
Vigyan Bhawan, New Delhi
26 February, 2011
4th Common Review Mission of the NRHM – Rajasthan

Team:
Mr. Avinash Mishra – Director Procurement MOHFW
Dr. Kaliprasad Pappu – Director NIPI
Dr. JN Srivastava – Consultant QI, NHSRC
Dr. Amitrajit Saha- Advisor CHSJ
Ms Huma Siddiquee – Consultant, NRHM
Ms Shifali Parmar – Finance Consultant, NRHM
Dr. Preeti Kumar – Associate Professor, PHFI
Focus of the CRM Review in Rajasthan

• Janani Suraksha Yojana (JSY)

• Mukhya Mantri Jeevan Raksha Kosh (MMJRK) for BPL populations

• Human Resources (HR)

• Nutrition

• Community Participation and demand generation
Top line findings of the CRM in Rajasthan

• JSY: Institutional Deliveries increase from 28% to 70%.
• MMJRK: Has increased coverage across the state; resulting in increased OPD and IPD footfalls.
• HR: Short-term measures successful; need for long term strategy. Addition by almost 4,000 managerial, and 17,000 clinical staff (80% clinical and 20% managerial).
• Nutrition: Inter-sectoral convergence is required to address childhood malnutrition in the State.
• Community mobilization and demand generation: active community participation through MRS, VHSC and PRI observed. Swaathya Chetana Yatras have increased community awareness.
<table>
<thead>
<tr>
<th>Key Indicators</th>
<th>Specific interventions by the State</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction of IMR</td>
<td>Strengthening of FBNCs. Operationalization of newborn stabilisation units (NBSUs) at 100 FRUs. Operationalization of block mobile medical units (MMUs) and facility-based integrated management of newborn and childhood infection (F-IMNCI) training. Drugs and supplies for child health. Additional ANMs. Hiring of specialist at FRU @ Rs. 60,000 per month. Infant Death Audit in all districts.</td>
<td>SRS – 2009 IMR decreased by 4 points (63 to 59)</td>
</tr>
<tr>
<td>Reduction of MMR</td>
<td>Maternal Death Audit in all districts. BPL (below poverty line) Ghee scheme. Block MMUs. Referral transport provision at block level. Drugs and supplies for maternal health. Recruiting and training additional ANMs. Rolling out the “Kalewa” scheme.</td>
<td></td>
</tr>
<tr>
<td>Reduction of TFR</td>
<td>Strengthening of the community-based family planning programme or the ‘Jan Mangal Programme’. Establishing of a non-scalpel vasectomy (NSV) resource centre. Rajiv Gandhi Population Stabilization Mission.</td>
<td>SRS – 2009 TFR lowered by 0.1 point (3.4 to 3.3)</td>
</tr>
</tbody>
</table>
Important Concerns/Challenges

Service Delivery: BPL utilization of free services in the facilities appears to be poor!

Nutrition: Large pool of malnourished children – great tracking, but poor interventions at grassroots.

HR: Quality training of all categories of personnel, and Institutions needed at Districts; this is an important area of health sector reform that is urgently needed.
Maternal and Child Health

- **Janani Suraksha Yojana** – Impact on Institutional Deliveries
  Institutional delivery (ID) have increased from 28 per cent in 05-06 to more than 70 per cent in 2009-10
  Source: (Coverage Evaluation Survey/CES 2010).

**Supplementary schemes initiated by the Rajasthan Government**

- **BPL First Delivery Desi Ghee Scheme**
- **Kalewa Scheme** – serving hot nutritious meal
- **Yashoda Scheme** – 555; DH and CHCs – To improve period of stay in facility and initiate post partum care (Breast Feeding; weight; OPV; BCG and home based care and delivery.)
Mukhya Mantri BPL Jeevan Raksha Kosh

Cashless Service to all BPL & 19 other categories for accessing all OPD/IPD services in all public facilities

Coverage since Inception – 1st January ‘09 to 30th Nov. 10
OPD – 53.14 lakh; IPD – 5.95 lakh (1st Jan 09- 30th Nov. 10)

However:

In all the facilities visited, the proportion of BPL in IPD appears low.

Thus deliveries averaged from 3%–7% for BPL category across a range of facilities (SDH, FRU and DH), while the BPL population in the district is around 15%. (JSK – 2006).

This will need further investigation in a policy environment of MMBSK and provision of cashless service for extensive categories of patients.
## Deliveries (01 April 2010 to 30 Nov 2010) in Facilities Visited - Pali

<table>
<thead>
<tr>
<th>Facilities</th>
<th>Deliveries</th>
<th>Normal Del.</th>
<th>LSCS</th>
<th>Total LSCS (APL + BPL)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BPL</td>
<td>APL</td>
<td>Total (APL+BPL)</td>
<td>APL</td>
<td>BPL</td>
</tr>
<tr>
<td>Kotbaliyan SC</td>
<td>02</td>
<td>17</td>
<td>19</td>
<td>19 N/A N/A N/A 19</td>
<td>19</td>
</tr>
<tr>
<td>Falna SC</td>
<td>04</td>
<td>48</td>
<td>52</td>
<td>52 N/A N/A N/A 52</td>
<td>52</td>
</tr>
<tr>
<td>Khimra SC</td>
<td>04</td>
<td>23</td>
<td>27</td>
<td>27 N/A N/A N/A 27</td>
<td>27</td>
</tr>
<tr>
<td>Kosalev PHC</td>
<td>09</td>
<td>155</td>
<td>164</td>
<td>164 N/A N/A N/A 164</td>
<td>164</td>
</tr>
<tr>
<td>Nana PHC</td>
<td>16</td>
<td>183</td>
<td>199</td>
<td>199 N/A N/A N/A 199</td>
<td>199</td>
</tr>
<tr>
<td>Sumerpur CHC</td>
<td>45</td>
<td>1075</td>
<td>1120</td>
<td>1078 42 0 42 1120</td>
<td>1120</td>
</tr>
<tr>
<td>Bali CHC</td>
<td>72</td>
<td>889</td>
<td>961</td>
<td>894 56 11 67 961</td>
<td>961</td>
</tr>
<tr>
<td>District Hospital</td>
<td>127</td>
<td>3066</td>
<td>3193</td>
<td>2861 323 09 332 3193</td>
<td>3193</td>
</tr>
</tbody>
</table>

Note: CT Scan at District Hospital – Total number – 723, BPL – 135 (18.62%)
Human Resources

Short-term measures: HR addition by almost 4000 managerial, and 17,000 clinical staff.

Special Initiatives by GOR to address the issue of HR
- Direct appointment of 1278 MOs on an ad-hoc basis, urgent, contract and temporary basis
- Requested the PSC for expediting the appointment process on the basis of written exam alone (749 candidates)
- MO with relevant qualifications posted at CHC/FRU level at appointment

Training: In-service training for EmOC and anesthesia appears insufficient.
- 12 weeks training of general MOs in EMOC - 62
- Most doctors reluctant to perform LSCS in FRUs, CHCs; but have capacity to manage other obstetric emergencies.
- Insufficient back up support for managing complications

Major challenge in filling specialist and SMO cadre:
Insufficient remuneration for specialists. Need to add performance-based incentives to fill specialist positions.
Inter-sectoral Convergence – Nutrition

Community Level:
Fairly good convergence of Health and WCD at the grassroots level (AWW/ANM/ASHA).

Good tracking of Malnutrition with good record keeping.
Interventions to tackle malnutrition are insufficient.
However, no active management of malnutrition at the community level.

Facility Level
Excellent facilities observed in MTCs.
However, Malnutrition Treatment Centres largely empty.
Fixing Health care in the Frontline

*Demand Generation:*

**Swasthya Chetna Yatras September 2010 – October 2010**

9160 health camps were organized all over the state. In these health camps 30,55,954 patients are treated and more than 42 thousand referred to mega health camps.

**ASHAs**

Are active, and in the field. Sahyogini (48,892 plus) for community mobilization and outreach. (89% of the target)

*Taking healthcare to the Doorsteps:*

**Rajiv Gandhi Rural Mobile Medical Units**

32 MMUs fully functional; camps organised 9564; lab tests 17844 Free consultation, medicines, lab tests referrals, Services to 8.72 lacs

Referrals for advanced care – 15,365