Assessing the Preparedness of CHCs as First Referral Units in Meghalaya

8 CHAPTER

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INTRODUCTION

The population of Meghalaya is 2.32 million according to 2001 census and is scattered over seven districts, 39 blocks and 6026 villages. The State has the population density of 103 persons per sq. km. As against decadal growth rate of 21.5 percent at the national level, the population of the State has grown by 30.6 percent over the period 1991–2001. The sex ratio of Meghalaya at 972 females to 1,000 males is higher than the national average of 933. Female literacy of the state rose to 60.4 percent in 2001 from 44.8 percent in 1991. Thirty four percent of its population are below the poverty line.

Meghalaya has come a long way in improving citizens' health status in the last 25 years, yet there are aspects that need improvement; for instance, reduction in maternal mortality and morbidity. As per the NFHS-3 survey in 2005–06, institutional deliveries were only 30 percent in the state. This is because of lack of qualified staff, medicines and infrastructure at the health centres, compelling people to either return home without being treated or access the district hospitals in the urban area. The district hospitals, which act as referral hospitals, are distant and inaccessible to most villagers.

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Table 1: Health profile of Meghalaya

Indicator	Meghalaya	India
Crude Birth Rate (SRS 2008)	25.2	22.8
Crude Death Rate (SRS 2008)	7.9	7.4
Total Fertility Rate (SRS 2007)	NA	2.7
Infant Mortality Rate (SRS 2008)	58	53
Maternal Mortality Ratio (SRS 2004–2006)	NA	254

NRHM has the goal of improving accessibility to health-care services in rural areas, with a special focus on poor women and children, water, sanitation and hygiene, immunization, nutrition and reducing both the IMR and the MMR. The Rogi Kalyan Samiti (RKS) at the CHC level is one of the key components responsible for provisioning, controlling and managing public health services and also for receiving funds to improve health standards. With the implementation of the NRHM programme in the state (Meghalaya is a high focus state under NRHM), overall numbers of health infrastructure and manpower have increased; however, there are areas that need improvement (see Box 1).

The Context

DLHS-3[1] data reveal that only 13 percent mothers in the state received full ANC and 32.5 percent received PNC. Only 24.4 percent of all deliveries were institutional, though there still exists the preference for home delivery in spite of emphasis for institutional delivery under NRHM. When faced with obstetric complications like haemorrhage or obstructed labour, there is considerable delay in reaching these hospitals, which results in maternal deaths.

The general health conditions of the women in the state are poor and are attributed to lack of awareness and education about their own health needs. According to a study done by the Hyderabad-based National Institute of

Box 1: Overall improvement in health system since NRHM

Achievements made

- Increase in general utilization of OPD and indoor services, institutional delivery, and immunization.
- Improved infrastructure and construction of new PHCs
- VHSC and RKS instituted at village and facility level.
- ASHAs are active, involved in VHND, JSY and immunization activities.
- Almost every Sub centre is functional with one ANM.

Areas for further improvement

- Strengthening of delivery services is required
- Rational utilization of RKS fund for patient care.
- Strengthening of ASHA programme is required.
- Encourage involvement of greater NGO support.
- HR positioning at CHC needs to be improved.
- Few PHCs in the state are functioning on 24x7 basis, the state needs to augment the process.

Infrastructure

- Further strengthening of infrastructure is needed.
- Need to optimize utilization of existing infrastructure through HR rationalization and better supervision to ensure accountability.

Source: http://www.mohfw.nic.in/NRHM/Documents/NE_Reports/Meghalaya_Report.pdf

Nutrition (NIN),[2] it was found that Meghalaya mothers were among the most anaemic in the country. The common ailments suffered by women are gastroenteritis, tuberculosis, malaria and general debility.

In addition, there is a severe shortage of medical personnel in the northeast region. The staffing levels of doctors are not even 50 percent of the IPHS standard. As a result, community health centres are not being able to admit patients.

Box 2: Strengthening CHCs for first referral care

A key strategy of the NRHM is:

- Operationalizing 3222 existing Community Health Centres (30-50 beds) as 24 Hour First Referral Units, including posting of anaesthetists.
- Codification of new Indian Public Health Standards, setting norms for infrastructure, staff, equipment, management etc. for CHCs.
- Promotion of Stakeholder Committees (Rogi Kalyan Samitis) for hospital management.
- Developing standards of services and costs in hospital care.
- Develop, display and ensure compliance to Citizen's Charter at CHC/PHC level.
- In case of additional outlays, creation of new Community Health Centres (30-50 beds) to meet the population norm as per Census 2001, and bearing their recurring costs for the Mission period could be considered.

Source: NRHM: Mission Document 2005-12

There is also an unwillingness of specialist doctors to join the public health system.[3] In addition to that, improper storage system of medicines and irregularities in despatch of medicines to the various health centres[4] compound the problem further. A lack of coordination and infrastructure also plague the public health system and therefore the delivery of service under NRHM.

Given the context, to get a clearer picture and understanding of the prevailing situation in peripheral areas and with regard to the new initiatives of NRHM, specifically to maternal and child health services, a study on "Strengthening CHC for First Referral Care" was undertaken by North East Network (NEN). Of the seven districts of Meghalaya, four districts namely East Khasi Hills, West Khasi Hills, Ri Bhoi District and Jaintia Hills district were chosen for assessing

the quality of services in the community health centre (CHC) with regard to NRHM standards.

The Objective

The present study sought to assess the preparedness of the CHCs to deliver MCH services as per NRHM norms.

Specific Objectives

- To map out the target population that the CHCs cater to.
- To understand and describe factors concerning availability and quality, accountability and affordability.
- To map and analyze existing healthcare delivery systems and concrete service guarantees from CHCs laid by NRHM in the context of maternal health.

METHODOLOGY

Sample Area

The population for the study was purposively selected by the State Programme Manager, NRHM. Four CHCs from four districts of Meghalaya were selected for conducting the study. These include Khliehriat CHC from Jaintia Hills district, Nongpoh CHC from Ri-Bhoi district, Pynursla CHC from East Khasi Hills district and Mairang CHC from West Khasi Hills district.

Sample Selection

The sample size of the present study consisted of about 63 respondents. The sample comprised:

- Seven staffs from each CHC who include medical health officers, nursing staffs, technicians, pharmacists and block programme manager.

- Five clients (pregnant women/mothers who have delivered their first or second child within a period of six months) accessing services from the least functional CHC.
- FGDs of five women each from three localities of the least functional CHC.

Purposive sampling was used for interviewing the CHC staff but for exit interview with clients, selective sampling was used. For house-to-house interview with the women from the three localities and FGD with RKS members and Women's Group of the least functional CHC, the sample was drawn through snowball technique.

Data Collection

A semi-structured, open-ended questionnaire was prepared to assess the functioning of the four CHCs in the four districts of Meghalaya (henceforth referred to as audit study). To prepare the questionnaire, several secondary data were referred to. The secondary data included browsing of different NRHM websites, referring proforma for CHCs on IPHS and books and research studies on NRHM. A pre-testing of the instruments was done during the initial stage of the study and adjustments and corrections were made for the tools for carrying out the field study. The parameters used in the tools were supplemented, subtracted and changes made according to the type of respondents.

Slight variations were made in the tool used for interviewing the Medical Health Officers, Nursing Staffs, Technicians, Pharmacists and Block Programme Manager. The questionnaire used for exit interview of clients, and that used for the house-to-house interview with the women from three localities of the least functional CHC were designed differently. A separate tool was again constructed for FGD with the RKS members and the Women Groups of the least functional CHC.

The questionnaire used for assessing the four CHCs had three sections, i.e., the 3As, viz., Availability and quality, Accountability and Affordability.

Ethical issues in research were adequately dealt with. Steps included:

- Acquisition of introduction letter from the funding organization in order to obtain an official permission from the State to conduct the study.
- Gain informed consent of the respondents.
- Maintain anonymity of the respondents.

Analysis of Data

The maximum obtainable score and minimum obtainable score for the responses to each of the items in Table 2 was scored based on the availability and functionality of the equipments, availability and sufficiency of the staff and number of funds received by the CHC as per the Indian Public Health Standard. The CHC equipped with all the equipments, staff strength and received majority of the funds as per the Indian Public Health Standard will obtain the maximum obtainable score whereas the least equipped CHC will receive the minimum obtainable score.

Table 2: Item-wise Maximum and Minimum Possible Scores

Sections	Items	No. of items	Maximum Scores	Minimum Scores
Availability and Quality	• Laboratory Equipment	10	10	0
	• Equipment for Labour Room and Neonatal Resuscitation	23	23	0
	• Operation Theatre Equipment	14	14	0
	• Staff strength	16	16	0
Accountability	Funds received	8	8	0

All items on the assessment tool were scored in binary fashion with unavailable/non- functional/inefficient/unclean being given a score of 0 and if present/functioning given a score of 1. Under affordability, free services got a score of 1, while if charges were levied, the score given was 0.

FINDINGS

I. From the Audit Study (see Annexure 1)

Availability and Quality

1. Monitoring: It was found out that the Medical Health Officer is in charge of all the four CHCs.
2. Equipments and functionality:
   a) X-ray machine: In terms of the availability of X-ray machine, all four CHCs shared an equal score 1 whereas 0 score was given to Pynursla and Khliehriat CHCs for non-functionality of the X-ray machine.
   b) Laboratory facility: Under laboratory facility are the essential laboratory services, availability and functionality of the laboratory equipment and blood storage facility.

      In the essential laboratory services, scores are given according to the basic tests conducted in the laboratory like blood smear test, malaria parasite test, sputum test for TB and pregnancy test. The CHCs which conduct all the basic lab tests were given a score of 4. All four CHCs obtained a maximum score for conducting the basic tests. Sugar/Albumin test and urine test is the additional test conducted in Pynursla and Nongpoh CHCs respectively.

      The CHC equipped with all the equipments under the laboratory according to the IPH Standard will get a score of 10. Based on the availability and functionality of the laboratory equipments, the scores vary from 7 to 9 and 4 to 6 respectively, among the four

CHCs. None of the four CHCs have a blood storage facility and were given 0 score.

c) Labour room: All the four CHCs gained a maximum score 2 for the availability and functionality of the labour room.

In terms of labour room and neonatal resuscitation equipments, the CHCs equipped with all the labour room and neonatal resuscitation equipments according to the IPH standard were given a score of 24. Pynursla and Nongpoh CHCs got the highest score of 20 and 19 respectively in terms of availability of equipments in labour room and neonatal resuscitation and acquired a score of 18 each for functional ability of the equipments. Khliehriat CHC which got the lowest score did not even have a delivery table and was found utilising the bed as a delivery table and the footstep as a stool. None of the four CHCs had a radiant warmer for neonatal care.

d) Operation theatre: All four CHCs have a separate room for operation theatre and obtain an equal score of 1. However, in terms of functionality, all the four CHCs have 0 score since the operation theatre is never utilized and is in a poor physical state.

In terms of OT equipments, the CHCs equipped with all the OT equipments according to the IPH Standard were given a score of 14. Khliehriat CHC was found to be the least equipped CHC in terms of OT equipments and Nongpoh CHC was somehow better-off in OT equipments.

e) Drugs and Medicines: The supply of medicines from the headquarters was found insufficient as most of the patients had to buy medicines from outside even for minor ailments like fever, diarrhoea etc. So a score of 0 was given to all four CHCs.

3. Facility for sterilising instruments: Nongpoh, Mairang and Pynursla got a score of 2 each for availability and functionality of the instruments and the Khliehriat CHC got a score of 0. Pynursla CHC was found inadequate with regard to sterilizing instruments whereas Nongpoh CHC was comparatively better equipped in terms of facility for sterilizing instruments. Nongpoh CHC was using electrical autoclave and heater autoclave for sterilizing instruments. Mairang CHC was using Lysol for sterilizing sharp instruments whereas blunt instruments were boiled in a heater. Stoves were used when there is no electricity. Khliehriat CHC was using stoves or heater for boiling instruments.
4. Provision of food to indoor patients: Only Mairang CHC was found providing food for the indoor patients, so got a score of 1. Despite the availability of a kitchen and a cook, the other three CHCs did not provide food to the indoor patients because there was no allotted budget for that provision. However, Nongpoh and Pynursla CHC were planning to start providing food to the CHC patients.
5. Medical Care services: Scoring of services is done based on the cases attended by the CHC, providers' attitude, maintenance of privacy and quality of service delivery. A score of 1 each is given if the CHCs are attending EmOC cases, normal cases of delivery, assisted cases of delivery and complicated cases of delivery and 0 score for not attending. Scoring for providers' attitude is based on satisfactory (1 score) and unsatisfactory (0 score) attitude. Satisfactory attitude indicates being courteous, listening attentively to the patient's complaint, examining properly and overall impression based on patient's response. Maintenance of privacy is scored based on the availability of curtains and bed-side screens to maintain privacy while examining the patients. Quality of service is scored based

on the number of deliveries conducted per month and discipline maintained in the CHC like in the duty timing and availability of doctors for conducting of deliveries.

All the four CHCs scored 1 for attending cases of normal delivery. Three of the CHCs scored 1 each for attending EmOC cases and assisted cases of delivery conducted mainly through forcep delivery and vacuum delivery. Only Nongpoh CHC to some extent attended cases of complicated delivery while in the rest of the three CHCs, high-risk cases were referred to the District Hospital.

Providers' attitude in all the four CHCs was found satisfactory. Privacy was maintained in the three CHCs with bed side screen available in every OPD clinic, emergency and labour room except for Khliehriat CHC which got a score of 0.

Three CHCs got a score of 1 each for satisfactory quality of service delivery whereas Khliehriat CHC scored 0. However, it may be noted that the number of deliveries per month in the three CHCs ranged from 6–20 cases, whereas the Khliehriat CHC, in spite of its poor infrastructure, was found handling about 150 cases of delivery per month. This high caseload might be one of the reasons for poor quality service delivery like nursing sisters conducting many cases of delivery. In this CHC, there was no provision of warm water for conducting of deliveries whether it is during the hot season or cold season, and there was lack of discipline in the CHC whether it is in the duty timing of the medical health officer or the dress code of the nursing sister which makes it difficult to distinguish between the nursing and non-nursing staff.

6. Opening timings: Scoring of this factor is done based on the 24 hours emergency services and delivery services and OPD timing. A score of 1 each is given if emergency and delivery cases are attended for 24 hours and 0 if not

attended. Scoring for OPD timing is done by calculating the mean from the OPD hours in the four CHCs, i.e., four hours. The CHC whose opening times fall below the mean are given a score of 1 and those with opening times above mean a score of 2.

Nongpoh and Mairang CHCs scored 2 each whereas Pynursla and Khliehriat CHCs got a score of 1. All four CHCs scored 1 each for providing 24 hours emergency services and delivery services though many times the CHC staffs were not available after the OPD timings.

7. Referrals: Zero score was given to all four CHCs as cases requiring surgical interventions like caesarean sections were referred to the District Hospital and CHC was not acting as a first referral unit.

8. Transport: 1 score each was given to Nongpoh, Mairang and Pynursla CHCs for the availability and functionality of ambulance for referral transport services whereas 0 score was given to Khliehriat CHC for the non-availability of transport. Pynursla CHC has a TATA Sumo ambulance which is mostly used for transporting medicines, fieldwork and immunization but is sometimes used for transporting women patients with complications during pregnancy and delivery and for infants with complications.

9. Staff strength: Scores are given according to the availability of staff based on the minimum requirements for quality care as per IPH Standard. The maximum obtainable score is 16. Nongpoh CHC was well equipped in terms of staff strength with a score of 14, followed by Mairang CHC (with a score of 11) and a score of 10 each for Pynursla and Khliehriat CHCs. It may be noted here that the low scores in the staff strength is mainly due to the unavailability of clinical manpower like the general surgeon, physician, obstetrician/gynaecologist, paediatrician, anaesthetist, and support manpower like the ward boys/nursing orderly.

Accountability

1. Framework for information dissemination: From a maximum score of 5, all the CHCs scored only 1 each because posters on NRHM were only available. Posters on NRHM were displayed in the maternity ward or family welfare room. Wall painting on family planning, prenatal care, immunization schedule, information on JSY in a local language were also seen in all the CHCs. But except the posters, other things like citizens' charter, list of medicines, banners or hoardings on NRHM were not available. List of medicines were maintained either in the register or on a piece of paper attached to the furniture.
2. Knowledge about RKS: All four CHCs were given a score of 0 as knowledge about RKS is shared only among the members, some non-members who participated in the RKS meeting like the Block Programme Manager and NRHM accountant. The majority of CHC staff and the community are not aware of the RKS.
3. Knowledge about funds: All four CHCs were given a score of 0 since most of the community people as well as CHC staff were not aware of the types of funds received by the RKS except its own members. Even majority of the beneficiary were not aware of the JSY funds and the reason for getting it. In Khliehriat CHC, only the member secretary and one doctor knew about the funds.
4. RKS members: RKS is formed in all the four CHCs. RKS of Nongpoh, Mairang and Pynursla CHCs met IPH standards whereas Khliehriat CHC, with only five RKS members, did not meet the stated standards. RKS meetings in Nongpoh, Mairang and Pynursla CHCs were held quarterly, whereas in Khliehriat CHC, the meeting was held once in six months. Because of its improper formation and functioning, Khliehriat CHC got 0 score, whereas the rest three CHCs got a score of 1.

5. Funds received: Scores are given according to the amount of funds received under the NRHM scheme, viz., annual maintenance fund, untied fund, RKS fund, JSY fund, VHSC fund, referral transport fund, VND fund and MSS fund. The CHC which received all the funds was given a maximum score of 8.

   All four CHCs got the maximum score as they received all the mandatory funds except that Nongpoh CHC did not receive the MSS fund for the year 2008 and Khliehriat CHC did not receive the referral transport fund.

6. Redressal mechanism: All four CHCs got a score of 0 as they did not have a system for the public to redress their grievances. For any inconvenience suffered, the patients either grumbled among themselves or complained to a Medical Health Officer.

Affordability and Medical Expenses

The study found that all the four CHCs provided free medical service to the patients except for the Rs.2 that had to be paid for registration and so all the CHCs got a score of 1 each. However, there are other costs that patients had to bear in certain circumstances. For instance, in Mairang CHC, the patients had to pay Rs.50 for the X-ray film but for poor patients this charge is waived. In Khliehriat CHC, the women patients had to bear travel expenses for referral cases of delivery as the CHC did not have an ambulance nor provided referral transport money since the CHC did not receive it.

Infrastructure Facilities

1. Electricity: Zero score is given to all four CHCs for occasional power failure but got 2 score each for availability and functionality of stand-by facility.
2. Water: Only Mairang CHC received 24-hour water supply and got a score of 1 whereas the remaining CHCs did

not receive regular supply of water and therefore got a score of 0. Mairang and Nongpoh CHCs got a score of 1 for water sufficiency. There was water shortage in the other two CHCs. In fact, Khliehriat CHC was not admitting patients because of water scarcity. Arrangements for drinking water was available only in Mairang CHC for indoor patients and so got a score of 1 and the rest three CHCs got 0 score. In these CHCs, the patients either had to bring water from home or fetch it from outside canteen.

3. Toilet facilities: Separate toilet facility for males and females were available only for the indoor patients of Mairang and Pynursla CHCs; so 1 score each was given to both CHCs. None of the four CHCs had toilet facility for OPD patients and therefore all got a score of 0.
4. Cleanliness: The CHC is said to be satisfactorily clean and given a score of 1 point based on the following observations:
   a) Walls were clean — white washed or not.
   b) Clean cemented floor — daily wiping was done or not.
   c) Toilets were cleaned or not.
   d) Laboratory was maintained in an orderly manner or not.
   e) Medicines in the storeroom were properly arranged or not.

   Cleanliness was also assessed based on the availability and unavailability of waste disposal and incinerator with a score of 1 point each.

   In terms of cleanliness, Khliehriat CHC scored 0 since the wards in the CHC were not in a good condition and windows needed renovation. The toilet was in a pathetic condition. The laboratory also was not clean and there was no proper place to keep the slides. The storeroom was not properly maintained as the space was not

sufficient and the ANM room was also used for storing medicines. The rest three CHCs scored 1.

Regarding waste disposal, Mairang, Nongpoh and Pynursla scored 1 each for availability of waste disposal whereas Khliehriat CHC scored 0 for unavailability of waste disposal. Medical wastes from the Mairang, Nongpoh and Pynursla CHCs were either burnt or buried or were disposed off in covered and sharp pits. Previously, Khliehriat CHC had a place for waste disposal but with the extension of the CHC as a 100-bedded hospital, wastes were now disposed off openly and were found littered everywhere.

None of the four CHCs had a safe method for disposal of syringes (incinerator), hence all scored 0.

5. Record maintenance: 1 score each was given if records were computerized, a personal computer was available, and if there was access to the internet. Mairang CHC was the only CHC which had a personal computer, so records were maintained both manually and electronically. The other CHCs got a score of 0. None of the four CHCs had an internet connection.
6. Storage: Scoring for storage is done based on the availability and sufficiency of a storeroom. All four CHCs scored 1 each for availability of storeroom for storing medicines, furniture and equipments. However, the space available for storage was not sufficient except for Mairang CHC.

The above findings revealed that the Khliehriat CHC was the least prepared in terms of providing quality of care to its patients. Therefore, to get the providers' and beneficiaries' views of the Khliehriat CHC, FGDs and interviews were conducted and the findings are presented below.

II. Findings from FGDs and Interviews

- The women beneficiaries had very little knowledge about the health programmes, its function, and various

provisions under NRHM. Some did not even know about the existence or role of the ASHAs.

- They did not have any knowledge about the existence of RKS.
- The RKS members in this CHC consisted of only five members, which did not fulfil the criteria as per the IPH Standard. Besides the members were not active and did not attend the meetings regularly. During their absence, the RKS Member Secretary who was also in-charge of the CHC took decisions in the meeting along with the other members present. Few days prior to this study, new members were elected for the RKS. During the focus group discussion, no information could be obtained from the members about the way of functioning of the RKS, the

Box 3: Ground Reality of Khliehriat CHC

- According to one woman who accessed service from Khliehriat, "there is no proper or strict rule followed for registration amount as I was made to pay Rs.30 for immunization card and OPD registration." She was also promised the JSY amount by the ANM, but till date she had got no reimbursement, though it had been 10 months since her delivery.
- Most of the women interviewed said that they never got the JSY cash incentive when they were discharged from the CHC and they have now stopped asking about it because "authority keeps on claiming lack of funds."
- Most of the women don't even know who the ASHAs were and their roles in the community.
- The women were of the view that the CHC services needs to be upgraded and improved as it is the only refuge for the poor and needy, particularly those who can't afford to bear heavy expenses for healthcare.
- No referral amount is being given by the CHC even though the case had been referred by the CHC. A woman was not even aware of the fact that she can ask money for arranging transport. She eventually spent Rs.1700 for her transport.

problems they encountered as this was their first meeting and most of the RKS members were unaware about their roles, except the Member Secretary.

- Records were not maintained to show the utilization of funds and the expenditure incurred for maintenance of the CHC.

CONCLUSION

The findings of the study indicate that all the four CHCs under study were not up to the standard laid down under the IPH guidelines and the worst affected one was the Khliehriat CHC. The CHCs need to meet the standards of the IPH guidelines in order to strengthen themselves. The study also brought forth the fact that all the four CHCs were not fully equipped with infrastructure and trained staffs, which is one of the reasons most of the CHCs were not able to treat and cater to cases of complicated deliveries, resulting in a situation where cases were being referred to the District Hospitals increasing their case load and thereby affecting quality of services. The present study was able to bring forth the issue of improper implementation of the NRHM programmes and also denial of healthcare rights to the community.

Suggestions

Based on the findings, some suggestions were made as follows:

- There is a need to provide adequate trained staff.
- Extensive training for the RKS members is required.
- The existing infrastructure, especially referral transport system needs to improve.
- Hygienic disposal of medical wastes and provision of necessary equipments or facilities for treating the wastes should be taken care of.

- Provision of separate and hygienic sanitation for IPD and OPD patients.
- Records need to be maintained properly as per guidelines.
- Timing for OPD must be fixed at convenient time for women to access health services.

NOTES

1. Ministry of Health and Family Welfare, Government of India: DLHS – 3, 2007-08.
2. Mohw.nic.in/NRHM/State%20Files/Meghalaya.htm-91k- Accessed on 10 July 2008.
3. *Shillong Times* (2008): "Medical staff crisis hits rural health care," 1 May.
4. *Shillong Times* (2008): "Pariong detects spoiled medicines in NRHM stores," 6 August.

Annexure 1: Scoring of the CHCs from the Audit Study

Sl. No.	Items	Nongpoh	Mairang	Pynursla	Khliehriat
1.	Monitoring	Medical officer in charge available	Medical officer in charge available	Medical officer in charge available	Medical officer in charge available
2.	Equipments and functionality				
(i)	X-ray				
	• Available	1	1	1	1
	• Functional	1	1	0	0
(ii)	Lab facility				
	• Essential laboratory services	4	4	4	4
	• Laboratory equipment				
	• Available	7	8	8	9
	• Functional	6	8	8	4
	Blood storage facility				
	• Available	0	0	0	0
	• Functional	0	0	0	0
	Labour room				
	• Available	1	0	1	1
	• Functional	1	1	1	1
	Equipment for labour room and neonatal resuscitation				
	• Available	19	17	20	10
	• Functional	18	17	18	8
(iii)	OT				
	• Available	1	1	1	1
	• Functional	0	0	0	0
	Operation theatre equipment				
	• Available	9	7	3	1
	• Functional	9	7	2	1
(iv)	Drugs and medicines				
	• Available	1	1	1	1

Sl. No.	Items	Nongpoh	Mairang	Pynursla	Khliehriat
	• Sufficient	0	0	0	0
3.	Facility for sterilising instruments				
	• Available	1	1	1	1
	• Functional	1	1	1	1
4.	Diet services	0	1	0	0
5.	Services				
	• Attending EMOC cases 1	1	0	1	
	• Normal cases of delivery	1	1	1	1
	• Assisted cases of delivery	1	1	0	1
	• Complicated cases of delivery	1	0	0	0
	• Provider's attitude	1	1	1	1
	• Maintenance of privacy	1	1	1	0
	• Quality of service delivery	1	1	1	0
6.	Time				
	• 24 hours Emergency services	1	1	1	1
	• 24 hours delivery services	1	1	1	1
	• OPD timing	2	2	1	1
7.	Referrals	0	0	0	0
8.	Transport				
	• Available	1	1	1	0
	• Functional	1	1	1	0
	Referral transport services	1	1	1	0
9.	Staff strength	14	11	10	10
10.	Framework for information dissemination	1	1	1	1

contd...

Annexure 1: Contd...

Sl. No.	Items	Nongpoh	Mairang	Pynursla	Khliehriat
11.	Knowledge about RKS	0	0	0	0
12.	Knowledge about funds	0	0	0	0
13.	RKS: Formation and function-ability				
	• Formation	1	1	1	1
	• Functional	1	1	1	0
14.	Funds received	7	8	8	8
15.	Redressal mecha-nism	0	0	0	0
16.	Cost of medical services	1	1	1	1
17.	Electricity				
	Available for 24 hours	0	0	0	0
	Stand-by facility (generator)	1	1	1	1
	• Available	1	1	1	1
	• Functional	1	1	1	1
18.	Water				
	• Availability of 24 hour water supply	0	1	0	0
	• Sufficient	1	1	0	0
	• Arrangements for drinking water	0	1	0	0
19.	Toilet facilities				
	• Separate for male and female	0	1	1	0
	• Separate for OPD and IPD	0	0	0	0
20.	• Cleanliness	1	1	1	0
	• Waste dis-posal	1	1	1	0
	• Availability of incinerator	0	0	0	0

Sl. No.	Items	Nongpoh	Mairang	Pynursla	Khliehriat
21.	Record maintenance				
	• Computerized	0	1	0	0
	• Availability of personal computer	0	1	0	0
	• Access to NIC terminal / E-mail	0	0	0	0
22.	Store room				
	• Available	1	1	1	1
	• Sufficient	0	1	0	0