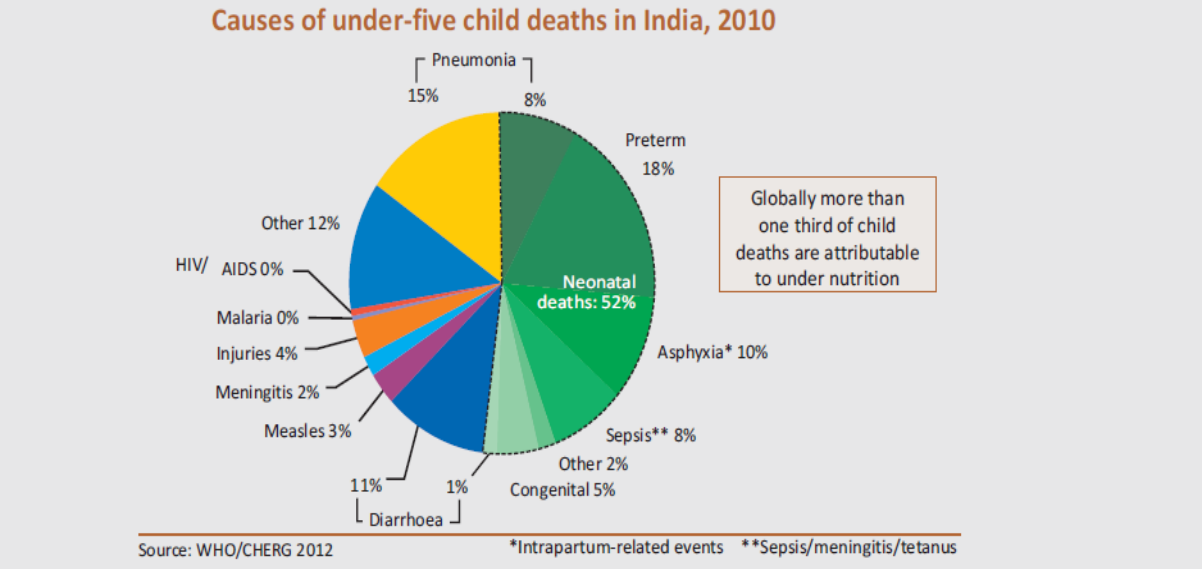
new-born and child survivalinterventions. The assumptions for the tool were developed based on the best available evidenceand, wherever required, through expert consensus.
For achieving the under-five mortality are of 33 per 1000 live births , corresponding to infant mortality rate of 25 per 1000 live births in 2017 (as articulated in 12th Five Year Plan), variable increases in the coverage levels for key interventions are required. These have been defined in the table below.

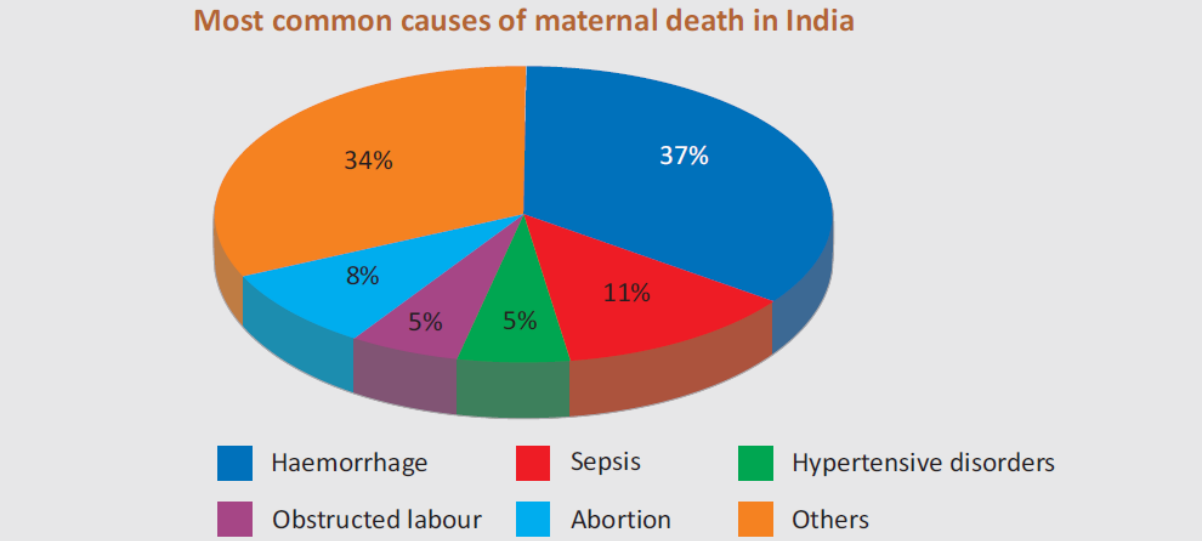
• Increase exclusive breast feeding rates at annual rate of 9.6% from the baseline of 36% (CES 2009)
• Reduce prevalence of under-five children who are underweight at annual rate of 5.5% from The baseline of 45% (NFHS 3)
• Increase coverage of three doses of combined diphtheria-tetanus-pertussis (DTP3) (12–23 Months) at annual rate of 3.5% from the baseline of 7% (CES 2009)
• Increase ORS use in under-five children with diarrhoea at annual rate of 7.2% from the Baseline of 43% (CES 2009)
• Reduce unmet need for family planning methods among eligible couples, married and Unmarried, at annual rate of 8.8% from the baseline of 21% (DLHS 3)
• Increase met need for modern family planning methods among eligible couples at annual Rate of 4.5% from the baseline of 47% (DLHS 3)
• Reduce anaemia in adolescent girls and boys (15–19 years) at annual rate of 6% from the Baseline of 56% and 30%, respectively (NFHS 3)
• Decrease the proportion of total fertility contributed by adolescents (15–19 years) at annual Rate of 3.8% per year from the baseline of 16% (NFHS 3)
• Raise child sex ratio in the 0–6 years age group at annual rate of 0.6% per year from the Baseline of 914 (Census 2011)

Rationale

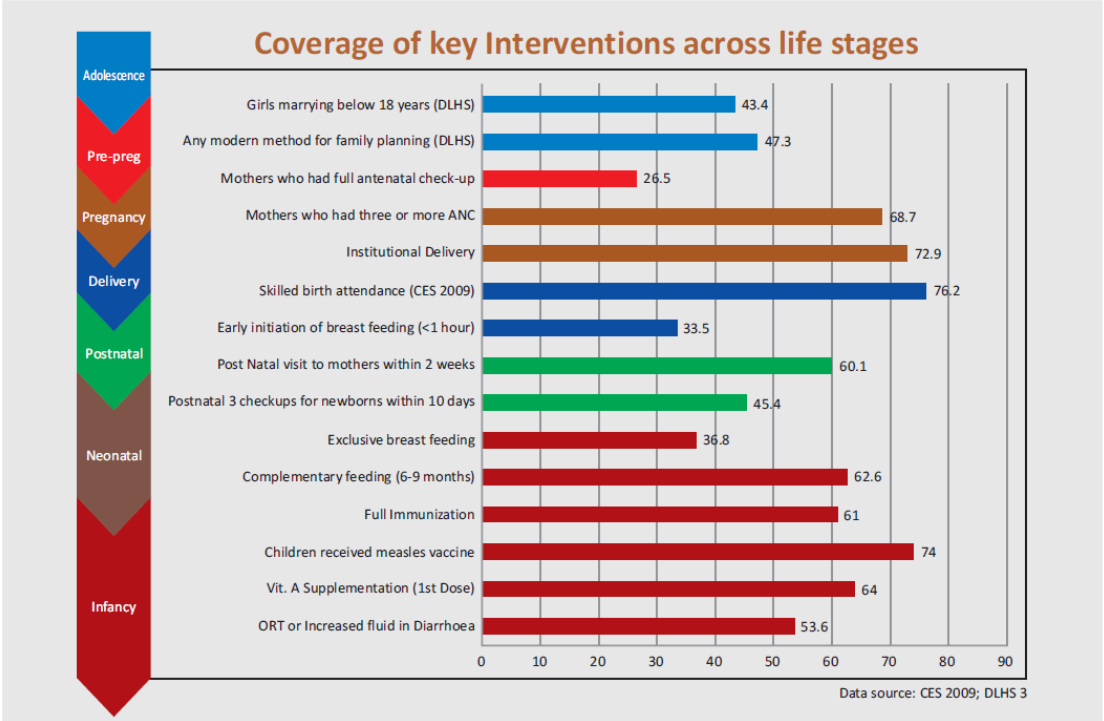
Uttar Pradesh has one of the highest MMR of 285 maternal deaths per 100,000 live births (SRS 2011–13) in India. IMR of Uttar Pradesh i.e. 50/1000 Live Birth is higher than the national average of 40/1000 LB (SRS 2013).and Shrawasti is one of the poorest in health indicator in entire Uttar Pradesh. MMR is 368 per 100,000 live births and IMR is 98 per 1000 live births (AHS 2013). Considering the large number of maternal and child deaths taking place in the country, it is important to understand why these deaths occur. This chapter provides a brief overview of the most common causes for maternal and child mortality in India. The analysis forms the basis for planning and identification of thrust areas for intervention. Maternal mortality is a key indicator for maternal health and reveals inequalities between and also within states that cannot be attributed to biological differences alone. Maternal mortality results from multiple reasons, which can broadly be classified as medical, socio-economic and health system-related factors.

The medical causes can be direct or indirect. The most common direct medical causes of maternal death as per SRS (2001–03) are haemorrhage, mainly postpartum (37%), sepsis because of infection during pregnancy, labour and postpartum period (11%), unsafe abortions (8%), hypertensive disorders (5%) and obstructed labour (5%). These conditions are largely preventable and once detected, they are treatable. A significant proportion of maternal deaths are also attributed to indirect causes', the most common of which are anaemia and malaria. Among children who die before their fifth birthday, almost one third of them die of infectious causes, nearly all of which are preventable. As per WHO-CHERG 2012 estimates, the causes of child mortality in the age group 0–5 years in India are (a) neonatal causes (52%), (b) pneumonia (15%), (c) diarrhoeal disease (11%), (d) measles (3%), (e) injuries (4%) and (f) others (15%). The major causes of neonatal deaths are prematurity (18%), that is, birth of a child before 37 weeks of gestation, infections (16%) such as pneumonia and septicaemia and asphyxia (10%), that is, inability to establish breathing immediately after birth and congenital causes (5%). Preterm birth has emerged as the leading cause of neonatal death, underlying the need for rapid scale-up of maternal health interventions in order to improve neonatal health outcomes.





Source: Causes of maternal deaths in India, SRS 2001-03



Research Questions

What is the current status of supplies and availability and accessibility in RMNCH+A intervention at Barabanki district in Uttar Pradesh

Objectives

1. To assess the availability of drugs and equipment's coverage for RMNCH+A
2. To identify gaps in services delivery of RMNCH+A

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Methodology

- Study Design: - Descriptive Cross-sectional study.
- Study Area: - District Barabanki, Uttar Pradesh.
- Study Duration: - Three months (8^{th} February 2016 to 8^{th} May 2016).
- Sample Size: – Random sampling was done for PHCs and SC and CHCs with one district women hospital. The sample design was Quota study design and sample size was 21 health facilities
- Study Participants: - Staff Nurse and ANM (Auxiliary Nursing Midwives) ASHA of the identified level 1 level 2 and level 3 delivery points.

Method of Data Collection:

1. Interview of ANMs through Government of India supportive supervision tool.
2. Interview of Staff nurse.

2. Review of records.

Data Collection Technique-Interview with ANMs and staff nurse

Data Collection Tool- Government of India Supportive supervision.

Data Analysis Plan:

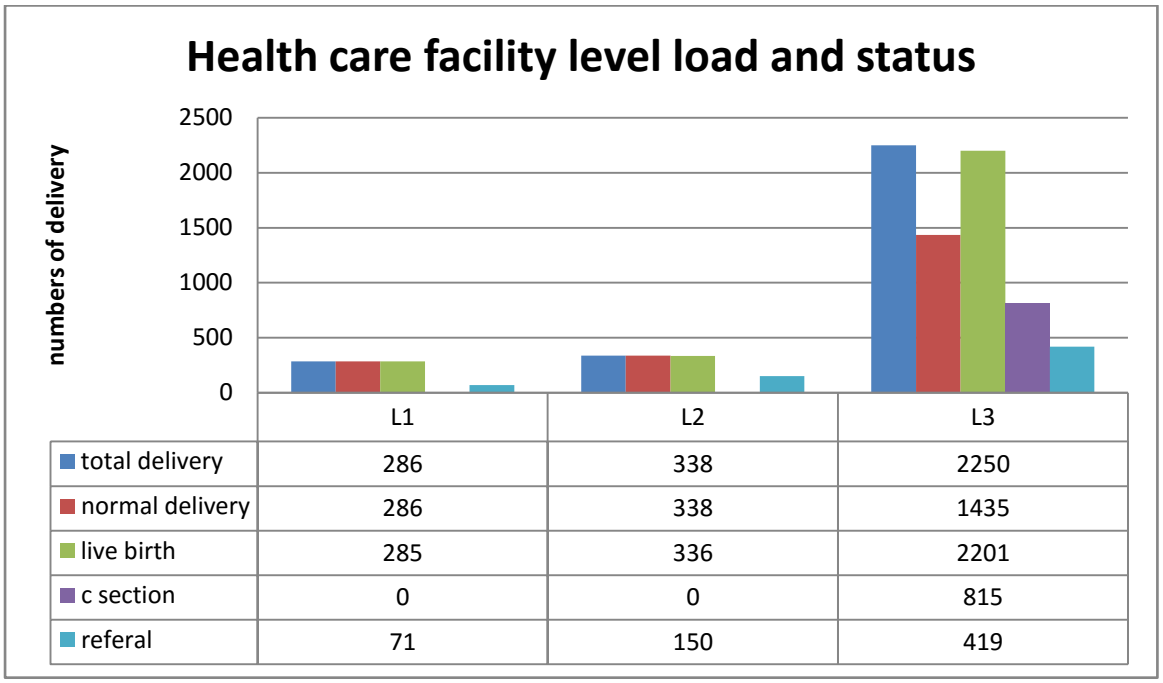
The data or information is compiled using MS Excel. Data is enter manually into the application and analyzed. Graphs and charts are being made using MS Excel package.

Ethical Considerations

- Data is collected after informed consent obtained after explaining the study objectives and procedure to the respondents.
- All information linked with personal identity of the respondents is only accessible to the principal investigator and will be removed from the data during all stages of analysis.

RESULTS

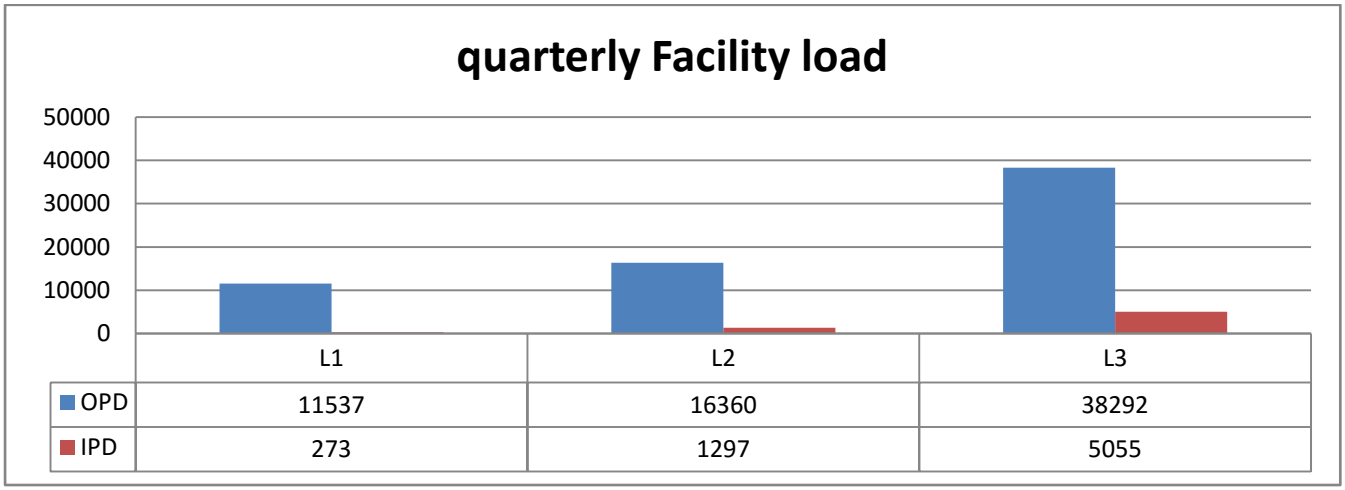
Table 1 Health care facility level load



	L1	L2	L3
total delivery	286	338	2250
normal delivery	286	338	1435
live birth	285	336	2201
c section	0	0	815
referal	71	150	419

Total L1(HSC and PHC including 24*7) facility load was 286 with all fall in normal delivery category but there was a death in past three months which having live birth 285.the referral is 71.As in L2 (CHC) total facility delivery 338 with 338 was normal delivery along with 336 live births reported. Total referral was 150.
In the L3 (FRU/DWH) facility total facility load was 2250 with normal delivery1435.live birth was reported 2201 and c section was 815, followed by 419 referral of three months.

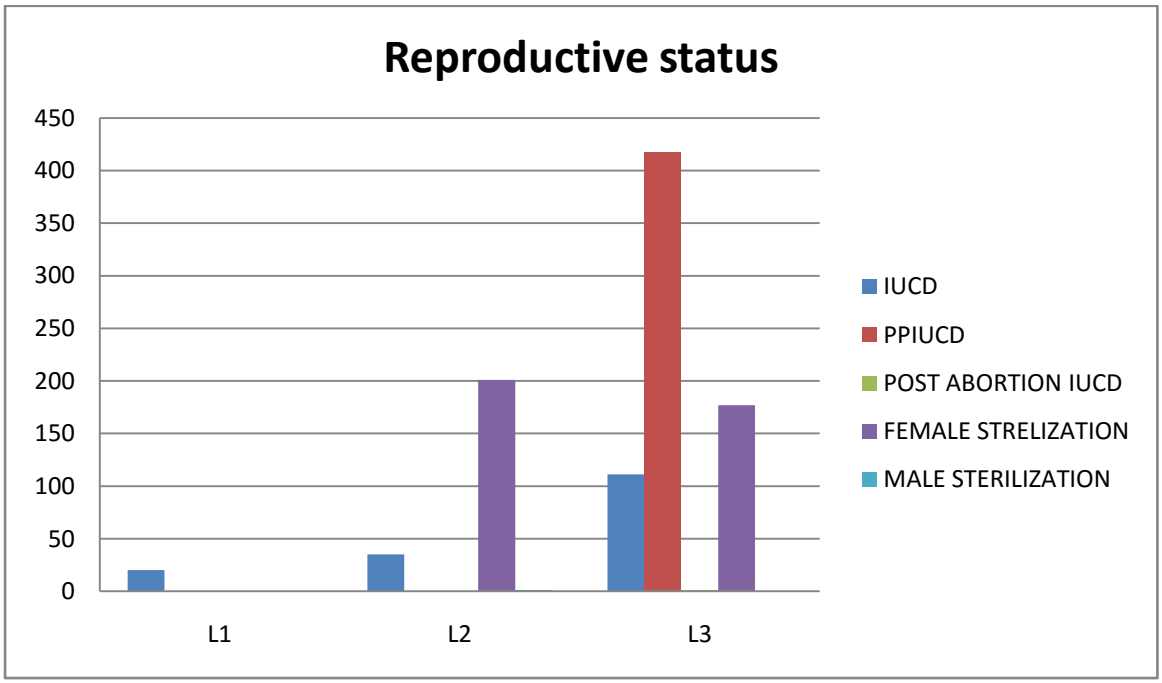
Table 2. IPD AND OPD LOAD..



The OPD load of L1 facility was 1157 followed by IPD load was 273 .In the OPD load of L2 facility was 16360 followed by IPD load was 1297.The OPD load of L3 facility was 38292 followed by IPD load was 5055

Break out of RMNCH+Aintervention in terms of accessibility and availability of resources at all three levels of health facility.

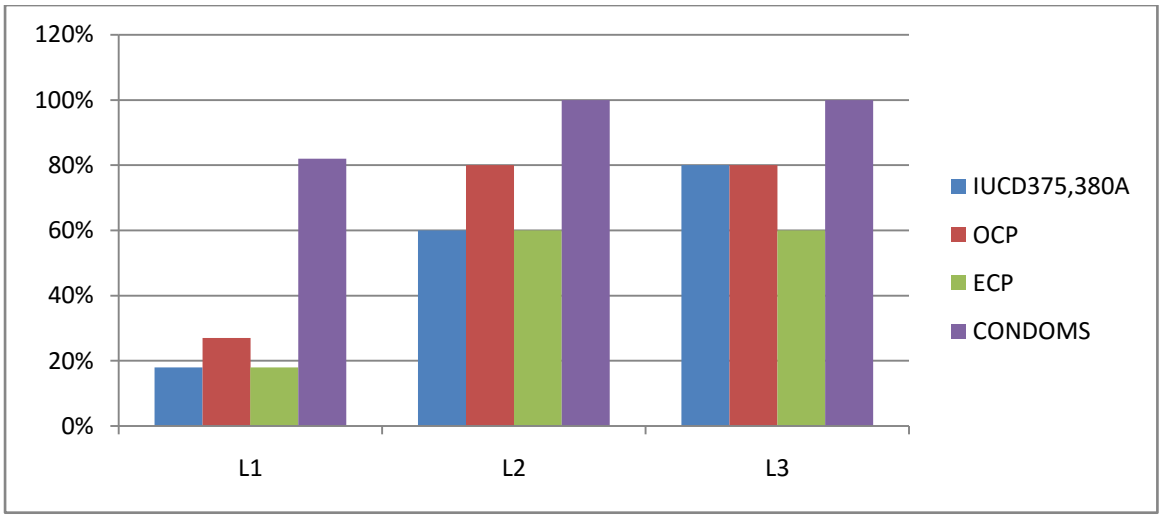
Table 3.REPRODUCTION HEALTH



Total number of delivery at L1 was 286 out of which 20 IUCD was only done (7%)Total number of delivery at L2 was n=335 out of which 35 IUCD (10%) was inserted with no PPIUCD reported, the female sterilization was 207(62%) and male sterilization was one only Total number of delivery at L3 was n= 2250 out of which IUCD was 111(5%), PPIUCD was 417 (19%), female sterilization was 177(8%) and zero male sterilization reported.

DRUGS AND SUPPLIES AVAILABILITY

Table 4 Reproductive health



Total number of L1 facility visited in three months-n=11

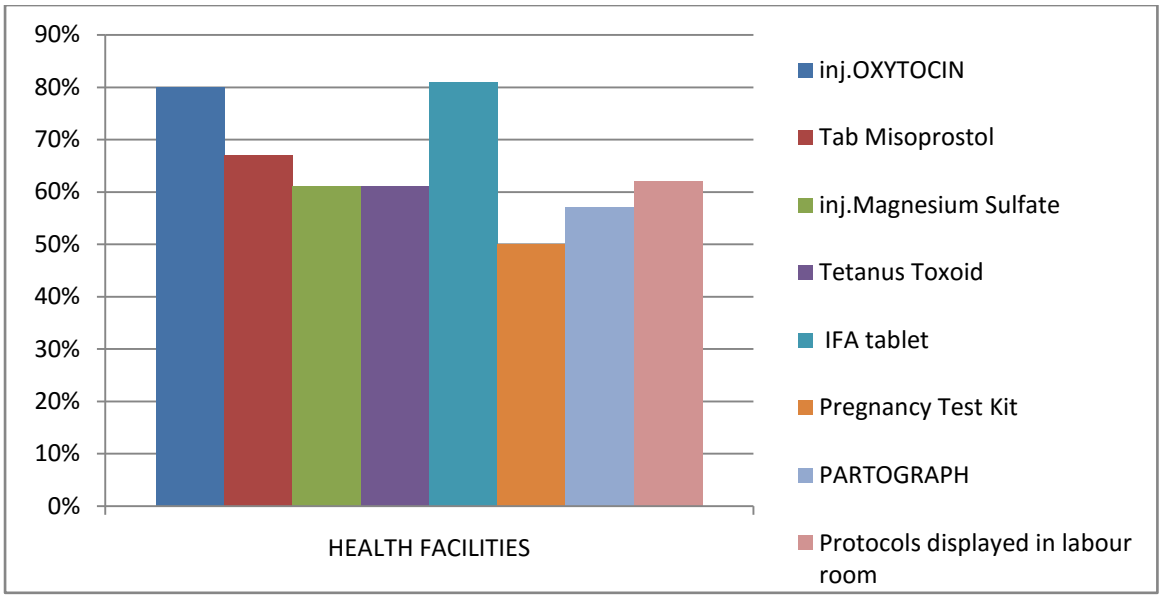
Out of 11 facilities only three facilities have IUCD375, 380A.so total availability was 27%. The OCP was only available at three facilities 27% only .ECP was only available at 2 facilities 18% only.Condoms available at all facility were 100%.

Total number of L2 facility visited in three months –n=5
Out of 5 facility only three facility have IUCD 375,380A means 60% .OCP is only available at 4 facility means 80% .ECP is only available at 3 facility means 60%condoms are available at all five facilities so it is 100%.

Total number of L3 facility visited in three months –n=5
N=5, out of 5 facility only four (80%) have IUCD375, 380A available.
OCP is only available at four facilities (80%).
ECP is available at three facilities (60%)
CONDOMS availability is five out of five (100%)

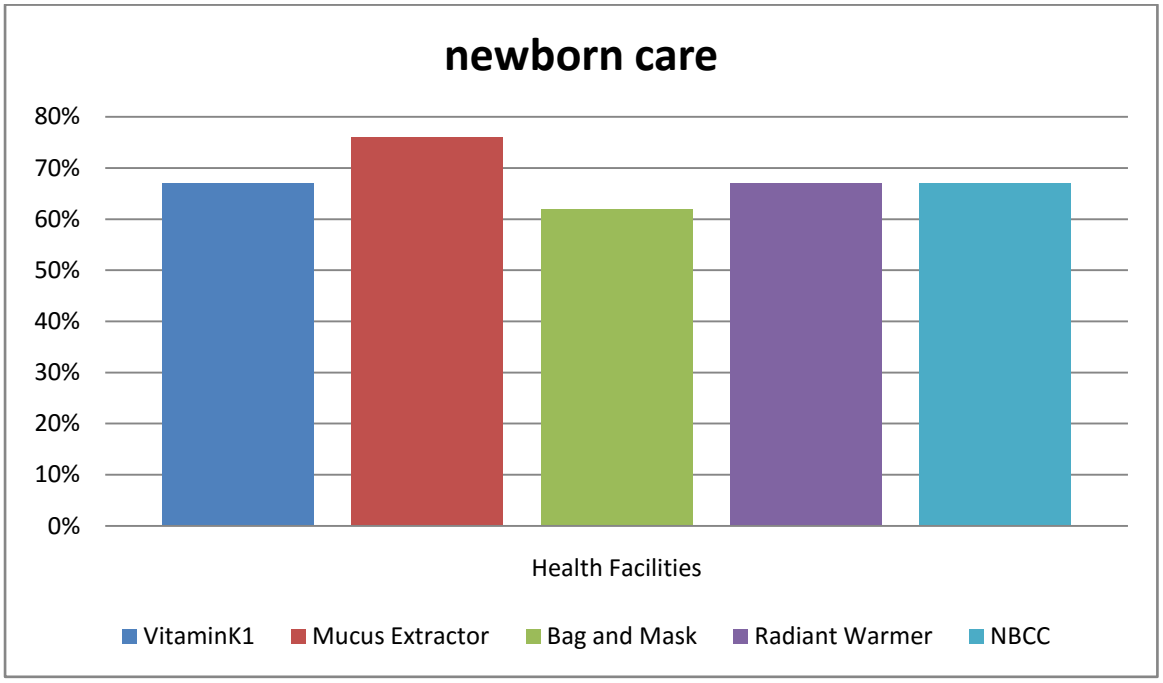
Table 5. MATERNAL HEALTH

.Availability status of drugs related to maternal care at the time of delivery.



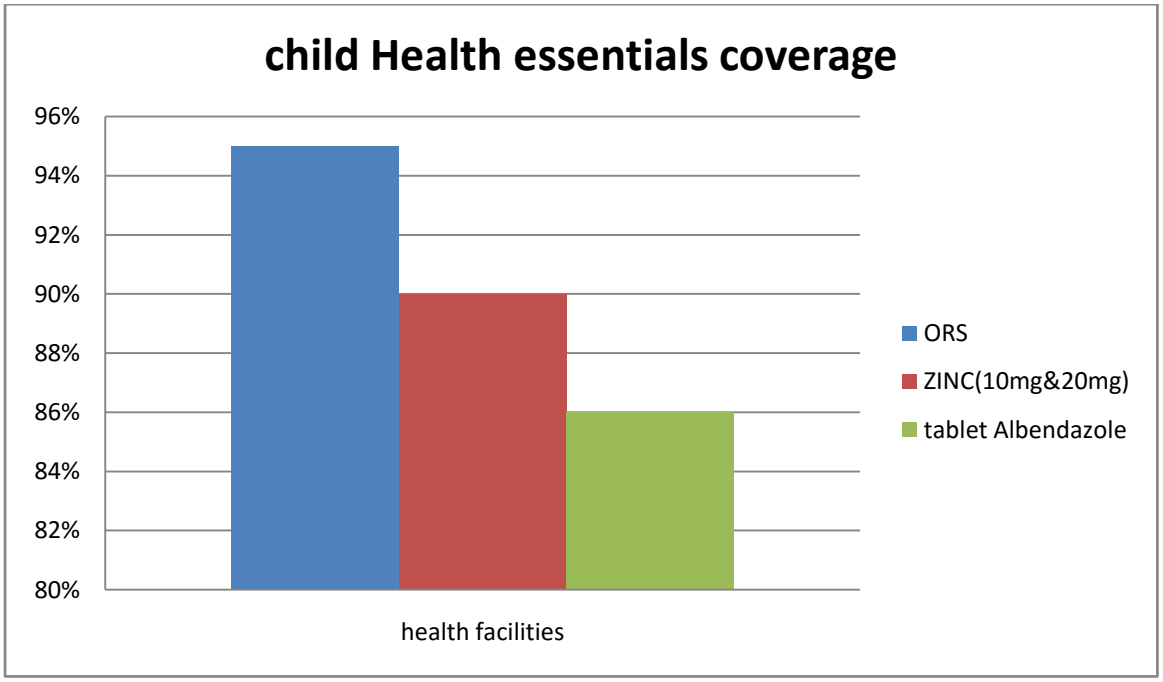
Total delivery point observed was twenty one. It has been seen that availability of injectable oxytocin was seventeen facilities (80%) the availability of tab misoprostol was at fourteen facilities (67%) the availability of injectable magnesium sulfate was 60%. the availability of tetanus toxoid was 60% .the availability of IFA tablet was 81%. the availability of pregnancy test kit was at only two sub center because it should be found in sub center.
The partographwas at twelve facilities (67%). theprotocols displayed in labour room were only at thirteen facilities (62%)

Table 6. Comparison of availability of drugs and essential of new born health.



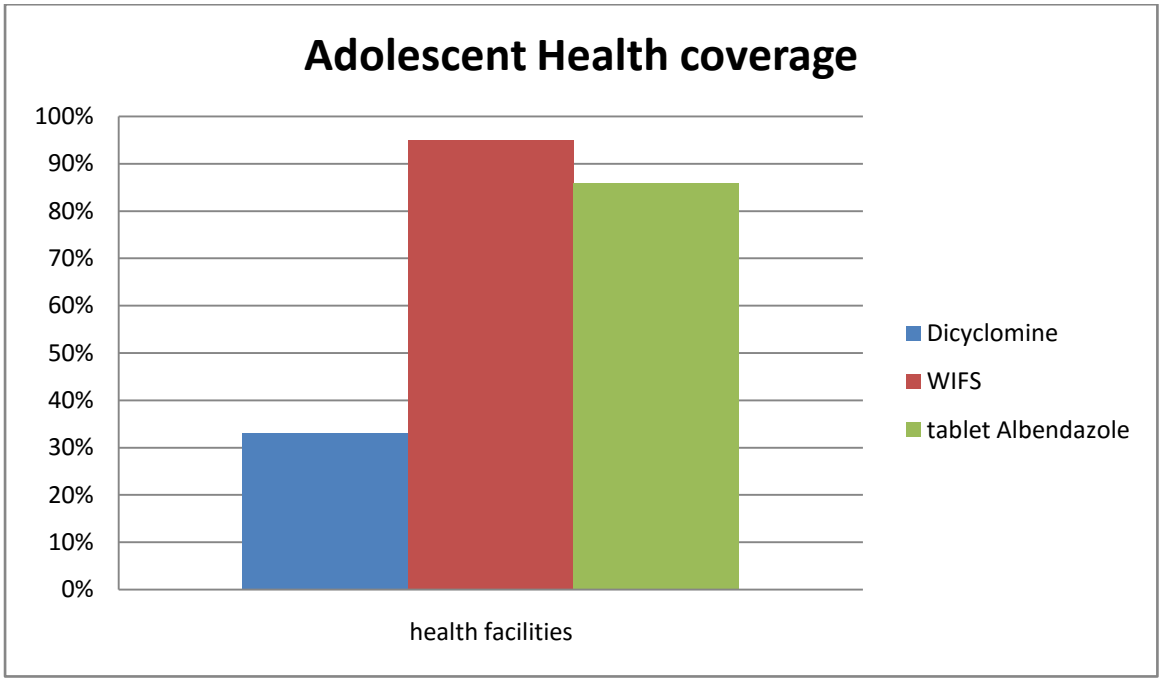
Out of total twenty one facilities vitamin k1 was only available at fourteen facilities (66%). the mucus extractor was available at sixteen facilities (75%),bag and mask available at thirteen facilities (61%) with radiant warmer available at fourteen facilities (67%)
And NBCC was at fourteen facilities (67%)

7. Table 7 child health drugs availability



Out of twenty one facilities observed ORS was present on twenty facilities (95%).The availability of Zinc was nineteen facilities (90%).The availability of syrup Albendazole was eighteen facilities (86%)

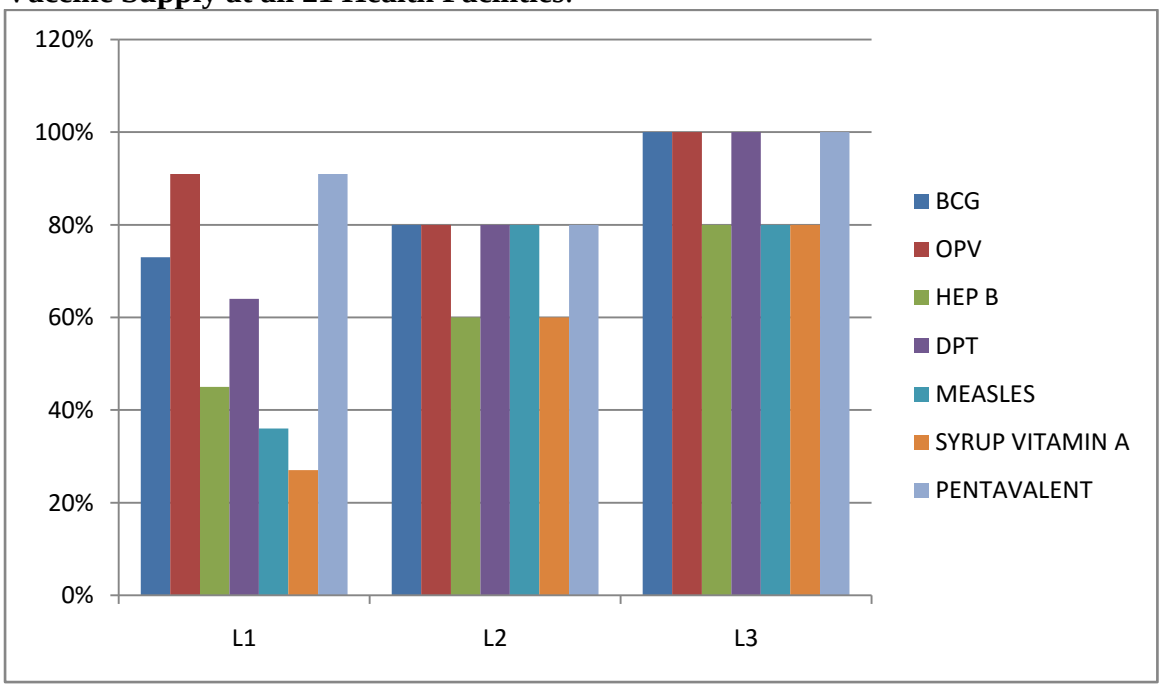
Table 8. Drugs availability of Adolescent Health coverage



Out of twenty one facilities Dicyclomine was available at only seven facilities (32%)
The availability of WIFS was at twenty facilities (95%)
The availability of tablets Albendazole at eighteen facility (85%)

Table9. Others essentials components

Vaccine Supply at all 21 Health Facilities.



At L1 Facility n=11

Out of total eleven facilities L1 Facilities BCG is available at only eight facilities (73%) At tenfacilities OPV was present (91%).Five facilities have only Hep B vaccine (45%)Seven facilities have DPT (64%).Four facilities have Measles vaccine (36%). Penatavalent was available at only 10 facilities (91%). Vitamin syrup was available only at 3 facilities (27%)

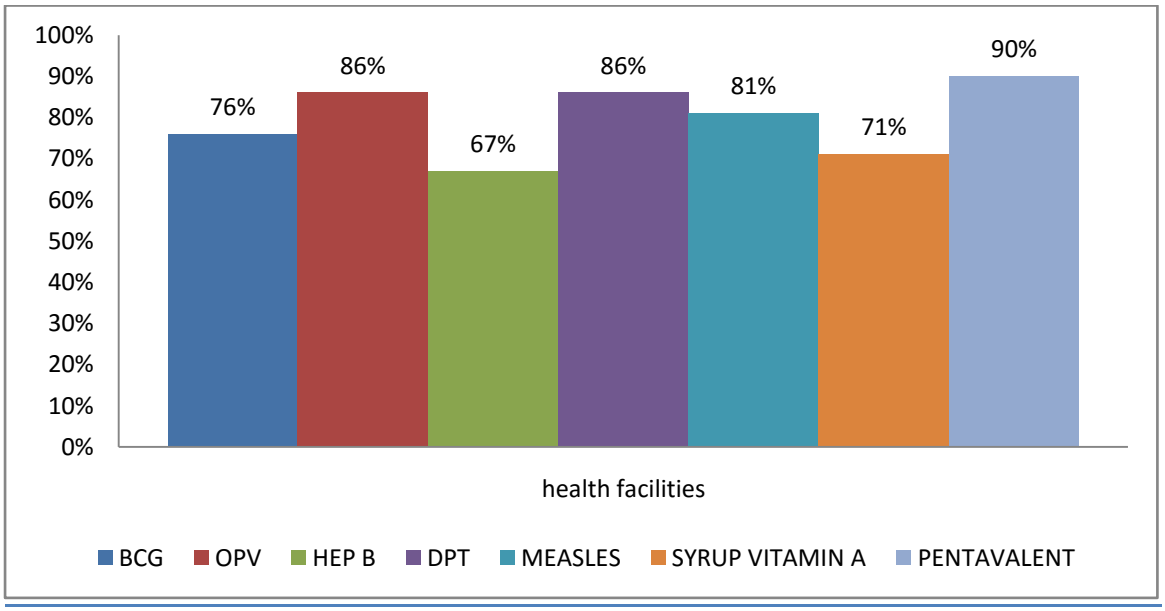
At L2 Facility n-=5

Out of total five Level 2 Facilities BCG was available at only in four facilities (80%). OPV availability was at four facilities (80%). Hep B availability was at only three facilities (60%) DPT availability was at four facilities (80%). Measles availability was at four facilities (80%) Syrup Vitamin was available at three facilities (60%).Pentavalent was available at four facilities (80%)

AT L3 Facility n=5

Out of total five L3 Facilities BCG was available at only in five facilities (100%).OPV availability was at five facilities (100%).Hep B availability was at only four facilities (80%) DPT availability was at five facilities (100%).Measles availability was at four facilities (80%) Syrup Vitamin was available at four facilities (80%). Pentavalent was available at five facilities (100%)

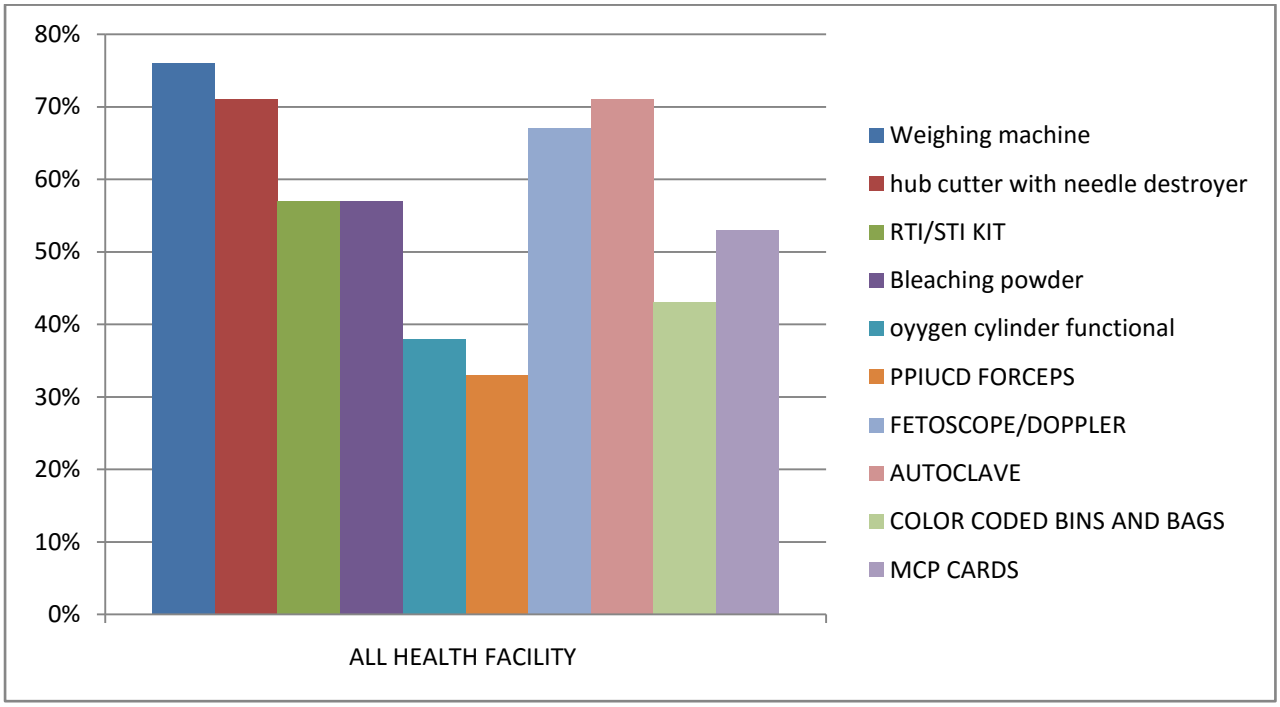
Table 10. VACCINES AVAILIBILTIY AT ALL TWENTYONE FACITIES.



Total twenty one facility was identified out of which at 16 facilities have BCG available (76%).OPV available at only eighteen facilities (86%).Hep B was available at fourteen

facilities (67%). Measles was available only at seventeen facilities (81%). Syrup Vitamin was present at fifteen facilities (71%). Pentavalent was available at nine teen facilities (90%)

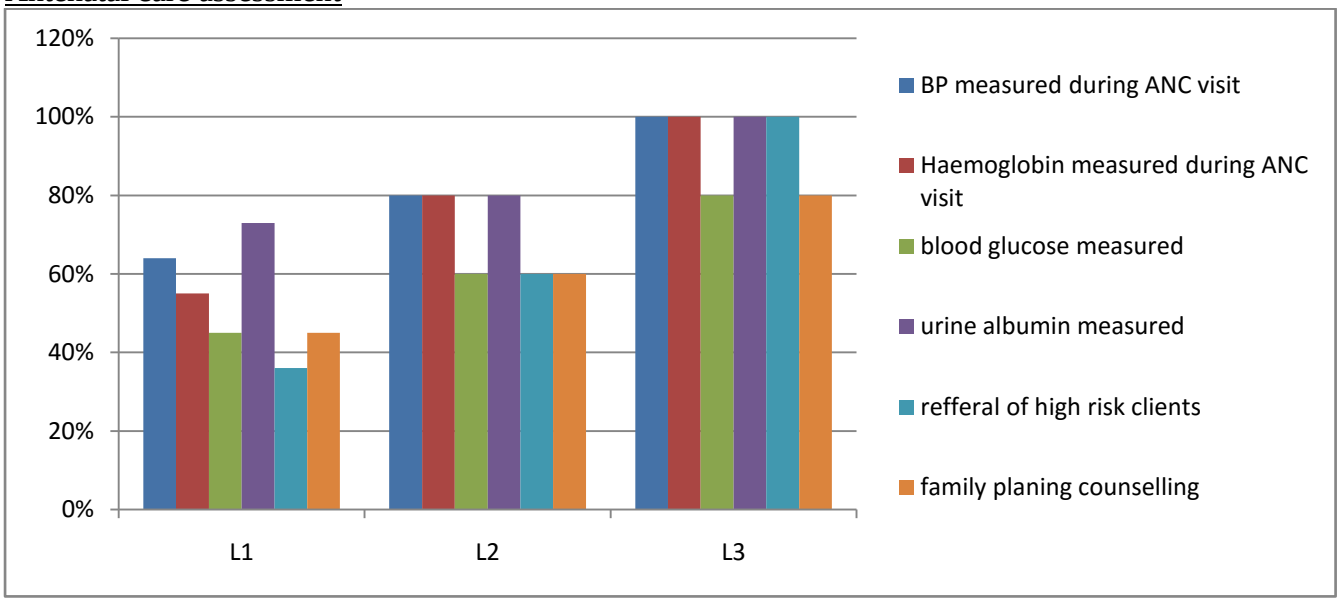
Table 11. OTHERS ESSENTIAL SUPPLIES AND EQUIPMENTS (FUNCTIONAL AND UTILIZATION) INFECTION PREVENTATAION



Out of twenty one facility .Weighing machine functional at only 16 facilities, 76%.Hub cutter was available only at 15 facilities 71%. RTI/STI kit was available at 12(57%).Bleaching powder was available at 12 facilities (57%). Oxygen cylinder was present at 8 facilities (38%)PPICUD forceps was available at 7 facilities (33%).Fetoscope/Doppler was available at 14(67%). Autocalve was available at 15 facilities (71%)Color coded bins was available at nine facilities (43%). MCP cards was available at 11 facilities (53%)

Table 12. Service accessibility at various level facilities

Antenatal care assessment



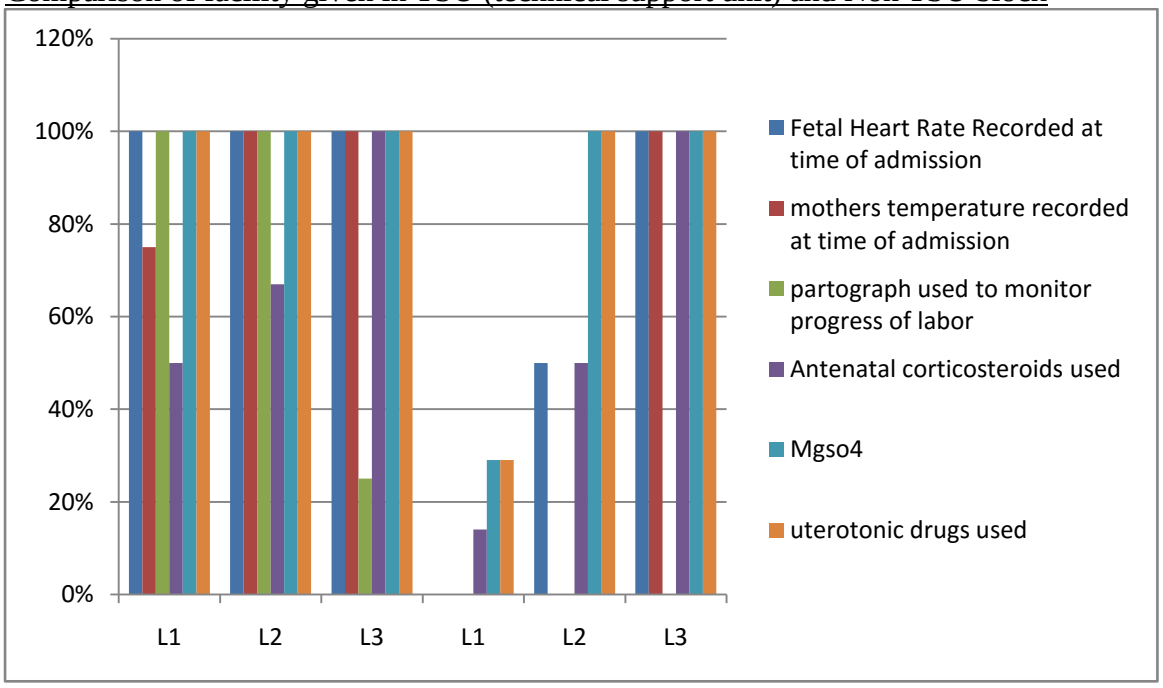
In Ante Natal Care assessment at eleven L1 facility at Barabanki District.
Blood Pressure measured during ANC visit is at only in 7 facilities(64%).Haemoglobinmeasured during ANC visit is at 6 facilities (55%).Blood glucose measured during ANC visit is at in 5 facilities. (45%).Urine Albumin measured during ANC visit is at 8 facilities. (73%)
Appropriate management /referral of high risk clients is only preforming at 4facilities (36%)
Family planning counseling happening during ANC visit is performing only at 5 facilities (45%)

In Ante Natal Care assessment at five L2 facility at Barabanki District.
Blood Pressure measured during ANC visit is at only in 4facility (80%) .Hemoglobinmeasured during ANC visit is at 4 facilities (80%).Blood glucose measured during ANC visit is at in 3 facilities. (60%).Urine Albumin measured during ANC visit is at 4 facilities. (80%)
Appropriate management /referral of high risk clients is only preforming at 3 facilities (60%)
Family planning counseling happening during ANC visit is performing only at 3 facilities (60%)

In Ante Natal Care assessment at five L3 facility at Barabanki District.
Blood Pressure measured during ANC visit is at only in 5facility(100%) .Haemoglobinmeasured during ANC visit is at 5facility(100%).Blood glucose measured during ANC visit is at in 4 facility.(80%).Urine Albumin measured during ANC visit is at 5 facility.(100%)
Appropriate management /referral of high risk clients is only preforming at 5facilities (100%) .Family planning counseling happening during ANC visit is performing only at 4facilities (80%)

Table 13.Intrapartum and immediate post –partum practices

Comparison of facility given in TSU (technical support unit) and Non TSU block



TSU blocks

L1-N=4Fetal Heart Rate Recorded at time of admission is at all four facilities (100%).Mothers temperature recorded at time of admission is done at three facilities(75%).partograph used to monitor progress of labour is filled at all four TSU blocks (100%).Antenatal corticosteroids used at only 2 facilities (50%).Mgso4 is used at all four facilities (100%) .Uterotonic drugs used at all four facilities (100%)

L2-N=3Fetal Heart Rate Recorded at time of admission is at all three facilities (100%).Mother's temperature recorded at time of admission is recorded at all four facilities (100%).partograph used to monitor progress of labour is all four facilities(100%).Antenatal corticosteroids used at two facilities (67%).Mgso4 is used at all three facilities (100%).uterotonic drugs used at all three facilities (100%)

L3-N4Fetal Heart Rate Recorded at time of admission is at all four facilities (100%).Mother's temperature recorded at time of admission is at all four facilities (100%).partograph used to monitor progress of labour is done only at one facility(25%) .Antenatal corticosteroids used at all four facilities (100%).Mgso4 is also at all four facilities (100%).uterotonic drugs used at all four facilities (100%)

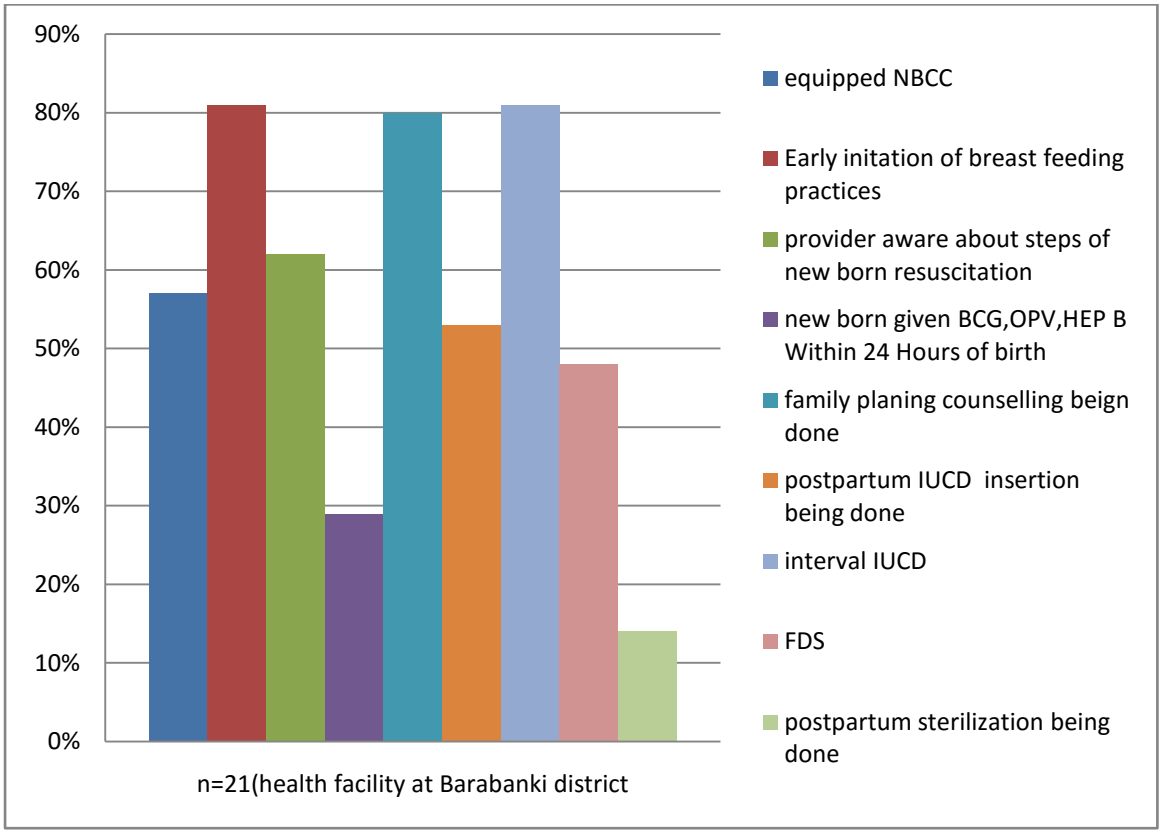
Non TSU blocks

L1-N=7Fetal Heart Rate Recorded at time of admission in not on L1 level (0%).Mothers temperature recorded at time of admission not recorded (0%).partograph is not functional in non TSU blocks(0%) .Antenatal corticosteroids used only at one facility(14%)
Mgso4 is at two facilities (29%).uterotonic drugs used at two facilities (29%)

L2-N=2Fetal Heart Rate Recorded at time of admission is at on one facility (50%)
No mother's temperature recorded at time of admission (0%)
No partograph used to monitor progress of labor(0%)
At one facility Antenatal corticosteroids used (50%).Mgso4 is used at all two facilities (100%).uterotonic drugs used is also used at two facilities(100%)

L3-N=1Fetal Heart Rate Recorded at time of admission is at one facility .Mothers temperature recorded at time of admission (100%).partograph not used to monitor progress of labor(0%).Antenatal corticosteroids used at one facility (100%).Mgso4 is also used at one facility (100%)uterotonic drugs used at one facility.(100%)

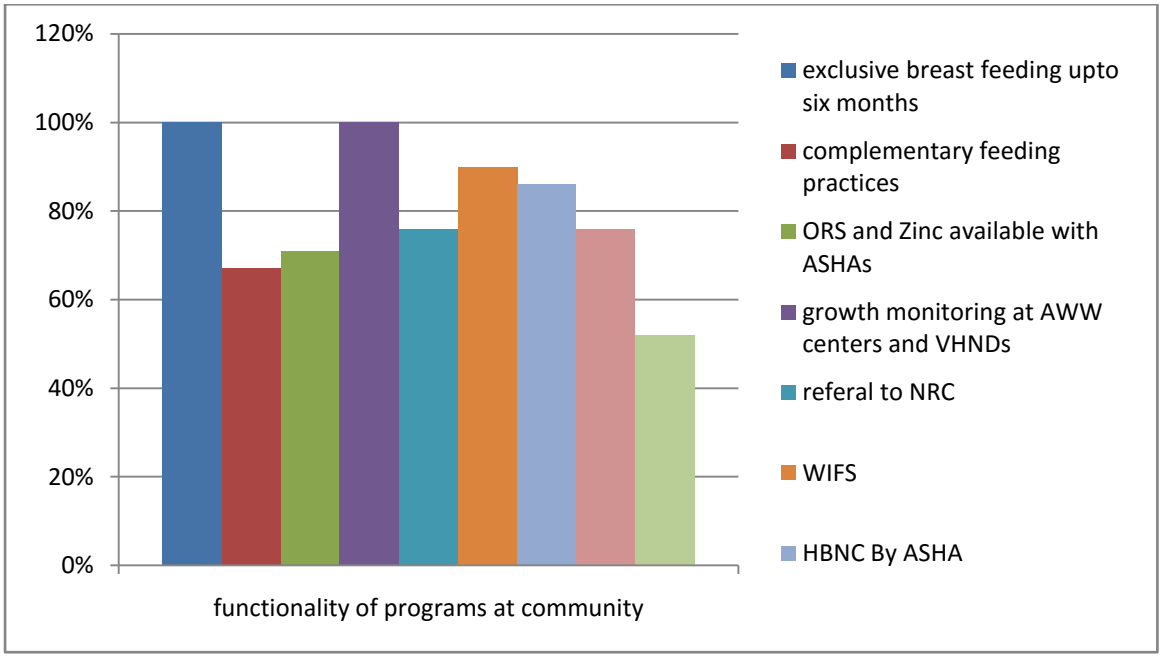
Table 14.Essential new born care (ENBC) and new born Resuscitation (NBR)



Out of total 21 facilities visited Equipped NBCC is only available at 12 facilities (57%)
Early initiation of breast feeding practices is only performed at 17 facilities (81%)
Provider aware about steps of new born resuscitation is only at 13 facilities (62%)
New born given BCG, OPV, HEP B within 24 Hours of birth is only at 6 facilities (29%)
Familyplanning counselling being done at 17 facilities (80%)
PostpartumIUCD insertion being done at 11 facilities (53%)
Interval IUCD is at 17 facilities (81%)
FDS was conducted at 10 facilities (48%)

Postpartum sterilization being done 3 facilities (14%)

Table 15.Services delivery at community level by ASHA and ANM



N=21 interview conducted at 21 facility by ANM and ASHA randomly .Exclusive breast feeding up to six months is done at all twenty one facilities (100%).Complementary feeding practices is only prevailing at 14 facilities (67%).ORS and Zinc available with ASHAs only at 15 facilities (71 %).Growth monitoring at AWW centres and VHNDs is at 21 facilities (100%).Referral to NRC is only done at 16 facilities (76%)
WIFS is distributed at 19 facilities (90%).HBNC by ASHA is done by 18 facilities ASHA (86%).HBNC kits available with ASHA are at 16 Facilities.(76%).Menstrual hygiene Practices being promoted at 11 facilities only (52%)

KEY FINDING

As compared quarterly delivery load then finding shows that L3 hospital (DWH/FRU) have very high delivery load with average delivery load 958. The C section is again followed in L3 facility that is only one district women hospital apart from this there is FRU but there is no any blood bank storage unit. Even in district women hospital don't have their own blood bank but district male hospital is same premises. Average referral among all facilities was 213 it shows that there was not proper handling of cases is being done. Quarterly IPD average load was 2208 and OPD average load was 220603.
If we see in reproductive health the average IUCD insertion was 55 on average delivery 958 of all the facilities which shows the poor indicator of family planning. On the quarterly basis only 8% was female sterilization was detected and only one male sterilization is being done. It is enough to show the poor indicator of family planning. As we see in availability of drugs

for reproductive health then at L1 facility there is very low of ECP 18% supplies among all other facility followed by 27% of IUCD supplies at L1. At L2 also ECP and IUCD supply 60%only.

Availability of drugs at maternal care basically if we talk about injetablesMgSO4 is only available is 60% by which Esclampsiaand pre Esclampsia management is properly done. The availability of partograph which is used to measure the progress of the labor is only is TSU blocks were IHAT is working is only showing 67%. The availability of drugs and essentials of new born health, the bag and mask is only present is 61% which is very low indicator for managing the Asphyxia in new born.

The availability of radiant warmer is only 67% among all facilities. Also the low distribution of tablet Albendazole. If we see in Adolescent health Dicyclomine availability is very poor at facility only 32%. The vaccine supplies at L1 faclity HEPB supply is only 45% followed by 27% vitamin syrup and Measles Vaccine is 36%. At L2 also Hep B availability is only 60% followed by in L3 HEP B, Measles and Syrup Vitamin supply is 80% only. If we see the overall availability HEP B is 67%, syrup Vitamin 71% is available only.

For the infection prevention quarterly data shows that color coded bins are only 43% which shows very poor facility of Bio medical waste management apart from this bleaching powder availability is only 57%. This indicator is enough for showing the poor status of infection control. The Fetoscope and Autoclave availability is only 67%, oxygen cylinder was present at eight facility only that is 38% only. In the Antenatal care assessment among all facility level at L1 having very low .such as in family planning counseling is only 45% was done, blood glucose measure indicator was 45%. Apart from that risk management only performing at eleven facilities with 36% only over all.

As comparisons is made in TSU (technical support unit blocks) and Non TSU blocks in Intrapartum and Immediate post-partum practices. In TSU blocks Fetal Heart Rate recorded at time of admission is 100%, partograph is filled is 100%, utertonic drugs use is 100%. The basic difference is that mother temperature recorded at time of admission is 77% in L1 and in L2 and L3 IS 100%. But in non TSU block it is not recorded in L1 and L2 only in one FRU which is L3 it is done. AntentalCorticosteriods used at all level L1 was 50%, L2 was 67% and in L3 100% But in non TSU block L1 is 14%, L2 (50%).
Essential New Born care and new born Ressuscitation equipped NBCC is available at L2 facility (57%). The services delivery at community level by ASHA and ANM .The status of menstrual hygiene is only 52%. The referral at NRC was done only 76% because they are unaware to detect the SAM child.

WAY FORWARD

Facility Action Plan.

	Major findings	Activities identified	Level of intervention	Responsibility	Time line
Reproductive health	Unavailability of ECP	Lack of supply	Indent not done	MOIC,DPM ,HEO	1 MONTH
Maternal health	Unavailability of oxytocin	Lack of supply	Local purchase procurement	MOIC,DPM ,HEO	15 days
New-born health	Vitamin k not available	Shortage of govt.supply	Local purchase	MOIC ,DPM HEO	1 MONTHS
Child health	Tab Albendazole	At main store (not available at facility)	Indent from Moic	CMO,MOIC	1 MONTH
Adolescent health	Not available Dicyclomine	Lack of supply	Local purchase	CMO,MOIC,DPM	1 MONTH

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Annexure

Supportive Supervision Checklist

C1: Name of the supervisor -	C2: Designation -	C3: Level of supervisor - Block / District / State /National / Other
C4: Facility Name – Block District	C5: Facility Type - SC/ Non 24*7 PHC /24*7 PHC/Non- FRU CHC/FRU CHC/SDH/DH/AREA HOSP/other	C6: Facility Level - L1/ L2/ L3
C7: Date of visit -	C8: Name of Facility in-charge/nodal officer -	C9: Designation of In-charge-

Data of previous month from facility

D1 Number of deliveries in facility

Total Deliveries	
Normal	
Assisted Vaginal Delivery	
C-section	
Referred out cases	
Live births	

D2 Number of new-borns immunized before discharge

D3 IPD load

D4 OPD load

D5 IUCD inserted in facility

Interval	
Postpartum	
Post Abortion	

D6 Sterilization done

Female interval sterilization	
Female postpartum sterilization	
Male sterilization	

D7 No. of clients received CAC services

D8 No of women received IFA tab

D9 No. of ANC clients with high risk conditions

D10 HR deployed/posted in Labor Room

	Posted	Trained in		
		SBA/ BEmOC	PPIUCD	NSSK
MO				
ANM/Staff nurse				

E Drugs/supplies availability (If possible, verify physically)

E1: Reproductive Health		E3: New Born Health		E7. Antibiotics	
E1.1: IUCD 375, 380A	☐	E3.1: Inj. Vit K1 (1 mg/ml)	☐	E.7.1 Antibiotics as per RMNCH+A 5X5 Matrix (Amoxyclillin, Ampicillin, Ampicillin, Gentamicin, Metronidazole, Trimethoprim & Sulphamethoxazole, Cefrtiaxone (oral/IM/IV as applicable)	☐
E1.2: OCP	☐	E3.2: Mucus Extractor	☐	**E8: Other essential supplies & equipments(check functionality & utilization)**	☐
E1.3: ECP	☐	E3.3: Bag and mask (240 ml) with both pre & term mask (size 0,1)	☐	E8.1 Weighing Machine	☐
E1.4: Condoms	☐	E3.4: Clean linen/towels for receiving new born	☐	E8.2: Hub cutter with needle destroyer	☐
E1.5: Mifepristone + Misoprostol (MMA)	☐	E3.5: Sterile cord cutting equipment	☐	E8.3: Refrigerator	☐
E1.6: MVA Kit/EVA	☐	E3.6: Designated Newborn Care Corner	☐	E8.4: RTI/STI Kit	☐
E2: Maternal Health		E3.7: Functional Radiant Warmer	☐	E8.5: Bleaching Powder	☐
E2.1: Inj. Oxytocin (check whether stored in cold box/refrigerator)	☐	**E4: Child Health**		E8.6: Oxygen Cylinder functional	☐
E2.2: Tab Misoprostol	☐	E4.1 ORS	☐	E8.7: BP apparatus with stethoscope	☐
E2.3: Antihypertensive (alpha methyldopa/Labetalol or Nifedipine)	☐	E4.2: Zinc (10mg & 20 mg)	☐	E8.8: Thermometer	☐
E2.4: Inj. Magnesium Sulfate	☐	E4.3: Syp Salbutamol/Salbutamol Nebulizing Solution	☐	E8.9: PPIUCD Forceps	☐
E2.5: Inj. Tetanus Toxoid	☐	E4.4: Tablet Albendazole	☐	E8.10: Fetoscope/ Doppler	☐
E2.6: Sterile pads	☐	**E.5: Adolescent Health**		E8.11: Autoclave/Boiler	☐
E2.7: IFA Tablet	☐	E5.1: Dicyclomine	☐	E8.12: Running water	☐
E2.8: Pregnancy Test Kit (only at sub-centres and with ASHAs)	☐	E5.2: Weekly Iron folic acid supplementation tablets	☐	E8.13: Soap	☐
E2.9: Functional Blood Bank/blood storage units	☐	E 5.3 Tablet Albendazole	☐	E8.14: Color coded bins and bags	☐
E2.10: Haemoglobinometer	☐	**E6: Vaccines**		E8.15: Electricity back-up	☐
E2.11: Urine albumin kit	☐	E6.1: BCG	☐	E8.16: Toilet near LR	☐
E 2.12: Blood grouping typing	☐	E6.2: OPV	☐		
E 2.13:HIV screening	☐	E6.3: Hep B	☐		
E 2.14:Hepatitis B screening	☐	E6.4: DPT	☐	E8.17: Cold box, ILR, Deep freezer present for vaccine storage as per requirement	☐
E2.15: Partograph	☐	E.6.5: Measles	☐		
E2.16: Protocols displayed in LR	☐	E.6.6: Syrup Vit. A	☐		
E2.17: IV Fluids	☐	E.6.7: Pentavalent vaccine (in relevant states)	☐	E 8.18 MCP cards	☐
E 2.18 Inj Dexamethasone	☐	E.6.8 JE Vaccine (where relevant)	☐		