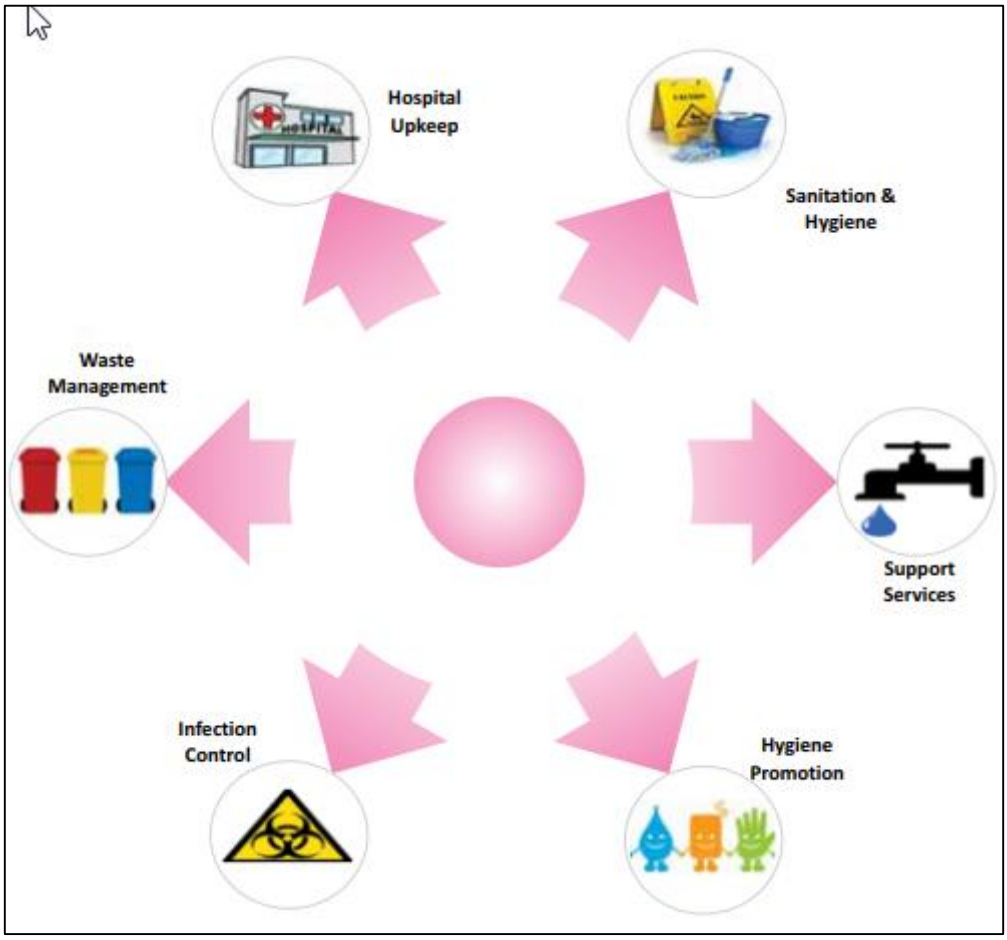
Better Water, Sanitation and Hygiene Access in Public Health Care Facilities

Two Day Training Program for HDS/RKS Members
Training Module



Organized by

SaciWATERs

South Asia Consortium for Interdisciplinary Water Resources Studies

Supported by

WaterAid

2018

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Foreword

The Hospital Development Society is a concept of managing Public Health Facilities through community participation. It is internationally recognized as a successful model. Of late, it has also gained significance in the NHM scheme of interventions. Though it is a highly decentralized intervention, there is not enough awareness about the same among multiple stakeholders at the local level, leading to its lackadaisical implementation.

To provide health services, there are 4863 Sub-centres, 675 Primary Health Centres, 114 Community Health Centres, 42 Area Hospitals, 8 District Hospitals, 5 Mother and Child Care hospitals and 5 Teaching hospitals in Telangana State.

The main purpose of constituting Hospital Development Society (HDS) is to improve the service delivery and management of Public Health Care Facilities (HCF). It is envisaged to play a key role in the upkeep of the public/government hospitals through community participation.

Water, sanitation, and hygiene (WASH) are fundamental in preventing disease and maintaining good health. WASH facilities are reportedly absent in most of the public healthcare institutions. It has been shown that HCF with poor WASH contributes to higher rates of maternal and infant mortality. Improving WASH services and behaviours, both inside as well as outside homes is bound to yield positive results and help reduce chronic malnutrition among children.

It is the primary responsibility of HDS to ensure provision of adequate toilets and safe drinking water, round the clock, in every health facility. Functional hand washing stations with the presence of soap and water promotes hand hygiene behaviour among people.

A 2-day training program has been scheduled to sensitize HDS members on Better Water, Sanitation and Hygiene Access in Public Health Care Facilities. A training module detailing the roles and responsibilities of HDS members in HCF is being developed towards accomplishing the task.

The training module is designed with a clear content, methodology and framework. While disseminating the information, facilitators are encouraged to try new techniques and develop facilitation tools as per the technical handouts appended. The facilitators however are expected to keep the training resource materials intact, while rolling out the training program.

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CONTENTS

Ground Rules

Ensure that the following ground rules are established:

- Be on time – otherwise the sessions get delayed.
- Never use mobile phones while the sessions are on; keep them in silent mode.
- Only one person will speak at a time.
- Respect others by listening to them while they are speaking.
- Don't repeat what has already been said.
- If one participant speaks all the time, the facilitator will keep that person under "lock" and s/he can only speak when the facilitator "unlocks" her/him.
- Refrain from using words, phrases or slogans that might hurt the sentiments of the others
- Respect the feelings of others.
- Refrain from eating or drinking in the training hall.
- If seating is on the floor of the training hall, footwear should be left outside, neatly arranged.
- All participants are equal; no one is 'big' or 'small'.

Recommended Daily Schedule	
9.30 am to 11 am	Training Sessions
11.00 am to 11.15 am	Tea Break
11.15 am to 1.00 pm	Training Sessions
1.00 am to 2.00 pm	Lunch Beak
2.00 pm to 3.30 pm	Training Sessions
3.30 pmto 3.45 pm	Teak Break
3.45 pm to 5.00 pm	Training Sessions

Better Water, Sanitation and Hygiene Access in Public Health Care Facilities

Two Day Training Program for HDS/RKS Members

Program Schedule

Day 1:

Session	Time	Duration (Minutes)	Topic
	9.30 am 10.00 am	30	Registration
Session 1	10.00am 11.00 am	60	Inauguration, Welcome and Introductions
	11.00 am 11.15 am	15	Tea Break
Session 2	11.15 am 11.45 am	30	Pre-training Assessment
Session 3	11.45 am 1.00 pm	75	HDS/RKS: Formation, Procedures and Functions – An Update
	1.00 pm 2.00 pm	60	Lunch Break
Session 4	2.00 pm 3.00 pm	60	HDS/RKS – Funds flow and utilization
Session 5	3.00 pm 3.30 pm	30	WASH and in HealthCare Facilities (HCF)
	3.30 pm 3.45 pm	15	Tea Break
Session 6	3.45 pm 4.45 pm	60	Overview of Kayakalp - an initiative for Award to Public Health Facilities
Session 7	4.45 pm 5.00 pm	15	Review and Reflections of the day

Day 2:

Session	Time	Duration (Minutes)	Topic
Session 8	9.30 am 10.00 am	30	Recap
Session 9	10.00am 11.00 am	60	Kayakalp Success stories in India and in Telangana State
	11.00 am 11.15 am	15	Tea Break
Session 10	11.15 am 12.00pm	45	Clean Hospital Initiative: Theme A, B, C, D,E and F of Kayakalp
Session 11	12.00 pm 1.00 pm	60	Mobilizing Community Support for WASH
	1.00 pm 2.00 pm	60	Lunch Break
Session 12	2.00 pm 3.30 pm	90	Adherence to Medical Ethics and Envisioning of HDS/RKS
	3.30 pm 3.45 pm	15	Tea Break
Session 13	3.45 pm 4.30 pm	45	Preparation and presentation of Action Plan
Session 14	4.30 pm 5.00 pm	30	Post-training assessment fallowed by Valedictory

TRAINING MODULE STRUCTURE AND HOW TO USE THE MODULE

Overall Purpose of the training module

The current training module is essential to rollout a training to the concerned members of the Hospital Development Society at HCF level. The module aims at giving Knowledge, Skill and Practice part of the WASH orientation among the HDS members**.**

Expected Outcomes

Once the training is completed, all the participants are going to significantly bring changes in their HDS performance, starts initiating required actions by bringing out an action plan.

Scope& structure of the training module

The Knowledge parts consists of imparting the complete update on formation and functions of Hospital Development Society (HDS), its financial management and importance of WASH in Health Care Facilities. The Skills part consists of monitoring of HCF by members of HDS, conducting periodic review meetings, obtaining citizens/patients feedback regarding satisfaction levels on the WASH aspects and assessing the facility as per the Kayakalp guidelines. Practice part consist of preparing the action plans and operationalising the decisions made to improve the facilities.

The training module framework consist of

1. Session title
2. Session Objective
3. Expected outcome
4. Session Content
5. Methodology
6. Materials Required
7. Time required for the session
8. Session flow/Process

Contents of the module

- HDS/RKS: Formation, Procedures and Functions – An Update
- HDS/RKS – Funds Flow and Utilization
- WASH in Health Care Facilities (HCFs)

- Overview of Kayakalp – an initiative for award to Public Health Facilities (HCFs)
- Kayakalp Success Stories in India and Telangana State
- Clean Hospital Initiative: Theme A, B, C, D, E and F of Kayakalp
- Mobilizing Community Support for WASH
- Adherence to Medical Ethics and Envisioning of HDS/RKS
- Preparation and presentation of Action Plan

The Participants

The training is intended to be organised to the HDS members. Once the training is conducted, the HDS members go back and initiate various actions in the centre.

Duration of the training

2 days

Day 1

Registration

Time required

30 Minutes (09.30 am – 10.00 am)

Session 1: Inauguration, Welcome and Introductions

Objectives

1. To welcome & mutually get introduced to each other
2. To create a learning environment
3. To collect the expectations of participants
4. To introduce the training purpose and expected outcomes of the training

Expected outcome

By the end of the session, all the participants develop a clear understanding on why they came here, articulate very well about the key messages/actions that they must take home.

Session Content

- Welcome to all the participants
- Participants introduction
- Participants expectations from the Training
- Training Objectives
- Logistics

Methodology

- Pair wise methods described in session flow
- Delphi method to collect responses from participants as described in session flow
- Presentations
- Announcements

Materials Required

- Writing board
- Chalk/marker pens

- Duster
- Chart paper
- Flash Cards with pair of pictures as described in session flow
- Empty flash cards

Time required for the session

60 Minutes (10.00 am – 11.00 am)

Session flow

Welcome to all the participants

- **The facilitator**: Welcomes all the participants for the training, tells the importance of the training, why they are organising the training. Do not tell all the objectives of the training and tell the participants that we will know more details in coming sessions, before getting in to more details, ask them that – is it a good idea to introduce each other?
- **Participant's introduction:** Tell the participants that you will not introduce yourself, but there is another person who will introduce you. We will be doing this through a simple exercise. Circulate the prepared flash cards in which various pairs like Pen and Paper, Mirror and Comb, Light and lamp etc, equal to the number of participants written. Circulate the all the cards to all the participants and ask them to pair with the relevant person by showing the card in the air, in 3 minutes all the participants identify their partners. Give 4 minutes, ask them to share the following 3 things about each other (2 minutes each), once they finish, one will introduce the other in half a minute. Ask the pair to come to the podium, they sit in their chairs and introduce their friends.

    1. Name of the person & from where she/he had come?
    2. His work and contribution in this current role?
    3. Why he came here?

If possible write these questions on a flip chart and display on the tripod.

- **Precaution:** Time keeping is very important. Half minute to each participant to be strictly followed, detailed description is not required.

Participants` Expectations

Delphi technique is a method which can be used to collect various responses from people like collecting participant's expectations. In this method, Flash cards will

be circulated to all the participants and ask one very important expectation from the training, give a minute to write and collect the cards from all the participants. Segregate the cards in to two lots – one lot you are going to take up in the training and the other lot which you are not going to take up during the current training but will be considered and/or dealt with these during time.

Summarise the expectations from the participants, also open your presentation, one slide on the specific objectives of the current training, what is expected out of the training**.**

TEA BREAK 15 Minutes (11.00 am to 11.15am)

Session 2: Pre-training Assessment

Objective

To assess the existing knowledge of participants on WASH related aspects in public health facilities

Expected outcome

The measurement of current knowledge of participants on the subject will help in modifying technical matter to be disseminated during training. It also helps in measuring the impact of training.

Session Content

An open-ended question and 15 statements pertaining to WASH and functioning of HDS.

Methodology

Filling up the questionnaire

Materials Required

Semi structured three-page questionnaire

Time required for the session

30 Minutes (11.15 am – 11.45 am)

Session flow

Distribute the questionnaire to all the participates **(Annexure 1**). Give them 20 minutes time to fill it. Tell them that the data collected will give a clear picture of their current knowledge about various aspects to be covered in the training.

Session 3: HDS/RKS: Formation, Procedures and Functions – An Update

Objectives

1. To orient the participants on the Importance and Objectives of HDS
2. To describe the structure of different categories of public health facilities as per Indian Public Health Standards (IPHS)
3. To define composition, roles and responsibilities of HDS

Expected outcome

By the end of the session, all the participants develop a clearer understanding on the importance, composition, structure, roles and responsibilities of HDS.

Session Content

- Importance of HDS
- Objectives of HDS
- Composition and structure of HDS at Primary Health Centre, Community Health Centre, Area Hospital and District Hospital
- Roles and Responsibilities of HDS

Methodology

- PowerPoint Presentation
- Question and Answer – Interactive session
- Group Discussion

Materials Required

- LCD Projector
- Writing board
- Chalk/marker pens
- Duster
- Chart paper
- Sketch pen

Time required for the session

75 minutes (11.45 am – 1.00 pm)

Session flow

Give a brief PowerPoint Presentation on structure of Primary Health Centre, Community Health Centre, Area Hospital and District Hospital as per PHS and an update on formation, composition, procedures and functions of HDS. Distribute **handout- 1** consisting of two parts.

Ask the participants – Why HDS is required in a Health Care Facility? Take some responses from participants, ask what are the objectives of the HDS? and major issues to be addressed by the HDS?

Ensure that those patients who are Below Poverty Line (BPL), vulnerable and marginalized groups and other groups as may be decided by the state government, do not incur any financial hardship for their treatment, and create mechanisms to cover part/full costs related to transport, diet, and stay of attendant.

Ensure provision of all non-clinical services and processes such as provisioning of safe drinking water, diet, litter free premises, clean toilets, clean linen, help desks, support for navigation, comfortable, patient waiting halls, security, clear signage system, and prominent display of Citizens' Charter

HDS/RKS, as a part of the endeavour to enable assured health services to all who seek services in the government health facility will allow the hospital in charge to procure essential drugs/ diagnostics not available in the health facility out of the HDS funds. Such local purchases must be made only as a short term interim measure. The Executive Committee will review such purchases in each meeting and ensure that the rationale for the purchase is justified and that this is not undertaken repeatedly.

Promote a culture of user-friendly behaviour amongst service providers and hospital staff for improved patient welfare, responsiveness and satisfaction through inter-alia organizing training/ orientation/ sensitisation workshops periodically.

Operationalize Grievance Redressal Mechanism including a prominent display of the "Charter of Patient Rights" in the Health facility and address complaints promptly thus building confidence of people in the public health facilities.

Create mechanisms for enabling feedback from patients, at least at the time of discharge and take timely and appropriate action on such feedback.

Undertake special measures to reach the unreached / disadvantaged groups e.g. Campaigns to increase awareness about services available in the facility.

Ensure overall facility maintenance to ensure that the facility conforms/aspires to conform to the IPHS/ NQAS/Kayakalp.

Supervise, maintain, and enable expansion of hospital building for efficient and rationalise and management of hospital land and buildings.

Facilitate the operationalization of National and State Health programmes as appropriate for the level of the facility.

Ensure accountability and community monitoring of HCF.

Group Work

Divide the participants in to 3 groups and give them the task of discussing on the following three aspects.

1. Structure of Primary Health Centre, Community Health Centre, Area Hospital and District Hospital as per Indian Public Health Standards (IPHS)
2. Composition of HDS
3. Functions of HDS

Second part of handout 1 provides a technical note on structure of different categories of public health facilities as per IPHS, composition and functions of HDS. Ask the groups to go through the content given in handout 1 and work on the above aspects.

Give 15 minutes for discussion and 10 minutes for the presentation

Handover required flip charts and markers to all the participants.

LUNCH BREAK 60 Minutes (1.00 pm to 2.00 pm)

Session 4: HDS/RKS - Funds Flow and Utilization

Objectives

1. To orient the HDS members on funds and its utilisation.
2. To train the HDS members on maintaining high level of transparency in the utilisation of funds.

3. To empower the HDS members in organising HDS regular meetings.
4. To enhance the skills of HDS members in reviewing the action plans.

Expected outcome

By the end of the session, all the participants developed a clear understanding on various types of funds available for the hospital development and how to use them with high level transparency.

Session Content

1. Nature of funds
2. Convening meetings
3. Financial powers and fund utilisation
4. Procurement procedures
5. Transparency

Methodology

- Question and Answer – Interactive session
- PowerPoint Presentation

Materials Required

- LCD Projector
- Writing board
- Chalk/marker pens
- Duster

Time required for the session

60 minutes (2.00 pm – 300 pm)

Session flow

- Give a briefing on various types HDS funds and its utilisation
- Ask the participants about their understanding on the nature of funds that are allowed by govt for hospital development.
- Also ask, why these funds are allocated?
- After few interactions, explain in detail various types of funds, their needs and procedures adopted for transparency while spending funds using the **handout - 2**through a brief PowerPoint Presentation**.**

Session 5: WASH in Health Care facilities (HCF)

Objectives

1. To orient the HDS members on the importance of WASH in Health Care Facilities (HCF)
2. To develop an understanding on losses due to poor WASH in HCF
3. To motivate the participants to improve WASH in HCF to reach theMaternal Mortality Ratio (MMR) andInfant Mortality Rate (IMR) targets set under NHM.

Expected outcome

By the end of the session, the participants would have developed a thorough understanding and motivated to initiate required actions to improve WASH (Water Sanitation and Hygiene) in Health Care Facilities.

Session Content

- Goals set under NHM
- Definition of WASH in health care facilities
- WASH targets and indicators in health care facilities
- WHO standards on water, sanitation and hygiene in health care facilities
- Water Sanitation and Hygiene (WASH) – brief status in India, In the state, in the district and within health care facilities
- The challenges ahead for India

Methodology

- PowerPoint Presentation
- Brainstorming
- Group Discussion
- Presentation

Materials Required

- LCD Projector
- Writing board

- Chalk/marker pens
- Duster
- Chart paper
- Sketch pen

Time required for the session

30Minutes (3.00pm – 3.30 pm)

Session flow

After a brief PowerPoint Presentation on NHM, its important goals, status of WASH in health care facilities, distribute **Handout - 3** to all the participants. Divide them in to 3 groups.

First group will brainstorm in detail on losses due to lack of WASH in HCFs and how it will affect Maternal Mortality Ratio (MMR) and Infant Mortality Rate (IMR).

Points to ponder

- Why is WASH important for health care facilities
- Faecal oral transmission – Diarrhoea, Stunting
- Hospital acquired infections
- Poor WASH infrastructure
- Poor hand hygiene

Second group discuss on present status of WASH in their respective Health Care Facilities.

Points to ponder

- WASH - Global scenario
- Status of WASH in Healthcare Facilities in India
- Areas of common gaps found in the healthcare facilities

Third group enumerate the challenges they might face while improving WASH related aspects in their respective HCFs.

Points to ponder

- Hurdles in accessing WASH,
- Disease & Death due to lack of adequate WASH
- Prevention and Control Measures

Give 10 minutes for discussion and another 10 minutes for presentations. Hand over required flip charts and marker pens to the respective groups.

TEA BREAK 15 Minutes (3.30pm to 3.45 pm)

Session 6: Overview of Kayakalp- an initiative for Award to Public Health Facilities

Objectives

- To introduce Kayakalp initiative undertaken by the Govt. of India.
- Encourage them to take steps for upgrading their respective health facilities so that they always stay clean and hygienic.

Expected Outcome

Various stakeholders - People, NGOs, Voluntary organisations, community-based organizations etc. voluntarily share the responsibility of maintaining cleanliness of the health facility. More involvement of the public representatives - MLAs, MLCs and MPs of the respective areas is expected in this initiative. Hopefully this initiative will provide an opportunity and incentive to strengthen inter-sectoral coordination in improving health systems at the state level.

Session Content

- Swachh Hospitals – Chain of benefits
- Key features of Kayakalp award scheme
- Criteria for assessment
- Assessment Process
- Compliance

Methodology

- PowerPoint Presentation
- Group Discussion
- Presentations

Materials Required

- LCD Projector
- Writing board
- Chalk/marker pens
- Duster
- Chart paper
- Sketch pen

Time required for the session

60 Minutes (3.45pm –4.45 pm)

Session Flow

Give a 30 minutes technical PowerPoint Presentation regarding recently introduced Kayakalp initiative in India**.** Distribute **Handout–4** to the participants**.** Later divide the participants into three groups. First group will work on how they can improve District hospital, second group on Area hospital/CHC and third group on PHC based on 6 identified parameters viz.,1. Hospital/Facility upkeep, 2. Sanitation and hygiene, 3. Waste Management, 4. Infection control, 5. Support Services and Hygiene Promotion, followed by group presentations. Give 15 minutes for discussion and another 15 minutes for presentations. Hand over required flip charts and marker pens to 3 groups.

Session 7: Review and Reflections of the Day

Time required for the session

15 minutes (4.45 pm - 5.00 pm)

It helps the facilitator to assess, whether deliverables reached the participants in desirable manner. It also helps to estimate the participants understanding levels, so that they can improve their facilitation techniques next day.

Day 2

Session 8: Recap of Previous Day

Time required for the session

30 minutes (9.30 am - 10.00 am)

The main objective of this session is to review the previous day`s program and try to keep participants in track of today`s sessions. Ensure total involvement and participation of all members in the day`s sessions.

Session 9: Kayakalp Success stories in India and in Telangana State

Objectives

- Sharing the success stories under Kayakalp initiative.

Expected Outcome

Participants try new, creative and innovative methods to improve cleanliness and hygiene in their respective health facilities.

Session Content

- G.O of Gov. of Telangana issued on 4.09.2017 regarding utilization of guidelines for Kayakalp cash awards for public Health Facilities in TS**(Annexure 5).**
- Details of Kayakalp award winning health facilities in Telangana and other states of India.

Methodology

- Screening of video films and pictures

Materials Required

- LCD Projector
- Video Films
- Pictures/photographs in PPT

Time required for the session

60 Minutes (10.00 am – 11.00am)

Session Flow

Share the details of Kayakalp awardee Khammam District hospital and Primary Health Centre (PHC) located in a Bheempur Mandal of Adilabad district.

Khammam Government district hospital bagged **Kayakalp Award** for maintaining the facilities clean and hygienic.

Screen the Video clipping link. https://www.youtube.com/watch?v=6R9famH-X9I

Primary Health Centre

A tribal Primary Health Centre (PHC) located in Bheempur Mandal of Adilabad district was given 'Kayakalp award' for the best hospital management for the year 2016.

The Bheempur tribal PHC, in a tribal dominating district, has been conferred with the National Quality Assurance Standard Certificate (NQAS) for providing quality medical services to the needy this year. The Union Ministry of Health and Family Welfare has recognised the services rendered by the PHC. The centre was spruced up, maintenance of proper sanitation was ensured, improvement of services and other parameters was given importance.

A team of external assessors from National Quality Assurance Standards (NQAS) assessed the PHC for identified parameter in all six departments including, Labour room, Pharmacy, Laboratory, In Patient and Out Patient, National Health Mission Programmes and Hospital Administration. After the assessment, the Bheempur PHC has been accredited with 94 per cent score.

Show pitures of before and after kayakalp initiatation introdcuced in other states of Indiathrough PowerPoint Presentation.

TEA BREAK 15 Minutes (11.00 am to 11.15am)

Session 10: Clean Hospital Initiative: Theme A, B, C, D,E and F of Kayakalp

Objectives

To explain what clean hospital initiatives is and orient the participants regarding 6 important aspects of cleanliness and infection control in Public Health Facilities.

Expected Outcome

By the end of session, all the participants will realize the importance of monitoring the housekeeping and cleanliness activities including services provided by outsourced agencies. And, they facilitate and support the training of the staff of their respective heath facility related to housekeeping & infection control.

Session Content

- Clean Hospital Initiative - Theme A, B, C, D, E, and F of Kayakalp
  - Theme A – Hospital / Facility upkeep
  - Theme B – Sanitation & Hygiene
  - Theme C – Waste Management
  - Theme D – Infection Control Practices
  - Theme E – Support Services
  - Theme F – Hygiene Promotion

Methodology

- PowerPoint Presentation
- Group Discussion
- Presentation

Materials Required

- LCD Projector
- Writing board
- Chalk/marker pens
- Duster
- Chart paper
- Sketch pen

Time required for the session

45minutes (11.15 am – 12.00 pm)

Session Flow

Give a 30-minute technical PowerPoint Presentation on Clean Hospital Initiative covering theme A, B, C, D, E and F of Kayakalpinitiative. Distribute **handout-5**. After the presentation divide the participants into **6** groups. First group will work on what role they can play in maintaining cleanliness and upkeep, second group on sanitation and hygiene, third group on waste management, fourth group on infection control, fifth group on support services and sixth group on Hygiene promotion aspects of their respective health facility, followed by group presentations. Give 15 minutes for discussion and another 15 minutes for presentations. Hand over required flip charts and marker pens to three groups

Session 11: Mobilizing Community Support for WASH

Objectives

1. To orient the participants regarding definition and importance Community Mobilization
2. To understanding benefits of community mobilization
3. To motivate the participants to form community mobilization Teams in their respective villages

Expected outcome

By the end of the session, the participants will realize the importance of community mobilization for successful implementation of various proposed plans to improve the WASH (Water Sanitation and Hygiene) related behaviours in Health Care Facilities.

Session Content

- What is Community,
- Its dimensions
- Why Mobilization
- Benefits of Community Mobilization
- Formation of Community Mobilization Team
- Role of Community Mobilizers

Methodology

- Interactive lecture, question and answers, group discussion

Materials Required

- Writing board
- Chalk/marker pens
- Duster
- Chart paper

Time required for the session

30 Minutes (12.00 pm – 1.00 pm)

Session flow

Ask the participants what comes first to their mind when they think or hear the word "COMMUNITY". Tell them that 'Community is a set of people living together with common interest' We all live in a community. There are different things that bind us together. They are: Beliefs, Values, Language, Territory, Religion, Culture, Occupation etc.

Mr. Henry Ford once said that Coming together is beginning, keeping together is progress and Working together is success.

Why Community Mobilization? It is a Mean as well as Strategy. One can use it to create demand for interventions, increase access to service, scale up interventions, increase effectiveness and efficiency of interventions, contribute additional resources to the response, reach the most vulnerable and increase community ownership and sustainability.

Benefits of Community: Improve quality; Improve results; Increase community ownership of the program; Develop an on-going dialogue between community members; Create or strengthen community organizations (Committees etc.); Create an environment in which individuals can empower themselves to address their own and their community's health needs; Promote community members' participation; Work in partnership with community members; Identify and support the creative potential of communities to develop a variety of strategies and approaches; Assist in linking communities with external resources; Commit enough time to work with communities, or with a partner who works with them.

Group Work

Divide the participants into 3 groups.

First group will discuss who can be potential members of proposed Community Mobilization Team (CMT) at village or sub/district level.

Points to ponder:

- At village level members of CMT can be Sarpanch, PRI members, DWACRA or SHG group leaders, Youth leaders, NGO representatives, Male and female villagers with social bent of mind, Teacher, ANM, AWW, ASHA, others – Specify?
- At District level members of CMT can be MLA, MLC, Municipal ward members, Youth leaders, NGO representatives, activists, Medical Officer, Health Educators, Teacher, others – Specify?

- Qualities of mobilizer - Good communication skills, Good facilitation skills, Good listener, Committed, Decision maker, Active, Negotiation skills, knows culture and values of society, well dressed, Catalyst, Possess Management skills.
- Role of Community Mobilizers - A mobilizer is a person who mobilizes, i.e. gets things moving. Social animator. A Catalyst - Bringing People Together, Building Trust, Encouraging Participation, Facilitating Discussion and Decision-making, Helping Things to Run Smoothly and Facilitation in community mobilization process.
- Attitude and Skills needed for Community Mobilizer – A willingness to examine and challenge his/her own assumptions, opinions and beliefs; a genuine respect for all community members; a non- judgmental and accepting approach; an understanding that different people have different views and perspectives and a belief in community capacity to take effective action.

Second group will discuss on various community mobilization techniques both traditional and innovative type.

Points to ponder

House to house visit, Rallies, Community Meetings, Gathering People at ONE Platform, Human Chain, Public announcements, Tam tam, Slogan shouting, Electronic & Print Media, Puppet Show, Street play, Pamphlets & Handouts, Sports & Games, any other innovative technique – Specify?

Third group will discuss on how to ensure community participation

Points to ponder:

- First analyse the Water, Sanitation and Hygiene related issues encountered by the villagers in your health care facilities, write how do you motivate villagers, create awareness, monitor the progress of interventions pertaining to WASH undertaken by Hospital Development Societies.
- Write a least one mean to enhance community participation? State one example you have done so far.
- Give 15 minutes for discussion and 10 minutes for the presentation. Handover required flip charts and markers to all the participants.

LUNCH BREAK 60 Minutes (1.00 pm to 2.00 pm)

Session12: Adherence to Medical Ethics and Envisioning of HDS/RKS

Objectives

1. To give basic information on Medical Ethics
2. To orient the HDS members on the need for envisioning
3. To support the HDS members in enhancing their skills of developing their own vision, Mission and Core WASH deliverables
4. To empower the HDS members in evolving their hospital WASH development plan
5. To enhance the skills of HDS members in reviewing the action plans

Expected outcome

By the end of the session participantswill get basic information on medical ethics and have a clear understanding on need for evolving a Vision and Mission statements of their Health Care Facilities. They should be able to develop their vision and mission statements, their commitment statement to the patients; develop their Hospital Development Plans which is inclusive of WASH components too.

Session Content

- Basic knowledge on Medical Ethics
- Purpose of Envisioning
- Vision & Mission statements
- Our commitment and mandates statement
- Hospital Development Plan
- Putting plans in to implementation, roles and responsibilities
- Monitoring and review of our plans

Methodology

- Question and Answer – Interactive session

- SWOT analysis
- Presentation

Materials Required

- Writing board
- Chalk/marker pens
- Duster
- Chart paper
- Sketch pen
- Blank Templates for SWOT analysis

Time required for the session

90 minutes (2.00 pm – 3.30 pm)

Session flow

Medical Ethics

HDS members should know that patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence, good relationships with patients and colleagues and observance of professional ethical obligations.

While treating a patient a doctor should take informed consent. It means a patient's willing acceptance of a medical intervention after adequate disclosure from their medical doctor of the nature of the intervention, risks, benefits and alternative treatment options.

What constitutes informed consent. **Disclosure:** information to allow reasonable person to make a decision. **Understanding:** comprehension of the information given. **Voluntary:** no coercion or incentive to accept or deny a treatment. **Agreement:** verbal or written (preferred) to discussed intervention. Even now, many are screening patients for HIV/AIDS without informed consent. Many are doing sex determination of foetus though under PC&PNDT act it is prohibited. HDS members should ensure that such instances do not take place in their respective health care facilities. Remember medicine is about "Can we?" and Ethics is about "Should we?".

Envisioning

Ask the participants – What they recollect when they listen to the word ENVISIONING.

- Take few responses from few participants for 2 to 3 minutes
- Request one participant to volunteer to come forward to the dais, ask the person, whether he/she had any form of dream for him/herself. Write down on a flip chart, what are the dreams, aspirations.
- The facilitator – Tell the participants that the Envisioning is the process of a Futuristic Thinking. Break down the word in to En-VISION
- What is Vision? Ask one member what your Vision for your son or a daughter is
- What you wanted her or him to be? Take few responses from the participants. Write down on a piece of paper.
- Use one of the example articulated by participants – Ask the same person, how he/she will reach there. What she/he need to do to reach there.
- Take some responses from the person and relate previous answer and present answer. Tell that Vision is what you want to be in future. From here to there. On the other hand, Mission – is how you will get there?

Ask the participant to write the Vision in few words. Facilitator to support the participant to put his or her thought in a sentence form.

Facilitator also asks the participant to put in to a statement form on how to get there. What actions to be initiated to reach the Vision. Tell them that this is called Mission.

The vision statement to be written on a flip chart and display to all the participants, in the same matter the Mission statement too.

Then tell the participants that, till now you have discussed the individual Vision and Mission and now, what is the Vision of your Hospital? What is purpose of your hospital?

Take some of points and write on the board or a flip chart. What are the core services offered by your hospital?

Are you satisfied with the services provided by your hospital? Are there any gaps in the provision of services?

Ask the participants to Try to articulate the Vision of your hospital. At What situation is in it now? How they want their Hospital in the coming 3 to 4 years timeline?

Pause and give some time for discussion and let the participants give their complete answers from their minds and write them in a flip chart.

After few minutes, ask the participants to attempt to put their Vision in a word form. Please circulate a flip chart. You can also give them a choice to the participants, in case someone is happy to represent the current situation and future in a pictorial form, facilitator can leave this choice to the participants.

Take one example of a vision developed by participants and ask the participants- how they will realise vision. Ask what they need to do, meaning actions that needs to be initiated to realise their Vision. Tell them it is called Mission.

Ask the participants to write their vision on a flip chart.

Ask participants whose responsibility is to ensure that they realise the vision. Take some answers from participants and tell the participants that the HDS has the responsibility to realise the Vision and Mission of the Hospital.

Ask what are the commitments that they would like to commit to the patients who visits their hospital. Tell that the Commitments are the Promises that they are making on behalf of the hospital and it is a responsibility.

Ask the participants to share 2 to 3 commitments that they are providing to hospitals and they will be displayed in the hospital along with Vision and Mission statements.

Ask the participants to identify the major challenges/gaps/problems identified in their hospital especially around Water Sanitation and Hygiene.

SWOT Analysis

Ask the participants to list down the core strengths of their hospital. For example, the staff, infrastructure with specific names/details

- **Strengths of your hospital:**
- **Weaknesses of our hospital:**
- **Opportunities:**
- **Threats/Limitations:**

Core and immediate (priorities identified out of the Weaknesses) to be addressed with in the hospital. Let the HDS members discuss this for 5 minutes and let them list down the core priorities. Ask one person to present the priorities.

List them on a chart.

Ask how they are going to address/key actions?

Following table can be used to prepare an action plan for addressing the key gaps in the HCF

Key gap	Action to be initiated	Time	Responsibility	Monitoring
Water				
Sanitation				
Hygiene				

Distribute the empty format for identification of the key gaps in Health Care Facilities (HCF)to the participants **(Annexure 2).**

Roles and Responsibilities of HDS members in implementation of the plan:

Ask the participants what roles they would like to take up in the implementation of the above plan?

Do they want to set up any sub committees with in the HDS in order to address the key gaps identified in the hospital?

If yes, what are those sub committees?

Name of the sub committee	Members	Role

Distribute the empty format for filling up information on subcommittees formed by HDS members for implementation of the action plan to the participants **(Annexure 3).**

TEA BREAK - 15 Minutes (3.30pm to 3.45pm)

Session 13: Preparation and Presentation of Action plan

Objectives

1. To prepare an action plan with the participants
2. To prepare a monitoring and follow up plan with key responsibilities

Expected outcome

By the end of the session, all the participants develop an action plan for their respective Health Care Facility.

Session Content

- Action plan
- Follow up and how the actions be closely monitored/responsibility setting
- Final remarks

Methodology

- Question and Answer – Interactive session
- Card storming method

Materials Required

- Writing board
- Chalk/marker pens
- Duster
- Chart paper
- Sketch pen
- Flash Cards
- Blank Templates for preparation of action plan

Time required for the session

45 minutes (3.45 pm – 4.30 pm)

Session flow

Facilitator recaps the entire training learnings so far. Facilitator may adopt a card storming method during the recap. In the card storming method – the facilitator circulates ***two flash cards*** each to all the participants. Ask the participants to write what are two key learnings from the training on one card and what they are going to do once they go back to their hospitals in the second card.

A facility wise action plan to be developed in the follow suggestive format:

Name of the Health Care Facility :

Village/Town name :

Mandal/Block :

District :

State :

Key activity	Dates	Responsible person	Reporting/Supervising person	Means of Verification

Distribute the empty format for preparation of facility wise action plan to the participants **(Annexure 4).**

Facilitator collects all the facility action plans and identifies one accountable person who is going to take the responsibility for the HDS and HCF strengthening.

Facilitator shares her/ his contact details for any follow up support after the training.

Conclusion: The training program will be concluded with a request that the accountable person to closely follow up the action plan and report the progress of the actions taken to the facilitators group.

Session 14: Post-training assessment followed by Valedictory

Objectives

To assess the knowledge gained by the participants on WASH related aspects in public health facilities and thank the participants.

Expected outcome

Post training assessment of knowledge gained by the participants on the subject and to obtain their feedback.

Session Content

An open-ended question and 15 statements pertaining to WASH, functioning of HDS and valedictory address.

Methodology

Filling up the questionnaire (Post- test) and farewell speech.

Materials Required

- Writing board
- Chalk/marker pens
- Duster
- Chart paper
- Sketch pen
- Semi structured two-page questionnaire

Time required for the session

30 minutes (4.30 pm to 5.00 pm)

Session flow

Inform the participants that day's sessions have come to an end. Before taking feedback and comments on training program, distribute the post training assessment questionnaire to all the participants **(Annexure 1).** Tell them that it will give a clear picture of knowledge gained because of 2-day training. Latter quickly list the points that emerge from feedback on the writing board or on a chart paper. Conclude by saying that their support and understanding would be critical in improving WASH related aspects in the Public Healthcare facilities. Thank all the participants for being present despite their busy schedules.

HANDOUT 1

HDS/RKS: Formation, Procedures and Functions – An Update

Part I:

Context

- The Rogi Kalyan Samiti (Hospital Development Society) is a concept of managing public institutions/hospitals through community participation, which has been internationally recognized as a successful model.
- It has also gained enhanced significance in the NRHM scheme of interventions.
- Though it is a highly decentralized intervention, there is not enough awareness about the same among multiple stakeholders at the local level, leading to lackadaisical implementation.

Hospital Development Societies (Rogi Kalyana Samithies)

The constitution of HDS is to improve service delivery and management of public hospitals through community participation.

This concept has been internationally recognized as a very successful model.

The Broad Objectives of HDS

- Improve the institutions/hospitals, upgrade the equipment and modernize the health services
- Ensure discipline in the institutions and supervise the staff
- Undertake construction and expansion in the hospital buildings
- Ensure optimal use of hospital land according to government guidelines
- Improve participation of the committees in the running of the institutions/ hospitals
- Ensure scientific disposal of hospital waste
- Ensure proper training for doctors and staff
- Ensure subsidized food, medicines and drinking water to the patients and their attendants
- Ensure proper implementation of National Health Programs and
- Ensure proper use, timely maintenance and repair of institution/hospital equipment and machinery.

Corpus Grants

- Government of India under National Rural Health Mission is providing a corpus grant to HDS @Rs.5.00 lakhs to each district hospital
- Rs.1.00 lakh to each Community Health Centre (CHC) and Primary Health Centre (PHC).
- The HDS has been constituted in all the District Hospitals, CHCs and PHCs.

Expected outcomes of HDS

- Increased participation of the community in the effective functioning of the hospitals/PHCs
- Improved physical infrastructure
- Better and regular carrying out of minor repairs
- Good maintenance of equipment, and availability of emergency drugs etc
- Increased confidence in poor patients
- Ability to access and obtain emergency healthcare services for maternal, infant and neonatal health emergencies
- Improvement in general health problems

Part II

Technical Note on Structure of Different Categories of Public Health Facilities as per Indian Public Health Standards (IPHS) and Composition of HDS

Details of Health Care Facilities in Telangana State

Sl. No.	District	Sub Centres	PHCs	CHCs	AH	DH
1	Mahbubnagar	680	84	14	4	1
2	Rangareddy	399	52	9	4	1
3	Hyderabad	53	85	10	3	1
4	Medak	489	67	8	3	1
5	Nizamabad	412	40	14	3	1
6	Adilabad	470	72	13	6	0
7	Karimnagar	580	71	16	3	1
8	Warangal	605	75	14	4	0
9	Khammam	549	57	11	5	1
10	Nalgonda	626	72	5	7	1
Total		**4863**	**675**	**114**	**42**	**8**

There are 4863 Sub-centres, 675 Primary Health Centres, 114 Community Health Centres, 42 Area Hospitals, 8 District Hospitals in Telangana state.

Indian Public Health Standards (IPHS)

Previously

- Hospital Standards available by Bureau of Indian Standards (BIS) which are very resource intensive
- No standards for public health institutions

The Indian Public Health Standards emphasizes on

- Describe benchmarks for quality expected from various components of health care organizations
- Standards for quality of services, facilities, infrastructure, manpower, machines & equipment, drugs etc.
- Standards for assessing performance of health care delivery system

Implementation of IPHS

- Under NRHM: All the following institutions are to be upgraded to IPHS
  - CHCs
  - PHCs
  - SCs
- In addition, standards prescribed for:
  - 31-50 bedded Hospital
  - 51-100 bedded Hospital
  - 101-200 bedded Hospital
  - 201-300 bedded Hospital
  - 301-500 bedded Hospital

IPHS for Primary Health Centre

Norms

- Population of 20,000 - 30,000
- 4-6 indoor beds
- Link between SC and CHC

Why IPHS for Primary Health Centre

- PHC - first port of call to a qualified doctor in rural areas

- Referring unit for 6 Sub-centres
- Referral unit to CHCs and DH
- Provides a range of curative, promotive and preventive health care services.

IPHS for PHC

- IPHS
  - Minimum resources available
  - Minimum functional standards
- Innovations
  - Constitution of HDS
  - Involvement of PRI and
  - Citizens' Charter

24x7 PHC should …

- Provide 24-hour delivery services, both normal and assisted
- Provide Obstetric First Aid and Referrals to First Referral Units (FRUs)/other hospitals, for high risk pregnancy cases beyond the capability of Medical Officer, PHC.
- Provide 24 hours emergency services for management of injuries and accidents.
- Provide emergency care of sick children

Minimum requirements for PHC

- Basis
  - Average case load of 40 patients per doctor per day,
  - 60% utilization of the available indoor/ observation beds (6 beds).
  - Standards upgraded with utilization
- Manpower
  - One more medical officer (AYUSH or lady doctor) and two more staff nurses existing total staff strength of 15 in the PHC

Proposed Manpower at PHC

	Existing	Recommended
Medical Officer	1	2(one AYUSH or LMO)
Pharmacist	1	1
Nurse-midwife (Staff Nurse)	1	3 (for 24-hour PHCs) (2 may be contractual)
Health workers (F)	1	1

Health Educator	1	1
Health Asstt. (M&F)	2	2
Clerks	2	2
Laboratory Technician	1	1
Driver	1	Optional/vehicles out-sourced.
Class IV	4	4
Total	**15**	**17/18**

Services at PHC

- MCH
- 24 X 7 Delivery & New born care
- ARSH
- Immunization
- NH Programs
- Permanent FP methods-TT/ vasectomy / NSV
- MTP using MV technique (if trained personnel and facility exists)
- common eye diseases and Refraction Services
- School Health
- Nutrition (coordinated through ICDS)
- Selected surgeries

Other services

- Referral transport
- ISM based treatment through AYUSH doctor
- Laboratory
    - Malaria
    - TB
    - STI/RTI
    - Enteric
    - Routine –Urine, stool, blood
- IDSP
- Training
- Waste Mgt.
- Laundry (outsourced)

Facilities at PHC under IPHS

- Waiting
- OPD

- Wards
- Nursing station
- OT, MOT, Labour room
- Laboratory
- Accommodation
- Store
- Dispensing
- Electricity, Telephone, Water

Monitoring and Supervision

- MO to SC once a month
- Health Assistants Male and LHV to SC once a week
- Internal Mechanism: Record maintenance, checking and supportive supervision
- External Mechanism: Monitoring through the PRI / Village Health Committee / RKS (as per guidelines of State Government).
- Charter of Patients' Rights available at PHC
- RKS

PHC : Modifications

Infrastructure: signage's, barrier free access, disaster prevention measures (desirable for new upcoming facilities), environmental friendly features, computer facility with internet for MIS,

- new born care corner
- one room for counselling,
- waste disposal pit, cold chain logistic and generator room, boundary wall,
    - Manpower: Added
    - Essential: One data handler
    - Desirable: One AYUSH Doc. and one pharmacy
- One LHV, One Accounts Manager

Composition of HDS at Primary Health Centre (PHC)

1.	The President of the Mandal Praja Parishad of the Mandal in which the PHC is situated	Chairperson	1
2.	All the Women Sarpanches and the SC/ST Sarpanches of the Gram Panchayats in that Mandal	Members	5
3.	Local Gram Panchayat Sarpanch	Member	1

4.	President of the local Mandal Mahila Samakhyaunder the Indira Kranthi Patham	Member	1
5.	2 or 3 MPTC Members (at least one SC/ST member and 1 woman) selected by the District Collector in consultation with in charge District Minister.	Member	3
6.	Mandal Revenue Officer	Member	1
7.	Mandal Development Officer	Member	1
8.	2nd senior most officer or staff member in PHC (MO/CHO/PHN/Staff Nurses, etc.,)	Member	1
9.	Medical officer of the PHC	Member-Secretary	1
TOTAL			**15**

- Drawl and disbursal of HDS funds: Medical Officer and Dy.DM&HO

IPHS for Community Health Centre

Objectives

- Provide optimal expert care to the community
- Achieve and maintain an acceptable standard of quality of care
- Make the services more responsive and sensitive to the needs of the community

CHC/FRU

- 30-bedded hospital located at the block headquarter,
- Secondary level of health care
- Specialist care
    - Medicine
    - Surgery
    - Ob &Gy.
    - Paediatrics
    - Anaesthesia
    - Public health
- 80,000 -1,20,000 pop.
- Catchment - 4 PHCs
- Referral point for PHCs (FRU for obstetric emergencies

Infrastructure for CHC under IPHS

Assured services at CHC

- Specialist care
    - Medicine

    - Surgery
    - Obstetrics and Gynaecology
    - Paediatrics
- Blood storage unit
- Operation theatre, labour room, X-ray laboratory, ECG.
- Referral transport
- NH Programs

Infrastructure for CHC under IPHS

- Entrance Zone and OPDs
- Admin. zone
- Emergency Room/Casualty
- Treatment room (MOT, Injection / dressing room)
- Wards- male and female with space between beds
- Other Services
    - CSSD
    - Electricity with Back-up, Water, Telephones
    - Laundry & Waste mgt.
    - Separate toilets for male & female
    - Maintenance and sanitation facility
    - Computerization for record and surveillance.

Manpower at CHC under IPHS

- Regular
    - Surgery,
    - Medicine,
    - Obstetrics and Gynaecology and
    - Paediatrics
- Contractual
    - Anaesthetist and
    - Public Health Program Manager
- Support manpower
    - Public health Nurse
    - ANM in addition to the existing staff.
    - Ophthalmic Assistant
- Recommended
    - One Ophthalmologist for every 5 CHCs
    - One Dental Surgeon,

- 6 GDMOs,
- One AYUSH specialist and
- One AYUSH general doctor

Specialists at CHC under IPHS

Personnel	Minimum requirement	Proposed
General Surgeon	1	1
Physician	1	1
Obstetrics and Gynaecology	1	1
Paediatrics	1	1
Anaesthetist	-	1
Public Health Manager	-	1
Eye surgeon	-	1
Total	**4**	**6/7**

Total Manpower for CHC under IPHS

- Block Health Officer
- Physician
- Surgeon
- Obstetrics and Gynaecology
- Paediatrician
- Anaesthetist
- Public Health Manager
- Dental Surgeon
- Ophthalmologist (one for 5 CHCs)
- 6 GDMO (2 LMOs)
- 1 AYUSH specialist
- 1 AYUSH GDMO
- Support Manpower (total 64) includes:
- 19 S/N, 1 PHN, 1ANM and 1 Ophthalmic Assistant

Ensuring Accountability and Quality

- Mandatory HDS
- A grievance redressal mechanism under supervision of HDS
- Social audit by involvement of the community through HDS is recommended.
- Charter of Patients' Rights displayed prominently at the entrance.
- Standard Operating Procedures and Standard Treatment Protocols
- External monitoring through PRIs, & internal monitoring

Manpower: CHC

Personnel	Essential	Desirable
Block Medical Officer	1	
General Surgeon		1
Physician		1
Obstetrician &Gynaecologist		1
Paediatrician		1
Anaesthetist		1
Public Health Specialist	1	
Dental Surgeon	1	
Medical Officer	7 (with training in specialties)	Total 9 +1
Medical Officer - AYUSH	1	
Staff Nurse	10	
Public Health Nurse (PHN)	1	1
Pharmacist	1	1
Pharmacist – AYUSH	1	
Lab. Technician	2	
Radiographer	1	
Dietician		1
Ophthalmic Assistant	1	
Dental Assistant	1	
Cold Chain & Vaccine Logistic Assistant	1	
Dresser (certified by Red Cross/ Johns Ambulance)	1	
Ward Boys / Nursing Orderly	5	
Registration Clerk	2	
Statistical Assistant/Data Entry Operator	2	
Account Assistant	1	
Admin Assistant	1	
OT Technician	1	
Multi Rehabilitation / Community Based Rehabilitation worker	1	1
Counsellor	1	
Driver*	0	3
Total	**45**	**75**

Composition HDS at Community Health Centre (CHC):

1.	The Member or" Legislative Assembly of the Constituency in which the Hospital/ CHC is located	Chairperson	1
2.	Municipal Chairman	Member	1
3.	2 or 3 Mandal Presidents representatives (at least one SC/ST member and 1 woman) selected by The District Collector in consultation with in-charge District Minister	Members	3
4.	2 or 3 ZPTC representatives (at least one SC/ST and 1 woman) selected by the District Collector in consultation with in charge district minister	Members	3
5.	District Coordinator of Hospital Services member, DM&HO/Dy DM&HO	Member	1
6.	Municipal Commissioner	Member	1
7.	Revenue Divisional Officer if it is a Sub Divisional headquarters, otherwise Mandal Revenue officer	Member	1
8.	One senior Medical Officer of Hospital	Member	1
9.	Gram Sarpanch of Headquarter Gram Panchayat	Member	1
10.	President of the local Mandal Mahila Samakhya under the Indira Kranthi Patham Scheme identified by the District Collector	Member	1
11.	Presidents of the local Rotary and Lions Clubs	Member	1
12.	The Superintendent/In-Charge Medical Officer of the Area Hospital/ Community Health Centre	Member-Convenor	1
TOTAL			**16**

Drawl and disbursal of HDS funds: CHC Superintendent and Senior Public Health Officer

IPHS for Sub-divisional /Sub-district or Area Hospitals

Norms

- 5-6 lakhs people
- Area hospitals with number of beds ranging from 50 to 100 beds or more
- Two IPHS Standards for AH have been prepared according to bed strength - for 31-50 beds and 51-100 beds

Need

- First Referral Units for specialist services from neighbouring Community Health Centres.
- A Sub-district/Sub-divisional Hospital provides emergency obstetric and neo-natal care
- It also saves travel time to the DH, reduces the workload of the district hospital.

Minimum Assured Services at AH

- OPD, indoor and emergency services
- Consultation
  - General Medicine
  - General Surgery
  - Obstetrics Gynaecology
  - Paediatrics
  - Anaesthesia
  - Orthopaedics
  - ENT
  - Radiologist and sonologist
  - Ophthalmology
  - Community Health
  - Skin &VD, RTI/STI
  - Dental care
  - AYUSH

Other services at AH

- Lab, X-ray, Ultrasound, ECG
- Blood transfusion and storage,
- Physiotherapy
- Medico legal/post-mortem*
- Ambulance services
- Dietary services
- Laundry services
- Security services
- Housekeeping
- Inventory Mgt.
- Waste management

Composition of HDS at Area Hospital (AH):

1.	The Member of Legislative Assembly of the constituency in which the Hospital/ CHC is located	Chairperson	1
2.	Municipal Chairman	Member	1
3.	2 or 3 Mandal presidents of that area (at least one SC/ST member and 1 woman) selected by The District Collector in consultation with In-Charge District Minister.	Members	3

4.	2 or 3 ZPTC representatives (at least one SC/ST and 1 woman) selected by the District Collector in consultation with in charge District Minister.	Members	3
5.	District Coordinator of Hospital Services/ member DM&HO/ Dy DM&HO of the area	Member	1
6.	Municipal Commissioner	Member	1
7.	Revenue Divisional. Officer if it is a Sub-Divisional headquarters, otherwise Mandal Revenue officer	Member	1
8.	Resident Medical officer of the Area Hospital	Member	1
9.	Gram Sarpanch of Headquarter Gram Panchayat	Member	1
10.	Presidents of the local Mandal Mahila Samakhya under the Indira Kranthi Patham Scheme selected by the District Collector	Member	1
11.	Presidents of the local Rotary and Lions Clubs;	Member	1
12.	The Superintendent / In-Charge Medical Officer of the Area Hospital Community Health Centre	Member-Convenor	1
TOTAL			**16**

Drawl and disbursal of HDS funds: Area Hospital Superintendent and Dy. DM&HO

IPHS for District Hospital

- Administrative unit
- Pop. 2-5 million

IPHS for DHs: objectives

- Provide comprehensive secondary health care (specialist and referral services).
- Achieve and maintain an acceptable standard of quality of care.
- Make services more responsive and sensitive to the needs of the people

DH and IPHS

- Services depend on size of bed compliment
- Norms vary based on bed compliment
- Norms developed for
  - 101-200 beds,
  - 201-300 beds and
  - 301-500 beds

Minimum Functional standards for DH

- Physical infrastructure
- Manpower
- Diagnostic and investigation facilities
- Equipment
- Drugs and
- Other supportive services

All districts hospitals will have following specialties

- Essential
  - Medicine
  - Surgery
  - Gynaecology
  - Paediatrics
  - Anaesthesia
  - Ophthalmology
  - Orthopaedics
  - Radiology
  - Pathology
  - ENT
  - Dental Science
  - Ayush
- Desirable
  - Dermatology
  - Microbiology
  - Psychiatry

DH Manpower - Medical

Specialist	100 Beds	200 Beds	300 Beds	400 Beds	500 Beds
Medicine	2	2	3	4	5
Surgery	2	2	3	3	4
Gynae	2	**3**	**4**	5	6
Paed.	2	3	4	4	5
Anaesth	2	2	3	3	4
Optho	1	1	2	2	2
Ortho	1	1	2	2	2
Radio	1	1	2	2	2
Pathology	1	2	3	3	4

ENT	1	1	2	2	2
Dental	1	1	2	3	3
MO	11	13	15	19	23
Dermo	1	1	1	1	1
Psych	1	1	1	1	1
Microbiology	1	1	1	1	1
total	27 +3	33 + 2	48	55	65
Doctors	**27**	**32**	**48**	**55**	**65**
Cadre	**100 Beds**	**200 Beds**	**300 Beds**	**400 Beds**	**500 Beds**
Staff Nurse	45	90	135	180	225
Lab Tech	6	9	12	15	18
Pharmacist	4	6	8	10	12
Storekeeper	1	1	2	2	2
Radiographer	2	3	5	7	9
ECG Tech/Eco	1	2	3	4	5
Audiometrician	-	-	1	1	1
Optho. Asstt.	1	1	2	2	2
EEG Tech	-	-	1	1	1
Dietician	1	1	1	1	1
Physiotherapist	1	1	2	2	3
OT.technician	4	6	8	12	14
CSSD Asstt	1	1	2	2	3
Social Worker	2	3	4	5	6
Counsellor	1	1	2	2	2
Dermatologist	**-**	**-**	**1**	**1**	**1**
Cyto Tech	-	-	1	1	1
PFT Technician	-	-	-	-	2
Dental Technician	1	1	2	2	3
Darkroom Asstt.	2	3	5	7	9
Rehabilitation Therapist	1	1	2	2	3
Biomedical Engineer	1	1	1	1	1
TOTAL MAN POWER STRENGTH					
Doctors	**27**	**32**	**48**	**55**	**65**
Staff Nurse	**45**	**90**	**135**	**180**	**225**
Paramedical	**30**	**41**	**65**	**80**	**99**
Total Strength	**102**	**163**	**248**	**315**	**389**

DH Manpower - Administration

Cadre	100 Beds	200 Beds	300 Beds	400 Beds	500 Beds
Hospital Administrator	**1**	**1**	**1**	**2**	**2**
Housekeeper/manager	1	2	3	4	5
Medical Records officer	1	1	1	1	1
Medical Record Asstt.	1	2	3	3	3
Accounts/Finance	2	3	4	5	6
A.O.	1	1	1	1	1
Office Asstt. Gr I	1	1	2	2	2
Office Asst. Gr II	1	1	2	3	4

Composition of HDS at District Headquarters Hospital (DH):

1.	Chairman Chairperson of the Zilla Parishad	Chairperson	1
2.	District Collector	Member	1
3.	Member of parliament whose constituencies fall wholly or partly in that District	Members	3
4.	2 or3 Members of Legislative Assembly of that district Nominated by district in-charge minister	Members	3
5.	Municipal Chair-person of the Municipality of the District Headquarters	Member	1
6.	2 or3 Mandal, PresidentsandZPTCrepresentatives(ineachcategoryatleastoneSC/ STmember rand1 woman)selected by The District Collector in consultation within-charge District Minister	Members	3
7.	District Coordinator of Hospital services	Member	1
8.	President of the Zilla Samakhya under the Indira Kranthi Patam Scheme	Member	1
9.	President of the District IMA branch	Member	1
10.	Secretary of the District branch of the Indian Red Cross Society	Member	1
11.	District Medical&Health Officer o the District	Member	1
12.	President of the Rotary and Lions Clubs at the District headquarters	Member	1
13.	Superintendent of the District HQ Hospital	Member-Convener	1
	TOTAL		**17**

Drawl and disbursal of HDS funds: District Collector & District Coordinator of Hospital Services and District Medical & Health Officer

HANDOUT 2

HDS/RKS – Funds Flow and Utilization

HDS Funds Flow

- Till recently Three types of funds viz., (i) untied funds (ii) annual maintenance grants and (iii) corpus grants to HMS/RKS were available separately.
- But from last year, all these three grants are merged into a single Untied Grant to the facility, to provide additional flexibility to the facilities, to prioritize need based expenditure on items which were hitherto covered under the three separate grants.
- Further, the untied grants for CHCs/AH and District Hospitals is doubled. The present annual untied grants for various health facilities are as follows:

Sl. No.	Facility	Untied Funds / Annual Maintenance Grants / Corpus Grants to HMS/RKS
1	Village Health & Sanitation Committee	Rs. 10,000
2	Sub-Centre	Rs. 20,000 where there is a Government building and Rs. 10,000 for others
3	Primary Health Centre	Rs.1,75,000
4	Community Health Centre / Area Hospital	Rs.5,00,000
5	District Hospital	Rs.10,00,000

- The annual untied grants would be topped up to the extent of fund utilization only. Therefore, if any facility fails to utilize the funds released, it will lose the opportunity.
- In case of District Hospitals and Area Hospitals / Community Health Centres, the State Health Society will make all occasions on performance
- In case of primary Health Centres, the District Health Societies should make responsive allocation to facilities based on caseload, funds utilization etc.
- HDS committees should meet once in quarter. Every facility will receive an assured fixed top up of 50% of the facility's entitlement
- The remaining 50% would be allocated amongst similar level facilities by District Health Society on rational principle of case load and range of services.
- Every facility will receive an assured fixed top up of 50% of the facility's entitlement and the remaining 50% would be allocated amongst similar level facilities by District Health Society on rational principle of case load and range of services.

- For example, every PHC in the district will receive a top up of fixed entitlement up to 50% i.e. Rs. 87,500.
- The pooled differential component of PHCs = Rs.87500 x total number of PHCs in the district, should be allocated differentially among similar level facilities based on rational principle of case load, services provided etc.,
- After explaining the fund allocation, ask the participants, who will take the decision on how and for what purposes the funds to be utilised.
- Take some answers and what process they follow in their hospital.
- Tell them that the HDS meeting need to happen with full attendance and explain the following bullet points on the need for organising meetings.

HDS: Utilization

- Funds shall be utilized with the approval of council members of the Hospital Development Society (HDS).
- Untied funds, Annual Maintenance Grant funds and HDS funds shall be kept in the Bank account of Hospital Development Society,
- All the funds along with HDS funds will be spent and monitored by the HDS.

Suggested areas for spending HDS funds

- Infrastructure modifications to the centre – Curtains to ensure privacy, repair of taps, Installation of bulbs, other minor repairs to Government building which can be done at the local level.
- Provision of running water supply
- Provision of electricity or electrical fittings – lights, fans etc.
- Ad hoc payments for cleaning up the centre, especially after child birth
- Transport of emergencies to appropriate referral centres
- Transport of samples during epidemics
- Minor equipment purchases – Patient examination table, delivery table, BP apparatus, haemoglobin meter, copper-T insertion kit, instruments tray, baby tray, weighing scales for mothers and for new born babies, plastic/rubber sheets, dressing scissors, stethoscopes, buckets, attendance stool, mackintosh sheet or any of the equipment required for the full functioning of the PHC as per IPHS norms
- Labour and supplies for environmental sanitation, such as cleaning or source reduction measures for vector control.

- Payment/reward to ASHA for certain identified activities
- Repair/operationalizing soak pits.
- Purchase of consumables such as bandages or drugs or bleaching powder and disinfectants, provided they are in the essential list approved for PHCs or in the IPHS standards and the provision is used only to tied over temporary gaps due to logistics failures and not as a substitute to-state, or central budgetary grants for drugs and supplies to PHCs. The same conditions as for minor equipment purchase from untied funds apply for these also.
- Health Education or IEC activities or counselling done to reach out key health messages to those who come to the facility for care of illness or as attendants.
- Reception and patient waiting hall amenities and services as well as patient assistance and grievance redressal mechanisms.
- Arrangements for stay of poor patients or their attendants.
- Establishing a kitchen or outsourcing of dietary arrangements for feeding in patients and where needed their attendants.
- Measures that make the hospital baby – friendly and handicapped friendly and safe for women.
- Special measures to ensure against stray dogs, rats and other vermin entering or being resident in hospital premises
- Evaluation
- Public health research
- Any local need-based innovations for effective implementation of National Health Programs.
- Skill training
- Guest lectures- CME
- Hiring specialist services

HDS Funds should not be Utilized for

- Purchase of motorized Vehicles etc.
- Salaries of full time or part time staff
- Payments towards inserting advertisements-in any Newspaper/journal/ Magazine and IEC related expenditure.

- Hiring stalls in any Mela for ostensible purpose of awareness generation of health schemes/programs.
- Taking up any individual based activity, except in the case of referral and transport in emergency situations, where no prior permission is required

Accountability

- Regular SOEs& UCs
- Periodic auditing
- Transparency
- Maintenance of double entry system registers
- Maintenance of both manual & digital accounts
- Local concurrent audition
- No diversion of funds
- The preparation of estimates and entrustment of works or procurement as case shall be resorted to as per the Govt. prescribed procedures.

Convening of meetings of the HDS

(I) The Hospital Development Society Shall conducts a meeting at least once in a quarter or more frequently when required. As a best practice it is suggested to organise a monthly meeting to have more discussions.

(II) A minimum of 7days notice shall be given for every meeting.

(III) The quorum for the meeting shall be at least one-third' of the members.

Explain the participants on the following bullet points on the financial powers for utilization of Funds.

Financial Powers, Utilisation of Funds

a) All expenditure by the society shall be discussed and approved in the Society's meeting before it is made.

b) The Hospital Institution Development Society is empowered to utilize the funds as follows:

Sl. No.	Activity / Work	Details	Agency
1.	Minor Civil Works repairs	a) Leaking roofs, b) Leaking taps,	**Through private contracting agencies on**

Sl. No.	Activity / Work	Details	Agency
		c) Water supply system, d) Electrical wiring e) White washing	**tender basis and Civil works, Electrical works, Water facilities by entrusting to APHMHIDC or any other Engineering Dept. which Offers superior quality at competitive costs, duly depositing the funds to that effect.**
2.	Proper maintenance of electrical items	a) Light, b) Switch bulbs, c) Fans and d) Replacing electrical spare parts	
3.	Supply of safe drinking water	a) Water tanks, b) Bathrooms, c) Toilets	
4.	Appropriate partnership arrangements	a) Cleaning services b) Laundry services c) Ambulatory services and, d) Diagnostic facilities.	**Through Entering into Annual Maintenance Contracts and Comprehensive Maintenance Contracts**
5.	Monitor proper functioning all hospital equipment	a) Equipment and furniture, b) Annual Maintenance Contract (AMC), c) Optimal utilization equipment	
6.	**Regular training. Programmes for Medical and Para Medical staff**	**a) To improve their Job Skills,** **b) Discharge of duties** **c) Morale and pride in their work**	**Periodical Skill Improvement Sessions Should be conducted on payment of honorarium**
7.	**Arrange guest lectures and CME programme**	**a) On Annual Hospital Day** **b) Hospital Cleanliness Week** **c) Quality Improvement Days** **d) World AIDS Day** **e) World Population Day** **f) World TB Day**	**Guest lecturers on hourly / daily basis to all the guest lecturers or** **Specialist Doctors at districts and Sub- divisional levels**
8.	**Identify the problems faced by the patients**	**If the patients are:** **a) Not having any sitting provision or without any other kind of furniture/ equipment**	**Through Open tender system.**

Sl. No.	Activity / Work	Details	Agency
9.	**Improve the in-patient bed arrangements and out-patient care**	**a) For in patients arrangements of Cots & Beds;** **b) For out-patient arrangements of furniture & sitting Equipment**	
10.	**Awards for staff-members**	**a) Incentives** **b) Small gifts** **c) Yearly extra payment**	
11.	**Adoption of patients wards by local institutions or individuals**	**a) Solar lightning System** **b) Solar refrigeration system** **c) Water harvesting** **d) Water recharging system.**	
12.	**Display a Citizen's Charter**		**Review Compliance of citizen charter and the effectiveness of the grievance redressal Mechanism**

Sanctions / Approvals

- Necessary approval from competent authority should be taken before hand for expenditure made.
- Expenditure made should be within approved budget limits.
- All approvals / expenditure made should be under the jurisdiction of the sanctioning authority in line with delegation of power as prescribed by the State.

Procedure to be followed for procurement of Drugs and Consumables:

1. Obtain No Stock Certificate from the concerned Drugs Stores (CDS).
2. Obtain Quotations form the reputed registered firms for providing lowest price for the required Drugs Consumables.
3. After Getting the Quotations make a comparative statement duly involving (RMO) and senior Doctor in the Hospital.
4. Placing Oder to the lowest quoted firm duly stipulating the timelines, technical specifications and price approved.
5. After getting the stocks duly verified for Physical and Quality parameters shall be entered the stock registers (main stock, sub store, dispensary).

6. Issue the Stocks for patient purpose.
7. After necessary Stock entry and validation of the bills by passing order, the amount towards procurement of drugs shall be placed before the Hospital Development Society for approval.
8. Payment shall be made on the administrative approval of Hospital Development Society committee only. And after payment the bills/vouchers have to be certified as paid and cancelled.
9. Increase of routine requirements, necessary prior approval from the Hospital Development Society shall be taken for calling sealed Quotations up to Rs.5000/-only and Open Tender system above Rs.5000/-
10. Undertake such works as will promote cleanliness of premises, beautification, including provisioning of play pen for children recuperating in the paediatric ward, Greenery with pathways for recuperating patients in geriatric wards etc., through annual maintenance contracts.
11. Hospital Development Society is also empowered to select contract or for supply of good diet in the institution by calling for tenders or as prescribed by the Government.
12. Development Society concerned staff should monitor and ensure the supply of good quality diet to patients as per norms and procedure prescribed by the Government from time to time.
13. Ask the participants, meaning of transparency and how they ensure transparency in their HDS.
14. Explain the procedures to be followed to ensure transparency.

Procedures to be Adopted for Transparency

- All decisions shall be taken on merit and in a transparent manner in the interest of providing best possible services and facilities to the patients / staff / trainees as case may be.
- In case of failure to provide services or to adhere to conditions of contractor quality specifications, the member-convener / head of the department / staff concerned shall record and communicate short comings to Development society for suitable action including recovery of costs or cancellation of contract or such action as required.
- The recommendation of the member convener in all such cases shall be followed by the development societies.
- Dispute or disagreements if any, shall be communicated to Head of the Department at District Level for appropriate decisions, who shall dispose the matters on merit or refer to the head of department / Government depending on issue involved.

- The Commissioner of Health & Family Welfare, Hyderabad, Mission Director, National Health Mission (NHM) shall monitor the constitution and organization of the Hospital Development Societies for the purpose of ensuring that they fulfil the NRHM norms and become eligible to receive grants under the National Health Mission(NHM).

The Hospital Development Societies shall send

(1) Copies of minutes of every meeting;

(2) Abstract of Progress reports as prescribed;

(3) Annual Audit Reports; and

(4) any other reports as prescribed,

To the concerned Head of Department through the District Controlling Officer (where applicable) on any matter concerning the functioning of the hospital, for suitable action by the Government, within one month of the last date of the Quarter.

HANDOUT 3

WASH IN HEALTH CARE FACILITIES

National Health Mission Targets (2012-17)

Indicator	India	Telangana	Target
MMR per one lakh deliveries	167	92	65
IMR per 1000 live births	40	39	25

Maternal Mortality Ratio 2011-13

Sl. No.	District	MMR (2011-2013)
1	State	92
2	Adilabad	152
3	Mahbubnagar	98
4	Rangareddy	78
5	Hyderabad	71
6	Medak	90
7	Nizamabad	79
8	Karimnagar	74
9	Warangal	78
10	Khammam	99
11	Nalgonda	90

Infant Mortality Rate 2013

Sl. No.	District	IMR (2013)
1	State	39
2	Adilabad	48
3	Mahbubnagar	53
4	Rangareddy	33
5	Hyderabad	20
6	Medak	49
7	Nizamabad	48
8	Karimnagar	37
9	Warangal	39
10	Khammam	45
11	Nalgonda	47

Institutional Deliveries in Government and Private Health Facilities – DLHS – 4 2012 - 13

Sl. No	District	Govt. Hospitals	Pvt. Hospitals
1	State	31.7	62.4
2	Adilabad	32.1	55.1
3	Mahbubnagar	29.1	65.5
4	Rangareddy	32.2	62.3
5	Hyderabad	18.1	80.1
6	Medak	29.9	66.0
7	Nizamabad	34.6	60.6
8	Karimnagar	25.5	73.8
9	Warangal	34.0	64.3
10	Khammam	30.6	64.2
11	Nalgonda	32.5	62.4

Definition of WASH in health care facilities

WASH element	Definition
Water	Presence of a water source or water supply in or near (within 500 m) the facility for use for drinking, personal hygiene, medical activities, cleaning, laundry and cooking. Does not consider safety, continuity or quantity.
Sanitation	Presence of latrines or toilets within the facility. Does not consider functionality or accessibility (e.g. for small children or the disabled).
Hygiene	Availability of handwashing stations with soap or alcohol-based hand rub

Assessments of WASH in Healthcare Facilities in India

- Water, sanitation, and hygiene (WASH) are fundamental in preventing disease and maintaining good health.
- Inadequate access to WASH facilities can significantly impact health and result in adverse consequences from exposure to pathogens.
- Some diseases are preventable, but may become life-threatening when the person has already lowered immunity, from say, malnutrition
- India has one of the highest rates of maternal and infant mortality in the world: 167 maternal deaths per 100,000 live births, and 28 neonatal deaths per 1,000 live births.

- Poor hand hygiene and contaminated surfaces during birth can lead to genital tract infections and sepsis.
- Approximately eight percent of maternal deaths are attributed to sepsis alone.
- With a push towards institutional deliveries stemming from the Janani Shishu Suraksha Yojana (JSSY), improving WASH standards and practices in healthcare facilities (HCFs) can be an essential step towards reducing statistics.

The WHO and UNICEF report on the status of WASH in healthcare facilities especially highlights how critical gaps in WASH can compound health conditions. The report noted that

1) WASH facilities are often absent in healthcare institutions;
2) While water may be available in facilities, the reliability of water and its quality are questionable;
3) WASH coverage varies by type of health facility (primary, secondary, tertiary);
4) National planning for WASH in HCFs is largely lacking;
5) Limited availability of data on WASH coverage in HCFs, and
6) Improving WASH services and behaviors can have beneficial impacts at home as well.
    - Studies suggest that clean birth practices in homes and facilities are associated with reduced sepsis and tetanus, a decline in neonatal deaths, and
    - Handwashing with soap and water by birth attendants results in protection against cord infections.
    - Hospitals with poor WASH facilities were found to have higher rates of maternal mortality.
    - Studies and efforts by agencies and institutions have identified that Skilled birth attendants and institutional deliveries are important contributors in reducing maternal mortality rate (MMR) and infant mortality rate (IMR)7.
    - The conditional cash transfer scheme provided by the Government of India has been successful in increasing the rate of institutional deliveries.
    - However, the safety of childbirth depends not just on delivering in a HCF, but also on the quality of care (QoC) provided.
    - The Swachhata guidelines mention that one of the key dimensions of QoC is cleanliness of health facilities.

- Maintenance of hygiene and cleanliness of health facilities is not only related to aesthetics and patient satisfaction, but also reduces the instances of Hospital Acquired Infections (HAI).

Areas of common gaps witnessed in the healthcare facilities across districts

- WASH infrastructure may be available in health facilities, but their adequacy, accessibility, functionality, and quality have been found inadequate and, in some places, inappropriate.
- The facilities lacked safe storage of water and availability of safe drinking water.
- Handwashing stations are poorly equipped with soap and other disinfectant materials to ensure hand hygiene of those availing the services.
- Even basic awareness messaging on handwashing steps and handwashing at critical times that can serve as reminders for good hygiene practices were found to be inadequate.
- Further, staff did not practice hand hygiene behaviours regularly.

Overview of states, districts and health facilities in the study

- Most healthcare facilities have poor management of solid, liquid and medical waste; even in facilities with mechanisms to segregate medical waste.
- Facilities may have adequate staff and supplies yet still toilets and water tanks were not cleaned, floors remained dirty and water tanks remain uncleaned.
- An overwhelming majority of the facilities visited had no guidelines on ensuring formal maintenance and cleaning.
- Most facilities had a severe shortage of cleaning staff.
- Wherever cleaning staff was available, they were poorly equipped with protective and adequate tools to carry out their work.
- Training of health staff too was largely inadequate.
- Types of provisioning of infrastructure and services were different between types of healthcare facilities, with PHCs and CHCs typically performing poorly compared to district hospitals.

Overall Recommendations

- Facilities must be equipped with accessible, adequate and appropriate safe WASH services.

- Facility staff should be trained to stock and use H2S water testing kits to assess bacterial contamination regularly.
- Facility-wise plans to improve solid and liquid waste management must be developed.
- The segregation, storage and final disposal of biomedical waste requires attentionto curb possible bacterial contamination and spread of infections.
- Hospital Development Committees must ensure that sufficient toilets are available in the health facility, especially in or near the labor room in PHCs and CHCs; and that the toilets are functional, well-managed and maintained regularly.
- Facilities must be equipped with functional handwashing stations with soap and water in patient care areas, outpatient departments (OPDs), operation theatres, and toilets to encourage hand hygiene behaviors among healthcare staff, caregivers accompanying patients, and patients themselves.
- Additionally, adequate Information, Education andCommunication (IEC) materials on handwashing steps and critical times for handwashing in the context of healthcare must be prominently displayed at handwashing stations.
- Adequate and regular supply of medical waste management materials, including colour coded bins and bags, sharps box, as well as transportation and storage of waste.
- There must be adequate and regular trainings for all health facility staff on WASH, especially on the link between WASH and health, and on the importance of handwashing during patient care.
- The trainings need to have a feedback and monitoring system integrated to gauge the efficacy of the trainings in leading to good hygiene practices.
- Strengthen the Hospital Development Committee by reinforcing their roles and responsibilities and encourage their participation in Village Health, Sanitation and Nutrition Committee (VHSNC) and Panchayati Raj Institution (PRI)meetings.
- Infection control programs and statutory norms for cleanliness and maintenance must be enforced and followed by health facility staff.
- Establish appropriate guidelines and waste management protocols to ensure better sanitation and hygiene measures at the facilitylevel.
- An appropriate monitoring system that includes various performance indicators of HCFs needs to be implemented to monitor work and help improve facilities where necessary in a timely fashion.

Global WASH Fast Facts

Access to WASH

- Worldwide, 780 million people do not have access to an improved water source.
- An estimated 2.5 billion people lack access to improved sanitation (more than 35% of the world's population),
- According to the World Health Organization and UNICEF, regions with the lowest coverage of "improved" sanitation in 2006 were sub-Saharan Africa (31%), Southern Asia (33%) and Eastern Asia (65%).
- In 2006, 7 out of 10 people without access to improved sanitation were rural inhabitants.
- According to the United Nations and UNICEF, one in five girls of primary-school age are not in school, compared to one in six boys.
- One factor accounting for this difference is the lack of sanitation facilities for girls reaching puberty.
- Girls are also more likely to be responsible for collecting water for their family, making it difficult for them to attend school during school hours.
- The installation of toilets and latrines may enable school children, especially menstruating girls, to further their education by remaining in the school system

Disease & Death

- An estimated 801,000 children younger than 5 years of age perish from diarrhea each year, mostly in developing countries.
- This amounts to 11% of the 7.6 million deaths of children under the age of five and means that about 2,200 children are dying every day because of diarrheal diseases.
- Unsafe drinking water, inadequate availability of water for hygiene, and lack of access to sanitation together contribute to about 88% of deaths from diarrheal diseases.
- Worldwide, millions of people are infected with neglected tropical diseases (NTDs), many of which are water and/or hygiene-related, such as Guinea Worm Disease, Buruli Ulcer, Trachoma, and Schistosomiasis.
- These diseases are most often found in places with unsafe drinking water, poor sanitation, and insufficient hygiene practices.
- Worldwide, soil-transmitted helminths infect more than one billion people due to a lack of adequate sanitation.

- Guinea Worm Disease (GWD) is an extremely painful parasitic infection spread through contaminated drinking water.
- GWD is characterized by spaghetti-like worms up to 1 meter in length slowly emerging from the human body through blisters on the skin anywhere on the body but usually on the lower legs or lower arms.
- Infection affects poor communities in remote parts of Africa that do not have safe water to drink. In 2015, 22 cases of Guinea Worm Disease were reported. Most of those cases were from Chad (41%).
- Trachoma is the world's leading cause of preventable blindness and results from poor hygiene and sanitation.
- Approximately 41 million people suffer from active trachoma and nearly 10 million people are visually impaired or irreversibly blind as a result of trachoma.
- Trachoma infection can be prevented through increased facial cleanliness with soap and clean water, and improved sanitation

Prevention

- Water, sanitation and hygiene has the potential to prevent at least 9.1% of the global disease burden and 6.3% of all deaths. The impact of clean water technologies on public health in the U.S.A is estimated to have had a rate of return of 23 to 1 for investments in water filtration and chlorination during the first half of the 20th century.
- Water and sanitation interventions are cost effective across all world regions. These interventions were demonstrated to produce economic benefits ranging from US$ 5 to US$ 46 per US$ 1 invested.
- Improved water sources reduce diarrhea morbidity by 21%; improved sanitation reduces diarrhea morbidity by 37.5%; and the simple act of washing hands at critical times can reduce the number of diarrhea cases by as much as 35%. Improvement of drinking-water quality, such as point-of-use disinfection, would lead to a 45% reduction of diarrhea episodes.
- In order to meet the United Nations' Millennium Development Goal (MDG) to halve the proportion of people without sustainable access to improved drinking water and basic sanitation by 2015:
- An estimated 784 million people will need to gain access to an improved water source.
- An estimated 173 million people on average per year will need to begin using improved sanitation facilities (accounting for expected population growth).

- Even if the United Nations' Millennium Development Goal for improved drinking water and basic sanitation is reached by 2015, it will still leave:
- An estimated 790 million people (11% of the world’s population) without access to an improved water supply.
- An estimated 1.8 billion people (25% of the world’s population) without access to adequate sanitation.
- An improved water source is defined as water that is supplied through a household connection, public standpipe, borehole well, protected dug well, protected spring, or rainwater collection. 36 per cent of the world’s population – 2.5 billion people – lack improved sanitation facilities and 768 million people still use unsafe drinking water sources; more than half that number belong in India and China.

HANDOUT 4

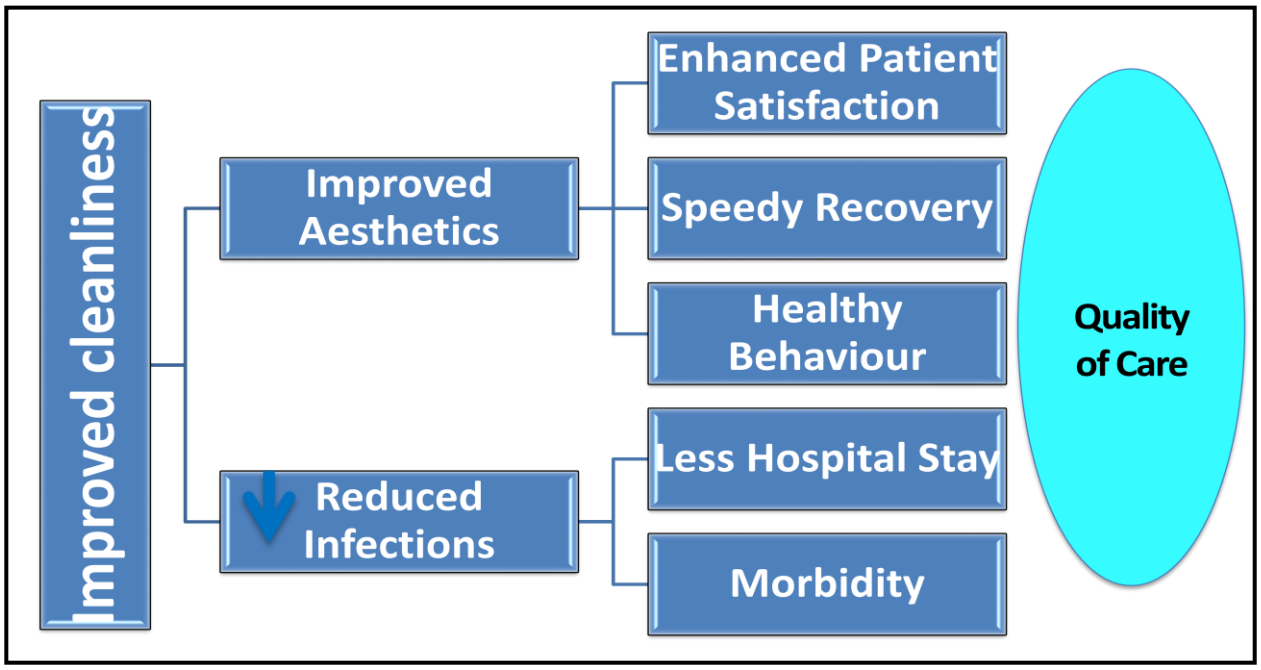
KAYAKALP – Clean Hospital Initiative

An Overview

Context

- Swachh Bharat Abhiyan launched by Prime Minister on 2nd October 2014 focuses on "promoting cleanliness in Public Spaces"
- Kayakalp- Clean Hospital Award for Public Health Facilities Launched by Union Health Minister on 15th May 2015

Swachh Hospitals-Chain of Benefits



Objectives of KAYAKALP Initiative

- To promote cleanliness, hygiene and Infection Control Practices
- To incentivize and recognize public healthcare facilities that show exemplary performance adhering cleanliness and infection control.
- To inculcate a culture of ongoing assessment and peer review of performance
- To create and share sustainable practices related to improved cleanliness

Key-feature of Award Scheme

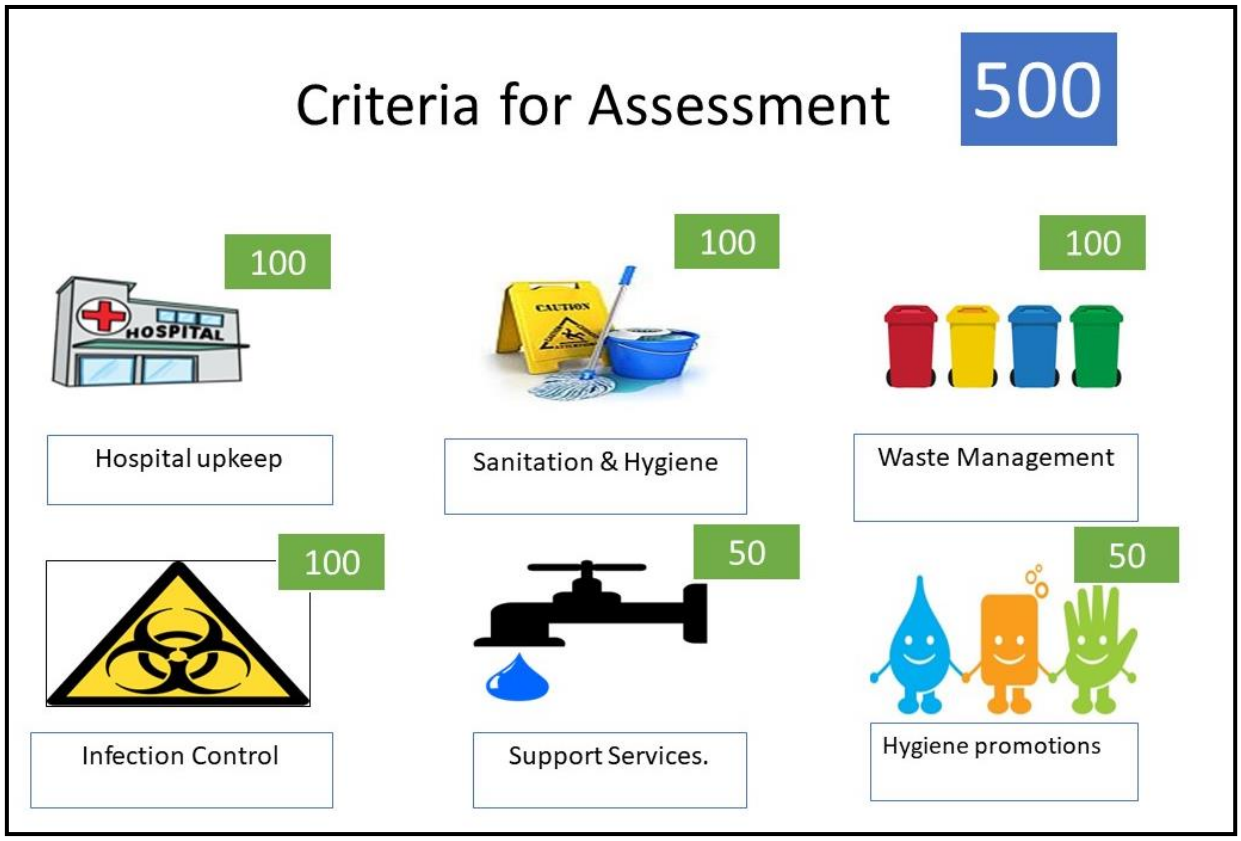
- Assessment on predefined objective criteria
- System of Peer-review

- Cash Award for two DHs and two SDHs/CHCs in a State (one award in each category for small states)
- Cash Award for one PHC in each District
- Certificate for commendation & cash award for facilities achieving more than 70% score
- Felicitation of best Hospitals at National Level

Cash Awards

Category	Type of Facility	Assessment Score	Amount (Rs. in Lakhs)
I. Large States	DH	Highest (Best)	Rs. 50.00
		Runner-up	Rs. 20.00
	SDH/ CHC	Highest (Best)	Rs 15.00
		Runner-up	Rs. 10.00
	PHC	One in each District	Rs. 2.00
II. Small States	DH	Highest (Best)	Rs. 50.00
	CHC	Highest (Best)	Rs. 15.00
	PHC	One in each District	Rs. 2.00
Commendation & Cash Award (70% or more)			
All States	DH	More than 70% Score	Rs. 3.00
	SDH/CHC		Rs. 1.00
	PHC		Rs 0.50

Criteria for Assessment



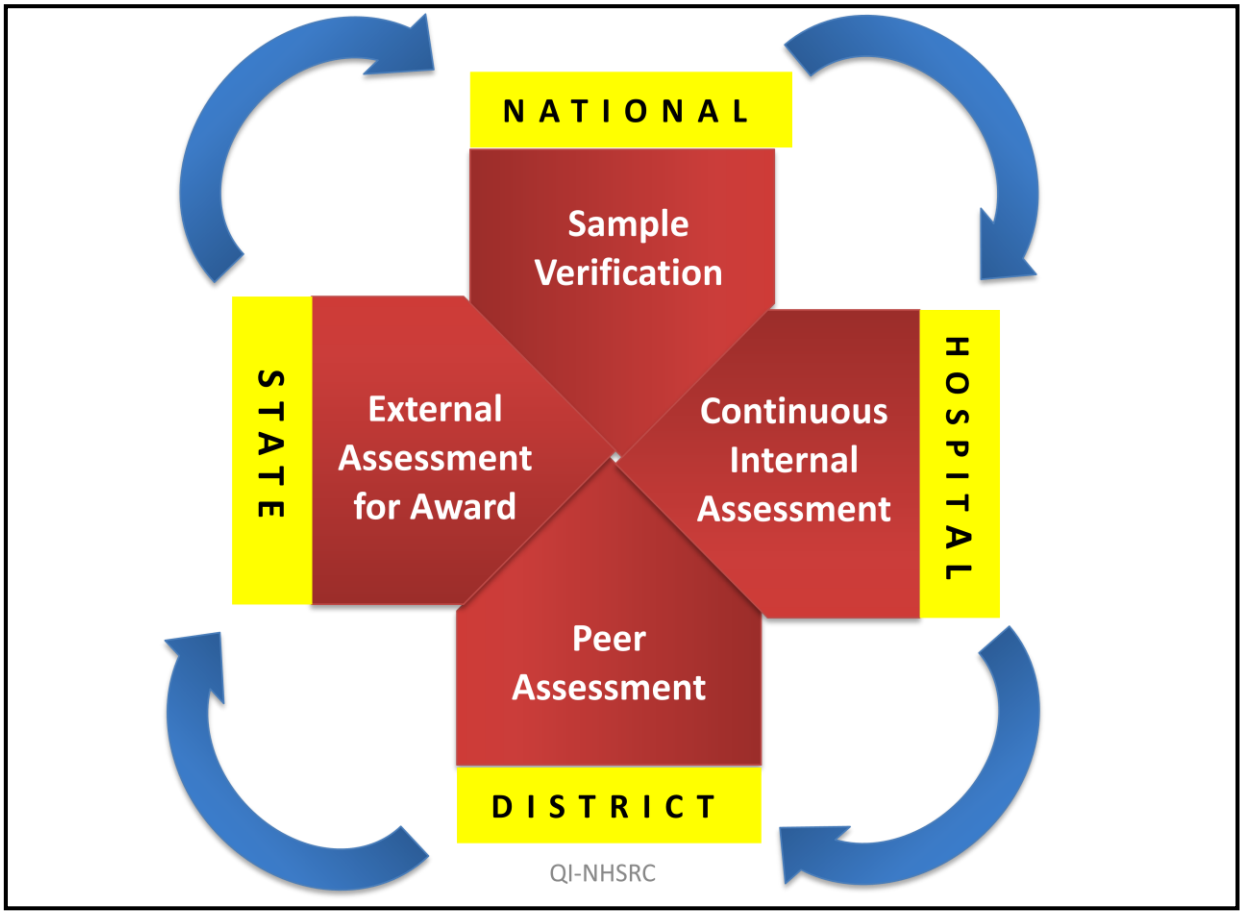
Institutional Framework

State Level Award Committee		Chairperson: MD/Health Secretary. Members: senior officers from Health directorate, SQAC. Development Partners Medical Colleges, NGOs Public Health Engineering department, Pollution Control Board and water and Sanitation department.		Dissemination, Assessors Team constitution, Trainings, coordinate &validate Assessment, finalize winners & award, conflict resolution

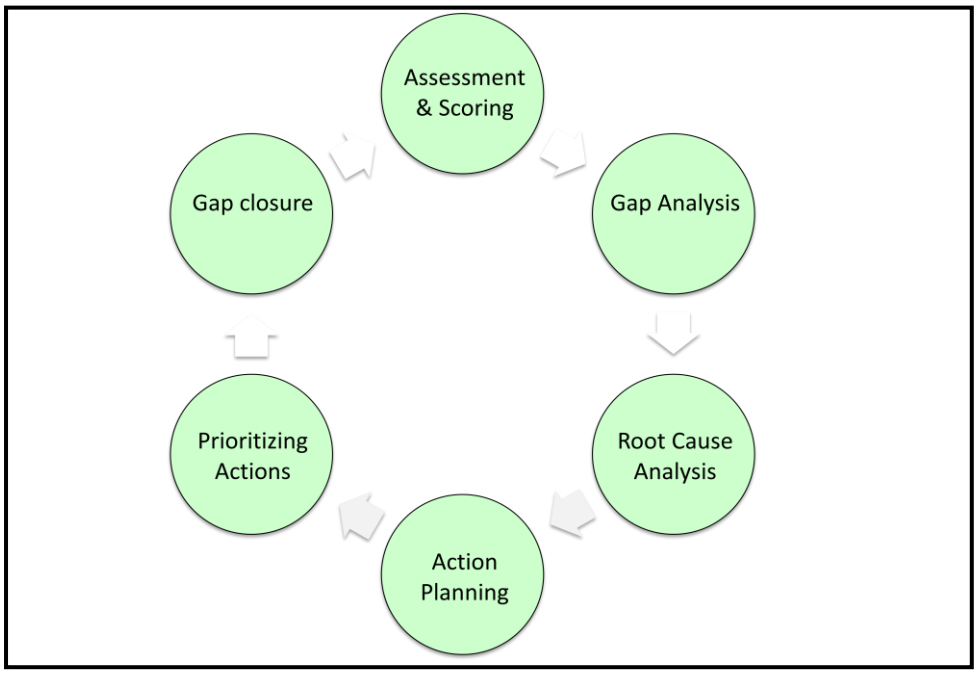
District level Award Nomination Committee		Chairperson: DM/CMO Members: Zilla Panchayat Health committee, DQAC, Civil society representatives, RKS members		Dissemination, internal & peer assessment, Trainings, monitoring, nomination for awards.

Hospital Cleanliness & Infection Control Committee		Medical Superintendent, Matron, Hospital Manager, Pathologist / Microbiologist, Departmental In charges		Internal Assessment, Action Planning, Gap Closure, Hands on Training, Monitoring of cleanliness

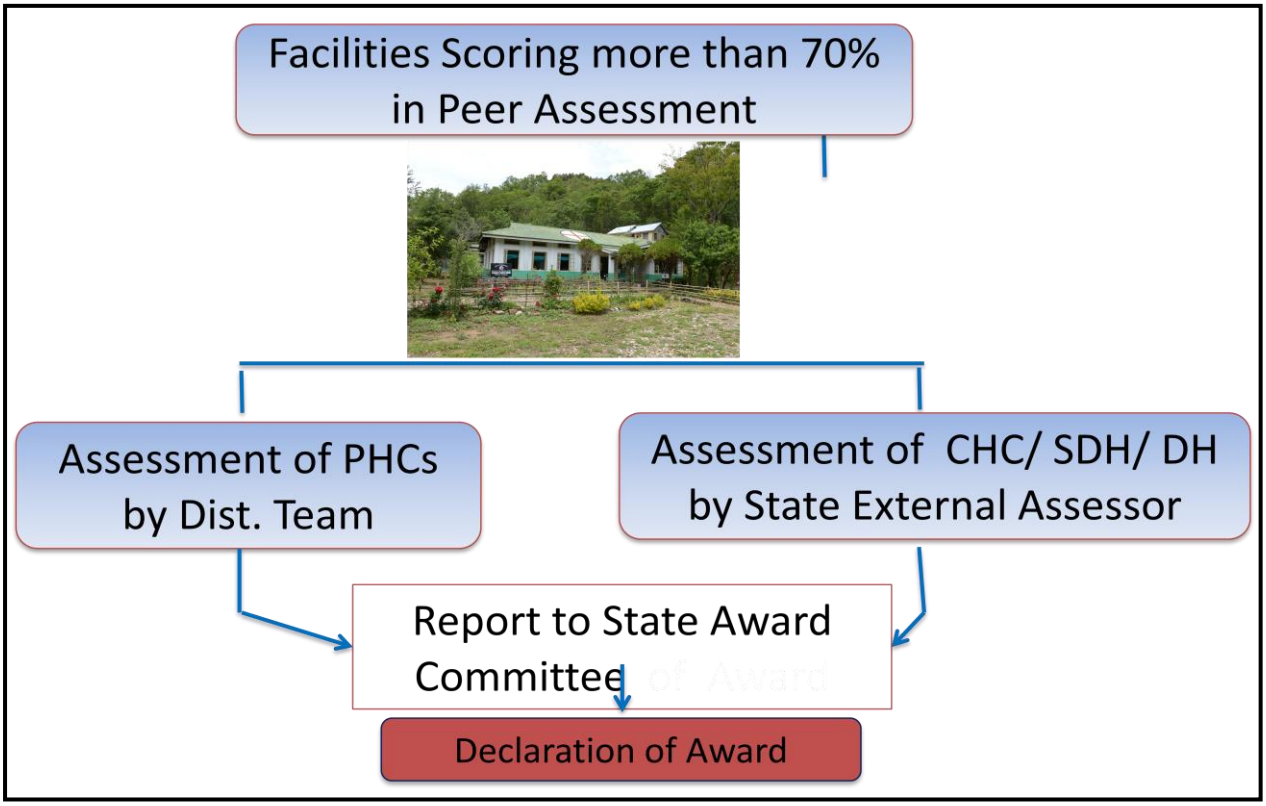
Assessment Process



Internal Assessment and Improvement Cycle



Protocol at State / Dist. Level



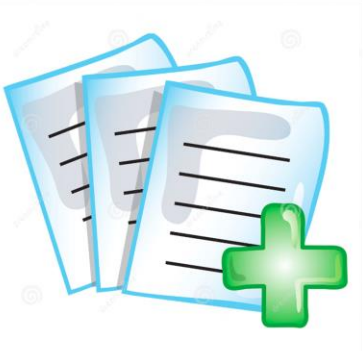
Assessment Checklist

Ref. No.	Criteria	Assessment Method	Means of Verification	Compliance
A.	**HOSPITAL / FACILITY UPKEEP**			
A1	**Pest & Animal Control**			
A1.1	No stray animals within the facility premises	OB/SI	Observe for the presence of stray animals such as dogs, cats, cattle, pigs etc. within the premises. Also discuss with the facility staff.	
A1.2	Cattle-trap is installed at the entrance	OB	Check at the entrance of facility that cattle trap has been provided. Also look at the breach, if any, in the boundary wall	
A1.3	Pest control measures are implemented in the facility	SI/RR	Ask the facility administration about pest control measures to control rodents and insect. Check records of engaging a professional agency for the same	

Assessment Method

OBSERVATION (**OB**)

STAFF INTERVIEW (**SI**)



RECORD REVIEW (**RR**)

PATIENT INTERVIEW (**PI**)

Compliance & Scoring Rules

Full Compliance	2	➢ All Requirements in Checkpoint are Meeting ➢ All Tracers given in Means of verification are available ➢ Intent of Checkpoint is meeting
Partial Compliance	1	➢ Some of the requirements in checkpoints are meeting ➢ All Least 50% of tracers in Means of verification are available ➢ Intent of checkpoint is partially meeting
Non-Compliance	0	➢ Most of the requirements are not meeting ➢ Less than 50% of tracers in Means of verification are available ➢ Intent of Checkpoint is not meeting

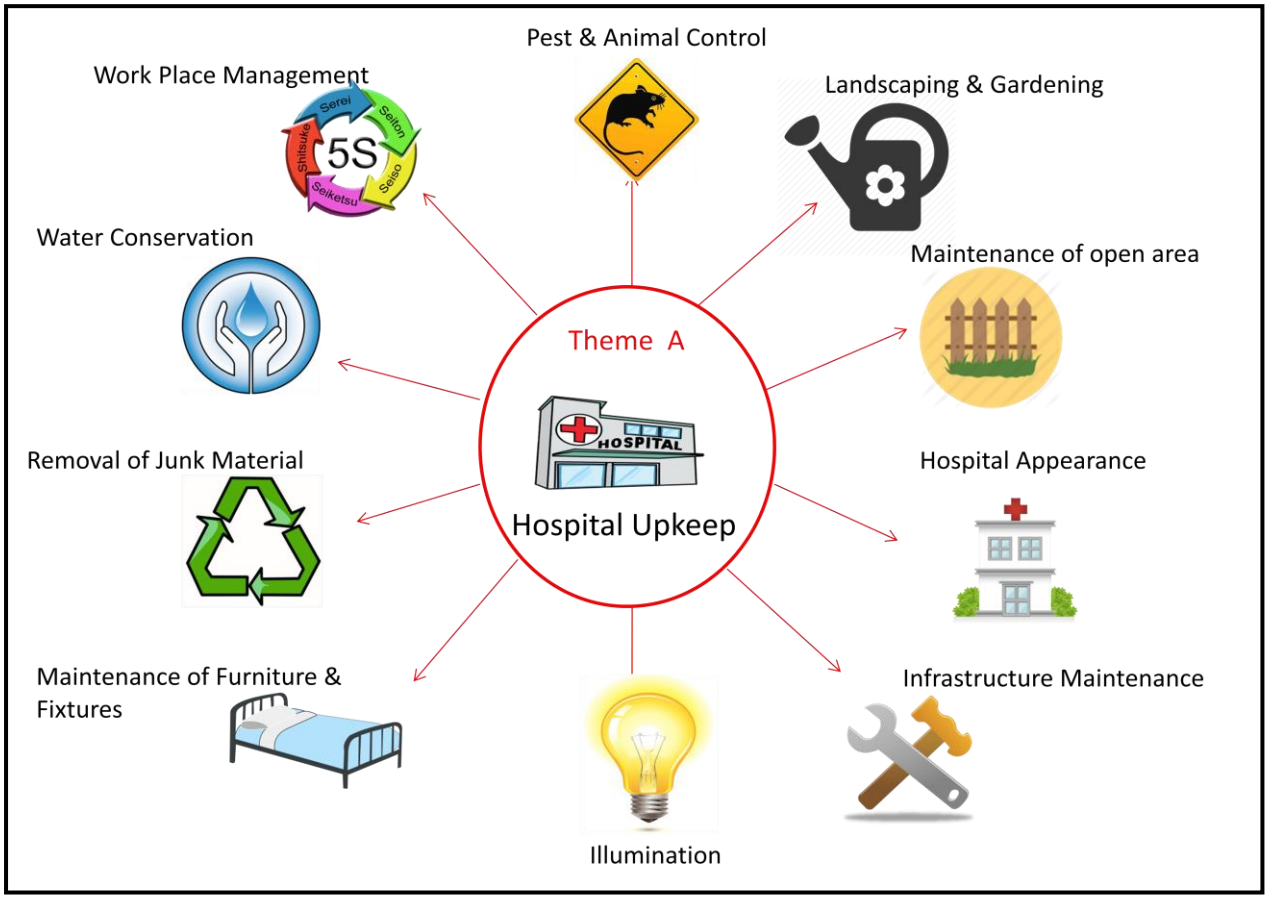
Trainings

Trainings	Location	Target Audience
Awareness Training	State Capitals	Half Day sensitization workshop at State level for Key officials from, State Health Directorate, State Health Society, Members of State level award Committee Representatives of NGOs & Development Partners working in state
External Assessors Training	State Capitals / NHSRC	One day Master Training of State level external assessors for using the assessment tool At least One officials should be nominated from every district who can work as master trainer for district level workshop.
Awareness cum Internal Assessors Workshop	At all district headquarters	4 Hour sensitization workshop at District Level on the Swachh Bharat Abhiyan and how to use assessment tool targeted for Service Providers Facility In Charge Doctors, Nurses, Hospital Managers, DPM, Members of District Quality Assurance Committees, representatives of Development partners & NGOs working at District Level.

HANDOUT 5

Theme A, B, C, D, E and F of Kayakalp

Theme A : Hospital / Facility Upkeep



Pest and Animal control

- No stray animal
- Installation of cattle-trap
- Implementation of Pest control measures
- Anti-termite treatment of wooden fixtures
- Mosquito free environment

Landscaping and Gardening

- Facility front area
- Maintenance of green areas/park/open spaces
- Internal roads, Pathways, Waiting area etc.
- Fencing of Gardens/ green area

- Herbal Garden

Maintenance of Open areas

- No abandoned/ dilapidated buildings
- Water logging in open areas
- No thoroughfare/ general traffic
- Open areas are maintained
- Encroachment of hospital land

Hospital/Facility Appearance

- Walls are well-plastered and painted
- Interior of patient care areas
- Name of the facility displayed
- Uniform signage system
- No unwanted/outdated posters

Infrastructure maintenance

- Facility Infrastructure
- Periodic maintenance of infrastructure
- Electric wiring and fitting
- Intact boundary wall and functional gates at entry
- Parking of vehicles

Illumination

- Illumination in circulation areas
- Illumination in Indoor areas
- Illumination in procedures areas(LabourRoom or LO/ Operating Theatre/OT)
- Illumination in front of facility and access road
- Energy efficient bulbs

Maintenance of Furniture and Fixtures

- Windows and Doors are intact
- Patient beds and Mattress

- Trolleys, Stretchers, Wheel chairs etc.
- Furniture at the nursing station, staff room, administrative office.
- Preventive maintenance of furniture and Fixtures

Removal of Junk material

- Junk material in patient care areas
- Junk materials in Open areas and corridors
- Junk material in critical service area
- Demarcated space for keeping condemned junk material
- Documented and implemented condemnation policy

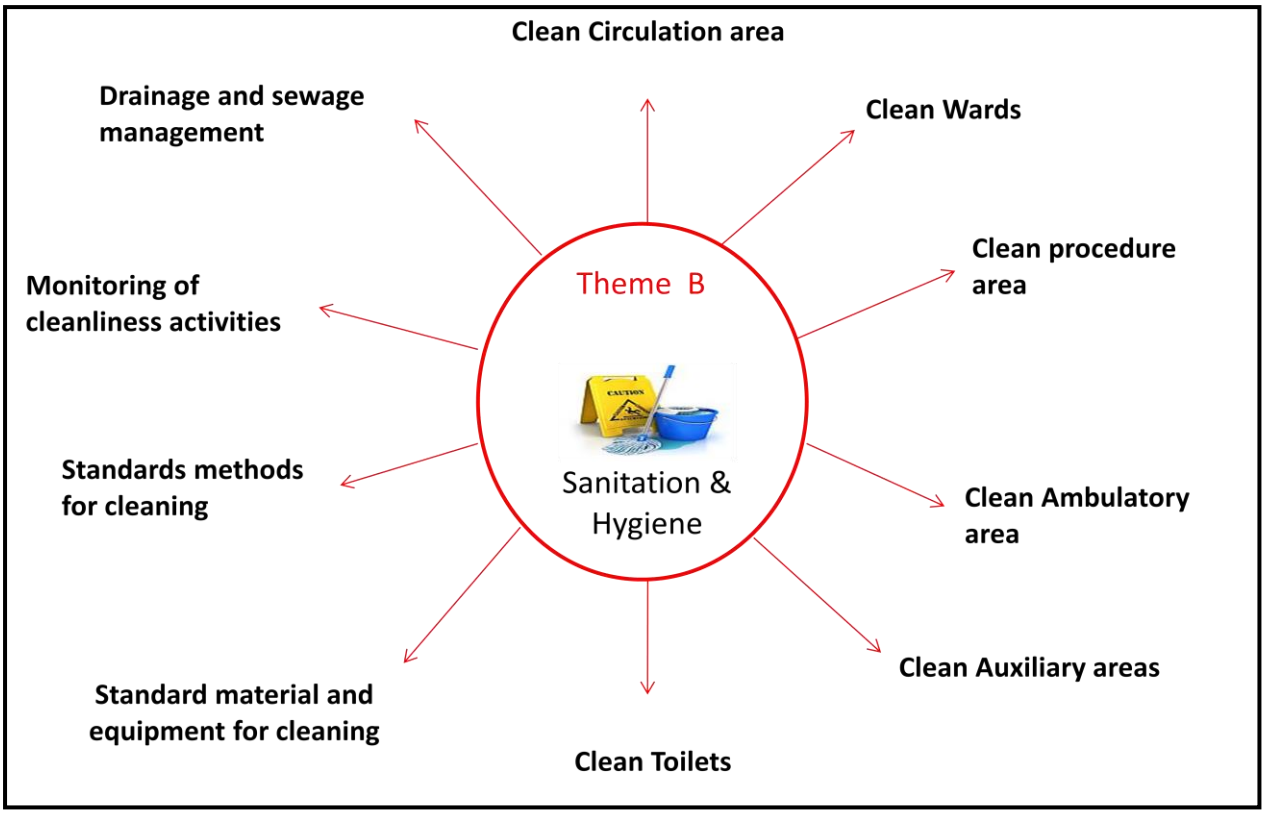
Water conservation

- Adequate quantity and quality
- Maintenance of water supply system
- Periodic inspection of water wastage
- Promoting water conservation
- Functional rain water harvesting system

Work place management

- Sorting useful and unnecessary articles at work station
- Arranging the useful articles, records in systematic manner
- Label the articles in identifiable manner
- Work stations are clean and dust free
- Staff trained for work place management

Theme B : Sanitation and Hygiene



Clean Circulation areas

- No dirt/ Grease/ stains
- No cobwebs/ Bird nest/ dust on walls and roofs of corridors
- Wet mop of corridors at least twice in a day
- Rigorously cleaned with scrubbing/ flooding once in a month
- Surfaces are conducive of effective cleaning

Clean Wards

- No dirt/ Grease/ stains
- No cobwebs/ Bird nest/ dust on walls and roofs
- Cleaning of wards at least thrice in a day
- Patient furniture, Mattresses fixtures are without grease and dust
- Cleaning of floors, walls, furniture and fixtures once in week

Clean Procedure Areas

- No dirt/ Grease/ stains

- No cobwebs/ Bird nest/ dust on walls and roofs
- Cleaning of OT/ Labour room at least twice in a day/after surgery
- Cleaning of floors, walls, furniture and fixtures once in week
- OT & Labour tables without body fluids, grease

Clean Ambulatory Area

- No dirt/ Grease/ stains
- No cobwebs/ Bird nest/ dust on walls and roofs
- Cleaning at least thrice in a day with wet mop
- Furniture & fixtures are without body fluids, grease and cleaned daily
- Cleaning of floors, walls, furniture and fixtures once in week

Clean Auxiliary Area

- No dirt/ Grease/ stains
- No cobwebs/ Bird nest/ dust on walls and roofs
- Cleaning at least twice in a day with wet mop
- Furniture & fixtures are without body fluids, grease and cleaned daily
- Cleaning of floors, walls, furniture and fixtures once in week

Clean Toilets

- No dirt/ Grease/ stains
- No foul smell
- Availability of running water and functional cisterns
- Cleaning of toilets
- Dry Floors

Use of Standard Material & Equipment for Cleaning

- Availability of Detergent Disinfectant for cleaning
- Using correct concentration of cleaning solution
- Carbolic acid/ Baciloacidfor surface cleaning
- Buckets and carts for mopping
- Cleaning equipment

Use of Standards Methods for Cleaning

- 3 Bucket systemfor cleaning
- Unidirectional method and out word mopping
- No use of brooms in patient care areas
- Separate mops for critical and semi critical areas
- Disinfection and washing of mops after every cleaning cycle

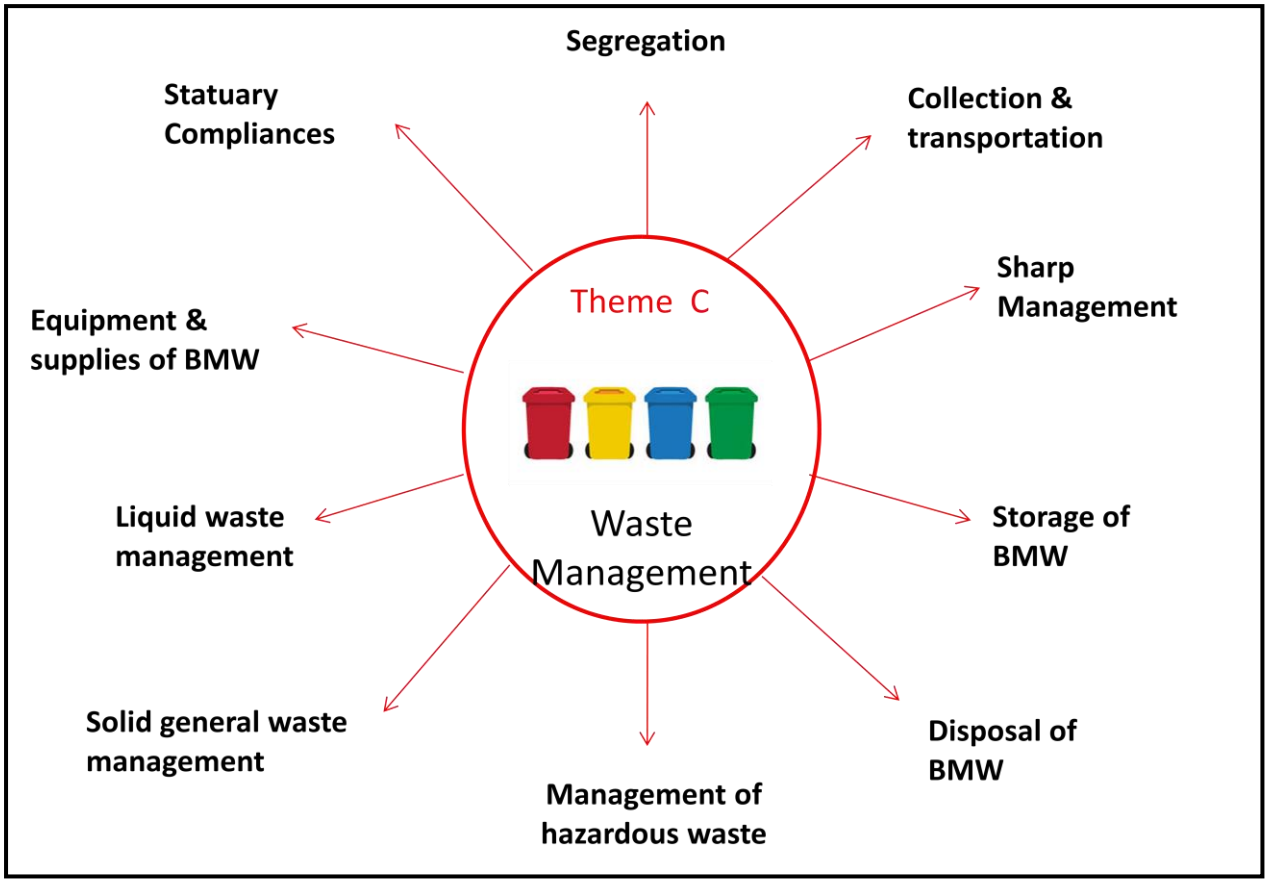
Monitoring of Cleanliness Activities

- Housekeeping checklists in toilets
- Housekeeping checklists in patient care areas
- Housekeeping checklists in procedure areas
- Designated person for monitoring
- Monitoring of adequacy and quality of material used for cleaning

Drainage and Sewage Management

- Closed drainage system
- Gradient of drains is conducive for free flow
- Connection with municipal sewage system/ Soak pit
- No block/ overflowing drains
- Cleaning of drains once in a week

Theme C : Waste Management



Segregation of Waste

- Anatomical waste segregated in yellow bin
- Soiled and solid infectious waste are segregated as per as BMW rules 1998.
- General and Infectious waste are not mixed
- Display of work instructions
- Does staff aware of segregation protocols

Collection and Transportation of BMW

- BMW bins are not over filled
- BMW bins are covered
- Defined schedule for collection of BMW from generation area
- Transportation of BMW done in closed trolley/container
- Route of transportation away from general traffic

Sharp Management

- Needle cutters used for cutting syringe hub
- Disinfection of sharp before disposal
- Using safe method for processing and transportation of sharp
- Staff knows what to do in case of needle stick injury
- Post exposure prophylaxis

Storage of BMW

- Availability of dedicated storage facility
- Storage facility located away from patient care area
- Disposal of BMW waste within 48 hours
- General waste not mixed with BMW
- Display of Bio-hazard sign

Disposal of BMW

- Facility for disposal of BMW
- Disinfection and Mutilation of plastic waste before disposal
- Disposal of anatomical waste
- Deep burial pit as per specifications
- Sharp pit as per specifications

Management of Hazardous Waste

- Management of Mercury spill as per protocol
- Availability of mercury spill management kit
- Disposal of developer and fixer in X-ray unit
- Disposal of disinfectant
- Disposal of Lab reagent

Solid General Waste Management

- Segregation of recyclable and Biodegradable waste
- Availability of compost pit
- Availability of general waste disposal services

- No mixing of infectious and general waste
- Daily removal of general waste

Liquid Waste Management

- Treatment of lab samples before disposal
- Treatment of body fluids before disposal
- Facility of treatment of infectious liquid waste
- Availability of septic tank
- Maintenance of septic tank

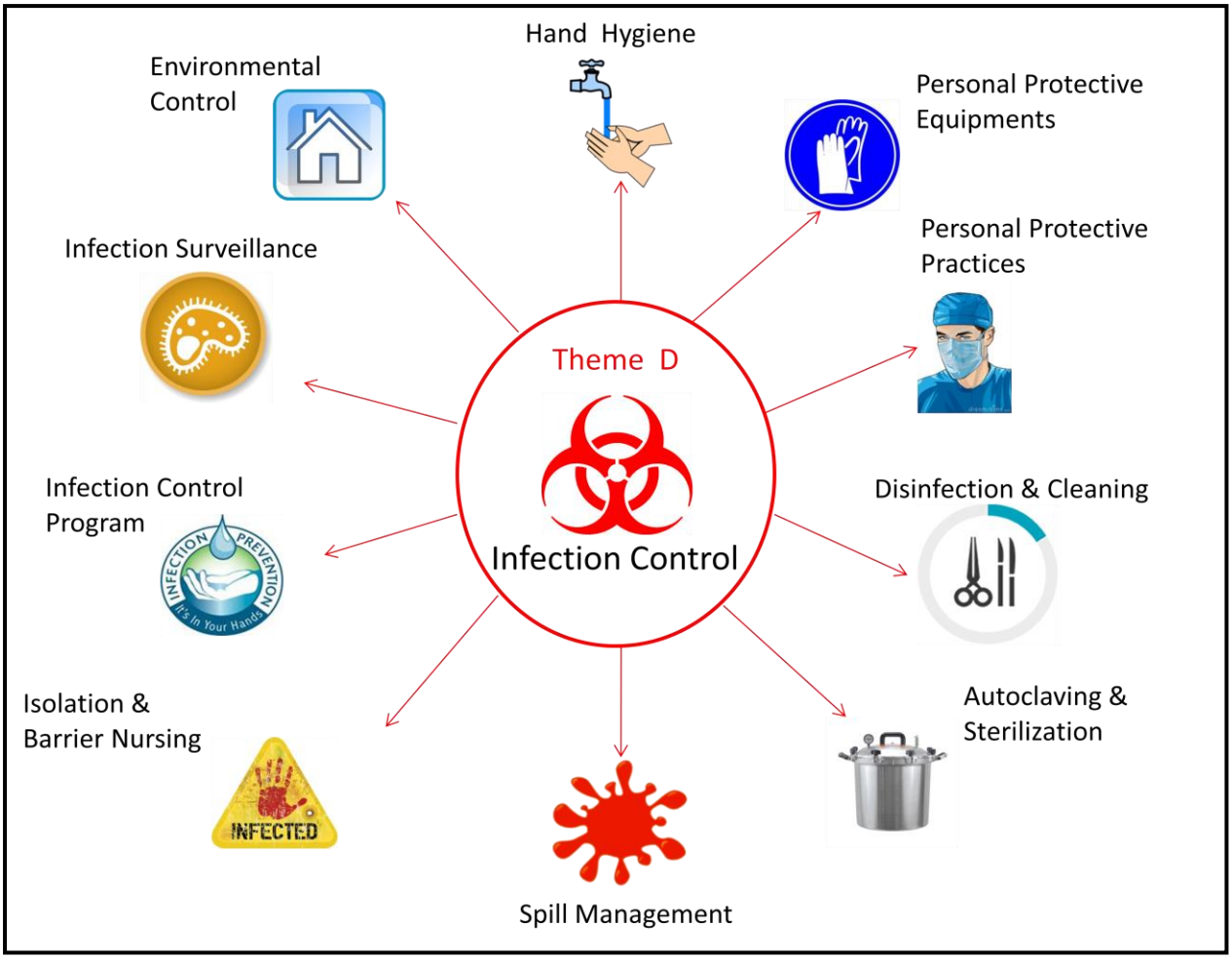
Equipment and Supplies for BMW

- Availability of colour coded bins for BMW
- Availability of bins for collections of general waste
- Availability of needle cutter and puncture proof box
- Availability of colour coded liner
- Availability of trolleys for waste collection and transportation

Statutory Compliances

- Authorization of BMW management
- Submission of Annual report
- Maintenance of records of waste generated
- Delegation of responsibility of monitoring BMW management
- Availability of copy of BMW management rules

Theme D : Infection Control Practices

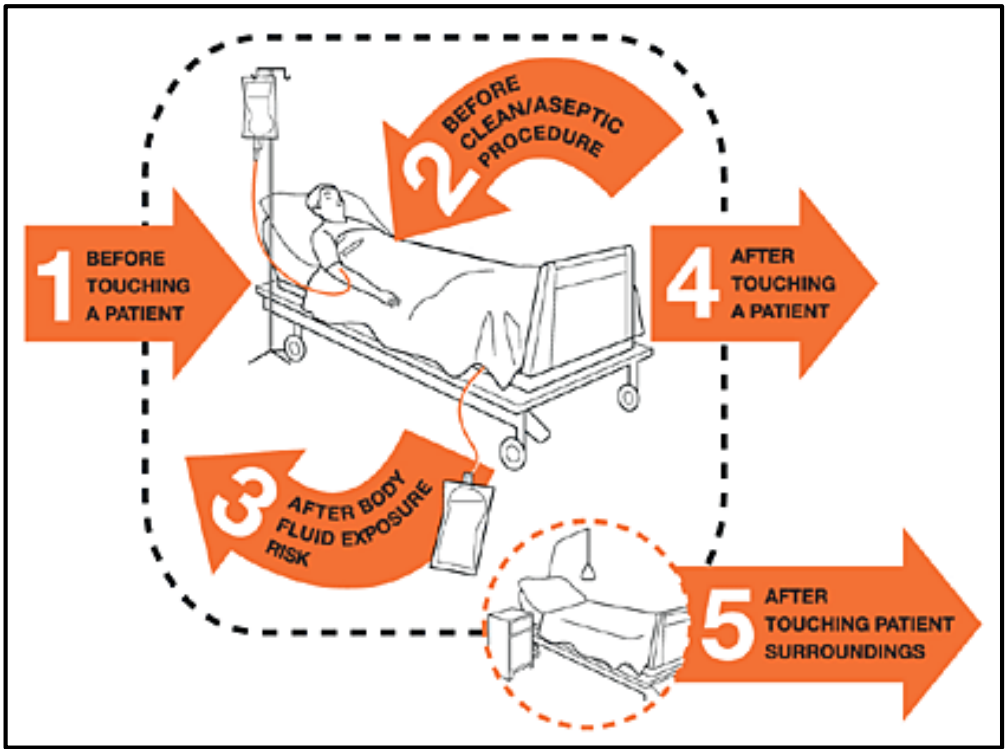


Hand Hygiene

- Hand Washing Facility
- Display of Hand washing Instructions
- Adherence to 6 Steps of Hand washing
- Availability of Alcohol Based Hand rub
- 5 Moments of Hand wash

6 Steps of Hand Washing

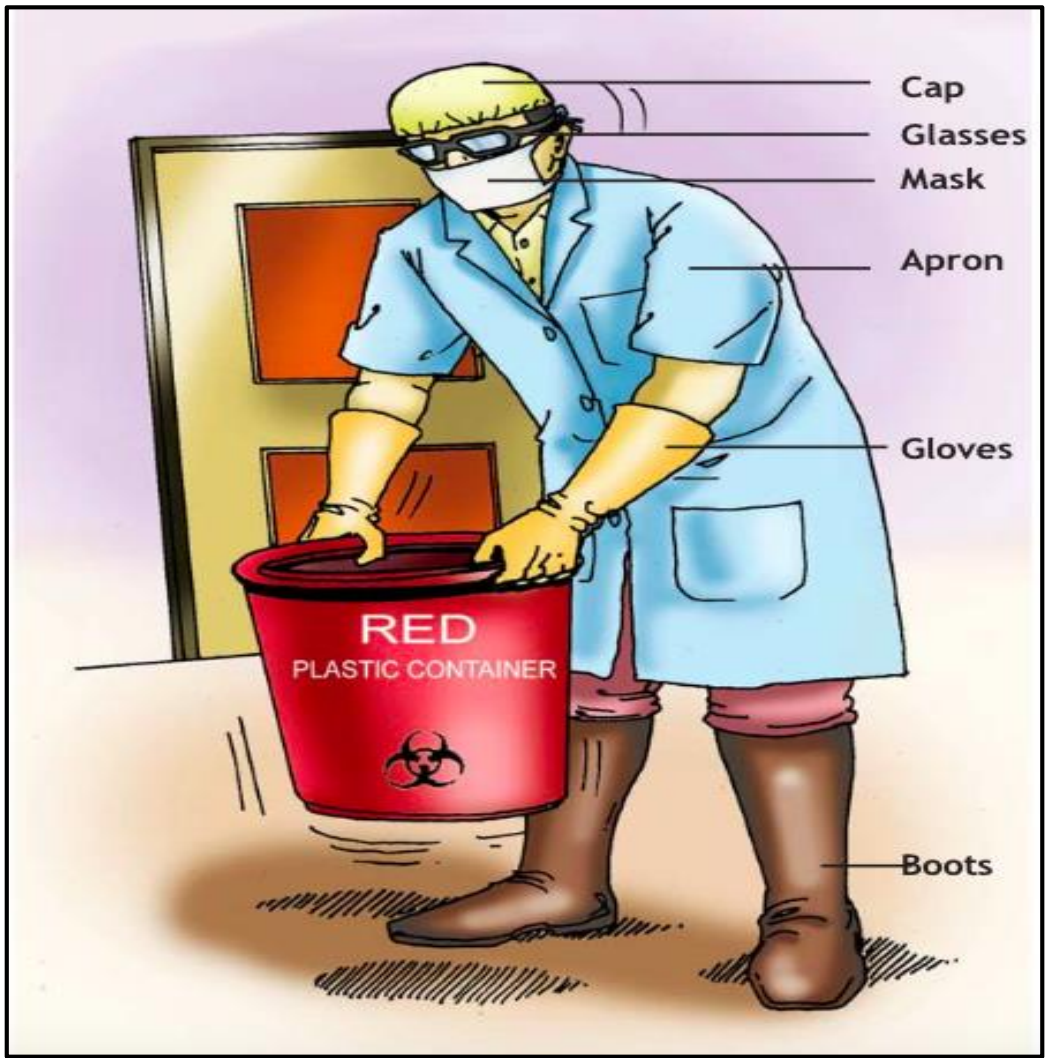
5Moments of Hand Washing



Personal Protective Equipment

- Use of Gloves
- Use of Mask and Head Cap
- Use of Heavy Duty Gloves and Gumboots
- Use of apron /Lab Coat
- Adequate supply of PPEs

Personal Protective Equipment

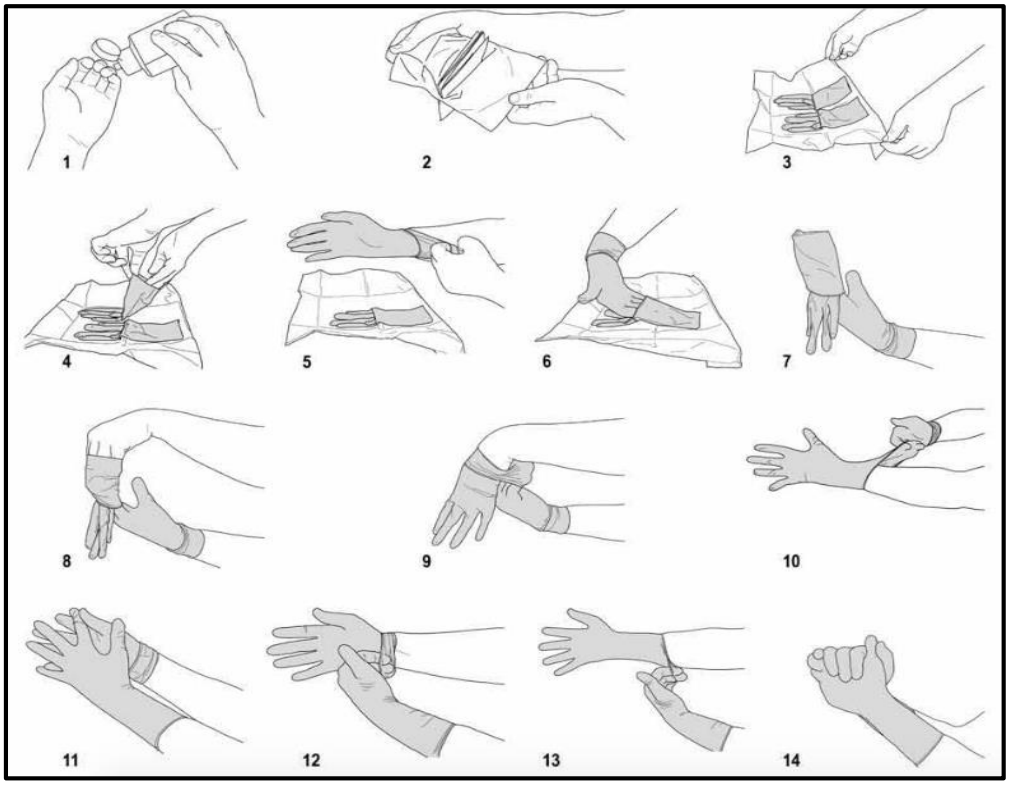


Personal Protective Practices

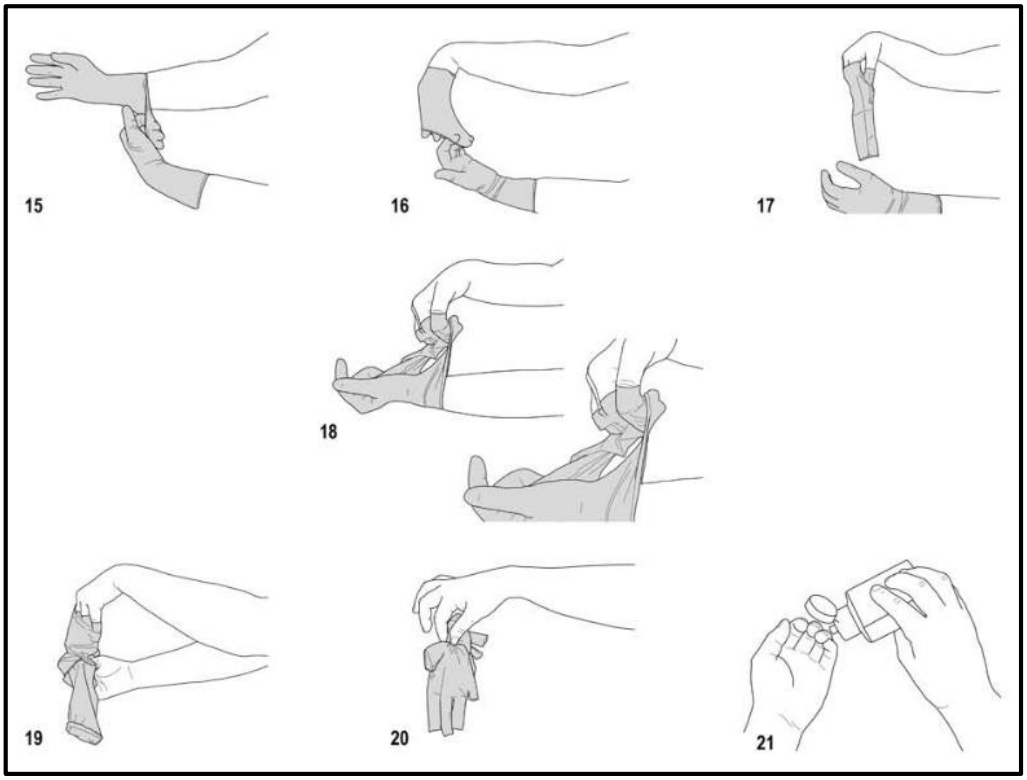
- Correct use of Sterile and Clean gloves
- Correct Method of wearing and removing Gloves
- Correct method of wearing mask and cap
- No reuse of Disposable Gloves & Masks

- Awareness about 5 Standards Precautions

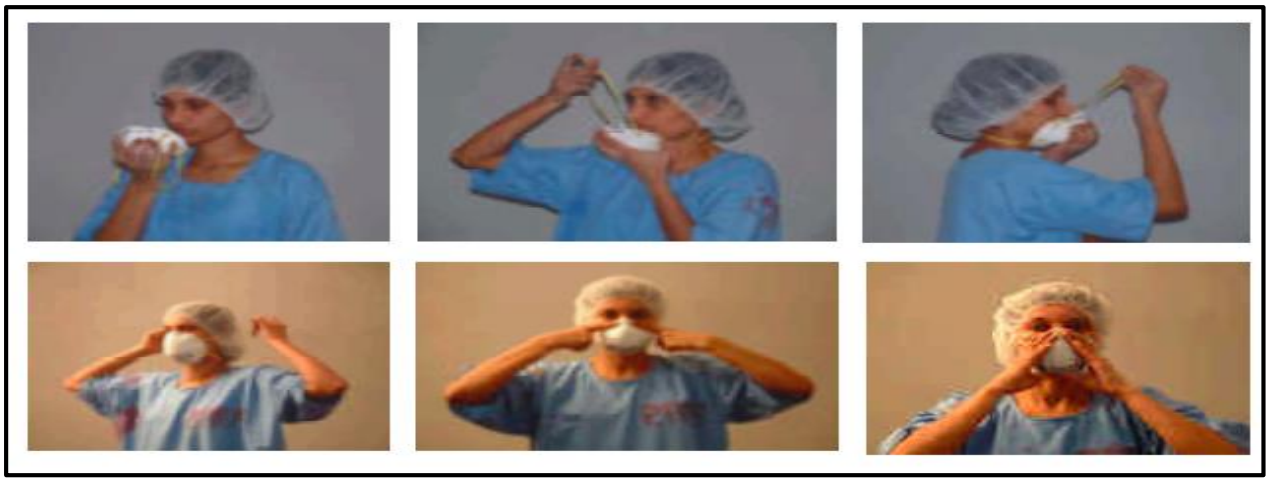
How to Wear Gloves



How to Remove Gloves



Steps in Wearing Mask

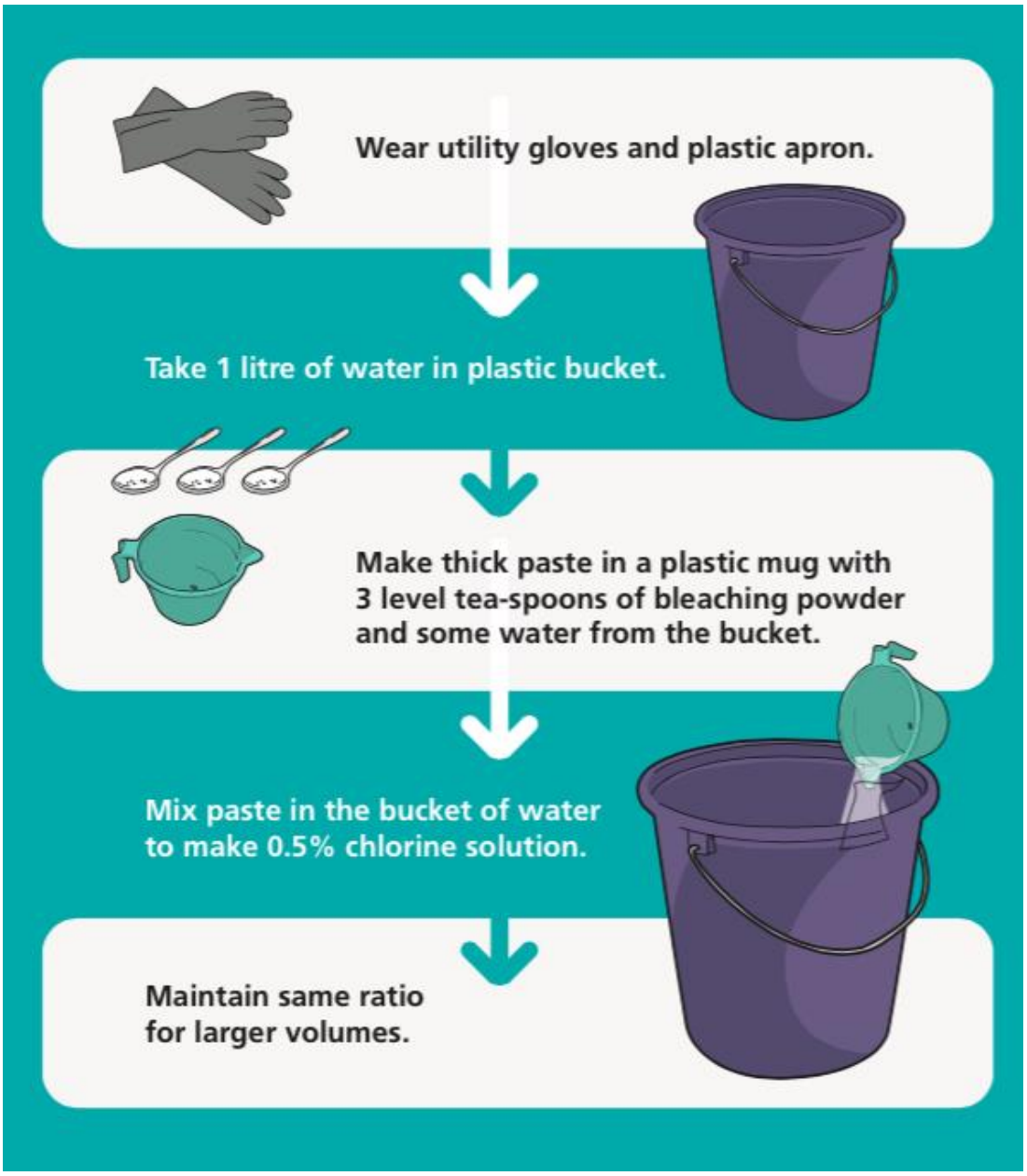


- Wash hands and dry.
- Remove the clean mask from the container with clean hands.
- Ensure the mask is fitted properly.
- If glasses are worn, fit the upper edge of the mask under the glasses.A secure fit will prevent both the escape and the inhalation of micro-organisms around the edges of the mask and fogging of the eyeglasses.
- Precautions
- Avoid talking, sneezing, or coughing if possible.
- Masks cannot be worn with beards/unshaven faces.
- The mask should completely seal the face always to ensure effective filtering of micro-organisms

Decontamination & Cleaning

- Preparation of Chlorine Solution
- Decontamination of Operating Surfaces
- Decontamination of Instruments after use
- Cleaning of Instruments
- Contact Time for Decontamination

Preparation of 1 Litre Bleaching Solution

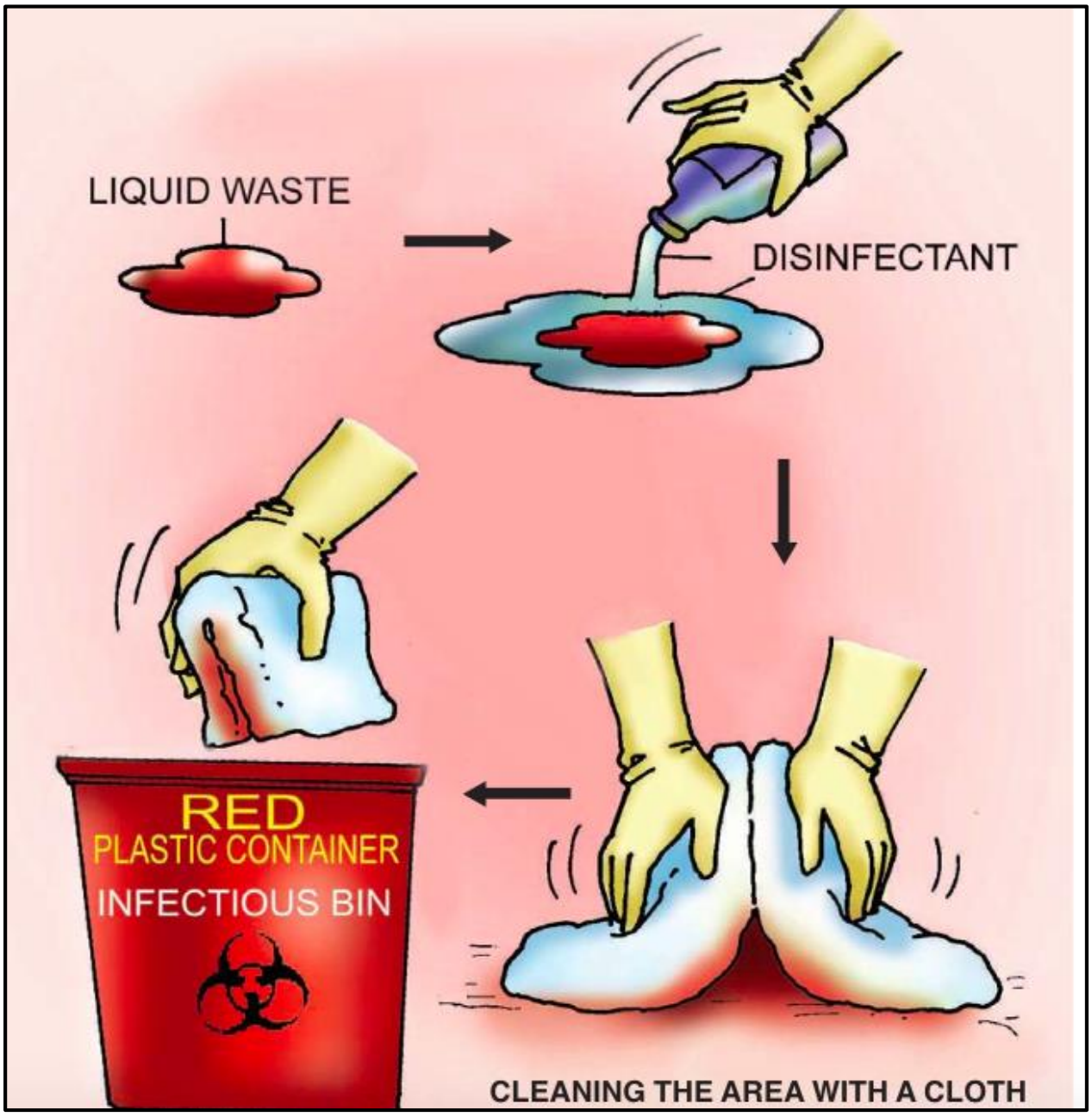


Disinfection and Sterilization

- Adherence to Protocols for Autoclaving
- Adherence to Protocols for High Level Disinfection
- Adherence to Protocols of Chemical Sterilization
- se of Indicators (Signal Locks) for Auto calving
- Storage of Sterilized instruments

Spill Management

- Adherence to protocols for Management of Small Spills
- Adherence to protocols for Management of Large Spills
- Availability of Spill Management Kit
- Training on Spill Management
- Display of Spill Management Protocols



Isolation & Barrier Nursing

- Provision of Isolation Ward
- Isolation of Infectious patients
- Maintenance of Bed to bed Distance
- Restriction of External Footwear in critical areas
- Restriction of Visitors in Critical Areas

Infection Control Program

- Functional Infection Control Committee
- Monitoring of Infection Control Practices
- Implementation of Infection Control Practices
- Immunization of Service Providers
- Medical Check-up of Staff

Hospital Acquired Infection Surveillance

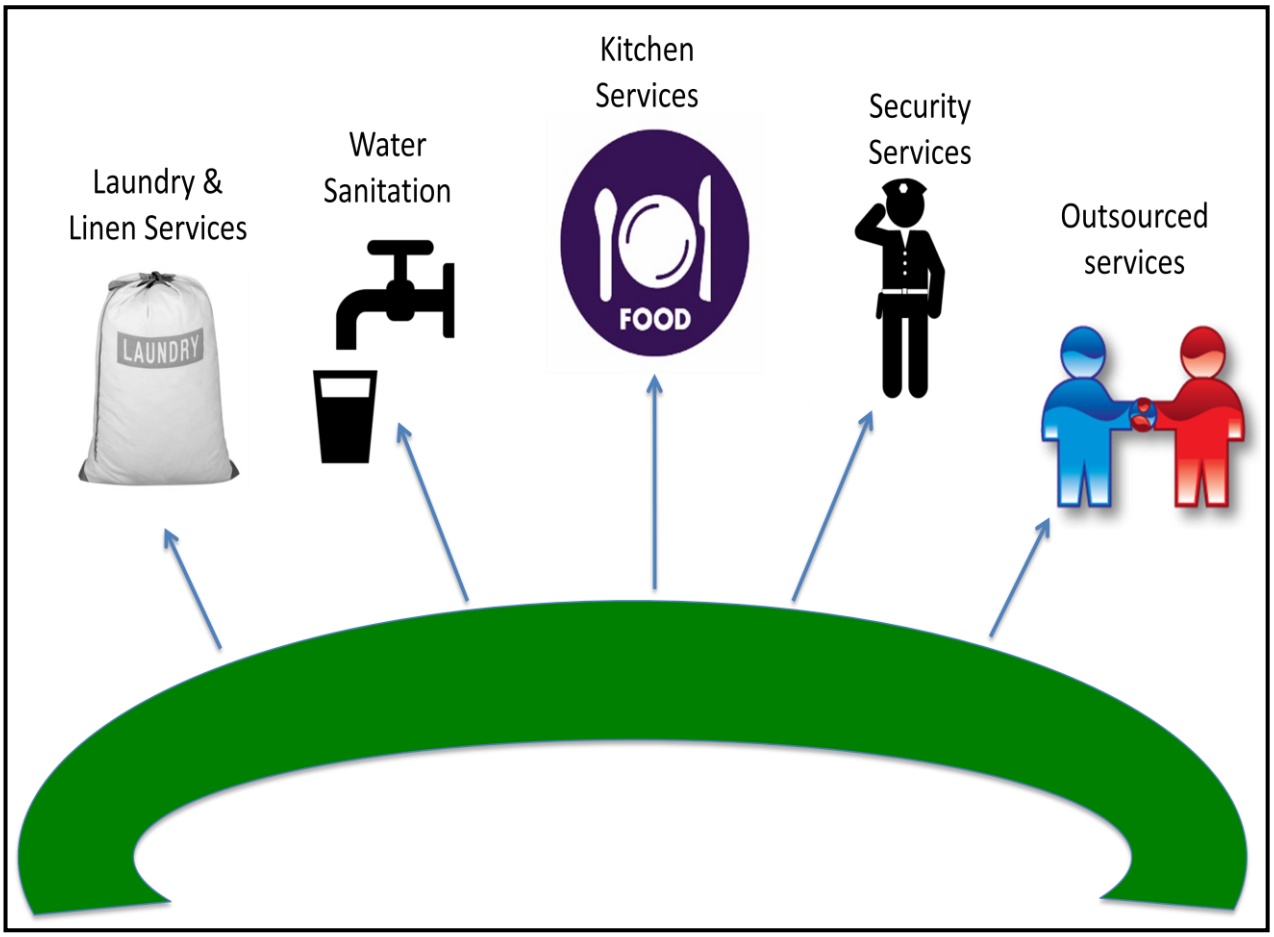
- Microbiological Surveillance of Critical Areas
- Measurement of Surgical Site Infection Rate
- Measurement of Device Related Infection Rates
- Measurement of Blood Related / Respiratory Infections
- Analysis and Corrective Action on Surveillance Findings

Environmental Control

- Maintenance of Positive Pressure in OT & ICU
- Maintenance of Air Exchanges in OT & ICU
- Layout of OT
- Carbolization of OT &Labour Room
- Segregation of General and Patient Traffic

Theme E : Support Service

Support Services



Linen & Laundry Services

- Adequate Stock of Linen
- Cleanliness of Bed sheets
- Linen changed daily
- Segregation of Soiled Linen
- Clean Patient Dress

Water Sanitation

- Adequate water supply
- Storage of Water
- Chlorination of Water
- Water Quality testing
- Availability of Potable ware at Point of Use

Kitchen Services

- Kitchen Located away from patient care areas
- Storage facility of food
- Ventilation and Fly proof
- Hygiene of Kitchen Staff
- Distribution of food in Covered trolleys

Security Services

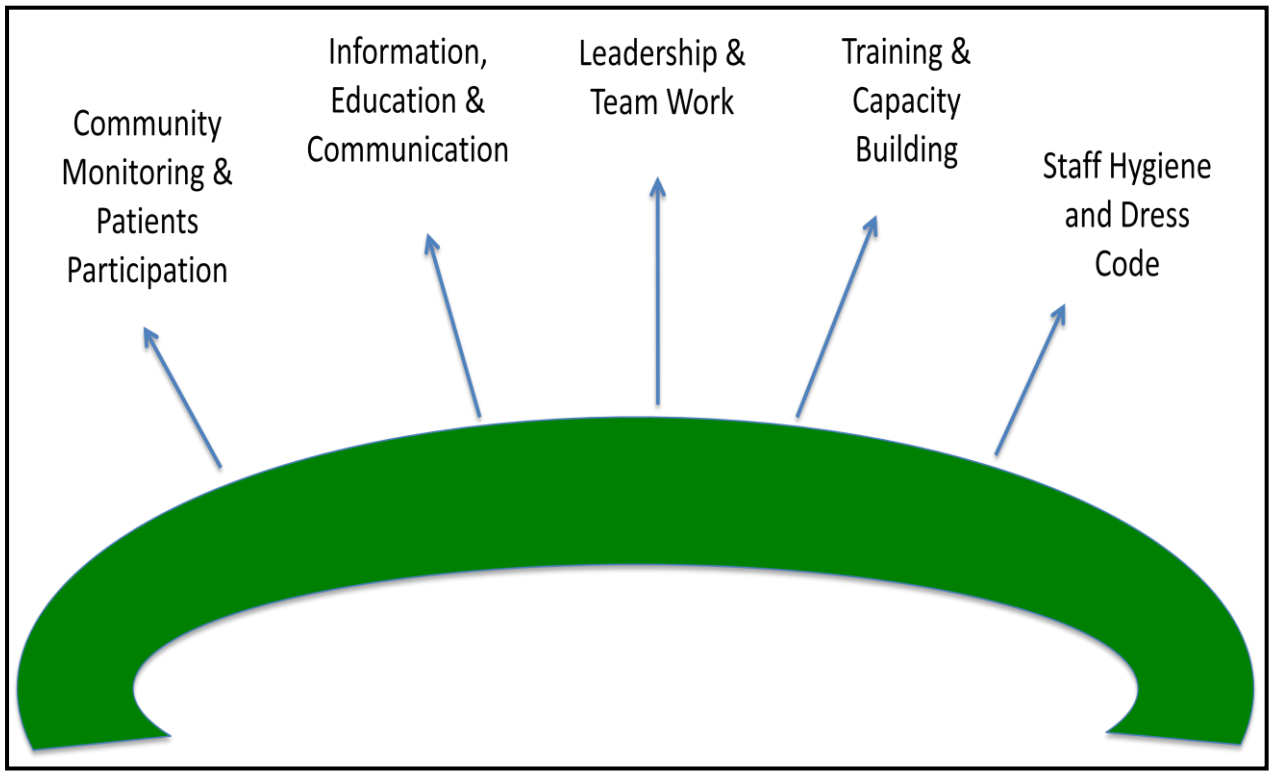
- Availability of security personal in critical areas
- Dress code of security personals
- Crowd management system
- Restriction to unauthorized entry and encroachment
- Monitoring of Unhygienic practice by security personals

Outsourced Services

- Valid Contract with Outsourced Serviced Provider
- Quality services is clearly defined
- Provision of Penalty in case of poor quality services
- Timely Payment to outsourced services contractors
- Periodic review of Quality of services

Theme F : Hygiene Promotion

Support Services



Community Monitoring & Patients Participation

- Involvement of RKS members in monitoring cleanliness
- Involvement of Local NGOs in Cleanliness
- Counselling of Patients for Hand Hygiene
- Promotion of Patients responsibility to keep facility clean
- Feedback from patients on cleanliness

Information Education and Communication

- IEC for promotion of Hand Hygiene
- IEC for SwachhtaAbhiyan
- IEC regarding use of Toilets
- IEC regarding water sanitation
- Innovative method of Hygiene promotion

Leadership & Teamwork

- Cleanliness & Infection Control Committee

- Representation of all cadres of staff
- Role and responsibility communicated
- Weekly Review of cleanliness
- Identification and appreciation of performers

Training, Capacity Building and Standardization

- Training need assessment regarding Cleanliness and Infection Control
- Training on Bio Medical Waste Management
- Training on Infection Control
- Standard Operating Procedures for Cleanliness
- SOPs for BMW Management & Infection Control

Staff Hygiene & Dress Code

- Policy of dress code for all cadre of staff
- Nursing Staff adhere to Dress code
- Support and Housekeeping staff adhere to dress code
- Regular Monitoring of Hygiene of Housekeeping and Kitchen Staff
- Identity Cards & Name Plates

Annexure 1

Better Water, Sanitation and Hygiene Access in Public Health Care Facilities

Two Day Training Program for HDS/RKS Members

Questionnaire

Pre-Training Assessment ☐ Post Training Assessment ☐

Date: ___/___/_____

1. Socio-economic Profile

1.1. Name of the participant : _____

1.2 Age in completed years : _____ Years

1.3. Gender : 1 Male 2. Female

1.4. Religion : 1. Hindu, 2. Christian, 3. Muslim 4. Others (Specify)

1.5. Caste : 1. Scheduled Caste 2. Scheduled Tribe 3. Backward Castes 4. Others (Specify)

1.6. Occupation– Specify : _____

1.7. Monthly Family Income from all sources : _____

1.8. Complete postal address : _____

_____

1.9. Phone No : _____

1.10. Email ID : _____

1.11. Name of the HDS : _____

1.12. Status in HDS : _____

1.13. Since how many Yearsyouhave been AssociatedwithHDS : _____ Years

2. Knowledge Assessment

2.1. Define WASH in 3 sentences

_____

_____

_____

2.2.: If you agree with the following statements write1 for **Yes** or2 for **No.**

S.No	Statement	1.Yes/2.No
2.2.1	Poor WASH infrastructure in Public Health Care Facilities is also responsible for higher Maternal and Infant mortality in the country.	
2.2.2	Upkeep of healthcare facility, its sanitation and hygiene Promotion are the responsibilities of Government alone.	
2.2.3	Hospital Development Society cannot ensure citizens participation for the improvement of patient care and welfare in healthcare facilities.	
2.2.4	Those who can afford, user charges can be levied for outpatient and inpatient treatment in health care facilities.	
2.2.5	Prominent display of Citizens' Charter in all Public Health Care facilities is optional, not mandatory	
2.2.6	It is the responsibility of HDS members to ensure that those patients who are Below Poverty Line (BPL), vulnerable and marginalized do not incur any financial hardship for their treatment.	
2.2.7	HDS is empowered to create its own mechanism to cover part/full costs related to transport, diet, and stay of attendant of the poor people.	
2.2.8	HDS can evolve mechanisms for enabling feedback from patients, at least at the time of discharge and take timely and appropriate action on such feedback	
2.2.9	HDS is entitled to collect donations from charitable and religious institutions, community organisations, corporate institutions for cleanliness and upkeep of the health care facility.	
2.2.10	Irrespective of utilization, untied funds, maintenance grants and corpus grants for HDS would be released every year by the government.	
2.2.11	Drawl and disbursal of HDS funds at Primary Health Centre is jointly operated by PHC Medical Officer and Mandal Revenue Officer.	
2.2.12	Drawl and disbursal of HDS funds at Community Health Centre is jointly operated by CHC Superintendent and Senior Public Health Officer.	

S.No	Statement	1.Yes/2.No
2.2.13	Drawl and disbursal of HDS funds at Area Hospital is jointly operatedby AH Superintendent and Senior Public Health Officer	
2.2.14	Drawl and disbursal of HDS funds at District Hospital is jointly operated by District Collector, District co-ordinator of Hospital Services and District Medical and Health Officer.	
2.2.15	External, internal and peer assessment is essential to bag Kayakalp- Clean Hospital Award instituted for best maintained Public Health Facilities in the district.	

Signature

Annexure 2

Format for identification of the key gaps in Health Care Facilities (HCF)

Key gap	Action to be initiated	Time	Responsibility	Monitoring
Water				
Sanitation				
Hygiene				

Name of the Participant: _____

Name of the Health Facility/Hospital Development Society:

_____

Annexure 3

Format for filling up information on sub-committees formed by HDS members for implementation of the action plan:

Name of the sub committee	Members	Description of Role

Name of the Participant: _____

Name of the Health Facility/Hospital Development Society:

_____

Annexure 4

Format for Preparation of Facility-wise Action Plan

Name of the Health Care Facility :

Village/Town name :

Mandal/Block :

District :

State :

Key activity	Dates	Responsible person	Reporting/Supervising person	Means of Verification

Name of the Participant: _____

Name of the Health Facility/Hospital Development Society:

_____

Annexure 5

Utilization of Guidelines for Kayakalp Cash award for Public Health Facilities in the State of Telangana

OFFICE OF THE COMMISSIONER, HEALTH & FAMILY WELFARE, TELANGANA, HYDERABAD

Rc.No.104/CH&FW/NHM/QA2017 Date.04.09.2017

Sub: CH&FW/NHM/QA -Utilization guidelines for Kayakalp Cash award for Public Health Facilities in the State of Telangana

Ref: Swachh Bharat Abhiyan (Kayakalp) Guidelines

*****

It is submit that the State of Telangana has successfully implemented Kayakalp during FY 2015-16, 2016-17 at secondary and primary health facilities as a part of Swachh Bharat Abhiyan (Kayakalp) to promote the cleanliness, hygiene & infection control in public health facilities.

As part of the programme, Incentives in the form of Cash will be awarded to different categories of public health institutions that successfully topped in the external assessment.

The following guidelines may be adopted for utilization of cash award:

Cash Award Norms:

Cash award has been divided into two components as per as MoHFW, GoI guidelines

1. Team Incentives (Comprises of 25% of awarded amount)
2. Facility incentives (Comprises of 75% of awarded amount)

Exemptions to Kayakalp cash reward:

Personnel who got retired / left at the time of issue of this circular were exempted to receive the cash reward.

District Hospital, Area Hospital and Community Health Centers:

1. 25% of the amount will be given to staff that were actively participated in Kayakalp Programme during particular period of programme implementation as a team incentive. For the distribution of the awarded money following percentage of incentive breakup shall be followed :
2. 35% of the fund shall be allocated for Staff who are performing duties of Housekeeping, Security, Gardening, Plumbing, electrical etc.
    a. If in case above mentioned services are outsourced through an agency, incentives can be paid to staff through outsourced agency, Bank statement of incentive paid to the staff of outsourced agency (Acknowledgement) shall be submitted to concerned Medical Superintendent within 15 days of distribution of incentives.
    - 25% of fund shall be paid for nursing staff within the facility.
    - 20% of fund shall be paid for doctors within the facility.
    - 15% of fund shall be paid for Paramedical staffs that are performing in the areas such as Laboratory, Radiology units, Operation Theatres, Dressing rooms etc.
    - 05% of fund for Ministerial staff who are functioning from establishment within the facility.

The above mentioned percentage of incentive shall be divided equally among the above listed sections of staff.

Disbursement of the above said sanctioned incentives shall be done by organizing a rewards & recognitions function under the supervision of state official.

Remaining 75% of the amount would be spend through HDS for improving the patient amenities, upkeep of services such as

1. Filling the gaps which were identified during the assessments.
2. Strengthening of staff rest room.
3. Library with books, journals, periodical for doctor, nurse and paramedical staff.
4. Improvement in amenities in Doctors/ Staff duty rooms.
5. Improving hospital facility /upkeep Like:
6. Pest & Animal Control
    - Landscaping & Gardening
    - Maintenance of Open Area
    - Facility Appearance
    - Infrastructure Maintenance
    - Illumination
    - Maintenance of Furniture & Fixture
    - Removal of junk material
    - Water Conservation
    - Work Place Management

A detail Plan shall be prepared for the utilization of the awarded money for fulfilling the standards of Kayakalp as well as National Quality Assurance Standards after due approval of Facility level Quality Team and Hospital Development Society. This plan shall be shared with State Quality Cell within 01 month of receiving funds.

Primary Health Centers

5. 25% of the awarded cash incentives disbursement shall be as follows -

    i. One Active Member among the staff shall be identified as a "star performer "during Quality team meeting and with the approval of Hospital Development Society, 20 % out of 25% incentive shall be awarded to the "star performer" as a token of greater efforts contributed towards achieving the award.

    ii. Remaining 80% of Incentive shall be disbursed uniformly among the staff irrespective of post by excluding the "star performer".

    Disbursement of the above said sanctioned incentives shall be done by organizing a rewards & recognitions function under the supervision of state official.

Remaining 75% of the amount shall be spend through HDS for improving the patient amenities, upkeep of services such as

- Filling the gaps which were identified during assessments.
- Improvement in amenities in Doctors/ Staff duty room.

- Improving hospital facility /upkeep Like:
- Pest & Animal Control
- Facility Appearance
- Infrastructure Maintenance
- Illumination
- Maintenance of Furniture & Fixture
- Water Conservation

For any query regarding guidelines you can communicate to State Quality Cell on E-mail – sqapts@gmail.com or to respective District Quality Assurance Manager.

Sd/-Smt.Karuna Vakati
Commissioner of Health &
Family Welfare & MD-NHM

// Attested //

Chief Programme Officer (NHM)

To
All the Medical Superintendents of the District and Area Hospitals in the State.

Copy to
1) Commissioner – TVVP
2) All DMHOs
3) All DCHCs
4) All DPOs
5) All DPMUs
6) All PHCs – Medical Officers
7) Chief Programme Officer – NHM, Telangana
8) Chief Administrative Officer – NHM, Telangana
9) All DQAMs

Abbreviations

AH	:	Area Hospital
AIDS	:	Acquired Immuno Deficiency Syndrome
ANM	:	Auxiliary Nurse Midwife
ARSH	:	Adolescent Reproductive and Sexual Health
ASHA	:	Accredited Social Health Activist
AWW	:	Anganwadi Workers
AYUSH	:	Ayurveda, Unani, Siddha and Homeopathy
BIS	:	Bureau of Indian Standards
BMW	:	Bio Medical Waste
BPL	:	Below Poverty Line
CDC	:	Concerned Drug Stores
CHC	:	Community Health Centre
CTI	:	Community Mobilization Team
DH	:	District Hospital
DM&HO	:	District Medical and Health Officer
DPM	:	District Program Officer
DWACRA	:	Development of Women and Children in Rural Areas
Dy. DM&HO	:	Deputy District Medical and Health Officer
FP	:	Family Planning
GWD	:	Guinea Worm Disease
HAI	:	Hospital Acquired Infections
HCF	:	Health Care Facility
HDS	:	Hospital Development Society
HIV	:	Human Immuno Deficiency Virus
ICDS	:	Integrated Child Development Services
IDSP	:	Integrated Diseases Surveillance Program
IEC	:	Information, Education and Communication
IMR	:	Infant Mortality Rate
IPHS	:	Indian Public Health Standards
ISM	:	Indian System of Medicine
JSSY	:	Janani Shishu Suraksha Yojana
JSY	:	Janani Suraksha Yojana
LHV	:	Lady Health Visitor
MDG	:	Millennium Development Goals
MIS	:	Management Information System

MLA	:	Member of Legislative Assembly
MLC	:	Member of Legislative Council
MMR	:	Maternal Mortality Ratio
NGO	:	Non-Governmental Organization
NHM	:	National Health Mission
NQAS	:	National Quality Assurance Standards
NRHM	:	National Rural Health Mission
NSV	:	No Scalpel Vasectomy
NTP	:	Neglected Tropical Diseases
OB	:	Observation
OPD	:	Out Patient Department
PC&PNDT	:	Pre-Conception and Pre-Natal Diagnostic Techniques
PHC	:	Primary Health Centre
PHCF	:	Public Health Care Facility
PI	:	Patient Interview
PRI	:	Panchayati Raj Institutions
QoC	:	Quality of Care
RKS	:	Rogi Kalyan Samiti
RMO	:	Regional Medical Officer
RR	:	Recorded Interview
SC	:	Sub Centre
SDH	:	Sub-District Hospital
SHG	:	Self Help Group
SI	:	Staff Interview
SOPS	:	Standard Operating Procedures
TB	:	Tuberculosis
TT	:	Tetanus Toxoid
UNICEF	:	The United Nations Children's Fund
USA	:	United States of America
VHNC	:	Village Health and Nutrition Committee
VHSC	:	Village Health and Sanitation Committee
WASH	:	Water, Sanitation and Hygiene
WHO	:	World Health Organization

Notes:

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