National Rural Health Mission

A Report On

Monitoring of Important Components of NRHM, Programme Implementation Plan in Dausa District, Rajasthan


Submitted to

Ministry of Health and Family Welfare
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ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
AFC	Adolescent Friendly Centres
ASHA	Accredited Social Health Activists
ANM	Auxiliary Nurse Midwife
AYUSH	Ayurveda, Yoga ,Unani, Siddha & Homeopathy
ARSH	Adolescent Reproductive and Sexual Health
BCG	Bacillus Calmette Guerin
BCC	Behaviour Change Communication
CBR	Crude Birth Rate
CDR	Crude Death Rate
CHC	Community Health Centre
CSR	Child Sex Ratio
CMO	Chief Medical Officer
DOTS	Directly Observed Treatment Strategy
DPT	Diphtheria, Pertussis (whooping cough), tetanus
DH	District Hospital
DPM	District Programme Manager
DPMU	District Programme Management Unit
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICDS	Integrated Child Development Service
IUD	Intra Uterine Device
IMR	Infant Mortality rate
IEC	Information Education and Communication
JSY	Janani Suraksha Yogna
JSSK	Janani Sishu suraksha Yogna
LHV	Lady Health Visitor
MCH	Maternal & Child Health
MIS	Management Information System
MMR	Maternal Mortality Rate
MTP	Maternal Termination of Pregnancy
NBSU	Newborn Stabilization Unit
NRHM	National Rural Health Mission
NNMR	Neo Natal Mortality Rate
ORS	Oral Rehydration Solution
OPV	Oral Polio Vaccine
PHN	Public Health Nurse
PIP	Programmne Implementation Plan
PNMR	Perinatal Mortality Rate
PNC	Post Natal Care
PHC	Primary Health Centre
RCH	Reproductive and Child Health
RKS	Rogi Kanyal Samiti
RBSK	Rogi Bal Swasthya Karyakaram
SNCU	Special Newborn Care Unit
SBA	Skilled Birth Attendant

EXECUTIVE SUMMARY

This Report focuses on the annual quality monitoring of essential components of NRHM of Dausa District (2013-14). This report is made by Population Research Centre, Delhi on the basis of the observation made during the Monitoring and Evaluation of the key components of NRHM. This report highlights the status of NRHM in the district. In this report we would discuss NRHM implementation status of Dausa District of Rajasthan. The PRC Delhi team undertook desk review of PIP document and prepared semi-structured interview schedules and observations checklist for the field study which included interaction with the MO/ICs, ANMs, ASHAs, Beneficiaries and few stake holders of the program.

The major strengths and weakness of the district are as follows-

Strengths:

- The DH is well equipped with all essential requirements .Laboratory services were present in the district despite of shortage of staff in the region. Blood bank was functional in the District hospital of Dausa. Monthly performance of DPT/OPV and Measles are quite satisfactory in District.

- ASHAs are getting their incentive regularly in the district, there are no issues regarding their payment. Proper targets have been set up for both JSY and JSSK schemes in the district.

- Immunization coverage of the districts quite convincing while state performance is poor. This shows that ANMs, ASHAs are performing their duties well and hardy in the particular district only

- The DH was providing all the essential new born care and manages sick neonates and infants.

Weaknesses:

- All the visited health centers were functioning in the government premises; however, both the S.Cs buildings were not properly maintained. The DH has constrained 24*7 supply of running water. The DH was facing electricity and water problem even drinking

water is a problem, cleanliness and sanitation remained seriously affected. CHC have quarter, both PHC and CHC were facing water and electricity problem.

- In the District Hospital use of bins were not proper, bins were used as normal dustbins and found at the different corners of the hospital. The wards were not cleaned and the walls were seen in a dilapidated state. All the class four staff is on contractual basis and are very reluctant for doing their duties.

- In cases of maternal deaths, still births and new natal cases, were reported to be high in the district hospital and in lower level facilities. This indicates constrained availability of quality amenities, thus suggesting an urgent need of managing high risk pregnancy cases. In DH and its below level facilities no one has expertise to manage high risk pregnancies. Mortality parameters are badly affected due to lack of expertise in providing ANC and PNC services and family planning services.

- Government initiatives have been for maintaining proper availability of medical and para-medical personnel, however, in spite of these efforts shortages exist in all categories of human resources at different levels in the health facilities. This situation is more acute in the remote areas where shortage of doctors and nursing staff has been a perennial problem. As a result one can see patient's long serpentine queues outside registration counters that move at a snail pace. Therefore, availability of appropriately prepared health workforce is required for achieving better health goals.

- Non availability of C-Section facility in CHCs and PHCs is causing very difficult situation for the serious pregnancies cases. Non-availability of C-Section facility in CHCs and PHCs is also causing delivery load in DH.

- No proper training for ASHAs and ANMs was given; their role in increasing institutional deliveries was not much realized. The beneficiaries were using health facilities not depend on ASHA, thus, their role needs to be strengthened. Also, training must be given to improve the quality of HMIS information as they are relevant indicators in further health research.

- Even no training were given to the doctors of CHC and PHC,in CHC Paparda doctors were not trained ,there were no female gynecologist and this was causing problem in conducting deliveries. Doctors require training for better understanding of their work.

- The efficiencies of the hospital systems depend on the availability of skilled manpower and their skill reflected in the quality services the hospitals' provides. About the quality parameters in the facilities i.e. DH,, CHC and PHC, none of the facility is resourceful enough to manage the high risk pregnancy cases. The staff does not know about the use of partograph and IUCD. The CHC also had trouble in using partograph and IUCD and found incapable of providing essential newborn care. The PHC was referring most of the sick neonates and infants.

- The sub centers are not much functional, but the ANMs know how to measure hemoglobin, urine albumin and protein, insert IUCD, support breast feeding methods and identify symptoms of pneumonia and dehydration. ANMs are not given training about the use of partograph and essential new born care.

- SNCUs were functionally well in the district, only issue was no of working machines in such units due to which limited number of children can be attended at a time. Most of the machines were not found in functioning condition because of poor management of the staff as well as higher authority of the hospital. Doctors in the district hospital are very reluctant for doing their duties.

- Total 40249 blood samples for malaria test had been collected while target was of 164552 blood samples, so there is a huge gap between target and achievement. More staff can be recruited in programs of TB, Malaria and Leprosy as there was shortage of staff in such programs.

1) INTRODUCTION

An effective feedback regarding the progress in implementation of key components of NRHM could be helpful for both planning and resource allocation purposes. Therefore, following the approval of National Rural Health Mission (NRHM) State Programme Implementation Plan (PIP) 2013-14 for, Rajasthan the Ministry of Health and Family Welfare (MoHFW) has asked Population Research Centre, Delhi (PRC Delhi) to conduct quality monitoring of its important components. While engaging with the quality monitoring of PIPs it is expected that PRCs would evolve suitable quality parameters and would assume a critical role in monitoring various components of NRHM every month. As part of this, our Delhi PRC was assigned to monitor and evaluate the NRHM activities in the district Dausa which is located in Rajasthan. The major objective of this whole monitoring and evaluation process was to have a common understanding about the district public health system and to bring clarity in the understanding regarding their interventions, suggesting them to get equipped with tools and skills required for better service delivery, and get them exposed to various replicable programmes and facilities under NRHM.

2) STUDY APPROACH

The present study aims to assess the out reaching of NRHM activities to the rural communities at large and to the underprivileged section of population in particular. This study also qualifies for quality monitoring of Programme implementation Plan (PIP), and also to obtain information on number of indicators about implementation of health care programmes. This will be helpful to policy makers and programme managers to strengthen the implementation of NRHM activities at the district and below district level. Moreover this will provide a direction for local planning, based on local evidence and needs. To achieve the developmental and welfare goals the practice of monitoring and evaluation has been largely emphasized in all areas of policy concern. As a part of this process, special focuses are expected to be given to VHND, delivery points, training component, flow of budget and expenditure and issues focused upon in RKS meeting. Apart from these discussed above the following essential factors that requires smooth functioning of health facilities have been assessed.

- Demographic characteristics and Health care behavior
- Availability of Infrastructure
- Availability of human resource and training
- Availability of equipments, drugs

- Functioning of service delivery quality parameter of facilities
- Provision of IEC display
- Progress under NRHM activities

The specific objectives of the study are as follows:

- To visit health facilities in a high focused district for monitoring the implementation of NRHM activities at the grassroots level.
- To observe and comment on broad areas related to the functioning of health facilities.
- To assess the availability of physical infrastructure, human resource, better service requirements of essential equipments and drugs, further an assessment of the various programs running under NRHM.
- To look into various other components those are essential for smooth functioning of the facility.

3) DISTRICT PROFILE

The Dausa district of Rajasthan is one of the district of Jaipur division and located in the eastern part of the state of Rajasthan. It is surrounded by Alwar district in the north, Sawai Madhopur district in the south, Bharatpur district in the northeast, Karauli district in the southwest and Jaipur district in the west. It has total area of 3404.78 sq. km in roughly semicircular or 'C' shape with tempering towards east and west at corners.

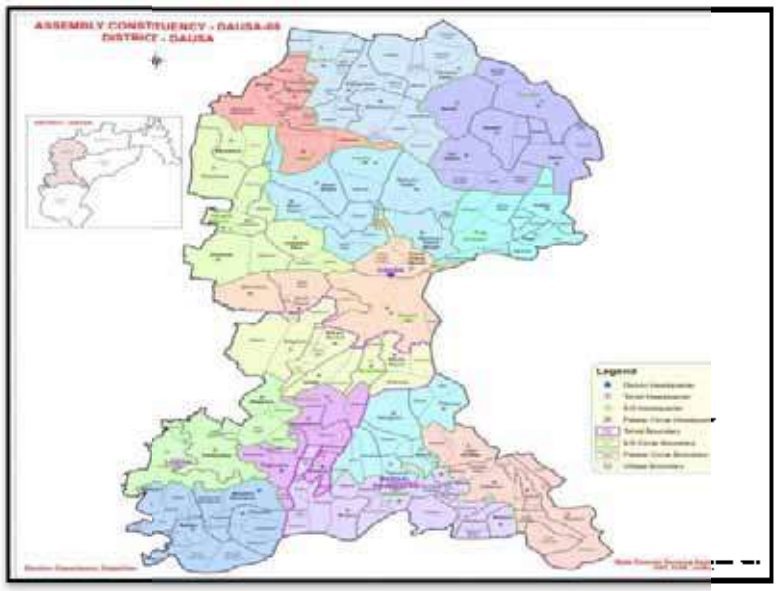

Fig1: District map of Dausa

Along with challenging geographical situation, socio-cultural & economic conditions are challenging in the district that makes health situation more crucial and challenging. The lack of adequate infrastructure at health facilities, adequate number of medical, para medical staff are another issues those are playing crucial role in providing quality health services. The major indicator adversely affecting the health condition of district are infant mortality rate for female child that is high as compared to male child and which is directly linked to practices of female infanticide. Patriarchy, caste-based discrimination and high rates of poverty are pervasive and contribute to poor health and nutrition status

4) KEY HEALTH ,DEMOGRAPHIC & SERVICE DELIVERY INDICATORS DETAILS

Table1: Socio-Economic Characteristic of Dausa District

Sl. No.	Socioeconomic/Demographic	State	District
1	Total Population (Census,2011)	685,48,437	**16,34,409**
	Male Population	35,550,997	**857787**
	Female Population	32,997,440	**776622**
2	Decadal Growth Rate	21.44	**24.09**
3	Density of Population(Census,2011)	200	**476**
4	Number of Blocks	249	**5**
5	Total Literacy Rate(Census,2011)	66.1	**68.1**
	Male literacy	79.19	**82.98**
	Female Literacy	47.76	**51.93**
6	Infant Mortality(AHS,2010-11)	60	**55**
7	Neonatal Mortality Rate(AHS,2010-11)	40	**32**
8	Under five mortality(AHS,2010-11)	79	**85**
9	Maternal Mortality Rate (State report or SRS)	264	**238**
10	Child Sex Ratio (Census 2011)	883	**846**
11	Sex ratio(No of Females per 1000 population(Census 2011)	928	**905**
12	Crude Birth Rate(AHS-2011)	24.4	**22.1**
13	Crude Death Rate(AHS-2011)	6.4	**6.5**
14	Total Fertility Rate(AHS-2011)	3.09	**2.4**
15	Institutional Deliveries (In %)(AHS-2011)	45.4	**83.9**
16	Full Immunization (In %)(AHS-2011)	48.7	**73.5**

Source; AHS, Census 2011

The above mentioned table 1 is showing the basic socio-economic indicators of the Dausa district. District is High focus district due to high maternal mortality rate and low sex ratio (0-6 years) which is clear from the table no 1.Still births are also very high in the districts this shows the lack of awareness about scheduled ANC checkups.

The district of Dausa enumerated a population of 685, 48,437 of which 857787 are males and 776622 are females. The percentage of institutional deliveries is 45.4 percent in the state and 83.9 percent in the district which is far higher than the state average. The risk of maternal death is very high during labour, delivery and up to 24 hours postpartum. The State has higher MMR i.e. 264 and district has reported 238 which is lower than the state MMR, certainly keeping in view of the poor development status of the district and over all very poor health indicators the MMR will be very high. The overall sex ratio in Rajasthan is 928 females per 1000 males. It may be noted that the sex ratio of Rajasthan is lower than the sex ratio of India (940 as per census 2011). As far as overall sex ratio for the district is concerned it is lower (905 females per thousand males) than the all India and state average, this reveals that the discrimination against females is prevalent.

5) HEALTH INFRASTRUCTURE

In the health sphere, while facilities as per the norms appear complete, there are problems with regard to actual work. For one, many health outlets are located far away from where the settlements are; as a result, there is less than possible usage of these. There are also problems of inadequate infrastructure- buildings, staff quarters, equipment and vehicles, to name a few. Also, there are issues in working capital: the expenses are just not sufficient to buy the necessary drugs, run vehicles, or up-keep the building structures. There is also acute shortage of personnel at all levels: particularly medical personnel. All these deficiencies have been reported in the Human Development Report, Dausa. Our visit in the district and its lower level health facilities confirm the findings. In the case of health the term infrastructure takes on a wider role than mere physical infrastructure. Healthcare centres, dispensaries, or hospitals need to be manned by well trained staff with a service perspective, such deficiencies at the district level is widely prevalent. On positive side district has one Malnutrition centre.

Table 2: Number of facilities running in the Districts

Sl. No.	Health Facility	Total Facilities
1	**District Hospital**	1
4	**CHC**	15
5	**PHC**	44
6	**Sub-Center**	3
8	**T.B Clinic**	1
10	**Combined hospitals**	0
11	**Medical College**	0
12	**Any other Govt. hospital**	0
	Total	377

Source: CMO office 2014

Dausa District has a total of 377 health facilities out of which there is one District hospital, 15 Community Health Centers, 44 Primary Health Centers and 316 sub centres and one T.B. Clinic and these facilities sum up to 377.In the district, the primal charge of each block and related facilities were under the supervision of Block Programme Manager. The map shows the distribution of health facilities in the district of Dausa, Rajasthan.

Fig2 Map of the Health Facilities in the Districts

5.1) HEALTH FACILITIES VISITED BY THE DELHI PRC TEAM FOR MONITORING AND EVALUATION

After the valuable discussion with the District Program Manager few facilities selected for monitoring purpose. During the field visit of PIP monitoring and Evaluation of DausaDistrict, Health facilities visited are mentioned below:

Table 3: Shows the number of facilities visited by Delhi PRC, for Monitoring and Evaluation

Sr. No.	Facility Type	Name of Facility
1	District Hospital	Shri. R.K.Joshi District Hospital
2	Community Health Centre	Community Health Centre, Paparda
3	Primary Health Centre	Primary Health Centre, Aluda
4	Sub Centres	Sub Centre, Nangalbersi Sub Centre, Chandrana

6) HUMAN RESOURCES

Lack of Human resource is one of the major flaws of district which in turn responsible for the weaker health indicators. Specially, crunch of senior officials and specialists at the facilities is causing a major hindrance. Most of the facilities were not having gynecologist, pediatricians and surgeons.

Table 4: Position of Human Resource in Dausa District

Position			
	Sanctioned	In Position	Vacancy
ASHA			
ANM	403	249	154
S.M.O	14	6	8
M.O.	87	77	10
Doctors	182	139	43
Doctors (J.S.)	51	32	19
Male Nurse(First)	21	13	8
Male Nurse (Second)	192	118	74
L.H.V.	59	24	35
Lab Technician	84	58	26

Source: CMO Office 2014

The number of ANMS sanctioned and in position gives the actual picture of the health system. There is a wide gap between these two which is significantly affecting the health care system in the

district. Major crunch was found in the class four employees, they work on contractual basis so they are very reluctant for doing their work. Clashes between the permanent and contractual staff also pose a problem for the entire Health system and service delivery by the district. Shortage of staff at the CHCs and PHCs causes impediments in providing smoothened service to the common masses. Table 4 depicts that there is a wide gap in no of doctors sanctioned and in position, no of Male nurse Sanctioned and in position and in case of LHV's also due to which burden was more on the present staff.

7) MATERNAL HEALTH

Promotion of maternal and child health has been an important objective of the NRHM to reduce Maternal and Infant and Child mortality by focusing on strategies of promoting wider utilization of essential obstetric and new born care for all, skilled attendance at every birth, emergency obstetric care for those having complications and referral services. The Maternal health care package of antenatal care, delivery care and postnatal care is a crucial component of NRHM to reduce maternal morbidity and mortality.

Dausa is one of the high focused districts of Rajasthan due to various factors which include performance of maternal health care services in the district. Further its tough geographical location also makes the situation more difficult. When it comes to human resources situation is same as there is crunch of specialists such as gynecologist, pediatrician in the facilities of the district. In this component we would examine the performance of basic maternal health indicators such as ANC, PNC, and Institutional and Home deliveries of the district. Proper records are maintained of anemic pregnant women and women who have recently delivered the child.

7.1) ANTENATAL CARE CHEK-UPS

The ANC services comprises of physical checks, checking position and growth of fetus and giving Tetanus Toxoid injection (TT) at periodic intervals during the time of pregnancy. At least three ANC checkups are required to safeguard women from pregnancy related complications and forewarn pregnant women about possible delivery complications. Institutional delivery and post-natal care in a health facility is promoted in NRHM through introduction of accredited social health activist (ASHA) at village level and Janani Suraksha Yojana, a 100% centrally sponsored scheme, providing cash assistance with delivery and post-delivery care.

Table 5: Block wise Target and achievement ANC Registration 2013-2014(up to April 14)

Block	ANC REGI.			ANC REGI. 12 Week			TT PW		
	TRGT	ACH.	%	TRGT	ACH.	%	TRGT	ACH.	%
Bandikui	9023	654	7.25	6767	307	4.54	9023	654	7.25
Dausa	10622	839	7.9	7967	311	3.9	10622	676	6.36
Lalsot	8906	551	6.19	6680	272	4.07	8906	462	5.19
Mahwa	6753	503	7.45	5065	219	4.32	6753	503	7.45
Sikrai	6745	446	6.61	5059	163	3.22	6745	451	6.69
Total	42049	2993	7.12	31538	1272	4.03	42049	2746	6.53

Source: CMO Office 2014

- The tables 5 indicate the block wise target achieved in the district regarding maternal health which includes registration of pregnant women, and TT injection given to them.
- Table 5 depicts that out of 42049 targeted ANC registrations only 2993 have been achieved i.e. only 7.1% of the set target. Similarly in case of ANC registration within 12 weeks only 4.03% is achieved of the set target. In case of Tetanus Toxoid injection (TT) 2746 was the achievement out of the set target of 42049 TT injections, i.e. 6.53 percent of the target in financial year 2013-14.

7.2) INSTITUTIONAL DELIVERIES

Figure 3 shows the trend of institutional deliveries from 2006 to 2014,it is clear from the figure that after the commencement of the NRHM institutional deliveries has been increased.Infact institutional deliveries at government hospital have been increased drastically since then. While at private institution deliveries has been decreased initially and thereafter slight increment can be seen.

Table 6: Physical progress of Institutional Delivery from year 2006 to 2014

Institutional Delivery	At Sub Centre	At Private Nursing home	At Govt. Hospitals	TOTAL
2006-07	1644	5799	9806	17249
2007-08	1107	4166	20510	25783
2008-09	452	5794	20936	27182
2009-10	326	10009	18387	28722
2010-11	217	8920	15782	24919
2011-12	220	12035	17598	29853
2012-13	200	11477	18730	30407
2013-14	387	11530	19888	31805
2014-15	21	524	1220	1765

Source: CMO Office 2014

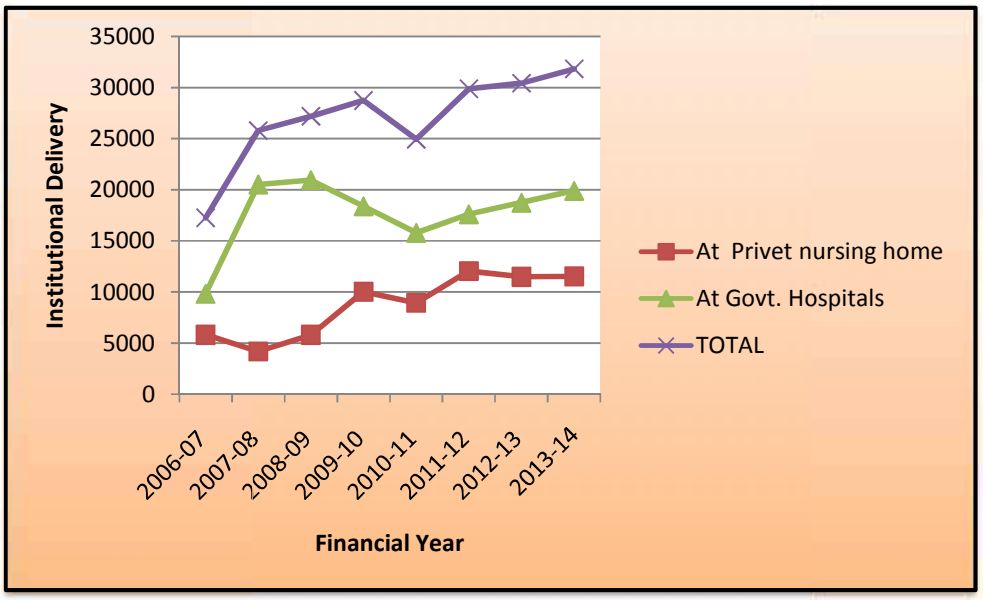

Fig 3: Trend of Institutional Delivery

Table 7 depicts the block wise institutional deliveries in the month of April. Maximum no of deliveries conducted in block Dausa and the reason behind this is the presence of district hospital in this block while in block Sikari minimum no of deliveries has been conducted. Looking at the type of institution and no of deliveries it is found that maximum no of deliveries is conducted by CHC's then private institution and after that district hospital therefore maximum contribution in conducting institutional deliveries is due to CHC's which is clear from the mentioned table.

Table 7: Number of institutional deliveries in the month of April 2014

Block	Dh	CHC	PHC	SC	Private	Total
Bandikui	0	95	29	11	167	302
Dausa	461	22	6	0	91	580
Lalsot	0	266	17		8	291
Mahwa	0	152	44	2	238	436
Sikrai	0	108	20	8	20	156
Total	461	643	116	21	524	1765

Source: CMO Office 2014

Table 8: Block wise Target and achievement of Institutional Delivery (2013-up to April 14)

Block	Inst. Delivery		
	TARGET	ACH.	%
Bandikui	7716	302	3.91
Dausa	9078	580	6.39
Lalsot	7614	291	3.82
Mahwa	6400	436	6.81
Sikrai	6361	156	2.45
Total	37169	1765	4.75

Source: CMO Office 2014

Table 8 depicts the block wise target and achievement of institutional deliveries from 2013 to April 2014 and it is clear from the table that maximum percentage achievement is of 6.81 percent which is by the block Mahwa and minimum achievement is of 2.45percent which is attained by the Block Sikrai.Therefore performance of Block Mahwa is better as compared to other blocks but the percentage achievement of Block Mahwa is low itself so cannot be appraised.

7.3) JANANI SISHU SURAKSHA KARYAKRAM

JSSK is another imitative taken by NRHM for safe motherhood. In this program free of cost medicines, diagnostics, diet and transport is provided to the pregnant women. Free entitlement services are as follows 1) Free cashless delivery, 2) Free C-Section, 3) Free drugs, 4) Free diagnostics, 5) Free diet during stay in the hospital, 6) Free provision of blood, 7) Exemption from user charges, 8) Free transport from home to health institutions, 9) Free transport to other facilities if required for referral, 10) Free drop from institution till home after 48 hours. Further, similar entitlements are given to sick new born till 30 days of birth.

JSSK is functioning well in the district, beneficiaries are availing the services of free diet, diagnostics and referral transport in the district. Further drop back facility is given from sub-centers also.

- Beneficiaries are aware about the benefits of JSSK in the district.
- The essential drug list is maintained at the facilities and if a certain drug which is required for a PW is not available in the facility then it is bought by the hospital authorities and is given free of cost to the beneficiary.
- The diet is provided on time to all the beneficiaries and the service outsourced is quite effective.
- From the above table it can be seen is that the number of beneficiaries availing the services under JSSK 2011 to April 2014.

Table 9: Performance of JSSK in the District

Sr.No.	Particulars	12/09/2011 to 31/03/2013	1/04/2013 to 31/03/2014	1/04/2014 to 30/04/2014
1	No of registered pregnant women	28111	20029	1220
2	No of women Availed free of cost medicines	38029	20704	1232
3	No of women Availed free of cost check ups	33153	20414	1228
4	No of women who are getting free of cost food	27724	19875	1216
5	No of women who availed free of cost transport	27715	19866	1208
	Services availed by sick newborns			
6	Free of cost medicines being provided to sick neonatal	4901	5819	415
7	Free of cost checkups being provided to sick neonatal	1851	4261	378
8	Referral transport being provided to sick neonatal	1302	2689	218

Source: CMO Office2014

- No facility was having any proper grievance cell which was one the lacking point among the facilities.
- It is clear from the table that in four month (January 2014 to April 2014) 1232 women and 415 sick neonatal availed free medicines.1208 Women and 218 sick neonates availed service of free transport.

7.4)MATERNAL DEATH REVIEW

A maternal death is the death of a woman while pregnant or within 42 days of the end of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Every maternal death that occurs within a refugee camp (of a refugee or a national) or at a referral health facility should be systematically reviewed.

A maternal death review provides a rare opportunity for a group of health staff and community members to learn from a tragic – and often preventable - event. Maternal death reviews should be conducted as learning exercises that do not include finger-pointing or punishment. The purpose of a maternal death review is to improve the quality of safe motherhood programming to prevent future maternal and neonatal morbidity and mortality.

- There was proper provision of Maternal Death Review in the district. Each facility recorded maternal death with name of the decease and reason for death.
- More awareness programs should be carried, so that less number of maternal deaths occurs.
- From table 9 is clear that all the maternal death has been reviewed by the district MDR committee from 2013 to March 2014 (in one financial year).Number of maternal deaths in the month of march was 7 while its cumulative total in one financial year was 22.
- 2 Death were reported due to Haemorrhage,1 due to Sepsis while rest 4 were due to other reasons in the month of March.
- Number of women had severe anemia (tested Hb<7-9.9gm/dl) was reported 1875 in the month of March and 19044 women in the period of one year which is clear from the table 9.

Table 10:Maternal Deaths in the month of March 2014

1	**Number of maternal deaths reported during the reporting month**	**7**			
2	**Cumulative number of maternal deaths from april 2013 to reporting month**	**22**			
3	**Number of maternal deaths reviewed during the reporting month by district MDR Committee of CMO**	**7**			
4	**Cumulative number of maternal deaths reviewed from april 2013 to the reporting month by district MDR Committee of CMO**	**22**			
5	**Number of maternal deaths not reviewed by district MDR Committee of CMO**	**Total cumulative number of MD's reported(a)**	**Total cumulative number of MD's reviewed(b)**	**Number of MD's not reviewed (a-b)**	**% of MD's not reviewed {(a-b)/aX100}**
		22	**22**	**0**	**0**
6	**Number of maternal deaths reviewed during the reporting month by district magistrate**	**0**			
7	**Cumulative number of maternal deaths from april 2012 to the reporting month by district magistrate**	**15**			
8	**Cause of MDs(Number and percentage) for the reporting month**	**Number**		**Percentage**	
	Haemorrhage(PPH)	**2**			
	Sepsis	**1**			
	Abortion				

	Abstructed Labour				
	Hypertensive disorders in pregnancy*				
	Others**(Anoems/Resp.arrot)	4			
	Total	7			
9	How many pregnant women had severe anaemia(tested Hb<7gm/dl) in number (c)	In March	Up to March		
	How many pregnant women had severe anaemia(tested Hb<7-9.9gm/dl) in number (d)	1875	19044		
	Number of maternal deaths in which anaemia has been identified as a cause(direct/associated) by Hb testing (c+d)	-			
	Proportion of maternal deaths in which anaemia has been identified as a cause(direct/associated) by Hb TESTING (c+d/ total MDs for the month X 100)	-			
10	Proportion of Meetings of MDR Committee of CMO held out of the expected number of meetings for the reported month (@ at least one meeting/district/month as per MDR Guidelines) :- no of meetings held/no of expected meetings X 100 %	Expalted Held 01 01 1=100%			
11	Remark(predominant cause of MDs, districts where MDs are concentrated-HF/non HF district, gaps identified etc)	PPH			
12	Steps taken by the state to improve reporting of maternal deaths	-			
13	Other corrective actions taken by the state	-			
14	#Number $ percentage of maternal deaths not reported for the year	No. of MDs expected for the state for onr year based on MMR (e)	Cumulative no. of MDs for the year april-march (f)	No. of MDs not reported (e-f)	Percentage of MDs not reported out of the numbers expected during the year ((e-f)/eX100)
		-	-	-	-

Source: CMO Office 2014

7.5)JANANI SURAKSHA YOJANA

Janani Suraksha Yojana is an initiative for safe mother hood under NRHM. It basically aims at reducing maternal and neo-mortality rate by promoting institutional deliveries among poor pregnant women.

Table11: Performance of JSY in the District

Block Name	Current				Last Year's Progress			
	UP TO APRIL 14				2013-14			
	BPL Families		APL	Total	BPL Families		APL	Total
	Home	Inst.	Inst.		Home	Inst.	Inst.	
Bandikuie	0	1	134	135	0	15	2029	2044
Dausa	0	28	461	489	0	455	7134	7589
Lalasot	0	10	273	283	3	184	4071	4258
Mahuwa	0	17	182	199	0	346	3208	3554
Sikray	0	16	126	142	22	275	2153	2450
	0	72	1176	1248	25	1275	18595	19895

Source; CMO Office 2014

- In the block Dausa maximum JSY beneficiaries were reported for the month of April of which 461 belongs to APL families and 28 belongs to BPL while minimum were reported by the block Bandikuie.Reason behind the better performance of block Dausa is the presence of District hospital in this block .
- In the financial year 2013-14,total 19895 JSY beneficiaries were reported in the district of which 18595 were from the APL families while only 1300 were from BPL families, so it is clear that APL families are availing more as compared to BPL families.
- JSY is performing well in the district. But with change in mode of payment, beneficiaries are facing difficulty in accessing their amount. As all the beneficiaries don't have bank account, so they are not being able to receive their desire amount. There should be some scheme in the district which provides aid to the beneficiaries who don't have account in the bank. Otherwise proper records are maintained in different facilities and patients are aware of this scheme in the district. In all the facilities visited by us it was seen that JSY payments were made on time and the records were neatly maintained by the ANMs and other concerned staffs.

Table 12:Progress report of JSY beneficiaries 2011-2014

Year	APL	BPL	Home BPL	Total
2011-12	16921	1411	58	18390
2012-13	17741	1310	6	19057
2013-14	20855	1275	25	22155
2014-15	1392	72	0	1464

Source; CMO Office 2014

It is clear from the table 11 that no of JSY beneficiaries has been increased significantly since 2011 and it was more in the families who belongs to APL families rather in BPL families.Increment of 3098 is reported in 2013-14 while in 2012-13 it was merely 667.Therefore it is clear that performance is getting better year by year.

8) CHILD HEALTH

Child health programme under NRHM stresses upon reducing IMR in India. The Child health program promotes the following points;

- Neonatal Health,
- Nutrition of the child,
- Management of common childhood illness and
- Immunization of the child.

In Dausa district child health program was functioning smoothly expect for the lack of manpower resources. Immunization days were Wednesday and Saturday in the district. SNCU is there in the district but not under proper functioning because of lack of trained staff and poor management. However the mother's are advised by the doctors and the ASHAs to provide proper nutrition to the children to prevent the child from many diseases during their growing period.

8.1) SICK NEWBORN CARE UNIT

Block wise reporting of SNCU's is presented in table 12 and 13, SNCU Bandikui reporting is not available due to absence of pediatrician at CHC Bandkui.Absence of pediatrician in the district which is of utmost importance for child health program.

Table 13: Facility based SNCU Dausa Reporting,Block Dausa(April 13 to March 14)

New admission	Discharged	LAMA	Reffered	Expired	Still Admitted
93	63	1	10	6	13

As we can see from the table 13, 93 sick neonates were admitted of which 63 discharged from the hospital ,10 referred ,1 LAMA ,6 expired and 13 are still admitted in the SNCU Dausa.

Table 14: Facility based SNCU Lalsot Reporting, Block Lalsot (April 13 to March 14)

S. No.		Details: Facility BasedSNCU Specific	Numbers
1		No of New born admitted in the SNCU	45
	1.a	Number of out born	0
	1.b	Institutional Births	0
	1.c	Home Births	0
	1.d	Number of Inborn	38
		Complications	
2		No of new born with Septicaemia	3
	2.a	Number of new born with Asphyxia	19
	2.b	Number of New Born with Pre Maturity	0
	2.c	Number of New born with Hyper bilirubinemia	0
	2.d	Number of New born with tetanus Neonatoreum	0
	2.e	Number of New Born with Congenital Anomalies	0
	2.f	Number of new born with Hypothermia	12
	2.g	Any other	10
3		Number of Neonate treated at CHC	30
4		Number of Neonate referred to higher centre	28
5		Number of Neonatal death	0

Source: CMO Office 2014

It is clear from the table 14 that 45 were admitted to the SNCU Lalsot, 3 newborn were reported with Septicaemia,19 with Asphyxia, and 12 reported with Hypothermia. Number of neonates treated at CHC are 30 and 28 were referred to higher centre.

Table 15: Facility based SNCU Mahwa Reporting, Block Lalsot (April 13 to March 14)

S.No		Details:Facility Based:SNCU Specific	Numbers
1		No of New born admitted in the SNCU	56
	1.a	Number of out born	7
	1.b	Institutional Births	7
	1.c	Home Births	0
	1.d	Number of Inborn	49
		Complications	
2		No of new born with Septicemia	9
	2.a	Number of new born with Asphyxia	20
	2.b	Number of New Born with Pre Maturity	8
	2.c	Number of New born with Hyper bilirubinemia	12
	2.d	Number of New born with tetanus Neonatoreum	0
	2.e	Number of New Born with Congenital Anomalies	0
	2.f	Number of new born with Hypothermia	0
	2.g	Any other	0
3		Number of Neonate treated at CHC	0
4		Number of Neonate referred to higher centre	0
5		Number of Neonatal death	0

Source: CMO Office 2014

From the table 14 it is clear that 56 were admitted to the SNCU Mahwa,9 were reported with Septicemia,20 with Asphyxia,8 were reported with Pre Maturity and 12 reported with Hyper bilirubinemia.

8.2) IMMUNIZATION

- Immunization days are Wednesday and Saturday in the district. Proper immunization card are maintained in DH, PHCs, CHCs and Sub- Centers. ANMs are actively involved in the process of immunization.
- Shortage of any vaccination and drug supply is not been reported in the district. ASHAs are also given duty to create awareness about vaccination program in the district.
- But more IEC material could have been displayed regarding immunization, which could create more awareness among people. Further Cold chain storage was available in most of the facilities

Table 16: Immunization Target and achievement in the District 2013-14

Block	INFANT	BCG		DPT		OPV		HEP B		MEASLS		FULL IMMU	
	TRGT	ACH.	%	ACH.	%	ACH.	%	ACH.	%	ACH.	%	ACH.	%
Bandikui	7752	310	4	520	6.71	520	6.71	524	6.76	474	6.11	474	6.11
Dausa	9125	551	6.04	636	6.97	644	7.06	648	7.1	555	6.08	555	6.08
Lalsot	7651	287	3.75	542	7.08	542	7.08	542	7.08	443	5.79	443	5.79
Mahwa	5801	452	7.79	362	6.24	362	6.24	362	6.24	317	5.46	317	5.46
Sikrai	5795	177	3.05	388	6.7	388	6.7	388	6.7	310	5.35	310	5.35
Total	36124	1777	4.92	2448	6.78	2456	6.8	2464	6.82	2099	5.81	2099	5.81

Source; CMO Office 2014.

- Table number 16is showing the status of achieved immunization in the district during 2013-14. Total target of district was 36124 while percentage achievement of BCG was 4.92%, percentage achievement of DPT was 6.78%, percentage achievement of OPV,HEP B and Measles were 6.78,6.8 and 5.81 respectively .Only 5.81 % of target got fully immunized .There was no shortage of vaccine so far, and process of immunization was running smoothly in the district.

9)FAMILY PLANNING

Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy

Table 17:Block wise Target and Achievement of Sterilization in the district

Block	Sterilisation		
	TARGET	ACHIEVEMENT	% ACHIEVED
Bandikui	2175	39	1.79
Dausa	2556	151	5.91
Lalsot	2145	8	0.37
Mahwa	1626	8	0.49
Sikrai	1627	8	0.49
Total	10129	214	2.11

Source; CMO Office 2014

- It can be seen from the table 17 that target for sterilization was set at 10129 but only 2.1% was achieved of the set target i.e. only 214 female .It is also clear that block Dausa is performing better as compared to other blocks.

Table 18: Physical progress of Sterilization and IUCD

YEAR	2012-13			2013-14			2014-15		
	TRGT	ACH	%	TRGT	ACH	%	TRGT	ACH	%
STERLISATION	16699	8081	49	10129	8455	83.46	10129	214	2.11
COPPER-T	11803	7322	62	11803	2286	19.36	11803	497	4.21

Source: CMO Office 2014

Table 19: Male sterilization Block wise Progress report

Male sterilizationProgress report block wise Up to March 2014						
Block Name	**up to MARCH 14**			**up to MARCH 13**		
	ELA	**Ach**	**%Ach**	**ELA**	**Ach**	**%Ach**
Bandikui	3587	1604	44.71703	3587	1585	44.18734
Dausa	4214	2246	53.29853	4214	2150	51.02041
Lalaot	3537	81	16.20258	3537	1336	263.9013
Mahwa	2679	1342	50.09332	2679	1288	48.07764
Sikrai	2682	1340	49.96271	2682	1176	43.84787
other		1842				
DISTRICT	16699	8455	50.63177	16699	7535	45.12246

Source: CMO Office 2014

- Table No. 18 is showing the situation of sterilization and insertion of IUD in the district. When sterilization is concern, 83.46 % was the achievement of the set target of 10129. Whereas insertion of IUD is concerned, 19.36 % was the achievement of the set target of 11803.Over the years the performance of female sterilization is somewhat satisfactory in the district. When it comes to male sterilization situation is worse in the district. Lot can be done to improve the situation regarding male sterilization which is clear from the table 17 and 18.

10)ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH

***There are no separate ARSH clinics in the District. The adolescents can consult the doctor in OPD.**

11)QUALITY IN HEALTH SERVICES

1.1)INFECTION CONTROL

The facilities were maintained quite neatly, but more can be done to improve the surroundings of the facility, Cleanliness of the toilets was a major issue, proper maintenance was required in that area. Mainly there is need to improve the situation of District hospital.

11.2)BIOMEDICAL WASTE MANAGEMENT

The bio medical waste in the district at all facility level except District Hospital is segregated into three colored bags or dust bins and then the agency Raj Putana Biotech which is outsourced to collect the bio-medical waste comes and collects it from every facility on alternate day basis. In District Hospital colored bins were used as normal dust bins and found at the different corners of the hospital. Hospital is not using the norms of segregating the bio medical waste in to different colored bins.

11.3)INFORMATION,EDUCATION AND COMMUNICATION

IEC was not at all effective in the facilities; posters of JSY, JSSK, vaccination and prevention of communicable diseases were not effectively displayed. There were only wall paintings which were found in majority. Further list of drugs, list of services were available in the in the District hospital and in the CHC.They could enhance their awareness about Family Planning services, Maternal Health, Child Health, HIV/AIDS and ARSH and understand the importance of improved indicators on maternal and child health. In considering priorities for health, greater effort and resources are required, to increase their awareness and changes attitudes towards health issues, IEC efforts can be very useful.

13.)COMMUNITY PROCESSES

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist ASHA or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system.

Below mentioned table discusses the percent trained and untrained human resource persons. From the table 20 it is clear that only 47% ASHAs, 34% ANMs and 13.5% LHVs are trained .Whereas in case of MOs and CEPO no training has been provided yet.

Table 20: Training Status of ASHAs in the District

Serial No.	Particulars	Total Load	Trained	%Trained	Untrained	%Untrained
1	ASHA	1259	591	47	668	53.1
2	ANM	278	95	34	183	65.8
3	GNM/M.N	310	1	0.3	309	99.7
4	LHV	37	5	13.5	32	86.5
5	MO	48	0	0	48	100.0
6	CEPO	5	0	0	5	100.0
Total		1937	692	35.7	1245	64.3

Source; CMO Office2014

14.)DISEASE CONTROL PROGRAMME

Provision of diagnostics of tuberculosis, Leprosy and Malaria was available in the district. But creating awareness through IEC was absent in all facilitates. Laboratories were present in the facilities and were functioning well.

Table number 21 is showing trend of leprosy control program from 2010-11 to 2013-14It is clear from the table that achievement has been increased initially but there after it has been decreased significantly and then remained constant for two consecutive years. Table 21 depicts the no of bold sample collected and found positive cases of Malaria; it is clear from the table that in 2013-14 out of 48031collected samples 22 were found with positive sign.

Table 21:Trend Report of National Leprosy Control Programme in the District

Year	Target	Achievement	Total expenditure	Remained
2010-11	35	23	161444	250802
2011-12	30	26	28400	210176
2012-13	22	10	143460	66157
2013-14	15	10	35700	80455
2014-15	15	0	0	80455

Source; CMO Office 2014

Table 22: Block wise reporting of Blood samples collected and resulting positive cases

Sr. No	BLOCK	POPULATION	BLOOD SAMPLES				POSITIVE CASES			
			ACTIVE	PASSIVE	MASS	TOTAL	ACTIVE	PASSIVE	MONTHLY	TOTAL
1	Dausa	337224	5179	4738	64	9981	0	5	0	5
2	Bandikui	359728	6362	3957	50	10369	0	7	0	7
3	Lalsot	344482	5050	4040	19	9109	0	1	0	1
4	Sikrai	270437	5061	6132	15	11208	0	3	0	3
5	Mahwa	263422	2447	4170	0	6617	0	1	0	1
		70229	0	747	0	747	0	5	0	5
	Total 2014	1645522	24099	23784	148	48031	0	22	0	22
	Total 2013					46626				22

Source; CMO Office 2014

15.)GOOD PRACTICES AND INNOVATIONS

- HMIS was one of the strong points of the district. Proper recording was there, and data operators were familiar with the HMIS portal.
- Ayush wing was functional in the district and people were aware of its benefits.

16)HMIS & MCTS

HMIS and MCTS were functioning well in the district. Data entry operators were recording the data from time to time. It was one of the plus points of the district as it helps maintained a record of the achieved status of various programs. MCTS portal helped to track anemic women and child in the district, proper record was maintained and checking was done from time to time. Overall both HMIS and MCTS were working well in the district.

18)OBSERVATIONS FROM THE FIELD

DISTRICT HOSPITAL, DAUSA

- The District hospital is located in middle of the city and is easily accessible to the beneficiaries. The district hospital is 150 bedded with an average of 500 to 600 deliveries being conducted at the facility every month. The hospital on a daily basis is facing many problems starting from Human Resource,JSSK, Cleanness & maintenance .

Fig 4: District Hospital Dausa

- The services of blood storage unit were available. There was functional blood bank, refrigerators and sufficient number of blood bags at the Centre. The DH had all the important OT equipments like ventilators, pulse-oximeters, multi-para monitor, and laparoscope. However, SDH has no mobile lights and multi-para monitor. Among the laboratory equipments, the DH does not have ultrasound scanners and CT scanner.
- As Dausa is a C-Class city so people refrain from applying for the post of Doctors on contractual basis. The DH has quarters for MOs and staff nurses, but no quarters are available for other staff members. It has functional labour room new born care corner, NBSU, SNCU, nutritional rehabilitation center and blood bank. It has no power backup and there is no 24*7 supply of running water.
- Hygiene level of the facility was very poor , no ward boy is appointed for the labour room .At the time of visit labor room was found in highly unhygienic condition .All the Class four employees work on contractual basis and they are very reluctant for their work. So premises remain unclean and in pathetic condition.
- The major problem which the contractual staff faces is of salary which they receive late, so most of the work assigned to them gets delayed. The diet provided to the patients in the hospital under the JSSK scheme is outsourced. The organization provides packed food according to the number of beneficiaries present in the hospital.
- It was observed that there was no shortage of drugs at the facility however there was a shortage of vaccines which has taken care by the authorities.

Fig5: Non Functional Operators **Fig6:SNCU Facility at DH**

- As there is only one Radiologist in the District so the ultrasound at the facility is not performed on a daily basis. It was observed that some of the registers were not properly maintained. The registers of PNC, list Lining of severely anemic pregnant women, pantograph were maintained properly. The record for OT, FP, ANC and MDR were available and maintained. The immunization register was not available at the time team visited the Centre
- The JSY cheques are given on time and the records are maintained properly in the facility with the photographs, signatures and thumb impressions of the beneficiaries who received the cheques.

Fig7: IEC at the DH **Fig8: Cold chain facility at the DH**

- For maternal death reviews the facility has formed a committee which consists of the doctors who review the whole case of maternal death and mention all the reasons of the death. Till now all the cases has been reviewed by the committee.
- There is even a committee formed for grievances of the beneficiaries as well as a complaint box is maintained in the hospital compound to drop in there complains.

- The provision of IEC was effective in the facility that is in the form of posters and hoardings. There are many wall paintings on the benefits of institutional deliveries and JSSK.Drug distribution and OPD registration is done from one room and the ANC register is not maintained properly.
- The provision of training is very poor for instance there is a Family Welfare Counselor appointed in the facility however she has not received any counseling training on the subject.
- It has been months to the recruitment of the SNCU staff however no training is given to the staff on SNCU intricacies and maintenance. No of machines are not functional and there is no proper management to take care of. Operation Theater was found locked at the time of visit.

Fig 9:Post Natal Ward at DH

Fig 10:Condition of Labour Room

- The laboratory of the facility has a functional microscope, hemoglobin meter, centrifuge, semi-auto analyzer and testing kits.
- Pregnancy testing kits, oral contraceptives, emergency contraceptives and IUCDs are available in the facility. There is a shortage of space for the seating of the attendants due to space crunch.

COMMUNITY HEALTH CENTRE, PAPARDA

- The CHC is a 9 bedded hospital with 50-60 deliveries being conducted on an average on a monthly basis.

Fig 11:CHC Paparda

- The CHC does not have a Surgeon, Gynecologist at the facility and a need of a lady doctor is highly required in the hospital due to certain prejudices of the community which comes for availing the facilities.
- The staff quarters are under renovation and will be provided to the staff in a month or two according to the officials. Rationale and equitable of deployment of HR is the major problem which the CHC faces.

Fig 12& 13: Shows the IEC for JSY and drug list CHC,Paprda

- In CHC, it has functional labour room and wards are maintained with general cleanliness. Ambulances are running effectively in the provision of the drop-back facilities of the beneficiaries.
- Only X-ray services are provided in the hospital as there is only one Radiologist in the whole district so provision of ultrasound facility becomes difficult.
- The diet provided to the patients in the hospital under the JSSK scheme is outsourced. The organization provides packed food according to the number of beneficiaries present in the

hospital. The contractual staff is receiving their salary quite late due to late approval of the budget.

- The JSY cheques are received by the beneficiaries on time and since 1st January, 2014 account payee cheques are provided at the facility.ANM is not there since long back ,she is on deputation. So officially she is allotted for this Centre but works for somewhere else.
- The OPD and the ANC registers are not maintained properly. The data in the MCTS registers is quite scattered and random. The O.T is well equipped with the equipments such as ventilators, pulse-oximeter, surgical diathermies, laparoscopes and autoclaves.
- The bio-medical waste is dumped in a pit and then is discarded manually if required. Biomedical waste is taken by the concerned Rajputana Biotech agency.
- The laboratory of the facility has a functional microscope, hemoglobin meter, centrifuge, semi-auto analyzer and testing kits. The essential drug list and the citizen charter is present at the facility. The provision of IEC in the District is an essential requirement at the facility.

PRIMARY HEALTH CENTRE,ALUDA

- It is recently converted to PHC from Sub-Centre.ANM was not present there and PHC was closed at the time of visit. It has converted to PHC two months back but till now this PHC is not providing services. Required staffs are not appointed to the PHC yet.

Fig14: PHC Aluda

- There were separate toilets for male and female and timing of the PHC were painted on the wall of the facility. The display of IEC is very poor at the facility.

SUB CENTRE, Nangalbersi

- A Sub-Health Centre (Sub-Centre) is the most peripheral and first contact point between the primary health care system and the rural community. There is general impression about the S.Cs that the current level of functioning of the Sub Centre's is much below the expectations.
- There was no running water supply and power backup in the facility.
- MCH, Delivery register, VHSNC Meeting register has been maintained in the facility.
- Pregnancy testing kit, OCP, ECP, sanitary napkins are delivered to sub center but sugar testing kit was not available.
- Record of IFA distribution, home deliveries, breast feeding and birth defect record has been maintained and updated in the district.
- No proper bio-medical waste system was available in the facility.
- IEC display was poor, there was lack of IEC material in the district.

SUB CENTRE, Chandrana

- MCTS, delivery register and VHSNC meeting register was available in the facility
- Further VHND session is being organized according to the schedule and minutes are recorded of the meeting.
- ANM's are trained properly and are delivering services to the beneficiaries on time .Sub Centre is facing the problem of water supply and power backup facility.
- It can be said that both Centre's do not function well due to lack of resources. There were no separate bins in the facility. The bio medical waste is not disposed properly.

19) CONCLUSIONS AND RECCOMENDATIONS

- The hospital and facilities have no adequate staff and health workers are untrained for various tasks. There is a lack of managerial capacity, shortage of skilled human resources including medical and para-medical. In order to overcome such problems there needs to have a short term training programmes for medical officers and nurses to provide emergency obstetric care. Necessary appointments of skilled persons against the sanctioned post and more posts are needed to be sanctioned.
- In post natal wards, both the facilities provide essential services like counseling on IYCF and family planning, free diet for beneficiaries and vaccine to newborns. Also, most of the time, the JSY payment is made soon after the discharge of the mother or at most within a week.

- In view of the deteriorating public health infrastructure, it needs immediate reforms to deal with new emerging challenges. On the one hand the role of private players is continuously increasing in healthcare sector, but simultaneously healthcare facilities are getting costly, and becoming non-accessible for the poor.
- The government health facilities institutions are facing the problem of lack of resources and infrastructure; there are inadequate number of essential manpower, beds, rooms, and medicines. There is lack of monitoring of the funds and resources, which are devoted towards the improvement of healthcare sector, need to have qualitative and quantitative aspect of health care plans.
- Further class 4 workers are contractual in nature and very reluctant for their work,so premises remained unclean. Salary of contractual staff was another major issue in the district. Especially for computer operators there was discrepancy in the salary pattern as some computer operators were getting less salary than others. This kind of problem exist with other fourth class employees.
- HMIS department can develop a plan for orientation of frontline workers and managers to improve data quality. State Demographic Cell and HMIS department should plan and conduct orientation/training of block and district level officials to improve data analysis and provision of appropriate feedback. The HMIS data maintenance is required at the facility level. It was found that the data on ANCs, immunization, referral cases was different in the HMIS format when compared with the registers. This problem can be solved if there are BPMs and data entry operators to keep proper check on the system
- Sub-centers are not working in a proper manner in the district, so more emphasis should be laid on them so that they can perform exceptionally great in their areas.
- There was high maternal mortality rate in the district. Due to repetitive pregnancies, most of the women were anemic. ARSH wing in the facilities should get established in the district as soon as possible. More training programs should be organized so that more staff can be trained which can lead to efficiency in work. Contractual staff also should get salary on time, so that they are motivated to perform better.
- Health facilities in the backward regions generally suffer from the shortfall in availability of equipments, the actual utilization of the available equipments, and also not in use or kept as reserve. The provision of repairing has not been effective, to some extent this happens due to improper and poor system of maintenance and repair. Therefore, proper provision of maintenance of existing equipments and repairing.

- Availability of adequate number of human resources with suitable skill and their appropriate deployment at different levels of health care set-up are essential for providing an effective health care service for the population. In spite of continue efforts for maintaining proper availability of medical and Para-medical personnel, however, shortage exists in all categories of human resources at different levels. This problem is more acute in the remote areas where the shortage of doctors and nursing staff have been a perennial problem with the result one can see patient's long serpentine queues outside registration counters that move at a snail pace. Therefore, availability of appropriately prepared health workforce is critical for achieving better health goals.
- Lower level health institutions in the district did not have essential facilities i.e. power backup, water supply, functional labor room and new born care corner. The facilities that are closer to the public should have some essentials, like equipments and health personal that fulfill the immediate needs of the population. Also, some of the equipments were lying non-functional in almost all the facilities, but the maintenance of these equipments has not been taken seriously by the hospital in charge.
- Regarding the allocation of the NRHM funds to various facilities, there absorptive capacity was not properly taken into consideration. Under mission's flexi pool the utilization of funds has been low where the allocation was higher and in some cases utilization has been higher than the allocated funds. Similarly under RCH Flexi Pool, low budgeting has been reported for maternal health, JSY and immunization.

ANNEXURE

Sl No.	ITEMS	QUESTIONS						
1	District Profile	No. of Blocks						
		No. of Villages						
		Population						
		Literacy						
		Sex Ratio						
		IMR						
		MMR						
		Female sex ratio						
		Male sex ratio						
2	Trends of various indicators over the period of 5 years	INDICATORS	2009	2010	2011	2012	2012	2013
		IMR						
		MMR						
		OPD						
		IPD						
		ANC						
		PNC						
		SBA						
		Immunization						
		Unmet need for FP						

		NMR						
3	Health facility	Total no. of health facilities in the District					Total no of Govt. building	Total no of rented building
		DH ☐	SDH ☐	CHC ☐	PHC ☐	SC ☐	☐	☐
4	What are the steps being taken by the District officials to fill the gap in health service delivery, If any?							

5	a)Human Resource: *** collect the human resource list from the District(Currently available/posted)**								
	b) Strategies followed for the retention of the contractual managerial staff under NRHM								
	c)The current status of the training received by the staff under NRHM for the year 2013-14								
	BeMOC	**EMOC**	**SBA**	**MTP**	**IMNCI**	**NSV**	**NSSK**	**IUD**	**RTI/STI**	**OTHERS**
	Remarks on training								

6	**Status of Implementation of JSSK**			**Remarks**
	a) Entitlements: Cashless services and User charges	**Whether G.O issued**	**Month(Start/Proposed)**	
	i) Provision of free drugs/consumables	Yes ☐ No ☐		
	ii) Provision of free diagnostics	Yes ☐ No ☐		
	iii) Provision of free diet	Yes ☐ No ☐		
	iv) Provision of free blood (inclusive of testing fee)	Yes ☐ No ☐		
	v) Provision of free treatment to sick newborns up to 30 days	Yes ☐ No ☐		
	vi) Free referral transport for PW (to and fro, 2nd referral)	Yes ☐ No ☐		
	vii) Free referral transport for sick newborns (to and	Yes ☐ No ☐		

	fro, 2nd referral)			
	viii) Exemption from all user charges for all PW and sick newborns	Yes ☐ No ☐		
	ix) Empowerment of MO in-charge to make emergency purchases	Yes ☐ No ☐		
7	Entitlements: Referral Transport	District owned	EMRI/EMTS	PPP
	i) Total number of ambulances/referral vehicles in the State/UT			
	ii) Vehicles fitted with GPS			
	iii) Call centre(s) for the ambulance network	District (No.)	State(Y/N):	
	iv) Toll free number	No.		
8	Grievance redressal	Status detail	Remarks	
	No. of complaints/grievance cases related to free entitlements			
	No. of cases addressed/ no. of cases pending			
9	Are special newborn care units (SNCU) established for care of the sick and newborn in all Medical Colleges and District Hospitals	Yes ☐ No ☐	Remarks	
10	Has the District prepared a detailed district plan for intensification of routine immunization with special focus on districts with low coverage?	Yes ☐ No ☐	Remarks	
11	Is the coverage of DPT 1st booster and measles2nd dose emphasized and monitored?	Yes ☐ No ☐		
12	Are special micro plans developed for inaccessible remote areas and urban slums?	Yes ☐ No ☐		
13	Is there any development of BCC/IEC tools highlighting the	Yes ☐ No ☐		

	benefits of Family Planning specially on spacing methods		
14	Status of School Health Programme		
	a) School health committee with diverse stakeholders	Yes ☐ No ☐	
	b) Involvement of nodal teachers from schools in the programme	Yes ☐ No ☐	
	c) Are all children in government (Aided) schools covered	Yes ☐ No ☐	
	d) Dedicated teams for health check-ups for children below 6 years at AWC	Yes ☐ No ☐	
	e) Status of School Health Programme	Yes ☐ No ☐	
15	Details of availability of drugs ?		
16	Status of JSY payment		

Total no. in 2011	Total no. in 2012	Total no. in 2013	Remarks

17	Data Surveillance		Remarks
	b) Data collections on key performance indicators	Yes ☐ No ☐	
	c) 100% registration of births and deaths under CRS	Yes ☐ No ☐	
	d) Epidemiological surveillance	Yes ☐ No ☐	
	e) Maternal Death Review	Yes ☐ No ☐	
	f) Infant Death Review	Yes ☐ No ☐	
	g) Tracking using MCTS	Yes ☐ No ☐	
	i) Is HMIS/MCTS implemented at all facilities	Yes ☐ No ☐	
18	HMIS/MCTS		
	Is HMIS /MCTS implemented at all the facilities	Yes ☐ No ☐	
	Is HMIS data analyzed and discussed with concerned staff at state and district levels for necessary corrective action to be taken in future?	Yes ☐ No ☐	

	Do programme managers at all levels use HMIS data for monthly reviews?	Yes ☐ No ☐	
	Is MCTS made fully operational for regular and effective monitoring of service delivery including tracking and monitoring of severely anaemic women, low birth weight babies and sick neonates	Yes ☐ No ☐	
	Is the service delivery data uploaded regularly	Yes ☐ No ☐	
	Is the MCTS call centre set up at the District level to check the veracity of data and service delivery?	Yes ☐ No ☐	
	Is HMIS data analyzed and discussed with concerned staff at state and district levels for necessary corrective action to be taken in future?	Yes ☐ No ☐	
19	Are SNCUs available in the District?	Yes ☐ No ☐	
	EQUIPMENTS		
	STAFF		
	ADMISSIONS		
	TREATMENT OUTCOMES		
	UTILIZATION		
20	Family planning (availability of contraceptives, IEC & availability of services at different level)		
21	Clinical Establishment Act : (PIP approval status and implementation)		
22	Current status of ASHAs (Total number of ASHAs) ASHAs presently working Positions vacant Skill development/refresher training of ASHAs Payment issues Other issues		
23	Immunization status in the district (micro plan, outreach plan, alternate vaccine, delivery stock)		
24	Total number of Rehabilitation Centre in the District ☐		
25	Intersectoral convergence including NGOS & PPPs		
	a) Effective coordination with key departments on		

	i) Water and Sanitation	Yes ☐ No ☐
	ii) Education (SSA)	Yes ☐ No ☐
	iii) Women and Child Development (SABLA, ICDS)	Yes ☐ No ☐
	iv) Gender and women empowerment	Yes ☐ No ☐
	b) Consultations with civil society	Yes ☐ No ☐
	c) Involvement of NGOs to fill service delivery gaps	Yes ☐ No ☐
	d) NGO involvement in community monitoring	Yes ☐ No ☐
	e) PPP for underserved and vulnerable areas	Yes ☐ No ☐
	f) PPP in family planning and diagnostic services	Yes ☐ No ☐
26	Community Involvement	
	a) Patient feedback mechanisms	Yes ☐ No ☐
	b) Grievance redressal mechanisms	Yes ☐ No ☐
	c) Empowered PRIs	Yes ☐ No ☐
	d) Effective VHSNC	Yes ☐ No ☐
	e) Social audit	Yes ☐ No ☐
	f) Effective VHND	Yes ☐ No ☐
	g) Strengthening of ASHAs	Yes ☐ No ☐
	h) Comprehensive communication strategy including BCC	Yes ☐ No ☐
	i) Dissemination in village/slums and peri-urban areas	Yes ☐ No ☐

Appendix 2:

DH level Monitoring Checklist

Name of District: _____ Name of Block: _____ Name of DH: _____
Catchment Population: _____ Total Villages: _____
Date of last supervisory visit:_____

Date of visit: _____ Name& designation of monitor:_____
Names of staff not available on the day of visit and reason for absence:_____

Section I: Physical Infrastructure:

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

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

Section II: Human resource:

S. no	Category	Numbers	Remarks if any
2.1	OBG		
2.2	Anaesthetist		
2.3	Paediatrician		
2.4	General Surgeon		
2.5	Other Specialists		
2.6	MOs		
2.7	SNs		
2.8	ANMs		
2.9	LTs		
2.10	Pharmacist		
2.11	LHV		
2.12	Radiographer		
2.13	RMNCHA+ counsellors		
2.14	Others		

Section III: Training Status of HR:

S. no	Training	No. trained	Remarks if any
3.1	EmOC		
3.2	LSAS		
3.3	BeMOC		
3.4	SBA		
3.5	MTP/MVA		
3.6	NSV		
3.7	F-IMNCI		
3.8	NSSK		
3.9	Mini Lap-Sterilisations		

3.10	Laproscopy-Sterilisations		
3.11	IUCD		
3.12	PPIUCD		
3.13	Blood storage		
3.14	IMEP		
3.16	Immunization and cold chain		
3.15	Others		

Section IV: Equipment:

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

4.22	Functional Ventilators	**Y**	**N**	
4.23	Functional Pulse-oximeters	**Y**	**N**	
4.24	Functional Multi-para monitors	**Y**	**N**	
4.25	Functional Surgical Diathermies	**Y**	**N**	
4.26	Functional Laparoscopes	**Y**	**N**	
4.27	Functional C-arm units	**Y**	**N**	
4.28	Functional Autoclaves (H or V)	**Y**	**N**	
	Laboratory Equipment			
4.1a	Functional Microscope	**Y**	**N**	
4.2a	Functional Hemoglobinometer	**Y**	**N**	
4.3a	Functional Centrifuge	**Y**	**N**	
4.4a	Functional Semi autoanalyzer	**Y**	**N**	
4.5a	Reagents and Testing Kits	**Y**	**N**	
4.6a	Functional Ultrasound Scanners	**Y**	**N**	
4.7a	Functional C.T Scanner	**Y**	**N**	
4.8a	Functional X-ray units	**Y**	**N**	
4.9a	Functional ECG machines	**Y**	**N**	

Section V: Essential Drugs and Supplies:

S.No	Drugs	Yes	No	Remarks
5.1	EDL available and displayed	***Y***	***N***	
5.2	Computerised inventory management	***Y***	***N***	
5.3	IFA tablets	***Y***	***N***	
5.4	IFA tablets (blue)	***Y***	***N***	
5.5	IFA syrup with dispenser	***Y***	***N***	
5.6	Vit A syrup	***Y***	***N***	
5.7	ORS packets	***Y***	***N***	
5.8	Zinc tablets	***Y***	***N***	
5.9	Inj Magnesium Sulphate	***Y***	***N***	
5.10	Inj Oxytocin	***Y***	***N***	
5.11	Misoprostol tablets	***Y***	***N***	
5.12	Mifepristone tablets	***Y***	***N***	
5.13	Availability of antibiotics	***Y***	***N***	
5.14	Labelled emergency tray	***Y***	***N***	
5.15	Drugs for hypertension, Diabetes, common ailments e.g PCM, metronidazole, anti-allergic drugs etc.	***Y***	***N***	

5.16	Adequate Vaccine Stock *available*	**Y**	**N**	
S.No	**Supplies**	**Yes**	**No**	**Remarks**
5.17	Pregnancy testing kits	***Y***	***N***	
5.18	Urine albumin and sugar testing kit	***Y***	***N***	
5.19	OCPs	***Y***	***N***	
5.20	EC pills	***Y***	***N***	
5.21	IUCDs	***Y***	***N***	
5.22	Sanitary napkins	***Y***	***N***	
S.No	**Essential Consumables**	**Yes**	**No**	**Remarks**
5.23	Gloves, Mckintosh, Pads, bandages, and gauze etc.	***Y***	***N***	

Section VI: Other Services :

S.no	Lab Services	Yes	No	Remarks
6.1	Haemoglobin	**Y**	**N**	
6.2	CBC	**Y**	**N**	
6.3	Urine albumin and sugar	**Y**	**N**	
6.4	Blood sugar	**Y**	**N**	
6.5	RPR	**Y**	**N**	
6.6	Malaria	**Y**	**N**	
6.7	T.B	**Y**	**N**	
6.8	HIV	**Y**	**N**	
6.9	Liver function tests(LFT)	**Y**	**N**	
6.10	Ultrasound scan (Ob.)			
6.11	Ultrasound Scan (General)			
6.12	X-ray			
6.13	ECG			
6.14	Endoscopy			
6.15	Others , pls specify	**Y**	**N**	
S.No	**Blood bank / Blood Storage Unit**	**Yes**	**No**	**Remarks**
6.16	Functional blood bag refrigerators with chart for temp. recording	**Y**	**N**	
6.17	Sufficient no. of blood bags available	**Y**	**N**	
6.18	Check register for number of blood bags issued for BT in last quarter			

Section VII: Service Delivery in last two quarters:

S.No	Service Utilization Parameter	Q1	Q2	Remarks
7.1	OPD			
7.2	IPD			
7.3	Expected number of pregnancies			
7.4	MCTS entry on percentage of women registered in the first trimester			
7.5	No. of pregnant women given IFA			

7.6	Total deliveries conducted			
7.7	No. of assisted deliveries(Ventouse/ Forceps)			
7.8	No. of C section conducted			
7.9	Number of obstetric complications managed, pls specify type			
7.10	No. of neonates initiated breast feeding within one hour			
7.11	Number of children screened for Defects at birth under RBSK			
7.12	RTI/STI Treated			
7.13a	No of admissions in NBSUs/ SNCU, whichever available			
7.13b	Inborn			
7.13c	Outborn			
7.14	No. of children admitted with SAM			
7.15	No. of sick children referred			
7.16	No. of pregnant women referred			
7.17	ANC1 registration			
7.18	ANC 3 Coverage			
7.19	ANC 4 Coverage			
7.20	No. of IUCD Insertions			
7.21	No. of Tubectomy			
7.22	No. of Vasectomy			
7.23	No. of Minilap			
7.24	No. of children fully immunized			
7.25	Measles coverage			
7.26	No. of children given ORS + Zinc			
7.27	No. of children given Vitamin A			
7.28	No. of women who accepted post-partum FP services			
7.29	No. of MTPs conducted in first trimester			
7.30	No. of MTPs conducted in second trimester			
7.31	Number of Adolescents attending ARSH clinic			
7.32	Maternal deaths, if any			
7.33	Still births, if any			
7.34	Neonatal deaths, if any			
7.35	Infant deaths, if any			

Section VII a: Service delivery in post natal wards:

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

Section VIII: Quality parameter of the facility:

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

S.No	Essential Skill Set	Yes	No	Remarks
8.1	Manage high risk pregnancy	Y	N	
8.2	Provide essential newborn care(thermoregulation, breastfeeding and asepsis)	Y	N	
8.3	Manage sick neonates and infants	Y	N	
8.4	Correctly uses partograph	Y	N	
8.5	Correctly insert IUCD	Y	N	
8.6	Correctly administer vaccines	Y	N	
8.7	Segregation of waste in colour coded bins	Y	N	
8.8	Adherence to IMEP protocols	Y	N	
8.9	Bio medical waste management	Y	N	
8.10	Updated Entry in the MCP Cards	Y	N	
8.11	Entry in MCTS	Y	N	
8.12	Action taken on MDR	Y	N	

Section IX: Record Maintenance:

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

Section X: Referral linkagesin last two quarters:

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

Section XI: IEC Display:

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

Section XII: Additional/Support Services:

Sl. no	Services	Yes	No	Remarks
12.1	Regular Fogging (Check Records)	Y	N	
12.2	Functional Laundry/washing services	Y	N	
12.3	Availability of dietary services	Y	N	
12.4	Appropriate drug storage facilities	Y	N	
12.5	Equipment maintenance and repair mechanism	Y	N	
12.6	Grievance Redressal mechanisms	Y	N	
12.7	Tally Implemented	Y	N	

Section XIII: Previous supervisory visits:

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

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

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

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

Appendix 3:

PHC/CHC (NON FRU) level Monitoring Checklist

Name of District: _____ **Name of Block:** _____ **Name of PHC/CHC:** _____

Catchment Population: _____ **Total Villages:** _____ **Distance from Dist HQ:** _____

Date of last supervisory visit:_____

Date of visit: _____ **Name& designation of monitor:**_____

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

_____

Section I: Physical Infrastructure:

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

Section II: Human resource:

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

Section III: Training Status of HR

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

Section IV: Equipment

S. No	Equipment	Yes	No	Remarks
4.1	Functional BP Instrument and Stethoscope	**Y**	**N**	
4.2	Sterilised delivery sets	**Y**	**N**	
4.3	Functional neonatal, Paediatric and Adult Resuscitation kit	**Y**	**N**	
4.4	Functional Weighing Machine (Adult and infant/newborn)	**Y**	**N**	
4.5	Functional Needle Cutter	**Y**	**N**	
4.6	Functional Radiant Warmer	**Y**	**N**	
4.7	Functional Suction apparatus	**Y**	**N**	
4.8	Functional Facility for Oxygen Administration	**Y**	**N**	

4.9	Functional Autoclave	**Y**	**N**	
4.10	Functional ILR and Deep Freezer	**Y**	**N**	
4.11	Functional Deep Freezer			
4.12	Emergency Tray with emergency injections	**Y**	**N**	
4.13	MVA/ EVA Equipment	**Y**	**N**	
	Laboratory Equipment	**Yes**	**No**	**Remarks**
4.14	Functional Microscope	**Y**	**N**	
4.15	Functional Hemoglobinometer	**Y**	**N**	
4.16	Functional Centrifuge,	**Y**	**N**	
4.17	Functional Semi autoanalyzer	**Y**	**N**	
4.18	Reagents and Testing Kits	**Y**	**N**	

Section V: Essential Drugs and Supplies

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

5.23	Gloves, Mckintosh, Pads, bandages, and gauze etc.	**Y**	**N**	

Section VI: Other Services :

S.no	Lab Services	Yes	No	Remarks
6.1	Haemoglobin	**Y**	**N**	
6.2	CBC	**Y**	**N**	
6.3	Urine albumin and Sugar	**Y**	**N**	
6.4	Serum Bilirubin test	**Y**	**N**	
6.5	Blood Sugar	**Y**	**N**	
6.6	RPR	**Y**	**N**	
6.7	Malaria	**Y**	**N**	
6.8	T.B	**Y**	**N**	
6.9	HIV	**Y**	**N**	
6.10	Others	**Y**	**N**	

Section VII: Service Delivery in last two quarters:

S.No	Service Utilization Parameter	Q1	Q2	Remarks
7.1	OPD			
7.2	IPD			
7.3	Expected number of pregnancies			
7.4	MCTS entry on percentage of women registered in the first trimester			
7.5	No. of pregnant women given IFA			
7.6	Total deliveries conducted			
7.7	Number of obstetric complications managed, pls specify type			
7.8	No. of neonates initiated breast feeding within one hour			
7.9	Number of children screened for Defects at birth under RBSK			
7.10	RTI/STI Treated			
7.11	No of admissions in NBSUs, if available			
7.12	No. of sick children referred			
7.13	No. of pregnant women referred			
7.14	ANC1 registration			
7.15	ANC3 Coverage			
7.16	ANC4 Coverage			
7.17	No. of IUCD Insertions			
7.18	No. of Tubectomy			
7.19	No. of Vasectomy			

7.20	No. of Minilap			
7.21	No. of children fully immunized			
7.22	Measles coverage			
7.23	No. of children given ORS + Zinc			
7.24	No. of children given Vitamin A			
7.25	No. of women who accepted post partum FP services			
7.26	No. of MTPs conducted			
7.27	Maternal deaths, if any			
7.28	Still births, if any			
7.29	Neonatal deaths, if any			
7.30	Infant deaths, if any			

Section VII a: Service delivery in post natal wards:

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

Section VIII: Quality parameter of the facility

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

S.No	**Essential Skill Set**	**Yes**	**No**	**Remarks**
8.1	Manage high risk pregnancy	**Y**	**N**	
8.2	Provide essential newborn care(thermoregulation, breastfeeding and asepsis)	**Y**	**N**	
8.3	Manage sick neonates and infants	**Y**	**N**	

8.4	Correctly Uses Partograph	**Y**	**N**
8.5	Correctly insert IUCD	**Y**	**N**
8.6	Correctly administer vaccines	**Y**	**N**
8.7	Alternate Vaccine Delivery (AVD) system functional	**Y**	**N**
8.7	Segregation of waste in colour coded bins	**Y**	**N**
8.8	Adherence to IMEP protocols	**Y**	**N**

Section IX: Record Maintenance:

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

Section X: Referral linkages in last two quarters:

S. no	JSSK	Mode of Transport (Specify	No. of women transport	No. of sick infants	No. of child	Free/Paid

		Govt./ pvt)	ed during ANC/INC/ PNC	transport ed	ren 1-6 years	
10.1	Home to facility					
10.2	Inter facility					
10.3	Facility to Home (drop back)					

Section XI: IEC Display:

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

Section XII: Additional/Support Services:

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

Section XIII: Previous supervisory visits:

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

13.3			
13.4			
13.5			

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

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

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

District:	**Block:**	**Village/Facility:**
Date of interview:	**Place of interview:**	**Name of interviewer:**

Name: ……

Age: ……

Education: ……

Health Facility (Name and type)……

Current place of residence: ……

Household size: ……

Household income (all members):

Occupation of beneficiary/ husband:

Caste of beneficiary:	1. General	2. OBC
	3. SC	4. ST
	5. Others: ……	
Religion of beneficiary:	1. Hindu	2.Muslim
	3. Christian	4. Sikh
	5. Others: ……	
Do you have any of these cards or all?(yellow card)	BPL Card	Y/N

	RSBY Card	Y/N
	Aadhar Card	Y/N

II. Janani Shishu Suraksha Karyakram (JSSK)

Q1	Where did you deliver your last child? (If the answer will be option 3,then ask for the reasons in question no 4)	1. Public Hospital 2. Private hospital 3. Home delivery ⇨ Q4(Reason)	
Q2	If Public than ask for type of facility	1. DH 2. CHC 3. PHC	1. DH 2. CHC 3. PHC 4. SC
Q3	Is Home dilivery being conducted by.	1. TBA(Traditional Dai) 2. SBA 3. Other (Please Specify)	
Q4	Why did you prefer to have your delivery at home?	REASONS:	
Q5	Was your delivery Normal or C-section?	1. Normal 2. C-section	
Q6	Did you pay anything for your delivery ? (Cashless delivery for both C-section/Normal)	1. Yes 2. No	

III. Out of pocket expenditure for delivery care

Q7	For how many days were you there in the dispensary/hospital after your delivery?	(Number of Days or hours): ……			
	Out of pocket expenditure	Yes	No	Partly	Amount (Rs.)
Q8	Did you pay any user charges?				
Q9	Did you get all the prescribed consumables/drugs for free at the dispensary?				
Q10	Were you provided all the diagnostics (Ultrasound & X-ray) for free at the dispensary ?				
Q11	Were you provided free transport from your place to the dispensary?				
Q12	Were you provided dropback facility for home?				
Q13	After your delivery were you provided free diet at the dispensary/hospital?				
Q14	Informal Payments (Dai, Watchmen, Nurse etc.)				

IV. ASHA & JSY

Q	ASHA & JSY	Yes		No
Q19	Have you heard about ASHA/Angadwadi worker?			
Q 20	Has ASHA ever visited you at your residence?			
Q21	Did ASHA provided you IFA/Vitamins ?			
Q 22	Did you visit health facility for ANC? (We can mention which health facility which includes angadwadi centre)			
Q23	Did ASHA accompany you for ANC?			
Q 24	For how many times you visited the facility for your ANC ?	1. First ANC 2. Second ANC 3. Third ANC 4. Fourth ANC		
Q25	Was the ASHA/Angadwadi worker, present with you while taking you to the hospital/dispensary for delivery?			
Q27	Did you a find bed after delivery?			
Q28	If yes, then did you share your bed with some one else or your bed got arrenged on floure due to shortage of beds?			
Q29	Did you receive JSY benefit amount for delivering at the hospital/dispensary (Received JSY)?	1. Yes 2. NO	If, yes than amount (Rs.)	Cash/Cheque
Q30	If, no than ask for the reason	REASONS:		
Q31	When did you receive your JSY (Janani Suraksha Yojana) cheque/cash?	1. At the time of discharge 2. Within one week 3. Within one week 4. More than a month		

V. Knowledge & Awareness

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	Indicators	Knowledge and Awareness	Yes/No	
Q32	Breastfeeding	Awareness on Breast feeding initiation within an hour after birth		
Q33		Adherence to Initiating BF within an hour of birth		
Q34		Awareness on Exclusive Breast feeding for Six months and continued BF till 2 years		
Q36	Complementary Feeding Practices	Awareness on initiating CF from 6 months onwards		
Q38	Diarrhea	Awareness about ORS+ Zinc		
Q39		Availability of the above with ASHAs		
Q40	Pneumonia	Awareness about danger signs		

Q41		Awareness about whom to approach on recognizing the danger signs		
Knowledge about Family Planning				
S.No	Indicators	Knowledge n Awareness	Yes/No	Remarks (Monthly Intake)
Q1.	Do you know about contraceptive methods?	OCP (Mala D)		
		IUCD		
		Condoms		
		Sterilisation (Nasbandi)		