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Topic

A BLOCKWISE COMPARATIVE ANALYSIS OF HUMAN RESOURCE AT PERIPHERAL LEVEL (CHC's & PHC's) WITH INDIAN PUBLIC HEALTH STANDARDS FOR DISTRICT KAWARDHA, CHHATTISGARH

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CERTIFICATE OF APPROVAL

The following dissertation titled " **A block wise comparative analysis of human resource at peripheral level (CHC's & PHC's) with Indian public health standards for district Kawardha, Chhattisgarh**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

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CERTIFICATE FROM DISSERTATION ADVISORY COMMITTEE

This is to certify that **Dr. Hemant K Sharma,** a participant of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. She is submitting this dissertation titled "A **block wise comparative analysis of human resource at peripheral level (CHC's & PHC's) with Indian public health standards for district Kawardha, Chhattisgarh**" in partial fulfillment of the requirements for the award of the **Post-Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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"A BLOCKWISE COMPARATIVE ANALYSIS OF HUMAN RESOURCE AT PERIPHERAL LEVEL (CHC's & PHC's) WITH INDIAN PUBLIC HEALTH STANDARDS FOR DISTRICT KAWARDHA, CHHATTISGARH"

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Dr. Hemant K Sharma.

ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
ANC	Anti Natal Care
AWW	Anganwadi Worker
CBR	Crude Birth Rate
CHC	Community Health Centre
CHV	Community Health Visitor
FRU	First Referral Unit
GOI	Government of India
ICDS	Integrated Child Development Services
IFA	Iron Folic Acid
MCH	Maternal & Child Health
HMIS	Health Management Information System
MIS	Management Information System
MMR	Maternal Mortality Rate
MO	Medical Officer
MPW	Multi Purpose Worker
PHC	Primary Health Centre
PIP	Programmed Implementation Plan
PPP	Public Private Partnership
PRIs	Panchayati Raj Institutions
TOR	Terms of Reference
VHG	Village Health Guide
AWC	Anganwadi Centre
MMR	Maternal Mortality Ratio
BETO	Block Education Training Officer
BMO	Block Medical Officer

PART 1: INTERNSHIP REPORT AT MINISTRY OF HEALTH AND FAMILY WELFARE

1.1 INTRODUCTION TO MINISTRY OF HEALTH AND FAMILY WELFARE:

The **Ministry of Health and Family Welfare** is the Indian government ministry charged with health policy in India. It is also responsible for all government programs relating to family planning in India.

The Minister of Health and Family Welfare is situated at Nirman Bhavan at Central Secretariat that holds a cabinet rank as a member of the Council of Ministers. The current minister is **Shri. Ghulam Nabi Azad**, who is assisted by a Minister of States for Health and Family Welfare, **Shri. Dinesh Trivedi** & **Shri. S. Gandhiselvan.**

The ministry is composed of three departments:

- Department of Health,
- Department of Family Welfare, and
- Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH).

DEPARTMENT OF HEALTH[1]

The **Department of Health** deals with health care, including awareness campaigns, immunization campaigns, preventive medicine, and public health. Bodies under the administrative control of this department are:

- National AIDS Control Organization (NACO)
- 13 National Health Programmes
    - National AIDS Control Programme (AIDS)
    - National Cancer Control Programme (cancer)
    - National Filaria Control Programme (filariasis)
    - National Iodine Deficiency Disorders Control Programme (iodine deficiency)
    - National Leprosy Eradication Programme (leprosy)
    - National Mental Health Programme (mental health)

    - National Programme for Control of Blindness (blindness)
    - National Programme for Prevention and Control of Deafness (deafness)
    - National Tobacco Control Programme (tobacco control)
    - National Vector Borne Disease Control Programme (NVBDCP) (vector-born disease)
    - Pilot Programme on Prevention and Control of Diabetes, CVD and Stroke (diabetes, cardiovascular disease, stroke)
    - Revised National TB Control Programme (tuberculosis)
    - Universal Immunization Programme
- Medical Council of India
- Dental Council of India
- All India Institute of Speech and Hearing (AIISH), Mysore
- All India Institute of Physical Medicine and Rehabilitation (AIIPMR), Mumbai
- Hospital Services Consultancy Corporation Limited (HSCC)

DEPARTMENT OF FAMILY WELFARE[1]

The **Department of Family Welfare** (**FW**) is responsible for aspects relating to family welfare, especially in reproductive health, maternal health, pediatrics, information, education and communications; cooperation with NGOs and international aid groups; and rural health services. The Department of Family Welfare is responsible for:

- 18 Population Research Centres (PRCs) at six universities and six other institutions across 17 states
- National Institute of Health and Family Welfare (NIHFW), South Delhi
- International Institute for Population Sciences (IIPS), Mumbai
- Central Drug Research Institute (CDRI), Lucknow
- Indian Council of Medical Research (ICMR), New Delhi - founded in 1991, it is one of the oldest medical research bodies in the world

DEPARTMENT OF AYUSH[1]

The **Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy** (**AYUSH**) deals with ayurveda (Indian traditional medicine), and other yoga, naturopathy, unani, siddha, and homoeopathy, and other alternative medicine systems.

The department was established in March 1995 as the **Department of Indian Systems of Medicines and Homoeopathy** (**ISM&H**).The department is charged with upholding educational standards in the Indian Systems of Medicines and Homoeopathy colleges, strengthening research, promoting the cultivation of medicinal plants used, and working on Pharmacopoeia standards. Bodies under the control of the Department of AYUSH are:

- Various research councils
    - Central Council for Research in Ayurveda and Siddha (CCRAS)
    - Central Council for Research in Unani Medicine (CCRUM)
    - Central Council for Research in Homoeopathy (CCRH)
    - Central Council for Research in Yoga and Naturopathy (CCRYN)
- Several educational institutions:
    - National Institute of Ayurveda, Jaipur (NIA)
    - National Institute of Siddha, Chennai (NIS)
    - National Institute of Homoeopathy, Kolkata (NIH)
    - National Institute of Naturopathy, Pune (NIN)
    - National Institute of Unani Medicine, Bangalore (NIUM)
    - Institute of Post Graduate Teaching and Research in Ayurveda, Jamnagar,Gujarat (IPGTR)
    - Rashtriya Ayurveda Vidyapeeth, New Delhi (RAV)
    - Morarji Desai National Institute of Yoga, New Delhi (MDNIY)
- Indian Medicine Pharmaceutical Corporation Limited (IMPCL), Mohan, Uttaranchal (a public sector undertaking)
- Professional councils
    - Central Council of Homoeopathy (CCH)
    - Central Council of Indian Medicine (CCIM)

NATIONAL RURAL HEALTH MISSION[2]:

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission in 2005 to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.

The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

VISION OF NRHM[2]:

The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

- These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.
- The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP.
- It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common

Minimum Programme and promote policies that strengthen public health management and service delivery in the country.

- It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and Funds for optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare.
- It seeks to revitalize local health traditions and mainstream AYUSH into the public health system.
- It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health.
- It seeks decentralization of programmes for district management of health.
- It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure.
- It shall define time-bound goals and report publicly on their progress.
- It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

GOALS OF NRHM[2]:

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH

- Promotion of healthy life.

STRATEGIES ADOPTED[2]:

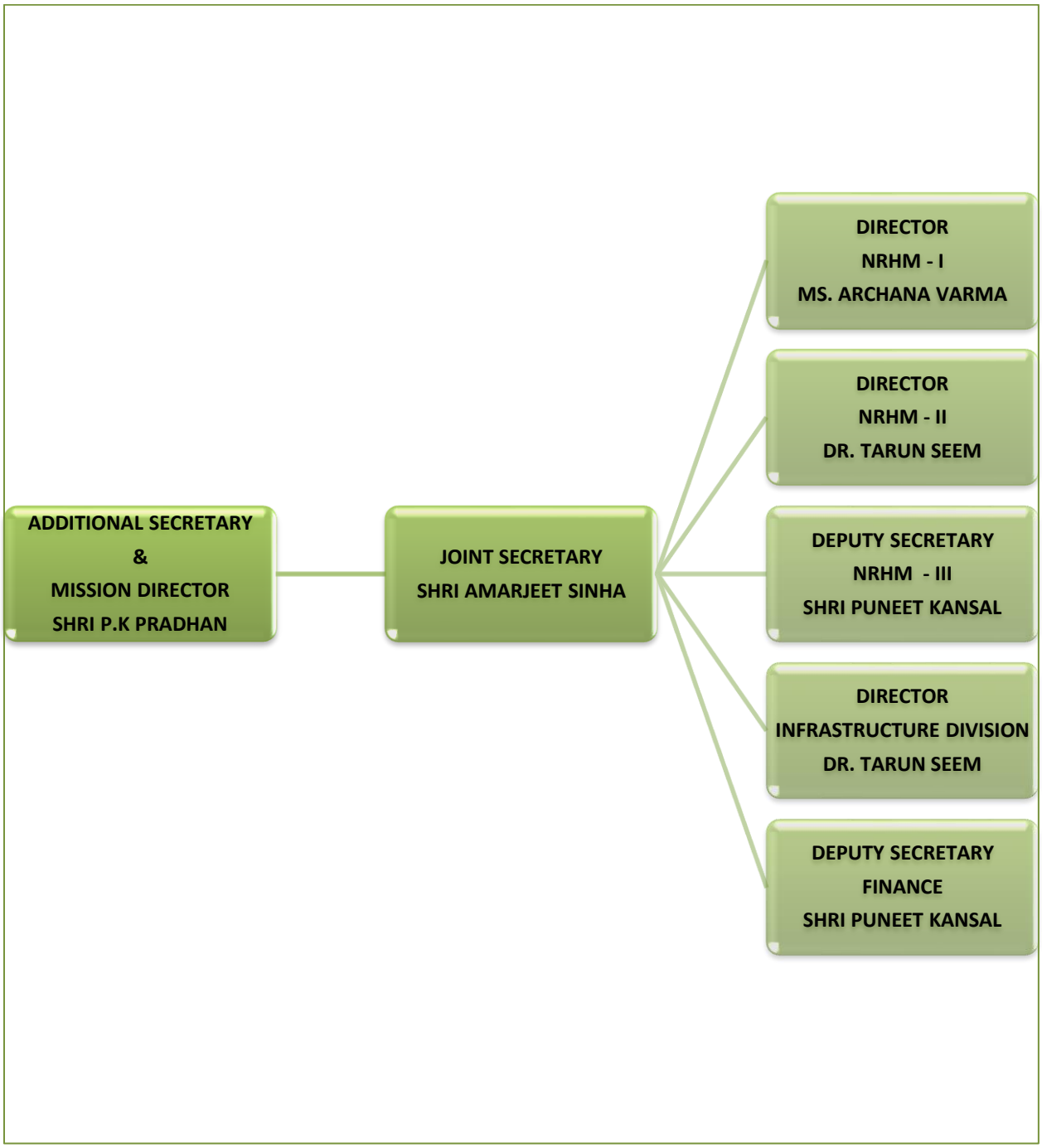
(a) Core Strategies:

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).
- Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation & hygiene and nutrition.
- Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels.
- Technical Support to National, State and District Health Missions, for Public Health Management.
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of Human Resources for health.
- Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc.
- Promoting non-profit sector particularly in under served areas.

(b) Supplementary Strategies:

- Regulation of Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.
- Promotion of Public Private Partnerships for achieving public health goals.
- Mainstreaming AYUSH – revitalizing local health traditions.
- Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.
- Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

ORGANIZATIONAL STRUCTURE OF NRHM



1.2 TASKS PERFORMED DURING INTERNSHIP:

The time of joining involved us in attending the NPCC meetings [National Programme Coordination Committee] where Statewise NPCC meetings were held at the Conference hall of MOHFW chaired by Health Secretary, **Ms. Sujatha Rao**, Additional Secretary and Mission Director, **Mr. P.K Pradhan** and Joint Secretary, **Mr. Amarjeet Sinha**. This meeting was also mandatory for NRHM Directors, Deputy Secretaries, Officials of all departments of MOHFW to attend. The Representatives from State (which constitutes the State's Principle Health Secretary, Mission Directors and Heads of other Departments of Health & Family Welfare of a State) presents a presentation in front of MOHFW stating their last year's targets, their successful achievements and the goals they have targeted for the coming year and the next 5 years of future, the core strategies and innovations (like incentives for ASHA, PPP, Health Insurance) they would like to implement within a State to achieve the set targets, the budget they would be required to implement such innovations and achieve the targeted goals.````

As a Consultant we were required to note down the minutes of Proceedings for NPCC Meetings and keep a close tab on the budget demanded by the State and its approval or rejection by the chaired members and noting the important discussions and decisions taking place in the meeting. The other routine job involves answering the Parliamentary Questions, studying the PIP's [Programme Implemetation Planning] documents of various States, reviewing their Health Action Plans and the comments of various divisions of department of MOHFW on PIP and NHSRC [National Health Systems Resource Centre] on the Health Action Plans of State.

IN - DEPTH STUDY:

Preparing the Records Of Proceedings (ROP's) for the States after the NPCC Meetings is indeed a unique and challenging task which requires the study of previous 5 years of ROP's of each State, focusing on their set targets for future and past and analyzing the progress they have made so far [with respect to every aspect], analyzing the budget allocated to Staes in past and its utilization and the budget demanded by them now, analyzing the targets they have achieved in

comparison to other States with respect to all the departments of Health and National Programmes and NRHM.

1.3 BRIEF REPORT ON MANAGERIAL TASKS PERFORMED IN VARIOUS DEPARTMENTS / PROGRAMMES:

The NPCC meetings involved us managing several aspects of management right from managing the Documentation part to organizing and conducting the National level meetings. The File management is a big task of responsibility.

12th April, 2010 was celebrated as the day when NRHM completed its 5 years and the event was organized at Vigyan Bhavan. This involved us in managing the event in various aspects and Rajasthan was awarded as the Best Performing State under NRHM. Event was attended by the National and State level Officials and Who's Who of the Ministry.

Preparation of ROP's for every State requires us to be a team player and deliver the work under the restricted time guidelines and work under pressure, coordinating with Ministry Officials, State Officials and NHSRC Officials.

The preparation of District Health Action Plan involves the same task responsibilities.

1.4 REFLECTIVE LEARNING DURING INTERNSHIP:

Understanding an Organizational Behaviour and culture is the biggest milestone if someone wants to excel in that Organisation. Previous professional experience with the private and Corporate Organisations is lot more different than what we have learnt in this Government Organisation. One Organisation with several Departments and thousands of employees working under its umbrella, dealing with their HR Issues and day to day administrative tasks is a remarkable thing to observe there and this teaches that India is democratic Country.

Attending the National level meetings and hearing the State's targets and their achievements taught us how far National Programmes have reached and what potential they have to accomplish their set targets.

Coordination and sense of Belongingness is what keeps such a large organization keep going and achieve remarkable targets. Preparing of ROP's taught us how many factors and not one factor is responsible for the development of any Nation's Health.

Preparation of District Health Action Plan taught me in depth the planning process.

Part II: Dissertation on "A block wise comparative HR analysis at peripheral level in relation to IPHS standards for district Kawardha, Chhattisgarh"

2.1 INTRODUCTION

Since independence, the country has created a vast public health infrastructure of Sub-centres, Public Health Centres (PHCs) and Community Health Centres (CHCs). There is also a large cadre of health care providers (Auxiliary Nurse Midwives, Male Health workers, Lady Health Visitors and Health Assistant Male). Yet, this vast infrastructure is able to cater to only 20% of the population, while 80% of healthcare needs are still being provided by the private sector (1). Rural India is suffering from a long-standing healthcare problem. Studies have shown that only one trained healthcare provider including a doctor with any degree is available per every 16 villages. Although, more than 70% of its population lives in rural areas, but only 20% of the total hospital beds are located in rural area. Most of the health problems that people suffer in the rural community and in urban slums suffer are preventable and easily treatable. In view of the above issues, the National Rural Health Mission (NRHM) has been launched by Government of India in April 2005 by GOI. It seeks to provide effective healthcare to rural population throughout the country.

Underlying Principles of NRHM[2] :

- Promote equity, efficiency, quality and accountability in Public Health Systems.
- Enhance People orientation and community-based approaches.
- Ensure Community Health (Mother Women, Children), Tribal, Dalit.
- Recognize value of traditional knowledge base communities like baigas traditional outlets /ISMPS /Ayush clinics.
- Promote new innovation, methods and process development.
- Decentralize and involve local bodies.
- Emerge as integrated plan of the district.

Goals of NRHM[2]:

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR);
- Universal access to integrated comprehensive public health services;
- Child health, Water, Sanitation and Hygiene;
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases;
- Population stabilization, gender and demographic balance;
- Revitalize local health traditions and main-stream Ayurvedic, Yoga, Unani, Siddha and Homeopathy Systems of Health (AYUSH);
- Promotion of healthy life styles.

Outcomes:

- Provision of trained and supported village health activist as per needs (ASHA).
- Preparation of health action plans by Panchayat as mechanism for involving community in health.
- Strengthening SC/PHC/CHC infrastructure development.
- Institutionalizing and substantially strengthening District Level Health Management system
- Increase utilization of First Referral Units by making it well equipped and functional.
- Strengthening sound local health traditions and local resource based health practices related to PHC and public health.
- Improved quality health services through system.

Core Strategies:

- Strengthening Local Governance through the PRIs to own, control and manage public health services.
- Promote access to healthcare by ASHA, Mitanin, SHGs, adolescent girls and boys.
- Strengthening sub center through a united fund to enable local planning and action through MPWs.
- Strengthening existing PHC and CHCs, and provision of 30 bedded CHC per lakh population for improve curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).
- Encourage safe and clean delivery at SHC/ PHC/ CHC level with 24 hour facility.
- Promote quality in Health care services.
- Address issues through Gram Sabha and make effective use of Gram Sabha and gram Sachivalaya.
- Preparation and implementation of an integrated district health plan prepared by the District Core Team.
- Strengthening capacities of staff for data collection assessment and review for evidence based planning – monitoring and supervision .
- Ensure formulation of transparent policies for deployment and career development of Human Resource for Health.

Supplementary Strategies

- Ensure participation of PPP, including the informal rural practitioners, to ensure availability of quality service to the community at their doorsteps.
- Promotions of public/ private partnership for achieving public health goals.

The Programme Implementation plan basically contains the strategies to be followed, the areas of concerns, and the areas sectors to be stressed while implementing the health programs in the district as well as strategies to improve the delivery of health services in the district.

2.2 THE PROBLEM STATEMENT

Health care delivery in India has been envisaged at three levels namely primary, secondary and tertiary. The secondary level of health care essentially includes Community Health Centres(CHCs), constituting the First Referral Units(FRUs) and the district hospitals. The CHCs were designed to provide referral health care for cases from the primary level and for cases in need of specialist care approaching the centre directly. 4 PHCs are included under each CHC thus catering to approximately 80,000 population in tribal / hilly areas and 1, 20,000 population in plain areas. CHC is a 30-bedded hospital providing specialist care in medicine, Obstetrics and Gynaecology, Surgery and Paediatrics. These centres are however fulfilling the tasks entrusted to them only to a limited extent. The launch of the National Rural Health Mission (NRHM) gives us the opportunity to have a fresh look at their functioning. NRHM envisages bringing up the CHC services to the level of Indian Public Health Standards. Although there are already existing standards as prescribed by the Bureau of Indian Standards for 30-bedded hospital, these are at present not achievable as they are very resource-intensive. Not only does the system require upgradation to handle higher patient load, but emphasis also needs to be given to quality aspects to increase the level of patient satisfaction. In order to ensure quality of services, the Indian Public Health Standards are being set up for CHCs so as to provide a yardstick to measure the services being provided there. This study tries to analyse HR requirements of the district in relation to minimum requirements of IPHS.

2.3 AIM OF STUDY:

The aim of the study was to assess the existing and projected HR needs of various facilities in the district to attain IPHS standards.

2.4 OBJECTIVES:

(a) Analysis of currently sanctioned & existing human resource in the district and how much additional human resource is required to attain IPHS standards.

(b) Identify manpower requirements at various facilities at peripheral i.e PHC and CHC level.

2.5 RESEARCH DESIGN

(a) Descriptive analysis of HR requirements to attain IPHS standards.

(b) Data collection was done through state HMIS while visiting the district for district health action planning.

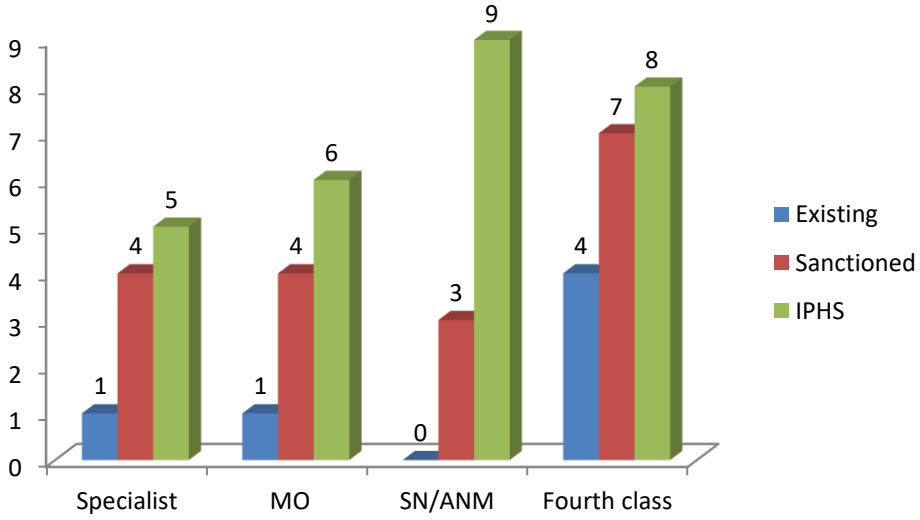
2.6 FINDINGS:

1.CHC Pandaria

Table-1

	Existing	Sanctioned	IPHS
Specialist	1	4	5
MO	1	4	6
SN/ANM	0	3	9
Fourth class	4	7	8

Figure-1



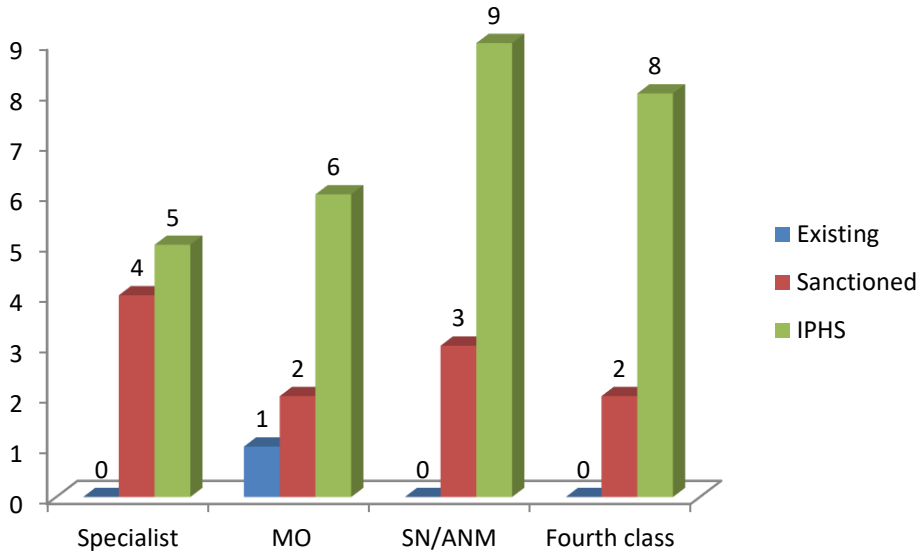
CHC Pandaria is deficient by 4 specialists, 5 MO's, 9 SN's and 4 fourth class employees and it needs sanctioning of 1 specialist, 2 MO's, 6 SN/ANM's and 1 fourth class employee.

2. CHC Piparia

Table-2

	Existing	Sanctioned	IPHS
Specialist	0	4	5
MO	1	2	6
SN/ANM	0	3	9
Fourth class	0	2	8

Figure-2



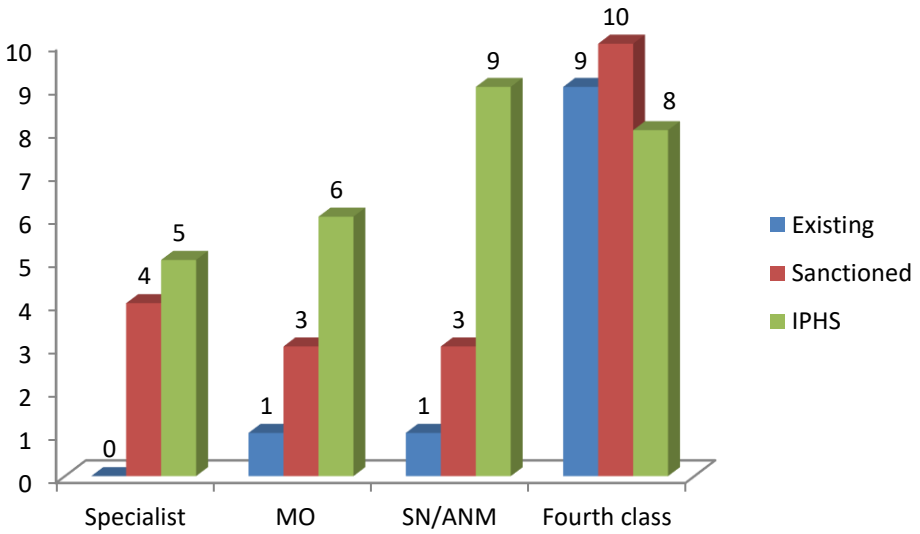
CHC Piparia is deficient by 5 specialists, 5 MO's, 9 SN's and 8 fourth class employees and it needs sanctioning of 1 specialist, 4 MO's, 6 SN/ANM's and 6 fourth class employees to attain IPHS standards.

3.CHC Bodla

Table-3

	Existing	Sanctioned	IPHS
Specialist	0	4	5
MO	1	3	6
SN/ANM	1	3	9
Fourth class	9	10	8

Figure-3



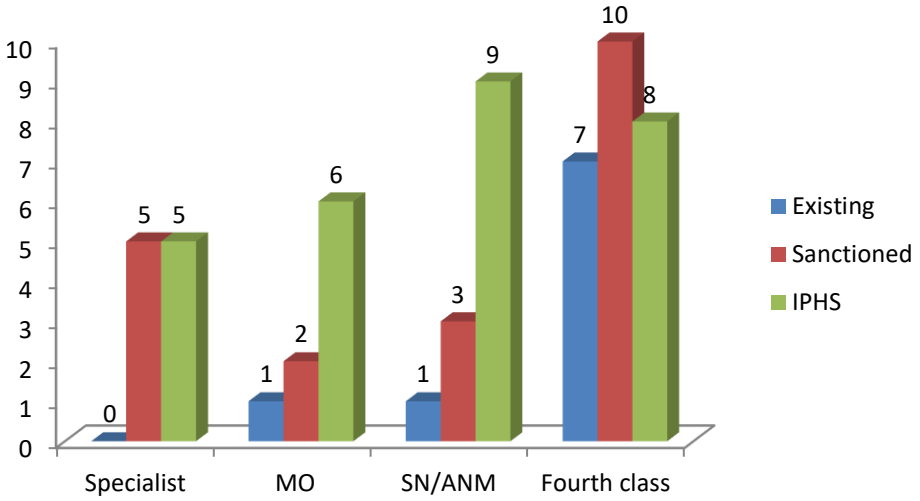
CHC Bodla is deficient by 5 specialists, 5 MO's, 8 SN's. 1 fourth class employee is overstaffed and can be transferred to another facilty. CHC needs sanctioning of 1 specialist, 3 MO's, 3 SN/ANM's to attain IPHS standards.

4.CHC S lohara

Table-4

	Existing	Sanctioned	IPHS
Specialist	0	5	5
MO	1	2	6
SN/ANM	1	3	9
Fourth class	7	10	8

Figure-4



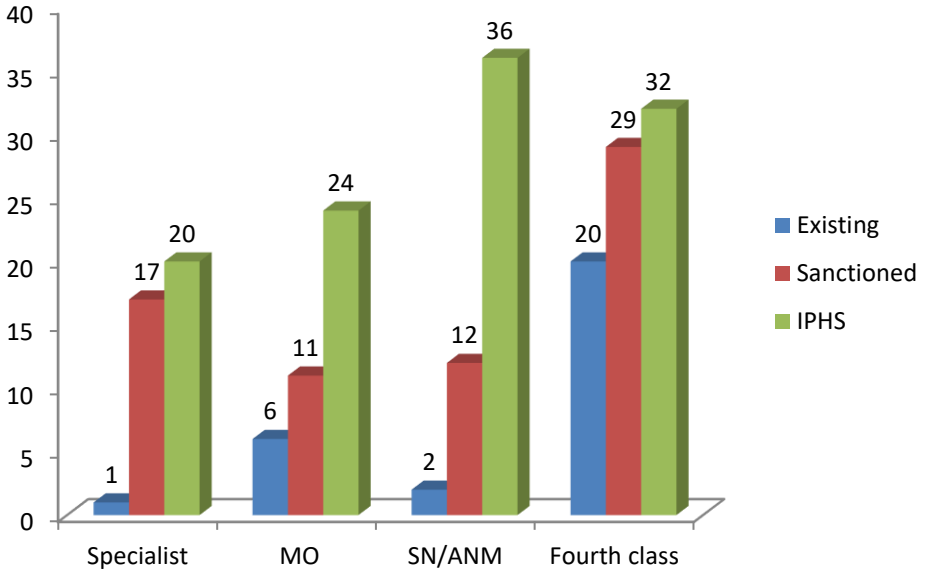
CHC S lohara is deficient by 5 specialists, 5 MO's, 8 SN's and 1fourth class employee. CHC needs sanctioning of 4 MO's, 6 SN/ANM's to attain IPHS standards. Sanctioned posts of 10 fourth class employees can be reduced to 8.

CHC TOTAL

Table-5

	Existing	Sanctioned	IPHS
Specialist	1	17	20
MO	6	11	24
SN/ANM	2	12	36
Fourth class	20	29	32

Figure-5



CHC's in the district are deficient by 19 specialists, 18 MO's, 34 SN's and 12 fourth class employees and needs sanctioning of 3 specialist, 13 MO's, 24 SN/ANM's and 3 fourth class employees to attain IPHS standards.

GAP BETWEEN EXISTING AND REQUIRED MANPOWER at CHC's

Existing gap at CHC	
Specialist	19
MO	18
SN/ANM	34
Fourth class	12

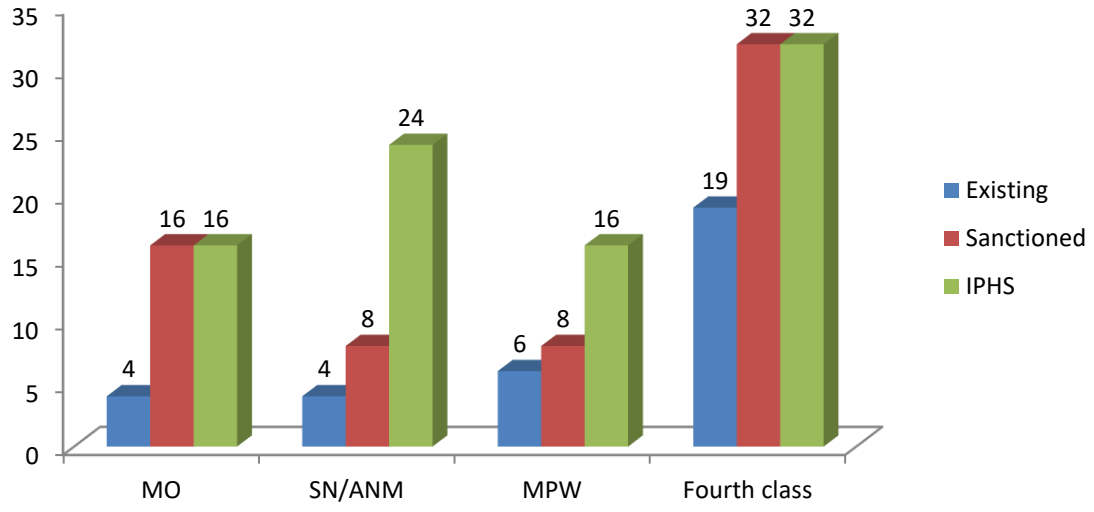
GAP ANALYSIS OF PHC'S

1.PHC's in block Pandaria

Table-6

	Existing	Sanctioned	IPHS
MO	4	16	16
SN/ANM	4	8	24
MPW	6	8	16
Fourth class	19	32	32

Figure-6



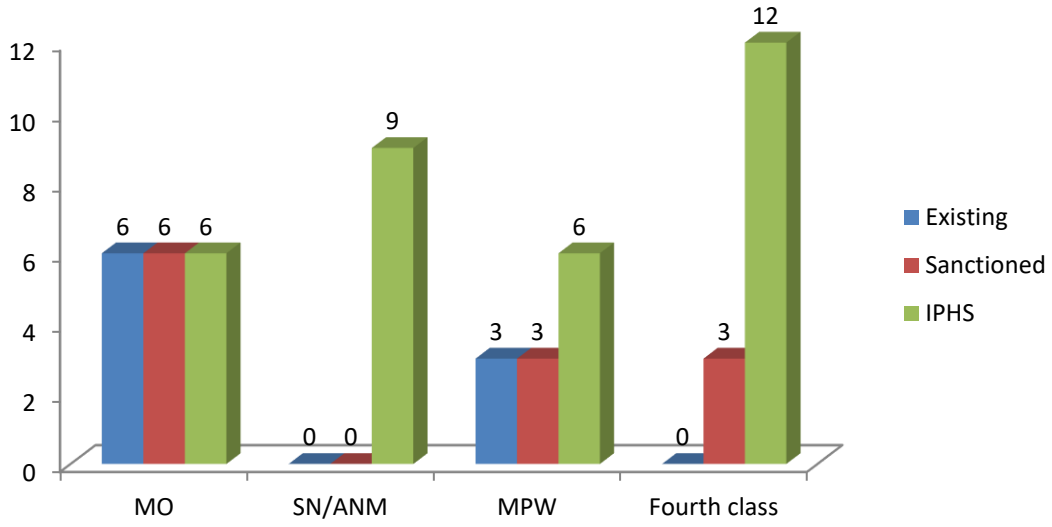
PHC's in block Pandaria are deficient by 12 MO's, 20 SN's/ANM's 10 MPW and 13 fourth class employees and it needs sanctioning of 16 SN/ANM'sand 8 MPW to attain IPHS standards

2.PHC's in Block Piparia

Table-7

	Existing	Sanctioned	IPHS
MO	6	6	6
SN/ANM	0	0	9
MPW	3	3	6
Fourth class	0	3	12

Figure-7



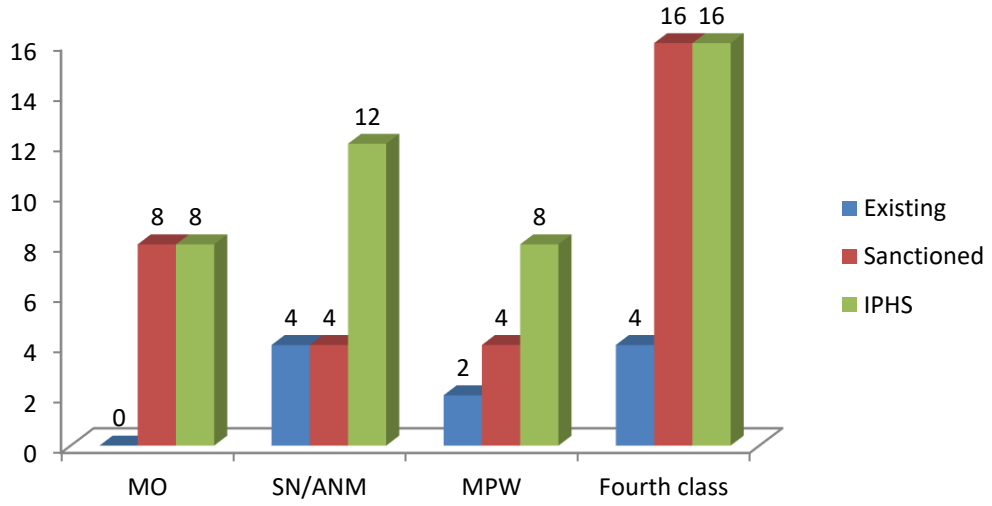
PHC's in block Piparia are deficient by 9 SN's/ANM's, 3MPW and 12 fourth class employees and it needs sanctioning of 9 SN/ANM's, 9MPW,9 fourth class employees to attain IPHS standards

3. PHC's in block Bodla

Table-8

	Existing	Sanctioned	IPHS
MO	0	8	8
SN/ANM	4	4	12
MPW	2	4	8
Fourth class	4	16	16

Figure-8



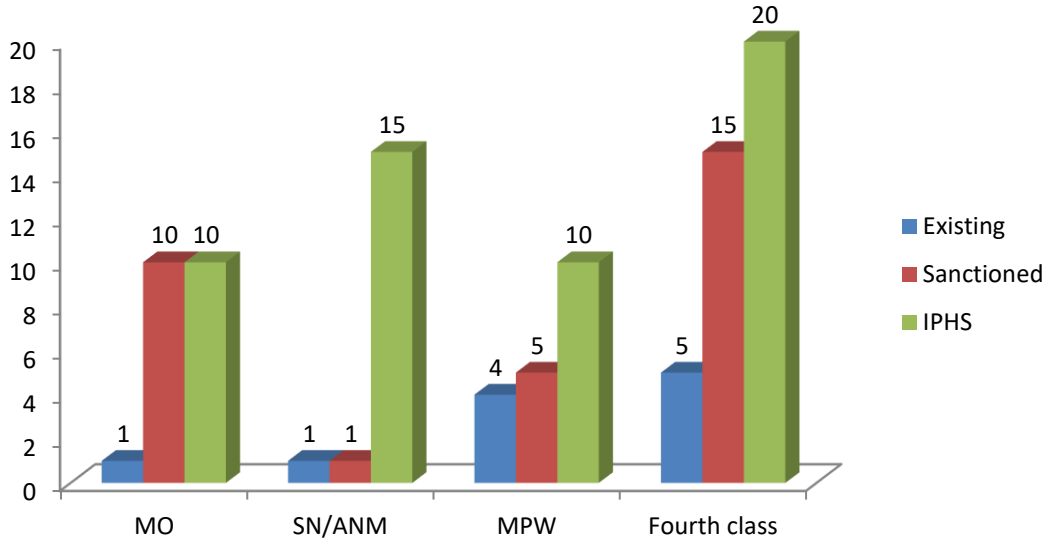
PHC's in block Bodla are deficient by 8 MO's, 8 SN's/ANM's, 6MPW and 12 fourth class employees and it needs sanctioning of 8 SN/ANM's, 4 MPW,12 fourth class employees to attain IPHS standards

4.PHC's in Block S lohara

Table-9

	Existing	Sanctioned	IPHS
MO	1	10	10
SN/ANM	1	1	15
MPW	4	5	10
Fourth class	5	15	20

Figure-9



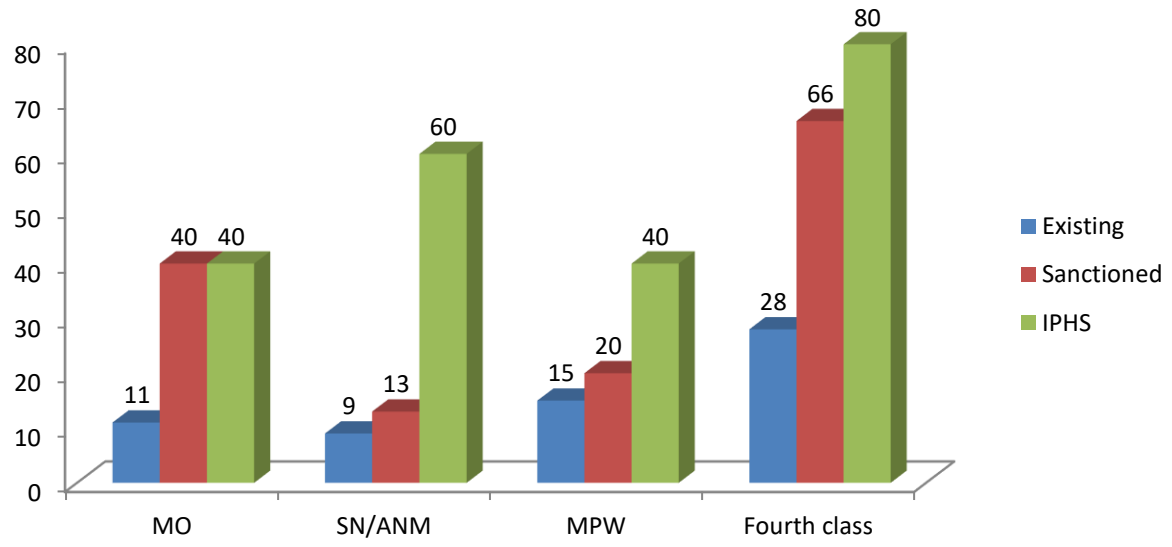
PHC's in block S lohara are deficient by 9 MO's, 14 SN's/ANM's, 6 MPW and 15 fourth class employees and it needs sanctioning of 14 SN/ANM's, 5 MPW, 5 fourth class employees to attain IPHS standards

PHC Total:

Table-10

	Existing	Sanctioned	IPHS
MO	11	40	40
SN/ANM	9	13	60
MPW	15	20	40
Fourth class	28	66	80

Figure-10



PHC's in the District are deficient by 29 MO's, 51 SN's/ANM's, 25 MPW and 52 fourth class employees and needs sanctioning of 47 SN/ANM's, 20 MPW, 14 fourth class employees to attain IPHS standards.

GAP BETWEEN REQUIRED AND EXISTING MANPOWER AT PHC LEVEL

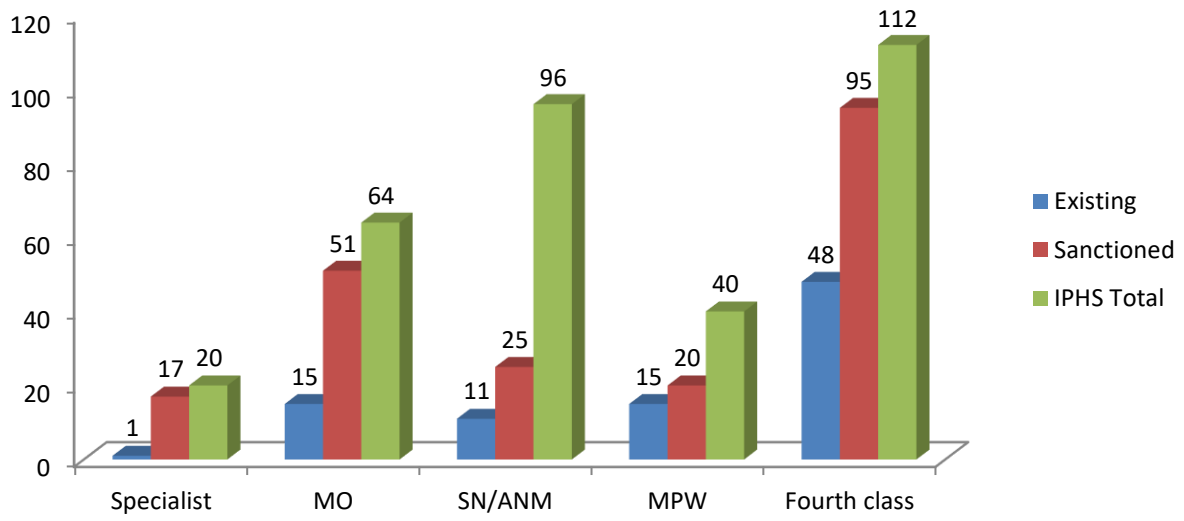
Existing gap at PHC	
MO	29
SN/ANM	51
MPW	25
Fourth class	52

COMBINED GAP IN CHC & PHC OF DISTRICT KAWARDHA

Table-11

	Existing	Sanctioned	IPHS Total
Specialist	1	17	20
MO	15	51	64
SN/ANM	11	25	96
MPW	15	20	40
Fourth class	48	95	112

Figure-11



In the district total deficit in relation to IPHS is 19 specialists, 49 MO's, 85 SN's/ANM's, 25 MPW and 64 fourth class employees and needs sanctioning of 3 specialists, 13 MO's, 71 SN/ANM's, 20 MPW, 17 fourth class employees to attain IPHS standards.

TOTAL GAP OF HUMAN RESOURCE IN RELATION TO IPHS

Table-12

Specialist	19
MO	49
SN/ANM	85
MPW	25
Fourth class	64

NO. OF ADDITIONAL POSTS TO BE SANCTIONED

Table-13

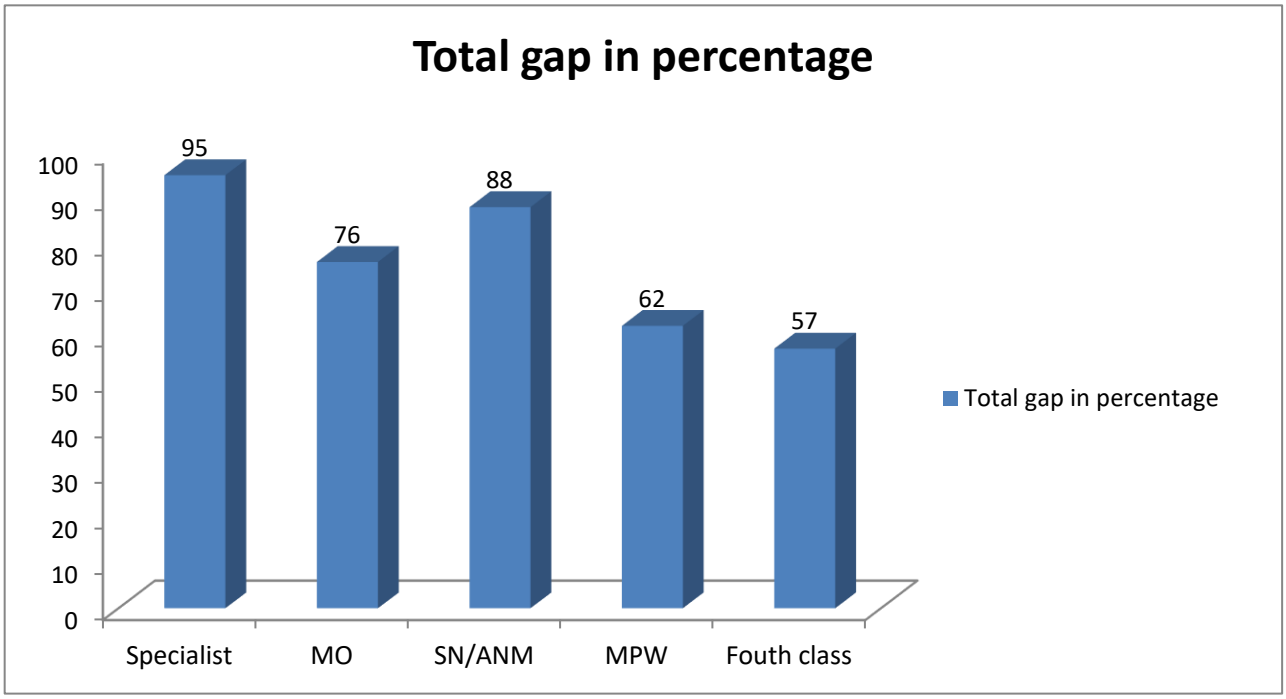
Specialist	3
MO	13
SN/ANM	71
MPW	20
Fourth class	17

TOTAL GAP OF HUMAN RESOURCE IN PERCENTAGE:

Table-14

	Total gap in percentage
Specialist	95%
MO	76%
SN/ANM	88%
MPW	62%
Fouth class	57%

Figure-14



Thus Specialists are deficient by 95%,MO's by 76%, SN/ANM's by 88%, MPW by 62% and Fourth class employees by 57%.

2.7 INTERPRETATION:

95% of Specialists,76% of MO's,88% of ANM's,62% of MPW and 57% of Fourth class posts are deficient in comparison to IPHS standards.

This huge gap in required manpower support is one of the major limiting factor for NRHM and other district action plans to achieve their objectives.

Thus, this gap needs to be addressed before implementing other programmes and to fulfill the community needs for adequate healthcare in these areas.

2.8 RECOMMENDATIONS:

1. HR Planning

Emphasis must be given to proper HR planning according to the need.

2. Incentives

For retaining and motivation of the staff working in rural areas an incentive driven approach would be best.

3. Training of staff

Staff must be given proper training in the tasks they have to perform. This will help them in understanding their roles and expected results from them.

4. Performance appraisal

A proper system of performance appraisal must exist and this should be done within a particular span of time.

2.9 LIMITATIONS

1.Financial limitations of state government,Unavailability of funds for HR functions.

NRHM flexible pool can be utilized and appointments can be made on contractual basis

2.Status of infrastructure

Needs to be updated so that adequate facilities are present before deployment of human resource.

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2. http://mohfw.nic.in/NRHM.htm

3. http://mohfw.nic.in/NRHM/iphs.htm

4. http://www.ncbi.nlm.nih.gov/pubmed/

5. Programme implementation plan of the district Kawardha collected from SHRC.

6. HMIS data of the state

7. National rural health mission manual published by MOHFW

8. Indian public health standards guidelines for CHC and PHC given by MOHFW

9. Indian public health standards (IPHS) for community health centres

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12.11 ANNEXURES

Annex 1

Proforma for PHCs on IPHS

Identification

Name of the State: _____

District:_____

Tehsil/Taluk/Block _____

Location Name of PHC:_____

Is the PHC providing 24 hours and 7 days delivery facilities

Date of Data Collection

Day Month Year

Name and Signature of the Person Collecting Data

I. Services

S.No.		
1.1.	**Population covered (in numbers)**	
1.2.	**Assured Services available (Yes/No)**	
a.	OPD Services	
b.	Emergency services (24 Hours)	
c.	Referral Services	
d.	In-patient Services	
1.3.		
a.	Number of beds available	
b.	Bed Occupancy Rate in the last 12 months (1- less than 40%; 2 - 40-60%; 3 - More than 60%)	
1.4.	Average daily OPD Attendence	
a.	Males	
b.	Females	
1.5.	**Treatment of specific cases (Yes / No)**	
a.	Is surgery for cataract done in the PHC?	

b.	Is the primary management of wounds done at the PHC?	
c.	Is the primary management of fracture done at the PHC?	
d.	Are minor surgeries like draining of abscess etc done at the PHC?	
e.	Is the primary management of cases of poisoning / snake, insect or scorpion bite done at the PHC?	
f.	Is the primary management of burns done at PHC?	

1.6.	**MCH Care including Family Planning**	
1.6.1.	**Service availability (Yes / No)**	
a.	Ante-natal care	
b.	Intranatal care (24 - hour delivery services both normal and assisted)	
c.	Post-natal care	
d.	New born Care	
e.	Child care including immunization	
f.	Family Planning	
g.	MTP	
h.	Management of RTI / STI	
i.	Facilities under Janani Suraksha Yojana	
1.6.2.	**Availability of specific services (Yes / No)**	
a.	Are antenatal clinics organized by the PHC regularly?	
b.	Is the facility for normal delivery available in the PHC for 24 hours?	
c.	Is the facility for tubectomy and vasectomy available at the PHC?	
d.	Is the facility for internal examination for gynaecological conditions available at the PHC?	
e.	Is the treatment for gynecological disorders like leucorrhoea, menstrual disorders available at the PHC?	
f.	If women do not usually go to the PHC, then what is the reason behind it?	

g.	Is the facility for MTP (abortion) available at the PHC?	
h.	Is there any precondition for doing MTP such as enforced use of contraceptives after MTP or asking for husband's consent for MTP?	
i.	Do women have to pay for MTP?	
j.	Is treatment for anemia given to both pregnant as well as non-pregnant women?	
k.	Are the low birth weight babies managed at the PHC?	
l.	Is there a fixed immunization day?	
m.	Is BCG and Measles vaccine given regularly in the PHC?	
n.	How is the vaccine received at PHC and distributed to Sub Centres?	
o.	Is the treatment of children with pneumonia available at the PHC?	
p.	Is the management of children suffering from diarrhea with severe dehydration done at the PHC?	

1.7.	**Other fuctions and services performed (Yes / No)**	
a.	Nutrition services	
b.	School Health programmes	
c.	Promotion of safe water supply and basic sanitation	
d.	Prevention and control of locally endemic diseases	
e.	Disease surveillance and control of epidemics	
f.	Collection and reporting of vital statistics	
g.	Education about health / behaviour change communication	
h.	National Health Programmes including HIV/AIDS control programes	
i.	AYUSH services as per local preference	
j.	Rehabilitation services (please specify)	

1.8.	Monitoring and Supervision activities (Yes / No)	
a.	Monitoring and supervision of activities of sub-centres through regular meetings / periodic visits, etc.	
b.	Monitoring of National Health Programmes	
c.	Monitoring activities of ASHAs	
d.	Visits of Medical Officer to all sub-centres at least once in a month	
e.	Visits of Health Assistants (Male) and LHV to sub-centres once a week	

II. Manpower

S.No.	Personnel	Existing pattern	Recommended	Current Availability at PHC (Indicate Numbers)	Remarks / Suggestions / Identified Gaps
2.1.	Medical Officer	1	2 (one may be from AYUSH and one other Medical Officer preferrably a Lady Doctor)		
2.2.	Pharmacist	1	1		
2.3.	Nurse - Midwife (Staff Nurse)	1	3 (for 24 hour PHCs; 2 may be contractual))		
2.4.	Health Worker (Female)	1	1		
2.5.	Health Educator	1	1		
2.6.	Health Assistant (One male and One female	2	2		
2.7.	Clerks	2	2		
2.8.	Laboratory Technician	1	1		
2.9.	Driver	1	Optional; vehicles may be out-sourced		
2.10.	Class IV	4	4		
	Total	**15**	**17/18**		

III. Training of personnel during previous (full) year

3.1.	Available training for	Number trained
a.	Tradition birth attendants	
b.	Health Worker (Female)	
c.	Health Worker (Male)	

d.	Medical Officer				
e.	Initial and periodic training of paramadics in treatment of minor ailments				
f.	Training of ASHAs				
g.	Periodic training of Doctors through Continuing Medical Education, conferences, skill development training etc. on emergency obstetric care				
h.	Training of Health Workers in antenatal care and skilled birth attandance				

IV. Essential Laboratory Services

S.No.		Current Availability at PHC	Remarks / Suggestions / Identified Gaps
4.1.	Routine urine, stool and blood tests		
4.2.	Blood grouping		
4.3.	Bleeding time, clotting time		
3.4.	Diagnosis of RTI/STDs with wet mounting, grams stain, etc.		
4.5.	Sputum testing for TB		
4.6.	Blood smear examination for malaria parasite		
4.7.	Rapid tests for pregnancy		
4.8.	RPR test for Syphills / YAWS surveillance		
4.9.	Rapid tests for HIV		
4.10.	Others (specify)		

V. Physical Infrastructure (As per specifications)

S.No.		Current Availability at PHC	If available, area in Sq. mts.)	Remarks / Suggestions / Identified Gaps
5.1.	Where is this PHC located?			
a.	Within Village Locality			
b.	Far from village locality			
c.	If far from locality specify in km			
5.2.	Building			
a.	Is a designated government building available for the PHC? (Yes / No)			
b.	If there is no designated government building, then where does the PHC located			
	Rented premises			

	Other government building			
	Any other specify			
c.	Area of the building (Total area in Sq. mts.)			
d.	What is the present stage of construction of the building			
	Construction complete			
	Construction incomplete			
e.	Compound Wall / Fencing (1-All around; 2-Partial; 3-None)			
f.	Condition of plaster on walls (1- Well plastered with plaster intact every where; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster)			
g.	Condition of floor (1- Floor in good condition; 2- Floor coming off in some places; 3- Floor coming off in many places or no proper flooring)			
h.	Whether the cleanliness is Good / Fair / Poor?(Observe)			
	OPD			
	Rooms			
	Wards			
	Toilets			
	Premises (compound)			
I.	Are any of the following close to the PHC? (Observe) (Yes/No)			
i.	Garbage dump			
ii.	Cattle shed			
iii.	Stagnant pool			
iv.	Pollution from industry			
j.	Is boundary wall with gate existing? (Yes / No)			
5.3.	Location			
a.	Whether located at an easily accessible area? (Yes/No)			
b.	Distance of PHC (in Kms.) from the farthest village in coverage area			
c.	Travel time (in minutes) to reach the PHC from farthest village in coverage area			
d.	Distance of PHC (in Kms.) from the CHC			
e.	Distance of PHC (in Kms.) from District Hospital			
5.4.	Prominent display boards regarding service availability in local language (Yes/No)			
5.5.	Registration counters (Yes/No)			
5.6.				
a.	Pharmacy for drug dispensing and drug storage			

	Yes/No)			
b.	Counter near entrance of PHC to obtain contraceptives, ORS packets, Vitamin A and Vaccination (Yes / No)			
5.7.	Separate public utilities for males and females (Yes/No)			
5.8.	Suggestion / complaint box (Yes/No)			
5.9.	OPD rooms / cubicles (Yes/No) (Give numbers)			
5.10	Adequate no. of windows in the room for light and air in each room (Yes/No)			
5.11.	Family Welfare Clinic (Yes/No)			
5.12.	Waiting room for patients (Yes/No)			
5.13.	Emergency Room / Casualty (Yes/No)			
5.14.	Separate wards for males and females (Yes/No)			
5.15	No. of beds : Male			
5.16	No. of beds : Female			
5.17.	Operation Theatre (if exists)			
a.	Operation Theatre available (Yes/No)			
b.	If operation theatre is present, are surgeries carried out in the operation theatre?			
	Yes			
	No			
	Sometimes			
c.	If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same?			
	Non-availability of doctors /staff			
	Lack of equipment / poor physical state of the operation theatre			
	No power supply in the operation theatre			
	Any other reason (specify)			
d.	Operation Theatre used for obstetric / gynaecological purpose (Yes / No)			
e.	Has OT enough space (Yes / No)			
5.18.	Labour room			
a.	Labour room available? (Yes/ No)			
b.	If labour room is present, arc deliveries carried out in the labour room?			
	Yes			
	No			
	Sometimes			
c.	If labour room is present. but deliveries are not being conducted there, then what are the reasons for the same?			
	Non-availability of doctors / staff			

	Poor condition of the labour room			
	No power supply in the labour room			
	Any other reason (specify)			
d.	Is separate areas for septic and aseptic deliveries available? (Yes / No)			
5.19.	Laboratory:			
a.	Laboratory (Yes/No)			
b.	Are adequate equipment and chemicals available? (Yes/No)			
c.	Is laboratory maintained in orderly manner? (Yes / No)			
5.20.	Ancillary Rooms - Nurses rest room (Yes/No)			
5.21.	Water supply			
a.	Source of water (1- Piped; 2- Bore well/ hand pump / tube well; 3- Well; 4- Other (specify))			
b.	Whether overhead tank and pump exist (Yes / No)			
c.	If overhead tank exist, whether its capacity sufficient? (Yes/No)			
d.	If pump exist, whether it is in working condition? (Yes / No)			
5.22	Sewerage			
	Type of sewerage system (1- Soak pit; 2- Connected to Municipal Sewerage)			
5.23.	Waste disposal			
	How the waste material is being disposed (please specify)?			
5.24.	Electricity			
a.	Is there electric line in all parts of the PHC? (1- In all parts; 2- In some parts; 3- None)			
b.	Regular Power Supply (1- Continuous Power Supply; 2- Occasional power failure; 3- Power cuts in summer only; 4- Regular power cuts; 5- No power supply			
c.	Stand by facility (generator) available in working condition (Yes / No)			
5.25.	Laundry facilities:			
a.	Laundry facility available(Yes/No)			
b.	If no, is it outsourced?			
5.26.	Communication facilities			
a.	Telephone (Yes/No)			
b.	Personal Computer (Yes/No)			
c.	NIC Terminal (Yes/No)			
d.	E.Mail (Yes / No)			
e.	Is PHC accesible by			

i.	Rail (Yes / No)			
ii.	All whether road (Yes / No)			
iii.	Others (Specify)			
5.27.	Vehicles			
	Vehicle (jeep/other vehicle) available? (Yes / No)			
		Current Availability at PHC	**If available, area in Sq. mts.)**	**Remarks / Suggestions / Identified Gaps**
5.28.	Office room (Yes/No)			
5.29.	Store room (Yes/No)			
5.30.	Kitchen (Yes / No)			
5.31.	Diet:			
a.	Diet provided by hospital (Yes/No)			
b.	If no, how diet is provided to the indoor patients?			
5.32.	Residential facility for the staff with all amenities			
	Medical Officer			
	Pharmacist			
	Nurses			
	Other staff			
5.33.	Behavioral Aspects (Yes / No)			
a.	How is the behaviour of the PHC staff with the patient			
	Courteous			
	Casual/indifferent			
	Insulting / derogatory			
b.	Any fee for service is charged from the users? (Yes / No). If yes, specify.			
c.	Is there corruption in terms of charging extra money for any of the service provided? (Yes / No)			
d.	Is a receipt always given for the money charged at the PHC? (Yes / No)			
e.	Is there any incidence of any sexual advances. oral or physical abuse, sexual harassment by the doctors or any other paramedical? (Yes / No)			
f.	Are woman patients interviewed in an environment that ensures privacy and dignity? (Yes / No)			
g.	Are examinations on woman patients conducted in presence of a woman attendant, and procedures conducted under conditions that ensure privacy? (Yes / No)			

h.	Do patients with chronic illnesses receive adequate care and drugs for the entire duration? (Yes / No)			
i.	If the health centre is unequipped to provide the services how and where the patient is referred and how patients transported?			
j.	Is there a publicly displayed mechanism, whereby a complaint/grievance can be registered? (Yes / No)			

k.	Is there an outbreak of any of the following diseases in the PHC area in the last three years?			
	Malaria			
	Measles			
	Gastroenteritis			
	Jaundice			
l.	If yes, did the PHC staff responded immediately to stop the further spread of the epidment			
m.	Does the doctor do private practice during or after the duty hours? (Yes/ No)			
n.	Are there instances where patients from particular social background dalits, minorities, villagers) have faced derogatory or discriminatory behavior or service of poorer quality? (Yes / No)			
o.	Have patients with specific health problems (HIV/AIDS, leprosy suffered discrimination in any form? (Yes / No)			

VI. Equipment (As per list)

Equipment	Available		Functional	Remarks / Suggestions / Identified Gaps

VII. Drugs (As per essential drug list)

Drug	Available	Remarks / Suggestions / Identified Gaps

VIII. Furniture

S.No.	Item	Current Availability at PHC	If available, numbers	Remarks / Suggestions / Identified Gaps
8.1.	Examination Table			
8.2.	Delivery Table			
8.3.	Footstep			
8.4.	Bed Side Screen			
8.5.	Stool for patients			
8.6.	Arm board for adult & child			
8.7.	Saline stand			
8.8.	Wheel chair			
8.9.	Stretcher on trolley			
8.10.	Oxygen trolley			
8.11.	Height measuring stand			
8.12.	Iron bed			
8.13.	Bed side locker			
8.14.	Dressing trolley			
8.15.	Mayo trolley			
8.16.	Instrument cabinet			
8.17.	Instrument trolley			
8.18.	Bucket			
8.19.	Attendant stool			
8.20.	Instrument tray			
8.21.	Chair			
8.22.	Wooden table			
8.23.	Almirah			
8.24.	Swab rack			
8.25.	Mattress			
8.26.	Pilow			
8.27.	Waiting bench for patients / attendants			
8.28.	Medicine cabinet			
8.29.	Side rail			
8.30.	Rack			
8.31.	Bed side attendant chair			
8.32.	Others			

IX. Quality Control

S.No.	Particular	Whether functional / available as per norms	Remarks
9.1.	Citizen's charter (Yes/No)		
9.2.	Constitution of Rogi Kalyan Samiti (Yes/No) (give a list of office order notifying the members)		

9.3.	Internal monitoring (Social audit through Panchayati Raj Institution / Rogi Kalyan Samitis, medical audit, technical audit, economic audit, disaster preparedness audit etc. (Specify)		
9.4.	External monitoring /Gradation by PRI (Zila Parishad)/ Rogi Kalyan Samitis		
9.5.	Availability of Standard Operating Procedures (SOP) / Standard Treatment Protocols (STP)/ Guidelines (Please provide a list)		

ANNEX 2

Proforma for CHCs on IPHS

Identification

Name of the State: _____

District:_____

Tehsil/Taluk/Block _____

Location Name of CHC:_____

Is This Health Facility Recognized as FRU? (Yes/No)

Date of Data Collection

Day Month Year

Name and Signature of the Person Collecting Data

I. Services

S.No.		
1.1.	Population covered (in numbers)	
1.2.	Specialist services available (Yes/No)	
a.	Medicine	
b.	Surgery	
c.	OBG	
d.	Paediatrics	
e.	National Health Programmes (Specify)	
f.	Emergency services (24 Hours)	
g.	24 - hour delivery services including normal and assisted deliveries	
h.	Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions	
i.	New-born care	
j.	Emergency care of sick children	
k.	Full range of family planning services including Laproscopic Services	
l.	Safe abortion services	
m.	Treatment of STI / RTI	
n.	Essential Laboratory Services (Specify the type of lab tests conducted)	
o.	Blood storage facility	
p.	Referral transport service	
1.3.	Bed Occupancy Rate in the last 12 months (1- less than 40%; 2 - 40-60%; 3 - More than 60%)	
1.4.	Average daily OPD Attendence	
a.	Male	
b.	Female	
1.5.	Types of Surgeries performed (specify)	
1.6.	HIV / AIDS	
a.	Availability of Counseling facility on HIV/ AIDS / STD etc. (Yes/No)	
b.	Is it a Voluntary Council and Testing Centre (VCTC)?	
1.7.	Service availability	Number of days in a month the services are available
a.	Ante-natal Clinics	
b.	Post-natal Clinics	

c.	Immunization Sessions	
1.8.	Number of cases of caeserian delivery (During last one year)	
1.9.	Total number of paediatric beds	
1.10.	Is separate septic labour room available	
1.11.	Availability of facilities for out-patient department in Gynecology/ obstetric (Yes / No)	
a.	Board /Name plates to guide the clients	
b.	Adequate working space	
c.	Privacy during examination	
d.	Facility for counselling	
e.	Separate toilet with running water	
f.	Facility for Starilizing instruments	
g.	Male specialist	
h.	Female specialist	

II.
Manpower

S.No.	Personnel	IPHS Norm	Current Availability at CHC (Indicate Numbers)	Remarks / Suggestions / Identified Gaps
A.	**Clinical Manpower**			
2.1.	General Surgeon	1		
2.2.	Physician	1		
2.3.	Obstetrician / Gynaecologist	1		
2.4.	Paediatrics	1		
2.5.	Anaesthetist	1		On contractual appointment or hiring of services from private sectors on case to case basis
2.6.	Public Health Programme Manager	1		On contractual appointment
2.7.	Eye Surgeon	1		For every 5 lakh population as per vision 2020 approved Plan of Action
2.8.	Other specialists (if any)			

2.9.	General duty officers (Medical Officer)			

B. Support Manpower

S.No.	Personnel	IPHS Norm	Current Availability at CHC (Numbers)	Remarks / Suggestions / Identified Gaps
2.10.	Nursing Staff	7+2		1 ANM and 1 Public Health Nurse for family welfare will be appointed under the ASHA scheme
a.	Public Health Nurse	1		
b.	ANM	1		
c.	Staff Nurse	7		
d.	Nurse/Midwife			
2.11.	Dresser	1		
2.12	Pharmacist / compounder	1		
2.13.	Lab. Technician	1		
2.14.	Radiographer	1		
2.15.	Ophthalmic Assistant	1		Opthalmic Assistant may be placed wherever it does not exist through redeployment or contract basis
2.16.	Ward boys / nursing orderly	2		
2.17.	Sweepers	3		
2.18.	Chowkidar	1		Flexibility may rest with the State for recuriment of personnel as per needs
2.19.	OPD Attendant	1		
2.20.	Statistical Assistant / Data entry operator	1		
2.21.	OT Attendant	1		
2.22.	Registration Clerk	1		
2.23.	Any other staff (specify)			

C. Training of MOs during previous (full) year

2.24	Available training in	Number of MOs trained
a.	Sterilization	
b.	IUD Insertions	
c.	Emergency contraception	
d.	RTI / STI, HIV/ AIDS	
e.	Newborn care	
f.	Emergency obstetric care	
g.	Other subjects (mention)	

III. Investigative Facilities

S.No.	IPHS Norm	Current Availability at CHC	Remarks / Suggestions / Identified Gaps
3.1.	Availability of ECG facilities (Yes / No)		
3.2.	X-Ray facility (Yes / No)		
3.3.	Ultrasound facility (Yes / No)		
3.4.	Appropriate training to a nursing staff on ECG (Yes / No)		
3.5.	Lab test facilities (specify kind of tests done)		
3.6.	Any lab test / diagnostic test outsourced to private lab / hospital (please specify the test)		
3.7.	All necessary reagents, glassware and facilities for collection and transportation of samples (Yes / No)		

IV. Physical Infrastructure (As per specifications)

S.No.		Current Availability at CHC	If available, area in Sq. mts.)	Remarks / Suggestions / Identified Gaps
4.1.	Where is this CHC located?			
a.	Within Village Locality			
b.	Far from village locality			
c.	If far from locality specify in km			
4.2.	Building			
a.	Is a designated government building available for the CHC? (Yes / No)			
b.	If there is no designated government building, then where does the CHC located			
	Rented premises			
	Other government building			
	Any other specify			
c.	Area of the building (Total area in Sq. mts.)			
d.	What is the present stage of construction of the building			
	Construction complete			
	Construction incomplete			
e.	Compound Wall / Fencing (1-All around; 2-Partial; 3-None)			
f.	Condition of plaster on walls (1- Well plastered with plaster intact every where; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster)			

g.	Condition of floor (1- Floor in good condition; 2- Floor coming off in some places; 3- Floor coming off in many places or no proper flooring)			
h.	Whether the cleanliness is Good / Fair / Poor?(Observe)			
	OPD			
	OT			
	Rooms			
	Wards			
	Toilets			
	Premises (compound)			
I.	Are any of the following close to the hospital? (Observe) (Yes/No)			
i.	Garbage dump			
ii.	Cattle shed			
iii.	Stagnant pool			
iv.	Pollution from industry			
4.3.	Location			
a.	Whether located at less than 2 hours of travel distance from the farthest village? (Yes/No)			
b.	Whether the district head quarter hospital located at a distance of less than 4 hours travel time? (Yes/No)			
c.	Feasibility to hold the workforce (e.g. availability of degree college, railway station, municipality, industrial/mining belt) (Yes/No) (specify)			
4.4.	Availability of Private Sector Health Facility in the area			
a.	Private laboratory/hospital/Nursing Home (Yes/No)			
b.	Charitable Hospital (Yes/No) (specify)			
c.	Hospital run by NGO (Yes/No)			
4.5.	Prominent display boards in local language / Charter of Patient Rights (Yes/No)			
4.6.	Registration counters (Yes/No)			
4.7.				
a.	Pharmacy for drug dispensing and drug storage (Yes/No)			
b.	Counter near entrance of hospital to obtain contraceptives, ORS packets, Vitamin A and Vaccination (Yes / No)			
4.8.	Separate public utilities for males and females (Yes/No)			
4.9.	Suggestion / complaint box (Yes/No)			
4.10.	OPD rooms / cubicles (Yes/No) (Give numbers)			

4.11.	Adequate no. of windows in the room for light and air in each room (Yes/No)			
4.12.	Family Welfare Clinic (Yes/No)			
4.13.	Waiting room for patients (Yes/No)			
4.14.	Emergency Room / Casualty (Yes/No)			
4.15.	Separate wards for males and females (Yes/No)			
4.16.	No. of beds : Male			
4.17.	No. of beds : Female			
4.18.	Operation Theatre			
a.	Operation Theatre available (Yes/No)			
b.	If operation theatre is present, are surgeries carried out in the operation theatre?			
	Yes			
	No			
	Sometimes			
c.	If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same?			
	Non-availability of doctors / anaesthetist / staff			
	Lack of equipment / poor physical state of the operation theatre			
	No power supply in the operation theatre			
	Any other reason (specify)			
d.	Operation Theatre used for obstetric / gynaecological purpose (Yes / No)			
e.	Has OT enough space (Yes / No)			
f.	Is OT fitted with air conditioner? (Yes / No)			
g.	Is the air conditioner working? (Yes / No)			
h.	Is generator available for OT? (Yes / No)			
i.	Is emergency light available in OT? (Yes / No)			
j.	Is fumigation done regularly? (Yes / No)			
k.	Is the days of sterilization in a week displayed on the public notice on OT? (Yes / No)			
4.19.	Operaion Theatre Equipment	Available (Yes/No)	Working (Yes/No)	
	Boyles apparatus			
	EMO Machine			
	Cardiac Monitor for OT			
	Defibrillator for OT			
	Ventilator for OT			
	Horizontal High Pressure Sterilizer			
	Vertical High Pressure sterilizer 2/3 drum capacity			

	Shadowless lamp ceiling trak mounted			
	Shadowless lamp pedestal for minor OT			
	OT care / fumigation apparatus			
	Gloves & dusting machines			
	Oxygen cylinder 660 Ltrs 10 cylinders for 1 Boyles Apparatus			
	Nitrous Oxide Cylinder 1780 Ltr. 8 for one Boyles Apparatus			
	Hydraulic Operation Table			
4.20.	Labour room			
a.	Labour room available? (Yes/ No)			
b.	If labour room is present, arc deliveries carried out in the labour room?			
	Yes			
	No			
	Sometimes			
c.	If labour room is present. but deliveries are not being conducted there, then what are the reasons for the same?			
	Non-availability of doctors / staff			
	Seepage in the labour room			
	No power supply in the labour room			
	Any other reason (specify)			
4.21.	X-ray room with dark room facility (Yes/No)			
4.22.	Laboratory:			
a.	Laboratory (Yes/No)			
b.	Are adequate equipment and chemicals available? (Yes/No)			
c.	Is laboratory maintained in orderly manner? (Yes / No)			
4.23.	Cold Chain	Available?	In working condition?	
a.	Walk-in coolers (Yes / No)			
b.	Walk-in freezers available (Yes / No)			
c.	Icelined freezers (Yes / No)			
d.	Deep freezers (Yes / No)			
e.	Refrigerators (Yes / No)			
4.24.	Blood Storage Unit			
a.	Blood Storage Unit available(Yes/No)			
b.	Is the CHC having linkage with district blood bank? (Yes / No)			
c.	Is regular blood supply available? (Yes / No)			
4.25.	Ancillary Rooms - Nurses rest room (Yes/No)			
4.26.	Water supply			

a.	Source of water (1- Piped; 2- Bore well/ hand pump / tube well; 3- Well; 4- Other (specify))			
b.	Whether overhead tank and pump exist (Yes / No)			
c.	If overhead tank exist, whether its capacity sufficient? (Yes/No)			
d.	If pump exist, whether it is in working condition? (Yes / No)			
4.27.	Sewerage			
	Type of sewerage system (1- Soak pit; 2- Connected to Municipal Sewerage)			
4.28.	Waste disposal			
a.	Is there an incinerator? (Yes / No)			
b.	If yes, type (1- electric; 2- Other (specify)			
c.	If no, how the medical waste disposed off?			
4.29.	Electricity			
a.	Is there electric line in all parts of the hospital? (1- In all parts; 2- In some parts; 3- None)			
b.	Regular Power Supply (1- Continuous Power Supply; 2- Occasional power failure; 3- Power cuts in summer only; 4- Regular power cuts; 5- No power supply			
c.	Stand by facility (generator) available (Yes / No)			
4.30.	Laundry facilities:			
a.	Laundry facility available(Yes/No)			
b.	If no, is it outsourced?			
4.31.	Communication facilities			
a.	Telephone (Yes/No)			
b.	Number of different telephone lines available			
c.	Personal Computer (Yes/No)			
d.	NIC Terminal (Yes/No)			
e.	E.Mail (Yes / No)			
f.	Is CHC accesible by			
i.	Rail (Yes / No)			
ii.	All whether road (Yes / No)			
iii.	Others (Specify)			
4.32.	Vehicles	Number of Vehicles		
a.	If running	Sanctioned	Available	On road
	Ambulance			
	Jeep			
	Car			
b.	If vehicle is not running	Reason		

			Driver not available	Money for POL not available	Money for repairs not available
	Ambulance				
	Jeep				
	Car				
			Current Availability at CHC	**If available, area in Sq. mts.)**	**Remarks / Suggestions / Identified Gaps**
4.33.	Office room (Yes/No)				
4.34.	Store room (Yes/No)				
4.35.	Kitchen (Yes / No)				
4.36.	Diet:				
a.	Diet provided by hospital (Yes/No)				
b.	If no, how diet is provided to the indoor patients?				
4.37.	Residential facility for the staff with living condition				
	General Surgeon				
	Physician				
	Obstetrician / Gynaecologist				
	Paediatrics				
	Anaesthetist				
	General Duty Medical Officer				
	Public Health Programme Manager				
	Eye Surgeon				
	Public Health Nurse				
	ANM				
	Staff Nurse				
	Nurse/Midwife				
	Dresser				
	Pharmacist / compounder				
	Lab. Technician				
	Radiographer				
	Ophthalmic Assistant				
	Ward boys / nursing orderly				
	Sweepers				
	Chowkidar				
	OPD Attendant				
	Statistical Assistant / Data entry operator				
	OT Attendant				
	Ambulance driver				
	Registration Clerk				
4.38.	Accommodation facility for families of				

	admitted patients			
a.	Facility for stay available (Yes / No)			
b.	Attached toilet available (Yes / No)			
c.	Cooking facility available (Yes / No)			
4.39.				
a.	Is the CHC open for outpatient services for the stipulated OPD time?			
	Yes, on all days excepting designated holidays			
	No, it always closes before time			
	Only on some days it functions for the stipulated time			
b.	If yes, specify stipulated OPD hours			
4.40	In cases where a patient needs to be admitted for inpatient care, is he/she admitted?			
	Yes, patients who can be managed at CHC are always admitted			
	Some deserving patients are not admitted but are referred to other facilities			
	Patients usually refused admission			
4.41.	Does the CHC provide treatment to emergency patients /victims of accident medical emergencies etc) at any time of the day/ night?			
	Emergency patients are given treatment. Where necessary, they are referred higher level Govt. hospital			
	Emergency patients are often not treated, referred to a public health care facility			
	Emergency patients are often not treated, referred to a private health care facility			
4.42.	If referred to a higher-level health care facility, how is the patient taken there?			
	Free transpbrt by hospital ambulance			
	By hospital ambulance, but fuel and other charges have to be made by the patient			
	Private/ personal conveyance			

4.43.	Behavioral Aspects			
a.	How is the behaviour of the CHC staff with the patient			
	Courteous			
	Casual/indifferent			
	Insulting / derogatory			
b.	Is there corruption in terms of charging extra money for any of the service provided? (Yes / No)			

c.	Is a receipt always given for the money charged at the CHC? (Yes / No)			
d.	Is there any incidence of any sexual advances. oral or physical abuse, sexual harassment by the doctors or any other paramedical? (Yes / No)			
e.	Are woman patients interviewed in an environment that ensures privacy and dignity? (Yes / No)			
f.	Are examinations on woman patients conducted in presence of a woman attendant, and procedures conducted under conditions that ensure privacy? (Yes / No)			
g.	Do patients with chronic illnesses receive adequate care and drugs for the entire duration? (Yes / No)			
h.	If the health centre is unequipped to provide the services needed, are patients transferred immediately without de1ay, with all the relevant papers, to a site where the desired service is available? (Yes / No)			
I.	Is there a publicly displayed mechanism, whereby a complaint/grievance can be registered? (Yes / No)			

V (A). Equipment (As per list)

Equipment	Available		Functional	Remarks / Suggestions / Identified Gaps

V (B). Drugs (As per essential drug list)

Drug	Available	Remarks / Suggestions / Identified Gaps

VI.Furniture

S.No.	Item	Current Availability at CHC	If available, numbers	Remarks / Suggestions / Identified Gaps

6.1.	Examination Table			
6.2.	Delivery Table			
6.3.	Footstep			
6.4.	Bed Side Screen			
6.5.	Stool for patients			
6.6.	Arm board for adult & child			
6.7.	Saline stand			
6.8.	Wheel chair			
6.9.	Stretcher on trolley			
6.10.	Oxygen trolley			
6.11.	Height measuring stand			
6.12.	Iron bed			
6.13.	Bed side locker			
6.14.	Dressing trolley			
6.15.	Mayo trolley			
6.16.	Instrument cabinet			
6.17.	Instrument trolley			
6.18.	Bucket			
6.19.	Attendant stool			
6.20.	Instrument tray			
6.21.	Chair			
6.22.	Wooden table			
6.23.	Almirah			
6.24.	Swab rack			
6.25.	Mattress			
6.26.	Pilow			
6.27.	Waiting bench for patients / attendants			
6.28.	Medicine cabinet			
6.29.	Side rail			
6.30.	Rack			
6.31.	Bed side attendant chair			

VII. Quality Control

S.No.	Particular	Whether functional / available as per norms	Remarks
7.1.	Citizen's charter (Yes/No)		
7.2.	Constitution of Rogi Kalyan Samiti (Yes/No) (give a list of office order notifying the members)		
7.3.	Internal monitoring (Social audit through Panchayati Raj Institution / Rogi Kalyan Samitis, medical audit, technical audit, economic audit, disaster preparedness audit etc. (Specify)		

7.4.	External monitoring (Gradation by PRI (Zila Parishad)/ Rogi Kalyan Samitis		
7.5.	Availability of Standard Operating Procedures (SOP) / Standard Treatment Protocols (STP)/ Guidelines (Please provide a list)		