DAKSHATA

Assessment Form 1: Assessment of Facility-based Services

Name of assessor: _____ **Date of assessment:** _____
District: _____ **Block:** _____
Facility name: _____ **Facility Type:** (CHC/SDH/DH)
Name of facility in-charge:_____ **Facility category: (L1/L2/L3)**

Section A: Statistics (*Start date to End Date***) 1st April, 2014 to 31st March, 2015**

Sr. No.	Data Element		Response	Source (LRR, PCTS/HMIS, Referral register)
A1	Total number of deliveries			
A2	Number of vaginal deliveries			
A3	Number of assisted vaginal deliveries (Forceps, Vacuum)			
A4	Number of caesarean deliveries			
A5	Number of Live births			
A6	Number of Intra Uterine deaths (IUD) + Still births in the facility			
A7	Number of newborn deaths (upto 28 days of birth) in the facility	In born		
		Out born		
A8	Number of Maternal deaths in the facility (Conception to 42days after delivery)			
A9	**Complications (Last Quarter)**			
A9.1	Numbers of Mothers with post-partum hemorrhage			
A9.2	Mothers with Sepsis			
A9.3	Mothers with Severe Pre-eclampsia/eclampsia			
A9.4	Mothers with obstructed labor			
A9.5	Newborn with asphyxia			
A9.6	Number of newborn with sepsis			
A9.7	Number of newborn who were premature births			
A9.8	Number of newborn who were Low Birth Weight			

Section B: Available Human Resources

Sr. No.	Health Care Providers involved in delivery care	Sanctioned	Posted
B1	Number of OBGyn specialist (includes specialist or MO with CEmONC/BEmONC)	(including MO)	
B2	Number of Pediatrician		
B3	Number of Anesthetist (includes specialist or MO with LSAS training)		
B4	Number of Senior Resident/JR/PG /Interns (only for TH)		
B5	Number of other Specialists(Who are engage in delivery care)		
B6	Number of Medical Officers (Non-specialists)		
B7	Number of AYUSH		
B8	Number of Staff nurses		
B9	Number of ANMs/LHVs		

Color coded box is not applied for the data element. Please do not fill any data in colored box

Section C: Trained Health Care Providers involved in MNCH

Sr. No.	Human Resource	Total number posted at present	SBA (21days)	BEmONC (10days)	EmONC (16 weeks)	LSAS (18 weeks)	NSSK (2 days)
C1	Obgyns						
C2	Medical Officers (non-specialist)						
C3	AYUSH						
C4	Staff nurses						
C5	ANMs/LHVs						
	Total						

Color coded box is not applied for the data element. Please do not fill any data in colored box

Form-1

Section D: Communication/Referrals/Services/Practices [look at last month (1st day to last day of previous month) records]

Source *of Information: Information needs to be verified and observed where required*

Sr. No.	Data Element	Response/Value				
D1	Total Number of deliveries in Last month (including C-section)					
D2	Total Number of newborn referrals in Last month (Monthly report / Referral Register)					
D3	Total Number of maternal referrals in Last month (Monthly report / Referral Register)					
D4	Average duration of stay (in hours) of mother and child in the hospital after delivery (approximately, as stated by the providers/facility incharge)	< 6	6-12	12-24	24-48	> 48
D5	Whether functional ambulance/108 facility available?	☐Yes ☐No				
D6	Whether alternative referral transportation source identified?	☐Yes ☐No				
D7	Whether Blood bank or functional Blood storage available in the facility?	☐Yes ☐No ☐ NA				
D8	Whether HIV tests are done in the facilities?	☐Yes ☐No				
D9	Family planning services: ***Information needs to be physically verified***					
D9.1	**a)** Family planning counseling provided in facility	☐Yes ☐No				
D9.3	**b)** Whether condoms available?	☐Yes ☐No				
D9.4	**c)** Whether emergency contraceptive pills (ECPs) available?	☐Yes ☐No				
D9.5	**d)** Whether oral contraceptive pills (OCPs) available?	☐Yes ☐No				
D9.6	**e)** Whether IUCD inserted in the facility?	☐Yes ☐No				
D9.7	**e.1)** Facility for PPIUCD for normal delivery	☐Yes ☐No ☐ NA				
D9.8	**e.2)** Facility for intra-caesarean PPIUCD	☐Yes ☐No ☐ NA				
D9.9	**e.3)** Facility for Interval IUCD	☐Yes ☐No				
D9.10	**f)** Whether Female sterilization service available?	☐Yes ☐No ☐ NA				
D9.11	**g)** Whether Male sterilization service available?	☐Yes ☐No ☐ NA				

Form-1

Section E: Data recording/ Database system (look at last month records)

Sr. No.	Data Element	Response
E1	Are drugs stock registers up to date with information columns completed? (Main store/ LR stock register)	☐Yes ☐No
E2	Are labor room registers up to date with information columns completed?	☐Yes ☐No
E3	Do the case sheets have up to date record of the mother's condition, procedures performed, and drugs administered? (to check randomly at least 5 Case sheet)	☐Yes ☐No
E4	Whether Data personnel (data entry operator/assistant) available?	☐Yes ☐No
E5	Whether Computer is available for data entry?	☐Yes ☐No
E6	Whether Internet is available for data entry?	☐Yes ☐No

Facility Contact List

S. No.	Name of Providers	Designation	Contact Number
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Section wise serial no. to be used for remarks, if any

S. No.	Remark