Assessment of Water, Sanitation and Hygiene services & practices at Functional Delivery Points of 8 High Priority Districts in Gujarat

Health and Family Welfare Department
Government of Gujarat

unicef

Assessment of Water, Sanitation and Hygiene services and practices at Functional Delivery Points of 8 High Priority Districts, Gujarat

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2. Medical College Baroda, Vadodara
3. GMERS Medical College, Gotri – Vadodara
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We sincerely hope that this report will be useful in enhancing WASH in health facilities. Your suggestions/queries for improving WASH in health are always welcome.

सत्यमेव जयते

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Commissioner (Health) & Secretary (PH & FW)

No. EA/WASH/Foreword/2015
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Foreword

The State Government is committed to make all public health facilities Water and Sanitation Hygiene (WASH) Compliant. In order to achieve this goal, the State Government conducted a WASH Gap Assessment exercise at all the Functional Delivery Points in eight High Priority Districts of the state, in partnership with UNICEF via Indian Association of Preventive and Social Medicine (IAPSM) - Gujarat Chapter.

For effective implementation of the efforts toward WASH compliant public health facilities, it is pertinent to find gaps in provision of WASH infrastructure, services and practices. Accordingly, a state report of WASH assessment has been prepared linking WASH gaps with strategic options and recommendations. This quantitative cum qualitative report of 118 public health facilities across 8 districts of state, will help state and district officials, facility in charges and end users to make necessary arrangements for WASH compliance of Public Health Care Institutions across the state.

To carry forward it further, it is being considered to strengthen the supportive supervision of these health facilities with the support of UNICEF and IAPSM, envisaging key commitment of making the public health facilities WASH compliant in the State.

I would like to acknowledge and appreciate hard work of the team and recommend the optimal use of the findings of WASH assessment exercise.

(J. P. Gupta)

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Preface

Gujarat presents a development paradox with impressive economic growth but relatively poor health and social development indicators. More than 70 per cent of the State's infant mortality is contributed by neonatal mortality. Maternal mortality also presents a challenge. As India moves towards the Millennium Development Goals (MDGs) and looks ahead to the post-2015 era, progress in reducing maternal and neonatal mortality are important frontiers that need to be addressed.

The Reproductive Maternal Newborn and Child Health + Adolescents (RMNCH+A) strategy, that focuses on the life cycle approach, is the cornerstone of the Government's response to Child Survival and Development. UNICEF, as the State Lead Partner for this Initiative in Gujarat, is committed to support acceleration of efforts to achieve the RMNCH+A goals with focus on eight High Priority Districts.

Evidence has shown that neonatal mortality and morbidity can be significantly reduced by preventive measures, including ensuring the availability of functional Water, Sanitation and Hygiene (WASH) facilities in health centers and the adoption of key WASH practices by mothers and caregivers at home and in the community. The capacity-building of health functionaries and front line workers to bring about this behavior change is equally important.

We are aware that the provision and functionality of appropriate WASH facilities in health centers has been a challenge. To address this, UNICEF, in partnership with the Indian Association of Preventive and Social Medicine – Gujarat Chapter (IAPSM-GC) and the Department of Health & Family Welfare, Government of Gujarat, facilitated the conduct of a WASH Gap Assessment exercise covering 118 Functional Delivery Points (FDPs) of the eight RMNCH+A High Priority Districts.

The objective of the assessment was to assess the extent of provision of WASH services and practices in health centers especially the labour room, post-natal ward and ANC OPDs of the 118 FDPs. The assessment, which was carried out from September to December 2014, documented some good practices and several bottlenecks relating to WASH compliance in delivering RMNCH+A services in health facilities, and came up with specific recommendations to improve this compliance. The teams from the Medical Colleges that carried out the assessment also proposed on-site adjustments/modifications, where feasible.

UNICEF sincerely hopes that the recommendations of the assessment will inform government plans to make health facilities WASH complaint so that they become patient and family-friendly. We are confident that the Department of Health and Family Welfare, Government of Gujarat, which is committed to achieve the goals of the *Mahatma Gandhi Swacchata Mission* (MGSM) will monitor implementation of these recommendations to make Gujarat's health facilities WASH compliant.

Jeroo Master,
Chief, Field Office
UNICEF,Gujarat

Acknowledgement

Provision of appropriate “Water Supply, Sanitation and Hygiene (WASH) services” at government health facilities are keys to improve quality of health care provided by government. It also improves overall image of government health care system in community. Many maternal and neonatal deaths are linked to unhygienic conditions. In this context this project was carried out to assess and to give recommendations for WASH related services and practices at Functional Delivery Points of 8 High Priority Districts of Gujarat (Kutch, Banaskantha, Sabarkantha, Panchmahal, Narmada, Dahod, Dang and Valsad).

At this point we would like to acknowledge with thanks to Mr. P. K. Taneja, Then Principal Secretary, Public Health, Mr. J. P. Gupta, Secretary and Commissioner, Health, Dr. N. B. Dholakia, Additional Director, Family Welfare, Dr. J. L. Meena, State Quality Assurance Medical Officer, Health & Family Welfare Department, Government of Gujarat, for providing administrative support to carry out WASH assessment of Functional Delivery Points of 8 high priority districts.

Thanks are also expressed to Ms. Jeroo Master, Chief of UNICEF, Gujarat office; Mr. Manish Wasuja, WASH specialist; Dr. Narayan Gaonkar, Health specialist and Dr. Kanan Desai, State Consultant –WASH Gap Assessment for advocating this project as well as for providing technical and financial support to this project.

We would like to thank Regional Deputy Directors, Chief District Health Officers and District Quality Assurance Medical Officers of respective districts for providing administrative support at the district level. We are also thankful to Hospital Superintendents, Medical Officers and also other staff of those District Hospitals, Sub-District Hospitals, Community Health Centres, Primary Health Centres and Sub-Centres of the districts which were visited during this project for providing co-operation during field visit.

We are especially thankful to all Head of Departments and team members of Community Medicine Departments of GMERS Medical College Dharpur – Patan, GMERS Medical College Gotri – Vadodara, Medical College Baroda - Vadodara, GMERS Medical College Valsad, GCS Medical College, Ahmedabad and PDU Govt. Medical College, Rajkot for carrying out this project.

Acknowledgement

We would also like to thank Dr. Chandresh Pandya, Associate Professor, Community Medicine Department, GMERS Medical College, Gotri and Dr. Atul Trivedi, Associate Professor, Community Medicine Department, Government Medical College, Bhavnagar for providing technical support to carry out this project. We are also thankful to Dr. Vihang Mazumdar, Professor & Head, Community Medicine Department, Medical College Baroda for reviewing the report. We also extend our thanks to Dr. Nirav Joshi and Dr. Dipesh Zalavadiya, Tutor, Community Medicine Department, PDU Govt. Medical College, Rajkot for preparing state level report of the project.

Dr. K. N. Sonaliya
President
IAPSM - GC

Dr. A. M. Kadri
Secretary
IAPSM - GC

Abbreviations

AD (FW)	Additional Director (Family Welfare)
AMC	Annual Maintenance Contract
ANC	Ante Natal Care
ASHA	Accredited Social Health Activist
BCC	Behaviour Change Communication
BMW	Bio Medical Waste
BMWM	Bio Medical Waste Management
CBWTF	Common Biomedical Waste Treatment Facility
CDHO	Chief District Health Officer
CDMO	Chief District Medical Officer
DQAMO	District Quality Assurance Medical Officer
CHC	Community Health Centre
COH	Commissioner of Health
CTF	Common Treatment Facility
DH	District Hospital
DoHFW	Department of Health and Family Welfare
FDPs	Functional Delivery Points
FHS	Female Health Supervisor
FHW	Female Health Worker
GCS	Gujarat Cancer Society
GDP	Gross Domestic Product
GMERS	Gujarat Medical Education and Research Society
GMSCL	Gujarat Medical Services Corporation Limited
GOI	Government of India
HBNC	Home Base Newborn Care
HOD	Head OF Department
HPD	High Priority District
HR	Human Resource
I/C	In charge
IAPSM - GC	Indian Association of Preventive and Social Medicine - Gujarat Chapter
IEC	Information Education Communication
ILR	Ice Lined Refrigerator
IMEP	Infection Management and Environment Plan
IPC	Inter Personal Communication
IPD	Indoor Patient Department
IYCF	Infant and Young Child Feeding
MBBS	Bachelor of Medicine and Bachelor of Surgery
MO	Medical Officer
MOU	Memorandum OF Understanding
MPHW	Multi Purpose Health worker
NHM	National Health Mission

Abbreviations

NSSK	Navjaat Shishu Suraksha Karyakram
O&M	Operation & Maintenance
OPDs	Out Patient Departments
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PIU	Planning Implementation Unit
POU	Point of Use
PPE	Personal Protective Equipment
RKS	Rogi Kalyan Samiti
RMNCH+A	Reproductive Maternal Neonatal Child Health + Adolescent
RMT	Regional Monitoring Team
RO Plant	Reverse Osmosis Plant
SC	Sub Centre
SDH	Sub District Hospital
SOP	Standard Operating Procedure
SRS	Sample Registration System
THO	Taluka Health Officer
TOR	Term Of Reference
UNICEF	United Nations Children's Fund
VHSC	Village Health and Sanitation Committee
WASH	Water Supply, Sanitation and Hygiene
WASMO	Water And Sanitation Management Organization

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Executive Summary

Background

Unimproved hygiene, inadequate sanitation, and insufficient and unsafe drinking water account for 7% of the total disease burden and 19% of child mortality worldwide. Globally, around 2.4 million deaths (4.2% of all deaths) could be prevented annually if everyone practiced appropriate hygiene and had good, reliable sanitation and drinking water.

Objectives

To assess extent of provision of WASH services, practices and challenges in health centers especially Labour room, Postnatal ward and ANC OPDs of FDPs of all 8 HPDs of Gujarat and to make strategic recommendations to improve WASH compliance

Methodology

As per the FDP list obtained from DoHFW, Govt. of Gujarat, 118 FDPs of all 8 HPDs were assessed including 4 DH, 7 SDH, 52 CHCs, 40 PHCs and 15 SCs. Total 103 postnatal wards, 117 Labor rooms and 103 ANC OPD areas were assessed. WASH gap assessment tool includes assessment of water supply, toilet facilities and excreta disposal system, hospital waste management, funding mechanism for WASH related services, identification of key enablers and barriers, area specific assessment of Postnatal ward, Labour room and OPD area. The tool includes personal observations, interview with in-charge, verification of vouchers, registers and request letter for corrective action and photos of good and bad practices.

Observations

Indicator	N (%)
No. of facilities where formal responsibility was assigned for monitoring of	
1) Water facility	1) 90 (76.3%)
2) Toilet facility	2) 90 (76.3%)
3) BMW Management	3) 98 (83.1%)
4) Post natal ward	4) 86 (83.5%)*
5) Labour room	5) 97 (82.9%)
6) ANC OPD	6) 86 (83.5%)*
Improved water supply available	115 (97.5%)

Adequately covered water storage tank	83 (73.8%)
Regular maintenance of water storage tank	55 (50.5%)
Regular Water Testing performed	23 (19.5%)
Functional treatment point available at Point of Use	61 (59.2%)*
Regular water purifier maintenance	23 (22.3%)*
Regular connectivity by CBWTF	102 (99.0%)*
Availability of Container and bags for BMW segregation	75 (72.8%)*
Availability of storage facility for BMW	31 (30.1%)*
Availability of PPE	72 (69.9%)*
PPE used while handling BMW	52 (50.5%)*
Functional toilet facility for 1) OPD room 2) Labour room 3) Postnatal ward	 1) 66 (64.1%)* 2) 60 (51.3%) 3) 52 (50.5%)*
Dustbin for Disposal of Sanitary pads	38 (36.9%)*
Satisfactory cleanliness of toilets 1) OPD room 2) Labour room 3) Postnatal ward	 1) 53 (51.5%)* 2) 44 (37.6%)* 3) 34 (33.0%)*
Satisfactory general cleanliness 1) OPD room 2) Labour room 3) Postnatal ward	 1) 98 (95.1%)* 2) 103 (88.0%) 3) 85 (82.5%)*
Schedule cleaning/mopping available 1) OPD room 2) Labour room 3) Postnatal ward	1) 39 (37.9%)* 2) 45 (38.5%) 3) 42 (40.8%)*

*= Subcenters (SCs) are not included

- The key enablers for WASH related services were; dedication towards work, sense of ownership, supervision, staff training, staff support

- The key hurdles were; other priorities, inadequate/irregular funding, lack of adequate manpower, belief of non importance and lack of IEC materials for WASH related activities

Conclusion

- Improved water supply was available at most of the health centres while regular maintenance of water purifier and water tank was an issue
- Lack of formal supervision system for the WASH is observed
- Insufficient number of bags and bins for BMW segregation and disposal due to lack of clarity about the local purchasing power.
- Good numbers of health centres were having toilets for labour room and ANC OPD, while maintenance of toilet in functional status was not proper
- Most of the individual areas were visibly clean while schedule of cleaning was not being practiced.

Recommendations

- Assigning formal written responsibility to a fixed person for regular supervision and monitoring
- Daily one round of premises by Institute head and vvisiting officers should also included WASH related issue in supervisory visits.
- Periodic training about importance of WASH and BMW management to staff of the centre including class VI, Sweeper, ward boys etc.
- Encouraging using the available funds (e.g. flexi funds, RKS funds, Misc.) for local purchase and small repair andmaintenance work.
- Establishing effective coordination between Health team and PIU team at district level.
- IEC materials for hand washing, use of toilets, waste disposal etc. targeting patients, and relatives needs to be prepared and displayed.

Background

Background

Global access to safe water, adequate sanitation, and proper hygiene education can reduce illness and death from disease leading to improved health, poverty reduction, and socio-economic development.

Unimproved hygiene, inadequate sanitation, and insufficient and unsafe drinking water account for about 7% of the total disease burden and 19% of child mortality worldwide. Globally, around 2.4 million deaths (4.2% of all deaths) could be prevented annually if everyone practiced appropriate hygiene and had good, reliable sanitation and drinking water.[1]

Globally 8% of maternal deaths and in developing countries estimated 10-15% maternal deaths are due to infections that can be directly linked to unhygienic conditions during labour and birth, at home or in facilities, and to poor hygiene practices in the six weeks after birth.[2][3][4]

Poor hygiene during and after umbilical cord cutting, such as unclean hands or use of dirty cloth, can produce significantly more cord site infections in newborns.[5]

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4. Simavi. (2012). Getting It Right: Imporving maternal health through water sanitation & hygiene.
5. WHO.int. (n.d.). Retrieved March 18, 2015, from http://www.who.int/pmnch/knowledge/publications/summaries/ks30.pdf

Background

Approximately half a million children die every year of diarrheal disease caused by unsafe water and poor sanitation and hygiene practices. Fifty percent of global malnutrition is due to waterborne diseases such as diarrhoea and intestinal worms and one quarter of stunting can be attributed to five or more episodes of diarrhoea before two years of age.[6] [7]

As per estimates, inadequate sanitation cost India almost $54 billion or 6.4% of the country's GDP in 2006. Over 70% of this economic impact or about $38.5 billion was health-related, with diarrhoea followed by acute lower respiratory infections accounting for 12% of the health-related impacts.[8]

Infant mortality and morbidity can be significantly reduced by preventive measures, including ensuring availability of WASH facilities in health centres and adoption of key WASH practices by mothers at home and capacity building of health functionaries and front line workers.

Provision and functionality of appropriate WASH facilities in health centres has been a challenge. Anecdotal evidence indicates lack of user friendliness and functionality of WASH facilities in health centres. These are affecting the utilization of services as well as leading to infection to the mother and newborns, who are utilizing the services.

6. Pruss-Ustun, A., Bos, R., Gore, F., & Bartram, J. (2008). *Safer water, better health*
7. Walker, C., Rudan, I., Liu, L., & Al, E. (2013). Global burden of childhood pneumonia and diarrhoea. *The Lancet*, *381*, 1405–1416.
8. Kumar, G., Kar, S., & Jain, A. (2011). Health and environmental sanitation in India: Issues for prioritizing control strategies. *Indian J Occup Environ Med*, *15*(3), 93–96.

WASH Impact on RMNCH+A [5]

Continuum of Care	WASH Interventions	RMNCH+A Impact
Adolescents and Pre-Pregnancy	• Menstrual hygiene management • Decreased distance to sanitation and safe water source	• Improved self-esteem, better school attendance and potential decrease in infections
Pregnancy	• Improved access and decreased distance to water, sanitation and safe water source	• Improved weight gain during pregnancy, due to fewer worm infections and decreased physical labour
Child Birth	• Implementation of "seven cleans" 1. Clean hands 2. Clean water 3. Clean delivery surface 4. Clean cord cutting 5. Clean cord tying 6. Clean cord care 7. Clean towel	• Decrease in maternal morbidity and mortality from puerperal sepsis
Post Natal		• Decrease in neonatal morbidity and mortality, due to tetanus infections and sepsis
Infancy and Childhood	• Improved access to safe water, sanitation and hygiene and decreased distance to safe water sources • Improved access to soap and consistency of hand washing with soap • Improved infant excreta disposal and reduction of open defecation	• Decrease in diarrhoeal disease, pneumonia and child mortality; reduction in stunting and improved weight gain and growth • Reduction in skin infections, childhood pneumonia and diarrhoea • Reduction in maternal and child trachoma and diarrhoea

5. WHO.int. (n.d.). Retrieved March 18, 2015, from http://www.who.int/pmnch/knowledge/publications/summaries/ks30.pdf

State Profile

Gujarat is situated on the west coast of India. It is bounded on the west by the Arabian Sea, on the north-west by Pakistan, on the north by Rajasthan, on the east by Madhya Pradesh and on the south and south-east by Maharashtra. The state of Gujarat occupies the northern extremity of the western sea-board of India. It has the longest coast line 1290 km among Indian states.

Gujarat Population Census Data shows that it has Total Population of 6.03 Crore which is approximately 4.99% of total Indian Population with decadal growth rate of 19.17 (Census 2011). Total Literacy rate is 79.31% compared to Nation's Total literacy rate of 74.04%. Infant Mortality Rate of Gujarat is 36 (SRS September 2014) and Maternal Mortality Ratio is 112 (SRS 2011-13) compared to 40 and 167 for India Respectively. Gujarat has 7274 Sub centres, 1158 PHCs and 318 CHCs (Source: RHS Bulletin, March 2012, M/O Health & F.W., GOI)

Objectives

Objectives

- To assess extent of provision of WASH services and practices in health centres especially Labour room, Postnatal ward and ANC OPDs of FDPs in High Priority Districts of Gujarat

- To identify the WASH related challenges and bottlenecks at health centres

- Providing on-site technical support to address issues that can be solved at local level

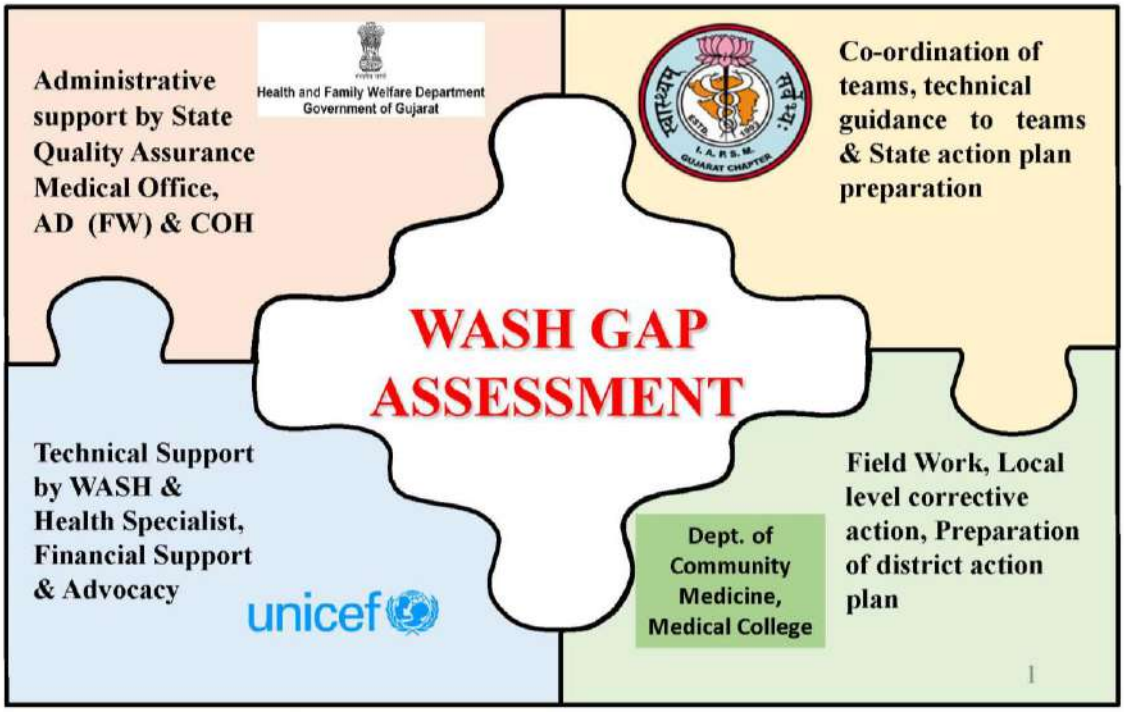
- To make strategic recommendations and preparing State Specific Action Plan for improving WASH compliance in health centres

Methodology

Methodology

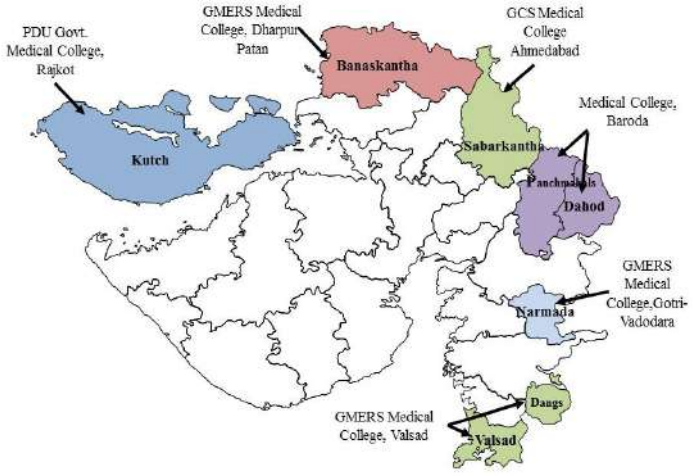
The assessment was conducted in partnership with DoHFW, Govt. of Gujarat; UNICEF, IAPSM-GC and Six Medical colleges.

Partnerships for the WASH Gap Assessment



The assessment was conducted in all the FDPs of 8 High Priority Districts of Gujarat identified under RMNCH+A**.** FDP list as on March, 2014 for all identified districts was obtained from DoHFW, Govt. of Gujarat, on request by IAPSM-GC. District was assigned to specific medical college depending on the college's RMT areas.

Mapping of High Priority Districts of Gujarat



District wise distribution of the FDPs

District	Medical College	DH	SDH	CHC	PHC	SC	Total
Panchmahal	Medical College Baroda	--	02	06	06	--	**14**
Dahod	Medical College Baroda	01	01	10	08	01	**21**
Banaskantha	GMERS Medical College, Dharpur-Patan	--	01	09	07	04	**21**
Valsad	GMERS Medical College, Valsad	01	01	04	01	--	**07**
Dang	GMERS Medical College, Valsad	--	NA	01	03	--	**04**
Sabarkantha	GCS Medical College, Ahmedabad	01	01	10	05	--	**17**
Narmada	GMERS Medical College, Gotri-Vadodara	--	NA	04	02	--	**06**
Kutch	PDU Govt. Medical College, Rajkot	01	01	08	08	10	**28**
Total		**04**	**07**	**52**	**40**	**15**	**118**

Letter from Additional Director (Family Welfare) was sent to concerned district CDHO/CDMO and Medical College Dean to facilitate for the WASH Gap Assessment.

Letter was also sent from Medical College to concerned district CDHO/CDMO with schedule of visits for WASH Assessment for effective co-ordination.

Each centre was visited by team of faculty and/or residents as per the schedule for detail observations and information collections as per the standard WASH Gap Assessment Tool. Uniformity of data collection was maintained by capacity building of assessor's at the state level training and provision of technical guide note for the tool from State.

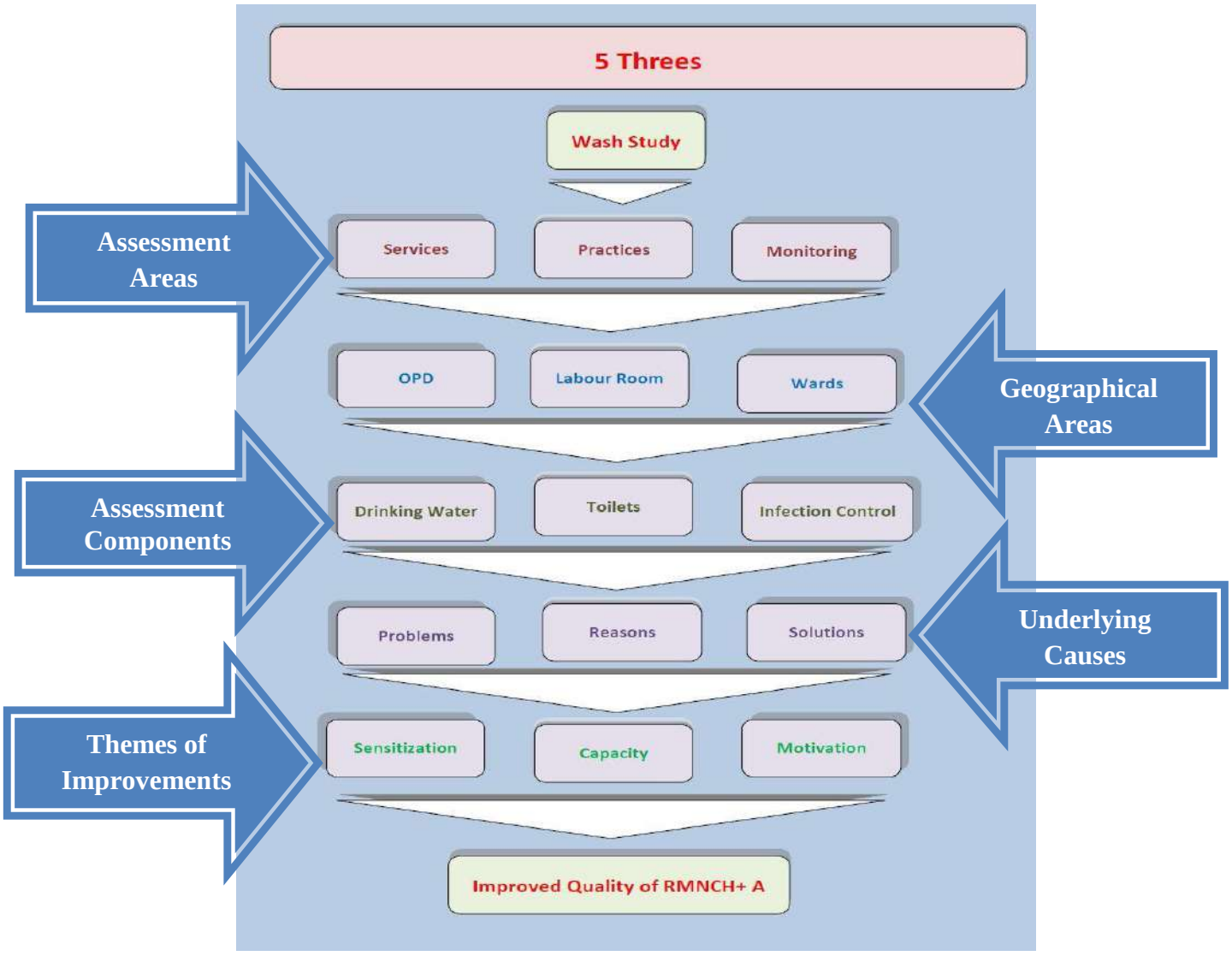
WASH Gap Assessment Tool

SECTION I: HARDWARE COMPONENTS OF WASH	
WATER SUPPLY	**MODE OF ASSESSMENT**
• Water Source, storage and distribution • Water Quantity and Quality testing • Functional Treatment Unit at POU • Monitoring Mechanism/corrective actions	• Personal Observations • Interview with I/C • Vouchers of Payment for Maintenance • Register Available for Maintenance, if any • Photos of good and bad practices
TOILET FACILITIES, EXCRETA DISPOSAL and O&M	
• Excreta Collection / Storage/disposal system • Toilet cleaning and maintenance • Monitoring mechanism/corrective actions	• Personal Observations • Interview with I/C • Vouchers of Payment for Maintenance • Register Available for Maintenance, if any • Checklist for Cleaning, if any • Request Letter to PIU • Peti Supply/Indent Register for Cleaning materials • Photos of good and bad practices
HOSPITAL WASTE MANAGEMENT	
• Waste Collection, Storage, Treatment /Disposal • Supply of consumables • Monitoring Mechanism /corrective actions	• Personal Observations • Interview with I/C • BMW Register • Stock of BMW bags and containers • Photos of good and bad practices
LOCATION BASED WASH STATUS (MAMTA CLINIC, LABOUR ROOM, POSTNATAL WARD)	
• Functional Drinking water Point Facility • Toilet Facility and cleaning • Hand washing Facility • Hospital waste Management • Monitoring Mechanism /Corrective Actions	• Personal Observations • Interview with I/C • Register Available for Maintenance, if any • Checklist for Cleaning, if any • Complaint Letter sent to Head of Institute • Peti Supply/Indent Register for Cleaning materials • Photos of good and bad practices
SECTION II: CLEANING FUNDS	
• Cleaning Fund and Expenditure on WASH	• Vouchers of Payment for Maintenance/Consumables

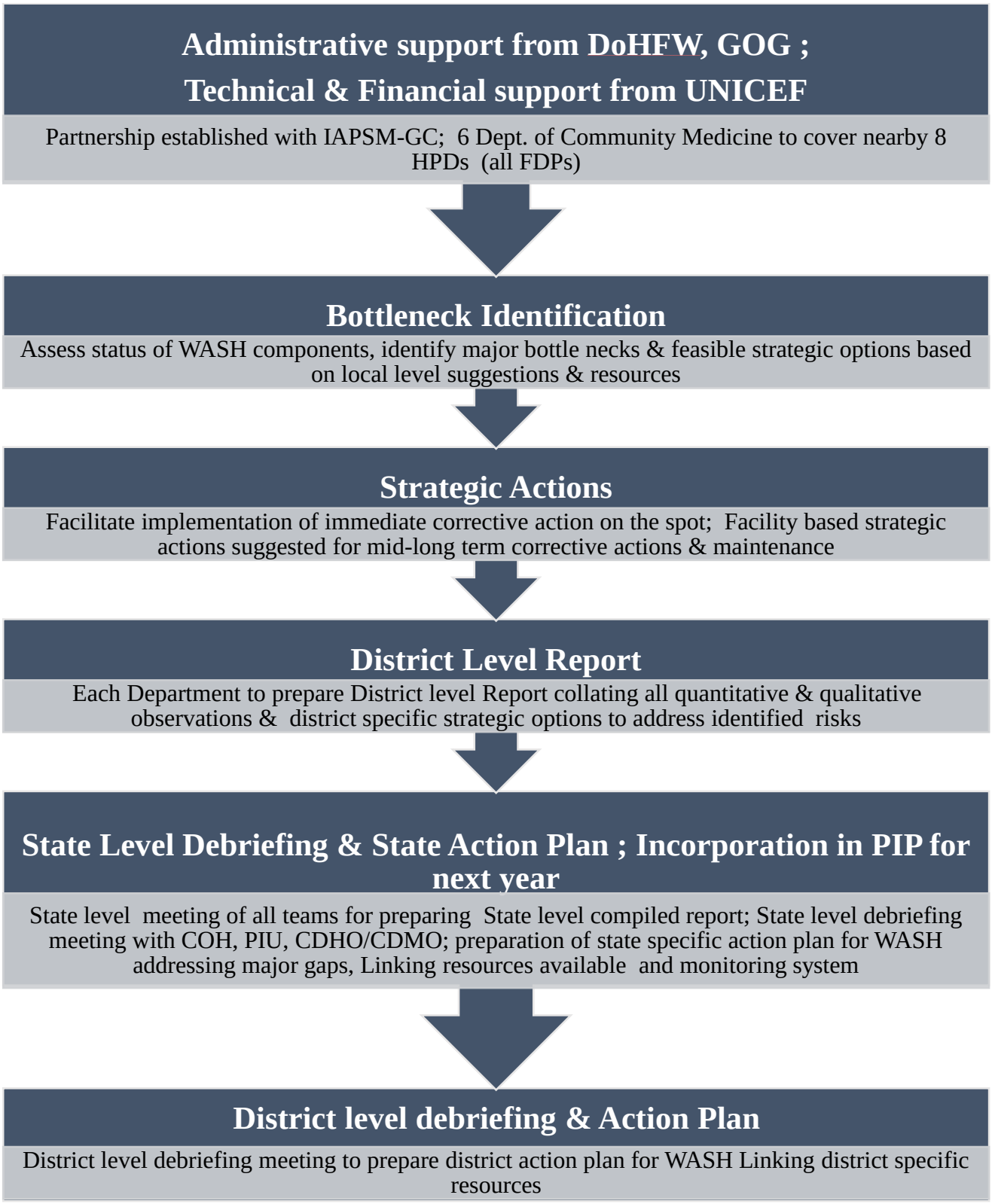
• Outsourcing for Housekeeping and HR	• Kharch Patrak of NHM Fund of Last year
SECTION III: SOFTWARE COMPONENTS	
• Clinical Hand washing Practices • Enablers and Barriers for WASH compliance • BCC and Monitoring for WASH • Suggestion from fields	• Personal Observations • Interview with I/C

Data was entered in pre-designed Microsoft Access 2007 Sheet (Annexure). Data cleaning was done followed by quantitative analysis using Microsoft Excel, 2007. Qualitative information was included in form observation of good and bad practices, photographs, identification of major gaps linked to strategic options keeping in mind availability of resources.

The assessment was conducts on the basis of following five threes



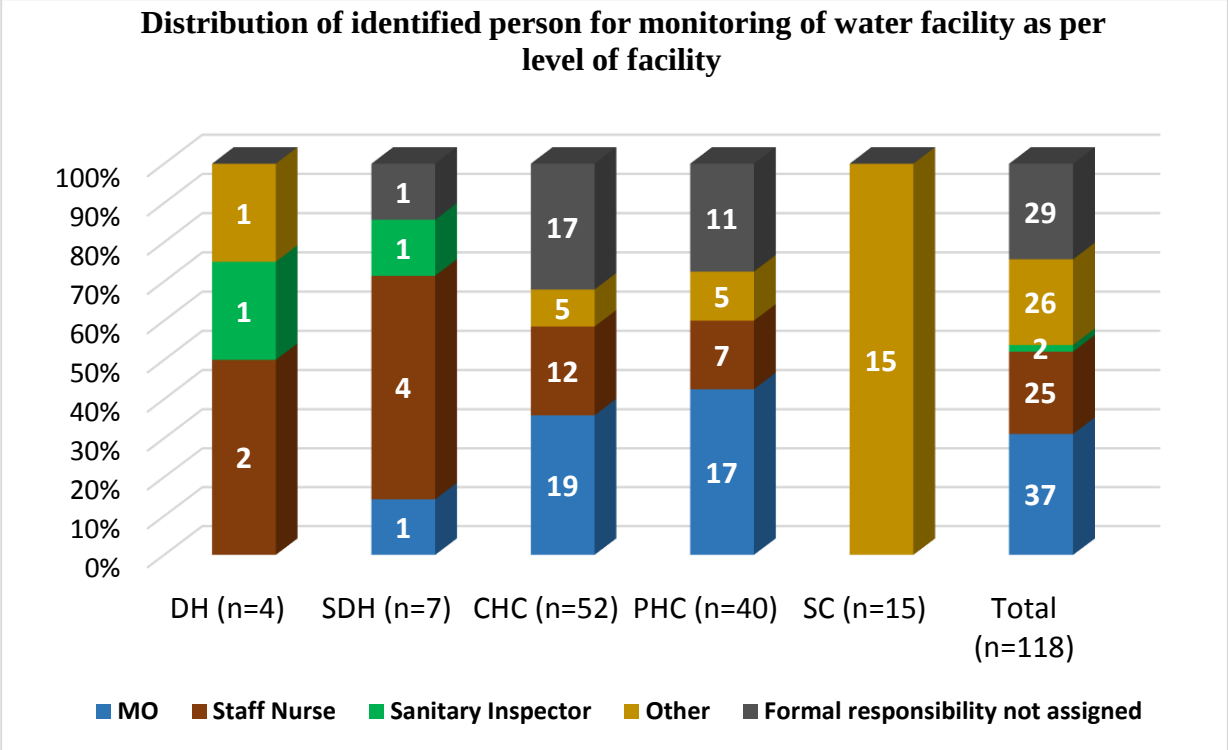
Flow Chart for WASH Gap Assessment



Observations

Monitoring mechanism

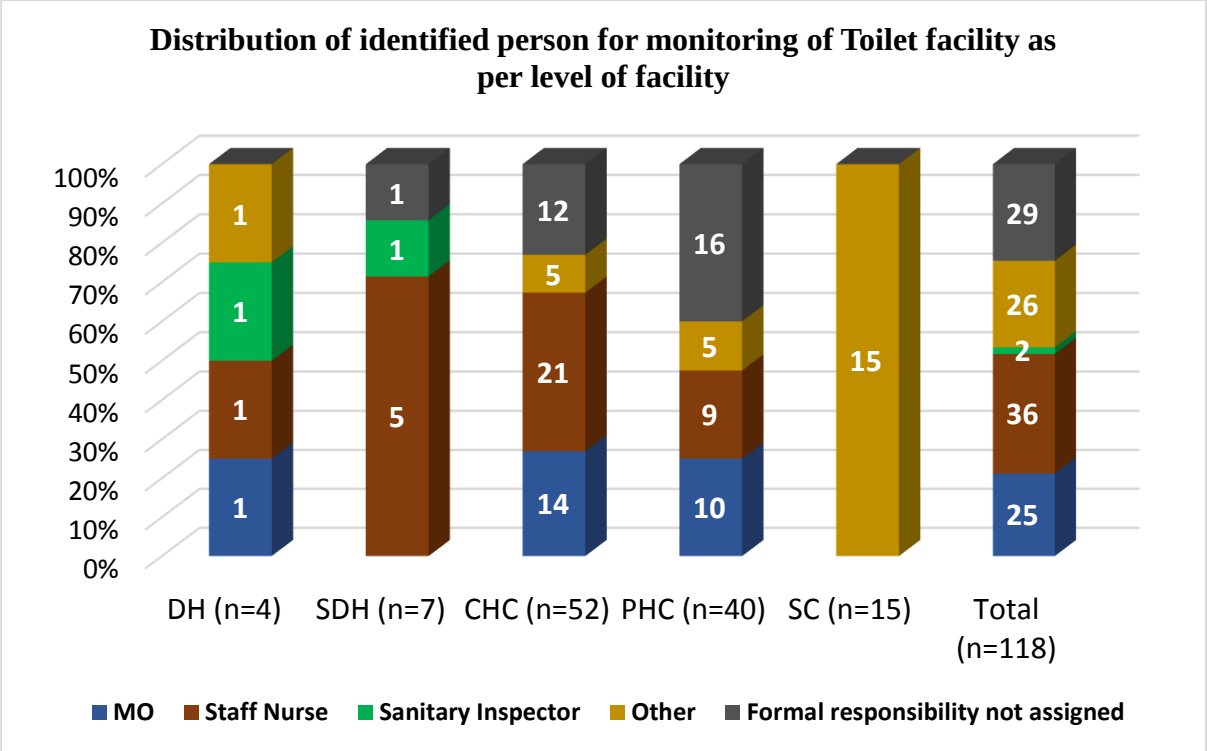
Figure 1: Monitoring Mechanism for water supply (n = 118)



As shown in above figure, MO was monitoring water facility in more than half of the PHCs and CHCs where there was any monitoring system. Staff nurse were monitoring the same in about two-third of the SDHs where monitoring mechanism was there. Lack of monitoring mechanism was identified in 14.3%, 32.7% and 27.5% of SDHs, CHCs and PHCs respectively. All DHs were having one or other person to monitor water facility. Among SCs, water facility was being monitored in 86.7% by ANMs.

Out of all 118 health centres, water facilities was being monitored in 31.4%, 21.9%, 1.7% and 20.3% by MO, Staff nurse, SI and Others like ANM, Class III/IV worker, chowkidar etc. respectively. 26.3% health centres were lacking in such monitoring mechanism.

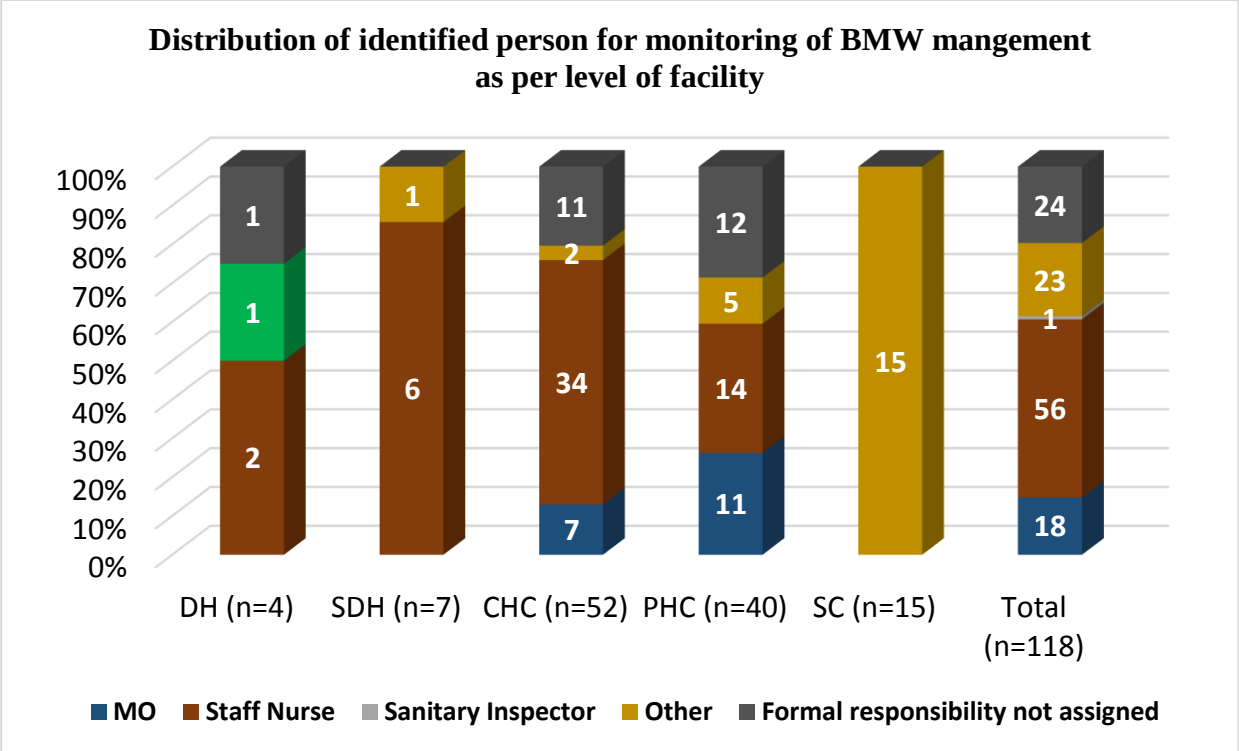
Figure 2: Monitoring Mechanism for Toilet facility (n = 118)



As shown in above figure, MO was monitoring toilet facility in 25% and 26.9% of PHCs and CHCs respectively. Staff nurse were monitoring the same in 71.4% of the SDHs. Lack of monitoring mechanism was identified in 14.3%, 23.1% and 40.0% of SDHs, CHCs and PHCs respectively. All DHs were having one or other person to monitor toilet facility. Among SCs, toilet facility was being monitored in 73.3% by ANMs.

Out of all 118 health centres, toilet facilities was being monitored in 21.2%, 30.5%, 1.7% and 18.6% by MO, Staff nurse, SI and Others like ANM, Class III/IV worker, chowkidar etc. respectively. 28.0% health centres were lacking in such monitoring mechanism.

Figure 3: Monitoring Mechanism for BMW Management (n = 118)



As shown in above figure, MO was monitoring BMW Management in 27.5% and 13.5% of PHCs and CHCs respectively. Staff nurse were monitoring the same in 85.7% of the SDHs. Lack of monitoring mechanism was identified in 14.3%, 17.3% and 30.0% of SDHs, CHCs and PHCs respectively. Among SCs, toilet facility was being monitored in 73.3% by ANMs.

Out of all 118 health centres, toilet facilities was being monitored in 15.3%, 48.3%, 0.9% and 16.1% by MO, Staff nurse, SI and Others like ANM, Class III/IV worker, chowkidar etc. respectively.

Observations

Table 1: Monitoring mechanism for Post natal Ward

Identified Person	Post Natal Ward				
	DH (%)	SDH (%)	CHC (%)	PHC (%)	Total
MO	0 (0.0)	0 (0.0)	7 (13.5)	5 (12.5)	12 (11.7)
Staff Nurse	4 (100.0)	7 (100.0)	33 (63.5)	21 (52.5)	65 (63.1)
Other	0 (0.0)	0 (0.0)	3 (5.8)	6 (52.5)	9 (8.7)
Formal responsibility not assigned	0 (0.0)	0 (0.0)	9 (17.3)	8 (20.0)	17 (16.5)
Total	4 (100.0)	7 (100.0)	52 (100.0)	40 (100.0)	103 (100.0)

As shown in above table, MO were monitoring Post natal ward in 12.5% and 13.5% of PHCs and CHCs respectively. Staff nurse were monitoring the same in all of the SDHs. Lack of monitoring mechanism was identified in 17.3% and 20.0% of CHCs and PHCs respectively.

Out of all 103 health centres (Excluding sub centres), Post natal ward was being monitored in 11.7%, 63.1% and 8.7% by MO, Staff nurse and Others like ANM, Class III/IV worker, chowkidar etc. respectively. 16.5% health centres were lacking in such monitoring mechanism.

Table 2: Monitoring mechanism for Labour room (n=117)

Identified Person	Labour room					
	DH (%)	SDH (%)	CHC (%)	PHC (%)	SC (%)	Total (%)
MO	0 (0.0)	0 (0.0)	9 (17.3)	7 (17.5)	0 (0.0)	15 (12.8)
Staff Nurse	4 (100.0)	5 (71.4)	32 (61.5)	23 (57.5)	0 (0.0)	64 (54.7)
Other	0 (0.0)	0 (0.0)	3 (5.8)	3 (7.5)	12 (80.0)	18 (15.4)
Formal responsibility not assigned	0 (0.0)	2 (28.6)	8 (15.4)	7 (17.5)	3 (20.0)	20 (17.1)
Total	4 (100.0)	7 (100.0)	52 (100.0)	40 (100.0)	15 (100.0)	117 (100.0)

As shown in above table, MO was monitoring Labour room in 17.5% and 17.3% of PHCs and CHCs respectively. Staff nurse were monitoring the same in 71.4% of the SDHs. Lack of monitoring mechanism was identified in 28.6%, 15.4% and 17.5% of SDHs, CHCs and PHCs respectively.

Out of all 117 health centres, Labour room was being monitored in 12.8%, 54.7%, 0.9% and 15.4% by MO, Staff nurse and others like ANM, Class III/IV worker, chowkidar etc. respectively. 17.1% health centres were lacking in such monitoring mechanism.

Table 3: Monitoring mechanism for OPD (n=103)

Identified Person	OPD				
	DH (%)	SDH (%)	CHC (%)	PHC (%)	Total (%)
MO	0 (0.0)	0 (0.0)	24 (46.2)	21 (52.5)	45 (43.7)
Staff Nurse	3 (75.0)	5 (71.4)	15 (28.8)	6 (15.0)	29 (28.2)
Other	0 (0.0)	2 (28.6)	5 (9.6)	5 (12.5)	12 (11.7)
Formal responsibility not assigned	1 (25.0)	0 (0.0)	8 (15.4)	8 (20.0)	17 (16.5)
Total	4 (100.0)	7 (100.0)	52 (100.0)	40 (100.0)	103 (100.0)

As shown in above table, MO was monitoring OPD in 52.5% and 46.2% of PHCs and CHCs respectively. Staff nurse were monitoring the same in 71.4% of the SDHs. Lack of monitoring mechanism was identified in 15.4% and 20.0% of CHCs and PHCs respectively.

Out of all 103 health centres (Excluding sub centres), OPD was being monitored in 43.7%, 28.2% and 11.7% by MO, Staff nurse and Others like ANM, Class III/IV worker, chowkidar etc. respectively. 16.5% health centres were lacking in such monitoring mechanism. Thus here MO was more involved in monitoring of the area as the area is more related to functioning of MO.

Table 4: Common current practices in case of non-assignment of responsibility for monitoring

1	Staff on duty look after it
2	FHS do it
3	Superintendent do it
4	As per their cleaning area, cleaning workers divided their duty on rotation basis
5	Regular cleaning done but they had not identified person for monitoring
6	Not in anybody's priority
7	Pharmacist looks after it
8	No Fixed identified person

Water Supply

Table 5: Source of Water Supply (n=118)

Source of Water Supply	No. of Facilities	Percentage of Facilities
Piped (Panchayat/Palika)	57	48.3
Bore Hole	59	50.0
Protected Well	3	2.5
Tanker Truck	7	5.9
Others	6	5.1
Improved Water Supply not Available	3	2.5

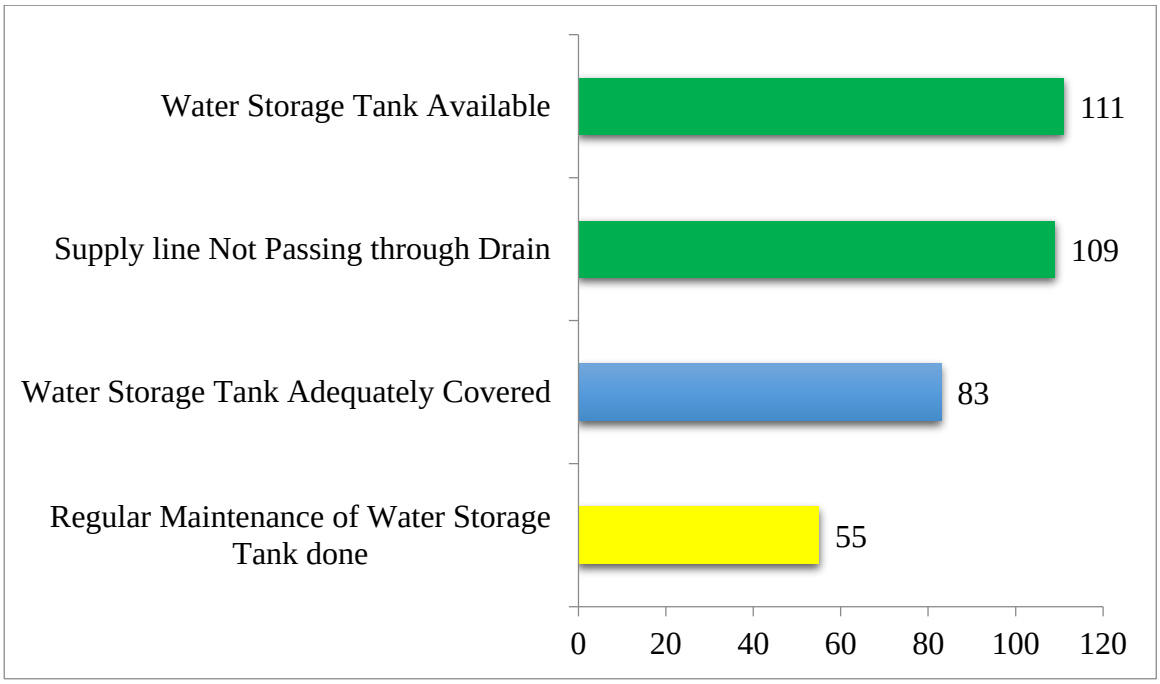
Fifty percent facilities had bore hole. 57 (48.3%) facilities were equipped with piped water supply either from palika or panchayat. Although 7 (5.9%) facilities had to depend on tanker truck for water. 3 (2.5%) facilities had no source of improved water supply.

Table 6: Quantity of Water Supply (n=118)

Quantity of Water Supply	No. of Facilities	Percentage of Facilities
Sufficient Water Supply Available	96	81.4
Insufficient due to Less Quantity/Irregular/Seasonal	16	13.6
Insufficient due to Low Pressure	5	04.2
Insufficient due to Other Reasons	3	02.5

Sufficient water supply was available at 96 (81.4%) facilities. The common reasons for insufficient water supply were less quantity, irregular supply or low pressure.

Figure 4: Condition of water supply line and water storage tank (n = 118)



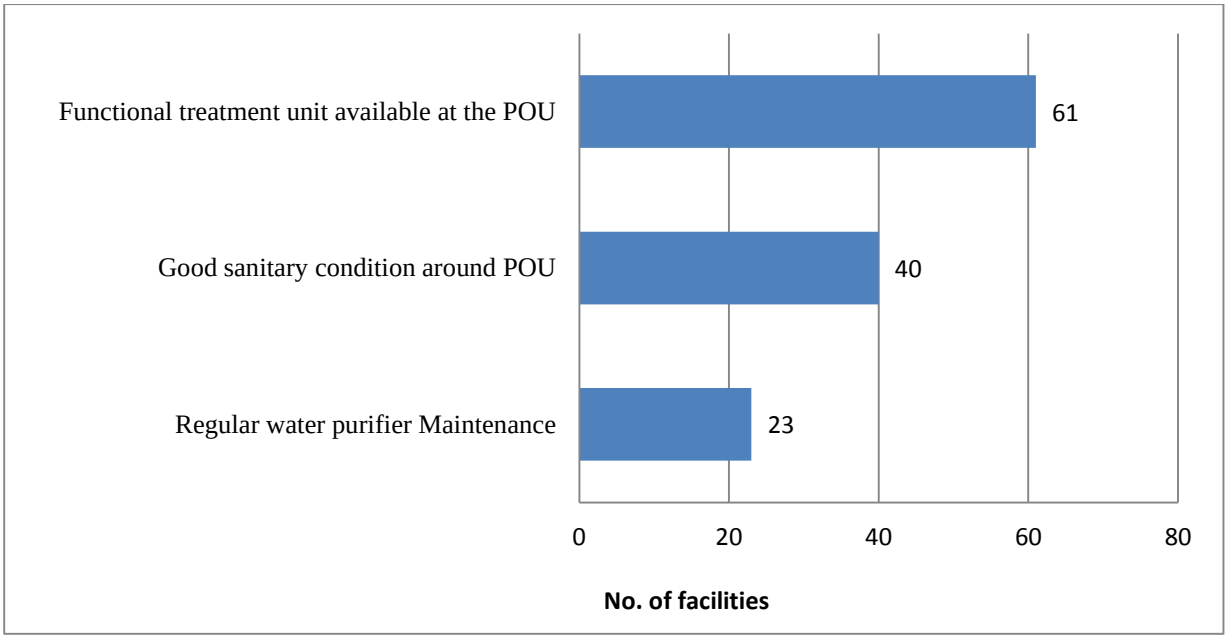
Supply line of 109 (92.4%) facilities were not passing through drain. 111 (94.1%) facilities had water storage tank, but adequate covering was available in 83 (70.3%) facilities and regular maintenance of water storage tank performed only at 55 (46.6%) facilities.

Table 7: Bacteriological Testing for Water (n=118)

Bacteriological Testing for Water	No. of Facilities	Percentage of Facilities
Regular Water Testing performed	23	19.5
Not performed due to non availability of kit	20	17.0
Not performed due to lack of awareness	56	47.5
Not performed due to lack of instructions for the same from District/State	5	4.1
Not performed due to other reasons	14	18.9

As per the quality manuals of Gujarat, health facility should regularly test the quality of water (bacterial analysis with H_2S strip. Regular testing of water was performed at 23 (19.5%) facilities. Most common reason for not testing was lack of awareness of such testing (47.5%).

Figure 5: Drinking Water Facility (n = 103)*



*= SCs are not included as they do not have water purifiers

Functional treatment unit was available at 61 (59.2%) facilities. Regular maintenance of water purifier was done at only 23 (22.3%) facilities.

Observations

Table 8: Common issues in water supply

Common issues for unavailability of improved water supply	
1	Devoid of improved water supply as there wasn't any panchayat water supply and there was unavailability of bore hole water supply
Common reasons for insufficient water supply	
1.	Low pressure of water supply
2.	Insufficient due to less quantity in summer season
3.	Electricity connection not provided even if presence of bore well at some facilities
4.	Irregular supply from the Panchayat
5.	Repeated non-functional water pumps requiring maintenance
Common reasons for irregular/no water testing	
1.	Instruction for such testing from higher authority was not given
2.	Testing kit not available at facility
3.	Unaware about how to do the testing
4.	Lack of responsible person for regular supervision
5.	No requirement felt as water filtration unit is available
6.	They were not aware of importance of regular water testing
Common reasons of non-maintenance/non-availability of water purifier	
1.	Breakdown due to issues related to irregular maintenance
2.	Grant for purchase of water purifier was not available/ not sufficient
3.	Lack of responsible person for regular supervision
4.	Water purifier company is not responding despite of many reminders.
5.	Insufficient fund for maintenance of water purifier System
Other observations about general water supply	
1.	Inadequate water storage due to seasonal water shortage
2.	Lack of information regarding clear guide line for water storage, tank cleaning, bacteriological testing and water purifier maintenance
3.	Lack of proper record keeping for cleaning and maintenance of water storage tank and water purifier system
4.	CHC, PHC and SC building are planned in such a way that there are no staircase to reach the water storage tank for cleaning and maintenance
5.	Make available Separate water point for utensil cleaning

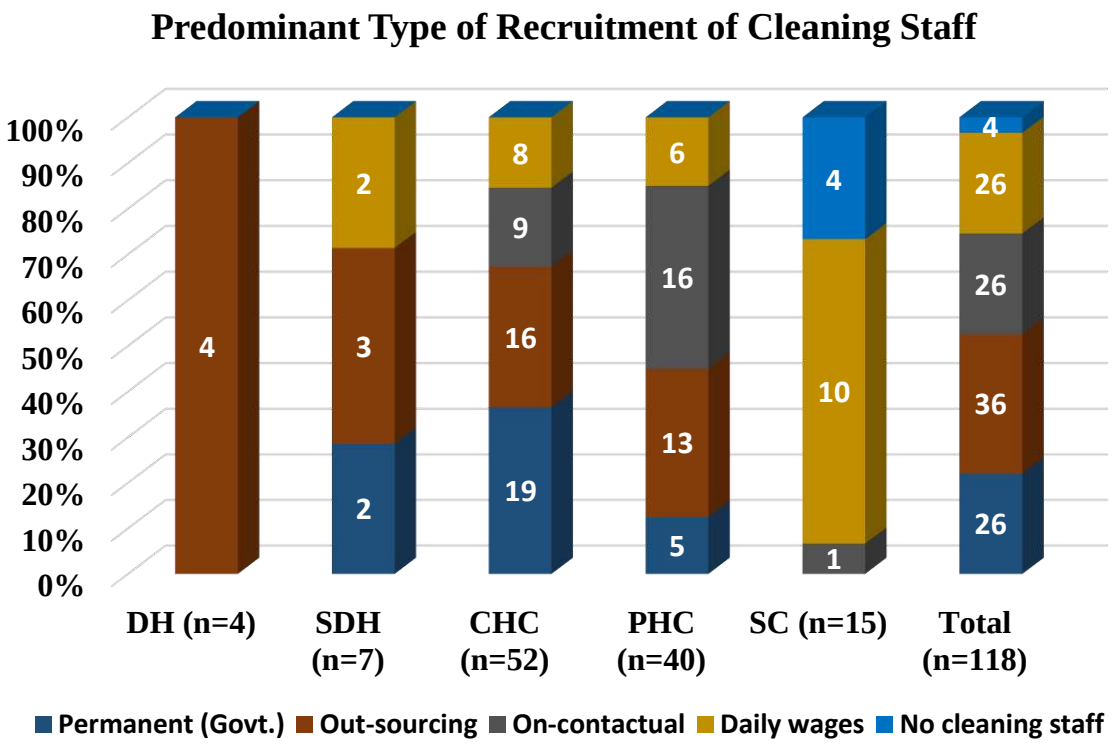
Toilet Facilities, Excreta Disposal, and O&M

Table 9: Cleaning and Maintenance Staff (n=118)

Type of Recruitment	No. of Facilities	Percentage of Facilities
No Cleaning staff	6	5.1
Permanent (Govt.)	11	9.3
Out sourcing	21	17.8
Daily wages	19	16.1
On contractual	22	18.6
Permanent (Govt.) and Out sourcing	20	17.0
Out sourcing and daily wages	4	3.4
Permanent and Contractual	6	5.1
Contractual and Daily wages	5	4.2
Out sourcing and contractual	1	0.9
Permanent (Govt.), Out sourcing and Contractual	1	0.9
Permanent (Govt.), Out sourcing and Daily wages	2	1.7

Majority of the facilities had cleaning and maintenance staff (94.9%).

Figure 6: Predominant Method of Recruitment of cleaning staff (n=118)



All DH were having Out-sourced cleaning staff as predominant method of recruitment. One of the PHC and CHC were not having any cleaning staff. Out of total 118 centres, 20.3%, 30.5%, 21.2% and 21.2% were having Permanent, out sourced, Contractual and Daily waged cleaning worker as predominant cleaning staff.

Figure 7: Source of fund for Cleaning materials (n=118)

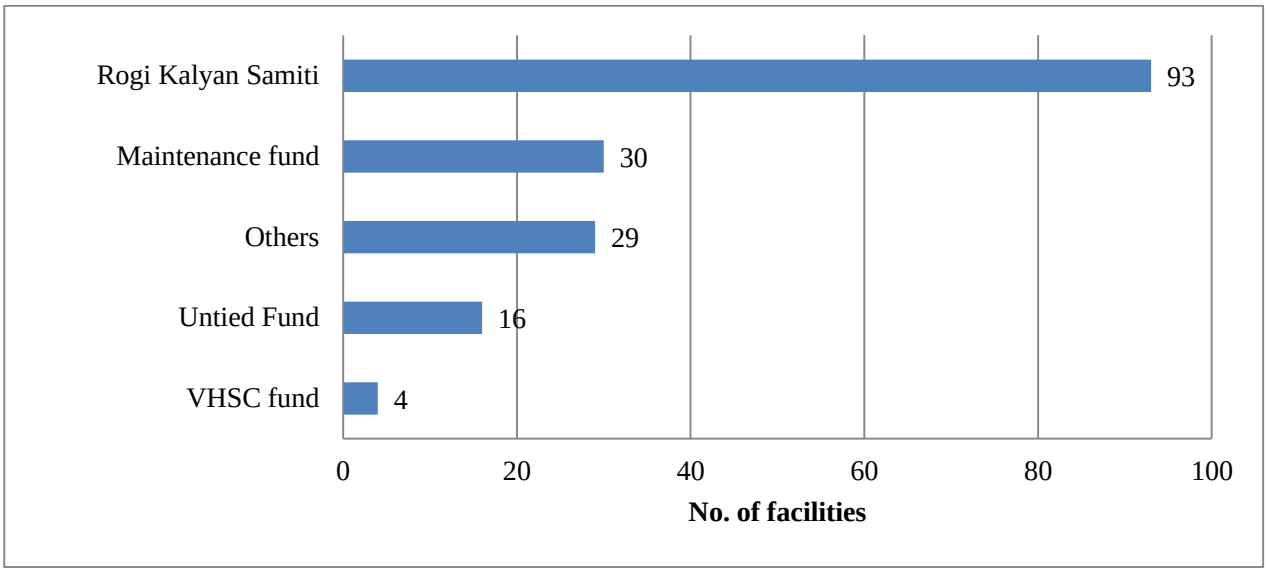
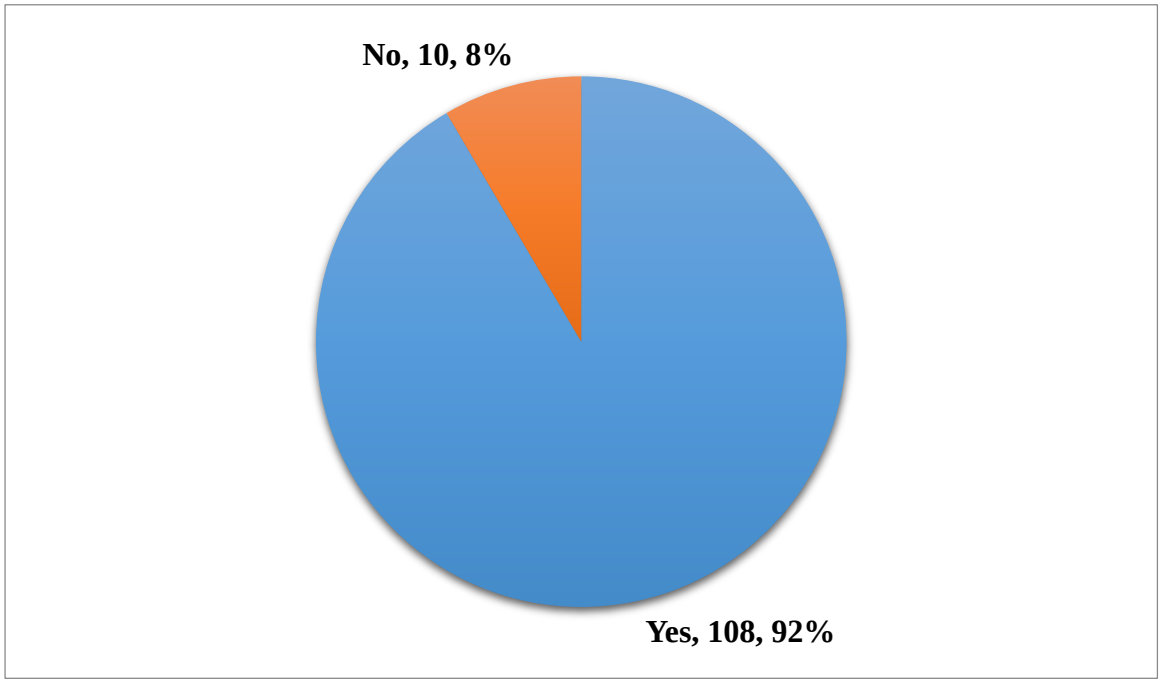


Figure 8: Cleaning materials like buckets, mop, brush, detergent availability (n=118)



Cleaning materials like buckets, mop, brush and detergent were available at 108 (91.5%) facilities.

Table 10: Excreta disposal system (n=97)

Excreta Disposal System	No. of Facilities	Percentage of Facilities
Pit Latrine	20	20.6
Flush Toilet	21	21.6
Pour Flush Toilet	56	57.7
(To) Septic Tank	76	78.4
(To) Closed drain	20	20.6
(To) Open drain	1	1.0

Almost all the facilities had safe excreta disposal system. Types of latrine available in the facilities were pour flush toilet 56 (57.7%) followed by flush toilet 21 (21.6%) and pit latrine 20 (20.6%). Septic tank was available in 76 (78.4%) facilities.

Table 11: Common issues and attempts in toilets, excreta disposal, O &M

What attempts to ensure availability of cleaning material	
1.	Didn't get the material for clerk office
What common attempts to correct situations	
1.	Written information regarding blockage of toilets was sent to concerned authorities

Hospital Waste Management

Table 12: Bio Medical Waste Management (BMWM)

BMW Management	DH (n=4) (%)	SDH (n=7) (%)	CHC (n=52) (%)	PHC (n=40) (%)	Total (n=103) (%)
Regular Connectivity by CBWTF	4 (100.0)	7 (100.0)	52 (100.0)	39 (97.5)	102 (99.0)
Regular Supply of hypochlorite and sterilium	2 (50.0)	6 (85.7)	36 (69.2)	23 (57.5)	67 (65.0)
Availability of Container and bags for BMW segregation	2 (50.0)	4 (57.1)	42 (80.8)	27 (67.5)	75 (72.8)
Availability of storage facility for BMW	2 (50.0)	5 (71.4)	17 (32.7)	7 (17.5)	31 (30.1)
Open air dumping/burning of waste seen	0 (0.0)	2 (28.6)	19 (36.5)	12 (30.0)	33 (32.0)
Availability of PPE	2 (50.0)	6 (85.7)	33 (63.5)	31 (32.5)	72 (69.9)
PPE used while handling BMW	2 (50.0)	4 (57.1)	20 (38.5)	26 (45.0)	52 (50.5)
Common Source of PPE (n=73)					
State supply	2 (50.0)	6 (85.7)	19 (36.5)	15 (37.5)	42 (40.8)
Rogi Kalyan Samiti	0 (0.0)	0 (0.0)	8 (15.4)	12 (30.0)	20 (19.4)
District supply	0 (0.0)	0 (0.0)	3 (5.8)	6 (15.0)	9 (8.7)
Other*	0 (0.0)	0 (0.0)	3 (5.8)	1 (2.5)	4 (3.9)

*= Other sources of PPE were JSSK, G-SACS grant, untied fund etc.

Majority of the centres (99.0%) had regular connectivity to Common Bio Medical Waste Treatment Facility (CBWTF). All four colour bags and containers were available at 75 (72.8%) facilities and Personal Protective Equipments (PPEs) were used at 52 (50.5%) facilities.

Table 13: Common issues and corrective attempts for Hospital Waste Management

No. of centres where any attempt was made to correct situation in absence of regular supply of hypochlorite and Sterilium (n=48)	**11 (22.9%)**
Common attempts made	
1.	Asked higher authority for supply of Sterilium
2.	Asked higher authority to provide enough fund for the purchase of same
3.	Instead of Sterilium, diluted Savlon used
4.	Purchased locally
Common current practices in absence of regular CTF connectivity	
1.	Sub centres sent their BMW to PHC for collection by CTF
2.	Burning of Bio Medical Waste
Common issues regarding unavailability/lack of containers and bags for segregation of waste	
1.	Insufficient supply
2.	Enough fund was unavailable for bags and bins
3.	Don't know from where to buy bags
4.	Improper stock management of different colour coded BMW bags
5.	Staffs are not so much sensitized regarding segregation of Waste
No. centres where there was any attempt to correct the situation of unavailability/lack of containers and bags (n=43)	**15 (34.9%)**
Common attempts made	
1.	Verbally told agency person to provide bags
2.	Purchased it from untied fund
3.	Informed higher authority regarding lack of containers and bags
No. of centres where attempt was made to correct the situation of unavailability of PPE (n=50)	**15 (30.0%)**
Common attempts made	
1.	Purchased it from untied fund
2.	Verbal complain to higher authority
Attempt by the centres for correcting situation of unavailability of proper and locked facility for BMW storage	
1.	Asked PIU to construct separate storage facility
2.	Unused bathroom was used as BMW storage room

Location based Water, Sanitationand Hygiene Status

Table 14: Drinking water point availability in/near patient care area

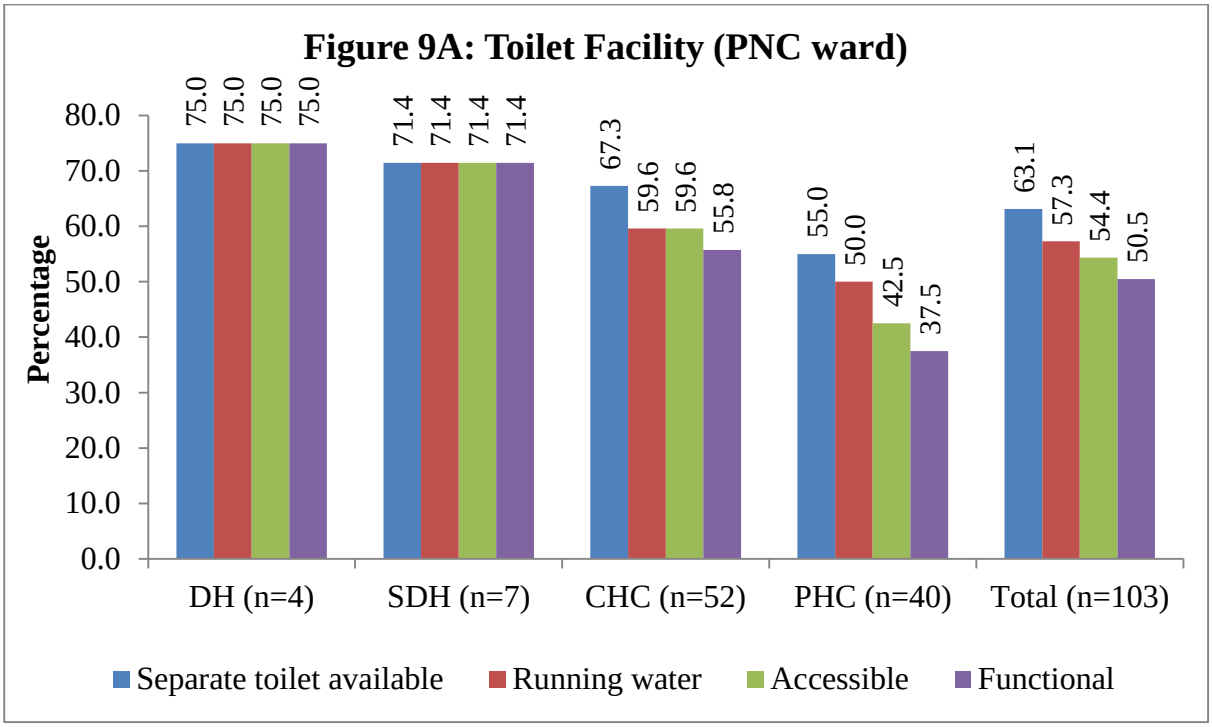
Drinking water point availability	No. of Facilities	Percentage of facilities
Postnatal ward (n=103)	31	30.1
Labor Room (n=117)	34	29.1
OPD (n=103)	49	47.6
Common practices in case of non availability of drinking water point		
1	Use drinking water from common drinking water source of the facility	
2	Hospital staff bring water from their homes for patients	
3	Bring water from nearby villagers' homes	
4	Buy packed drinking water	
5	Patients bring water from their homes	

Area specific drinking water point was available in less than half of facilities: 30.1% in PNC ward 29.1% in Labour room and 47.6% in OPD area.

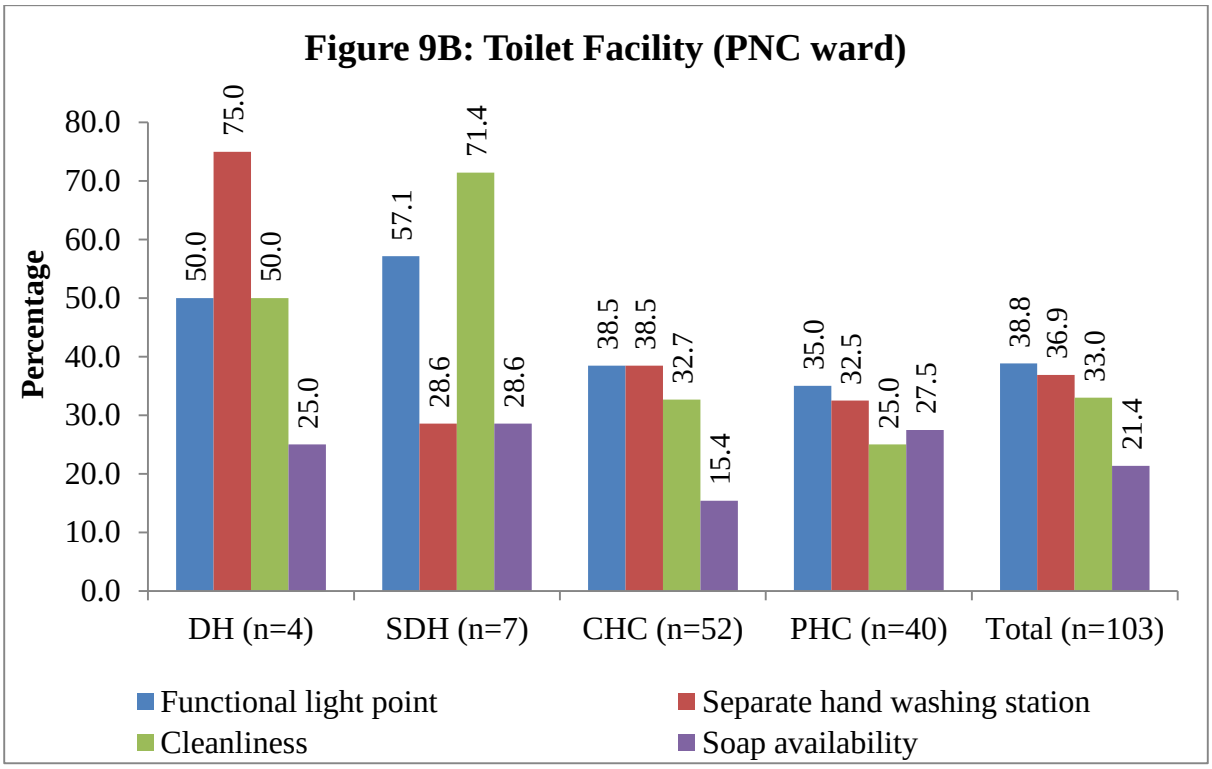
Table 15: Area wise Assessment of Toilet Facility

Toilet Facility	Postnatal Ward (n=103) N (%)	Labour room (n=117) N (%)	OPD room (n=103) N (%)
Available	65 (63.1)	75 (64.1)	88 (85.4)
Accessible	56 (54.4)	70 (59.8)	76 (73.8)
Functional/Non Broken	52 (50.5)	60 (51.3)	66 (64.1)
General cleanliness satisfactory	34 (33.0)	44 (37.6)	53 (51.5)
Running Water available	59 (57.3)	70 (59.8)	75 (72.8)
Separate hand washing station for toilet	38 (36.9)	51 (43.6)	45 (43.7)
Soap availability for hand washing	22 (21.4)	35 (29.9)	29 (28.2)
Functional light point	40 (38.8)	52 (44.4)	50 (48.5)
Dustbin for Disposal of Sanitary pads	38 (36.9)	-	-
IEC for Disposal of Sanitary pads	4 (3.9)	-	-

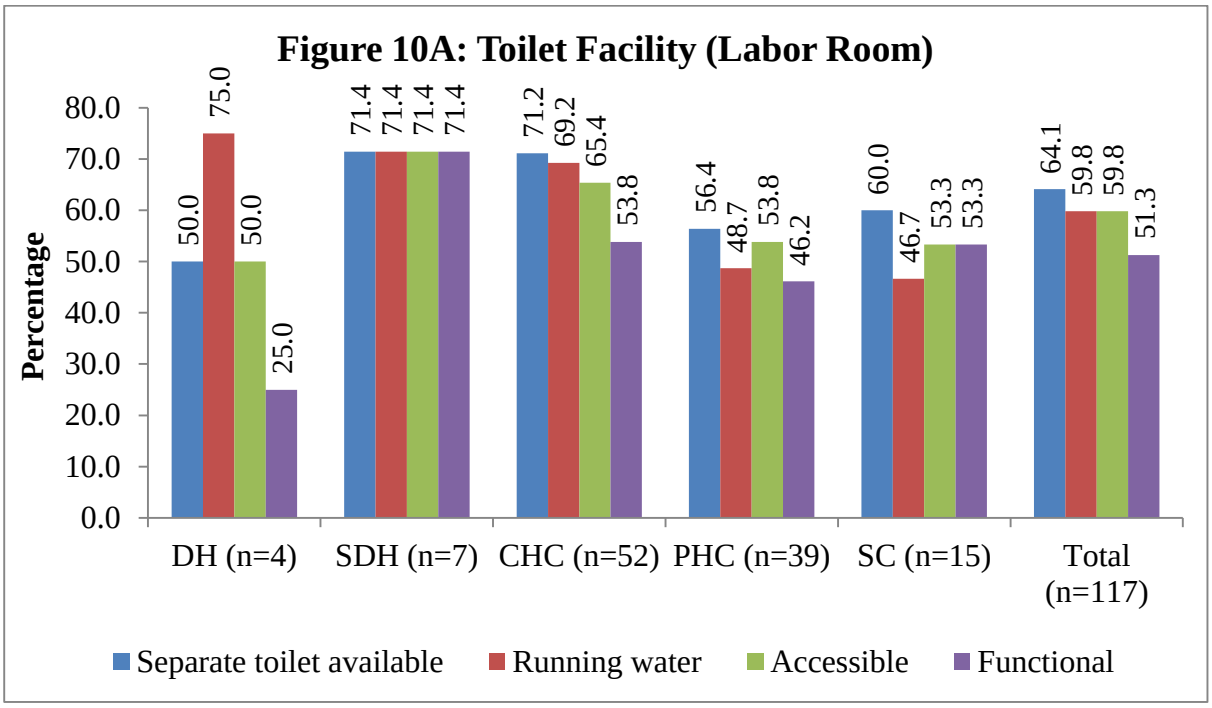
Area specific functional toilet was available in 52 (50.5%), 60 (51.3%) and 66 (64.1%) facilities respectively for PNC ward, Labour room and OPD room. Soap availability for hand washing was 22 (21.4%), 35 (29.9%) and 29 (28.2%) respectively for PNC ward, Labour room and OPD room. Dustbin for disposal of sanitary pads in PNC ward was available in 38 (36.9%) facilities.



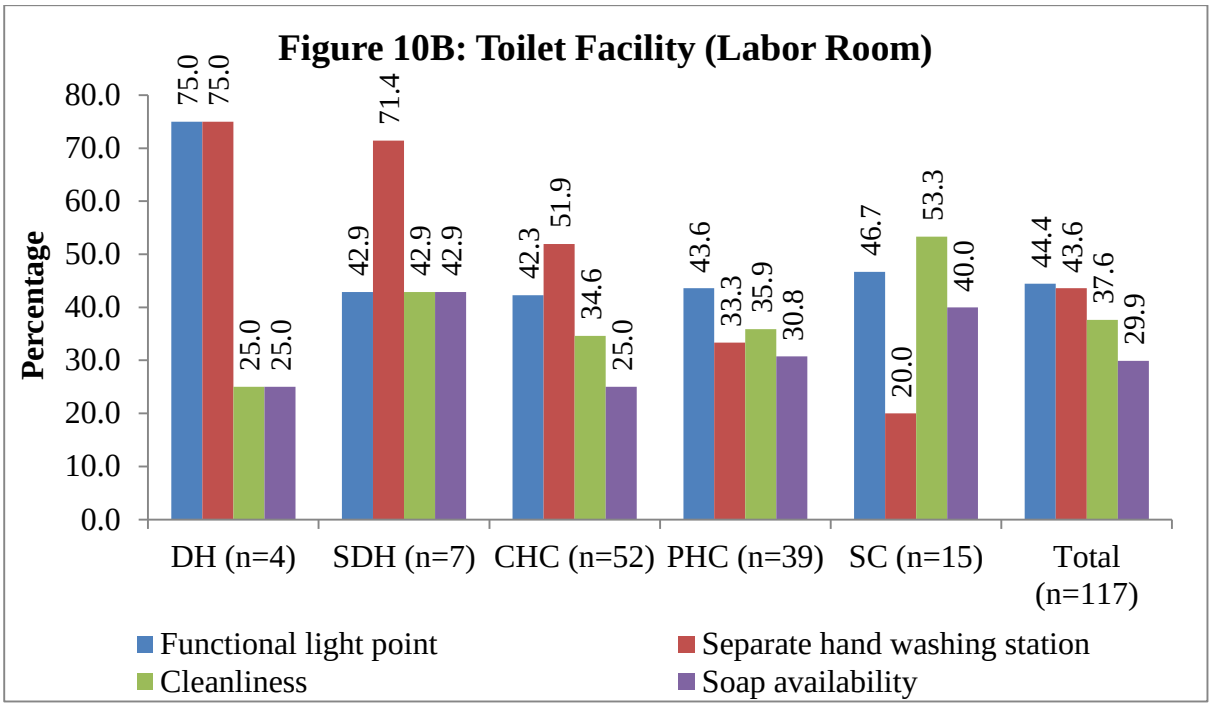
PNC ward specific functional toilet was available in 75%, 71.4%, 55.8% and 37.5% facilities respectively for DHs, SDHs, CHCs and PHCs.



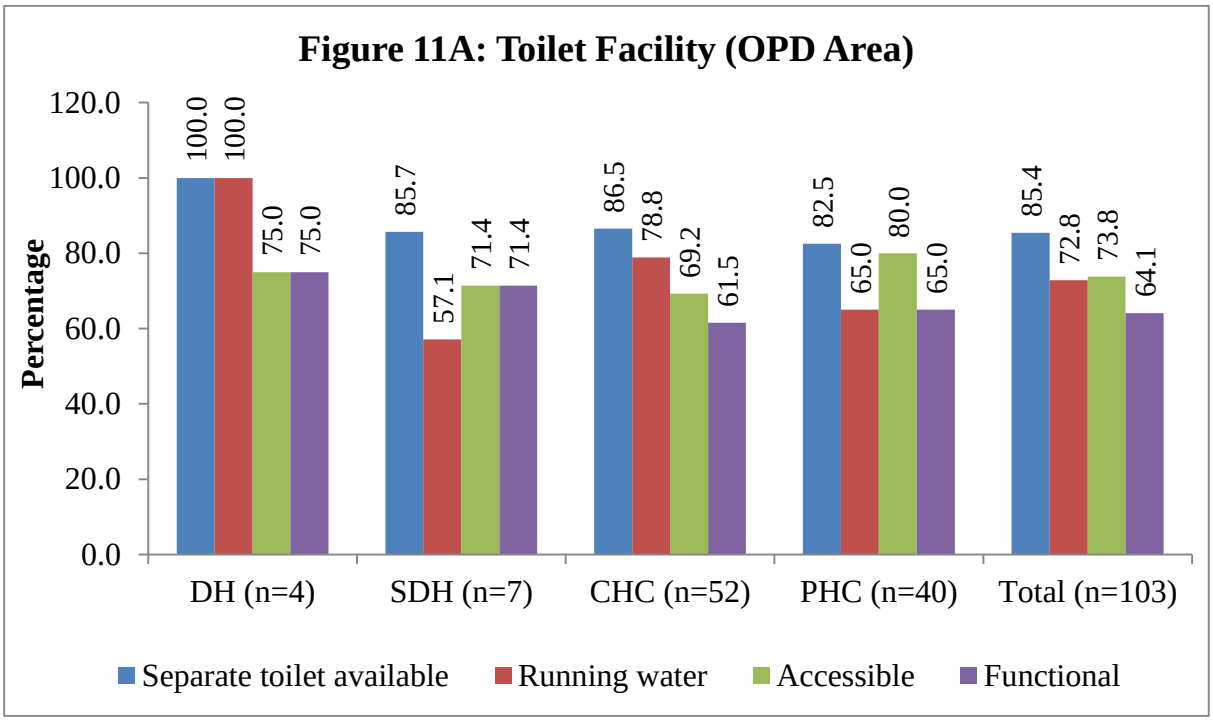
PNC ward specific soap availability for hand washing after toilet use was 25%, 28.6%, 15.4% and 27.5% respectively for DHs, SDHs, CHCs and PHCs.



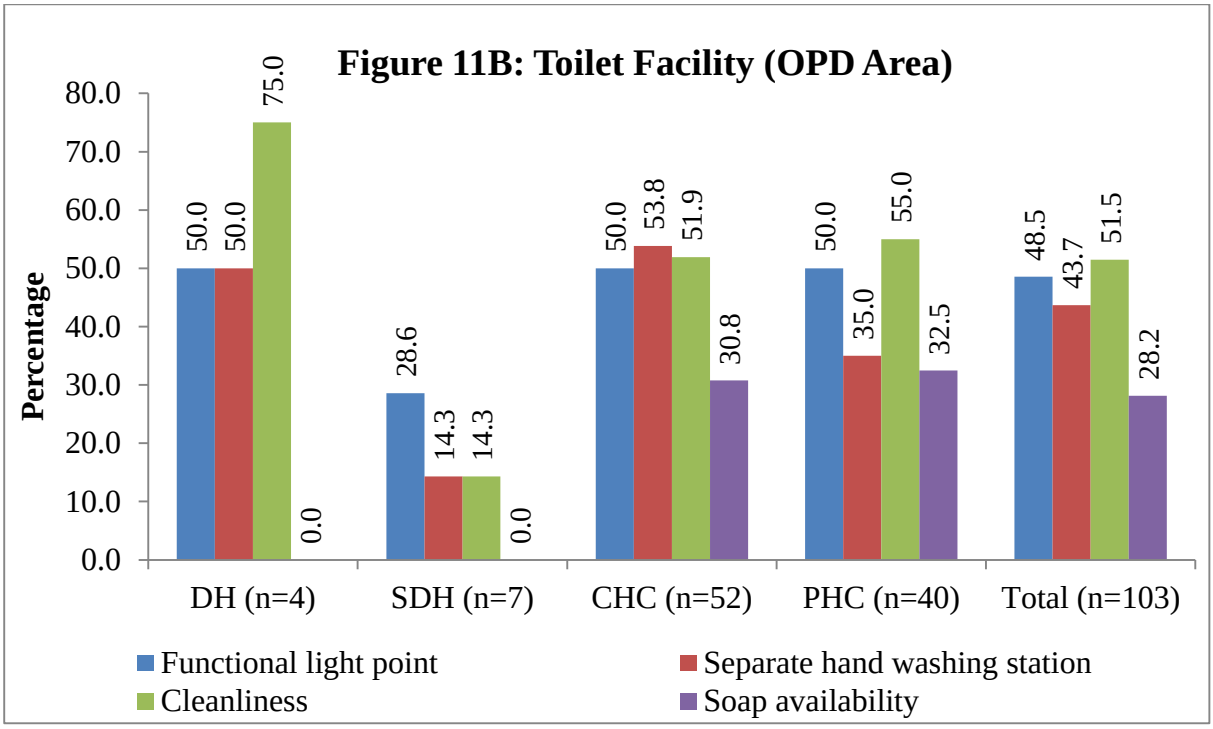
Labour room specific functional toilet was available in 25%, 71.4%, 53.8%, 46.2% and 53.3% facilities respectively for DHs, SDHs, CHCs, PHCs and SCs.



Labour room specific soap availability for hand washing after toilet use was 25%, 42.9%, 25%, 30.8% and 40% respectively for DHs, SDHs, CHCs, PHCs and SCs.



OPD area specific functional toilet was available in 75%, 71.4%, 50% and 65% facilities respectively for DHs, SDHs, CHCs and PHCs.

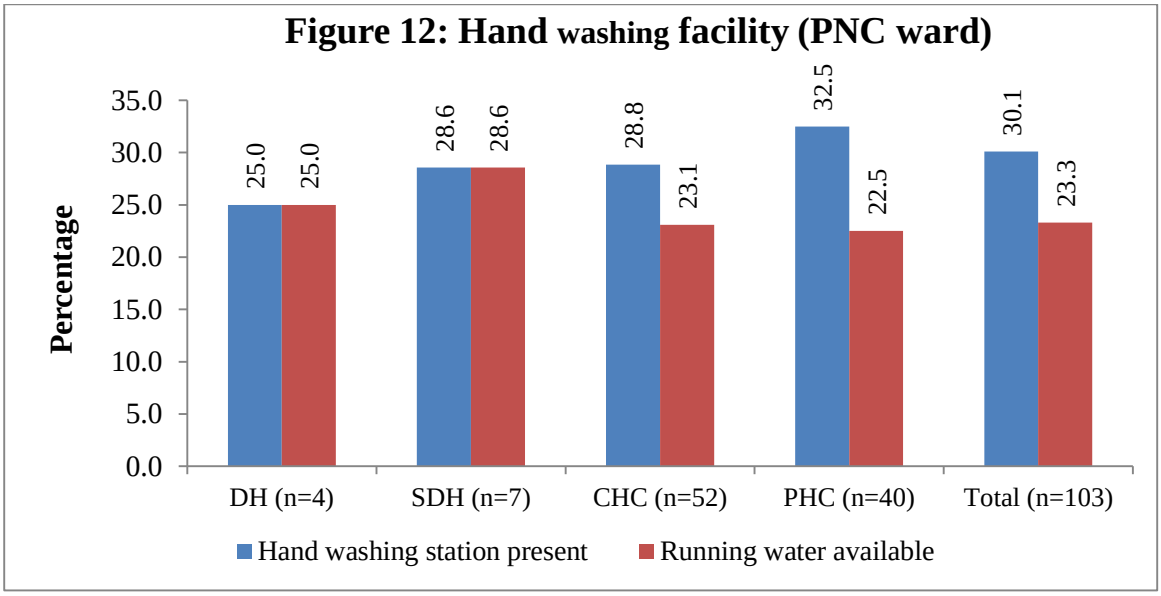


OPD area specific soap availability for hand washing after toilet use was 0%, 0%, 30.8% and 32.5% respectively for DHs, SDHs, CHCs and PHCs.

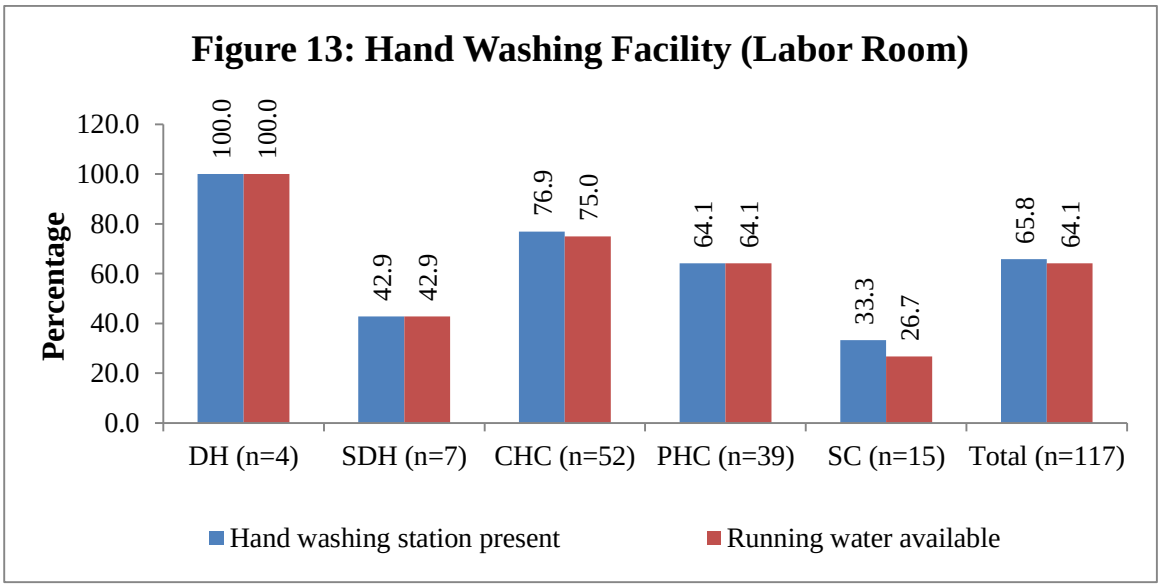
Table 16: Area wise Assessment of Hand washing station

Hand washing station facility	Postnatal Ward (n=103) N (%)	Labour room (n=117) N (%)	OPD room (n=103) N (%)
Presence of Hands Washing station for Patients	31 (30.1)	77 (65.8)	42 (40.8)
Running water at hand washing station	24 (23.3)	75 (64.1)	38 (36.9)
Soap availability for hand washing	13 (12.6)	51 (43.6)	22 (21.4)
Liquid hand sanitizer-sterilium available	21 (20.4)	34 (29.1)	19 (18.4)

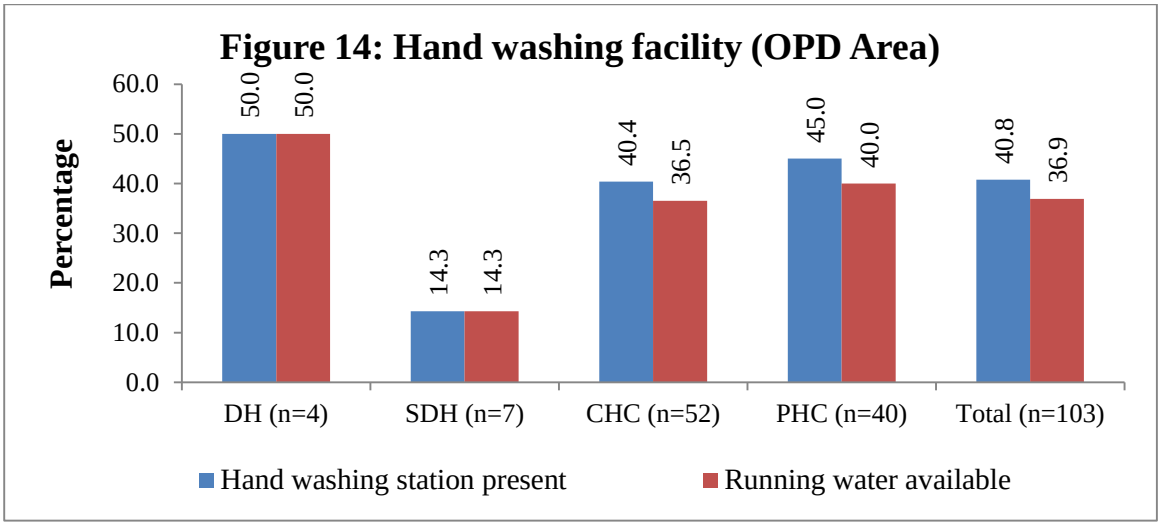
Area specific hand washing station for patients was available in 31 (30.1%), 77 (65.8%) and 42 (40.8%) facilities respectively for PNC ward, Labour room and OPD room. Availability of soap for hand washing was 13 (12.6%), 51 (43.6%) and 22 (21.4%) respectively for PNC ward, Labour room and OPD room.



PNC ward specific hand washing station was available in 25%, 28.6%, 28.8% and 32.5% facilities respectively for DHs, SDHs, CHCs and PHCs. Running water availability was 25%, 28.6%, 23.1% and 22.5% respectively for DHs, SDHs, CHCs and PHCs.



Labour room specific hand washing station was available in 100%, 42.9%, 76.9%, 64.1% and 33.3% facilities respectively for DHs, SDHs, CHCs, PHCs and SCs. Running water availability was 100%, 42.9%, 75.0%, 64.1% and 26.7% respectively for DHs, SDHs, CHCs, PHCs and SCs.

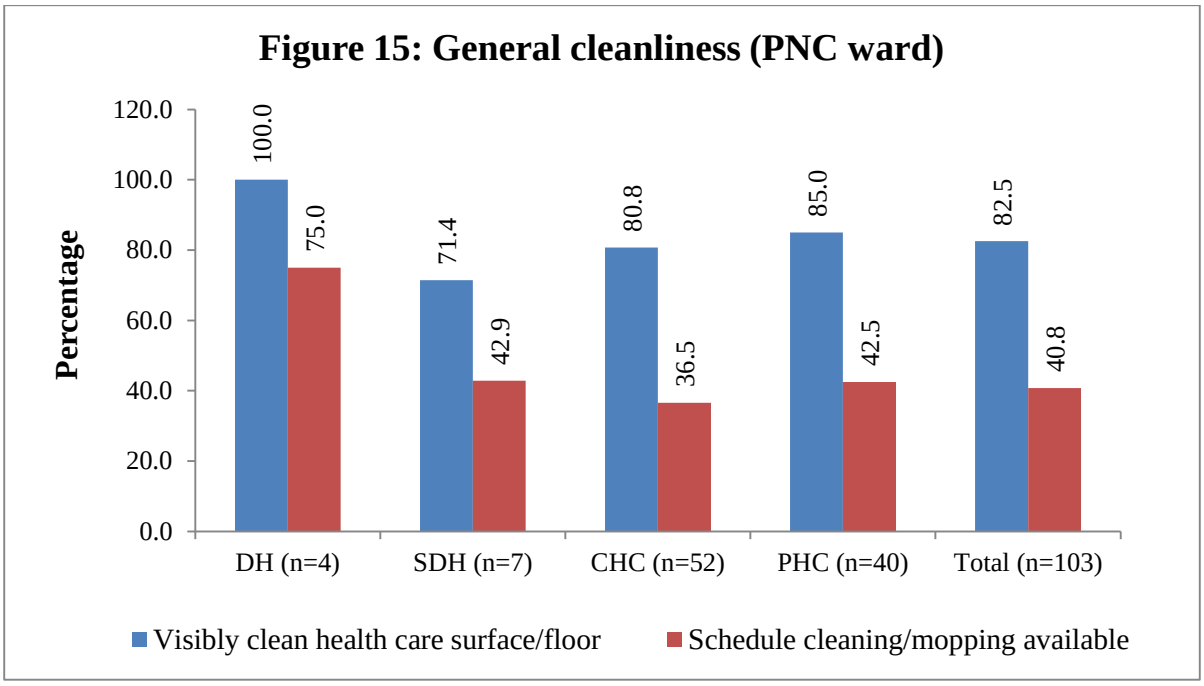


OPD area specific hand washing station was available in 50%, 14.3%, 40.4% and 45% facilities respectively for DHs, SDHs, CHCs and PHCs. Running water availability was 50%, 14.3%, 36.5% and 40% respectively for DHs, SDHs, CHCs and PHCs.

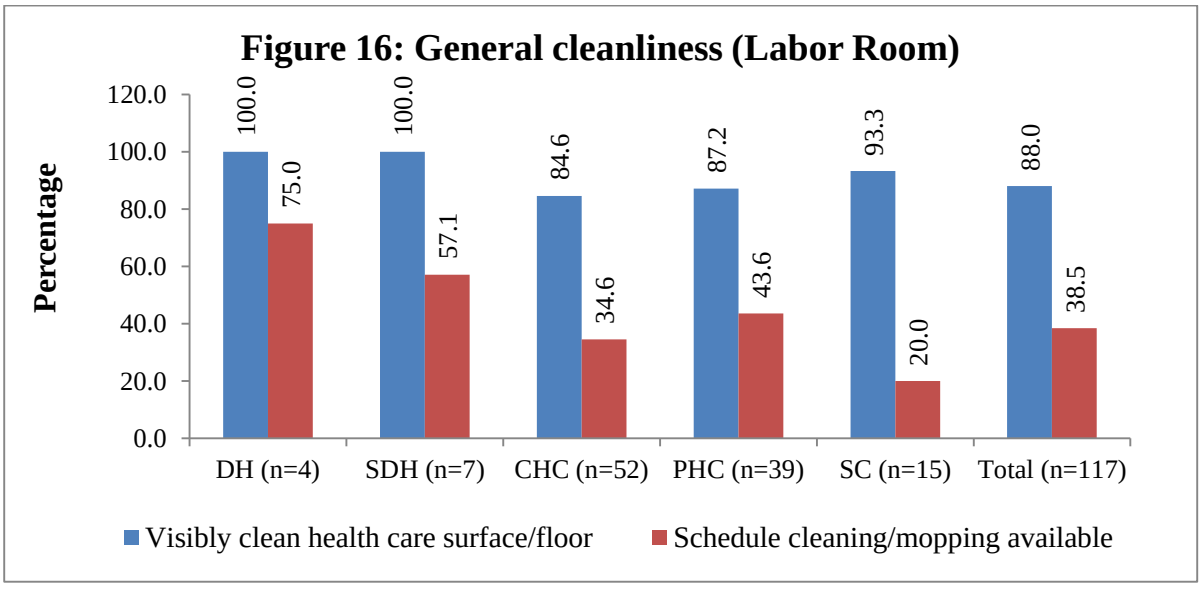
Table 17: General Cleanliness of area

Cleanliness	Postnatal Ward (n=103) N (%)	Labour room (n=117) N (%)	OPD room (n=103) N (%)
Visibly clean health care surface/floor	85 (82.5)	103 (88.0)	98 (95.1)
Schedule cleaning/mopping available	42 (40.8)	45 (38.5)	39 (37.9)

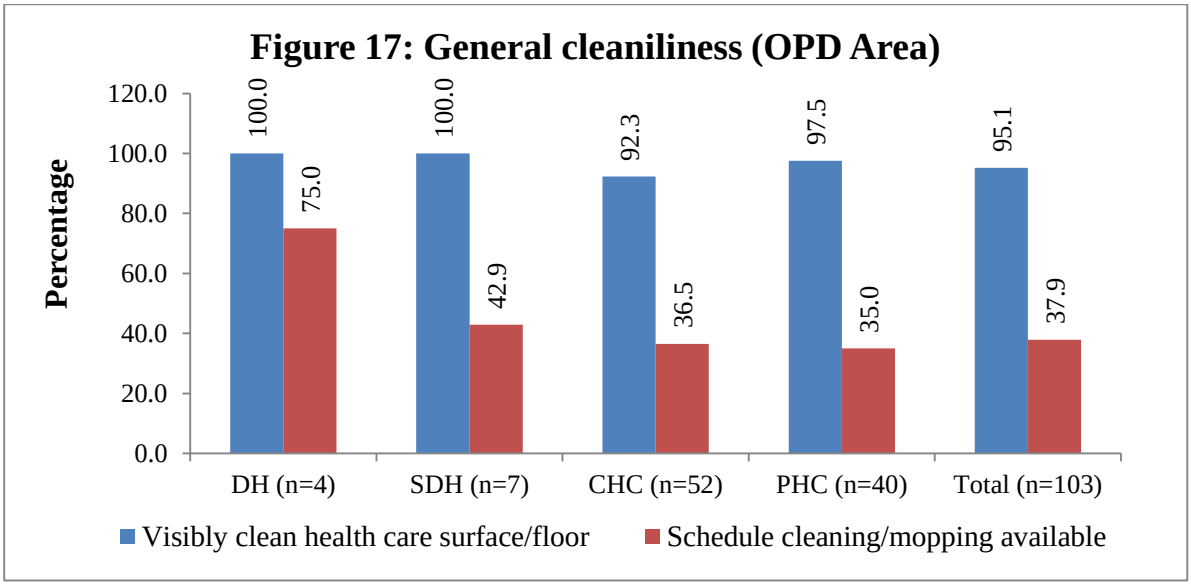
General cleanliness of all three areas was good in majority of health facilities, but schedule cleaning was available in 42 (40.8%), 45 (38.5%) and 39 (37.9%) facilities respectively for PNC ward, Labour room and OPD area.



General cleanliness of PNC ward was satisfactory in 100%, 71.4%, 80.8% and 85.0% facilities respectively for DHs, SDHs, CHCs and PHCs; but schedule cleaning availability was 75%, 42.9%, 36.5% and 42.5% respectively for DHs, SDHs, CHCs and PHCs.



General cleanliness of Labour room was satisfactory in 100%, 100%, 84.6%, 87.2% and 93.3% facilities respectively for DHs, SDHs, CHCs, PHCs and SCs; but schedule cleaning availability was 75%, 57.1%, 34.6%, 43.6% and 20% respectively for DHs, SDHs, CHCs, PHCs and SCs.

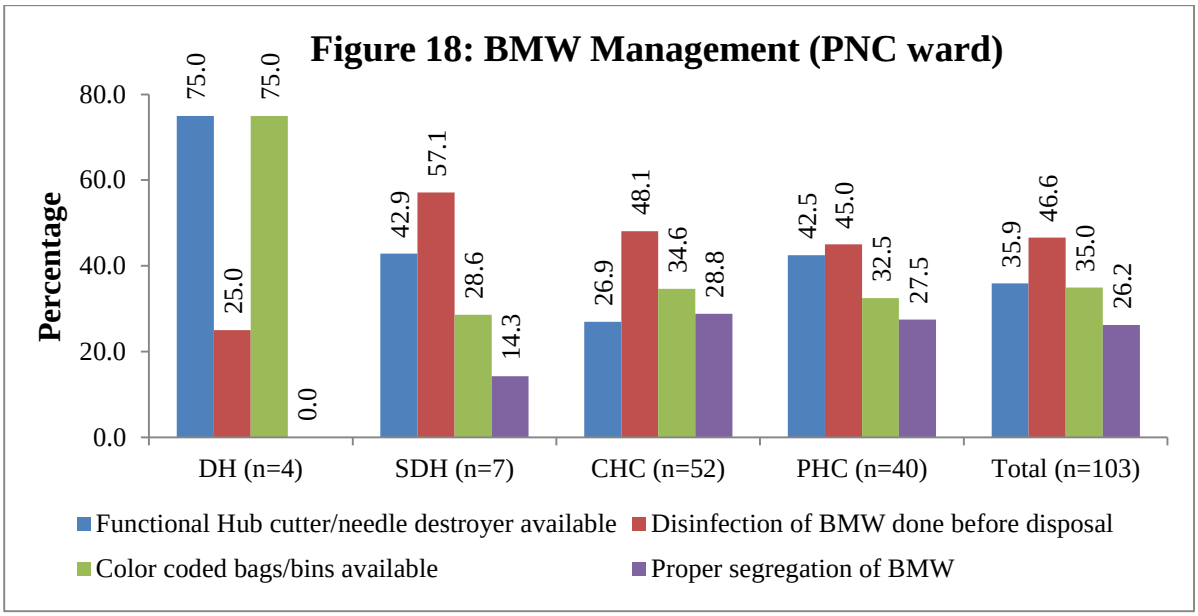


General cleanliness of OPD area was satisfactory in 100%, 100%, 92.3% and 97.5% facilities respectively for DHs, SDHs, CHCs and PHCs; but schedule cleaning availability was 75%, 42.9%, 36.5% and 35% respectively for DHs, SDHs, CHCs and PHCs.

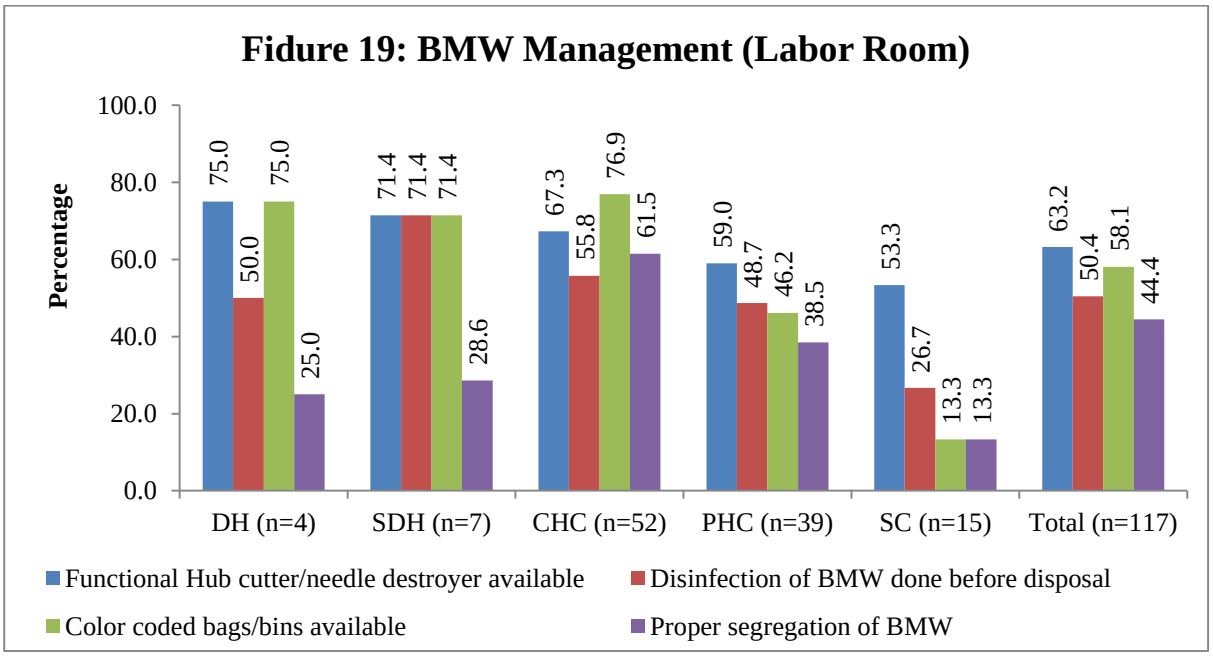
Table 18: Hospital waste Management

Hospital waste management	Postnatal Ward (n=103) N (%)	Labour room (n=117) N (%)	OPD room (n=103) N (%)
Colour coded bags available	36 (35.0)	68 (58.1)	37 (35.9)
BMW correctly segregated	27 (26.2)	52 (44.4)	30 (29.1)
Hub cutter /needle destroyer available	37 (35.9)	74 (63.2)	58 (56.3)
Disinfection of BMW before disposal	48 (46.6)	59 (50.4)	46 (44.7)

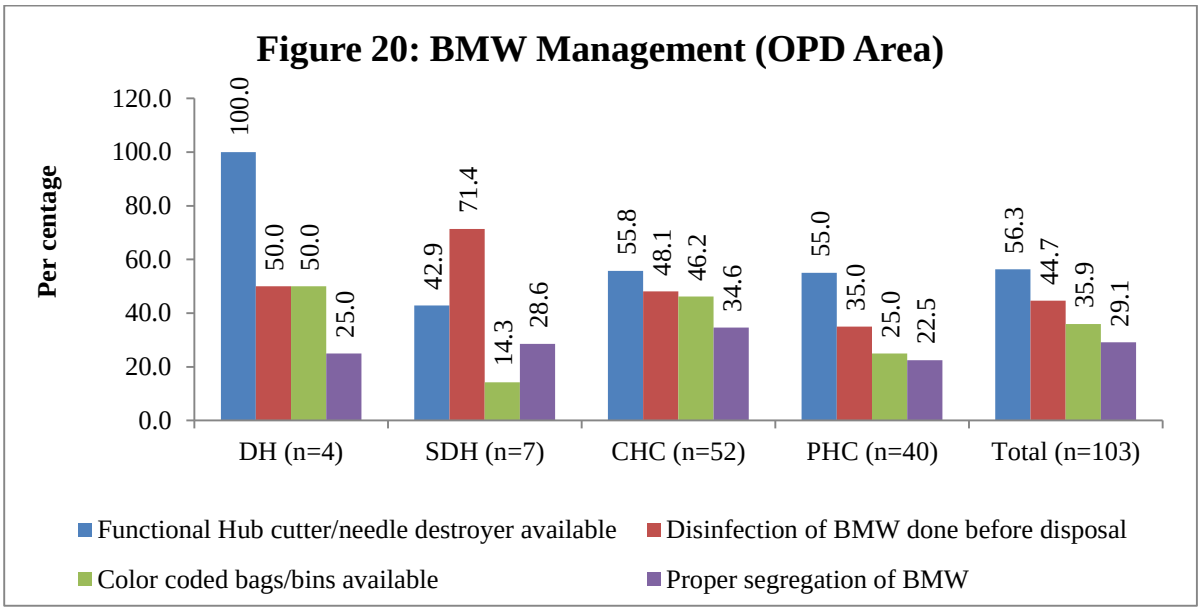
Correct segregation of BMW was done at only 27 (26.2%), 52 (44.4%) and 30 (29.1%) facilities respectively for PNC ward, Labour room and OPD area. Hub cutter/needle destroyer was available at 37 (35.9%), 74 (63.2%) and 58 (56.3%) facilities respectively for PNC ward, Labour room and OPD area.



Correct segregation of BMW at PNC ward was done at 0%, 14.3%, 28.8% and 27.5% facilities respectively for DHs, SDHs, CHCs and PHCs. Hub cutter/needle destroyer was available at 75%, 42.9%, 26.9% and 42.5% facilities respectively for DHs, SDHs, CHCs and PHCs.



Correct segregation of BMW at Labour room was done at 25%, 28.6%, 61.5%, 38.5% and 13.3% facilities respectively for DHs, SDHs, CHCs, PHCs and SCs. Hub cutter/needle destroyer was available at 75%, 71.4%, 67.3%, 59% and 53.3% facilities respectively for DHs, SDHs, CHCs, PHCs and SCs.



Correct segregation of BMW at OPD area was done at 25%, 28.6%, 34.6% and 22.5% facilities respectively for DHs, SDHs, CHCs and PHCs. Hub cutter/needle destroyer was available at 100%, 42.9%, 55.8% and 55% facilities respectively for DHs, SDHs, CHCs and PHCs.

Table 19: Common reasons for unavailability of area specific toilet

1.	Separate toilet not in the plan of the centre
2.	Old infrastructure so inadequate space available for new construction
3.	Instruction not given from higher authority for area specific separate toilet
4.	Ongoing renovation
5.	Separate PNC ward unavailable

Table 20: Common practices in case of unavailability of area specific toilet

1.	Use common toilet
2.	Use toilet of nearby area

Table 21: Common reasons for unclean toilet

1.	Irregular cleaning
2.	Cleaning staff deficient
3.	Cleaning staff reluctant
4.	Instruction from higher authority not given for scheduled cleaning
5.	Cleaning schedule unavailable
6.	Inadequate water
7.	Responsibility not assigned to any person for monitoring
8.	Drainage lines were chocked
9.	Cleaning was done in the morning only
10.	Neglected issue due to other priority

Table 22: Common reasons for non functional toilet

1.	Damaged toilet pan
2.	Chocked toilet
3.	Inadequate water
4.	Responsibility not assigned to any person for monitoring
5.	Given application for maintenance but action was not taken by the authority
6.	Toilet was clogged due to sanitary pad disposal in it
7.	Irregular cleaning
8.	Toilets became non-functional after renovation by PIU due to blockage
9.	Broken line

Table 23: Common reasons for inaccessible toilet

1.	Toilet was kept locked due to maintenance problem
2.	Toilet was used as a store room
3.	Patients and their relatives didn't know how to use western type toilet, so kept locked
4.	Blocked toilet, so it was kept locked
5.	Blocked drainage line
6.	Some toilets were kept for spare
7.	Toilet was reserved for staff, so not accessible to patients
8.	Toilet lock was non functional

Table 24: Common reasons for running water supply not being present in toilet

1.	Tap was not working
2.	Insufficient water supply
3.	Overhead tank under repairing
4.	Water line clogged

Table 25: Common reasons for soap not being present for toilet

1.	Soap was frequently stolen by patients and their relatives so it was not kept
2.	Inadequate fund for regular purchase of soap
3.	Soap was not included in routine supply
4.	Other conflicting priorities so soap was not kept
5.	Adequate stock of soap was unavailable
6.	Hand washing station unavailable, so soap was not kept
7.	Forgot to keep soap
8.	Lack of monitoring by an identified person
9.	Belief of non requirement
10.	Non functional toilet/hand washing station, so soap was not kept
11.	It was not kept as staff believed that patients and relatives would finish whole soap in one day

Table 26: Common reasons for functional light not being present in toilet

1.	Patients and their relatives stole bulbs
2.	Lack of monitoring
3.	Toilet not in use so light was not kept
4.	Given application for maintenance but action was not taken by the authority
5.	Unaware about non-functional bulb due to other conflicting priorities
6.	Building was under renovation
7.	Electrical line problem
8.	Any person not identified for repairing and maintenance of light source
9.	Belief of non requirement
10.	Lamp was not purchased
11.	Inadequate/no stock

Table 27: Common reasons for scheduled cleaning not done for toilet

1.	Unaware of availability of the schedule
2.	Cleaning staff was insufficient
3.	Guideline of scheduled cleaning was unavailable at the centre
4.	Instruction from higher authority was not given for the scheduled cleaning
5.	Schedule was not prepared and duty was divided orally
6.	Cleaning staff was reluctant
7.	Any person was not identified for monitoring/supervision

Table 28: Common reasons for dustbin for sanitary pads not being present

1.	Need not perceived
2.	Staff was not sensitized about the importance of such bin
3.	Staff was unaware of keeping separate dustbin for sanitary pads
4.	Neglected issue due to other conflicting priorities
5.	Common dustbin was used for disposal of sanitary pads

Table 29: Common current practices in absence of running water

1.	Use toilet wash basin for hand washing
2.	Use common hand washing station
3.	Use nearby washing station
4.	Use pre-filled bucket for hand washing

Table 30: Common current practice in case area specific hand washing station is not available

1.	Hand washing was done in toilet itself
2.	Use common hand washing station
3.	Use bathroom near the toilet for hand washing
4.	Use any nearby hand washing station
5.	Use water in pre-filled bucket
6.	Hand washing practice was not followed

Table 31: Common reasons for non availability of liquid hand sanitizer

1.	Fund was inadequate to purchase it in enough quantity
2.	It was not provided in routine supply
3.	Requirement of liquid hand sanitizer was not perceived by the staff
4.	Staff forgot to keep it
5.	Staff was not aware that it should be kept at all areas
6.	Any guideline for keeping liquid hand sanitizer was unavailable
7.	Instead of it, soap was used

Table 32: Common reasons for unclean floors and surfaces

1.	Inadequate staff especially cleaning workers
2.	Irregular cleaning
3.	Patients and their relatives not maintaining cleanliness
4.	Cleaning workers were not working properly
5.	Cleaning was not done on weekends
6.	Neglected issue due to other conflicting priorities
7.	Monitoring mechanism was not implemented
8.	Scheduled cleaning was unavailable
9.	Ongoing renovation
10.	Staining due to hard water

Table 33: Common reasons for Unavailability of area specific colour coded bags/bins

1.	They were not provided in routine supply
2.	Insufficient fund to purchase required numbers of bags and bins
3.	Staff was unaware of requirement of different colour coded bags for segregation of BMW
4.	They were unavailable in market
5.	Inadequate space in the facility to keep all bins
6.	Bins present in nearby area were used
7.	Neglected issue due to other priority
8.	Staff believed that they were not required at OPD area

Table 34: Common reasons for incorrect segregation of BMW

1.	All colour coded bags and bins were not available for proper segregation at the source
2.	Lack of knowledge and awareness about proper segregation of BMW among staff especially class IV workers
3.	Untrained staff especially newer recruitment and class IV workers
4.	IEC suggesting correct segregation of waste was not displayed properly

Table 35: Common reasons for unavailability of area specific hub cutter and needle destroyer

1.	Need was not perceived by the health care staff
2.	Inadequate stock of hub cutter
3.	Use hub cutter in nearby area so hub cutter was not put
4.	It was kept inside cupboard
5.	Separate injection room available, where all needles were destroyed and cut

Table 36: Common reasons for not practicing Disinfection of BMW before disposal

1.	All coloured bags and bins not available
2.	Hypochlorite solution was not available in sufficient quantity
3.	Unaware of such guidelines/ they didn't follow such guidelines
4.	Forgot to disinfect
5.	Staff was not knowing how to prepare hypochlorite solution
6.	Lack of supervision and motivation
7.	Staff didn't know how to disinfect the BMW

Table 37: Distribution according to washing of hands by functionaries

Washing of hands by functionaries	Prior to round (n = 15) N (%)	Prior to examination of patients (n = 36) N (%)	Prior to delivery (n = 11) N (%)
Yes	4 (26.7)	15 (41.7)	9 (81.8)
No	11 (73.3)	21 (58.3)	2 (18.2)

Practice of hand washing was followed at 4 (26.7%), 15 (41.7%) and 9 (81.8%) observed sites respectively for prior to round, prior to examination of patients and prior to delivery.

Table 38: Distribution according to condition of soaps where observed (n=20)

Soap looks used	In ward for staff members N (%)	In doctor's chamber N (%)	In Labour room N (%)
Yes	12 (60)	13 (65)	12 (60)
No	8 (40)	7 (35)	8 (40)

Soap was looked used at 12(60%), 13 (65%) and 12 (60%) facilities respectively for ward, doctor's chamber and labour room.

Observations about WASH related Practices

Table 39: Common key enablers for the maintenance of clean, functional toilets in the premises

1.	Support, sincerity and dedication of staff
2.	Active work by Medical Officers and team work
3.	Good administration and supervision
4.	Self-motivated Medical Officer and other staff
5.	5 ‘S’ project implementation and regular training
6.	Understanding the importance of hygiene
7.	Sense of ownership of the facility

Table 40: Common reasons for non maintenance of clean, functional toilets in the premises

1.	Unavailability of extra fund for this purpose
2.	Inadequate manpower for such activities
3.	Lack of responsibility for such activities
4.	Class IV workers not following instructions
5.	Unawareness regarding such actions
6.	Busy with patients as too much patient load
7.	Ongoing renovation process
8.	Other priorities
9.	Cleaning schedule unavailable

Table 41: Common key enablers for availability of soap in labour room, IPD and OPD hand washing station for the use of staff and patients

1.	Demand from staff
2.	Self-motivated Medical Officer and other staff
3.	Support and dedication of staff
4.	Regular purchase
5.	Regular supervision of all places

Table 42: Common reasons for unavailability of soap in labour room, IPD and OPD hand washing station for the use of staff and patients

1.	Soap stolen by patients and their relatives
2.	Other priorities to do
3.	Any particular staff was not assigned for this
4.	Inadequate/ No stock
5.	Hand washing stations not there in building design
6.	Unavailability of funding guideline at the centre

Table 43: Common key enablers for displaying material on use of toilet, in the health facility

1.	District society has sent materials
2.	Enough funds available
3.	Self- motivated Medical Officer and other staff

Table 44: Common reasons for not displaying material on use of toilet, in the health facility

1.	Lack of responsibility for such activities
2.	Unavailability of proper space for displaying it
3.	Staff unaware of such thing
4.	Belief of non importance
5.	Unavailability of guideline at the centre

Table 45: Common key enablers for display material on the practice of hand washing

1.	Availability of display material
2.	Regular supervision
3.	Support from district
4.	Personal interest

Table 46: Common reasons for non availability of display material on the practice of hand washing

1.	IEC material not provided from district/state
2.	Belief of non importance
3.	Staff unaware about such things
4.	Ignorance
5.	Material kept in store
6.	Hand washing facility was unavailable

Table 47: Common key enablers for counselling and review on hand washing before infant feeding

1.	Trained nursing staff
2.	Home Based Newborn Care (HBNC) training
3.	Dedication towards work
4.	Monitoring and checking by senior staff
5.	Active work done by FHWs
6.	Good administrative support
7.	Good support of staff
8.	Review by RMNCH+A counsellor

Table 48: Common reasons for not doing counselling and review on hand washing before infant feeding

1.	Other conflicting priorities
2.	Unavailability of tools to aid counseling
3.	Belief of non importance
4.	Staff was unaware about those things
5.	Inadequate staff
6.	Unavailability of counsellor
7.	Unavailability of guideline at the centre

Table 49: Common key enablers for counselling and review on use of toilet

1.	Supervision by senior staff
2.	Staff nurses doing team work
3.	Active support from Medical officer
4.	Good administration
5.	Self-motivated Medical Officer and other staff

Table 50: Common reasons for not doing counselling and review on use of toilet

1.	Other conflicting priorities
2.	Untrained staff for counselling
3.	Belief of non importance
4.	There are no tools to aid counseling
5.	Unavailability of counsellor

Table 51: Common key enablers for adopting hygiene practices including hand washing with soap before examining patients

1.	Dedication towards work
2.	Trained nursing staff
3.	Medical officer, staff nurse supervision
4.	UNICEF video available for good demonstration
5.	Habituated for hand wash practice since undergraduate and internship time of MBBS
6.	Regular stock maintenance of soaps at hand washing station
7.	Good IEC materials for hand washing

Table 52: Common reasons for not adopting or irregularly adopting hygiene practices including hand washing with soap before examining patients

1.	Lack of enough time before each patient's examination
2.	Other conflicting priorities
3.	Difficult to practice due to unavailability of washing station in each ward
4.	Soap stolen or not procured
5.	Unaware about those things
6.	Untrained staff
7.	Belief of non importance

Common key gaps/challenges enumerated by respondents and users

Water Supply

1.	Irregular maintenance/ non functional water purifier system
2.	Poor response from PIU/ PIU not supporting
3.	Leakage and damage of pipelines and water storage tanks
4.	Poor documentation and guide for bacteriological testing.
5.	Seasonal water supply problem
6.	Reluctant staff

Sanitation

1.	Inadequate/No cleaning staff
2.	Lack of PPE and logistics for waste handling
3.	Any responsible person not assigned for monitoring
4.	Unavailability of cleaning schedule
5.	Reluctant staff
6.	Blockage of drainage lines
7.	Non-functioning or non availability of hand washing stations
8.	Lack of IEC material for toilet use and for disposal of sanitary pad

Observations

Hygiene

1.	Poor knowledge about importance of sanitation and maintenance of hygiene among beneficiaries Unavailability of IEC material to display
2.	Poor knowledge regarding hygiene and sanitation counselling techniques among health workers
3.	Any responsible person was not assigned for monitoring
4.	Poor stock management for soap and sterilium
5.	Non-functioning or non availability of hand washing stations

Hospital Waste Management

1.	Irregular supply and unavailability of bags and bins for proper BMW segregation
2.	Unavailability of separate room for BMW storage
3.	Poor knowledge regarding proper BMW segregation among health care staff especially class IV workers
4.	Any responsible person was not assigned for monitoring
5.	PPE not available; If available not used regularly

Conclusions

Conclusion

Monitoring and Supervision

- Whereas most facilities have some health personnel to monitor WASH, but at many places absence of formal assigned responsibility for supervision and monitoring was observed.
- Record keeping for maintenance of facility and instruments was found improper at many centres

Water Supply

- Improved water supply was available in almost all (97.5%) health centres and was sufficient for most of them (81.4%)
- In few centres (19.5%) bacteriological water testing of drinking water was done
- Regular repair and/or maintenance of water tanks (46.6%) and Water purifier/ Water treatment unit (22.3%) was lacking at many places.

Sanitation and Hygiene: Operation and Maintenance

- Almost all facilities were having cleaning staff (94.4%) for maintenance of cleanliness of the health centre with outsourcing as a predominant method of recruitment
- Sanitary excreta disposal system was available in all facilities
- Most of the individual areas were visibly clean but schedule of cleaning was not available and maintained for about 2/3 of these areas
- About half of the facilities were having functional toilet in all areas
- Around one forth facilities had soap availability for hand washing
- Good number of health centres were having toilets for labour room (64.1%) and ANC OPD (85.4%) but maintenance of toilet in functional status was not proper

Bio Medical Waste Management

- Availability of bags and bins (72.8%) for BMW segregation and disposal was insufficient
- Segregation and disinfection of BMW before final disposal was poor at many health centres
- PPEs were used in limited manner (50.5%) while handling BMW waste
- Functional hub cutter was unavailable in about half of required areas even though they were available in store at some place

- Insufficient and irregular use of liquid sanitizer was observed where it's required
- Separate locked storage facility for BMW was available and was in good condition at some centres (30.1%). This type of storage facility for BMW should be made available at all the health centres

Finance

- Fund for logistics of cleaning and sanitation was being made available by utilizing RKS, untied, maintenance and VHSC which were sufficient at most facilities

IEC and BCC

- Few facilities were having IEC materials for hand wash, for toilet use and for disposal of sanitary pad
- Separate bin for disposal of sanitary pad in Post natal ward was placed in some health centres (36.9%) with display of signage regarding the same

Recommendations

Recommendations

Key gaps and Recommended Strategic actions

Major Gaps	Strategic Option suggested/ Onsite correction made
Monitoring	
Implementation of fixing the responsibility - answerability at institute level is weak	✓ Ensuring the implementation of monitoring mechanism as per the job chart ✓ MO to be sensitized for cleanliness issues and to take a daily 5-10 min round ✓ THO/DQAMO to do continues monitoring, supervision and regular review ✓ The ownership attitude needs to be created in all cadres of staff ✓ Monitoring checklist should be implemented and revised periodically (3 monthly) in implement-improve-maintain-revise cycle ✓ Regular review in monthly meeting to discuss and solve problems identified at local health facility to be started ✓ Implementation of 5S at all health facilities
Water Supply	
Functional Treatment Unit and water storage tank unavailable/ not covered	✓ Authority and fund for local/district purchase for Functional Treatment Unit to be provided ✓ Proposal for new construction of water storage tank in new budget plan to be made
Maintenance of water treatment unit and water tanks were irregular	✓ Maintenance of water purifier/water treatment unit and water tanks must be ensured on regular basis through Annual Maintenance Contracts ✓ The same can be linked to ILR maintenance mechanism as that mechanic is already present within the system ✓ Minimum twice a year (once before and once after

	monsoon) water tank cleaning must be done to prevent contamination from rain water ✓ In higher case load facilities with high turnover water tanks are to be cleaned more frequently ✓ Proper records should be kept for repair/maintenance of water tanks/water purifier system ✓ Each level of facilities like SC, PHC, CHC, and DH should have different SOP for water management (water treatment) specific for that level of facility ✓ The layouts of health centres to be modified to ensure water tank accessibility ✓ The existing facilities without water tank accessibility to arrange a ladder for the same
Leakage of pipelines at few centres	✓ Prompt reporting and response mechanism for repair to be ensured ✓ Provision to be made in PIU budget for replacing old corroded GI pipes with new ones after few years
Irregular/ Absence of water testing	✓ Bacteriological testing of drinking water should be done on regular basis preferably every month. Proper training and guidelines regarding water testing to be provided ✓ Regular supply of H_2S kit to be ensured ✓ Possibility of linkages with WASMO needs to be explored at panchayat/nagarpalika level for water testing ✓ MPHW/ASHA can also do water testing of the health facility water along with household level testing
Hand washing and hygiene	
At few centers hand washing stations and running water were not available in the OPD, LR	✓ Proposal to PIU for creating washbasin at such centers to be prepared

and Post Natal Ward	
Guiding display for hand washing and disposal of sanitary pad at place of use was lacking	✓ Prescriptive display for hand washing and disposal of sanitary pad at place of use to be ensured ✓ Behaviour change for use of soap is required ✓ Various IPC tools and target audience for sensitization for the same needs to be defined ✓ Training of staff nurse on IPC skills must be done. Counselling material for same need to be supplied. ✓ Small video spots on importance WASH can be showed
Sterigen machines were not working properly	✓ AMC of this machine needs to be renewed. ✓ Training on local maintenance/ repairing (circuit) needs to be included in IMEP training of CHC officers. ✓ Availability of solution for the machine to be ensured at taluka level
Non availability of soaps at washbasin due to stolen soaps	✓ Wall mounted soap dispenser with liquid soap can be used in place of soap
Sanitation	
Lack of implementation of cleaning schedule checklist	✓ Inclusion of cleaning schedule checklist in routine monitoring may help
Inadequate and reluctant sweepers	✓ The TOR of sweeper for each level of facilities including the frequency of cleaning toilet based on the utility, needs to be defined by the head of the institute ✓ The time schedule of the class IV also needs to be defined as the class IV should work before OPD timings for cleaning. ✓ The type of recruitment of cleaning workers depends on type of facility. At SC, PHC were no. of toilets are less,

	class IV worker can be kept on daily wage for hourly basis (Twice a day) with flexible approach. But minimum wages law needs to be applied. At bigger facilities permanent sweeper is required or the service contract can be outsourced. ✓ The agency for such out sourcing must be registered and accountable. Their TOR must include provision of Penalty/punishment clause in the MOU ✓ As daily different cleaning staff is sent by outsourced agency, the insistence should be that outsourced agency itselfshould train and send the manpower
Toilets were unclean and non functional at few centers	✓ Routine items for sanitation should be either supplied from state/district or else dedicated fund for WASH related services and maintenance should be ensured ✓ In all toilets availability of had washing station with soap, functional light point and proper door with locking facility should be ensured ✓ Sensitization of staff and beneficiaries for developing and sustaining clean health facility using IPC or displaying related material on TV or banner in the health centre should be initiated ✓ The design of toilet for patient and staff needs to be different. For e.g. in PHC Anglo-Indian/Indian toilets needs to be present rather than western style. The slope of toilet needs to be correct. PIU should take inputs from user before construction. The height of the commode needs to be specified.
Delayed /irregular Repair of toilets and poor co-ordination with PIU	✓ Mechanism of timely complain, maintenance of complaint register and follow up/tracking of complaint with local PIU office to be established ✓ The HR strength of supervisory staff of PIU should be

	sufficient to respond to emergency. Also the staff distribution should be based on health centre load in each district. ✓ PIU should be given guidelines on how to prioritize from different grievance requests. ✓ PIU officers need to be invited in all relevant district and state meetings.
Availability of area specific toilets, hand washing station and drinking water point at few places lacking	✓ Inclusion of area specific toilet, hand washing station and drinking water point in the plan/layout of health centers to be ensured ✓ One handicap toilet in each facility is must be ensured
BMW Management	
Separate BMW storage facility unavailable at few centres	✓ Inclusion of separate storage room in the plan for health center by PIU to be ensured
All four bags and containers unavailable at each point of waste generation	✓ The BMW (CTF) agency must provide bags regularly as a part of their contract in different size to avoid bags-bins size mismatch, as per the need of the facility ✓ RC of BMW bags needs to be renewed. Usage of BMW bags to be reversed audited by weight of waste ✓ The BMW bags, cleaning material including IMEP equipment can be purchased by GMSCL at state level from cost negotiation point of view. Buffer stock of all logistics to be kept at regional stores. (Currently these are purchased at PHC/SC level which increases the cost and lowers the quality)
Improper Segregation of BMW seen at point of	✓ Induction/refresher training is required of all health workers from MO to class IV, on BMW/preparation of

generation PPE for BMW is irregularly used	hypochlorite/ housekeeping. ✓ The training modules for the same needs to be designed ✓ Local reviewing/supervision needs to be strengthened ✓ PPE should be supplied regularly in adequate quantity for handling BMW. ✓ Rubber gloves should be used instead of surgical gloves while handling PPE ✓ Functional hub cutter should be ensured at all relevant areas
Open air dumping and burning at few health centers	✓ Local sensitization/ Supervision needs to be strengthened

District wise Executive Summary

Kutch District

- Formal responsibility was not assigned in 9 (32.1%), 8 (28.6%), 9 (32.1%), 4 (16%), 6 (22.2%) and 4 (16.7%) facilities respectively for water supply, toilet facility and excreta disposal, Hospital waste management, ANC OPD, Labour room and PNC ward.
- Majority facilities (92.9%) had piped water supply and 64.3% facilities had adequate water supply.
- 17 (60.7%) facilities had functional treatment unit at point of utilization but regular water testing was done at only 2 (7.1%) facilities.
- All the facilities had cleaning/maintenance staff and safe excreta disposal system. Approximately 60% cleaning staff were either contractual or on daily wage basis.

- Three forth (75%) facilities had regular connectivity to common Bio Medical Waste Treatment Facility (CBWTF). All four bags and containers were lacking at 11 (39.3%) facilities.
- Area specific functional toilet was available at 9 (37.5%), 14 (51.9%) and 17 (68%) facilities respectively for PNC ward, Labour room and OPD room.
- Visibly clean health care surface/floor was found in 22 (91.7%), 26 (96.3%) and 25 (100%) facilities respectively for PNC ward, Labour room and OPD room but schedule cleaning was available in 8 (33.3%), 8 (29.6%) and 5 (20%) facilities respectively for PNC ward, Labour room and OPD area.
- The key enablers for WASH related services were dedication towards work, sense of ownership, supervision, funding mechanism, staff training, staff support.
- The key hurdles were other priorities, no scope for extra fund, lack of adequate manpower, lack of responsibility, belief of non importance and lack of IEC materials for WASH related activities.

Banaskantha District

- Formal responsibility was not assigned in 5 (23.8%), 5 (23.8%), 2 (9.5), 5 (23.8%), 4 (19.1%), and 3 (14.3%) facilities respectively for water supply, toilet facility and excreta disposal, Hospital waste management, ANC OPD, Labour room and PNC ward.
- Majority facility 90.5% had piped water supply and 81% facilities had adequate water supply.

- 12 (57.1%) facility had functional treatment unit at point of utilization but regular water testing was done at only 8 (38.1%) facilities.
- All the facility had cleaning/maintaining staff except 3 (14.3%) and safe excreta disposal system. Approximately 52% cleaning staff were either contractual or daily wage basis.
- All the facilities had regular connectivity to Bio Medical Waste treatment Facility (CBWTF). All four bags and containers were lacking at 3 (14.3%) facilities.
- Area specific toilet functional toilet was available at 14 (66.6%), 12 (57.1%) and 13 (61.9%) facilities respectively for PNC ward, Labour room and OPD room.
- Visibly clean health care surface/floor was found in 16(76.2%), 17(81%) and 17(81%) facilities respectively for PNC ward, Labour room and OPD room.
- The key enablers for WASH related services were dedication towards work, sense of ownership, supervision, funding mechanisms, staff training, staff support.
- The key hurdles were other priorities, no scope for extra fund, lack of adequate manpower, lack of responsibility, belief of non importance and lack of IEC materials for WASH related activities.

Dang District

- Formal responsibility was not assigned in 3 (75%), 3 (75%), 2 (50%), 4 (16%) facilities respectively for water supply, toilet facility and excreta disposal, Hospital waste management, while for ANC OPD, Labour room and PNC ward it was 2(50%) at all FDPs..
- All facilities had piped water supply and 90% facilities had adequate water supply except one center but which was also only in summer season.
- 1(25%) facilities had functional treatment unit at point of utilization but regular water testing were not doing at all 4(100%) facilities.

- All the facilities had cleaning/maintenance staff and safe excreta disposal system. Approximately 75% cleaning staff were either contractual or on daily wage basis.
- All facilities had regular connectivity to common Bio Medical Waste Treatment Facility (CBWTF). All four bags and containers were also available at all centers but only at 1(25%) center segregating BMW correctly. Three fourth 3(75%) of facilities were no proper storage facilities for BMW.
- Area specific functional toilet was available at 2(50%) facilities for PNC ward, Labour room and OPD room.
- Visibly clean health care surface/floor was found in 3(75%), 2 (50%) and 4 (100%) facilities respectively for PNC ward, Labour room and OPD room but schedule cleaning was not available at all facilities for PNC ward, Labour room and OPD area.
- The key enablers for WASH related services were dedication towards work, sense of ownership, supervision, funding mechanism, staff training, staff support.
- The key hurdles were other priorities, no scope for extra fund, lack of adequate manpower, lack of responsibility, belief of non importance and lack of IEC materials for WASH related activities.

Valsad District

- Poor findings regarding assigning responsible person were noted for each component of WASH (water, toilet, BMW, stock management etc.)
- Average to poor results was observed for many components of WASH e.g. IEC materials, cleaning schedule charts, stock management and documentation etc.
- Average to poor level of stock management (e.g. Hypochlorite solution, soaps, sterilium, BMW bags etc.) and documentation for WASH practices were observed. E.g. water tanks cleaning, water testing, maintenance of water purifier etc.

- No separate and clear budgetary guideline at state level for WASH activities.
- There was no any schedule for supportive supervision externally as well as internally.
- Overall cleaning of floor space was average to satisfactory level at different FDPs.
- Majority of FDPs had functional toilets. But separate toilets for different wards were not available due to old construction. So at majority of FDPs, sharing of toilets of different wards was observed. No separate toilets for male and female were found at majority of FDPs.
- Soaps and liquids for hand washing were observed at staff toilets whereas poor availability of soaps and liquids was noted at patient's toilets. The common reason for that were soaps and liquids were stolen.
- There was lacking of separate hand washing station outside the toilets at majority of FDPs.
- There was lacking of separate lock and key BMW storage room.
- BMW segregation was average to satisfactory level at different FPDs.

Sabarkantha District

- Responsibility of monitoring was not assigned in 4 (24.0%), 6 (35.3%), 5 (29.4%), 5(29.4%), 5 (29.4%) and 5 (29.4%) facilities respectively for water supply, toilet facility and excreta disposal, Hospital waste management, ANC OPD, Labour room and PNC ward.
- 4 (23.5%) facilities had piped water supply and 15 (88.2%) facilities had adequate water supply.
- 64.7% facilities had functional treatment unit at point of utilization but regular water testing was done at only 17.6% facilities.
- All the facilities had cleaning/maintenance staff and safe excreta disposal system. Approximately 40% cleaning staff were contractual and 13% was on daily wage basis.
- It was good to know that all 17 (100%) facilities had regular connectivity by CBWTF.
- However the knowledge regarding BMW segregation was very low amongst the staff of these facilities.

- Area specific functional toilet was available at 13 (76.5%), 8 (47.1%) and 16 (94.1%) facilities respectively for PNC ward, Labour room and OPD room.
- Hand washing stations were available at 6 (35.3%), 14 (82.4%) and 8 (52.9%) facilities of PNC ward, labour room and OPD area respectively. Liquid Hand sanitizer was unavailable at 13 (76.5%), 13 (76.5%) and 5 (70.6%) of facilities respectively for PNC ward, Labour room and OPD room.
- The key hurdle opined by responsible persons were : Lack of sense of responsibility, lack of awareness regarding guidelines, administrative concerns in utilization of RKS and other funds for expenses towards WASH facilities, Inadequate manpower and resistance from existing manpower for maintenance of WASH facilities.

Dahod District

- Formal responsibility was not assigned in 4 (19.0%), 6 (30.0%), 3 (14.28%), 3 (15.0%), 3 (15.0%) and 2 (10.0%) facilities respectively for water supply, toilet facility and excreta disposal, Hospital waste management, ANC OPD, Labour room and PNC ward.
- Majority facilities 20 (95.2%) had Bore hole and 90.5% facilities had adequate water supply.
- 10 (50.0%) facilities had functional treatment unit at point of utilization but regular water testing was done at 4 (19.0%) facilities.
- Most the facilities had cleaning/maintenance staff and safe excreta disposal system. Approximately 85% cleaning staff were either contractual or outsourced.
- All facilities had regular connectivity to common Bio Medical Waste Treatment Facility (CBWTF). All four bags and containers were lacking at 9 (42.9%) facilities.

- Area specific functional toilet was available at 10 (47.6%), 13 (61.9%) and 16 (76.2%) facilities respectively for PNC ward, Labour room and OPD room.
- Visibly clean health care surface/floor was found in 18 (85.7%), 17 (80.9%) and 18 (85.7%) facilities respectively for PNC ward, Labour room and OPD room but schedule cleaning was available in 14 (66.7%), 12 (57.1%) and 12 (57.14%) facilities respectively for PNC ward, Labour room and OPD area.

Panchmahal District

- Formal responsibility was not assigned in 1 (7.1%), 0 (0.0%), 9 (0.0%), 1 (7.1%), 0 (0.0%) and 0 (0.0%) facilities respectively for water supply, toilet facility and excreta disposal, Hospital waste management, ANC OPD, Labour room and PNC ward.
- Majority facilities 11 (78.6%) had Bore hole and all facilities had adequate water supply.
- 7 (50.0%) facilities had functional treatment unit at point of utilization but regular water testing was done at 4 (28.57%) facilities.
- Almost all the facilities had cleaning/maintenance staff and safe excreta disposal system. Approximately 70% cleaning staff were either contractual or Outsourced.
- All facilities had regular connectivity to common Bio Medical Waste Treatment Facility (CBWTF). All four bags and containers were lacking at 5 (28.6%) facilities.
- Area specific functional toilet was available at 9 (64.3%), 11 (78.6%) and 13 (92.9%) facilities respectively for PNC ward, Labour room and OPD room.
- Visibly clean health care surface/floor was found in 12 (85.7%), 14 (100.0%) and 13 (92.9%) facilities respectively for PNC ward, Labour room and OPD room but schedule cleaning was available in 8 (57.1%), 9 (64.3%) and 9 (64.3%) facilities respectively for PNC ward, Labour room and OPD area.
- The key enablers for WASH related services were dedication towards work, sense of ownership, personal interest, supervision, funding mechanism, staff training, staff support.
- The key hurdles were other priorities, no scope for extra fund, lack of adequate manpower, lack of responsibility, belief of non importance and lack of IEC materials for WASH related activities.

Narmada District

- Formal responsibility was not assigned in 2 (33.3%), 3 (50.0%), 3 (50.0%), 2 (33.3%), 1 (16.7%) and 1 (16.7%) facilities respectively for water supply, toilet facility and excreta disposal, Hospital waste management, ANC OPD, Labour room and PNC ward.
- Majority facilities (83.3%) had bore hole and 83.3% facilities had adequate water supply.
- 4 (66.7%) facilities had functional treatment unit at point of utilization but regular water testing was done at no centers.
- All the facilities had cleaning/maintenance staff and safe excreta disposal system.
- All facilities had regular connectivity to common Bio Medical Waste Treatment Facility (CBWTF). All four bags and containers were lacking at 4 (66.7%) facilities.

- Area specific functional toilet was available at 2 (33.3%), 4 (66.6%) and 6 (100%) facilities respectively for PNC ward, Labour room and OPD room.
- Visibly clean health care surface/floor was found in 5 (83.3%), 5 (83.3%) and 6 (100%) facilities respectively for PNC ward, Labour room and OPD room but schedule cleaning was available in 1 (16.7%), 1 (16.7%) and 0 (0.0%) facilities respectively for PNC ward, Labour room and OPD area.
- The key enablers for WASH related services were dedication towards work, supervision, funding mechanism, staff training,.
- The key hurdles were other priorities, no scope for extra fund, lack of adequate manpower, lack of responsibility, other priorities, belief of non importance and lack of IEC materials for WASH related activities.

Photo Gallery

Water: Good practices

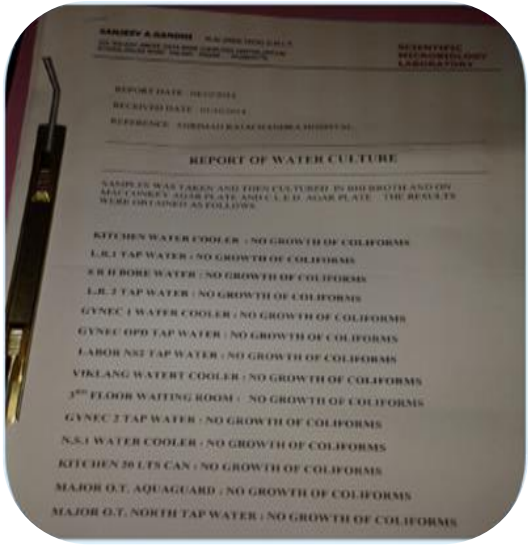
Instruction about reducing water wastage, CHC Garudeshwar, Narmada

Clean Well Maintained Functional Drinking Water Point, CHC Nakhatrana, Kutch

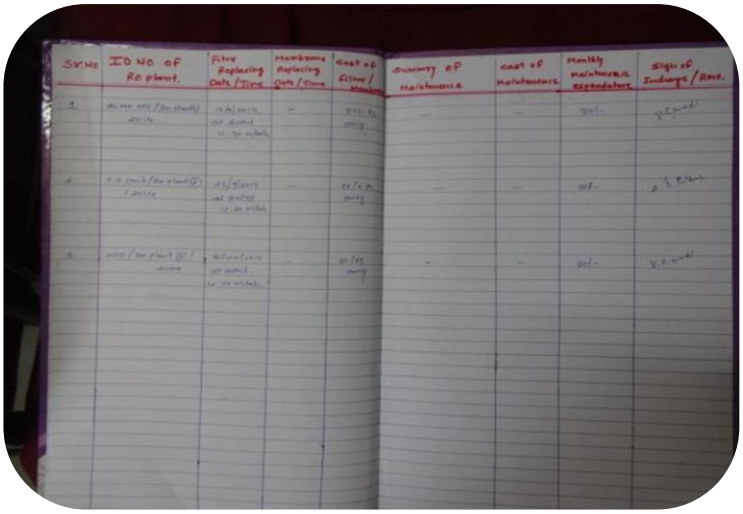
Drinking Water Point Available with help of local donor, CHC Idar, Sabarkantha

Well maintained, covered water storage tank, Civil Hospital, Valsad

Covered Drinking Water Point, CHC Chorivad, Sabarkantha



Water quality tests reporting, Shrimad Raj chandra hospital, Dharampur



Record book made available for monitoring of RO system maintenance & cleaning-DH Himatnagar, Sabarkantha

Water: Issues that need to be addressed

Poor sanitation maintenance near Point of Use of Drinking water facility- CHC Tilakwada, Narmada

Formation of Algae Inside RO Plant, PHC Dudhiya, Dahod

Open Overhead tank with cover near it – CHC Naliya, Kutch,

Poorly Maintained Water tank with Algae- SDH Khedbrahma, Sabarkantha

Toilet Facilities: Good practices

Proper Signage for Toilets in Local Language with Picture- CHC Malpur, Sabarkantha

Adequate Stock of cleaning material stored properly-CHC Vadali, Sabarkantha

Clean Functional Toilet – PHC Gagodar, Kutch

IEC material in local language, CHC Garudeshwar, Narmada

Toilet facilities: Issues that need to be addressed

Overflowing choked toilet in - DH Valsad, Valsad

Uncovered underground sewage system & leaking sewage water- DH Bhuj, Kutch

Toilet used as store room in wards- DH, Rajpipla, Narmada

No Light Bulb in Toilet in -CHC Sihori, Banaskantha

BMW management: Good practices

Locked storage for BMW - CHC Bhachau, Kutch

Well Maintained BMW Register -SDH Devbaria, Dahod

Functional Hub cutter & correct segregation of waste in bins with bags- CHC Sihori, Banaskantha

Tag indicating type of waste to be segregate in red bag in gujarati, PHC Khedipada, Narmada

BMW management: Good practices

Good practice of BMW Management,
PHC Khedipada, Narmada

BMW Management: Issues that need to be addressed

Color coded bags were poorly available due to irregular supply from district-SDH Devbaria,

Only container without bag and BMW coming out of it at PNC ward - PHC Ratnal, Kutch

Common Bathroom occupied by BMW waste at PHC: Mithi Paldi, Block : Deodar, Dist: Banaskantha

Non-functional Needle Destroyer & sharps- Kankapur PHC, Dahod

Good and Bad Practices for hygiene:

Expensive Machine for Sterisol Lying Idle due to Maintenance Issues-CHC Amodara, Sabarkantha

Washbasin for OPD patients with poster of hand washing steps- CHC Halol, Dahod

Washbasin with Liquid Soap, & Hand washing Technique Poster Displayed, PHC Kadiyadar, Sabarkantha

Broken Washbasin stand used to keep mops- DH Valsad, Valsad

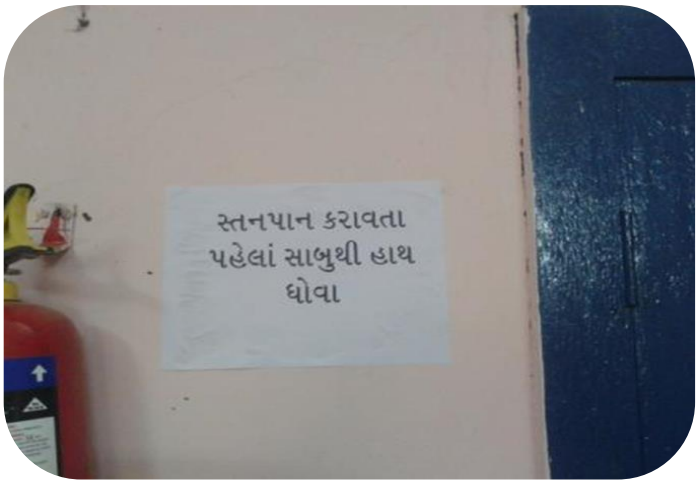
Photo Gallery

Instruction about toilet usage, CHC Garudeshwar, Narmada

Changes that were suggested in initial visit and observed during surprise visit 3 day afterwards - CHC Nakhatrana, Kutch

IEC material of hand washing, PHC Adesar, Kutch

IEC material displayed for proper disposal of Sanitary pad in toilet facility- PHC Sathamba, Sabarkantha



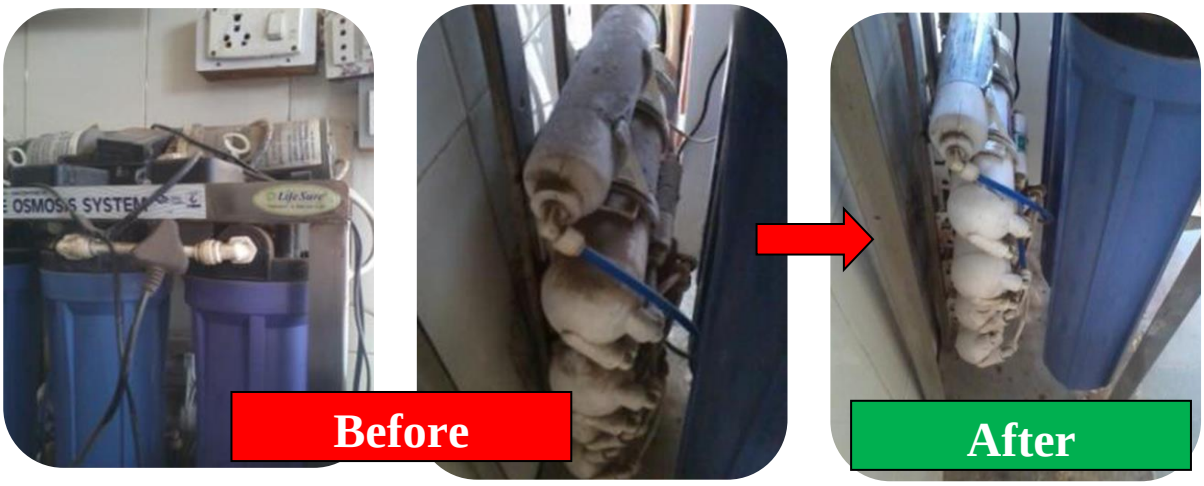
Temporary instructions for hand washing before breastfeeding displayed at post natal ward - PHC Sathamba, Sabarkantha

Dirty Soiled Labor Table– SDH, Sabarkantha

Clean Labor Table, CHC Vadali, Sabarkantha

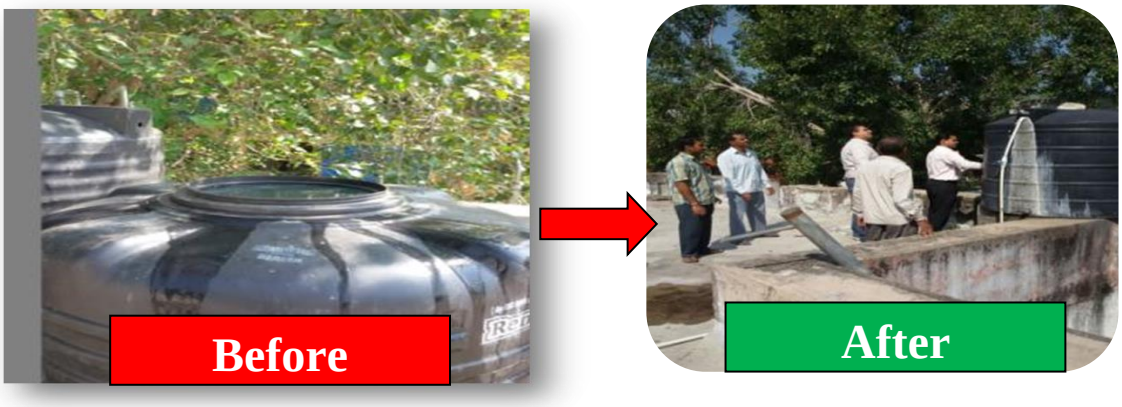
Some On-site Corrective Actions:

- **CHC Limdi, Dahod**



Cleaning of RO plant and connecting it into socket to make both RO and cooler functional

- **CHC Tilakwada, Narmada**



Open overhead tank was cleaned & was closed with lid

- **PHC Khediapada, Narmada**

Sweeper was called immediately for toilet cleaning

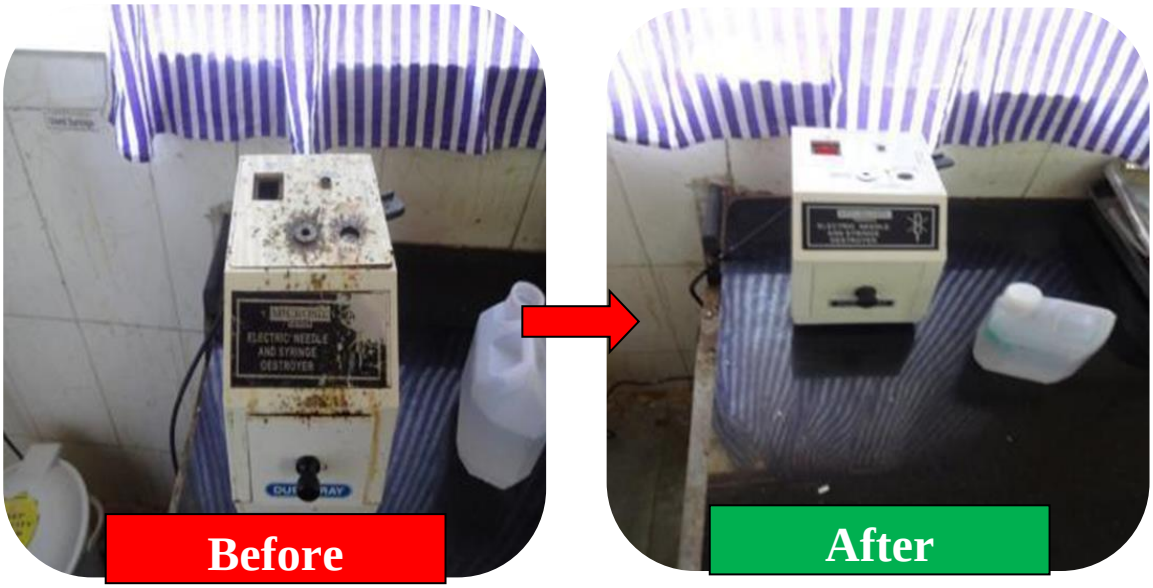
- **CHC Nakhatrana, Kutch**

Sweeper was called to clean toilet and bathroom

- **CHC Anjar, Kutch**

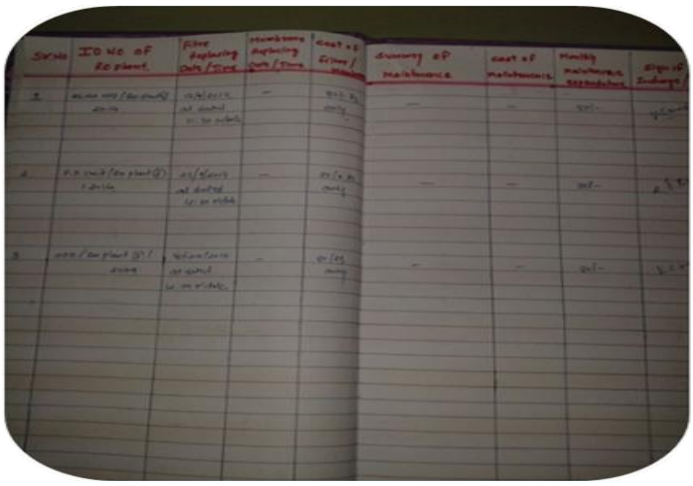
Staff nurse wascinsisted to keep the black bag for proper segregation of waste

- **DH Himmatnagar, Sabarkantha**



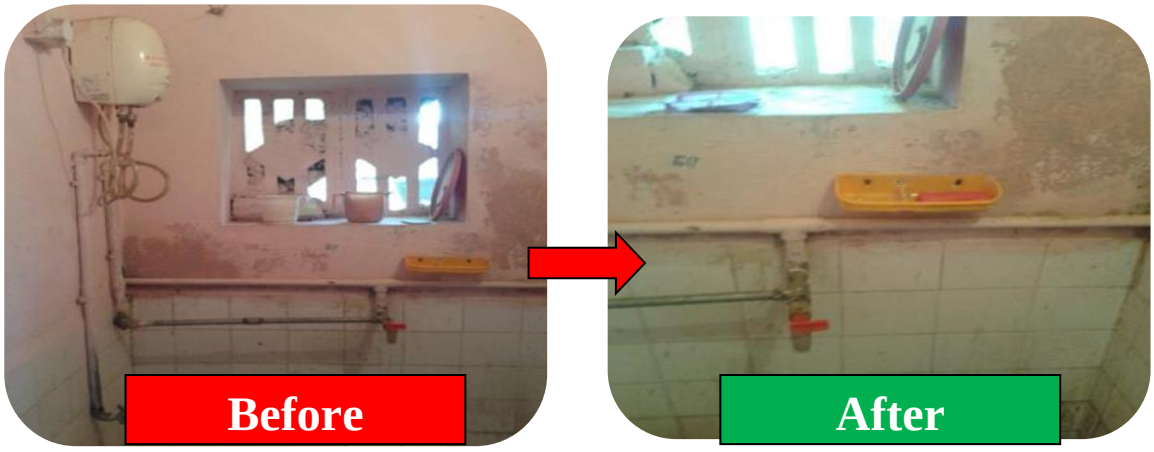
Availability of New hub cutter in store was identified. Hub cutter was brought out for use

- **DH Himmatnagar, Sabarkantha**



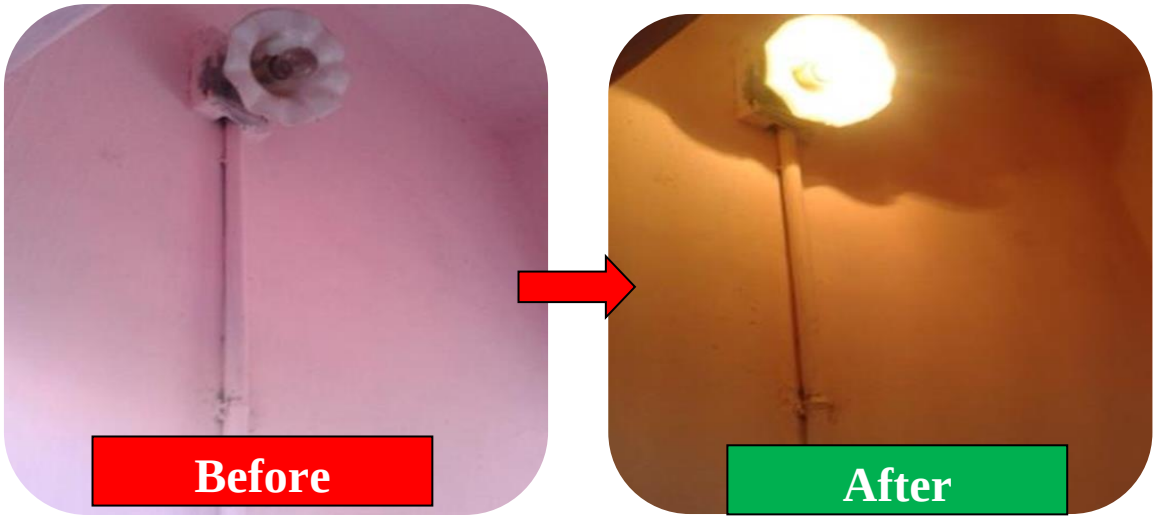
record book made available for monitoring
of RO system maintenance & cleaning-DH

- **PHC Sathamba, Sabarkantha**



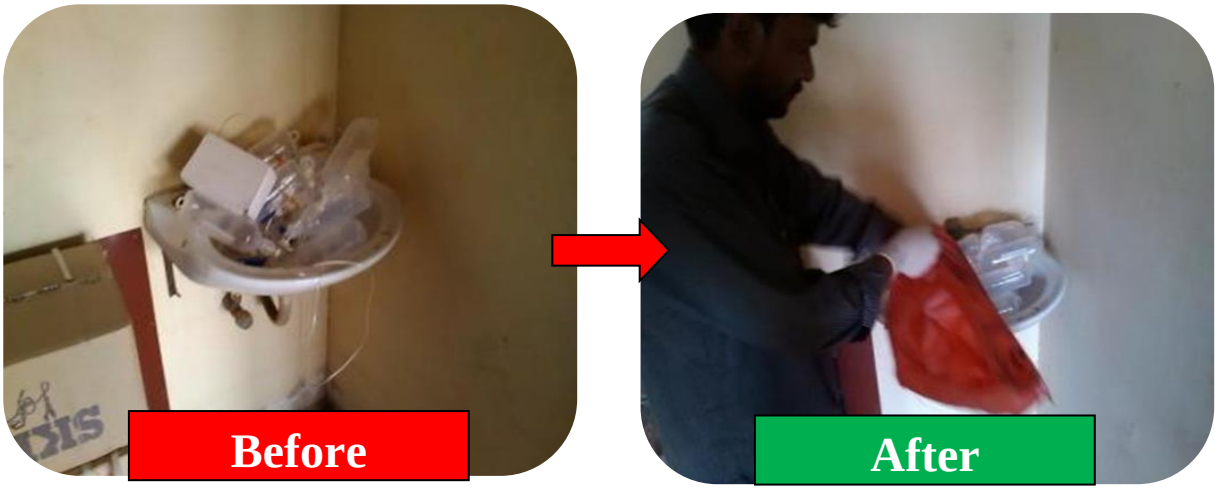
Soap was made available by
WASH Team

- **PHC Sathamba, Sabarkantha**



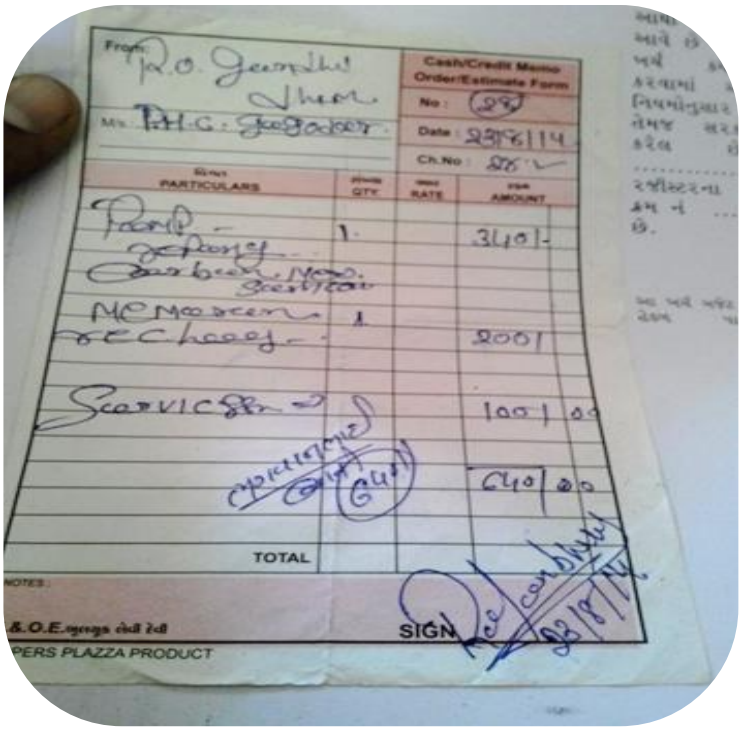
Light Bulb was purchased from RKS fund to make the point functional in toilet of OPD

- **PHC Ratnal, Kutch**

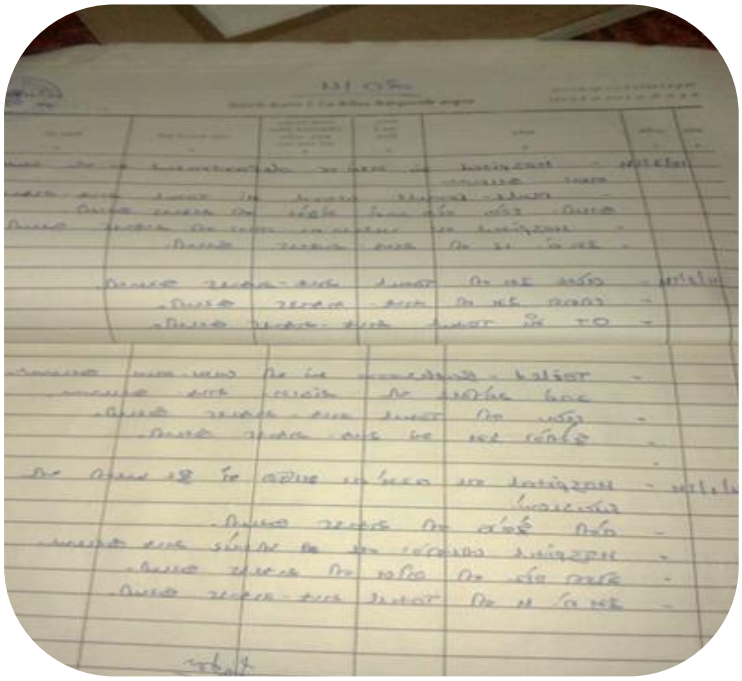


Sweeper instructed to dispose the waste immediately with proper segregation

Vouchers, application to PIU, records and registers



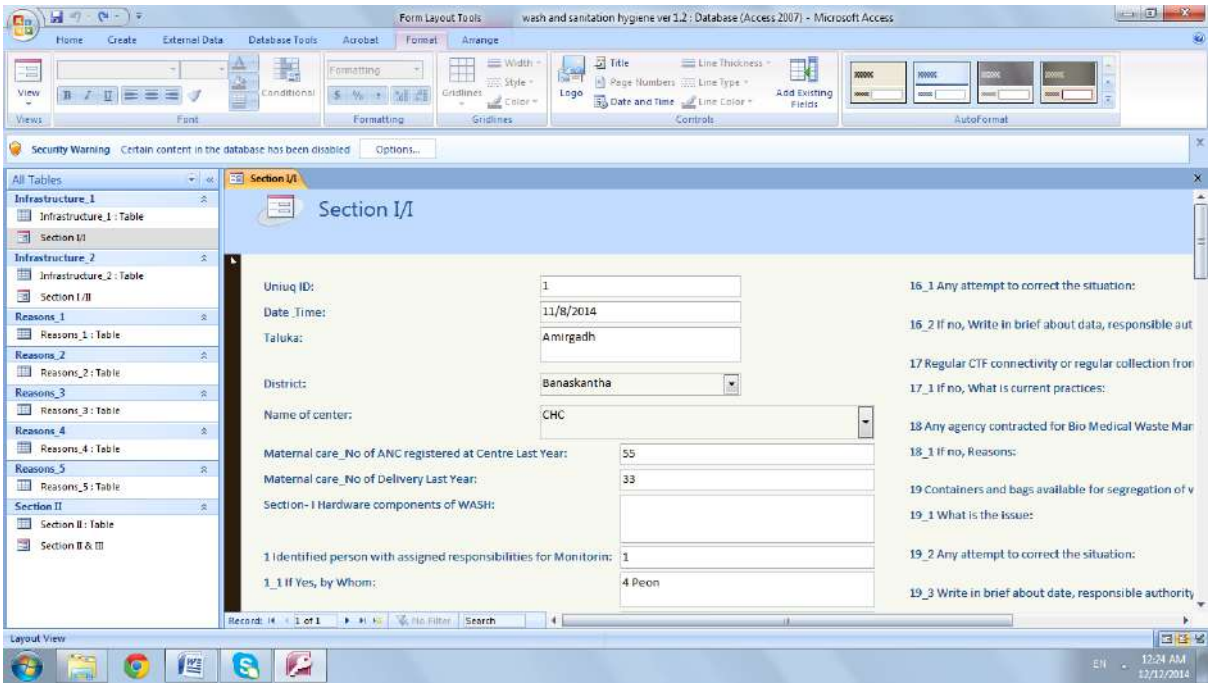
Expense receipt of maintenance - PHC Gagodar, Kutch

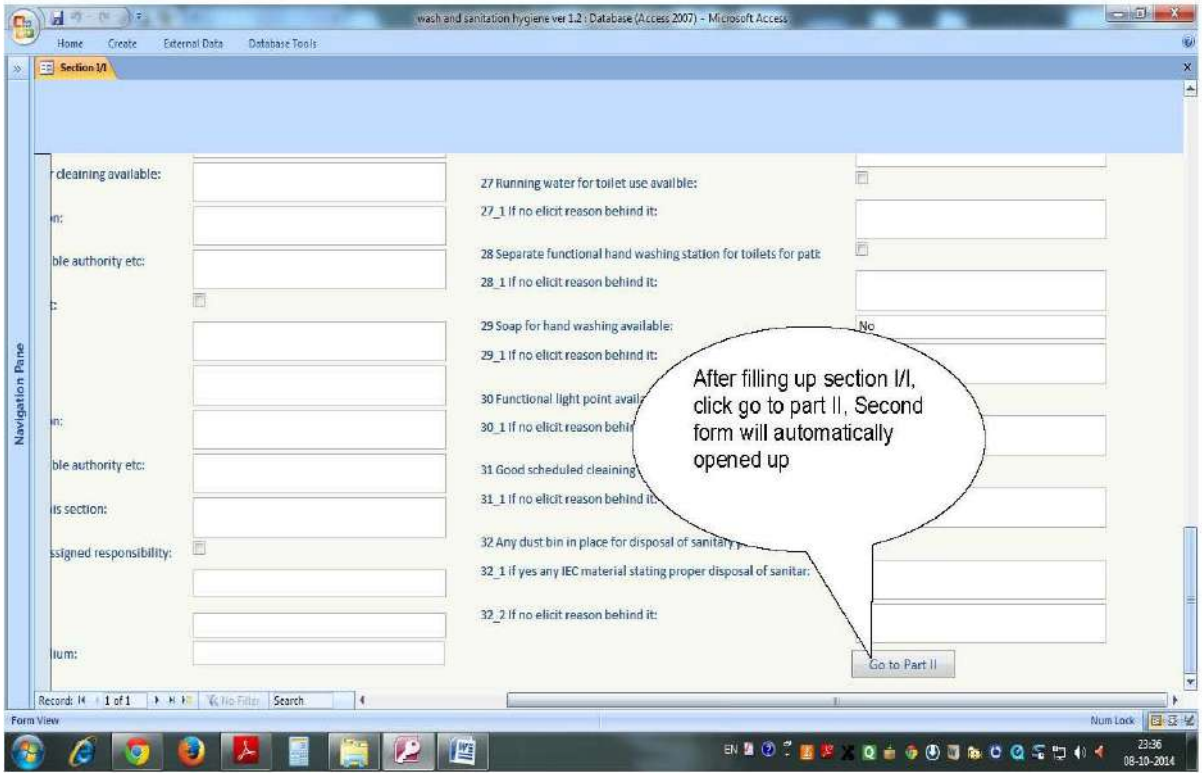


Record of cleaning schedule -CHC Bhachau, Kutch

Annexure

Annexure I: Data entry sheet in Microsoft Access 2007





Annexure II: Team Members

Banaskantha District		
Community Medicine Department, GMERS Medical College Dharpur - Patan		
Sr. No.	**Name**	**Designation**
1	Dr. Sunil Nayak	Associate Professor
2	Dr. Nilesh Thakor	Assistant Professor
3	Dr. Krunal Modi	Assistant Professor
4	Dr. Rakesh Ninama	Assistant Professor
5	Dr. Mayur Vala	Assistant Professor
6	Dr. Jagruti Darji	Lady Medical Officer
Dang District		
Community Medicine Department, GMERS Medical College, Valsad		
Sr. No.	**Name**	**Designation**
1	Dr. Hitesh Shah	Associate Professor
2	Dr. Ravikant Patel	Associate Professor
3	Dr. Darshan Mahyavanshi	Assistant Professor
4	Dr. Mehul Patel	Tutor
Valsad District		
Community Medicine Department, GMERS Medical College, Valsad		
Sr. No.	**Name**	**Designation**
1	Dr. Hitesh Shah	Associate Professor
2	Dr. Darshan Mahyavanshi	Assistant Professor
3	Dr. Mitali Patel	Assistant Professor
4	Dr. Kapil Govani	Assistant Professor
5	Dr. Priti	Assistant Professor
6	Dr. Hinal	Assistant Professor
7	Dr. Mehul Patel	Tutor

Annexure

Narmada District		
Community Medicine Department, GMERS Medical College, Gotri		
Sr. No.	**Name**	**Designation**
1	Dr Chandresh Pandya	Associate Professor
2	Dr Rohit Parmar	Assistant Professor
3	Dr Dharmendra Jankar	Assistant Professor
4	Dr Sanat Rathod	Assistant Professor
5	Dr Gaurang Suthar	Tutor
Sabarkantha District		
Community Medicine Department, GCS Medical College, Ahmedabad		
Sr. No.	**Name**	**Designation**
1	Dr. K. N. Sonaliya	Professor & Head
2	Dr. Viral Dave	Assistant Professor
3	Dr. Venu Shah	Assistant Professor
4	Dr. Arpit Prajapati	Assistant Professor
5	Dr. Bhavik Rana	Assistant Professor
6	Dr. Mansi Patel	Tutor
7	Dr. Asha Solanki	Tutor
Dahod District		
Community Medicine Department, Baroda Medical College, Baroda		
Sr. No.	**Name**	**Designation**
1	Dr. Jivraj Damor	Associate Professor
2	Dr. Preeti Panchal	Assistant Professor
3	Dr. Pritesh Patel	Assistant Professor
4	Dr. Niyati Parmar	Tutor
5	Dr. Ajay Parmar	Tutor

Panchmahal District		
Community Medicine Department, Baroda Medical College, Baroda		
Sr. No.	**Name**	**Designation**
1	Dr. Jivraj Damor	Associate Professor
2	Dr. Preeti Panchal	Assistant Professor
3	Dr. Pritesh Patel	Assistant Professor
4	Dr. Niyati Parmar	Tutor
5	Dr. Ajay Parmar	Tutor
Kutch District		
Community Medicine Department, PDU Govt. Medical College, Rajkot		
Sr. No.	**Name**	**Designation**
1	Dr. Rajesh Chudasama	Associate Professor
2	Dr. Kaushik Lodhiya	Assistant Professor
3	Dr. Chintan Dasharatha	Assistant Professor
4	Dr. Nirav Joshi	Tutor
5	Dr. Dipesh Zalavadiya	Tutor

Annexure III: Post Debriefing Letter from Commissionerate of Health

सत्यमेव जयते

J. P. Gupta IAS
Commissioner(Health) & Secretary(PH & FW)

No. FW/15-16/SQIP/WASH/May-15
Commissionerate of Health,
Medical Services, Medical Education & Research, Gujarat
Block. No.-5, Dr. Jivraj Mehta Bhavan
Gandhinagar – 382010
Phone: (079) 23253271, Fax: (079) 23256430
E-mail: cohealth@gujarat.gov.in
Date: 12-05-2015

Subject: Water, Sanitation and Hygiene (WASH) services and practices in health facilities

There is a great need to improve WASH services in public health facilities for improving the image and utilization of the public health system and also for the safety of the beneficiaries mainly from sepsis.

As per the key finding of the WASH Gap analysis, you are hereby instructed to ensure that all the health care facilities have following non-negotiable services and practices.

A. Monitoring

1. One assigned person must be identified in each patient care area at each facility for monitoring Water supply, Sanitation, and Hygiene (WASH) services and practices. Each facility to prepare a written matrix of the same.
2. Strict supervision and review should be done from BHO/DQAMO/CDHO/RDD and state level

B. Water Supply

1. There is **zero tolerance for leaking/missing water taps, leaking water pipeline**s in health facilities
2. **Regular water quality testing of drinking water** of all health facilities with H2S bulb must be ensured. A tendering process to be initiated from state for procuring the H2S bulb. Till than the H2S bulb can be procured from WASMO from district/local level.
3. Each facility must have one identified person for operating motor for water to avoid overflowing of water tanks and wastage of electricity
4. All **water tanks (both underground and overhead) should be covered and regular cleaning** of the same must be ensured. All water treatment units must be maintained at regular frequency.

C. Sanitation

1. **Dustbin and bags for disposal of sanitary pads must be available in all female toilets (especially in postnatal ward) without fail and is non-negotiable**. Pictorial signage on disposal of sanitary pad must be ensured at all such places
2. It is to be ensured without fail that **all toilets (especially in labor room and postnatal ward) are unlocked, accessible, not used as storage room, with intact door and stopper, functional, clean, with water available, with functional light points, with bucket/tumbler and without broken toilet seats**. This is **non-negotiable** for ensuring quality health services.
3. There is **zero tolerance for leaking/missing water taps, and broken toilet seats** in toilets in health facilities
4. Each labor room and postnatal ward should have an attached toilet.
5. All toilets should have an attached hand washing station.

D. Hygiene

1. **All hand washing stations** including the ones in patient's toilets (especially in **Labor room, Postnatal wards**) **must be functional, clean, with running water and without any missing/leaking taps.**
2. **Soap availability at all hand washing stations** (especially in Labor room, Postnatal wards) must be ensured without excuse and is **non-negotiable**.
3. All **hand washing station** at key patient care areas like Labor room, PNC ward, SNCU, NICU, NBCC must have **displayed standard protocols** and reminder poster on hand washing including who, when, how one should wash hands.
4. **Dumping of cleaning material, instruments, or other waste in the washbasin is strictly not acceptable.**
5. Tendering for purchase of wall mounted soap dispense and liquid soap for entire state to be initiated
6. Each labor room, postnatal ward and OT must have a hand washing station.
7. **Hand washing practices by staff at critical times during maternal and newborn care must be ensured and is non-negotiable**.
8. IPC of the patients (specially post natal mothers) on hand washing must be ensured.

E. BMW Management

1. No open air dumping of BMW must be strictly ensured

2. All patient care area must have a functional hub cutter and four colour coded bags and bins.
3. Disinfection of BMW as per the protocol must be ensured. Hypochlorite availability for the same must be ensured.
4. To ensure zero reuse of BMW, all pints, gloves, etc. should be disposed only after mutiliation/cutting.
5. CBWTF agency collecting waste must cover all the FDP at regular frequency and should supply all four colour coded bags and containers. The clause for the same in their contract must be revised.

A check list with guide note for assessment and monitoring of the health facility is attached herewith, which must be filled and submitted to this office within 10 working days.

B No lacunae in the stringent implementation, supervision, monitoring and review of the above actions will be acceptable. I urge you all to ensure strict follow-up of the above said non-negotiable activities.

(J.P. Gupta)

Enclosure,

- ✓ Checklist with guidenote

Copy to,

- ✓ Additional Director (PH, FW, MS, ME), Gandhinagar
- ✓ Chief Engineer (PIU), Gandhinagar
- ✓ Deputy Director (Rural Health), Gandhinagar
- ✓ Deputy Director (Urban Health), Gandhinagar
- ✓ Medical Superintendent & Dean, Medical College Hospital (All)
- ✓ Dean, Dental College Hospital (All)
- ✓ Medical superintendent, Mental Hospital (All)
- ✓ Regional Deputy Director, (All)
- ✓ Chief District Medical Officer, (All)
- ✓ Chief District Health Officer, (All)
- ✓ Medical officer of Health, Municipal Corporation (All)
- ✓ SQAMO, Gandhinagar

Copy with compliments to,

- ✓ MD (NHM), Gandhinagar
- ✓ MD (GMSCL), Gandhinagar
- ✓ Collector (Eight HPDs)
- ✓ DDO (Eight HPDs)
- ✓ Chief, UNICEF, Gujarat Field Office
- ✓ Secretary, IAPSM-GC

Annexure

WASH Checklist													
	Name of the facility…… Month and Year:- ……		1	2	3.1	3.2	3.3	3.X	4.1	4.X	5.1	X	
Sr No.	Check List	Cleaning Frequency	OPD area	Labor room	Postnatal ward	Male general ward	Female general ward	Ward-X	OT-1	OT-X	Laboratory	Area X	
1	Each area wise assigned person for ensuring and monitoring WASH compliance identified and matrix prepared	_	Name										
a	Name of the responsible persons	_											
b	Name of the Supervisors	_											
2	Water Supply		(Yes/No)										
a	Sufficient Water Supply available at facility for routine hospital work	_											
b	No leakages present in the water pipelines	_											
C	Water purification system present for drinking water	_											
C.1	Water purification system is functional	_											
C.2	Water purifier is maintained regulrly	As specified by the company											
C.3	Drinking Water taps are non leaking and functional	_											
d	Responsible person is identified for operating motor	_											
e	Overhead and underground Water tank (esspecially connected to drinking water lines) are covered	_											
f	Overhead and underground Water Tank (esspecially connected to drinking water lines) are cleaned minimum biannualy	Minimum biannual											
g	Water quality testing is conducted at regular frequency with H2S Bulb	Once a fortnight											
3	Sanitation												
3.1	No. of Toilets available (N)		1	X	Y	1	1	1	1	1	1	1	
3.2	Toilet no. -1		(Yes/No)										
a	Toilet accessible?	_											
b.	Toilet Functional?	_											
c	Light Point is Functional in the toilet?	_											
d	Running water is available in toilet?	_											
e	Water Taps is present, Functional and not-leaking	_											
f	Toilet have intact (non -broken) bucket and tumbler	_											
g	General cleanliness of toilet (e.g. Absence of stinking, dirty, blacken tiles/kamods)	Clean minimum twice daily											
h	Attached washbasin present	_											
i	Washbasin water tap is present, functional and not-leaking	_											
j	Washbasin have running water	_											
k	Washbasins have soap present	_											

l	Wash basin have handwashing protocol displayed	_										
m	Pipe below the washbasin is intact	_										
n	Is this a female Toilet?	_										
o	Does female toilet have a dustbin for sanitary pad disposal	_										
p	Is IEC present with dustbin for disposal of sanitary pad?	_										
q	Toilet door intact and lockable from incide	_										
3.3	Toilet no.-X		(Yes/No)									
a	Toilet accessible?	_	_			_	_	_	_	_	_	_
b.	Toilet Functional?	_	_			_	_	_	_	_	_	_
c	Light Point is Functional in the toilet?	_	_			_	_	_	_	_	_	_
d	Running water is available in toilet?	_	_			_	_	_	_	_	_	_
e	Water Taps is present, Functional and not-leaking	_	_			_	_	_	_	_	_	_
f	Toilet have intact (non -broken) bucket and tumbler	_	_			_	_	_	_	_	_	_
g	General cleanliness of toilet (e.g. Absence of stinking, dirty, blacken tiles/kamods)	Clean minimum twice daily	_			_	_	_	_	_	_	_
h	Attached washbasin present	_	_			_	_	_	_	_	_	_
i	Washbasin water tap is present, functional and not-leaking	_	_			_	_	_	_	_	_	_
j	Washbasin have running water	_	_			_	_	_	_	_	_	_
k	Washbasins have soap present	_	_			_	_	_	_	_	_	_
l	Wash basin have handwashing protocol displayed	_	_			_	_	_	_	_	_	_
m	Pipe below the washbasin is intact	_	_			_	_	_	_	_	_	_
n	Is this a female Toilet?	_	_			_	_	_	_	_	_	_
o	Does female toilet have a dustbin for sanitary pad disposal	_	_			_	_	_	_	_	_	_
p	Is IEC present with dustbin for disposal of sanitary pad?	_	_			_	_	_	_	_	_	_
q	Toilet door intact and lockable from incide	_	_			_	_	_	_	_	_	_
3.4	Toilet no. -Y		(Yes/No)									
a	Toilet accessible?	_	_	_		_	_	_	_	_	_	_
b.	Toilet Functional?	_	_	_		_	_	_	_	_	_	_
c	Light Point is Functional in the toilet?	_	_	_		_	_	_	_	_	_	_
d	Running water is available in toilet?	_	_	_		_	_	_	_	_	_	_
e	Water Taps is present, Functional and not-leaking	_	_	_		_	_	_	_	_	_	_
f	Toilet have intact (non -broken) bucket and tumbler	_	_	_		_	_	_	_	_	_	_
g	General cleanliness of toilet (e.g. Absence of stinking, dirty, blacken tiles/kamods)	Clean minimum twice daily	_	_		_	_	_	_	_	_	_
h	Attached washbasin present	_	_	_		_	_	_	_	_	_	_

i	Washbasin water tap is present, functional and not-leaking	_	_	_		_	_	_	_	_	_	_
j	Washbasin have running water	_	_	_		_	_	_	_	_	_	_
k	Washbasins have soap present	_	_	_		_	_	_	_	_	_	_
l	Wash basin have handwashing protocol displayed	_	_	_		_	_	_	_	_	_	_
m	Pipe below the washbasin is intact	_	_	_		_	_	_	_	_	_	_
n	Is this a female Toilet?	_	_	_		_	_	_	_	_	_	_
o	Does female toilet have a dustbin for sanitary pad disposal	_	_	_		_	_	_	_	_	_	_
p	Is IEC present with dustbin for disposal of sanitary pad?	_	_	_		_	_	_	_	_	_	_
q	Toilet door intact and lockable from incide	_	_	_		_	_	_	_	_	_	_
4	Hygiene		(Yes/No)									
a	Washbasin in patient care area present	_										
b	Washbasin water tap is present, functional and not-leaking	_										
c	Washbasin have running water	_										
d	Washbasins have soap present	_										
e	Wash basin have handwashing protocol displayed	_										
f	Pipe below the washbasin is intact	_										
5	Biomedical Waste		(Yes/No)									
a	All four Red, Yellow, Blue, and Black bags and bins present in patient care area	_										
b	Mutilators (Needle / syringe cutters) present	_										
c	1% fresh Sodium hypochlorite or Bleaching Powder Solution preparation and disinfection As per BMW Guide line.	Daily										
d	Regular Waste collection by CBWTF (not more than 48 hr storage)	every 48 hr maximum										

Annexure

Guidance note

1. **Each area wise assigned person for ensuring and monitoring WASH compliance identified and matrix prepared**

Template for matrix

Name of the health facility:			
Sr. No.	**Patient care area**	**Name of the person responsible for ensuring and monitoring WASH compliance**	**Monitoring Frequency**
1.	OPD area	Mr. X, Staff Brother	Twice daily before morning and afternoon OPD
2.	Ward-1	Mrs. Y, Staff Nurse	Once daily in morning before rounds
3.	Ward-2	Mr. Z, Staff Brother	Once daily in morning before rounds
4	OT-1	Mrs. A, Staff Nurse	Once daily in morning before OT
5	Labor room	Mr. B, Staff Brother	After each delivary
6	....	.....	
7	Operating motor	Mr. A, Peon	Daily at the time of operating motor as per the facility
8	Overall responsibility	Dr. B, MO/MS/Ayush MO	Daily surprise visit in one randomly selected area

Such matrix should be prepared at each facility. A copy of the same should be submitted to the DQAMO. CDHO should monitor and review implementation of the same.

2. **Water Supply**

2.1 Sufficient water supply

Minimum water quantity required in the health-care setting is Outpatients 5 litres/consultation, Inpatients 40–60 litres/patient/day, Operating theatre or maternity unit 100 litres/intervention as per WHO guidelines. But the actual quantities of water required will depend on a number of factors, such as climate, availability and type of toilets. If the water is sufficient for the drinking, medical and housekeeping purpose it is considered sufficient.

2.2 Leakage in pipeline

There should be no leakage in water supply line from source to point of use to avoid wastage of water. All leaky water pipes should be repaired promptly in co-ordination with district PIU office.

2.3 Water purification

Drinking-water should be acceptable to patients and staff, or they may not drink enough, or may drink water from other, unprotected sources, which could be harmful to their health. Particular care is needed to ensure that safe drinking-water is supplied to immunocompromised patients, because of their high susceptibility to infection. Provision of any acceptable water purification method like electric-non electric water purifier, chlorine like disinfectant is acceptable as water purification system.

The water purification system should be in use (functional) and the water for drinking purpose must be provided after purification only.

As per the quality standards, there should be provision for maintenance of water purifier. The water purifier membrane must be cleaned regularly as per manufacturer's requirement because of plugging of the small membrane pores by hardness/organic compounds decreasing the flow. The health facility should get it done from local fund. At larger health facility AMC can be done. The same can also be done from district level.

2.4 Water taps

Water tap for drinking purpose must be present (not missing), Intact, Functional (Running water must be coming out with adequate flow), without any leakages (to avoid wastage of water)

2.5 Responsibility for Motor Operation

Each health facility should have one identified person for operating motor of water tank on daily basis. He should operate motor timely to avoid any overflow of water tank and wastage of water and electricity.

2.6 Water tank

All the water storage tanks should have close fitting covers and none should be leaking.

As per quality manuals for Gujarat there should be cleaning of water storage tanks at regular interval. The health facility should get the tanks cleaned from local fund. At larger health facility AMC can be done. The same can also be done from district level.

2.7 Water Quality

Water for drinking, cooking, personal hygiene, medical activities, cleaning and laundry should be safe for the purpose intended. Drinking-water supplied to health-care settings should meet national standards and follow WHO guidelines for drinking-water quality. Microbial quality is of overriding importance for infection control in health-care settings. The water should not present a risk to health from pathogens and should be protected from contamination inside the health-care setting itself. As per the quality manuals of Guajrat, health facility should regularly test the quality of drinking water (bacterial analysis with H2S bulb) once a month as part of a routine surveillance and control programme. The H2S bulb can be procured from WASMO at district/local level till such mechanism is started at state level.

3. Sanitation

3.1 Toilet Block

As per IPHS, dedicated toilets with running water facility and flush shall be provide for each patient care area.

3.2 Accessibility

Toilet should not be locked or uses as storage room, nor should its entrance be blocked by other objects.

3.3 Functional

Functional means that the toilets are not broken and can be used by patients. Not functional means that the toilet is broken/chocked/over flowing/ in such a way that it cannot be used.

3.4 Light Point

Working light bulb/tubelight must be present inside the toilet. If the light bulbs are stolen, one can keep a metal mash over it or replace it with tubelight.

3.5 Cleanliness

The purpose of this question is to assess the latrine cleanliness cause patients may be less likely to use the latrines if they are dirty. Clean Toilet is one with e.g. Absence of stinking, not dirty, not with blacken tiles/kamods Toilets should be cleaned whenever they are dirty, and at least twice per day, with a disinfectant used on all exposed surfaces and a brush to remove visible soiling. Strong disinfectants should not be used in large quantities, as this is unnecessary, expensive, potentially dangerous. If no disinfectant is available, plain cold water should be used.

3.6 Water Taps

All the water taps should be functional, not missing, not leaking with good flow of running water, causing no wastage of water

3.7 Wash basin

Hand washing station/washbasin must be present attached with the toilets for hand washing after use of toilets. The purpose is to assess the availability of the first requirement for hand washing practice.

As per the IPHS norm, uninterrupted water supply should be present in all the hand washing station.

As per IPHS space shall be provided for soap with hand washing stations. If soaps are stolen, make arrangements for wall mounted soap dispenser with liquid soaps from local/district level, till such supply becomes available from state.

Hand washing protocols in vernacular language with pictures including when to wash hands (before cooking, after toilet use, after cleaning child's feces, after touch with animal, before having food, before and after touching the newborn) , how to wash hands, must be displayed at all washbasin's for patients use.

Wash basin is functional if it is without broken pipes, leaking/missing taps, dumping in the basin etc. and accessible/usable for the staff or patients. Washbasin with missing pipes must be repaired promptly with help of local plumber.

3.8 Sanitary pad disposal

All female toilets must have a dustbin, bag and pictorial signage in vernacular language for proper disposal of sanitary pads. If dustbins are stolen, one may try to hang it in a stand in toilet block.

3.9 Door

The door of the toilet must be intact, not broken. One should be able to close and lock it from inside

4. Hygiene

4.1 Wash basin

Hand washing station/washbasin must be present in all the patient care areas. The purpose is to assess the availability of the first requirement for hand washing practice.

As per the IPHS norm, uninterrupted water supply should be present in all the hand washing station.

As per IPHS space shall be provided for soap with hand washing stations. If soaps are stolen, make arrangements for wall mounted soap dispenser with liquid soaps from local/district level, till such supply becomes available from state.

Hand washing protocols with pictures including when to wash hands (before and after touching the patients, before and after each invasive procedure, before and after conducting delivary, before and after touching the newborn) , how to wash hands, must be displayed at all washbasin's for staff use. Frequent hand washing reminder posters like " Have you WASH your hands?" must be displayed in all patient care areas.

Wash basin is functional if it is without broken pipes, leaking/missing taps, dumping in the basin etc. and accessible/usable for the staff or patients. Washbasin with missing pipes must be repaired promptly with help of local plumber.

5. BMW

Handling of BMW must be as per the legal act.

All four coloured bags/containers must be present in all patient care areas. No mismatch is acceptable regarding colour of bag and container as it has grave final disposal consequences. Hub cutter must be present in each patient care area for destruction at the site of generation. Disinfection of waste is another imp point.

There should be minimum every third day collection of hospital waste by CTF, which is to avoid more than 48 hr storage of waste at facility.

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Annexure IV: Minutes of Debriefing Meeting

WASH Gap Assessment Debriefing Meeting

Minutes of the Meeting, Date: 5th May, 2015

WASH Gap Assessment was conducted by Dept. of Health & Family Welfare, Govt. of Gujarat in partnership with UNICEF and IAPSM-GC. A Debriefing meeting of the assessment findings was organized under chairpersonship of Commissioner of Health.

Members as per Annexure 1 attended the meeting.

Following action points were discussed and decided in the meeting:

Sr. No.	Name of activity	Responsible Person
1	Head of the Facility has overall responsibilities for monitoring Water supply, Sanitation, and Hygiene (WASH) services and practices in health facilities. But for institutional monitoring as well as area wise monitoring (specifically in Labor room and PNC areas) one assigned person should be identified in each patient care area at each facility. Each facility to prepare a matrix of the same. Everyone in the facility to be aware of their responsibility as per the matrix. A copy of the same to be sent to THO/DQAMO/CDHO, who should supervise for the implementation of the same.	**SQAMO**
2	Each facility should have an identified person for operating motor for water. Motor should be started and turned off timely to avoid overflowing of water tanks and wastage of electricity	**SQAMO**
3	Standard protocols on hand washing including who, when, how should wash hands for both staff and patients to be designed and disseminated for display. Reminder posters for hand washing (e.g. Have you wash your hand?) by staff at key patient care areas like Labor room, PNC ward, SNCU, NICU, NBCC to be designed and disseminated for display for continuous reminder. IPC of the patients (specially post natal mothers) on hand washing (How? When?) to be ensured.	**SQAMO**
4	All water tanks (both underground and overhead) should be covered and regular cleaning of the same to be ensured	**SQAMO**
5	Minor repairing such as replacement of leaking/missing water taps, repair of broken toilet seats, etc. to be ensured at the institutional level by the head of the facility.	**SQAMO**
	Other major problems like leaking water pipes are to be resolved in co-ordination with PIU.	**PIU**
6	Total gap assessment for infrastructure/practices/services of Labor	**AD (FW)**

	room, SNCU, NICU of all health facilities across the state to be done using a standardized checklist on utmost priority basis. List of such facilities to be updated on priority basis and complete plan of such assessment to be prepared. All the gaps coming out of the assessment to be fulfilled. Explore the possibilities of using medical colleges for such assessment. Explore possibilities of using NQS checklist for such assessment.	
7	Monthly monitoring, review and follow-up of health facilities for gaps in WASH related infrastructure to be ensured.	**SQAMO & PMCC**
8	Tendering process for wall mounted soap dispenser and liquid soap for all the health facilities across the state as per the need to be completed	**GMSCL**
9	Tendering process for H2S bulb for water quality testing for all the health facilities across the state as per the need to be completed	**GMSCL**
	Standard protocols for the use of the H2S bulb, frequency of testing, follow-ups to be circulated	**SQAMO**
10	Possibilities of supplying a standard housekeeping kit from state level across the facilities to be explored with unit cost, essential commodities	**SQAMO**
11	Implementation of changes in layouts of health centers for RMNCH+A including WASH Compliant Labor rooms, PNC wards, SNCU, NICU, NBCC to be followed up with PIU	**SQAMO; PIU**
12	No open air dumping of BMW to be strictly ensured and followed-up for	**SQAMO**
13	Dustbin and bags for disposal of sanitary pads should be ensured in all female toilets (especially in postnatal ward) without fail. Pictorial signage on disposal of sanitary pad to be ensured at all such places	**SQAMO**
	Designing and dissemination of the pictorial signage on disposal of sanitary pads to the districts	**SQAMO**
14	All four colored containers and bags of appropriate size for BMW management as per the need of the facility are to be supplied by CBWTF agency collecting the waste. The clause for the same to be included in the contract with the CBWTF agency. Monitoring and review of the CBWTF agency for the same to be ensured.	**AD (MS)**
15	Regular monitoring and review of the performance of CBWTF agency including frequency of collection of wastes to be ensured.	**SQAMO**
16	All FDP SC are to be covered by CBWTF agency for waste collection or an alternate mechanism of waste collection from SC to PHC to be arranged for such FDP SC.	**SQAMO**
17	Frequent sensitization of the health functionaries on WASH compliance and BMW management to be done. Knowledge, Attitude and Practices of such trained health functionaries to be assessed to ensure translation of training in to practices in the field. Use of Audio-visual tests during such assessment can be explored.	**SQAMO**

18	It is to be ensured that all hand washing stations including ones in patient toilets (especially in Labor room, Postnatal wards) are functional, clean with running water and soap availability.	**SQAMO**
19	A template of 10-15 important actionable points from the WASH Gap Assessment reports with timeline is to be prepared for further planning and submitted to commissioner of Health.	**SQAMO**
20	Concurrent Improvement and supportive supervision/mentoring will be continued in next phase by medical colleges coordinated by IAPSM with technical and financial support from UNICEF in close collaboration with the Dept. of Health & FW	**SQAMO**
21	AV materials for WASH e.g. IEC/IPC job aids such as role play on counseling of patients on WASH, hand washing, BMW handling, role model facilities; for sensitization of both health functionaries and patients to be designed and disseminated. Such videos can be circulated once a week during the SatCom.	**State IEC Officer, SQAMO**
22	The possibilities of assuring no floor beds across the state to be explored.	**AD (PH, MS, FW)**
23	Complete Mechanism of BMW management in State including gaps, what is working, what is not working, to be submitted to Commissioner of Health	**SQAMO**
24	It is to be ensured without fail that no toilets (especially in labor room and postnatal ward) are broken, dirty, chocked, without water, with broken toilet seats. Facility specific area wise (PNC ward, Labor room, OPD, OT, etc.) responsibility for the same list to be prepared.	**SQAMO**
25	An official letter for follow-up actions of the meeting minutes to be submitted to commissioner of health for circulation to all concerned officers.	**SQAMO**

The meeting ended with a vote of thanks.

Commissioner of Health, MS & ME
Dept. of Health & FW,
Gandhinagar

Annexure

Invitees present in the meeting-

Sr. No.	Name	Designation
1	Dr. Vinod Rao	MD-NHM
2	Dr. NB Dholakia	AD (FW)
3	Dr. RM Mehta	DD (MS)
4	Dr. Prakash Vaghela	DD (RH)
5	Dr. JL Meena	SQAMO
6.	Mr. PB Patel	Deputy Executive Engineer (PIU)
7.	Dr. AM Kadri	Secretary, IAPSM-GC; Professor & Head, Dept. of Community Medicine, PDU Medical College, Rajkot
8.	Dr. Narayan Gaonkar	Health Specialist, UNICEF
9.	Mr. Manish Wasuja	WASH Specilaist, UNICEF
10.	Dr. Dipesh Zalavadiya	Tutor, Dept. of Community Medicine, PDU Medical College, Rajkot
10.	Dr. Apurva Ratnu	CTA Consultant
11.	Dr. Kanan Desai	State Consultant-WASH

Annexure V: WASH Gap Assessment tool

Health and Family Welfare Department
Government of Gujarat

unicef
unite for children

STUDY ON ASSESSING WATER, SANITATION AND HYGIENE (WASH) RELATED SERVICES AND PRACTICES IN HEALTH CENTRE OF HPDS, GUJARAT

Note: Please take photographs/videos at appropriate place to document good as well as bad practices

	Date :			**Taluka:**			**District:**	
	Name of The Centre :						**SC / PHC / CHC /SDH / DH**	
	Brief about Maternal Care							
			Number of ANC registered at Centre Last Year :					
			Number of Delivery in Last Year :					
SECTION: I HARDWARE COMPONENTS OF WASH								
							Column 1	**Column 2**
System Element	**Description and Status of System element /components**						**Yes=1 No=0 NA=99 Option**	**Remarks**
GENERAL								
WATER								
WATER	**Monitoring**	1	Is there any identified Person with assigned responsibilities for Monitoring at institute level **(If no, skip to 1.2)**					
		1.1	**If yes,**	*(Put the number →)* 1. MO 2. Nurse 3.Sanitary Inspector 4. Other (Specify _____) **(Skip to 2)**				
		1.2	**If no,**	what is current practice *(Put in Remarks)*			**99**	
	Water Supply	2	Improved water supply source (piped/bore hole/protected well) available **(If no, skip to 2.2a)**					
		2.1	**If yes,**	(Multiple Answers possible) *(Put the number →)* 1. Piped(Panchayat/Palika) 2.Own Bore hole 3. Protected well 4. Tanker Truck 5. Others (Specify _____)**(Skip to 3)**				
		2.2a	**If no,**	Since : _____			**99**	
		2.2b		What is the issue? *(Put in Remarks)*			**99**	
		2.2c		Is there any attempt to ensure Improved Water supply? **(If no, Skip to 3)**				
		2.2d		**If yes,**	Write in brief about (after verification from record) : Date, Responsible authority and status *(Put in Remarks)*		**99**	

		3	Sufficient water supply present? **(If Yes, Skip to 4)**				
		3.1	**If no,**	Reason for Insufficient Water Supply *(Put the number →)* 1. Low pressure 2. Less quantity/Irregular/Seasonal 3.Others (Specify _____)			
		4	Supply line not passing through drains/ sewers/ unsanitary conditions and bore hole not near unsanitary conditions **(If yes, Skip to 5)**				
		4.1a	**If no,**	If any attempt to correct the situation **(If no, skip to 5)**			
		4.1b	**If no,**	**If yes,**	Write in brief about (after verification from record): Date, responsible authority and status. *(Put in Remarks)*	**99**	
	Water Quality	5	Regular water testing (bacteriological testing conducted monthly - check from records) **(If yes, skip to 6)**				
		5.1	**If no,**	write the reasons *(Put in Remarks)*		**99**	
	Water Storage	6	Water storage tank available (Overhead/underground) **(If no, skip to 9)**				
		6.1	**If Yes,**	Adequately sealed and covered/not leaking?			
		6.2		Proper maintenance / cleaning? (Cleaning frequency of at least once a month- check from records/vouchers)			
	Drinking water treatment at point of use	7	Source of Drinking Water: *(Put the number →)* 1. Piped (Panchayat/Palika) 2. Own Bore hole 3. Protected well 4. Tanker Truck 5. Others (Specify _____)				
		8	Functional Treatment Unit available at point of use **(If no, skip to 8.4)**				
		8.1	**If yes,**	Good sanitary conditions around POU?			
		8.2		Regular Water purifier/RO maintenance (Verify with records/voucher)			
		8.3		Date of Last maintenance (Verify with records/Vouchers) _ _/_ _/_ _ _ _(dd/mm/year) **(Skip to 9)**		**99**	
		8.4	**If no,**	Write reasons *(Put in Remarks)*		**99**	
	Miscellaneous	9	Any qualitative observation about this section :			**99**	

TOILET FACILITIES, EXCRETA DISPOSAL & O&M						
TOILET FACILITIES, EXCRETA DISPOSAL AND O&M	Monitoring	10	Is there any identified Person with assigned responsibilities for Monitoring at institute level **(If no, skip to 10.2)**			
		10.1	**If yes,**	*(Put the number →)* 1. MO 2. Nurse 3. Sanitary Inspector 4. Other (Specify _____) **(Skip to 11)**		
		10.2	**If no,**	What is the current practice?*(Put in Remarks)*	**99**	
	Toilet Cleaning / O&M	11	Cleaning and maintenance staff available? **(If no, skip to 12)**			
		11.1	Type of recruitment of cleaning Staff (Multiple options) *(Put the numbers →)* 1. Permanent (Govt.) 2. Out sourcing 3. On contractual 4. Daily wages-part time 5. Others (Specify _____)			
		11.2	Predominant method of staff recruitment for cleaning *(Put the number →)*			
		12	Buckets, mops, brushes & detergent for cleaning available **(If yes, skip to 13)**			
		12.1	**If No,**	Any attempt to correct the situation? **(If no, skip to 13)**		
		12.2	**If No,**	**If Yes,** Write in brief about (after verification from record): date, responsible authority and status *(Put in Remarks)*	**99**	
	Excreta disposal	13	Safe Excreta disposal system Present **(If no, skip to 13.2)**			
		13.1	**If Yes,**	System of Excreta disposal *(Put the number →)* 1. Pit Latrine 2.Flush Toilet 3.Pour Flush Toilet 4. (To)Septic Tank 4. (To)Closed Drain 5. (To) Open Drain 6. Others (Specify ____) (Multiple Options possible)**(Skip to 14)**		
		13.2	**If no,**	If no, write current practice *(Put in Remarks)*	**99**	
		13.3		Any attempt to correct the situation? **(If no, skip to 14)**		
		13.4		**If yes,** Write in brief about (after verification from record) : date, responsible authority and status. *(Put in Remarks)*	**99**	
		14	Any qualitative observation about this section :		**99**	

HOSPITAL WASTE MANAGEMENT							
HOSPITAL WASTE MANAGEMENT	Monitoring	15	Is there any identified Person with assigned responsibilities for Monitoring at institute level **(If no, skip to 15.2)**				
		15.1	**If yes,**	*(Put the number →)* 1. MO 2. Nurse 3. Sanitary Inspector 4. Other (Specify _____) **(skip to 16)**			
		15.2	If no, what is current practice? (Put in remarks)			**99**	
	Hospital waste Disposal	16	Regular supply of Hypochlorite & sterilium **(If yes, skip to 17)**				
		16.1	**If No,**	Any attempt to correct the situation? **(If no, skip to 17)**			
		16.2		**If yes,**	Write in brief about (after verification from record): date, responsible authority and status. *(Put in Remarks)*	**99**	
		17	Regular CTF connectivity or regular collection from CTF **(If yes, skip to 18)**				
		17.1	**If No,**	What is the current practices (Put in remarks)		**99**	
		18	Any agency contracted for Bio Medical Waste Management **(If yes, skip to 19)**				
		18.1	**If no,**	Reasons *(Put in Remarks)*		**99**	
		19	Containers and bags available for segregation of waste				
		19.1		What is the issue? (Put in Remarks)		**99**	
		19.2	**If No,**	Any attempt to correct the situation? **(If no,skip to 18.3)**			
		19.3		**If yes**	Write in brief about (after verification from record): date, responsible authority & status *(Put in Remarks)*	**99**	

		20	Personal protective equipment available **(If no, skip to 19.2)**				
		20.1	**If yes,**	Source:_____ _____		**99**	
		20.2		Personal protective equipment used for BMW collection & disposal **(skip to 20)**			
		20.3		Any attempt to correct the situation **(If no, skip to 20)**			
		20.4	**If No,**	**If yes**	Write in brief about (after verification from record): date, responsible authority and status. (Put in remarks)	**99**	
		21	Proper & Locked storage facility available for BMW at central storage facility. **(If yes, skip to 21)**				
		21.1		Any attempt to correct the situation **(If no, skip to 21)**			
		21.2	**If No**	**If yes**	Write in brief about (after verification from record) : date, responsible authority and status. (Put in remarks)	**99**	
		22	Deep burial pit available for placenta/ infectious bio medical & sharp waste **(If no, skip to 23)**				
		22.1		Waste pits properly secured (Not visibly cracked / broken / leaking/lack of cover/broken cover)? **(If yes, skip to 23)**			
		22.2			Any attempt to correct the situation? **(If no, skip to 23)**		
		22.3	**If Yes**	**If no**	**If yes** Write in brief about (after verification from record): date, responsible authority and status. (put in remarks)	**99**	
		23	Open air dumping of waste not seen/ Dumping and burning open air not seen				

LOCATION BASED WATER SANITATION HYGIENE STATUS										
AREA : 1 POST-NATAL WARD										
AREA I: POST NATAL WARD	Monitoring	24	Is there any fixed identified Person with assigned responsibilities for Monitoring **(If no, skip to 24.2)**							
		24.1	**If yes,**	*(Put the number →)* 1. MO 2. Nurse 3. Sanitary Inspector 4. Other (Specify _____) **(skip to 25)**						
		24.2	**If no,**	What is current practice (put in remarks)					**99**	
	Drinking Water	25	Presence of Functional Drinking Water Point in/near ward **(If yes, skip to 26)**							
		25.1	**If no,**	specify what is current practice : *(Put in Remarks)*					**99**	
	Toilet facility	26	Toilet available (exclusive for ward) **(If no, skip to 26.10)**							
		26.1	**If yes,**	Is Toilet accessible? (not locked) **(If any toilet inaccessible, skip to 26.9)**						
		26.2		**If yes,**	Is Toilet functional/no broken toilet? **(If any toilet non functional, skip to 26.5)**					
		26.3			**If yes,**	General cleanliness of toilet (e.g. Absence of stinking, dirty, blacken tiles/kamods) **(If yes, skip to 27)**				
		26.4				**If no,**	Elicit reason behind*(Put in Remark)***(skip to 27)**		**99**	
		26.5			**If any toilet non functional**	Since : _____			**99**	
		26.6				Elicit reasons behind *(Put in Remarks)*			**99**	
		26.7				Any attempt to solve the issue? **(if no, skip to 27)**				
		26.8				**If yes**	Write in brief about (after verification from record):date, responsible authority & status *(Put in Remarks)* **(skip to 27)**		**99**	
		26.9		**If any toilet not accessible**	Elicit reasons behind it: *(Put in Remarks)* **(skip to 27)**				**99**	
		26.10	**If no,**	Specify what is current practice *(Put in Remarks)*					**99**	
		26.11		Elicit reasons behind it: *(Put in Remarks)* **(skip to 33)**					**99**	
		27	Running water for toilet use available **(If yes, skip to 28)**							
		27.1	**If no,**	Elicit reasons behind it: *(Put in Remarks)*					**99**	
		28	Separate functional hand washing station for toilets for patients **(If yes, skip to 29)**							
		28.1	**If no,**	Elicit reasons behind it: *(Put in Remarks)*					**99**	

		29	Soap for hand washing available **(if yes, skip to 30)**				
		29.1	**If no,**	Elicit reasons behind it *(Put in Remarks)*		**99**	
		30	Functional light point available **(if yes, skip to 31)**				
		30.1	**If no,**	elicit reasons behind it *(Put in Remarks)*		**99**	
		31	Good Scheduled cleaning available (at least thrice a day)? **(if yes, skip to 32)**				
		31.1	**If no,**	Elicit reasons behind *(Put in Remarks)*		**99**	
		32	Any dust-bin in place for disposal of sanitary pads **(if no, skip to 32.2)**				
		32.1	**If yes,**	Any IEC material stating proper disposal of sanitary pads in dust bin & not in toilet **(skip to 33)**			
		32.2	**If no,**	Elicit reasons behind *(Put in Remarks)*		**99**	
	Hand Washing	33	Presence of Hand Washing Station (within ward) for patients **(if no, skip to 33.5)**				
		33.1	**If yes,**	Running Water available **(If yes, skip to 33.3)**			
		33.2		**If no,**	what is current Practice *(Put in Remarks)*	**99**	
		33.3		Soap is present **(if yes, skip to 34)**			
		33.4		**If no, Skip to34**	Elicit reasons behind it *(Put in Remarks)*	**99**	
		33.5	**If no,**	what is current Practice *(Put in Remarks)*		**99**	
	Infection control	34	Floors & health-care surfaces visibly clean (Pt bed/examination table) **(If yes, skip to 35)**				
		34.1	**If no,**	Elicit reasons behind it. *(Put in Remarks)*		**99**	
		35	Scheduled cleaning/mopping available? **(if yes, skip to 36)**				
		35.1	**If no,**	Elicit reasons behind it *(Put in Remarks)*		**99**	
		36	Liquid hand sanitizer - sterillium available **(if yes, skip to 37)**				
		36.1	**If no,**	Elicit reasons behind it *(Put in Remarks)*		**99**	
	Hospital Waste Management	37	Color coded Bins/ bags (Red, Yellow, Blue, Black/Green) available **(If no, skip to 37.3)**				
		37.1	**If yes,**	BMW correctly segregated in various color coded bags **(If yes, skip to 38)**			
		37.2		**If no,**	Elicit reasons behind it *(Put in Remarks)(* **Skip to 38)**	**99**	
		37.3	**If no,**	Elicit reasons behind it *(Put in Remarks)*		**99**	
		38	Hub cutter & needle destroyer available **(if yes, skip to 39)**				
		38.1	**If no,**	Elicit reasons behind it *(Put in Remarks)*		**99**	
		39	Disinfection of BMW done before disposal **(if yes, skip to 40)**				
		39.1	**If no,**	Elicit reasons behind it *(Put in Remarks)*		**99**	

AREA : 2 LABOR ROOM									
LABOUR ROOM	Monitoring	40	Is there any fixed identified Person with assigned responsibilities for Monitoring **(if no, skip to 40.2)**						
		40.1	**If yes,**	*(Put the number →)* 1. MO 2. Nurse 3. Sanitary Inspector 4. Other (Specify _____) **(skip to 41)**					
		40.2	**If no**	what is current practice *(Put in Remarks)*				**99**	
	Drinking Water	41	Availability of Drinking Water						
	Toilet facility	42	Toilet available (attached within Labour room) **(if no, skip to 42.10)**						
		42.1	**If yes,**	Is Toilet accessible? (not locked) **(If any toilet not accessible, skip to 42.9)**					
		42.2		**If yes,**	Is Toilet functional/not broken toilet? **(if any toilet non functional, skip to 42.5)**				
		42.3			**If yes**	General cleanliness of toilet (e.g. Absence of stinking, dirty, blacken tiles/kamods) (All must be absent for affirmative answer) **(if yes, skip to 43)**			
		42.4				**If no**	Elicit reason *(Put in Remark)* **(skip to 43)**	**99**	
		42.5			**If any toilet non functional**	Since : _____		**99**	
		42.6				elicit reasons behind: *(Put in Remarks)*		**99**	
		42.7				Any attempt to correct **(if no, skip to 43)**			
		42.8				**If yes,**	Write in brief about (after verification from record) : date, responsible authority and status *(Put in Remarks)* **(skip to 43)**	**99**	
		42.9		**If any toilet not accessible**	Elicit reasons behind it *(Put in Remarks)*			**99**	
		42.10	**If no,**	Elicit reasons behind it *(Put in Remarks)*				**99**	
		42.11		Specify current practice *(Put in Remarks)* **(skip to 48)**				**99**	
		43	Running water for toilet use available **(if yes, skip to 44)**						
		43.1	**If no,**	Elicit reasons behind it *(Put in Remarks)*				**99**	
		44	Separate functional hand washing station for toilets for patients **(if yes, skip to 45)**						
		44.1	**If no,**	elicit reasons behind it. *(Put in Remarks)*				**99**	
		45	Soap for hand washing available **(if yes, skip to 46)**						
		45.1	**If no,**	elicit reasons behind it. *(Put in Remarks)*				**99**	

		46	Functional light point available **(if yes, skip to 47)**				
		46.1	**If no**	elicit reasons behind *(Put in Remarks)*		**99**	
		47	Good Scheduled cleaning available (at least thrice a day)? **(if yes, skip to 48)**				
		47.1	**If no**	elicit reasons behind *(Put in Remarks)*		**99**	
	Hand Washing	48	Presence of Hand Washing Station (within labor room) **(if no, skip to 48.5)**				
		48.1	**If yes,**	Running Water available **(if yes, skip to 48.3)**			
		48.2		**If no,**	what is current Practice *(Put in Remarks)*	**99**	
		48.3		Soap is present **(if yes skip to 49)**			
		48.4		**If no,**	Elicit reasons behind it. *(Put in Remarks)*	**99**	
		48.5	**If no,**	what is current Practice *(Put in Remarks)*		**99**	
	Infection control	49	Floors and health-care surfaces visibly clean (Pt bed/ examination table/ Labor table) **(if yes, skip to 50)**				
		49.1	**If no,**	Elicit reasons behind it *(Put in Remarks)*		**99**	
		50	Scheduled cleaning/mopping available? **(if yes, skip to 51)**				
		50.1	**If no,**	Elicit reasons behind it. *(Put in Remarks)*		**99**	
		51	Liquid hand sanitizer - sterillium available **(if yes, skip to 52)**				
		51.1	**If no,**	Elicit reasons behind it *(Put in Remarks)*		**99**	
	Hospital Waste Management	52	Color coded Bins/ bags (Red, Yellow, Blue, Black/Green) available **(if no, skip to 52.3)**				
		52.1	**If yes,**	BMW correctly segregated in various color coded bags **(if yes, skip to 53)**			
		52.2		**If no,**	elicit reason *(Put in Remark)* **Skip to 53**	**99**	
		52.3	**If no,**	Elicit reasons behind it. *(Put in Remarks)*		**99**	
		53	Hub cutter & needle destroyer available **(if yes, skip to 54)**				
		53.1	**If no,**	Elicit reasons behind it. *(Put in Remarks)*		**99**	
		54	Disinfection of BMW done before disposal**(if yes, skip to55)**				
		54.1	**If no,**	Elicit reasons behind it. *(Put in Remarks)*		**99**	

AREA : 3 OUT DOOR PATIENT DEPARTMENT										
Out Door Patient Department (OPD)	Monitoring	55	Is there any fixed identified Person with assigned responsibilities for Monitoring **(if no, skip to 55.2)**							
		55.1	**If yes**	*(Put the number →)* 1. MO 2. Nurse 3. Sanitary Inspector 4. Other (Specify _____)						
		55.2	**If no**	what is current practice? (put in remarks)					**99**	
	Drinking Water	56	Presence of Functional Drinking Water Point exclusive for OPD area **(if yes, skip to 57)**							
		56.1	**If no,**	specify what is current practice : *(Put in Remarks)*					**99**	
	Toilet facility	57	General Toilet available **(if no, skip to 57.11)**							
		57.1	**If yes**	Separate Toilets for females available						
		57.2		Is Toilet accessible? (not locked) **(If any toilet not accessible, skip to 57.10)**						
		57.3		**If yes**	Is Toilet functional/no broken toilet? **(if any toilet nonfunctional, skip to 57.6)**					
		57.4			**If yes**	general cleanliness of toilet (e.g. Absence of stinking, dirty, blacken tiles/kamods) (Affirmative answer if all clean) **(if yes, skip to 58)**				
		57.5				**If no**	elicit reasons *(Put in Remarks)**(skip to 58)***		**99**	
		57.6			**If any toilet non functional**	Since : _____			**99**	
		57.7				elicit reasons behind *(Put in Remarks)*			**99**	
		57.8				Any attempt to solve issue **(if no, skip to 58)**				
		57.9				**If yes**	Write in brief about (after verification from record) : date, responsible authority and status *(Put in Remarks)* **(Skip to 58)**		**99**	
		57.10		**If any toilet not accessible**	Elicit reasons behind it *(Put in Remarks)*				**99**	
		57.11	**If no**	specify what is current practice *(Put in Remarks)*					**99**	
		57.12		Elicit reasons behind it. *(Put in Remarks)* **(skip to 63)**					**99**	
		58	Running water for toilet use available **(if yes, skip to 59)**							
		58.1	**If no,**	elicit reasons behind it *(Put in Remarks)*					**99**	
		59	Separate functional hand washing station for toilets for patients **(if yes, skip to 60)**							
		59.1	**If no,**	elicit reasons behind it *(Put in Remarks)*					**99**	

		60	Soap for hand washing available **(if yes, skip to 61)**				
		60.1	**If no,**	elicit reasons behind it *(Put in Remarks)*		**99**	
		61	Functional light point available **(if yes, skip to 62)**				
		61.1	**If no**	elicit reasons behind *(Put in Remarks)*		**99**	
		62	Good Scheduled cleaning available (at least thrice a day)? **(if yes, skip to 63)**				
		62.1	**If no**	elicit reasons behind *(Put in Remarks)*		**99**	
	Hand Washing	63	Presence of Hand Washing Station (within OPD area for patients) **(if no, skip to 63.5)**				
		63.1	**If yes**	Running water available **(if yes, skip to 63.3)**			
		63.2		**If no**	what is current practice *(Put in Remarks)*	**99**	
		63.3		Soap is present **(if yes, skip to 64)**			
		63.4		**If no**	Elicit reasons behind *(Put in Remarks)*	**99**	
		63.5	**If no,**	what is current Practice *(Put in Remarks)*		**99**	
	Infection Control	64	Floors and health-care surfaces visibly clean **(if yes, skip to 65)**				
		64.1	**If no,**	elicit reasons behind it *(Put in Remarks)*		**99**	
		65	Scheduled cleaning/mopping available? **(if yes, skip to 66)**				
		65.1	**If no,**	elicit reasons behind it *(Put in Remarks)*		**99**	
		66	Liquid hand sanitizer - sterillium available (ANC OPD) **(if yes, skip to 67)**				
		66.1	**If no**	elicit reasons behind it. *(Put in Remarks)*		**99**	
	Hospital Waste Management	67	Color coded Bins/ bags (Red, Yellow, Blue, Black/Green) available in OPD area (Affirmative answer if all is available) **(if no, skip to 67.3)**				
		67.1	**If yes**	BMW correctly segregated in various color coded bags **(if yes, skip to 68)**			
		67.2		**If no**	elicit reasons behind it *(Put in Remarks)*	**99**	
		67.3	**If no**	elicit reasons behind *(Put in Remarks)*		**99**	
		68	Hub cutter & needle destroyer available **(if yes, skip to 69)**				
		68.1	**If no,**	Elicit reasons behind it *(Put in Remarks)*		**99**	
		69	Disinfection of BMW done before disposal **(if yes, skip to sec II)**				
		69.1	**If no,**	Elicit reasons behind it *(Put in Remarks)*		**99**	

SECTION II: CLEANING FUNDS PROVIDED FOR DELIVERY POINT FACILITIES					
				Response	
INFORMATION TO BE COLLECTED FROM FOCUSED DELIVERY POINT INSTITUTIONS					
CLEANING FUND	1	Mechanism of Funds Availability for Cleaning			
	2	Any dedicated Allocation of fund **(if no, skip to 3)**			
	2.1	**If yes**	Rs. for last financial Year & Its % utilization	Rs.	%
	3	Cleaning agency engaged or not **(if no, skip to 3.2)**			
	3.1	**If yes**	Mechanism for engaging agency **(skip to 4)**		
	3.2	**If no**	Reason		

SECTION III: SOFTWARE COMPONENTS (WASH RELATED PRACTICES)
GUIDELINES
1. The observations have to be made without questioning the functionaries through silent observation 2. The visit should be timed in order to be present around the time the rounds in the wards are being made. 3. The practice related questions are for the in-charge of the setup. 4. The key enablers have to be enlisted by hand. Please do not offer any options as leading answers. 5. The question on barriers and their elaboration is open-ended, unaided. Tick only those options that are enumerated by the respondent. Please do not offer any options as leading answers. 6. The list of options is only for your reference and not to be shared with the respondent. 7. The list of options for key barriers is indicative and not exhaustive. If there are any statements which do match the list, please record them verbatim.
OBSERVATIONS

		Observation Points		Yes	No	Couldn't see
OBSERVATION	1	The functionaries wash their hands with soap prior to rounds in ward				
	2	The functionaries wash their hands with soap prior to examination of patients				
	3	The functionaries wash their hands with soap prior to delivery				
	4	There is soap available in WASH area of the ward for staff **(if no, skip to 5)**				
	4.1	**If yes,**	The soap in the ward looks used			
	5	There is soap available in Dr's Chamber for staff **(if no, skip to 6)**				
	5.1	**If yes,**	The soap in the chamber looks used			
	6	There is soap available in the labor room for staff **(if no, skip to next)**				
	6.1	**If yes**	The soap in the labor room looks used			

PRACTICES						
Respondent: Medical Officer of the PHC/ Supervisor of CHCs/ Matron/Other_____ **(Encircle)**						
practice #1						
PRACTICE 1	1	**Do you ensure the maintenance of clean, functional toilets in your PHC premises-**(minimum list: in the labour room, and one for access to IPD-postnatal and OPD patients) **(√ yes if clean toilet observed at all of the above places)**		**Yes**	**No**	**Partially/ sometime**
	1.1	If **YES** the key enablers for to do so are : (list top 3)				
		a				
		b				
		c				

	1.2	If **NO/sometimes**, the key reasons for not maintaining clean, functional toilets in your PHC are, ***Tick on those options that the respondents enumerates. This has to be unaided.***			
	S. No	**Alternative answers**	**Tick**	**remarks**	
	a	Maintenance of clean, functional, toilets is not my responsibility		If so, whose is it?	
	b	I do not have the authority to take action on this		If so, whose is it?	
	c	There is no human resource who can be employed/ contracted for this purpose			
	d	There is no scope for funds to be allocated for this purpose			
	e	I have other priorities.			
	f	I don't believe this is amongst the contributors to morbidity/ mortality in my PHC			
	g	Others. Please specify			
practice #2					
PRACTICE 2	2	**Do you ensure soap in Labour room, IPD and OPD hand washing stations for the use of staff & patients (tick yes if soap observed at all of the above places)**	**Yes**	**No**	**Some time**
	2.1	If **YES** the key enablers for to do so are : (list top 3)			
		a			
		b			
		c			
	2.2	**If NO/sometimes**, the key reasons for not ensuring soap in Labour room, IPD and OPD for the use of staff & patients are: ***Tick on those options that the respondents enumerates. This has to be unaided.***			
	Sr. no.	**Alternative answers**	**Tick**	**remarks**	
	a	This is not my responsibility		If so, whose is it?	
	b	I do not have the authority to take action on this		If so, who has it?	
	c	There is no scope for funds to be allocated for this purpose			
	d	I have other priorities			
	e	I am not expected to report on this on a regular basis			
	f	I don't believe this is amongst the top most contributors to morbidity/ mortality of in my PHC			
	g	Others. Please specify			
practice #3A					
PRACTICE 3A	3A	**At present, Is there any display material on use of toilet, in the health facility?**	**Yes**	**No**	**What & Where?**
	3A.1	If **YES** the key enablers for to do so are : (list top 3)			
		a			
		b			
		c			

	3A.2	If **NO**, the key reasons for not displaying any IEC/ BCC material on use of toilets in the health facility are: ***Tick on those options that the respondents enumerates. This has to be unaided.***			
	Sr. no.	**Alternative answers**	**Tick**	**remarks**	
	a	This is not my responsibility		If so, whose is it?	
	b	There is no human resource who can be assigned for this purpose			
	c	There are no such IEC materials provided from the Dist./state			
	d	I don't believe this is important			
	e	Others. Please specify			
practice #3B					
PRACTICE 3B	3B	**At present, Is there any display material on the practice of hand washing with soap especially prior to feeding children, in the health facility?**	**Yes**	**No**	**What & Where**
	3B.1	If **YES** the key enablers for to do so are : (list top 3)			
		a			
		b			
		c			
	3B.2	If **NO**, the key reasons for not displaying any IEC/ BCC material on the practice of hand washing with soap especially prior to feeding children in the health facility are: ***Tick on those options that the respondents enumerates. This has to be unaided.***			
	Sr. no.	**Alternative answers**	**Tick**	**remarks**	
	a	This is not my responsibility		If so, whose is it?	
	b	There is no human resource who can be assigned for this purpose			
	c	There are no such IEC materials provided from the Dist./state			
	d	I don't believe this is important			
	e	Others. Please specify			
practice #4A					
PRACTICE 4A	4A	**Is there a functional system of counselling and a review mechanism in place that reviews if functionaries are counselling patients, esp. mothers of new born and infants on hand washing before feeding**	**No Counseling done**	**Only Counseling done No Review**	**Both Counseling & Review done**
	4A.1	If **BOTH COUNSELING & REVIEW DONE** the key enablers for to do so are : (list top 3)			
		a			
		b			
		c			

	4A.2	If **NO COUNSELLING DONE/ONLY COUNSELING DONE, NO REVIEW**, the key reasons are: ***Tick on those options that the respondents enumerates. This has to be unaided.***			
	Sr. no.	**Alternative answers**		**Tick**	**remarks**
	a	This is not my responsibility			If so, whose is it?
	b	There are other conflicting priorities for time.			
	c	There are so many other indicators to be monitored			
	d	We have not received training on counselling on hygiene and its relation to health			
	e	There are no tools to aid counselling			
	f	I don't believe this is important			
	g	Others. Please specify			
practice #4B					
PRACTICE 4B	4B	**Is there a functional system of counselling and a review mechanism in place that reviews if functionaries are counselling patients, esp. mothers of new born and infants on use of toilet**	**No Counseling done**	**Only Counseling done No Review**	**Both Counseling & Review done**
	4B.1	If **BOTH COUNSELING & REVIEW DONE** the key enablers for to do so are : (list top 3)			
		a			
		b			
		c			
	4B.2	If **NO COUNSELLING DONE/ONLY COUNSELING DONE, NO REVIEW**, the key reasons for are: ***Tick on those options that the respondents enumerates. This has to be unaided.***			
	Sr. no.	**Alternative answers**		**Tick**	**remarks**
	a	This is not my responsibility			If so, whose is it?
	b	There are other conflicting priorities for time.			
	c	There are so many other indicators to be monitored			
	d	We have not received training on counselling on hygiene and relation to health			
	e	There are no tools to aid counselling			
	f	I don't believe this is important			
	g	Others. Please specify			
practice #5					
PRACTICE 5	5	**Is there a functional system to ensure and monitor that the functionaries in your PHC/CHC adopt hygiene practices including hand washing with soap before examining patients? (Affirmative if both ensuring and monitoring takes place)**	**Yes**	**No**	**Irregularly followed**
	5.1	If **YES** the key enablers for to do so are : (list top 3)			
		a			
		b			
		c			

	5.2	If **NO/irregularly followed** the key reasons are: ***Tick on those options that the respondents enumerates. This has to be unaided.***		
	Sr. no.	**Alternative answers**	**Tick**	**remarks**
	a	This is not my responsibility		If so, whose is it?
	b	There are other conflicting priorities for time.		
	c	There are so many other indicators to be monitored		
	d	We have not received training on counselling on hygiene and relation to health		
	e	I don't believe this is important		
	f	Others. Please specify		

SUGGESTIONS OF RESPONDENT ON IMPROVING THE SYSTEM FOR WASH	
Key Gaps/Challenges	**Suggestions by respondents**

Any other suggestions to Improve WASH/Any Good Practices to share:-

Name & Sign of the Field Investigator

Name & Sign of the Monitor