

Integrated Monitoring Checklist for DOH Facilities

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| **FACILITY DESCRIPTION** | | | | | | | | | |
| **Name of facility:** | | | | | | | | | |
| **Category of facility:** DHQ \_\_\_\_ THQ: \_\_\_\_ RHC: \_\_\_\_\_\_ BHU: \_\_\_\_\_ Private/ | | | | | | | | | |
| ***Location(UC and Tehsil/ District)*** |  | | | | | | | | |
| ***Catchment Population*** |  | | | | | | | | |
| ***List of monthly targets*** | EPI: | FP: | | Deliveries at HF: | | | Live Births: | | |
| ***Sign Board of HF*** | Available | Not available | | ***Sign Plates in the HF*** | | | Available | Not Available | |
| ***Health Education Material*** | Displayed | Not displayed | | ***Monthly DHIS reports submitted*** | | | Regular | Irregular | |
| ***DHIS tools*** | Available | Not available | | ***Last month DHIS report submitted*** | | | Yes | No | |
| **GENERAL OUTLOOK OF HF** ***(Observe & Tick the relevant Box)*** | | | | | | | | | |
| General condition of the building | | | Good | | Need Repair | Poor | | |  |
| Cleanliness | | | Good | | Satisfactory | Poor | | |  |
| Waiting area | | | Common | | Male | Female | | |  |
| OPD Registration Desk | | | Available | | Not available |  | | |  |
| Furniture | | | Available | | Not available |  | | | |
| Drinking water | | | Available | | Not available |  | | | |
| Toilets | | | Available | | Not available |  | | | |
| Waste management | | | Available | | Not available |  | | | |
| Insecticide | | | Sprayed | | Not Sprayed |  | | | |
| Fumigation | | | Yes | | No | Date of last fumigation | | | |
| ***Other Resources (tick the box)*** | | | ***Check Availability*** | | | ***Check Functionality*** | | | |
| Electricity | | | Yes | | No | Yes | | | No |
| Generators (with fuel) | | | Yes | | No | Yes | | | No |
| Other power supplies | | |  | |  |  | | |  |
| Water supply | | |  | |  |  | | |  |

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| ***Communications (tick the relevant box)*** | | | | | ***Check Availability*** | | | | | ***Check Functionality*** | | | | | |
| ***Yes*** | | ***No*** | | | ***Yes*** | | | ***No*** | | |
| Telephone | | | | |  | |  | | |  | | |  | | |
| Fax | | | | |  | |  | | |  | | |  | | |
| Internet | | | | |  | |  | | |  | | |  | | |
| Ambulance | | | | |  | |  | | |  | | |  | | |
| Vehicle | | | | |  | |  | | |  | | |  | | |
| Motorcycles (for vaccinators) | | | | |  | |  | | |  | | |  | | |
| **MANAGERIAL INSTRUMENT AVAILABLE AT THE TIME OF VISIT *(Tick the relevant box)*** | | | | | | | | | | | | | | | | |
| ***Attendance Register*** | ***Visitor Book*** | | ***Movement Book*** | ***Cash Book*** | | ***Stock Register*** | | ***Condomn Register*** | | | ***DHIS Instruments*** | | | ***Others:*** | | |
|  |  | |  |  | |  | |  | | |  | | |  | | |
| **SERVICES AVAILABLE AT HF (tick the relevant box)** | | | | | | | | | | | | | | | | | |
| ***General services*** | | | OPD | Dispensary | | ORT Corner | | Laboratory | | Radiology | | | Sonology | | | Causality | |
|  |  | |  | |  | |  | | |  | | |  | |
| ***Specific services*** | | | FP | Labor Room | | Dental | | Operation Theatre | | Indoor | | | Surgical Consultancy | | | Others: | |
|  |  | |  | |  | |  | | |  | | |  | |
| ***Preventive programs*** | | | EPI | MNCH | | Nutrition | | TB | | Malaria | | | Hepatitis | | | HIV | |
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| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | | | | | | | | | | | | | |
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| **Signature of Monitoring Officer:** | | | | | | | | | | | | | | | | | |
| **Name & Designation:** | | | | | | | | | | | | | | | | | |
| **Date of Visit:** | | | | | | | | | | | | | | | | | |
| **DETAILS ON AVAILABLE PREVENTIVE PROGRAMS SERVICES** | | | | | | | | | | | | | | | | | |
| ***Maternal & Child Health (MCH) Services*** *(ANC, Delivery & PNC) (Check Maternal Health Register. To fill this section use HF data of previous month)* | | | | | | | | | | | | | | | | | |
| ***Number of ANC Visit*** | | | | | | | | | Number: | | | | | | | | |
| ***Number of PNC Visit*** | | | | | | | | | Number: | | | | | | | | |
| ***Number of Deliveries Conducted*** | | | | | | | | | Number: | | | | | | | | |
| ***Number of Live Births during last month*** | | | | | | | | | Number: | | | | | | | | |
| ***Number of Still Births during last month*** | | | | | | | | | Number: | | | | | | | | |
| ***IMR*** | | | | | | | | | Number: | | | | | | | | |
| ***Maternal Deaths during last month*** | | | | | | | | | Number: | | | | | | | | |
| ***Blood Transfusion Services Provided*** | | | | | | | | | Yes | | | | | | No | | |
| ***MCHC Tools Available*** | | | | | | | | | Yes | | | | | | No | | |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | | | | | | | | | | | | | |
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| **Signature of Monitoring Officer:** | | | | | | | | | | | | | | | | | |
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| ***Nutrition Services*** *(Check OPD, Child Health & Stock Register. To fill this section use HF data of previous month)* | | | | | |
| ***Number of children <5 years*** | Number: | | | | |
| ***Number of malnourished children diagnosed*** | Number: | | | | |
| ***Number of follow up of defaulted children maintained*** | Number: | | | | |
| ***Anthropometric Measurement Instrument*** | **Available** | | **Functional** | | |
| **Yes** | **No** | **Yes** | **No** | |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | |
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| ***EPI Services*** *(Check EPI Register. To fill this section use HF data of previous month)* | | |
| ***Number of children <12 months fully immunized*** | Number: | |
| ***Number of children received measles 1*** | Number: | |
| ***Number children received Penta 3*** | Number: | |
| ***Number of women received TT1*** | Number: | |
| ***BCG scar verified children present at HF*** | Yes | No |
| ***Monthly Movement Plan available at HF*** | Yes | No |
| ***Cold Chain Maintained*** | Yes | No |
| ***All vaccines available*** | Yes | No |
| ***Permanent Register EPI available*** | Yes | No |
| ***Daily Register EPI available*** | Yes | No |
| ***Updated list of defaulters available*** | Yes | No |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | |
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| **Signature of Monitoring Officer:** | | | |
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| **Date of Visit:** | | | |

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| ***FP Services*** *(Check Family Planning Register. To fill this section use HF data of previous month)* | | | | |
| ***Number of Family Planning users*** | ***Old:*** | | ***New:*** | ***Total:*** |
| ***FP commodities available at the start of month*** | ***Yes*** | | ***No*** | ***If “Yes” write numbers*** |
| ***FP commodities available at the end of month*** | ***Yes*** | | ***No*** | ***If “Yes” write numbers*** |
| ***Write number of users by methods during last month*** | | | | |
| ***Condoms*** | | ***Number:*** | | |
| ***Pills*** | | ***Number:*** | | |
| ***Injectables*** | | ***Number:*** | | |
| ***IUCD (if applicable)*** | | ***Number:*** | | |
| ***Implants (if applicable)*** | | ***Number:*** | | |
| ***TL (if applicable)*** | | ***Number:*** | | |
| ***Vasectomy (if applicable)*** | | ***Number:*** | | |
| ***Emergency Contraceptive*** | | ***Number:*** | | |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | |
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| **Signature of Monitoring Officer:** | | | | |
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| ***LHW Services*** *(Check Monthly Reports of LHW. To fill this section use HF data of previous month)* | | | | | | |
| ***Number of LHWs posted at HFs*** | | | *Number:* | | | |
| ***Number of population covered by LHW*** | | | *Number:* | | | |
| ***% of population covered by LHWs*** *(Total number of covered population by LHW/HF catchment population X 100)* | | | ***%*** | | | |
| ***Number of pregnant women registered*** | | | *Number:* | | | |
| ***Number of expected pregnancies*** | | | *Number:* | | | |
| ***Number of high risk pregnancies identified*** | | | *Number:* | | | |
| ***Number of delivered registered*** | | | *Number:* | | | |
| ***Total number of FP users*** | | | *Number:* | | | |
| ***Number of FP clients refereed by LHWs*** | | | *Number:* | | | |
| ***Number of FP clients by methods*** | ***Condoms*** | ***Pills*** | | ***Injectables*** | ***Implants*** | ***IUCD*** |
|  |  | |  |  |  |
| ***Number of FP clients for surgical services*** | ***Tubal ligation:*** | | | | | ***Vasectomy:*** |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | | |
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| ***Malaria Control*** *(Check Lab. Register & office record. To fill this section use HF data of previous month)* | | | |
| ***Total number of slides collected*** | ACD: | PCD: | |
| ***Total number of positive slides*** | ACD: | PCD: | |
| ***Advance monthly program submitted by Malaria Supervisor*** | | Yes | No |
| ***Malaria Supervisor collecting the blood slides for MP from FLCF regularly*** | | Yes | No |
| ***Malaria Microscopist posted*** *(Check this only in RHC & above HFs)* | | Yes | No |
| ***RDT performed*** | | Yes | No |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | |
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| ***TB Control*** *(Check Lab. Register & office record. To fill this section use HF data of previous month)* | | | | | | | | |
| ***Total number of cases with cough >2 weeks*** | | | | | | Number: | | |
| ***Total number of sputum smear taken for AFB*** | | | | | | Number: | | |
| ***Total number of sputum smear for AFB done*** *(Check in RHC & above)* | | | | | | Number: | | |
| ***Total number of sputum smear for AFB +ve in series*** | | | | | | Number: | | |
| ***Total number of cases lost as defaulters*** | | | | | | Number: | | |
| ***Total number of defaulter action taken*** | | | | | | Number: | | |
| ***DOTS protocol observed*** | | | | Yes | | No | | NA |
| **MIS Instruments** | | **Available** | | | | **Maintained** | | |
| **Yes** | | **No** | | **Yes** | | **No** |
| ***TB Register*** | |  | |  | |  | |  |
| ***Lab. Register*** | |  | |  | |  | |  |
| ***Abstract Register*** | |  | |  | |  | |  |
| ***TB F Card*** | |  | |  | |  | |  |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | | | | |
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| **Signature of Monitoring Officer:** | | | | | | | | |
| **Name & Designation:** | | | | | | | | |
| **Date of Visit:** | | | | | | | | |
| ***Hepatitis Control*** *(Check Lab. Register & office record. To fill this section use HF data of previous month)* | | | | | | | | |
| ***Total number of suspected for Hepatitis registered*** | | | | | Number: | | | |
| ***Total number of cases referred for screening*** | | | | | Number: | | | |
| ***Number of feedback received*** | | | | | Number: | | | |
| ***Number of advocacy meetings held*** | | | | | Number: | | | |
| ***Number of Hepatitis B cases +ve*** | Total: | | On ICT: | | On ELISA: | | On PCR: | |
| ***Number of Hepatitis C cases +ve*** | Total: | | On ICT: | | On ELISA: | | On PCR: | |
| ***Number of Hepatitis D cases +ve*** | Total: | | On ICT: | | On ELISA: | | On PCR: | |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | | | | |
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| ***HIV/AIDS Control*** *(Check Lab. Register & office record. To fill this section use HF data of previous month)* | | |
| ***Total number of suspected cases for AIDS registered*** | | Number: |
| ***Total number of cases referred for screening*** | | Number: |
| ***Number of feedback received*** | | Number: |
| ***Total number of STD cases screened*** | | Number: |
| ***Number of +ve cases*** | | Number: |
| ***STD Clinic/Surveillance Center established*** | Yes | No |
| ***Syndromic Management protocol followed*** | Yes | No |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | |
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| **GENERAL SERVICES** | | | | | | | | |
| **OPD ROOM *(Physically check/direct observation and tick the relevant column)*** | | | | | | | | |
| ***General condition (Sanitary condition)*** | | | Good | | | Average | Poor | |
| ***Light*** | | | Good | | | Average | Poor | |
| ***Health education/Counseling material available*** | | | Yes | | | No |  | |
| ***OPD Register available*** | | | Yes | | | No |  | |
| ***Abstract Form available*** | | | Yes | | | No |  | |
| **Tick the relevant box:** | | | | | | | | |
| ***Furniture available*** | Doctor’s Chair | Table | | Patient’s Stool | Examination Coach | | | Screen |
|  |  | |  |  | | |  |
| ***Instruments available*** | Thermometer | Tongue Depressor | | Flash Light | Sphygmomanometer | | | Stethoscope |
|  |  | |  |  | | |  |
| Tuning Fork | Measuring Tape | | Weight Machine | Others: | | | |
|  |  | |  |  | | | |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | | | | | |
|  | | | | | | | | | |
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| INDOOR WARD | | | | | |
| Male Ward (Physically check/direct observation and tick the relevant column) | | | | | |
| *General condition (Sanitary condition)* | | | Good | Average | Poor |
| *Light* | | | Good | Average | Poor |
| *Health education/Counseling material available* | | | Yes | No |  |
| *Duty Doctor Desk available* | | | Yes | No |  |
| *Nurse/Dispenser Desk available* | | | Yes | No |  |
| *Indoor Register available* | | | Yes | No |  |
| *Abstract Form available* | | | Yes | No |  |
| Tick the relevant box: | | | | | |
| *Furniture available* | Bed | Side Table | Screen | Attendant Bench | Other |
|  |  |  |  |  |
| *Instruments available* | Thermometer | Drip Stand | Flash Light | Sphygmomanometer | Stethoscope |
|  |  |  |  |  |
| Tuning Fork | Measuring Tape | Weight Machine | Ambu Bag | Resuscitation Board |
|  |  |  |  |  |
| Female Ward (Physically check/direct observation and tick the relevant column) | | | | | |
| *General condition (Sanitary condition)* | | | Good | Average | Poor |
| *Light* | | | Good | Average | Poor |
| *Health education/Counseling material available* | | | Yes | No |  |
| *Duty Doctor Desk available* | | | Yes | No |  |
| *Nurse/ Dispenser Desk available* | | | Yes | No |  |
| *OPD Register available* | | | Yes | No |  |
| *Abstract Form available* | | | Yes | No |  |
| Tick the relevant box: | | | | | |
| *Furniture available* | Bed | Side Table | Screen | Attendant Bench | Other |
|  |  |  |  |  |
| *Instruments available* | Thermometer | Drip Stand | Flash Light | Sphygmomanometer | Stethoscope |
|  |  |  |  |  |
| Tuning Fork | Measuring Tape | Weight Machine | Ambu Bag | Resuscitation Board |
|  |  |  |  |  |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | | |
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| **LABOR ROOM** | | | | | | | | |
| **(Physically check/direct observation and tick the relevant column)** | | | | | | | | |
| ***General condition (Sanitary condition)*** | | | Good | | | Average | Poor | |
| ***Light*** | | | Good | | | Average | Poor | |
| ***Health education/Counseling material available*** | | | Yes | | | No |  | |
| ***Duty Doctors desk available*** | | | Yes | | | No |  | |
| ***Nurse/Dispenser desk available*** | | | Yes | | | No |  | |
| **Tick the relevant box:** | | | | | | | | |
| ***Furniture & Instruments available*** | Labor Table | Instrument Trolley | | OT Light | Almirah | | | Screen |
|  |  | |  |  | | |  |
| Thermometer | Drip Stand | | Flash Light | Sphygmomanometer | | | Stethoscope |
|  |  | |  |  | | |  |
| Tuning Fork | Measuring Tape | | Weight Machine | Neonatal Resuscitation Kit | | | Ambu Bag |
|  |  | |  |  | | | |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | | | | |
|  | | | | | | | | |
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| **OPERATION THEATER *Check the HF category, availability & functionality of OT*** | | | | | | | | |
| *General condition (Sanitary condition)* | | | Good | | | Average | Poor | |
| *Air Conditioning* | | | Good | | | Average | Poor | |
| *Check & note last date of Fumigation* | | | Date: | | | | | |
| *Separate Wash Room available* | | | Yes | | | No |  | |
| *Separate Sterilization room available* | | | Yes | | | No |  | |
| *Oxygen available* | | | Yes | | | No |  | |
| *Nitrous Oxide available* | | | Yes | | | No |  | |
| *Health education//Counseling material available* | | | Yes | | | No |  | |
| *Duty Doctors desk available* | | | Yes | | | No |  | |
| *Nurse/Dispenser desk available* | | | Yes | | | No |  | |
| Tick the relevant box: | | | | | | | | |
| ***Furniture & Instruments available*** | Operation Table | Instrument Trolley | | OT Light | Anesthesia Machine | | | Autoclave |
|  |  | |  |  | | |  |
| Thermometer | Drip Stand | | Flash Light | Sphygmomanometer | | | Stethoscope |
|  |  | |  |  | | |  |
| Laryngo Scope | Megils Forceps | | ETT | Neonatal Resuscitation Kit | | | Ambu Bag |
|  |  | |  |  | | | |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | | | | |
|  | | | | | | | | |
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| **RADIOLOGY & LABORATORY SERVICES** | | | | |
| ***Services*** | ***Check Availability*** | | ***Check Functionality*** | |
| ***Yes*** | ***No*** | ***Yes*** | ***No*** |
| Blood Bank |  |  |  |  |
| Mini Lab. |  |  |  |  |
| Microscopes |  |  |  |  |
| X-Ray Machine |  |  |  |  |
| Ultra Sound Machine |  |  |  |  |
| Check number of investigation done in last month, if any | | | Number: | |
| Check the number of X-Ray done in last month, if any | | | Number: | |
| Check the number of Ultrasound done in last month, if any | | | Number: | |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | |
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| ***LIST OF SURGICAL & OBSTETRICAL INSTRUMENTS*** (check & tick against each) | | | | | |
| **Item** | **√** | ***Days*** | **Item** | ***√*** | ***Days*** |
| Scalp handle (Lancet) |  |  | Suture Scissor (Blunt Blunt) |  |  |
| Thumb Forceps |  |  | Mayo Dissecting Scissor (Straight and curved) |  |  |
| Dissecting Forcep |  |  | Speculum |  |  |
| Sponge Forcep (ovum) |  |  | Mouth Speculum |  |  |
| Tissue Forcep |  |  | Suture Scissor (Blunt Blunt) |  |  |
| Allis Forcep |  |  | Rectal Speculum |  |  |
| Kocher Forcep |  |  | Sim's Vaginal speculum |  |  |
| Babcock Forcep |  |  | Cusco's vaginal speculum |  |  |
| Towel Clamp Forcep |  |  | Sponge Bowl |  |  |
| Sponge Holding Forcep |  |  | Sterilization Tray |  |  |
| Haemostatic Forcep |  |  | Suction Machine |  |  |
| Kelly Forceps |  |  | Surgical Elevator (periosteal) |  |  |
| Artery Clip Curved Forcep |  |  | Surgical Spoon (curator) |  |  |
| Mosquito Forcep |  |  | Towel Clamp |  |  |
| Retractor |  |  | Tongue Depressor |  |  |
| Hook |  |  | Intestinal Clamp |  |  |
| Obstetrical |  |  | Trocar |  |  |
| Skin Hook |  |  | Self-retaining retractor |  |  |
| Needle Holder |  |  | Cutting Scissor |  |  |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | |
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| **LIST OF ESSENTIAL MEDICINES STOCK OUT (check & tick against each)** | | | | | |
| **Item** | **√** | ***Days*** | **Item** | **√** | ***Days*** |
| Amoxicillin Cap |  |  | Tab. Iron/Folic Acid |  |  |
| Amoxicillin Syp |  |  | ORS |  |  |
| Co-trimoxazole Tab |  |  | Oral pills (COC) |  |  |
| Co-trimoxazole Syp |  |  | Condoms |  |  |
| Tab. Metronidazole |  |  | Progesterone Inj. |  |  |
| Syp. Metronidazole |  |  | IUCDs |  |  |
| Inj. Ampicillin |  |  | Implants |  |  |
| Tab. Diclofenac |  |  | Emergency Contraceptives |  |  |
| Syp. Paracetamol |  |  | Bandages |  |  |
| Inj. Diclofenac |  |  | Anti-septic Solution |  |  |
| Chloroquine Tab |  |  | Disposable syringes |  |  |
| Syp. Salbutamol |  |  | Anti-sera for blood testing |  |  |
| Syp. Antihelminthic |  |  | Misoprostol |  |  |
| I/V infusions |  |  | Chlorhexidine (CHX) |  |  |
| Inj. Dexamethasone |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **LIST OF VACCINES STOCK OUT (check & tick against each)** | | | | | | |
| **Item** | **√** | ***Days*** | **Item** | **√** | ***Days*** | |
| BCG Vaccine |  |  | Tetanus Toxoid |  |  | |
| Pentavalent Vaccine |  |  | Anti-Rabies Vaccine |  |  | |
| Polio Vaccine |  |  | Anti-Snake Venom |  |  | |
| Hepatitis B Vaccine |  |  | Vaccine Syringes |  |  | |
| Measles Vaccine |  |  |  |  |  | |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | |
|  | | | | | |
| **Signature of Monitoring Officer:** | | | | | |
| **Name & Designation:** | | | | | |
| **Date of Visit:** | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **HUMAN RESOURCE** | | | | | | | | |
| Total # of staff at facility | Number: | | # of LHWs attached to the HF | | | | Number: | |
| # of Vaccinators attached to the HF | | | | Number: | |
| **Staff Category** | | **Sanctioned** | | **Filled** | **Vacant** | **Deputation/Detailement** | | |
| **In** | | **Out** |
| MS/AMS/Deputy MS | |  | |  |  |  | |  |
| Medical Specialist | |  | |  |  |  | |  |
| Surgical Specialist | |  | |  |  |  | |  |
| Cardiologist | |  | |  |  |  | |  |
| Chest Specialist | |  | |  |  |  | |  |
| Neurosurgeon | |  | |  |  |  | |  |
| Orthopedic surgeon | |  | |  |  |  | |  |
| Child specialists | |  | |  |  |  | |  |
| Gynecologists | |  | |  |  |  | |  |
| Eye Specialists | |  | |  |  |  | |  |
| ENT Specialists | |  | |  |  |  | |  |
| Anesthetist | |  | |  |  |  | |  |
| Pathologist | |  | |  |  |  | |  |
| Radiologist | |  | |  |  |  | |  |
| PMO/APMO/CMO/SMO/MO | |  | |  |  |  | |  |
| PW/MO/APWMO/SWMO/WMO | |  | |  |  |  | |  |
| Medical Assistant | |  | |  |  |  | |  |
| Dental Surgeon | |  | |  |  |  | |  |
| Physiotherapist | |  | |  |  |  | |  |
| Matron | |  | |  |  |  | |  |
| Head Name | |  | |  |  |  | |  |
| Staff Nurse/Charge Nurse | |  | |  |  |  | |  |
| Lab Assistant/Techs | |  | |  |  |  | |  |
| X-ray Assistant/Techs | |  | |  |  |  | |  |
| Dental Assistant/Techs | |  | |  |  |  | |  |
| ECG Assist/Techs | |  | |  |  |  | |  |
| Lady Health Visitors | |  | |  |  |  | |  |
| Health/Medical Assistants | |  | |  |  |  | |  |
| Dispensers | |  | |  |  |  | |  |
| Sanitary Inspectors | |  | |  |  |  | |  |
| Midwives | |  | |  |  |  | |  |
| Others | |  | |  |  |  | |  |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | | | | | |
|  | | | | | | | | | |
| **Signature of Monitoring Officer:** | | | | | | | | | |
| **Name & Designation:** | | | | | | | | | |
| **Date of Visit:** | | | | | | | | | |

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| **AVAILABLE STAFF TRAINED IN THE AREAS *(Write the number against each category)*** | | | | | |
| ***Training Areas*** | ***Staff Categories*** | | | | |
| ***WMO*** | ***MO*** | ***Paramedics (Male)*** | ***Paramedics (Female)*** | ***Others*** |
| FP |  |  |  |  |  |
| DHIS |  |  |  |  |  |
| EPI |  |  |  |  |  |
| CDC |  |  |  |  |  |
| NNT |  |  |  |  |  |
| Management |  |  |  |  |  |
| TB DOTS |  |  |  |  |  |
| TOT LHW |  |  |  |  |  |
| CDD |  |  |  |  |  |
| ARI |  |  |  |  |  |
| IMNCI |  |  |  |  |  |
| LMIS |  |  |  |  |  |
| Health Education |  |  |  |  |  |
| Others |  |  |  |  |  |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | | | |
|  | | | | | |
| **Signature of Monitoring Officer:** | | | | | |
| **Name & Designation:** | | | | | |
| **Date of Visit:** | | | | | |

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| **HEALTH FACILITY STORE *(Physically check/direct observation and tick the relevant column)*** | | | |
| ***General condition (Sanitary condition)*** | Good | Average | Poor |
| ***Light*** | Good | Average | Poor |
| ***Temperature chart maintained in the store*** | Yes | No |  |
| ***Bin cards used by the store keeper?*** *(Also check entries are proper)* | Yes | No |  |
| ***Stock Register maintained till date as per prescribed procedure*** | Yes | No |  |
| ***Does the facility report LMIS?*** | Yes | No |  |
| **GENERAL COMMENTS & RECOMMENDATIONS** | | | |
|  | | | |
| **Signature of Monitoring Officer:** | | | |
| **Name & Designation:** | | | |
| **Date of Visit:** | | | |