ASSESSMENT OF SEXUAL AND REPRODUCTIVE HEALTH SERVICE AT 24X7 PHCS IN FOUR DISTRICT OF RAJASTHAN

Dissertation
At
Prayas, Chittorgarh

By
Pankaj Mahure

Under the guidance of
Dr. Anoop Khanna

MBA Hospital & Health Management
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2015

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 Dr. Pankaj Mahure student of MBA in Hospital and Health Management from the IIHMR University, Jaipur has undergone internship training at Prayas, Chittorgarh from 14th March to 13th May 2015.

This candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course requirement.

I wish him all the success in all his future endeavours.

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प्रयास Prayas

Certificate of completion of dissertation

This gives me immense pleasure to certify that Dr. Pankaj Mahure, student of MBA Hospital and Health Management at the IIHMR University, Jaipur has successfully completed his dissertation titled **'Assessment of Sexual and Reproductive Health Services at 24x7 PHCs in four districts of Rajasthan'** from Prayas, Chittorgarh, Rajasthan. Dr. Pankaj Mahure is committed, sincere and diligent person with sharp analytical skills. I wish him all the success in his future endeavours.

Dr. Narendra Gupta
Adviser

F. No: 40/15
May 13, 2015

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

IIHMR UNIVERSITY

CERTIFICATE BY SCHOLAR

This is certified that the dissertation titled "Assessment of Sexual and Reproductive Health Services at 24x7 PHCs in Four Districts of Rajasthan" and submitted by Dr. Pankaj Mahure Enrollment No. 1473 under the supervision of Dr. Anoop Khanna for award of MBA in Hospital and Health Management of the Institute carried out during the period March 14 to May 13, 2015 embodies my original work and has not formed the basis for the award of any degree, diploma associated ship, Fellowship, title in this or any other similar institution of higher learning.

P.K. Mal

Signature

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ACKNOWLEDGEMENT

It gives me immense pleasure to remember the moments when my teachers, seniors and batch mates were extending their support and guidance to me. I feel highly fortunate to express my deep sense of gratitude to all of them at this moment.

At the outset I feel great pleasure to express my sincere regards to Dr. Anoop Khanna, Professor, IIHMR University for his incessant moral boosting, inspiring encouragement, patients and ever readiness to help. It is my privilege to work under his dynamic supervision.

I am sincerely thankful to Dr. Narendra Gupta, Prayas, my external guide who lent me a caring and supporting hand throughout my dissertation period.

It gives me immense pleasure to express gratitude and thanks to my family and friends, which constantly fostered me for my efforts during this learning period and made me free from all the responsibilities.

I am thankful to the faculty at IIHMR University, Jaipur for providing me the invaluable learning experience.

Last but not least I would like to thank god for all that I achieve every day by his grace.

Pankaj Mahure

PREFACE

Dissertation is an integral part of the MBA curriculum. As a part of course; students of the second year are required to undergo summer training at an organization to get in depth exposure of the organization and understanding of the health care delivery system.

The major objective of the dissertation programs are to better understand the existing health delivery system, observe the implementation of various National Health Programs at National/State/District levels, understand various functions of health systems by interactions with key stakeholders, policy makers program managers, academicians and researchers and work on the project/task assigned by summer training organizations.

During our training period we had an opportunity to work for Prayas, Chittorgarh in their ongoing project of SRHR (Sexual and Reproductive Health Rights).

List of Abbreviations

S. No.	Abbreviation	Full Form
1	**AIDS**	Acquired Immune Deficiency Syndrome
2	**ANC**	Ante Natal Care
3	**ANM**	Auxiliary Nurse Midwife
4	**BemOC**	Basic Emergency Obstetric Care
5	**ECP**	Emergency Contraceptive Pills
6	**FW**	Female Worker
7	**HLD**	High Level Disinfected
8	**HPDs**	High Priority Districts
9	**IPHS**	Indian Public Health Standards
10	**IUD**	Intra Uterine Device
11	**JFM**	Joint Forestry Management
12	**LHV**	Lady Health Visitor
13	**MO**	Medical Officer
14	**MTP**	Medical Termination of Pregnancy
15	**MVA**	Manual Vacuum Aspiration
16	**NGO**	Non Government Organization
17	**NHPDs**	Non High Priority Districts
18	**OCP**	Oral Contraceptive Pills
19	**OT**	Operation Theatre
20	**PHC**	Primary Health Centre
21	**PPS**	Probability Proportion to size
22	**RPR**	Rapid Plasma Reagin
23	**RTI**	Reproductive Tract Infections
24	**SRHR**	Sexual and Reproductive Health Rights
25	**STI**	Sexual Tract Infections
26	**UN**	United Nations
27	**UNICEF**	United Nations Children's Fund
28	**VDRL**	Venereal Disease Research Laboratory

Dissertation

Background:

There is widespread and growing demand for primary health care in developing countries especially in India. This demand in turn displays a growing eagerness among policymakers and program managers for knowledge related to how health systems can become more equitable, inclusive and fair (1). The declaration of Alma-Ata on primary health care in 1978 guided and directed path for establishing effective primary health care in member countries and especially in India (7). Further, the Bhore Committee (1946) strongly proposed the primary health care approach for effective and equitable health care services in India (8).

There are several reproductive health concerns in India which need to address in order to improve reproductive health status of people. Reproductive health programmes must place emphasis on improving access to quality reproductive health services by gender sensitive providers. There are 2-3 million people living with HIV in India and up to 90% of these people do not know their HIV status. (11). 5% of the whole population of reproductive age in India (approximately 25 million people) suffer from a reproductive tract (RTI) or sexually transmitted infection (STI). (12) Maternal death and disability can be reduced dramatically if every woman has access to health services throughout her lifecycle, especially during pregnancy and childbirth. The highest priority needs to be given to ensuring that women have access to skilled birth attendants at the time of giving birth and that woman who develop life-threatening complications during pregnancy, childbirth or post partum can immediately access treatment at adequately-equipped facilities. National government has made efforts since independence in 1947 to improve health infrastructure and access to primary care including delivery care. (2). Despite having tiered healthcare system to improve access for the basic healthcare needs including obstetric care at the community level, significant proportion of population in rural areas do not have round the clock access (3). Under the National Rural Health Mission, launched in the year 2005, fundamental changes were made in the health care delivery system with a view to make it accountable, accessible and affordable system of quality maternal health care (4).

Unmet need for family planning is an important indicator for assessing potential demand for family planning in India There is a high unmet need for family planning, with 6.2 % for spacing and 6.6% for limiting methods among currently married women. Nearly 63,000 Indian women, accounting for almost 18 per cent of estimated global maternal deaths, die every year due to causes related to pregnancy and childbirth. Available data also indicates that a significant proportion of women suffer from obstetric morbidities. There are 23,673 PHCs are functioning according to Rural Health Statistics Bulletin 2010 of Ministry of Health and Family Welfare, Government of India and out of them 8409 are functioning as 24 × 7 (10).
The IPHS for PHCs are designed to provide comprehensive primary health care to the community through these centres, to achieve and maintain an acceptable standard of quality of care, to make the services more responsive and sensitive to the needs of the community. IPHS is a novel concept to fix benchmarks of infrastructure, including building, manpower, equipments, drugs, and quality, through introduction of treatment protocols, and accountability to the public, through the concept of citizen's charter enforced through the hospital management society at the health facility level and quality assurance committee at state and district levels. (13) As per the recommendations of the revised draft of the IPHS for PHCs (2010), 24×7 PHCs should have functional

operation theatre (OT), labour room, cold chain facility and laboratory facility. According to the revised draft of the IPHS for PHCs (2010), 24×7 PHC should have two medical officers, five staff nurses, study shows that there is a less number of medical officers, staff nurses (9). To explore the issue, recently the Planning Commission of India carried out a study to evaluate the functionality of 24x7 health care facilities in high focus states and found that health system issues such as infrastructure and logistics that adversely affected the performance of these facilities (5). Medical termination of pregnancy (MTP) services, facility for tubectomy and vasectomy, and facility for internal examination for gynaecological conditions were poor at PHCs, which need to be addressed for further strengthening of primary health centres. (13)

Demographic profile (AHS 2012-13)

Indicators	Banswara	Rajsamand	Baran	Pratapgarh	Rajasthan
Total population (Census 11)	17,98,194	9,87,024	12,22,755	8,67,848	6,85,48,437
Total tribal population (Census 11)	13,72,999 (76.4%)	1,60,809 (13.1%)	2,76,856 (21.2%)	5,50,427 (63.4%)	92,38,534 (13.5%)
Rural tribal population (Census 11)	6,83,104 (49% of total tribal pop.)	75,628 (47% of total tribal pop.)	1,36,520 (49% of total tribal pop.)	2,74,113 (50% of total tribal pop.)	86,93,123 (94% of total tribal pop.)
CBR	30	27.1	24.9	-	24.1
CDR	7.2	8.2	6.4	-	6.4
Natural growth rate	22.8	18.9	18.5	22.78	17.7
Sex Ratio	984	1017	940	983	932
Total literacy rate	66.3	73.6	75.4	55.97	74.2
TFR	3.9	3.4	3	-	2.9

Research Question:

1. What is the availability of sexual and reproductive health services at 24x7 PHCs as per IPHS guidelines in HPDs and NHPDs of Rajasthan?

Objectives of the study:

1. To assess the availability of sexual and reproductive health services at 24x7 PHCs.
2. To identify the gaps in sexual and reproductive health services at 24x7 PHCs.
3. To compare the sexual and reproductive health services at 24x7 PHCs of HPDs and NHPDs.

Research Methodology

Study type- Descriptive study, cross sectional
Study Duration-2 months
Study Area- 24x7 PHCs
High Priority Districts- Rajsamand, Banswara

Non High Priority Districts- Baran, Pratapgarh
Selection criteria- Majority of the population of these four selected districts is live in rural area.

Study Respondents- Medical officers, ANMs, LHVs, Pharmacists, Lab technicians

Sample Size Determination
Sampling technique-Probability Proportion to Size (PPS)
Sample size- 20% of 24x7 PHCs in the selected districts.

Rajsamand- 5 PHCs (20% of 25 PHCs)
Banswara- 5 PHCs (20% of 27 PHCs)
Baran- 5 PHCs (20% of 23 PHCs)
Pratapgarh- 2 PHCs (20% of 11 PHCs)
Medical officers- 17
ANMs- 17
LHVs- 17
Pharmacists- 17
Lab technicians- 17

Data collection:
Observation: By facility check list which is developed for 24x7 PHCs as per IPHS guideline; information regarding sexual and reproductive health services, infrastructure and personnel, equipments, drugs and supplies available at health centres is gathered.

Interview schedule: Facility check list which is developed for 24x7 PHCs would be used to seek information on the Human resources, infrastructure, equipments, drugs and supplies and services regarding sexual and reproductive health services at 24x7 PHCs.

Ethical Consideration:
An informed consent would be obtained from all the respondents before interview. Participation in the study would be voluntary and participants shall have all the rights to withdraw from the study at any time.

Data Analysis: The collected data was entered into SPSS to perform analysis and accordingly required tables and graphs were generated and interpreted.

Work Plan:

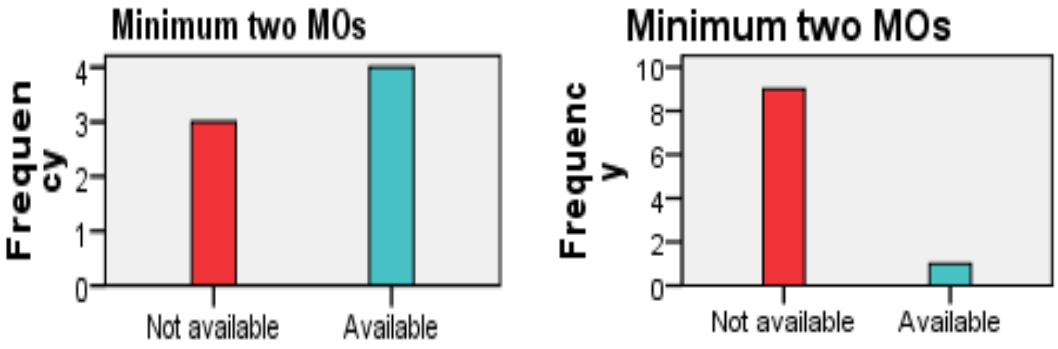
S No.	Tasks	Timeline	Duration
1)	Document study	15th March 15 to 21st 15	7 days
2)	Development of study design and tools	22nd March 15 to 2nd April 15	12 days
3)	Field testing of tools	3rd April 15 to 8th April 15	6 days
4)	data collection	9th April 15 to 22nd April 15	14 day
5)	Data entry	23rd April 15 to 27th April 15	5 days
6)	Data analysis	28th April 15 to 3rd May 15	6 days
7)	Finalization of Data And Report writing	4th May 15 to11th May 15	8 days

Results:

A. Human Resource

1) 24x7 PHCs having minimum two MOs (In NHPDs, n=7 & In HPDs, n=10)

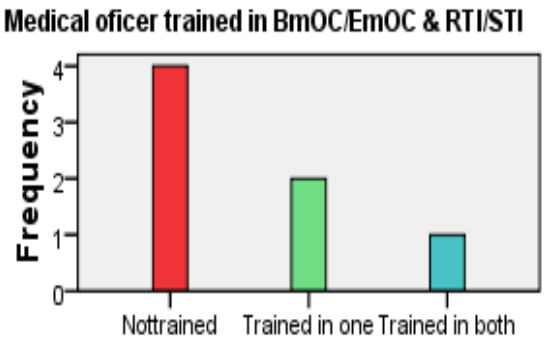
NHPDs **HPDs**

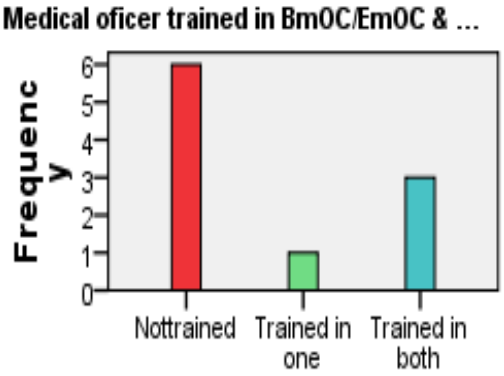


Out of seven selected 24x7 PHCs in non high priority districts, four PHCs have minimum two medical officers whereas three PHCs have only one medical officer. In two high priority districts, out of ten 24x7 PHCs, only one PHC has minimum two medical officers whereas nine PHCs have only one medical officer.

2) **24x7 PHCs having at least one trained Medical Officer in handling Basic Emergency Obstetric Care and RTI/STI (In NHPDs, n=7 & In HPDs, n=10)**

NHPDs **HPDs**





Out of seven 24x7 PHCs in Non High Priority Districts, only one PHC has trained medical officer in both BemOC and RTI/STI, two PHCs have trained MO in only one service and four PHCs have no medical officer trained in both BemOC and RTI/STI. Out of ten 24x7 PHCs High Priority Districts, three PHCs have trained medical officer in BemOC and RTI/STI, only one PHC has trained MO in only one service and six PHCs have no medical officer trained in both BemOC and RTI/STI.

3) **24x7 PHCs having trained and registered Medical Officer to conduct MTP (In NHPDs, n=7 & In HPDs, n=10)**

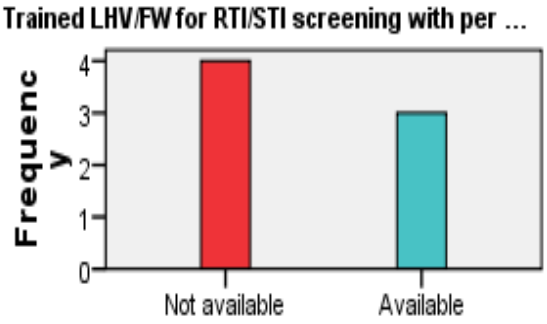
NHPDs **HPDs**

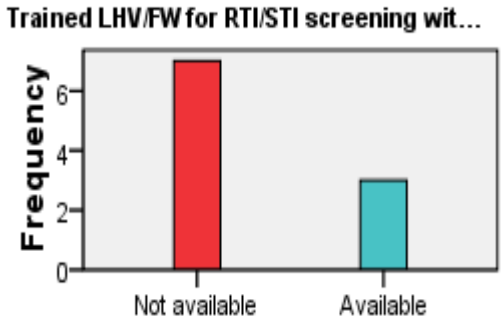
According to analysis, out of seven 24x7 PHCs in non high priority districts, only one PHC has trained and registered Medical Officer who can conduct MTP whereas six PHCs have no trained and registered MO to conduct MTP.

In addition, the analysis of high priority districts suggests three 24x7 PHCs have trained and registered Medical Officer to conduct MTP whereas seven PHCs have no trained and registered MO to conduct MTP.

4) **24x7 PHCs having trained LHV/FW for RTI/STI screening with per speculum examination (In NHPDs, n=7 & In HPDs, n=10)**

NHPDs **HPDs**

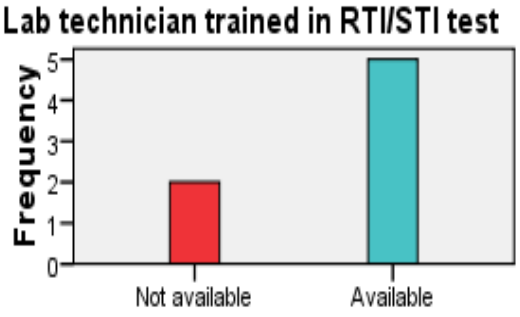


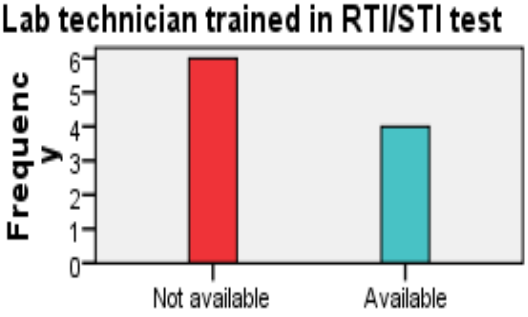


Out of seven 24x7 PHCs in non high priority districts, three PHCs have trained LHV/FW for RTI/STI screening with per speculum examination and four PHCs have no trained LHV/FW for RTI/STI screening with per speculum examination.
In high priority districts, out of ten 24x7 PHCs, three PHCs have trained LHV/FW for RTI/STI screening with per speculum examination whereas seven PHCs don't have trained LHV/FW for RTI/STI screening with per speculum examination.

5) **24x7 PHCs having trained Lab technician in conducting RTI/STI tests (In NHPDs, n=7 & In HPDs, n=10)**

NHPDs **HPDs**



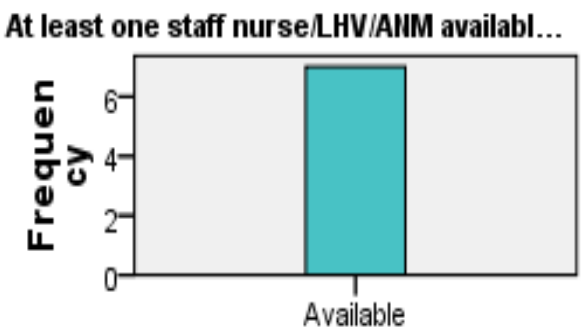


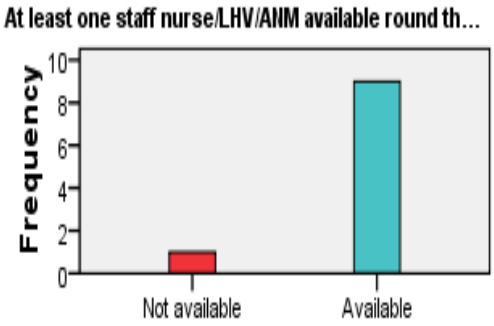
Analysis with regards to trained lab technician in RTI/STI test in non high priority districts shows that out of seven 24x7 PHCs, five PHCs have trained lab technician in RTI/STI test whereas two PHCs have lab technicians who are not trained in RTI/STI test.

In high priority districts, out of ten 24x7 PHCs, four PHCs have trained lab technicians in RTI/STI test and six PHCs have untrained lab technician in RTI/STI test.

6) **24x7 PHCs having at least one staff nurse/LHV/ANM round the clock at the facility in eight hourly duties (In NHPDs, n=7 & In HPDs, n=10)**

NHPDs **HPDs**





According to analysis, out of seven 24x7 PHCs in non high priority districts, all the PHCs have at least one staff nurse/LHV/ANM round the clock.

In high priority districts, nine PHCs have at least one staff nurse/LHV/ANM round the clock while only one PHC don't have at least one staff nurse/LHV/ANM round the clock.

7) **24x7 PHCs having Pharmacist (In NHPDs, n=7 & In HPDs, n=10)**

NHPDs **HPDs**

According to analysis, out of seven 24x7 PHCs in non high priority districts, only two PHCs have pharmacist while five PHCs do not have pharmacist.

In high priority districts, out of ten 24x7 PHCs, no PHC has pharmacist.

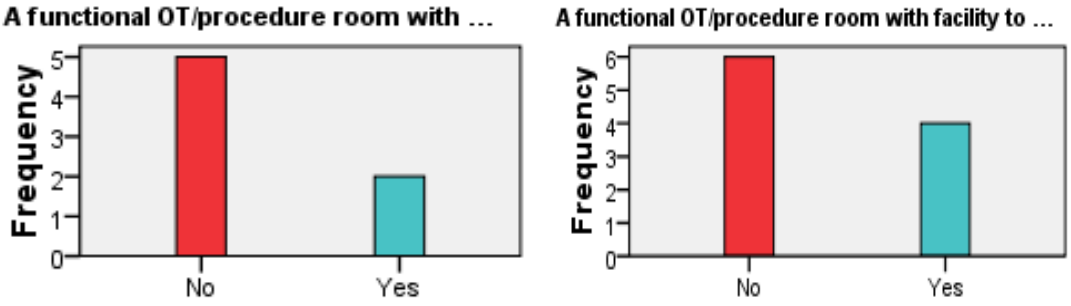
Major gaps in human resources: Gap regarding human resources like availability of two MOs, trained MO in BemOC and RTI/STI, round the clock availability of staff nurse, trained lab technician in RTI/STI test and availability of pharmacist is more in high priority districts as compare to non high priority districts.

Reasons: Majority of the doctors and pharmacist don't want to live in rural inferior area because of fewer facilities in rural areas.

B. Infrastructure

8) 24x7 PHCs having a functional OT/procedure room with facility to conduct sterilization operations (In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**

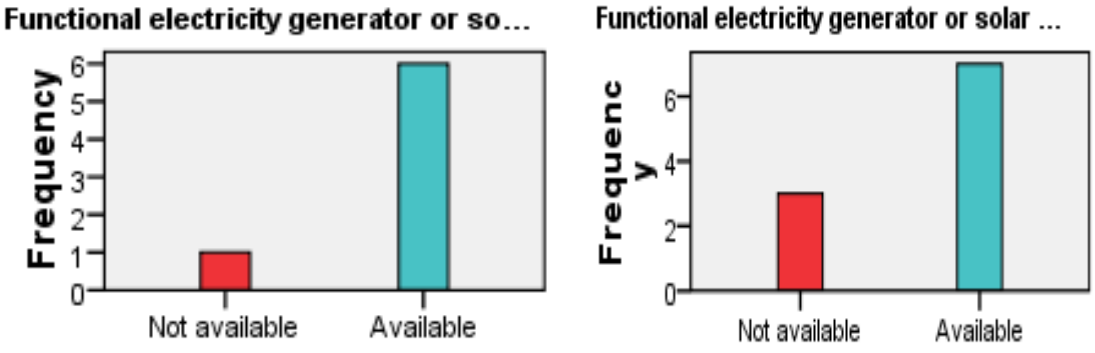


According to analysis, out of seven 24x7 PHCs in non high priority districts, only two PHCs have a functional OT/ procedure room with facility to conduct sterilization operations whereas five PHCs don't have a functional OT/ procedure room with facility to conduct sterilization operations.

In addition, the analysis of high priority districts suggests four PHCs have functional OT/ procedure room with facility to conduct sterilization operations and six PHCs don't have functional OT/ procedure room with facility to conduct sterilization operations.

9) 24x7 PHCs having functional electricity generator/solar system or inverter connected to procedure room and OT (In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**

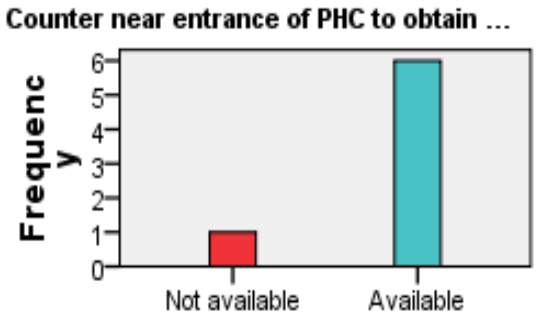


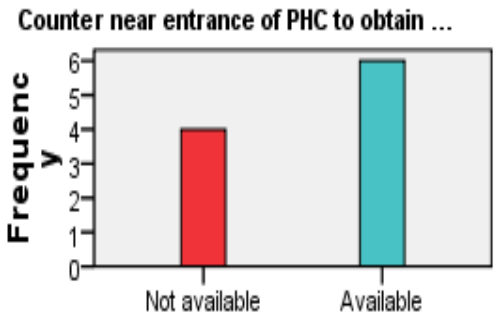
According to analysis, out of seven 24x7 PHCs in non high priority districts, six PHCs have functional electricity generator/solar system or inverter connected to procedure room and OT whereas only one PHC don't have functional electricity generator/solar system or inverter connected to procedure room and OT .

In addition, the analysis of high priority districts shows that seven PHCs have functional electricity generator/solar system or inverter connected to procedure room and OT and three PHCs don't have functional electricity generator/solar system or inverter connected to procedure room and OT.

10) 24x7 PHCs having counter near entrance of PHC to obtain contraceptives (In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**





Out of seven 24x7 PHCs in non high priority districts, six PHCs have a counter near the entrance of PHC to obtain contraceptives and at only one PHC, a counter near the entrance of PHC to obtain contraceptives is not available.

In high priority districts, out of ten 24x7 PHCs, a counter near the entrance of PHC to obtain contraceptives is present at six PHCs while four PHCs do not have a counter near the entrance of PHC to obtain contraceptives.

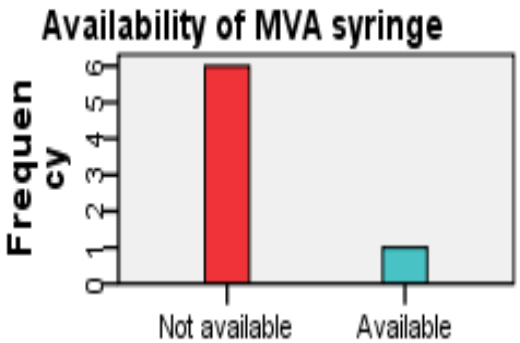
Gaps in availability of infrastructure: Gaps in availability of infrastructure like functional OT for sterilization, functional electricity generator or inverter attached to OT and counter for contraceptives are more prominent in high priority districts as compare to non high priority districts.

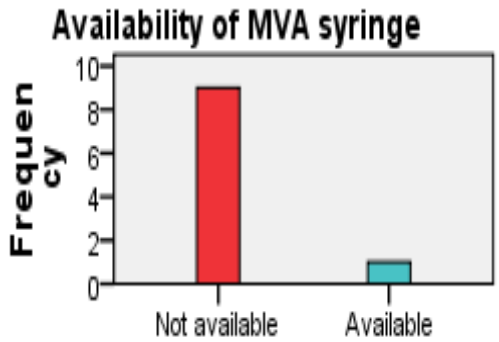
Reason: Infrastructure is not available because of lack of fund flow from top to bottom.

C. Equipments and supplies

11) 24x7 PHCs having sterile/HLD Manual Vacuum Aspiration (MVA) syringe with sterile cannula (4 -10 mm) for managing incomplete abortion (In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**

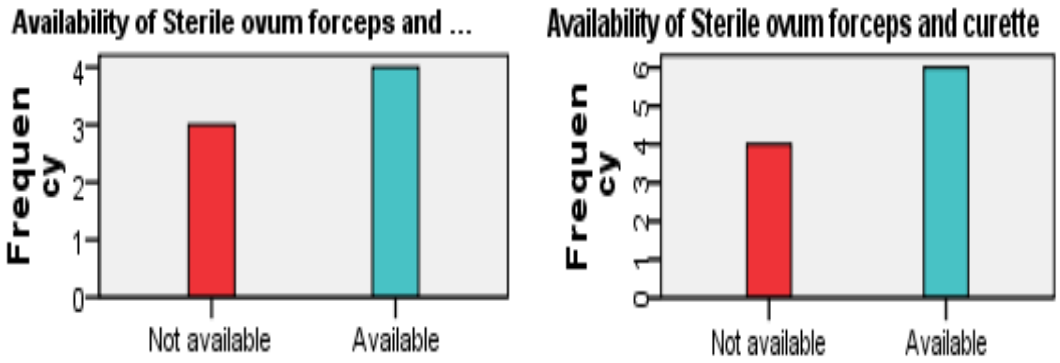




Analysis with regards to availability of MVA syringe at 24x7 PHCs in non high priority districts shows that out of seven 24x7 PHCs, only one PHC has MVA syringe whereas six PHCs do not have MVA syringe.
In high priority districts, only one PHC has MVA syringe while nine PHCs do not have MVA syringe.

12) 24x7 PHCs having sterile ovum forceps and curette (In NHPDs, n=7 & In HPDs, n=10)

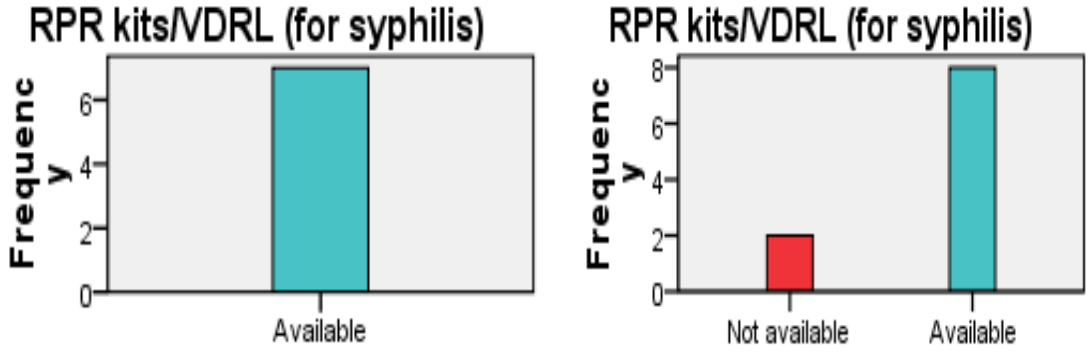
NHPDs **HPDs**



Out of seven 24x7 PHCs in non high priority districts, four PHCs have sterile ovum forceps and curette and at three PHCs, sterile ovum forceps and curette are not available.
In high priority districts, out of ten 24x7 PHCs, sterile ovum forceps and curette are available at six PHCs while four PHCs do not have sterile ovum forceps and curette.

13) 24x7 PHCs having RPR kit/VDRL test for Syphilis (In NHPDs, n=7 & In HPDs, n=10)

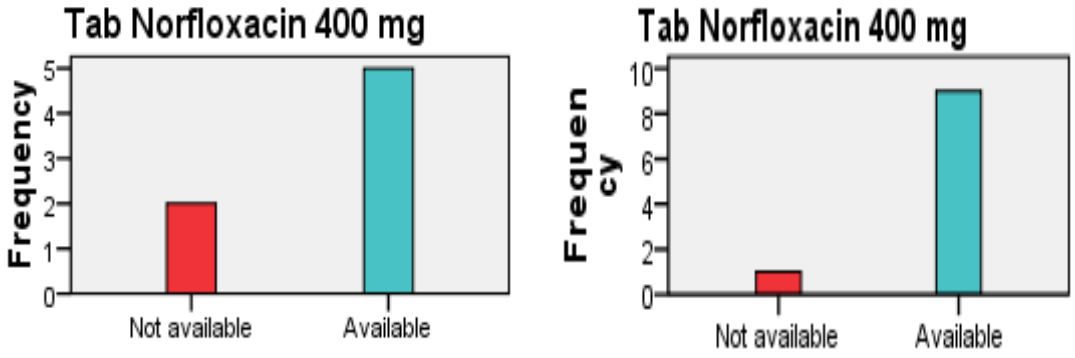
NHPDs **HPDs**



Out of seven 24x7 PHCs in non high priority districts, all PHCs have RPR kit/VDRL for Syphilis.
In high priority districts, out of ten 24x7 PHCs, RPR kit/VDRL test for Syphilis is conducted at eight PHCs while two PHCs do not have RPR kit/VDRL test for Syphilis.

14) 24x7 PHCs having availability of Tab Norfloxacin 400mg (In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**

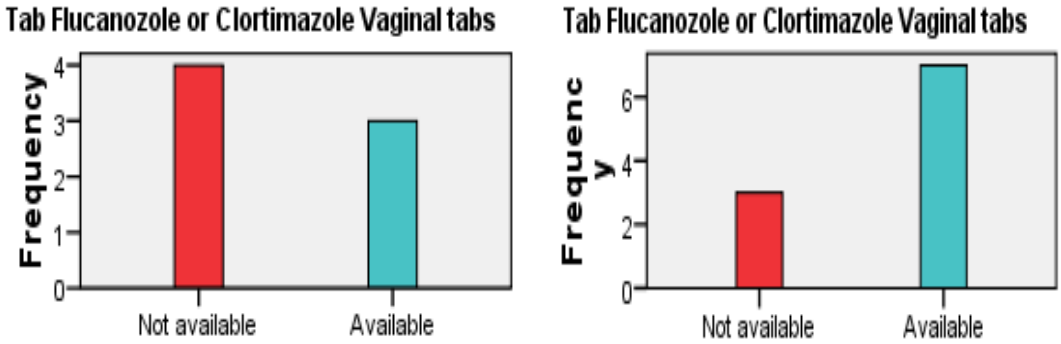


Out of seven 24x7 PHCs in non high priority districts, five PHCs have Tab Norfloxacin 400mg while two PHCs do not have Tab Norfloxacin 400mg.

In high priority districts, out of ten 24x7 PHCs, Tab Norfloxacin 400mg are available at nine PHCs while one PHC do not have Tab Norfloxacin 400mg.

15) 24x7 PHCs having Flucanozole or Clotrimazole vaginal tablets (In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**

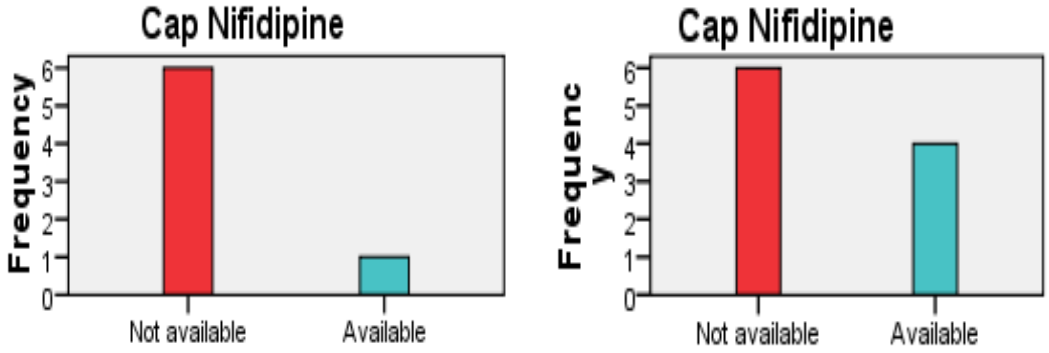


Analysis with regards to availability of Flucanozole or Clotrimazole vaginal tablets at 24x7 PHCs in non high priority districts shows that out of seven 24x7 PHCs, three PHCs have Flucanozole or Clotrimazole vaginal tablets whereas at four PHCs, vaginal Tablets Flucanozole or Clotrimazole are not available.

In high priority districts, seven PHCs have Flucanozole or Clotrimazole vaginal tablets while at three PHCs, vaginal Tablets Flucanozole or Clotrimazole are not available.

16) **24x7 PHCs having Capsule Nifidipine (In NHPDs, n=7 & In HPDs, n=10)**

NHPDs **HPDs**

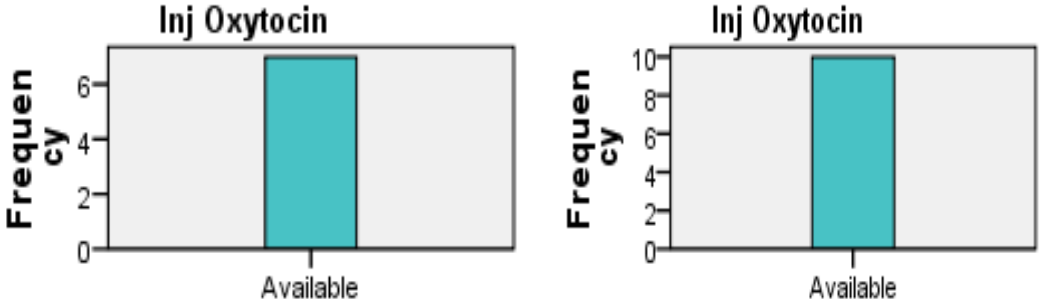


According to analysis, out of seven 24x7 PHCs in non high priority districts, at only one PHC, there is availability of Cap Nifidipine whereas six PHCs don't have Cap Nifidipine.

In addition, the analysis of high priority districts suggests four 24x7 PHCs have Cap Nifidipine and six PHCs don't have Cap Nifidipine.

17) **24x7 PHCs having Inj. Oxytocin (In NHPDs, n=7 & In HPDs, n=10)**

NHPDs **HPDs**

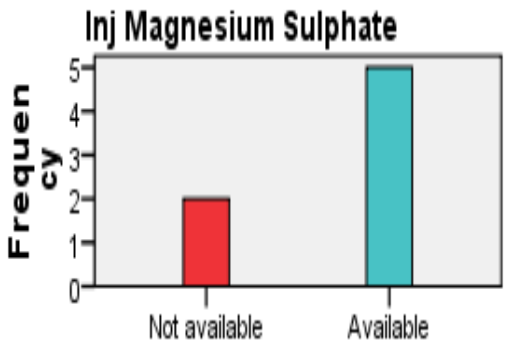


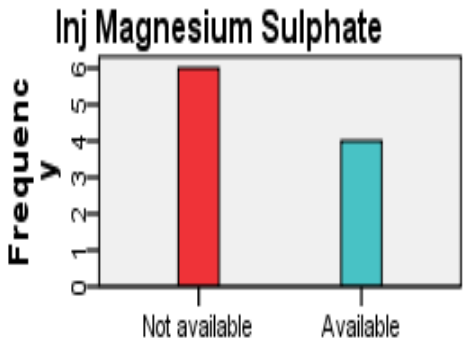
According to analysis, out of seven 24x7 PHCs in non high priority districts, there is availability of Inj. Oxytocin at all PHCs.

In addition, the analysis of high priority districts shows that all selected 24x7 PHCs have Inj. Oxytocine.

18) 24x7 PHCs having Inj. Magnesium sulphate (In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**

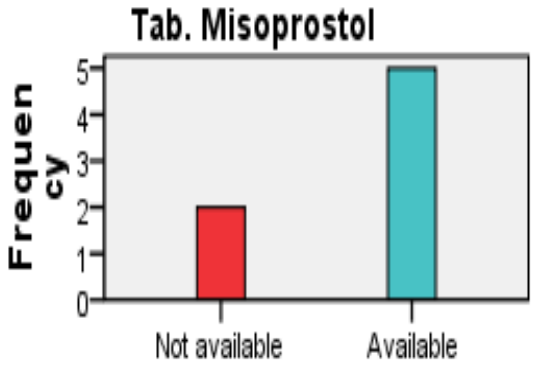


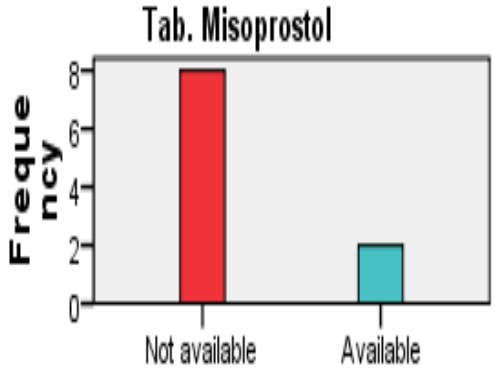


Analysis with regards to availability of Inj. Magnesium Sulphate at 24x7 PHCs in non high priority districts shows that out of seven 24x7 PHCs, five PHCs have Inj. Magnesium Sulphate whereas at two PHCs, Inj. Magnesium Sulphate are not available. In high priority districts, four PHCs have Inj. Magnesium Sulphate while at six PHCs, Inj. Magnesium Sulphate are not available.

19) 24x7 PHCs having Tab Misoprostol (In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**





According to analysis, out of seven 24x7 PHCs in non high priority districts, at five PHCs, there is availability of Tablets Misoprostol whereas two PHCs don't have Tablets Misoprostol.

In addition, the analysis of high priority districts shows that, only two 24x7 PHCs have Tablets Misoprostol and eight PHCs don't have Tablets Misoprostol.

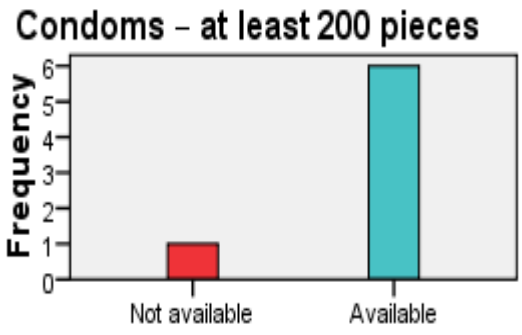
Gaps for equipments and supplies: The gaps for the availability of MVA syringe, forceps and curette and RPR kit are more in HPDs as compare to NHPDs and also the gaps for essential drugs like Tab Norfloxacin, Flucanozole or Clotrimazole vaginal tablets, Inj. Magnesium sulphate which is of critical importance in management of hypertension postpartum, Tab Misoprostol and capsule Nifidipine are found in both HPDs and NHPDs.

Reason: Equipments and drugs are not available because of lack of fund flow and gaps in supply chain management.

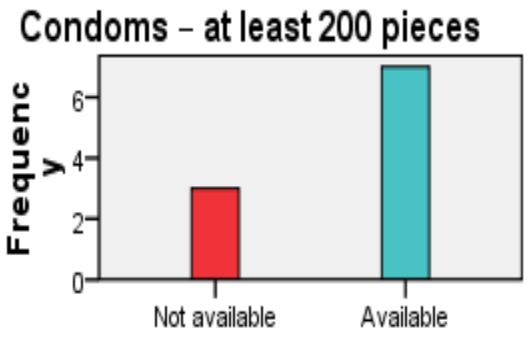
D. Contraceptives

20) 24x7 PHCs having Condoms – at least 200 pieces In NHPDs, n=7 & In HPDs, n=10)

NHPDs



HPDs

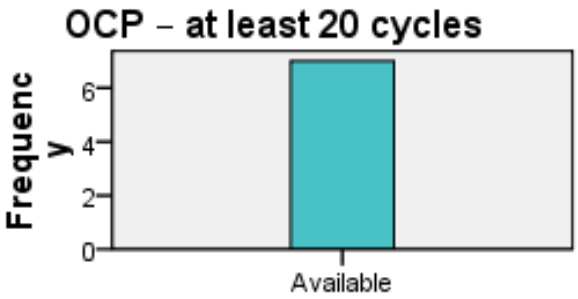


According to analysis, out of seven 24x7 PHCs in non high priority districts, six PHCs have at least 200 pieces of condoms whereas only one PHCs do not have condoms.

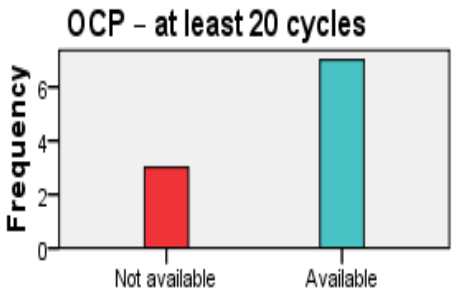
In addition, the analysis of high priority districts shows that seven PHCs have at least 200 pieces of condoms and three PHCs do not have condoms.

21) 24x7 PHCs having OCP – at least 20 cycles (In NHPDs, n=7 & In HPDs, n=10)

NHPDs



HPDs

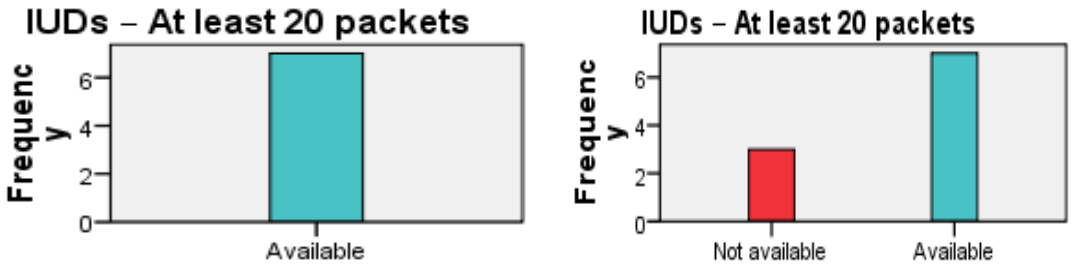


Analysis with regards to availability of OCP at least 20 cycles at 24x7 PHCs in non high priority districts shows that out of seven 24x7 PHCs, all PHCs have at least 20 cycle OCP.

In high priority districts, seven PHCs have OCP- at least 20 cycles whereas three PHCs do not have OCP.

22) **24x7 PHCs having IUDs – at least 20 packets (In NHPDs, n=7 & In HPDs, n=10)**

NHPDs **HPDs**

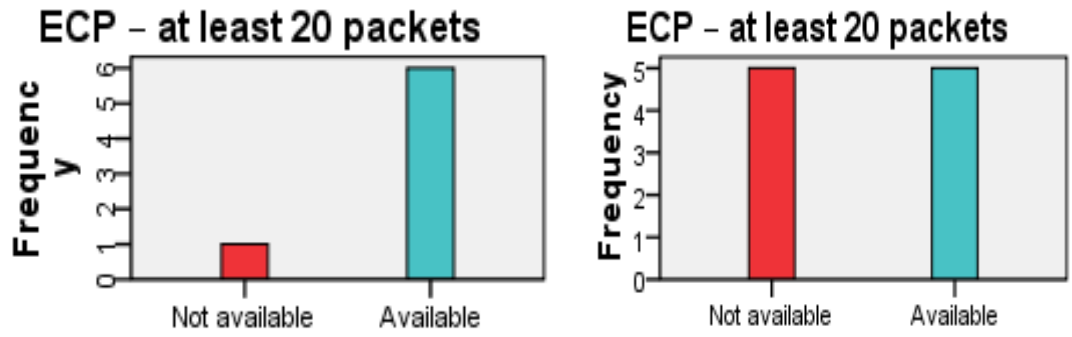


According to analysis, out of seven 24x7 PHCs in non high priority districts, all have at least 20 packets of IUDs.

In addition, the analysis of high priority districts suggests seven PHCs have at least 20 packets of IUDs while three PHCs do not have IUD packets.

23) **24x7 PHCs having ECP – at least 20 packets (In NHPDs, n=7 & In HPDs, n=10)**

NHPDs **HPDs**



According to analysis, out of seven 24x7 PHCs in non high priority districts, six PHCs have at least 20 packets of ECP whereas only one PHC do not have ECP.

In addition, the analysis of high priority districts suggests five PHCs have at least 20 packets of ECP and five PHCs don't have ECP.

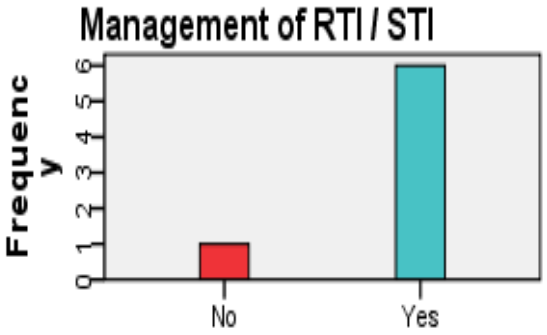
Gaps in availability of contraceptives: Gaps related to availability of condoms, OCPs, IUDs and ECPs at the facility are more in HPDs as compare to NHPDs.

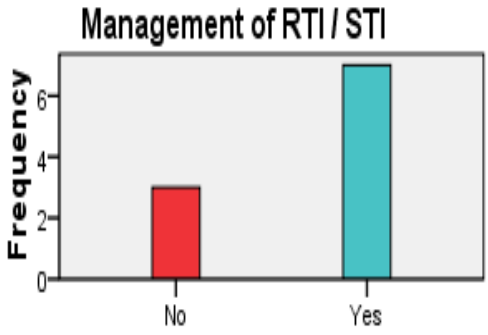
Reason: There is a gap in availability of contraceptives at the facility because whenever the contraceptives come to PHC, LHVs and ANMs distributes it in the field and due to this; stock is not available at PHCs.

E. Service Availability

24) 24x7 PHCs having management of RTI/STI (In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**



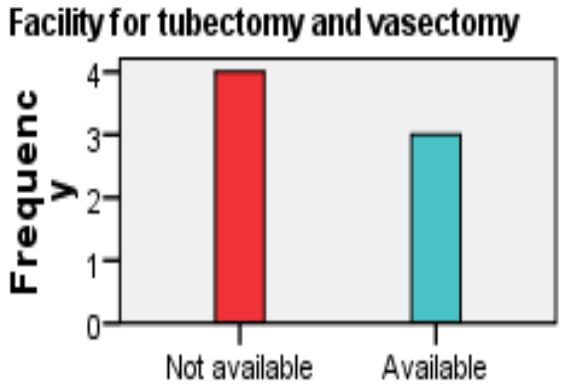


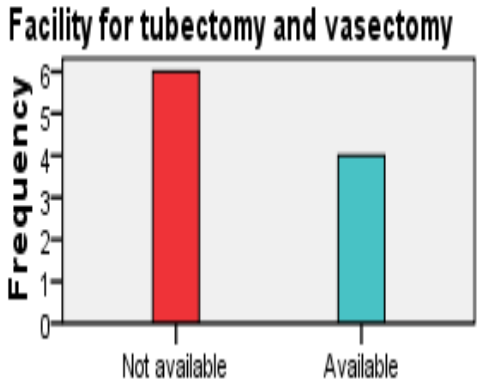
According to analysis, out of seven 24x7 PHCs in non high priority districts, six PHCs manage RTI/STI whereas only one PHC don't have RTI/STI management.

In addition, the analysis of high priority districts shows that seven PHCs have RTI/STI management and three PHCs do not have RTI/STI management.

25) 24x7 PHCs having the facility for tubectomy and vasectomy (In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**



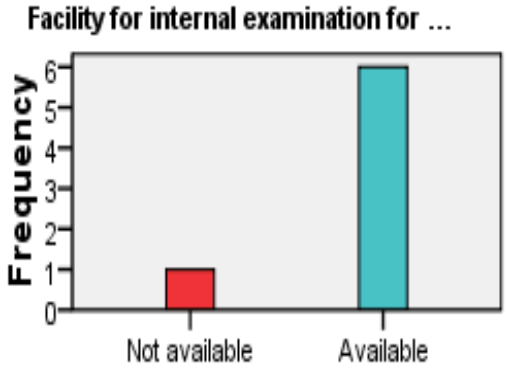


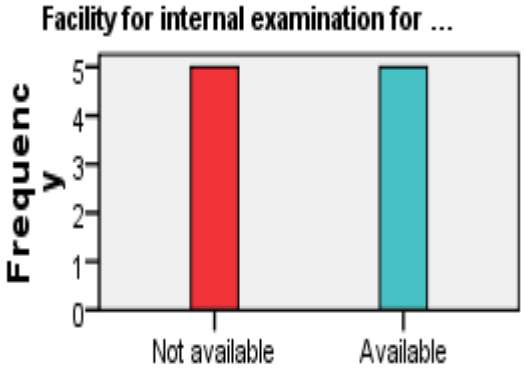
According to analysis, out of seven 24x7 PHCs in non high priority districts, three PHCs have the facility for tubectomy and vasectomy whereas four PHCs do not have the facility of tubectomy and vasectomy.

In addition, the analysis of high priority districts shows that, out of ten 24x7 PHCs, four PHCs have facility for tubectomy and vasectomy while six PHCs do not have facility for tubectomy and vasectomy.

26) 24x7 PHCs having the facility for internal examination for gynaecological conditions (In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**



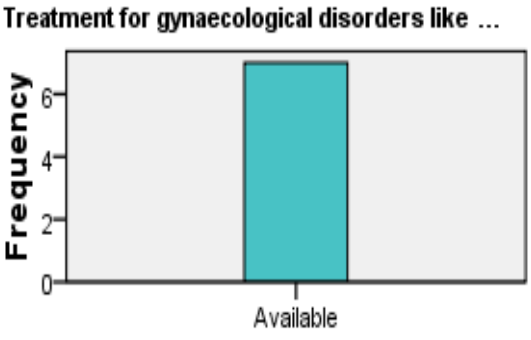


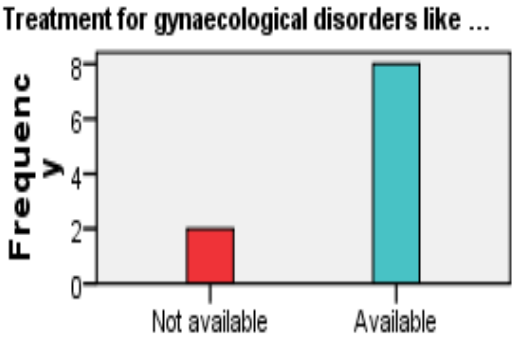
Analysis with regards to internal examination for gynaecological condition at 24x7 PHCs in non high priority districts shows that out of seven 24x7 PHCs, six PHCs have facility for internal examination whereas only one PHC do not have facility for internal examination.

In high priority districts, five PHCs have facility for internal examination while five PHCs do not have facility for internal examination.

27) 24x7 PHCs having the treatment for gynaecological disorders like leucorrhoea, menstrual disorders (In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**



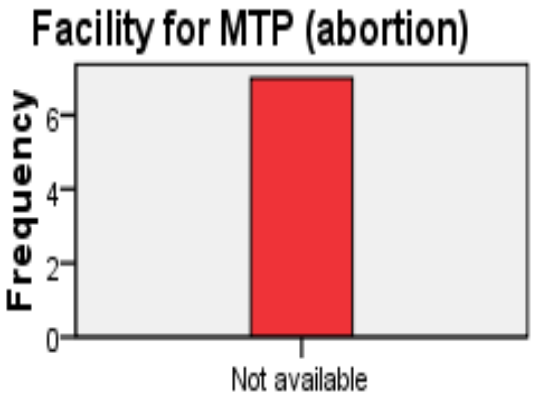


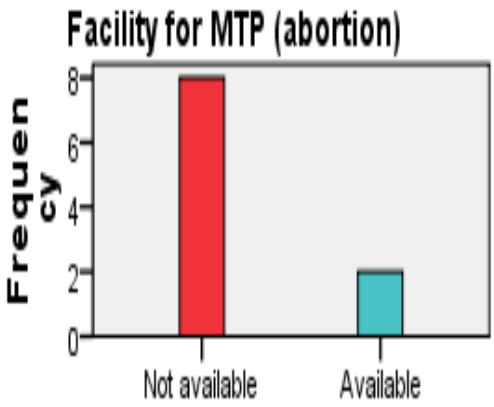
According to analysis, out of seven 24x7 PHCs in non high priority districts, doctor prescribe the treatment for gynaecological disorders at all PHCs.

While high priority districts shows that, at eight 24x7 PHCs, doctors treat the patients of gynaecological disorders like leucorrhoea, menstrual disorders whereas at two PHCs, doctors don't prescribe the treatment for gynaecological disorders.

28) 24x7 PHCs having the facility for MTP (abortion)
(In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**

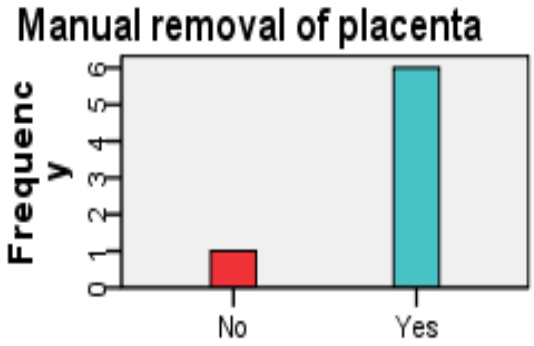


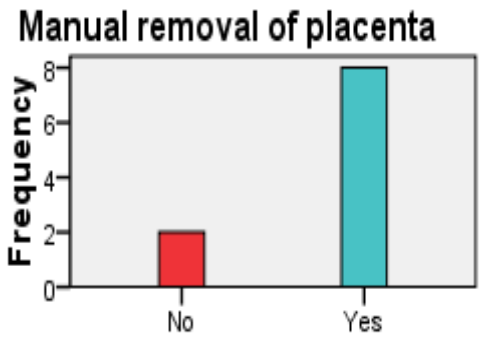


Out of seven 24x7 PHCs in non high priority districts, no PHC has MTP facility.
In high priority districts, only two PHCs have facility of MTP while eight PHCs do not have MTP facility.

29) 24x7 PHCs conducted manual removal of placenta
(In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**

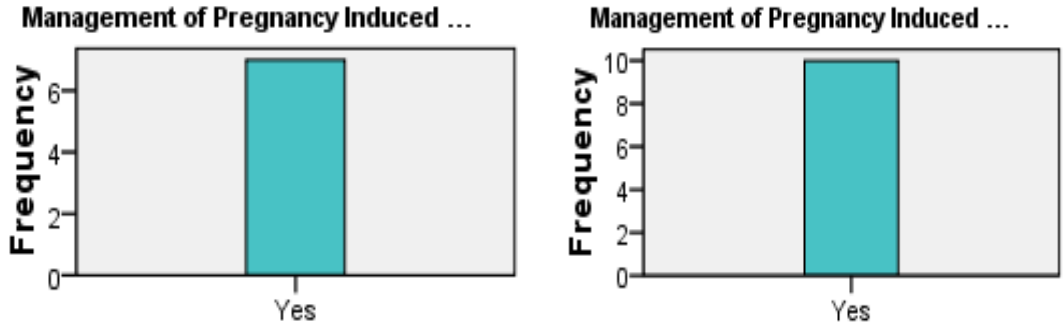




Analysis with regards to manual removal of placenta at 24x7 PHCs in non high priority districts shows that out of seven 24x7 PHCs, at six PHCs, doctor or other nurse staff manually remove the placenta whereas at one PHC, doctor or other nurse staff do not remove the placenta manually.
In high priority districts, eight PHCs out of ten PHCs where placenta is removed manually while at two PHCs, doctor or other nurse staff do not remove the placenta manually.

30) 24x7 PHCs having Management of Pregnancy Induced hypertension including referral (In NHPDs, n=7 & In HPDs, n=10)

NHPDs **HPDs**



According to analysis, out of seven 24x7 PHCs in non high priority districts, at all PHCs, there is a management of pregnancy induced hypertension including referral. In addition, the analysis of high priority districts shows that, doctor can manage pregnancy induced hypertension including referral at all selected 24x7 PHCs.

Gaps in service availability: After comparing HPDs with NHPDs, gaps are found more in HPDs as compare to NHPDs for management of RTI/STI, tubectomy/vasectomy, internal examination for RTI/STI and manual removal of placenta.

Reason: Most of the PHCs have untrained staff to provide the sexual and reproductive health services.

Conclusion:

The present study assessed the availability of human resources, infrastructure, investigative facilities and facilities for sexual and reproductive health services at the 24 × 7 PHCs with respect to IPHS. The study found that the 24 × 7 PHCs in the study districts (both in HPDs and NHPDs) are lacking in terms of human resources, infrastructure, investigative services and sexual and reproductive health services but according to study, condition of 24x7 PHCs in HPDs is not good when we compared it with 24x7 PHCs in NHPDs. There are very few studies to assess the availability of infrastructure, human resources, investigative services and sexual and reproductive health services at the 24x7 PHCs and therefore efforts are required to conduct more such studies to better understand the situation of 24 × 7 PHCs in terms of IPHS norms prescribed by the Government of India and how far we need to go to achieve these norms.

The study findings revealed that 24 × 7 PHCs should be provided adequate equipments as recommended by the IPHS so as to become effective and functional to provide sexual

and reproductive health services in the rural areas. One of the major reasons for the poor quality of new born health services is the lack of human resources for sexual and reproductive health services especially at 24 × 7 PHCs for a prolonged period of time. The NRHM made some efforts to strengthen the necessary infrastructure for the same, however, much remains to be done. Efforts are required to complete the basic infrastructure needed for good sexual and reproductive health services delivery in rural areas. 24x7 PHCs also have less supply of contraceptives and drugs related to sexual and reproductive health Investigative services at public health facilities need to be strengthened at the 24 × 7 PHCs levels. Also, there is a shortage of trained manpower in BemOC and RTI/STI services as well as to conduct MTP at 24x7 PHCs. This would require not only infrastructural strengthening, but also adequate human resource support.

Recommendations:

The research study was aimed at assessing sexual and reproductive health services at 24x7 PHCs in four districts of Rajasthan. Consequently, the following recommendations were made

1. It is recommended that public health facilities, particularly 24 × 7 PHCs, which have more number of ANC and delivery related cases and which are more utilized. There is a need for better infrastructure and human resources as per IPHS norms especially in high priority districts for providing sexual and reproductive health services.

2. Further, one of the main issues of human resource planning is the shortage of trained professionals related to sexual and reproductive health services in public health systems in rural areas in both HPDs and NHPDs. It is recommended that to deal the issue of human resources at 24 × 7 PHCs, various measures need to be considered. These measures are as follows:

a) Pay-for-performance linked to the health outcomes.
b) Group housing for health workers living in remote areas which is introduced by West Bengal and Chhattisgarh.
c) Short duration training programs for BemOC and RTI/STI.
d) Tamil Nadu has posted 3 staff nurses to provide 24X7 delivery care in PHCs and the intervention has improved provision of obstetric services at the community level (6).

3. There is a need for evidence based human resource policy and its implementation at the grass root level to improve current situation.

4. There is a need to improve supply chain management to address the shortage of drugs and other supplies related to sexual and reproductive health with more emphasis on HPDs.

5. Increase participation by NGOs and private sector in the sexual and reproductive health services provision in both HPDs and NHPDs.

6. Full involvement of Panchayati Raj Institutions (PRIs) in monitoring and delivering sexual and reproductive health services to local population specially in HPDs.

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Annexure

Informed consent : I would like to thank you for taking the time to meet me. My name is Pankaj K. Mahure. I would like to talk to you about your experience regarding sexual and reproductive health services at 24x7 PHC. The interview would take about 15 minutes. The responses will be kept confidential. This means that the interview responses will be shared only with the research team. Remember, you don't have to talk about anything that you don't want to and you can end the interview at any time.
Do you have any questions about what I just explained?
Are you willing to participate in the interview?

Interviewee Signature

Pro forma for Facility Survey for 24x7 PHCs as per IPHS

Identification

Name of the State: _____

District: _____

Tehsil/Taluka/Block: _____

Location Name of PHC: _____

Is the PHC providing 24 hours and 7 days delivery Facilities?

Date of Data Collection

Day Month Year

Name and Signature of the Person Collecting Data

FORM 1 – A. PROVIDERS AVAILABILITY

Q. No.	Sub-elements Instructions: On day of visit ASK MO I/C and/or other staff and fill the following questions	Response		
		Score (3)	Score (1)	Score (0)
QA.1	Minimum two Medical Officers	Available		Not available

QA.2	At least one Medical Officer trained in handling Basic Emergency Obstetric Care (PHC) and RTI/STI	Both BEmOC and RTI/STI	Only BEmOC or Only RTI/STI	No additional training
QA.3	A trained and registered Medical Officer available to conduct MTP	Available and trained		Not Available
QA.4	An HS (LHV) and/or HW (F) trained for RTI/STI screening with per speculum examination	Available and trained	Available but not trained	Not Available
QA.5	Lab technician trained in conducting RTI/STI tests	Available and trained	Available but not trained	Not Available
QA.6	At least one staff nurse/LHV/ANM available round the clock at the facility in eight hourly duties	Yes		No
QA.7	Availability of Pharmacist	Available		Not available

FORM 1 – B. INFRASTRUCTURE

Q. No.	**Sub-elements Instructions: Walk around the 24x7 PHC area and OBSERVE the following**	**Response Score**	
		Available	**Not available**
	FACILITIES		
QB.1	A functional OT/procedure room with facility to conduct sterilization operations		
QB.2	Functional electricity generator or solar system or inverter connected to procedure rooms and OT		
QB.3	Counter near entrance of PHC to obtain contraceptive		

FORM 1 – C. AVAILABILITY OF EQUIPMENT AND SUPPLIES

	Sub-elements Instructions: Go to respective rooms/lab and PHYSICALLY	**Response Score**

	VERIFY the availability/functionality		
		Available	Not available
QC.1	Sterile/HLD Manual Vacuum Aspiration (MVA) syringe with sterile cannula (4 -10 mm) for managing incomplete abortion		
QC.2	Sterile ovum forceps and curette available		
	Lab equipments and supplies		
QC.3	RPR kits (for syphilis) available		
	Essential Drugs for RTI/STIs:		
QC.4	Tab Norfloxacin 400 mg		
QC.5	Tab Flucanozole or Clortimazole Vaginal tabs		
	Essential supplies for active management of infections/ complications in pregnancy/ puerperium		
QC.6	Cap Nifidipine		
QC.7	Inj Oxytocin		
QC.8	Inj Magnesium Sulphate		
QC.9	Inj. TT (Tetanus Toxoid)		
QC.10	Tab. Misoprostol		

FORM 1- D: FAMILY PLANNING QUALITY ASSESSMENT

	FP Supplies	Response Score	
		Yes	No
QD.1	Condoms – at least 200 pieces		
QD.2	OCP – at least 20 cycles		
QD.3	IUDs – At least 20 packets available		
QD.4	ECP – at least 20 packet		

FORM 1- E: SERVICE AVAILABILITY

	Service availability (Yes / No)	Response	
		Yes	No
QE.1	Management of RTI /		

	STI		
QE.2	Is the facility for tubectomy and vasectomy available at the 24x7 PHC?		
QE.3	Is the facility for internal examination for gynaecological conditions available at 24x7 PHC?		
QE.4	Is the treatment for gynaecological disorders like leucorrhoea, menstrual disorders available at the 24x7 PHC?		
QE.5	Is the facility for MTP (abortion) available at the 24x7 PHC?		
QE.6	Manual removal of placenta		
QE.7	Management of Pregnancy Induced hypertension including referral		


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महिला
पुरुष
बालिका शिशु
को बचाओ


EMERGENCY TRAY
DELIVERY TRAY
EPISIOTOMY TRAY
MVA / EVA TRAY
MEDICINE TRAY
BABY TRAY


चिकित्सा एवं स्वास्थ्य विभाग, राजसमन्द