Third

# Common Review Mission

State Report

# Rajasthan

2009

National Rural Health Mission (NRHM),
Ministry of Health & Family Welfare,
Govt. of India

# 3RD COMMON REVIEW MISSION

(NOVEMBER 2009)

RAJASTHAN

# 3rd Common Review Mission (CRM): RAJASTHAN

under

# National Rural Health Mission (NRHM)
# (4th-9th November 2009)

Organised by:

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# Abbreviations

| | |
|---|---|
| AMG | Annual Maintenance Grant |
| AMTSL | Active Management of the Third Stage of Labour |
| ANC | Ante Natal Care |
| ANM | Auxiliary Nurse Midwife |
| ANMTC | Auxiliary Nurse Midwife Training Centre |
| API | Annual Parasite Index |
| ASHA | Accredited Social Health Activist |
| AWC | Angan**w**adi Centre |
| AWW | Angan**w**adi Worker |
| AYUSH | Ayurveda Yoga Unani Siddha Homeopathy |
| BCC | Behaviour Change Communication |
| BDO | Block Development Officer |
| BMWM | Bio Medical Waste Management |
| BP | Blood Pressure |
| BPL | Below Poverty Line |
| CBR | Crude Birth Rate |
| CDR | Crude Death Rate |
| CHC | Community Health Centre |
| CPR | Cardio-Pulmonary Resuscitation/ Couple Protection Rate/ Contraceptive Prevalence Rate |
| CRM | Common Review Mission |
| CTF | Common Treatment Facility |
| CuT | Copper T |
| DH | District Hospital |
| DHS | District Health Society |
| DNB | Diploma National Board |
| DOTS | Direct Observation Therapy Short-course |
| DPT | Diphtheria Pertussis Tetanus |
| DT | Diphtheria and Tetanus |
| EC-SIP | European Commission Sector Investment Programme |
| ERS | Emergency Response Services |
| FBNC | Facility Based Newborn Care |
| FRU | First Referral Unit |
| GF&AR | General Finance and Administration Rules |
| GNM | General Nurse Midwife |
| GNMTC | General Nurse Midwife Training Centre |
| GoI | Government of India |
| HR | Human Resources |
| ICDS | Integrated Child Development Scheme |
| ICT | Integrated Counselling and Testing |
| IDSP | Integrated Disease Surveillance Project |
| IEC | Information Education Communication |
| IMA | Indian Medical Association |
| IMNCI | Integrated Management of Neonatal and Childhood Illnesses |
| IMR | Infant Mortality Rate |
| IOL | Intra Ocular Lens |
| IPHS | Indian Public Health Standards |
| IPP | India Population Programme |
| IUCD | Intra Uterine Contraceptive Device |

| | |
|---|---|
| IUD | Intra Uterine Device |
| JRM | Joint Review Mission |
| JSY | Janani Suraksha Yojana |
| LCS | Lower Caesarean Section |
| LHV | Lady Health Visitor |
| LT | Lab Technician |
| MCHN | Maternal and Child Health, and Nutrition |
| MDR TB | Multi Drug Resistance Tu**b**erculosis |
| MMJRK | Mukhya Mantri (BPL) Jeevan Raksha Kosh |
| MMR | Maternal Mortality Rate |
| MMU | Mobile Medical Unit |
| MO | Medical Officer |
| MOIC | Medical Office In-Charge |
| MPW | Multi Purpose Worker |
| MRS | Medical Relief Society |
| MTC | Malnutrition Treatment Centre |
| NCU | Neonatal Care unit |
| NFHS | National Family Health Survey |
| NGO | Non Government Organisation |
| NHSRC | National Health Systems Resource Centre |
| NIC | National Informatics Centre |
| NIPI | Norway India Partnership Initiative |
| NLEP | National Leprosy Eradication Program |
| NPCB | National Program for Control of Blindness |
| NPCC | National Programme Coordination Committee |
| NRC | Nutrition Rehabilitation Centre |
| NRHM | National Rural Health Mission |
| NSV | Non Scalpel Vasectomy |
| NVBDCP | National Vector Borne Disease Control Program |
| OB | Obstetrics |
| OE | Office Expenses |
| OPD | Out Patient Department |
| OT | Operation Theatre |
| PCTS | Pregnancy and Child Tracking System |
| Pf | Positive falciparum |
| PHC | Primary Health Centre |
| PHN | Public Health Nurse |
| PIP | Programme Implementation Plan |
| POL | Petrol Oil and Lubricants |
| PPP | Public Private Partnership |
| PRI | Panchayati Raj Institutions |
| Pv | Positive vivax |
| QFMR | Quarterly Financial Monitoring Report |
| RCH | Reproductive and Child Health programme |
| RDK | Rapid Diagnostic Kit |
| RHSDP | Rajasthan Health Systems Development Project |
| RKS | Rogi Kalyan Samiti |
| RMRS | Rajasthan Medical Relief Society |
| RNTCP | Revised National Tuberculosis Control Program |
| ROP | Record of Proceedings |
| SBA | Skilled Birth Attendant |

| | |
|---|---|
| SC | Scheduled Caste/Sub Centre |
| SDH | Sub Divisional Hospital |
| SNCU | Sick Newborn Care Unit |
| SOE | Statement of Expenditure |
| SRS | Sample Registration Survey |
| TFR | Total Fertility Rate |
| TT | Tetanus Toxoid |
| UC | Utilisation Certificate |
| UNICEF | United National International Children's Emergency Fund |
| USAID | United States Agency for International Development |
| VHND | Village Health and Nutrition Day |
| VHSC | Village Health and Sanitation Committee |
| VRS | Voluntary Retirement Scheme |

# Chapter 1: Introduction

### 1(a) Rajasthan: An Introduction to the state

Rajasthan, with a geographical area of 3.42 lakhs square kilometres is the largest state, constituting 10.43 percent of the total area of the country. Geographically, Rajasthan can be divided into three distinct regions: (i) southern hill zone, (ii) north-eastern plains and (iii) western dry zone. The north-eastern plains are better endowed with natural resources, such as water and productive land. The physical environment of the southern region is marked by a sub-humid climate, thick forests and rugged and ravine topography. Tribal people mainly inhabit this region. The tribal area in the state constitutes 5.85 per cent of the state landmass with a population of 12.44 per cent of the total state population.

The population of the state is 56.5 million according to 2001 census, which is 5.49 percent of the national population. The ratio of the rural and urban population is 77:23. The population of scheduled caste and the scheduled tribes according to 2001 census are 17.15 and 12.56 percent respectively of the state's total population, as against the national average of 16.2 and 8.2 percent. The growth rate of population in the state (28.41%) was higher than that of the country (21.34 %). Population density was 165 as compared to 325 for India according to Census 2001.

**Table 1.1: Demographic Profile of Rajasthan and India**

| Indicators | Rajasthan | India |
|---|---|---|
| Population (2001) in million | 56.5 | 1028 |
| Decadal population growth rate, 1991-2001 | 28.41 | 21.34 |
| Sex ratio (females per thousand male) | 921 | 933 |
| Population density (persons per sq km) | 165 | 325 |
| Per cent urban | 23.39 | 27.8 |
| Percent 0-6 yr. | 18.85 | |
| Literacy rate total | 60.4 | 64.8 |
| Literacy rate male | 75.70 | 75.3 |
| Literacy rate female | 43.9 | 53.7 |
| Per cent Scheduled Caste | 17.15 | 16.2 |
| Per cent Scheduled Tribe | 12.56 | 8.2 |
| Total fertility rate * | 3.2 | 2.3 |
| Crude birth rate ** | 27.5 (SRS 2008) | 23.8 |
| Crude death rate ** | 6.8 (SRS 2008) | 7.6 |
| Infant mortality rate ** | 63 (NFHS 2008) | 53 (NFHS 2008) |

Sources: *Census of India 2001, * NFHS-III 2005-2006*
***SRS-2005*

The age distribution of the population in the Rajasthan is typical of high fertility populations, with a high proportion of the population in the younger age groups: 39.89 percent are below 15 years of age and 4.84 percent are age 65 or older. The sex ratio defined as the number of females per thousand males is 921 females for every 1000 males as per Census 2001 for Rajasthan. The Sex Ratio was found to be lower in urban (890) than the rural (930). An important reason for the rural urban differential is migration of rural men to urban areas in search of education and livelihood.

Rajasthan has made significant gains in literacy by achieving literacy rate of 60.41 in 2001 as against 38.55 percent in 1991. Rajasthan has got a distinction in achieving the highest decadal difference of literacy rate of 21.86 percent from all the states of India. Rajasthan has made a fourfold progress in the field of literacy during the last decade especially among females. Among males, the literacy rate has increased from 54.99 percent in 1991 to 75.70 percent in 2001, which is higher than that of all India average i.e. 75.30 percent. In case of females, it has increased more than double from 20.44 percent to 43.85 percent from 1991 to 2001 respectively, which is still lower than the all India average of 53.7.

Rajasthan is heavily dependent on low-productive agriculture, which depends upon the vagaries of monsoon, and coupled with skewed land distribution. The backwardness is more profound in Scheduled Caste and Scheduled Tribe people. Indicators on poverty, work participation rate, and development indices, further reveal the poor socio-economic profile of the state. Rajasthan has one of the largest concentrations of Scheduled Castes and Tribes in the country. According to 2001 census, the Scheduled Caste and Scheduled Tribe population constituted 17.15 percent and 12.56 percent of the total population of the state respectively. At the district level Banswara (72.27%), Dungarpur (65.13%), Udaipur (47.86%) and Dausa (26.8%) districts have a high proportion of Scheduled Tribe population, whereas Ganganagar (33%) and Hanumangarh (25%) districts have a high proportion of Scheduled Caste population

Net State Domestic Product at constant (1993-94) prices, in the year 2000-01 has been estimated at Rs. 45,267 crore as against Rs. 46,574 crore in 1999-2000, and Net State Domestic Product at current prices works out to Rs. 70,211 crore for the year 2000-01 as compared to Rs. 69,491 crore during 1999-2000. A significant feature of SDP for Rajasthan has been its year-to year fluctuations mainly due to the behaviour of the monsoon since the primary sector (agriculture, animal husbandry, forestry, fisheries, etc.) contributes about 45-50 percent to total SDP. The per capita income for the year 2000-01 at current prices works out to Rs. 12,570 as against Rs. 12,765 during 1999-2000, registering decrease of 1.52 percent during the year.

Administratively, the state has been divided into 7 divisions, 33 districts comprising 9189 village panchayats, 40476 inhabited villages and 183 municipalities. Rajasthan was the first state to implement provision of *Panchayati Raj* in which *Panchayat Samities* (village level elected bodies) and Z*ila Parishads* (district level elected bodies) have been formed for decentralisation of administrative power to the locally elected bodies. One-third seats in these bodies are reserved for women representatives.

## 1(b) Public Health System in Rajasthan

### i. Infrastructure

The public health infrastructure in the state of Rajasthan shows a near adequacy in terms of numbers, but also shows a lot of scope of improvement in terms of functionality. Various health projects and programmes in the state, since the 1990's had brought in a substantial improvement in the health infrastructure, especially with projects like IPP-VIII and IPP-IX focussing on FRUs and the RHSDP focussing on district and sub-district/block level health facilities. Also, programmes like EC-SIP had invested heavily on upgrading a large number of Sub Health Centres and PHCs in selected districts. The present scenario of health infrastructure in Rajasthan is shown in the table below.

**Table 1.2: Public Health Infrastructure in Rajasthan**

| No. | Facility | Required (as per 2001 Census) | Sanctioned | In Position* |
|---|---|---|---|---|
| 1 | Sub-centres | 11319 | 11,488 | 11,488 |
| 1.1 | Sub-centres functional | | | 11,488 |
| 2 | Primary Health Centres | 1,780 | 1,503 | 1,503 |
| 2.1 | PHCs offering 24 hour services | | | 750 |
| 2.2 | Block PHCs functioning as FRUs | | | NA |
| 3 | Community Health Centres | 438 | 367 | 368 |
| 3.1 | CHCs functioning as FRUs | | | 102 |
| 4 | Sub-divisional Hospitals | - | 12 | 12 |
| 4.1 | SDHs functioning as FRUs | | 12 | 12 |
| 5 | District Hospitals | - | 33 | 33 |
| 5.1 | DHs functioning as FRUs | - | 33 | 33 |

* Source: State's presentation to the 3rd CRM team

The above table highlights the requirement of various health facilities State per 2001 census, based on norms for establishing sub centers, PHCs and CHCs. Sub Centres seem to available in adequate quantity. Regarding Primary Health Centres, out of 1780 PHCs that are required, 1503 are functional (84%). It is also reported that almost 50% of the PHCs are working 24x7 and almost 27% of the CHCs are working as fully functional FRUs. The state is also in the process of accrediting 3000 Sub Centres (almost 26% of the Sub Centres) as 'Model Sub Centres'.

### ii. Human Resource for Health

As everywhere else in India, the state of Rajasthan is also facing acute shortage of skilled health human resources to provide quality healthcare to the rural people in the state. The shortage of staff exists across all levels, including doctors (including specialists), nurses, paramedical staff and outreach workers. The Rajasthan State gazette's figures of the state's health staff, as on April 2008, are given in the table 3 below.

**Table 1.3: Health Administrator's staff position in Rajasthan (April 2008)**

| S.No | Name of the Post | No. of Post Sanctioned | In position | No. of Posts Vacant | Vacancy % |
|---|---|---|---|---|---|
| 1 | Director | 3 | 3 | 0 | 0% |
| 2 | Ad. Director | 8 | 7 | 1 | 12% |
| 3 | S.L.O. | 1 | 0 | 1 | 100% |
| 4 | Joint Director | 21 | 14 | 7 | 33% |
| 5 | Dy. Director & Equal | 92 | 72 | 20 | 21.7% |
| 6 | Senior Specialist | 285 | 216 | 69 | 24% |
| 7 | Junior Specialist | 1892 | 1318 | 574 | 30% |
| 8 | S.M.O & Equal | 819 | 651 | 168 | 20% |

| S.No | Name of the Post | No. of Post Sanctioned | In position | No. of Posts Vacant | Vacancy % |
|---|---|---|---|---|---|
| 9 | DY CMHO | 52 | 40 | 12 | 23% |
| 10 | S.M.O. {Dental} | 12 | 11 | 1 | 8% |
| 11 | Medical Officer | 3948 | 3134 | 814 | 20.6% |
| 12 | M.O. {Dental} | 114 | 65 | 49 | 43% |

The shortage of critical health staff is faced more at the peripheral level, seriously affecting the quality of care, especially at the first referral level. The inadequacy of doctors and specialists at the CHC/FRU level is shown in the table 4 below. Meanwhile the state had created a cadre of Rural Medical Service (RMS) and recruited many doctors and technicians under the RMS scheme.

**Table 1.4: Staff in 367 CHCs in Rajasthan against the IPHS norms**

| S.No | Specialty | No. of Post Sanctioned | No. of Posts as per IPHS | Gap | Gap % |
|---|---|---|---|---|---|
| 1 | Anaesthesia | 81 | 381 | 300 | 79% |
| 2 | ENT | 17 | 77 | 60 | 78% |
| 3 | Gynecology | 154 | 381 | 227 | 60% |
| 4 | Medicine | 360 | 381 | 21 | 5% |
| 5 | Ophthalmology | 69 | 135 | 66 | 49% |
| 6 | Forensic Medicine | 0 | 77 | 77 | 100% |
| 7 | Pediatrics | 105 | 381 | 276 | 72% |
| 8 | Superintendent (DD) | - | 77 | 77 | 100% |
| 9 | Pathologist | - | 14 | 14 | 100% |
| 10 | Radiologist/ Radiographer | 1/234 | 91 | 90 | 99% |
| 11 | Dermatologist | - | 77 | 77 | 100% |
| 12 | Surgeon | 364 | 381 | 17 | 4% |
| 13 | Dental Surgeon | 63 | 367 | 340 | 93% |
| 14 | Sr. Medical Officer | 383 | 304 | -79 | 20% extra available |
| 15 | Medical Officer | 806 | 2307 | 1501 | 65% |

As clearly seen in the table 4 above, the state is facing huge problems to obtain adequate manpower to meet the IPHS norms.

### iii. Health and Performance Indicators

The CBR was 37.1 live births per thousand populations in 1981 and it steadily declined to 28.6 in 2005. In rural areas it declined from 38.3 to 30.2 and in urban areas from 31.2 to 23.8 during the same period (SRS 2005). The CDR declined sharply over the same period. The estimated CDR for the state was 14.3 deaths per thousand populations in 1981 and it declined to 7.0 in 2005. The IMR for the state was 108 per thousand live births in 1981 and declined to 84 in 1990 and further to 68 in 2005.

**Table 5: Current Status of RCH Indicators and Future Goals**

| OUTCOMES | STATE | | | INDIA | | |
|---|---|---|---|---|---|---|
| | Current Status | Goal | | Current Status | Goal | |
| | | 2008-09 | 2011-12 | | 2008-09 | 2009-10 |
| MMR | 388 (SRS 06) | 323 | 148 | 254 (SRS 06) | 200 | <100 |
| IMR | 63 (SRS 08) | 55 | 32 | 53 (SRS 08) | 45 | <30 |
| TFR | 3.2 (NFHSIII) | 3.0 | 2.1 | 2.3 (NFHSIII) | 2.3 | 2.1 |

Some more health indicators for the state of Rajasthan is given in the table 6 below.

**Table 6: Health Indicators of Rajasthan**

| Indicators | Source | | |
|---|---|---|---|
| **Health Indicators** | | **Rajasthan** | **India** |
| 1. CBR (per 1000 population) | SRS 2008 | 27.5 | 23.8 |
| 2. CDR (per 1000 population) | SRS 2008 | 6.8 | 7.6 |
| 3. IMR (per 1000 live births) | SRS 2008 | 63 | 53 |
| 4. MMR (per 100,000 live births) | SRS 2004-06 | 388 | 301 |
| 5. TFR (per Woman, age 15-49) | NFHS-III (2006) | 3.2 | 2.3 |
| 6. Sex Ratio (females per 1000 males) | Census 2001 | 921 | 933 |
| 7. Unmet need (of Eligible Women) | NFHS-III (2006) | 14.7% | 13.2% |
| 8. Institutional deliveries | NFHS-III (2006)<br>DLHS-III (2008) | 32.20%<br>45.5 % | 40.70% |
| 9. Fully immunised (0-5 years) | NFHS-I (1993) | NFHS-II (1999) | NFHS-III (2006) |
| **Rajasthan** | 21.1% | 17.3% | 26.5% |
| **India** | 35.4% | 42.0% | 43.5% |

It may be noted that as per the table 6 above, the institutional deliveries in Rajasthan is reported to be 32% only (as per household level data of NFHS in 2006), but the state government reports

approximately 70% institutional deliveries (of the ANC cases registered). Also the immunisation levels showed a decline from 1993 to 1999, which although showed a increase in 2006, is still much less than the national average. Other indicators are also poorer than the national average.

### iv. Status of PRI framework in the state

Rajasthan has the three-tier PRI structure, as per the 73rd Constitutional Amendment Act and *panchayat* elections are held regularly. Two points worth noting with reference to NRHM is that there is no *panchayat* level set up at the village (Revenue Village) level and there may be one or more ward-*panch's* in one village. Secondly, the *Zila Parishad* chairman is junior to the District Collector and so all *panchayat* plans and schemes need sanction from the Collector. Also, the District Planning Committee of the *Zila Parishad* exists but is mostly non-functional. NRHM envisages strengthening of VHSCs. The 5th Committee constituted under the Panchayati Raj Institutions is responsible for the supervision of the VHSCs which is constituted under NRHM. This supports the fact that there is institutional integration between the two committees.

### v. Special constraints

As described in the background section on Rajasthan, the state has three distinct geographical divisions. The northern and north-eastern plains are relatively fertile and densely populated. But in this region lies the districts of Karauli and Dholpur, which has broken country-side and is sparsely populated with difficult communication, affecting transportation in medical emergencies and also discourages skilled health staff to be posted to the interiors. Similarly, the western desert region is devoid of any vegetation, is dry, thinly populated with vast distances amongst habitations and poor communication, affecting reach. The desert region is also inhabited by shifting/nomadic population (*Banjaras*) making it difficult to track service delivery, especially for ANC, immunisation and DOTS. The southern hills have thick jungles and inhabited by tribal population with less penetration of the public health system and the population relying more on faith healers and traditional systems of medicine. These difficult terrains limit the reach of the health workers and staff and also hinder timely transportation of critically ill patients to referral centres.

### vi. List of facilities visited by the CRM team

The CRM team had five members for the field visit in the state of Rajasthan and they split into two groups of three and two members respectively, and visited health facilities and interacted with health staff, officials, key stakeholders and community in two districts of Rajasthan. Team-A, comprising Dr. Sanjay Dixit (MG Medical College, Indore), Mr. Gautam Chakraborty (NHSRC) and Dr. Lovleen Johri (USAID) visited the facilities in Alwar districts; and Team-B, comprising Dr. P. Anbazhagam (Sr. Regional Director, Bangalore) and Dr. Ritu Priya (NHSRC) visited the district of Bhilwara. Between them, the CRM team visited 4 Sub Health Centres, 5 PHCs, 3 CHCs, 1 Satellite hospital, 2 District Hospitals, 4 VHSC meetings, and 4 MCHN Days (VHND). In Bhilwara, they also visited an Ayurvedic hospital and the ANMTC. The details of the facilities visited are given in the table 7 below.

**Table 7: List of facilities visited by the CRM team**

| 3rd Common Review Mission | | | | |
|---|---|---|---|---|
| 4th to 9th November 2009 | | | | |
| Name of State | | | RAJASTHAN | |
| Names of Districts visited | | | | |
| Sno | Name | District HQ | Name of DM/Collector | Name of CMHO |
| 1 | ALWAR | Alwar | Sh. Kunjilal Meena | Dr. Subodh Agrawal |

| 2 | BHILWARA | Bhilwara | Ms. Manju Rajpal | Dr. Ramesh Chand Samariya |
|---|---|---|---|---|
| Health Facilities visited | | | | |
| S. No | Name | Address / Location | | Level (SC/PHC/ CHC/other) |
| 1 | Indpura | Alwar | | Anganwadi centre (MCHN day) |
| 2 | Kalsada | Alwar | | Anganwadi centre (MCHN day) |
| 3 | Kalsada | Alwar | | Sub Centre |
| 4 | Harsora | Alwar | | PHC |
| 5 | Gunta | Alwar | | PHC |
| 6 | Neemrana | Alwar | | PHC |
| 7 | Behror | Alwar | | CHC |
| 8 | Thanagazi | Alwar | | CHC |
| 9 | District Hospital | Alwar | | District Hospital |
| 10 | Women's Hospital | Alwar | | District Hospital |
| 11 | Khari ka Lamba | Bhilwara | | Anganwadi centre (MCHN day) |
| 12 | Bhilwara | Bhilwara | | Anganwadi centre |
| 13 | Sangwa | Bhilwara | | Sub Centre |
| 14 | Bera | Bhilwara | | Sub Centre |
| 15 | Chamanpura | Bhilwara | | Sub Centre |
| 16 | Gurla | Bhilwara | | PHC |
| 17 | Rayala | Bhilwara | | PHC |
| 18 | Banera | Bhilwara | | CHC |
| 19 | Shahpura | Bhilwara | | Satellite Hospital |
| 20 | Bhilwara | Bhilwara | | District Hospital |
| 21 | Bhilwara | Bhilwara | | ANMTC |

# Chapter 2: Desk Review of NRHM Rajasthan

The Common Review Mission (CRM) has been set up as part of the Mission Steering Group's[1] mandate of review and concurrent evaluation. These are annual events and covered thirteen states each on the last two occasions. The Missions comprise state briefings, field visits and state level debriefings eventually culminating in state reports filed before the Government of India. The reports are placed in public domain and widely disseminated to all stakeholders. The CRM provides occasions for state review, sharing of experiences across the states, discussions with wide range of stakeholders and an opportunity for mid course corrections by the Mission at all levels.

The National Rural Health Mission (NRHM) has time-bound quantifiable goals to be achieved through specific road maps with appropriate linkages and financial allocations for strengthening the health infrastructure. The items reviewed during the review mission are in two parts – (a) change in key aspects of Health delivery system including quality of services and outreach, and (b) progress against the approved PIP of the current year.

Apart from the observations from the field, the 3rd CRM also involved a desk review based on information provided by the state, before the CRM team went to the field. This desk review formed the background of the enquiries made by the CRM team in the state. The desk review for the state of Rajasthan is discussed in the subsequent sections.

**(a) Health Facilities in Difficult, Most Difficult, and Inaccessible areas**

As per the information submitted by the state of Rajasthan, of the 12,821 government health facilities of all types, 3,953 (31% of all public health facilities) do not have road connectivity throughout the year. The table below gives the details of the health facilities in Rajasthan.

**Table 2.1 Status of Health Facilities in Rajasthan**

| Parameter | | No. of Health facilities (%) |
|---|---|---|
| Health facilities (all types) | | 12,821 (100%) |
| Road connectivity | Connected by road round the year | 8,868 (69%) |
| | Not connected by road round the year | 3,953 (31%) |
| Amenities available at health facility | Electricity | 8,135 (63%) |
| | No electricity | 4,686 (37%) |
| | Housing | 8,065 (63%) |
| | No housing | 4,756 (37%) |
| | Water supply | 6,872 (54%) |
| | No water supply | 5,949 (45%) |
| | School facility within 2km radius | 11,579 (90%) |
| | No school facility within 2km radius | 1,242 (10%) |

[1] The Mission Steering Group (MSG) and Empowered Programme Committee (EPC) of NRHM are the highest policy making institutions under NRHM and have the mandate to steer the overall NRHM Policy. For detailed constitution and powers refer http://www.mohfw.nic.in/NRHM/msg.htm and http://www.mohfw.nic.in/NRHM/epc.htm

As is evident from the above table, almost 30% of the facilities are not always accessible. Also, the health facilities lack basic amenities like electricity and housing (37%), pointing to constraints in retaining medical/para-medical staff in these facilities on a 24x7 basis.

Breaking up the health facilities by levels, the state of Rajasthan has classified some of the facilities as "difficult area", as shown in the table below.

**Table 2.2 Health Facilities in Rajasthan in Difficult, Most Difficult and Inaccessible areas**

| **Level of Health Facility** | **Number of Health Facilities falling in** | | | |
|---|---|---|---|---|
| **Health Centres** | **Total** | **Difficult areas** | **Most Difficult Areas** | **Inaccessible Areas** |
| Primary Health Centre | 1503 | 556 (37%) | 0 | 0 |
| Other facilities below the block level (Sub-centres) | 11488 | 6027* (52%) | 0 | 0 |
| Community Health Centres | 368 | 0 | 0 | 0 |
| Other facilities below the district level | 130** | 0 | 0 | 0 |
| District Hospitals (Including Satellite Hospitals) | 33 | 0 | 0 | 0 |
| Other facilities at District level | 281*** | 0 | 0 | 0 |

** The 6027 sub-centres falling in 'Difficult Areas' comprises of the sub-centres in desert and tribal areas.*
*** The 130 Health Facilities below district level includes 12 Sub-district hospitals and 118 Maternal & Child Welfare Centres*
**** 281 Facilities at District level includes 199 City Dispensaries, 4 Mobile Surgical Units, 25 Hospitals attached to Medical Colleges and 53 other hospitals (that includes 06 Satellite Hospitals)*

As can be seen from the above table, almost one-third of the PHCs and more than half of the Sub Centres were classified by the state of Rajasthan as located in difficult areas. The state had not shown any health facility to be located in most difficult and inaccessible areas. This is because In Rajasthan, the health facilities are classified as "Normal' and "Difficult" Areas. Hard duty allowances are being given to the manpower working in the 'hard to reach'/ inaccessible areas. This includes 556 PHCs and 4488 sub-centres.

**(b) Progress of NRHM in Rajasthan**

The National Rural Health Mission (NRHM) started in the state of Rajasthan in 2005-06 with the release of Rs.7.93 crores (for NRHM additionalities). Thereafter, from 2006-07 onwards, the releases were as per Record of Proceedings (ROP) of the National Programme Coordination Committee (NPCC) against the annual Programme Implementation Plans (PIP) submitted by the state. The ROP approvals in the year 2006-07 were Rs. 9.19 crores, which increased to Rs. 41.50 crores in 2009-10

(an increase of more than four times). The physical progress of activities under NRHM Additionalities in the state of Rajasthan is shown in the table below.

**Table 2.3 Physical Progress of Initiatives approved by ROP in Rajasthan**

| S.No. | Initiatives | Physical Progress | Remarks |
|---|---|---|---|
| **ASHA** | | | |
| 1. | ASHA | 42496 selected out of which 40361 trained. | |
| **Infrastructure** | | | |
| 2. | Major Civil Works for operationalisation of FRUs | 102 FRUs made functional | Under RCH shifted to MFP |
| 3. | Improving physical infrastructure of SHC/PHC/CHC/Taluk/Distirct Hospital including construction of new Sub-Centres | 633 works completed | --- |
| 4. | Upgradation of 176 CHCs to IPHS | Works at 68 CHCs have been completed | --- |
| 5. | Upgradation of 305 PHCs as per IPHS | Works at 133 PHCs have been completed | --- |
| 6. | Establishment of Central & District level Drug Warehouse with Pharmacists & Computer operators | Recruitment of pharmacists completed and establishment of District level Drug warehouses is under process. | --- |
| 7. | MMU | 26 MMU fully functional | --- |
| 8. | Emergency & Referral Services | 164 free “108” Ambulances deployed | --- |
| 9. | Procurement of IPHS friendly institutions sonography machines other equipments as per facility survey | Equipments have been procured as per the budget availability | --- |
| **Human Resources** | | | |
| 10. | Manpower cost | 14,140 personnel hired under NRHM | Includes 2nd ANM, Staff Nurse, and MO |
| 11. | Remuneration of Specialists at CHC | *Rs.40,000/- is being offered to the specialists hired under NRHM.* | --- |
| 12. | AYUSH Integration – Remuneration of AYUSH Doctors and Nursing Staff | 1054 AYUSH doctors & 614 AYUSH Compounder Selected | --- |
| 13. | Remuneration of Staff Nurses at CHC Level | 698 Staff Nurses hired | --- |
| 14. | Remuneration of Staff Nurses at PHC Level | 3006 Staff Nurses hired | --- |
| 15. | Selection , training and remuneration of ANMs/GNMs at Sub Centre | 2500 nurses/GNMs hired | --- |
| 16. | Remuneration to technicians | *Recruitment under process* | --- |
| 17. | Additional allowances to MOs at PHC | *Rs. 3000/- as Hard duty* | --- |

| S.No. | Initiatives | Physical Progress | Remarks |
|---|---|---|---|
| | | *allowance and Rs. 4000/- as Rural Duty Allowance* | |
| **Programme Management** | | | |
| 18. | SHSRC | 3 Project Officers hired under SHRC | --- |
| 19. | Management costs | BPMUs hired in all Blocks | --- |
| 20. | Preparation of District/Block/Village Health Action Plans | District PIPs prepared for all 33 districts | Village plans initiated for all revenue villages since 2008 |
| 21. | State & District Public Health Reports | *Under process* | --- |
| 22. | Community monitoring | Started in 180 villages, 36 PHCs in 12 blocks of 4 districts, on a pilot basis | --- |
| 23. | Monitoring & Evaluation studies | 6 M&E studies completed | --- |
| 24. | Logistics Management and improvement | *Logistic management is being carried out at the State and district level* | --- |
| 25. | Creation of Directorate of Hospital Administration | *Under process* | --- |
| 26. | Mobility support to BMOs | All BMOs provided mobility support | --- |
| 27. | M&E | 6 M&E studies completed | |
| **Untied Funds, Annual Maintenance Grants and RKS funds** | | | |
| 28. | RKS grants to DH/SDH/ Satellite Hospitals/ CHCs/PHCs | Funds transferred | --- |
| 29. | Untied Funds for Sub Centres | Funds transferred | --- |
| 30. | Untied Funds for PHC | Funds transferred | --- |
| 31. | Untied Funds for CHC | Funds transferred | --- |
| 32. | Untied Funds for Satellite hospitals | Funds transferred | --- |
| 33. | Untied Funds for District hospitals | Funds transferred | --- |
| 34. | Untied Funds for Medical colleges | Funds transferred | --- |
| 35. | Untied Funds for VHSC | Funds transferred | --- |
| 36. | AMG to Sub Centres in govt. buildings | Funds transferred | --- |
| 37. | AMG to PHC in govt. buildings | Funds transferred | --- |
| 38. | AMG to CHC in govt. buildings | Funds transferred | --- |
| **Training & Capacity building** | | | |
| 39. | Establishment / strengthening of Nursing Schools | SIHFW and HFWTCs are strengthened | --- |
| 40. | Workshops for National, State, District, And Block Level Mission Teams | *Being convened* | --- |
| 41. | Constitution & Orientation of all community leaders on village, SHC, PHC, CHC Committees | *Constitution of 40476 VHCs completed, trainings are planned from Feb 2010.* | --- |
| 42. | Reviving ANMTC @ Zenana Hospital, Jaipur | *Work in progress* | --- |

| S.No. | Initiatives | Physical Progress | Remarks |
|---|---|---|---|
| 43. | Other trainings | *Proposal for training of RMPs is submitted* | --- |
| **Innovations** | | | |
| 44. | Heath Melas | *Clubbed with Swasthya Chetna Yatra* | Innovation |
| 45. | Swasthya Chetna Yatra | Organised once a year | Innovation |
| 46. | IEC for Swasthya Chetna yatra | *Pre-camp publicity through traditional media organised, various types of posters, brochures and handbills were printed at state level and supplied to districts for further dissemination.* | Innovation |
| 47. | Medicines for Swasthya Chetna Yatra | *Medicines are procured at state level and supplied to district for free distribution during the SCY camps.* | Innovation |
| 48. | Swasthya Mitra Yojna | Scheme is launched | Innovation |
| 49. | Swastha Gram Yojana | Best performaing panchayats in terms of health indicators are being awarded | Innovation |
| 50. | Drugs & supplies for Child Health | *Funds released to the districts for drugs and supplies* | Under RCH |
| 51. | Maternal Health – other strategies and activities | *Includes collaboration of centres with Rajasthan State Women Commission and compensation package for C-Section in private hospitals (in areas where government facilities/ doctors are not available* | Under RCH |
| 52. | Integrated and comprehensive HMIS | Operationalised | IT/MIS |
| 53. | Inter-sectoral convergence | *Covergence with WCD, AYUSH and PRIs* | Convergence/AYUSH |
| 54. | Mainstreaming of AYUSH | *309 Ayurved Deptt. dispensaries have been co-located with PHC/CHC under one-roof scheme. 750 AYUSH doctors (in 2007-08), 501 doctors (in 2009-10) and 589 paramedical staff have been appointed.* | Convergence/AYUSH |
| 55. | IEC activities | *Traditional media* | IEC/BCC activities |

| S.No. | Initiatives | Physical Progress | Remarks |
|---|---|---|---|
| | | *activities on local specific issues were organised through District Authorities and State level activities on NRHM components were organised through mass media.* | |
| 56. | Health Insurance scheme | Insurance scheme withdrawn | Innovation |
| 57. | Mukhya Mantri BPL Jeevan Raksha Kosh | Free treatment and medicines being provided to all BPL patients in govt. health hospitals | Special scheme |
| 58. | Adolescent services at health facilities | *Teen Clinics are being organised on weekly basis, counseling sessions for adolescent girls are being held once in a month through ASHA Sahyoginis.* | Under RCH |
| 59. | Recurring Expenses for Telemedicine vans at Medical Colleges | *Fund transferred to District hospitals for strengthening of Telemedicine programme* | |
| 60. | Drug supply to CHC/FRU | *We haven't received supply from GoI* | State has limited budget for drugs |

As can be seen from the above table, the major lacunae had been in Trainings & Capacity Building, followed by infrastructure strengthening/upgradation to IPHS of CHCs and PHCs. Among others, strengthening of service delivery at CHC level by engaging private specialists had still not taken off in a big way. Orientation of community leaders (who are members of VHSC/SC Committees/MRS) have not started yet. Also, many of the initiatives mentioned under Innovation are actually routine activities under RCH.

Based on the desk review, the CRM team undertook field visits in two districts in the state of Rajasthan, to validate the issues emerging from the desk review, and also other issues related to systems reform and programme implementation. The findings of the CRM team are presented in the next chapter.

# Chapter 3: Findings

### 3(a) Change in key aspects of health delivery system

Previous two CRMs looked at the system strengthening and new initiatives started under NRHM at the state, district, health facility and community level. This 3rd CRM, in addition, also looked in details at the initiatives undertaken under RCH-II, which earlier used to be part of Joint review Mission (JRM), thereby effectively merging the CRM and JRM. Also, the underserved areas and Nutrition were given special focus in this CRM. The findings, in terms of progress observed by the CRM team and also the areas of improvement, are enumerated below.

i. **Infrastructure upgradation**
- Progress so far
    - Department has in-house Civil Wing (absorbed from the civil wing created under RHSDP). Renovation works undertaken for block and district level facilities under RHSDP
    - Construction at CHC and PHC levels planned for in 2006-09 has been almost entirely completed and handed over in Bhilwara district.
    - Model Sub Centres (with ANM quarter and Labour Room, as per IPHS approved design) being constructed and accredited for JSY
- Areas for improvement
    - No facility mapping undertaken since 2006-07.
    - Severe overcrowding in the Labour rooms and maternity wards in the Zenana hospital in the state capital, with a large proportion being normal deliveries coming in even from the rural areas.
    - It was observed that out of 16 FRUs only 2 are fully functional in Alwar and 3 out of 13 in Bhilwara.
    - Construction of Labor Room is behind schedule (only 10% of Sub Centres completed in Alwar and 20% in Bhilwara). Follow ups with the Construction Agencies is being done. Cost revisions as required by the Construction Agencies are also underway.
    - 4% shortfall in SHC; 9% shortfall in PHCs; 23% shortfall in CHCs (against the population-norm based need)
    - 15% SHC without buildings; 2% PHCs without buildings
    - Construction of OT in CHC (Thanagazi) not taken up by RHSDP, thus making it a non-functional FRU.
    - Major renovations and upgradations are required for ANMTC/GNMTC and Drug Warehouses.
    - The condition of hostel in ANMTC in Alwar was observed to be very pathetic. Six students are living in one room. It is suggested that since the centre is getting renovated, better accommodation for students be made available. In Bhilwara the Nursing college has no hostel and the building of the ANMTC is unusable. ANMTC is being upgraded / rebuilt and hostel infrastructure is being developed.

ii. **Human Resource Planning**
- Progress so far
    - At district level NRHM has provided bulk of the nursing (Staff Nurse, PHN, ANM) staff (in Alwar 34% of such staff is under NRHM)

  - Trainings, especially under NIPI support for SNCU, added skill and confidence to doctors & nurses
  - Although MPW is a dying cadre, Male Nurses are available in good numbers
  - The Rural Medical Officers cadre has provided doctors to the PHCs.
- Areas for improvement
  - Shortage of specialists continues (the state may consider increasing rates for contracting private Specialists for normal delivery/LCS to Rs.1500/Rs.5000 as they are not coming under presently applicable rates). Innovation of short term specialist trainings for practice in the state is being tried.
  - Quality of ANMs and MOs poor regarding knowledge and skill related to IMNCI, cold-chain management, Family Planning (especially IUD).
  - Poor motivation among doctors and field staff
  - No career progression plan/ long-term HR plan regarding contractual staff. Contractual staff was dissatisfied, especially regarding salary and promotion/regularization prospects.
  - Clinical training was been found very weak. All PHC doctors and all ANMs to be upgraded on clinical skills. The team recommends that training should be adequately monitored for quality and monitoring may be outsourced.
  - GNMs were not trained on IUCD insertion and so were not providing any family planning messages or services. Their involvement is essential for stronger family planning program especially in facilities where ANMs are unavailable.
  - In Alwar ANMTC, only 3 out of 7 recommended faculties were in position in the centre visited. There is need to fill up vacant positions.
  - Currently admissions are happening every 18 months for 18 months course. The admissions can be done every year or every six months so that two or three batches are studying at a given time and trained ANMs are available every six month or every year. This can cover the shortfall. Currently one batch is ready after every one and a half year.
  - It was observed that the 1977 curriculum is used for ANM training. Though the tutor mentioned about a new curricula being adopted, it was unavailable at the ANMTC.
  - All efforts to be made to improve quality of training in the training centres, training methodology and faculty. New curriculum to be adopted immediately.
  - Training supervision is poor. Mechanism of training supervision is to be formalized or outsourced. Pre and post tests need to be conducted as integral part of quality control of trainings.

**iii. Assessment of the case load being handled by the Public System at all levels**

- Progress so far
  - Increase (from 2005 to 2008) in delivery cases across PHC/CHC and fall in normal delivery cases in DH (in Alwar normal deliveries increased by 50% in PHC, more than 100% in CHC and fell by 50% in DH). In Bhilwara, between 2008 and 2009, increase in CHC, PHC and accredited Sub-centre deliveries were accompanied by a marginal fall in deliveries at the DH.
  - Increase in OPD, and the increase (in OPD) was observed more at CHC level
  - Increase in admissions at DH/CHC level (almost by 100% increase observed in Alwar)
  - Fall in malnourishment cases recorded (at OPD) noted across all levels in Alwar (fall by around 90% at PHC/CHC and by 40% at DH)

  - Fall in delivery related complications at FRUs, but increase in such cases at DH (in Alwar fall at FRU is almost 100%, whereas at DH there is almost 200% increase)
  - The shift of normal deliveries from DH to PHCs and SCs is a positive development.
  - The FBNC services in DH Bhilwara have developed very well, with a baby-friendly approach, segregation of different categories of babies and clinical outcomes where babies of less than 1kg have survived.
- Areas for improvement
  - Complicated delivery cases still referred out of FRUs (almost 90% cases referred out in Alwar, i.e. not managed at the FRU level)
  - In Bhilwara, the DH has experienced a decline in OPD attendance, and if delivery cases are excluded, also a decline in indoor admissions.
  - Fall in OPD cases observed at PHC level in Alwar
  - Despite the excellent FBNC services, the neonatal mortality rate in the hospital is 40/1000 live births. This, most likely, indicates a disadvantage at birth, including maternal malnutrition and LBW as well as congenital abnormalities.

**iv. Preparedness of health facilities for patient care and utilization of services**

The CRM team in both the districts observed that institutional deliveries have increased substantially in government health facilities. Also, the facility level data across the levels of health facilities revealed that normal delivery cases have reduced in District Hospital level and a subsequent increase (shift) is visible at PHC and CHC level.

It seems that the following factors have worked in favour of this positive shift:

- Strengthening of services at CHCs;
- Posting of doctors & nurses at PHCs;
- Accrediting Sub-centres for deliveries, and improving infrastructure such as building a labour room with amenities, equipment for ANC.

The CRM team feels that the following needs to be done to strengthen this further:

- Completing strengthening of all facilities and increase no. of facilities to decrease coverage area.
- Ensuring timely emergency transport and quality referral services.
- Strengthening SBA training.

To capture the developments at the District Hospital level and to examine the issues therein, the case of District Hospital Bhilwara is presented as under:

- Current situation (at DH Bhilwara)
  - It is a 450 bedded hospital, with excellent FBNC unit.
  - It was observed that female medical & surgical wards had poor occupancy, but maternity ward overflowing. On the other hand, male wards full.
  - Institutional Deliveries have more than doubled since 2006-07 [3,025 in 2006-07 to 7,262 in 2008-09]. Total OPD declining since 2006 [3,04,551 in 2006-07 to 2,51,584 in 2008-09]. Total indoor increased [38,743 in 2006-07 to 40,536 in 2008-09]. But if deliveries are excluded, there is a decline even in indoor [35,718 in 2006-07 to 33,276 in 2008-09].
- Reason for falling utilization (as felt by the CRM team)
  - VRS by Specialists, might have lead to loss of public image.

  - o Image of the DH as a Maternity Hospital, especially in light of the JSY and focus on institutional delivery as the main task of ASHA, resulting in women not being brought for other diseases & largely JSY only.
  - o Large but poorly utilized infrastructure.
  - o Shift of patients to private facilities, aided by the outsourced MMU that allows the NGO to publicise its clinical services through the MMU.
- Areas for improvement
  - o Needs a face-lift, which can attract more patients and indirectly be used for attracting specialists.
  - o Also, other alternative innovation might be tried to attract and retain specialists like exploring possibility of DNB recognition for Paediatrics and OB/Gyn. or starting a Govt. Medical College with the hospital.

The CRM team also observed the Facility Based Neonatal Care units (FBNC) at the District Hospital level, and have the following observations:

- Progress so far
  - o Separate cells for different categories of neonates
  - o Care-taking by mother or relative
  - o Breast feeding as much as possible
  - o Innovative infection control methods like supply of clothes for neonate from hospital, and use of tissue that is disposed away each time instead of cloth diapers or huggies.
- Areas for improvement
  - o Neonatal Mortality Rate is still about 40/1000 live births (despite most children being from deliveries in the hospital).
  - o Partial reason may be that death of proportion of children with congenital problems (generally about 10%) is difficult to prevent. Also, malnutrition of mother & Low Birth Weight Babies is another cause.
  - o It was also observed that Paediatric surgeries are not being done even as a life saving procedure because the general surgeon is no longer undertaking them and there is no Paediatric surgeon posted there.

**v. Outreach Activities of Sub Centres**

- Progress so far
  - o At least 1 ANM was reported almost 97% SCs, 17% with 2 ANMs/GNM
  - o Infrastructure addition was found to be adequate
  - o Increase in number of Deliveries at SCs were observed, as per facility records and feedback of the community
  - o The CRM team also observed increasing use of 2-wheelers by large no. of ANMs, positively influencing their mobility.
- Areas for improvement
  - o GNM as an alternative to 2nd ANM may not be useful, as they are not trained in public health and outreach services. This practice should be reviewed, especially in SCs where population covered is less than 4000 and ASHAs are functional.
  - o Labour rooms may be constructed for all SC
  - o ANM clinical skills to be strengthened—especially ANC checkups, identifying high risk cases, and SBA trainings
  - o They state may also consider facilitating loans to ANMs for 2-wheelers, as a mark of mobility support.

**vi. Utilisation of Untied Funds**

- Progress so far
    - Expenditure has increased at SHC and PHC level. In Alwar expenditure at SHC/PHC level was around 110% of funds received during the year (using previous years' unspent balance)
    - Since the start of NRHM (2005-06) expenditure at SHC/PHC have increased 5-6 times (2008-09)…this includes funds handled for JSY, mobility support, ASHA payment, etc. [total funds handled are 3-5 times the amount of untied grants]
- Areas for improvement
    - AMG to hospitals should be need based (based on no. of beds and bed-occupancy)
    - Untied Funds should be an additionality and not replacement of hospital funds under treasury budget (especially for Waste Management, OE, POL, drugs & consumables, diet, etc.)
    - Decision on Untied Funds is to be authorised only by the committee at the respective level and not by state or district level.
    - Untied funds (for all levels) to be released on priority basis, in spite of outstanding balances i.e. in spite of unspent balances from previously released untied grants, the grants due for the subsequent year should be released on a priority basis.

**vii. Thrust on difficult areas and vulnerable social groups**

- Progress so far
    - Although the state has many identified vulnerable groups like the tribals in south-eastern Rajasthan and the *Banjaras* in western Rajasthan; but the CRM team did not have the opportunity to visits these districts.
    - Urban slum population is another vulnerable section of the population, which had been neglected since long in terms of basic health services, as the focus had been on rural population. The CRM team visited one such initiative in Alwar district, undertaken under NRHM in PPP mode.
    - State has established 33 urban RCH centres through NGOs to cater to the health needs of urban slum population. State transfers Rs 14 lakh annually to the NGO to run the Centre (in Alwar). The centre was operational with 11 staff: 1 MO, 4ANMs, LHV, 1 LT, 1 GNM, 1 comp. operator and a peon. On an average it has an OPD of around 80 patients per day. Last month's records showed 1696 patients treated. Medicines and lab tests are conducted for free. Last month 7 vasectomies and 11 tubectomies were conducted through the centre. The community is satisfied with the services provided.
    - Apart from focus on slum population the state also initiated two other schemes to address the needs of the vulnerable population. Mukhya Mantri Jeevan Raksha Kosh (MMJRK) was established to provide free treatment and medicines to BPL patients, and online data (by patients, treatment, facility, prescription, and cost) is available through NIC.
    - The state is also providing 5kg Ghee is to all BPL women after their first delivery.
- Areas for improvement
    - There are no delivery services in urban slums centre and women have to be taken to District Women's hospital for delivery services adding to the load of deliveries in the district hospital. Community desires that delivery facilities be available in the vicinity.
    - The possibilities of adding delivery services in well functioning centres can be explored.

- Since the RCH centre is fully staffed, IUCD insertion services should be available on all days. The staff be trained on IUCD insertion services and on family planning methods
- For the MMJRK scheme, the system needs strengthening so that record is available for all medicines purchased for the patient. This is a good system to track distribution of medicines and maintaining dispensary stocks. It may be expanded to include records of general (non-BPL) patients also.
- It was observed that not all BPL families are covered under this scheme. District JSY data showed that the proportion of BPL deliveries catered to was a one-third of the proportion of BPL families in the district.
- Mapping of BPL families and difficult to reach areas within villages is required for special focus and resources may be allocated accordingly. Supportive supervision and monitoring of services must be focused on these underserved households/areas.

**viii. Quality of services provided**

- Progress so far
    - Waste management services were found satisfactory almost at all places. Coloured bins were available as per GoI norms. Placenta and other biological waste were managed through CTF (Central Treatment Facility) contract through an external agency at DH and CHCs.
    - The facilities visited were reasonably clean and had separate toilets for male and female patients. Waiting area was clean at district hospitals and CHC in Alwar but amenities for sitting were suboptimal in Bhilwara.
    - Great stride had been made by the state regarding Emergency Response Services (ERS). Since September 2008, State is supporting 164 fully equipped ambulances to transfer patients / women in labour from difficult areas to health facilities. The service is centrally controlled toll free # 108 is operational to facilitate early response. Majority (57%) of cases transferred through the ambulance in last year were pregnancy related cases in Alwar (women in labour or having post delivery complications) followed by trauma cases (20%). In Bhilwara more trauma cases were reported using the ambulance.
    - Ambulance services are effectively addressing the 2nd delay in the three delays of causes of maternal death. In the last year 45 deliveries were conducted in the ambulance in Alwar.
    - Ambulance Driver and Nurse are trained in CPR and other life saving measures. All emergency medicines / oxygen, etc, are available in the ambulance.
    - Quality Assurance (on a pilot basis) initiated in 4 districts Sikar, Nagaur, Ajmer and Udaipur.
    - In the districts visited no quality assurance mechanism was established to address quality of health services provided. On the spot training of staff on quality assurance is required. Quality assurance committees for family planning were not functional in districts visited.
    - Women were not staying in facilities for 48 hours after delivery. At some places women were staying for 24 hrs. None of the CHCs visited had blood storage facility in Alwar. In Bhilwara blood storage facility was available in two CHCs and blood was available. Maternal or infant death audits at facilities were not done.
    - Ice packs (for immunization sessions during MCHN Days) were not prepared as per guidelines in Alwar. One facility did not have cord tie (was using common stitching thread to tie cord of the new born. Cord clamps were also not available). Partographs were not being used in any facility.

- Areas for improvement
  - The ambulance services should not be seen as standalone facility but should be linked to strengthened quality services at facilities.
  - Currently each ambulance is running at a cost of Rs 1.10 lakh per month. Efforts to be made to reduce current cost. Also, ambulances are running sub-optimally – currently only 2 trips per ambulance per day (optimum is 6 – 8 trips per day).
  - Ambulance nurse to be trained in management of post-partum hemorrhage (commonest cause of maternal death)

**ix. Diagnostic services**

- Progress so far
  - New generation diagnostic equipment made available to the health facilities under NRHM/RHSDP/NCU/MTC
  - RDKs available at PHC level.
  - Lab technicians being hired by MRS/RKS of bigger hospitals (with larger funds) and under NRHM.
- Areas for improvement
  - Need to train ANMs in RDKs for malaria and distribute the kits to them.
  - Procurement of diagnostic equipment should also include training of the operators at the health facility where they are installed.

**x. Logistics & Supply Chain Management**

- Progress so far
  - Drugs available for BPL patients free of cost under Mukhya Mantri Jeevan Raksha Kosh (MMJRK)
  - Emergency medicines and supplies/consumables procured from RMRS funds
  - Waste Management supported under RHSDP
  - Jan Aushadhalaya functional with generic drugs from Public Sector, available at lower than market rates
- Areas for improvement
  - Almost 50% items of medicines & consumables found out-of-stock across all facilities (PHC/CHC/DH)
  - Stock-outs lasting from 3 to 10 months were observed in the sample facilities visited by the CRM team.
  - Supply of drugs and consumables are top-down and not need-based. Although there exists an indenting process, but only those drugs and consumables that are available at the district store are issued. Also, drugs are directly received from the state, especially those procured under RHSDP, irrespective of the need at the facility level.
  - No tracking and record keeping of drugs (except under MMJRK)… MMJRK software may be extended to cover regular hospital supplies too.
  - Reorder happens only when zero-stock position is reached at the store (no concept of ‘safety/buffer stock’ followed…this needs training in inventory management for the storekeepers)

**xi. Decentralised Planning**

Although the state had prepared District, Block and Village plans for the whole of Rajasthan, the CRM team felt that there exists following areas for improvement:

- **Village plans** contain only physical activity target numbers; should be used for higher planning and local service delivery. Inter-sectoral convergence should be included.
- **VHSC Plans**: Should be local specific need-based plans, prepared by VHSC with community consultation.
- **District Plans** contain only activity based Budget Lines with no background or rationale given.
- **Block & District Plans** should identify difficult areas for coverage & hotspots of health problems for focused action. [eg. in an area with mines (Bhilwara district), orthopaedic services and trauma care; provision of ambulance as priority where difficult to reach areas are large and women are unable to come, and there are doctors posted in these traditionally underserved areas]

**xii. Decentralised local health action**

- Progress so far
  - RMRS is functional in all health facilities, down to the PHC level.
  - VHSCs are formed in all villages. Actively functional in some. The CRM team also observed that records of VHSC minutes of the meetings (coinciding with MCHN Days) with key agenda items, decisions taken, are well maintained.
- Areas for improvement
  - RMRS funds must not be used to substitute State treasury allocations, as seems to be happening for budget heads of diet, office expenditure and POL.
  - VHSCs should be encouraged/empowered to plan community action for improving their own health. This could also help identify some local priority areas for local health problems and addressing them may lead to better health outcomes.

**xiii. Community processes under NRHM**

- Progress so far
  - MCHN Days are being organised regularly, where good participation of women, AWW, ANM and ASHA was observed by the CRM team
- Areas for improvement
  - Immunisation is the major activity in MCHN Days, along with ANC and PNC activities. But Nutrition is not a major focus. In these sessions growth monitoring charts can be checked for identification of grade 2, 3 & 4 by the ANMs.
  - The CRM team also felt that VHSC involvement in organising VHND is a must. VHSC meetings are meant to happen on this day, but state data shows that this has not become a village event everywhere.

**xiv. ASHA**

- Progress so far
  - 42,385 selected and 40,361 ASHA-Sahayoginis in place with complete training upto 4th module.
  - While interacting with a group of ASHAs in Alwar as well as in Bhilwara, the CRM team felt that the ASHA-Sahayoginis have good knowledge about the activities they perform. This is an improvement from previous year's CRM observation. The 3rd CRM team felt that the ASHA-Shayoginis showed a high level of empowerment in the way they interact and speak out with self-confidence. As per feedback from the community membes and Jan mangal couples met by the CRM team, they (ASHAs) command respect and confidence from the community in both districts.

- Areas for improvement
    - There is a need to rationalise the authority structures in implementation of the ASHA programme, since she is answerable to both the ICDS and Health system.
    - The 'Accredited Social Health Activist' has to be given a greater role as 'social activist', and not as a 'health worker'; if she is to help in making a dent in the health of the village and the IMR and MMR. If she is loaded with too many health worker tasks, then she will not have the time or orientation for the activist role.
    - She should be able to link the nutrition and health care components in the social context of the village.

The CRM team visiting Bhilwara witnessed the ASHA Pilot Project in Bhilwara. The team felt that the learnings from the pilot project must be considered when evidence-based planning is to be done for scaling up across the state.

When the Bhilwara pilot project began, the district had the lowest achievement of institutional delivery cases accompanied by ASHA-Sahyoginis (9.66%). Between July to Nov 2009, it increased remarkably to 37% of institutional deliveries accompanied by ASHAs, despite an increase in the denominator (total no. of institutional deliveries).

What seems to have resulted in the improved performance of ASHAs in the Bhilwara pilot, as felt by the CRM team, are the following:

- Greater powers given to MOIC – payment of honorarium after performance review/ verification by MO; weeding out & termination powers; selection of new ASHAs ; allocation of tasks to ASHAs. Only to inform ICDS.
- Regular and early payment through e-transfers.
- Rs. 1000/- as advance for transporting women in labour.
- The transport allowance of 300/- given to the woman if she comes without the ASHA was stopped, so that it did not remain a factor in discouraging them from coming with the ASHA.
- Increase in SC deliveries has also contributed to this.

**xv. National Disease Control Programmes**

The CRM team observed that there is lack of coordination between technical program managers and NRHM program managers. It was also felt by the team that the NRHM program managers were not clear about their role in National Disease Control programmes, i.e. they were aware of only Parts A, B and C of NRHM and not aware of the plans and their roles therein for Part D.

- RNTCP
    - All lab technicians met were trained and equipment was available.
    - Select cases were being referred to ICT centres for counseling.
    - In Alwar about 12 – 15% of treated cases were reported to have relapse after being sputum negative for 6 months to 2 years.
    - IMA is not involved in RNTCP programme for reporting and administration of DOTS.
- NLEP
    - ASHAs were not trained neither are they involved in identification of suspected leprosy cases.

  - The reported prevalence rate of leprosy in Rajasthan is 0.8 per 10,000 cases.
  - There is no coordination with NRHM staff for the Leprosy programme.
- NVDCP (Malaria programme)
  - API is 0.69 and Pv is common and Pf is very low.
  - In Alwar case fatality rate was 0.04 % in 2005 and 0.10 in 2008.
  - No resistant case is reported.
  - In some centres that were visited by the CRM teams, slides were not available and not being sent for back checks.
- NPCB
  - Annually about 6 – 8 thousand cataract operations are performed in Alwar.
  - Only two operating microscopes are available in working condition (in Alwar district). Two are not working. Reallocation of operating microscopes is required in the CHC where OT and ophthalmologist is available. (CHC Thanagazi had an operating microscope but no OT and no sanctioned post of ophthalmologist). IOLs were available in one CHC.
  - It will be good if Phaeco-emulsification machines are made available where operating microscopes are functional to provide quality cataract operation services.

**xvi. RCH-II**

- Maternal Health
  - Antenatal coverage is low as expressed by the District Collector in Alwar during in briefing.
  - Computerized pregnancy tracking system functional in certain areas.
  - All facilities and ANMs visited were seen to be provided with mercury and electronic BP apparatus. Hemoglobinometer was available at all centres visited.
  - Almost all facilities visited were providing 24X7 services for delivery. Nishchay pregnancy test kits are available.
  - ASHAs are referring clients for institutional deliveries and had knowledge on maternal and child health.
  - In Bhilwara data shows that the deliveries are shifting from DH to CHCs, PHC and SCs over last year, thus relieving load on DH. Cesarean section rate is around 18 % at the district women's hospital in Alwar and 10 % in Bhilwara.
  - Labour rooms lacked suction machines at most facilities visited.
  - Almost all medicines were available in labour rooms. Injection Magsulf was not available at PHC and CHCs visited. At some places Injection Methergin was still being used.
  - Partographs were not used anywhere.
  - None of the staff providing maternal health services was trained on SBA training in Alwar.
  - None of the staff at visited CHC or PHC could explain AMTSL.
  - Post-partum care is getting addressed in select areas through Yashodas (counselors) and ASHAs. Yashodas need to be trained on promoting family planning.
- JSY
  - Institutional deliveries have increased due to JSY scheme, but quality needs to be addressed. It was reported by the staff as well as the beneficiaries that women are not staying for 48 hours after delivery.
  - 107 private hospitals at subdistrict level are accredited for JSY in the State of Rajasthsan . As PHCs and SCs get functional for delivery, the DH load is getting shifted downward.

  - JSY is a good opportunity to counsel women in family planning. Since the state has Yashodas in place, they can include family planning messages along with counseling on post –delivery care, breast feeding, nutrition, etc.
  - JSY payments are given timely (mostly within a week).
  - It was suggested by the Collector Alwar that JSY money may be linked to improve antenatal and post delivery care along with delivery services. Innovative ways of JSY money distribution can be thought.
- Child Health
  - Priyadarshini scheme is operational in the state (SNCU). Technical capacity building provided through Kolkata PGI medical college, supported by NIPI.
  - Enough newborn incubators are available and functional at the district hospital and CHC in Alwar. Bhiwara had a well functional FBNC Unit.
  - Yashodas are trained on kangaroo mother care and essential newborn care.
  - Complete immunization status is not satisfactory in Alwar. Coverage in 2008 – 09: TT (10 yr) – 10.78 %; TT Booster – 5.38 %; Measles – 33.87%; DT- 27.78%
  - Malnutrition Treatment Centres were established at the district hospital. It is recommended that the centres be renamed as Nutrition Rehabilitation Centres rather than treatment centres.
  - Blood component separator may be made available, especially for blood transfusion to severely anemic cases. It was observed in Alwar District Hospital that one severely anemic child was given whole blood where packed cells should have been given.
- Family Welfare
  - Family planning program is lacking focus.
  - In both Bhilwara and Alwar it was observed that oral pills and Condoms were kept in box to be picked up by clients. Oral Pills need to be provided with instructions.
  - Female sterilization remains the most common acceptable method. Spacing contraceptive use needs to be increased.
  - All staff needs to be trained on contraceptive updates to orient staff on newer advances in family planning.
  - ANM and even the Medical Officer in some PHCs visited could not differentiate between expiry date of the IUCD and duration of its action. (Both ANM and the medical officer seeing the expiry date on the IUCD wrapper as October 2010, said that if a woman gets this CuT inserted today, the CuT will be effective only for next nine months as the expiry date is written as October 2010. This thinking needs to be corrected).
  - ANMs and Staff Nurses in the health facilities visited, have not received any training on IUCD insertion or any contraceptive update. GoI has initiated new training in IUCD insertion, which needs to be initiated in the state.
  - There were no IUCD or Oral Pills registers available in PHCs and CHCs visited.
  - IUCD is not provided to clients till they resume menstrual cycle. Thus a woman with lactational amenorrhoea is denied IUCD insertion. Since Nishchay (pregnancy) kits are available now, pregnancy test can be done for these women and IUCD provided if test is negative.
  - BCC / IEC materials were not available in sufficient quantity. As observed in some IEC materials, the State is promoting two child norm for families. This may be perceived as violation of reproductive rights and the information needs to be modified to recommend adopting a family planning method.
  - Post- delivery family planning programme needs to be strengthened to avoid missed opportunities.

  - At some places double puncture technique is used for doing laparoscopic tubectomy. In some places single puncture technique is used which may be considered for comfort to clients. Abdominal tubectomy and NSV training may be given to medical officers to improve availability of family planning services on all days.
  - IUCD insertion services need to be made available during sterilization camp days.
  - Pregnancy test kits be made available during sterlization camp days to exclude pregnancy in lactational amenorrhic women and a contraceptive / IUCD provided to such women.
  - All clients refused for sterilization services may be identified for provision of other family planning methods.

**xvii. Preventive and promotive health aspects with special reference to inter-sectoral convergence and convergence with social determinants of health**

- IEC/BCC
  - The IEC / BCC materials were not available in sufficient quantity in all centres visited by the CRM team.
  - The IEC coordinator (contractual staff appointed under NRHM) at the district level in Alwar was not aware of the National Programmes and the concept of behaviour change communication. The consultant was not involved in planning, preparing, training, etc on IEC / BCC.
- Mainstreaming AYUSH
  - A large number of AYUSH practitioners and paramedics have been recruited for co-locating at the facilities
  - The construction of space for the AYUSH services was found to be lagging, even in Bhilwara where other construction activities at PHC and CHC had been completed.
  - Good examples of 'Revitalising Local Health Traditions' exist in the state, but are not being adopted under NRHM activities.

**xviii. Nutrition**

Although nutrition is integrated in the MCHN Days, which is organised in the Anganwadi Centres (AWC), a lack of focus was observed within the health staff. In Alwar no undernourished (Grade III/IV classification) children were reported. The observation and impressions of the CRM team in this regard as follows:

- Identification of Malnourished children is inadequate. In Bhilwara not more than 2 children per AWC were reported in grades 3&4, while surveys show this figure is expected to be around at around 33-40% of the children.
- The ICDS recording of growth charts & identification of malnourished children should be checked by the ANM & MOs.
- Identification of parts of the village which are under-served and where more malnourished children reside. Special attention by ASHA/ANM/AWW to these families.
- Referral of sick-malnourished to MTC/NRC needs to increase.
- Incentive for reporting malnourished children should be considered.
- VHSCs may be involved in identification and dealing with the problem at community level for provision of extra support to non-sick but malnourished children.

**xix. Non-government partnerships**

- Progress so far
  - Community Monitoring undertaken in collaboration with NGOs
  - NGO run Urban-RCH centre functioning optimally (covering 50,000 population @ Rs.13 lacs pa)
  - 108-Ambulances functioning effectively in urban/semi-urban areas.
  - MMUs functional under PPP
- Areas for improvement
  - Non-governmental participation is still peripheral (not mainstream) to the core strategies of NRHM.
  - Costing and reimbursements to private parties needs to be realistic
  - Performance parameters of partnerships needs to be monitored and financing may be related to performance (108-ambulance making around 2 trips per day per ambulance, even in the 2nd year of operations)
  - Need to reduce coverage area to ensure more frequent visits and follow-up (for MMUs operating under PPP)

**xx. Overall programme management**

- Progress so far
  - Program Managers, Accountants and Data Analysts under NRHM, assisting the department in better physical and financial monitoring
  - Facilitators for ASHA, AYUSH, IEC put at district and block levels for increased monitoring and mentoring
- Areas for improvement
  - Lack of coordination amongst NRHM and departmental (ministerial) staff
  - Emphasis on monitoring of physical and financial numbers, at the cost of quality of services/activities
  - No orientation of program management staff regarding the concepts, strategies and components of NRHM and the health priorities of the local area
  - Vacancy exists at block and facility level (recruitment of block and facility level contractual staff may be delegated to DHS)

**xxi. Financial management**

- Progress so far
  - The state had already booked 60% of the sanctioned PIP for 2009-10 by Nov'09.
  - Accountants available at district, block and facility level
  - Updated (latest) QFMR format being used
  - Tally installed upto block level
- Areas for improvement
  - RCH-I unspent balance not yet booked
  - Tally needs to be customised and all reporting centres linked for real time funds position information
  - At a given point of time, almost 20-25% of funds lie as outstanding (advances), of which 33% is actually spent and awaiting UC/SOE. This implies that of the 25% of funds that shows as outstanding, 8% is actually consumed and not outstanding, but because of the procedural delays UC/SOE is cannot be produced and this deficit continues for all subsequent releases.
  - Decision to spend money from VHSC Untied Funds taken at state/district level
  - NRHM accountants and managers need more orientation on GF&AR, and on the other hand, public accounts officials and auditors need to be oriented on NRHM spirit and guidelines/orders.

**xxii. Data management**

- Progress so far
  - Pregnancy & Child Tracking System (PCTS) and MMJRK software provide excellent tool for tracking & monitoring
  - Computers and operators available at block and facility level
- Areas for improvement
  - Redundancy exists among myriad registers and formats (ANMs need to spend 2-working days per week for filling up formats)
  - IDSP software not functional at PHC level
  - Feedback is not happening down the reporting chain. For example, it was observed in Alwar that the district data shows lower CBR as well as lower CPR than the state average (both cannot be true at the same time); no drop-outs shown between DPT-2 and 3; there were missing cases of babies born in institutions but weight not taken, which could not be explained by programme/data managers.

## 3(b) Status of progress of Rajasthan against specific objectives, expected outcomes, and expected outcomes at community level under NRHM

The National Rural Health Mission, while initiating an architectural correction to health systems, maintained focus on some key health indicators lke IMR, MMR, TFR, etc. The CRM team reviewed the progress of the state of Rajasthan vis-à-vis these key indicators, which is presented below.

**Table 3.1 Progress with respect to Key Health Indicators in Rajasthan**

| Indicators | PIP : 2009-10 (ROP) | Achievement (year) |
|---|---|---|
| IMR | 32 | 63 (2008) |
| MMR | 148 | 388 (2004-06) |
| TFR | 2.1 | 3.2 (2005-06) |
| Malaria mortality | --- | 0.04% (2005); 0.10% (2008); 0.05% (Oct '09) |
| Dengue mortality | --- | 1.35% (2005); 0.58% (2008); 1.37% (Oct '09) |
| Cataract cases | 3,00,000 | 66,176 (Sep '09) |
| Leprosy prevalence | --- | 0.24 per 10,000 (2005-06); 0.19 (2008-09); 0.19 (Sep '09) |
| DOTS cure rate | > 85% | 88% (2007) |

| | | |
|---|---|---|
| Bed occupancy of FRUs | --- | --- |
| No. of ASHA | 46,905 | 42,496 of which 38,011 functional |

As can be seen from the above table, the state of Rajasthan is still far from achieving the IMR, MMR and TFR goals. If the state wants to come anywhere near the goals, it has to intensify its efforts in increasing coverage, especially in difficult, most difficult and inaccessible areas. Also, the state has to improve production of medical and paramedical staff (by opening new medical and paramedical colleges), improve intake and retention of staff (by monetary and non-monetary incentives) and improve clinical and skill-based trainings. Further, it has to address the problem of malnutrition to make the expected dent in IMR and MMR.

It is also observed from the above table that case-fatality rates of Malaria and Dengue is not showing any consistent and declining trend. This calls for a review of the treatment and diagnostic protocols. Active surveillance is needed in this regard, and the field workers may be mobilised accordingly. Also, in spite of high cure rate under DOTS, the CRM team's observation regarding relapse of sputum negative cases with MDR TB is a cause of concern. May be, greater involvement and motivation of ASHA-Sahayoginis can address the treatment drop-out cases.

### 3(c) Progress against approved PIP of the state

The state had already booked 60% of the sanctioned PIP for 2009-10 by Nov '09. But still here are some areas where there is huge unspent balance, signifying not much work had been done in these specific areas. The major gaps identified, of the activities approved by ROP, are presented in the table below.

**Table 3.2 Major gaps in Rajasthan in implementation of 2009-10 PIP (as on Nov 2009)**

| Serial No. | Activity | Variance (%) |
|---|---|---|
| A.1.1.1 | Operationalise FRUs | -66.67 |
| A.1.1.3 | MTP services at health facilities | -89.87 |
| A.1.3.1 | RCH Outreach Camps | -71.56 |
| | **Maternal Death Audit** | **-88.90** |
| **A.2.1** | **IMNCI** | **-92.56** |
| A.2.4 | School Health Programme | -56.75 |
| A.3.1.2 | Female Sterilisation camps | -53 |
| **A.3.1.3** | **NSV camps** | **-76.32** |
| A.3.1.4 | Compensation for female sterilisation | -60.48 |
| A.3.1.5 | Compensation for male sterilisation | |
| A.3.2.1 | IUD camps | -83.90 |
| **A.3.2.2** | **IUD services at health facilities** | **-90.13** |
| A.3.3 | POL for Family Planning | -81.45 |
| **A.3.4** | **Repairs of Laparoscopes (Other activities)** | **-98.62** |
| A.4.1 | Adolescent services at health facilities. | -56.40 |
| A.5 | URBAN RCH | -80.38 |

| Serial No. | Activity | Variance (%) |
|---|---|---|
| **A.8.4** | **Other innovations( if any)** | **-87.28** |
| A.9.1.2 | Laboratory Technicians | -69.80 |
| A.9.1.3 | Staff Nurses | -61.94 |
| **A.9.1.4** | **Specialists (Anesthetists, Pediatricians, Ob/Gyn, Surgeons, Physicians)** | **-99.54** |
| A.9.1.5 | Others - Computer Assistants/ BCC Co-ordinator/ ASHA Link Worker etc (PHN) | -89.80 |
| A.9.3.1 | Minor civil works | -37.59 |
| A.10.3 | Monitoring & Evaluation / HMIS | -79.81 |
| | **Sub Centre Rent & Contingencies** | **-100.00** |
| **A.11.1** | **Strengthening of Training Institutions** | **-86.55** |
| **A.11.3.2** | **EmOC Training** | **-94.40** |
| **A.11.3.3** | **Life saving Anesthesia skills training** | **-90.31** |
| **A.11.3.4** | **MTP training** | **-94.60** |
| **A.11.3.5** | **RTI / STI Training** | **-95.78** |
| **A.11.3.6** | **Dai Training** | **-0.000** |
| A.11.3.7 | Other MH Training (ISD Refresher ) | -87.02 |
| A.11.5.4 | Care of Sick Children and severe malnutrition | -0.00 |
| **A.11.6.2** | **Minilap Training** | **-100.00** |
| **A.11.6.3** | **NSV Training** | **-100.00** |
| **A.11.6.4** | **IUD Insertion Training** | **-96.97** |
| A.11.7 | ARSH Training | -52.30 |
| **A.11.8.1** | **SPMU Training** | **-95.35** |
| **A.11.8.2** | **DPMU Training** | **-84.34** |
| **A.11.9** | **Other training (pl. specify)** | **-97.38** |
| **A.12.3.1** | **BCC/IEC activities for MH** | **-82.79** |
| **A.12.3.2** | **BCC/IEC activities for CH** | **-96.35** |
| **A.12.3.3** | **BCC/IEC activities for FP** | **-92.52** |
| **A.12.3.4** | **BCC/IEC activities for ARSH** | **-100.00** |
| A.13.1.1 | Procurement of equipment: MH | -45.05 |
| **A.13.2.2** | **Drugs & supplies for CH** | **-100.00** |
| A.13.2.4 | Supplies for IMEP | -74.98 |
| A.14.1 | Strengthening of State society/State Programme Management Support Unit | -70.51 |
| A.14.2 | Strengthening of District society/District Programme Management Support Unit | -64.55 |
| B1.1 | ASHA | -81.08 |
| B2.2 | Untied Fund for PHCs | -40.77 |
| B2.3 | Untied Fund for Sub Centers | -56.29 |
| **B3** | **Hospital Strengthening (Creation of Directorate of Hospital Management)** | **-95.21** |
| B4.2 | PHCs | -68.64 |
| B5.1 | Constructions | -53.22 |
| B5.6 | Construction of BHO, Facility improvement, civil work, BemOC and CemOC centers & Others | -74.34 |
| **B6.4** | **Other Grants to RKS/HMC** | **-90.00** |

| Serial No. | Activity | Variance (%) |
|---|---|---|
| B8.1 | Constitution and Orientation of Community leader & of VHSC,SHC,PHC,CHC etc | -86.28 |
| B10.1 | Health Mela (Swasthya Mitra Yojana) | -70.57 |
| B11 | Mobile Medical Units (Including recurring expenditures) | -53.76 |
| B14.1 | Additional Staff/ Supervisory Nurses PHC,CHC (Including Ayush Stream) | -39.62 |
| B14.2 | Additional ANM, ,LHV, MPW | -71.64 |
| B14.5 | Additional Allowances to MOs PHC, CHC | -69.35 |
| B14.6 | Lab technicians, Gynecologists, Anesthetists, Pedisterian, Specialist CHC, Radiologist, Sonologist, Pathologist, Dental Surgeons. | -97.13 |
| B16.1 | Strengthening of Existing Training Institutions/Nursing School | -68.11 |
| **B16.3.3** | **Other training and capacity building programmes** | **-100.00** |
| **B18.1.2** | **District level** | **-93.79** |
| **B18.3.1** | **Computerization HMIS and e-governance, e-health** | **-81.20** |
| B18.3.2 | Other M & E | -88.55 |
| **B19.1** | **Drugs (Drug & Supplies for CH)** | **-100.00** |
| **B19.3** | **Others (ARSH-Sanitary Napkins)** | **-100.00** |
| B21 | Regional drugs warehouses | -82.71 |
| **B22** | **New Initiatives/ Strategic Interventions (As per State health policy)/ Innovation/ Projects (Telemedicine, Hepatitis, Mental Health, Nutrition Programme for Pregnant Women, Neonatal) NRHM Helpline) as per need (Block/ District Action Plans)** | **-100.00** |
| C.1 | RI strengthening project | -75.24 |
| **C.3** | **Pulse Polio operating costs** | **-81.47** |
| **D** | **Other Programmes (Vertical)** | **-63.72** |

The variance in the above table is based on the sanctioned budget for the activity (as per ROP) and the actual expenditure booked till 30th November 2009. Activities that are pending by over 90% are highlighted in bold.

It is clearly emerging that Trainings and IEC/BCC are major areas of concern. It seems that the state has planned a lot of training and IEC/BCC activities without realistically taking into account the capacity and infrastructure issues. Procurement is also an area of concern, which is lagging far behind, and with only 4-5 months available to undertake it, it is doubtful if the entire amount can be booked in the present financial year.

# Chapter 4: Recommendations

Based on the observations and findings of the CRM team had made the following recommendations to the state:

**a. Infrastructure**

- Facility mapping and infrastructure/civil works audit may be undertaken separately.
- Construction of Sub Centres, being low value contract, may be entrusted to local task force comprising of PRI member, tehsildar/BDO, etc. and all local contractors may be invited (in a common meeting) and asked for open bid. The work can be awarded in the same meeting at the local level.
- Major renovations and upgradations are required for ANMTC/GNMTC (including hostels) and Drug Warehouses.

**b. Human Resource & Training**

- The state may consider increasing rates for contracting private Specialists for normal delivery/LCS to Rs.1500/Rs.5000 as they are not coming under presently applicable rates
- The proposed HR Cell in the Directorate (at the state level) may take up the issue of No career progression plan/long-term HR plan regarding contractual staff.
- All trainings should be adequately monitored for quality and monitoring may be outsourced. There is need to provide skill based training rather than class room training. Training supervision can be formalized or outsourced. Pre and post tests need to be conducted as integral part of quality control of trainings.
- The admissions in ANMTCs can be done every year or every six months so that two or three batches are studying at a given time and trained ANMs are available every six month or every year. This can cover the shortfall.
- All efforts to be made to improve quality of training in the training centres, training methodology and faculty. New curriculum to be adopted immediately **[*this was recommended by the previous CRM too, but no action seems to have been taken*]**.

**c. Improvement of health facilities for patient care and utilization of services**

- Complete strengthening of all facilities and increase no. of facilities to decrease coverage area.
- Ensure timely emergency transport and quality referral services.
- Strengthen SBA training.
- Other alternative innovation might be tried to attract and retain specialists like exploring possibility of DNB recognition for Paediatrics and OB/Gyn. at the District Hospitals, or starting a Govt. Medical College with the District Hospital.

**d. Outreach Activities & Sub Centres**

- ANM clinical skills needs to be strengthened—especially ANC checkups, identifying high risk cases, and SBA trainings
- State may also consider facilitating loans to ANMs for 2-wheelers, as a mark of mobility support.

**e. Untied Funds**

- The state may explore flexible financing options so that AMG to hospitals are need-based (based on no. of beds, bed-occupancy, etc.)

- Untied Funds should not replace funds under treasury budget (especially for the detailed heads of Waste Management/BMWM, OE, POL, drugs & consumables, diet, etc.)
- Decision on Untied Funds is should be authorised only by the committee at the respective level and not by state or district level.
- Untied funds (for all levels) may be released on priority basis, in spite of outstanding balances i.e. in spite of unspent balances from previously released untied grants, the grants due for the subsequent year should be released on a priority basis.

**f. Thrust on difficult areas and vulnerable social groups**

- The possibilities of adding delivery services in well functioning Urban RCH centres can be explored.
- Since the currently functioning Urban-RCH centre is fully staffed, IUCD insertion services should be available on all days. The staff be trained on IUCD insertion services and on family planning methods
- For the MMJRK scheme, the system for tracking of medicines and cost for BPL patients may be scaled up state-wide and expanded to include records of general (non-BPL) patients also.
- Mapping for special focus is required for BPL and difficult to reach areas and resources may be allocated accordingly.
- Identification of malnourished children must be improved through the VHNDs and greater attention given by the ASHA and ANM to them.

**g. Quality of services**

- The ambulance services should not be seen as standalone facility but should be linked to strengthened quality services (emergency care) at facilities.
- Currently each ambulance is running at a cost of Rs 1.10 lakh per month. Efforts to be made to reduce current cost. Also, ambulances are running sub-optimally – currently only 2 trips per ambulance per day (optimum is 6 – 8 trips per day).

**h. Diagnostic services**

- Need to train ANMs in RDKs for malaria and distribute the kits to them. **[T*his was recommended by the previous CRM too, but no action seems to have been taken*]**.
- Procurement of diagnostic equipment should also include training of the operators at the health facility where they are installed.

**i. Logistics & Supply Chain Management**

- Formats for calculating buffer/safety stock may be developed across all facilities and storekeepers trained in materials/inventory management, to avoid stock-out situations. **[T*his was recommended by the previous CRM too, but no action seems to have been taken*]**.
- MMJRK software for tracking prescriptions and drugs dispensed to BPL patients may be extended to cover all patients in all hospital, covering all hospital supplies.

**j. Decentralised Planning**

- VHSC Plans should be local specific need-based plans, prepared by VHSC with community consultation.
- The involvement of VHSC in planning and organising VHND is a must.
- Block & District Plans should identify difficult areas for coverage & hotspots of health problems for focused action.
- RMRS funds must not be used to substitute State treasury allocations, as seems to be happening for budget heads of diet, office expenditure and POL.

**k. ASHA**

- The 'Accredited Social Health Activist' has to be given a greater role as 'social activist', and not as a 'health worker' only; if she is to help in making a dent in the health of the village and the IMR and MMR.
- She should be able to link the nutrition and health care components in the social context of the village.
- Since many women are coming for institutional deliveries brought by families without the ASHA, other criteria should be decided for assessing and incentivizing her work.

**l. National Disease Control Programmes**

- RNTCP
  - The causes of relapse of sputum negative cases within 2 years may be examined thoroughly and necessary strategies drawn up accordingly.
  - IMA may be engaged more closely in RNTCP programme for reporting and administration of DOTS.
- NLEP
  - ASHAs need to trained and involved in identification of suspected leprosy cases.
- NVDCP (Malaria programme)
  - Malaria and Dengue endemic areas (SC/PHC area) may be identified and active surveillance undertaken in the season. Cases of drug resistance may be searched more rigorously.
- NPCB
  - Relocation of operating microscopes is required in the CHC where OT and ophthalmologist is available.
  - It will be good if Phaco-emulsification machines are made available where operating microscopes are functional to provide quality cataract operation services.

**m. RCH-II**

- Maternal Health
  - Focus on making available suction machines in all labour rooms.
  - Injection Methergin may be withdrawn, especially from Sub centres/PHC.
  - Use of Partographs should be encouraged and monitored.
- JSY
  - JSY money may be linked to improve antenatal and post delivery care along with delivery services. Innovative ways of JSY money distribution can be thought.
- Child Health
  - It is recommended that the centres be renamed as Nutrition Rehabilitation Centres rather than treatment centres.
  - Blood component separator may be made available, especially for blood transfusion to severely anemic cases.
- Family Welfare
  - All staff needs to be trained on contraceptive updates to orient staff on newer advances in family planning.
  - Post- delivery family planning programme needs to be strengthened to avoid missed opportunities. All clients refused for sterilization services may be identified for provision of other family planning methods.
  - IUCD insertion services need to be made available during sterilization camp days.

**n. IEC/BCC**

- The IEC material needs to be made available in sufficient quantity in all health centres.
- The IEC coordinator (contractual staff appointed under NRHM) needs to be involved in planning, preparing, training, etc on IEC / BCC.

**o. Nutrition**

- The ICDS recording of growth charts & identification of malnourished children should be checked by the ANM & MOs.
- Referral of sick-malnourished to MTC/NRC needs to increase. Incentive for reporting malnourished children should be considered to promote this.
- VHSCs may be involved in identification and dealing with the problem at community level for provision of extra support to non-sick but malnourished children.

**p. Non-government partnerships**

- Costing and reimbursements to private parties needs to be realistic
- Performance parameters of partnerships needs to be monitored and financing may be related to performance
- Need to reduce coverage area to ensure more frequent visits and follow-up (for MMUs operating under PPP)
- The government /NRHM stationary should be used for all MMU services including those by NGOs through outsourcing arrangements.

**q. Overall programme management**

- There has to renewed emphasis on quality of services/activities along with monitoring of physical and financial numbers
- Orientation of program may be initiated for management staff regarding the concepts, strategies and components of NRHM and the health priorities of the local area
- Recruitment of block and facility level contractual staff may be delegated to District Health Societies

**r. Financial management**

- Speed up the booking of RCH-I unspent balance
- Tally needs to be customised and all reporting centres linked for real time funds position information
- NRHM accountants and managers need more orientation on GF&AR, and on the other hand, public accounts officials and auditors need to be oriented on NRHM spirit and guidelines/orders.

**s. Data management**

- IDSP software may be made functional down to the PHC level
- Ensure timely feedback across all the reporting chain. Data managers may be trained in basics of epidemiology and demography along with statistical tools for establishing causal relationships and identifying significant variations, for this purpose.

# Chapter 5: State Specific Issues

## 1) Mukhya Mantri (BPL) Jeevan Raksha Kosh (MMJRK)

Rajasthan had initially implemented the 'Rajasthan Swasthya Bima Yojana', funded under NRHM, which covered BPL patients (identified by BPL medical cards) in 2008. They were provided cashless treatment in government hospitals across the state and the MRS of each hospital earned substantial amounts of funds through this scheme. The funds were managed by the state insurance department, but not more than 50% of the funds paid as premium by the department of Health were paid to the hospitals and the payout ratio was low. The insurance department expressed its inability to refund the balance amount citing the MOU where no such provisions were made.

With the provision of central subsidy from the Ministry of Labour and Employment (MoLE) for 'Rashtriya Swasthya Bima Yojana' (RSBY), the Government of Rajasthan scrapped the earlier scheme and launched a comprehensive social security scheme named 'Bhamashah' scheme, where the smart card was applicable for not only health insurance, but also other social security payments/transfers. But this comprehensive smart card was compatible with the RSBY software, and therefore the MoLE refused to support the Bhamashah scheme. Meanwhile the state government had incurred large expenses in printing lakhs of smart cards, and that investment went in vain. Also, as the central subsidy did not come for this scheme, there was no fund with the insurance company to pay the hospitals that entertained patients who received their smart cards under the Bhamashah scheme. Thus there was resentment among private hospitals to be associated with government health insurance schemes.

Meanwhile the government changed in Rajasthan, after the assembly elections of November 2009, and the new government scrapped the Bhamashah scheme. In consultation with officials in IRDA, the government decided to launch the previous insurance scheme but minus the insurance company/TPA and also expanding the scope of the scheme. For expansion of scope, the funds under the earlier Mukhya Mantri Jeevan Raksha Kosh were linked with this scheme. The new scheme called BPL-MMJRK scheme, is managed solely by the department of health where the funds from MMJRK are paid to the government hospitals based on the rates charged for the BPL cases treated by them for diagnostic/surgical/medical procedures, as well as medicines dispensed outside the government supplied medicines. The state has also developed software to track in real time the patients, treatment, prescriptions, costs by hospital. The CRM team visited some of such hospitals and witnessed the BPL-MMJRK and the software in operation.

As per the experience of the state officials managing this scheme, the BPL-MMJRK scheme is better than the previous subsidised insurance scheme because of the following reasons:

- Low cost – the average incremental cost paid per patient in MMJRK scheme is around Rs.70, whereas in the earlier insurance scheme it was around Rs. 300 per case.
- No limit of coverage – earlier insurance schemes had a limit of Rs.30,000 per family of five. The MMJRK has no financial limit (till now, the maximum amount paid for one case had been more than Rs.10 lakhs). Also there is no limit of family size for insurance coverage in the BPL family.
- Comprehensive – all diseases and procedures are covered. No exclusions.

- No loss of funds either through payout for charges to insurance company, or through non-payment of premium funds to hospitals because of no claims. All expenditure booked under this scheme is book against direct patient care provided by the hospitals.

Till now the only source of funding for the MMJRK is funds allotted by Chief Minister's office for this purpose. As this is not RSBY, central subsidy through MoLE cannot be accessed for this scheme. Therefore ***the state proposes to partially (70%) fund it from NRHM funds under 'Innovations', for which MoHFW clearance is sought***.

**2) Pregnancy and Child Tracking System (PCTS)**

The state had piloted Pregnancy Tracking System (PTS) in Dungarpur district, which was witnessed and recorded by the 2nd CRM in 2008. The PTS was a simple excel based software which digitised the records of all the pregnant women (by name) who are registered with the ANM, along with the details of the Maternal Health services availed by them and also the details of their children. The database was managed and monitored at the district Collector's office, and each health supervisor/ANM were informed about the due date of delivery/ANC etc. by name and address of each woman/beneficiary.

Realising the potential benefits of such a system, the state had scaled it up state-wide and also expanded the scope including child (immunisation status) tracking by name of the child. The software is developed in-house by NIC, with an incremental cost of around Rs. 5 lakhs. The software is being installed in all districts and the process of digitising the women and child records is underway, as witnessed by the 3rd CRM team.

As all RCH and immunisation related data/indicators can be generated from this software, the state ***seeks permission of MoHFW to do away with redundant formats, registers and softwares***, while not compromising on the reporting requirements.

**3) Civil Works Cell**

The World Bank aided Rajasthan Health Systems Development Project (RHSDP), which had focussed on infrastructure development and renovations of secondary level public health facilities across the state, had created Project (Civil Works) Cell in the Project Implementation Unit (PIU) within the department of health. The project, after being cleared by the Bank for a 2-year extension (till Sep 2011), will expand the scope of the Projects Cell to also award works contract and supervise such works that is mandated under NRHM or facility upgradation plan. The state proposes to subsume the Projects cell within NRHM and seeks MoHFW sanction for the ***additional establishment consultant engineers/architects' costs*** (needed for NRHM works over and above the pending RHSDP works).

**4) Supplementary budget for 2009-10**

As the state had already booked around 60% of the approved (as per ROP) PIP for 2009-10, the state needs additional funds for sanctioned activities, without which the pace of implementation of NRHM will suffer. In view the additional requirements the state of Rajasthan had prepared a proposal for supplementary PIP for 2009-10 and had sought approval of the same. The details of the supplementary PIP are as under.

**Table 5.1: Additional Resources proposed for PIP 2009-10**

| S.No. | Particulars | Propsed amount (Rs. Lakhs) |
|---|---|---|
| 1. | RCH flexipool | 5,998.06 |
| 2. | Mission flexipool | 10,934.95 |
| 3. | Routine Immunisation | 184.31 |
| 4. | Vertical Programs | --- |
| 4.1 | NVBDCP (Malaria link worker) | 100.00 |
| 4.2 | RNTCP | 95.42 |
| 4.3 | IDSP | 1.40 |
| 4.4 | Control of food adulteration | 150.00 |
| 5. | Infrastructure maintenance | 6,000.00 |
| **Total (Rs. In lakhs)** | | **23,464.14** |

**Table 5.2: Additional allocation for left out activities in RCH flexipool PIP 2009-10**

| S.No. | Particulars | Propsed amount (Rs. Lakhs) | Remarks |
|---|---|---|---|
| 1. | Procurement of equipment for maternal health (FRUs & 24x7 PHCs) | 800.00 | |
| 2. | Procurement of laparoscopes | 700.00 | Lump sum |
| | Contingency for repair of laparoscopes at state level | 2.00 | Lump sum |
| | Contingency for repair of laparoscopes at district level | 17.00 | 34 districts @ Rs.50,000 |
| 3. | Procurement of equipment and supplies for 3000 model Sub Centres | 1,208.13 | |
| 4. | Compensation for MTCs | 32.83 | Rs.30 per child admitted per day to be given to care-giver of malnourished child admitted to MTC (Rs.30 x 8 beds x 30 days x 12 months = Rs.86,400 per MTC per year x 38 MTCs) |
| | Procurement of equipment and supplies for MTC | 22.80 | Equipment @ Rs.35,000 per MTC (one time) and Supplies @ Rs.25,000 per year for 38 MTCs |
| 5. | Implementation of FBNC activities in districts | 180.00 | Per FBNC @ Rs.5 lakhs for 36 FBNCs |
| | 36 specialists (paediatrics) and 36 MOs in 36 FBNCs | 118.80 | 1 paediatric @ Rs.40,000 and 1 MO @ Rs.15,000 pm for a FBNC (6 months salary in 2009-10) |
| | Set up of New Born Care units in 100 CHCs | 1,000.00 | Minor construction and procurement of equipment @ Rs.10 lakhs per NBC |

| S.No. | Particulars | Propsed amount (Rs. Lakhs) | Remarks |
|---|---|---|---|
| 6. | IMNCI Trainings | 576.00 | Additional provision |
| 7. | Compensation for failure of sterilisation cases decided by court of law | 20.00 | Lump sum |
| 8. | Mobility support for Joint Directors (at Division level) | 4.20 | 7 JDs @ Rs.5000 pm each for fuel expenses (7 x 5000 x 12 = 4.20 lakhs) |
| | Mobility support to Deputy Director at JD office | 10.80 | 6 DDs @ Rs.15,000 pm (6 x 15000 x 12 = 10.80 lakhs) |
| 9. | Referral transport arrangement for institutional deliveries (provision of Rs. 50 lakhs in PIP) | 305.50 | One vehicle @ Rs.25,000 pm for 237 Blocks (25000 x 237 Blocks for 6 months) |
| 10. | Additional Urban RCH Centres and Aid Posts | 500.00 | Provision of 33 Urban Centres @ Rs.14 lakhs is kept in PIP 09-10. Additional provision for 16 Urban RCH Centres @ Rs.14 lakhs per centre and 43 Aid Posts @ Rs.4.50 lakhs per Post. |
| 11. | IEC/BCC | 350.00 | Additional provision of Rs. 5 crores |
| 12. | School Health Program | 150.00 | Collaboration with NICE Foundation |
| **Total (Rs. In lakhs)** | | **5,998.06** | |

**Table 5.3: Additional allocation for left out activities in NRHM Mission flexipool PIP 2009-10**

| S.No. | Particulars | Propsed amount (Rs. Lakhs) | Remarks |
|---|---|---|---|
| 1. | Procurement of MMU at Block level | 650.00 | 65 Blocks @ Rs.10 lakhs for each vehicle |
| | Operating cost for MMU at Block level | 975.00 | 65 Blocks @ Rs.5 lakhs each for 3 months |
| 2. | Civil works (renovation and maintenance of health institutions) | 3,000.00 | Additional provision for construction of labour rooms at 205 PHCs @ Rs.5 lakhs each, construction of housing for Satellite Hospitals (2 MO quarters @ Rs.10 lakhs each, 2 paramedical quarters @ Rs.8 lakhs each, 1 peon quarter @ Rs.4 lakhs each) |
| 3. | Drugs logistics | 1,000.00 | Additional Rs.10 crores |
| 4. | Swasthya Chetna Yatra | 500.00 | Additional provision of medicines of Rs.5 crores |
| 5. | Human Resources | 1,000.00 | Salary for 2500 additional ANMs |

| S.No. | Particulars | Propsed amount (Rs. Lakhs) | Remarks |
|---|---|---|---|
| 6. | Procurement of drugs & supplies for Maternal Health, Child Health, ARSH, IMNCI, etc. | 3,809.95 | |
| **Total (Rs. In lakhs)** | | **10,934.95** | |