NRHM First Common Review Mission
Rajasthan State
14-21, 2007

Mission Report

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Summary

1. Background

Rajasthan with a population of 56 million spread across 32 districts is a relatively 'poor health' state with an IMR of 67 (India 57 in 2006), MMR of 445 (India 301 2001-03), and TFR of 3.2 (India 2.7 in 2005-06). A disquieting feature of the State is also the adverse female-to-male ratio of 921 (India 933 in 2001) reflecting the anti-female biases persistent in society.

Health systems reforms in Rajasthan have been underway since 2004 under the World Bank's Health Systems Development Project. The launch of the NRHM in April 2006 has given further impetus to on-going initiatives.

The purpose of the First Common Review Mission was to (i) identify the main developments in health systems that have resulted from the recent implementation of the NRHM; (ii) assess the progress being made towards ensuring health for all; and (iii) flag critical issues that need to be addressed for improving health delivery. This Report on Rajasthan is based on field visits between 14-21 November 2007 by the Team to Jaipur; and two districts of Rajasthan: Alwar and Churu[1]

Given the recent launch of the NRHM, it has not been always possible to provide hard evidence to back all the findings; nor is it possible to judge the impact of the NRHM on health outcomes. Nevertheless, we have commented on the changes that are being effected to improve health systems and health delivery. Our perceptions and judgments are based on our field visits, interactions with the community, health officials and with personnel in health facilities, and a careful review of materials presented to us during the Mission.

2. Key NRHM-related developments

We find considerable momentum building up in Rajasthan for health systems reforms with the launch of the NRHM providing an additional boost. Five key developments are listed below:

1. Decentralized societies and direct flow of funds: Rajasthan has done well to set up societies at different levels. The Rajasthan Medicare Relief Societies (RMRS) that had been started in the late 1990s now cover all 45 District and sub-District hospitals, 354 out of 352 CHCs and 1,489 out of 1,503 PHCs. These three sets of institutions have started receiving Rs. 5 lakhs, Rs. 1 lakh and Rs. 25,000 respectively every year as untied funds. Also, 10,398 sub-centres out of 10,742 have opened bank accounts for receiving untied funds; and most have received three remittances of Rs. 10,000 every year. ANMs at the sub-centre have been particularly benefited by inflow of

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[1] Alwar district, where most health outcome indicators are above the State average was selected by the State. Churu District, where most health outcome indicators are below state average was identified by the Review Mission Team.

united funds every year. They have used this money to improve the condition of the sub-centre and to equip themselves better. Rajasthan Medical Relief Societies were existing upto CHC level prior to NRHM. However, these societies were extended upto PHC after launch of NRHM.

2. Completion of facilities survey: On the whole, Rajasthan has been intensifying efforts to improve health facilities across the State as part of the World Bank project (Rajasthan Health System Development Project). NRHM inputs have further supplemented the efforts. The State, in collaboration with research agencies and NGOs, has completed health facilities surveys to identify shortfalls and plan for upgrading them according to IPHS standards. Covered by the survey so far are 290 out of 352 CHCs and 105 out of 1,503 PHCs in an effort to make 365 health institutions as 24x7 health care facilities by the end of the year.

   However, we found that the picture is quite mixed. For instance, the District Hospital in Alwar, the CHC in Kishengarh and the sub-centre at Dhani were fairly well-equipped in terms of facilities and staff. However, conditions were not as good in the CHC at Thana Gaji and the PHC at Harore.

3. Formulation of District Health Plans: District Health Plans have been drawn up for 26 out of the 32 districts in the State; and 23 of these have been appraised. Work on formulating District Health Plans for the remaining six districts has been initiated.

4. Appointment and training of ASHAs: So far, 37,431 ASHA-Sahayoginis have been selected against the target of 42,592. Drug kits have been given to 23,443 ASHAs. ASHA Resource Centres and ASHA Monitoring Groups have been set up. So far, 35,654 ASHAs have been trained in the First and Second Modules and 23,096 in the Third Module.

5. Programme Management Units: PMUs as per NRHM norms have been established at state and district levels. Vacancies of accountants are being filled up. Processes are on for establishing Block level PMUs.

Positive features

Listed below are five positive changes that we observed during the visit to Rajsthan:

1. Sharp rise in institutional deliveries: Institutional deliveries in government facilities have risen dramatically - to 4,25,253 between April-September 2007 – a jump of 62 percent over the corresponding period in 2006. Almost all of this can be attributed to the monetary incentives offered under the JSY.[2] We found, for instance, that between

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[2] In rural areas, Government of Rajasthan pays Rs. 1400 to every woman who delivers in a government facility; and an additional Rs. 300 to cover transportation costs. The health worker accompanying the woman gets Rs. 500 (Rs. 400 paid at the time of delivery and the remaining Rs. 100 at the end of completing DPT 3)

1995-2003, the CHC in Kishangarh conducted, on average, 33 deliveries a year. This rose to 75 during 2004-05 and to 275 in 2006. Between January-mid November 2007, the CHC had already conducted 919 deliveries. The State government has also simplified the system of making payments under JSY. Women who deliver in institutions are given a cheque that can be cashed the same day.

2. Increased confidence in government facilities: We found a general increase in the use of government health facilities that signals a positive change in people's perceptions regarding government health facilities. Observing the improved facilities at the time of deliveries has made people regain their confidence in government services. This is reflected in the increased use of government facilities. For instance, at the District Hospital in Alwar, we found that apart from institutional deliveries, there was a noticeable increase in in-patient treatment, out-door care, surgical operations, laboratory investigations. Bed occupancy at the CHC in Alwar, for instance, was 70 percent now; and in the summer months, it rises to 100 percent.

3. ASHA-Sahayoginis with a difference: We find that the Government of Rajasthan has made some innovative adjustments to the ASHAs. To begin with, assistants in the anganwadi centres under the Department of Women and Child Development (originally called *sahayoginis*) have been renamed Asha Sahayoginis. Asha-Sahayoginis are paid a monthly stipend of Rs. 500 (over and above which they receive incentives for different tasks); they are required to do 10 household visits daily; and they function out of the anganwadi centre. This has led to better integration of ICDS and health; greater accountability (as the asha-sahayogini is required to work half day) and greater coordination of ASHAs with anganwadi workers. On average, an ASHA earns around Rs. 2000 a month.

4. Revenue mobilization by RMRS: The health societies functioning in Rajasthan have been able to generate their own resources locally. A well-thought out set of guidelines govern the functioning of the RMRS. For instance, free medical care is provided to everyone below the poverty line, pensioners and senior citizens. The rest are required to pay a modest amount for services ranging from Rs. 5 for registration to Rs. 30 for ECG and blood tests and Rs. 60 for X-rays. The guidelines also prescribe how the moneys collected ought to be spent – 25 percent on purchase of medicines and so on. These inflows combined with the direct transfer of untied funds from NRHM have led to the accumulation of reasonable sums of discretionary funds at each level. However, officials are still not comfortable about spending the money.

5. Integration of national health programmes: We found that all National Health Programmes including RNTCP, blindness control, vector-borne diseases and IMNCI are operated through the health facilities at all levels – Sub Centres, PHC, CHC and district hospital. These facilities also offer the Indian System of Medicine especially Ayurveda though on a limited scale.

Areas requiring attention

Listed below are areas where we feel that greater clarity is needed.

1. Awareness regarding NRHM provisions: We found that the CHMO and others were not often very clear about the provisions of the NRHM. For instance, they were not very confident regarding use of untied funds, the role and functions of a Public Health person as specified in the IPHS norms, and about the possibilities for public-private partnerships that could be promoted under NRHM.

2. Physical conditions: We found that the physical state of health facilities leaves much to be desired. We found stagnant water, leaking pipes and dirty corridors even in the CHCs. Equally worrying was the lack of public hygiene and cleanliness in many of the health centres we visited. Another feature was the near-absence of charts and posters on the walls that would spell out the protocols to be observed. This, we feel, is an important aspect to address immediately.

3. Shortage of manpower: There is a shortage of specialists especially in gynecology, anesthesia and public health. We found that the posts of MPW(M) were being wound up; and that the training centres for them were non-functional across the State. An assessment of future health manpower requirements is needed.

4. Private health facilities at the sub-district levels: We found that health facilities in the private sector were virtually non-existent at the sub-district level – even in Alwar district that enjoys proximity to Delhi. This clearly points to the urgent need to step up provisioning of health facilities in the public sector especially since options of public-private partnerships at the sub-district level are so few.

5. Incentives for ASHAs: The innovation of paying ASHA-Sahayoginis a monthly stipend and linking them to the anganwadi centres is a good practice. However, we found several problems with the system of differential incentives. ASHAs tended to concentrate only on those activities that offered them incentives. They gave higher priority to those activities where the prospects of earning more were greater. As a result, many critical areas such as child care, counseling, etc. that were not tied to incentives remained neglected. We got reports of several instances of conflicts between ASHAs and Anganawadi workers arising out of the incentives. This was particularly so in the case of JSY where the two workers would often fight over who gets the incentive amount. We also heard of some families that do not want the ASHA to accompany the pregnant woman to the health facility; as they can then collect the transport charges themselves.

6. Rationale behind monetary payments: Many health officials and workers expressed concern over the future of the JSY especially since coverage extended to all women and to all children (not limited to two). While they admitted that institutional deliveries helped to reduce maternal mortality, they were also worried about the huge financial implications. Similarly, health workers could not fully understand why

NRHM had decided to increase the compensation for lost wages paid to men and women under sterilization. In the case of women, the demand for sterilization was high; and the real constraint was in terms of ensuring safe good quality service. With men, most health workers felt that money – and that too Rs. 1100 – could not be the determining factor. They also felt that introduction of money often corrupts the system.

7. Payments to doctors: Doctors in Rajasthan are appointed at Rs. 8000 per month on a contract for a year. In addition, they get a hardship allowance when they are posted in some regions. While this seems a relatively small amount, we also found that such doctors are allowed to engage in private practice. Thus, at a PHC, doctors do government duty between 9 am and 1 pm; and again between 4 and 6 pm. Thereafter, and especially since they reside in the premises, they continue to see patients in his private capacity. A more careful study is needed of the terms of employment as well as the compensation and incentive package to doctors.

8. Integration of PMU: We found that the PMU staff needs to be better integrated with the entire health system. At the moment, they are seen as agents of NRHM whose sole function is to ensure that monies coming from NRHM are properly accounted for. This is creating some tension with the regular staff (that is paid much less) and also not ensuring optimal use of the skills of the PMU staff. Concerns were also expressed about the accountability of contract PMU staff. Programme Management Unit at the state and district level should fill up the gaps at the different level for smooth functioning of the health facilities specially the human resources and financial resources. They should also assist to the Block Medical Officers in financial aspects. He should also be involved in district level deliberation for the over all development of district plan.

9. While conducting the facility surveys for the health facilities Medical Officer should be a part of team so that he will also aware about the gaps in the health facility.

10. Electronic Fund Flow below the district level is delayed because of the branches of ICICI Bank are not available below block level

Areas for further action

We are listing below some areas for further study and action:

1. a systematic effort at disseminating NRHM guidelines and practices

2. a thorough review of the systems of payments and incentives to ASHAs (as the present system of differential and targeted incentives could prevent the establishment of a strong community-based primary health care system)

3. a re-examination of the rationale for monetary payments under JSY and for sterilization

4. a review of appropriate compensation packages for doctors

5. developing a set of options for public-private partnerships especially at the sub-district level

6. outlining clear roles and responsibilities for PMU staff so as to better service health societies.

7. There is a need to study the integration of the programme at the state level. Since it is found that there is verticality in the national programmes as well as there is separate Director for RCH, PH, IEC and AIDS and there is no coordination amongst them.

Detailed field notes follow as Appendix 1.

Appendix 1

NRHM First Common Review Mission
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Field Notes

Ministry of Health and Family Welfare launched the National Rural Health Mission in April, 2005. After launching the NRHM, Ministry of Health and Family Welfare proposed to undertake the first Common Review Mission in 13 states from 14th to 21st November, 2007. The Terms of Reference for this review mission was given to the team members by Ministry of Health and Family Welfare.

The intention of Common Review Mission is to undertake the health system centric assessment rather than disease or programme assessment progress in state. It is the need to look the preparedness of the health facilities at various levels to meet the people's need and extend to which community organization and the institutions under the umbrella of Panchayati Raj Institutions as started owing health sector initiatives.

The team members identified by Ministry of Health and Family Welfare to visit the states during the Common Review Mission. The team comprising of Dr. Shiva Kumar, Dr. D.C. Jain, Dr. Sunil D. Khaparde, Shri Arun Baroka and Dr. T. Bir visited the Rajasthan to assess the performance of NRHM in the state. The team has identified two districts on the basis of family welfare indicators. The one is the low performance and the other is high performance district. Accordingly, the Churu and Alwar districts were selected for the review.

The team arrived in Jaipur on 15th November, 2007 (forenoon) and held discussions with the Mr. R. K. Meena, Principal Secretary Health, Dr S. P. Yadav Director (RCH/NRHM), Dr. M. L. Jain Director (PH) and other Senior health officials dealing with NRHM and other national health Programs. The team briefs the officials about the purpose of their visit. Thereafter, the state officials briefed the team on the functioning and achievements of NRHM and other national health programs in the state. The NRHM has been implemented from 1st April 2006 in the state.

State Profile:

The state is having the population of 56.507 millions spread over 39,753 villages of 9188 Panchayats in 237 blocks of 32 districts. The state is having 45 district/sub district hospitals, 352 CHCs, 1503 PHCs and 10,742 Sub- centres. The sex ratio in the state is 921 females per 1000 males. The major health indicators in the state are: MMR 445 (2001-03), IMR 65 (NFHS III), TFR 3.2 (NFHS III), Institutional Deliveries 39.9 (2006-07), CBR 28.6 (2005) and CDR 7 (2005).

Maternal Health:

- As per the information received from the state government, the achievement during first six months (April-September, 07) of the financial year in institutional deliveries is 425253 (23.06%) against the target 1844445, JSY Beneficiaries 336244 (79.07%) against 425253, ANC Registration 1052554 (51.36%) against 2049383, RCH Camp 702(36.56%) against 1920, Dai training 807(13.45%) against 6000 and SBA training 165(16.50%) against 1000.

- The increase in Institutional Deliveries is 61.5%, ANC 16%, JSY beneficiaries 62.3% as compared to achievements during the corresponding period (April-September, 06) of financial period of 2006-07.

- The state has completed the facility survey of 137 CHCs, 105 PHCs to operationalize 365 health institutions as 24*7 health care facilities.

- The state has purchased 137 each, blood bank refrigerators and generator sets. To meet the required manpower as per IPHS standards the state has created the additional 18 JS for 18 CHCs, 52 SMOs for 52 CHCs, 67 MOs for 56 CHCs, 171 Nurse /Grade II for 150 CHC and 28 Assistant Radiographers for 28 CHCs.

- State to strengthen the institutional delivery system has adopted the public Private Partnership Model by accrediting the 27 Sub-District level Hospitals for JSY and 182 private institutions for sterilization and 171 for IUD insertion under family Planning Program.

Child Health:

Integrated Management of Neonatal and Child Illness (IMNCI) was being implemented in 9 districts (Tonk, Dholpur, Karuali, Sawai Madopur, Baran, Bundi, Jhalwar and Kota) of the state. The Program has been scaled up, across 9 districts in the sate during 2007-08.

- *18 TOTs at Medical colleges and 147 training courses* in 9 districts have been organized and 3606 health functionaries have been trained.

- 711869 (40.95%) children under one year of age against the target of 1738250 have been fully immunizes up to September, 2007.

Family Planning:

The state achievement in total sterilization is 74877 (16.36%) against the target of 457655 (Male; 2.77%, Female; 17.87%), IUD insertion 211266 (61.99%) against the

target of 340827, Oral Pills user (new) 393414 (70.92%) against the target of 554705 and *CC* users 453608 (72.73%) against the target of 623690.

- The increase in sterilization is 6%; female sterilization is 6.5%, IUD insertion 24% during the April-September, 2007 of this financial year as compared to achievements during the corresponding period (April-September, 06) of financial period of 2006-07.

- 16 (16.0%) health officials have been trained in Laparoscopy against the proposed target of 100, 19 (39.58%) in manila against 48, 13(10.83%) in MTP against 120 and 165(16.50% against 1000 during April-September, 2007.

Revised National Tuberculosis Programme (RNTCP) status in Rajasthan

- RNTCP in Rajasthan covers whole State which implies all 32 districts with a population of more than six crores. All districts have a TB clinic coordinated by a TB Cell at state level. A network of 145 TB units, 725 microscopy centers and 1978 treatment centers exists in the State. In all 14000 places have been identified throughout the state to provide directly observed treatment under supervision.
- Under NRHM ASHA Sahyogini are involved in DOT.
- In 17 districts TB-HIV committees have been constituted.

Blindness Control

- Under Cataract Blindness project 1994-2000, mobile eye units were created in all districts. Eye departments of Medical Colleges were upgraded. Separate mobile unit was given to each medical college. At state level one ophthalmic cell to monitor a programme was established in Rajasthan. District Blindness Control Society provides grant-in-aid for free cataract operations to NGO/PRI.
- Under NRHM ASHA Sahyogini are involved in Blindness control programme for bringing the cataract patient at camp.

National Vector Borne Disease Control Programme

- Malaria and Dengue are prevalent in Rajasthan. Malaria is wide spread and present in all the districts but Dengue is limited to 10-15 districts. There is no significant difference between rural and urban areas. Anopheles Stephensi, A, Culicifacies and Aedes Aegypti are the common vectors responsible for transmission of these diseases in state. Wide and varied disease burden seen in the state is due to its varied socio-economic and geographical disparity. The tribal and desert areas contribute 70% of Malaria diseases burden.
- API ranging from 10 to 35 in Jaislmer and Bamer districts.
- Dengue scenario : Dengue is major public health problem; major outbreak was reported following the outbreak in October, 2003 mainly affecting urban areas of Jaipur.

- 1222 zero positive cases and 30 deaths were reported in 2005.
- Under NRHM ASHA Sahyogini are involved in distribution of anti malaria drugs.
- Establishment of Malaria Clinic in private sector has to be taken into consideration. It is proposed an honorarium of Rs. 3 per slide examination not exceeding to a limit of Rs. 45000 per month may be provided to LTs working in private clinic and NGOs.
- HIV/AIDS in Rajasthan : Rajasthan is a low prevalence state for HIV. However, there is significant promotion of the High Risk group, high in/out migration, high truck traffic, poverty, high population of youths and no organization role of women in the society.
- Number of AIDS cases upto March 2005 were reported to be 1284 and HIV positive in the state was reported to be 88560.

URBAN RCH:

- State proposed to set up 43 urban health post in 8 cities and 13 Aid Post
- These will be managed under the mode of Public Private Partnership.

ASHA-SAHYOGINI:

- 37431 ASHA-SAHYOGINIS have been selected against the target of 42592.
- 35654 ASHAs have been trained in 1st and 2nd module and 23096 in 3rd module.
- Drug kits to 23443 ASHAs have been given.
- ASHA Resource Centre and ASHA Mentoring Group have been set up.

Human Resources under NRHM:

- The Program management as per the NRHM norm has been established at state and district level and functional. However the three post of District Account managers and six Data Assistants are lying vacant.
- 9 District Child Health Coordinators out of 18 have been hired for implementation of IMNCI.
- 492 out of 1087 accountants have been hired CHC/PHC.
- None of the specialist, Nurse grade II, Block program manager, Data entry operator; AYUSH Medical Officers have been hired for CHC/PHC.

- To strengthen NRHM state has hired 2500 ANM/GNM against the target of 7502 for providing an additional ANM/GNM at each sub center.

- The state has initiated the process for establishing Block program management units.

ROGI KALYAN SAMITI / RAJASTHAN MEDICARE RELIEF SOCITY (RMRS):

- 1879 (98.89%) RMRS against the target of 1900 have been formed. These are established at district/sub district hospitals, CHC and PHCs. These are functional at different levels. The details are as under:

    - In all District/Sub-district hospitals (45/45)
    - In 345 out of 352CHCs
    - In 1489 out of 1503 PHCs

DISTRICT HEALTH PLAN:

- 26 districts out of 32 have prepared district health plan with the technical support of identified 6 Non-government agencies.

- 23 district plans out of 26 have been appraised.

- State has initiated the process for preparation of health plan of remaining six districts.

FUND FLOW:

- Societies under various health programs have been merged in State/District health Society.

- All funds are received by the State Health Society being transferred to all district health societies through e-transfer.

- *Untied grant for 10742 Sub-centres@ Rs 10000 per Sub-centre, 1503 PHCs@ Rs 25000/- per PHC, 352 CHC@ Rs 100000 per CHC and 45 District/Sub-district hospitals @ Rs 500000 per District/Sub-district hospitals have been realsed.*

- 10398 Sub-centres out of 10742 have opened bank account for operating untied funds.

- Three tranches of untied funds each of Rs 10000/- have been released.

CIVIL WORK:

- State has also initiated the civil work for OT, LR and the residential quarters for Doctors, staff nurse as per suggestion of IPHS i.e. (4MO+4S/N+1Peon) for CHCs and (1MO+3S/N) for PHCs.
- Facility survey of 290 CHCs out of 352 has been completed.
- Civil work have been completed in 42 CHCs, work is in progress in 232 CHCs out of work sanctioned for 325 CHCs.
- Civil work have been completed in 3 PHCs, work is in progress in 85 PHCs out of work sanctioned for 100 PHCs.
- The expenditure of Rs 3235 lacs and 95 lacs have been incurred in the civil work of CHC and PHCs respectively.

OTHER ADDITIONALITIES:

- Orders for 52 Mobile medical units have been placed.
- Tenders for 52 diagnostic vans and 100 ambulances have been floated.
- State Health System has been established at State institute of health and family welfare.
- 5 new ANM training centres are being established.

ISSUES:

- MPW (M) training centers are non functional in the state. State expressed that GNM may be allowed to function against the post of MPW(M).
- There is shortage of the specialists in the field of Gynecology, Anesthesia and Public health. Therefore, the state is facing the problem of placing these specialists at the level of Sub district hospitals and CHCs.
- Public private partnership model in providing medical and health services at PHCs/CHCs needs to establish where there is shortage of health manpower.
- The training of ASHA in all the modules is needed to be geared up.

- Seeing the desert area condition hard duty allowance may be extended to the rural area

The team was divided into two groups. For the Alwar district Dr. Shiva Kumar, Dr. Sunil D. Khaparde and Dr. Shri Arun Baruka and for Churu district Dr. D.C. Jain, Dr. T. Bir and Shri H.P. Yadav, Regional Director, Govt. of India also joins the mission.

During the visit to the Alwar district, the team members visited the different health facilities – District Hospital, CHC, PHC, Sub-Centre and also have interaction with the different health and non health functionaries – District Collector, CMHO, Medical Superintendent, Block Medical Officer, PHC Medical Officer, ANM and ASHA Sahyogini and AWW and find the following observations :

District Hospital, Alwar

- District Hospital, Alwar is a specialized hospital with 413 beds strength having all the specialists including medicine, surgery, Pediatrics, Gyanea, ENT, Ortho and Blood Bank.
- All the National Health Programme including RNTCP, HIV/AIDS, Blindness control programme, Malaria, Vector Born , IMNCI is running through district hospital. It is also observed that under the same roof of the hospital, Indian System of Medicine especially Ayurveda system services are also providing to the population.
- There is a good back up support of laboratories, X-rays, Sonography and Operation Theatre in the district hospital.
- After the launching of NRHM and the implementation of the Janani Suraksha Yojana the number of institutional deliveries at the hospital has increased tremendously. This is mainly because of the incentive under the JSY. As compared to the last year, the number of institutional deliveries increased double. Since the institutional deliveries has increased people starts using the government facilities which increase health seeking behavior of the patients.
- Apart from the institutional deliveries the other services in the hospital like in-patient, out-door, surgical operations, laboratory investigations has also increased proportionately.
- Operations like cesarean section, hysterectomy, hydroceal, are also performing during the last two years because of the facilities available in the hospital under the NRHM.
- There is a general impression amongst the health providers and the community that JSY promote the institutional deliveries and also have impact on reduction maternal morbidity and child mortality.
- Immunisation services at the district hospital were provided every day and also maintaining the cold chain, AD syringes were used for the measles vaccinations. Log book for the cold chain was maintaining by the concerned nursing staff.

- Rogi Kalyan Samiti (Medical Relief Society) is well established and very old society before the NRHM launch. MRS is having the good fund and this is utilized for the welfare of the hospital and the account is maintained and audited by Chartered Accountant. Separate expenditure is not maintained for untied fund received through NRHM.
- District Hospital is fully equipped with the medicines/drugs and the equipment for providing the services.

Community Health Centre (Kishengarh)

- This CHC having 50 bedded hospital and identified for the strengthening for IPHS standards. Infrastructure of the building is good and it is newly constructed by the Rajasthan Health system Project.
- CHC having Operation Theatre, Laboratory services, 50 bedded hospital and doctors' rooms and OPD are well maintained.
- Assured services under IPHS like RCH, RNTCP, Vector Born Disease Control Programme, Immunisation, clinical and medical services are provided by CHC.
- Required manpower as per the IPHS standards is available at CHC which include specialists like Anesthesia, Guyana, Pediatrics and general physicians, surgical and general duty medical officer are available at the CHC.
- The Public Health Officer at CHC as per requirement of IPHS is not available in centre.
- The remarkable thing of the CHC is that more than 100 operations including caesarian section, hydroceal, ovarion cyst and other minor operations are being performed in the CHC.
- The OPD attendants of the CHC are 100, and beds occupancy is more than 70 per cent in this season. During the summer season it is 100 per cent bed occupancy.
- The blood storage unit is existing at hospital but not in operation. Hospital authorities already applied for the license from Food and Drug Administration.
- The Rogi Kalyan Samiti (Medical Relief Society) is well established and utilizing the fund for the welfare of the hospital.
- The maintenance fund for strengthening the CHC and untied funds given under NRHM also included in the Medical Relief Society but separate expenditure is not maintaining. The purpose for which the fund received under the NRHM is not aware to the Medical Officer for which the sensitization and orientation of the Medical Officer is required.
- Janani Suraksha Yojana is implemented in this centre and institutional delivery rate is increased in double as compared to the last year.
- All assured services under IPHS, RCH emergency Obst. & Gyanae, Pediatrics, immunization and other national health programmes like Malaria, TB are also provided through CHC.

- Laproscopic camps organized in the CHC on a fixed day in the month at the same time the out reach immunization session were also conducted through this CHC.
- The CHC act as a referral centre for the PHC and Sub-Centre in that area.
- All the required medicines and equipments as per the IPHS are available at the CHC.

CHC, THANA GAJI

- This CHC is not identified for the strengthening under IPHS. Total area serving is around 1 lakh population.

- This CHC is not having good infrastructure. Surrounding of the building is not clean and lot of water logging in front of the CHC which itself is causing the mosquitoes nuisance in the hospital.

- Total manpower strength of the CHC is 15, out of the 5 Medical Officers and rest are supporting staff. 1 Medical Officer is on long leave and another is on deputation. All the posts of Para Medical Staff are filled up.

- OPD attendance is around 50 to 60 per day and average occupancy of the bed is only 30 per cent. This shows that CHC is not functioning and utilization is low.

- No skill mix Medical Officer is existing in the CHC. Anesthetist and a Gynecologist are not posted.

- All the assured services under the IPHS are not provided. Emergency Obst. cases are referred to the District Hospital directly. Laproscopic and Mini Lab. Camps organized monthly.

- All required medicines and equipments are available as per IPHS standard.

- Institutional deliveries increased as compared to last year.

- New construction of the CHC under the Rajasthan Health Project is under process.

- Medical Relief Society is functioning. However, the account is not maintained properly. Medical Officer is not aware about the untied funds and maintenance fund for the CHC which is received from the NRHM. This indicates that there is the need to sensitize the Medical Officer about the untied fund and its utilization for the welfare and cleanliness of the hospital.

Primary Health Centre (HARORE)

- Primary Health Centre catering about 30 to 40 thousand population having 6 bed capacities but only 4 beds are in utilization. PHC is delivering 24 hours services for institutional delivery. Condition of hospital is not good.
- 1 Medical Officer is posted who is on contractual appointment and about 10 supporting staff LHV/ANM/Lab. Technicians etc. are existing in the hospital.
- Hospital is having high delivery rate until today 470 deliveries has been performed. This is the impact of the incentives under Janani Suraksha Yojana.
- Store room having the condemn items is required to be disposed off and which can be utilized for keeping the hospital items.
- The immunization services, laboratories services and the out-reach services for immunization are conducted regularly.
- All the required medicines and equipments are available at PHC.

Sub-Centre (Dhani)

- The Sub Centre is under the PHC Biteda covering the population of 3000 and only one village under the Sub-Centre.
- Sub-Centre building is very good and having the delivery room along with the residential facility for ANM.
- 1 ANM and 1 Male Nurse is posted at Sub-Centre. ANM is under gone the skill birth attendance training and she is able to conduct the deliveries. However, the deliveries are not conducted at the Sub-Centre.
- Other services like Copper-T insertion, immunization and family welfare services perform by the ANM. She is also involved in the national programme and distributed drugs under RNTCP, Malaria and minor ailment. She is also distributing the emergency pills and the condom.
- All the required medicine and necessary equipments as per IPHS are available at Sub Centre.

Asha Sahyogini

- The team has interviewed 5 to 6 Asha Sahyogini at different facilities.
- Asha Sahyoginies are the Angan Wadi Workers appointed by the Women and Child Development Department and they are paid regularly Rs. 500/- per month.
- Over all performance of the Asha Sahyogini of Rajasthan is very good and she is involved in most of the national health programme including RNTCP, Malaria, RCH, Blindness Control etc.
- She is earning around Rs. 2000/- per month by performing the services under different programmes. This is really encouraging step for the programme.

Manpower

- There are in general shortages of Medical and Para Medical staff at the different health facilities at the same time there is the poor distribution of the specialists. There is no skill mix at the CHC specially the Gyanae and Anesthetists are not available even on the contractual appointment.
- The Public Health Manager post is vacant at CHC because of the non availability of the Public Health professional.
- State need to develop the human resource plan to overcome this shortages by multi skilling of the medical officer, resource pulling at block level and proper mapping of the skill health manpower at the block level.
- An accreditation of the private nursing home in the geographic area and contractual appointment at the local level.

Programme Management Unit

The team has also interviewed the State Programme Management unit as well as the District Management unit. It is observed that district management unit is required to more involved to fill up the gaps for smooth functioning of the hospital specially the human resource and financial resource. At the same time the resources is to be made available at health facilities at different level so that it will assist the Medical Officer in the accounts and audit systems for smooth function of the funds. They should also advise to undertake the sensitization /orientation workshop for the Medical Officer for the utilization of the funds available at the NRHM.

During the visit to the Churu District team members find the following observations:

District Profile:

The **CHURU District** was visited by the team. Following health institutions were visited and discussion held with the following officials/personnel by the team.

District Level: Collector, CMHO, Dy. CMHO, DPM, and PMO District hospital and the Staff.

Block Level: Medical Officer In charge and other staff of Bidasar & Salasar CHC and Talchapar and Charawas PHCs.

Village level: ANM, ASHA and Sarpanch of Gulariya and Lodiya Sub Centres/villages.

The Churu district is having the population of 1.69 millions spread over 13858Sq Km.. The district is having three sub district hospitals, 10 CHCs, 59 PHCs and 352 Sub-centers.

- **District Rural Health Mission**: has been constituted in the district Churu. There are 41 members in the district mission having representation from PRIs, NGOs and district level officials.

- **District Rural Health Society**: has also been constituted and registered on 17 March 2006 under the chairmanship of collector. 18 meetings of the society have been convened.

- **District Program Management Unit**: has been set up in June,05 in the district as per NRHM norms.

IPHS Standard: Dudhvakhara and Salasar institutions are taken up for up gradation as per IPHS standards. Rs 58.1 Lac for Dudhvakhara and Rs 19.30 Lac for Salasar have been sanctioned and construction work is being undertaken by PWD as per standards specified by state Government.

District Health Plan: SAAFI, a Non-government agency has been assigned the responsibility of District Health Plan preparation. The plan could not be completed by the agency.

IDSP: Data Manager, Accountant and data entry operators and Assistants are hired on contract and unit is functional. 332 health workers have been trained out of 385. HEALING software is also being used for reporting IDSP is also made an integral module of this software.

ASHA-SAHAYOGINI: 1227 ASHAs have been selected in total 1431 Angan Wadi Centres. ASHA on 204 AWC has yet to be selected in Churu district. 1067 ASHAs have been trained.

Streamlining of AYUSH: It is proposed to bring AYUSH in mainstream. At District Hospital Churu, CHC Taranagar and 6 PHCs. AYUSH health care facilities are being provided under the program *EK HI CHAT Ke NICHE* (Under one Roof) in selected institutions.

Model Sub-Centers: 25 Sub centres have been strengthened under this scheme in which construction of labour room, training of Dai, supply of water and electricity is been facilitated along with the essential equipments.

Untied Funds: Accounts in 347 Sub-centres have been opened out of 360 sub-centres. Three installments of untied funds have been released so far.

Rogi kalyan samiti / Rajasthan medicare relief society (RMRS): have been formed in one district hospital, 10 CHCs and 57 PHCs of the district and all are functional.

Family Planning:

- 11934 (19.83%) deliveries are supported by institutions against the target of 61564.
- 125 Male and 2775 females have been sterilized against 12768 which are mere 4.4% of the proposed targets.
- IUD insertion 5817 (66.6%) against the target of 8730
- Oral Pills user (new) 24044 (85.92%) against the target of 20661.
- 28320 (41.4%) ANC have been achieved against a target of 68405.
- 26504 (45.4%) children were fully immunized against a target of 58020.

BEmCO/Model PHC: Labour Room has been constructed on 6 identified institutions.

Maternal and Child Health and Nutritional Days: Every month MCNH days are organized on fixed Thursday.

Opinion of District Collector:

- Mr Arjun Meghwal, Collector praised the program and its flexibility. Some objectives of the Mission re achieved.
- Issue of prescription of Generic medicine is a problem as there is no fixation of rates and medical stores are charging on MRP which is on higher side. Some doctors are also not prescribing generic medicine.
- Training for the Medical Officers on rational use of generic drugs, which is very important needs to be addressed.
- SWOT analysis for the district health care services is essential while developing District Action Plan.
- 11 PHCs are not having its own buildings for which some PPP initiatives are in the process.
- Timely Utilization certificates are not received from all the institutions.
- Village health & sanitation committees are not functioning upto mark
- Blood storage capacity is on lower side and infrastructure needs to be strengthened.
- Snake bite and dog bite case are higher
- Orientation of representative of PRIs needs to be undertaken in a phased manner to ensure there effective participation.
- JSY has promotion of institutional deliveries in a big way.

Opinion of CMHO:

This district has got a number of VIPs, Shri Rajender Sigh Rathor, Minister of PWD from BJP and Shri Ram Singh Kushwa, MP Lok Sabha. Mrs. Kamala wife of Shri Ram Singh Kushwa is the president (Pramukh) of Zila Parishad of Churu District.

Mrs. Kama is the chairperson of the District Heath Society, but most of the time she does not attend the meeting of the Society. Being member secretary Dr. Giridhari CMHO used to take all necessary steps.
CMHO has stated that district is having a lot of political interventions in the function of the district health care activities like

- CMHO office is still now situated at a distant place Ratangarh which is 52 Km far from the District HQ. It causes lot of incontinence for smooth functioning of the CMHO office.
- Proper deployment of manpower is also affected
- Equipments and other facilities received from NRHM are also disrupted for proper installation.

Observation of the team:

- CMHO is not very clear on many issues of NRHM like proper utilization of untied fund, functioning & progress of MRS in relation to NRHM activities and utilization of fund generated from user charges.
- CMHO needs orientation especially on public private partnership for converting health care delivery services more effective and efficient as reported by Collector and CMHO lots of NGOs and donors are interested to extend their cooperation for managing health development in district.
- DPM could not spare sufficient team for monitoring of NRHM activities due to his preoccupation with chores activities.
- IEC display needs to be strengthening at District hospital level specially the services guaranteed by the institution.
- Post lying vacant at district needs to be filled in urgently as 25% supporting staff posts are lying vacant.
- Infrastructure for indoor need further enhancement however there were 150 sanctioned beds at the district hospitals though the bed occupancy rate was as high as 99%.
- Female and child ward has been merged due to shortage of IPD infrastructure and staff.
- Physical infrastructure of ANM training centre is not appropriate as some of the staff quarter and vehicle provided for the centre are being used by Dy CMHO staff, cook has been transferred to other place which has created a lot

of problems for the trainees, the accommodation for the trainees was not sufficient as 6-8 trainees are staying in single room, there are some other problem of securities. The qualification of the tutor is also not as per prescribed guidelines for the training centre. A tutor who has to be B.Sc. nursing but merely a GNM was given this responsibility and she was in position since last 5 years students express their concerned for faculty of desired qualification. Nursing superintendent post is also lying vacant.

- As reported by Dr Khtri of CMHO office earlier there was a provision for POL (Rs 60 per case) but in revised guidelines there is no such provision for sterilization camp. This is causing problem in team mobility for organizing the camps, especially in rural and remote areas.
- The building of the Bidasar was good. It was donated by Tanta Trust Calcutta. There were two JS(Med) at Bidasar CHC it was having negative impact in the functioning of the doctors of same specialty. Utilization of funds of MRS and united fund is very low at CHC.
- Charawash PHC was manned by a MO and all the recommend staff was there. The Mr Neeraj Saxena, MO I/c is staying in PHC itself and taking good initiatives for utilization of untied fund and MRS collection. He has used the untied fund for upgrading the labour room and makes it functional 24*7. Other basic facilities were also added by him. All Records were properly maintained as per NRHM norms and produced before the team in a very short time.
- Mrs Anees Avira, ANM of Gulariya Sub centre is staying in the SC building itself and has been doing good services in the village and villagers and Sarpanch were very much satisfied. A fish hatchery was also managed by her. She has received unified funds regularly and properly used by purchasing necessary facilities for the SC. She has been maintaining the record and reports in a proper way. She expressed her need for an additional room so that she can conduct the deliveries at the SC level as she has been conducting delivery in SC itself. She conducted 21 deliveries out of which 13 cases are yet to receive the payments of JSY which has been delayed due to strike of the doctors. She also express that some incentive for conducting delivery. Smt Jammuna Devi, ASHA in her village is selected in Dec, 2006 but has not recive3d any training as result she is not involved in any activity of SC. She wanted ASHA or any person as a helper at the time of conducting delivery.
- Salasar CHC which has been selected for IPHS upgradation in 2006-07. Practically, no progress have been made both in case of manpower deployment as only one Medical Officer is placed there to look after for the patient at CHC. Equipment purchased are not installed, blood storage & OT unit are not functional. It is 30 bedded hospital and having 27% Bed occupancy which may be increased if all the specialties are posted at the CHC. Ambulance is not working at Salasar CHC.
- ANM of the Lodiyas Sub centre is also staying at the SC itself. She is not conducting any deliver at SC as there is no labor room. Untied funds are properly used and records are maintained. ASHA has undergone two modules of training and involved in NRHM activities. ASHA told that she is

motivating for sterilization but not getting the incentive as person prefer to accompany by ANM for sterilization rater than ASHA as of which she is not getting incentive. Incentive for immunization is due from last couple of months. Sarpanch of the village is deeply associated with Sub centre activities including participation in meeting. He stated that activities of ANM and ASHA are going well for institutional delivery and other health programs.