Summer Training at
United Nation Children's Fund,
Jaipur

KAP Analysis of Post Natal Care in Ahore Block of Jalore District

By
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Under the guidance of
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MBA Hospital and Health Management
2015-2017

The IIHMR University, Jaipur
2016

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

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that Ms Eti Khatri has undergone summer training in UNICEF, Jaipur (Rajasthan) from 1st April to 31st May 2016.

The candidate herself completed the project assign to her during summer training. Her approach to the project was sincere and proactive. This summer training is partial fulfillment of the course requirement recommended for the award of MBA in Health & Hospital Management.

I wish her success in all her future endeavors.

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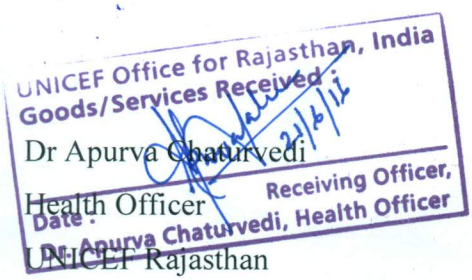
Certificate

This is to certify that Ms Eti Khatri has undertaken her summer training project at District Jalore from 1st April 2016 to 31st May 2016 with UNICEF. During her summer training she undertook an assessment of the interpersonal communication skills of frontline functionaries on key maternal, newborn and child survival interventions (Specific: Post Natal Care) delivered with the aid of an android based application called E – Janswasthya in Ahore Block. During the course of summer training the trainee was also exposed to the functioning of government health system, health centres at various levels as well as community and outreach services at district level.



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ACKNOWLEDGEMENT

Every successful story is a result of an effective team work, a team which comprises of a good coach and good team players. Likewise this project report is no exception. This has been a meticulous effort of a group of people along with me. I want to take this opportunity to thank each and every one who has been a part of this report.

To start with, I take immense pleasure to thank Dr. S.D. Gupta (Director Indian Institute of Health Management Research-Jaipur) and Dr. Ashok kaushik (Dean, Indian Institute of Health Management Research- Jaipur) for placing us in such an esteemed organization (UNICEF) to undertake me summer training; and our mentor, Dr. Goutam Sadhu for their timely advice and encouragement for the successful conduction of my project.

I highly indebted to Dr. Anil aggarwal, Health specialist; UNICEF and Mrs. Apurvachaturvedi, Health officer; UNICEF with this opportunity and giving me Jalore district as my field work.

Also, I wish to thank Mr. Inderpalarora, District coordinator of jalore; UNICEF for helping me in getting the relevant information for the completion of my project.

Lastly, I thank all the ANM's, and Anganwadi workers, for being highly cooperative and for helping me in collecting and compiling the data for this report.

PREFACE

Summer internship is an integral part of the MBA curriculum. As a part of the course; students of the first year are required to undergo summer training at an organization to get in depth exposure of various departments in the organization to get a better understanding of the health care delivery system. The significance of the summer training can be appreciated from the fact that it is an opportunity for the students to put into, practice the knowledge gained during the entire first year.

The major objectives of the summer training programs are as follows:

1) To better understand the existing health delivery system including public and private sectors.

2) To observe the implementation of various National Health Programs at National/State/District levels.

3) To understand various functions of health systems by interactions with key stakeholders, policy makers, program managers, academicians and researchers

4) To work on the project/task assigned by summer training organizations.

Abbreviation

AHC = Annual Health Survey

ANC = Ante- Natal Care

ANM = Auxiliary Nurse Midwife

ASHA = Accredited Social Health Activist

AWC = Anganwadi Centre

AWW = Anganwadi Worker

BCC = Behavioral Change Communication

BCMO= Block Chief medical officer

CBC = Complete Blood Count

CCE = Continuous and Comprehensive Evaluation

CHC = Community Health Centre

CMHO = Chief Medical Health Officer

DAP = District Action Plan

DCHM = District Child Health Manager

DH = District hospital

DHS = District Health Society

DLHS = District Level Household Survey

DPMU = District Program Management Unit

ECE = Early Childhood Education

FRUs = First Referral Units

GDP = Gross Domestic Production

ICDs = Integrated Child Development Services

ICPS = Integrated Child Protection Scheme

ICU = Intensive Care Unit

IEC = Information, Education and Communication

IGO = Inter-Governmental Organization

IFA = Iron and Folic Acid

IMNCI = Integrated Management of Neonatal and Childhood Illness

IMR = Infant Mortality Rate

IUCD = Intra Uterine Contraceptive Device

JSY = JananiSurakshaYojana

KMC = Kangaroo mother care

LHV = Lady Health Visitor

MCHN = Maternal and Child Health Nutrition

MCP = Maternal and Child Protection

MIS = Management Information System

MMR = Maternal Mortality Rate

MO = Medical Officer

NFHS = National Family Health Survey

NRHM = National Rural Health Mission

NUHM = National Urban Health Mission

OCP = Oral Contraceptive Pill

ODK = Open Data Kit

PNC = Post Natal Care

PHC = Primary Health Centre

RCH = Reproductive Child Health

RMNCH+A = Reproductive, Maternal, Newborn, Child+ Adolescent health

SAM = Severe Acute Malnutrition

SC = Sub-Centre

SIHFW = State Institute of Health and Family Welfare

SNCU = Special Newborn Care Unit

UNICEF = United Nations Children's Fund

WASH = Water, Sanitation and Hygiene

WHO = World Health Organization

Introduction

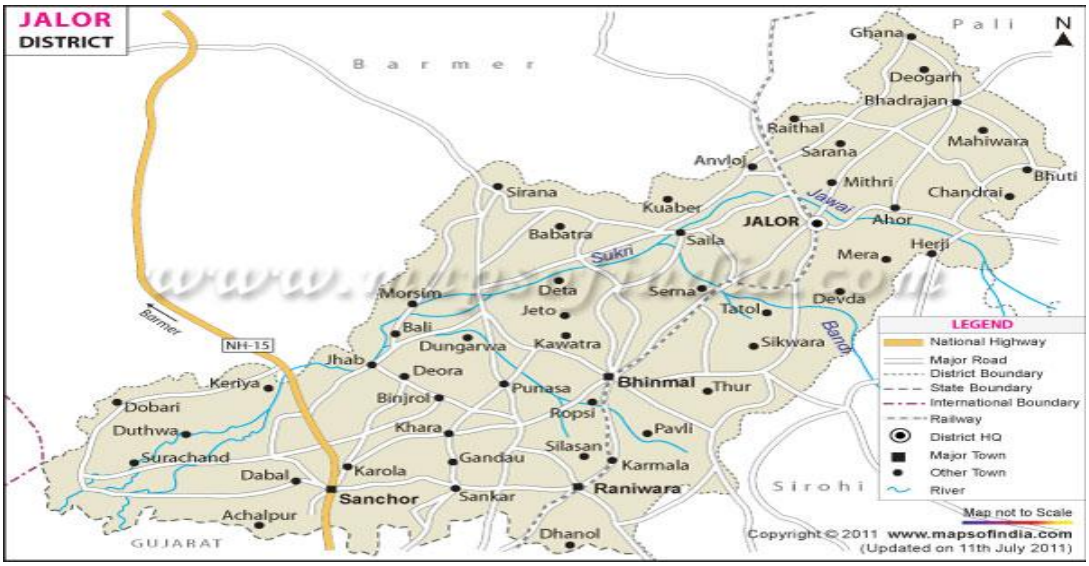
Jalore district profile:- Jalore is located in the western zone of Rajasthan. The district, one amongst 34 districts in the state has a projected population of 1.98 million (year 2015), accounting for about 3% of the state's population. It has an area of 10,640 sq. km. rendering a population density of 183 persons per square kilometers. The district's decentralized governance includes 8 JanpadPanchayatSamitis and 264 Gram Panchayats across 805 revenue villages.

DEMOGRAPHIC PROFILE & HOUSEHOLD CHARACTERISTICS				
Population (Census 2011)				
	Total	Male	Female	0 - 6 Year
Jalore	1828730	936634	892096	313808
Rajasthan	68621012	35620086	33000926	10504916
District Share	2.66	2.63	2.70	2.98

It is estimated that every year 59, 000 women become pregnant, around 53,000 children are born and as many as 49, 500 nursing mothers of infants below one year require counseling for exclusive breastfeeding up to 6 months, initiation of complementary feeding thereafter with continued breastfeeding well in to and up to 2 years, apart from caring advice on significance of immunization and need to adhere to the schedule of services for the same. The district has the highest Infant Mortality Rate of 72 in the state, while the state's IMR stands at 55 (Annual Health Survey 2012-13). It is however, notable that female IMR is 12 points higher than that of males at 66. The phenomenon is more pronounced in rural area of the jaloredistrict. Further the neo-natal mortality rate for the district at 52 accounts for 73% of the IMR, thus indicating the direction and efforts which cannot be delayed. It is apprehended that around 3900 children would not survive up to the age of 1 year at this rate in the district during the year 2014-15. As regards the Maternal Mortality Ratio, Jalore AHS 2012-13 records the same at 222, as determined for the region including 5 other districts, namely Jodhpur, Jaisalmer, Barmer, Sirohi and Pali. Health Institutions in Jalore District -

Name of Block	No DH	No of CHC	No of PHC	No of SHC	Total
Ahore	0	1	10	54	65
Bhinmal	0	1	8	54	63
Chitalwana	0	1	9	48	58
Jalore	1	1	10	39	51
Jaswantpura	0	1	7	40	48
Raniwara	0	2	9	53	64
Sanchore	0	1	6	57	64
Sayla	0	2	10	62	74
Total	1	10	69	407	487

There are 1 DH, 10 CHCs, 69 PHCs, and 407 SCs in Jalore District which are giving health services to around 1.98 million people. If we see these institutions in the reference of maternal & Child health services, facility of Ante/Intra/Post Natal care are available as per level of institutions.



<u>Ahore block</u>

Ahor or Ahore is a city in Jalore District of Rajasthan state in India. It is situated 17 km east of the Jalore on Jalore-Sanderao road (SH-16). It is the headquarters of the tehsil by the same name. Population of Ahore is 16,873 according to census 2011. Where male population is 8,602 while female population is 8,271. Ahore is famous for its steel handicraft, Grill, Railing and Steel Designer gate for Temple.

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जागरूकता के जतन

• राष्ट्रीय शहरी स्वास्थ्य मिशन की द्वितीय कार्यशाला

जालोर @ पत्रिका

जालोर स्वास्थ्यकर्मी ने शहरी स्वास्थ्य मिशन की कार्यशाला को सम्बोधित करते जिला कलक्टर।

एएनएम को मिलेंगी अब तकनीकी सुविधा

जालोर @ पत्रिका. जिले में अब एएनएम को तकनीकी सुविधा मुहैया कराई जाएगी। जिले के आहोर व सायला ब्लॉक की एएनएम को पीसी टेबलेट दिए जाएंगे। जिला कलक्टर डॉ. जितेन्द्र कुमार सोनी ने बताया कि यूनिसेफ के सहयोग से आहोर व सायला ब्लॉक की एएनएम को 150 टेबलेट वितरित किए जाकर उन्हें आधुनिक तकनीकी से लेस किया जाएगा। यूनिसेफ की ई-जन स्वास्थ्य योजना के अन्तर्गत एएनएम को 31 मार्च तक प्रशिक्षित किया जाएगा। इसके पश्चात 1 अप्रेल से उप स्वास्थ्य केन्द्र स्तर के सामान्य कार्यों के डाटा ऑनलाइन पर्यवेक्षित किए जा सकेंगे। 30 अप्रेल तक इसको प्रायोगिक तौर पर चलाया जाएगा। इस दौरान सॉफ्टवेयर एवं हार्डवेयर संचालन के दौरान सामने आने वाली तकनीकी समस्याओं का समाधान करके 1 अप्रेल से विधिवत चालू कर दिया जाएगा। कार्यशाला में एएनएम को टेबलेट पीसी वितरित भी किए गए।

इस मौके यूनिसेफ के स्वास्थ्य अधिकारी अपूर्वा, यूनिसेफ के आईटी सलाहकार विवेक अग्रवाल, राज्य बाल एवं परिवार कल्याण संस्थान के विकास भारद्वाज उपस्थित थे।

About the organization

We were given a chance by UNICEF to explore the health care facilities at block level. We were asked to visit one of the high priority district of Rajasthan,Jalore (Ahore Block) under the guidance of Mr. InderpalArora, Focus district coordinator, UNICEF. The district has no separate office of UNICEF, the coordinator and other staff works in coordination with NHM staff at CMHO office. The main focus was on RMNCH+A approach. Besides this currently running programme by UNICEF E- Janswasthya, a state initiative to provide tablets to ANMs to digitize data. Timeline of our study was –

Table (1):- Timeline of the study

S.No.	Task	Timeline	Duration
1)	Exploration of Field	3rd April' 16 to 9th April' 16	1 week
2)	Document study and development of study design and tools	11th April'16 to 16th April'16	1 week
3)	Intervention with the case ANMs for giving live counselling	18th April'16 to 24th April'16	1 week
4)	Field testing of tools, field study and data collection (supervision of Case ANMs and observation of control ANMs)	26th April'16 to 14th May'16	2weeks
5)	Supporting E Janswasthya	16th May to 24th May' 16	8 days
6)	Data analysis	25th May'16 to 30th May'16	1 week
7)	Finalization of Data and presentations	31th may'16 to 9th June'16	10 Days
8)	Presentation	10th June'16 `	1 day

The United Nations Children's Fund (UNICEF) is a United Nations Program Headquartered in New York City that provide long term humiliation and developmental assistance to children and mothers in developing countries. It is one of the members of the United Nations Development Group and its executive community.

UNICEF was created by the United Nations General Assembly on December 11, 1946 to provide emergency food and healthcare to children in countries that had been devastated by World War II. In 1953UNICEF become a permanent part of United Nations System and its name was Shortened from the original United Nations International Children's Emergency Fund but it has continue to be known by the popular acronym based on this previous title.

Most of UNICEF's work is in the field, with staff and over 190 countries and territories.

UNICEF is an intergovernmental organization (IGO) and UNICEF's salary and benefits package is based on the United Nations Common System. UNICEF is not funded exclusively by voluntary contributions, and the national committee collectively raise around one third of UNICEF's annual income. This comes through contributions from corporations, civil society organization around 6 million individual donors worldwide. They also have many different partners-including the media, national and local government officials, NGO's, Specialists such as Doctors and Lawyers, corporations, schools, young people and general public - on issue related to children rights .

UNICEF in RAJASTHAN

Located in north-western India, Rajasthan is the country's largest state by area. At 342,239 km^2, it encompasses 11 per cent of the total geographical area of the country. Along with this large area comes a wide and diverse topography: rolling sand dunes, fertile plains, rocky, undulating regions and even some forested areas.

Rajasthan has been at the forefront of India's economic reforms and is now among the country's six fastest-growing states. Its main economy is agriculture, but industrial sectors such as textiles and vegetable oil and dye production also contribute significantly to the state's GDP. Other private sector industries include steel, cement, ceramics and glassware, electronics, leather and footwear, stone and chemical industries.

The state is home to more than 68 million people, almost 50 per cent of whom are under the age of 18 years (2011 census). It is predominantly rural, with 75 per cent of its population living in villages. More than 30 per cent of its population belongs to scheduled castes (17.8 per cent) and scheduled tribes (13.5 per cent).

Over recent decades, successive Rajasthan governments have shown a commitment to address the state's many development concerns, especially those of children, adolescents and women. They have instituted the Girl Child Policy of 2012, to ensure the survival, growth and development and empowerment of girls, and have taken a lead in child labor programs through a rare initiative to raise the bar on child labor from 14 to 18 years.

UNICEF has been an active partner, supporting government in planning and implementing programs and working to accelerate progress on social development indicators. After large investments in the health sector targeting children through the National Rural Health Mission (NRHM) and Integrated Child Development Services (ICDS) program. These are reflected in the decline in the IMR and improvements in other morbidity and mortality indicators.

However, the improvements have not been adequate and there are several challenges that continue to affect the health status of children, particularly neonatal health. Rajasthan's feudal, strongly patriarchal and caste-centred society has fostered social norms that continue to impede the progress of social development in the state.

Challenges and Opportunities (Rajasthan)

Rajasthan, which has an enrolment of 95 per cent in elementary schools, faces a challenge in achieving age-appropriate learning outcomes among children and in creating a protective environment for them. Societal norms still conform to caste and gender-based discrimination, resulting in high levels of gender discrimination which have, in turn, led to a troubling sex ratio and high incidences of child labour, child marriage and corporal punishment.

UNICEF is working to provide technical support to address the bottleneck of poor pedagogy and gender disparity and social gaps in learning outcomes. Another challenge is an attendance rate of about 60-65 per cent. UNICEF is striving to improve the learning outcomes of children in Rajasthan through a focus on activity-based teaching and comprehensive and continuous evaluation in education.

Child Protection is an area of great concern in Rajasthan. The state contributes 10 per cent of the country's total child labour problem. According to the state Department of Home, 6,749 girls up to the age of 18 years have been reported missing since January 2009, and 864 of these girls are untraceable. The tradition of child marriage on auspicious days of the year continues in the state and approximately 42 per cent girls are married before the legal age of 18 years (NFHS-3).

UNICEF is working in the state to address Child Protection issues and advocate for zero tolerance of violence in any form against children.The National Family Health Survey 2005-6 (NFHS-3) showed that 43.7 per cent of Rajasthan's children aged zero to five years suffered from chronic under nutrition (stunting); seven per cent, or 650,000 children, suffered from severe acute malnutrition (SAM) and the state's rate of exclusive breastfeeding for the first six months of life was just 29.4 per cent.

Therefore, UNICEF's current Child Survival programming in Rajasthan centres on efforts to remove bottlenecks in areas that pose challenges particularly to addressing neonatal mortality, chronic and severe malnutrition and exclusive breastfeeding. It is working to improve access to sanitation facilities at the household level, within the general community and in schools and health centres.

Rajasthan experiences vast disparities on health measures amongst western and southern districts due to the difficult terrain and poor socio-economic indicators. Other problems, such as inadequate deployment of human resources and poor quality of services, lead to high levels of inefficacy. Poor motivation of managers and service providers further accentuates the situation as this leads to high inefficiency and high neonatal mortality.

More than 73 per cent of people in Rajasthan's rural areas live in an environment of open defecation, putting them at risk of illness and death from diarrhoea and other diseases transmitted by the faecal-oral route. The situation is worse in the remote southern part of Rajasthan which has difficult terrains and a high number of tribal communities. Here, more than 90 per cent of the population defecates in the open.

Despite progress in access to essential sanitation services at the community level, access in schools and health facilities continues to be a problem. While about 73 per cent of toilets in schools are in a usable condition, toilet usability drops to 65 per cent in the case of toilets for girls and more than one-third of Anganwadis (government health and day care centres) do not have access to toilets.

UNICEF initiatives include:

As a partner of choice for the Government of Rajasthan, UNICEF is working on a set of models and pilot interventions, particularly in tribal areas in the districts of Udaipur, Dungarpur, Barmer and Baran. The intent is to ensure the survival, growth and development particularly of children belonging to marginalized communities.

Child Survival

- Setting up and scaling up Special Newborn Care Units (SNCU), with a focus on real time monitoring and quality of services.
- Supporting improvements in the care of women and their babies during childbirth through increasing the quality of services.
- Health system strengthening through supportive supervision and capacity-building.
- Demonstrating a mechanism to improve the quality of services in the most deprived blocks to address the issue of inequity.
- Innovations for real-time monitoring of survival and development outcomes.

Nutrition

- Offering a facility and community-based support and tracking mechanism to improve breastfeeding and complementary feeding. The special HajuSuru (healthy well-nourished child) strategy in the tribal districts of Banswada and Dungarpur promotes family empowerment in feeding through community monitoring and tracking.
- Supporting a high rate of dose for vitamin A supplementation, with two doses every six months.
- Working with the government towards universal salt idolization and tracking access and use of iodized salt at the family level.
- Improving care and treatment for children with severe acute malnutrition (SAM) and providing facility and community-based strategies to help support children with SAM.

Education

- Enhancing learning outcomes of children through transforming the teaching learning process, making it more student-centric, activity-based, learning-focused and equity-oriented.
- Introducing a continuous comprehensive assessment as part of the pedagogy in all schools by 2018. In 2014, 22,000 schools will implement Continuous and Comprehensive Evaluation (CCE) as their assessment system.
- Providing technical support to monitor learning outcomes in real time.
- Offering a school leadership programme to complement the quality improvement initiative in schools.
- Lending technical support to create an enabling environment for early childhood education (ECE); putting in place a curriculum, syllabus and a state policy for ECE and facilitating coordination with the state Education Department for capacity development of Anganwadi workers and their continuous support on ECE.

Child Protection

- UNICEF in Rajasthan is working to strengthen systems for Child Protection by ensuring quality education to all children with a special focus on out-of-school, never-enrolled and drop-out children.
- It is building the capacities of and mobilizing families and the community to take collective action to protect their children and help them develop.
- To increase families' adult incomes and prevent child labour, UNICEF is enhancing access to service providers and social protection schemes for vulnerable families and children such as the widow pension, old age pension, AapkiBetiYojana, Palanhar and MukhyaMantriHunarVikasYojana.
- UNICEF is also helping to improve the state policy framework and delivery systems related to Child Protection; improve access to and the quality of social protection schemes and the Integrated Child Protection Scheme (ICPS); and assessing various Acts, policies and programmes related to Child Protection.
- It is strengthening and supporting the capacity of the ICPS to promote and deliver the best services to the most vulnerable children in the state.
- Designing interventions to reduce child marriage, child labour, out-of-school children and corporal punishment in schools.

Water, Sanitation and Hygiene

- UNICEF is building the capacity for the government and communities to eliminate open defecation by supporting the development and implementation of effective behavior change strategies at the state level.
- Supporting the state to improve the quality of health care in health institutions by improving Water, Sanitation and Hygiene (WASH) facilities and practices through capacity-building of National Rural Health Mission (NRHM) stakeholders.
- Developing monitoring systems and providing access to evidence-based tools and guidelines and promoting key hygiene practices in schools through sustainable, simple and scalable models of WASH.
- Sharing scalable WASH approaches that address priority gaps and bottlenecks in delivering and promoting sanitation facilities and hygiene promotion.
- Supporting rural WASH sector development through improved management information systems (MIS) for WASH access and use, including identification and corrective action for the state's most marginalized areas.
- Creating an enabling environment for improved WASH facilities and practices in health centres through a convergence of Health and WASH programmes in 100 centres in four priority districts.
- Creating an enabling environment to adopt key WASH practices in schools, through innovative technologies and child-centred approaches in the tribal districts of Udaipur and Durgapur.

- Supporting the state's institutionalization of the WASH validation system to monitor WASH outcomes on a regular basis.

Disaster Risk Reduction

- Working with the State Disaster Management Authority to pilot risk-informed planning systems to improve disaster preparedness and response.

Communication for Development

- Developing strategic approaches to communication through the development of evidence–based and theory-driven communication strategies in the areas of the WASH, Health (RMNCH+A and RI), Child Protection (addressing social norms on the Prevention of Child Marriage and Child Labour), Education (community mobilization for the promotion of girls education). These have been developed with the state government and UNICEF frameworks adopted by national flagships and have been customized for rollout across state.

- Building the capacities of frontline service-providers from government flagship programmes so they can effectively engage with families and communities to promote social and behaviour change in relation to key child survival and development issues.

- Using new technologies for Communication for Development- The potential of technologies such as the internet, digital tools, mobile phones and the like will be harnessed to communicate with families and frontline functionaries in a changing social and cultural context.

MISSION and GOAL

- UNICEF is mandated by the United Nations General Assembly to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential.
- UNICEF is guided by the Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behaviour towards children.
- UNICEF insists that the survival, protection and development of children are universal development imperatives that are integral to human progress.
- UNICEF mobilizes political will and material resources to help countries, particularly developing countries, ensure a "first call for children" and to build their capacity to form appropriate policies and deliver services for children and their families.
- UNICEF is committed to ensuring special protection for the most disadvantaged children - victims of war, disasters, extreme poverty, all forms of violence and exploitation and those with disabilities.
- UNICEF responds in emergencies to protect the rights of children. In coordination with United Nations partners and humanitarian agencies, UNICEF makes its unique facilities for rapid response available to its partners to relieve the suffering of children and those who provide their care.
- UNICEF is non-partisan and its cooperation is free of discrimination. In everything it does, the most disadvantaged children and the countries in greatest need have priority.

- UNICEF aims, through its country programmes, to promote the equal rights of women and girls and to support their full participation in the political, social, and economic development of their communities.
- UNICEF works with all its partners towards the attainment of the sustainable human development goals adopted by the world community and the realization of the vision of peace and social progress enshrined in the Charter of the United Nations.

PART-1

Observational learning

Table (2):- Number of health facilities visited in Jalore district

S.no	Health facility centers	No. of facility center studied
1.	DH, Jalore	1
2.	CHC, Ahore	1
3.	PHC (Nosra and Gudabalotan)	2
4.	SC	12
5.	AWC	4

Research question

What are the current health facilities available in district hospital, community health centre, primary health centre&subcentre in jalore district with respect to physical infrastructure, availability of equipments,human resources & given services?

Objectives

. 1. To visit the health facility centres in jalore district.
2. Compare all the current facilities and services with the standards.
3. To find out the gap in comparison with standard guidelines.

Methodology

Study area- Jalore district

Study respondent- Medical officer or any senior staff of the centre, ANM's and ASHA at SC.

Mode of data collection – Standard checklist (see annexure)

Observations of Field Visits during the Internship

(1) The agony of cultural taboos is still widely prevalent under the umbrella of development in Jalore. Also, the caste system affects the functioning at large.
(2) There are a lot of Health department-related IEC materials available in the SC for Behavior Change Communication and Education of the community, but not properly counseled by them.
(3) Many of the ANMs are located far-off from their designated area and thus the ANMs and AWWs find it difficult to bring the children to the centres.

(4) Visits by the supervisors are quite less and occurs once in two or three months, due to which the supervision of these SC's is improper.
(5) The strength of children and females at the SC's and AWCs visited, was found to be quite lower than the total registered, which might be due to a wedding season in Jalore during the months of April and May, along with the vacation time of school-going siblings of the beneficiaries, due to which the children do not come to the AWCs and rather are off on vacations or for a nearby wedding.
(6) ANM's are having a very nasty roster to enter the all entries of beneficiaries and other works, meetings etc.

Findings in different level

.(1) At District level



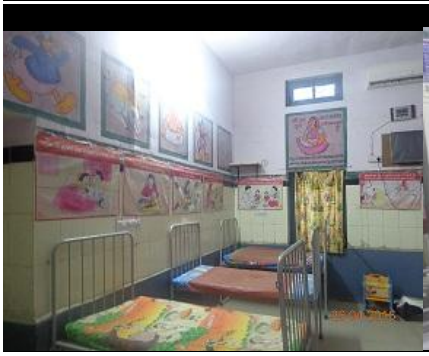


Table (3):-Department wise observations at DH Jalore

S.no	Services	Remarks
a.	Service delivery	OPD and IPD 600-700. No. of deliveries: 10-15 daily
b.	Physical Infrastructure	Health facility easily accessible, functional govt. building, electricity and power back up and running 24*7 water supply with water cooler, separate washroom for male and female and clean condition, functional and clean labor room with all facilities but non active new born care corner as child is referred to SNCU which is functional with radiant warmer, proper biomedical waste

		management, ICU: Two bedded, no machinery was there, no ventilator facility.
c.	Human resource	78% post were filled and 22% vacant (no other specialist, no adolescent health counselor and not any other type of counseling desk.)
d.	Equipment	All the required equipment's were available in all departments.
e.	Essentialdrugs and supplies	All sort of drugs were available.
f.	Other services	Hemoglobin check done by hemoglobin strip method which does not provide accurate results as very old method. For accuracy CBC has to be done which is performed by cell counter. All laboratory testswere performed. Functional blood storage unit with proper board.
g.	Quality parameters of the facility	Manage high risk pregnancy, provide special newborn care, BWM, updated entry in MCP cards, and manage sick neonates and infants.
h.	Record maintenance	Able to see the available records only which were properly maintained.
i.	IEC display	The essential IEC materials were available in all the hospital premises.
j.	Admission of the patient	Don't handle the highly complicated case and refer to jodhpur.

Learning – Bhandari district hospital covered almost 51000 populations. OPD & IPD were 600-700/ day and deliveries were conducted 10-15/ day. It was easily accessible to people, functional govt. building, electricity with power back up and running 24*7 water supply with water cooler, separate ward for male and female and in adequate clean condition, functional and clean labor room with all facilities, critical child is referred to SNCU-functional with radiant warmer, 12 bedded (5 newborns were there at that time), proper biomedical waste management, ICU: Two bedded, no machinery was there as such and family members of the patient were having their lunch sitting on the floor of ICU, no ventilator facility was there. All essential IEC material was displayed in all the hospital premises. There was functional blood bank with chart that how many units of which blood group were there at that time, adequate cleaning was there.

Extra activity

District health society (DHS) –NRHM, Jalore meeting

All districts held monthly District Health Society meeting that convene the district's administrative leadership. DHS is a meeting taken by collector as chairperson and CMHO as co-chairperson. The DHS will be responsible

for planning and managing all health and family welfare programs in the district, both in the rural and urban areas.

Place:-collectorate office, Jalore

Date:-25/04/2016

Chairperson:-District Collectore,Jalore.

Co-chairperson:- CMHO

Members: - RCHO, DPM (NRHM & NUHM), BCMOs, MOs, District Coordinator OF UNICEF & WHO, Nodal Officer of SIHFW.

Picture caption: - ANM gave demo on Ejanswasthya application by tablet to district collector in the DHS meeting.

Picture caption:- District collector and CMHO see the presentation which was given on the topic of E-janswasthya application.

Learning

1. Hierarchy(CMHO office)

CMHO

⬇

Additional CMHO

(Family welfare)

⬇

Deputy CMHO

(Gazette and non-gazette)

(Integrated disease surveillance program management)

⬇

RCHO

2. Staff available in CMHO office - Two officers from national health mission working as DPM under NUHM and NRHM unit. NUHM DPM performs the following functions: Mahilaaarogyasamiti and analyze sector and organize camps. And NRHM DPM sees to the IEC material (RKSK, RBK). Other than these there are District ASHA Coordinator and District Nodal Officer. PCPNDT cell is available for monitoring sonography. It has separate committee, an operator and a coordinator.

3. RMSCL: Rajasthan medical society corporation limited

- Nishulkdavavitran or service yojana monitor
- Send demand by software
- PHC supply to SC and so on.

4.Programs:

1. JSY (Jananishurakshayojana): Under this program at the time of delivery mother gets a cheque of rupees 1400 on birth of baby boy and 2100 on birth of girl child.
2. JSSK (Jananishishushurakshakaryakram): from ANC to after 42 days of delivery all the expenses are bear by government and for baby from birth to one year of age.
3. Shubhlakshmiyojana: JSY+ 2100 rs on the birth of girl child. After one-year full immunization and again gets 2100 rs, at the age of five years given 3100 rs. But from 1st June 2016 it will be renamed as Rajshriyojana and all amount is also changed.
4. Sterilization: Female is given 1400 Rs and male is given 2000 Rs and if sterilization is done just after delivery then 2200 Rs is given.
5. Immunization schedule:

   a. After birth, BCG (one year) + OPV zero (15 days) + hepatitis birth dose zero (within 24 hours)

   b. After six weeks: Pentavalent 1 + OPV 1

   c. After 10 weeks: Pentavalent 2 + OPV 2

   d. After 14 weeks: Pentavalent 3 + OPV 3 + IPV (recently started from 1st April 2016)

e. After 9 months: Measles 1st dose + vitamin A 1st dose

f. After 16-24 months: DPT booster 1 + OPV booster + measles 2 + vitamin A 2 (after every six months 9 dose total)

g. 5 years: DPT booster 2

h. 10 years: TT

i. 16 years: TT (Minimum 28-day gap is given between two doses and after third dose for booster six months gap.)

(2)At CHC Level

Table (4):- Department wise observations at CHC

S.no	Services	Remarks
1.	Services	24 hours' emergency services available including all specialist services (medicine, surgery, OBG, pediatrics), National health programme, no gynecologist is there in CHC therefore staff which is there for delivery (LHV) is available for limited duration, no emergency obstetric care, blood storage facility is non- functional as cases are referred to DH jalore, transportation services available on call. No. of beds: 80, OPD: 400 daily
2.	Human Resource	80% available, 20% vacant
3.	Availability of investing facility	Available (ECG, X-ray, Ultrasound, Pathological tests)
4.	Infrastructure	18 kmfar from DH, OT available so all minor surgeries are carried out. Labor room available with all required facilities so deliveries are carried out. Laboratory available: all diagnostic tests are done, 24 hours water (unfiltered water, water cooler is available) and electricity supply with backup, Biomedical waste management, User charges: OPD- 5 rs, IPD- 15 rs and 200 rs for ECG, X ray and blood test and deliveries are free of cost.

Learning –Emergency services were there, blood storage facility was there but in non-functional condition, complicated cases were referred to DH, all types of laboratory tests, investing tests were done there, 24*7 water facility but unfiltered and electricity facility with power backup was there. All tests were done free of cost except ECG. Labor room was in adequate condition and attached with Amritkaksh.

Extra activity

(a) Block meeting:- Block will be the key level for development of decentralized plans so each block will be covered under the DAP(district action plan) and a block level plan will be prepared for each block in each district. Every month block meeting of ANM's is held in the CHC Ahore. In order to strengthen skills and capacities of Nursing staffs, "ANM Samvad" is organized which innovatively uses technology for reaching to ANMs at negligible cost.It was observed during field visits that basic skills of the nursing staffs were poor in the areas of ANC and PNC service, high risk pregnancy identifications and also records were not maintained properly, so block meeting help in this.

Key objectives of block meeting:-

1. Regular planning, review and monitoring
2. Continuous capacity development to improve the knowledge and skills of ANM's.
3. Review the performance monitoring.
4. Discussion on one health topic every month.
5. Problem solving and grievance redress of ANM's.

Picture caption:- ASHA supervisor, FDC of UNICEF and MO's give in depth knowledge of services to ANM's and solve some issues related to services which were ask by ANM's.

Picture caption:- FDC of UNICEF solve tab related issues and sync all the entries which were present in the ANM' tab at the time of block meeting.

(3) At PHC level

Table (5):- Department wise observations at PHC

S.no.	Services	PHC 1 Nosra	Remarks	PHC2 Gudabalotan	Remarks
I.	Services delivery				
(a)	Emergency services	-	Neither 24 hours staff nor services are available	-	Neither 24 hours staff nor services available
(b)	Beds				
(c)	New born care	-	Only normal delivery takes place and no gynae available so caesarian cases are not taken and therefore referred to CHC or DH.	-	Only normal delivery takes place and no gynae available so caesarian cases are not taken and therefore referred to CHC or DH.
(d)	Water and sanitation	Available	No filtered water for drinking.	Available	No filtered water for drinking.
(e)	Transport	-	No services patient manages on their own. Government has not provided the facility till now.	-	No services patient manages on their own. Government has not provided the facility till now.
II.	Human resources				
	MO	Available	Newly appointed	Available	Newly appointed
	Pharmacist	Available		-	Compounder distributes the drug.
	LHV	Available		Available	At the age of retirement.
	ANM	Available	Does not perform her duty well. RCH registers were almost blank.	-	Transferred
III.	Infrastructure				
	Labor room	Available	Not in a good condition. Only normal deliveries are performed.	Available	Not in a good condition. Only normal deliveries are performed.

(4) At Subcentre level

Table (6):- Department wise observations at Sub centres

S.no	Service	SC	Available	Not available	Remarks
1.	Doctor or LHV visiting SC once in a month	Bhenswara		-	No one is there to supervise it. This is not focused.
		Sanvada		-	No one is there to supervise it.
		Bithuda		-	No one is there to supervise it.
		Jogava		-	No one is there to supervise it.
		Dodiyali		-	No one is there to supervise it.
		Kamba		-	No one is there to supervise it.
		Nimbla		-	No one is there to supervise it.
		Charli	Available		MN2 is present there on regular basis.
		Paota		-	ANM manages everything. Distance issue.
		Hariyali		-	No one is there to supervise it.
		Sedariyabalotan		-	No one is there to supervise it.
		Bedana		-	No one is there to supervise it.
2.	Labor room	Bhenswara		-	One room SC. ANM not staying there, up down from ahore. Timings for ANM: 9-1 pm.
		Sanvada	Available		Delivery point. Only delivery table is available can have a better infrastructure. Normal deliveries take place. No new born care unit
		Bithuda	Available		ANM stop taking delivery cases because of the age.
		Jogava	Available		4-5 delivery per year. As CHC ahore is just few kms from SC so people prefer to go there for delivery.
		Dodiyali		-	No facilities available at SC. Cases are referred to PHC harji or else many migrants live there so they move to Ahmedabad or Deshawar.
		Kamba	Available		No delivery takes place as CHC ahore is few kms away.
		Nimbla		-	ANM not taking the case as facility is not available.
		Charli	Available		Recently SC is taken care off by Jain community. A day before the visit first delivery took place.
		Paota		-	Cases are referred
		Hariyali		-	Cases are referred
		Sedariyabalot		-	Cases are referred

		an			
		Bedana		-	Cases are referred
3.	Water facility	Bhenswara		-	ANM no staying there. So no need of water is found. If required packed water bottles are purchased.
		Sanvada	Available		SC and home of the ANM are same. So facility is available. Public tap but water comes alternative day.
		Bithuda	Available		SC and home of the ANM is same. Water comes by tanker.
		Jogava	Available		SC and home of the ANM is same. Tanker as a water source.
		Dodiyali		-	SC is located in the mid of hills. Timings for ANM 9am-1 pm. ANM not staying at SC. Up down from thanvla.
		Kamba		-	ANM not staying at SC. Up down from Ahore.
		Nimbla	Available		ANM staying at SC.
		Charli	Available		Supported by Jain community.
		Paota	Available		ANM staying at SC
		Hariyali	Available		ANM staying at SC
		Sedariyabalotan	Available		ANM staying at SC
		Bedana	Available		ANM staying at SC.
4.	Electricity	Bhenswara		-	No connection is provided.
		Sanvada	Available		ANM staying at SC
		Bithuda	Available		ANM staying at SC
		Jogava	Available		ANM staying at SC. So home facilities are connected to SC. But no fan and light available.
		Dodiyali		-	No fan and light. No electricity connection.
		Kamba	Available		
		Nimbla		-	ANM stays at SC but the SC room has no electricity connection.
		Charli	Available		Supported by Jain community so all facilities are available.
		Paota	Available		
		Hariyali	Available		
		Sedariyabalotan	Available		
		Bedana	Available		

(5) At Aaganwadi

Table (7):- Department wise observations at Aaganwadi

S.no	Services	AWC Bhenswara	Remarks	AWC Kamba	Remarks	AWC Nosra	Remarks	AWC Khara	Remark
1.	Display of IEC material	×	One chart was display and that too was covered with dust.	✓	Properly displayed on all sides of wall	×	Damaged walls no material was seen	×	Post of ANM and AWC was vacant so no one was there to look after the center. ANM was appointed newly.
2.	Maintenance of registers	✓	RCH register were filled properly	✓	RCH register were filled properly	×	ANM not having complete record of any beneficiary	✓	RCH register were filled properly
3.	Sanitation and hygiene of children	×	Center was clean but hygiene was not seen. No soap was available for hand washing, no nail cutter, hair was not combed, no washroom, no dish washing bar, no dustbin.	×	Center was clean but hygiene was not seen. No soap was available for hand washing, no nail cutter, hair was not combed, no washroom, no dish washing bar, no	×	Center was not clean. No soap was available for hand washing, no nail cutter, hair was not combed, no washroom, no dish washing bar, no dustbin.	×	Center was clean but hygiene was not seen. No soap was available for hand washing, no nail cutter, hair was not combed, no washroom, no dish washing bar, no

					dustbin.				dustbin.
4.	Weighing machine	✓	Only for adult. Baby machine was not there	✓	Only for adult. Baby machine was not there	✓	Only for adult. Baby machine was not there	✓	Only for adult. Baby machine was not there
5.	Poshahar	✓	Hot meal is not served.	✓	Hot meal is not served.	✓	Hot meal is not served.	✓	Hot meal is not served.
6.	Water facility	✓	Water filled in matka. No filtered water.	✓	Water filled in matka. No filtered water.	×	Water filled in matka. No filtered water.	✓	Water filled in matka. No filtered water.
7.	Health workers	✓	AWC, ASHA, ANM	✓	AWC, ASHA, ANM	✓	AWC, ANM	✓	ANM

MCHN day

MCHN Day is government of India (started in 2004) initiative organized at each Anganwadicentre (AWC) & sub centre and provide bucket of services to the targeted beneficiaries including health checkup, ante/post natal monitoring and immunization of women and children. Due to non-administration of MCHN Days in most of the AWC these services are out of reach from the community. MCHN day organized once every month preferably on Thursdays.

Picture caption: -These pictures depict services which were provided on the MCHN day by ANM. ANM gave TT injection, measured weight of pregnant lady, hemoglobin test was done, Heartbeatcount of fetus was also done. etc.

Services on MCHN day

• Registration of all pregnant women

• ANC Services

• Dropouts to be tracked and services provided

• Vaccination

• Vitamin A solution to be given

• Weigh all children & record. Prepare growth monitoring chart also.

• Anti-TB drugs to be given

• Distribution of condoms & OCPs to all eligible couples

• Supplementary nutrition to underweight children

Issues for discussion

• Danger signs during pregnancy

• Importance of PNC

• Counseling by different methods

• Registration for JSY

• Counseling for better nutrition

• Exclusive Breastfeeding and signs of breastfeeding

• Weaning & complementary feeding (The weaning process begins the first time your baby takes food from a source other than your breast).

Findings

Table (8):- Observations at AWC

S.no	Services	AWC Bhenswara	Remarks	AWC Kamba	Remarks	AWC Nosra	Remarks	AWC Khara	Remark
1.	Organized table with stool	Available	Stool was not there, only table was arranged properly.	Available	Table and chair are there.	NA	AWC was in very poor condition. Only mat was there.	NA	Table was organized with all the amenities but that table was examination table.
2.	Examination bench	NA	Mat was used	Available	Was not in use. Waste material was	NA	There was no space, very conjusted, table cannot be	Available	used to keep vaccine kit, medicines, registers etc.

					kept on it. And table was very dusty.		kept there.		
3.	Weighing machine	Available	Adult weighing machine only. Baby machine was not there. Baby was weighed on adult machine	Available	Adult weighing machine only. Baby machine was not there. Baby was weighed on adult machine	NA	Adult machine was not working. Baby weighing machine is there but not in use.	Available	Adult weighing machine only. Baby machine was not there. Baby was weighed on adult machine
4.	BP instrument	Available	Without stethoscope	Available	Without stethoscope	NA	Machine was not working	Available	BP machine not functional.
5.	ANC checkups (urine test, hemoglobin)	Available	Urine test by Uri strips and Hb by Hb strips	Available	Urine test by Uri strips and Hb by Hb strips	NA	No strips are there in AWW.	**Available**	Urine test by Uri strips and Hb by Hb strips
6.	Vaccine kit	✓	Properly covered. Bought from PHC or CHC by health workers.	✓	Properly covered. Bought from PHC or CHC by health workers.	✓	Properly covered. Bought from PHC or CHC by health workers.	✓	Properly covered. Bought from PHC or CHC by health workers.
7.	Tablets and powder	✓		✓		✓	Oral pills not available	✓	

8.	Counseling	×	Due to time issue for both ANMs and beneficiaries they are able to communicate properly. And to counsel 25 or more people at a time ANM found it tedious work.	×	Due to time issue for both ANMs and beneficiaries they are able to communicate properly. And to counsel 25 or more people at a time ANM found it tedious work.	×	Due to time issue for both ANMs and beneficiaries they are able to communicate properly. And to counsel 25 or more people at a time ANM found it tedious work.	×	Due to time issue for both ANMs and beneficiaries they are able to communicate properly. And to counsel 25 or more people at a time ANM found it tedious work.
9.	Waste bin	×	Only polythene bag was available to throw the waste. No bins according to biomedical waste management.	×	Only polythene bag was available to throw the waste. No bins according to biomedical waste management.	×	Only polythene bag was available to throw the waste. No bins according to biomedical waste management.	×	Only polythene bag was available to throw the waste. No bins according to biomedical waste management.
10	Poshahar	✓	Hot meal was not served. Once	✓	Hot meal was not served.	×	Hot meal was not served. Once	✓	Hot meal was not served. Once

			cooked and kept till the session is over. Usually khichdi is provided which gets dry by the time.		Once cooked and kept till the session is over. Usuall y khichdi is provide d which gets dry by the time.		cooked and kept till the session is over. Usually khichdi is provided which gets dry by the time.		cooked and kept till the session is over. Usually khichdi is provided which gets dry by the time.
11	Health worker	✓	ANM, ASHA and AWW	✓	ANM, ASHA and AWW	✓	ANM and AWW	×	Only ANM
12	Dropouts	✓	People don't know the importance of immunizatio n Old beliefs and customs, societal myths, females went to farm during the session time, they are not being informed, unawarenes s.	✓	People don't know the import ance of immun ization Old beliefs and custom s, female s went to farm during the session time, they are not being inform ed, unawar eness	✓	People don't know the importance of immunizati on Old beliefs and customs, females went to farm during the session time, they are not being informed, unawarene ss	✓	People don't know the importance of immunizati on Old beliefs and customs, females went to farm during the session time, they are not being informed, unawarenes s

Learning- It was observed that, ANMs lack in basic knowledge on correct techniques for estimation of Blood Pressure, or estimation of Hemoglobinetc. despite ANMs being in service for many years. This was a common observation during MCHN sessions. One reason for this gap observed was lack of sufficient 'refresher trainings' for in-service ANMs.

Suggestions for improvement

1. The ANM's and AWWs should be empowered enough to put forward their opinions and problems before the higher authorizes, even out of the chain of command, if required; and these points should be given a fair weightage. With a vision to enhance and improve the skills of ANM, boost their confidence and improve the quality of data.

2. A comprehensive and intense focus on BCC activities is the most approachable solution to combat the cultural barriers to a fair nutrition of children of both the sexes. A more intensive involvement of PRIs can also be helpful in this regard.

3. ANM's, AWWs and AWHs should be given timely refresher training on how to conduct IEC activities and how to counsel the beneficiaries.

4. An active supervision is the only way through which we can assure a timely functioning of our Subcentre, Anganwadis, and thus supervisors should be mandated to visit each of their Subcentre, Anganwadis, at least once in a week.

6. The Subcentre should be located at a fair distance from the community specified, for an easy travelling of the AWH to the houses of beneficiaries to bring the children from their homes to the AWC.

7. Fulfill the vacant posts of ANM/ASHA/AWW for efficient running of health system.

8. The ASHA/ANM/AWW should counsel the parents and Family about all the parameters for proper care of the new born.

10. The parents should be informed about scheduled days of visit of LHV and MO to be made to the Subcentre.

11. ANM/ASHA/AWW should follow the standard Protocols.

PROJECT REPORT

Ejanswasthya: An innovation hub

According to the geographical point, Rajasthan though there is 80% increment in institutionl deliveries but MMR is reducing at very slow rate. The health department with the help of health workers are trying to identify the danger signs of mother and infants but the situation is still not good.

During the ANC checkups of a pregnant lady it is necessary to check Blood pressure, haemoglobin, weight etc. but lack of sources, lack of information among health workers, improper counselling, lack of motivation, manual records such things hinders the overall process.

Therefore, there's a need to ascertain these issues on the right time and timely tracking of each mother and new born. After expenditure of currency on Complex tracking system, dependency on internet and computers, training to workers for motivation etc. still there is lack of improvement.

Keeping in mind the above complications, State institute of health and family welfare with the support of UNICEF developed an android based application "e-janswasthaya'

Objectives of the program

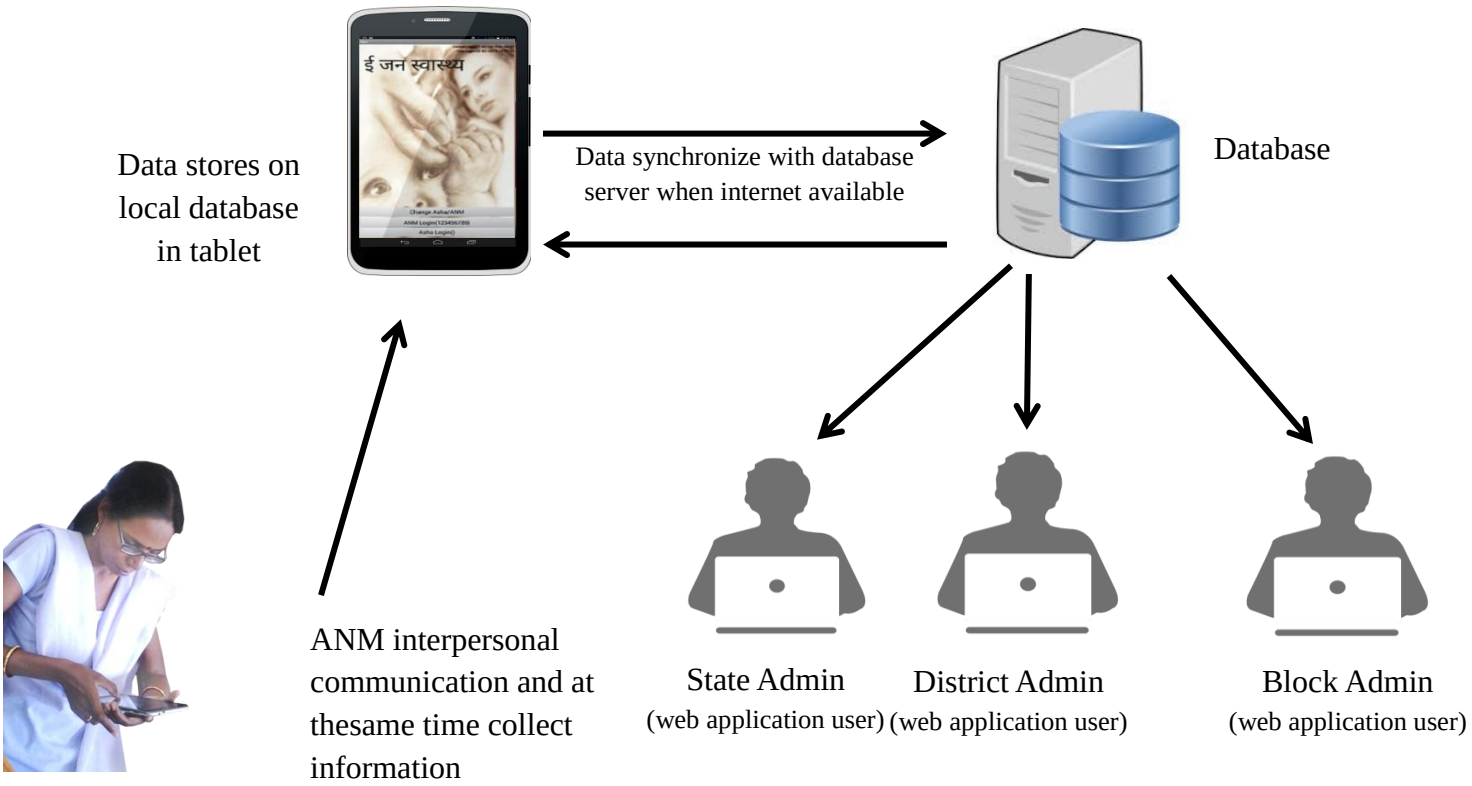
- Facilitate in improving quality of interpersonal communication
- Improving counseling skill through Video.
- Identification of danger signs/ high risk
- Growth monitoring and identification of sick & undernourished children
- Real time tracking – RCH Register
- Due list / Evidence based work plan
- Logistics planning
- Quick & seamless reporting
- Actions at local level

Users of the Application

The use of this application is at the Sub Center level by the health workers. The main users are

1. ANMs
2. ASHA

Process implementation



Need of the program (Bottlenecks)

- Interpersonal Communication
- Identification of Danger signs and facilitation of actions at the family level
- Weak memories both users and providers
- Tedious process of planning – Still incomplete
- Data collection multiple registers
- Data computerization/ Quality of data
- Performance monitoring/ transparency/accountability

Pilot Testing started by

- ASHAs in PHC Jasol (Barmer)
- ANMs in Pali
- Jhalawar district

How many bottlenecks can be addressed?

- Improved interpersonal communication
- Identification of danger signs/ High risk
- Actions at local level
- Real time tracking – RCH Register
- Due list / Evidence based work plan
- Reminders
- Seamless reporting
- Logistics planning
- Growth Monitoring and identification of sick and undernourished children
- Monitoring of time appropriate care

Application key features

- Less typing work
- Weight & BP through Bluetooth devices
- Registration through photo
- Auto play counselling videos & Message POPUP
- No all-time internet is required
- Hindi language support
- Multilevel monitoring mechanism
- Support all android version
- Location tracking (offline)
- Reminder mechanism (Work plan)

Picture caption: - These are the screenshots of Ejanswasthya application in the tab. In this main screen 4 major parts are: - Eligible couple survey, ANC, PNC and Immunization. So this is the process of filling the entries in the tab.

Work done –

1. Selection of ANM's who are not using tablets frequently.
2. Interaction with them at their subcentre.
3. Making them learn the application and solve small issues regarding tab,
4. Motivate them to use tab in case of counseling of beneficiaries.

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Table (9):- Work done in support of E janswasthyaprogramme

S.No.	Place	Distance from jalore	Person interacted	Work done
1.	CHC, ahore	25 kms	Approx. 45 ANM	Synchronization of data in both the block meeting.
2.	CHC, ahore	25 kms	20 ANMs	Assist Inderpal Sir in providing training to ANMs regarding app.
3.	PHC, guda balotan	33 kms	MO and LHV and ANMs during sector meeting	Change the version of application and sync. Data.
4.	SC, Bedana	40 kms	ANM	Sync data, solve tab related problems (double entries, entry not shown in ANC, Name of ASHA, AWC problem)
5.	SC, Hariyali	55 kms	ANM	Solve application related issues (e- Janswasthya stopped and problem related to ANC & PNC entry)
6.	SC, Sedariya balotara	66 kms	ANM	Assist ANM in using tablet and application.
7.	SC, Khara	29 kms	ANM	Synchronise data on the day of data collection and MCHN day.
8.	SC, Charli	30 kms	ANM	Make ANM learn the tablet and application by doing some entries and then ask her to do.
9.	SC, Paota	67 kms	ANM	Got tab in last block meeting i.e. 6th may 2016. make her learn using tablet.
10.	Thanvla	40 kms	ANM	Got tab on last block meeting. Make her learn tab and the application and ask her to do entries.
11.	Madri	37 kms	ANM	Change the SC and synchronise data.
12.	Ajeetpura	45 kms	ANM	Change the SC and make her learn application and entries done and sync.

Odk application

Open Data Kit (ODK) is a free and open-source set of tools which help organizations author, field, and manage mobile data collection solutions. ODK provides an out-of-the-box solution for users to:

1. Build a data collection form or survey (XLS Form is recommended for larger forms)

2. Collect the data on a mobile device and send it to a server

3. Aggregate the collected data on a server and extract it in useful formats.

In addition to socio-economic and health surveys with GPS locations and images, ODK is being used to create decision support for clinicians and for building multimedia-rich nature mapping tools. ODK is supported by a growing community of developers, implementers and users as well as various companies. Open Data Kit (ODK) is an open-source suite of tools that helps organizations author, field, and manage mobile data collection solutions. Our goals are to make open-source and standards-based tools which are easy to try, easy to use, easy to modify and easy to scale.

ODK's core developers are researchers at the University of Washington's Department of Computer Science and Engineering department and active members of Change, a multi-disciplinary group at UW exploring how technology can improve the lives of under-served populations around the world. ODK began as a google.org sponsored sabbatical project under the direction of Gaetano Borriello in April of 2008 at Google's Seattle offices. ODK is funded by a Google Focused Research Award and through donations from users. ODK is supported by a growing community of developers, implementers and users.

The major goals of the ODK Application Designer are:

1. Simplify the form-design process by providing a preview of your form with the same screen geometry as your target Android device. You no longer have to copy each iteration of your form onto your device to see how it will look or fit on a smaller screen.

2. Simplify the design and testing of customized list- and detail- views in ODK Tables, and in the design of graphical representations of data within ODK Tables

3. Simplify the customization of the look-and-feel of your forms through a simple visual theme editor / generator where your modifications can be immediately viewed and the resulting CSS styles or theme can be saved to a file for later incorporation into application deployment.

4. Simplify the conversion of the XLSX file into a form definition by providing a drag-and-drop conversion app running locally on your desktop.

5. Simplify the transition to the use of ODK Survey as a replacement for ODK Collect by generating a stub XML form definition that can be uploaded to ODK Aggregate and used by ODK Survey to submit data into ODK Aggregate's X Forms submission processing and publishing pipeline (the one used by ODK Collect).


Knowledge awareness and practices study on Postnatal care : A case study of Ahore block of Jalore district Rajasthan


Background

Postnatal Care

The postnatal period, or puerperium, is defined as the period beginning about one hour after the delivery of the placenta and extending through the next six weeks. The client should receive care after labor and delivery, when the pelvic organs return to their pre-pregnant condition. This period of involution typically takes six to eight weeks, though it may take much longer for some organs to return to normal. Postnatal care is the attention given to the general mental and physical welfare of the mother and infant. Care should be directed toward prevention, and early detection and treatment, of complications and diseases. In addition, postnatal care should include counseling, advice, and services on breastfeeding, family planning, immunization, and maternal nutrition. Postnatal care services are the recommended intervention aimed at preventing MMR & IMR worldwide. Jalore is one of the district of Rajasthan with a high proportion of home deliveries, a low attendance of postnatal care uptake. Rationale, including reasons for not using these services, the services received during postnatal care, and cultural practices during postnatal periods in Jalore districts of Rajasthan.

For women who give birth in health facilities in resource-limited settings and their newborns does discharge from hospital within 24 or 48 hours of birth compared with discharge any time later increase the risk of maternal or neonatal readmissions for morbidity and stopping breastfeeding at six weeks or six months after birth.

Providing basic care to newborns and Mother at home has been identified as a critical intervention that helps in preventing MMR & IMR. However, postnatal care has not received adequate attention until recently and NFHS-III records only a small percentage of women or children being visited by a health worker during the first month of life.

The Government of India has recommended that all mothers and newborns receive three postnatal (PNC) checkups within 42 days of delivery as follows: first within 48 hours, second between 3-7 days and the third within 42 days of delivery.

With regard to cord care, NFHS-3 and DLHS-3 data show that the practice of clean cordcutting was almost universal in rural, 95-98 percent of women reported that a sterilized blade was used to cut the cord. However, several studies have reported the application of various substances, such as ghee (clarified butter), turmeric, linseed oil, mustard oil and powders and ointments provided by local health care providers to hasten the healing of cord stump.

The objective of postnatal care is to support the mother and her family in the transition to a new family constellation, and respond to their needs through:

- Prevention, early diagnosis, and treatment of common problems or complications in both mother and infant, including preventing mother-to-infant disease transmission.
- Referral of mother and infant for specialist care when necessary.
- Counseling and information for the mother on newborn care and breastfeeding.
- Support of optimal breastfeeding practices.
- Education of the mother and her family concerning maternal nutrition and supplementation if necessary.
- Counseling and provision of contraceptives before the resumption of sexual activity.
- Immunization of the infant.

Counseling

(a) Exclusive Breast feeding –

1. Breastfeed as soon as possible after birth.

2. Breastfeed frequently, whenever the infant is hungry, both day and night (generally at least eight times during 24 hours and at least once during the night).

3. Breastfeed exclusively for the first six months, giving no water, other liquids, or solid foods.

4. Give complementary feeds after six months (breastfeed before giving complementary feeds). Continue to breastfeed for up to two years, and beyond, if possible.

5. Continue breastfeeding even if the mother or the baby becomes ill.

6. Check, Weather chin of child does not touch the breast, Lower lip covers the areola, and Child opens his /her complete mouth.

(b) Rest- Encourage the mother to take rest and encourage other family members to help her with the household tasks including preparing food, cleaning the house, and caring for the other children. A well-rested mother is a better mother and spouse.

(c) Diet- Suggest the Mother to eat 1/3 extra food than the normal diet. Encourage the mother to eat a well-balanced diet including the following: eat protein and energy rich foods, vitamins, mineral and fluids; continue taking supplements (e.g. iron). Encourage the mother to drink fluids every time she breastfeeds.

(d) Personal Hygiene and sanitation - The mother can and should bathe herself daily after giving birth. Bathing is not harmful; Recommended bathing practice is to use a shower, if available, or to pour water over the body.

1. Wash breasts and perineum as part of the daily bath.

2. Wash hands before and after going to the bathroom. Wash the genital area with mild soap and water after passing urine or stool.

3. Wipe or cleanse vulva from front to back, anus last.

4. Wash the hands every time before touches the child.

5. Keep the infant in a clean place away from smoke and dust. Change the diaper or bedding each time the infant wets or dirties the diaper.

(e) Sleeping Arrangement and Positions - The baby should sleep in a clean, safe, smoke-free and warm area and not far from the mother. The preferred position for the newborn/infant is on the baby's right side. From time to time, turn the baby's head from the right side to the left. When putting the baby to sleep, advise the mother not to place the infant on his or her abdomen.

(f) Kangaroo Mother care - In kangaroo care, the baby is placed in a flexed (fatal position) with maximal skin-to-skin contact on parent's chest. The baby is secured with a wrap that goes around the naked torso of the adult, providing the baby with proper support and positioning (maintain flexion), constant containment without pressure points or creases, and protecting from air drafts (thermoregulation).

(g) Care of Cord - Keep the cord clean and dry. Normally, it falls off within 7-14 days. Do not cover the cord or apply any medicine or ointment to the cord area. If a bad smell, pus, or signs of infection occur in the navel (cord) area, take the infant to the health centre for care.

(h) Immunization - Make the women aware about the immunization, its importance, how it is beneficial for the child. Number of vaccines, when child vaccinated.

(i) Sexuality - It is advised to abstain from sexual intercourse for six weeks after delivery, to prevent infection and also to allow the perineum to heal. However, if the vaginal area has healed and bleeding (lochia) has stopped, there is no medical risk in having intercourse.

Research question:- What culture beliefs, practices and knowledge influence the care of newborn in Ahore block of Jalore district?

Objective:-

1. To study the current status of Postnatal care practices of Mother and Newborn at Ahore block of Jalore district.

2. To assess the Mother knowledge on the care of Newborn.

3. To study the effect of some demographic characteristic on the care of Mothers and Newborn.

Research methodology:-

(a) Study Design : Descriptive Research

(b) Study Area: The study area was Ahore Block of Jalore District of Rajasthan. 12 Subcentre of Ahore block were covered in the study.

Jalore in specific was chosen as study area because Neonatal Mortality Rate is 53 which is highest in Rajasthan as compared to average 40(AHS 2010-2011).Women and children have limited accessibility and affordability to quality healthcare and counseling services due to hardships imposed by life in the lack of infrastructure of health care services. Sources reveal that in the given district, 4 women die due to pregnancy/ Child Birth related complication, 112 children are not able to complete their first year of life and 84 children are not able to make it for the first month of life.

(c) Study Population : Females Who Delivered in the months of December 2015- May 2016.

(d) Study Period : The was carried out for 2 Months (1st April to 31st May, 2016)

(e) Sampling Design: Purposive sampling and Non-Probability Sampling (Mother who only delivered in December 2015- May 2016)

(f) Data Collection : Interview method

. Face to Face interview – All the Mothers of newborns whosoever delivered child in December 2015- May 2016 were interviewed by Door to Door visit and in Hospital (CHC, PHC, SCs).

. Semi-structured Questionnaire – A questionnaire of close ended questions was made and used as a tool for data collection; having various questions related to post natal care and observational parameter framed to assess the things.

(g) Data Entry or Preparation-.

. All the responses were entered into Odk application at the time of interview.

. Different responses from the respondent were coded in the excel sheet.

. Cleaning of data

. Missing values were removed from the data set.

. Interpretation and analysis of the data.

(h) Quality Control:- Filled questionnaires will be checked daily for completeness and consistency of the responses to eliminate possible errors.

Limitations of the Survey:-

The results of awareness for postnatal care in Ahore were entirely dependent on memory of the caregivers to correctly recall the case and correctly define the conditions as specified in this study. Generalizability of the research results will be limited to Ahore due to critical limitations such as sampling process. The following limitations of the survey were identified:

a) Sample sizes were taken was small and the size might not represent the entire universe of the study.
b) There was scope for more in-depth probing of various components making the study more interesting.
c) Time constraints for various activities of the project.
d) Information bias: Information bias is where the caregivers tend to opt for answers they feel the investigator would like to hear, or answers that are pleasing (less humiliating to them). Thus, the data collected might not have been exact or reliable with what was actually happening due to the incorrect responses. This was minimized by use of a standardized structured questionnaire.
e) Selection bias: Selection bias is due to use of non-random method of snow ball for selecting the sample.
f) Response burden: This could have been a limitation to the study in such a way that the participants might have gotten tired due to the length of the questionnaire.

RESULT

(A) **Demographic characteristic**

Table (10):- Socio demographic profile of the respondent

(N- Case=50, Control = 50)

Serial no.	Characteristic	Case N= 50	Case In %	Control N= 50	Control In %
1.	Sex of Newborn				
	a. Male	28	56	29	58
	b. Female	22	44	21	42
2.	Distribution of caste				
	a. General	4	8	5	6
	b. OBC	22	44	25	50
	c. SC	11	18	11	22
	d. ST	13	30	9	8
	e. Others	0	0	0	0
3.	Education of Mother				
	a. Illiterate	31	62	39	78
	b. Class 1-5	10	20	5	10
	c. Class 6-9	9	18	6	12
	d. Class 10-12	0	0	0	0
	e. Graduate	0	0	0	0
	f. Postgraduate	0	0	0	0

It depicts that the society was male dominant as 60 per cent were male. The results showed that both groups had no significant difference in terms of sexual status. Accordingly, it can be concluded that, in the present study, the two groups had almost identical sexual demographic characteristics. In the Ahore block mostly people were fall in OBC category, almost ½. Other major category was ST (schedule tribe). Additionally that there was no significant difference in both test and control group. Additionally mostly (approx. 65 per cent) Mothers were illiterate due to many cultural beliefs, early marriage as average marriage age of girls were 20 years) etc. If they literate then mostly mothers were only 5th pass. Education affects the knowledge and

practices of mothers in the daily life as they had less knowledge about breastfeeding and postnatal care. Accordingly, it can be concluded that, in the present study, the two groups had almost identical socio demographic characteristics like sex, education, category etc.

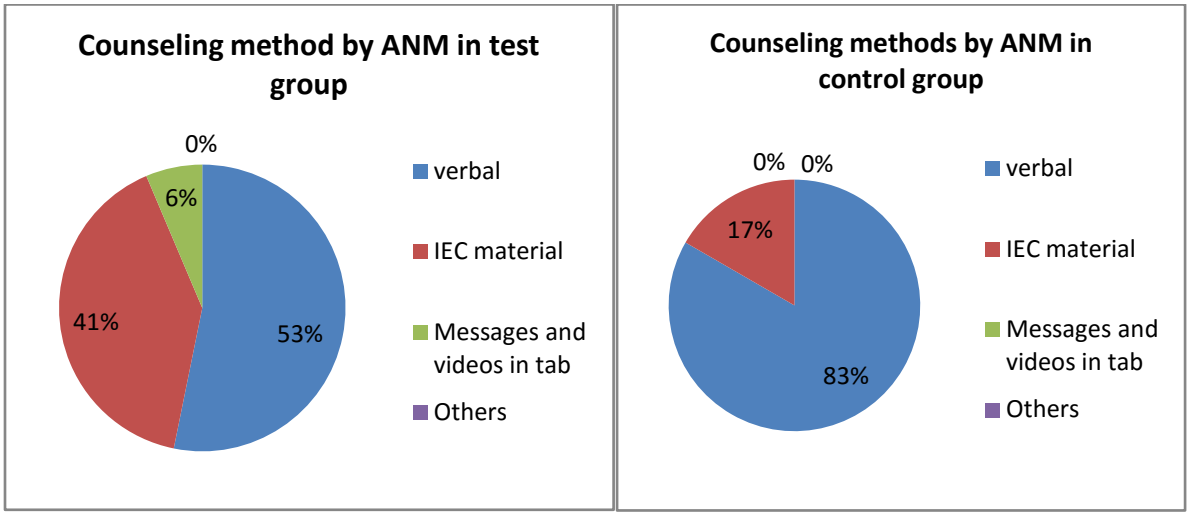
Table (11)<u>Comparison of test and control group</u>– N = 100 (test =50 & control = 50)

Serial no.	Indicators	Case		Control	
		N = 50	%	N = 50	%
1.	Counseling(Multiple option)				
	a. Verbal	50	100	50	100
	b. IEC material	38	76	10	20
	c. Messages and videos in tab	6	12	0	0
	d. Others	0	0	0	0
2.	Interaction with ANM				
	a. Weekly	41	82	5	10
	b. Monthly	8	16	41	82
	c. 2 times in a month	1	2	4	8
	d. 3 times in a month	0	0	1	2
3.	Know about importance of breastfeeding				
	a. Yes	47	94	46	92
	b. No	03	6	4	8
4.	Do you know period of exclusive breastfeeding				
	a. Yes	20	40	13	26
	b. No	30	60	37	74

5.	What are the signs of breastfeeding				
	a. Chin touching breast	40	80	45	90
	b. Mouth wide open	06	12	05	10
	c. Lower lip turned outward	03	6	0	0
	d. More of the darker skin (areola) above the baby mouth than below.	01	2	0	0
6.	Interested for family planning				
	a. Yes	20	40	18	36
	b. No	30	60	32	64
7.	Give substitute before 6 months				
	a. Yes	34	68	40	80
	b. No	16	32	10	20
8.	Feed colostrum after delivery				
	a. Yes	48	96	32	64
	b. No	2	4	18	36
9.	How long baby should suckle				
	a. Every time baby seems hungry	45	90	50	100
	b. Every hour	0	0	0	0
	c. Every 1-2 hour	2	4	0	0
	d. Every 2-3 hour	3	6	0	0
10.	Think that there are complications occur at the time of delivery				
	a. Yes	43	86	5	10
	b. No	7	14	45	90

Graphs and interpretation

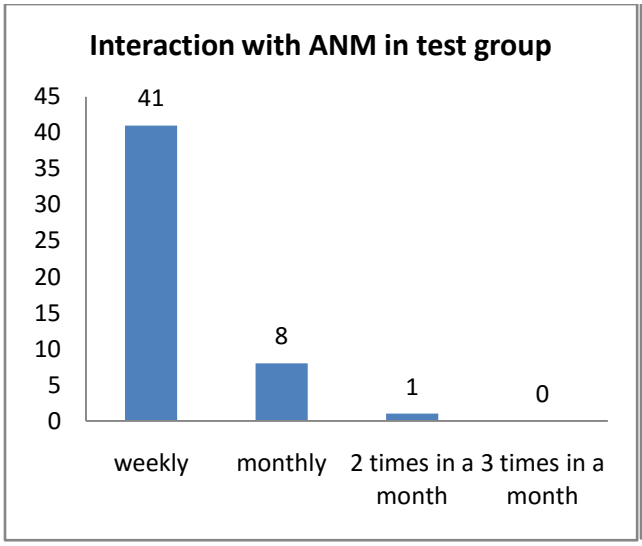
Figure (1) Mode of counseling

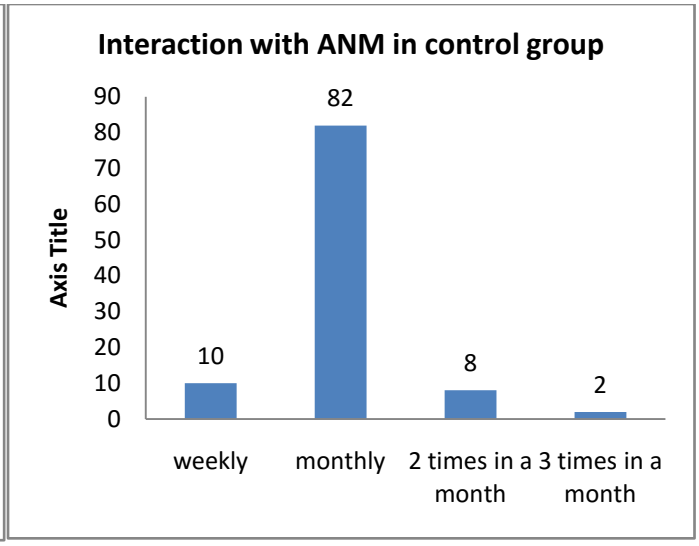


From the survey it is found that, the counseling was given to beneficiaries very well and all the 100 respondents told that everything was told to them and they found it easy to understand. As observed from the field health workers convey the messages in their local and regional languages so that beneficiaries easily understand them. But every health worker uses different medium of communicating the messages. In test group ANM's used IEC material for counseling (41per cent) more than control group (17per cent). Graph suggest that control group ANM's did not use tablet as a mode of counseling while only six per cent counseling is present in the test group by tablet which is also very less. Another finding is that in both group test and control ANM's does not use any other different type of method for beneficiaries counseling like telling stories, telling some incidents, by newspaper etc. ANM's used only verbal method which is very easy to use.

Figure (2) Interaction with ANM

Figure (2) depicts that in the test group, interaction with ANM of beneficiaries were more frequent as compare to control group. In the test group 82 per cent beneficiaries interacted with ANM weekly while only 20 per cent beneficiaries interacted with ANM weekly. In control group people rarely interacted with ANM, so this may be issue that control group had less knowledge and awareness.





Another finding was that people agree that they know about importance of breastfeeding but don't practice it sincerely, as in test group 94 per cent people know the importance of breastfeeding and in control group 92 per cent people know the importance of breastfeeding. So there was not much difference between the test and control group data. They know that breastfeeding is necessary but don't know what is the exact reason and which nutrients are there in breast milk.

Table (11) told that people know about importance of breastfeeding but they didn't know about the period of exclusive breastfeeding. Exclusive breastfeeding as WHO says that the infant receives only breast milk. No other liquids or solids are given – not even water – with the exception of oral rehydration solution, or drops/syrups of vitamins, minerals or medicines. In the test group only 40 per cent people know what the exact period of exclusive breastfeeding is while in control group only 26 per centpeople know about period of exclusive breastfeeding. They give different substitute to newborn (especially water in summer) with spoon or finger before six months as they thought that these things are essentials for newborn.

It showed that in the test group 60 per cent people were not interested in family planning, they want more babies or want boy child. In control group 64 per cent people are not interested in family planning due to the same reason. Use of birth control is not supported by father also in this society.On the other side of the spectrum, in society a woman often lives with her mother-in-law, who influences how many children she'll have, it called Matriarchal tradition.Married adolescents have the lowest use of contraception, the highest number of children, an increased chance of high-risk pregnancies, and less access to education. Some myths are also present in the society related to family planning like –OCP causes infertility and reduces a woman sex drive etc.

Additionally In the test group 68 per cent people gave substitute to newborn before six months while 80 per cent people in control group gave substitute to newborn before six months. They give water in summer, goat's milk, honey for taste etc. to newborn because they thought that these are essential for newborn.Many mothers feel uncomfortable with breastfeeding so they give other substitute to the newborn.

Figure (2) Feeding of colostrum

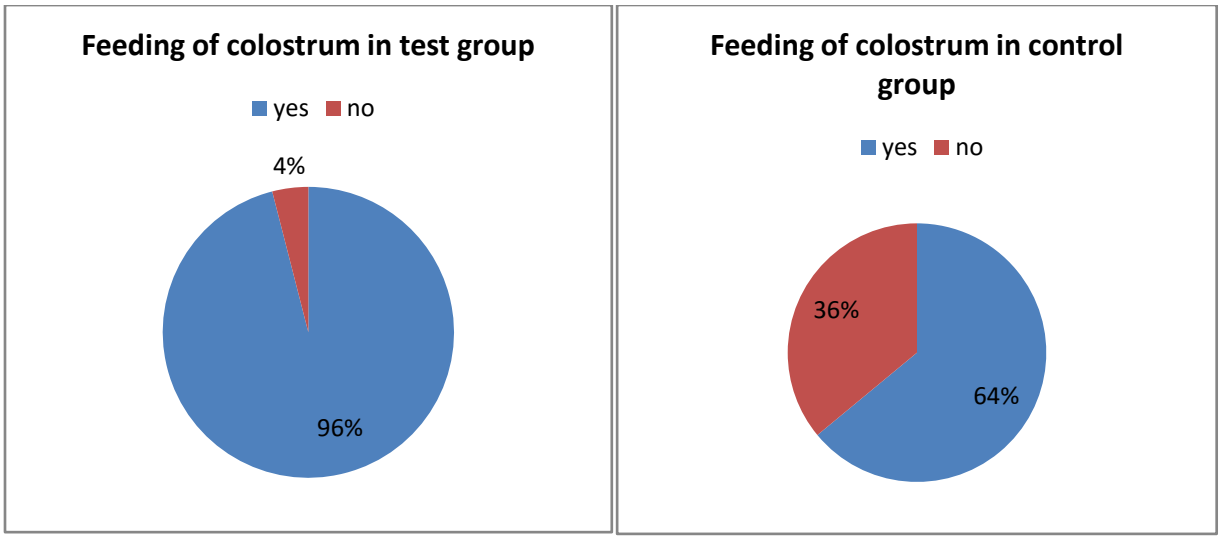


Figure (2) 96per cent people in test group and 64per cent people in control group feed colostrum to baby. Some people don't feed colostrum because they thought that it was harmful for baby, colostrum is impurity of milk etc. In case of home delivery people don't feed colostrum because no one is there to guide them and motivate them, while deliveries in hospital nurses, doctors are there for motivation to people that feeding the colostrum is essential for immunity (mother's first milk which contains all nutrients and antibiotics).

In the test group 86 per cent people were aware about complications at the time delivery while in control group only 10 per cent people were aware. People thought that delivery is a natural process so there were no worries about any complications at the time of delivery.

Figure (2) Awareness about knowing how long should baby suckle

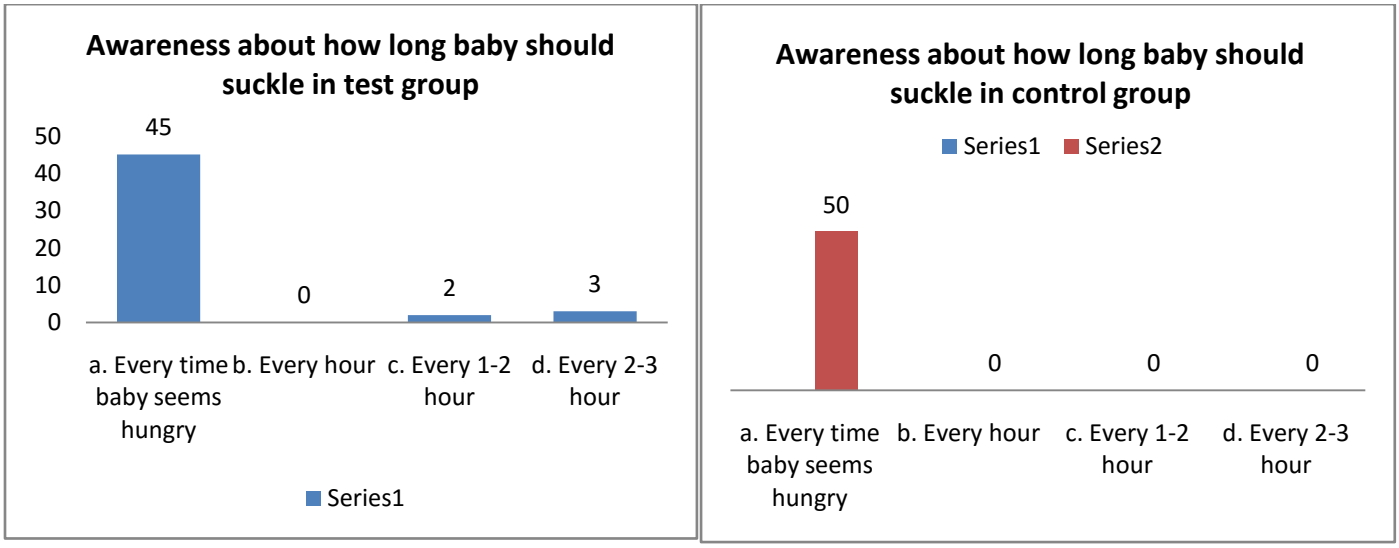


Figure (2) depicts that in both case and control group major people know that whenever baby cries, it is due to hunger and they breastfeed them. There was very less approx. 4-5 per cent awareness in people that how long baby should suckle.

Assessment of birth weight of newborns (at the time of delivery v/s at present when questionnaire were filled) in test and control group with the help of paired t- test method

Table (12)a. Comparison of Birth weight using paired t-test

	Null hypothesis	Alternative hypothesis	$t_{cal.}$	Degrees of freedom	p-value	Mean of differences	Remarks
Test group vs Control Group	Birth Weight is equal for both the groups.	Birth Weight for Control group is lower than Birth weight for test group.	4.7726	57	$6.534 * 10^{-6}$	1.010345	As p-value is very much smaller than cut-off value of 0.05 so we strongly reject null hypothesis and conclude that the birth weight of control group babies is very much significantly lower than that of test group babies and control group babies are quite significantly weak at time of birth than test group babies.

Table (12)b. Comparison of Present weight using paired t-test

	Null hypothesis	Alternative hypothesis	$t_{cal.}$	Degrees of freedom	p-value	Mean of differences	Remarks
Test group vs Control Group	Present Weight is equal for both the groups.	Present Weight for Control group is lower than present weight for test group.	3.2263	57	0.00104	1.04431	As p-value is smaller than cut-off value of 0.05 so we reject null hypothesis and conclude that control group babies reported significantly lower present weight as compared to test group babies.

Table(12)c. Birth weight to present weight comparison using paired t-test (in test group)

	Null hypothesis	Alternative hypothesis	$t_{cal.}$	Degrees of freedom	p-value	Mean of differences	Remarks
Birth weight vs present weight – test group	Birth weight is equal to present weight.	Present weight is lower than the birth weight.	-6.3333	57	1	-1.206379	

Table (12)d. Birth weight to present weight comparison using paired t-test (in control group)

	Null hypothesis	Alternative hypothesis	$t_{cal.}$	Degrees of freedom	p-value	Mean of differences	Remarks
Birth weight vs present weight – control group	Birth weight is equal to present weight.	Present weight is lower than the birth weight.	-7.1465	57	1	-1.172414	

Discussion

The health of mothers is mostly regarded as an indicator the health of the society. Globally, more than half a million women die each year from complications of pregnancy and childbirth. A large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery. Thus, postnatal care (PNC) is important for both the mother and the child to treat complications arising from the delivery, as well as to provide the mother with important information. Every year, four million infants die within their first month of life, representing nearly 40 % of all deaths of children under age 5 year old. Almost all newborn deaths are in developing countries.

Children below 6 months are generally breastfed exclusively, with most respondents introducing complementary foods before 6 months. When complementary feeding is introduced, households with different economic capabilities feed their children differently. There is a prevalence of starchy foods being given to poor children and a more limited diet in terms of variety and nutritional content. This assessment also finds that a high percentage of children in the lower economic categories do not receive three meals a day. This study registered a poverty level of 47.6 per cent among respondent households. The poverty level, combined with the feeding regime of families in rural areas, may account for the stunted growth of children. Improving the living standards of families in rural areas will go a long way towards rectifying this situation.

Conclusion

The uptake of postnatal care services is adequate in Ahore block. Huge variations exist in receiving postnatal care at both the individual and community levels. Findings suggest that interventions to increase the use of postnatal care services should target the uneducated, and those women who live in disadvantaged communities.

In the postpartum period, women need: Information/counseling on different topics like- care of the baby and breast feeding, what happens to their bodies, including signs of possible problems, self-care and hygiene and healing, sexual life, contraception, nutrition. They need support from health care providersfor suspected or manifest complications.

References

(a)**http://unicef.in/State/Rajasthan**

(b)**http://unicef.in/StateInfo/Rajasthan/Unicef-In-Action**

(c)Post Natal Care, June 10, 2002.

(d)Postpartum care of the mother and newborn: a practical guide (WHO/RHT/MSM/98.3; http://www.who.int/maternal_child_adolescent/ documents/who_rht_msm_983/en/).

(e) Integrated management of pregnancy and childbirth – pregnancy, childbirth, postpartum and newborn care: a guide for essential practice, published in 2004 (http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/92415 9084X/en/index.html).

(f) Guidelines for community health centre by Indian Public Health Standard, 2012

(g) AHS 2010-2011

Annexure

DH LEVEL MONITORING CHECKLIST

Name of District: ..... Name of Block: ..... Name of DH: .....

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

Date of last supervisory visit: .....

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

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

Section I: Physical Infrastructure

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

1.22	Availability of complaint/suggestion box	Y	N	
1.23	Availability of mechanisms for Biomedical waste management (BMW)at facility	Y	N	
1.24	BMW outsourced	Y	N	
1.25	Availability of ICTC/ PPTCT Centre	Y	N	
1.26	Availability of functional Help Desk	Y	N	

Section II: Human Resource

S.No.	Category	Numbers	Remarks if any
2.1	OBG		
2.2	Anaesthetist		
2.3	Paediatrician		
2.4	General Surgeon		
2.5	Other Specialists		
2.6	MOs		
2.7	SNs		
2.8	ANMs		
2.9	LTs		
2.10	Pharmacist		
2.11	LHV		
2.12	Radiographer		
2.13	RMNCH+A counsellor		
2.14	Adolescent Health Counsellor (1 female & 1 male)		
2.15	Others		

Section III: Training Status of HR

S.No.	Training	No. trained	Remarks if any
3.1	EmOC		
3.2	LSAS		
3.3	BeMOC		
3.4	SBA		
3.5	MTP/MVA		

3.6	NSV		
3.7	F-IMNCI		
3.8	NSSK		
3.9	Mini Lap-Sterilisations		
3.10	Laparoscopy-Sterilisations		
3.11	IUCD		
3.12	PPIUCD		
3.13	Blood storage		
3.14	IMEP		
3.15	Immunization and cold chain		
3.16	MO training on Adolescent Health (RKSK)		
3.17	ANM/LHV training on Adolescent Health (RKSK)		
3.18	Counsellor training on Adolescent Health (RKSK)		
3.19	Others		

Section IV: Equipment

S.No.	Equipment	Yes	No	Remarks
4.1	Functional BP Instrument and Stethoscope	Y	N	
4.2	Sterilised delivery sets	Y	N	
4.3	Functional Neonatal, Paediatric and Adult Resuscitation kit	Y	N	
4.4	Functional Weighing Machine (Adult and child)	Y	N	
4.5	Functional Needle Cutter	Y	N	
4.6	Functional Radiant Warmer	Y	N	
4.7	Functional Suction apparatus	Y	N	
4.8	Functional Facility for Oxygen Administration	Y	N	
4.9	Functional Foetal Doppler/CTG	Y	N	
4.10	Functional Mobile light	Y	N	
4.11	Delivery Tables	Y	N	
4.12	Functional Autoclave	Y	N	
4.13	Functional ILR and Deep Freezer	Y	N	
4.14	Emergency Tray with emergency injections	Y	N	
4.15	MVA/EVA Equipment	Y	N	
4.16	Functional phototherapy unit	Y	N	

4.17	BMI Chart	Y	N	
4.18	Height Chart	Y	N	
4.19	Snellen's Chart	Y	N	
S.No.	**O.T Equipment**	**Yes**	**No**	**Remarks**
4.20	O.T Tables	Y	N	
4.21	Functional O.T Lights, ceiling	Y	N	
4.22	Functional O.T lights, mobile	Y	N	
4.23	Functional Anaesthesia machines	Y	N	
4.24	Functional Ventilators	Y	N	
4.25	Functional Pulse-oximeters	Y	N	
4.26	Functional Multi-para monitors	Y	N	
4.27	Functional Surgical Diathermies	Y	N	
4.28	Functional Laparoscopes	Y	N	
4.29	Functional C-arm units	Y	N	
4.30	Functional Autoclaves (H or V)	Y	N	
S.No.	**Laboratory Equipment**	**Yes**	**No**	**Remarks**
4.1a	Functional Microscope	Y	N	
4.2a	Functional Haemoglobin meter	Y	N	
4.3a	Functional Centrifuge	Y	N	
4.4a	Functional Semi autoanalyzer	Y	N	
4.5a	Reagents and Testing Kits	Y	N	
4.6a	Functional Ultrasound Scanners	Y	N	
4.7a	Functional C.T Scanner	Y	N	
4.8a	Functional X-ray units	Y	N	
4.9a	Functional ECG machines	Y	N	

Section V: Essential Drugs and Supplies

S.No.	Essential Medical Supplies	Yes	No	Remarks
5.1	EDL available and displayed	Y	N	
5.2	Computerised inventory management	Y	N	
5.3	IFA tablets	Y	N	
5.4	IFA tablets (blue)	Y	N	
5.5	IFA syrup with dispenser	Y	N	
5.6	Vit A syrup	Y	N	
5.7	ORS packets	Y	N	

5.8	Zinc tablets	Y	N	
5.9	Inj Magnesium Sulphate	Y	N	
5.10	Inj Oxytocin	Y	N	
5.11	Misoprostol tablets	Y	N	
5.12	Mifepristone tablets	Y	N	
5.13	Availability of antibiotics	Y	N	
5.14	Labelled emergency tray	Y	N	
5.15	Drugs for hypertension, Diabetes, common ailments e.g. PCM, anti-allergic drugs etc.	Y	N	
5.16	Vaccine Stock available	Y	N	
5.17	Tab Albendazaole	Y	N	
	Supplies	**Yes**	**No**	**Remarks**
5.18	Pregnancy testing kits	Y	N	
5.19	Urine albumin and sugar testing kit	Y	N	
5.20	OCPs	Y	N	
5.21	EC pills	Y	N	
5.22	IUCDs	Y	N	
5.23	Sanitary napkins	Y	N	
S. No	**Essential Consumables**	**Yes**	**No**	**Remarks**
5.24	Gloves, Mckintosh, Pads, bandages, and gauze etc.	Y	N	

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

Section VI: Other Services

S.No.	Lab Services	Yes	No	Remarks
6.1	Haemoglobin	Y	N	
6.2	CBC	Y	N	
6.3	Urine albumin and sugar	Y	N	
6.4	Blood sugar	Y	N	
6.5	RPR (Rapid Plasma Reagin) test	Y	N	
6.6	Malaria (PS or RDT)	Y	N	
6.7	T.B (Sputum for AFB)	Y	N	
6.8	HIV (RDT)	Y	N	
6.9	Liver function tests(LFT)	Y	N	
6.10	Ultrasound scan (Ob.)	Y	N	

6.11	Ultrasound Scan (General)	Y	N	
6.12	X-ray	Y	N	
6.13	ECG	Y	N	
6.14	Endoscopy	Y	N	
6.15	Others, pls specify	Y	N	
S.No.	**Blood bank/Blood Storage Unit**	**Yes**	**No**	**Remarks**
6.16	Functional blood bag refrigerators with chart for temp. recording	Y	N	
6.17	Sufficient no. of blood bags available	Y	N	
6.18	Check register for number of blood bags issued for BT in last quarter			

Section VII: Service Delivery in last two quarters

S.No.	Service Utilization Parameter	Q1	Q2	Remarks
7.1	OPD			
7.2	IPD			
7.3	Expected number of pregnancies			
7.4	No. of pregnant women given IFA			
7.5	Total deliveries conducted			
7.6	No. of assisted deliveries (Ventouse/ Forceps)			
7.7	No. of C section conducted			
7.8	Number of obstetric complications managed, pls specify type			
7.9	No. of neonates initiated breast feeding within one hour			
7.10	Number of children screened for Defects at birth under RBSK			
7.11	RTI/STI Treated			
7.12	No of admissions in NBSUs/ SNCU, whichever available			
S.No.	**Service Utilization Parameter**	**Q1**	**Q2**	**Remarks**
7.13	No of admissions: Inborn			
7.14	No of admissions: Outborn			
7.15	No. of children admitted with SAM			
7.16	No. of sick children referred			
7.17	No. of pregnant women referred			

7.18	No. of IUCD Insertions		
7.19	No. of Tubectomy		
7.20	No. of Vasectomy		
7.21	No. of Minilap		
7.22	No. of children fully immunized		
7.23	Measles coverage		
7.24	No. of children given ORS + Zinc		
7.25	No. of children given Vitamin A		
7.26	No. of women who accepted post-partum FP services		
7.27	No. of MTPs conducted in first trimester		
7.28	No. of MTPs conducted in second trimester		
7.29	Maternal deaths, if any		
7.30	Still births, if any		
7.31	Neonatal deaths, if any		
7.32	Infant deaths, if any		

Section VIII: Service delivery in post-natal wards

S.No.	Parameters	Yes	No	Remarks
8.1	All mothers initiated breast feeding within one hour of normal delivery	Y	N	
8.2	Zero dose BCG, Hepatitis B and OPV given	Y	N	
8.3	Counselling on IYCF done	Y	N	
8.4	Counselling on Family Planning done	Y	N	
8.5	Mothers asked to stay for 48 hrs	Y	N	
8.6	JSY payment being given before discharge	Y	N	
8.7	Mode of JSY payment (Cash/ bearer cheque/Account payee cheque/Account Transfer)			
8.8	Any expenditure incurred by Mothers on travel, drugs or diagnostics (Please give details)	Y	N	
8.9	Diet being provided free of charge	Y	N	

Section IX: Adolescent Friendly Health Service

S No.	Service utilization Parameters	Q1	Q2	Remarks

9.1	No of adolescents attending AFHC			
9.2	No of adolescents counselled at AFHC			
9.3	No of adolescents referred to higher facility			
9.4	Percentage of teenage pregnancy out of total preganancies			
	Quality parameters	**Y**	**N**	**Remarks**
9.5	Privacy & confidentiality maintained during counselling			

Section X: Quality parameter of the facility

Through probing questions and demonstrations assess does the staff know how to…

S.No.	Essential Skill Set	Yes	No	Remarks
10.1	Manage high risk pregnancy	Y	N	
10.2	Provide essential newborn care (thermoregulation, breastfeeding and asepsis)	Y	N	
10.3	Manage sick neonates and infants	Y	N	
10.4	Correctly uses partograph	Y	N	
10.5	Correctly insert IUCD	Y	N	
10.6	Correctly administer vaccines	Y	N	
10.7	Segregation of waste in colour coded bins	Y	N	
10.8	Adherence to IMEP protocols	Y	N	

Sl. No	Record	Available, Updated and correctly filled	Available but Not maintained	Not Available	Remarks/Timeline for completion
11.1	OPD Register				
11.2	IPD Register				
11.3	ANC Register				
11.4	PNC Register				
11.5	Indoor bed head ticket				
11.6	Line listing of severely anaemic pregnant women				
11.7	Labour room register				
11.8	Partographs				
11.9	FP-Operation Register (OT)				

Sl. No	Record	Available, Updated and correctly filled	Available but Not maintained	Not Available	Remarks/Timeline for completion
11.10	OT Register				
11.11	FP Register				
11.12	Immunisation Register				
11.13	Updated Microplan				
11.14	Blood Bank stock register				
11.15	Referral Register (In and Out)				
11.16	MDR Register				
11.17	Infant Death Review and Neonatal Death Review				
11.18	Drug Stock Register				
11.19	Payment under JSY				
11.20	Untied funds expenditure (Check % expenditure)				
11.21	AMG expenditure (Check % expenditure)				
11.22	RKS expenditure (Check % expenditure)				
11.23	AFHC register				

Section XII: Referral linkages in last two quarters

S.No.	JSSk	Mode of Transport (Specify Govt./ pvt)	No. of women transported during ANC/ INC/PNC	No. of sick infants transported	No. of children 1-6 years	Free/Paid
12.1	Home to facility					
12.2	Inter facility					
12.3	Facility to Home (drop back)					

Section XIII: IEC display

S.No.	Material	Yes	No	Remarks
13.1	Approach roads have directions to the health facility	Y	N	
13.2	Citizen Charter	Y	N	
13.3	Timings of the health facility	Y	N	
13.4	List of services available	Y	N	
13.5	Essential Drug List	Y	N	
13.6	Protocol Posters	Y	N	
13.7	JSSK entitlements (Displayed in ANC Clinics/PNC Clinics)	Y	N	
13.8	Immunization Schedule	Y	N	
13.9	JSY entitlements (Displayed in ANC Clinics/PNC Clinics)	Y	N	
13.10	Other related IEC material	Y	N	

Checklist for Community Health Center

Identification	
Name of District	.....
Name of Tehsil/ Taluka/ Block	.....
Name of CHC	.....
No. of PHC under the CHC	.....
Distance of PHC from CHC	.....
Distance of DH from CHC	.....
Is the CHC providing 24 hours and 7 days delivery facilities? (Yes/No)	.....
Respondents:	
Date of Data Collection	☐☐ Date ☐☐ Month ☐☐☐☐ Year

Section I: Services		
1.1	**Population Covered** (in numbers) ☐☐☐☐☐	
1.2	**Specialist Services Available (Yes=1/No=2)**	
a	Medicine	
b	Surgery	
c	OBG	
d	Paediatrics	
e	National Health Programmes (Specify)	
f	Emergency Services (24 Hours)	
g	24-hour delivery services including normal and assisted deliveries	
h	Emergency Obstetric Care including surgical interventions like Ceasarean Sections and other medical interventions	
i	New-born care	
j	Emergency care of sick children	
k	Full range of family planning services including Laproscopic Services	
l	Safe abortion services	
m	Treatment of STI/RTI	
n	Essential Laboratory Services (Specify the type of lab tests conducted)	
o	Blood storage facility	
p	Referral transport service	
1.3	**Beds**	
	Number of beds available	
1.4	**Average Daily OPD Attendance**	
a	Male	
b	Female	
1.5	**Types of Surgeries performed (Specify)**	
1.6	**Service Availability (Yes=1/No=2)**	
a	Ante-natal Clinics	
b	Post-natal Clinics	
c	Immunization Sessions	

Section II: Human Resources			
S. No.	Personnel	Current Availability at CHC (Indicate Numbers)	Remarks/ Suggestion/ Identified Gaps
A.	**Clinical Manpower**		
2.1	General Surgeon		
2.2	Physician		
2.3	Obstetrician/ Gynecologists		
2.4	Paediatrics		
2.5	Anaesthetist		On contractual appointment or hiring of services from private sectors on case to case basis
2.6	Public Health Programme Manager		On contractual appointment
2.7	Eye Surgeon		For every 5 lakh population as per vision 2020 approved Plan of Action
2.8	Other specialists (if any)		
2.9	General duty officers (Medical Officer)		
B.	**Support Manpower**		
2.10	Nursing Staff		1 ANM and 1 Public Health Nurse for family welfare will be appointed under the ASHA scheme
a	Public Health Nurse		
b	ANM		
c	Staff Nurse		

d	Nurse/ Midwife		
2.11	Dresser		
2.12	Pharmacist/ Compounder		
2.13	Lab Technician		
2.14	Radiographer		
2.15	Ophthalmic Assistant		Ophthalmic Assistant may be placed wherever it does not exist through redeployment or contract basis

Section III: Availability of Investigating Facilities			
S. No.	**Services**	**Current Availability at CHC (Yes=1/No=2)**	**Remarks/ Suggestions/ Identified Gaps**
3.1	ECG		
3.2	X-ray		
3.3	Ultrasound		
3.4	Pathological tests		

Section IV: Infrastructure			
S. No.		Current Availability at CHC	Remarks/ Suggestions/ Identified Gaps
4.1	**Location**		
	Distance of CHC (in km.) from District Hospital		
4.2	**Building**		
a	Is a designated government building available for the CHC? (Yes/No)		
b	Whether the cleanliness in the building is Good/Fair/Poor? (Observe)		
c	Prominent display boards regarding service availability in local language? (Yes/No)		
4.3	**Operation Theatre**		
a	Operation Theatre available (Yes/No)		
b	If operation theater is present, are surgeries carried out in the operation theatre? (Yes/No)		
c	If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/ staff.....1 Lack of equipment/ poor physical state of the OT.....2 No power supply in the operation theatre.....3 Any other reason (specify).....4		
d	Operation Theatre used for obstetric/ gynaecological purpose		
4.4	**Labour Room**		
a	Labour room available? (Yes/No)		
b	If labour room is present, are deliveries carried out in the labour room? (Yes/No)		
c	If labour room is present, but deliveries are not being conducted there, then what are the reasons for the same? • Non-availability of doctors/ staff • Poor condition of the labour room • No power supply in the labour room • Any other reason (specify).....		
4.5	**Laboratory**		
a	Laboratory (Yes/No)		
b	Is the laboratory a RNTCP designated Microscopy Centre (DMC) under RNTCP? (Yes/No)		
c	Are adequate equipment (including function Binocular Microscope) and chemical reagents available? (Yes/No)		
4.6	**Cold Chain Facility (Yes/No)**		
4.7	**Water Supply**		
	Source of water Piped.....1 Bore well/ Hand pump/ Tube well.....2 Well.....3		
4.8	**Sewerage**		
	Type of sewerage system Soak pit.....1 Connected to Municipal Sewerage.....2		
4.9	**Waste Disposal**		
	How the waste material is being disposed? (Please specify).....		
4.10	**Electricity**		
	Is there electric line in all parts of the CHC? In all parts.....1 In some parts.....2 None.....3		
4.11	**Communication Facilities**	Yes.....1 No.....2	
a	Telephone		
b	E-Mail		
c	Fax		
4.12	**Vehicles**		
	Vehicles (jeep/ other vehicle) available?		
4.13	**Residential facility for the Medical Officer with all amenities (Yes=1/No=2)**		
4.14	**User charges**		
	Any fee for service is charged from the users? Yes.....1 No.....2 If Yes, (Specify).....3		

Section VI: Structure of Fees and Charges		
S. No.	Particulars	Amount (Rs.) (Give Range)
6.1	Normal Delivery	
6.2	Caesarean Section	
6.3	Major Surgery	
6.4	ECG	
6.5	X-ray	
6.6	Blood Test	
6.7	Outdoor patient per episode	
6.8	Indoor patient per hospitalization	

Section V: Quality Control			
S. No.	**Particular**	**Whether functional / available as per norms**	**Remarks**
5.1	Citizen's charter Yes.....1 No.....2		
5.2	Constitution of **RMRS** Yes.....1 No.....2		
5.3	Internal monitoring (Social audit through Panchayati Raj Institution/**RMRS**, medical audit, technical audit, economic audit, disaster preparedness audit etc. (Specify)		
5.4	External monitoring (Gradation by PRI (Zila Parishad) **RMRS**		
5.5	Availability of Standard Operating Procedures (SOP)/ Standard Treatment Protocols (STP) Guidelines.		

Checklist for Primary Health Center

Identification	
Name of District	.....
Name of Tehsil/ Taluka/ Block	.....
Name of PHC	.....
No. of Sub-centers under the PHC	.....
District of CHC from PHC	.....
District of DH from PHC	.....
Is the PHC providing 24 hours and 7 days delivery facilities? (Yes/No)	.....
Respondents:	
Date of Data Collection	☐☐ ☐☐ ☐☐☐☐ Date Month Year

Section I: Service Delivery		
1.1	**Population Covered** (in numbers) ☐☐☐☐☐	
1.2	**Assured Services Available (Yes=1/No=2)**	
a	OPD Services	
b	Emergency Services (24 hours)	
c	Referral Services	
d	In-patient Services	
1.3	**Beds**	
a	Number of beds available	
1.4	**Average Daily OPD Attendance**	
a	Males	
b	Females	
1.5	**Treatment of Specific Cases (Yes=1/No=2)**	
a	Is surgery for cataract done in the PHC?	
b	Is the primary management of wounds done at the PHC?	
c	Is the primary management of fracture done at the PHC?	
d	Are minor surgeries like draining of abscess etc done at the PHC?	
e	Is the primary management of cases of poisoning/snake, insect or scorpion bite done at the PHC?	
f	Is the primary management of burns done at PHC?	
1.6	**MCH Care including Family Planning**	
1.6.1	**Service Availability (Yes=1/No=2)**	
a	Ante-natal care	
b	Intra-natal care (24-hour delivery services both normal and assisted)	
c	Post-natal care	
d	New born care	
e	Child care including immunization	
f	Family Planning	
g	MTP	
h	Management of RTI/STI	
i	Facilities under Janani Suraksha Yojana	

1.6.2	**Availability of Specific Services (Yes=1/No=2)**	
a	Are antenatal clinics organized by the PHC regularly?	
b	Is the facility for normal delivery available in the PHC for 24 hours?	
c	Is the facility for tubectomy and vasectomy available at the PHC?	
d	Is the facility for internal examination for gynae? Conditions available at PHC?	
e	Is the treatment for gynecological disorders like leucorrhoea, menstrual disorders available at the PHC?	
f	Is the facility for MTP (abortion) available at the PHC?	
g	Are the low birth weight babies managed at the PHC?	
h	Is there a fixed immunization day?	
i	Is BCG and Measles vaccine given regularly in the PHC?	
j	Is the treatment of children with pneumonia available at the PHC?	
k	Is the management of children suffering from the diarrhea with severe dehydration done at the PHC?	
1.7	**Other Functions and Services Performed (Yes=1/No=2)**	
a	Nutrition services	
b	School health programmes	
c	Promotion of safe water supply and basic sanitation	
d	Prevention and control of locally endemic diseases	
e	Disease surveillance and control of epidemics	
f	Collection and reporting of vital statistics	
g	Education about health/ behaviour change communication	
h	National Health Programmes including HIV/AIDS control programmes	
i	AYUSH services as per local preference	
1.8	**Outbreak of any in the last three year (Yes=1/No=2)**	
a	Malaria	
b	Measles	
c	Gastroenteritis	
d	Jaundice	
1.9	**Is the PHC providing 24 hours and 7 days delivery facilities (Yes/No)**	

Section II: Human Resources				
S. No.	**Personnel**	**Recommended**	**Current Availability at PHC (indicate Numbers)**	**Identified Gaps**
2.1	Medical Officer	2 (one may be from AYUSH and one other MO preferably a Lady Doctor		
2.2	Pharmacist	1		
2.3	Nurse – Midwife (Staff Nurse)	3 (for 24 hour PHCs; 2 may be contractual)		
2.4	Health Worker (Female)	1		
2.5	Health Educator	1		
2.6	Health Assistant (1 Male and 1 Female)	2		
2.7	Clerks	2		
2.8	Laboratory Technician	1		
2.9	Driver	Optional; vehicles may be out-sourced		

Section III: Essential Laboratory Services			
S. No.	Services	Current Availability at PHC Yes=1/No=2)	Identified Gaps
3.1	Routine urine, stool and blood tests		
3.2	Blood grouping		
3.3	Bleeding time, clotting time		
3.4	Diagnosis of RTI/STDs with wet mounting, grams stains, etc.		
3.5	Sputum testing for TB		
3.6	Blood smear examination for malaria parasite		
3.7	Rapid tests for pregnancy		
3.8	RPR test for Syphilis/ YAWS surveillance		
3.9	Rapid tests for HIV		

Section IV: Infrastructure			
S. No.		Current Availability at PHC	Identified Gaps
4.1	**Location**		
a	Distance of PHC (in km.) from the farthest village in coverage area		
b	Distance of PHC (in km.) from District Hospital		
4.2	**Building**		
a	Is a designated government building available for the PHC? (Yes/No)		
b	Whether the cleanliness in the building is Good/Fair/Poor? (Observe)		
c	Prominent display boards regarding service availability in local language? (Yes/No)		

4.3	**Operation Theatre**		
a	Operation Theatre available (Yes/No)		
b	If operation theater is present, are surgeries carried out in the operation theatre? (Yes/No)		
c	If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same? • Non-availability of doctors/ staff • Lack of equipment/ poor physical state of the OT • No power supply in the operation theatre • Any other reason specify).....		
d	Operation Theatre used for obstetric/ gynaecological purpose		
4.4	**Labour Room**		
a	Labour room available? (Yes/No)		
b	If labour room is present, are deliveries carried out in the labour room? (Yes/No)		
c	If labour room is present, but deliveries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/ staff.....1 Poor condition of the labour room.....2 No power supply in the labour room.....3 Any other reason (specify).....4		
4.5	**Laboratory**		
a	Laboratory (Yes/No)		
b	Is the laboratory a RNTCP designated Microscopy Centre (DMC) under RNTCP? (Yes/No)		
c	Are adequate equipment (including function Binocular Microscope) and chemical reagents available? (Yes/No)		

Section III: Essential Laboratory Services			
S. No.	Services	Current Availability at PHC Yes=1/No=2)	Identified Gaps
3.1	Routine urine, stool and blood tests		
3.2	Blood grouping		
3.3	Bleeding time, clotting time		
3.4	Diagnosis of RTI/STDs with wet mounting, grams stains, etc.		
3.5	Sputum testing for TB		
3.6	Blood smear examination for malaria parasite		
3.7	Rapid tests for pregnancy		
3.8	RPR test for Syphilis/ YAWS surveillance		
3.9	Rapid tests for HIV		

Section IV: Infrastructure			
S. No.		Current Availability at PHC	Identified Gaps
4.1	**Location**		
a	Distance of PHC (in km.) from the farthest village in coverage area		
b	Distance of PHC (in km.) from District Hospital		
4.2	**Building**		
a	Is a designated government building available for the PHC? (Yes/No)		
b	Whether the cleanliness in the building is Good/Fair/Poor? (Observe)		
c	Prominent display boards regarding service availability in local language? (Yes/No)		

4.6	**Water Supply**		
	Source of water Piped.....1 Bore well/ hand pump/ tube well.....2 Well.....3		
4.7	**Sewerage**		
	Type of sewerage system Soak pit.....1 Connected to Municipal Sewerage.....2		
4.8	**Waste Disposal**		
	How the waste material is being disposed? (Please specify).....		
4.9	**Electricity**		
	Is there electric line in all parts of the PHC? In all parts.....1 In some parts.....2 None.....3		
4.10	**Communication Facilities**	Yes.....1 No.....2	
a	Telephone		
b	E-Mail		
c	Fax		
4.11	**Vehicles**		
	Vehicles (jeep/ other vehicle) available?		
4.12	**Residential facility for the Medical Officer with all amenities (Yes=1/No=2)**		
4.13	**User charges**		
	Any fee for service is charged from the users? Yes.....1 No.....2 If Yes, (Specify).....3		

Section V: Quality Control			
S. No.	**Particular**	**Whether functional / available as per norms**	**Remarks**
5.1	Citizen's charter (Yes/No)		
5.2	Constitution of Rajasthan Medicare Relief Society **(RMRS)** has been constituted at PHC? (Yes/No)		
5.3	Internal monitoring (Social audit through Panchayati Raj Institution/ **RMRS**/ medical audit, technical audit, economic audit, disaster preparedness audit etc. (Specify)		
5.4	External monitoring/ Gradation by PRI (Zila Parishad) **RMRS**		
5.5	Availability of Standard Operating Procedures (SOP) Standard Treatment Protocols (STP) guidelines.		

Checklist for Sub-Center

Identification	
Name of District	.....
Name of Tehsil/ Taluka/ Block	.....
Name of Sub-center	.....
No. of Villages under the SC	.....
Distance of SC from PHC	.....
Distance of SC from nearest CHC	.....
Is the SC providing 24 hours and 7 days delivery facilities? (Yes/No)	.....
Respondents:	
Date of Data Collection	☐☐ ☐☐ ☐☐☐☐ Date Month Year

Section I: Services		
1.1	Population Covered (in numbers)	
1.2	MCH care including FP: Services Availability	
1.2.1	Services Available **(Yes=1/No=2)**	
a	ANC	
b	INC	
c	PNC	
d	Newborn	
e	Immunization	
f	FP and contraceptive	
g	Adolescents health	
h	School health education	
i	JSY	
j	Treatment of common illness	
1.2.2	Availability of specific services **(Yes=1/No=2)**	
a	Does doctor visit the sub centre at least once in a month?	
b	Is the day and time of this visit fixed?	
c	Are the residents of the village aware of the timing of the doctor's visit?	
d	Does the health assistant (male) or LHV visit the sub centre at least once a week?	
e	Is the antenatal care (inj.TT/IFA tablets, weight and BP checkup) provided by those in the sub centre?	
f	Is the facility for referral of complicated cases of pregnancy/delivery available at sub centre for 24 hours?	
g	Do the ANM /any trained personnel accompany the woman in labor to the referred care facility at the time of referral?	
h	Are the immunization services as per government schedule provided by the sub centre?	
i	Is the ORS for prevention of diarrhea and dehydrations available in the sub centre?	
j	Is the treatment for minor illness like fever, cough, cold, worm, disinfestation etc. available in the sub centre?	

k	Is the facility for taking peripheral blood smear in case of fever for detection available in the sub centre?	
l	Are the contraceptive services like insertion of copper-T, distributing oral contraceptive pills or condom provided by the sub centre?	
m	Is it a DOT centre?	
1.3	**Other function and services performed (Yes=1/No=2)**	
a	Disease surveillance	
b	Control of local endemic disease	
c	Promotion of sanitation	
d	Field visit and home care	
e	National health programme including HIV/AIDS control programmes	
1.4	**Monitoring and supervision activities (Yes=1/No=2)**	
a	Training of traditional birth attendants and ASHA	
b	Monitoring of water quality in the village	
c	Watch over unusual health events	
d	Coordinated services with AWWs, ASHA village health and sanitation committee, PRIs	
e	Coordination and supervision of activities of ASHA	
f	Proper maintenances of records and register	
g	Is there a village health plan / sub centre plan?	
h	Is the scheme of ASHA implement in sub centre?	

Section II: Human Resources

S. No.	Personnel	Existing	Recommended	Present availability at SC	Identified gaps
2.1	Health worker (Female)	1	1 or 2 (optional)		
2.2	Health worker (Male)	1	1 or 0 (optional) may be replaced by female health worked		
2.3	Voluntary Worker to keep the sub centre clean and assisting ANM. she is paid by the ANM from her contingency fund @ Rs 100 per month	1 (optional)	1 (optional)		

Section III: Physical Structure			
S. No.		If available (area in Sq mts.)	Remarks/ Suggestions/ Identify Gaps
3.1	**Location**		
a	Location of SC		
i	Distance of SC (in km.) from the farthest village in coverage area		
ii	Distance of SC (in km.) from District Hospital		
b	Distance of SC from PHC (in km)		
c	Distance of SC from CHC (in km)		
3.2	**Building**		
a	Is a designated Government building available for the SC? **(Yes=1/No=2)**		
b	Whether the cleanliness is Good----------1 Fair----------2 Poor----------3		
3.3	**Availability of Labour Room (Yes=1/No=2)**		
a	If labour room is present are deliveries carried out in the labour room Yes----------1 No----------2 Sometimes----------3		
b	If labour room is present ,but deliveries not being conducted there, then what are the reasons for the same: • Staff not staying • Poor condition of the labour room • No power supply in the labour room • Any other (specify)		
3.4	**Clinic room (Yes=1/No=2)**		
3.5	**Examination Room (Yes=1/No=2)**		
3.6	**Water Supply**		
	Tap water----------1 Borewell/Handpump/Tubewell----2 Well----------3 Any other (specify)----------4		

3.7	**Electricity Facility (Yes=1/No=2)**		
3.8	**Communication Facility (Yes=1/No=2)**		
3.9	**Transport Facility (Yes=1/No=2)**		
3.10	Residential facility for the staff Yes ----------1 No----------2	**If available (area in Sq mts)**	**If available Whether staff staying or not**
a	Health worker (Female)		
b	Health worker (Male)		
3.11	Whether health worker (male) available in the sub centre?		

ANGANWADI CENTRE VISIT CHECKLIST TO BE USED BY DISTRICT LEVEL OFFICERS

Name of the Visiting Officer with designation**:**

Date of Visit:

Name of AWC:

1 Please check whether the following schemes are being implemented properly*

1.1 SNP Morning Snacks, Hot Cook Meal, Take Home Ration

1.2 Mamta

1.3 VHND

1.4 PustularDiwas referral

1.5 Fix Immunization Day

1.6 AACP

1.7 Sabla / KSY

2 Whether the following Committees are functional, if possible please interact.

2.1 Jaanch Committee

2.2 Mothers Committee

2.3 Self Help Groups

2.4 GaonKalyanSamiti

3 Fund Flow (whether the following funds are being received regularly)

3.1 SHG Payment (supplying morning snacks)

3.2 Honorarium of AWW and Helper

3.3 SNP funds to joint account

3.4 MamtaInstalments

3.5 Flexi funds

4 Last visit of supervisor / CD PO / PO & action taken

5 Overall remarks

SUPERVISION CHECKLIST TO BE USED BY PO & CDPO

Date of Visit: Time of Arrival: Time of Departure:

Name of AWC/Mini AWC: AWC Type: Rural/Urban/Tribal

AWW's Name: Date of Last Visit:

WOMEN AND CHILD DEVELOPMENT DEPARTMENT

1 Display of

1.1 Entitlement Chart for SNP Y N

1.2 Citizen Charter Y N

1.3 ICDS Calendar Y N

1.4 MAMATA Calendar Y N

1.5 Time Table Y N

1.6 Details of Jaanch Committee Members Y N

1.7 Details of Mothers Committee Members Y N

1.8 AWC Sign Board Y N

1.9 Workers wearing Badge & Uniform Y N 1.10 Pre School Children wearing Uniform Y N

2 Sanitation & Hygiene of Children:

2.1 Availability of Soap:

(Please ask children if they wash hands before eating, you should also inspect their hands).

2.2 Nails Cut Y N

2.3 Hair Combed Y N

2.4 Face Cleaned Y N

3 Functional Weighing Machine:

3.1 Salter (hanging for Children) Y N

3.2 Adult (Floor based) Y N

(Please check the correctness of weighing by test check of two children and compare with weight noted in growth register).

4 Register

Which register was not maintained up to

4.1 Which register was not maintained up to date?

5 Feeding:

5.1 Hot Cooked Meal and Morning Snacks given as per weekly menu chart. Y N

5.2 Attendance (Head Count) during spot feeding on the day of visit.

5.3 No. of days Hot Cooked Meal not given last month.

Why? _____

(Check sign of Jaanch Committee Members)

6. When was the last date of Jaanch Committee Visit?

7. When was THR given last?

8. During last THR distribution whether Mothers Committee Members present?

(Verify Signature) Y N

9. Was THR given twice in last 30 days? Y N

If not, why?

10. How many children completed 6 months during last month?

11. When was last Anaplasia conducted?

12. Number of children who have completed one year.

13. Number of children fully immunized.

14. Number of Pregnant/Lactating mothers attended VHND/MAMATA Diwas.

15. Topic discussed in NHED last month.

16. Number of children identified for referral to PustularDiwas during last month.

17. How many children attended PustularDiwas?

17.1 How many children have improved from severely malnourished?

18. Preschool:

18.1 Number of Children enrolled in preschool. Y N

18.2 Number of Children present in preschool. Y N

18.3 Number of PWD Children attending preschool. Y N

18.4 Whether preschool kit (toys, materials) available and being used? Y N

19 Whether NiaArunima module followed? Y N

19.1 Are preschool children wearing uniform on the day of visit? Y N

19.2 Are preschool children using workbook? Y N

19.3 Was Parent-Teacher Meeting held last quarter? Y N

19.4 P.O/CDPO must meet beneficiaries (MAMATA, Jaanch and Mothers Committee member, Mother of New-born, severely under wt.) and write the details.

1 Name of the child _____

Age _____ Weight _____

Issues _____

2 Name of the child _____

Age _____ Weight _____

Issues _____

20 C.D.P.O must weigh at least 2 children among new-born and severely underweight and check plotting.

Was plotting correct? Y N

(If no then AWW should be counselled.)

21 Whether MAMATA Calendar up to date? Y N

22. Whether KishoriSamuha / BalikaMandals are formed? Y N

23. Number of Adolescent Girls consumed IFA last week.

24. Whether KishoriSwasthyaMelaorganised last quarter? Y N

25 Date of receipt of Flexi Fund.

Date of receipt of Contingency. Y N 26 Last month honoraria received. Y N

27 Last month SNP fund received. Y N

28. Whether GaonKalyanSamiti is functioning Y N

29 If G.K.S is functioning specify about utilisation of funds:

30. Overall supportive supervision inputs/on the spot guidance provided by CDPO

(Critical work related to areas that need improvement in the AWC)

1

2

3

Any change since last visit

1

2

3

Visiting Officers Name & Signature Date

CD PO's/PO Signature

ANGANWADI CENTRE VISIT CHECKLIST TO BE USED BY SUPERVISOR

Date of Visit: Time of Arrival: Time of Departure:

Name of AWC/Mini AWC: AWC Type: Rural/Urban/Tribal

Name of the AWW: Date of Last Visit:

WOMEN AND CHILD DEVELOPMENT DEPARTMENT

1	Display of:		
1.1	Entitlement Chart for SNP	Y	N
1.2	Citizen Charter	Y	N
1.3	ICDS Calendar	Y	N
1.4	MAMATA Calendar	Y	N
1.5	Time Table	Y	N
1.6	Details of Jaanch Committee Members	Y	N
1.7	Details of Mothers Committee Members	Y	N
1.8	Sign Board	Y	N
1.9	Workers wearing Badge & Uniform	Y	N
1.10	Pre-School Children wearing Uniform	Y	N

2.	Maintenance of Registers:		
2.1	Survey Register	Y	N
2.2	Pregnancy Register	Y	N
2.3	Immunization Register	Y	N
2.4	Pre School Attendance Register	Y	N
2.5	T.H.R Receipt & Distribution Register	Y	N
2.6	S.N.P Hot Cooked Meal Attendance Register	Y	N
2.7	Procurement Plan Register	Y	N
2.8	Stock Register of S.N.P	Y	N
2.9	M.C.P Card	Y	N
2.10	Growth Monitoring Register	Y	N

3 Sanitation & Hygiene of Children:

3.1 Availability of Soap:

(Please ask children if they wash hands before eating, you should also inspect their hands).

3.2 Nail Cutter Y N 33 Hair Combed Y N

3.4 Face Cleaned Y N

3.5 Dish washing Detergent Y N

3.6 Foot Wear for Toilet Y N

3.7 Towel Y N

3.8 Dustbin Y N

3.9 Whether keeping the room clean Y N

3.10 Whether Toilet is available Y N

4 Functional Weighing Machine:

4.1 Salter (hanging for Children) Y N

4.2 Adult (Floor based) Y N

(Please check the correctness of weighing by test check of two children and compare with weight noted in growth register).

5 Beneficiary Details:

5.1 Number of Pregnant Women

5.2 Number of Lactating Mothers

5.3 Number of Children below 2 years

5.4 Number of severely Underweight Children

5.5 Number of Adolescent Girls (11-18 years)

5.6 Number of out of school Adolescent Girls (11-18 years)

5.7 Number of Adolescent Girls anemic (After Test)

(Counsel AWW on deworming, HB Test, BMI and IFA)

6. Feeding:

6.1 Hot Cooked Meal and Morning Snacks given as per weekly menu chart. Y N

6.2 Attendance (Head Count) during spot feeding on the day of visit.

6.3 No. of days Hot Cooked Meal not given during last month.

Why? _____

(Check sign of Jaanch Committee Members)

6.4. When was the last date of Jaanch Committee Visit?

6.5. When was THR given last?

6.6 During last THR distribution whether Mothers Committee Members present? (Verify Signature) Y N

. 6.7 Was THR given twice in last 30 days? Y N

6.8 Whether last month SNP fund received. Y N

If not, why?

7. Preschool:

7.1 Number of Children enrolled in preschool.

7.2 Number of Children present in preschool.

7.3 Number of PWD Children attending preschool.

7.4 Whether preschool kit (toys, materials) available and being used? Y N

7.5 Whether NiaArunima module followed? Y N

7.6 Are preschool children wearing uniform on the day of visit? Y N

7.7 Are preschool children using workbook? Y N

78 Was Parent-Teacher Meeting held last quarter? Y N

8. Health Check Up.

8.1 Whether Fixed Health Day planned &organised Y N

8.2 Was plotting correct?

8.3 No of severely malnourished Children under 3 yrs. age

8.4 No of severely malnourished children during last month 3-6 yrs.

8.5 No of Children identified for referral to PustularDiwas during last month

8.6 No of Children attended PustularDiwas during last month

8.7 How many children have improved from severely malnourished?

8.8 Supervisor must meet beneficiaries (MAMATA, Jaanch and Mothers Committee member, Mother of New-born, severely under wt.) and write the details.

1 Name of the child _____

Age _____ Weight _____

Issues _____

2 Name of the child _____

Age _____ Weight _____

Issues _____

8.9 Supervisor must weigh at least 2 children among new-born and severely underweight and check plotting.

Was plotting correct? Y N

(If no then AWW should be counselled.)

9. MAMATA.

9.1 Whether Pregnancy Survey has been made

9.2 Whether MAMATA Calendar up to date? Y N

9.3 No of Pregnant Women eligible for MAMATA

9.4 Whether AWW copy of MCP Card of Mamta beneficiaries Y N
Available

9.5 Whether the ANM is filling the portion marked for her in the MCP Card. Y N

9.6 Whether Mamta Scheme AWC survey register Annexure - A Y N
(Part-2 is maintained)

9.7 Whether the Mamta beneficiary Tracker Annexure-C (Part-2 is maintained) Y N

9.8 Mamta Scheme beneficiary tracker is maintained Y N

9.9 Mamta Scheme AWC Monthly Report-Annexure-D Y N

10. . How many children completed 6 months during last month?

11. When was last Anaplasia conducted?

12. Number of children who have completed one year.

13. Number of children fully immunized.

14. Number of Pregnant/Lactating mothers attended VHND/MAMATA Diwas.

15. Topic discussed in NHED last month.

16 Whether KishoriSamuha / BalikaMandals are formed? Y N

17 Number of Adolescent Girls consumed IFA last week.

18 Whether KishoriSwasthyaMelaorganised last quarter? Y N

19 Date of receipt of Flexi Fund.

20. Date of receipt of Contingency.

21 Last month honorarium received. Y N

22 Whether GaonKalyanSamiti is functioning Y N

मॉनिटरिंग प्रपत्र– एम.सी.एच.एन दिवस					
1	मॉनिटर का नाम		2	पद	
3	जिले का नाम		4	दिनांक/दिन	
5	ब्लॉक का नाम		6	प्रा.स्वा.केन्द्र	
7	उपकेन्द्र		8	ग्राम पंचायत	
9	राजस्व गॉव का नाम		10	कुल जनसंख्या	
11	पिछले 2 माह गॉव में हुए कुल प्रसव		12	इनमें से संस्थागत प्रसव	
13	एवं घरेलू प्रसव		14	इनमेंसे वर्तमान में जीवित माताओं की	
15	एवं जीवित शिशुओं की संख्या		16	भ्रमण किये गये क्षेत्र का नाम एवं समय	
17	सत्र का प्रकार	*A/B/C/D*	18	सत्र आयोजित किया गया	*हाँ / नहीं*
19	क्या आपने सत्र आयोजित होते हुए देखा	*हाँ/नहीं*	20	अगर नहीं, कारण दीजिए. नीचे दिये गये कोड डाले	
21	स्वास्थ्य कार्यकर्ताओं की उपस्थिति (गोला करें एवं नीचे नाम लिखें)	*ए.एन.एम / जी.एन.एम/ अति एएनएम*	22	आंगनवाड़ी कार्मिकों की उपस्थिति (गोला करें एवं नीचे नाम लिखें)	*कार्यकर्ता/ आशा / सहायिका*
23	ए.एन.एम का नाम		24	मोबाईल नम्बर	
25	अति. एएनएम का नाम		26	मोबाईल नम्बर	
27	आशा का नाम		28	मोबाईल नम्बर	
29	आंगनवाड़ी कार्यकर्ता का नाम		30	मोबाईल नम्बर	
31	क्षेत्र पर्यवेक्षक का नाम (स्वास्थ्य)		32	मोबाईल नम्बर	
33	क्षेत्र पर्यवेक्षक द्वारा किये गये पिछले भ्रमण कि दिनांक		34	आयोजित हुए पिछले सत्र कि दिनांक	
35	सत्र स्थल	*आंगनवाड़ी / उपकेन्द्र / अन्य.....*	36	सत्र माईक्रोप्लान के अनुसार है	*हाँ / नहीं*
37	उपरोक्त के अलावा कोई कार्मिक उपस्थित है तो उसका नाम		38	कार्मिक का पद	
39	क्या आशा/ मोबिलाइजर के पास लाभार्थियों की सूची उपलब्ध है?	*हाँ / नहीं*	40	आशा/ मोबिलाइजर लाभार्थियों को सत्र स्थल पर ला रही है	*हाँ / नहीं*
सत्र में आने वाले लाभार्थियों की अपेक्षित संख्या			**सत्र में आये वास्तविक लाभार्थियों की संख्या**		
41	गर्भवती महिला नये पंजीकरण		42	गर्भवती महिला नये पंजीकरण	
43	गर्भवती महिला पूर्व में पंजीकृत		44	गर्भवती महिला पूर्व में पंजीकृत	
45	बीसीजी		46	बीसीजी	
47	पेन्टावेलेंट 1		48	पेन्टावेलेंट 1	
49	पेन्टावेलेंट 2		50	पेन्टावेलेंट 2	
51	पेन्टावेलेंट 3		52	पेन्टावेलेंट 3	
53	पोलियो 1		54	पोलियो 1	
55	पोलियो 2		56	पोलियो 2	
57	पोलियो 3		58	पोलियो 3	
59	मीजल्स		60	मीजल्स	
61	विटामिन ए		62	विटामिन ए	
63	*1 वर्ष से कम बच्चे कुल*		64	*1 वर्ष से कम बच्चे कुल*	
65	*डी.पी.टी. बूस्टर 1*		66	*डी.पी.टी. बूस्टर 1*	
67	*पोलियो बूस्टर 1*		68	*पोलियो बूस्टर 1*	
69	मीजल्स 2		70	मीजल्स 2	
71	*डी.पी.टी. बूस्टर 2*		72	*डी.पी.टी. बूस्टर 2*	
73	0–5 वर्ष तक के कितने बच्चो का वज़न लिया जाना है		74	0–5 वर्ष तक के कितने बच्चो का वज़न लिया गया	
75	कुल कुपोषित बच्चो की संख्या		76	कुल कुपोषित बच्चो की संख्या	
77	क्या टीकाकरण में छूटे हुए व्यक्तियों के लिये अलग प्रयास हुए	*हाँ / नहीं*	78	क्या किसी तरह की आई.ई.सी. दिखाई देती है?	*हाँ / नहीं*
79	वैक्सीन किसके द्वारा सत्र मे उपलब्ध कराई गई	*एवीडी / एएनएम/ सुपरवाईजर/ अन्य .....*	80	क्या वैक्सीन कैरियर मे चार आईसपैक के साथ पॉलिथीन में है	*हाँ / नहीं*

शिशु स्वास्थ्य एवं पोषण सम्बन्धित सेवाएं					
81	क्या बच्चो का वजन तिमा जा रहा है	हाँ / नहीं	82	क्या पोषाहार उपलब्ध कराया जा रहा है	हाँ / नहीं
83	क्या गम्भीर लक्षणो की पहचान की जा रही है	हाँ / नहीं	84	क्या गम्भीर लक्षणो का उपचार किया जा रहा है	हाँ / नहीं
85	क्या टीकाकरण किया जा रहा है	हाँ / नहीं	86	सत्र के दौरान कौन-कौन सी वैक्सीन उपलब्ध थी	बी.सी.जी./ डी.पी.टी. / हिप-बी / मिज़ल्स / टी.टी. / पोलियो
87	वैक्सीन के साथ उपलब्ध डाइलयूएन्ट	बी.सी.जी / मिज़ल्स	88	वॉयल्स के बिना कौनसी वैक्सीन चाई गई	बी.सी.जी./ डी.पी.टी. / हिप-बी / मिज़ल्स / टी.टी. / पोलियो
89	क्या कोई वैक्सीन उसी दूसरे अवस्था में चाई गई	हाँ / नहीं	90	मदि हां तो कौनसी	डी.पी.टी. / हिप-बी / टी.टी. /
91	बी.सी.जी का टीका कहाँ लगाया जा रहा	राईट थाँह /राईट थाँह/	92	मीज़ल्स का टीका कहाँ लगाया जा रहा है	राईट थाँह /राईट थाँह/
93	पैन्टावेलेंट का टीका कहाँ लगाया जा	राईट थाँह /राईट थाँह/	94	विटामिन ए मिज़ल्स के साथ दिया जारहा	हाँ/नहीं
95	क्या डीपीटी का टीका लगाने के बाद बुखार की दवा दी गई	हाँ/नहीं	96	क्या माता-पिता को 4 महत्वपूर्ण सदेश के बारे में जानकारी दी जा रही है	हाँ/नहीं
उपकरण जो सत्र में चालू हालत में पाये गये एवं अन्य आवश्यक सामग्री की उपलब्धता					
97	BP machine with Stethoscope	Yes / No	98	Weighing machine- Adult	Yes / No
99	Weighing machine- Baby	Yes / No	100	Examination table with Stool	Yes / No
101	Side Screen	Yes / No	102	Hemometer	Yes / No
103	Syringe Hub Cutter	Yes / No	104	Uri-Sticks	Yes / No
105	MCP Cards sufficient quantity	Yes / No	106	Refarral Slips sufficient quantity	Yes / No
107	Red Black Bags	Yes / No	108	AD 0.1 ml syringe sufficient	Yes / No
109	5 ml syringes for reconstitution	Yes / No	110	AD 0.5 ml syringe sufficient	Yes / No
111	PCM Tab/ Syp	Yes / No	112	(Nischay) Pregnancy Test Kits	Yes / No
113	ORS Packets	Yes / No	114	Zink tablets	Yes / No
115	Cotrimoxazole tablets/syp	Yes / No	116	Amoxicilin Cap/syp	Yes / No
117	Injection Gentamycin	Yes / No	118	Jention violet paint	Yes / No
प्रसव पूर्व जाँच व परामर्श					
119	गर्भवती की जाँच में गोपनियता का ध्यान रखा जा रहा है	हाँ / नहीं	120	गर्भवती के पेट का परीक्षण	हाँ / नहीं
121	गर्भवती की रक्त ग्रेपार जांच	हाँ / नहीं	122	गर्भवती का वजन	हाँ / नहीं
123	हीमोग्लोबिन की जांच	हाँ / नहीं	124	पेशाब की जांच (एल्बुमिन व शुगर)	हाँ / नहीं
125	टी.टी. वैक्सीन दी जा रही है	हाँ / नहीं	126	आई. एस. ए दी जा रही है	हाँ / नहीं
127	आई.एफ.ए के बारे में परामर्श	हाँ / नहीं	128	पौष्टिक आहार के बारे में परामर्श	हाँ / नहीं
129	सस्थागत प्रसव के बारे में परामर्श	हाँ / नहीं	130	प्रसव पूर्व तैयारी के बारे में परामर्श	हाँ / नहीं
131	स्तनपान के बारे में परामर्श	हाँ / नहीं	132	परिवार नियोजन पर परामर्श	हाँ / नहीं
133	खतरे के लक्षणों पर परामर्श	हाँ / नहीं	134	ममता कार्ड के बारे में संदेश	हाँ / नहीं
135	जे. एस. एस. के योजना पर जानकारी	हाँ / नहीं	136	जननसुरक्षा योजना पर जानकारी	हाँ / नहीं
मातृ एवं शिशु स्वास्थ्य सेवाओं का रिकार्ड					
137	विगत 3 माह में 7 ग्राम से कम हीमोग्लोबिन वाली महिलाओं कि संख्या		138	विगत 3 माह में 7 ग्राम से कम हीमोग्लोबिन वाली महिलाओं कि संख्या जिन्हे आयरन सुक्रोज 4 dose दिया	
139	विगत 3 माह खतरे के लक्षण वाली महिलाओं कि संख्या जिन्हे उच्च संस्था पर रैफर किया गया		140	विगत 3 माह मे दस्त से ग्रसित बच्चों संख्या	
141	विगत 3 माह मे दस्त से ग्रसित बच्चों संख्या जिन्हे ORS/ZINC दिया गया		142	विगत 3 माह मे दस्त से ग्रसित बच्चों संख्या जिन्हे उच्च संस्था पर रैफर किया	
143	विगत 3 माह मे ARI/Pneumonia से ग्रसित बच्चों संख्या जिनका इलाज किया गया		144	विगत 3 माह मे ARI/Pneumonia से ग्रसित बच्चों संख्या जिन्हे उच्च संस्था पर रैफर किया गया	
परिवार नियोजन सेवायें					
145	निरोध की उपलब्धता	हाँ / नहीं	146	निरोध का वितरण	हाँ / नहीं
147	ओरल पिल्स की उपलब्धता	हाँ / नहीं	148	ओरल पिल्स का वितरण	हाँ / नहीं
149	कॉ पिल्स की उपलब्धता	हाँ / नहीं	150	कॉ पिल्स का वितरण	हाँ / नहीं
*1.ANM not present, 2. AWC/SC Closed, 3. Vaccine not availbale, 4.Other Reason					

1. INTERVIEW SCHEDULE FOR ANM

<table>
<tr><td>S.no.</td><td></td><td colspan="3"></td><td></td></tr>
<tr><td>1.</td><td>Type of health facility</td><td colspan="3">1. PHC
2. SC
3. AWC</td><td></td></tr>
<tr><td>2.</td><td>Health worker</td><td colspan="3">1. ANM
2. ASHA
3. AWW</td><td></td></tr>
<tr><td>3.</td><td>Age of health worker</td><td colspan="4"></td></tr>
<tr><td>4.</td><td>Health facility address</td><td colspan="4"></td></tr>
<tr><td>5.</td><td>Population covered by health facility</td><td colspan="4"></td></tr>
<tr><td rowspan="3">6.</td><td rowspan="3">SOCIO DEMOGRAPHIC PROFILE</td><td>Caste</td><td>Religion</td><td>Education</td><td>Experience</td></tr>
<tr><td>General 1
OBC 2
SC 3
ST 4
Other 5</td><td>Hindu 1
Muslim 2
Sikh 3
Other 4</td><td>1-5 1
5-9 2
9-12 3
Graduate 4
Illiterate 5</td><td rowspan="2"></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>7.</td><td>Are you using tabs?</td><td colspan="3">1. YES
2. NO</td><td></td></tr>
<tr><td>8.</td><td>If yes, how frequently?</td><td colspan="3">1. Daily
2. Weekly
3. Monthly</td><td></td></tr>
<tr><td>9.</td><td>What are your responsibilities?</td><td colspan="3">1. Holding weekly meeting with ASHA
2. Training to ASHA
3. Informing and guiding to ASHA to bring beneficiaries
4. Updating EC register
5. Counselling
6. Motivating pregnant women for coming to SC for checkups
7. Guiding, educating and orienting ASHA</td><td></td></tr>
<tr><td>10.</td><td>How many parents you have counselled last month and on what issues?</td><td colspan="3">A. Family planning
B. Immunization
C. Breast feeding
D. Importance of safe delivery
E. Complementary feeding
F. Contraception
G. Child health
H. Others</td><td></td></tr>
<tr><td>11.</td><td>Where do you counsel them?</td><td colspan="3">A. At home</td><td></td></tr>
</table>

		B. Health facility center C. MCHN day D. Others	
12.	**How do you counsel your beneficiaries?**	A. Verbally B. Audio C. Video D. Messages E. IEC material F. Others	
13.	**Has the tablets made your life**	1. Easier 2. Average 3. Difficult	
14.	**Whatever is the answer, how**		
15.	**Suggestions**		

Questionnaire for PNC

Serial no.	Questions	Response
1.	Has your child been breastfeed 1. Yes 2. NO	
2.	Do you know the importance of breastfeeding 1. Yes (If Yes, describe) 2. No	
3.	Who has spoken to you regarding this 1. Family member 2. Health worker 3. Relative 4. Others	
4.	What have you been told 1. Importance of breastfeeding 2. Frequency of breastfeeding 3. Avoiding water or tea 4. Introducing complementary foods 5. Feed your child the first yellowish milk (colostrum)	
5.	Till what time exclusive breastfeeding should be given	
6.	What are the signs of proper breastfeeding 1. Chin touching breast 2. Mouth wide open 3. Lower lip turned outward 4. More of the darker skin (areola) above the baby mouth than below.	
7.	Have you ever provided with a substitute for breast milk 1. Yes (Name them) 2. No	
8.	If Yes, what were the reasons 1. Mother in poor health 2. Sore nipples 3. Does not have enough milk. 4. Others	
9.	When health worker told you that feed your baby colostrum, you do this at the time of delivery 1. Yes 2. No	

10.	If No, what was the reasons 1. Harmful to child or mother health 2. Cultural restriction or traditional practices 3. Concept of purity or pollution 4. Others	
11.	Are you satisfied with the consultation regard to breastfeeding 1. Yes 2. No (if no what all are things are required)	
12.	12. Did you and your baby have any trouble with latching on in early hours or days immediately after delivery 1. No 2. Little trouble but resolved without help 3. Little trouble but resolved with help 4. So much trouble that I did not breastfeed.	
13.	How many antenatal visits did you make to this health facility for care before you gave birth?	
14.	What type of delivery did you have? 1. Normal 2. Caesarean without general anesthesia 3. Caesarean with general anesthesia	
15.	What advice have you been given about how long your baby should suckle 1. No advice given 2. Every time my baby seems hungry 3. Every hour 4. Every 1-2 hour 5. Every 2-3 hour 6. Other	