Block Public Health Strategies
An Action Plan
Kalwakurthy

2014-2015

Model Districts Health Project
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The Earth Institute team in Telangana is led by State Technical Consultant, Dr. Chetan Purad based in Hyderabad, two District Project Co-ordinators Mr. Rajesh Kumar and Dr. Vikram Reddy based in Medak and Mahbubnagar respectively.

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List of Abbreviations

CGC |EI	Columbia Global centres | Earth Institute
AH	Area hospital
ANA	Accredited nutrition activist.
ANM	Auxiliary nurse and mid-wife
APVVP	Andhra Pradesh vaidhya vidhana parishat
ASHA	Accredited social health activist.
AWC	Anganwadi centre
AWW	Anganwadi worker
AYUSH	Ayurveda, Unani, Siddha, Homeopathy
BB/BSU	Blood bank / blood storage unit
BEmOC	Basic emergency obstetric care
CEmOC	Comprehensive emergency obstetric care
CH	Civil hospital
CHC	Community health centre
CHNC	Community health and nutrition cluster
DEO	Data entry operator
DH	District hospital
DHAP	District health action plan
DM&HO	District medical and health officer
DP	Delivery point
FRU	First referral unit
GA	Gap Analysis
GoI	Govt. of India
GoT	Govt. of Telangana
HRC	High risk condition (in pregnancy)
HRP	High risk pregnancy
IMR	Infant mortality rate
IPHS	Indian public health standards
LHV	Lady health visitor
MCH	Maternal and child health
MDG	Millennium development goals
MDHP	Model district health project
MMR	Maternal mortality ratio
MNH	Maternal and New-born health
MO	Medical officer
MoHFW	Ministry of Health and family welfare
NHM	National Health Mission
NRHM	National rural health mission
NUHM	National Urban health mission
PHC	Primary health centre
PIP	Programme implementation plan
RCH-II	Reproductive and child health – phase II
RI	Routine immunisation
RMNCH+A	Reproductive, Maternal, New-born, Child health and Adolescent health.
SC	Sub-centre
SDH	Sub district hospital
TFR	Total fertility rate.
UHC	Universal health coverage.

Summary of Recommendations

In view of the data from HMIS and the primary data from the field survey we can conclude with reasonable accuracy that,

Strengths

1. There are sufficient facilities and infrastructure, including HR available at the PHC level.
2. At the Sub centre level adequate HR (ANMs) and equipment are available for conduct of Maternal and child health services.
3. Availability of private nursing homes which can be involved in PPP schemes.

Draw backs

1. Limited facilities for conduct of quality Ante natal and post natal care at the sub centre level.
2. Limited utilisation of services at the PHC level.
3. The infrastructure at the Sub centre level needs significant investment.
4. Confidence and skill for conduct of MCH services at the Sub centre level needs strengthening.
5. Referral services are affected by non-availability of ambulances at PHC Level.

Glimpse of the Recommendations,

Sr. no	Theme	Strategy	
		Immediate	Long term
1	Sub centre Infrastructure	i)To make available a safe place to conduct ANC, PNC, and FP. ii) Reduce the out of pocket expenditure of the ANM by timely release of budgets for the rented sub centres	Plan for New SCs and ANM quarters
2	Training of ANMs	On site / block level hands on training	Establishment of a peer and expert trainers pool and mobile training unit for continuous sustained training effort
3	Referral Services	i) Strengthen the referral transport service using available staff and vehicles. ii)To streamline the MCP card use	i)Equip all the PHC with independent referral transportation. ii)To establish a three tier documentation referral system
4	Enhance Demand at PHC	IEC for enhanced visibility and interim accommodation arrangements for MO / SN	Have an equipment repair mechanism in place and New buildings for qtrs.
5	Strengthening the CHC	i)Establishing a Blood storage unit ii) Strengthen the YUVA clinic for adolescent.	Establishing an FRU centre
6	Strengthen the SPHO office	Strengthen SPHO by trained supervisory staff and vehicle provision	Exclusive and full-fledged health office with dedicated HR and transport
7	Home Deliveries and Maternal Deaths	Training of ASHA / CHV in SBA and HBNC. Encourage Maternal death report and audit.	Establish high risk identification and referral to FRU / PHC using dedicated transport arrangement.

Introduction

The Earth Institute at Columbia University collaborated with the MOHFW to work towards the Model Districts Health Project to provide technical support in implementing the recommendations from the mid-term evaluation of NRHM, conducted by the Earth Institute. More specifically the focus was on the Millennium Development Goals 1, 4 and 5: improving the nutrition status of women and children and reducing maternal and child mortality by 2015. Currently Earth Institute supports three states- Rajasthan, Telangana and Jharkhand. Within these states EI works in two districts. In Telangana, Mahbubnagar and Medak were selected for implementation of Models District concept.

The Model Districts Project focuses on health systems strengthening through implementation research, strategic technical advice, monitoring and evaluation, and policy advocacy to help ensure the successful scaling up of services. It is ultimately the district governments and district health units that are responsible for implementing the quality improvements, best practices, and innovations based on the situational analysis. State governments and NRHM offices have a key role to play in driving innovations at a district level, and providing additional funding on evidence based need.

The **Block Health Strategies**is an attempt to look down at the pillars of health care services namely the sub centres and primary health centres with an intention to understand the constricts in the delivery of effective and efficient health care services to the people. The document lays special emphasis on the maternal and child health services as it is widely known that the MCH service parameters are a sensitive indicator for the utilisation of services and are in line with the current intervention areas of MDG's 4 & 5.

The **Approach**has been to collect the primary data through field survey of the primary health centres and sub centres in the block, both qualitative and quantitative. Secondary data, which is complimentary, has been taken from the public domain of HMIS. The analysis of the data is listed in chapter-3.

As part of the block health strategies, Kalwakurthy CHNC has been identified in consultation with the District Medical and health officer for case study as the services of MCH are low despite having relatively good infrastructure at the PHC level.

In this document we look at various possible solutions within the gambit of the opportunities and limitations in the CHNC.

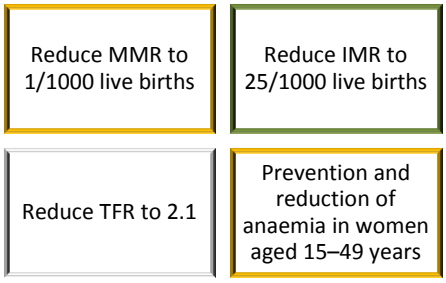
We also explore some unconventional approaches as an interim to mid-term solution to address MMR and NMR till the time the health infrastructure is completely functional.

1. Back ground - Health

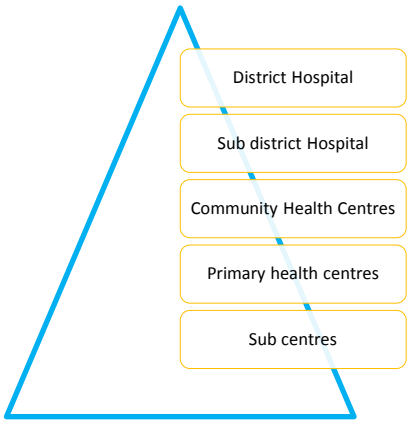
In the wake of the 'call to action' conference at Mahabalipuram in February 2013, the MoHFW developed an action plan to strengthen the maternal and child health services through the 'life cycle approach' under the flagship programme of the national health mission (NHM), the RMNCH+A strategy to focus on all aspects of the life stages of reproductive, maternal, new born, child and adolescent health to achieve the millennium development goals of MDG 4, MDG 5 & MDG 6 with an intention of having an immediate and long term impact aimed at reducing the Maternal and childhood mortality rates.

In any country the mothers, children and women in the reproductive age constitute the largest consumers of health services. The health of this vulnerable group also sets standards of the health care services available and delivered.

National Health mission is committed and essentially focuses on strengthening the primary health care across the country with emphasis on strengthening health facilities and services up to the district level in urban and rural areas.



The Twelfth Plan document states that expenditures on primary health care should account for at least 70% of the health care expenditure. Tertiary care and regulatory functions should be a part of the other Central Sector and/or Centrally Sponsored scheme, namely, Human Resources & Medical Education.



The health delivery system in the country is structured at three tiers as Primary, Secondary and Tertiary care levels. The District hospital is at the top of the hierarchy and the sub centre is foremost post of service delivery. In general the different levels of health care are directed towards promotive, preventive, curative and rehabilitation services.

As the deadline for the achievement is fast approaching, it is common knowledge that India in general has a long way to go before there is significant and sustainable impact in the maternal mortality ratio and the child mortality rate.

As part of this document we take a closer look at the pillars of health care namely the sub centres and the primary health centres to understand the constricting factors affecting the effective and efficient delivery of health care services and seek implementable steps for accelerating the efforts.

2. Block Profile

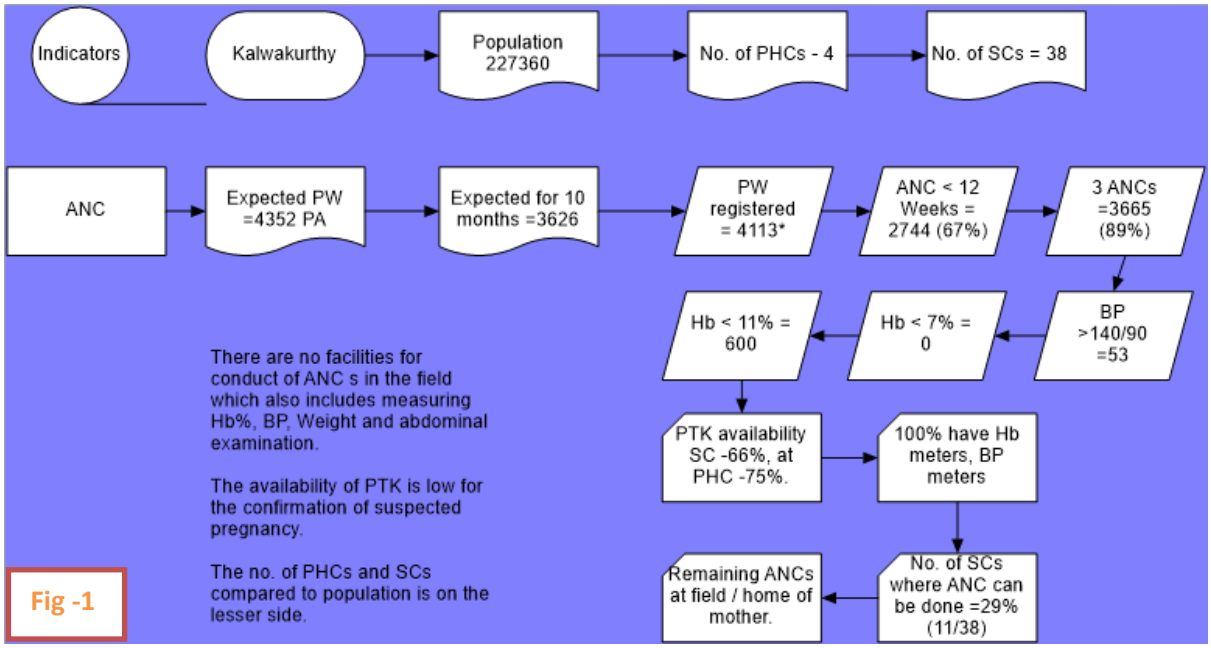
Kalwakurthy, also spelled as Kalvakurti, is a town and taluka headquarters in Mahbubnagar district of Telangana, India. It is 80 km from Hyderabad on Srisailam highway. It is around 56 km from the district headquarters of Mahbubnagar

General Information Kalwakurthy		
1	No of CHC	1
2	No of PHC's	4
3	No of SC.	38
4	Total Population	227360
5	Total No Of House Holds	51377
6	No Of GP's	92
7	No Of Villages	130
8	No Of Tandas	118
9	0-5 Years Population	22714
10	No of Schools	256
11	Total No School Going Children	25216
12	No AWW Centers	310
13	No AWW Teachers	310
14	No of Kasthuriba Schools	4
15	No of Private Nursing Home (Ultra Sound)	7
16	No Of ASHA Workers	210
17	No AYUSH Centers	5

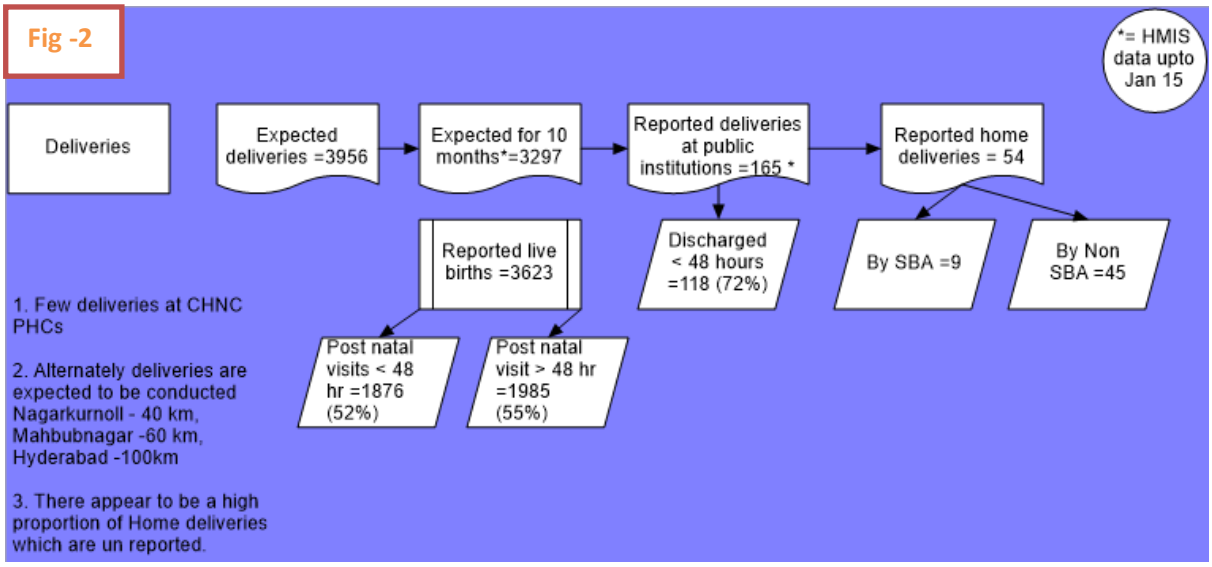
Human Resource Details			
		Sanctioned	**Posted**
1	Specialist at CHC	2	2
2	MO-CHC		
3	Mo-PHC	7	5
4	1st ANM	35	28
5	2nd ANM	38	37
6	Staff Nurse	12	10
7	Pharmasist	3	3
8	Lab.Tech	3	2
9	ASHA	202	200

3. Analysis and Discussion

3.1 Ante Natal Care:



3.2 Delivery and Post natal services:



Analysis of the Fig-1& 2 based on the data from HMIS (Up to Jan 15) available on the public portal and Table -1, Table -2 in the annexure, the following inference can be arrived at with reasonable accuracy.

Table 3.1

S.no	Inference	Implication
1	Sub centre building is located near the main habitation.	Access is not a problem (↑)
2	5/38 are functioning in govt. building	There might not be adequate space for ANC in rented buildings(↓)
	29% of the functioning SC's are in good condition.	Will affect the quality and motivation for services (↓)
3	100% ANM (HR) ,Hb meter, BP meter, drugs and FP stock	HR and logistics available (↑)
4	No electricity, running water, toilets, labour room	Affects quality (↓), maternal morbidity.
5	No ANM quarters	Affects round the clock services (↓)
6	PHC –MO, SN, Electricity, water, clean labour room, toilets	All basic facilities available (↑)
7	PHC – Drugs and logistics – available	Potential to create demand (↑)
8	MO, SN quarters and NBSU not available	Affects quality, round the clock services (↓)
9	No line listing of high risk cases	Affects quality, MMR increases (↓)
10	No JSY payments, free diet and SBA protocol	No demand for services (↓)
11	Overall record maintenance is poor	Affects monitoring and tracking (↓)

3.3 Following is the discussion and possible recommendations:

a) **Sub centre Infrastructure** needs significant encouragement for ANC and FP services considering that there are few ANM posts vacant and that logistics is not a problem. The problem appears to be in the lack of appropriate place for delivery of services which needs to be addressed immediately by identification of alternate places having adequate space and privacy for conducting the ANC, FP and immunisation services.

Such facilities need to be occupied on rent and the expenses may be incurred from the un-tied fund pool. If this is not possible then alternate head may be created for the payment of rent as currently this is being incurred by the ANMs from OPE and is again a demotivation for efficient functioning.
At present out of 38 sub centres 20 are rented in private facilities which costs around 800-1000 Rs per month which would cost Rs.2, 40,000 annually which still does not meet our requirement of a fully functional sub centre. whereas a new sub centre would cost about 16 lakhs which would provide a permanent solution.

However in the long run a detailed plan needs to be drawn for the construction of the sub - centre building which may have a staggered approach targeting the places which

have potential or are doing well in service delivery on a priority basis. The requirement needs to be reflected in the district PIP and advocated to the state.

b) **Training of ANMs:** There appears to be no clear data available at the CHNC on the training status, however even if there has been training conducted (unless < 1 year) there is a need to retrain the ANMs for ANC, FP, HBNC and identification of high risk pregnancies. This stems from the view that if a skill is not practiced regularly then the quality and confidence will gradually wane away.

For this we recommend that a training be conducted (at least hands on) ideally at the district level. If this is not possible then a CHNC level training may be done which is spread over a few weeks for a few days which are fixed in a week. The ANMs can learn a skill every week. The pool of trainers from the district level, competent staff from other PHCs and from within the CHNC area may be identified.
The emphasis is to be on a continued skill improvement and update on newer practices and strategies.
Field experience has shown that the sub centre staff are not aware of most of the new strategies including the RMNCH+A.

c) **Referral Services:** During the field survey it was observed that the block does not have an independent referral transportation 108 services are available in the cluster but the vehicle is stationed in Amangal cluster which is 20 kms away and which has 5 PHC's so in case of any emergencies it would be a difficult situation. Kalwakurthy CHC is placed in an RTA prone area the data from the CHC suggests that as many as 918 RTA cases were registered & 289 were referred in the year 2014-15. CHC kalwakurthy has its own ambulance but lack of budget and Driver has lead to non functionality of the services. Non availability of Referral transport within the block is also one of the reasons for the low performance of the PHC in terms of conducting deliveries in the facilities

d) **Streamline the use of MCP cards:** The data available points towards the underutilisation of services at the PHC level even though the PHCs are adequately equipped in terms of HR, infrastructure, equipment and logistics. There is an urgent need to generate demand to enhance utilisation. One of the ways to do it is to refer the eligible beneficiaries for the services available at the PHCs through a documented referral mechanism.
For this a three copy referral paper may be adopted. One stays with the ANM, one at the PHC through the patient and one for the patient's record. After the consultation the mother or other beneficiary brings back the referral slip to the ANM so as to complete the loop.
In case of pregnant women and mothers the **MCP card** has to be made operational with sufficient quantity made available at the SC s and PHCs.
ASHA's as a referral system needs to be strongly encouraged and closely monitored with prompt payment of honorarium (E.g.: payment decentralised to the CHNC level). Well educated, trained and motivated ASHAs can serve as a sustainable referral

mechanism. Additionally ASHAs may be trained in SBA and HBNC to attend to the home deliveries.

e) **Enhance Demand at PHC:** Current data suggests there is huge potential for the PHCs to function optimally. However there seems to be less utilisation of services despite the fact the PHC s are relatively well equipped.
The low utilisation may be due to,
- Non availability of staff or available for shorter period of time. This could probably be due to the time spent in transit, as there are no quarters available.
  A long term plan is inevitable for the provision of quarters, but that should not deter in identifying tailor made solutions on a stop gap basis including the provision of HRA to staff nurses to enable them to find local hired accommodation.
- A second reason seems to be the lack of transport services locally for travel to the PHC. This needs to be addressed by encouraging the involvement of PRIs and other health activists locally to find a sustainable way for transportation including the possibility of identifying local private vehicle which may be used and reimbursed either from the PRI or the untied / HDS funds etc.
- Finally training of the MO and SN in BEmOC, SBA.

f) **Strengthening CHC:** CHC kalwakurthy is the next higher centre in the block but it is not equipped with proper facilities. Data from the CHC is suggestive that C-sections can be conducted in the CHC if blood storage unit is established at this centre which would also be useful to the RTA cases that have been mentioned earlier. At present there are at least 7 private nursing homes which are conducting around 1000 deliveries in a year which again increases the economic burden of the patients availing the services of these private nursing homes. The nearest FRU for Kalwakurthy is AH Nagarkarnool which is 40 kms away.
Adolescent health is one of the prime focuses as per the RMNCH+A strategies. In order to full fill this strategy YUVA clinic was established in the CHC but non availability of a trained doctor in dealing with the adolescent age group has reduced the utility of this clinic. So providing a dedicated trained person for this clinic within the CHC will not only solve the purpose of clinical treatment but also help in health education and counselling.

g) **Strengthen the SPHO office:** The senior public health officer is the nodal person of all health related activities at the sub district level. SPHO is entrusted with the responsibility of ensuring that the health systems functional smoothly. One of the purposes of creating this relatively new post was to facilitate seamless implementation of activities and act as a local trouble shooting person.
SPHO's office in general suffers from,
- Lack of public health specialist, clinical specialist as an SPHO has limited utility.
- Shortage of support staff.
- No or limited mobility support.

There is an urgent need to strengthen the SPHO office to enable effective monitoring and supportive supervision. Sufficient finances and HR needs to be allotted.

- ASHA honorarium payment process may be decentralised to SPHO as it be easy and quick disbursement with limited or no hassles.

h) <u>Home Deliveries and Maternal Deaths:</u> Analysis of the data shows that,

- 54 home deliveries and 165 institutional deliveries are done up to Jan 2015.[1]
- 45 of 54 home deliveries are conducted by untrained birth attendant.
- Expected no. of deliveries is 95/ month
- Average monthly delivery at the CHNC is <5 / month.
- The estimated deliveries for 10 months are 3297. (HMIS Up to Jan 15)
- Total live births reported in 10 months is 3623 (HMIS Up to Jan 15)

The next logical assumption is that these pregnant women may get delivered in the nearest or neighbouring PHC / CHC. Following is the estimated distance of facilities from Kalwakurthy,

i) Nagarkurnool – nearest FRU – 40 km
ii) Mahabubnagar – 60 km
iii) Amangal (nearest non FRU) – 20 km
iv) Hyderabad – 100 km.

In light of the above it would be unfair to assume that all pregnant women have the resources, accessibility or family support to undertake such a journey, however that's not to say that no pregnant women approach the above mentioned facilities, which we believe they do, but the proportion of such women may be small.

The next most feasible thing to do is to approach the private health provider which may be of the following types,

	Type of private provider	Implication – Health	Implication - OPE
1	Qualified and registered medical professional – MBBS and above	↑ Quality, minimal morbidity and mortality.	↑ expenditure
2	AYUSH qualified	Minimal morbidity and mortality	↗ moderately high
3	Untrained SBA	↑↑ Morbidity, mortality	↗OPE is present
4	Trained SBA	↔ MMR may not increase	↔ OPE mild to moderate

More than the need, affordability is the biggest factor while choosing health care services and naturally , except the few who can afford qualified private care, the choice is for the birth attendant's (trained / untrained).

Hence there is reason to believe that in rural Kalwakurthy, significant number of deliveries are conducted at home and are often unreported.

As the public health sector is currently unable to provide services close to the patients home and in view of a high maternal mortality rate due to preventable causes as shown in the figure, below, we are left with no option but to recommend for safe home deliveries till the time there is demand and service provision enhancement in the PHC s of the CHNC.

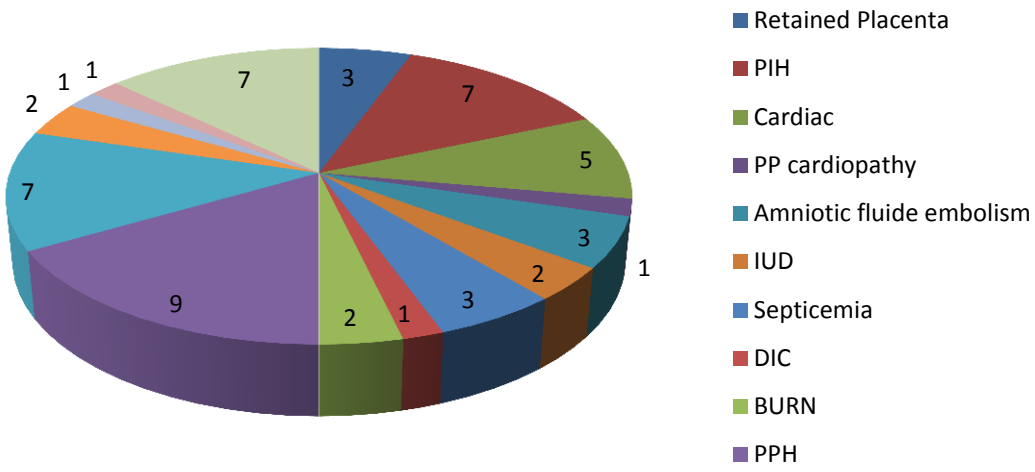


Fig -3

Encourage home deliveries by trained SBA:

- Identify amongst the ASHA pool that are eligible and committed to conducting deliveries.
- Train the ASHA and other eligible CV in SBA, HBNC.
- Provide safe delivery kits well in advance, prevent stock outs.
- More than one person can be trained in each village.
- The trained SBAs should display their certificate on request to the pregnant women so that the untrained BA‘s are not encouraged.
- The SBA and HBNC trained volunteers are to be monitored by the PRI.
- An exclusive honorarium is to be paid for the SBA conducting SBA and HBNC. This honorarium to be ideally delegated to the SPHO office for efficient payment.

Encourage private facility reporting:

- Steps are to be taken to ensure monthly reporting of the deliveries and sharing of relevant demographic details of the mother with the health authorities.
- This activity needs thrust from the district and where needed from the state health authorities.

Delivery by a trained person not only improves the maternal health indicator s but also child health mortality indicators mainly the Infant mortality rate, but more importantly the now stagnant Neonatal mortality rate (NMR) for which the main causes are asphyxia, sepsis. Deaths due to Asphyxia and sepsis are due to prolonged labour and faulty delivery techniques.

Additionally the trained SBA can identify any complications of labour and promptly refer them to the FRU or nearest PHC for further management and can function as a liaising person for this purpose.

A trained person can also conduct home visits post-delivery for PNC and HBNC and refer promptly when needed.

We believe that the above intervention has the potential to reduce MMR and NMR quickly and sustainably till the time institution facilities are available.

g) Human Resource and Rationalization: The process of rationalization of HR and equipment's has been initiated in the district for all the blocks. This activity of data collection is expected to be completed by the end of 1Q15. Following which the process of rationalization would taken - up by the district health authorities and is expected to address the HR and equipment related constraints in the district on an immediate basis. Earth Institute will provide technical assistance to the district where requested.

4. Operational Plan

Theme	Recommendation		Partnership needed with	Responsibility		
	Immediate / Interim	Mid to Long term		Primary	Secondary	Overall
Sub centre Infrastructure	a) Hiring of fit for use building	d) New SC buildings	1) PRI of the village.	MO - PHC	SPHO	DMHO
	b) Ensuring availability of water and Electricity	e) New ANM quarters	2) Electricity & water departments			
	c) Equipment and logistics availability					
	f) Rent payment through untied funds					
Training of ANMs	a) Line list the training status of ANMs in SBA, FBNC and HBNC	d) Establishment of Trainers pool from amongst the peer.	ASHA / ICDS			
	b) Plan for hands on CHNC level training	e) Establishment of the continuous monthly training mechanism at the block level.				
		f) Mobile training units may be established *				
Referral advice and follow-up	a) Train ANMs , ASHAs and Identified CHVs in identification of high risk and referral	b) Introduce three tier referral documentation				
	c) Strengthen MCPC card use by ensuring quantity and monitoring					
Enhance Demand at PHC	a) Enhance demand by enhancing visibility - of the available services through IEC at village level.	g) Equipment repair mechanism for all the essential equipment	Engineering division / HMIDC	DMHO	SPHO	

	b) liaison with the local transport department to ply buses via the PHC (Enhance public transport connectivity)	h) Special travel allowance or mobility support through provision of vehicles for MO & SN.	NRHM / State Govt.	MO	SPHO	DMHO
	c) Address the HR vacancy through rationalisation	i) identify locally sustainable transport mechanisms E.g.: Auto rickshaws / tractors and a mechanism to reimburse based on distance	PRI	DMHO / MO	MO / SPHO	DMHO / SPHO
	d) Ensure round the clock availability of staff by strengthening the SPHO office.	j) New staff quarters MO / SN	HMIDC			
	e) House rent allowance for Staff nurses - to hire rented houses					
Strengthen the SPHO office	a) Public health specialist as SPHO	e) Exclusive SPHO office with trained staff		DMHO		
	b) Supportive supervisory staff	f) Direct budget release to SPHO.		DMHO		
	c) Vehicle and pol for mobility - exclusive	g) Process and payments to ASHAs - delegated to SPHO.		DMHO	SPHO	
	d) Office equipment - where needed			DMHO	SPHO	
Home Deliveries and Maternal Deaths	a)Encourage maternal death reporting and audit - irrespective of the place of origin or delivery	d) Transport mechanism for complicated cases / emergencies to the nearest FRU.		SPHO	PRI	
	b) Train the ASHAs and CHVs in SBA and HBNC			MO PHC	SPHO	DMHO
	C) Delivery kits for home delivery to SBAs			MO PHC	SPHO	DMHO

(Annexures as separate attachment)

5. Concluding Remarks:

The wide range of recommendations discussed on SC infrastructure, Capacity building, Referral advice and transport, Enhancing demand of PHC, Home and institutional deliveries are the potential game changers. The above discussion proposes ways in which to improve or improvise existing strategies in a widely discussed area of health systems strengthening all over the world.

No single strategy employed in the block has been indisputably successful in enhancing the efficiency and significant strides are necessary to strengthen the strategies in place.

At its core, the issue stems from the inherent lack of elementary infrastructure, equipment and facilities which compound the unattractiveness of working and living in rural areas for the health staff and doctors.

As discussed the key ingredient to all systems is the 'motivation' and 'will' to bring about a significant and sustainable change. There is no better place than to start with a strong political and administrative commitment to develop this under developed block.

The Interim recommendations have the potential to enhance the efficiency of the system almost on an immediate basis, while the long term and medium term strategies need to be implemented in a systematic manner to achieve universal health coverage.

Trainings both induction and continued needs emphasis. A system of peer learning at the PHC level on a continuous basis has been advocated. As a first step, educating and empowering the ANM and nursing cadre to provide primary and basic care is necessary to reduce the burden on higher level facilities and ensure that only the complicated or severe cases are referred.

Motivation by means of acknowledgements, appreciations and growth aspects for the frontline health workers and providing Hard reach allowances and some reservations for higher studies/ Promotions to all nursing staff. ASHAs are mandatory to enhance the service delivery and utilisation in terms of quality and numbers.

Over the years the private health sector in the block has grown remarkably. PPPs offer an opportunity to overcome the 108 ambulances services issue, Ultrasound and specialist service availability issues at block level.

Strengthening of the SPHO office to undertake designated monitoring and supervision activities with a view of providing mentoring support needs to be given highest importance. The competency of the SPHO has to be enhanced by posting public health qualified doctors and reserving the other specialist cadre to clinical services. Certain administrative privileges to the SPHO who needs to function as the sub-district health officer will go a long way in enhancing the credibility of the M&E system.

We conclude by recommending that all the long-term and interim recommendations mandate at the block to improve the health care services. Districts and states need to be aware and empowered about the hurdles in achieving universal health care. The DHAP, BHAPs are very much needed to be used as an effective tool for projecting the requirements of the blocks and making an effective case for mobilisation of funds from the central, state governments and the private sector to health care facilities.

Table -1	Parameter – SC –CHNC Kalwakurthy	Available	Total SC	Proportion %
1.1	Sub centre located near a main habitation	38	38	100
1.11	General cleanliness in the facility	38	38	100
2.2	2nd ANM	37	38	97
3.1	Equipment for Haemoglobin Estimation	38	38	100.0
3.3	BP Instrument and Stethoscope	38	38	100.0
3.6	Adult weighing machine	38	38	100.0
3.8	Needle &Hub Cutter	38	38	100.0
4.1	IFA tablets	38	38	100
4.2	IFA syrup with dispenser	38	38	100
4.3	Vit A syrup	38	38	100
4.4	ORS packets	38	38	100
4.9	Antibiotics, if any, pls specify	38	38	100
4.1	Availability of drugs for common ailments e.g PCM, anti-allergic drugs etc	38	38	100
5.3	OCPs	38	38	100
5.5	IUCDs	38	38	100
8.2	Annual maintenance grant (Rs 10,000-Check % expenditure	38	38	100
8.3	Payments under JSY	38	38	100
8.6	Eligible couple register	38	38	100
8.7	MCH register (as per GOI)	38	38	100
8.9	Stock register	38	38	100
8.1	Due lists	38	38	100
8.12	Village register	38	38	100
8.16	Updated Microplan	38	38	100
8.17	Vaccine supply for each session day (check availability of all vaccines	38	38	100
10.1	Approach roads have directions to the sub centre	38	38	100
10.4	Visit schedule of "ANMs"	38	38	100
10.5	Area distribution of the ANMs/ VHND plan	38	38	100
10.8	Immunization Schedule	38	38	100
10.1	Other related IEC material	38	38	100

Table -2	Parameter – SC –CHNC Kalwakurthy	Available	Total SC	Proportion %
1.2	Functioning in Govt building	5	38	13.2
1.4	Electricity with functional power back up	0	38	0
1.5	Running 24*7 water supply	0	38	0
1.6	ANM quarter available	1	38	2.6
1.8	Functional labour room	1	38	2.6
1.9	Functional and clean toilet attached to labour room	1	38	2.6
1.1	Functional New Born Care Corner (functional radiant warmer with neo-natal ambu bag)	0	38	0
1.13	Availability of deep burial pit for waste management / any other mechanism	0	38	0
2.7	Others, specify	0	38	0
3.2	Blood sugar testing kits	6	38	15.8
3.5	Neonatal ambu bag	0	38	0.0
3.9	Color coded bins	0	38	0.0
3.1	RBSK pictorial tool kit	0	38	0.0
4.6	Inj Magnesium Sulphate	0	38	0
4.7	Inj Oxytocin	0	38	0
4.8	Misoprostol tablets	0	38	0
5.4	EC pills	0	38	0
5.6	Sanitary napkins	0	38	0
8.8	Delivery Register as per GOI format	0	38	0
8.11	MCP cards	0	38	0
8.13	Referral Registers (In and Out)	0	38	0
8.14	List of families with 0-6 years children under RBSK	0	38	0
8.18	Due list and work plan received from MCTS Portal through Mobile/ Physically	0	38	0

	Table -3 Section I: Physical Infrastructure: PHCs	Midgil	Veldanda	Raghupatipetha	Vangoor			Pro %
1.1	Health facility easily accessible from nearest road head	1	1	1	1	4	4	100
1.2	Functioning in Govt building	1	1	1	1	4	4	100.0
1.3	Building in good condition	1	1	1	1	4	4	100.0
1.7	Electricity with functional power back up	1	1	1	1	4	4	100.0
1.8	Running 24*7 water supply	1	1	1	1	4	4	100.0
1.9	Clean Toilets separate for Male/Female	1	1	1	1	4	4	100.0
1.1	Functional and clean labour Room	1	1	1	1	4	4	100
1.14	Clean wards	1	1	1	1	4	4	100
1.17	Availability of mechanisms for waste management	1	1	1	1	4	4	100
4.1	Functional BP Instrument and Stethoscope	1	1	1	1	4	4	100
4.2	Sterilised delivery sets	1	1	1	1	4	4	100.0
4.4	Functional Weighing Machine (Adult and infant/newborn)	1	1	1	1	4	4	100
4.5	Functional Needle Cutter	1	1	1	1	4	4	100
5.1	EDL available and displayed	1	1	1	1	4	4	100
5.3	IFA tablets	1	1	1	1	4	4	100.0
5.4	IFA tablets (blue)	1	1	1	1	4	4	100
5.5	IFA syrup with dispenser	1	1	1	1	4	4	100
5.6	Vit A syrup	1	1	1	1	4	4	100.0
5.7	ORS packets	1	1	1	1	4	4	100.0
5.1	Inj Oxytocin	1	1	1	1	4	4	100
5.13	Antibiotics	1	1	1	1	4	4	100
5.15	Drugs for hypertension, Diabetes, common ailments e.g PCM, anti-allergic drugs etc.	1	1	1	1	4	4	100.0
5.16	Vaccine Stock available	1	1	1	1	4	4	100.0
5.23	Gloves, Mckintosh, Pads, bandages, and gauze etc.	1	1	1	1	4	4	100.0
6.1	Haemoglobin	1	1	1	1	4	4	100
6.3	Urine albumin and Sugar	1	1	1	1	4	4	100.0
6.7	Malaria (PS or RDT)	1	1	1	1	4	4	100.0

6.9	HIV (RDT)	1	1	1	1	4	4	100.0
7.1a	All mothers initiated breast feeding within one hr of normal delivery	1	1	1	1	4	4	100
7.3a	Counseling on IYCF done	1	1	1	1	4	4	100.0
7.4a	Counseling on Family Planning done	1	1	1	1	4	4	100
7.5a	Mothers asked to stay for 48 hrs	1	1	1	1	4	4	100
7.7a	Mode of JSY payment (Cash/ bearer cheque/Account payee cheque/Account Transfer)	1	1	1	1	4	4	100.0
7.8a	Any expenditure incurred by Mothers on travel, drugs or diagnostics(Please give details)	1	1	1	1	4	4	100.0
9.1	OPD Register	1	1	1	1	4	4	100
9.2	IPD Register	1	1	1	1	4	4	100.0
9.7	Labour room register	1	1	1	1	4	4	100.0
9.12	Updated Microplan	1	1	1	1	4	4	100.0
9.13	Drug Stock Register	1	1	1	1	4	4	100
9.15	Payments under JSY	1	1	1	1	4	4	100.0
9.16	Untied funds expenditure (Check % expenditure)	1	1	1	1	4	4	100.0
9.18	RKS expenditure (Check % expenditure)	1	1	1	1	4	4	100.0
11.1	Approach roads have directions to the PHC	1	1	1	1	4	4	100
11.5	Area distribution of the ANMs/ VHND plan	1	1	1	1	4	4	100
11.8	Immunization Schedule	1	1	1	1	4	4	100.0
11.9	JSY entitlements	1	1	1	1	4	4	100.0
11.1	Other related IEC material	1	1	1	1	4	4	100
12.1	Regular sterilisation of Labour room (Check Records)	1	1	1	1	4	4	100
12.2	Funtional laundery / Washing services	1	1	1	1	4	4	100.0
12.4	Appropriate drug storage facilities	1	1	1	1	4	4	100

	Table -4 Section I: Physical Infrastructure: PHC	Midgil	Veldanda	Raghupatipetha	Vangoor			
1.4	Habitable Staff Quarters for MOs	0	0	0	0	0	4	0
1.6	Habitable Staff Quarters for other categories	0	0	0	0	0	4	0.0
1.13	Functional Newborn Stabilization Unit	0	0	0	0	0	4	0
4.13	MVA/ EVA Equipment	0	0	0	0	0	4	0
	Laboratory Equipment							
4.17	Functional Semi autoanalyzer	0	0	0	0	0	4	0
5.2	Computerised inventory management	0	0	0	0	0	4	0.0
5.9	Inj Magnesium Sulphate	0	0	0	0	0	4	0.0
5.11	Misoprostol tablets	0	0	0	0	0	4	0
5.12	Mifepristone tablets	0	0	0	0	0	4	0.0
S.No	**Supplies**	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**	0	4	0
5.2	EC pills	0	0	0	0	0	4	0
5.22	Sanitary napkins	0	0	0	0	0	4	0.0
S.No	**Essential Consumables**	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**	0	4	0.0
6.4	Serum Bilirubin test	0	0	0	0	0	4	0
6.6	RPR (Rapid Plasma Reagin) test	0	0	0	0	0	4	0.0
6.1	Others	0	0	0	0	0	4	0
7.6a	JSY payment being given before discharge	0	0	0	0	0	4	0.0
7.9a	Diet being provided free of charge	0	0	0	0	0	4	0.0
9.4	PNC Register	0	0	0	0	0	4	0
9.5	Indoor bed head ticket	0	0	0	0	0	4	0
9.6	Line listing of severely anaemic pregnant women	0	0	0	0	0	4	0.0
9.9	OT Register	0	0	0	0	0	4	0.0
9.1	FP Register	0	0	0	0	0	4	0
9.17	AMG expenditure (Check % expenditure)	0	0	0	0	0	4	0.0
11.2	Citizen Charter	0	0	0	0	0	4	0.0
11.3	Timings of the Facility	0	0	0	0	0	4	0.0
11.4	Visit schedule of "ANMs"							

11.6	SBA Protocol Posters	0	0	0	0	0	4	0.0
12.3	Availability of dietary services	0	0	0	0	0	4	0.0
12.5	Equipment maintenance and repair mechanism	0	0	0	0	0	4	0
12.6	Grievance redressal mechanisms	0	0	0	0	0	4	0.0
12.7	Tally software implemented	0	0	0	0	0	4	0.0

Table -5

Deliveries till Oct 2014			
PHC	During month	Cumulative	Avg.
Midjil	12	62	9
Vangoor	3	25	4
Veldanda	5	11	2
Raghupathipet	3	17	2