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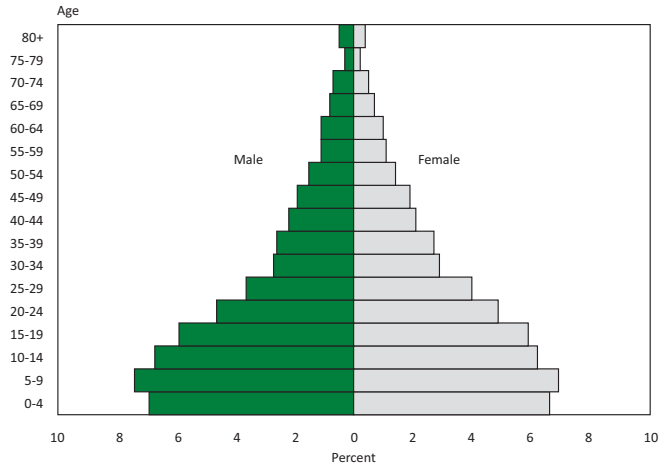
FAMILY PLANNING SERVICE DELIVERY

Country Profile

Pakistan is the sixth most populous country in the world, with an estimated population growth rate of around 1.9 percent per annum in 2016, representing an annual addition of almost three million people. The country is facing great challenges to attain socio-economic development and break the vicious cycle of poverty. This annual addition to the population, in the context of low socio-economic indicators, not only dilutes the results of development efforts but also creates overwhelming demand on limited resources. According to the Population Reference Bureau , Pakistan's population in 2015 was 199 million, and it ranked 6th in the world and 4th in the region, after Indonesia. The 2050 projections are alarming; with Pakistan's population projected at 344 million. Based on these growth patterns and trends, the economy will be unable to sustain the growing population with hardly any scope for improvement in the quality of life, even under the most favourable circumstances. This situation is, therefore, a matter of deep concern and becomes a central issue in the overall planning perspective as well as the strategy for alleviating poverty in the country.

Figure 1-1. Distribution of Men and Women of Reproductive Age in Pakistan



Source: National Institute of Population Studies (NIPS) [Pakistan].. Pakistan Demographic and Health Survey 2012 - 2013. National Institute of Population Studies and Macro International Inc.: Islamabad, Pakistan.

Pakistan's Population Welfare Programme: History

Family planning (FP) activities were introduced in Pakistan's First Five Year Plan (1955–60) through the Family Planning Association of Pakistan (FPAP) and other voluntary organizations. In the second Five Year Plan (1960–65), FP services were extended through the health infrastructure; however, in the third Five Year Plan (1965–70), an independent Family Planning set-up was created, mass- scale information, education, and communication (IEC) activities were launched, and a service delivery network was established. In the next plan (1970–75), the "Continuous Motivation Approach" was introduced by employing male-female teams of workers at the Union Council level. During 1975–80, the programme operated at a low key due to re-organization, political unrest, and suspension of IEC activities.

In 1981, an administrative re-organization was undertaken and a broad-based, multi-sectoral, and multi-dimensional strategy was conceived, developed, and introduced. In the sixth Plan period (1983–88), field activities were provincialized through a 1983 ordinance, the role of nongovernmental organizations (NGOs) was institutionalized through the NGO Coordination Council (NGO CC), social marketing of contraceptives (SMC) was introduced, and the National Institute of Population Studies (NIPS) was established. The strategies of the sixth Plan were pursued in the seventh Five Year Plan (1988–93), with emphasis on lowering the fertility level and a focus on a motivational campaign and widening the range of contraceptive methods for voluntary choice. Also, a special IEC programme and quality FP service delivery facilities were developed for the country's large cities, with a view to set trends for rural areas. The role of the District Office was expanded, and Divisional and Tehsil tiers were created. In fact, a breakthrough in the programme occurred during the later part (1990–93) of the seventh Plan.

In the eight Plan (1993–98), the population programme continued to receive strong political support from the highest levels, but because the plan was finalized before the International Conference on Population and Development (ICPD) held in 1994, the reproductive health (RH) framework was not fully reflected in it. However, an institutional mechanism to oversee, guide, and strengthen collaborative efforts to advance the FP/RH agenda was established by the creation of a Coordination Committee of Health and Population Welfare Department. Later, in the ninth Five Year Plan (1998–2003), the programme was realized with a post-ICPD Plan of Action (PoA), while keeping in view the local socio-cultural conditions and priorities.

In March 2000, the Government initiated restructuring and right-sizing of the public sector; an assessment of the Population Welfare Programme was also undertaken, wherein it was noted that the programme was moving in the right direction and the fertility transition had set in and had to be sustained. The process led to formulation of the Population Policy in 2002, setting the long- term vision for the population sector. By end of the ninth Plan and later, the programme has been able to raise the contraceptive prevalence rate (CPR) and reduce the population growth rate (PGR), thereby heading towards achievement of population stabilization.

In 2010, devolution of power to provinces through 18th amendment in the constitution resulted in dissolution of Ministry of Population Welfare and transfer of the subject to the provinces. Thus, the Population Welfare Departments in provinces took a lead role in population policy, plans, programs and projects and their implementation.

The provincial Population sectors introduced following programmatic interventions in line with the stated strategies:

- Launch a well-conceived IEC campaign to address macro-population issues and socio-cultural constraints.
- Introduce a cadre of Male Mobilizers at Union Council level for enhancing male involvement in FP/RH.
- Conduct human resource development (HRD) activities for programme managers to promote result-oriented management through the Management Information System (MIS).
- Facilitate and oversee FP service delivery in health outlets and Provincial Line Departments and compare against agreed-upon performance indicators.
- Increase the existing level of SMC and engage private sector industrial organizations to undertake FP, advocacy, and service delivery programmes.
- Involve NGOs/civil society organizations through the National Trust for Population Welfare (NATPOW) and strengthen public-private partnership.
- Decentralize operational activities at district level and below for efficiency of fiscal, administrative, and programme transfers.
- Enhance involvement of trained private sector service providers in rural and slum areas.

FP2020 and Pakistan's Response

On July 11, 2012, at London Summit on Family Planning, Pakistan committed to work towards achieving universal access to reproductive health services and improve contraceptive prevalence rate to 55% by 2020. The commitment was taken forward with all four provinces to involve public and private healthcare facilities in improving the CPR. Table 2 provides a snapshot of national and provincial commitments for 2020 and their status in 2012/13. The province of Sindh has developed their Costed Implementation Plans (CIP) to provide guidance for implementation of a family planning program with defined targets and a roadmap to deliver the outcomes to advance towards FP2020 goals as per commitment made by Pakistan.

Table 2: Current Status on FP2020 Commitments

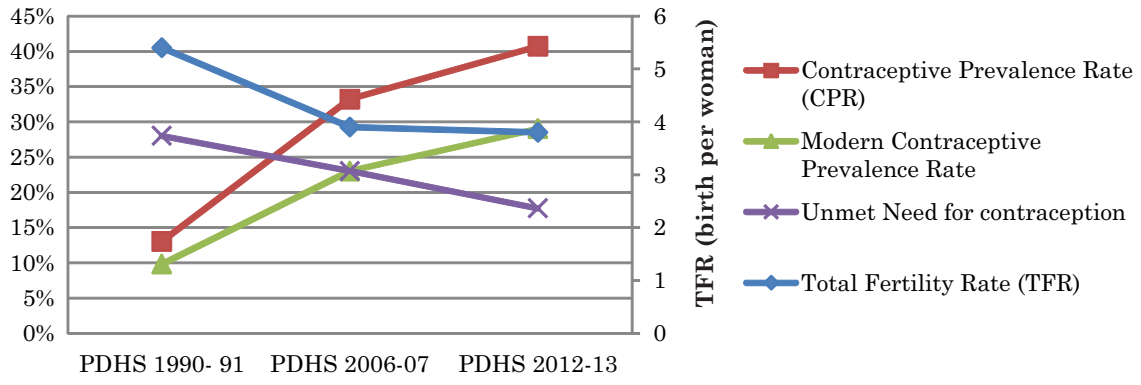
	Current Status - 2012-13			FP2020 Commitments
	CPR (%)	Unmet Need (%)	Total Demand (%)	CPR (%)
Pakistan	35	20	55.5	55
Sindh	29.5	20.8	50.3	45
Punjab	40.7	17.7	58.3	52
KPK	28.1	25.5	53.6	42
Baluchistan	19.5	31.2	50.6	35
Source: NIPS; Pakistan Demographic and Health Survey 2012-13, Islamabad				

Provincial Context:

Punjab

Punjab is the largest province with estimated population of 101 million in 2015. The present growth rate indicates alarming situation in future when population will be doubled after 36 years. In 2015, there were approximately 26 million women of reproductive age and estimated to reach 30 million by 2020. The CPR has increased considerably and the unmet needs and total fertility rate (TFR) has shown a declining trend.

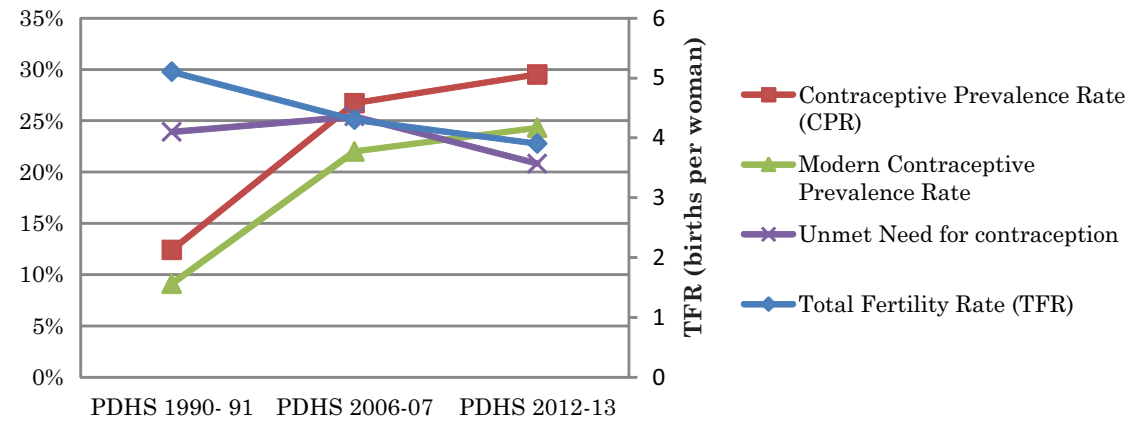
Figure 1: Trend in FP Indicators of Punjab from 1990 - 2012



Sindh

In 2015, the estimated population of Sindh was approximately 42.4 million. With current fertility rate of 3.9 births and continuous migration from within the country and outside, the population is expected to reach 50 million by 2020. The CPR has increased as compared to PDHS 1990-91 data but has not improved much compared to PDHS 2006 – 07. Similarly the unmet need did not show any significant improvement compared to PDHS 1990-91.

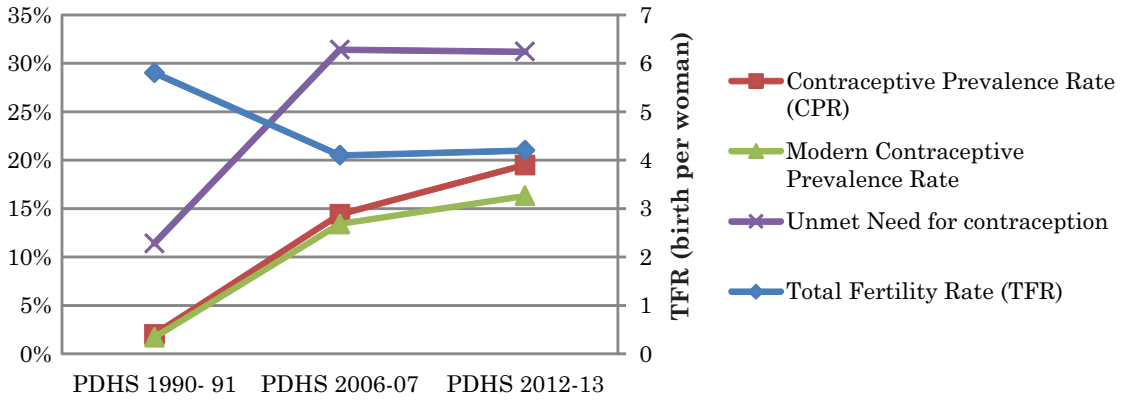
Figure 2: Trend in FP Indicators of Sindh from 1990 - 2012



Baluchistan

The population of Baluchistan was approximately one million in 1951, which has increased to 8.5 million in 2015. It is estimated that within next 30 years the population will double. Though CPR has increased as compared to PDHS 1990 but the proportion of women with unmet needs has swollen. This can be attributed to increasing awareness about FP services. However, extensive efforts are warranted to address the unmet needs of 33% of women in Baluchistan.

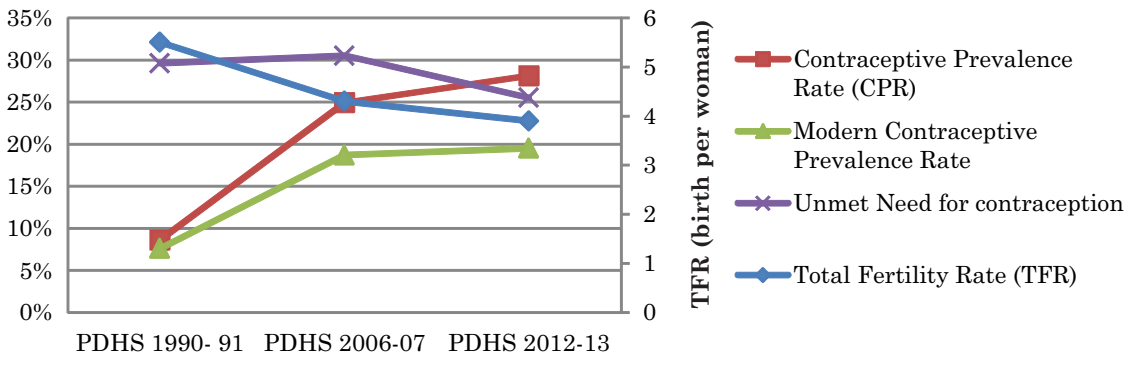
Figure 3: Trend in FP Indicators of Baluchistan from 1990- 2012



Khyber Pakhtunkhwa

In 1951 census, the population of Khyber Pakhtunkhwa (KPK), then NWFP, was approximately 4.5 million that reached to approximately 28 million in 2015. The fertility rate has decreased significantly from 5.5 births in 1990 to 3.9 in 2012. A drastic increase in the use of contraceptive services was observed starting from 8.6% in 1990 to 28% in 2012. However, not much difference was observed in the proportion of women with unmet need of FP.

Figure 4: Trend in FP Indicators of Khyber Pakhtun Khuwa from 1990 - 2012



The Sustainable Development Goals

The United Nations General Assembly Open Work Group, on 19th July 2014, proposed Sustainable Development Goals (SDGs) as successor to the Millennium Development Goals. The proposal consisted of 17 goals with 169 targets including ending poverty and hunger, improving health and education, making cities more sustainable, combating climate change, and protecting oceans and forests. Listed below is the SDG-3 and its targets.

Goal 3. Ensure healthy lives and promote well-being for all at all ages

1. By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
2. By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.
3. By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
4. By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
5. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
6. By 2030, halve the number of global deaths and injuries from road traffic accidents.
7. By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
8. Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
9. By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.
    a. Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.
    b. Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.
    c. Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries,

especially in least developed countries and small island developing States.

d. Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

Pakistan's National and Provincial Population Sector Initiatives

- National Population Commission, 2006
- Provincial Population Councils, 2006
- Joint Steering Committee of Health and Population, 2005
- Cabinet Committee for Social Sector Coordination (CCSSC)
- Focal points in all relevant Ministries/Divisions
- Revitalization of District Technical Committees
- Expansion of service delivery outlets
- Capacity building of training and research institutes
- Partnership with private and corporate sector organizations
- International Standards Organization (ISO) certification of service delivery outlets
- International Ulema Conference, 2005
- Follow-up of IDPD, 2006
- International Population Summit, 2005
- Follow-up of Population Summit, 2006
- Advocacy seminar for parliamentarians, 2005, and step-down activities to bring advocacy to lower levels of government
- International best practices for scaling up FP/RH
- Donor collaboration
- Friends of Family Welfare Centres
- National Commission for Human Development
- National Voluntary Movement
- Pakistan Postal Services
- Mass-media campaign for advocacy and behaviour change communication
- Youth/male involvement through interpersonal communication
- Adolescent and men's advisory centres
- Population issues included in curricula of 9th to 12th classes

Population Policy of Sindh, 2016

In the aftermath of devolution under the 18th Constitutional Amendment, the provinces have been leading to designing and implementing policies, plans, programs, and projects. Keeping this fact in view, the Government of Sindh has introduced its Population Policy. The policy envisages promoting a prosperous, healthy, educated and knowledge-based society where all citizens are provided opportunities to access information and quality services about Family Planning and reproductive health care.

The objectives of the Policy are:

- Enhance CPR from 30 % in 2015 to 45 % by 2020.
- Achieve the replacement level fertility i.e. 2.1 births per woman by 2035.
- Achieve universal access to safe and quality reproductive health/family planning services by 2020.
- Increase access to family planning and reproductive health services to the most remote and farthest areas of the province by 2017.
- Increase efforts to reduce unmet need for family planning from 21 to 14% by 2020.
- Attain a decrease in fertility level from 3.9 (2013) to 3.0 births per woman by the year 2020.
- Ensure contraceptive commodity security up to 80% at all public service outlets by 2018.

Costed Implementation Plan (CIP) on Family Planning for Sindh

Based on Pakistan's international commitments at the London Summit, 2012, the Sindh became first province in the country that developed its Costed Implementation Plan (CIP) on Family Planning. The CIP is a roadmap for reforms and consisting of best and proven practices that enhanced the Contraceptives Prevalence Rate (CPR) drastically at various developing countries including Pakistan. The CIP serves as first Five Year Plan for the Population Policy.

The CIP has six Strategic Areas that include:

Strategic Area 1 – Functional Integration: Enhancing strategic coordination and oversight between the population and health sectors at the provincial, district and sub district levels regarding functional integration of services at the sub district level.

Strategic Area 2 – Quality of Care: Ensuring quality of services by enforcing standards, improving providers' skills and ensuring client satisfaction.

Strategic Area 3 – Supply Chain Management: Improving contraceptive security to the last mile, including distribution and availability of contraceptives at service delivery points.

Strategic Area 4 – Expansion of services: Expanding services with supply- and demand-side interventions for enhancing access, especially to urban slums, peri-urban and rural areas, and creating space and linkages for public-private partnerships to reach vulnerable segments of the population including the poor and youth.

Strategic Area 5 – Knowledge and Meeting Demand: Increasing knowledge and meeting the demand for FP services by focusing on MWRA, emphasizing male engagement and young people.

Strategic Area 6: - Governance, Monitoring and Evaluation: Strengthening the health and population systems by streamlining policy planning, governance and stewardship mechanisms, and performance monitoring and accountability.

The CIP is a joint initiative of Population Welfare Department, Department of Health, PPHI, Sindh and development partners.

The CIP is being implemented which proves that its not just a document but a practical initiative.

Service Delivery outlets in Sindh provinces under Population and Health Departments

(Source: Costed Implementation Plan Sindh 2015-20)

Nature of Facility	Description	Department	Number of Facilities	No. of Human Resources	Population Covered
Static Units					
FHC-A	Hospital based units for provision of full range of reproductive health services comprising FP methods including CS (male, female); MCH care; prevention and management of reproductive tract infections and sexually transmitted infections including HIV/AIDS; management of reproductive health issues of adolescent boys and girls, men and women; infertility; early detection of breast and cervical cancers by promoting self-examination	PWD[1]	75	RHS-A - 11; RHS Master Training Centre 19; Training Centre 15	Population across a taluka
Family Welfare Centre (FWC)	FP information, counselling, follow-up for all methods except for implants CS; availability of contraceptives, medicines; MCH services, infant care including nutrition, growth monitoring, and common illnesses; referral of cases of infertility, HIV/AIDS; CS/implants	PWD	961	6 staff (male and female) led by Family Welfare Worker (BPS 8)	7000 (through satellite clinics/ outreach covers 12000)
No-Scalpel Vasectomy (NSV)	The five no-scalpel vasectomy (NSV) centres are situated at Karachi, Hyderabad, Larkana, Nawabshah and Moro. NSV is preferred method for male CS and is more simple and safe	PWD	5	Staff NSV Training Centre 7, NSV Centre 6	

[1]Population Welfare Department, Population Welfare Programme Sindh PC-1, Five Year Plan (2010–2015).

Basic health units	A first-level care facility (FLCF) at Union Council level with preventive and basic curative services, referral, and FP modern methods i.e. implant, IUDs under PPHI	PPHI / DOH	783 (611 - PPHI)	Doctors/ specialists 21,042 Nurses 2628 LHVs 894 Paramedics 40,000	Union Council level (15,000)
Rural health centres	A First-Level Care Facility at town level with curative services, basic surgeries and referral, FP modern methods	DOH (recently out sourced)	125 (2-PPHI)		Cluster of Union Councils (50,000)
Taluka headquarters hospitals (THQ)	A secondary-level care facility at the taluka level with curative and surgery facilities with FP modern methods under emergency obstetrics and neonatal care (EmONC)	DOH (some of those out sourced)	44[1]		200,000
District headquarters hospital (DHQ)	A secondary-level care facility with specialties of medicine, surgery, Gynaecology , Paediatric FP modern methods and EmONC	DOH (some of those out sourced)	18		
Tertiary care and Specialized care Hospitals	Specialties in areas of medicine, surgery; FP methods. Specialized hospitals are dedicated to a certain specialty	DOH	9+27=36		
Outreach Facilities					
Mobile service units (MSU)	MSUs provide FP and reproductive health services to remote areas where other facilities are not available. The MSU operate from specially designed vehicles, which possess all the facilities of a mini-clinic. MSU ensures complete privacy for gynaecological procedures. Each MSU requires the organization of 10–12 outreach camps every month. Due to resource constraints MSUs are not fully functional.	PWD	10–12 outreach camps in a month	03 led by a Women Medical Officer or Field Technical Officer (FTO)	40,000
Social male mobilizers	Social Male Mobilizers are union council based workers. They are supposed to establish their office in their home. Two male mobilizers are to be recruited at each FWC. The mandate of Male Mobilizers is to increase acceptance of FP among the male population and use of male contraception methods. Male Mobilizers dispense condoms and pills. Most of the mobilizers are non-functional. In the wake of FP2020 goals, their role needs to be revisited.	PWD	Housed in each Union Council	1250	10,000

[2]Health Sector Reforms Unit, Department of Health, Situation Analysis for Post Devolution Health Sector Strategy of Sindh Province.

Lady health workers (LHWs) and lady health supervisors	LHWs are women from within the community who are educated up to class ten and are trained in delivering FP maternal, neonatal and child health (MNCH) services; promotion of health education, nutrition promotion and basic sanitation etc.[1] They promote FP methods like condoms, pills, emergency contraceptive pills, and also provide second injection to married women of reproductive age, free of cost.	DOH/ National Programme on FP and primary health care	01 Health House in a population of 1000 (48 % covered area)	22575 770	1000
Lady Health Visitors (LHVs)	LHVs are placed at BHUs and rural health centres (RHCs) to provide primary health care services including FP to women.	DOH	Attached to public facilities/ private clinic	894	-
Community Midwives (CMWs)	CMWs provide skilled maternity care services at the community level. Their skills in FP need to be improved.	DOH/MNCH Programme	Linked to public facility/ NGOs clinic	1705	15000
Training Institutes					
Regional Training Institute	Specialized training centres in family planning and reproductive health package	PWD	4	-	-
Provincial Health Development Centre (PHDC) and District Health Development Centre (DHDCs) (select districts)	Training centres of DOH to provide trainings to DOH doctors, LHVs and other providers on health and FP	DOH	PHDC 01; DHDCs; Training Schools 44	-	-

Quality of Care

Quality of Care (QoC) is a client-centred approach to provide high-quality health care as a basic human right; it is considered a critical element of FP/RH services.

It has been promoted by all stakeholders in the public and private sectors as well as by NGOs, as affirmed at international conferences. High-quality services ensure that clients receive the care that they deserve. Furthermore, providing better services at reasonable prices attracts more clients, increases the use of FP methods, and reduces the number of unintended pregnancies.

[3]National Programme for Family Planning & Primary Healthcare, *The Lady Health Workers Programme, 2010–2015, PC-1* (Islamabad: Government of Pakistan, Ministry of Health, 2010).

Improving QoC for clients means understanding their cultural values, previous experiences, and perceptions of the role of the health system, and then bringing RH service providers and the community together to map out a shared vision of quality. Similarly, enhancing the QoC given by health care providers requires identifying their motivations, addressing their needs (including general administrative and logistical support), and helping them to better understand and address clients' concepts of quality (Annex II). Creating a shared vision for improved QoC requires that programme managers, service providers, researchers, and consumers advocate the idea that quality matters. Given time and effort, the ongoing attempt to improve the QoC will translate into services that meet minimum quality standards and satisfy the needs of clients and providers to bridge the gap of unmet need.

Elements of Quality

Choice of FP method refers both to the number of methods offered on a reliable basis and to their intrinsic variability. The methods offered serve significant subgroups as defined by age, sex, contraceptive intention, lactation status, and health profile.

Information given to client refers to the information imparted during service contact that enables clients to freely choose and use contraception with satisfaction.

Technical competence involves factors such as the skill of the health care provider, observance of protocols, and meticulous asepsis required for dispensation of clinical methods.

Inter-personal relations are the personal dimensions of service provision.

Mechanisms to encourage continuity indicate a programme's interest and ability to promote continuity of contraceptive usage.

An appropriate constellation of services refers to the location of FP service delivery points at a given locality and their referral linkages.

ISO Certification

During 2004, the Standing Committee of the National Assembly desired that service delivery points of the Population Welfare Programme have ISO Certification so that their QoC would be recognized at par with the international standards and protocols. The programme's network of outlets is mandated to deliver FP services, keeping special focus on QoC. Quality assurance is regularly monitored at district, provincial, and federal levels.

List of Quality of Care Indicators

Provider

- Demonstrates good counselling skills.
- Treats client with respect/courtesy.
- Assures confidentiality.
- Asks client about reproductive choice.
- Discusses client's preference among contraceptive mix.
- Discusses methods for preventing pregnancy and STIs/RTIs, HIV/AIDS, and hepatitis through proper use of barrier methods.
- Tailors key information on the accepted method, explaining its use, side effects, and possible complications.
- Gives instructions on when to return for follow-up.
- Follows infection prevention and control procedures according to guidelines.
- Recognizes/identifies contraindications, consistent with guidelines.
- Performs clinical procedures according to guidelines.

Staff (other than provider)

- Treats clients with respect.
- Provides relevant information to assist clients in using the facility.

Client

- Participates actively in discussion and selection of method.
- Receives his or her method of choice.
- Believes the provider will keep his or her information confidential.

Facility

- Has all (approved) contraceptive methods available, with minimum stock for 3 months.
- Has basic equipment/items needed for delivery of methods offered by the facility (including sterilizing equipment, gloves, blood pressure apparatus, specula, adequate light source, adequate water supply, and sewerage).
- Ensures privacy for pelvic examination/IUCD insertion.
- Has sufficient flexibility to make local-level changes based on client feedback.
- Should undergo periodic supervisory visits within a certain pre-determined period.
- Has adequate storage of contraceptives and medicines (away from moisture, heat, direct sunlight) on premises.
- Follows standard clinical guidelines.
- Has comfortable waiting area and ensures minimum waiting time.

Checklists on QoC for Service Delivery Points

Checklist on Readiness for Handling Emergency Situation

A. Equipment

Sr. No.	Equipment	Availability		Functional	
		Yes	No	Yes	No
1.	Airway				
2.	Ambu bag/resuscitator				
3.	Laryngoscope				
4.	Endotracheal tube				
5.	Oxygen cylinder, regulator, and tubing				

B. Emergency Medicines List as per National Standards

Sr. No.	List Displayed	Yes	No
	Medicines being checked weekly with reference to:		
	• Availability		
	• Expiry		

List of Emergency Medicines attached at Annex IV.

Checklist on Segregation/Disposal of Infectious Waste (In Coloured Bags) and Non-Infectious Waste (In White Bags)

Sr. No.	Waste Disposal	Yes	No
1.	Segregation of infectious and non-infectious waste		
2.	Infectious waste disposed of in black bags to incinerator		
3.	Non-infectious waste disposed in white bags to the general waste		

Checklist on Infection Prevention Protocols Observed as per National Standards

Sr. No.	Method	In Practice		Knowledge	
		Yes	No	Yes	No
1.	Decontamination with 0.5% chlorine solution				
2.	Cleaning				
3.	High-level disinfection through boiling				
	Sterilization:				
	• Autoclave				
	• Manual pressure cooker				
	• Chemical sterilization				

Checklist on Client-Oriented Services

Sr. No.	Counselling	Knowledge		InPractice	
		Yes	No	Yes	No
1.	Greet				
2.	Ask/Assess				
3.	Tell				
4.	Help				
5.	Explain				
6.	Return/follow-up visit				

Insertion Room Checklist

Sr. No.	Insertions Room	Yes	No
1.	**Housekeeping:**		
	• Dusting		
	• Cleaning		
	• Things in order		
2.	**Steps of infection prevention observed:**		
	• Handwashing		
	• Handscrubbing		
	• Gloving		
	• Decontaminating:		
	– Insertion room table		
	– Couch		
	– Buckets		
	– Floor		
3.	**Equipment:**		
	• Boiler (sterilizer)		
	• Autoclave		
	Separately packed sterilized or HLD IUCD kits for individual clients:		
	• Insertion kits		
	• Removal kits		

Operating Theatre Checklist

Sr. No.	Operating Theatre	Observed		Frequency	
		Yes	No	Proposed	Practice
1.	Housekeeping			Twice daily	
2.	Decontamination with 0.5% chlorine solution			Twice daily	
3.	Cleaning			Twice daily	
4.	Carbolization			Quarterly	
5.	Ultraviolet light			Once daily	
6.	Sterilized or HLD functional Instrument availability			Not applicable	Not applicable
7.	Instruments in functioning order			Not applicable	Not applicable
8.	Soiled linen placed in a defined storage area (hampers)			Not applicable	Not applicable

Checklist on Calibration of Following Essential Equipment Used in RHS-A Centre

Sr. No.	Equipment	Calibration		Date of Calibration	Expiry Date
		Yes	No		
1.	Thermometer				
2.	Blood pressure apparatus				
3.	Weighing scale				
4.	Oxygen cylinder gauge				
5.	Autoclave gauge				

Checklist on Client Feedback

Sr. No.	Proforma	Yes	No
1.	Adequately filled		
2.	6-monthly analysis		
3.	Clients' feedback/suggestions incorporated accordingly for improvement of outlet (service delivery point)		

Checklist on Awareness of Quality Standards

Sr. No.	Auditable Areas From (Quality Management System)	Yes	No
1.	Quality policy and job description awareness		
2.	Quality objective update		
3.	Availability of counsellor's kit		
4.	Availability of consent forms		

Checklist of Contraceptive Mix

Sr. No.	Auditable Areas Form (Quality Management Systems)	Yes	No
1.	Availability of all contraceptives according to minimum stock level		
2.	Random checking of contraceptive client record		
3.	Monthly performance report of previous 6 months duly filled in		
4.	Proper storage of facility medicines in cool and dry place		

Checklist of HRD/Training/Records

Sr. No.	Auditable Areas Form (Quality Management Systems)	Yes	No
1.	Training record of previous 1 year		
2.	Payment record of contraceptive surgeries completely filled up		

Checklist on Maintenance of Infrastructure

Sr. No.	Auditable Areas Form (Quality Management Systems)	Yes	No
1.	Housekeeping (whitewash)		
2.	Sanitation		
3.	Leakages		

Emergency Medicine List

1.	Atropine Sulphate 1 mg/10 ml	5 ampoules
2.	Dopamine 400 mg/10 ml	2 ampoules
3.	Inj Dexamethasone 4 mg/ml	5 ampoules
4.	Inj Epinephrine 1:10000/ml	5 ampoules
5.	Inj Narcan 0.4 mg/ml	3 ampoules