

# Facility Development in District Planning

1. Which facilities to develop ?
2. What are the HR gaps?
3. - What are the Training Needs?
4. - What are Infrastructure Gaps?
5. - Ensuring Quality of Care
6. -Special Plans for Inaccessible/Vulnerable Areas

# Outcome based Facility Development District

## Plan:

1. **Package of Services:** Clearly decide the package of services that a facility would provide – and the levels of such care needed in different facilities. Define standards for HR, Infrastructure, Equipment and Supplies and support services needed for quality care
2. **Identifying Facilities for Strengthening:**
  1. Already functional and managing case load and Range of services as required.
  2. Areas where access is the issue and we need functional facilities even if currently no case load is there. Those which have no case load because people have a better public or private sector alternative can be left out.
  3. Propose PPPs where an existing and willing Pvt. partner can close the gap
3. **Close Gaps in HR and Infrastructure in identified facilities**
4. **Close gaps in skills :** Estimate precise training load and prioritize.
5. **Differential financing-** Provide more funds to those facilities, public or private and those providers who provide a greater volume, range and quality of services.
6. **Transport and Communication Linkages between Facilities.**

## Example: For RCH:

### Level 1 facilities –Skilled Birth Attendance

- **Maternal Health**
- **ANC Package** –Registration (within 12 weeks), Physical Examination, Identification of referral for danger signs, IFA for Pregnant and anaemic women
- **Delivery Package**-Normal Delivery with use of Partograph, AMTSL, Infection Prevention, Pre referral Management for obstetric Emergencies
- **PNC Package**-Minimum 6 hrs post delivery stay; Home visits for PNC check up
- **Safe abortion Services**-Counselling and Facilitation
- **New Born Health**
- Newborn Resuscitation, Warmth, Infection Prevention, Support for Breast feeding initiation, Weighing, Care of LBW<2500gm and referral of sick newborn
- **RTI /STI Management**
- Counselling and Referral
- **Family Planning Services**
- Emergency Contraceptive pills, Counselling and motivation for small family norm, Distribution of OCP, Condoms, IUD Insertion y, Follow up of beneficiaries
  - “Assured” referral systems to higher facilities
  - Complete Immunisation
  - Counselling for feeding, Nutrition, Family Planning, Immunization
- ***Human Resources: Minimum Two Skilled Birth Attendants- midwives.***

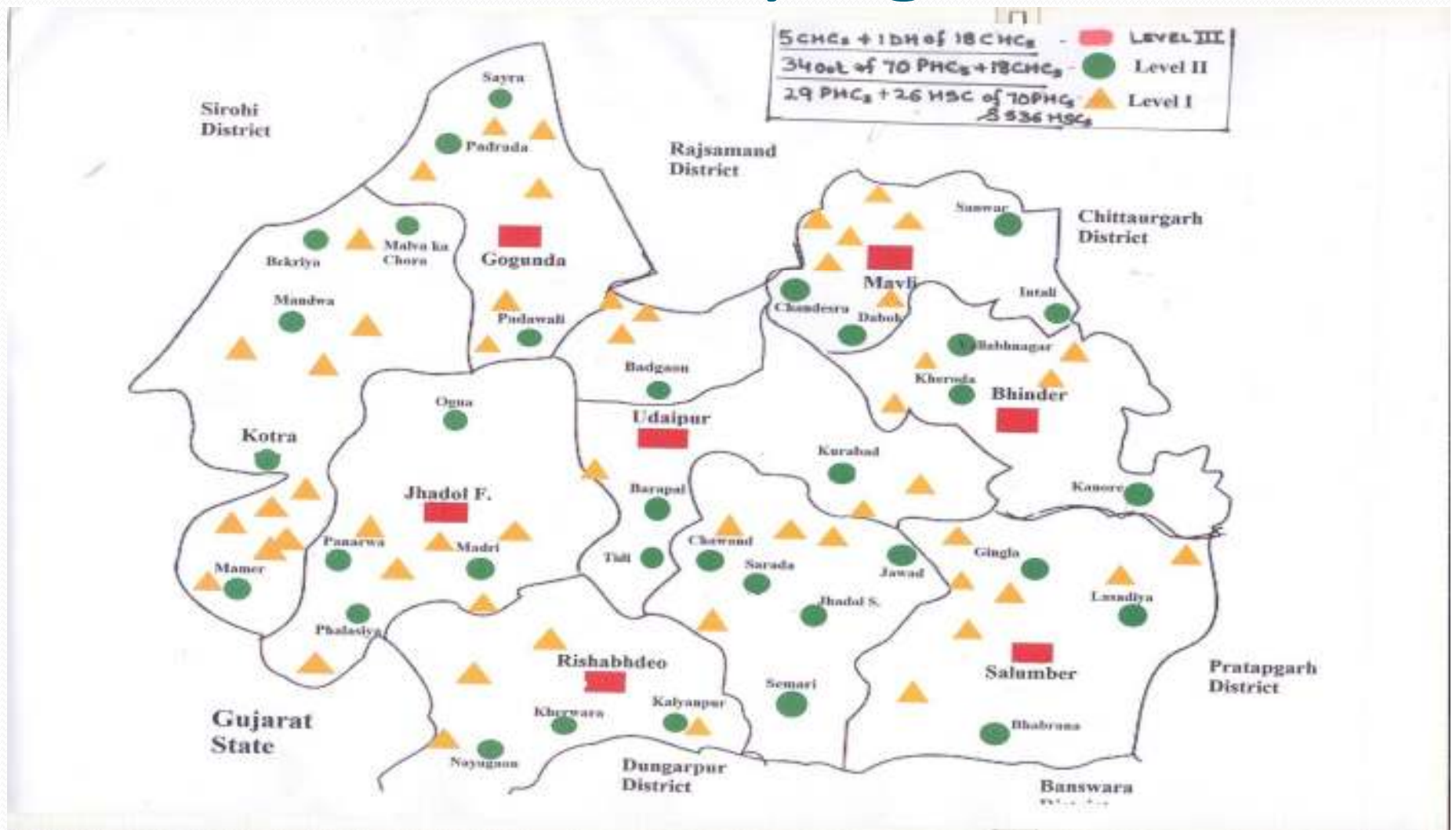
## Level 2 facilities –Basic Obstetric and Newborn Care

- **ALL SERVICES AS IN Level I +**
- **Maternal Health**
- **ANC Package-** Blood grouping, RH typing, , RPR/VDRL, linkage with nearest ICTC/PPTCT
- **Delivery Package-** All complications management other than those requiring Blood transfusion and surgery: Episiotomy and suturing cervical tears, Assisted vaginal delivery, Stabilisation of patients with obstetric emergency requiring surgery before referral
- **PNC Package-**Minimum 48 hrs post delivery stay, Stabilisation of mother with Post natal complications
- **Safe abortion Services-**MVA up to 8 weeks- desirable services as per MTP act, Medical Methods uptill 7 weeks with referral linkages,
- **New Born Health**
- Antenatal Corticosteroid to mother in case of preterm babies, Care of LBW>1800gms and other newborn complications referral where appropriate, Vit K to premature babies, Sepsis management
- **RTI /STI Management**
- Identification and management, Wet Mount Referral linkage to ICTC
- **Family Planning Services**
- Desirable- Male sterilization-NSV, Tubectomy, IUD insertion
  - “Assured” referral transport linkages to higher facilities
- **Human Resources: One or two Medical officers, three to 5 nurses or midwives with SBA training**

## Level 3 facilities –Comprehensive Obstetric and Newborn Care

- **ALL SERVICES AS IN LEVEL II +**
- **Maternal Health**
- Management of Severe Anaemia, Management of Intra partum and postpartum complications including those requiring Caesarean section and blood transfusion. Blood storage/Bank.
- **Safe abortion Services-** Both First and Second Trimester abortion services(Up to 20 weeks),Management of post abortion complications
- **New Born Health**
- Care of sick new born, Management of LBW babies less than 1800 gms
- **RTI /STI Management**
- Identification and management, Desirable- ICTC/PPTCT services
- **Family Planning Services**
- Male sterilization-Non Scalpel Vasectomy, Female Sterilisation : Conventional Tubectomy, Minilap, Laparoscopic Tubectomy , All other FP services as mentioned in Level 1 and level 2 Plus Management of complications
- **Human Resources:** *An obstetrician, an anaesthetist and a paediatrician ...or medical officer with short term training for appropriate specialist skills. Also a technician or medical officer with skills for blood transfusion support and nine nurses. Medical officers and nurses as per case load.*

# Process of Identifying Facilities







# Process of identifying facilities.

- Maps showing all facilities
- List of facilities with current case loads
- Mapping: which village uses which facility- distances and time taken.
- Note Peoples Preferences: Where would they like to have the facility? Consultative ,Participatory Process-
- Finalising Facility: looking at geographical feasibility, case load, population served –
- Principle: UNIVERSAL ACCESS IS ENSURED but because of development of transport; health seeking behavior changes, segregation of package of services - a lesser number of facilities -can guarantee this for some types of services.



## Packages in a facility- and packages across facilities-

- Picture from MNH guidelines – showing distribution of deliveries across the district.



## How a 1000 deliveries – and all facility based RCH services would be distributed across the 3 levels

	Level - III	Level II	Level -I
Normal Del	200	400	200
Complicated	60	70	0
LCS	70	0	0
Safe Abortion	25	25	0
Female Sterilization	150	150	0
Male Ster.	50	50	0
Sick Newborn care	50	100	0
AN/PN complications	50	50	0
<b>TOTAL</b>	<b>330</b>	<b>470</b>	<b>200</b>



# Planning HR

- Minimum HR specified in a standard –
- Case load very important factor
  - Example-24x7 with a case load -25-30 delivery per month-  
Calculate the number of doctors , ANMs and Nurses
- But-Importance of context in HR
  - Example-Level I with 4 deliveries, 50% home deliveries in nearby 15 villages –Block data showing this
- Prioritise and Rationalise



# Training

- Calculate the load- to meet quality of care
- Prioritize – who is to be trained first, sequence
- Plan infrastructure and faculty needed - for training
  - If necessary bring in trainers/agencies from outside, but also build up internal capacities in training for future.
  - Note: all training need not be done within district.
  - Training Calendar-Try and make it comprehensive:  
Example—SBA+IUCD, BeMONC +MTP
- Plan alternate staff for those undergoing training
- Budget



# Infrastructure

- Prioritization of facilities
- Beds
- Physical- LR, OT, NSU, SNCU, Wards, Quarters
- Water, Electricity, Toilets, Sitting, Stay for patients and relative
- Supportive-Food, Laundry, Toilet Cleaning
- Equipments
- Decision on how to get it constructed with quality. –steps involved and construction agency/intermediary-- PWD? Panchyat? RES? Private contractor? RKS? Others?
- Budget



# What More

Is this enough?



# Quality Certification

- Infrastructure +HR+ Equipment+ Consumables≠ Quality
- Quality is a set of processes, a form of organization called the Quality Management System - QMS
  - Decide on the process
  - Document the process
  - Follow what is documented.
  - Record what is followed.
  - Take corrective action if there is non conformity
- 24 parameters on which quality is to be followed .





# Process Parameters addressed

## Patient Experience:

1. Patient satisfaction scores improve as measured by periodic exit interviews.
2. Decreased patient waiting time and improved promptness of care - in both outpatient and in emergency rooms.
3. Decreased crowding and better patient amenities in outpatient department.
4. Timely reporting of investigations
5. Complaint resolution time- ( involves setting up a measurable process for registering and resolving grievances).
6. Improved cleanliness and aesthetics of surroundings.
7. Improved indoor illumination levels(measured regularly)

## Clinical Processes: Better patient outcomes.

1. Sturdy admission and improved discharge processes
2. Institution of system for medical and death audits
3. Calibration of all instruments
4. Verification of investigation results to ensure accuracy and standards.
5. Sterilization and infection control measures.



## Administrative Processes that are addressed:

1. Improved bio-medical waste management - achieving well defined standards.
2. Improved management of hospital sanitation especially of cleanliness.
3. Improved management of laundry services ensuring that all beds have clean laundry.
4. Improved management of hospital kitchen and diet services.
5. Compliance with all laws and regulations especially AERB, PNDT.
6. Stores and inventory management functions.
7. Maintenance of records and documents.
8. Regularity of functioning and involvement of Rogi Kalyan Samitis.
9. Clear calculation and architect level proposals for what further constructions and improvement on inputs are needed - money follows utilization and quality.



# The Quality Building Process Followed:

- “As-Is” Survey of existing processes by technical team
- Identification of process “gaps.”
- Facilitating participatory development of Action Plan to address gaps
- Developing “To- Be” processes and its documentation
- Developing work instructions protocol as per Quality System requirements
- Training in capacity building for all members of the Hospital Management Committee which included:
  - Quality Management System awareness
  - Administrative process
  - Clinical process
  - Support process
- Implementation of the documentation process
- Evaluation of extent of documentation through Internal Audit.
- External Audits : any suitable system



# Achieving Quality- Role of Supervision

- Two supervisory skill sets- one related to clinical skills and another to management/logistics
- Skill supervisor must ensure that protocols of care are in place and are followed- providing on the job training where required.
- Management supervisor – must ensure all other aspects of QMS- the 24 parameters and their documentation and audit is in place.



## Inaccessibility Area identification and its role in Facility Development

- Why so important?
- Designing incentive packages
- Part of HR Retention Policy, transparent transfer mechanism
- Positive motivation



**Is this applicable only for MCH?**

**Or could we follow this for all morbidity:**

- NO:
- All major disease groups would have a community level care requirement, a primary health care level, a secondary health care level and a tertiary health care level.
- EG: Tuberculosis
- EG: Snake-Bite:
- EG: Epilepsy- first aid and follow up care; stabilisation in emergency and treatment of usual epilepsy case after initial specialist consultation, specialist care and all symptomatic or refractory cases.



# Example at Level III –Communicable disease and Non Communicable disease

- (Example- MCH...where C-Sections happening these are level III.
- While deciding on these proposed facilities look at the PHCs and sub-centers which have and which do not have a FRU within 1 hr of motorized vehicle travel time. Also consider specialist availability.
- Similarly, identify 5 top priority conditions for Communicable and NCDs in a block and see facilities for tertiary level care where such a package can be offered within 2-3 hours of motorized travel time.
- (e.g. status asthmaticus: stabilization at primary and thereafter at secondary / tertiary care facilities). Cerebral malaria, epilepsy, stroke, hematemesis, acute abdomen requiring surgical intervention.

# Example at Level III – Communicable disease and Non Communicable disease

- Example from MCH:
  - This will include all those which were to be made FRUs, but could not reach that level. It would include all PHCs which have over 20 deliveries per month, should also include some PHCs which have less this level of delivery but has three nurses and potentially services are available and round the clock .Making these existing facilities each quality standard in terms as HR and amenities as laid down in the MHN guidelines is a priority, to this the district suggest further facility as proposed 24x7 facilities. These are to be carefully chosen and prioritized so that every area has such a facility as far as possible to which women can reach out within an hour from their residence. This is the level II facility list proposed and existing
- 
- ***Identification of facilities which have functional OPDs and IPD facilities for common illnesses like severe diarrhea, moderate pneumonia, snakebites, jaundice.***
- ***1<sup>st</sup> aid and stabilization for trauma.***
- ***Stabilization of status asthmaticus and status epilepticus.***
- ***1<sup>st</sup> aid for bites and toxicities.***
- ***Differentiation between secondary and primary hypertension.***



# So how to make this work

- Differential Planning needs to be accompanied by differential resource allocation- Human Resources and Financial Resources:
- Flexible Use of untied funds
- Flexible funds from other programmes, state budgets.
- Funds to be given per facility for strengthening infrastructure and supervision and per case – for drugs and supplies, and all support services- diet, laundry, hygiene and sanitation, security , provider incentives, etc.- very much in the future- but we can make a start.



# Efficiency in use of Resources

- In this approach HR, infrastructure and training development is directly linked to service delivery outcomes.
- Efficiency in the public health system requires innovation in financing – this would ensure that funds do not stagnate in facilities which are non functional or sub-optimally functional, while those with case loads have poor quality
- Ideally part of the funds should allotted be per identified facility and part of it should follow the case load , range of services and quality of services rendered.
- The problem of district planning- is not only the issue of participation- it is of how to plan resource allocation.



**Thank You**