Summer Training at

State Institute of Health and Family Welfare Haryana, Panchkula

A Descriptive study on Infrastructure, Manpower, Service Delivery and Beneficiary perspective for availability of service delivery for Maternal and Newborn Care in First Referral Unit, CHC Samalkha, district Panipat, Haryana

By
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Under the guidance of
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MBA- Hospital & Health Management (MBA-HM)
2013-2015

The IIHMR University, Jaipur
2014

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CERTIFICATE

This is to certify that Dr. Amita Kshirsagar has completed the summer training at **State Institute of Health and Family Welfare (SIHFW), Haryana** from 1.04.2014 to 31.05.2014 and has conducted the following projects under my personal guidance and supervision. All the data related to the study is the first hand data collected by her.

Projects:

1. A Descriptive study on Infrastructure, Manpower, Service Delivery and Beneficiary perspective for availability of service delivery for Maternal and Newborn Care in First Referral Unit, CHC Samalkha ,district Panipat, Haryana.
2. A report on evaluation of PHC, Kot (according to the IPHS guidelines).
3. A report on evaluation of Sub-centre, Ramgarh (according to the IPHS guidelines).
4. An observation-based report on District hospital, Panchkula.

Her approach to the project has been sincere, scientific and analytical. This work is partial fulfillment to the course requirements, recommended for the Post Graduate Diploma in Hospital and Health with specialization in Health Management.

I wish her all the success in future endeavors.

Col. (Dr.) Ashok Kaushik
Dean (Academic & Students Affairs)
IIHMR, Jaipur

Dr. Goutam Sadhu
Dean (Rural Management)
IIHMR, Jaipur

STATE INSTITUTE OF HEALTH & FAMILY WELFARE,
HARYANA

TO WHOM IT MAY CONCERN

This is to certify that **Dr. Amita Kshirsagar**, PGDHM (Health) student from IIHMR Jaipur, did her summer training under State Institute of Health & Family Welfare, Haryana on the topic ***"A descriptive study on infrastructure, manpower, service delivery and beneficiary perspective for availability of services for maternal & newborn care at a First Referral Unit (CHC FRU Samalkha) of District Panipat, Haryana"*** from **1st April 2014** to **31st May 2014.**

Her approach has been sincere, scientific and analytical towards the study. I wish her good luck in all future endeavours.

Principal

Dated: 31/5/2014 **SIHFW Haryana**

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ACKNOWLEDGEMENT

At the onset of the report I would like to express my special gratitude and appreciation **Dr. Rakesh Gupta, Commissioner FD & Mission Director (NHM), Haryana** for allowing me to pursue my summer internship from **State Institute of Health and Family Welfare, Haryana.**

I would also like to acknowledge with much appreciation the crucial role of **Dr. Usha Gupta, Principal SIHFW, Haryana** during the internship period for her timely guidance, monitoring and words of encouragement.

I express my gratitude and respectful regards to my mentor **Prof. Dr. Goutam Sadhu, IHMR, Jaipur** for her able guidance and useful suggestions, which helped me in completing the project work .

This acknowledgement note would be not be complete without special thanks to **Dr. Puneet Gupta Consultant Training, SIHFW,Haryana** who despite of other pre occupations and busy schedule was there to guide me and whose stimulating suggestions and encouragement helped me complete my training.

I would like to thank **Dr.Arpita Kapoor, Dr Kamna Goel (Faculty**) for their support all the other staff members of SIHFW for being so helpful all the time and making this summer training project an unforgettable experience.

I would also like to extend my gratitude towards **Dr. Sudhir Batra, Dy. Civil Surgeon, NRHM (Panipat), Dr. Jitendra Tyagi (SMO,Samalkha),**doctors and other staff of facility for support throughout the field work.

My colleagues, Dr. Neha Sharma, Dr. Vidhi Tomar, Dr. Sakshi Sharma and Dr. Rohit Sharma and Placement Committee members also hold a special mention here for supporting me throughout the summer internship training.

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

Amita Kshirsagar
Jaipur

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PREFACE

Summer internship is an integral part of the PGDHM currriculum.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 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 Programmes at National/State/District levels.
3) To understand various functions of health systems by interactions with key stakeholders, policy makers, programme managers,academicians and researchers
4) To work on the project/task assigned by summer training organizations.

During my training period I had an overview of working of SIHFW and their initiatives,Various health facilities ranging from grass root level(Sub center) to Secondary level(District Hospital) and service delivery system and various programmes. I also carried out a small study on-

“Infrastructure,manpower,service delivery and beneficiary perspective for availability of services for maternal and newborn care in FRU CHC”

ABBREVIATIONS

ANM	Auxiliary Nurse Mid-Wife
ANMTC	Auxiliary Nurse Mid-Wife Training Centre
ASHA	Accredited Social Health Activist
BEmOC	Basic Emergency Obstetric Care
BOH	Bad Obstetric History
CHC	Community Health Center
CSSD	Centralized Sterilization Storage Department
CTI	Collaborating Training Institute
CTP	Comprehensive Training Plan
DH	District Hospital
DH	District Hospital
DOTS	
DPM	District Program Manager
EmOC	Emergency Obstetric Care
E-PDC	E-Learning Professional Development Course
E-PMSU	E-Learning Program Management Support Unit
F-IMNCI	Facility Based Integrated Management Of Neonatal And Childhood Illness
FRU	First Referral Unit
GNMTC	General Nurse And Midwife Training Centre
GOI	Government Of India
GOVT	Government
HBPNC	Home Based Newborn Care
ILR	Ice Lined Refrigerator
IMR	Infant Mortality Rate
IPD	Indoor Patient Department
IPHS	Indian Public Health Standards
IUCD	Intrauterine Contraceptive Device
JSSK	Janani Shishu Suraksha Karekram
JSY	Janani Suraksha Yojana
LBW	Low Birth Weight
LHV	Lady Health Visitor
LMO	Lady Medical Officer
LSCS	Lower Segment Caesarean Section
MMR	Maternal Mortality Ratio
MO	Medical Officer
MPWTC	Multi-Purpose Health Worker Training Centre
MTP	Medical Termination of Pregnancy
NHSRC	National Health System Resource Centre
NIHFW	National Institute Of Health And Family Welfare
NSSK	Navjaat Shishu Suraksha Karekram
NSSK	Navjat Shishu Suraksha Karekram
OPD	Out Patient Department
OTA	Operation Theatre Assistant
OTN	Operation Theatre Nurse

PHC	Primary Health Center
PPH	Post Partum Haemorrhage
PPIUCD	Post Partum Intra Uterine Contraceptive Device
PV	Per Vaginal
PVT	Private
RCH	Reproductive and Child Health
RNTCP	Revised National Tuberculosis Control Program
RTI	Reproductive Tract Infections
SBA	Skill Birth Attendant
SC	Sub Center
SDH	Sub District Hospital
SIHFW	State Institute Of Health And Family Welfare
SKS	Swasthya Kalyan Samiti
SNCU	Special Newborn Care Unit
STI	Sexually Transmitted Disease
TT	Tetanus Toxoid
WHO	World Health Organization

ABOUT SIHFW

SIHFW, Haryana was established in 1992 and is the apex training institute of Department of Health & Family Welfare, Haryana. Since its inception, SIHFW has been envisaged as state level institution for improving the effectiveness of health care delivery system by imparting knowledge and skill based trainings to the medical and Para-medical health personnel at different levels.

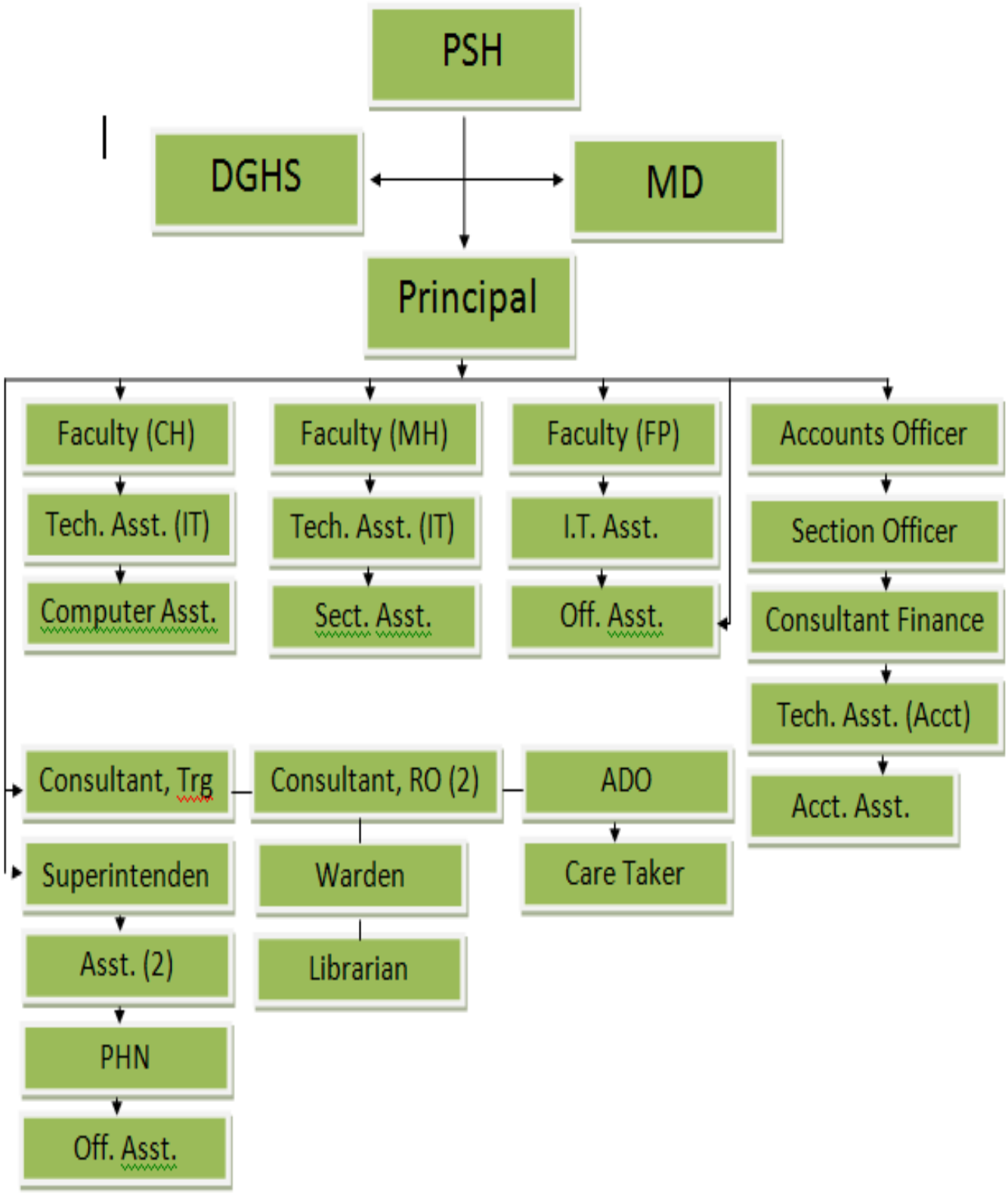
Apex Training Institute - The institute provides umbrella support to the following training institutions in the state:

Training Institute	Number	Location
Medical College	2(Govt) + 2 (Pvt)	Rohtak, Hisar, Ambala & Sonipat
State Level Public health training institutes	1	Gurgaon (HIPA)
Regional Institute of Health and Family Welfare	1	Rohtak
DTCs	21	One in each district headquarter
Nursing Training Centre (GNMTC)	3 (Govt) + 38 (Pvt)	Bhiwani, Hisar, Karnal.
MHPW(F)Training Centre (ANMTC)	8 (Govt) + 35 (Pvt)	Ambala, Rohtak, Narnaul, Faridabad, Gurgaon, Sirsa, Bhiwani, Mewat.
MPWTC	**2**	Sonepat, Rohtak

Table1

The Institute has active collaboration with various other institutes of national repute like PGI Chandigarh, All India Institute of Medical Sciences (AIIMS), Jawaharlal Nehru University (JNU), Haryana Institute of Public Administration (HIPA), Accounts Training Institute (ATI), Public Health Foundation of India (PHFI), IIHMR, Jaipur for sourcing faculties and sharing experiences etc. NIHFW and NHSRC have always been a source of inspiration for all the training, monitoring and evaluation activities and are guiding force in execution at all levels.

ORGANOGRAM OF THE INSTITUTE:



VISION OF SIHFW:

"THE VISION OF THE INSTITUTE IS TO DEVELOP, UPDATE AND REFRESH THE KNOWLEDGE AND SKILLS OF THE HEALTH CARE PERSONNEL IN THE STATE BY PROVIDING QUALITY TRAININGS AT STATE LEVEL AND ENSURING STANDARDIZED TRAININGS AT DISTRICT LEVEL FOLLOWING THE TRAINING NEEDS ASSESSMENT WITH CONTINUAL IMPROVEMENT"

SIHFW as a Society

To effectively monitor and systematically manage the training and infrastructure activities of the Institute, an effective accounting system – to process all aspects of the institute"s financial performance and facilitate appropriate strategic decisions about the future has been developed and the Society was formally registered with the Registrar of Societies, Panchkula on November 11, 2010 in the name "Swasthya Prashikshan Kendra, Panchkula".

The Society functions and operates under the privileged guidance of the honorable Principal Secretary, Govt. of Haryana, Health, Medical Education &

Ayurveda, who is the Chairman of its Governing Body. The Mission Director, NRHM is the Chairman of the Executive Committee. During this year, one Governing Body meetings and one Executive Committee meetings have been held in the FY 2012-13.

SIHFW as Collaborating Training Institute (CTI)

Collaborating Training Institutes (CTIs) were identified out of various State training institutes by NIHFW to achieve the goal of Comprehensive Training Plan (CTP). SIHFW, Haryana was recognized as CTI in year 2005 and is also supporting UT Chandigarh and State of J&K in implementing their CTPs apart from Haryana. SIHFW Haryana provides trainings to the health personnel on the basis of nominations received and also share pool of master trainers so as to impart trainings in their respective States. Under CTI scheme, NIHFW provides financial assistance to help the States in achieving CTP targets. Human resource is recruited as per the ToRs devised by NIHFW. SIHFW Haryana has recently recruited 1-Consultant Finance, 3 Consultant ROs and 4-Technical Assistants under CTI scheme. SIHFW received funds amounting ` 2,862,820 from NIHFW during the FY 2012-13 and has spent ` 2,618,429 till March, 2013.

Curing Clubfoot Pilot Project

SIHFW has taken the initiative to run a project on pilot basis at GH, Sector-6, Panchkula for which infrastructure and human resource will be generated.

In this context, a seminar was organized by SIHFW in which Orthopaedic Surgeons from Haryana and UT Chandigarh and Dy. Civil Surgeon (IBSY & School Health Programme) of State Haryana were sensitized about Clubfoot. The Seminar was conducted under the chairmanship of Dr. N.K. Arora, Director General Health Services, Haryana. Dr. P.N. Gupta from GMCH-32, Chandigarh and Dr. Nirmal Raj from PGIMER, Chandigarh were the trainer/faculty for the seminar. The seminar was attended by 29 Orthopaedic Surgeons, 14 Dy. Civil Surgeons and 2 Consultants from NRHM & SIHFW. PGIMER, Chandigarh were the trainer/faculty for the seminar. The seminar was attended by 29 Orthopaedic Surgeons, 14 Dy. Civil Surgeons and 2 Consultants from NRHM & SIHFW.

Assessment of ANMTC/GNMTC of the State

The biggest challenge for the provision of health care services is the acute shortage of health personnel and disproportionate skill mix of the existing staff. Adequate knowledge and skills of ANMs and Staff Nurses working in the public as well as private sector facilities is one of the major bottlenecks in delivering quality RMNCH services particularly at primary and secondary level health facilities. In this regard, SIHFW take the responsibility to reform the pre-service education and midwifery in Haryana and conduct a baseline assessment/supportive supervision visit on 28th Feb 2013 at all Government and certain selected private ANMTC/GNMTC (25 and 22 respectively) to assess the basic knowledge and skills of final year students of ANM and GNM courses and the basic infrastructure and school management as per the performance standards provided by GoI.

After a thorough analysis of the data compiled, a detailed analysis of the same was done and various gaps were identified with respect to infrastructure, training material and knowledge/skills of students and the same were discussed in the meeting on 26th March, 2013 with the stakeholders under the chairmanship of Dr. Rakesh Gupta, Mission Director, NRHM. All the Principal Tutors (Govt +Pvt.) ANMTC/GNMTC of Haryana (approx.130) were called for the meeting. DGMER, DGHS-II, Country Head JHPIEGO were also present.

Training given by SIHFW:

Maternal Health Trainings:

Under Maternal Health Programme, following trainings are being imparted by SIHFW, Panchkula at State as well as at district level: -

Sr. No.	Name of Training	Duration of the training	Category of trainees	Participants per batch
1.	Skilled Birth Attendant	21 days	Staff Nurse ANMs	4/PB
2.	Emergency Obstetric Care	16 weeks	Medical Officers	8 P/B
3.	Life Saving Anesthesia Skill	18 weeks	Medical Officers	4 P/B
4.	Basic Emergency Obstetric Care + PPIUD	10 days	Medical Officers	5 P/B
5.	Medical Termination of Pregnancy	12 days	Medical Officers	3 P/B
6.	RTI/STI	2 days	Medical Officers, Lab Technicians Staff Nurses	30 P/B

Table 2

Child Health Trainings:

Following trainings are being imparted under Child Health Programme: -

Sr. No.	Name of Training	Duration of the training	Category of trainees	Participants per batch
1.	F-IMNCI	11 days	Medical Officers	16 P/B
2.	F-IMNCI	5 days	Medical Officers trained in IMNCI	16 P/B
3.	NSSK	2 days	Medical Officers Staff Nurses & ANMs	32 P/B
4.	IMNCI	8 days	ANMs	25 P/B
5.	HBPNC Supervisory Training	2 days	Medical Officers, DPM, ANM, BEE	30 P/B

6.	HBPNC Software Training	1 days	Information Assistants	20 P/B
7.	HBPNC BTF	2 days	Medical Officers Staff Nurses, LHVs	25 P/B
8.	Yashoda Supervisory Training	4 days	Yashoda, Yashoda Supervisor, SNCU Counselor	5-14 P/B

Table 3

Family Planning Trainings

Following trainings are being imparted under Family Planning Programme: -

Sr. No.	Name of Training	Duration of the training	Category of trainees	Participants per batch
1.	Laparoscopic Sterilization	12 days	Medical Officers OTA, OTN	3 P/B
2.	Non Scalpel Vasectomy	5 days	Medical Officers	4 P/B
3.	Alternative Training Methodology in IUCD	6 days	Medical Officer Staff Nurses & ANMs	10 P/B
4.	Post Partum IUD	10 days	Medical Officers	5 P/B

Table 4

MONITORING & EVALUATION

Monitoring & Evaluation is an important part of any program as it helps in calculating the outcome of the program as per the desired objective, but it is very important that the action taken for it should be evaluated in such a manner that all the pitfalls coming in the way of the success of that program should be cleared. Monitoring & Evaluation determines the relevance and fulfillment of objectives, as well as efficiency, effectiveness, impact and sustainability. They are as important as the other tools of the training. In continuation of the policy of the SIHFW keeping quality on top priority, institute has developed the different methods which are followed during the training and after the training to evaluate the entire schedule of training period, like session evaluation forms to assess the effectiveness of the training sessions, Pre & Post evaluation forms to assess the knowledge of the participants on first & last day of the training. While

conducting evaluation test for sessions, the identity of the participants is concealed and is represented by a code.

Monitoring by Consultants & Faculty, SIHFW

With availability of human resource, it became possible to carry out regular monitoring of the trainings at district level. The institute with its well qualified Faculty members and Consultants ensure a thorough check of all the trainings as per the guidelines issued by GOI. M&E visits are done on regular basis by the committee comprising consultants & faculty up-to the peripheral parts of Haryana, for on the spot monitoring check to ensure the quality & effectiveness of training programs.

E-course and distance learning course contact centre:

Haryana is one of the 8 states selected for the pilot course of the Professional Development Course (e-PDC) launched by NIHFW with the support of EU funded Institutional and Technical Strengthening (ITS)project. This course is meant for medical officers having an experience of more than 10 years to develop in them a sense of public health system, managerial skills and health communication.

Another course is E-learning Course for Program Managers in Program Management and Support Unit (PMSU) to strengthen public healthcare delivery system.

Apart from the above mentioned e-courses, SIHFW, Haryana also serves as a contact centre for 2 distance learning programs:

- Health And Family Welfare
- Hospital Administration

EXECUTIVE SUMMARY

First Referral Unit are the facilities(DH, SDH, CHC) which are designated to provide Emergency Obstetric care including Caesarean section and other surgeries, newborn and sick child care and blood storage facility to the closest vicinity of the rural area which can reduce the maternal and child morbidity and mortality by handling the complications more effectively and efficiently.

The study covered the CHC as FRU of district Panipat. Study area was FU Samalkha of district Haryana. Study is qualitative and quantitative type and design is Descriptive Cross Sectional done in small period of 2 months.

FRU was assessed by a semi structured checklist to know the current status of infrastructure, manpower, referral system and service delivery for maternal and new born care as per FRU and IPHS norms. Indepth interviews were taken from doctors ,staff nurses and other staff of FRU.

24 OPD ANCs and 8 IPD PNCs were interviewed with semi structured questionnaire for their opinion on availability of services in the facility.

Records and registers were assessed.

Field findings were CHC Samalkha is a Non Operational FRU not fulfilling critical determinants of FRU. .Infrastructure was poor and badly maintained. Manpower crunch regarding specialist was existing in the facility. Service delivery was partially potential, Referral rate to higher centers were very high, referral transport were efficient.

1. INTRODUCTION

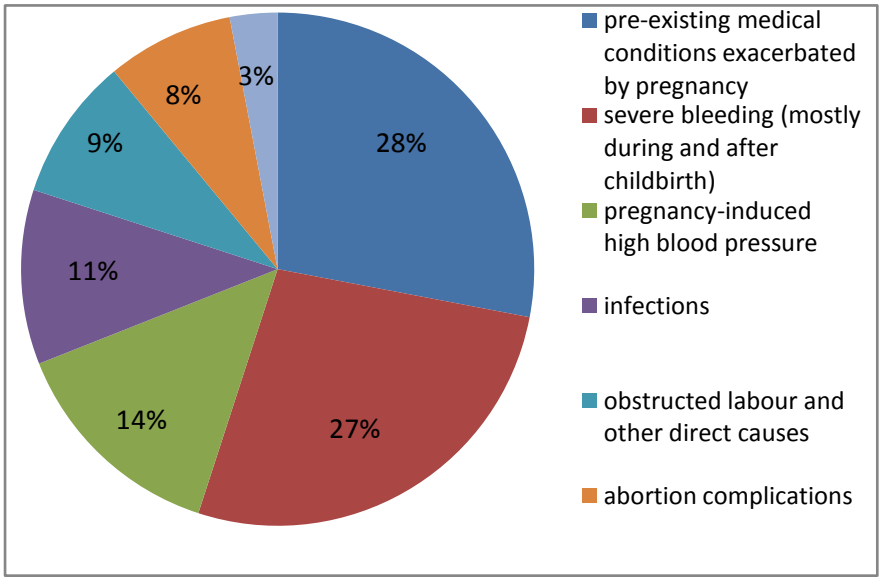
Millennium Development Goal 4 and 5 has targeted Infant mortality rate and maternal mortality ratio as 70 per 1000 live births and 109 per 100000 live births respectively by 2015 [1,2]

Though India has made an appreciable progress in improving the overall health status of its population but it is far from satisfaction. The pace of decline of infant and child mortality on one hand and maternal mortality on the other hand has been quite low. The neonatal mortality is primarily consequences of endogenous factors, which are largely governed by the maternal causes and thereby call for the monitoring of maternal mortality ratio in the population.

The results of large-scale survey have however shown that there was no decline in MMR over time indicating an urgent public health concern. The complications of pregnancies and the births are found to be the leading causes of deaths and disability among women of reproductive age [3]. The health problems of mothers and newborns arise as a result of synergistic effects of malnutrition, poverty, illiteracy, unhygienic living conditions, infections and unregulated fertility. At the same time, poor infrastructure and ineffective public health services is also responsible for low inadequate obstetric care. The exact ascertainment of the situation could be monitored with the availability of MMR estimate and causes of maternal deaths [3] .

Causes of Maternal death

- A related WHO study of causes of more than 60 000 maternal deaths in 115 countries shows that pre-existing medical conditions exacerbated by pregnancy (such as diabetes, malaria, HIV, obesity) caused 28% of the deaths.[4]



Other causes included:

- severe bleeding (mostly during and after childbirth) 27%
- pregnancy-induced high blood pressure 14%
- infections 11%
- obstructed labour and other direct causes 9%
- abortion complications 8%
- blood clots (embolism) 3%.

- Maternal health and newborn health are closely linked. Almost 3 million newborn babies die every year[5], and an additional 2.6 million babies are stillborn[6].

It is not possible to predict which mother will develop complications. Every woman, irrespective of socio-economic status is equally at risk and hence the high-risk approach does not help much. Most complications cannot be prevented by good ANC. Hence, ANC alone cannot prevent maternal mortality. Cost-effective approach to reducing maternal mortality by ensuring high quality emergency obstetric care (EmOC) to mothers who develop complications during delivery is needed

It is in this context that efforts were initiated in 1992 with the implementation of the Child Survival and Safe Motherhood (CSSM) Programme for upgrading the existing community health centers

and sub-district hospitals into First Referral Units (FRUs), to be equipped for providing delivery of emergency obstetric care to pregnant women with complications

2. BACKGROUND

Over the years, a number of steps have been taken under the Reproductive and Child Health (RCH) Programme for facilitating the operationalisation of these FRUs. These have included funds for operationalising Operation Theatre (OTs) and Labour Rooms (LRs), supply of equipment kits, supply of drug kits containing emergency obstetric care drugs and funds for hiring of Anaesthetists from private sector. Drugs and Cosmetics Rules have also been amended to enable setting up of Blood Storage Units in the institutions designated as First Referral Units (FRUs) [7].

In Reproductive and Child Health Programme, Phase II, efforts have to be made for operationalising 2000 FRUs in a phased manner. The guidelines on operationalisation of FRUs have been prepared to assist the states to plan for operationalising of the FRUs.

RCH PhaseII 3rd JRM (15th January- 8th February,2007)[8] focused -

- To first establish levels of care according to FRU guidelines, i.e. operationalise FRUs first while the long-term focus to continue to be on IPHS standards.
- To focus the states in developing a training strategy and plans and ensure availability of training material, trainers and examiners, especially for anaesthesia training. They would also provide support to states in preparing plans for monitoring training quality and post training follow ups for highly skilled clinical trainings.
- Guidelines for management of sick children including newborn, diarrhoea and severe malnutrition for referral care at FRUs.
- Develop FRU equipped to provide family planning services as per client choice

Tenth Plan: Recommended approach

The working group on health care for women and children for Tenth Five Year Plan have identified establishment of fully functional and operational FRUs as the priority area for the provision of Emergency Obstetric and New-born Care.

The group has recommended as under:

"*It is imperative that the existing infrastructure and specialist manpower at FRUs/CHCs is looked into critically and re-organized, and mis-matches between infrastructure and manpower corrected. At the first instance it would be desirable to ensure provision of quality Emergency Care Services at least at the district hospital and sub-district hospital followed by FRUs/CHCs. Thus, developing some FRUs in a district by ensuring that they have the required number of specialists in position or have access to the services of specialists on call, would be a preferred option rather than having a number of FRUs which may not be providing full range of services. The information on location of such emergency services/FRUs will be made available to all villages in the area so that the population knows where they should reach for getting appropriate emergency care. The provision of emergency care has also to be supported by appropriate referral services from sub-centers to PHCs and from PHCs to the functioning First Referral Units providing emergency service .*"

In view of the foregoing, it is considered imperative that the States look at the existing facilities and identify clearly their requirements for putting into place fully functional FRUs. It is envisaged that by the end of the Tenth Five Year Plan, each district should have at least 3-4 fully functional facilities which are equipped to provide the full range of Emergency Obstetric and New-born Care on a round-the-clock basis.

Guidelines for Operationalising First Referral Units[7]

The guidelines were an attempt to facilitate the planning exercise by the States and also take into account the recommendations of the National workshop organized in 1999 for operationalisation of FRUs, in which all the States, donor agencies, experts and

programme officers of the Department of Family Welfare participated.

They may be used for mapping the existing health facilities, available manpower and other resources for each district. This exercise will facilitate proper placement of the available resources and at the same time will bring out additional requirements in terms of training, equipment and infrastructure required for operationalising the identified CHCs/sub-district hospitals as FRUs. To facilitate this exercise, formats have been designed and are given in Annex III {Formats I,II & III}. Based on this exercise, it should be possible to draw the district-wise action plans for operationalising FRUs in a phased manner.

Consolidation of the district plans at the state level will thus bring out the overall requirements of the State in various areas, like infrastructure, equipment, manpower and training needs for operationalising FRUs during the Tenth Plan.

It is expected that proper functioning of FRUs, adequately supported by well formulated referral system which will contribute positively to bring down the maternal mortality and early neonatal mortality rate and also decrease the load of higher centres.

3.CRITICAL DETERMINANTS OF FIRST REFERRAL UNIT

An existing facility (district hospital, sub-divisional hospital, community health centre etc.) can be declared a fully operational First Referral Unit (FRU) only if it is equipped to provide round-the-clock services for Emergency Obstetric and New-born Care, inaddition to all emergencies that any hospital is required to provide.

MINIMUM SERVICES PROVIDED BY FRU
• 24-hour delivery services including normal and assisted deliveries
• Emergency Obstetric Care including surgical interventions like Caesarean Sections(*)
and other medical interventions
• New-born Care(*)
• Emergency Care of sick children
• Full range of family planning services including Laproscopic Services
• Safe Abortion Services
• Treatment of STI / RTI
• Blood Storage Facility (*)
• Essential Laboratory Services
• Referral (transport) Services
(*): Critical determinants of functionality

Table 5

It should be noted that there are three critical determinants of a facility being 'declared' as a FRU: Availability of A) Surgical Interventions,
B) New-born Care and
C) Blood Storage
Facility on a 24-hour basis.

The planning effort in relation to operationalising the FRUs, therefore, has to focus on carefully selecting such existing CHW/Sub-district hospitals which can be quickly equipped to handle all obstetric emergencies including those requiring surgical interventions like the Caesarean Section.

4.LITERATURE REVIEW

1. **Status of maternal and newborn care at first referral units in the state of West Bengal.** *Indian Journal Public Health J 2004;48:21-6.* Biswas AB, Nandy S, Sinha RN et al

The study concluded that the infrastructure facilities in FRU in West Bengal were inadequate with poor utilization of equipments, lack of trained service providers , incomplete records poor referral system and data on maternal and neonatal mortality and its causes.

2. **An evaluation of first referral units in border districts of West Bengal.** *The Journal of Obstetrics and Gynaecology of India Vol. 55, No. 1 : January/February 2005 Pg 52-56*
Ray *Sandip Kumar*, Mallik *Sarmila*, Kumar *Satish*, Biswas *Biswajit*

Another study to assess the facilities and manpower availability in 3 district of West Bengal bordering Bihar and Orissa showed that 2/3rd of FRU have adequate manpower but rural hospital did not have. Equipments were available but not used. Manpower lacked training. Blood Bank ceased functioning after afternoon. Predominant causes of obstetric emergencies were found to be Delay I and II.

3. **Assessing the Regional and District Capacity for Operationalizing Emergency Obstetric Care through First Referral Units in Gujarat**. *IIM ,Ahemdabad publication W. P. No. 2009-04-01, April 2009.* Parvathy Sankara Raman, Bharati Sharma, Dileep Mavalankar, Mudita Upadhyaya.

A study on assessment of regional and district capacity for Operationalizing Emergency Obstetric care through FRU in 27 facilities in Gujarat had conclusion that Government health institutional network was fairly good but infrastructure was incomplete , staff were unskilled standard evidence based on clinical protocols are not followed ,MIS does not capture the functioning of FRUs.

4. **Status of First Referral Unit-Assam.**
http://jaipur.iihmr.org/Research/student-dissertation/research-details.aspx?research=Status-of-First-Referral-Units-Assam accessed on 8/4/2014. ,Dissertation-Dr Deepak Kar IIHMR(PGDHM Batch 2007-2009)

A dissertation study of Dr. Deepak Kumar Kar (IIHMR) on the status of FRUs in Assam showed gaps in resource availability, irrational utilization of available resources, non streamlined processes and lack of planning of selection and up gradation of facilities to the status of FRUs.

5.RATIONALE

All pregnant women are at risk of obstetric complications. About 15 percent of deliveries, an unpredictable complication[9] occurs, such as severe bleeding, hypertension, infection, and obstructed labour, either for foetal or maternal reasons. When this happens, it is essential that women have access to life-saving emergency obstetric care, including caesarean delivery.

The leading causes of maternal death can be treated at a well-staffed, well-equipped health facility that is able to provide emergency obstetric care services. Many newborns that would otherwise die can also be saved at such a facility. The facility of FRU should be available in the vicinity i.e. up to a maximum of time limit of one hour. The facility of FRU will decrease both the MMR & IMR and also decrease the morbidity of the mothers and infants. As per GoI guidelines all DH, SDH & CHC should be operationalized as FRUs

Many women are not able to access timely emergency care because health facilities in remote and rural areas are often poorly equipped to manage obstetric complications.

Haryana is a small State with good road infrastructure and a robust referral transport system. Consequently, it has been decided by the NRHM Haryana that in addition to District Hospital 1 or 2 Sub-district Hospitals or CHCs per district will be fully operationalized as FRUs. Thus it is proposed to operationalize 39 FRUs in the entire State of Haryana in the year 2012-13.

Thus this study will give us the true insight of the current status of infrastructure, manpower and their traintng status in FRU and the gaps in service delivery which are restricting the strengthening of the FRU

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6. OBJECTIVES

General objectives-

To assess the current status of FRU for providing maternal and newborn care and Beneficiary perspective regarding maternal and newborn care service delivery

Specific Objectives-

1) To assess the infrastructure available in the selected FRU's for maternal and newborn care.
2) To assess the availability of manpower and its training status regarding maternal and newborn care.
3) To assess the Records of deliveries, OPD and IPD in the selected FRU
4) To assess the referral system and causes of maternal referral in the selected FRU
5) To find out the bottlenecks in the service delivery of maternal and new born care.
6) To study the beneficiary perspective regarding availability of services regarding maternal and newborn are in selected FRU

7.MATERIALS AND METHODS

- A Descriptive cross sectional study was conducted in FRU Samalkha of district Panipat assigned by SIHFW, Haryana for period of 15 days from 25th April till 9th of May
- Pre testing of the tools were conducted at FRU Kalka, Haryana, after pretesting changes were made in the questionnaire of Beneficiary.
- FRU was visited personally and observed, health providers and staff of FRU was interviewed according to checklist prepared on the basis of Guidelines of FRU and IPHS norms of CHC (FRU).
- Purposive sampling was done for Beneficiary perspective for availability of services. 24 ANCs of all trimester visiting the OPD for ANC checkups and 8 women of Postnatal period were selected purposively and interviewed for their opinion on the availability and satisfaction level of service delivery of maternal and newborn care with the help of Semi structured questionnaire.
- Data collection of Deliveries, OPD and IPD registration, Bed occupancy rate, referral of delivery cases and its cause, through the records available in the FRU.
- **Target population**-Specialists (Gynaecologist and Paediatrician) and Medical officers, staff nurses , ANMs, Laboratory technicians , Blood Bank Technician, ANCs and post delivery patients.
- Transcription of case studies observed in the FRU regarding service delivery and referrals.

DATA COLLECTION

Data collection Technique- used were Direct Observation, In depth semi structured interview from the health providers and staff, Transcription of observation and records and face-to-face interview of beneficiaries

Data collection Tools used-

- Observation checklist (IPHS guidelines, FRU guidelines,blood bank guidelines)
- Records and registers
- In-depth semi structured interview schedule
- Photographs
- Semi structured questionnaire-separate for PNC and ANC.

➢ ANALYSIS OF DATA

- Non statistical analysis of qualitative data,
- Transcript of observation made,
- Direct quotations in response to open ended questions
- Photographs
- Quantification of responses of beneficiary by percentage and represented in pie diagram.

➢ Limitations of the Study:

The following limitations of the study was identified:

- Sample sizes were taken was small and the size might not represent the entire universe of the study
- Chances of selection bias due to purposive sampling and response bias of the beneficiaries may be present.

8.RESULT

Figure 1

CHC Samalkha covers approximately 1,70,000 population. Majority of the population dwelling in this area were migrants from Bihar and Uttar Pradesh states for employment in the Foundry and industries situated near by.

CHC Samalkha heads over

	Name of PHC	Distance
4 PHCs-	PHC Atta,	12 km.
	PHC Pattikalyana,	6 km.
	PHC Chamkhana	6 km.
	PHC Nariana	6 km.
2 Sub centers	SC Samalkha	0 km.
	SC Bapoli	2 km.

Table 6

CHC Samalkha was proposed to be designated as FRU in 2012-2013. But it is **a Non Operational First Referral Unit .**It is **not providing the EmOC services and the Blood Storage facility** which are the critical determinant of a FRU.

8.1 PHYSICAL INFRASTRUCTURE

CHC Samalkha is located at a distance approximately 1.5 km interiors from the highway. Signages were not displayed on the approach road. Facility was fenced with intact boundary wall with a gate. Display board of name of FRU in local language was visible. Premise was well maintained with a garden which was well maintained.

OPD and IPD areas, Laboratory and Dispensing areas were in different buildings in the facility premises.

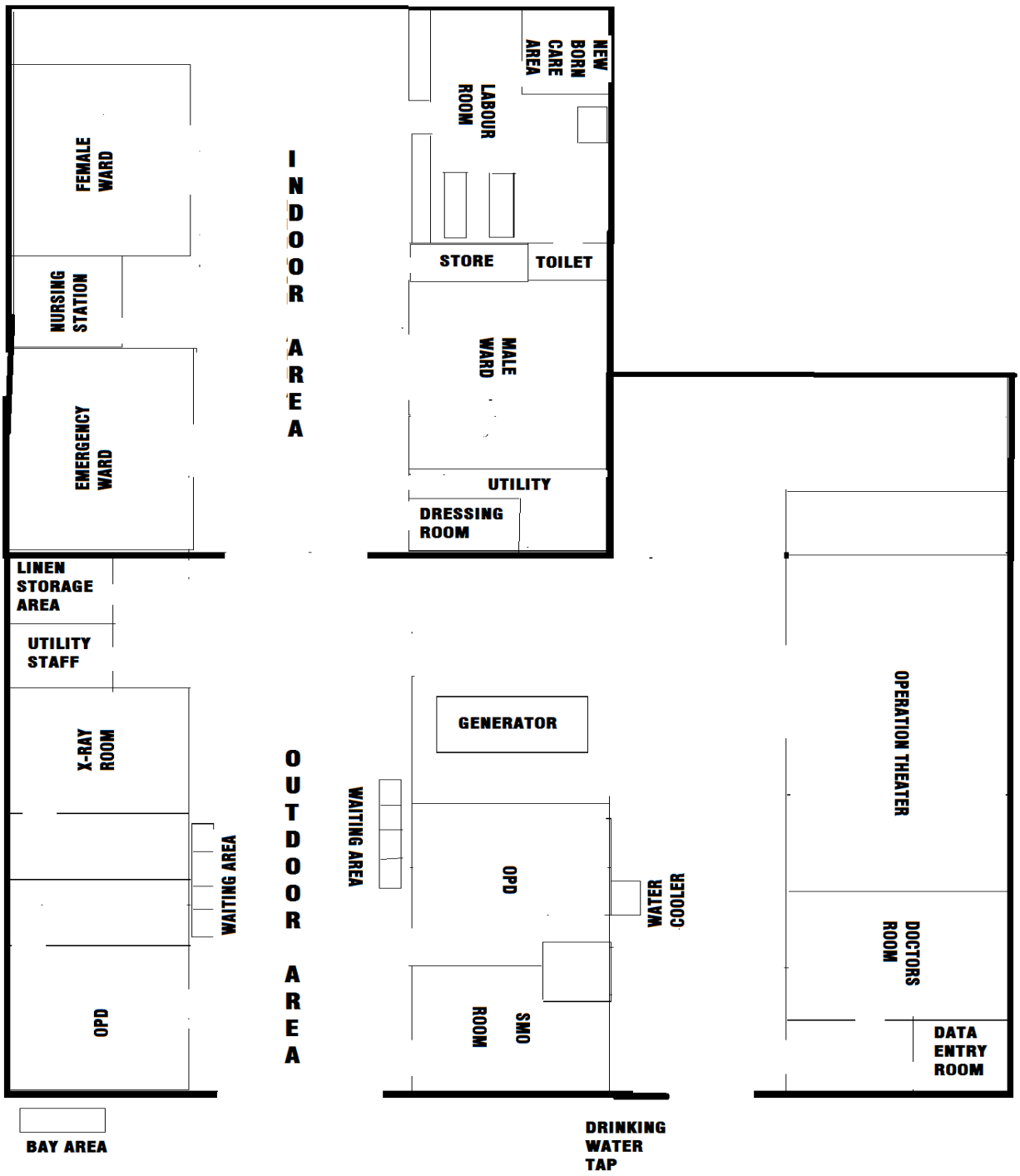


Figure 2

Layout of 1st building

(Outdoor and Indoor Area, Labour Room, Ancillary Area and Operation Theatre)

Entrance Zone:

Signage Display board in local language for services available in the facility was displayed at entrance but timing of the hospital was not displayed. OPD layout displayed in local language, SKS members list were displayed.

Figure 3

Figure 4

But citizen charter was not displayed. Adequate number of IEC materials were not displayed in the entrance zone. Registration cum enquiry room was unavailable, OPD records were centrally maintained by the pharmacist at dispensary.

Outdoor Patient Area:

CHC did not have any specialised departments except for Paediatrics. Neither separate OPDs for doctors were available, nor were names of doctors and their timings displayed. Only **3 OPDs were available for 5 doctors**. 2 doctors were seated in one, 2 LMO in other and paediatrician in third.

Lady medical officer OPD had condemned X-ray machine, making the room congested. Due to construction of new emergency ward and shifting of X-ray room in this OPD, LMOs were shifted in the Paediatrician OPD, resulting in overcrowding of OPD at peak hours

Crowding around doctor table at peak OPD hours, due to inadequate space.

Figure 5

Figure 6

IBSY and ARSH clinic were never conducted nor was any one designated for this purpose.

Figure 7

Dental OPD was well equipped and well maintained.Along with paediatric patient, Paediatrician has to examine general patients too.

OPD Supplies:

Lady medical officers were sharing same doctor‟s table and only one patient seat. No follower‟s seat was available in OPDs. No wash basin for hand washing in OPDs. Examination table was available only in LMO OPD. Neither privacy was maintained, nor did it have mattress over it. Due to lack of privacy, internal examination of female patients was done in labour room.

Figure 8

Examination equipments were also not available in OPD.Cleanliness of OPD was average. Rooms were filled with cobwebs.

Patient Waiting Area:

Two small cement made benches in the corridor, were used by patient for waiting purpose, out of which one is placed in **close proximity of the electricity board** whose doors were open, but chairs were placed before the inspection of Deputy Commissioner.

Figure 9

Injection and Dressing Room:

Both the rooms were separate in different buildings. Injection room was managed by one of the pharmacist. Both the rooms were well maintained, waste disposal was done properly according to guidelines.

Emergency Ward:

Recently 5 bedded emergency ward was constructed (made functional on 4th May)in the indoor area.

Previously a single emergency bed was placed in OPD corridor, emergency patient were examined without privacy. CLW suturing was done here or in OPD, as Minor OT is not available

Figure 10

(New Emergency Ward)

Figure 11

(Old emergency bed at corridor)

Nursing Station:

Common for all wards. Nursing station was well maintained and clean.Hand washing facility was available. Colour coded bins for bio waste disposal was properly done, but bins were not covered with lids.Hub cutter and needle destroyer were available and used by the staff. Syringes were not immediately discarded after use by some staff nurses

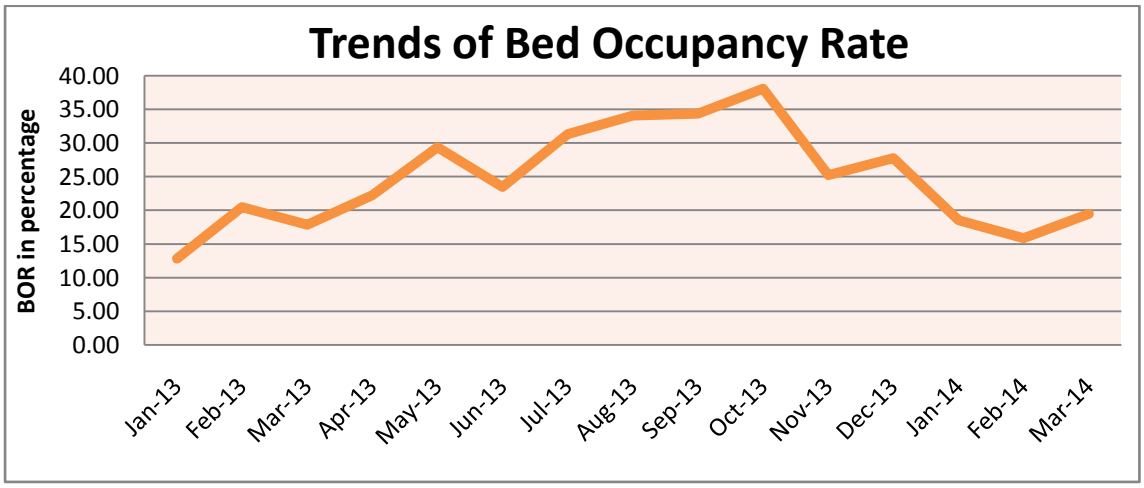
Figure 12

(Arrow shows non discarded syringes)

Emergency drugs were available in the nursing station but not properly segregated. Medicines for the Emergency patients were given from the nursing station after 4 pm (as dispensary close at 4 pm).

Indoor Area:

Separate wards for male and female were available. Bed Strength sanctioned is **30 but functional only 21** (Male Ward-8, Female Ward-8,Emergency-5).Average Bed occupancy rate was **24.7%** (considering 30 beds) per month is considered as poor according to the guidelines of FRU and IPHS norms for CHC.



Trends of Bed Occupancy rate from period January 2013 to March 2014 shows that there is fluctuation in the Bed Occupancy rate. Highest occupancy rate (38%) was in month of October 2013. Bed occupancy was above 30% in month of July, August, September, and October, but in rest of the months it remains below 30%. Thus we can conclude that rate of bed occupancy was poor in the facility.

Wards were clean and spacious and airy. Female ward windows were covered with curtains.Enough space was there between beds. No separate space for the patient who required isolation.

2

Figure 14

Figure 15

Utility :

Figure 16

Common utility for indoor and outdoor area. Separate utilities for male and female were available, **but only one was functional since 2 months**, because female utility was converted into store room for condemn materials. Cleanliness of utilities were average ,dark. No dustbins were in toilets for waste disposal.

Ancillary Area:

Nursing rest room was not separate, a bed was placed in the nursing station

Central Sterilisation Storage Department- Major sterilisation was done in OT autoclave, every week (on Thursday), Labour room also had a separate autoclave (small size) for temporary sterilization. Separate linen storage was available.

Laundry – Soiled linen were washed in the facility premises in open area behind the laboratory and dried on the ground.

Staff quarters were available in the facility.

Labour room :

Figure 17

Figure 18

Labour room and newborn care unit were well maintained.

Patient waiting area: Separate area was not designated for patients in first stage labour, mostly they were directly shifted in the labour room till delivery.

Recovery Room: No Post partum room was available. Patients were directly shifted in the female ward after delivery.

Staff Area: No designated staff area in the labour room.

Scrub Area: Wash basin without hand free tap was available with a soap bar(liquid hand wash was not available).

Figure 19

Sterile instruments and drums and supplies were placed on the marble counters of labour room.Waste disposal was done in colour coded bins and segregated properly according to guidelines.

Supplies:

24 hr water supply was available.

Electricity backup supply with common generator. Inverter was common for wards and labour room. Shadow less lamp and resuscitator did not have backup of inverter hence staff **had to perform deliveries in torch light during power cuts**(observed during this study as inverter got exhausted due to long hours of power cut and petrol was not in stock to operate generator.), this scenario was frequent according to staff nurses.

Labour room had attached toilet, clean and well maintained.

Equipments: Instruments for Vaginal examination were available, but was mainly used for IUCD insertion. Povidine iodine was stored in "Limca" bottle. Bowl of antiseptic solution was available but staff nurses did not use during PV examination.

For delivery:2 labour tables with foam mattress, Macintosh and Kelly"s pad were available. Suction machine, Oxygen trolley was common for New born care area and labour room. Used instrument were directly transferred in the bleaching powder solution without washing. Kidney tray was not used for keeping used instruments.Instrument trolley and cabinet was not available.Wheel chair and trolley for patient were common for wards and labour room and were used rarely.Normal delivery kit was available. Cap and mask were not available.Forceps and Vaccum delivery kits were unavailable, since assisted deliveries were not conducted in the facility. Fresh pair of gloves was used by staff for examining the patient every time. Adequate quantity of gloves, sterile pads were available

Emergency Drug Tray:

Inj. Diazepam and Tab. Nifedepin was unavailable in the emergency tray, but was available at nursing station, rest other drugs were available but not properly segregated in different labelled boxes.

Cleanliness and ventilation: Cleanliness of labour room was well maintained. Air conditione

Privacy: Labour tables were separated by curtains. Windows were glassed and covered with curtains.

.New Born Care Area:

Figure 20

A corner was earmarked in labour room for new born care. It was well equipped with warmer with trolley, oxygen trolley with face mask, suction machine(automatic and foot operated both) with suction catheter, hand operated resuscitator(AMBU bag), Weighing machine and Ultra violet lamp with floor stand. Kit N-Neonatal Resuscitation equipments were available except for nasal catheter. Mucus extractors were in limited stock, hence used rarely. Paediatric intra cath was not available. Inj. Vitamin K was unavailable since 2-3 months. Newborn care corner was not supported by inverter, hence non functional on power failure. For drying and wrapping baby cotton clothes were used, which were washed and reused. New born corner had cobwebs on the walls.

Operation Theatre:

Figure 22

Figure 23

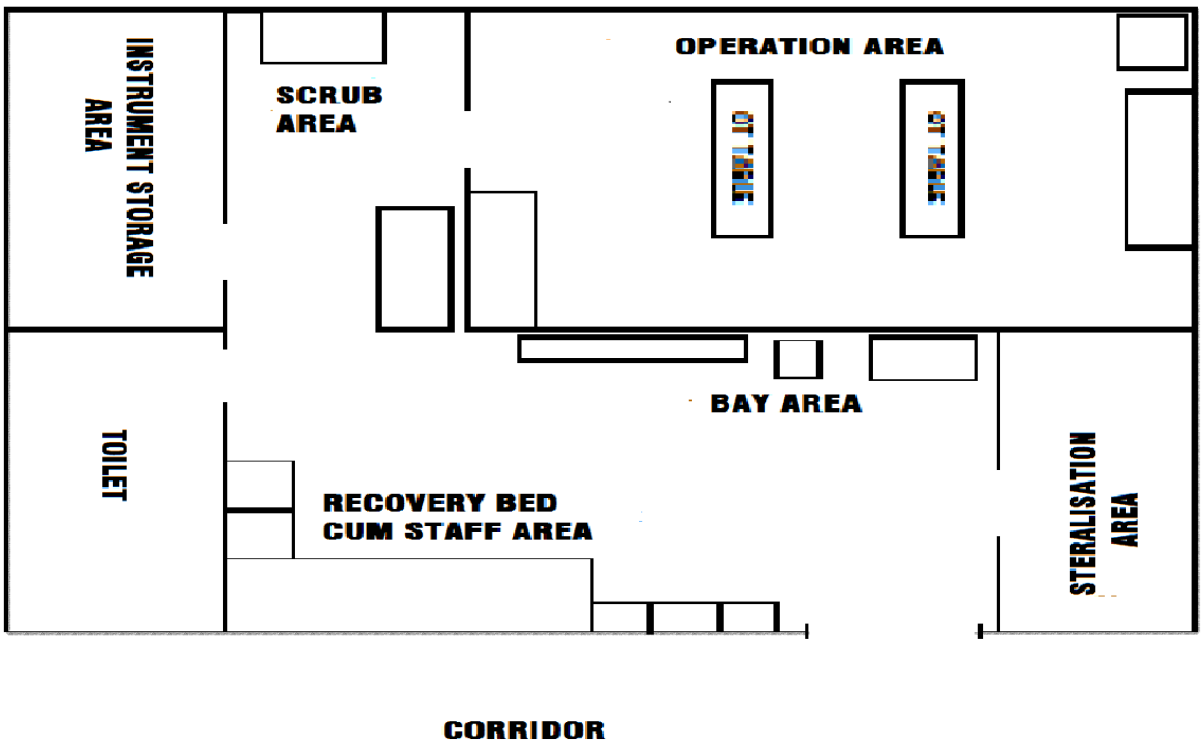


Figure 21

Layout of Operation Theatre

OT was functional only on FRIDAY every week for Family planning surgeries. Only Tubectomy and Vasectomy surgeries were conducted in the facility, occasionally Ear lobe repair was done. Laproscopic sterilisation surgeries were not performed in the facility.

Patient waiting Area: Patient for tubectomy has to wait outside the OT in the veranda and were made to sit on the floor till their turn.

Preoperative room: No separate room available. Pre operative examination done by LMO in labour room or in OPD by closing the door. Part prepare was done in dressing room. Patients are given sedation in the veranda where they were sitting.

Post operative room: Post operative room was unavailable. Patients were shifted to female ward after surgery. A recovery bed was earmarked for emergency purpose.

Staff area: Separate staff area was unavailable. 2 chairs were placed next to recovery bed for doctors and staff to sit and complete their operative notes. No separate changing room for doctors nor the patient given a change(OT clothes) before surgery.

Scrub area: Scrub area was present outside the main operation area, but neither hand free tap was available, nor liquid soap.

Storage area for sterile supplies: Sterile drums were kept on the marble counter in the operating room. Storage of OT equipment and other supplies like linen,drugs were in a separate store room

Instrument sterilisation area: Separate area for sterilisation of instruments, well equipped with Electric Sterilizer and a large size Autoclave machine.

Operating room: It was equipped with 2 Hydraulic operation tables, ceiling mounted shadowless lamp separate for both tables, suction machine, oxygen trolley, Anaesthesia trolley wad resuscitator which was not functional due to unavailability of anaesthetist, hence packed and placed at corner.

Waste disposal area: Well maintained, colour coded bins were used but not closed with lid cover.

Wheel chair,trolley for patient was available but after operative, patient who are partially conscious were walked back to the wards and completely sedated ones were shifted on wheel chair and these patient were discharged after 2 hrs.

Instruments:

Surgical Kits according to IPHS norms were unavailable**.** Instruments for Hysterectomy and other surgeries were unused due to unavailability of surgeon. Instrument regularly used:

Instruments	Quantity
For Tubectomy surgery	5 Sets
1. B.P. handle	1
2. Artery forcep	1
3. Babcocks forcep	1
4.Plain forcep	1
5. Kocher's forcep	1
6. Needle holder	1
For NSV surgery	2Sets

Table 7

These instruments were sterilised in boiler and reused, if more than 5 surgeries were scheduled.

Cleanliness and Sterilisation:OT was air conditioned.After surgery, OT was not immediately cleaned; cleaning was done a day before next surgeries was scheduled i.e. on Thursday. OT was fumigated by sprinkling Formalin on the floor, since fumigator was unavailable.

LABORATORY

It was a microscopic center under RNTCP programme.

A complete building was assigned for laboratory purpose still the space was not judicially utilised.

Timings-Mon to Fri-9 am to 4 pm. Building had 2 working stations but, due to no water supply and no proper lighting facility, only one was utilised

Working station was small and congested for the 3 technician to work at a time, no free space to move. Room is damped due to leakage of water from water tank over the roof. Wooden almirah was also damped and swollen filled with cobweb.

Figure 24

Figure 25

Laboratory was almost well equipped according to the IPHS requirement.Power back up was with the inverter.

DOTS medicines and reagents were arranged on racks, with their expiry date clearly mentioned and pasted on the racks in separate room adjacent to laboratory

Figure 26

Patient waiting area: Patient waiting room is filled with dust and scrap material(wooden doors).

Figure 27

Figure 28

Utility: Toilet for patient was at the back side of the laboratory. 2 Utilities attached, but one was used by the staff for personal use and other one was not in working condition. Both were badly maintained, dirty and filled with cobwebs.

Figure 29

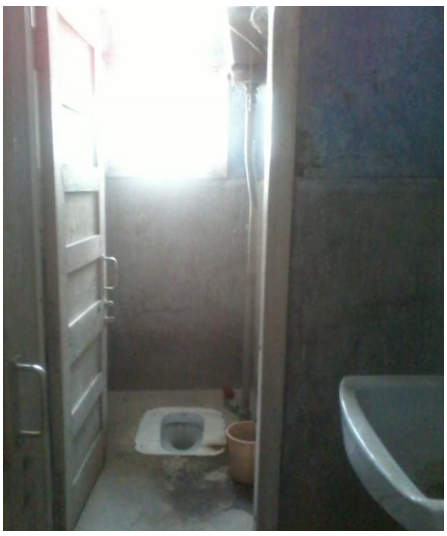


Figure 30

Diagnostic Services available:

Available laboratory tests	
a) Haematology	Haemoglobin estimation
	Total Leucocyte count
	Differential Leucocyte count
	Absolute Eosinophil count
	Reticulocyte count
	Total RBC count
	E.S.R.
	Malaria/Filaria Parasite
	Platelet count
	Blood grouping Rh typing
b) Urine Analysis	Urine for Albumin, Sugar bile salts, bile pigments, acetone,
c) Stool Analysis	Stool for Ovacyst (Eh)
	Hanging drop for V. Cholera
	Occult blood
II PATHOLOGY **Sputum**	
	Sputum cytology
IV SEROLOGY	VDRL
	Urine Pregnancy test
	WIDAL test
V BIOCHEMISTRY	Blood Sugar

Table 8

PHARMACY

Drugs were stored according to the labels. But in dispensing area the drugs were placed in card board open boxes. No system of storage was there.

Figure 31

Figure 32

Figure 33

Figure 34

Drugs like Isoxsuperine, Norethisterone which were prescribed by doctors, patient had to buy from stores as these medicine were not in supply of CHC but was a routine requirement for obstetric and gynaecological problems. Intra caths were purchased from the SKS funds, but paediatric intra caths were unavailable patient has to buy from nearby store. Along with the dispensing part, the pharmacist to maintain the OPD registrations, hence great load of patient near dispensing window at peak hours, as only one person and window to dispense the medicine.

Figure 35

One of the pharmacists is maintaining the injection room; she is injecting drugs to the OPD patients. Hub cutter and needle cutter was used and waste segregation was done properly.

Cold Chain:

Deep freezer and ILR were available.Cold chain was properly maintained, all the vaccines, ice packs and ice bags were available in adequate quantity, but has no back up with inverter.

Figure 36

Figure 37

8.2 HUMAN RESOURCE

Level and Category	*IPHS NORMS*	Sanctioned	In position (including those assigned to duties on attachement basis)	Recruited on contract basis
Superintendent Medical officer	1	2	1	
Public health Specialist	1	0	0	
PHN	1	2	1	
Doctors-	2	Total=11	5	1
(MBBS) Male			2	
(MBBS) Female			1	1
Dental surgeon	1		1	
Surgeons	1		0	
OBG specialists	1		0	
Anaesthetists	1		0	
Paediatricians	1		1	
Staff Nurses	10	Total=17	15	4(RCH)
Lab technicians	2	Total=3	2	1
LHVs		1	1	
ANMs		4	2	2
Pharmacist	1,+1	3	3	
Radiographer	1	1	1	
Ophthalmic assistant	1	1	1	
OT technician	1	0	0	
Counsellor	1	1	1	
Registration clerk	2	0	0	
Data entry operator	2	1	1	
Accounts assistant	1	1	1	
Administration assistant	1	0	0	
Dresser	1	0	0	
Ward boys/Nursing orderly	5	24	14	
Driver(may be out sourced)	1	1	1(permanent)	

Table 9

Human resource crunch regarding specialist was in the facility. Sanctioned post for doctors were 11 (including specialist) but only 6 were filled.Only Paediatrician post was filled, no other specialists were available. LMOs were newly recruited and were not EmOC trained.Class IV employees were outsourced and there contract expired in January but not yet renewed.

8.3 TRAINING STATUS

Only 2 doctors are trained, rest did not have any training. None of the doctors were BEmOC, EmOC and MTP trained.Out of 17 staff nurses only 1 nurse did not have any training. Table 11 gives information about training status of staff nurses.

Trainings	No. of Staff nurses trained
SBA	12
FIMNCI	13
NSSK	9
IUCD	8
PPIUCD	11
RTI/STI	3
BIOWASTE	3

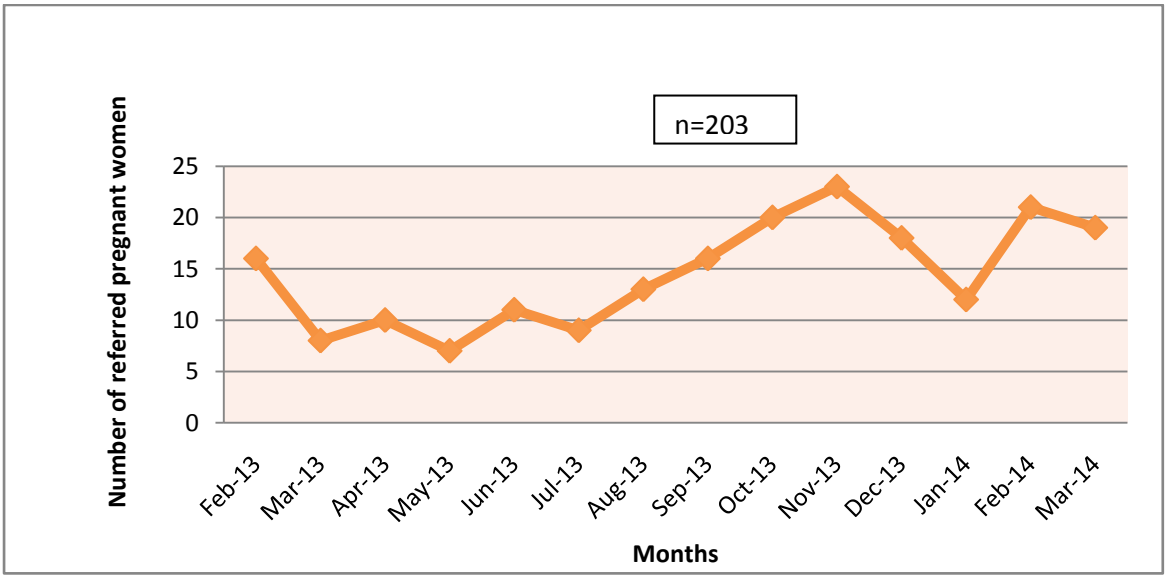
Table 10

8.4 REFERRAL SERVICE

102 Ambulance Service was efficient.But staff of facility asked the patient to call 102 from their personal phone, since no landline phone was available, it would be cumbersome to call if patient did not have a mobile.Referral from PHC to the CHC was less.Referral rate to DH was very high. Average 14.5 women/month were referred to DH Panipat(came for delivery)

From the figure 38 we can depict that number of referrals of pregnant women who came for delivery were in increase trend from period of Feburary 2013to March 2014 . Highest referrals (23) were in the month of November approximately 50% female were referred who came for delivery

Figure 38:Trends of Referred Pregnant Women from the facility



and from figure 39, the two major cause of referral in pregnant women who came for delivery were Anaemia (35%) and Non Progress of labour/Obstructed labour (22%).Thus we can con conclude that due to unavailability of blood storage facility and C-section most of them were referred to the district hospital.

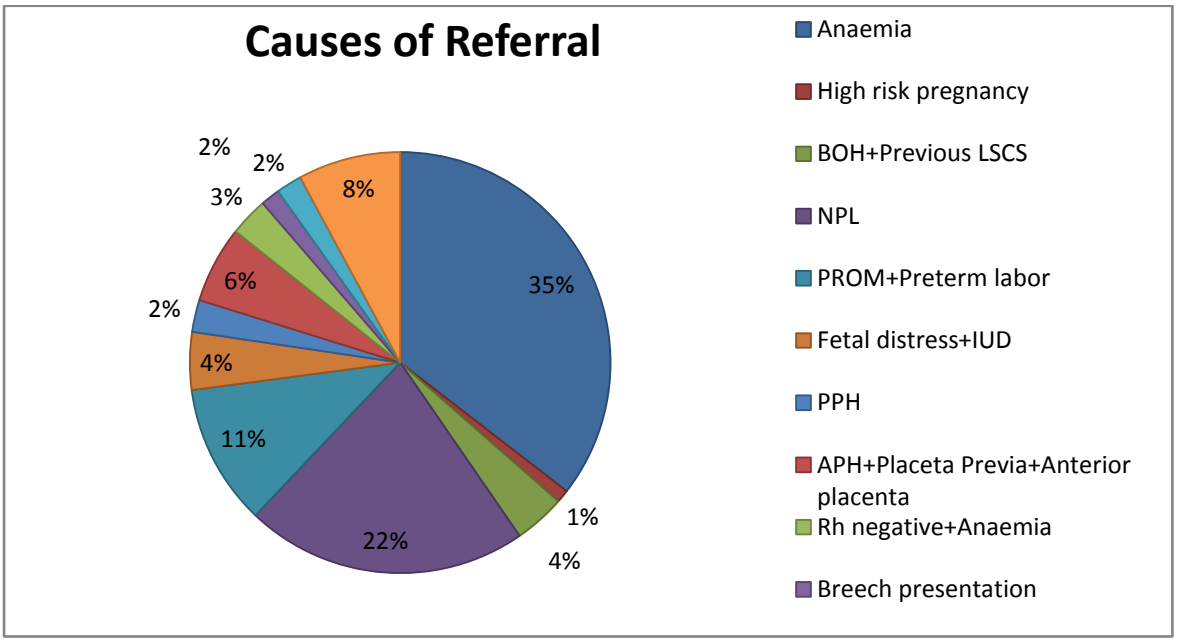


Figure 39: Cause of referral of pregnant women from the facility

Previously (1month back), Rh negative pregnant women were referred to DH as Inj. Anti D was not available.MTP facility was not available in the hospital, hence patient requiring/willing were referred to DH, Panipat. Mostly PHCs referred their patient directly to DH, after giving first aid.

8.5 SERVICE DELIVERY

Antenatal care

ANC Registration: Registrations of ANC were done by ANM and the ANC card was provided by ANM. No system of registration was available, who are visiting only the facility for their checkups. Most of the patient did not bring their old case paper in their visits. ANC card was not completely filled by ANM(only the first page and TT injection details).Detailed history taking and recording was practiced only by few doctors.

In Physical examination of pregnant women, vitals were not examined in any patient. Weight of pregnant women were not regularly checked at every visit of ANC**.** Blood Pressure was not regularly checked at every visit of ANC. Abdominal examination was done rarely (a patient of C-Section to examine her scar was examined in OPD without any privacy). Fundal Height was not regularly checked in every visit of ANC**.** Foetal Heart Sound was not examined due to unavailability of foetal Doppler. Internal examination i.e. PV examination was done only in preoperative examination for Tubectomy operative (examined in Labour room or in OPD by closing door). PV examinations for gynaecological problems were not practiced by the doctors. Privacy of patient was only maintained, if patient was examined in Labour room

Identification of danger sign occurring during pregnancy was examined, only if patient complained about it.

Management of severe Anaemia- Patient in last trimester were referred to DH Panipat due to unavailability of blood transfusion facility. Previously, due to unavailability of intra venous iron infusion in the facility, patient in second trimester were only treated with oral iron supplementation, which have been made available now.

Essential Laboratory investigation was done regularly after period of 2 month and every month in anaemic patient.

All ANCs were immunized with tetanus toxoid injection regularly. Nutrition counselling was done in anaemic patient only and if patient asked for it.

24X7 normal delivery services was available in the facility.

MTP services were not provided, due to unavailability of trained doctors.

Family planning services were available except for OC Pills which were not in stock since 1 month and laparoscopic sterilisation.

Only first aid was provided for the management of complication occurring during pregnancy and delivery, then these patients were referred to DH Panipat.

Provision of JSSK and JSY was available, most of the pregnant women had information of JSSK(partial)as free delivery but no knowledge about JSY .JSSK system was active, but diet facility was not available in the facility, patient were provided with a voucher of 100 Rs. given to the attendant of the female to buy fruits, from the shop authorised by the facility.

Intranatal care

24X7 Normal deliveries conducted by the staff nurses, but were not efficient enough to handle complications**.** Assisted and emergency obstetric surgery services were unavailable due to unavailability of gynaecologist or EmOC trained doctors and Anaesthetist. Staff nurses were trained in Managing labour with partograph but were performed in those patients who visited the facility in first stage of labour, mostly

patient came for delivery on complete dilation. Active management of labour and third stage of labour was efficient.

Deficiency in Infection prevention during delivery was observed like-Staff were not cleaning the perineum with antiseptic solution before PV examination. They were not using cap and mask during delivery.Delivery instruments were kept with cover on the stool and the used instrument on the stool; they did not use the kidney tray. Instrument like Sim‟s speculum after PV examination is not washed and directly transferred in the bleaching solution.Skin is not cleaned with spirit swab before putting intra cath or injecting injections.

Only first aid were given to manage the obstetric emergencies and then immediately shifted to DH Panipat for further management. Mostly deliveries are conducted by the staff nurses as doctors not available 24X7.

Neonatal care

Suction catheter for baby was reused without washing it and was not covered after use.

Immediate care of LBW newborns(>1800gm) was done only if the parameters of baby were in good condition or else they were referred to DH as paediatrician was not available round the clock or on call. LBW new born <1800 gm were directly referred to Panipat for the management.Vitamin K injections were not in supply since 4-5 months

Advice for immediate initiation of breast feeding and exclusive breast feed and wrapping the baby are given by the staff nurse.Zero day immunisation was given to all babies. Sick new born were mostly referred as Paediatrician was not available after OPD hours.

Postnatal care

Patient hospital stay ranged from 6 hours to 24 hrs after delivery; they mostly left the facility by taking LAMA.Post natal care from 0 to 3 days was available in the facility except for diet but the later PNC care of sending direction to the ANM of the concerned area for ensuring 7th & 42nd day post-natal home visits was not followed.

8.6 RECORDS

OPD patients:

Figure 40: Trends of Outdoor patients in the facility

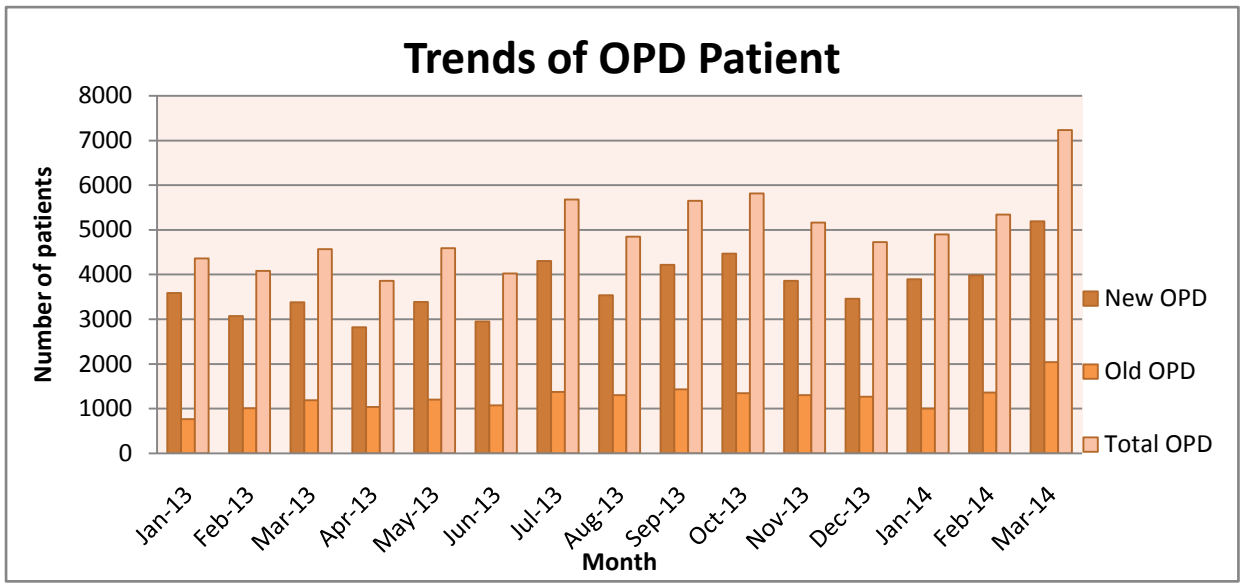


Figure 40 shows the trends of outdoor patient visiting the facility, which clearly shows that the number of OPD patients were in increasing trend (both for old and new). Number of new OPD was considerably high because majority of patients did not bring their old case paper in their next visit. On an average 166 patients per day were treated (including old and new).A doctor examined on an average 28 patients per day. According to the IPHS norms a doctor should examine approximately 150 patients per day at CHC level. But considering the above patient trend it almost negligible patient flow, considering the population of area and level of facility.

Indoor Patients:

Figure 41: Trends of Indoor patients in the facility

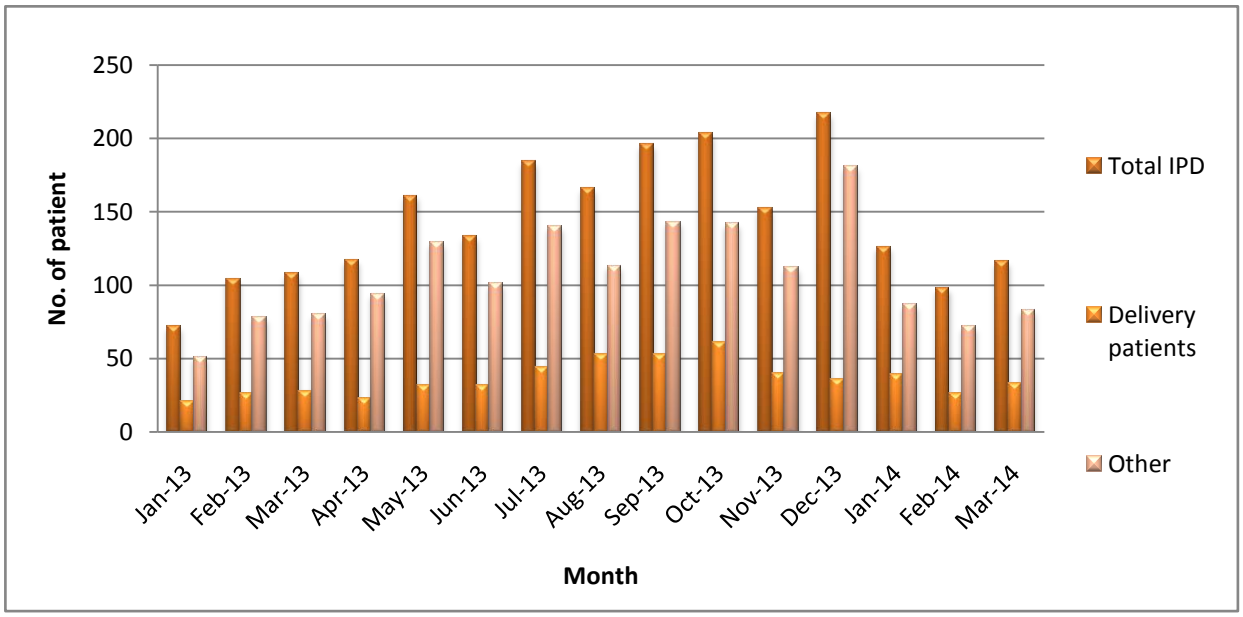
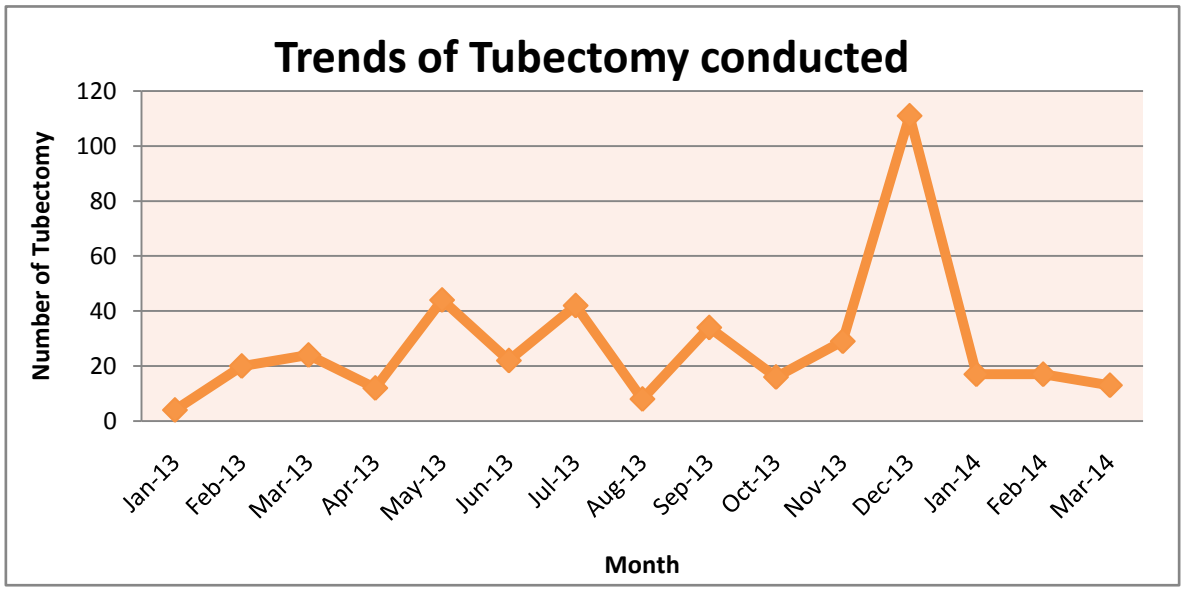


Figure 41 the shows the trend of Indoor admissions from period January 2013 to March 2014 which is in increasing trend from month of January till December then again it decreases, this fluctuation might be due to seasonal variation of diseases. Highest IPD admission were in the month of December. On an average 6

patients per day were admitted for treatment. Trend of deliveries in the facility was also fluctuating. Highest deliveries were recorded in the month of August, September and October. On an average 36 deliveries per month were conducted in the facility. Thus from this trend we can conclude that Indoor admission and deliveries were considerably low in the facility

Figure 42: Trends of Tubectomy operation conducted in the facility



Tubectomy:

In Figure 42 the number tubectomy performed in the facility were in same pattern. In the month of December, number of tubectomy performed were highest due to a major camp. On an average 28 tubectomy per month are conducted.

8.7 SITUATION ANALYSIS & BENEFICIARY PERSPECTIVE FOR AVAILABILITY OF SERVICES

24 OPD ANCs (6 were first visitors) of all trimester and 8 IPD PNCs were interviewed for their opinion on availability of services in the facility.

Findings were-

Demographic Profile	
Age	
<15	0
15-19	2
20-24	20
25-29	5
30-34	5
>34	0
Education	
Uneducated	8
Primary	4
Secondary	9
Higher secondary	5
Graduation	4
Others	2
Occupation of Husband	
Labour	10
Job	5
Shopkeeper	5
Unemployed	1
Others	3
Income of Husband	
Don't know	3
10,000-25,000	1
25,000-50,000	2
50,000-1,00,000	12
1,00,000-1,50,000	4
1,50,000-2,00,000	0

Table 11 : Demographic profile of females who availed ANC and PNC services in the facility.

Table 11 predict that nearly two third (62%)females who availed the ANC and PNC facilities were in the age group 20-24 whereas 16% where found to be in age group of 30-34 and rest 6% were in age group 15-19.

It was surprising to note that one of four (25%) females who availed the ANC and PNC facilities were found to be uneducated, little more than one fourth(28%) had an education up to higher secondary level whereas only 13% females were graduate, which shows that even the uneducated females are aware of importance of antenatal check up and institutional delivery. But it also highlights the fact that the level of education of women in this area was poor.

Out of 24 OPD respondents 41% female spouse had prime occupation as labour work and had income between 50,000to 1,00,000 per annum. We can conclude that females of low socioeconomic status mostly prefer to avail treatment from the government hospital due to its free services.

Table 12: Obstetric profile of females who availed ANC and PNC services in the facility

Obstetric profile	
Gravida	
Primi Gravida	6
Second Gravida	13
Third Gravida	2
Fourth Gravida	4
Fifth Gravida	1
Sixth Gravida	1
Parity	
Nullipara	5
Primi para	13
Second para	10
Third Para	4

Table 12 shows that, 48% females were second gravida, 22% were primi gravida, 5th and 6th gravida females were also present but their parity profile was 41% females were primi para and 12% were third para which indicates that most of the females had underwent recurrent abortions.

Figure 43: Distribution of person who recommended or referred the female to avail the treatment in the facility

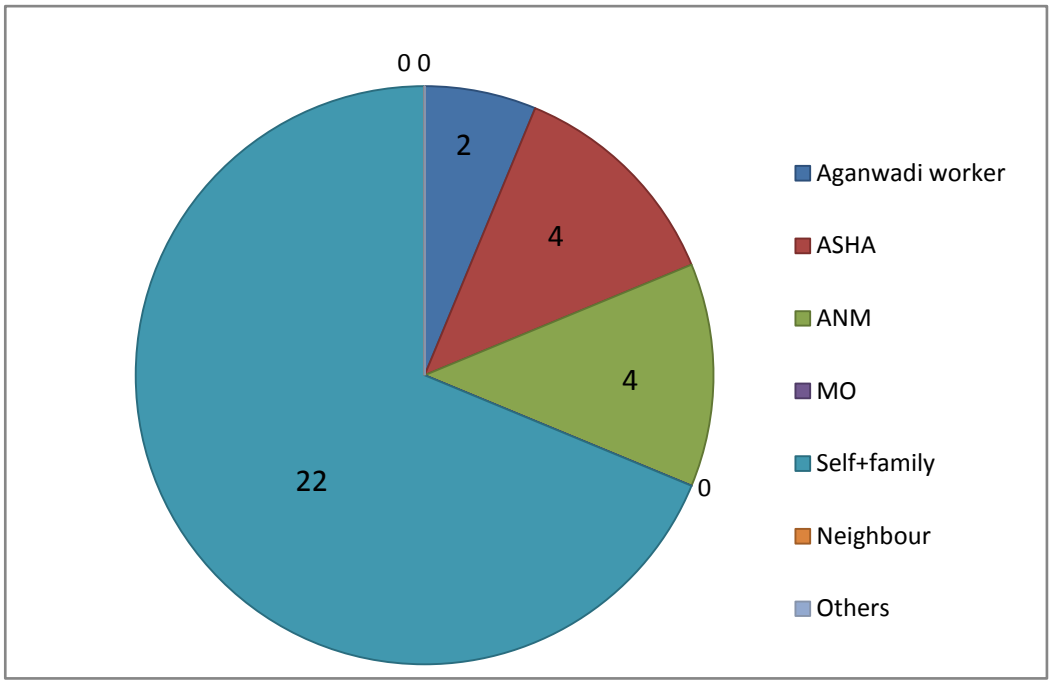


Figure 43 which shows the person who recommended or referred the female to the facility were link persons like Anganwadi worker(6%), ASHA(12%), ANM(12%), Medical Officer(0), Self and family members(69%), Neighbours and others (0). From this distribution we can conclude that three fourth females were self motivated to visit the facility for ANC check up and delivery which indicates the increase in awareness of ANC check up and institutional delivery among them and among link persons ASHA and ANM were playing the key role.

Figure 44: Frequency of visit by the female to the facility to avail the treatment in the facility

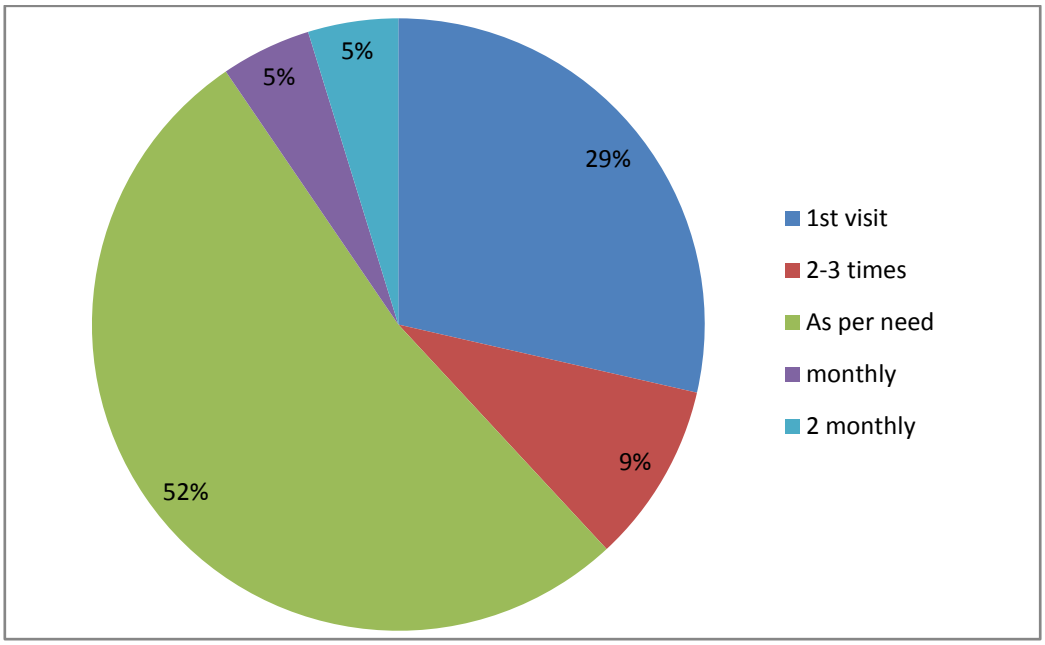
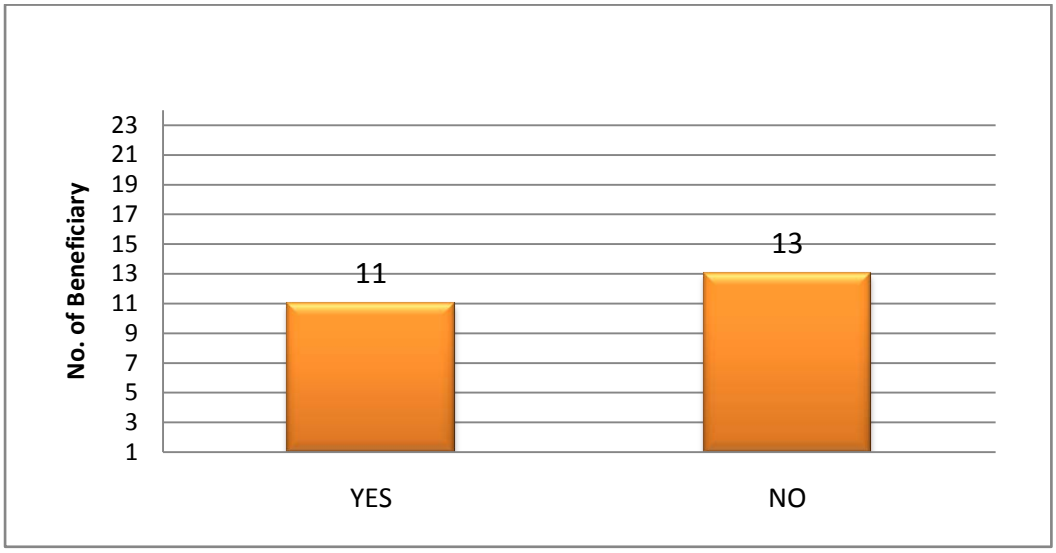


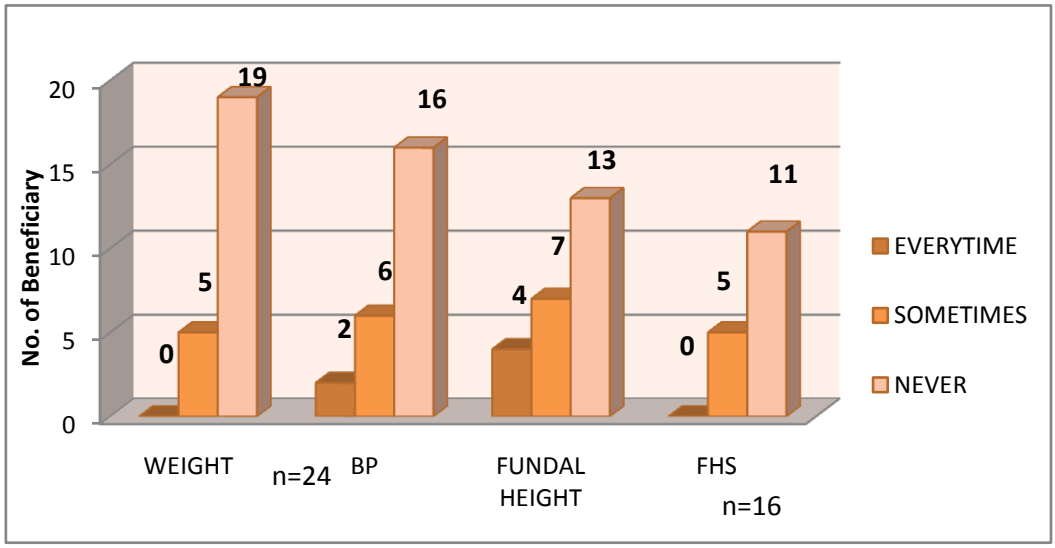
Figure 44 shows that out of 24 OPD ANCs visiting the facility, half of the whole responded that they visited the facility as per their need, or if they have any problem which could be once in complete pregnancy or weekly, this shows that the females were unaware of importance regular ANC visits.

Figure 45: Status of ANC registration of the ANC beneficiaries by the availability of ANC card



For the status of ANC registration, ANC card availability was taken as an indicator. Above figure 45 states that, out of 24 ANC patients, 45 percent (11) females had ANC card but out these 11 cards, 10 were partially filled with only TT details only 1 card was completely filled and rest 60 percent females did not have ANC card, this shows that there was poor registration system of pregnancy in the facility and also poor link with the ANMs.

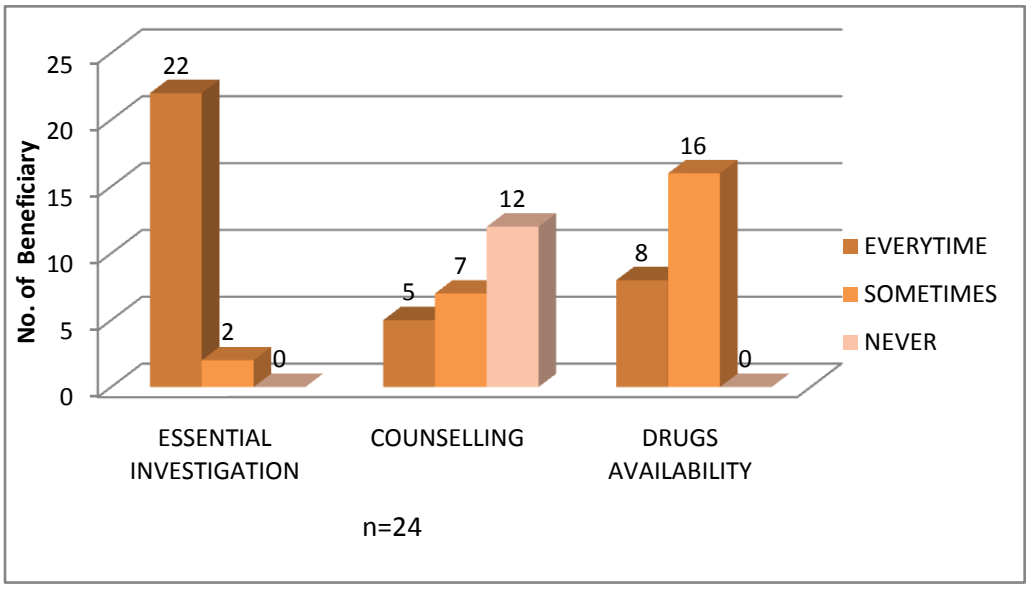
Figure 46: Status of availability of Physical examination service during the ANC check up



Examination of weight, blood pressure, fundal examination and foetal heart sound during each visit of ANC check up is an integral part of ANC service delivery. From the above figure it is evident that none of them responded that they were weighed every time they visit the facility for checkup , one fourth responded sometimes, three fourth that they were never weighed. 67 percent female responded that blood pressure was never measured 25 percent responded sometimes and only 8 percent responded never, during their each visit to the facility. More than half respondents responded that fundal height was never examined even once during their visit. Out of16 women who were in second trimester and third trimester foetal heart sound were

never monitored in 70 percent women in their visits, thus we can conclude that status of this service was very poor, mainly for foetal heart sound which is a crucial examination for viability of foetus.

Figure 47: Status of Laboratory services, counselling for IFA & nutrition, Drug availability



According to the guidelines a pregnant woman should be given two doses of tetanus toxoid injection and investigated for haemoglobulin, urine, HIV, etc. In figure 47 approximately 90 percent women responded that they were immunized with tetanus toxoid according to schedule and investigated for essential laboratories in the facility every time they visit the facility. ANCs should be counselled for nutrition and iron folic acid tablet consumption.Half of the ANCs responded that were never counselled about nutrition and iron tablet consumption, one fourth responded sometimes and one fourth as every time during their each visit to the facility. More than 60 percent ANC women responded that they receive the prescribed drugs sometimes in every visit to the facility and fourty percent responded they receive the drugs every time. Thus we can conclude that the laboratory services and drug availability services were good in the facility, where as the counselling services was average.

According to guidelines, the postnatal women should be counselled for newborn care and babies should be weighed and immunized with zero dose. Above figure 48 shows that, out of 8 PNC women, three fourth PNCs responded that their babies were weighed after birth, staff nurses explained and counselled them about initiation of breastfeeding, newborn care and exclusive breast feeding and zero dose of immunization was given. Thus we can conclude that the postnatal services were up to the mark in the facility.

Figure 48: Status of Post natal services in newborn care

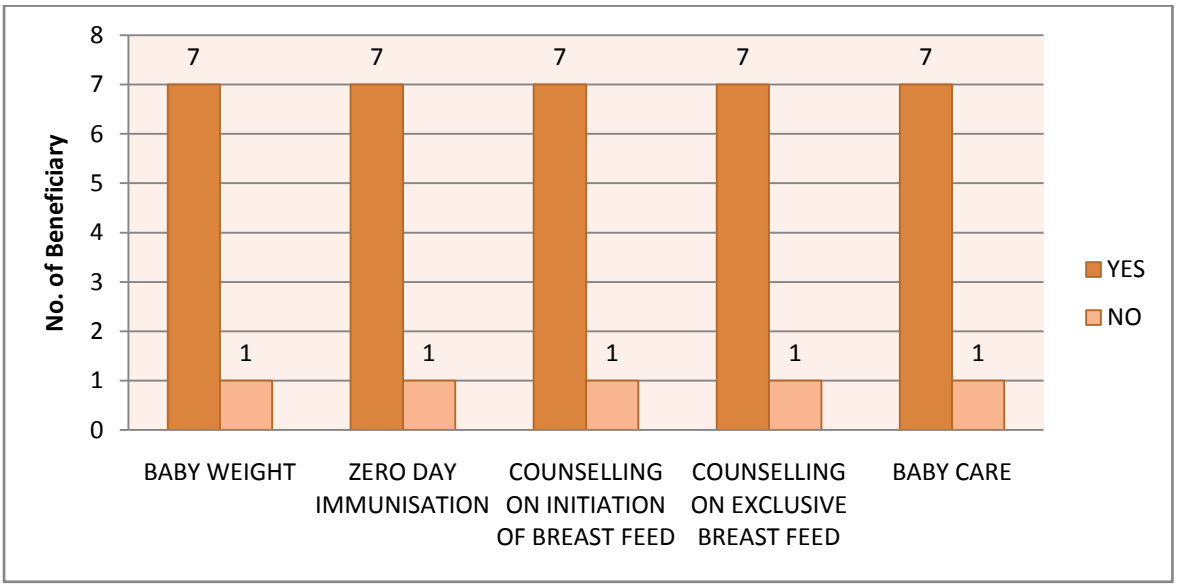


Figure 49: Patient's perception of satisfaction for availability of ANC and PNC services in the facility

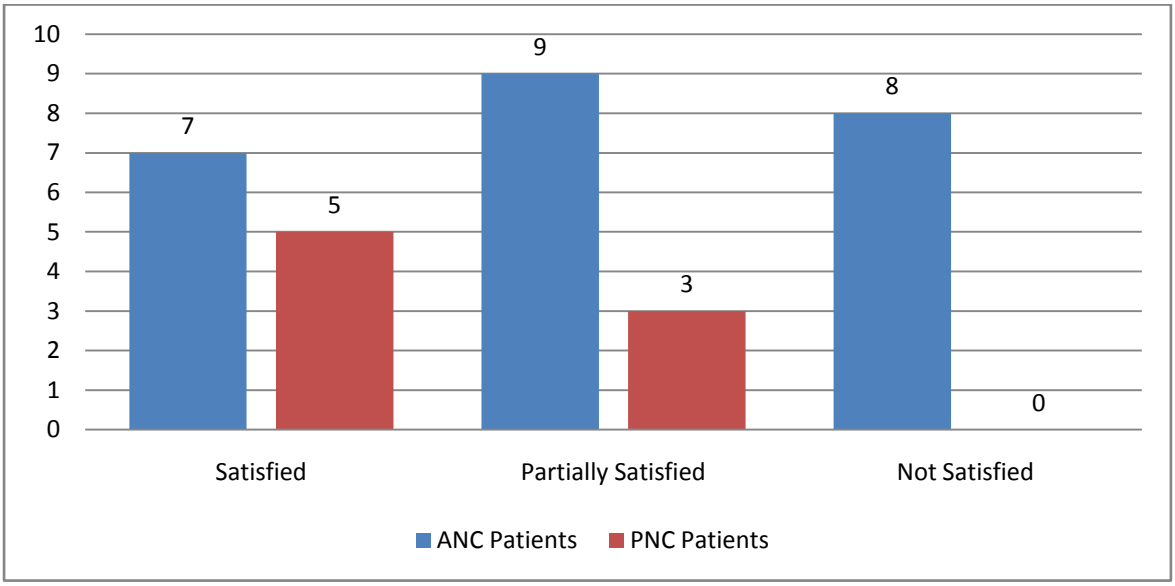


Figure 49 depicts that more than one third ANC patients were partially were partially satisfied with the availability of services, one third were not satisfied and less than one third were completely satisfied. Where as 60 percent PNC patients were completely satisfied with the availability of postnatal services and rest 40 percent were partially satisfied. PNC patients were more satisfied than the ANC patients. Thus we can conclude that Postnatal services were much better provided than the Antenatal services in the facility

8.8 OTHER FINDINGS

ANM advised sonography test from local private practitioner to the ANCs

False reporting of PPIUCD insertion on case paper.

Non ambulatory patient were carried by their relatives.

Majority of the women visiting facility were found to be anaemic.

9. CONCLUSION

CHC Samalkha is a non operational FRU though it was designated as FRU in records, as it was not fulfilling the critical determinant of FRU.

Infrastructure is poor except for labour room and lack of administration was observed.

Staff was not inherently motivated to take initiative.

Human resource crunch regarding specialist was observed

Facility was equipped to handle obstetric emergencies, except for surgeries, but lack skilled manpower to perform it.

Referrals to higher centers were high, in deliver patient mainly due to Anaemia and Non progress of labour, because deliveries were mainly conducted by staff nurses and facility of assisted deliveries, emergency services and blood facility was unavailable.

24X7 Normal delivery facility was available. Safe abortion facility was unavailable,

Physical examination and counselling of ANCs in every visit was not religiously followed. Essential laboratory services and immunisation services were properly given.

Out of pocket expenditure was there for drugs and sonography services.

LBW babies were not managed in the facility due to lack of availability of paediatrician round the clock or on call.

Bed occupancy rate and patient load on FRU was average.

Anaemia was prevalent among women. Neonatal death and abortions were high (according to the interview taken from beneficiary)

Malpractices were observed in the facility.

10.POSSIBLE STRATEGIES

First aim should be to make it operationalise.

Infrastructure problem can be resolved by judicious planning, and efficient administration as adequate free space is available and rooms which were unused.

Auction of condemn stock can relieve the pre occupied space.

Biometrics system and strict administrative action can overcome the problem of absenteeism.

LMO can be trained in EmOC and MTP.

Performance based incentives should given to Doctors, Nurses, ANMs.

Monthly scrutiny of the facility should be done by administration, and Staff can be motivated to take initiative by giving recognition and awarded for their initiatives.

Drugs like Isoxsuperine, progesterone derivative can be purchased from untied funds.

To overcome overcrowding at pharmacy additional window can be opened and pharmacist who was handling injection room should engaged and in injection room a staff nurse should be appointed.

Public private partnership for anaesthetist and sonography.

By administrating IV Iron Injection prevalence of anaemia can be reduced by many folds.

Proper channelizing of ANCs to ANM for registration purpose. Co-ordination between LMO and ANM can be made since sub center is in the same premises, ANM can be oriented by LMO regarding ANC check ups.

Diet facility can be made available by out sourcing it.

After delivery , staff nurse can inform ANM so that they can track them for PNC

Staff nurse can be reoriented for infection prevention by LMO.

Strict action should be taken against malpractices.

A channelized system for ANC check up can be followed.

Registration ⟶ Physical examination ⟶ Consultation by LMO ⟶ Medication/Laboratory.

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12. ANNEXURES

12.1) Checklist for FRU

INFORMED CONSENT

Respected Sir

My name is ---------- and I am from State Institute of Health and Family welfare Haryana, Panchkula conducting a study to assess the current status of First Referral Units in context of their infrastructure , manpower and service delivery system regarding Mother and New born care in your facility.I will observe the service delivery system and interview the staff.

Need yours and staffs co-operation . Information you provide will be kept strictly confidential and used only for research. Hope for your kind support.

May I begin with my study.

Name of the FRU Incharge

Date

Signature

FRU CHECKLIST

Name of FRU	
District	
Name of in charge	
Designation	
Population	

A) SITE

Connecting facilities	Distance	Time taken to travel to FRU

B)INFRASTRUCTURE

Bed strength	

Bed occupancy rate	Average-	
SERVICES	**Availability**	**Remark**
Functional OT		
Fully operational Labour Room		
Functional Laboratory		
Blood storage unit		
24 hrs water supply		
Waste disposal system		
Electricity with backup in OT and labour room		
Cold chain and blood storage facility		
Telephone		
Ambulance(self/ hired)		
Separate Utilities		
Radiography		

B.1 PHYSICAL INFRASTRUCTURE

	Availability	**Remark**
On –the- way signage on all the approach roads.		
Intact Boundary Wall with gate		
Display Board of name of FRU at the entrance		
Fire Fighting equipment		

ENTRANCE ZONE

Signages Display board in local language for service available and timing of the		

institute.		
Directional & layout signages for department(bilingual and pictorial)		
Directional & layout signages for utilities(bilingual and pictorial)		
Citizen charter displayed at OPD and entrance		
Saftey, hazard and caution signs		
Barrier free environment		
Ramps, hand railing		
Registration cum Inquiry counter		
Pharmacy and drug dispensing storage		
Clean utilities		
Separate utilities		

OPD

Display of Department, doctors name, timing and user charges		
Medicine department		
General Surgery department		
Obstetrics & Gynaecology department		
Paediatric department		
Family welfare department		
OPD SUPPLIES		
doctor‟s table, chair,		
patient‟s stool,		

follower‟s seat, washbasin with hand washing facilities, examination couch equipment for examination.		
Cleanliness, hygiene Light Airy and spacious		
Waiting room for patient		
Emergency Room		
Minor OT		
Injection and dressing room		
Observation Room		
Ward (Separate for male and female)		

NURSING STATION

Spacious hand washing facilities, sinks, dressing tables with screen in between colour coded bins (as per IMEP guidelines for community health centres).		
Hub cutters and needle destroyers. Examination and dressing table.		

PATIENT AREA

Enough space between beds. Toilets; separate for males and females. Separate space/room for patients needing isolation		

ANCILLARY ROOMS

Nurses rest room. an area separating OPD and Indoor facility.		
Central Sterilization SupplyDepartment		
Laundry		

ADMINISTRATIVE ZONE

Offices Stores		
Staff Quarter		

C) LABOUR ROOM

	Availability	Remark
Patient waiting Area.		
Recovery room.		
Staff area.		
Storage area for sterile supplies.		
Scrub area.		
Instrument sterilization area.		
Disposal area.		
Newborn care Corner		

C.1.)INSTRUMENT FOR VAGINAL EXAMINATION

Equipment	Availability	REMARKS
Sim"s /Cusco"s vaginal speculum	a) Available and used b) Available but not used c) Not available	
Anterior vaginal wall retractor	a) Available and used b) Available but not used c) Not available	
Sterile Gloves	a) Available and used b) Available but not used c) Not available	
Sterile cotton swabs and swab sticks in jar with lid	a) Available and used b) Available but not used c) Not available	
Kidney tray for keeping used instruments	a) Available and used b) Available but not used c) Not available	
Bowl for antiseptic solution	a) Available and used b) Available but not used c) Not available	
Steel tray with lid to keep sterile/ HLD instruments for use	a) Available and used b) Available but not used c) Not available	
Antiseptic solution: povidone iodine	a) Available and used b) Available but not used	

	c) Not available	
Cheatle forceps with a dry bottle to hold it	a) Available and used b) Available but not used c) Not available	
Proper light source	a) Available and used b) Available but not used c) Not available	

COMMENT- .....

C.2.) FOR DELIVERY

Equipment	Availability	REMARK
A labour table with foam mattress, Macintosh and Kelly‟s pad	a) Available and used b) Available but not used c) Not available	
Shadow less lamp	a) Available and used b) Available but not used c) Not available	
Wheel chair	a) Available and used b) Available but not used c) Not available	
Cabinet Instrument	a) Available and used b) Available but not used c) Not available	
Dressing drum	a) Available and used b) Available but not used c) Not available	
Trolley for Patient	a) Available and used b) Available but not used c) Not available	
Instrument trolley	a) Available and used b) Available but not used c) Not available	
I/V Stands	a) Available and used b) Available but not used c) Not available	
Suction Machine	a) Available and used b) Available but not used c) Not available	
Facility for Oxygen Administration	a) Available and used b) Available but not used c) Not available	

Sterilisation equipment- Autoclave	a) Available and used b) Available but not used c) Not available	

SUPPLIES

24 hr running water(Wash Basin)		
Electricity supply with back up		
Attached toilet facility		
Cleaniness		
Ventilation		
Privacy		
Drugs		
Emergency drug tray-		
Inj. Diazepam Tab. Nifedepin Inj. Magnesium sulphate Inj. Lignocaine Hydrochloride Inj. Gentamicin		
Sterilised cotton and gauze		
Adequate number of gloves		
Sterile syringes and needles		
Sterile drip I/V sets		
Delivery Kits Kit I- Normal delivery kit Surgical kits Forcep delivery kit Vaccum delivery		
Inj. Vitamin K		

KIT-I NORMAL DELIVERY KIT			
Equipments	**Standard Quantity**	**Availability**	**REMARK**
Trolley , dressing carriage size 76cm long x46cm wide and 84 cm high	1EA	a) Available and used b) Available but not used c) Not available	
Towel , trolley 84cmx 54cm	1EA	a) Available and used b) Available but not used c) Not available	
Gown, operation, cotton	1EA	a) Available and used b) Available but not used c) Not available	
Cap. Operation, surgeon‟s 36x46cm	1EA	a) Available and used b) Available but not used c) Not available	
Gauze absorbent non-sterile 200mmx 6m	2EA	a) Available and used b) Available but not used c) Not available	
Tray instrument with cover 450mm(L)x300mm(W)x80mm(H)	1EA	a) Available and used b) Available but not used c) Not available	
Macintosh, operation, plastic	1EA	a) Available and used b) Available but not used c) Not available	
Mask, face, surgeon‟s cap rear ties: B)Beret type with elastic hem	1EA	a) Available and used b) Available but not used c) Not available	
Towel, glove	1EA	a) Available and used b) Available but not used c) Not available	
Cotton wool absorbent non-sterilize 500G	2EA	a) Available and used b) Available but not used c) Not available	
Drum, sterilizing cylindrical - 275mm Dia x 132mm, ss	2EA	a) Available and used b) Available but not used c) Not available	

Table instrument adjustable type with tray ss	1Set	a) Available and used b) Available but not used c) Not available	

COMMENTS

NEW BORN CARE AREA

SERVICES		
Care at birth		
Resuscitation		
Provision for warmth		
Early initiation of breast feeding		
Weighing the neonate		
Electricity supply		
Ventilation		
Cleanliness		
Equipment	**Availability**	**REMARKS**
Radiant Warmer with trolley	a) Available and used b) Available but not used c) Not available	
Drawers	a) Available and used b) Available but not used c) Not available	
Oxygen Bottles	a) Available and used b) Available but not used c) Not available	
Resuscitator(hand operated)	a) Available and used b) Available but not used c) Not available	
Neonate weighing scale	a) Available and used b) Available but not used c) Not available	
Suction Pump(foot	a) Available and used b) Available but not used	

operated)	c) Not available	
I/V cannula 24, 26G	a) Available and used b) Available but not used c) Not available	
Examination light, mobile 220-12V	a) Available and used b) Available but not used c) Not available	
Mucus extractor, 20ml, sterile,disposable	a) Available and used b) Available but not used c) Not available	
Dee Lee Towel for drying wrapping baby	a) Available and used b) Available but not used c) Not available	
Feeding Tube	a) Available and used b) Available but not used c) Not available	
Oxygen cylinder	a)Available and used b) Available but not used c) Not available	
Sterile Gloves	a) Available and used b) Available but not used c) Not available	
Kit N: Equipment for Neonatal Resucitation	a) Available and used b) Available but not used c) Not available	

Kit N-Neonatal Resuscitation

Equipments	Standard quantity	Availability	Remarks
Catheter, mucus, rubber, open ended tip, size 14FR	2EA	a) Available and used b) Available but not used c) Not available	
Catheter, nasal, rubber, open tip, funnel end, size 8Fr	2EA	a) Available and used b) Available but not used c) Not available	
Catheter, endotracheal, open tip, funnel end	3EA	a) Available and used b) Available but not used	

rubber, 12Fr		c) Not available	
Stilette, curved, for stiffening tracheal catheter SS	1EA	a) Available and used b) Available but not used c) Not available	
Catheter, suction, rubber, size 8Fr	3EA	a) Available and used b) Available but not used c) Not available	
Laryngoscope, infant, w/three blades and spare bulbs.	1EA	a) Available and used b) Available but not used c) Not available	
Lateral mask, with ventillatory bag, infant size	2EA	a) Available and used b) Available but not used c) Not available	
Resuscitator, automatic, basinet type	1EA	a) Available and used b) Available but not used c) Not available	
Lamp, ultra-violet (heat source) with floor stand	1EA	a) Available and used b) Available but not used c) Not available	
Cells for laryngoscope	2EA	a) Available and used b) Available but not used c) Not available	

COMMENTS/NOTES- .....

D) Operation Theatre

Operation theatre		
Patient waiting Area.		
Pre-operative room		
Post operative(recovery) room.		
Staff area.		
Changing room separate for males and females.		
Storage area for sterile supplies.		
Operating room/Labour room.		

Scrub area.		
Instrument sterilization area.		
Disposal area.		
Newborn care Corner		

Equipment	Availability	REMARKS
Diathermy machine	a) Available and used b) Available but not used c) Not available	
Dressing drum all sizes	a) Available and used b) Available but not used c) Not available	
Lamp shadowless: Celing lamp, portable type	a) Available and used b) Available but not used c) Not available	
Steriliser	a) Available and used b) Available but not used c) Not available	
Suction apparatus	a) Available and used b) Available but not used c) Not available	
Stand with wheel for single basin	a) Available and used b) Available but not used c) Not available	
Table operation, hydraulic: Major,Minor	a) Available and used b) Available but not used c) Not available	
Trolley for patients	a) Available and used b) Available but not used c) Not available	
Trolley for instruments	a) Available and used b) Available but not used c) Not available	
X-ray view box	a) Available and used b) Available but not used c) Not available	
Wheel chairs	a) Available and used b) Available but not used c) Not available	

E.2.) Anaesthesia Equipments for OT

Equipment	Standard quantity	Availability	REMARKS
Facemask, plastic w/rubber cushion & headstrap, set of 4	4set	a) Available and used b) Available but not used c) Not available	
Airway Guedel or Berman, autoclavable rubber, set of 6	1set	a) Available and used b) Available but not used c) Not available	
Laryngoscope, Set with infant, child, adult blades	3set	a) Available and used b) Available but not used c) Not available	
Catheter ,endotracheal w/cuff, rubber set of 4	1set	a) Available and used b) Available but not used c) Not available	
Catheter, urethral, stainless steel, set of 8 in case	1set	a) Available and used b) Available but not used c) Not available	
Forceps, catheter, Magill, adult and child sizes, set of 2	1set	a) Available and used b) Available but not used c) Not available	
Connectors, catheter, straight/curved,3, 4, 5mm(set of 6)	1set	a) Available and used b) Available but not used c) Not available	
Cuffs for endotracheal catheters, spare for item 4	1EA	a) Available and used b) Available but not used c) Not available	
Breathing tubes, hoses, connectors for item 1, anti-static	1set	a) Available and used b) Available but not used c) Not available	
Valve, inhaler, chrome-plated brass, Y-shape	1EA	a) Available and used b) Available but not used c) Not available	
Bag, breathing, self-inflating, anti-static rubber, set of 4	1set	a) Available and used b) Available but not used c) Not available	
Vaporiser, halothane, dial setting	1set	a) Available and used b) Available but not used c) Not available	
Vaporiser, ether or methoxyflurane, wick type	1EA	a) Available and used b) Available but not used c) Not available	

IV set in box	6EA	a) Available and used b) Available but not used c)Not available	
Needle, spinal, stainless set of 4	1Set	a) Available and used b) Available but not used c) Not available	
Syringe, anaesthetic, control 5ml Luer mount glass	2EA	a) Available and used b) Available but not used c) Not available	
Cells for item laryngoscope	3EA	a) Available and used b) Available but not used c) Not available	

INSTRUMENTS AVAILABLE IN CHC

Equipment	**Quantity**	**Availability**	**Remark**

E) BLOOD STORAGE FACILITY

Space		
Well lighted		
Clean		
Air conditioned(optional)		
Manpower		
Medical officer		
Technician		
24 hrs electricity with back up generator		
Equipment		
Blood bag Refrigerator		
Deep freezer for ice pack		
Insulated carrier boxes		

Microscope and centrifuge		
Consumables		
Pasteur pipette		
Glass tubes glass slides		
Test tube racks		
Rubber teats		
Gloves		
Blotting tissue paper		
Marker pencil (alcohol based)		
Tooth picks		
Reagents- Anti A Anti B Anti AB Anti D		
Cold chain		
Records		

Storage-

.....

.....

Issue of blood -

.....

.....

Disposal of Blood-

.....

.....

COMMENTS

F) HUMAN RESOURCE

Level and Category	**IPHS NORMS**	**Sanctioned**	**In position (including those assigned to duties on attachement**	**Recruited on contract basis**

			basis)	
Superintendent Medical officer	1			
Public health Specialist	1			
PHN	1			
Doctors-				
(MBBS) Male				
(MBBS) Female	2			
Dental surgeon	1			
Surgeons	1			
OBG specialists	1			
Anaesthetists	1			
Paediatricians	1			
Staff Nurses	10			
Lab technicians	2			
LHVs				
ANMs				
Pharmacist	1,+1			
Radiographer	1			
Ophthalmic assistant	1			
OT technician	1			
Counsellor	1			
Registration clerk	2			
Data entry operator	2			
Accounts assistant	1			
Administration assistant	1			
Dresser	1			

Ward boys/Nursing orderly	5			
Driver(may be out sourced)	1			

COMMENTS/NOTES- .....

G) TRAINING STATUS

Level and Category	Trained in	Trained in year
Medical Officer		
Nursing Staff		
ANM		

H) REFERRAL TRANSPORT

.....
.....
.....

I) LABORATORY SERVICES

a) Haematology	Haemoglobin estimation	
	Total Leucocyte count	
	Differential Leucocyte count	
	Absolute Eosinophil count	
	Reticulocyte count	
	Total RBC count	
	E.S.R.	
	Peripheral Blood Smear	
	Malaria/Filaria Parasite	

	Platelet count	
	Packed Cell volume	
	Blood grouping	
	Rh typing	
	Blood Cross matching	
b) Urine Analysis	Urine for Albumin, Sugar bile salts, bile pigments, acetone, specific gravity, Reaction (pH)	
c) Stool Analysis	Stool for Ovacyst (Eh)	
	Hanging drop for V. Cholera	
	Occult blood	
II PATHOLOGY a) Sputum	Sputum cytology	
III MICROBIOLOGY	Smear for AFB, KLB	
	Grams Stain for Throat swab, sputum etc.	
IV SEROLOGY	VDRL	
	Pregnancy test (Urine gravindex)	
	WIDAL test	
V BIOCHEMISTRY	Blood Sugar	
	Blood urea	

	Liver function tests	
	Kidney function tests	
	Blood lipid profile	

J)DRUGS

J.1.) Drugs for emergency obstretics

Drugs	Standard required	Available	Remark

J.2.) Drug Kit for Sick Newborn & Child Care - FRU/CHC

Drugs	Standard required	Available	Remark

J.3.) List of Other Essential Drugs for CHC

Drugs	Standard required	Available	Remark

COMMENTS .....

RECORDS

	Normal Delivery	Forcep Delivery	C-Section
March2012-13			
March2013-14			
	NEW OPD	**OLD OPD**	**TOTAL OPD**
March2012-13			
March2013-14			

TOTAL IPD	
March2012-13	
March 2013-14	

REFERRALS	
MONTH	**CAUSE**

SERVICE DELIVERY FRAMEWORK

A) Antenatal Care

	Services	Availability		Remarks
1	Registration (within 12 weeks)	a)Yes b)No		
2	History taking	a)Regularly b)Occasionally c)Never		
3	Physical Examination A) ANC Checkup	a)Regularly b)Occasionally c)Never		

	B) Gynaecological problems C) Pre operative examination (tubectomy)	a)Regularly b)Occasionally c)Never a)Regularly b)Occasionally c)Never		
4	Weight	a)Regularly b)Occasionally c)Never		
5	Blood Pressure	a)Regularly b)Occasionally c)Never		
6	Abdominal examination	a)Regularly b)Occasionally c)Never		
7	Identification of danger sign (if any)	a)Regularly b)Occasionally c)Never		
8	Ensuring consumption of at least 100 IFA (for all pregnant women) 200 (for anaemic women)	a)Regularly b)Occasionally c)Never		
9	Management of severe anaemia	a)Regularly b)Occasionally c)Never		
10	Blood transfusion	a)Regularly b)Occasionally c)Never		
11	Essential lab investigations	a)Regularly		

		b)Occasionally c)Never		
12	Pregnancy test	a)Regularly b)Occasionally c)Never		
13	HB%	a)Regularly b)Occasionally c)Never		
14	Urine for Albumin	a)Regularly b)Occasionally c)Never		
15	Urine for sugar	a)Regularly b)Occasionally c)Never		
16	Blood Group& Rh type	a)Regularly b)Occasionally c)Never		
17	VDRL	a)Regularly b)Occasionally c)Never		
18	HIV testing	a)Regularly b)Occasionally c)Never		
19	Counselling of HIV mother	a)Yes b)No		
20	TT immunisation	a)Regularly b)Occasionally c)Never		

21	Counselling on nutrition	a)Regularly b)Occasionally c)Never		
22	Counselling on Birth preparedness	a)Regularly b)Occasionally c)Never		
23	Institutional delivery(24X7)	a)Yes b)No		
24	Safe abortion	a)Yes b)No		
25	Family Planning	a)Yes b)No		
26	Management of complications in pregnancy referred	a)Yes b)No		
27	Provisions of Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK) as per guidelines.	a)Yes b)No		

B) Intranatal Care

	Services	Availability		Remarks
1	24 hrs Normal delivery	a)Yes b)No		
2	Managing labour with use of partograph	a)Regularly b)Occasionally c)Never		
3	Active management of labour	a)Yes		

		b)No		
4	Infection Prevention	a)Yes b)No		
5	Identification of danger signs	a)Yes b)No		
6	Comprehensive Management of all Obstetric emergencies , e.g. eclampsia, PPH, shock	a)Yes b)No		
7	Episiotomy and suturing cervical tear	a)Yes b)No		
8	24 hrs Assisted vaginal deliveries like outlet forceps, vaccum	a)Yes b)No		
9	In house blood storage center	a)Yes b)No		
10	Essential and Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions	a)Yes b)No		
11	Referral linkages with higher center	a)Yes b)No		

C) Postnatal Care

	Services	**Availability**		**Remarks**
1	48 hrs stay post delivery post delivery and all the postnatal services for zero and third day to mother and baby	a)Yes b)No		
2	Clinical management of all maternal emergencies such as PPH, Puerperal sepsis, Eclampsia, Breast abscess shock			

3	Clinical management of postnatal complication such as RH incompatibility etc.	a)Yes b)No		
4	Referral to higher centers	a)Yes b)No		
5	Ensure post-natal care for 0 & 3rd day at thehealth facility both for the mother and newborn and sending direction to the ANM of theconcerned area for ensuring 7th & 42nd day post-natal home visits.	a)Yes b)No a)Yes b)No		

D) Newborn Care

D.1) Essential Newborn care

	Services	Availability		Remarks
1	Neonatal resuscitation	a)Regularly b)Occasionally c)Never		
2	Warmth	a)Regularly b)Occasionally c)Never		
3	Infection prevention	a)Regularly b)Occasionally c)Never		
4	Support for initiation of breastfeeding within an hour of birth	a)Regularly b)Occasionally c)Never		
5	Screening for congenital anamolies	a)Regularly		

		b)Occasionally c)Never		
6	Weighing of newborns	a)Regularly b)Occasionally c)Never		
7	Antenatal Corticosteroids to mother in case of pre term babies to prevent Respiratory Distress Syndrome(RDS)	a)Regularly b)Occasionally c)Never		
8	Immediate care of LBW newborns(>1800gm)	a)Regularly b)Occasionally c)Never		
9	Care of LBW new borns <1800 gm	a)Yes b)No		
10	Vitamin K for premature babies	a)Yes b)No		
11	Care of sick newborns	a)Yes b)No		

D.2.) Latent New born care

	Services	Availability		Remarks
1	Warmth	a)Regularly b)Occasionally c)Never		
2	Hygiene and Cord care	a)Regularly b)Occasionally c)Never		

3	Exclusive breastfeeding for 6 months	a)Regularly b)Occasionally c)Never		
4	Zero day immunisation OPV, BCG, Hepatitis B	a)Regularly b)Occasionally c)Never		
5	Care of LBW newborns <2500gm	a)Regularly b)Occasionally c)Never		
6	Management of sepsis	a)Regularly b)Occasionally c)Never		
7	Referral linkages with higher facilities	a)Yes b)No		

I CLINICAL PATHOLOGY

Physical Structure for Laboratory at CHC

1	Marble/Stone Table Top for Platform	1	
2	Wash-basins (Steel/Porcelain)	1	
3	Water Taps	1	
4	Electric Fittings	As per requirement	
5	Office Table	1	
6	Office Chairs	3	
7 8 9	Revolving Stools Almirah (Steel/Wooden) Wooden/Steel Racks	2 1 1	

Laboratory Equipment

1	Binocular Microscope with oil immersion		
2	Lancet		
3	Ice box		
4	Stool transport carrier		
5	Test tube rack		
6	Table top centrifuge		
7	Refrigerator		
8	Spirit lamp		
9	Smear transporting box		
10	Sterile leak proof containers		

Laboratory Supplies

1	Clean slides		
2	Slide markers		
3	Gloves		
4	Transport medium (Cary Blair)		
5	Sterile test tubes		
6	Plastic vials		
7	Sterile cotton wool swabs		
8	Rapid Diagnostic Kit Typhoid		
9	Rapid test kit for faecal contamination		
10	Blood culture bottles with broth		
11	Zeil Neelsen Acid fast stain		
12	Aluminium Foil		
13	Cotton		
14	Sealing material		

COMMENTS .....

12.2Beneficiary Perspective for Availability of Service Delivery for Intranatal and PNC.

Questionnaire Code.....

BENEFICIARY PERSPECTIVE FOR INTRANATAL AND POSTNATAL SERVICE DELIVERY

PERSONAL DETAILS			
1.	**Name of Beneficiary-**		
2.	**Age –**		
3.	**Education-**		
4.	**a) Religion-**		
	b) Income-		
5.	**Village-**		
6.	**Distance from CHC**		
PREGNANCY DETAILS			
7.	**Parity**		
8.	**Gravida-**		
9.	**Delivery Date**		
10.	**Type of Delivery**		
11.	**From where did you take the Antenatal care service?**		
		CODING	**REMARKS**
	a) CHC itself	1	
	b) At PHC level	2	
	c) At Sub center level	3	
	d) ANC checkup not done	4	
	e) Private clinic	5	
	f) Others (specify)	99	
12.	**Who recommended /referred you to this facility for delivery?**		
	a)Anganwadi Worker	1	
	b) ASHA	2	
	c) ANM	3	
	d) MO of PHC	4	
	e) Self (Skip to Q.15)	5	
	f) Family members or Relatives	6	
	g) Neighbours	7	
	h) Others (specify)	99	

13.	**Why were you referred to this facility?** **.....** **.....** **.....**		
14.	**Who accompanied you to the facility for delivery (other than relative)?**		
	a) ASHA	1	
	b) ANM	2	
	c) LHV	3	
	d) Medical Officer	4	
	e) None	5	
15.	**Did you have a referral letter from the referral center?**		
	a) Yes	1	
	b)No	2	
16.	**How did you reach the facility?** **.....**		
17.	**Did you pay for transportation?**		
	a) Yes	1	
	b) No	2	
18.	**How much time it took you to reach the facility? .....**		
19.	**Do you have provision of JSSK/JSY?**		
	a)Yes(Skip to 21)	1	
	b) No	2	
	c) Don't know(skip to 21)	3	
20.	**If no, Why? .....**		
21.	**Were you promptly attended, when you reached the facility?**		
	a) Yes(skip to Q23)	1	
	b)No	2	
22.	**If no, what was the waiting time? .....**		
23.	**Who attended you firstly?**		
	a) Doctor	1	
	b) Nurse	2	
	c) None	3	
24.	**Did the Doctor explain you and your relatives about your condition / complication and procedure to be followed?**		
	a)Yes	1	
	b)No	2	
25.	**Were your examination / delivery done in a separate and private room?**		

	a)Yes	1	
	b)No	2	
	c)Don' Know	3	
26.	**Are you satisfied with the behaviour of doctor?**		
	a)Satisfied	1	
	b)Partially satisfied	2	
	b)Not satisfied	3	
	c)Don't know	4	
27.	**Are you satisfied with the behaviour of nurses?**		
	a)Satisfied	1	
	b)Partially satisfied	2	
	c)Not satisfied	3	
	d)Undecided	4	
28.	**Are you satisfied with the behaviour of other staff members?**		
	a) Satisfied	1	
	b)Partially satisfied	2	
	c)Not Satisfied	3	
	d)Undecided	4	
29.	**Was the delivery room clean?**		
	a) Yes	1	
	b)No	2	
	c)Don't know	3	
30.	**Was your baby weighed after birth?**		
	a)Yes	1	
	b)No	2	
31.	**Did the doctor/ staff explained about the initiation of breastfeeding immediately after birth?**		
	a)Yes	1	
	b) No	2	
32.	**Does the doctor visit wards every day for rounds ?**		
	a) Yes	1	
	b) No	2	
33.	**Did the doctor/ staff explain you about new born care and exclusive breast feeding?**		
	a)Yes	1	
	b)No	2	
34.	**Was the baby given ZERO dose of**		
	i) BCG a) Yes	1	
	b)No	2	
	ii) OPV a) Yes	1	
	b)No	2	
	iii)Hepatitis B a) Yes	1	
	b)No	2	
35.	**Did the doctor/ staff explain you about family planning methods and its advantages?**		

	a)Yes	1	
	b)No	2	
36.	**How do you rate the cleanliness of the facility?**		
	a)Very Bad	1	
	b)Bad	2	
	c)Good	3	
	d)Very good	4	
37.	**How do you rate the cleanliness of the utilities?**		
	a)Very Bad	1	
	b)Bad	2	
	c)Good	3	
	d)Very good	4	
38.	**How do you rate the drinking Water supply?**		
	a)Very Bad	1	
	b)Bad	2	
	c)Good	3	
	d)Very good	4	
39.	**Are all drugs available in the hospital, prescribed by the doctor?**		
	a) Yes	1	
	b) No	2	
	c) Don't know	3	
40.	**How do you rate the service delivery in the facility?**		
	a) Satisfied	1	
	b) Partially satisfied	2	
	c) Not satisfied	3	
	d) Undecided	4	

12.3 Beneficiary Perspective for Availability of Service Delivery for ANC

Questionnaire Code……

BENEFICIARY PERSPECTIVE FOR ANTENATAL CARE SERVICE DELIVERY

PERSONAL DETAILS		
1.	**Name of Beneficiary**	
2.	**Age**	
3.	**Village**	
4.	**Religion**	

5.	**Education**		
6.	**a) Occupation of Husband** **b) Income**		
PREGNANCY DETAILS			
7.	**Gravida**		
8.	**Parity**		
9.	**Gestational age**		
10.	**Trimester**		
	I trimester		
	II trimester		
	III trimester		
11.	**Who recommended/referred you to the facility?**		
	a)Anganwadi Worker	1	
	b) ASHA	2	
	c) ANM	3	
	d) MO of PHC	4	
	e) Self (skip to 13)	5	
	f) Family members or Relatives	6	
	g) Neighbours	7	
	h) Others (specify)	99	
12.	**Why were you referred?** **.....** **.....** **.....**		
13.	**How many times did you visit the facility?** **.....**		
14.	**What was the means of transport? .....**		
15.	**Every time you visited this facility for check up , was the doctor available?**		
	a) Every time (skip to 19)	1	
	b) Sometimes	2	
	c) Never (skip to 18)	3	
	d) Yes(if first visitor)	4	
	e) No(if first visitor)	5	
16.	**If sometimes, what was the reason**		
17.	**If never what were the reason**		
18.	**Are they available on timings (OPD timing)**		
	a) Yes	1	
	b) No	2	
	c) Don't know	3	
19.	**How much you have to wait to see the doctor every time (an average)?** **.....**		

20.	**Do you have the ANC card?**		
	a) Yes(skip to23)	1	
	b) No	2	
21.	**If no, why?**		
22.	**Is it filled by the concerned person every time?**		
	a) Yes(skip to25)	1	
	b) No	2	
23.	**If no, why?**		
24.	**Did the doctor enquire about your problem?**		
	a) Every time	1	
	b) Sometimes	2	
	c) Never	3	
	d) Yes(if first visitor)	4	
	e) No(if first visitor)	5	
25.	**Did they enquire you about consumption of Iron folic acid tablets**		
	a) Every time	1	
	b) Sometimes	2	
	c) Never	3	
	d) Yes(if first visitor)	4	
	e) No(if first visitor)	5	
26.	**How do you rate the behaviour of doctor?**		
	a) Very bad	1	
	b) Bad	2	
	c) Good	3	
	d) Very good	4	
27.	**Did they respond to your queries in a polite manner**		
	a) Yes	1	
	b) No	2	
28.	**How is the behaviour of the nurses?**		
	a) Very bad	1	
	b) Bad	2	
	c) Good	3	
	d) Very good	4	
29.	**Did they respond to your queries in a polite manner**		
	a) Yes	1	
	b) No	2	
30.	**Was the physical examination done by the doctor**		
	a) Every time	1	
	b) Sometimes	2	

	c) Never	3	
	d) Yes(if first visitor)	4	
	e) No(if first visitor)	5	
31.	**Were your examination done in separate and private room?**		
	a) Yes	1	
	b) No	2	
32.	**Did they check your**		
A	**Weight** a) Every time	1	
	b) Sometimes	2	
	c) Never	3	
	d)Yes(if first visitor)	4	
	e)No(if first visitor)	5	
B	**B.P** a) Every time	1	
	b) Sometimes	2	
	c) Never	3	
	d)Yes(if first visitor)	4	
	e)No(if first visitor)	5	
C	**Fundal height** a) Every time	1	
	b) Sometimes	2	
	c) Never	3	
	d)Yes(if first visitor)	4	
	e)No(if first visitor)	5	
D	**Foetal Heart sound (applicable in II trimester)** a) Every time	1	
	b) Sometimes	2	
	c) Never	3	
	d)Yes(if first visitor)	4	
	e)No(if first visitor)	5	
E	**Hb%** a) Every time	1	
	b) Sometimes	2	
	c) Never	3	
	d)Yes(if first visitor)	4	
	e)No(if first visitor)	5	
F	**Urine sugar** a) Every time	1	
	b) Sometimes	2	
	c) Never	3	
	d)Yes(if first visitor)	4	
	e)No(if first visitor)	5	
G	**Urine albumin** a) Every time	1	
	b) Sometimes	2	
	c) Never	3	
	d)Yes(if first visitor)	4	
	e)No(if first visitor)	5	
H	**Blood Group** a) Yes	1	
	b) No	2	
I	**HIV** a) Yes	1	
	b) No	2	
33.	**Were you immunised by TT Injection (applicable in II trimester)**		
	a) Yes	1	
	b) No	2	

34.	**Did they explained high risk conditions like leaking, pain in abdomen, reduced foetal movement, bleeding per vagina**		
	a) Yes	1	
	b) No	2	
35.	**Do they counsel you for nutrition on every visit?**		
	a) Every time	1	
	b) Sometimes	2	
	c) Never	3	
	d) Yes(if first visitor)	4	
	e) No(if first visitor)	5	
36.	**Did they explain you and your relatives about the complication and its management?**		
	a) Yes	1	
	b) No	2	
37.	**Do you know about JSSK/JSY scheme?**		
	a) Yes(skip to 40)	1	
	b) No	2	
38.	**How do you rate the cleanliness of facility?**		
	a) Very bad	1	
	b) Bad	2	
	c) Good	3	
	d) Very good	4	
39.	**How do you rate cleanliness of utilities?**		
	a) Very bad	1	
	b) Bad	2	
	c) Good	3	
	d) Very good	4	
40.	**Do you get clean drinking water?**		
	a) Yes	1	
	b) No	2	
	c) Don't know	3	
41.	**Do you get all the drugs in the facility, prescribed by the doctor**		
	a) Every time	1	
	b) Sometimes	2	
	c) Never	3	
	d) Yes(if first visitor)	4	
	e) No(if first visitor)	5	
42.	**Are you satisfied with the service delivery of the facility?**		
	a) Satisfied	1	
	b) Not satisfied	2	
	c) Partially satisfied	3	
	d) undecided	4	

43.	Where did you take previous ANC treatment		
	a) Anganwadi	1	
	b) ANM	2	
	c) Private clinic	3	
	d) None	4	

VISIT REPORT

- **General Hospital, Sector 6, Panchkula.**
- **Primary Health Center, Kot, Panchkula.**
- **Subcenter, Ramgarh, Panchkula.**

13 REPORT ON VISIT TO DISTRICT HOSPITAL,SECTOR-6, PANCHKULA

Departments observed:

I. OPERATION THEATER(OT) :

- Operation theatre area is divided into zones - preoperative, post operative area and 6 OTs (separate for each department), separate scrub area, CSSD, Dirty area.
- OT and surgical ward was on same floor for the convenience for shifting of patients.
- Though nursing station were in pre & post operative room, but was not being utilised, as nursing staff also had to do the records, hence seated in the common nursing station.
- Most of the patients were operated under MMIY scheme.
- OT had emergency power back-up.
- Records were well maintained.

II. SURGICAL WARD

- In surgical wards, pre-operative and post operative patients were admitted separately.
- Comatose and extubated patient were not isolated from general patients.
- Patients were unaware of bedside calling system.

III. ORTHOPEDIC WARD

- This ward was on the same floor as of surgical ward for the ease of shifting of the patients.

IV. PSYCHIATRY AND DRUG REHABILITATION WARD

- This ward had common corridor with surgical and orthopaedic wards.
- Bell system, though installed, was not in the knowledge of the patients, so as to avoid unnecessary calls by the patients, as reported by a posted nursing student.

V. GYNAECOLOGY AND OBSTETRIC DEPARTMENT

- Gynaecology and obstetrics OPD, IPD and Labour room were on the same floor.
- Labour room and MTP centre were adjacent to each other.
- Privacy was maintained in the labour room.
- Staff nurses conducted the normal deliveries.

VI. PAEDIATRICS WARD:

- Paediatrics ward had common corridor with chest department.
- It also had rooms for DEIC, NRC.
- There was a play room.

VII. CHEST WARD:

- TB and other chest-ailment(asthma etc.) were observed sharing the same room.

SCHEMES:

1. **Mukhyamantri muft ilaaj yojna(MMIY)** is implemented from January 1, 2014 in Haryana.

The following services are provided completely free to all the patients coming to the health institutions of the State under the MMIY:

- Surgery package program(For Haryana Residents Only)
- Basic Laboratory Investigations, along with free X-Ray, ECG and USG (wherever available in the Government Health Institutions).
- Indoor Services.
- Drug supply.
- Referral transport/ambulance services.
- Dental treatment

2. RBSK/District Early Intervention Centre (DEIC):

- Rashtriya Bal Swasthya Karyakram (RBSK) is a new initiative aiming at early identification and early intervention for children from birth to 18 years to cover 4 „D"s viz. Defects at birth, Deficiencies, Diseases, Development delays including disability. The 0-6 years age group is specifically managed at District Early Intervention Center (DEIC) level while for 6-18 years age group, management of conditions is done through existing public health facilities. DEIC acts as referral linkages for both the age groups.
- An Early Intervention Centre is established at the District Hospital under RBSK. The purpose of Early Intervention Centre is to provide referral support to children detected with health conditions during health screening.
- A team consisting of Paediatrician, Medical officer, Staff Nurses, Paramedics will be engaged to provide services and a manager who carries out mapping of tertiary care facilities in Government institutions for ensuring adequate referral support. Children and students presumptively diagnosed to have a disease/ deficiency/disability/ defect and who require confirmatory tests or further examination are referred to the designated tertiary level public sector health facilities through the DEIC.
- The DEIC promptly responds to and manage all issues related to developmental delays, hearing defects, vision impairment, neuro-motor disorders, speech and language delay, autism and cognitive impairment. Beside this, the team at DEICs is involved in newborn screening at the District level. This Centre has the basic facilities to conduct tests for hearing, vision, neurological tests and behavioural assessment.

3. **NutritionRehabilitationCentres(NRCs)**:

Severe Acute Malnutrition is an important contributing factor for most deaths amongst children suffering from common childhood illness, such as diarrhoea and pneumonia. Deaths amongst SAM children are preventable, provided timely and appropriate actions are taken.

Nutritional Rehabilitation Centre (NRCs) has been set up in GH for inpatient management of severely malnourished children, with counselling of mothers for proper feeding and once they are on the road to recovery, they are sent back home with regular follow up.

Positives:

- OT was well-maintained.
- Microbial limit monitoring is being done in the OT on a regular basis so as to minimize the probability of cross-infection/ hospital- acquired infections. Staff nurse accompanying us for

orientation honestly reported us about a recent *Psuedomonas* contamination which was followed by carbolization

- A wing was allotted for DEIC, which was focussed on rehabilitation of physical and psychological disabilities in children till 15 years of age.
- Another wing was allotted to NRC to provide service to malnourished children.
- Installation of the bell system for calling nurses in all wards was a good initiative.

Negatives:

- There was no arrangement for sitting in waiting area; patients and their attendants were seen sitting on the floor.
- Nurses were performing normal vaginal deliveries, without the presence of doctors.
- Sterilization and disinfection was not being maintained; nurse was observed receiving a phone call with gloved hands while handling a case in 2nd stage of labour.
- Cotton/gauze pieces fallen on the floor were re-used during the procedure.
- SNUC was there, but staff was not trained about its appropriate usage.
- Paediatric and chest wards had common corridor, which could be a potential source of cross-infection especially for children.
- Lack of privacy was observed in O & G OPD.

14. REPORT ON VISIT TO PRIMARY HEALTH CENTER, KOT

- Name of the District: **Panchkula**
- Name of Tehsil/Taluka/Block: **Panchkula/Raipur Rani**

- Name of the PHC : **PHC KOT**
- No. of Sub-centers under the PHC**: 5**
- District of CHC from PHC: **Panchkula**
- District of DH from PHC: **Panchkula**
- 24*7 service delivery
- Population Covered**: 34136**

SERVICES:

Number of Beds: 6

Average Daily OPD: 150 (proportion of Female patients reporting daily were more as compared to males)

Services Available:
OPD
Emergency Services (24 hours)
Referral Services
In-Patient Services
Specific services:
Primary management of wounds
Primary management of fracture (first aid)
Primary management of cases of Poisoning
Primary management of burns
Abscess drainage
No Cataract surgeries are performed.
MCH Care Services:
ANC
Intra Natal care
Post-natal care
Immunization
Family planning
Management of RTI/STI
No newborn care was provided, MTP services were yet not available*,
* MO was undergoing training pertaining to MTP.

Specific Services:

Organization of Antenatal clinics on regular basis.

On call doctors available for 24 hrs. Delivery services and 24*7 nursing staff available

Tubectomy and vasectomy

Internal examination for gynaec patients

Treatment for gynaecological disorders

BCG and measles vaccine

Treatment of children with pneumonia

Management of children with diarrhea

No management of Low birth babies.

Other functions and services:

School health programme conducted by dentist

Prevention and control of locally endemic disease

Control of epidemics

Collection of vital statistics

Ayush services

No nutrition services were available

No behaviour change communication services

National AIDS control programme was not functional

INFRASTRUCTURE

Location: Distance of PHC is 25 km from farthest village in coverage area

Distance of PHC from District hospital is 17 km

Building: Government designated building is available for PHC. Cleanliness is fair prominent display boards regarding services and IEC material is available

Operation Theatre: Laparoscopic sterilization surgeries are carried out.

Labor room: Normal deliveries were conducted. No caesarean section was performed.

Water supply: Piped water supply was available

Sewerage: Soak pit

Waste Disposal: Sharp pit was available

Electricity: Electric lines were available in all parts of PHC

Communication Facilities: Telephone, E-mail, Fax services were available

Vehicles: Ambulance services were available. Residential facility for MO was available

User charges: Free of cost services were available

Quality Control: Citizen‟s charter was available outside the facility.SKS Audit was available

HUMAN RESOURCES

S.no.	Recommended	Current availability at PHC	Current Availability	Identified gaps
1	Medical officer	2	2-MO 1-AMO	2nd medical officer was not performing the physical examination of patients
2	Pharmacist	1	1 1-Ayush	
3	Nurse-midwife(staff nurse)	3	4	One nurse was suffering from osteoarthritis, so she was managing the opd register and was not allotted any duty of nurse
4	Health worker	1	1	
5	Health educator	1	0	
6	Health assistant	2	1	
7	Clerks	2	1	
8	Lab Technician	1	1	
9	Driver	optional	1	

Essential Laboratory services:

Hb, Urine, TLC, DLC, Blood grouping, BT, CT, Rapid test for pregnancy, VDRL test, Sputum Collection center.

HIV test was unavailable.

Lab technician was not wearing gloves

Other significant findings:

Negatives-

- There was foul-smelling litter at the entrance of the hospital.

- There were flies all over.
- There was dung/ faeces in the hospital premises.
- Laboratory was in a shabby condition.

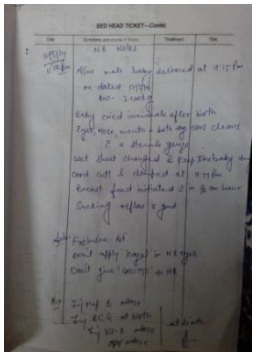
- There was a private pharmacy within the hospital premises

- Dental wing had no technician/assistant.
- Dental Lab was not available.
- MO was observed not doing physical examination of a single patient.
- Hot air oven was available, but not in use.
- LHV was on a long leave, so pharmacist was handling the cold chain unit.
- In spite of AYUSH pharmacist being available, a staff nurse was managing the pharmacy in the absence of the pharmacist.
- Ambulance tough present, had punctured tyre

Positives-

- Citizen charter was displayed in Hindi at a readable height.

- There was provision of utilizing natural light.
- Bed head ticket notes were well drafted and maintained.
- Records were well maintained.



15. REPORT ON VISIT TO SUB-CENTER, RAMGARH

- Name of the sub center: **Ramgarh**
- No. of villages under the SC: **12**
- Distance of SC from PHC: **8 Km**
- Distance of SC from nearest CHC: **20 Km**
- 24*7 service delivery
- Population covered**: 1063 7**

SERVICES

MCH Care Available:
a) ANC
b) INC
c) PNC
d) Newborn
e) Immunization
f) Family Planning And Contraception
g) JSY
h) JSSK
i) Treatment Of Common Illness
MCH Care Not Available:
a) Adolescent Health
b) School Health Education

Availability of specific services

a) Doctor visits the sub center once or twice a month, but the days of visit are not fixed.
b) LHV visits the sub-center at least once a week.

c) The ante-natal care (inj. TT/IFA tablets, weight and BP check up) is provided by the manpower in the sub center.
d) The facility for referral of complicated cases of pregnancy/delivery is available at the sub center for 24 hours.
e) The ANM/any trained person does not accompany the woman in labour to the referred care facility at the time of referral.
f) Immunization services are provided as per government schedule provided by the sub center.
g) ORS for the prevention of diarrhoea and dehydration is available in the sub center.
h) The treatment of minor illness like fever, cold, cough, worm disinfestations etc. is available in the sub center.
i) The facility for taking peripheral blood smear in case of fever for detection is available in the sub center.
j) Contraception services like insertion of Copper-T, distributing oral contraceptive pills or condoms are provided by the sub center.
k) The Ramgarh sub center is also a DOT center.

Other functions and services

a) Disease surveillance
b) Control of local endemic disease
c) Promotion of sanitation
d) Field visit and home care
e) National health programs including HIV/AIDS control programs

Monitoring and supervision activities

a) Training of ASHA is not done at the sub center(done at PHC).
b) For monitoring the quality of water in the village, sample is collected and taken to PHC, Kot.
c) An eye is kept over unusual health events.
d) Services are provided in coordination with AWWs, ASHAs, Village Health and Sanitation Committee and PRIs.
e) Records and registers are properly maintained.
f) The scheme of ASHA is implemented in the sub center.

HUMAN RESOURCES

Sub-Center Ramgarh			
STAFF	**ESSENTIAL**	**DESIRABLE**	**AVAILABLE**
ANM/Health Worker(Female)	2		3(2 ANM + 1 LHV)
Health Worker(Male)	1		-
Staff Nurse(or ANM, if Staff Nurse is not available)		1**	-
Safai-Karamchari*	1(Full-time)		1

*To be outsourced.
**If number of deliveries at the sub-center is 20 or more in a month.

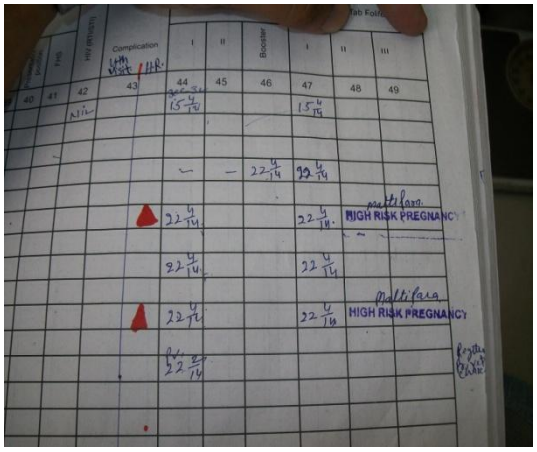
Physical structure

a) Berwala is the farthest village in the coverage area of sub center Ramgarh(15 km).
b) There is a designated government building available for the sub center.
c) The cleanliness was good.
d) Labour room is available with a separate clinic room and n examination room.
e) Water supply is through tube well.
f) Electricity supply is present with a back-up facility of an inverter.
g) Health care providers have government SIM card for communication. The sub center, otherwise, does not have telephone/fax/e-mail facility.
h) Residential facility is available for the staff

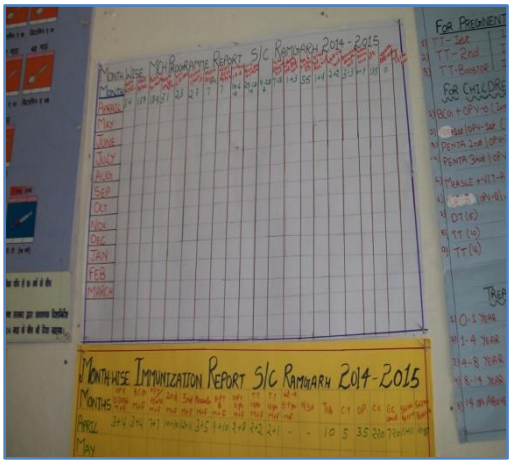
Positives:

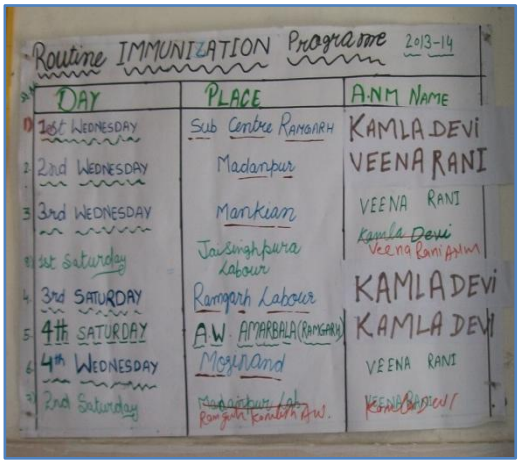
a) Location of the sub center is accessible.
b) Citizen charter is displayed outside the clinic room; written in Hindi.

c) Center is well maintained in terms of cleanliness, equipment, medicines, IEC material and records.



d) Staff seemed motivated. There were hand-made charts for various activities.





e) There are separate rooms for clinic, examination, delivery and sterilization.

Negatives:

a) There was litter and garbage on the linking road to the sub center as well as just outside the sub center.

b) Shadow-less lamp of the labor room was out of order.

c) Toilet was not attached to the labor room and nearest door to the washroom was blocked due to wrong placement of patient bed, which could be a cause of inconvenience to the patient.

d) Use of gloves or spirit swab was not observed during Hb-estimation.
e) Ambulance was not available.
f) Pit for placenta disposal had temporary lid.