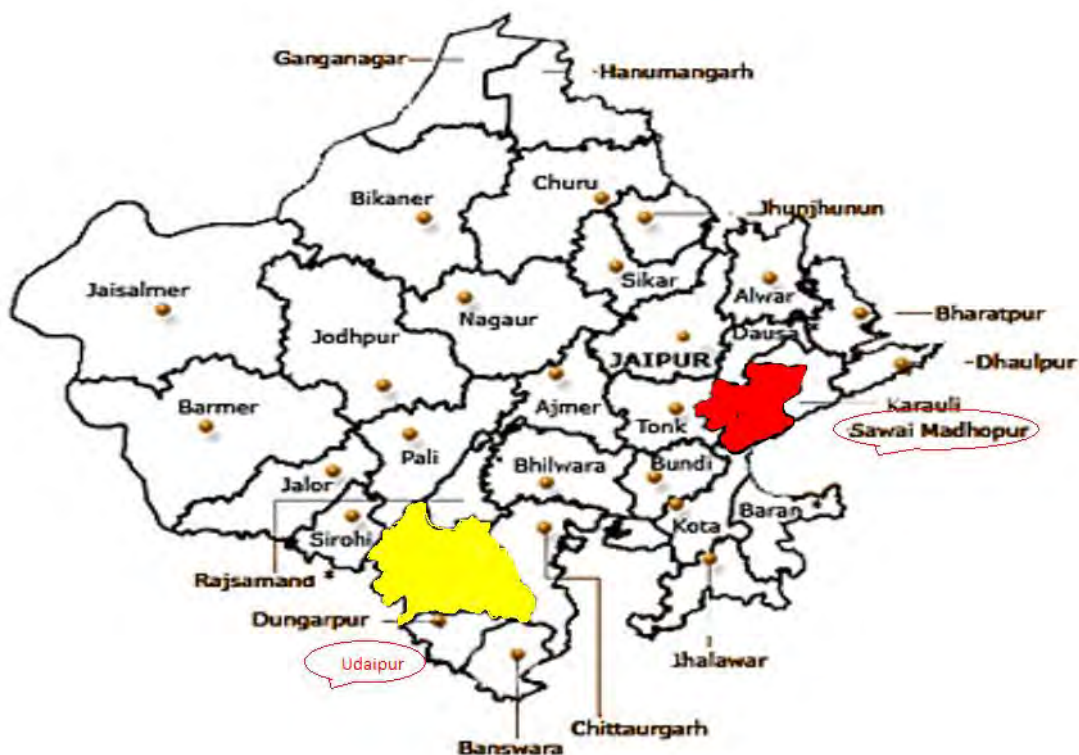




NATIONAL RURAL HEALTH MISSION

6th Common Review Mission (2nd to 9th November 2012)

Rajasthan State Report



Ministry of Health and Family Welfare,
Government of India

November 2012

Contents

Part- I - Introduction

- a. The State profile.
- b. Major achievements under NRHM
- c. Progress across CRMs
- d. State Innovations

Part- II

A. CRM Objectives and TORs

1. 6th CRM Objectives
2. 6th CRM TORs

B. Composition of 6th CRM Team to Rajasthan

- a. Composition of 6th CRM Team
- b. Composition of Team to District Sawai Madhopur
- c. Composition of Team to District Udaipur
- d. The facilities visited in District Sawai Madhopur and District Udaipur

Part- III - Observations of the 6th CRM Team

1. Facility based curative services-accessibility, affordability & quality.
2. Outreach & Patient transport services-Sub-centers, Mobile Medical Unit/EMRI,ALS/BLS etc
3. Human Resource for Health-Adequacy in Numbers, Skills and Performance
4. Reproductive and Child Health Programme.
5. Disease Control Programs-Communicable and Non Communicable
6. Community Processes including ASHA,PRI,VHSNC, Community Based Monitoring and NGO involvement
7. Promotive Health Care, Action on Social Determinants and Equity concerns.
8. Program Management including monitoring, logistics and issues of integration and institutional capacity.
9. Knowledge Management including technical assistance, SIHFWs, SHSRC, ANMTCs, DTCs and use of Information Technology.
10. Financial Management-especially fund flows, accounting and absorption

Part- IV

- a. Strength's and Weakness
- b. State Specific issues
- c. Recommendations

Part- V

Annexures

Part- I

State profile:

Rajasthan is largest State in India and is located in the northwest part of India. It has borders with Punjab in the north, Haryana and Uttar Pradesh in the northeast, Madhya Pradesh in the east and Gujarat in the south. On the western side, it shares a long stretch of international border with the neighbouring country Pakistan.

Temperatures range around 40°C in summer and between 22°C and 8°C during winter. The climate is generally dry (except Aravali region) with scanty rainfall during July and September.

The state has a population of 68.6 million and an area of 342,239 sq. km. It has 33 districts, 249 blocks and 44672 villages. The population density is 201 per sq. km. (as against the national average of 382 per sq. km).

The decadal growth rate is 19.6 % against 14.7 % for the country. The State population continues to grow at a much faster rate than the national decadal growth rate. (Census 2011)

Table 1 Facts & figures¹:

Date of formation	1st Nov 1956
State Capital	Jaipur
Area	3,42,239 square kms
Area under desert (total)	Sq. Kms
Literacy rate	67.06 %
Male	80.51 %
Female	52.66 %
Per Capita Income (03-04)	Rs. 39, 967 per annum
No. of Districts	33
Urbanization Ratio	29.26 %
Population (2001)	68, 621, 012
- Male	35,620,012
- Female	33,000,926
- Rural	51,540,236 (75.11%)
- Urban	17,080,776 (24.89%)
Scheduled Caste	0.97crores (14.1%)
- Male	0. 50 crores (8.96 %)
- Female	0.46 crores (8.2 0%)
Scheduled Tribe	0.71 crores (12.56%)
- Male	0.36crores (6.46%)

- Female	0.34crores (6.1%)
Sex Ratio	926
Decadal Growth Rate	21.44%
Density of Population	165 per sq. km.
District Population	
Highest (Jaipur)	0.66 crores
Lowest (Jaisalmer)	0.06 crores
Total Literacy Rate	67.06%
Male	80.51%
Female	52.66%
Highest Literacy Rate (Kota)	77.48 %
Lowest Literacy Rate (Jalore)	55.58 %
No. of Blocks	249
No. of Tehsils	244
No. of villages(inhabited)	44672
No. of Towns	222

Data Source Census 2011

- SC and ST population constitute 14.1 % and 12.56 % respectively. Together they constitute – 26.6 % of the state population.
- This is comparatively higher than the All India figures of 13.8 % SC and 8.43 % ST population.
- Total SC population in Sawai Madhopur is 0.22 crores (19.98 %) out of which male SC population is 0.12 crores (10.52 %) and Female SC population is 0.10 crores (9.46 %).
- Total Schedule Tribe population in Sawai Madhopur is 0.02 crores (21.58 %) out of which – male ST population is 0.01 crores (10.79 %) and female ST population is 0.01 crores (10.79 %).
- Total schedule Caste population in Udaipur is 0.01 crore (6.01 %) out of which male SC population is 0.008 crores (3.08 %) and female ST population is 0.007 crores (2.93 %).
- Total Scheduled Tribe population in Udaipur is 0.12 crores (47.86 %) and the male ST population is 0.06 (23.93 %) crores and female population is 0.06 (23.93 %)

Present Status of Reproductive Child Health (RCH) Indicators

Table 2

INDICATOR	Rajasthan			INDIA	
	State	Sawai Madhopur	Udaipur	Current status	NRHM (2012) goal
Maternal Mortality Ratio (MMR)	318 (SRS 07-09)	292 (AHS 2010)	364 (AHS 2010)	212 (SRS 07-09)	<100
Infant Mortality Rate (IMR)	63 (SRS 2011)	67 (AHS 2010)	62 (AHS 2010)	44 (SRS 2011)	<30
Total Fertility Rate (TFR)	3.1 (SRS 2010)	State Average		2.5 (SRS 2010)	2.1

Current status of Health Indicators – State vis-à-vis Districts

Table 3

SN.	Indicators (%)	Comparative Analysis of Health Indicators			
		Rajasthan	Sawai Madhopur	Udaipur	Remarks
1	Improved Sources of Drinking Water	88.6 %	83.6 %	79.6 %	The access to drinking water has improved considerably.
2	Have Access to Toilet facility	38.7 %	27.8 %	30.1 %	Access to Toilet facility is still limited. (less than 40 % for State and only 30 % or less for districts))
3	Any Modern method of contraception	58.8 %	53.8 %	61.8 %	There is high unmet need for contraception.
4	Total unmet need	19.6 %	21 %	16 %	The basket of FP services needs be increased.
5	Mothers who had at least 3 Ante-Natal care visits during the last pregnancy	47.5 %	47.8 %	40.0 %	The overall ANC's have improved in the State but remain below 50 % mark. With MCTS in place there appears

5.1	Mothers who had Full Ante-Natal care visits during the last pregnancy	8.5 %	5.1 %	10.4 %	to be no reason for low ANC coverage.
6	Institutional births	70.2 %	80.8 %	57.6 %	Overall Institutional deliveries in the State have improved. Udaipur among the two districts needs special attention.
7	JSY Beneficiaries	76.5 %	81.3 %	82.3 %	
8	Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles)	70.8 %	41.1 %	85.7 %	Over all full Immunization has improved however Sawai Madhopur district needs special attention.
9	Children breastfed within one hour of birth	48.6 %	50.0 %	44.7 %	The Breast feeding (BF) rates are low – below 50 %, with Yashodha' programme in place Breast feeding (BF) rates should have been higher.
9.1	Children breastfed exclusively during first 6 months	24.7 %	61.8 %	34.2 %	
9.2	Women who were aware of ORS	91.5 %	89.6 %	77.5 %	Good awareness on ORS in the community
9.3	Women who were aware of danger signs of ARI	91.7 %	89.5 %	88.9 %	The awareness on ARI in the community is good
10	Women who have heard of HIV/AIDS (age group of 15-49)	80.5 %	57.0 %	78.3 %	The community awareness on HIV/RTI is good.
11	Women who have heard of RTI/STI (age group of 15-49)	81.1 %	70.3 %	65.2 %	
Source: (AHS 2010 -11)					

Progress across CRMs (2nd to 6th) on RCH Indicators

The comparative progress over different CRM has been captured from the 2nd CRM to 6th CRM. The second CRM report has been used to indicate progress across CRMs, as substantive quantitative analysis was done during the 2nd CRM.

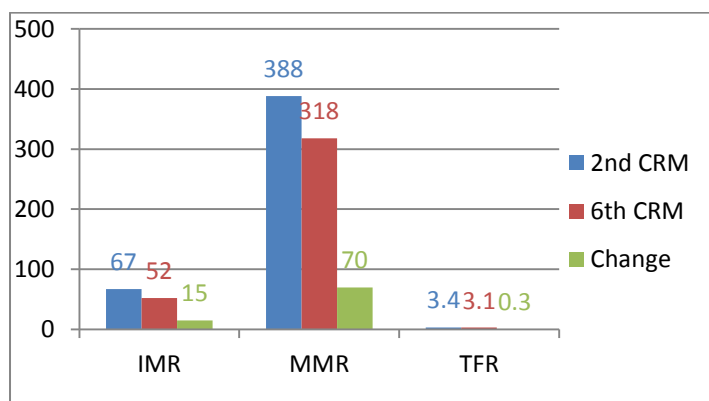


Figure 1 Trends in Indicators

Indicators	2nd CRM	6th CRM	Change
IMR	67	52	15
MMR	388	318	70
TFR	3.4	3.1	0.3

TFR 2.4 2.4 0

- A major achievement for the state under NRHM is in terms nearly 70 points drop in maternal mortality. MMR 388 SRS (2004-2006) and MMR 318 SRS (2007-2009).
- A similar achievement is seen in the IMR, which shows a drop of 15 points from 67 (SRS 2005) to 52 (SRS 2011) A drop of approx. 2 points every year. This is quite significant for a State like Rajasthan.
- TFR has decreased by a meagre 0.3 over the CRMs from 3.4 in 2005 to 3.1 in 2010. The State needs to work on its family planning programme.

Progress across CRMs (1st CRM to 6th CRM)

An attempt has been made to capture the progress shown by the State across CRMs. Effort has been made to capture the progress on Infrastructure, Human Resource, Service Delivery, Programme management and Finance management. This is place below in tabular format.

Table 4 Progress across CRMs

Progress across CRMs						
Infrastructure	2 nd CRM	3 rd CRM	4 th CRM	5 th CRM	6 th CRM	Remarks
No. of Medical College and Hospitals (Government)	-	-	-	23	23	Keeping in mind the shortage of doctors/specialists, there appears to be need for some more medical colleges. Alternatively there is a need for increasing the number of UG/PG seats
No. of District Hospitals (Capital Hospital, BBSR & R.G.H RKL)	28	33	33	34	34	
No. of Sub-Divisional Hospitals	12	12	12	16	16	
No. of Community Health Centres	-	-	-	-	376	
No. of Primary Health Centres	1503	1503	1517	1528	1612	Overall increase
No. of Sub-Centres	10742	11487	11487	11487	11487	Overall increase
No. of Rural Family	-	-	-	-	-	

Welfare Centres						
No. of Urban Family Welfare Centres	-	-	-	-	-	
No. of Postpartum Centres	-	-	-	-	-	
No. of Other Hospitals	53	53	53	55	56	
No. of Satellite hospitals	6	6	6	6	6	Not much increase in Satellite hospitals across CRMs
No. of Health Posts	13	13	13	13	13	
No. of Rural Health Centres	-	-	-	-	-	
No. of A.N.M. Training Schools	16	16	16	16	17	
No. GNM Training Schools	15	15	15	15	15	
No. of M.P.H.W.(Male) Training School	-	-	-	-	-	
No. of Ayurvedic Hospitals	106	106	118	118	118	AYUSH health institutions have seen a marginal increase in numbers.
No. of Ayurvedic Dispensaries	3559	3559	3577	3577	3577	
No. of Homoeopathic Hospitals	2	4	6	6	6	
No. of Homoeopathic Dispensaries	175	178	183	183	183	
No. of Unani Dispensaries	102	110	118	118	119	
Human Resource	2nd CRM	3rd CRM	4th CRM	5th CRM	6th CRM	Remarks
Specialist (Total)	1089	1154	1251	1602	1602	Marginal increase

Specialist (Total) Contractual in place		37	85	44	29	in numbers across CRMs is seen, however this is not commensurate to the facility requirement's
a. Surgeon	488	535	570	584	635	
b. O&G	271	273	286	398	402	
c. Anesthetics	82	94	124	226	231	
d. Pediatrician	192	195	208	326	332	
e. Radiologist	56	57	63	68	72	
Medical Officer	3739	3947	4447	4461	4933	Marginal increase in numbers across CRMs is seen
Ayush Doctors	1092	1034	1028	1014	917	Decrease is seen
Staff Nurse Nurse Grade I	1979	1988	1988	1828	1782	Decrease in numbers seen across CRMs is seen
Nurse Grade II	10565	11016	13004	11118	11112	Marginal increase in numbers across CRMs is seen
Pharmacist	15	15	15	15	1336	Substantial increase in numbers across CRMs
a. LT regular	2079	2179	2159	2264	2303	Marginal increase in numbers across CRMs is seen
. LT Contractual	143	142	142	140	158	Marginal increase in numbers across CRMs is seen
LHV regular	1300	1300	1300	1429	1438	Marginal increase in numbers across CRMs is seen
b. ANM regular	12122	12496	12992	13962	14222	Substantial increase in numbers across

						CRMs
ANM Contractual	1321	4174	5648	5798	3163	Substantial increase in numbers across CRMs
GNM Contractual	-	7797	7203	7069	7249	
c. MPW	-	-	-	-	-	
Training	2nd CRM	3rd CRM	4th CRM	5th CRM	6th CRM	Remarks
Maternal Health (Total)						Training has generally been poor across programmes except for IMNCI.
a. LSAS	-	116	22	-	22	
b. Bemoc	120	-	-	119	61	
c. CEmoc	-	-	-	-	-	
d. Emoc	-	-	51	-	5	
Child Health (Total)						
a. NSSK	-	-	-	1181	179	
b. FMNCI	--	-	-	148	6	
c. IMNCI	5451	13420	7157	4630	137	
Family Planning						
NSV	--	-	-	35	-	
Min Lap	-	-	-	65	6	
Health care Service Delivery	2nd CRM	3rd CRM	4th CRM	5th CRM	6th CRM	Remarks
Total No. of OPD Services	-	24650705	37762710	46673619	37761207 Up to Oct 12	The public health facilities utilisations have increase across. There are more footfalls to be seen
Total No. IPD Services	-	1209720	2117068	2251118	1903994	
Number of Lab Tests	18980	3349808	5967200	6876778	5387699	

conducted						across facilities.
Referral Transport(Total)	46936	279139	240609	902476	597505	
a. Total Delivery Cases	4593	63339	54920	204112	79536	
b. Emergency cases	42343	215800	235119	698364	517969	
ILR Points	-	-	-	-	2010	
Schools Health service (total no of child screened)	35.5 lakhs	53.92 Lakhs	34.96 Lakhs	48.65 Lakhs	-	School health appears to be good in parts.
Male/Female Sterilization	-	-	-	-	-	
Programme Management	2nd CRM	3rd CRM	4th CRM	5th CRM	6th CRM	Remarks
Total Staff Strength in SPMU	10	16	36	29	20	Programme management has been strengthened. Substantial increase in numbers across CRMs. Especially for BPMUs.
Total No. of functioning DPMUs	34	34	34	34	34	
Total no. of staff in functional DPMUs	129	229	264	268	268	
Total No. of functioning BPMUs	237	237	237	237	249	
Total no. of staff in functional BPMUs	1539	3276	3664	3280	3280	
Community Mechanism/Out Reach Service	2nd CRM	3rd CRM	4th CRM	5th CRM	6th CRM	Remarks
ASHA Selected	42496	43201	47126	50587	51500	More than 87 % of ASHAs selected are working
ASHA working	42496	42496	42496	43400	45178	
VHSNC	40479	40479	43437	43440	43440	
VHND achieved	566729	672564	666802	655580	672609	
MMU	25	32	32	202	202	MMUs / Outreach

Outreach Camps	2294	4630	4214	4601	6093	camps have increased in the NRHM period
Finance(Rs.)	2nd CRM	3rd CRM	4th CRM	5th CRM	6th CRM	Remarks
Proposed Budget	769.41	556.21	980.27	1235.02	2433.56	The State has shown steady improvement in fund utilisation across NRHM period. However the unspent balance has remained an issue.
Administrative Approval (Including funds routed through treasury & kind grant)	980.8	525.49	1196.37	1029.21	1535.31	
Released (Including State share) (Excluding funds routed through treasury)	798.15	748.96	863.97	1045.35	551.68	
Utilization (Excluding funds routed through treasury)	909.16	1001.74	1172.06	1040.35	173.54	
Unspent (Excluding funds routed through treasury)	211.37	-41.4	-346.69	-164.69	-28.42	

Progress across CRMs (2nd to 6th) - Key Observations

Infrastructure Development

- The State has increased its Infrastructure Development across CRMs by increasing its District Hospitals (from 28 to 34), Sub District Hospitals (from 12 to 16), Community Health Centres, Primary Health Care Centres (from 1503 to 1612) and Sub Health Centres (from 10742 to 11487). This is quite significant for a State like Rajasthan.
- The State has established an engineering wing under NRHM to support the Infra Structure Development which has increased the progress of constructions in the State. Out of 5393 works sanctioned, 4226 have been completed and handed over
- There has however been not much progress across CRMs in Other Hospitals (from 53 to 56), Satellite Hospitals (from 6 to 6) and Health Posts (from 13 to 13), which have remained more or less the same.
- In the case of ANM and GNM training schools, the State has not added any more schools since 2nd CRM except one ANM training School (from 16 to 17).

- Medical Equipment's were found in sufficient numbers and were being utilized but equipment maintenance was poor.

Human Resource

- There has been an increase in the recruitment of doctors and specialists during the NRHM period .The number of Specialists have increased from 1089 to 1602 (Surgeons from 488 to 635; O & G from 271 to 402; Anesthetist's from 82 to 231; Pediatricians from 192 to 332), however the number of specialists on contractual has decreased from 37 to 29.
- The number of Medical Officers have increased across CRMs, from 3739 to 4933; ANM (regular) from 12122 to 14222 and ANM (contractual) from 1321 to 3163, however the number of AYUSH Doctors have decreased from 1092 to 917.
- The number of pharmacists have increased from 15 to 1336, Lab Technicians from 2079 to 2303, Nurse Grade II from 10565 to 11112, however Nurse Grade I decreased from 1979 to 1782.

Health Care Service Delivery

- The number of OPD and IPD across CRMs have increased from 24650705 to 37761207 (upto Oct 2012) and from 1209720 to 1903994 respectively, indicating greater utilization of health facilities across CRMs.
- Referral Transport and the number of emergency cases have increased from 4593 to 597505 and from 42343 to 79536 respectively indicating the improvement in reach and accessibility to services in case of need.
- The State has 1665 delivery points (L1 583, L2 220 and L3 31) and 36 SNCU, 160 NBSU & 1003 NBCC to address Maternal Health and Child health.

Training

- Training has been generally weak across CRMs. Training status is very poor in the State. The aggregate figures for training in Phase 1 of NRHM for SBA are 7 %; BEmOC 25 % and LSAS is 31 %.
- The only good progress is the implementation of IMNCI training in all the 33 districts.

Community Processes

- The number of ASHAs have increased from 42496 to 51500
- Training of ASHA for module 5 is 67.61 % complete. ASHAs are escorting pregnant women to facility for Institutional deliveries.
- Training of module 6 & 7 has been completed only for 46 % of ASHAs

Programme Management

- The total strength of staff for SPMU across CRMs has increased from 10 to 20 and the number of DPMU has increased from 129 to 268 and that for BPMU from 1539 to 3280.
- However there are vacancies at district and block level management positions.

Financial Progress against the approved PIP

- Out of approved annual SPIP of **Rs.1541.04 crores**, expenditure of **Rs. 437.04 crores (28.4 %)** has been reported during the year 2011-12 under NRHM.
- Since the launch of the RCH – II Programme, an amount of Rs. 144769 lakh has been released, the State has incurred 115.93% expenditure i.e. Rs.167838 lakh. The overall fund utilization against the available fund is good. The State may clarify the sources of additional funds.
- The State has reported expenditure of the approved annual PIP under the heads Training (6.92 %), Infrastructure & Human Resources (34.1%) and Family Planning Services (Other than Compensation and Camps) (11.53 %), Compensation for Female/Male Sterilisation/NSV and Female Sterilisation Camps (26.1%) and Programme Management (37.48%).
- Out of approved annual SPIP of Rs. 642.79 crores, reported expenditure is Rs. 74.57crores during the year 2012-13 under Mission Flexi pool i.e. (11.6 %) expenditure against approved PIP.
- Since the launch of the NRHM, out of the total release of Rs. 166219 lakh for the Mission Flexible Pool, the state has incurred 101.97% expenditure i.e. Rs.169488 lakh.
- The State had a negative unspent balance of Rs.19976 lakh as on 1st April, 2012 as per GoI and Rs. 13632 lakh has been released up to the 2nd quarter 2012-13. Hence State has negative available funds of Rs.6344.00 lakh and reported an expenditure of Rs. 16724.63 lakh. The source and the reason for the excess funds utilized may be clarified.
- The State has reported Nil utilisation of approved PIP under PPP/NGO. The reasons for the same may please be clarified. The State needs to take necessary steps to improve the pace of utilization under these activities with effective planning and monitoring.
- The State has reported low expenditure under the Core Activities under Maternal Health (3.45%), Child Health (4.73%), Family Planning Services (other than Sterilization) (11.19%), JSY (38.32%), JSSK (14.11%) and Sterilization & IUD Compensation and NSV Camps (25.24%) of the approved PIP which reflects slow implementation of the approved activities.
- The State has reported expenditure of less than 10% under Adolescent Reproductive and Sexual Health/Arsh (7.50%), Urban RCH (0.56%), Training (6.92%) and Vulnerable Groups (0.29%) of the approved PIP. The State may explain the reasons for low utilization.
- The State has reported expenditure of less than 40% under PNDT Activities (31.50%), Infrastructure & Human Resources (34.15%) and Programme Management (37.48%) of the approved PIP. The State may explain the reasons for low utilization.
- The State has reported low expenditure in Non-Negotiable Activity i.e. ASHA (25.84%), Untied Funds (8.95%), Annual Maintenance (6.04%) and Corpus Grant to HMS/RKS (8.26%) of the approved PIP which reflects slow implementation of the approved activities.
- The State has reported less than 10% expenditure under New Constructions/ Renovation and Setting up (5.51%), Panchayati Raj Initiative (0.08%), IEC-BCC NRHM (7.04%), Mobile Medical Units (9.38%), Planning, Implementation and Monitoring (0.17%), Procurements (2.49%), State level

health resources centre (SHSRC) (3.23%) and Support services (0.18%) of the approved PIP. State may clarify the reasons for low utilization.

- The State has reported high expenditure under New Initiatives/ Strategic Interventions (As per State health policy) (24.90%) of the approved PIP. State may clarify the reasons for this high expenditure.
- The State has reported expenditure of less than 40% under PNDT Activities (31.50%), Infrastructure & Human Resources (34.15%) and Programme Management (37.48%) of the approved PIP. The State may explain the reasons for low utilization.

A summary of the activities with low and nil utilization during the year 2012-13 under RCH Flexible Pool and Mission Flexi Pool is given below:

RCH Flexible Pool:

Table 5

(Rs. in lakhs)

FMR Code	Activities	SPIP	Utilisation	% Utilization
A.1	Maternal Health Activities	47.57	1.64	3.45%
A.2	Child Health	2845.94	134.51	4.73%
A.3	Family Planning	733.80	82.13	11.19%
A.4	ARSH	72.89	5.47	10.00%
A.5	Urban RCH	404.08	2.26	0.56%
A.9	Training	1732.95	119.95	6.92%
A.11	Vulnerable Group	1500.00	4.36	0.29%

Mission Flexible Pool:

Table 6

(Rs. In lakhs)

FMR Code	Activities	SPIP	Utilisation	% Utilization
B.5	New Construction	27996.6	1541.24	5.51%
B.1	ASHA	3018.14	589.67	25.84%
B.2	Untied Funds	6590.13	589.67	8.95%
B.3	AMG	3999.49	241.38	6.04%
B.6	Corpus Grant	2492.37	205.91	8.26%

FMR Code	Activities	SPIP	Utilisation	% Utilization
B.8	PRI	62.25	0.05	0.08%
B.10	IEC/BCC	794.61	55.94	7.04%
B.13	PPP/NGO	160.25	0.00	0%
B.16	Procurement	7380.02	183.58	2.49%
B.15	Planning Implementation and Monitoring	1566.26	2.63	0.17%
B.21	SHSRC	89.23	2.88	3.23%

State Innovations

The State has introduced a number of innovative schemes to address maternal and child health issues in the State across CRMs. Some of the innovations are as follows:-

Yashoda Scheme

Janani Suraksha Yojana led to a huge increase in institutional deliveries from 6.5 lakhs to, 12 lakhs in less than 2 years. This increased load without a corresponding increase in staff presented a major challenge of providing quality service to mothers and newborns. In this context, Yashoda, a volunteer support worker was introduced in the three District Hospitals of Alwar, Bharatpur and Dausa from July, 2008 with support of Norway India Partnership Initiative (NIPI). The 'Yashoda' is paid a performance linked incentive; acts as a catalyst and supports the nursing staff.

Key strategies:

- Yashoda fills a critical gap for counseling the mother on newborn care and coordinates services within the maternity ward.
- One Yashoda takes care of 4-5 newborns. Typically a Yashoda works on 8 hours shifts and is paid Rs 100 per delivery for taking care of each mother and newborn.
- The RKS has the overall managerial responsibility for all decisions related to the intervention.
- At the district facilities appointment of the Child Health Supervisor/ Deputy Child Health Supervisor must precede the engagement of Yashoda.
- Districts build their in-house capacity by developing the ANMTCs to meet the continuous learning needs and on the jobs skills building requirements of Yashodas.
- Formal assessment mechanism must be established for monitoring Yashoda performance on an ongoing basis along with feedback mechanism.

Based on the preliminary observation, learning and feedback from the Hospitals the intervention was expanded to 27 District Hospitals and 42 Community Health Centres covering 33 districts. Currently, a total of 555 Yashodas are working across the state and they have counselled around 4 lakh mothers till 31 December, 2010¹

Dhanwantri Comprehensive Emergency Response Services

To provide comprehensive emergency response (health, police, fire) services to the people of Rajasthan the Dhanwantri Scheme was launched in 2008 on the lines of the EMRI 108 in Andhra Pradesh. The Government of Rajasthan entered into a MoU with EMRI, Hyderabad on May, 23rd 2008; the contract was eventually awarded to Ziqitza Health Care Ltd. on 1st July, 2010.

Key strategies:

- Comprehensive emergency response services round the clock free of cost within 30 minutes of call being received in the call center.
- Pre –hospital acute care and transport to patient with illness and injuries in medical emergencies.
- An uninterrupted fully functional call center and overall Emergency Response Services.
- Networks with hospitals, police stations and fire brigades to address all emergencies.
- EMT to provide victim pre-hospital care during transportation.
- Toll free number 108 for emergency services which can be reached from any landline or mobile set.
- Regular monitoring and evaluation of the project activities based on quantifiable indicators and reports received.
- Coordination with other government agencies for making available the required

Evidence of success:

- Starting from 101 ambulances the services has been scaled up to 267 ambulances in 33 districts of Rajasthan.²



Figure 2 108 Ambulance

¹ Rajasthan SPIP2011-12

² <http://rajswasthya.nic.in/108%20information%202013.05.11/Hindinote%20on%20108%20Amb.%20revised.pdf>

Mobile Medical Unit (MMU)

In 2008 DoHFW, Government of Rajasthan launched the Mobile Medical Unit scheme to cater to the health needs of the community in remote and underserved areas of the state.

52 Mobile Medical Units are in place. Each unit consists of 2 vehicles: one for the movement of doctors and paramedical staff and the second vehicle is fully equipped with diagnostic facilities like X-Ray, ECG, Ultra Sound etc.

Key strategies:

- Route planning for the placement of mobile health units are done after the mapping and demarcation of the outreach areas.
- MMU placed strategically at a fixed place like AWC, panchayat bhawan or health center.
- The MMU vans are operated on a predetermined route plan on regular basis every month. The tour /camp plan details are submitted at least 15 days in advance.
- GPS tracking of the vehicle.
- Provision of free medicine and diagnostic tests.
- Services provided by both MBBS doctor and AYUSH doctor.
- Monthly review meeting are held at district level to ensure proper utilization and review of the services provided by MMU.

Evidence of success:

- Medical Mobile units are operational in 32 ambulances in 22 districts and the process of scaling it up to all Panchayat samities of Rajasthan has been initiated.³

Malnutrition Treatment Centres

In December 2000, the Rajasthan Department of Women and Child Development, and UNICEF jointly initiated Anchal Se Angan Tak (ASAT) strategy as a community based care model in seven districts. Under ASAT, Special Plan of Action for Management of Severe Child Malnutrition was initiated in 2005 in 14 blocks of seven districts using WHO standards based on a two pronged strategy viz. Hospital Based and Community based care of malnutrition. The Department of Medical and Health Services, Department of Women and Child Development, Government of Rajasthan, and UNICEF took the lead in addressing acute undernourishment in children, by operationalizing Malnutrition Treatment Centres (MTCs) as a pilot initiative in 2005.

Malnutrition treatment centre (MTC) is a unit for the management of SAM children where they are kept under observation and provided with medical and nutritional care. The MTC first check the children's height, weight and appetite and shortlist those in need of treatment. The children will then have to undergo a diet therapy, drug therapy and investigation. Thereafter, s/he will be admitted, along with the

³ Rajasthan SPIP2011-12

mother, at the MTC. The treatment process will take 15-20 days to complete depending on the severity of malnutrition. Not only the MTCs, ASHA and Aaganwadi workers in the district are equipped with a special measuring tape to measure the arms of a child to judge whether s/he needs help.

Key strategies:

- Orientation of state level functionaries from Health and ICDS department.
- Identification of SAM children by AWW and ASHA. Children with severe malnutrition are directly referred to the MTCs by ASHA and Aaganwadi workers.
- Counseling and motivating parent of SAM children to stay in MTC.
- Provision of residential medical treatment of malnourished children in MTC for 22 days.
- Counseling and health education of mother by doctor.
- Referral of SAM children to higher hospital if required.
- Follow up of treated children by ASHA.

Evidence of success:

- The pilot initiative has been scaled up to 32 districts of Rajasthan.⁴

⁴ Rajasthan SPIP2011-12

Part- II

A. Common Review Mission

National Rural Health Mission (NRHM) uses an intensive accountability framework through a three pronged process of (i) community based monitoring, (ii) external surveys and (iii) stringent internal monitoring on a regular basis.

Common Review Mission (CRM) is part of this intensive accountability framework. CRMs have regularly taken place to review and assess the progress of the NRHM programme. Till date 5 CRMs have taken place. This is the 6th CRM

Objective of 6th CRM

1. Review progress of National Rural Health Mission with reference to the functioning of NRHM vis-à-vis its goals and objectives-Identify the changes that have occurred in last seven years and reasons for the current states and trend.
2. Review programme implementation in terms of accessibility, equity, affordability and quality of health care services delivered by public health systems including public private partnership (PPP).
3. Review of progress against conditionality and the State's response to conditionalities.
4. Review follow up action on recommendations of last Common Review Mission.
5. Note additional outcomes other than those envisaged under approved plans.
6. Identify constraints faced and issues related to each of the components outlined and possible solutions.
7. Document best practices, success stories and institutional innovations in the states.
8. To identify strategies and outcomes in the State in addition to the ones envisaged by the Mission, both positive and negative.
9. Make recommendations to improve programme implementation and design.

TERMS OF REFERENCE (TOR)

Progress of NRHM will be reviewed on the following ten essential components of the NRHM.

- I. Facility based curative services-accessibility, affordability & quality.
- II. Outreach & Patient transport services-Sub-centers, Mobile Medical Unit/EMRI, ALS/BLS etc
- III. Human Resource for Health-Adequacy in Numbers, Skills and Performance
- IV. Reproductive and Child Health Programme.
- V. Disease Control Programs-Communicable and Non Communicable
- VI. Community Processes including ASHA, PRI, VHSNC, Community Based Monitoring and NGO involvement

VII. Promotive Health Care, Action on Social Determinants and Equity concerns.

VIII. Program Management including monitoring, logistics and issues of integration and institutional capacity.

IX. Knowledge Management including technical assistance, SIHFWs, SHSRC, ANMTCs, DTCs and use of Information Technology.

X. Financial Management-especially fund flows, accounting and absorption

Composition of the 6th CRM Team to Rajasthan

Table 7

SN	Name of Team Members	Designation	Organisation & Location
1.	Dr. Baya Kishore,	Deputy Commissioner	Ministry of Health & Family Welfare, Gol, New Delhi
2	Sh. Ravindar Pattar	Director	Ministry of Health & Family Welfare, Gol, New Delhi
3	Sh K N Verma	Dy Dir NRHM)	Ministry of Health & Family Welfare, Gol, New Delhi
4	Sh Vipin Garg	National Consultant JSY	Ministry of Health & Family Welfare, Gol, New Delhi
5	Sh.Prashanth Subramanium	Sr Consultant NHSRC	Ministry of Health & Family Welfare Gol, New Delhi.
6	Ms Renuka Patnaik	National Consultant FP	Ministry of Health & Family Welfare, Gol, New Delhi
7	Sh Kaushalendra	Sr National Consultant FMG NRHM	Ministry of Health & Family Welfare, Gol, New Delhi
8	Dr. Faisal Shaikh	National Consultant , Policy and Planning	Ministry of Health & Family Welfare, Gol, New Delhi
9	Dr Gyan Singh	Sr Medical Officer NIHFW	NIHFW, Ministry of Health & Family Welfare, Gol, New Delhi
10	Dr B R Thapar	National Consultant NVBDCP	Ministry of Health & Family Welfare, Gol, New Delhi
11	Sh Satyavrat Vyas	Programme Officer	PHFI, New Delhi
12	Dr Narottam Pradhan	Immunisation Officer	UNOPS NIPI
13	Dr. Narendra Gupta	Director	Prayas, Rajasthan

Team - I District Sawai Madhopur

Table 7.1

Dr. Baya Kishore	Deputy Commissioner	Ministry of Health & Family Welfare, Gol, New Delhi
Sh K N Verma	Dy Dir NRHM)	Ministry of Health & Family Welfare, Gol, New Delhi
Ms Renuka Patnaik	National Consultant FP	Ministry of Health & Family Welfare, Gol, New Delhi
Sh Kaushalendra	Sr National Consultant FMG	Ministry of Health & Family Welfare, Gol, New Delhi
Dr. Faisal Shaikh	National Consultant NRHM	Ministry of Health & Family Welfare, Gol, New Delhi
Dr Narottam Pradhan	Immunisation Officer	UNOPS NIPI



Figure 3 District Review Team Sawai Madhopur

Team - II District Udaipur

Table 7.2

Sh. Ravindar Pattar	Director	Ministry of Health & Family Welfare, Gol, New Delhi
Sh Vipin Garg	National Consultant JSY	Ministry of Health & Family Welfare, Gol, New Delhi
Sh.Prashanth Subramaniam	Sr Consultant	NHSRC Ministry of Health & Family Welfare, Gol, New Delhi
Dr Gyan Singh	Sr Medical Officer	NIHFW Ministry of Health & Family Welfare, Gol, New Delhi
Dr B R Thapar	National Consultant NVBDCP	Ministry of Health & Family Welfare, Gol, New Delhi
Sh Satyavrat Vyas	Programme Officer	PHFI, New Delhi
Dr. Narendra Gupta	Director	Prayas, Rajasthan



Figure 4 District Review Team, Udaipur

State Officials who accompanied the CRM Team

Table 7.3

Dr R P Jain	Project Director Immunization	Department of Health & Family Welfare, GoR, Jaipur
Dr Nupur Jain	Project Director Maternal Health	Department of Health & Family Welfare, GoR, Jaipur
Dr Giriraj	Programme Officer JSY	Department of Health & Family Welfare, GoR, Jaipur
Dr. Jhalaj	Programme Officer Child Health	Department of Health & Family Welfare, GoR, Jaipur
Dr Dwivedi	Programme Officer,FP	Department of Health & Family Welfare, GoR, Jaipur
Ms Vaidehi	Consultant Community process	Department of Health & Family Welfare, GoR, Jaipur

State/District officials met during the 6th CRM TEAM

- ❖ Sh Deepak Upreti, Principal Secretary, Health & Family Welfare, Govt. of Rajasthan
- ❖ Smt Gayatri Rathore, Special Secretary & State Mission Director, Rajasthan
- ❖ Sh.Giriraj Singh Kushwaha, District Collector Sawai Madhopur, Rajasthan
- ❖ Dr Hari Singh Meena, Chief Medical and Health Officer, Sawai Madhopur, Rajasthan
- ❖ Dr R N Bairwa, Chief Medical and Health Officer, Udaipur, Rajasthan
- ❖ Other State Government Officials & District Health Officials and District /Doctors/Nurses/ANMS/Male Nurse/Project Management Teams/ RKS members, PRI Members, Village Health Functionaries, ASHAs, AWWs Beneficiaries etc.

Health Facilities visited by CRM Team in Rajasthan:

Table 8

Type of Facility	Availability status of Health Facilities in Sawai Madhopur	No. of Health Facilities visited by CRM team at Sawai Madhopur	Availability status of Health Facilities in Udaipur	No. of Health Facilities visited by CRM team at Udaipur
District Head Quarter Hospital	1	1	1	1
No. of Blocks	5	4	12	6
Sub Divisional Hospital/Satellite Hospital	1	1	1 Satellite Hospital	1
No. of CHC	4	1	21	3
PHC	22	2	69	4
Sub-centre	228	5	558	3
District Drug Ware House	1	1	1	1
Others (MMU, Maternity Waiting Hall & GKS, AWC, VHND,VHSNC, ASHA, Beneficiary		4		2
Total	262	19	663	21

Details of Facilities visited

Table 9

District visited – Sawai Madhopur				
Sno	Name	District HQ	Name of DM	Name of CMHO
1	Sawai madhopur	Sawai madhopur	Sh.Sh Giriraj Singh Kushwaha	Dr. H S Meena
Health Facilities visited				
Sno	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
1	District Hospital – Sawai Madhopur	Sawai Madhopur	DH	Dr. N B Jain PMO
2	SDH-Ganagapur	Ganagapur city	CHC	Dr B R Meena MO I/C
3	CHC-Khandar	Khandar block	CHC	Dr. Chet Ram MO I/C
4	PHC Bharwanda	Khurd, Khandar	PHC	Dr. Dinesh Kr, MO I/C
5	PHC Bhadoti	Bonli	PHC	Dr. S S Ali, MO I/C
6	Sub Centre Khedli,	Ganagapur	SC	Ms Rameshwari Devi, ANM
7	Sub Centre Kilchipur	Sawai Madhopur	SC	Ms Kaniz khan, ANM
8	Sub Centre Kusthala	Sawai Madhopur	SC	Ms. P R Radha ANM
9	Sub Centre Peepalda,	Bonli	SC	Ms. Lucy Verghese, ANM
10	Sub Centre Kijuri	Khandar	SC	Ms. Meena kamlesh, ANM
11	ANMTC	Sawai Madhopur	ANMTC	Principal Mithalal Maharwal
12	Kilkari Pvt Hospital	Sawai Madhopur	Accredited (FP)	Dr Sudhir Agarwal
13	Anganwadi Centre Rasulpur	MCHN Day	AWC	ANM Mithilesh Gupta

Table 10

District visited – Udaipur				
Sno	Name	District HQ	Name of DM	Name of CMHO
1	Udaipur	Udaipur	Sh. Vikas .S .Bhale	Dr. R N Bairwa
Health Facilities visited				
Sno	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
1	Satellite Hospital- Hiran magri	Udaipur	Satellite Hospital	Dr. Mahesh Bhatnagar
2	SDH- Salumbar	Salumbar	CHC	Dr.Jailal Badgurjar
3	CHC-Mavli	Mavli	CHC	Dr. Rajkumar Yadav, MOI/C
4	CHC-Bhinder	Bhinder	CHC	Dr. Ganpat Jain, MOI/C
5	CHC- Kotda	Kotda	CHC	Dr.ShankarChavan, MOI/C
6	PHC- Charand	Sarada	PHC	Dr. Chandan Jain MOI/C
7	PHC -Tidi	Girwa	PHC	Dr.Harish Gurjar, MOI/C
8	PHC-Barapal	Girwa	PHC	Dr. Tarun Anand,MOI/C
9	PHC - Dabole	Mavli	PHC	Dr. D.S.Rao, MOI/C
10	SC- Gadoli	Mavli	SC	Ms. Durga Ameta, ANM
11	SC- Balua	Sarada	SC	Ms. Raksha Jain, ANM
12	District Drug Ware House	Udaipur	DDW	Dr Rajesh Bharadia
13	Village	Virathala	Village	
14	Village	Kabaiya	Village	

Part- III

Observations of 6th CRM Team

The 6th CRM team after reviewing the facilities and services in the two districts has observed the following progress under NRHM.

The observations on the TORs are as follows:-

1. Facility based curative services-accessibility, affordability & quality

1.1 Infrastructure Development (ID)

The progress made by the State in Infrastructure is commendable. The State has over a period gradually enhanced its health facilities to meet its Infrastructure requirements. The State has been able to meet its 10th and 11th Plan requirements.

The table below indicates the State achievement in Infrastructure development for the period of 10th & 11th 5 years plan⁵

Table 11

TYPE OF FACILITIES	10 TH PLAN (2002-2007)	11 TH PLAN(2007-2012)	STATUS AS ON OCT 2012
Sub Centre	10612	11487	11487
Primary Health Centre	1499	1517	1612
Community Health Centre	337	376	376
District hospital	33	33	34

The State has also taken some important measures to meet its infrastructure development needs:-

- An Engineering Wing (Infrastructure Development) was established at the State level with a Sr Engineer heading the ID wing. He supports and expedites all infrastructure development and civil constructions under NRHM.
- The State has upgraded many health facilities and constructed new facilities to meet its critical gap as indicated by the table below:-

⁵ Data Source RHS 2011.

Table 12

Table J: Information on Progress of Up gradation of Health Facilities under NRHM in the State (October 2012)⁶								
Health Facility	Upgradation sanctioned under NRHM so far		Progress of New Constructions					
	High Focus Districts	Non High Focus Districts	Completed		Under Construction		Sanctioned but Yet to start ⁷	
			High Focus	Non High Focus	High Focused	Non High Focus	High Focused	Non High Focus
DHHs	58	38	17	13	3	1	38	24
SDHs	13	15			3	8	10	7
CHCs	247	133	116	80	54	22	77	31
PHC-	581	419	230	153	24	12	327	254

Table 13

Table J: Information on Progress of New Construction of Health Facilities under NRHM in the State (October 2012)⁷								
Health Facility	New Construction sanctioned under NRHM so far		Progress of New Constructions					
	High Focus Districts	Non High Focus Districts	Completed		Under Construction		Sanctioned but Yet to start ⁸	
			High Focused	Non High Focus	High Focused	Non High Focus	High Focused	Non High Focus
DHHs	-	-	-	-	-	-	-	-

^{6 & 7} Data Source State HMIS

SDHs	-	-	-	-	-	-	-	-
CHCs	7	7	7	7	-	-	-	-
PHC-	59	63	50	58	6	1	3	4

New construction sanctioned during Mission period :

District Hospital

96 works under upgradation sanctioned under NRHM, 40(41.6%) complete and 62(64.58%) of works have not yet started.

Sub Divisional Hospital

28 works for SDH upgradation have been sanctioned of which 17(60.7%) have not yet been started.

Community Health Centre (CHC)

7 new CHCs were sanctioned and completed (100 %).

MCH centres - A total of 22 dedicated **Maternal and Child health centers** have been approved for 20 high focus districts hospitals worth (20.00.crore each) and for 2 medical colleges sanctioned but construction has not started.

Primary Health Centre (PHC)

122 complete new PHC were sanctioned out of which 108 have been completed (88.5%) and rest (11.5%) are in progress or yet to start.

Sub Centre (SC) - Labor Rooms in 383 Sub centres were upgraded. Labor rooms and toilets for 200 Sub centers and residential facilities for ANM in 700 Sub centres were sanctioned in this Financial Year.

Staff Quarters:

In terms of availability of residential accommodation, the state has a shortage of staff quarter at some facilities. Staff quarters were available at some DHH, SDH, CHC & PHC level. However these are insufficient to provide accommodation to all staff.

The State has sanctioned the following staff quarters to fill the gap in residential accommodation.

- (i) 364 qtrs. at PHC, 299 have been completed. 44 works is in progress and in 23 no work has been initiated.
- (ii) 1840 qtrs. at CHC, 1780 completed, 46 works in progress and 14 no work has been initiated.

Major and Minor Constructions works

Under NRHM 5393 Major and Minor Constructions works were sanctioned.

- (i) Out of this 5393 works
 - a. 4226 works have been completed and handed over;
 - b. 284 have been completed but not handed over;
 - c. 341 works are in progress.
 - d. In 279 places, work has not been started.
- (ii) Among the completed works, maximum is residential quarters (1752).
- (iii) Out of the 383 labour room constructions at Sub centres, 71 have been completed and handed over.
- (iv) There are 102 constructions that have been going on for more than 2 years in Udaipur. This inspite of the Engineering Wing under NRHM supervising these constructions. The 2 major reasons for delay given by the district - are the (a) 'issues with Panchayati Raj department' and (b) 'slow progress of the contractor' despite all clearance on time.
- (v) The state reported that executive engineers and assistant engineers for infrastructure development are now deputed from PWD to health department to ensure better coordination.

As of now the State has the following health facilities in place.

- (i) 108 FRUs (including DH),
- (ii) 382 CHCs, 1528 PHCs,
- (iii) 37 UHCs, 11487 SCs,
- (iv) 196 dispensaries/ health posts,
- (v) 13 City aid posts and
- (vi) 118 Mother and Child welfare centres.

The major challenge however for the State is making available the required human resources (doctors/nurses/ANMs/Lab Tech etc) at these facilities.

- If the Rural Health Infrastructure norm of coverage of population is taken (population covered by each health centres) for the state, it is observed that the coverage by population (4487 for the State) is well within the national average (5624) for Sub Centres, Primary Health Centres (33975 for the State to national average 34876) and Community Health Centres (1, 37,075 for the State to national average of 1, 73,235).

Table 14

RURAL HEALTH INFRASTRUCTURE - NORMS AND LEVEL OF ACHIEVEMENTS (Rajasthan)						
S.No	Indicator	National Norms		Present Average Coverage Rajasthan	Present Average Coverage India	Remarks
1	Rural Population (2011) (Provisional) covered by a	General Tribal	Hilly/Desert			
2	Sub Centre(SC)	5000	3000	4487	5624	Within

RURAL HEALTH INFRASTRUCTURE - NORMS AND LEVEL OF ACHIEVEMENTS (Rajasthan)						
S.No	Indicator	National Norms		Present Average Coverage Rajasthan	Present Average Coverage India	Remarks
1	Rural Population (2011) (Provisional) covered by a	General Tribal	Hilly/Desert			
						National Average
3	Primary Health Centre (PHC)	30000	20000	33975	34876	Within National Average
4	Community Health Centre (CHC)	120000	80000	1,37,075	173235	Within National Average
5	Number of Sub Centres per PHC	6	-	8	6	
6	Number of PHCs per CHC	5	-	4	5	
7	Ratio of HA (M) at PHCs to HW (M) at Sub Centres	1:6	-	1:8	1.3	
8	Ratio of HA (F) at PHCs to HW (M) at Sub Centres	1:6		1:12	1.13	
9	Average Rural Area (Sq. Km) covered by a:					
	Sub Centre			29.32	21.05	The State covers greater land area per health centre/Sq. Km
	PHC			222.02	130.54	
	CHC			895.77	648.43	
10	Average Number of villages covered by					
	SC			4	4	
	PHC			29	27	
	CHC			119	133	

- However, the scenario totally changes when compared with the average area covered (Sq. Km.) by each health centre. It is seen that in Rajasthan, the area covered by a Sub Centre (29.32 Sq. Km to national average of 21.05 Sq. Km) - the distance covered is much more; Similarly for the Primary Health Centre (222.02 Sq. Km to national average of 130.54 Sq. Km) – the distance covered is much more and the same is the case for the Community Health Centre (895.77 Sq. Km to national average of 648.43 Sq. Km). The area covered by each health centre is much larger than the National Average leading to a need for reassessing the area covered by health facilities norm for Rajasthan; otherwise the accessibility issue will always remain.
- Districts like Jaisalmer, Barmer and Dungarpur (High Focus districts) have very large district areas with very scarce population making the accessibility to health facility very difficult. Therefore there is a need for re-examining the ID Norms for such districts to improve accessibility.

1.2 Utilisation of Health Facilities

The OPD, IPD have increased across the NRHM period. The number of OPD and IPD have increased from 24650705 during 2nd CRM to 37761207 (up to Oct 2012) and from 1209720 during 2nd CRM to 1903994 respectively, indicating greater utilization of health facilities.

The Institutional deliveries in the State have improved during the NRHM period. The institutional deliveries have increased from 24.5 % in 2005 -06 to 70.4 % in 2010-11 and there is a corresponding decline in maternal mortality as indicated by Fig.1 (Institutional delivery trend) and Fig. 2 (MMR trends)

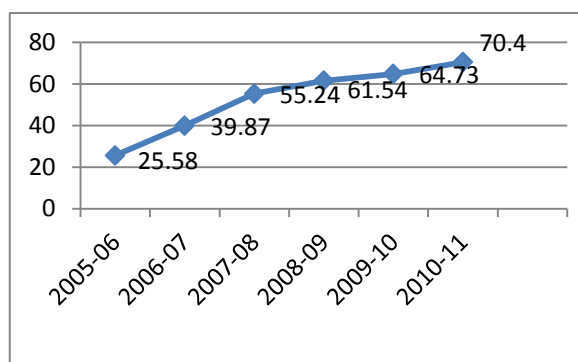
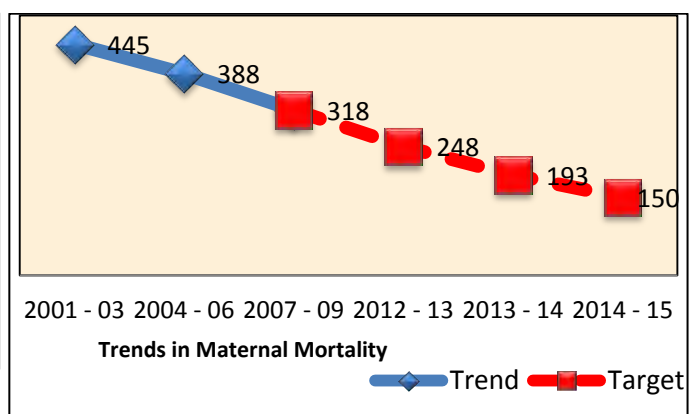


Figure 5 Trends in Institutional Deliveries



However, the State has a long way to go before it achieves the NRHM goal and the MDG goal.

1.3.1 Rajasthan Medical Services Corporation Major Observations

- Availability of drugs/medicines has vastly improved in the State due to the establishment of Rajasthan Medical Services Corporation (RMSC), operational from October, 2011. The state has brought 477 medicines under its Essential Drug List and distributes these throughout the State.
- Under the new drug procurement policy, procurement of Drugs and Surgical's including Sutures has been made competitive through bidding. Purchase preference is restricted to 25% only, out of which 10% for state PSU's and 15% for state SSI's, that too on condition that it would be necessary for them to match with the L1 rates obtained through tendering. Drug warehouses have been established at district headquarters to store and distribute drugs to health facilities in the districts. All this has greatly improved the availability of drugs in the State.
- Quality control (QC) is ensured by sampling of supplies randomly from each batch. Samples drawn are sent to the Head office for Quality Control.
- Empanelled Laboratories analyse the drug samples as per specifications and suitable test protocols. If the drug fails in assay or any other parameters, action is taken immediately by the Department of Q.C. and confirmed with the other Empanelled Laboratories/ Government Analysts before taking final decision. The results are then sent to the warehouses through E-mail, besides other methods
- The manufacturing premises of the participating agencies are inspected for compliance of Good Manufacturing Practices (GMP), Good Laboratory Practices (GLP) and for verification of their production capacity.

- Most institutions were accessible by road in Udaipur (village to FRU travel time by the team was maximum 2 hours), but this was not the case in Sawai Madhopur. This was attributed to the district being a preferred tourist destination in the state.

1.4 Diagnostic services

- Diagnostic services were available at most health facilities and were free for pregnant women.
- However the range of services provided in the lab were not as per IPHS guideline in many PHCs.
- Medical Equipment's (Suction machine, Radiant Warmer etc) were available and functioning at most places. The staffs on duty at facilities were able to explain in general the use of equipment's.

1.5 District Specific Observations:

- The patient amenities at health facilities visited in the two districts was variable. Availability of amenities, like drinking water, diet and seating arrangements was good in district Udaipur but was not good in the case for Sawai Madhopur. Signages indicating services were present at most Health Facilities in both districts.
- There were issues of privacy (lack of screens etc.) for women observed at Sawai Madhopur, however this was not the case in Udaipur where good privacy was provided to women by having curtains etc in labour rooms.
- The facilities for new born and infant were also in place at most health facilities. Like FBNC and NBSU at DH and SDH/ FRU. However the staff posted at facilities was not trained especially in new born care and use of specialised equipment. As the satellite health centres SDH/CHC were not providing adequate new-born care services, there was overcrowding at the FBNC at DH Sawai Madhopur. As a result, there were 2 – 3 new born babies to one Radiant Warmer.



When facilities and health service delivery are good, there is an upsurge in patient demand. Institutions must plan for augmenting the existing satellite facilities like SDH/FRU/CHC etc.

Figure 6 Three Children in One Warmer

- However this differed in the two districts visited - Udaipur was better than Sawai Madhopur in this regard.
- Availability of blood was a big issue in Udaipur. For example in Udaipur district, there are 2 satellite hospitals (one of them designated as DH), 1 SDH, 20 CHCs, and 71 PHCs. None of these centres had facilities for blood storage center.
- SDH Salumbar had a 'functional blood storage center', which has not done a single blood transfusion for the last 6 months, despite it being an FRU / level III center and doing C-sections. The

district relies on the Medical College hospital for all blood transfusion requirements of the public sector.

- The situation at Sawai Madhopur was different, there was a functioning blood storage unit at the DH and had trained manpower manning the unit. At the time of visit the Blood Storage Unit had one unit of A +, B + and O +. DH had performed 67 CS in the month of October, 2012.
- Essential Drug List was displayed in all the facilities visited till PHC however it was not in local language.



Figure 7 Burning of Waste in Open

1.6 Bio Medical Waste Management (BMWM)

- The infection prevention and bio-medical waste management was generally poor in both districts with Udaipur being slightly better than Sawai Madhopur.

- In Udaipur, the BMW was largely in place with waste segregation at source. Disinfection and disposal was also in place with a few exceptions. The problem was largely with and clearance as clearance was done only twice a week. This caused storage of waste for 3-4 days at the hospital itself.

- In Sawai Madhopur, the BMW was generally not in place. Waste disposal bins were seen but segregation of waste at source was not being done thus exposing the staff and public to serious health effects. Most of the waste collected at Sawai Madhopur was being burnt in open areas.

2. Outreach & Patient transport services-Sub-centers, Mobile Medical Unit/EMRI,ALS/BLS etc

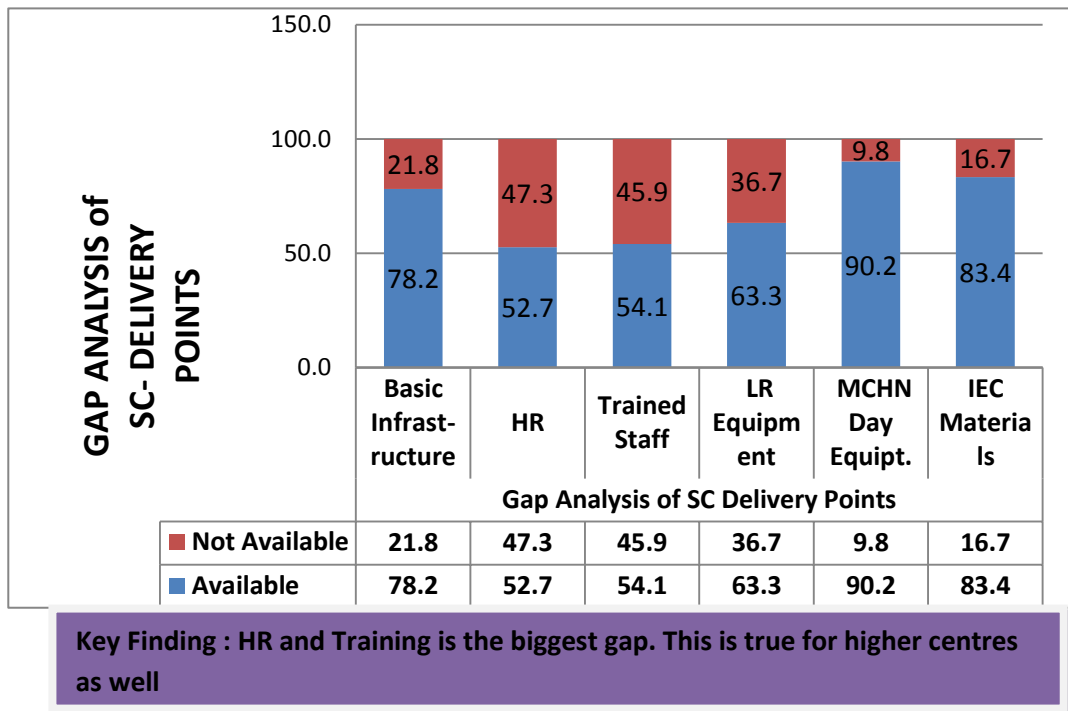
Outreach services

- There were 11487 functional SHCs in the State with another 1209 is planned this financial year and should be able to meet 90% of the SHC requirement of the state. The SCs are providing ANC,
- FP and Out-reach services. There are 793 SHCs functioning as delivery points (L1). A few SHCs are having a good case load.
- Gap analysis of facilities has been done by the state to assess the capacity of these SHCs to function as delivery points.
- The gap analysis showed a huge shortage of HR (47.3 %), trained manpower (45.9 %) and LR equipment (36.7 %).



Figure 8 Baluwa SHC, Udaipur, Average delivery points per month is 25-30

- Unless the State is able to address this shortage the delivery point cannot be made fully functional.



- ASHA Sahayogini's are contributing to outreach services. ASHAs are providing contraceptives and sanitary napkins at door step.
- 1014 AYUSH doctors have been employed under NRHM and out of them 654 had undergone training in SBA. The AYUSH doctors have conducted 15331 (up to Sep. 2012) normal deliveries.
- The state has constituted 43440 VHSNCs and Rajasthan Medical Relief Societies (RKS) in all hospitals having more than 30 beds.

2.1 Emergency transport services:

- Emergency transport services in the State are in place. The 104 Janani Express services were launched in October, 2012 only. The 108 services have 464 ambulances in place and have been deployed in 249 blocks. The technicians have been trained and basic support is available in the ambulances. The drivers and technicians, however, complained that their salary is low and no revision has happened since they joined.
- The 104 toll free Medical Advice Services is also operational. The cell has received 190757 calls and has been able to address/respond to 184118 calls. Among the calls 1131 were relating to complaints against doctors or non-availability of drugs etc.

2.2 Mobile Medical Units

- The state has 49 Mobile Medical Units and 143 Mobile Medical Vans operational. Since 2008-09 18 lakhs patients have received benefit from these services. The MMVs are preferentially deployed in desert, tribal and Dang blocks.

2.3 District Specific Observations

- Referral services were largely available for inter facility transfers and drop back to homes.
- Awareness about Janani (104) express among beneficiaries seemed lacking; a few pregnant women interviewed had made their own arrangements to reach the delivery centre.
- HSC were functional through the week with further village level services on certain days; a micro plan for MCHN days was available at PHCs and CHCs.
- Outreach services in terms of MCHN services were regularly providing a package of ANC, Immunization and outpatient services.
- In one PHC area (Sawai Madhopur), MCHN services seemed hampered by irregular vaccine supply.
- A variety of logistics related to Antenatal care (Nischay kits, BP app, stethoscope, HB meter and reagents, weighing machine), Immunization (vaccines, diluents, syringes, vaccine carriers) and treatment of minor ailments (ORS, Zinc, IFA tablets) were available in the health sub-centers and MCHN (VHND) site and Health sub-centers visited. In addition Health sub-centers also had RNTCP drugs and malarial slides.
- Despite availability of equipment and reagents, Hb estimation, BP measurement and abdominal examination was not being practiced during ANC (facility and outreach). There was also a gap in skills related to BP measurement and Hb estimation.
- Outreach sites (MCHN) did not have facility for privacy or abdominal examination.
- In general counseling for family planning services by Health workers in MCHN days appeared poor.
- There was a knowledge gap among ANMs related to use of Zinc (dose/schedule) and treatment of RTIs.
- Alternate Vaccine Delivery was mostly not functional and ANMs picked up their own vaccine supplies for the MCHN activity, there appears to be a distinct possibility of unused vaccines and logistics (following MCHN days) not being returned in time.
- Records relating to outreach services (MCHN days, ANC, Immunization) were found to be well maintained in registers called SDRs. ANMs generally filled these registers accurately and completely (one instance of fudging data was seen where two successive DPT doses was given within 25 days - Sawai Madhopur)
- Work-plans generated from MCTS/PCTS were not found in any outreach site/ Health sub-center visited. New due list registers had been recently supplied and a three copy system (ANM, ASHA, AWW) and seemed to be working well.
- Estimated 20-30% HSCs had ANMs residing and there were few exceptional centers with delivery services round the clock.
- There was lack of running water and sanitation facilities at most Health sub-centers (one HSC had a water tank made through community resources); facility for hand washing was not available in/ around the MCHN session sites visited. A functional system for proper disposal of immunization/other wastes from outreach sites was also lacking.



Figure 9 104 Janani Express Ambulance.

- ASHAs were reported to be actively participating mobilization of beneficiaries for MCHN services and in social marketing of contraceptives and sanitary napkins.
- In general good convergence was seen between ANMs, ASHAs and AWWs

Recommendations:

- IEC campaign for awareness generation on Janani express to improve utilization.
- Capacity building for ANMs to provide skills and services related to MCHN days (ANC investigations, counseling, use of Zinc)
- Running water and sanitation facilities should be provided at functional sub-centres
- As AVD for MCHN services is not working in many places, the State may consider a AVD which is functional.

3. Human Resource for Health-Adequacy in Numbers, Skills and Performance

The State has made efforts to expand its Human Resource (HR) base by recruiting health personnel against various cadres through regular as well as contractual staff. However the gap between “needed” and “available” is immense. This is especially seen in the case of specialists (Anesthetist & Radiologists), MPW (M), Lab technician etc.

- The vacancy against various sanctioned positions for health personnel ranges from 0.40 % to 46.7 % against sanctioned posts. However the vacancy situation worsens on comparing it to the IPHS norms.
- During the NRHM period the State has concentrated in filling the critical gap in terms of recruitment and availability of health personnel in the health system. The State has increased the number of sanctioned posts for specialists from 1089 in 2007 to 1602, an increase of 513 sanctioned specialists’ positions (47 % increase).
- There has been an increase in the position of regular medical officers from 3739 in 2007 to 4933 in 2012.
- The position of staff nurses in the health system is in excess. The numbers of SNs in position (11926) is more than the sanctioned posts (5628). Additional 6298 SN are present in the system.
- AYUSH doctors were added to the health workforce. As there were no sanctioned posts in 2005, sanctioned posts were added and presently 916 AYUSH doctors are in place as against 1014 sanctioned positions. Most of them are on contractual basis.
- The Management Unit at the State & district has 4000 qualified professionals with the educational background of MBBS/ CA/MBA/MA/MCA etc.
- Human resource allocation (hiring, allocation, transfers) needs to be aligned with the actual existing requirements keeping in view the attrition due to retirement and transfers. Frequent changes in crucial management positions.
- Low expenditure (6, 83 lakhs against 126 lakhs) reported against additional incentives for MOs at CHC / PHCs, salaries for computer assistants and incentives to SNs and ANMs (2012).

The table below highlights the human resource situation in the State.

3.1 Status of Human Resource: as on Oct 2012

Table 15

Position	Sanctioned strength	In Position	Vacancy against sanction	Requirement as per IPHS	Vacancy against IPHS
Specialists	1068	569	-499 * (46.7 %)	1504	-935 (62.1 %)
Medical Officers at PHC	1478	1472	-6 (0.04 %)	1517	-45 (2.97 %)
Pharmacist	362	551	+189 # (152 %)	1893	-1342 (70.89 %)
Staff Nurse	5628	11926	+ 6298 (211 %)	4149	+ 7777 (287 %)
ANM at SC and PHC	14348	17638	+ 3290 (122 %)	13004	+ 4634 (135 %)
MPHW(Male)	2217	1592	-625 (28.1 %)	11487	- 9895 (86.14 %)
Radiographer	208	260	+ 52 (125 %)	376	- 116 (30.85 %)
Lab Technician	1818	2639	+ 821 (145 %)	1893	+746 (139 %)
LHV	1369	1420	+51 (103 %)	1517	- 97 (6.39 %)

*Negative Indicates Shortage

#Positive Indicates Excess

- Observing the Human Resource (HR) status in Rajasthan it is seen that there is a mix of excesses and shortages in different categories.

3.2 Excess of HR (in position against sanctioned)

- The state has an excess of HR (in position against sanctioned) in the following categories:-

Table 15.1

Position	Excess (Actual Number)	Remarks
Pharmacist	189	152% (in excess against sanctioned posts.)
Staff Nurse	6298	211% (in excess against sanctioned posts)
ANM	3290	122% (in excess against sanctioned posts)
Lab Technician	821	145% (in excess against sanctioned posts)
LHV (Lady Health Visitors)	51	103 % (in excess against sanctioned posts)
Radiographer	52	125 % (in excess against sanctioned posts)

3.3 Shortage in HR

The state has shortage in the following category:-

Table 15.2

Position	Shortage (Actual Number)	Remarks
Specialist	499	46.7% (shortage against sanctioned posts)
MPHW	625	28.1% (shortage against sanctioned posts)
Medical Officer	6	0.04% (shortage against sanctioned posts)

3.4 HR in the state is compared to the IPHS standards

If the HR in the state is compared to the IPHS standards, it is seen that the shortage and the excess are more or less similar except pharmacists, radiographers and LHV.

The details are as follows:-

Table 15.3

Position	Shortage/Excess (Actual Number)	Remarks
Pharmacist	1342	70.89 % (shortage against IPHS requirement)
Staff Nurse	7777	287 % in excess shortage against IPHS requirement)
ANM	4634	135 % in excess against IPHS requirement)
Lab Technician	746	139 % (in excess against IPHS requirement)
LHV (Lady Health Visitors)	97	(6.3 % shortage against IPHS requirement)
Radiographer	116	(30.85 % shortage against IPHS requirement)

		requirement)
--	--	--------------

There appears to be a lack of rational recruitment policy of health personnel in the State. There are huge excesses in some of the HR (pharmacists/Lab Tech/ SN/ ANM/ LHV/ and Radiographer), whereas there are shortages in HR (specialists, MPW/) when HR is observed against sanctioned posts. The situation is almost similar when seen against IPHS requirements except in the case of pharmacists, LHVs and radiographers.

3.5 Details of recruitment done during 2011–2012 & 2012-13 to meet the critical gaps in paramedical personnel:

Table 15.4

Para medical personnel	Regular		NRHM		Total
	2011	2012	2011	2012	
Staff Nurse	876	06	-	-	882
Pharmacist	--	1401	--	---	1401
MPHW (F)/ Addl ANM	1678	08	--	---	1687
MPHW (M)	--	--	--	--	--
L.T	--	181	--	--	181

*Note: No recruitment done under NRHM in the FY 2011-12 and 2012-13 (up to Nov.) in compliance to the Finance Department's circular dated 17.6.2011, related to the prohibition on the deployment of contractual manpower in the State of Rajasthan.

3.6 District Specific Observations:

- Availability of gynaecologists (1/3), paediatricians (0/3) and anaesthetists (0/2) in ---district of Sawai Madhopur indicates a poor situation as far as specialists are concerned.
- Large vacancies exist in the districts e.g Udaipur, has 50 % vacancies in ASHA against a sanctioned in Kotda Block.
- In Sawai Madhopur there is shortage of 98 % for specialist against sanctioned posts and 26.86 % for Medical officers and 9.46 % for ANMs and 25 % for MPWs.

Table 15.5

Designation	Sanction	Working	Vacant	% Vacant positions
1. Jr. Specialists				
Surgeon	07	00	07	100
Gynecologist	03	01	02	66.66
Pediatricians	03	00	03	100
Anesthetists	02	00	02	100
2. Medical Officers				
SMOs	05	01	04	80
MOs at	47	37	10	21.27
AYUSH MO	15	11	04	26.66

Table Showing Vacancy of Specialists and Medical Officers in Sawai Madhopur

- There is a shortage of 80 % for block programme manager.
- The gap in availability of medical officers is adversely affecting the health services delivery in the district, resulting not only in shrinking of the range of services available across the health facilities but also reducing the number of facilities that can provide the health services mandated for First Referral Units.
- District Sawai Madhopur reports a total of 1436 IMNCI trained 108 RI trained service providers.
- Udaipur district reports 0 % achievement for all the trainings except RI which is less than 2 %.
- Supportive supervision and monitoring in the field (i.e. in District Sawai Madhopur) is poor.
- **Incentives and HR policies:** Difficult area allowances not been implemented by the health service. This is causing great dissatisfaction among most service providers.
- Promotions take a long time and most doctors receive their first promotion after many years of being in service. Most retire with two promotions at the most. There was an agreement for time bound promotions but this has not been implemented.

State Initiative

- State has taken the following initiatives to address the HR issues.
 - A State HRD cell has been created under NRHM headed by a Senior RAS officer. HR policy has been put in place. However many of the HR policy directives have not been implemented.
 - The State has handed over the recruitment of medical personnel to medical University to expedite recruitments.
 - A data base of health personnel is now being created.

Recommendations

Human Resource

- The State should not only have a Human Resource Policy but implement it. The HR policy recommendations have not been implemented.
- HR Policy should include non-monetary incentives - **non-monetary incentives** for example posting in better districts after serving for a certain period of time in difficult districts, preference /reservation quota in academic and professional institutions for children whose parents have served for long in HFD, letters of appreciation, additional weightage for each year spent in HFD district during

promotion , special quota in post graduate studies for young doctors willing to serve in difficult areas are some of the suggestions that must be given due consideration.

- Cadre reform in terms of Dynamic Assured Career Progression (DACP) is an urgent need of the hour. Difficult area allowances can also be given to doctors in senior administrative positions (eg; ACOMO).
- **Health Manpower Information System** should be put in place to address the basic and well-known bottlenecks in HR management (i.e how transfers are done, posts are filled, tenure of middle-management) need to be addressed.
- Staff remuneration, incentive structures, and career paths, need to be defined and assessed for reform. Improved conditions for medical doctors could be a quid pro quo for banning private practice.(Most of the doctors at districts do private practice at the cost of public sector – (doctors use govt facilities – admissions to /drugs/operation from govt hosp etc to do practice).
- Recruitment should be rational and need based and as per the requirement of facilities, so that actual numbers required are recruited. While recruiting the attrition rate should be taken into consideration.
- The highly centralized system of HR management cannot effectively meet the challenges of an expanding system. Decentralization of HR decisions, accompanied by the necessary capacity development, should be planned for the medium-term.
- Many of the recruitment especially of paramedical personnel could be decentralized.

4. Reproductive and Child Health Programme

- The State has shown considerable progress under Reproductive Child Health programme.
- The major achievement for the state under NRHM is nearly 70 points drop in maternal mortality. MMR 388 SRS (2004-2006) and MMR 318 SRS (2007-2009).
- A similar achievement is seen in the IMR, which shows a drop of 15 points from 67 (SRS 2005) to 52 (SRS 2011). A drop of approx. 2 points every year. This is quite significant for a State like Rajasthan. However, TFR decreased by a meagre 0.3 over the CRMs from 3.4 in 2005 to 3.1 in 2010. The State needs to work on its family planning programme.
- The numbers of OPD, IPD cases have increased over the NRHM period. The number of OPD and IPD cases have risen from 24650705 during 2nd CRM to 37761207 (up to Oct 2012) and from 1209720 during 2nd CRM to 1903994 respectively, indicating greater foot falls and utilization of health facilities.
- The Institutional deliveries in the State have also improved over the NRHM period. The institutional deliveries increased from 24.5 % in 2005 -06 to 70.4 % in 2010-11.
- Free and cashless delivery services were being provided to all pregnant women at government facilities.
- Staff at delivery points appeared to have been trained in SBA, field staff was generally familiar with ANC and other outreach based MCHN services such as immunization (but not HBNC).

The State' has shown improvement in the following:-

- Over all Institutional deliveries in the State have increased from 25.58 to 70 .4 % with only two districts (jaisalmer & Barmer) having less than 60 % institutional deliveries
- The total delivery point in the State are 1665, out of which L1 is 583; L2 is 220 & L3 is 31.
- Number of Immunization sessions have increased from 93.3 % to 109.8 %
- Number of infants receiving OPV zero dose increased from 32.5 % to 35.6 %

The State's performance however has shown a decline in the following:-

- ANC registrations have decreased from 100.8 % to 92 % against the estimated number of pregnant women.
- Proportion of home deliveries by SBA have decreased from 47.7% in 2010 – 11 to 40 .9 % in 2011-12.
- Proportion of deliveries discharged after 48 hrs. of deliveries have declined from 57.3 % in 2010 – 11 to 31 % in 2011 – 12.
- Numbers of FRU functional have come down from 223 in 2010 – 11 to 206 in 2011 – 12.
- Newborn weighed at birth declined from 78.2 % in 2010 – 11 to 72.8 % in 2011 – 12
- Full immunization declined from in 2010 – 11 69.9 % to 67.1 % in 2011 – 12.
- Post-partum sterilization have declined from 17 .4 % in 2010– 11 to 16.3 in 2011 – 12 %.

4.1 District Specific Observations:-

4.1.1 Maternal Health

- o MCH (for delivery and newborn care services) /delivery points fairly well distributed geographically;
- o Despite good planning on paper, there were very few functional FRUs at district (only 1 in Sawai Madhopur and 3 in Udaipur);
- o There were issues of very few C sections being performed and “non-operating surgeons” in FRUs. At one FRU it was observed that despite having been trained in LSAS, the Medical officer was not providing anesthesia for C section operations.
- o Issues of privacy and space observed at very few facilities especially at L1facilities.
- o Infection prevention practices appeared to be poor
- o Effective management of labour (3rd stage) was insufficiently being practiced at places.
- o Labour room protocols at some facilities were not displayed.
- o Essential drugs and equipment for safe delivery care were available at most facilities visited.
- o Misoprostol had a short expiry date (same month) at some facilities and local health staffs were not aware of this.
- o Delivery records maintained fairly well. However on further probing the partographs had many false entries and proper monitoring of third stage of labour was not being undertaken.
- o Birth preparedness and quality of care for high risk pregnancies seemed poor. Records indicated that high risk deliveries were being referred to higher centres at last moment.
- o Home deliveries are not being tracked and post natal care coverage was poor.

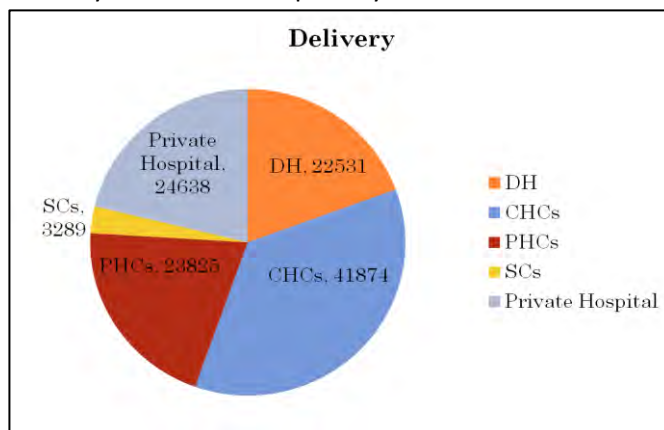


Figure 10 Delivery Load across facilities

4.1.2 JSY:

- JSY and JSSK programme were being implemented and free package of services were being provided for pregnant women and newborn.
- JSY payments through cheques are regular and found to be made before the discharge from the health facility.
- Food for pregnant women was being provided by self-help groups at some facilities.
- In Level 2 and 3 facilities, 48 hrs of stay after delivery was variable across the two districts. Stay for 48 hrs was not uniformly observed in Level 1 MCH facilities and payment before discharge was again variable across facilities.
- Public display of JSY beneficiaries was not being made at the health facilities.
- Grievance redressal cells were yet to be established.

4.1.3 Accredited JSY Health Facility:

- Under JSY, sub-centres run by ARTH NGO have been accredited in Udaipur.
- These sub-centres are manned by three qualified ANMs and on dedicated days in a week a gynaecologist and paediatrician visit the sub-centre for ANC, PNC and care of the newborn.
- The sub centres are running in rented premises and have two labour tables, one radiant warmer, emergency drug, two OPD rooms, and six functional beds.
- The facility conducts around 60 deliveries a month.
- A fees of Rs. 500/ is paid by the mothers towards the medicines and other incidental expenses.
- Interaction with the mothers reveal that despite a fees of Rs. 500, they still prefer to come to ARTH Subcentre because of certainty about the availability of health staff, presence of specialists at the Subcentre at designated days and quality ANC and PNC services available through the Subcentre.
- However, it was noted with concern that criteria regarding accreditation of health facilities is not available with the health authorities nor any monitoring of these centres have been made by the district and block health authorities.
- JSY payments to these mothers have been made at the PHC level.

4.1.4 Adolescent Health:

- ARSH clinics were not operational in any of the facility visited in districts. Further, counselors have not been appointed in the facilities to manage adolescent issues. No convergence is visible with teen clubs, NYKS, NSS and AEP. ARSH programme needs to be implemented at the districts.
- ARSH guidelines were not available at any of the facilities visited.
- It is learnt that on the MCHN day (VHND) kishoris are provided IFA tablet and health education on the basis of Kishori kits provided by WCD department and the health education sessions with kishoris were documented in a register.
- 12 districts were selected for provision of Adolescent friendly Health services. State reported that 1359 adolescents availed these services this year. Udaipur was one of the districts selected. But during field visit, none of the institutions were seen providing dedicated AFH services.
- Under the School Health programme, teams have been formed for screening the school children. However, these teams are not dedicated for school health only.

- As regards WIFS scheme, low levels of awareness are found among the ANMs and ASHAs about the roll-out of the programme. Orientation training on WIFS for block level functionaries and ANMs is yet to be initiated.

4.1.5 Child Health

Table 16

S. No.	Name of the District	No. of existing delivery points	No. of NBCC operational	SNCU	Remarks
High Focus districts					
1.	Sawai madhopur	26	1	1	
2.	Udaipur	81	83	1	

- SNCU had been established at district hospitals and were functional; however the staff had not received training related to facility based newborn care (or NSSK) or in handling the equipment.
- Some equipment (50% of radiant warmers) was non-functional and had been out of service for a period of 6 months to several weeks in district Udaipur.
- In DH Sawai Madopur SNCU was overcrowded with 3 newborns to one radiant warmer.
- The NBSU and NBCCs were in early phases of establishment; there were still issues relating to untrained personnel, improper use/ cleaning of equipment and improper functioning of new born corners.
- Large number of stillbirths observed from the records.
- Early breast feeding initiation was being practiced at most facilities.

Observations

- Facility based newborn care has been prioritized by the state government and the largest sum has been budgeted under it. State has reported 74.4% live births (6.90 lakhs) as against the estimated live births (9.28 lakhs) in first half of 2012-13.
- The percentage of newborns weighed at birth and breast fed within the first hour of birth has improved by 2 %age points and 3.5 % age points respectively in first half of 2012-13 as compared to first half of 2011-12.
- However low birth weight babies have increased by 5.3 %age points this year against the same period last year

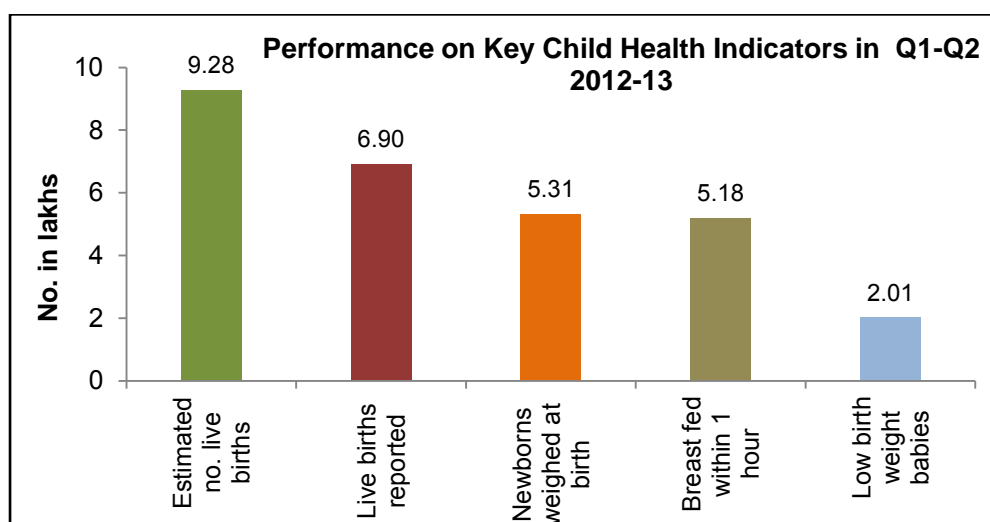


Figure 11 Child Health Key Indicators

- Early neonatal deaths (occurring within the first week of life) account for 67% of infant deaths while late neonatal (one week to 28 days of life) and post neonatal (after 28 days to first year of life) account for 15% and 18% of infant deaths respectively. The figures are suggestive of poor newborn care practices at the facility level; hence there is need for intensification of facility based newborn care.

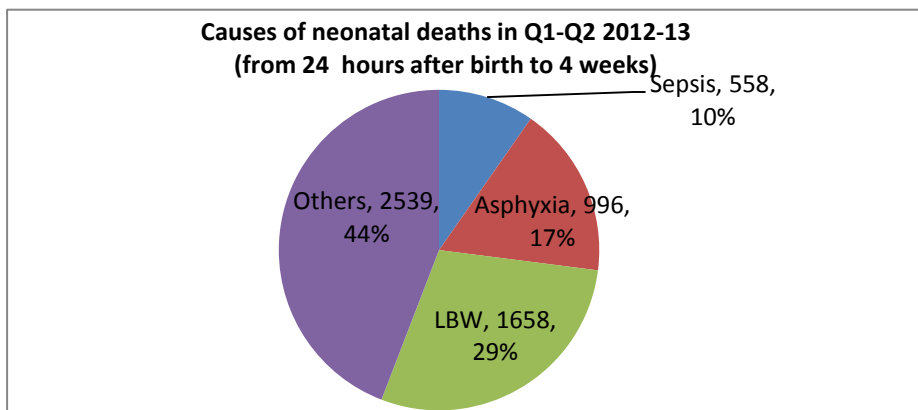


Figure 12 Distribution of Neonatal Death

The state currently has 2010 ILR point, 1 state Vaccine Store and 33 District Stores. Across the facilities visited in the two districts the cold chain maintenance was variable.

Observations

- Overall there is positive trend in full immunization coverage with increase from 29.9% in 2003-04 (DLHS 2) to 70.8% AHS (2010). Although there is increase in coverage of full immunization for Sawai Madhopur but overall immunization coverage is poor
- **Full immunization coverage** for the first six months of 2012-13 was 72.5%, 3.8 %age point less than the same period last year.
- BCG and OPV zero dose coverage rates were low at 44% and 72.4% respectively. The state needs to strengthen its facility based immunization sessions in order to improve BCG and OPV 0 coverage rates.

- District Udaipur has Full immunization coverage of 85.3% whereas District Sawai Madhopur needs greater attention as full immunization coverage is just 41.1% (AHS, 2010).

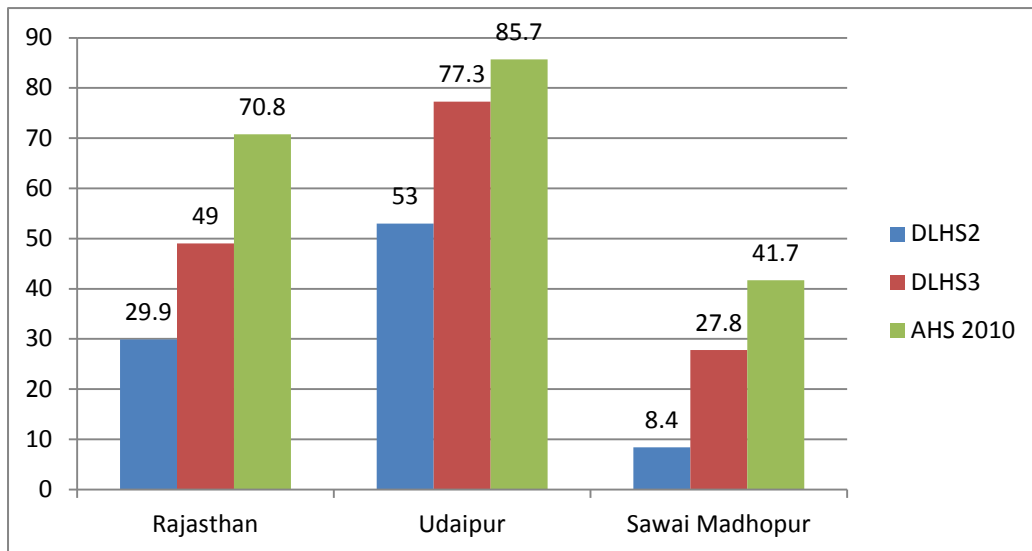


Figure 13 Full Immunization Coverage for children aged 12-23 months

- Also immunization sessions held have decreased by 2.2 %age points as compared to last year.
- In Sawai Madhopur monitoring of cold chain maintenance was poor.
- In the district store in Sawai Madhopur, many of ILR was lying unutilized.
- In order to strengthen the RI programme , state has started the *Swasthya Sandesh Sewa*, which is a system where SMSs are sent to ANMs and beneficiaries before the RI days. From June 2011 to October 2012, 5.67 lakh messages have been sent to ANMs and 4.2 lakh messages to the beneficiaries.

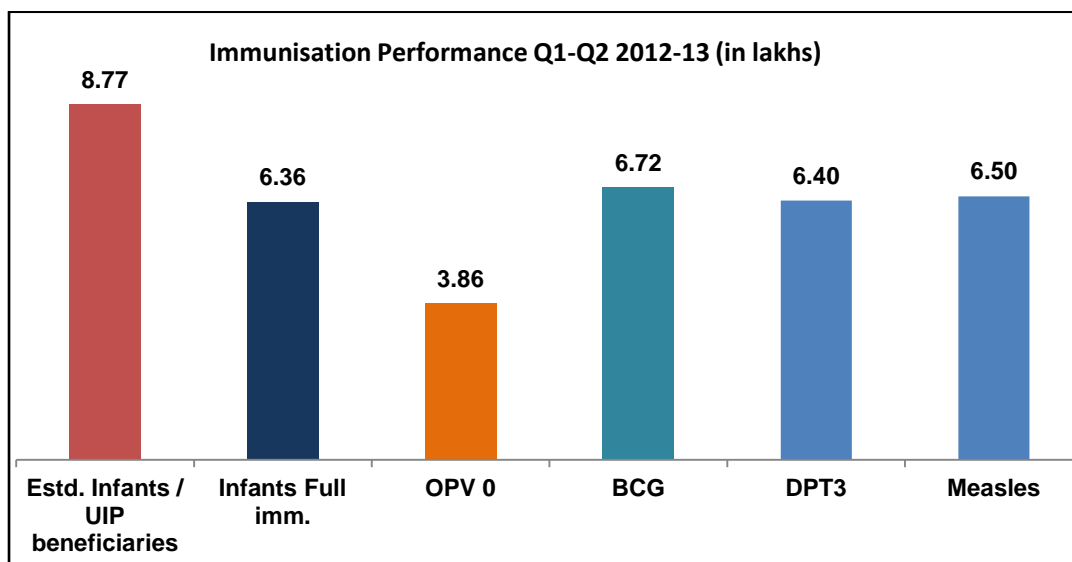


Figure 14 Performance of Immunization in 2012-13 for Rajasthan State.

4.1.6 Malnutrition Treatment Centre

- Although a separate area had been designated in district hospital as an MTC , there were several issues related to its functioning; - solitary staff designated for MTC. untrained, bed utilization was poor, protocols were seen displayed
- One child admitted in MTC Sawai Madhopur was given formula feed purchased from market.



Figure 15 MTC, Sawai Madhopur

4.1.7 Family planning:

- District Quality assurance committee for family planning had been constituted and had convened few meetings
- Fixed days services for sterilization and IUCD was not available at most facilities at districts
- Sterilization, minilap, PPIUCD and IUCD performance was poor.
- ANMs and staff nurses were not familiar with IUD insertion techniques
- ASHAs were distributing contraceptives and sanitary pads to beneficiaries at doorsteps.

4.1.8 Maternal Death audits

- Maternal death audits were being conducted but documentation was poor.
- Awareness on maternal and infant death audits was generally lacking among service providers.
- As regards grievance redressal, very recently a 24 x7 complaint number has been activated in the DM's office to register any type of grievance pertaining to health services which is found to be working.
- Trainings have been conducted up to block level and ASHAs have started reporting maternal deaths. But notification of institutions for conducting FBMDR and subsequent review in the institutions is yet to happen.
- Since April, 2012 a total of 494 maternal deaths have been reported and review reports of 322 deaths are conducted at district level. But these reviews are not conducted District Magistrate as per GOI guidelines.
- Analysis done by the state on these deaths is given below. Many of the deaths are coming under the category 'others', which makes the analysis less useful. Among the identified causes, hemorrhage (37%) is the largest. It also highlights a need for orientation of service providers on the correct classification of maternal and infant deaths.
- An amount has been budgeted for Infant Death Audit to be initiated as a pilot in the high focus districts with instructions to the state to share the methodology and findings with GoI; the entire sum remains unutilized. If properly utilized this can help in improving the reporting practices and provide reliable data on infant mortality rates.

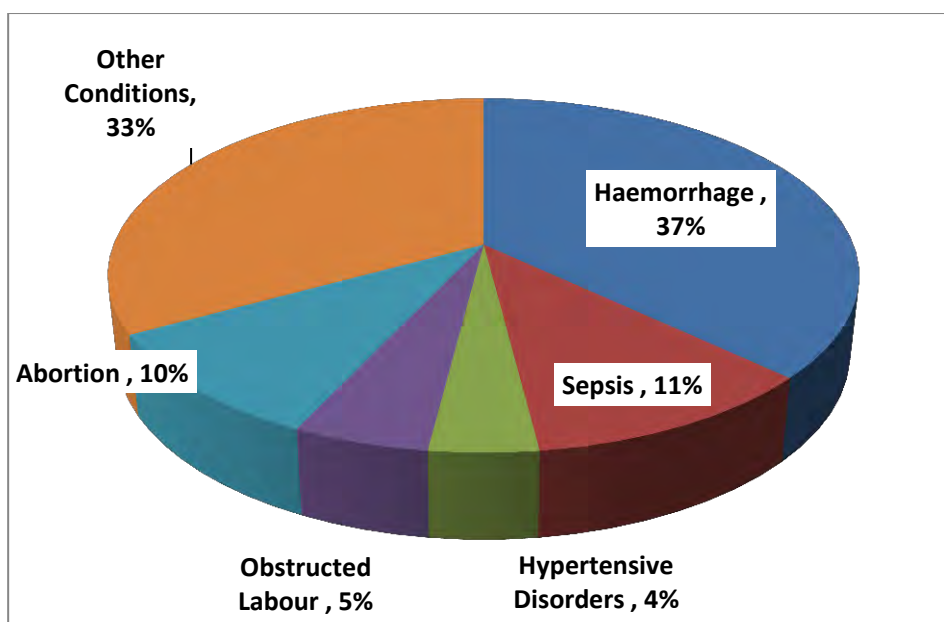


Figure 16 Causes of Maternal Death

○

Recommendations:

- Comprehensive capacity building, particularly for skill-sets related to MH, CH and FP services required.
- Rational deployment of available staff for optimum utilization needs to be worked out on a case-to-case basis.
- More Level 2 & Level 1 facilities need to be made operationalized through specialist deployment of trained staff.
- Internal monitoring and supervision to be strengthened by using block level, district level and state level RI monitoring teams using structured formats and updating on standardized excel sheets.
- Quality assurance committees at district should be monitored from the State HQ on a monthly basis.
- The State needs to analyse Parity-wise data (in the given format of GOI) for performance in sterilizations as well as IUCD, which will not only help the State but also the monitor district performance and any improvement in the trend of services provided.
- Counsellors need to be appointed at the earliest, which will help in uptake of IUCD and PPIUCD services. The State should also enhance the skills of medical officers to carry out Minilap operations in order to enhance the services in the peripheral health institutions. The State also needs to maintain a database of (empanelled) trained providers to carry out minilap operations. Unless the State ensures district specific strategy in high focus districts with regard to Family Planning services, the unmet need for family planning in these districts will continue to remain high and decline in State TFR (3.1 SRS,2010) will remain a distant dream.
- Large number of high-end equipment need to be made functional through a system of regular maintenance and repair. Annual Maintenance Contract should be put in place at all districts.
- Promotion of spacing through provision of PPIUCD and interval IUCDs services.
- State need to address systemic issues, if any, underlying maternal deaths and action taken.
- IEC in local language for greater awareness on JSSK entitlements at all health facilities.

- Similarly awareness regarding 104 referral services should be increased through enhanced IEC.
- As regards grievance redressal, very recently a 24 x7 complaint number has been activated in the DM office (Udaipur) to register any type of grievance pertaining to health services which is found to be working.
- Activities under ARSH, Child Health, Training and Urban RCH needs to be strengthened by the state immediately.
- The policy of operationalization of delivery points may be reviewed. Strengthening of facilities is taken up based on catchment population and flow of deliveries.
- Special efforts need to be made to operationalize ARSH counseling at CHCs and
- An effective system of identification, referral and follow up of mild, moderate and SAM children be established. The state government may take up pilots with support from business and Development Partners.,

5. NATIONAL DISEASE CONTROL PROGRAMMES (NDCP)

The State is doing well on the National Disease Programme front. The case load and deaths due to diseases over the years have been declining.

The details of the programmes being implemented under NDCP are as follows:

5.1 NVBDCP:-

Positives

- ABER recorded more than ten during last three years in the state. Surveillance has been found to be satisfactory.
- The API & SPR of last three years recorded less than one which indicates that low level transmission is being maintained in few pockets/villages and remaining areas are free from Malaria.

Observations:

- The post of Zonal Entomologist at Udaipur and state entomologist at Jaipur are lying vacant.
- The reasons for increasing mortality due to Malaria to be identified and remedial measures for reducing the deaths to be undertaken.
- Separate Action Plan for high risk areas may be prepared and included in PIP 2013-14.
- The effected anti malaria drug, rapid diagnostic kit (RDT) and adequate funds available with state utilized for reducing deaths due to Malaria.
- Under PIP 2013-14 for high and low risk villages separate Action Plan to be drawn for reducing the transmission. The areas free from Malaria, status to be maintain in 2013.
- In most of the PHCs & CHCs monocular microscopes are still being used for detection of Malaria parasites even though the binocular microscopes were available
- Disposable lancet were not used for preparing blood slide
- Staining Jars for JSB I & II were not seen during the visit. For quality staining these equipment's are essential may be supplied to PHCs/CHCs.

- Blood slides of all fever cases reporting at OPD in PHC/CHC and District Hospitals to be prepared for screening the malaria parasites.
- The kits used for detection of Dengue/Chikungunya positive at PHCs/CHCs is not technically approved under the programme.

Table 17

Year	ABER	SPR	API	%PF	Death
2009	11.4	0.42	0.48	5.4	18
2010	12.6	0.58	0.74	4.6	26
2011	12.5	0.63	0.79	5.5	45
2012*		0.57		2.5	0
2011*		0.67		4.9	29

*Compared up to October.

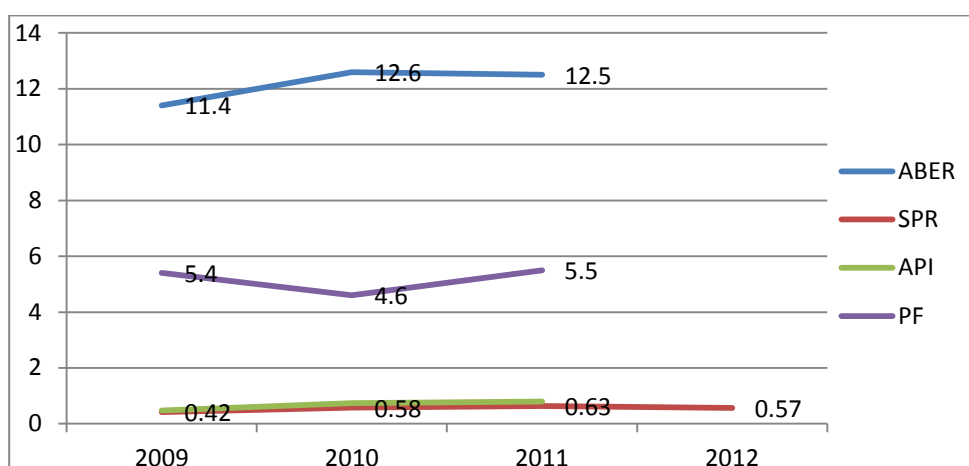


Figure 17 Trend in Various indicator of Malaria Control Programme.

Recommendations

- All the vacant post at District/Zonal entomological team need to be filled up.
- In view of changes in ecology of vectors of VBDs, there is a need to monitor the vector surveillance such as density, resting and feeding behavior including susceptibility of malaria vectors in high risk areas.

5.2 Situation of Dengue & Chikungunya in Rajasthan (2009 to 2012):-

Table 17.1

Year	Dengue		Chikungunya		Districts affected by Chikungunya
	Cases	Deaths	Cases	Deaths	
2009	1389	18	106	0	105-Jaipur, 1-Dausa
2010	1823	9	531	0	284-Jaipur, 247-Bikaner

2011	1072	4	266	0	120-Jaipur, 122-Bikaner, 12-Alwar, 01-Ganganagar, 01-Karauli, 02-Sikar, 01-Dausa, 01-Churu
2012 Upto 27.10.12	528	8	38	0	

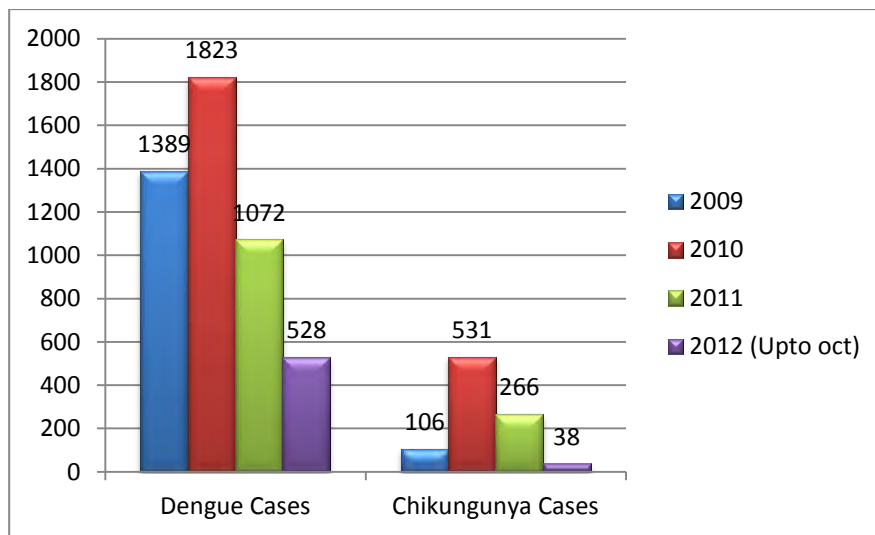


Figure 18 Comparison of Dengue and Chikun Gunya Cases

- The standard test kits for Dengue detection developed by NIV pune have been used

5.3 Vector Control:-

- At PHCs/CHCs Headquarter Hatchery have been constructed under World Bank project in Udaipur District.
- These hatcheries to be maintained for rearing the larvivorous fishes.
- Before the transmission these fishes are to be released in natural breeding places to reduce larval density.
- In CHC, Mavali it has been observed that fogging operation have been undertaken in the villages, where dengue positive cases found in Medical College, Udaipur.
- Under IEC/BCC source reduction once in week to be observed.
- All the earthen pots to be made empty by shifting water using clothes for screening and separating larvae.

Recommendations

- The surveillance found to be satisfactory. The SPR recorded below 1%. There is need for stratification of Malaria Cases village wise to find out the villages free from Malaria in last three years.
- State to identify the poor surveillance districts and facilities and ensure that Target ABER is achieved in these identified districts/ Facilities.
- Special Action Plan in PIP 2013-14 to be prepared for the villages which have reported Malaria and reported Malaria Free in last three years.
- There is need for establishing a Sentinel Site for Dengue at District Hospital, Hiran Magri, Udaipur.
- Special Action Plan for villages reported malaria and villages free from malaria may be prepared & included in PIP 2013-14.
- Most of the places monocular microscopes or were used for detection of malaria parasites need to be replaced by binocular.
- The lancet used for preparing blood slide was defective in all the laboratory of PHC/CHC. Disposable approved lancet to be used for pricking the finger of patients.
- The periodical activities need to be undertaken in high risk areas for prevention & control of VBDs including IEC/BCC for dengue.

5.4 NLEP

Under National Leprosy Eradication Programme 62961 cases has been detected out of that 61863 patients have been cured and released from treatment after completion of treatment in the State. At present 1098 patients are under treatment. The State prevalence rate is 0.16 per 10000 Populations and National prevalence rate is 0.69 per 10000 Population. 641 new cases have been detected and 675 patients have been made RFT after completion of treatment up to Nov 2011.

Positives

Prevalence Rate of Leprosy decreased from 0.20 in 2007 to 0 .15 in 2012 (NLEP), the State has achieved elimination level for some years now. (Provisional CBHI 2011) As per HMIS the prevalence rate is 0.16.

5.5 State Initiatives

- Capacity building of ASHA.
- Monitoring and supervision at State and district level.
- Plan for reconstructive surgery Disability prevention and medical Rehabilitation (DPMR)
- MDT drugs are readily available at every PHCs/CHC and DHH.
- Prevalence rate at Udaipur is per 10000 and at Sawai Madhopur is per 10000.
- The district wise annual new case detection rate (ANCDR) at Udaipur is per 100000 and at Sawai Madhopur it is per 100000 populations.
- None of the districts have a prevalence rate of more than one per 100000 with district having the highest prevalence of and District has the lowest prevalence of 0.23 per 100000.
- Availability of funds and drugs at all levels – the budget received its adequacy and its utilization and the drug logistics.

- MCR footwear: - GI MCR footwear supplied by State Leprosy cell and being supplied to Beneficiaries.
- New cases are referred by ASHA, HW (F) to block CHC. Block CHC MO I/c screen cases and Validate done by DMO/ ADMO (PH) then after MDT is given.

Recommendations:

- The State should continue the good work under NLEP.
- The focus should be on the maintaining the elimination in the entire state.
- Vacant DLO post should be filled at the earliest

5.6 National Programme for Control of Blindness (NPCB)

The aim of NPCB programme is to decrease the prevalence rate of Blindness from 2.24 to 0.34. At present the prevalence rate of the Blindness is 1%. The major causes of blindness being cataract (62.6 %) and refractive errors (19.7 %).

Major Causes of Blindness

Table 17.4

S. No.	Causes	Prevalence
1	Cataract	62.60%
2	Refractive Error	19.70%
3	Glaucoma	5.80%
4	Corneal Blindness	0.90%
5	Posterior Segment Disorder	4.70%
6	Surgical Complication	1.20%
7	Posterior Capsular Opacification	0.90%
8	Other	4.19%

As part of NPCB the Cataract Operations performed

Table 17.5 Achievements

Year	Target	Achievement	%
2004-05	230000	263315	114.48
2005-06	230000	271215	117.92
2006-07	230000	265950	115.63
2007-08	325000	316676	97.44
2008-09	300000	223690	74.56
2009-10	300000	216573	72.19
2010-11	300000	251899	83.97
2011-12 (Upto Nov)	285000	145109	50.93

11)			
Total	2200000	1954427	88.84

Second Eye Screening: - Refractive error and low vision is reported to be second most important cause of visual impairment next to cataract. More than 19.70% of population is having refractive error. They are easy to detect and treatment is easy and cost effective.

Out of the approx 115 lacs students in the age group of 6 to 14, the State has screened 10372031 students against a target of 73,000,00 up to November 2011. (April 2004 to Nov. 2011).

State Initiatives

Prevention of ROP Blindness – A Public Private Partnership with National Rural Health Mission Rajasthan/State Programme Committee (Blindness), Rajasthan & Nethralaya of Bangalore

Retinopathy of Prematurity (ROP)

The pilot project will consist of setting up Tele-ROP screening in 2 divisional headquarters with medical college hospitals with facility to perform retinal procedures on infants.

5.7 Revised National Tuberculosis Control Programme (RNTCP)

RNTCP was pilot tested in Jaipur City in the years 1995-1997 and was implemented as a national programme in the year 1997 and expanded throughout the State in phased manner. The whole State was covered under RNTCP by the end of the year 2000.

The phase wise expansion in the State has been as follows:-

- 2008-09 - Seven districts (Jaipur, Ajmer, Bhilwara, Tonk, Dausa, Alwar, Sikar)
- 2009-10 - Eight districts (Jhunjhunu, Nagaur, Jodhpur, Pali, Jalore, Sirohi, Barmer and Jaisalmer)
- 2010-11 - Six districts (Udaipur, Dungarpur, Banswara, Rajsamand, Chittorgarh, Pratapgarh)

The State has made good progress under RNTCP. Reference laboratories have been upgraded.

State initiatives

- State TB Cell has been established.
- 34 District TB centres established.
- 150 TB Units established (one for every 5 lakh population and one in 2.5 lakh population in desert areas which are inaccessible).
- 825 Microscopy centres established (one in one lakh population and one in 0.5 lakh population in desert areas).
- 2000 Treatment centres established (one in 15 000 to 30 000 population).
- 2 culture labs established Ajmer & Jaipur).
- One DOT Plus centre (SMS Med College)

Observations

- i. Annualised case detection rate has declined from 172.5 per lakh population to 170 from 2006 to 2011.
- ii. New Smear Positive Rate (64 %) has remained constant from 2006 to 2011.
- iii. Success rate for treatment has improved from 85 % in 2006 to 89 % in 2011. Financial Managements guidelines of NRHM are being shared with programme officers.

INTEGRATED DISEASE SURVEILLANCE PROGRAM (IDSP):

- The State has one surveillance Unit and 34 district surveillance units functional with IT manpower.
- The State surveillance officer and district surveillance officer and state and district epidemiologists are all in place.
- All districts are reporting on time Early Warning System (EWS) is in place and is reporting outbreaks.

State Initiative

To address outbreaks the State has adopted the following initiatives:-

- Multi sectoral approach
- Identification of vulnerable pockets
- Health Education
- Strengthen routine surveillance and reporting

Observations

- The IDSP data are analyzed at District level every week & the epidemiological situation assessed.
- Though the State claims that all posts were filled the District Surveillance Medical Officer & Epidemiology posts are vacant.

- The IDSP Early Warning report generating every week (even if 'Nil' report also) & submitted to the State Surveillance Unit in time.
- The analysis reports are shared with district administration in the Monthly Review meeting & also in State Health Review meeting.
- Weekly reporting of Key diseases done regularly.

Recommendations

- The health administration at the state and district levels should be sensitized to possible increased demands for achieving ambitious objectives under the various disease-control programs during the 12th Plan. This, for example, would include identification of and planning for the capacity required to implement MDR-TB response.
- Malaria control may provide a particular opportunity for a “quick win” in Rajasthan, where malaria transmission is in many places moderately endemic, and may therefore be amenable to being broken. Government should consider mass distribution of LLINs which would provide a “community-level” effect, breaking the transmission of the parasite, as well as individual protection, with the potential to substantially reduce malaria incidence. This should be accompanied by ensured access to malaria diagnosis and effective treatment.
- In health facilities, inpatient beds should systematically be covered by LLINs.

6. Community Processes including ASHA, PRI, VHSNC, Community Based Monitoring and NGO Involvement.

6.1 State Initiatives

- Convergence with ICDS, ASHA sahyogini are paid an honorarium of Rs. 1100 from Women and Child Development Department.
- To organize ASHA trainings in timely, state plans to issue common guidelines & budget for all ASHA trainings & build up a team of trainers.
- Monthly review meeting of District ASHA co coordinator are organized at state level.
- For the capacity building of ASHA supervisory structure, 5 days training of all structure has been planned by December 14, 2012 with support from Development Partners.
- To monitor the work of ASHA the State has implemented the performance monitoring tool.
- To insure the regular payment of ASHA state planned to integrate all ASHA incentives for paying in monthly meetings of PHC level.
- For Motivation of ASHAs, state planned to give award to three best ASHAs in every district on the lines of ANM based on their performance indicators.



Figure 19 ASHA Sahyogini

- Draft of ASHA Newsletter & ASHA Diary is ready to print so in this year, every ASHA will get the ASHA Diary
- Eligibility criteria for selection of ASHA is minimum 10th Pass, but in those places where the literacy rate is poor, state has relaxed the eligibility criteria to 5th pass candidate.

6.2 POSITIVES

- 54915 ASHAs were selected out of 51500 (93.78%) required.
- Drug Kit has been provided to 45178 ASHAs.
- The ASHA (Sahayogini's – in Rajasthan, they are called so), are able to manage an income ranging between 1500 and 2500; thanks to the monthly honorarium of 1100.
- The Sahayogini's with whom the team interacted were very proactive and shared support from ANMs. Many of them are doing (in addition to JSY) blood slides for malaria.
- 43440 VHSCs are constituted, these VHSCs work under the chairpersonship of elected members of Panchayat. (97% of the required VHSCs)
- Till September 2011, 202036 members from 35363 VHSCs have been oriented.

6.3 Constraints

- Training of module 6 & 7 has been completed only by 46% of ASHAs.
- No career path has been designed for ASHA.
- Proper Grievance redressal mechanism is not in place.

6.4 Observations:

- ASHA are the vibrant face of NRHM and well-motivated. Of the selected ASHA only 87.7% are functioning.
- Of the working ASHA (45178) all have received drug kit.
- ASHA have been well trained and retain the skills learnt.
- Training of ASHA is done by the ASHA Resource Centre and Training have been started for module 6 and 7. All the State trainers (10) and District and Block Trainer (633) have completed training on 6th and 7th Module.
- Almost all the ASHA trained till module 5 have received training in IMNCI.
- ASHA are coordinating the VHSCs; however attendance of ASHA in meeting is very poor.
- Almost 50% of the posts in Udaipur (Kotda Block) are lying vacant as this being a Tribal Block and they are finding it difficult to get an eligible candidate.
- State shared ASHA contribution in many of its achievements, table 1.
- Achievement of ASHA for Motivation for Complete ANC (53.19%) PNC (68%) is good however for institutional delivery is low.
- HBPNK The guideline and kit has not yet been distributed to ASHAs.
- Many Instances of delayed payment to extent of 2-3 months was observed in District Sawai Madhopur. State has asked district officials to give regular information of non payment to state & ASHAs can directly send non payment information on toll free no. 104). However the awareness about 104 was poor among the ASHA.
- In Sawai Madhopur, as VHSC meeting were conducted at Panchayat level ASHA were paid incentives of Rs 100 on every Alternate months thereby monthly incentives for ASHA going down,
- Almost all the ASHA get paid an amount of less than Rs 350 monthly from the health sector and as ASHA being paid from WCD department an amount of Rs 1100 earn around Rs 1500/month.
- Concern was shared by ASHA in Sawai Madhopur that the fixed incentive payment to AWW was increased to about Rs 3000/month which was leading to de de-motivation of ASHA workers.

Table 18. Performance of ASHA-Sahyogini (April to Sept.2012)

Indicators	State Achievement	Contribution of ASHAs	Contribution %
ANC Registration	976805	397986	40.74 %
Complete 3 ANC	685749	364724	53.19 %
Institutional Delivery assisted	649694	178357	27.45 %
PNC Visits	314153	214953	68.42 %
Sterilization Cases motivated	97213	26777	27.54 %
Provided Dots to TB Cases	78865	6844	8.68 %
Cataract Cases Motivated	91618	1595	1.74 %
Attendance in VHSC Meetings	542136	173676	64.07 %
Attendance in PHC Meetings	542136	208009	76.74 %

6.5 Support Structures for ASHA

- State has a good ASHA supervisory Structure in place.
- Almost 60% of the Block Health Supervisor (earlier called Block ASHA supervisor) and 27% of PHC Health Supervisor posts are lying vacant.
- Many instances of District ASHA co coordinator being given the Additional Charge of DPM were observed hampering the programme implementation.
- Acute shortage of Master Trainers most of them have other administrative duties as most of them are district level officers.

Table 18.1

Status of ASHA Support structure in Rajasthan 2012-13			
S.No.	Name of Post	Sanction	Working

1.	District ASHA Co-Ordinator	34	25
2.	Block Health Supervisor	249	100
3.	PHC Health Supervisor	1472	1076

6.6 Community Based Monitoring

The Community Monitoring process was carried out in 180 villages, 36 PHCs and 12 blocks. In the first phase of monitoring, four districts were chosen, Alwar, Chittorgarh, Jodhpur and Udaipur in Rajasthan. (National Report on Community Monitoring, NHSRC 2009).

After the first round of monitoring it was observed that there was a significant improvement in health services delivered in all the four districts. However after the first phase of implementation this community monitoring was discontinued.

6.7 Observation

- None of the facilities were monitored in the districts visited.
- Display of Citizen Charter was found in some places facilities.
- Even though the drugs, diet, lab services and free transport was found to be available, display of availability of these services except drugs were limited.

6.8 Panchayati Raj Institutions

- State direction that the ANM and ASHA worker to work under the supervision of PRI is yet to be implemented.
- Involvement of PRI in District Health Mission is poor.

Recommendations

- In Tribal areas where eligibility criteria for ASHA selection are not being met, need to relax the criteria for ASHA selection could be considered.
- A separate strategy to be devised for their selection, training and operationalization for difficult areas.
- ASHA in the Tribal area should be provided with IEC materials in local dialect with pictures to bring better communication and awareness in those areas.
- A career progress plan could be considered for ASHAs who are performing well and can become role model for other ASHAs.
- All the vacant position of Block ASHA coordinator needs to be filled up. This recruitment could be de centralized to the districts.
- The training of 6th & 7th module being highly technical requires hands on training and should be given by qualified trainers well versed in the clinical aspects.
- Waiting Hall for ASHAs should be considered while escorting all pregnant women for deliveries to institutions.

- Appropriate grievance redressal mechanism at state and district level should be put in place.
- The process of community monitoring should be reintroduced and scaled up to the entire state.

7 PROMOTIVE HEALTH CARE, ACTION ON SOCIAL DETERMINANTS AND EQUITY CONCERNS.

7.1 Observations

- State has made significant efforts to bring about the convergence between the health and health related sectors, like sanitation and drinking water etc.
- Observance of VHNDs, joint micro planning at the sub centre level (for immunisation, health checkups) are found to be effective in bringing functionaries of two departments (health & ICDS) together in addressing common issues.
- Also, use of the new mother and child protection (MCP) card, and growth monitoring chart has resulted in convergence at village levels.
- Regular meetings of VHNSC with participation of health personnel (LHV/ANM/ASHA) on the planned dates have led stronger convergence between health and ICDS and PRI.
- Key factor observed in the Rajasthan Districts was excellent coordination between frontline functionaries of ICDS and Health particularly between ASHA and AWW.
- Demand for better quality health and nutrition services from the community through community mobilization efforts like. VHSNCs

Recommendation:

- There is need to strengthen functioning of VHSNCs through training of VHSNCs members.
- Field assessment of functioning of VHSNCs through NGO support is required.
- NGOs can take up exercise of gradation of functional VHSNCs based on certain criteria such as Monthly meetings, Village Health Plan Status, Activities implemented, record maintenance, health bulletins and statement of expenditure submission.
- Need to strengthen the referral mechanism from community to Health centres to address Malnutrition at community levels.
- Data on severely malnourished children should be shared with the ASHA and ANMs on a regular basis for timely actions and referrals during VHNDs and Monthly meeting held at PHCs.
- Recent guidelines of GoI (MWCD) on formation of monitoring & support committee at the AWC level under the chairpersonship of PRI Member to monitor AWC activities may be considered and roles of such committee may be appropriately integrated with that of GKS, to have better convergence and to avoid any overlap/duplication.

7.2 PCPNDT:

- The declining child sex ratio (883, AHS, 2010-11) is a cause for concern.

- The PCPNDT act is being implemented in the districts. District advisory committee has been formed under the Chairmanship of Collector and District Magistrate with representation from the police (Deputy Superintendent) and representatives from DPMU, Directorate of health services and Social welfare officer.
- A total of 2169 facilities were registered under the PCPNDT Act. However conviction rate of cases is poor (2 conviction out of 469 complaints filed).
- Rajasthan Medical Council has suspended registration of 21 doctors pending trials.
- 15 decoy operations have been conducted so far.

7.3 State Initiatives:

- **Mukhbir Yojana:** launched for the person giving information about the Sex Selection in which award of one lac provided.
- State Government established 7 Upper Chief Judicial Magistrate Courts at zonal headquarters for speedy disposal
- Four “Hamaribeti Express” vans launched on the 11th April 2012 and are creating awareness among the people regarding declining sex ratio.
- 342 NGOs identified have been identified to ensure the NGO participation in the IEC and implementation of activities related to PCPNDT.
- PCPNDT Bureau of Investigation has been constituted, 120 new posts have been created.

Total Registration under PCPNDT Act	2149
Government facilities-	142
Private	2007
Total Inspections	3477
Seal & seizures	330
Suspension	164
Cancellation	321
Complaint filled in court	469
Convictions (1-Jodhpur & 1 Bikaner court)	2

Table 19 Showing the status of Implementation of PCPNDT act.

RECOMMENDATION

- There is urgent need to intensify the conviction of court cases. Implementation of the current PCPNDT strategy should be a priority.
- There is urgent need to revisit the strategy of PCPNDT implementation at state level and need for intensification of mass communication and involvement of all the stakeholders including the inlaws in sensitizing them.
- The first step is to collect information from a sample of female health workers in the state on the incidence of such problems.
- Gender sensitivity training for mid- and upper-level management in the health system should be done.

7.4 School Health Programme.

District Observations

- In the primary school visited by the team in Udaipur district, the children were provided annual health check-up, the head master reported quarterly visit by ANM and a register capturing health conditions of the students could also be seen.
- At the time of visit, mid-day meal was being provided.

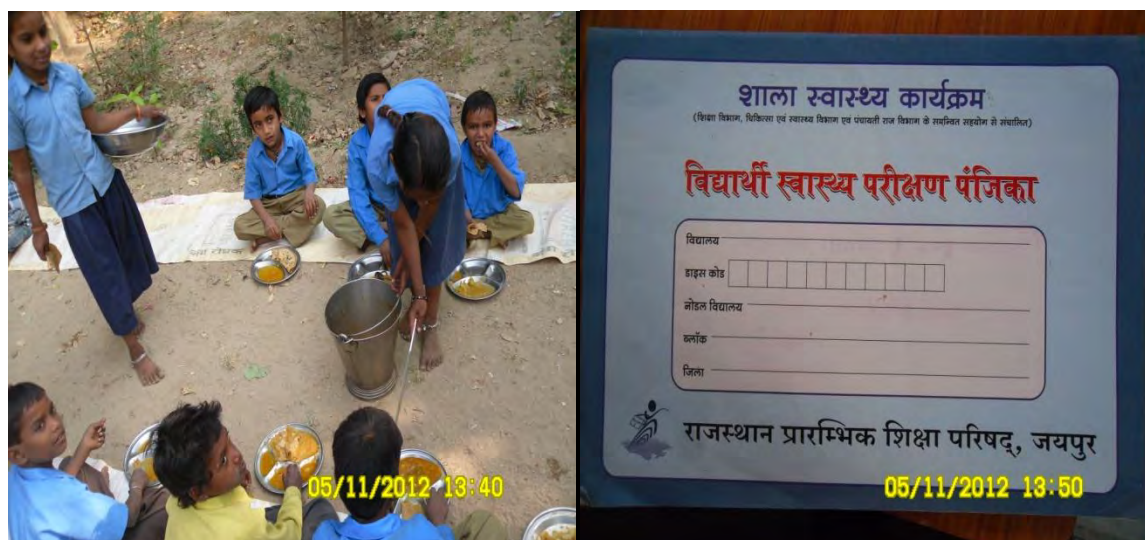


Figure 20 Primary School Jhadol.

8. Program Management including monitoring, logistics and issues of integration and institutional capacity.

8.1 PROGRAM MANAGEMENT

State Initiative

- The total strength of staff for SPMU across CRMs has increased from 10 to 20 and the number of DPMU has increased from 129 to 268 and that for BPMU from 1539 to 3280.
- However there are vacancies at district and block level management positions.
- After introduction of NRHM, investment in the health sector has increased manifold. Unilateral increase in health budgets will not be sufficient to attain the health outcomes unless sound and enabling structures, institutions and adequate manpower is in place. In order to provide techno managerial support to programme, accounts and data analysis and monitoring for Mission activities; there is a programme management unit at block and district levels. DPMs, Accounts Managers, DHIOs for MIS are in place in all DPMUs to facilitate overall management.
- In addition to the staff available, all blocks that have initiated MCTS (Mother and Child Tracking System) should have an additional Data Entry Operator/MIS Coordinator and a Community level

mobilizer. The managers are good, dedicated, but lack of supervisory skills, which required to be supported by the technical knowledge of regular health services officers, both at the State level and at the district level. The gap between the Programme Officers (State & district) and the SPMSU/ DPMSUs was evident with out any effort.

8.2 DRUG PROCUREMENT SYSTEM

Drug availability in the state has improved due to the Rajasthan Medical Services Corporation (RMSC), which came into force from October, 2011. Under the RMSC the state has prepared an Essential Drug List with 477 medicines, distributed through Drug warehouses to drug stores in the institutions.

Process of tendering

Under the new drug procurement policy, procurement of Drugs, Surgicals & Sutures were made Competitive through Bidding. Purchase preference was restricted to 25% only, out of which 10% was for the state PSU's and 15% for state SSI's, that too on the condition that it would be necessary for them to match with the L1 rates obtained through tendering. Tenders were invited after adequate publicity through State and national level news papers and by displaying on the official website of Medical Department of the state.

Bid evaluation

The technical bid was evaluated on the basis of 'evaluation criteria' prescribed in the tender document. A list of qualified bidders was then displayed on the website of Medical and Health Department. Subsequently, price bids of qualified bidders were opened in the presence of bidders. Finally the rates quoted in the financial bids were compared and contracts awarded to lowest evaluated and responsive bidders.

Good Manufacturing Practices

The manufacturing premises of the tenderers participating in the RMSC tender were inspected for compliance of Good Manufacturing Practices, Good Laboratory Practices and for verification of their production capacity. After Purchase Committee approval, letters were issued to the L-1 tenderers for execution of agreements and deposit of Security amount. This procedure ensured transparency and quality in procurement.

Quality Control

Quality control was ensured in the following manner. As soon as the drugs were received in the warehouses from the suppliers, the corrugated boxes were numbered and same fed into the computer system. Samples were drawn randomly from the supplies from each batch. The samples drawn were then sent to the Quality Control department in the Head office.

After the samples were received in the Head office from all the warehouses, common batch of an item was mixed and samples were drawn from pooled batch. Steps were taken to remove / hide the identity of the manufacturer and encode the formulations secretly. The formulations / items

assigned secret codes were sent to Empanelled Laboratories for analysis. The Empanelled Laboratories analyse the drugs as per specifications; and suitable test protocols. Upon receipt of reports from the Empanelled laboratories, the results were sent to the warehouses through E-mail, besides other methods. If any sample sent to the Empanelled laboratories failed in quality, the result was reconfirmed with the other Empanelled laboratories/ Government Analyst before taking final decision.

If the drug failed in assay or any other parameters, action was taken by the Q.C. Department immediately; the stock frozen and removed from the main stock and kept separately until it was cleared by the Quality Control department. If the Empanelled Laboratories/ Government Analyst confirmed the failure of the drug to meet the standards, steps were taken to return the stocks to the supplier. After 30 days of the letter for return of stocks, if the stocks were not taken by the Supplier and were lying in the warehouses, penalty of 2% per week was levied on the value of stocks in the warehouse till it was destroyed by RMSC (90 days).

In the case where statutory sample drawn by a Drug Control Officer from user storage point (hospital) was declared substandard by the Government Analyst, the issue of the product was stopped immediately and the drug supplied recalled from the hospital. The Warehouse in-charge intimates every institution where the batch was supplied, for retrieval of the drugs. Total value of the quantity supplied by the supplier was deducted from their bills. Depending on the nature and extent of non-conformance of the product, decision to blacklist the product/ Company was to be taken after due procedure.

The State Drugs Controller was informed of the drug being declared 'Not of Standard Quality' so that appropriate action could be taken to ensure the quality of drugs of the manufacturer in question. The stability of the drugs during storage period in the warehouses was also checked from time to time by drawing samples and getting the drugs analyzed.

In the institutions visited, the drug stores had enough stock of medicines, and the book of records (stock, indent etc.) kept.

9 Knowledge Management including technical assistance, SIHFWs, SHSRC, ANMTCs, DTCs and use of Information Technology.

The State besides SIHFW, State has 17 ANM training centres and 15 GNMTC.

9.1 State Institute of Health & Family Welfare –Rajasthan

SIHFW- an apex Level autonomous training Institute was established in July 1995 as a registered society by the Government of Rajasthan (Dec 1995 to Dec.2001 – IPP- 1X).

The Faculty at SIHFW consists of Director, Registrar, 2 Faculty, Senior Research officers-14 and Research officers- 09

The Functions of SIHFW are Training, Research, Monitoring, Recruitments, Consultancy, and Documentation.

In spite of SIHFW being an apex institute for training has not been able to improve trainings/capacity building in the State. The aggregate figures for training in Phase 1 of NRHM for SBA are 7 %; BEmOC 25 % and LSAS is 31 %.

9.2 ANMTC

The State has 17 ANMTCs. The ANMTCs has a faculty of principal, 6 Tutors and one warden. The regular posts of faculty are filled up by deputation of LHV/ANMs from Health centres. Most of the faculty has not been trained to train ANM students.

Students are admitted after 10 th for 18 months training.

District Observation

The ANMTC at Sawai Madhopur has been temporarily taken over by the Drug Department and is being used as a depot for storing drugs. It is understood that this arrangement will continue till the Drug Ware House being constructed is not complete.

In the meantime the students are taught using one room as a lecture. There are no chairs or tables for the students.

The numbers of students have been increased to 90 without any increase in the faculty. This raises question on the quality of training

9.3 DISTRICT TRAINING CENTRES (DTC)

Out of 33 DTCs, only 15 DTC were in place. There was no DTC at Sawai Madhopur.

- No MPH training schools in the State.

9.4 Training

- Training status is poor in the State. The aggregate figures for training in Phase 1 of NRHM for SBA are 7 %; BEmOC 25 % and LSAS is 31 %.
- The only good progress is the implementation of IMNCI training in all the 33 districts
- Progress on Training - especially for 1st Qtr 2012-13. Was poor - MH – 0.78 %, CH – 0.32 %, family planning (0.0 % and ARSH – 0.0 % as per NIHFW). The State figures are however different where they reflect the training in CH as – 23.87 % NSSK, 8.06 % IMNCI, 2.34 % FIMNCI and 4.17 % MTC training and in the case of MH – 25.42 % BEMOC; 12.5 % EMOC . Training needs to be improved in the State.

9.5 NGOs and Collaboration with Development Partners.

State in order to promote Maternal and Child health partners with both National and International Organisation.

The following are the details of partnerships:-

- UNICEF: Quality improvement of prenatal services; community mobilization; capacity of supervisor for supportive supervision; technical support for improving FBNC services, IMNCI, operationalization of MTC. *Technical support under RCH is provided in 5 High Focus District of Rajasthan and technical persons have been deployed at these 5 districts.*

- UNFPA: population stabilization, facilitation and technical inputs in FW training, quality assurance of health institutions and services.
- NIPI is promoting newborn care through Yashodas.
- Other Agencies: also support in RCH activities- Marie Stopes, IPAS, JHPEIGO, PSI,HLFPPT, ARTH.

Yashoda programme by NIPI

- *Intervention started in three NIPI districts in August 2008*
- *Intervention up-scaled in all the districts in July, 2009*
- *555 Yashodas working in the state at 28 District Hospitals and 42 CHCs*
- *Based on data from three districts visible improvement in:*
- *Weighing Newborns (100%)*
- *The Initiation of Breast Feeding (<1hr) which was 41.9% (DLHS 3) is now around 81.35 percent where Yashodas are deployed*
- *BCG and Zero Dose Polio Vaccination which was around 60-65% before deployment of Yashodas is over 90%*
- *Stay of mothers more than 24hrs (99%)*

9.6 Information Technology

The State is using Information Technology to improve Monitoring and Evaluation (M & E). The Demographic Wing is reporting unit for HMIS. A seven member team has been constituted for HMIS & MCTS. Data is being uploaded at PHC/CHC level.

A concurrent evaluation has been proposed by external agencies along with regular monthly monitoring by State.

State has its own portal called Parent and Child Tracking System and all the data is being entered into this through online portal. In those districts where Computers and Internet facilities are not there till PHC, data is entered at block PHC level. However state does not have an interface with MCTS portal and entry in MCTS portal is done manually at district level which might lead to gross error in data.

There no system of internal validation of data. Most of the data entered in PCTS is manually checked and corrected by the statistical inspectors without verification. This might lead to gross error in HMIS information.

Mission Connect

- In Sawai Madhopur, under this scheme, all the ANMs and ASHAs have been provided with CUG post-paid SIM cards for better communication and service among employees of H & FW departments. The related cost is being managed from the untied fund of the sub centres.
- It helps in better communication and service delivery, Strengthening MIS and reporting tools, develop interaction between user groups, prompt information sharing during epidemic & other emergencies

9.7 Recommendations

- Training or capacity building is a huge issue in the State. Training performance of the State is poor. It is suggested that training be given greater priority. SIHFW should be given the overall responsibility of training.
- Regional (Divisional) Training centres under SIHFW should be developed to oversee the training in the State. Each Regional (Divisional) Training Centre should have 4-5 districts under them and should be responsible for all trainings in these districts.
- Each district should have its own training centres to undertake training within the district. The training should be monitored regularly (bi-monthly) centrally by the State.
- The creation of posts for health facility/hospital and public health administrators should be especially considered to handle planning, programming and management tasks.
- Given the shortage of specialists in the district, it is suggested that multi-skilling of the Doctors be taken up on a priority. This will help in bridging the gaps for specialists. Medical Officers could be trained in LSAS and EmOC and FIMNCI to overcome the shortage of Gynecologist's, Anesthetist's and Pediatrician's at CHC's and FRU's.
- All 33 DTC should be made operationalized with proper staff and training materials.
- The ANMTCs faculty should be increased in accordance to the increase in students. 6 faculties for a batch of 90 plus students are compromising the quality of training.
- The faculty should be well trained and should be against regular posts filled by the districts and not by deputation. This will be able to address the ANM requirement within the districts.
- State need to develop an interface and synchronize the PCTS masters with the common masters of MCTS.

10. Financial Management-especially fund flows, accounting and absorption

10.1 Human Resource:

State level: In the State there is good team of finance personnel on deputation from the State Government who has strengthened the financial management at State level. Team Consist of Deputy Director (Finance), Joint Director (Finance) led by Director (Finance).

State Finance Manager is also place in the state. Position of the State Accounts Manager is vacant since July, 2008 due to court stay.

District Level: There is vacancy of 2 District Accounts Manager out of 34 positions. In the Districts of Udaipur and Sawai Madhopur are having District Accounts Manager in place.

Block, CHC & PHC level: There is vacancy of 54 Accountants out of sanctioned post of 1098 in the state. In Udaipur District against of 66 positions (PHC, CHC and Block) Accountants only 47 are working. Hence there is overall vacancy to the extent 28% similarly in case of Sawai Madhopur out of 36 positions(PHC,CHC and Block) Accountants only 25 are working .Hence there is vacancy to the extent 30% which is cause of concern.

10.2 Financial Management:

1. Books of Accounts:

- (a) State Level: Books of Accounts at state level is being maintained at default Tally.
- (b) District Level: Books of Accounts at Districts are being maintained on Tally ERP 9.0 not customized version
- (c) Block Level: Books of accounts in block levels are being on Tally ERP 9.0.
- (d) CHC/PHC and below level: Books of Accounts are maintained manually at CHC/PHC level.

2. E-Banking: Fund from State to District is transferred through e-transfer, funds from district to blocks it is being done through e transfer. From block to peripherals level funds is being transfer through cheque in some of the block.

3. Funds transfer: Funds from the state to district level is transfer pool wise not activities. District health action is not being use at state level. In the beginning of the year approved PIP is being sent to district. From the district to block level funds is being transferred poolwise. But from block to peripheral level funds of both pool is send in consolidated manner i.e. RCH and NRHM in combined. At block level there is no segregation of funds.

4. Banking operation: It was observed that in case of SDH, Gangapur One cheque amounting to Rs.1, 00,000 was available with facilities which was bearer signed by one signatory PMO. Second signatory is Joint Director who is situated in Bharatpur. It was explained to the team that Accountant will take cheque to Bharatpur and get it signed which is serious concern and chance of loss of cheque cannot be ruled out.

5. Single Bank Account: It was observed that single bank is used at DHS. District Hospital, Block, CHC, PHC. Funds pertaining to Mission, state sponsored programme and Donor funds like (UNICEF and NIPPI) is being kept is single bank account. It leads non frequent diversion of funds for the activities which is state sponsored like Desk Ghee scheme, Jan-Mangal, RMS etc.

6. At state level there are five bank accounts a) ICICI Bank –2 Accounts (one each for RCH and Mission Flexible), b) Bank of Baroda (Mission Flexible),c) Punjab National Bank d) State Bank of Bikaner and Raipur
7. **Bank Reconciliation Statement:** Bank Reconciliation statement is being prepared at District level as well Block level in Sawai Madhopur district level. It was observed that Bank Reconciliation statement at Block, CHC and PHC prepared wrongly. In the Bank Reconciliation old entries were shown as opening difference in many facilities visited by CRM team. This is not correct financial practice. Further in case of District Hospital, Sawai Madhopur Bank Reconciliation Statement was not prepared for the year 2010-11 and 2011-12 as told by Statutory Auditor of the RMRS (RKS) of the district hospital.
8. **Financial Reports:**
9. It was noticed that FMRs are not submitted in time by DHS to SHS due to non-receipt of UCs from block level (Udaipur).From this month onwards both the DHS are going to submit FMRs by incorporating physical progress.
10. **Concurrent Audit:** Concurrent Auditor is appointed in 33 districts out of 34 districts in the year 2011-12.As informed by the state 23 districts has submitted their report to State Health Society in the year 2011-12.State has not analysed the report submitted by the districts. Further Concurrent Auditor has not been appointed for State Health society for the year 2009-10, 2010-11and 2011-12. The state has appointed Concurrent Auditor for the State Health Society for the year 2012-13.Concurrent Audit for the year 2012-13 is under process. For the appointment of Concurrent Auditor at District health society level for the year 2012-13 tender has been published and process would be over by 15th December'2012. There is lack of attention given to Concurrent Audit as noticed in delayed appointment of Concurrent Auditor. Further there is no mechanism for compliance of Concurrent Auditor's observation at District level as no compliance report has shown to the team.
11. **Tally ERP 9.0:** Tally ERP-9 is implemented at state level, DHS level & Block level. There is difficulty in implementation of customized Tally due to lack of training to staff & frequent modifications in the format of ledgers in accordance with FMR prescribed by GOI. It was noticed that in many blocks Tally ERP 9.0 default version is being used It was noticed that in many blocks Tally ERP 9.0 default version is being used.
12. **Statutory Audit:** Statutory Audit Report for the year 2011-12 in respect of both districts has been taken place. Report submitted to SHS for consolidation. However in respect of SHS there is delay of more than 3 months in submission of Statutory Audit Report to GOI. There is no

definite action is available in district to comply the observations of Statutory Audit reports resulting noncompliance of Statutory Audit observations for the year 2007-8 to 2009-10 (Udaipur).

- 13. Integration of NDCPs:** There is no integration of disease control programme with DHS and SHS. Funds for Disease control programme's is not routed through DHS which causing non reconciliation resulting delayed submission of UCs.
- 14. Monitoring, Evaluation and Capacity Building:** District In charges have been appointed as well as programme wise Nodal Officers have been designated for effective monitoring & coordination. It was observed that Reports/Action action reports are not available at district level for verification. As far capacity building is concern training plan for financial management have been prepared for the year 2012-13.It was observed that there is urgent of training at all level from PHC to District level on financial Management.
- 15. Diversion of Funds:** In case Sawai Madhopur, diversion of funds was noticed from RCH Flexi pool to RI. (As per the direction of Statutory Auditor).
- 16. Financial Utilization:** Utilization of funds is low in case of both RCH (26.81%) and Mission Flexible Pool (12.05%) against approved PIP up to second quarter of the year 2012-13. Further activities having low utilization under RCH /Mission Flexi pool are as follows:

Table 20

RCH Flexi pool Utilization upto sept 2012		Mission Flexi pool Utilization upto sept 2012	
Head	Utilization	Head	Utilization
Maternal Health	1.12%	Untied Fund	8.95%
Child Health	5.53%	AMG –	6.04%
Family Planning	11.10%	New Construction	5.62%
ARSH	7.5%	Corpus Grant –	8.26%
Urban RCH	0.56%	District Action Plan –	0.00%
Training	6.92%	Panchayati Raj Initiative –	0.08%
Vulnerable Group	0.29%	PPP/NGO-	0%
----	----	Procurement –	2.49%
----	----	Planning & Implementation & Monitoring –	0.17%
----	----	SHSRC –	3.23%

Funds were utilized to the extent of 35% as whole in Sawai madhopur district however low utilization was noticed under activities of Family Planning, Training, Untied Funds and MMU. The reasons for low utilization are as follows:-

- Non functionality of FBMNC and MTC.
- Trainings have not been started as per the schedule.
- Less utilization due to non-submission of UCs on time etc.

However in Udaipur low utilization under Child Health, Training, AMG, Corpus grant and Planning Implementation and monitoring. In case Sawai Madhopur low utilization was noticed under these activities are Family Planning, Training, Untied Funds and MMU. The reasons for low utilization are as follows:-

17. Single Bank Account: It was noticed that only single bank account is maintained for JSY, VHSC, Untied Fund/AMG by ANM instead of ASHA. This practice is not as per guidelines.

18. VHSC Banks Account: It was observed that Bank Account has not been opened for VHSC in the state. Untied funds for VHSC were still being transferred to Bank Account of Sub centre.

19. Status of Pending Utilization Certificates:

The State had not furnished Utilization Certificates to the Government of India of Rs. 386.56crore under Mission Flexi Pool and Rs. 339.51 crore under RCH as on 31.03.2012.

Table 20.1

Programme	2010-11 (Rs. in Crore)	2011-12 (Rs. in Crore)	Total(Rs. in Crore)
RCH-II Flexible Pool	40.44	299.07	399.51
Mission Flexible Pool	66.99	319.57	386.56

20. Advances: The State had Rs. 11.10 crore outstanding as advances under RCH Flexible Pool as on 31.03.2012 which increases to Rs. 49.30crore as on 30.09.2012 there is an increase of 4.5 times during the 2012-13 at state level .In case of Mission Flexible Pool Rs.22.84 crore was outstanding as advances under as on 31.03.2012 which increases to Rs.120.61 crore as on 30.09.2012 there is increase of more than 6 times during the year 2012-13. Apart from the advance at state level under RCH and Mission Flexible pool state has other advance as on 30.09.2012 which are as follows:

Table 20.2

Rs.In Crore

Programme	01.04.2012	30.09.2012	% Increase
RCH Flexible Pool	11.10	49.30	344%
Mission Flexible Pool	22.85	120.62	428%
Routine Immunization	0.90	1.04	15%
Other Advances	22.82	23.91	4%
Advances to District	161.87	169.90	4%
EC SIP	8.59	8.59	-
Total	228.12	373.36	63.66%

Further on review of other advances it was observed that some of the **advance is outstanding since 2010-11:-**

Ayush Ajmer : Rs.17.04 crore

National Mental Health Programme : Rs.1.78 crore

Further there are some advances having **negative balance** of since the year 2010-11.

Director (FW) (Naguar DHS) : Rs.2.59 lakhs

Advance RI & PPI (DHS) : Rs.2962 lakhs

Old Advance RCH-II Flexi Pool : Rs.31.63 lakhs

Director, ICDS Sahyogini : Rs.70.08 lakhs

RHSDP Advance (Executive Engineer) : Rs.312.18 lakh

State may take corrective actions to settle the pending advances and do the reconciliation to clear negative balances under above advance.

21. State contribution: During the year 2012-13 the State contributed Rs. 101.90 Crore. State share amounting to Rs.219.02 crore is due on the of basis of allocation for the year 2012-13.Details are as under:

Table 20.3

Year	Amount required to be credited on basis of releases (Rs. in Crore)	Amount Credited in SHS Bank Account (Rs. in Crore)	Shortfall/ (Excess) (Rs. In Crore)
2007-08	116.63	45.00	71.63
2008-09	140.85	110.00	30.85
2009-10	132.17	109.75	22.42
2010-11	152.47	146.77	5.70
2011-12	184.51	321.18	-136.67
2012-13	326.99	101.90	225.09
Total	1053.62	834.60	219.02

22. Delay in Payment of JSY: Our observation on the payment of JSY beneficiaries are as under

- Substantial delay in payment of JSY beneficiaries in some of the facilities (Details are as per Annexure I).
- In case of deliveries in accredited hospital the payment to beneficiaries has been made even after two month (SDH: Gangapur)
- In case of cross border (From JSY beneficiaries payment is not being made by the facilities where deliveries actual taken place. Out of total deliveries of 425 nearly 105 deliveries is from the neighboring state which nearly 25% of the total deliveries.

23. Payment of AHSA Incentive: It was observed that the incentive was being paid to ASHA after delay 3-4 months. Payment to ASHA is being made through cheque instead of e-transfer.

24. Delay in Deposit of User Charges: It was observed that user charges collected by facilities (District & Sub-district Hospital) is being deposited after substantial delay, it is from 10-120 days.(SDH-Gangapur).Details are as per Annexure II.

25. Non Payment of Incentive to Sterilization beneficiaries in case of accredited private hospitals(Shastri Hospital,Gangapur)

26. Unspent balance under RCH-I and EC-SIP: The State has unspent balance of Rs.76.38 crore of closed programme like RCH-I and EC-SIP.

10.3 Recommendations:

- Financial Management at District level may to be strengthened by way of training, regular Monitoring and Evaluation. Efforts may be focused on generation of computerized books of accounts by entering real-time data.
- Definite action plan may be drawn up to comply the observations of Statutory Audit reports
- Definite action plan may be drawn up for compliance of CAG observations as per the Report no .08 of 2005-08 pertaining to state of Rajasthan.
- Funds pertaining to RCH-I amounting to Rs.76.38 crore should be refunded to GOI.
- Separate Bank Account for RMRS should be open
- Ensure timely payment to all JSY beneficiaries (at the time of Discharge).
- Plan for training of existing Finance personnel in financial management and customized Tally ERP.
- Avoid delay in deposit of User Charges into Bank Account.
- Incentive to ASHA to be paid on time through e-transfer.

Part-IV

STRENGTHS AND WEAKNESS

STRENGTHS

- **Rajasthan Medical Services Corporation**
Since the establishment of Rajasthan Medical Services Corporation (RMSC) in October, 2011, availability of drugs/medicines has vastly improved in the State.
- **Drug Procurement Policy**
The state has brought 477 medicines under its Essential Drug List and distributes these throughout the State. The new drug procurement policy put in place, mandates procurement of Drugs and Surgical's including Sutures through competitive bidding. Purchase preference is restricted to 25% only, out of which 10% for state PSU's and 15% for state SSI's, that too on condition that it would be necessary for them to match with the L1 rates obtained through tendering.
- **Quality Control**
Quality control (QC) is ensured by sampling of supplies randomly from each batch. Samples drawn are sent to the Head office for Quality Control. Empanelled Laboratories analyse the drug samples as per specifications and suitable test protocols. If the drug fails in assay or any other parameters, action is taken immediately by the Department of Q.C. and confirmed with the other Empanelled Laboratories/ Government Analysts before taking final decision. The results are then sent to the warehouses through E-mail, besides other methods
- **Good Manufacturing Practices**
The manufacturing premises of the participating agencies are inspected for compliance of Good Manufacturing Practices (GMP), Good Laboratory Practices (GLP) and for verification of their production capacity.
- **Drug Ware Houses**
Drug warehouses have been established at district headquarters to store and distribute drugs to health facilities in the districts.
All the above have helped in availability of drugs at facilities which seems to be reducing the out of pocket expenses for patients.

Infrastructure Development

- An Engineering Wing for Infrastructure Development has been established at the State level under NRHM and is headed by a Senior Engineer and supported by a team of professional's supports and expedites all infrastructure development and all civil construction in the State. This has resulted in a substantial improvement in the Infrastructure in the State. This has also helped the State to upgrade many of its health facilities and construct new health facilities to meet its critical ID gap

Management of Sub Centre by NGO

- Under JSY, sub-centres run by ARTH NGO have been accredited in Udaipur. These sub-centres are manned by three qualified ANMs and on dedicated days in a week a gynaecologist and paediatrician visit the sub-centre for ANC, PNC and care of the new-born. The sub centres are running in rented premises and have two labour tables, one radiant warmer, emergency drug, two OPD rooms, and six functional beds. The facility conducts around 60 deliveries a month. A fees of

Rs. 500/ is paid by the mothers towards the medicines and other incidental expenses. Interaction with the mothers reveal that despite a fees of Rs. 500, they still prefer to come to ARTH Sub centre because of certainty about the availability of health staff, presence of specialists at the Sub centre at designated days and quality ANC and PNC services available through the Sub centre.

Referral transport

- Emergency transport services in the State are in place. The 104 Janani Express services were launched in October, 2012 only. The 108 services have 464 ambulances in place and have been deployed in 249 blocks. The technicians have been trained and basic support is available in the ambulances. The drivers and technicians, however, complained that their salary is low and no revision has happened since they joined.
- The 104 toll free Medical Advice Services is also operational. The cell has received 190757 calls and has been able to address/respond to 184118 calls. Among the calls 1131 were relating to complaints against doctors or non-availability of drugs etc.

WEAKNESS

- System Strengthening – is weak in the State. The State has tried to meet its infrastructure requirements without providing for the commensurate human resource and ancillary services. This has resulted in the quality in service delivery being compromised at facility level.
- Health Facilities have been re-named rather than being upgraded as per norms (GoI/IPHS) resulting in mis-match in infrastructure and Human Resource and equipment. There are no sanctioned beds at many Health Facilities though they have been designated as CHC/PHC.
- Some Sub Centre are delivery points and deliveries occur but since, there are no beds the women after delivery are not kept for mandatory 48 hrs. This is resulting in quality being compromised. The State has a very high MMR and IMR if these quality issues are not addressed the MMR and IMR will continue to be high. *e.g. Sub Centre Khetri, had 40 to 50 deliveries per month SC Khetri has no sanctioned beds despite having delivery load of heavy delivery load per month. This has resulted in no patients staying after delivery for 48 Hrs. This has also caused acute shortage of HR as HR is sanctioned against bed strength.*
- District ownership of NRHM is weak. Majority of the district officials are there for a short period and nearing the retirement age with no public health background. There is also no coordination between the CMHO and PMO of the district hospital thus effecting the implementation of NRHM.

STATE SPECIFIC ISSUES

- Regular monitoring and supportive supervision lacking at all levels. Supportive supervision is one of the mechanisms for improving health care delivery at facilities.
- Data at facilities are collected and reported but are not used for analysis. Inadequate analysis and utilization of facility data results in not having the true picture. Data analysis is mandatory to prepare a true de-centralized district action plan.
- Though the State has carried out a facility survey for HR rationalization. However, there appears to be need for further facility survey for better HR utilization.e.g *Sub Centre, Khusthala had two ANMs (One regular and one additional ANMs) with hardly any delivery load.* The second ANM could be adjusted at a centre where there is adequate delivery load.
- Community Health Centres (CHC) remained a weak link in the Health System as many new CHCs do not have adequate HR (no anaesthetist at CHC Khandar)and sanctioned beds resulting in deficient in service delivery.
- Standard Protocols were not being maintained though the protocols issued by Govt of India are readily available at most facilities. *e.g. Most Labour rooms visited (Sawai Madhopur) did not have display of protocols.*
- High Still births (Ganagapur) are recorded but not reported. Still Births generally reflect the quality of ANC and Natal Care. Monitoring of still births would help improve ANC and Natal Care
- IPHS norms were not in place. Many sub centre have been upgraded to PHCs, as in Sawai Madhopur. This has led to a situation where PHC still function as a Sub Centre due to deficient number of functional beds, and infrastructure support services (eg; ward, labs,).
- Staff quarters and sanctioned positions for various cadres of health service providers was generally lacking. Facility up gradation has not been thought out properly. It is suggested that the State plan it's up gradation through a needs/gap/feasibility assessment and develop a Master Plan keeping in view the IPHS norms.
- Training and management of specialised equipment for newborn care was deficient at most places.
- Most GNMs were posted as store keepers at drug stores at facilities who had no training in drug management.

OVER ALL RECOMMENDATIONS

- Monitoring and supportive supervision needs strengthening both at the State and district level on a regular basis. This is an important mechanism under NRHM to provide for hand holding and for ensuring proper delivery of services. Monitoring visits at all levels should be made mandatory and should be made part of State and District action plans and should be reviewed regularly. Monitoring visits would also help in ensuring that PIP action plans are being properly implemented.
- District ownership of NRHM is weak. Majority of the district officials are there for a short period and nearing the retirement age with no public health background. No Coordination between the CMHO and the PMO at the district level, thus effecting the implementation of NRHM. This is a major stumbling block in effective programme implementation.
- A District Mission Director with over all command of NRHM at district level will improve the ownership and also bring about greater accountability under NRHM. This could be on the same pattern as State Mission Director with delegated powers under NRHM.
- Many of the facilities are not fully functional with some time very little staff. A Model for facility strengthening may be developed: Strengthening of Sub Center/ PHC with adequately trained Ayush doctor, Staff Nurses, Pharmacist etc who can deliver RCH services.
- DHAPs should reflect actual requirements (HR, equipment, and infrastructure) based on facility survey and on IPHS norms.
- Better convergence between health and other related sectors for optimal utilization of resources (funds and manpower) and accelerated results may be ensured through development of district integrated plans. ICDS has budgets for training of its field functionaries and as well as IEC, which can be used for joint training and IEC on nutrition. Similar exercise can be undertaken for the other health related sectors like water and sanitation and rural development.
- Still births are going unrecognized at health facilities. Peri-natal death enquiry system to be put in place to address large still births.
- There is hardly any system put in place for Biological and hospital waste management. Most places have a poor disposal mechanism for waste. Generally these are discarded in open places creating a health hazard. The waste and biological waste management needs radical strengthening.
- Mandatory stay after delivery is not happening at facilities. This is mainly because of lack of sanctioned beds at facilities. The mother and the newborn child are bundled and sent home thus

compromising the health of the newborn and the mother. The State should make provision for sanctioned beds with proper HR and equipment. This would help in the mother staying in the facility for 48 hrs.

- Standard Protocols are not being maintained despite these being available at facilities. This is again leading to a situation where the health of the mother and the newborn are being compromised. Standard Protocols should be made mandatory.
- Large number of facilities visited had unusable and broken equipment and furniture locked in rooms. Thus depriving the facility of these rooms. There is a need to operationalise the condemnation policy in a systematic fashion to ensure better utilization of the available space. Annual Maintenance Contract (AMC) should be part of Annual Health Action Plan.
- The gap in availability of medical officers is adversely affecting the health services delivery in the district, resulting not only in shrinking of the range of services available across the health facilities but also reducing the number of facilities that can provide the health services mandated for First Referral Units.
- With RMSC in place in the State trained pharmacists should be posted as store keepers and not GNMs.
- Financial Management at District level may to be strengthened by way of training, regular Monitoring and Evaluation. Efforts may be focused on generation of computerized books of accounts by entering real-time data.
- Districts like Jaisalmer, Barmer and Dungarpur (High Focus districts) have very large district areas with very scarce population making the accessibility to health facility very difficult. Therefore there is a need for re-examining the ID Norms for such districts to improve accessibility.

Part-V

Table J: Information on Progress of Up gradation of Health Facilities under NRHM in the State (October 2012) ⁹								
Health Facility	Upgradation sanctioned under NRHM so far		Progress of New Constructions					
	High Focus Districts	Non High Focus Districts	Completed		Under Construction		Sanctioned but Yet to start ¹⁰	
			High Focused	Non High Focus	High Focused	Non High Focus	High Focused	Non High Focus
DHHS	58	38	17	13	3	1	38	24
SDHs	13	15			3	8	10	7
CHCs	247	133	116	80	54	22	77	31
PHC-	581	419	230	153	24	12	327	254

Table J: Information on Progress of New Construction of Health Facilities under NRHM in the State (October 2012)¹¹								
Health Facility	New Construction sanctioned under NRHM so far		Progress of New Constructions					
	High Focus Districts	Non High Focus Districts	Completed		Under Construction		Sanctioned but Yet to start ¹²	
			High Focused	Non High Focus	High Focused	Non High Focus	High Focused	Non High Focus
DHHS	-	-	-	-	-	-	-	-
SDHS	-	-	-	-	-	-	-	-
CHCs	7	7	7	7	-	-	-	-
PHC-	59	63	50	58	6	1	3	4

ASHA training status in financial year 2012-13												
ASHA Training												
S.No	Name of District	Induction		V Module		6 & 7 Module						
		Target	No. of ASHA s Trained	Target	No. of ASHA s Trained	Target at 2012-13	No of ASHA s Trained 12-13	Target 2011-12	Training Ach 2011-12	Total Target	Total Achivment	Achivment %
1	2	3	5	6	7	8	9	10	11	12	13	14
1	AJMER	294	60	116	0	360	0	0	0	360	0	0.00%
2	BHILWARA	271	0	0	0	360	0	0	0	360	0	0.00%
3	NAGAU	475	0	0	0	360	0	0	0	360	0	0.00%
4	TONK	179	0	0	0	360	313	0	0	360	313	86.94%
5	BIKANER	156	0	0	0	360	75	0	0	360	75	20.83%
6	CHURU	175	0	0	0	990	0	300	400	1290	400	31.01%
7	GANGANAGAR	375	0	0	0	360	89	0	0	360	89	24.72%
8	HANUMANGARH	93	0	0	0	360	360	0	0	360	360	100.00%
9	BHARATPUR	206	0	0	0	0	0	0	0	0	0	#DIV/0!
10	DHOLPUR	121	30	30	0	660	0	150	153	810	153	18.89%
11	KARALI	155	0	183	0	870	23	180	175	1050	198	18.86%
12	S.MADHOPUR	154	0	59	0	660	356	180	183	840	539	64.17%
13	ALWAR	375	0	0	0	0	0	0	0	0	0	#DIV/0!
14	DAUSA	69	0	160	0	0	0	0	0	0	0	#DIV/0!
15	JAIPUR I	375	0	0	0	360	162	0	0	360	162	45.00%
16	JAIPUR II	375	0	0	0	360	127	0	0	360	127	35.28%
17	JHUNJHUNU	69	0	118	0	360	0	0	0	360	0	0.00%
18	SIKAR	127	0	138	0	360	0	0	0	360	0	0.00%
19	BARMER	500	0	0	0	720	110	300	297	1020	407	39.90%
20	JAISALMER	275	0	0	0	390	0	150	0	540	0	0.00%
21	JALORE	451	29	0	0	690	408	0	255	690	663	96.09%
22	JODHPUR	375	0	0	0	600	0	360	370	960	370	38.54%
23	PALI	300	0	0	0	1110	266	450	265	1560	531	34.04%
24	SIROHI	275	60	191	90	360	317	150	148	510	465	91.18%
25	BARAN	149	0	0	0	690	118	300	30	990	148	14.95%

26	BUNDI	129	0	0	0	810	0	90	60	900	60	6.67%
27	JHALAWAR	202	0	149	0	870	140	210	210	1080	350	32.41%
28	KOTA	70	30	58	0	360	130	0	0	360	130	36.11%
29	BANSWARA	96	0	94	0	900	452	450	468	1350	920	68.15%
30	CHITTORGARH	165	0	0	0	840	243	360	375	1200	618	51.50%
31	DUNGARPUR	208	30	0	0	600	0	270	175	870	175	20.11%
32	RAJSAMAND	103	0	0	0	360	0	0	0	360	0	0.00%
33	PRATAPGARH	208	0	25	0	240	33	300	297	540	330	61.11%
34	UDAIPUR	500	120	0	0	690	599	300	347	990	946	95.56%
	Total	8050	359	1321	90	17370	4321	4500	4208	21870	8529	39.00%

ASHA training status in financial year 2012-13

ASHA Training

S.No	Name of District	Induction		V Module		6 & 7 Module						
		Target	No. of ASHAs Trained	Target	No. of ASHAs Trained	Target 2012-13	No of ASHAs Trained 12-13	Target 2011-12	Training Ach 2011-12	Total Target	Total Achievement	Achivment %
1	2	3	5	6	7	8	9	10	11	12	13	14
1	AJMER	294	60	116	0	360	0	0	0	360	0	0.00%
2	BHILWARA	271	0	0	0	360	0	0	0	360	0	0.00%
3	NAGOUR	475	0	0	0	360	0	0	0	360	0	0.00%
4	TONK	179	0	0	0	360	313	0	0	360	313	86.94%
5	BIKANER	156	0	0	0	360	75	0	0	360	75	20.83%
6	CHURU	175	0	0	0	990	0	300	400	1290	400	31.01%
7	GANGANAGAR	375	0	0	0	360	89	0	0	360	89	24.72%
8	HANUMANGARH	93	0	0	0	360	360	0	0	360	360	100.00%
9	BHARATPUR	206	0	0	0	0	0	0	0	0	0	#DIV/0!
10	DHOLPUR	121	30	30	0	660	0	150	153	810	153	18.89%
11	KARALI	155	0	183	0	870	23	180	175	1050	198	18.86%
12	S.MADHOPUR	154	0	59	0	660	356	180	183	840	539	64.17%
13	ALWAR	375	0	0	0	0	0	0	0	0	0	#DIV/0!
14	DAUSA	69	0	160	0	0	0	0	0	0	0	#DIV/0!
15	JAIPUR I	375	0	0	0	360	162	0	0	360	162	45.00%

16	JAIPUR II	375	0	0	0	360	127	0	0	360	127	35.28%
17	JHUNJHUN U	69	0	118	0	360	0	0	0	360	0	0.00%
18	SIKAR	127	0	138	0	360	0	0	0	360	0	0.00%
19	BARMER	500	0	0	0	720	110	300	297	102 0	407	39.90%
20	JAISALMER	275	0	0	0	390	0	150	0	540	0	0.00%
21	JALORE	451	29	0	0	690	408	0	255	690	663	96.09%
22	JODHPUR	375	0	0	0	600	0	360	370	960	370	38.54%
23	PALI	300	0	0	0	111 0	266	450	265	156 0	531	34.04%
24	SIROHI	275	60	191	90	360	317	150	148	510	465	91.18%
25	BARAN	149	0	0	0	690	118	300	30	990	148	14.95%
26	BUNDI	129	0	0	0	810	0	90	60	900	60	6.67%
27	JHALAWAR	202	0	149	0	870	140	210	210	108 0	350	32.41%
28	KOTA	70	30	58	0	360	130	0	0	360	130	36.11%
29	BANSWARA	96	0	94	0	900	452	450	468	135 0	920	68.15%
30	CHITTOG ARH	165	0	0	0	840	243	360	375	120 0	618	51.50%
31	DUNGARPU R	208	30	0	0	600	0	270	175	870	175	20.11%
32	RAJSAMAN D	103	0	0	0	360	0	0	0	360	0	0.00%
33	PRATAPGA RH	208	0	25	0	240	33	300	297	540	330	61.11%
34	UDAIPUR	500	120	0	0	690	599	300	347	990	946	95.56%
	Total	8050	359	132 1	90	173 70	4321	450 0	4208	218 70	8529	39.00%

Sn	Type of training	Physical Progress (Apr-Sep 12-13)		
		Planned	Achieved	Variance %
1	SBA/ BEmOC - MOs	1306	87	6.66
2	SBA - ANMs/ SNs			
3	EmOC			
4	LSAS	72	14	19.44
5	MTP	100	6	6
6	RTI/ STI - MOs			
7	RTI/ STI - ANMs/ SNs			
8	IMNCI - MOs			
9	IMNCI - ANMs/ SNs			
10	NSV			

Delay in deposit of user charges in to Bank Account			
OPD - 92 -receipt No's	Date of money received by accountant	Amount	Date of deposit in the Bank
380201 – 390000	30.04.2012	78,560.00	15.05.2012
390001 – 395000	12.05.2012	57,020.00	
398001 – 402000	29.05.2012	43,260.00	10.07.2012
402001 – 405000	08.06.2012	32,510.00	
405001 – 410000	19.06.2012	42,445.00	
410001 – 414000	27.06.2012	42,565.00	
414001 – 418000	14.07.2012	44,525.00	08.10.2012
418001 – 424000	25.07.2012	57,195.00	
424001 – 429000	09.08.2012	42,965.00	
429001 – 434000	25.08.2012	41,370.00	
	17.09.2012	2,09,720.00	
Note : Receipt no is fro OPD but amount include is complete collection			

Annexure III Delay in JSY payment at Sub-district Hospital, Gangapur		
Registration no.	Date of Delivery	Date of Payment
1062	22.05.2012	04.06.2012
1053	21.05.2012	04.06.2012
1080	24.05.2012	04.06.2012
907	04.05.2012	04.06.2012
1047	21.05.2012	05.06.2012
1039	20.05.2012	06.06.2012
1065	22.05.2012	06.06.2012
350	12.02.2012	06.06.2012
1169	31.05.2012	06.06.2012
1670	23.05.2012	15.06.2012
1217	06.06.2012	15.06.2012
1240	08.06.2012	15.06.2012
1645	21.05.2012	15.06.2012
850	26.04.2012	20.06.2012
1245	09.06.2012	20.06.2012
1279	12.06.2012	20.06.2012
1212	05.06.2012	20.06.2012
1223	06.06.2012	21.06.2012
1141	28.05.2012	22.06.2012
846	26.04.2012	22.06.2012
1027	13.05.2012	22.06.2012
1041	20.05.2012	22.06.2012
1074	23.05.2012	22.06.2012
1112	26.05.2012	22.06.2012
1246	05.06.2012	25.06.2012
890	02.05.2012	26.06.2012
1219	06.06.2012	26.06.2012
1271	11.06.2012	28.06.2012
1236	08.06.2012	02.07.2012
1235	07.06.2012	03.07.2012
1251	10.06.2012	04.07.2012
1420	26.06.2012	16.07.2012
1244	08.06.2012	16.07.2012
1147	28.05.2012	20.07.2012
1284	12.06.2012	21.07.2012
1572	08.07.2012	23.07.2012
1260	11.06.2012	23.07.2012

1321	16.06.2012	24.07.2012
1856	01.08.2012	17.08.2012
1423	27.06.2012	17.08.2012
1866	02.08.2012	15.08.2012
1526	04.07.2012	21.08.2012
1845	30.07.2012	23.08.2012
911	04.05.2012	24.08.2012
1811	26.07.2012	27.08.2012
1886	03.08.2012	27.08.2012
1577	09.07.2012	27.08.2012
1530	03.07.2012	01.09.2012
1670	16.07.2012	03.09.2012
2022	15.08.2012	03.08.2012
1848	19.08.2012	03.09.2012
1310	16.06.2012	04.09.2012
1002	26.07.2012	04.09.2012
1855	31.07.2012	05.09.2012
1778	24.07.2012	05.09.2012
1776	24.07.2012	05.09.2012
1143	21.07.2012	06.09.2012
863	20.04.2012	06.09.2012
1529	05.07.2012	06.09.2012
1923	07.08.2012	07.09.2012
1876	03.08.2012	10.09.2012
1836	28.07.2012	10.09.2012
1968	06.08.2012	10.09.2012
1879	03.08.2012	10.09.2012
1896	05.08.2012	10.09.2012
1932	03.08.2012	14.09.2012
1899	05.08.2012	15.09.2012
1891	04.08.2012	15.09.2012
1882	03.08.2012	17.09.2012
1870	02.08.2012	22.09.2012
2214	03.08.2012	22.09.2012
2037	22.08.2012	26.09.2012
1791	25.07.2012	26.09.2012
2122	26.08.2012	28.09.2012
2343	14.05.2012	01.10.2012
2031	16.08.2012	01.10.2012
1844	30.07.2012	03.10.2012
2135	27.08.2012	06.10.2012
2156	28.06.2012	05.10.2012
1807	26.07.2012	06.10.2012
2336	13.09.2012	06.10.2012

Physical Progress Report				Month upto Oct'12					
S.No.	Progress	Type of Cases	2008-09	2009-10	2010-11	2011-12	2012-13	Total	
			September 08 to March 09	April, 09 to March, 10	April 10 to March, 11	April 11 to Mar '12	April 12 to Oct '12		
1	Physical Progress	Number of ambulances	101	164	254	464	464	464	
2		Emergency Cases	Medical	34406	196236	227523	690403	506068	1654636
3			Police	7752	19471	7522	7265	11315	53325
4			Fire	185	93	74	696	586	1634
5		Total Emergency Cases	42343	215800	235119	698364	517969	1709595	
6		Pregnancy Cases	4593	63339	54920	204112	79536	406500	
Total Cases			46936	279139	290039	902476	597505	2116095	

N.R.H.M.Sawai Madhopur		
JSY Private Hospital Accreditation List		
S.No.	Hospital Name	I/C Name & address
1	Jain Nursing Home & Diagonostic Center, Gangapur City 07463-231734	Dr.I.P.Jain Behind Agarwal Dharmshala Gangapur City Ph No.07463-231734
2	Riya Hospital ,Gangapur City 9414806888	Dr.Sumitra Meena Saloda Mode, Gangapur City Ph No.07463-233374
3	Kamala Hospital ,Gangapur City,07463-235545, 9414364951	Dr.Kamla Meena 32 Gandhi Nagar Behind Hr Sec School Ganagpur City Ph.No.07463-235545
4	Gupta Nursing Home ,Gangapur City ,9413503937	Dr.Ravi Gupta Near Police Thana,Sindhi Colony rd Gangapur City 07463-035900
5	C.P.Hospital, Gangapur City, 9414386550	Dr.C.P.Gupta Hospital Rd Gangapur City Ph No.07463-231550
6	Shastri Nursing Home, Gangapur City,9414231007	Dr.Shial Shastri Sindhi Colony Gangapur City 07463-234293
FW Private Hospital Accreditation List		
1	Riya Hospital ,Gangapur City 9414806888	Dr.Sumitra Meena Saloda Mode, Gangapur City Ph No.07463-233374
2	Kamala Hospital ,Gangapur City,07463-235545, 9414364951	Dr.Kamla Meena 32 Gandhi Nagar Behind Hr Sec School Ganagpur City Ph.No.07463-235545
3	C.P.Hospital, Gangapur City, 9414386550	Dr.C.P.Gupta Hospital Rd Gangapur City Ph No.07463-231550
4	Shastri Nursing Home, Gangapur City	Dr.Shial Shastri Sindhi Colony Gangapur City 07463-234293
5	Rupinder Kaur Ex Dir 9413380608	Ranthombhore Savika Sherpur Khilicipur Distt Sawai Madhopur
6	Dr.K.D.Gupta 9414030650	Vatslya Hospital, Near Rly Bridge Sawai Madhopur
7	Dr.Sushil Gupta 9414030283	Jyoti Nursing Home, 61 Bal Mandir Colony Sawai Madhopur
8	Dr.R.K.Meena 9414234885	Jeevan Surgical, Near Old Truk Union Sawai Madhopur
9	Dr.Beena Choudhary 9414030244.	Chourdary Nusing Home, Near Old Truk Union Sawai Madhopur
10	Dr.Sudhir Agarwal 9414031255	Kilkari Hospital ,Alanpur Sawai Madhopur
MTP Center		
1	Shastri Nursing Home, Gangapur City	Dr.Shial Shastri Sindhi Colony Gangapur City 07463-234293

2	Dr.K.D.Gupta 9414030650	Vatslya Hospital, Near Rly Bridge Sawai Madhopur
3	Dr.Sushil Gupta 9414030283	Jyoti Nursing Home, 61 Bal Mandir Colony Sawai Madhopur
4	Dr.Beena Choudhary 9414030244.	Chourdary Nusing Home, Near Old Truk Union Sawai Madhopur
5	Dr.Sudhir Agarwal 9414031255	Kilkari Hospital ,Alanpur Sawai Madhopur
6	Dr,M.Sharma 9414225255	indra Colony Sawai Madhopur

Annexure XI

JANANI EXPRESS (2 Oct.-4 Nov. 2012) Progress				
Pregnant Mothers		Sick Newborns		Referred
Home to Hospital	Hospital to Home	Home to Hospital	Hospital to Home	
1482	3850	242	621	66
