

**4th Common Review Mission of the National Rural
Health Mission**

Report from Rajasthan

Dates: 16 December, 2010 to 22 December, 2010.

4th CRM of the NRHM Rajasthan Team
January, 2011

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Abbreviations

AERB	Atomic Energy Regulatory Board
AMG	annual maintenance grant(s)
ANM	auxiliary nurse midwife
ANMTC	auxiliary nurse midwife training centre(s)
APL	above poverty line
AWC	Anganwadi centre
AWW	Anganwadi worker
AYUSH	(Department of) Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
BARC	Bhaba Atomic Research Centre
BCC	behaviour change communication
BER	beyond economic repair
BOR	bed occupancy rate
BPL	below poverty line
BPMU	Block Programme Management Unit(s)
C&DST	culture and drug sensitivity (DOTS-Plus, RNTCP)
CDPO	community development programme officer(s)
CEmOC	Comprehensive Emergency Obstetric Care
CES	Coverage Evaluation Survey(s), UNICEF
CHC	community health centre
CMHO	Chief Medical and Health Officer (district health officer)
CRM	Common Review Mission
DF	deep freezers (for preparing ice packs for immunisation sessions)
DH	district hospital(s)
DHAP	district level health action plan(ning)
DOHFW	Department of Health and Family Welfare
DOTS	Direct Observed Therapy, Short-course (treatment for tuberculosis)
DPMU	District Programme Management Unit(s)
DSO	district surveillance officer
DSU	district surveillance unit
ECR	Eligible Couple Register(s)
EMOC	emergency obstetric care
ESIS	Employees' State Insurance Scheme
FBNC	facility-based newborn care
F-IMNCI	facility-based integrated management of newborn and childhood infections
FMR	financial management report
FP	family planning
FRU	first referral unit
FY	financial year
GNM	general nurse and midwife
GOI	Government of India
GOR	Government of Rajasthan
HMIS	Health Management Information System
HR	human resource(s)
ICDS	Integrated Child Development Services scheme
ID	institutional delivery(ies)
IDSP	Integrated Disease Surveillance Programme
IEC	information, education and communication
ILR	ice-lined refrigerator(s) for storing vaccines
IMR	infant mortality rate
IPD	inpatients' department(s)
IRL	intermediate reference laboratory (DOTS-Plus, RNTCP)
ISO	International Organization for Standardization

JLN Medical College	Jawaharlal Nehru Medical College, Ajmer
JSY	Janani Suraksha Yojana
LHV	lady health visitor
LPA	line probe assay (DOTS-Plus, RNTCP)
LSAS	life-saving anaesthesia skills
LT	laboratory technician(s)
MDR	maternal death review
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Scheme
MMR	maternal mortality ratio
MMU	mobile medical unit(s)
MO	medical officer
MOHFW	Ministry of Health and Family Welfare
MO-i-C	medical officer-in-charge
MPW M/F	multi-purpose worker male/female
MRS	medical relief society/ies
MS	medical superintendent
MTC	malnutrition treatment centre
NBSU	newborn stabilisation unit(s)
NGOs	nongovernmental organization(s)
NMR	neonatal mortality rate
NRHM	National Rural Health Mission
NSV	non-scalpel vasectomy
OB-GYN	Obstetrics & Gynaecology (department)
OPD	outpatients' department(s)
PHC	primary health centre
PHN	public health nurse(s)
PHS	Principal Health Secretary (Government of Rajasthan)
PIP	Programme Implementation Plan
PMO	principal medical officer (superintendent)
PMU	Programme Management Unit(s)
PRI	Panchayati Raj institution(s)
PWD	Public Works Department
RCH-II	Reproductive and Child Health Programme Phase II
RKS	Rogi Kalyan Samiti (also referred to as Medical Relief Society/MRS in Rajasthan)
RNTCP	Revised National Tuberculosis Control Programme
RSPC	Rajasthan Public Service Commission
SC	health sub centre
SDH	sub divisional hospital(s)
SHG	self-help group(s)
SIHFW	State Institute of Health and Family Welfare
SMO	senior medical officer
SMS Medical College	Sawai Man Singh Medical College, Jaipur
SOE	statement of expenditure
SPMU	State Programme Management Unit
STDC	State TB Training and Demonstration Centres
TB	tuberculosis
TFR	total fertility rate
TLD	thermo luminescent dosimeter
UC	utilisation certificate
UID	Unique Identification card/number
VHND	village health and nutrition day(s)
VHSC	village health and sanitation committee(s)
WCD	(Department of) Women and Child Development

4th Common Review Mission of the National Rural Health Mission

Report from Rajasthan

1. Mission Members

The 4th Common Review Mission (CRM) of the National Rural Health Mission (NRHM) was convened to evaluate the existing health delivery system in each of 15 states selected for review. The review dates were from 15-22/23 December 2010. Rajasthan was selected for review during this CRM. The Rajasthan team for the 4th CRM of the NRHM comprised of seven members whose detailed coordinates are provided below (Table-1).

On reaching Rajasthan, the CRM Team interacted with the Principal Secretary Health, Department of Health and Family Welfare (DOHFW) Government of Rajasthan (GOR) and the Mission Director, NRHM Rajasthan, and the State Health Officials. As per itinerary proposed by the DOHFW GOR, the plan was to visit two districts – Ajmer (a better performing district) and Pali (a relatively poor-performing district). The CRM team consequently divided themselves into two teams. The Ajmer team comprised of Mr. Avinash Mishra, Dr. Kaliprasad Pappu and Ms Huma Siddiquee; while the Pali team comprised of Dr. JN Srivastava, Dr. Preeti Kumar, Ms Shifali Parmar and Dr. Amitrajit Saha (Table-1).

Table-1. Members of the Rajasthan Team for the 4th CRM of the NRHM.

District	Title and Name	Designation/Affiliation	Address with Email
AJMER TEAM	1. Mr. Avinash Mishra	Director, Ministry of Health and Family Welfare	Room No. 406-D Nirman Bhawan New Delhi 110008 Phone-91-11-23063968 Email: avinashindia@gmail.com
	2. Dr. Kaliprasad Pappu	Director, NIPI Programmes	NIPI-UNOPS, New Delhi Tel: +91-11-30417405 Fax: +91-11-43518587 Cell: +91-9871848733 Email: KaliprasadP@unops.org
	3. Ms Huma Siddiquee	Consultant NRHM Ministry of Health and Family Welfare	Room No. 526-C Nirman Bhawan New Delhi 110008 Cell: +91-9999618634 Email: huma_siddiquee@yahoo.com
PALI TEAM	4. Dr. Preeti Kumar	Associate Professor & Project Director, HIV/AIDS Project, Public Health Foundation of India	Public Health Foundation of India 4, Institutional Area, Vasant Kunj New Delhi 110070 Cell: +91-9899008707 Email: preeti.kumar@phfi.org
	5. Dr. JN Srivastava	Sr. Consultant – QI, National Health Services Resource Centre (NHSRC)	NHSRC, NIHFW Campus, Baba Gangnath Marg, Munirka New Delhi 110067 Tel: 011-26108982 to 93

District	Title and Name	Designation/Affiliation	Address with Email
	6. Ms Shifali Parmar	Finance Assistant, NRHM-Finance Division, Ministry of Health and Family Welfare	Cell: +91-9871212528 Email: jn.nhsr@gmail.com Room No-510-D Nirman Bhawan, New Delhi 110008 Cell: +91-9999602766 Email: shifaliparmar@yahoo.com
	7. Dr. Amitrajit Saha	Advisor, Centre for Health & Social Justice	C/o Centre for Health & Social Justice Basement of Young Women's Hostel No. 2 (Near Bank of India), Avenue 21, G Block, Saket, New Delhi 110017 Tel: +91-11-41752443 Cell: +91-9910108836 Email: amitrajitsaha@gmail.com

2. Introduction

Figure-1. District Map of Rajasthan showing Districts Ajmer and Pali.



a. Introduction to Rajasthan

Rajasthan, physically the largest state in the Indian Union is situated in the North-west part of the country, and has 56 million (or 5 per cent) of the country's population. The population density is 165 persons per sq. km. (as against the national average of 312). The decadal growth rate of the state is 28.41 per cent (against 21.54 per cent for the country), and the population of the state continues to grow at a rate much faster than the national rate.

Rajasthan is divided into six zones covering 33 Districts, 237 blocks and 41,353 villages. The state is largely rural and 80 per cent of the population is dependent on agriculture for livelihood. Water availability is very low. More than 60 per cent of Rajasthan is desert, with 1 per cent of India's water resources to support 10 per cent of the country's land and 5 per cent of the population. Drought and scarcity conditions are common, as are food shortages and even famine. This situation is compounded by unequal land distribution, with 50 per cent of landholdings less than two hectares in size and cover only 10 per cent of the total area under cultivation. Rajasthan is a net out-migrating state and migrants from this state go to all parts of the country, especially to the big urban centres in India.

As per the latest round of National Family Health Survey (NFHS-3; 2005-06), less than one-third (29 per cent) of Rajasthan's households are in urban areas, and the remaining (71 per cent) are in rural areas. On average, households in Rajasthan are comprised of about five members. Nineteen per cent of households belong to a scheduled caste, 14 per cent belong to a scheduled tribe, and 45 per cent belong to other backward classes (OBC). Thirty-nine per cent of the population in Rajasthan is under age 15; only 5 per cent is age 65 and over. Half of households in Rajasthan live in a *pucca* houses. Sixty-six per cent of households (96 per cent of urban households and 54 per cent of rural households) have electricity, up from 64 per cent at the time of NFHS-2 and 52 per cent in NFHS-1. Thirty-one per cent of households have toilet facilities, up from 28 per cent at the time of NFHS-2 and 20 per cent in NFHS-1. Only 33 per cent have water piped into their dwelling, yard, or plot. *In rural areas, 92 per cent of households do not have any toilet facilities. In rural areas of Rajasthan, only 54 per cent of households have electricity.*

Twenty per cent of Rajasthan's households (with 19 per cent of the population) are in the highest wealth quintile, and 25 per cent of households (with 24 per cent of the population) are in the lowest wealth quintile. Thirty-five per cent of rural households are in the lowest wealth quintile and only 4 per cent are in the highest wealth quintile.

Eighty per cent of primary-school age children (6-10 years) attend school (87 per cent in urban areas and 78 per cent in rural areas). Gender disparity in education is quite prominent in the population; 36 per cent of women and 74 per cent of men age 15-49 are literate in Rajasthan.

b. Baseline of public health system in Rajasthan

- i. Public Health Infrastructure. Table-2 shows the number of public health care institutions/facilities available in the State as per the most current information available (presentation by NRHM/RCH-2, GOR to the 4th CRM Team on 16 December, 2010). However, as the following table (Table-3) shows, there are gaps in infrastructure in the state. Tribal areas lack the requisite numbers of PHCs, while desert and general areas lack

both the requisite numbers of CHCs and PHCs. There is however, no reported gap in the number of sub centres (SCs).

Table-2. Public health care institutions/facilities currently available in Rajasthan.

Type of Institutions/Facilities	Number
Medical Colleges	07
District Hospitals	34
Sub District Hospitals	12
Satellite Hospitals	05
Community Health Centres (CHCs)	376
Primary Health Centres (PHCs) rural	1,517
Primary Health Centres (PHCs) urban	37
Dispensaries	199
Health Sub-centres (SCs)	11,487
Total beds available	45,078

Table-3. Infrastructure gap in public health facilities in Rajasthan.

S.N.	District situated in	Estimated Rural Population in lakhs (2001)	CHC	PHC	Sub-centre
1.	Tribal area	44.89	0	24	0
2.	Desert area	155.92	39	78	0
3.	General area	231.87	65	37	0
	Total	432.68	104	139	0

- ii. Human resources. Although within the NRHM process, Rajasthan has initiated increase of human resources for health, specifically in recruitment of accredited social and health activists (ASHAs); the state continues to report significant gap between required and posted health functionaries at all levels, but with special respect to rural medical officers, junior and senior specialists, nurses, ANMs and laboratory technicians. The tables below (Table-4, Table-5 and Table-6) show briefly the status of health workforce for the state. As Table-4 shows, vacancies are present in almost all levels of hierarchy, however, the most significant vacancies are noted for junior and senior specialists (851 posts vacant), senior medical officers (225 posts vacant), medical officers (763 posts vacant), and rural medical officers (424 posts vacant). Additionally, across the state, 15 posts for the deputy chief medical officer remain unfilled. This situation reflects that the state is yet unable to fulfil its role in providing quality health services to majority of people as it is expected to under the NRHM. Similarly, Table-5 shows that there remains significant vacancy for nurses (2,186), ANMs (1,731), laboratory technicians (457) and other staff (2,880). The state however did also report that they have initiated a number of steps to address this key challenge (Table-6).

Table-4. Sanctioned, filled and vacant posts for gazetted officers in DOHFW-GOR.

S. No	Name of the Post	Sanctioned Posts (No.)	In position (No.)	Posts Vacant (No.)
1	Director	3	2	1
2	Additional Director	7	7	0

4	Joint Director	21	15	6
5	Dy. Director & Equal	93	77	16
6	Senior Specialist	319	211	108
7	Junior Specialist	2,022	1,279	743
8	Senior Medical Officer (SMO) & Equal	838	613	225
9	Dy. Chief Medical & Health Officer (CMHO)	52	37	15
10	SMO (Dental)	13	9	4
11	Medical Officer (MO)	1,796	1,033	763
12	Rural Medical Officer	2,651	2,227	424
13	MO (Dental)	127	72	55
	SUB TOTAL	7,942	5,582	2,360
14	Under Employees' State Insurance Scheme (ESIS)	219	163	56
	GRAND TOTAL	8,161	5,745	2,416

Table-5. Sanctioned, filled and vacant posts for non-gazetted health staff in DOHFW-GOR.

S. No	Name of the Post	No. of Post Sanctioned	No. of Posts Filled	No. of Posts Vacant
1.	Nursing Staff	15,190	13,004	2,186
2.	ANM	14,723	12,992	1,731
3.	LHV	2,000	1,300	700
4.	Lab Technician	2,656	2,159	457
5.	Radiographer	690	585	105
6.	Others	21,721	18,881	2,880
	Total	56,980	48,921	8,059

Table-6. Vacancies of Specialist and Medical Officers for next 2 years in Rajasthan.

Cadre	Number of positions vacant	Action taken till date
Medical Officer	1214	Selection procedure started
Rural Medical Officer	749	Proposal send to RPSC
Medical Officer (Dental)	56	Proposal send to RPSC
Total positions vacant (total proportion vacant)	2019 (42.5%)	

iii. Indicators

The median age at first marriage among women and men in the age group of 20-49 in Rajasthan is 15 years and 19 years, respectively. At current fertility levels, a woman in Rajasthan will have an average of 3.2 children in her lifetime, 3.6 children per woman in rural areas and 2.3 in urban areas. Female sterilization is the most widely known method, known by almost all women and men and it accounts for almost three-quarters (72 per cent) of contraceptive use. Fifteen per cent of married women in Rajasthan have an unmet need for family planning.

Rajasthan is part of the “BIMARU” and Empowered Action Group (EAG) states and fairs poorly on the health and epidemiological parameters. As per the NFHS-3, infant mortality is currently estimated at 65 deaths before the age of one year per 1,000 live

births. The infant mortality rate is almost the same in rural and urban areas, *but the child mortality rate is almost twice as high in rural areas as in urban areas. The infant mortality rate in Rajasthan is the sixth highest in the country. One out of every 15 children dies within the first year of life.* Among women who gave birth in the five years preceding the survey, 73 per cent received antenatal care from a health professional (34 per cent from a doctor and 39 per cent from an ANM/LHV/nurse/midwife or other health personnel) for their last birth. One-quarter of women did not receive any antenatal care. Ninety per cent of urban women received antenatal care from a health professional, compared with 69 per cent of rural women. *Despite substantial improvement in the coverage of antenatal care for mothers, only 4 in 10 women in Rajasthan received at least three antenatal care visits for their last birth in the past five years. Seventy per cent of the births in Rajasthan take place at home.*

A little more than one-quarter (27 per cent) of children age 12-23 months are fully vaccinated against six major childhood illnesses: tuberculosis, diphtheria, pertussis, tetanus, polio, and measles. However, most children are at least partially vaccinated: only 6 per cent have received no vaccinations at all. *Full immunization coverage is lower in Rajasthan than in any other state except Nagaland and Uttar Pradesh.*

Forty-four per cent of children under age five years are stunted, or too short for their age, which indicates that they have been undernourished for some time. Forty per cent are underweight, which takes into account both chronic and acute under-nutrition. Under nutrition is particularly serious in rural areas, in the lower wealth quintiles, among teenagers, and among scheduled tribes. *Children's nutritional status in Rajasthan has improved substantially since NFHS-2, but 40 per cent of children under age five years are still underweight.* Among children between the ages of 6 and 59 months, the great majority—70 per cent—are anaemic. Adults in Rajasthan suffer from a dual burden of malnutrition; 37 per cent of women and 41 per cent of men are thin, and 9 per cent of women and 6 per cent of men are overweight or obese.

Over half of men (60 per cent), but only 8 per cent of women, use some form of tobacco. Among men who drink alcohol, only 7 per cent drink alcohol almost every day. The use of alcohol among men is lower in Rajasthan than in any other state except Jammu and Kashmir and Gujarat.

- iv. Status of Panchayati Raj Institution (PRI) framework in the state: With respect to the NRHM and its linkages with the PRI, the state reported that 43,437 village health and sanitation committees (VHSCs) have been constituted in the state, where an elected PRI member is the chair and the ASHA is the convener. As per the State Mission's report, over 3 lakh persons are involved with VHSCs in the state. With the objective to develop VHSCs as strong vibrant groups addressing village level health issues, the State Institute of Health and Family Welfare (SIHFW), with the support of nongovernmental organizations (NGOs) have provided training to 109,303 members of 17,655 VHSCs.
- v. Access to health care by the population: As per the NFHS-3 (2005-06), the public medical sector is the main source of health care for most households in the state. Fifty-nine per cent of urban households and 75 per cent of rural households use public health services. Among households that do not use government health facilities, the main reasons given for not doing so are poor quality of care (63 per cent), lack of a nearby facility (35 per cent), and long waiting time (17 per cent).

- vi. Special Constraints: as identified during briefing of the 4th CRM team include specialist care shortage (50 per cent); transport challenges and lack of assured delivery points within 2 hours, and inadequate reviews of maternal deaths (out of 708 maternal deaths reported in 2010-2011, only 299 were reviewed), for reducing maternal mortality in the state. Similarly, constraints in reducing infant and child mortality include lack of training of providers in IMNCI, gradual initiation of facility-based newborn care units, and most important lack of departmental convergence. Challenges identified in reducing total fertility rate (TFR) in the State include, early age of marriage (40 per cent, DLHS III) and high adolescent fertility rate (16 per cent); lack of motivation of the couples to adopt limiting methods after having two children and son preference; not meeting the unmet need of family planning through regular provision of FP services, and lack of service providers for fixed day approach with 50 per cent vacancy of gynaecologists and 53 per cent vacancy of surgeons at CHCs. There is also a need to focus on promoting spacing methods.
- vii. The complete list of facilities visited by the CRM Team (Table-7).

Table-7. Complete list of facilities visited by the 4th CRM Team.

4 th Common Review Mission				
16 th December, 2010 to 22 nd December, 2010				
Name of the State			Rajasthan	
Name of District visited				
Sl. No.	Name	District HQ	Name of District Collector	Name of CMHO
1.	Pali	Pali	Sri. Niraj Kumar Pawan	Dr. Yudhvirsingh Rathore
Health facilities visited				
Sl. No.	Name	Address/Location	Level	Name of person in-charge
1.	Mahila Chikitsalaya	Sawai Man Singh Medical College, Jaipur	Tertiary level hospital	Dr. Vimla Jain (Head of Department of OB-GYN)
2.	Koselao PHC	Block Sumerpur, District Pali	24x7 PHC	Dr Niranjan Rajpurohit (MO-i-C)
3.	Khemara SC	Village Khemara, Block Sumerpur, District Pali	Sub centre	Olive Fields (ANM)
4.	Nana PHC	Village Nana, Block Bali, District Pali	24x7 PHC	Dr. Mahendra Kumar Dabi (MO-i-C)
5.	Kotbaliyan SC	Village Kotbaliyan, Block Bali, District Pali	Sub centre	Batri Devi Rameswari (ANM) and Megha Ram (Male Nurse/Class-I Compounder)

6.	Chopra Referral Hospital/Bali FRU	Bali, Block Bali, District Pali	First Referral Unit	Dr. Kailash Singh Dewra (MO-i-C)
7.	Falna SC	Village Falna, Block Bali, District Pali	Sub centre	Annamma (ANM)
8.	District Hospital Pali	Pali, District Pali	District Hospital	Dr. RK Pamocha (PMO) and Dr. LBJ Chowdhury (Health Manager, NRHM)
9.	Musaliya SC	Village Kharchi, Block Marwar	Sub centre	Baby Dhawan (ANM) and Poker Ram Chodhury (MPW-M)
10.	AWW Centre Gurha Padamsingh at Sanskrit Higher Primary School	Village Gurha Padamsingh	AWW Centre (VHND)	BL Pankaj (ASHA Supervisor), LK Sudamma (Block LHV-F), Sukumari (AWW)
Name of District visited				
Sl. No.	Name	District HQ	Name of District Collector	Name of CMHO
1.	Ajmer	Ajmer	Sri. Rajesh Yadav	Dr. J.L. Gargia
Health facilities visited				
Sl. No.	Name	Address/Location	Level	Name of person in-charge
11.	VHSC meeting	Village Jajota, Block Kishangarh, District Ajmer	VHSC meeting at village Jajota under Bhadoon PHC	Mulchand Parikh, Sarpanch
12.	Jajota SC	Village Jajota, Block Kishangarh, District Ajmer	Sub centre	Julie Grace, ANM
13.	Rasulpura SC	Under Srinagar PHC, Block Nasirabad, District Ajmer	Sub centre	Anita Srivastava (ANM)
14.	Sub-divisional Hospital, Nasirabad	Nasirabad, Block Nasirabad, District Ajmer	FRU	Dr. Pradeep Mathur (SMO)
15.	Bijaynagar FRU	Bijayanagar, District Ajmer	FRU	Dr. A.P. Mathur (SMO)
16.	Urban RCH centre, Nagphani	Nagphani, District Ajmer	Urban RCH Centre	Sri. Hari Om (MPW)

17.	PHC Saradhna	Saradhana, District Ajmer	24X7 PHC	Dr. Pushpendra Prabhakar (MO-i-C)
18.	Kesherpura SC	Kesherpura, Peesangan Block, District Ajmer	Subcentre	Kushum Lata Vijaivergiya (ANM)
19.	Lamana SC	Lamana, District Ajmer	Subcentre	Santa Rajni (ANM)
20.	ANM Training Centre, Beawar	Beawar, Block Beawar, District Ajmer	ANM Training Centre	Dorris Samuel (in-Charge)
21.	Beawar District Hospital	Beawar, Block Beawar, District Ajmer	District Hospital	Dr. Bharat Singh Gahlot (PMO)
22.	Satellite Hospital, Ajmer	Ajmer, District Ajmer	Satellite Hospital	Dr. B.D. Heda (PMO)
23.	Sarana, PHC	Sarana, Block Bhinay, District Ajmer	24x7 PHC (to access Quality Assessment Initiative)	Dr. Pradeep Verma, (MOIC)
24.	PHC –Srinagar	Srinagar, Block Nasirabad, District Ajmer	24X7 PHC	Dr. Rajesh Gupta (MO-i-C)
25.	Jawaharlal Medical College, Ajmer	Ajmer, District Ajmer	Medical College to review MTC/FBNC	Dr. Achla Arya (MS)

Figure-2. District Map of Pali.

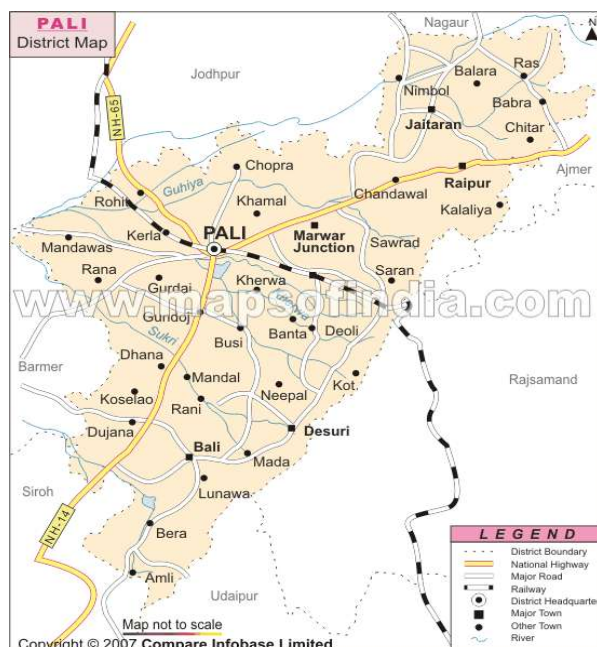
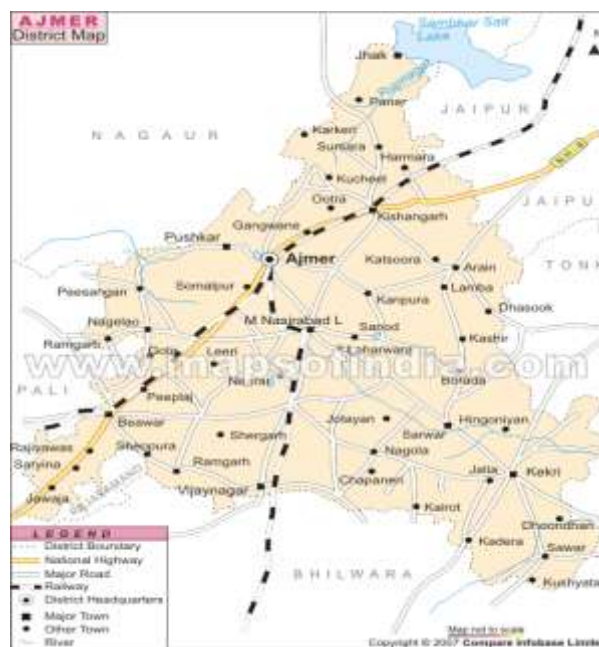


Figure-3 District Map of Ajmer.



3. Findings of the 4th CRM in Rajasthan

The findings of the Rajasthan CRM team are organized as follows:

Changes in key aspects of Health Delivery System

These changes are organized under the following eleven thematic areas:

Infrastructure Up-gradation

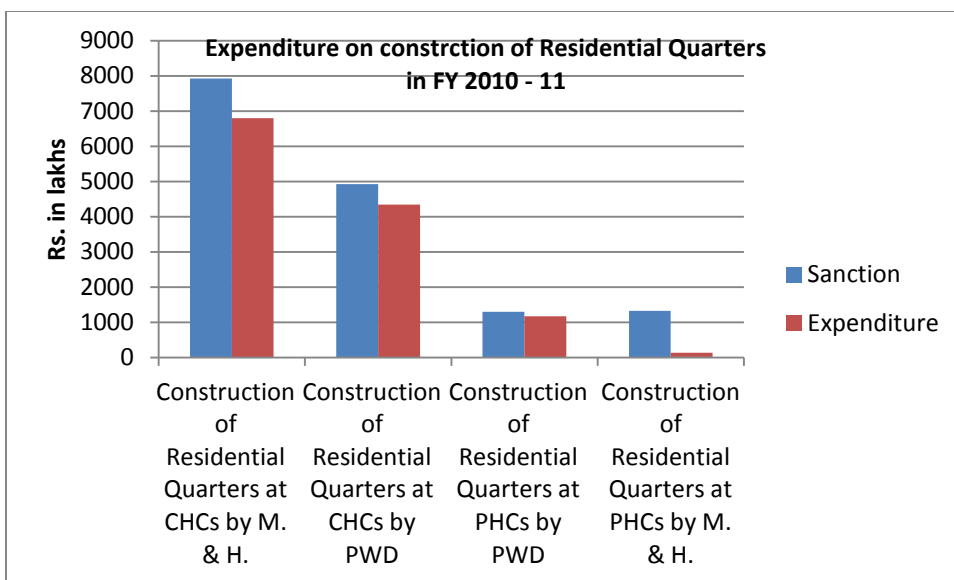
The Rajasthan Government has taken many initiatives for development of all-inclusive comprehensive facility development plans, separately for each health facility. Construction work has been phased according to priority and availability of funds.

At most of the facilities, bed occupancy has increased considerably, mainly due to increase in number of deliveries after introduction of Janani Suraksha Yojana (JSY). However, expansion of infrastructure has not kept pace with the rising demand.

Infrastructure Development (Civil Construction Work) under NRHM

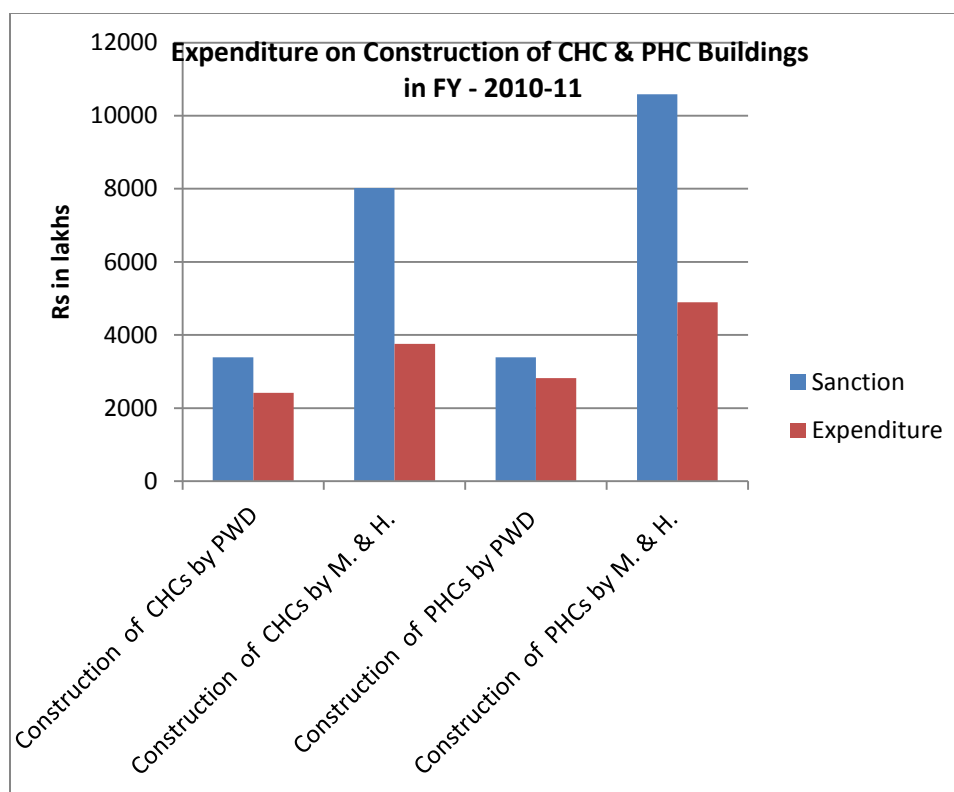
Planned expenditure on Infrastructure has been good except at those locations, where responsibility of the construction has been entrusted to either Medical & Health Department or CMHO Office. Only approximately 10.24 per cent of funds, earmarked for construction of residential quarters at PHCs in the current financial year (FY) 2010 to 2011, could be spent by Medical & Health Department, while the state Public Works Department (PWD) achieved an expenditure of approximate 90 per cent on construction of the residential quarters.

Figure-4. Sanction and expenditure for construction of residential quarters at CHCs by different GOR agencies in FY 2010-11.



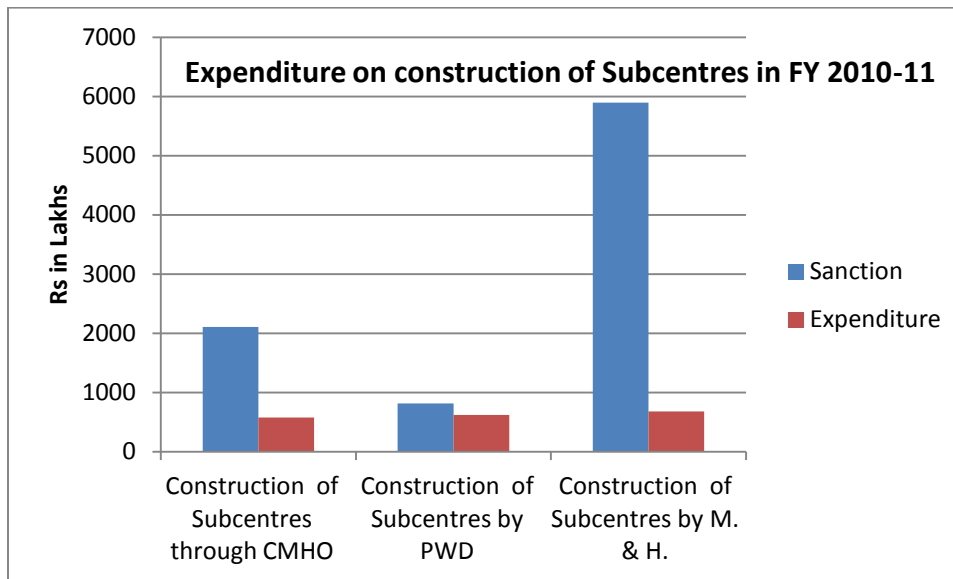
Similarly, expenditure on construction of CHC and PHC buildings by Medical & Health Department continues to be low (Figure-5). This needs to be expedited in remaining three months of the current of financial year.

Figure-5. Sanction and expenditure for construction of CHCs by different GOR agencies in FY 2010-11.



In the current financial year, construction of 931 Sub centres was planned under the NRHM. However, construction work is behind schedule at those locations, where the work is being executed either by CMHO or Medical & Health Department as is shown below.

Figure-6. Sanction and expenditure on construction of Sub centres by different GOR agencies for FY 2010-11.



Labour rooms have been added / renovated in 142 PHCs against the planned target of 189 PHCs (i.e., 75 per cent achievement). However, construction of JSY wards has not kept pace.

Table-8. Status of Civil Works under NRHM in Rajasthan

S. No.	Activity	Works sanctioned	Works completed	Per cent completed
1.	Residential quarters at CHCs and PHCs	2170	1787	82.4
2.	Renovation in CHCs buildings	235	111	47.2
3.	Renovation in PHC buildings	548	242	44.2
4.	JSY Maternity Wards in CHCs	206	99	48.1
5.	Sub centre buildings	931	282	30.3
6.	ANMTC building and Hostels	10	1	10.0
7.	Drug Ware Houses (Construction / Repair)	29	14	48.3
8.	Swasthya Bhawans	10	9	90.0
9.	Labour Room at PHCs	189	142	75.1

10.	FBNC / MTC at District Hospitals	30	29	96.7
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As Table-8 demonstrates, civil works construction under NRHM in Rajasthan shows skewed pattern and inadequate prioritising, with critical elements required for service delivery at the grassroots level yet to be completed (just 30 per cent of sanctioned sub centres; less than half or sanctioned labour rooms under JSY constructed; and less than half of sanctioned renovations of CHC/PHCs completed).

Recommendations with regards to infrastructure development and planning.

1. Since hospital architectural planning, in terms of development of site plan and space planning entail specialised work, its expertise may not be readily available. The DOHFW-GOR may consider having a specialised cell, which is manned with facility planners, hospital architects and biomedical engineers.
2. The state may consider quality assurance checks on all new works and construction conducted by an independent agency.
3. Considering the geographical terrain of the state, creation of a pool of specialised biomedical engineers with workshop facilities may be undertaken at Zonal level, which could be entrusted with following functions:
 - a. Assisting the GOR in procurement of new equipment – developing technical specifications, quality assurance, finalisation of contract for comprehensive maintenance of equipment, etc.
 - b. Regular maintenance of equipment by periodical visits to hospitals/FRUs.
 - c. Calibration of hospital equipment.
 - d. Condemnation of equipment, when the equipment is beyond economic repair (BER)

Human Resources Planning

(a) Operationalising the Programme Management Unit (PMU): The state has 45 sanctioned posts in the State Programme Management Unit (SPMU), out of which 14 (31 per cent) posts are vacant, mainly due to attrition. Staffing of district programme management units (DPMUs) is satisfactory, while staffing of block programme management units (BPMUs) is a cause of concern, since approximately 18 per cent of the posts at BPMU level are vacant.

(b) Contractual Manpower under NRHM: Not many professionals are willing to join the health system to serve at underserved locations. Therefore, shown in Table-9 below, there remains considerable gap between sanctioned and currently filled posts. This gap is highest for medical officers, with more than 70 per cent posts currently vacant. Similarly, almost 50 per cent of paramedical staff and 30 per cent of AYUSH cadre remain yet unfilled.

Table-9. Status of Contractual Manpower under NRHM in Rajasthan.

Category of Staff	Sanctioned	Filled	Vacant	Remarks
1. Medical Staff	500	136	364	Break-up of posts sanctioned: Medical Specialists for FRUs 200; Medical Officers (General Duty/MBBS) 150; and Medical Officer (Dental/BDS) 150.

				Vacancy proportion: 73 per cent.
2. Paramedical Staff	1,308	668	640	Break-up of posts sanctioned: Pharmacist (Warehouse) (500), Physiotherapist (22), Lab Technicians (100), X-Ray Technicians (60), Dental Technicians (100), Ophthalmic Assistants (100), Anaesthesia Assistants (100), ECG Technicians (10), Public Health Nurses (PHN) under RCH (158), Laboratory Technicians (LT) under RCH (158). Vacancy proportion: 49 per cent.
3. Nursing Staff	11,280	10,694	586	Break-up of posts sanctioned: ANM (2500), Additional ANM (1321), GNM / Nurse Grade II (7459). Vacancy proportion: 5 per cent
4. AYUSH Staff	2,105	1,469	636	Break-up of posts sanctioned: AYUSH Doctors (1100), AYUSH Compounders (1005). Vacancy proportion: 30 per cent

(c) **Training and skill upgrading:** Rajasthan had launched Emergency Obstetric Care (EMOC) training programme and number of doctors have undergone the training. The CRM team visited the Department of Obstetrics & Gynaecology, Sawai Man Singh Medical College, Jaipur and interacted with the department's faculty. A total of 62 candidates have undergone the training since September 2007. However, as Table-10 (below) shows, the number of medical officers trained is way lower than numbers required. The table also shows the skewed deployment of MOs trained in EMOC, with majority of MOs inappropriately posted at satellite hospital/SDH/DH level (Table-10).

Table-10. Number of EMOC trained medical officers deployed in different categories of health facilities in Rajasthan

Type of Health Facility	Number of Health Facility	Number of EMOC trained doctors deployed in the facilities
1. FRU/DH	34	19
2. CHC	376	03
3. PHC	1517	13
4. Sub divisional hospitals (SDH)	12	10
5. Satellite hospitals	5	17
Total	1944	62

Thus it appears that full utilisation of trained manpower has not taken place. From our discussions with the faculty, a number of reasons for such low utilisation emerged.

1. Poor selection process. Doctors volunteered for EMOC training so that they could stay at a large city like Jaipur, though they do not have inclination for providing EMOC services.
2. Poor confidence level of EMOC-trained MOs. The Head of Department, OB-GYN SMS Medical College commented that after completing the training, most doctors were reluctant to perform caesarean section independently. The faculty did agree however, that other obstetric emergencies like retained placenta, post-partum haemorrhage, etc. were competently managed by the EMOC-trained MOs.
3. Non-availability of 'back-up' support. EMOC-trained doctors felt that there was no support to take care of complications, if 'something' went wrong.
4. Master Trainers have moved out the system, been posted elsewhere, and their replacements have not yet been identified and trained.

The CRM recommends that the State should streamline the current system of EMOC training, to enable Rajasthan in achieving the required improvement in delivery of maternal health services including managing of complicated births.

(d) Mainstreaming of AYUSH: On the subject of mainstreaming AYUSH, our observations have been mixed. We found that at Ajmer, there was good integration of AYUSH doctors at the district hospital. However, in contrast, we observed in Pali (PHC Nana), we noticed that the AYUSH practitioner was working independently, without contributing his services to deliver RCH services.

Table-11. Status of AYUSH physicians in Rajasthan under the NRHM.

S. No.	Sanctioned posts	Presently in position number (per cent)	
1	Ayurveda	930	Ayurveda 760 (81.7)
	Homoeopathy	170	Homoeopathy 138 (81.2)
	Unani	150	Unani 130 (86.7)
	Sub-total	1250	Sub-total 1028 (82.2)
2	Junior Ayurveda Nurses	1005	Junior Ayurveda Nurses 435 (43.3)

(e) Pre-service training capacity: Current status of training institutes for health cadres as reported by the office of Public Health, DOHFW-GOR is provided in Table-11.

Table-11. Institutes for training different cadre of health workers currently functioning in Rajasthan

Training institute	Number in position
Medical College	7
Government GNM Nursing School	15
Private GNM Nursing School	147
Government B.Sc. Nursing College	1
Private BSC Nursing College	68
Government ANM Training Centre	32

(f) Plan for Augmentation of Health Human Resources: Realising that the state is suffering from inadequate numbers of trained health personnel, particularly medical officers, the DOHFW/NRHM of the GOR have undertaken the following steps to address at the first instance the dearth of medical officers at PHC/CHC/FRU level:

- Direct appointment of MO / RMO by the Department.
- Appointment of 1278 MO on an ad hoc / urgent / temporary and contract basis.
- Request to the Rajasthan Public Service Commission (RPSC) for appointment of 749 RMOs after only written examination.
- Suggestion to provide 4 additional salary increments to post-graduate MOs at the time of their appointment.
- MO with relevant post-graduate qualifications will be posted at CHC/FRU level at the time of appointment.
- 50 per cent of JS vacancies to be filled by direct recruitment through RPSC.
- Relaxation of current norms with regard to experience for promotions.

Health Care Service Delivery – Facility Based – Quantity and Quality; Outreach services; ASHA Programme; RCH II (Maternal Health, Child Health and Family Planning Activities).

Rajasthan, a state with a relatively higher infant mortality rate (IMR; 63/1000 live births), maternal mortality ratio (MMR; 388/100,000 live births) and total fertility rate (TFR; 3.3) in the country has proposed to address it in their 2010-11 State Programme Implementation Plan (PIP) by strategically focusing on reduction in neonatal mortality rate (NMR), population stabilization and quality maternal care in the facilities with assured referral. The goal by 2012 (11th Five-Year Plan goals) is to bring the IMR to 32, MMR to 148 and TFR to 2.1.

These bench-marks on IMR, MMR, and TFR set for 11th Five-Year Plan period have become the basis for refining objectives of RCH-II in 2010-11. Arresting gender imbalance, restructuring of health care delivery system, human resource development and capacity building and decreasing burden of diseases and promoting healthy life style are at the heart of formulating objectives for the RCH-II 2010-11.

Accordingly, the thrust of the operational strategy incorporated in the current PIP is to:

- Make health facilities family friendly (with water, electricity, clean toilets, waiting area, security, etc.).
- Ensure quality assurance through National Accreditation Board for Hospitals (NABH) / International Organization for Standardization (ISO) / Family Friendly Hospital certification of Government health facilities through State Health Services Resource Centre (SHSRC).
- Have a supervisory cadre for monitoring and supervision, district specific innovations proposed for 15 high-focused districts; and a
- Incorporate a comprehensive training plan in the PIP.

Additionally, specific interventions proposed are incorporated in Table-12 (below):

Table-12. Specific interventions proposed to enable reduction in key negative health indicators in Rajasthan

Key indicators	Specific interventions proposed
Reduction of IMR	<ul style="list-style-type: none"> • Strengthening of FBNCs. • Operationalization of newborn stabilisation units (NBSUs) at 100 FRUs. • Operationalization of block mobile medical units (MMUs) and facility-based integrated management of newborn and childhood infection (F-IMNCI) training. • Drugs and supplies for child health. • Additional ANMs. • Hiring of specialist at FRU @ Rs. 60,000 per month. • Infant Death Audit in all districts.
Reduction of MMR	<ul style="list-style-type: none"> • Maternal Death Audit in all districts. • BPL (below poverty line) Ghee scheme. • Block MMUs. • Referral transport provision at block level. • Drugs and supplies for maternal health. • Recruiting and training additional ANMs • Rolling out the “Kalewa” scheme – where hot nutritious meals are provided by self-help groups (SHGs) to women who have delivered at all CHCs to increase their post-partum stay at the facility to at least 48 hours. • Hiring of specialist at FRU @ Rs. 60,000 per month. • Establishment of a midwifery resource centre. • Operationalizing ‘108 Emergency Services’ and CHC Base Ambulance services.
Reduction of TFR	<ul style="list-style-type: none"> • Strengthening of the community-based family planning programme or the ‘Jan Mangal Programme’. • Establishing of a non-scalpel vasectomy (NSV) resource centre. • Rajiv Gandhi Population Stabilization Mission.

To deliver the above interventions, the approved Reproductive and Child Health Programme Phase-II (RCH-II) outlay is Rs. 329.10 crores (as against Rs. 288.33 crores in 2009-10); out of the total outlay of Rs. 1196.37 crores.

Of this outlay, the RCH-II Base Flexi-pool, including maternal health, child health, family planning, urban health, tribal health, adolescent reproductive and sexual health (ARSH), training, information education and communication (IEC) and operations, including infrastructure, human resources (HR), facility/institutes and management strengthening and procurements, etc. accounts for Rs. 148.46 crores. The other major share is outlay for JSY amounting to Rs. 143 crores. The remaining 37.64 crores is allocation for incentive money for FP.

Achievements at the State level

- Rajasthan has recorded an impressive increase in institutional delivery (ID) from 28 per cent in 2005-06 to more than 70 per cent in 2009-10 (Coverage Evaluation Survey/CES 2010). With the expected IDs (JSY beneficiaries) in the range of 10 lakhs plus the State has planned, and is operationalizing, maternal and child health (MCH) centres ('level/L 3 level/L 2 and level/L 1 facilities') to address this increased load. As of November 2010, 172 facilities have been identified as L3, and 635 as L2 (227 CHCs and 408 PHCs) facilities.
- Of the 33 FBNCs planned by 2010-11, all have been operationalized.
- The State reported that Maternal Death Review (MDR) was initiated in all the districts with the constitution of MDR Committees in the two Districts visited.
- The State has begun capturing information in specified formats for name-based tracking of pregnant women and children. There is a decision to link this up with the eligible couple register (ECR) and with the Unique Identification (UID) number.
- AYUSH practitioners have been functionally integrated with the mainstream health system even though it is not uniformly observed across the Districts visited.
- Under the Kalewa Scheme, hot nutritious food is given to postpartum women at all CHCs to increase the 48 hours stay by Self Help Group.
- To address poor sex ratio, novel online schemes like "Hamaribeti.com" need to be followed up for their desired effect.
- 43,288 ASHAs have been trained up to Module 4 and are in place.
- 43,336 VHSCs have been constituted, and till the time of the CRM visit 158,095 VHSC meetings have been held by ASHAs.

During the 4th CRM, two districts in Rajasthan were visited by the CRM; one a high focus district (Pali) and the other a non-high focus district (Ajmer). Through visits to different levels of facilities, interaction with key functionaries and examination of records and instruments/tools the team assessed the changes in key aspects of health delivery system including volume, quality and range of services, as well as progress against the approved PIP of the current year as obtained in these two Districts.

In both the Districts Ajmer and Pali, the CRM teams observed that there was a largely functional public health system. **In common with both districts, some general observations are as follows:**

- The reception areas for the outpatient department (OPD) and inpatient department (IPD) were clean, manned with separate booths clearly marked for BPL patients and with online BPL database available till the PHC level.
- Most facilities have a Jana Aushadhalay (generic drugs store) and some had Lifeline drug counters run by the district-level medical relief societies (MRS).
- In Ajmer, the District Hospital and the two SDHs visited have well organized OPDs but the Satellite Hospital Ajmer stands out for its clean environment, well-maintained wards and overall organization.

- The JSY payments were mostly up to date and the mothers as a rule receive payments through cheques at the time of discharge.
- While there was a Standard Treatment Protocol developed at the State level, the use of it to practice driven by the protocol was not noticed in any facility visited in both the districts.
- In select Blocks and PHC the quality assurance system was very well established with protocols, systems and procedures in place for providing quality maternal, newborn and child health care.
- Water, lights and security systems were largely in place. In one sub centre in Pali district (Musaliya SC, Marwar Block); the labour room was very well-appointed with a sucker machine, an air conditioner an inverter and multiple fans – all of which were provided for from local client donations. All levels of health facilities visited that had a labour room had a newborn corner, with at least one 200 watt electric lamp to provide radiant warmth.
- IDSP structure at the District level and up to PHC level was in place in Ajmer.
- Drugs, vaccines with functioning ice-lined refrigerators (ILRs) and deep freezers (DFs) and reproductive health service products were in place in most facilities visited.

Facility Planning

- In the State as a whole, out of 14,810 facilities available from district hospital to sub centres, 3,057 (22%) facilities have been identified for acting as MCH centres of different levels. Of these 3,057 facilities, 172 are level 3, 635 are level 2 and 2,250 are Level 1 facilities. The HR and training gaps in these facilities have been identified along with infrastructure and equipment gaps.
- Ajmer and Pali have both registered a remarkable up gradation in many existing facilities, with new buildings and renovations. These are now better equipped and clean. However, the challenge still is that of HR and more specifically of adequate numbers of Specialists to make these facilities work to their full potential.
- **Ajmer** with a population of 26.59 lakhs and with a CBR of 27.5 (2010-11 PIP) will have an estimated 73,122 deliveries of which 80 per cent are targeted for institutional deliveries. A target of 42,000 deliveries has been budgeted under JSY beneficiaries in the current PIP.
- Ajmer has 336 primary care facilities (11 CHCs, 43 PHCs and 288 SCs) and 6 secondary care facilities (including 1 Medical College, 1 Jenana Hospital, 1 District Hospital, 2 SDH, and 1 Satellite Hospital).
- In the recent planning of the MCH Centres 7 centres (1 DH, 2 SDH, 1 Satellite Hospital and 3 CHCs) have been identified as Level 3 facilities with availability of 740 beds.
- 25 Level 2 facilities (7 CHCs and 18 PHCs 24x7) have been identified.
- **Pali** with a population of 22.19 lakhs has estimated delivery load of 61,022 of which, 80 per cent are targeted for institutional deliveries.
- In the recent planning of the MCH Centres 7 centres (1 DH, 1 SDH and 5 CHCs) has been identified as Level 3 with availability of 620 beds
- 22 Level 2 facilities (8 CHCs and 14 PHCs 24x7) have also been identified.

Snapshots of some additional issues: achievements and challenges observed at District Pali.

1. Overall, district health staff were all highly motivated and committed.
2. Community participation and ownership by the community as observed through interactions with *Sarpanches* and VHSC members, seemed excellent in the sites visited.
3. PRI members were observed to take an active interest in the functioning of the sub centres and PHCs. However, the CRM team feel that their active participation in management of public health facilities could be increased at CHCs, sub-divisional hospitals and at the district hospital levels.
4. Meetings of the MRS (as the Rogi Kalyan Samitis are known as in Rajasthan) need to be held regularly at predefined intervals. (For example, the last recorded MRS at PHC Kosalao was held in July 2010. Similarly the last recorded MRS at CHC Sumerpur was held in February 2010).
5. All facilities have injection Oxytocin available for managing third stage of labour and/or postpartum haemorrhage. However nowhere was the injection stored in cold chain at its optimum storage temperature. This requires looking into at the state level.
6. The CRM observed that operation theatres at different facilities were fumigated regularly. However, based on the most current evidence that suggest that fumigation does not offer any added advantage over thorough scrub wash of operation theatre floors and walls at a pre-defined interval, this practice requires changing through directives issued from the state level.
7. Biomedical waste disposal systems at all levels requires strengthening in term of waste segregation practice, disinfection and handling and final disposal of human tissue, biological wastes and sharps.
8. With respect to radiology units, a major concern was the safety of health workers and x-ray technicians. The Pali team observed (a) non-adherence to Bhaba Atomic Research Centre (BARC) guidelines, (b) lack of Atomic Energy Regulatory Board (AERB) clearances/certification and (c) inadequate use of thermo luminescent dosimeter (TLD) badges and their periodical analysis.
9. Training of the eleventh batch of newly recruited ASHAs (no. 703) was in progress during the CRM visit to Pali. While interacting with the CRM members, the ASHA trainees expressed their need for training on managing their own finances.
10. The CRM team in Pali noticed that the incidence of anaemia among antenatal women is high. However, birth weight of newborn babies did not seem to be commensurate with the nutritional status of antenatal women. This is an issue that requires looking into.
11. An analysis of all deliveries (normal and caesarean section) recorded from 1 April 2010 to 30 November, 2010 in the sites visited by the CRM team in District Pali revealed that delivery services, particularly caesarean delivery services were yet to reach BPL clients in the district (Table -13). This was shared with the district authorities as a point of concern.

Table-13. District Pali: Deliveries (01 April 2010 to 30 Nov 2010) in Facilities Visited

Facilities	Total Deliveries	Normal Deliveries	Caesarean section	Total
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	BPL	APL	Total (APL+B PL)		APL	BPL	Total LSCS (APL + BPL)	
Kotbaliyan SC	02	17	19	19	N/A	N/A	N/A	19
Falna SC	04	48	52	52	N/A	N/A	N/A	52
Khimra SC	04	23	27	27	N/A	N/A	N/A	27
Kosalao PHC	09	155	164	164	N/A	N/A	N/A	164
Nana PHC	16	183	199	199	N/A	N/A	N/A	199
Sumerpur CHC	45	1075	1120	1078	42	0	42	1120
Bali CHC	72	889	961	894	56	11	67	961
District Hospital	127	3066	3193	2861	323	09	332	3193

Outreach Services

Overall, outreach activities were being carried out in both the districts. Sub centres visited had ANMs in residence. Most were conducting antenatal check-ups and normal deliveries. Integration with Anganwadi worker (AWW) and with ASHAs were noticed in a number of sub centre areas. Review of labour records showed normal deliveries were being conducted even in the evening. Interactions with *Sarpanches* also revealed that they were involved and the VHSCs were active. In one sub centre in Pali district, the *Sarpanch* confessed that he had been voted back to power on the basis of his earlier engagement in improving health services in his community. It was clear to CRM members that better-functioning and active sub centres were those where there was integration between the health, AWW centres and PRI. Some element of micro-planning of immunisation outreach and VHNDs were observed in the SCs visited, although more improvement is required on this score.

Mobile medical units (MMUs) named 'Rajiv Gandhi Rural Medical Units are operational in Rajasthan providing free consultations, laboratory tests, medication and referrals. As per records, till date, 32 such MMUs are operational across the state and have till November 2010 organised 9,564 camps, provided 17,844 laboratory tests and served 8.72 lakh patients. Patients referred for advanced care number 15,365. However, the MMUs require strengthening so that these can reach the most underserved and hard-to-reach areas of the State.

RCH II (Maternal Health, Child Health and Family Planning Activities)

i. Pregnancy and Child Tracking System in Rajasthan:

- Was launched on 15th September 2009 by the Honourable Union Health Minister Shri Gulam Nabi Azad in Rajasthan, which was one of 3 State in India to launch the system initially.
- It is implemented in all 33 districts, all blocks, PHCs and sub centres of Rajasthan.
- Till November 2010, 18.78 lakh pregnant women and 9.94 lakh children have been registered on the system and are being tracked.
- Monthly health management and information system (HMIS) reports from sub centre to district level are being uploaded through the system, by the 9th day of every month. More than 99 per cent of institutions are providing such data.
- All 14,000 health facilities i.e. sub centres, PHCs, CHCs, SDH and DH data are available on the system.

- ii. Functioning of JSY in Rajasthan. JSY has been one of the main drivers of institutional deliveries. The quality of delivery and post natal care in the facilities however, continue to be a challenge. The State has adopted several measures to improve the quality of service delivery including upgrading of infrastructure, additional HR mobilization through contractual appointments (17,000 medical, nursing and paramedical staff), labour room hygiene and privacy, multiskilling of medical officers and through innovative schemes like Yashoda, and Kalewa scheme. Table-14 provides a snapshot of increase in JSY beneficiaries and JSY expenditure in Rajasthan.

Table-14. Rajasthan: JSY beneficiaries and expenditure under JSY 2005-2010.

Year	JSY Beneficiaries	Expenditure Under JSY (Rs. 0,000)
2005-06	4,928	17.70
2006-07	388,890	3,056.66
2007-08	774,877	13,005.00
2008-09	916,674	14,975.23
2009-10	978,615	16,248.08
2010-11 (Up to Oct. 10)	591,953	10,608.14

- iii. An important shift was observed in JSY case load from secondary levels to the primary levels in the districts visited. There is a trend of sustained increase in institutional deliveries against estimated deliveries at the PHC, CHC and the DH. A sample of L1, L2 and L3 level facilities were visited in both the Districts and common observations from those visits are noted below:
- The labour rooms as a general rule were clean, having privacy; and each had a newborn corner with warmers, Umbo Bag and Masks (two types).

- b) The maternity wards were clean but all had some beds available – the visit being during the post peak months of delivery.
- a) Quality of institutional deliveries and use of partograph in labour rooms was noted. Most women were staying for 24 hours and some beyond 48 hours in the hospital after delivery. Yashodas located in the District Hospitals were an enthusiastic group, friendly with the mothers and were making them comfortable.
- iv. Family planning:** The reduction of a relatively still high TFR of 2.6 is being done through strengthening of the Jan Mangal Program, the establishing of an NSV Resource Centre and through the Rajiv Gandhi Population Stabilization Mission. The determinants of the high TFR continues to be early age of marriage (40 per cent, DLHS III), high adolescent fertility rate (16 per cent), the unmet need, and programmatic issues like non-availability of trained manpower for a fixed day approach, and the predominant emphasis on limiting methods and minimal spacing method promotion. The State has started to improve access and availability of NSV services for increasing share of male sterilization in the method mix. In line with the GOI guidelines, State has increased the monetary incentive for all sterilisations. There is a huge potential untapped for increasing postpartum FP interventions by capitalising on the increase in institutional deliveries. A well thought out multiple-level FP strategy to reach different segments of eligible couples with a basket of options was absent in both the districts. This is a gap that the State and districts require to address.

Table-15. Progress in Family Planning (Expected vs. Achieved) in Rajasthan in 2010-2011

S. No.	Family Planning Activity	Expected level of achievement	Achievement (up to Nov. 10)	Per cent Achieved
1	Sterilization	481,248	Male: 3,211 Female: 21,766 Total: 124,977	25.97
2	Intra-uterine device insertion	458,207	303,977	66.34
3	Oral pill users	1,231,789	787,271	63.91
4	Condom users	1,452,985	977,663	67.29

Nutrition

Rajasthan continues to have poorer health indicators as compared to national average with significant morbidity and mortality, especially among infants, children and mothers. Out of 1.6 million children born every year in Rajasthan, 0.15 million die within 12 months of their birth and many more die before they reach the age of five years. To what extent this can be attributed to poor nutrition is unknown; however, the poor indicators on nutrition captured during the teams' visit enable to highlight the issue.

Nutrition is one of the socio-economic determinants of health along with water, hygiene, and sanitation that has a definite impact on morbidity of infants and children. The outcomes of improved nutrition at the state and community level are influenced by policies and strategies to address the issue, implemented through trained community level workers at district, block, and village level. Some of these activities include observing Health Day at Anganwadi level on a fixed day/month for provision of immunization, ante/post natal checks and services related to mother and child healthcare, including nutrition. Over and above this requires close coordination between different schemes for rural social development including Health, Nutrition, Safe Water, Sanitation, Integrated Child Development Services (ICDS) scheme,

Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGA) etc. However, the team found evidence of uneven progress of work on improving Nutrition which may have been influenced by the following factors:

Nutrition as a State priority

Though the state has policies and strategies in place to improve nutrition, it is not certain whether improving nutritional status of children was a top political priority. There appears to be limited understanding of convergence between DOHFW and Women and Child Department (WCD) departments at the top level. This was apparent as there was no participation from the WCD department both during briefing and debriefing sessions by the NRHM team at the State level. However, the coordination is relatively higher at the implementation level at the district, block and village level. There are clear attempts to ensure proximity of Anganwadi centres (AWCs) and sub centres for better coordination between the respective staff and for ease of delivery of services. Unfortunately, there was no participation of community development programme officers (CDPOs) and other ICDS functionaries at any time during the CRM visit, underscoring the disconnect that exist between the two departments.

Availability of manpower at the facilities

Rajasthan is attempting to build up its infrastructure of trained AWWs at the community level though a much larger pool of functionaries is needed at the community level to make an impact. However, the full complement of staff at each AWC visited was not available. Thus though AWW are available at most centres, vacancies exist for Anganwadi helpers (Sahayika) and ASHA Sahyoginis. Moreover, AWWs and ASHAs find it difficult to motivate and mobilize community members and women to volunteer for these positions. Those that reported some success in filling these positions had support from Sarpanch and ANMs.

Client load

Most centres had a far lower registration of mothers and children than what would be expected in the community. Most registered around 50 per cent of the expected numbers. One of the reasons offered for poor attendance of children in AWCs was the mushrooming of private schools in the villages that are admitting children below 5 years of age. On the positive side, based on the scrutiny of records in the AWCs, the CRM team observed that girls were as likely to be registered as boys in the AWCs.

Interventions: Tracking Malnutrition

Rajasthan has developed a good system for tracking malnutrition among the children registered in its AWCs. One of the striking features at most centres, visited by the team was the availability of meticulously maintained records of growth charts and functional accurately-calibrated weighing machines. The records clearly show sex differentials in the levels of malnourishment with far larger number of girls showing Grade II and III malnourishment than the boys at similar ages. There is also a gap between the number of children registered and provided services in the AWCs and those which are expected for that age group in the population. The CRM team also found that though the onset of malnutrition was captured by the AWWs at an early stage, the AWWs were not sufficiently capacitated to educate and influence the dietary patterns and habits of mothers and children. Most reported that nutrition supplementation was delayed till such time the children began visiting the AWCs. It was

disconcerting to find no substantial improvement in nutrition even when the malnourished children entered the AWCs.

Use of Advocacy and Communication

There is state-wide use of IEC and behaviour change communication (BCC) material for advocating complementary feeding. This was displayed prominently at all AWCs centres in local language. The staff were aware of their roles and responsibilities as well as key interventions such as early initiation and exclusive breast feeding till 6 months of age, complementary feeding, need for iron fortification, etc. However, on random enquiry from visiting mothers, few could clearly explain what was meant by complementary feeding, exclusive breastfeeding, appropriate duration for breastfeeding and weaning, etc.

Complementary strategies

There was increasing participation of both health and ICDS departments as well as VHSCs/Sarpanch on Village Health and Nutrition Days (VHNDs). Some credit may be due to the "Swasthya Chetna Yatras" organised by the state in recent months which has led to increased awareness, mobilisation of the community and uptake of services on such days. However, complementary strategies of hygiene, safe water and sanitation for improving nutritional levels are not promoted at all. We also did not find any involvement of school teachers in the program nor found any focus on development of community kitchens, or Vitamin A and micro-nutrient supplementation.

Planning and Monitoring at the Village level

We found no evidence of any strategy on improving nutrition, assessment of malnutrition or plans for improving nutrition or monitoring of health and nutrition functionaries such as AWWs in the village health plans. Similarly, the community stakeholders were not fully aware of their role and nature and level of participation in the AWCs at the community level; although there were isolated instances of intense involvement of PRIs at the village was found where individual Sarpanch/Gram Sabha members were actively involved in supporting and overseeing the work at AWCs. This will require active follow up to ascertain whether synergies between PRIs and health functionaries have led to improved outcomes in nutrition in the community.

Malnutrition treatment centres (MTCs)

The Malnutrition Treatment Centres (MTCs) visited by the team had no or little client load. The district authorities acknowledged the problem and some of the supply side issues identified include absence of referral mechanism, lack of coordination between the health and ICDS department, etc. Issues on the demand side including inability to retain mothers and their children in the MTCs for the prescribed treatment period due to loss of wages, neglect of other siblings in the family during the mother's absence from home. District hospital officials also mentioned that the compensation that mothers received (Rs. 30/- per day) did not match up either to their minimum wages or to MGNREGA wages and that too was a reason for not wanting to stay in the MTC. Considering that Rajasthan has one of the largest loads of severely malnourished children among states in India, there should be more pilot studies and field research on home-based management of severely malnourished children using therapeutic foods in the state.

Suggestions to improve Nutrition

It is evident that there is a large pool of malnourished children in the rural areas of Rajasthan, with clear gender differentials in the grade of malnourishment. Some of the positive work that is being done in this area include a growing recognition of the problem, excellent tracking of malnourished children registered with AWCs, involvement of PRIs as well as closer coordination between ANMs and AWWs at the grass root level. However, on the flip side, there is limited emphasis on addressing the problem at the grass root level, where effective interventions are urgently needed.

Suggestions/Recommendations

Keeping in mind the scale of the problem, we suggest the following for improving nutrition levels among children in the state. Firstly, nutrition must be accorded a political priority at the highest level in the state to bring the program to prominence and to scale in order to tackle the severe problem of malnutrition. Secondly, the foremost operational issue for the state is to fill the vacancies at all levels. This needs to be followed up with development of district and block-wise plans for capacity building of the Health and ICDS workers to ensure effective performance of the AWW centres. Thirdly, monitoring of nutritional management needs to be strengthened substantially through a multi-sectoral approach. We found perceptible differences in those AWCs where PRIs are taking interest in monitoring and supporting the functioning of the AWCs. Thus, there is a need to generate awareness among the community members, women's SHGs and PRIs; build capacity of VHSCs and their members through peer led trainings and provide support to them for generating and mobilizing funds; building village health plans for health and nutrition and monitoring the activities. This can be facilitated through existing NGOs and CBOs that are already working in the community and who have a buy-in among the community members.

In order to improve the services in MTCs, AWWs, the CDPOs need to be made aware of these centres and referral mechanisms and be involved more actively for tracking and referral of severe/Grade-III malnutrition to MTCs. Some form of monetary incentives to AWWs may be considered for achieving set targets.

Lastly, in view of the substantial numbers of children with Grade II and III malnutrition, and the inability to retain women and their malnourished children in MTCs for the minimum requisite period, innovative thinking is required to address this problem through alternative mechanisms other than MTCs. One of the alternatives can be through community-based interventions, hot meals feeding programs at community level, involvement of mother's groups, SHGs etc.

National Disease Control Programmes (NDCP)

Integrated Disease Surveillance Project in Rajasthan

Integrated Disease Surveillance project (IDSP) is a decentralized and state-based surveillance programme, implemented in all the districts of Rajasthan since April 2005. It aims to detect early warning signals of impending disease outbreaks and help initiate an effective response in a timely manner. It is also expected to provide essential data to monitor progress of on-going disease control programmes and help allocate health resources more efficiently.

- Except for the new district of Pratapgarh, all districts in the State have an established district surveillance unit (DSU).
- All district surveillance officers (DSOs) are trained.
- All 8 labs are functional and are working for outbreak detection.
- 88 per cent of major hospitals enrolled and are sharing P & L forms and information.
- 5 reputed major private hospitals are sharing weekly surveillance reports.
- A toll free number 1075 is accessed by all districts and is used by the community for reporting any outbreaks.
- Community-based surveillance is yet to be established. However ASHA Sahayoginis are being imparted training to support in early detection of outbreaks.

National Vector Control Programme in Rajasthan

Malaria and dengue are two principal vector borne diseases prevalent in state. The tribal and desert areas contribute 70 per cent malaria cases. The far flung areas with low population density are the major reasons responsible for hindrance in implementation of public health programmes in western Rajasthan.

Malaria is endemic in Ajmer, Alwar, Banswara, Baran, Barmer, Bharatpur, Bhilwara, Bikaner, Bundi, Dholpur, Hanumangarh, Jaisalmer, Jhalawar, Kota, Nagaur, Rajsamand, Sawai Madhopur, Udaipur and Pratapgarh districts in Rajasthan. Although the State shows low P. falciparum (PF) per cent as compared to the national average, even at this low percentage, deaths can occur in remote and difficult areas where surveillance is poor.

Dengue is endemic in Ajmer, Alwar, Bharatpur, Bhilwara, Bikaner, Chittorgarh, Dausa, Jaipur, Jodhpur, Karuli, Kota, Sawai Madhopur, Sikar, Udaipur districts of Rajasthan. Spread of dengue has increased in the State if we compare the data of last 9 years. Out of 33 districts, 20 are dengue endemic. In 12 Districts there have been cases in one or the other year. Currently, there are 14 dengue prone districts in the State. This year cases have been reported from rural areas.

Challenge for NVBDCP in Rajasthan: The projected population of Rajasthan is around 7 crores in 2010. However, there are only 1,354 sanctioned posts of laboratory technicians, out of which 309 are vacant. In all there should be a total number of 2,333 laboratory technicians, so actually the State needs 1288 additional laboratory technicians.

Revised National Tuberculosis Control Programme (RNTCP) in Rajasthan

Rajasthan is amongst better performing states in country. RNTCP covered the whole of the State in January 2001. The State has constantly performed well and has exceeded the target of 70 per cent case detection and 85 per cent cure rate. In general, RNTCP has performed consistently well in the State. Supervision of activities is being performed at all levels of health infrastructure by relevant officers of RNTCP. However there is a concern raised by the State that for these supervisory visits the provided TA/DA insufficient.

Table-16. RNTCP: State Profile of Rajasthan

Population – (Projected 2010)	66.76 million
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No. of districts	33
No. of district TB Centres	34
No. of Tuberculosis Units	150
No. of District Microscopy Centres	819
No. of Direct Observed Treatment Short-course (DOTS) Centres	>15,000
No. of Medical Colleges	6 + 4
No. of TB Hospital	1
Percentage of tribal population	12.65

Table-17. DOTS-Plus Activities under RNTCP in Rajasthan

	Activity	Action taken till date
1	Intermediate Reference Laboratory	At State TB Training and Demonstration Centre (STDC) Ajmer, accredited on 26.03.2009 for solid culture.
2	Other Culture & Drug Sensitivity Testing Laboratories in pipeline	
A	SMS Medical College, Jaipur	Laboratory located in the Department of Microbiology, and accredited on 21.05.2010 for solid culture.
B	Desert Medical Research Centre (ICMR), Jodhpur	Under consideration.
C	Medical Colleges, Jodhpur and Udaipur	
D	Line Probe Assay (LPA) and Liquid Culture Facility at IRL (STDC Ajmer).	Funds for Civil Works released to STDC.
E	LPA and Liquid Culture Facility at SMS Medical College, Jaipur.	Accreditation in process.

Iodine Deficiency Disorder Control Programme Action Plan

The situation in Rajasthan, where reported proportion of households consuming adequately iodized salt was 40 per cent in 1999, is lesser than the national average. The decline observed in the national average is also observed in Rajasthan. The state has indicated following strategies such as laboratory monitoring of iodised salt and urinary iodine excretion and Health Education and IEC/BCC will be undertaken throughout the State. Also the capacity of the State

Iodine Testing Laboratory would be further strengthened with UNICEF's support. Similar labs are proposed to be established at divisional level and capacity building efforts of the manpower undertaken for timely and effective monitoring based on tests conducted at divisional labs.

National Leprosy Eradication Programme (NLEP)

National Leprosy Eradication Programme started in the year 1970-71 in the State. Rajasthan has reached a level of elimination i.e. prevalence below 1/10,000. Existing prevalence rate of the disease in the state is 0.18/10,000 population in comparison to the national prevalence of 0.72/10,000. Rajasthan therefore is very near to eradication of the disease.

National Programme for Control of Blindness

In 2010-2011, the target for cataract operations in Rajasthan was 300,000 cases, of which 118,000 cases or 39 per cent was achieved till November 2010. The State has 23 functional eye banks, of which only 9 are government run, while the rest 14 are run privately.

Institutional mechanisms and Programme Management

Although key institutional mechanisms under the NRHM have been put in place in the State, the CRM team observed that the functioning of these mechanisms varied. There were issues with programme management as well, which were observed by the CRM team and commented upon in the previous paragraphs. The general concerns with regards to institutional mechanisms and programme management include the following:

- The district and sub-district level planning continues to be template based despite huge amount of information available, including relevant denominator populations for various activities.
- The CRM observed that the approved District PIP usually had a 20 per cent reduction in their proposed plans. These cuts removed key items like the mandatory annual maintenance grants (AMG) for secondary-level care facilities etc., while about 7 items not initially included in the District PIP were approved. A similar situation exists at the State level PIP where the Principal Health Secretary, GOR pointed out that there was an element of surprise since what was removed from the State PIP was not known by the State before final approval from the MOHFW, GOI.
- The CRM observed that equity was still eluding the public health system despite several schemes. Notable among which was the Mukhya Mantri BPL Jeevan Raksha Kosh (MMJRK), the Desi Ghee Scheme for BPL women pregnant for the first time, and the JSY. However, the percentage utilization by BPL is consistently very low at different levels and across different schemes.
- A huge pool of malnourished children (Grade II and III) was found on examining records at a number of AWC, while the MTC (now renamed as nutritional rehabilitation centres) remain vacant, primarily due to lack of inter-sectoral convergence between departments.
- The CRM observed that the State required to initiate more productive ways for utilising the VHND to help in ANC, FP, nutrition counselling, and for identifying malnourished children for community based management and referral to MTCs.
- The availability of specialists particularly, anaesthetists and gynaecologists continue to be major challenge. The lack of confidence of General Duty Medical Officers trained in life-saving anaesthesia skills (LSAS) and comprehensive emergency obstetric care (CEmOC)

to apply their skills needs review of the post training supervision and on the job handholding.

- The management of trainings, including setting up criteria for selecting appropriate candidates, quality assurance of trainings conducted, and post-training follow-up of placement, application of skills, etc. continues to be exception rather than rule.

Financial management

Based on the Finance Management review in facilities visited, and interaction with district and State officials following are the major observations of the CRM for Rajasthan:

Statutory Audit report for FY 2009-10: The State has not yet submitted the Audit Report FY 2009-10. Although Audit has been completed, it has not yet signed by the Auditor. At Pali district copy of statutory audit could not be found but soft copy of same was available.

Concurrent Audit: Districts are not submitting their audit reports timely to State. At Pali district, the auditor had not provided the concurrent audit report of the 2nd quarter.

E-banking: Funds are transferred by e-transfer system through the State Bank. Districts transfer funds to blocks either through e-transfer if available, or by cheques.

Tally ERP 9: Accounts are maintained on Tally in all districts but a customised version of the software was not yet implemented. In Pali district, block level accounts were also maintained on Tally. Tally training has been provided to District Account Managers at the State level.

Manpower Status: The CRM team noted that the major issue was the lack of manpower in finance and accounts. Accountants at block were also doing work at other PHCs. And at some units the MO-i-C was maintaining books of accounts. The State needs to ensure that all positions of accountants get filled as soon as possible.

Maintenance of books of accounts: Books of accounts were not properly maintained below the district level. One accountant was handling accounts of two facilities. Bank reconciliation statements were usually not prepared at PHC level. Also, the latest Bank Statements were often not available for review at health facilities.

Integration of NDCPs: The integration of NDCPs is only at the State level. For example, at district Pali, officials of NDCP division, except for RNTCP, were sitting in same office, but were reporting directly to the State.

Books of Accounts under NDCP: Based on the books of accounts verified under NDCPs, we noted that ledgers were maintained without opening balance. Further, we observed that the books were not maintained before the new staff joined. The district needs to organise trainings for NDCP officials on maintenance of books too. However, the regular staff in NDCP division was keeping their cash book regularly updated.

Reporting by NDCPs: On analysing the reporting balances forwarded by NDCPs to the State level, CRM review found that the reporting format was not clear to the staff, as a result of which, wrong balances were reported. State therefore has to arrange training for district NDCP officials to understand these reporting formats.

HMIS status: All the districts were not uploading their data on HMIS. During the 2nd Quarter in the current FY, 26 districts out of 33 districts had uploaded their financial management reports (FMRs) on the HMIS.

Clarifications required by the districts from State: We observed that the district officials need clarification from the State on some of the issues mentioned below:

- At health facilities untied funds were lying unused; could such untied funds be used for expenses in more active health facilities where such funds were required?
- JSY beneficiary payments: during June-July 2010, the GOR had ordered that JSY beneficiaries will be paid by account payee cheques only; but a month later that order was rescinded. However, the beneficiaries of this particular period had not yet been paid. The districts had requested an order from the State to pay those beneficiaries through bearer cheques.
- District officials were not clear on the rules around utilization of bank interest lying at the district level, and require State-level clarification on this matter.

Finance/Accounts training: Based on our observations, requirement of finance training is felt at all levels. A training plan for this should be prepared and orders given to districts to meet or discuss the finance/accounts issues regularly. Training of regular staff for maintenance of accounts should also be taken at State level.

Reporting format: Based on the finance and management review at PHC/CHCs the CRM found that some of the units were sending utilisation certificates (UCs) with the Statement of Expenditure (SOE), while in other instances units were submitting only the UCs to the block level. Therefore the CRM team recommends that the reporting format should be same for all levels of financial reporting.

ASHA Payments: The CRM observed that in one PHC, the ASHA were paid using bearer cheques in contravention to established procedure. The CRM therefore recommends that all ASHA need to have their bank accounts opened immediately following their training, before they are deployed, and should be paid only through account payee cheques.

Treatment of untied fund and RKS/MRS: At the district level, funds disbursed under the head 'untied funds' are treated as advances. The CRM therefore recommends that it should be ensured that regular UCs are submitted by all health facilities, and accounts should be adjusted upon receiving the UC at respective level. The CRM also observed that utilization of untied funds under the MRS was low, and at lower levels of staff, guideline for utilisation of RKS funds too was not clear.

Periodic field visit: The CRM recommends that periodic visits should be planned at district level to analysis the management of finance/accounts and to ensure that proper books of accounts were maintained at block/sub district levels. A similar procedure needs to be adapted by the block accountant, for review visits to the facilities assigned to them from time to time.

District and block-level PIP: The CRM observed that district programme officials need to be notified if any major component recommended during developing the PIP is reduced or not approved in the final PIP. The CRM further observed that copies of the final district PIP could not be found at the block level, and recommends that all blocks should have a copy of the final (approved) block PIP on time.

Bank Charges not waived off: The CRM observed that bank interest charges were not waived in most of the PHCs/CHCs, and recommended that the District Health Society take initiative to standardise/waive this for all blocks/facilities.

Decentralized Local Health Action

Mechanisms and Strategies for Community Participation

For ensuring better community participation, committees / organizations have been formed at various levels, which at the village level include the VHSC and the ASHA. VHSCs have been formed at the village level for decentralized planning and monitoring up to the grass root level. The VHSCs are expected to be best positioned to analyse the health problems, decide the health priorities and take appropriate action to overcome the problems at the village level apart from optimum utilization of health funds in the village.

The State of Rajasthan presently has 9,189 Gram Panchayats where such committees exist. The VHSC comprises of Panchayat representatives, ANM, Anganwadi workers, teachers, community health volunteers and ASHAs. The VHSCs have access to Rs.10000 as untied funds to support their efforts in developing Village Health Plans.

Issues/Concerns

Our experience in the two districts visited indicates that the process of community participation in Rajasthan is heterogeneous, varying both in extent and intensity of the community involvement. There are several issues which have impacted the slow community participation in the NRHM at the community level.

Perception of Health as a priority

Health is generally not accorded high priority by an individual as well as community. For the PRIs, local health institutions are not a priority and development projects and funds disbursement activities get priority over health concerns.

Recently, the State government of Rajasthan has initiated steps to partially devolve fiscal and administrative authority and responsibility of Health and WCD department up to the district level to the PRIs. In a three tier format, the staff of the health and nutrition programs at the district, block and village level will be accountable to the corresponding levels of PRIs, the Zilla Parishad, the Panchayat Samitis and the Gram Panchayats. Unfortunately, the State has had mixed success in their earlier attempt to devolve authority to PRIs as the policy has been successively implemented and then withdrawn in different regimes of the government. It is not certain to what extent the government will be able to achieve their goals this time around, given the limited capacity of PRIs to take on the role.

Awareness of Roles and Responsibilities

Lack of awareness and motivation has led to minimal community participation. It appears to be an uphill task to initiate a social audit at the village level. The mandate of the VHCs is comprehensive and includes planning, implementation and oversight functions. However, the community stakeholders are hardly aware of their role and nature and level of participation in NRHM at the community level.

Rajasthan has a tradition of involvement of PRIs in the health care facilities that pre-dates NRHM, as Medical Relief Societies have been in place for the past 8-10 years. These perform similar functions as envisaged by the RKS. The role of RKS has however been limited to budgetary approvals with little or no emphasis on planning or monitoring of services.

Limited Institutional Mechanism of PRIs

The mandated community-based structures have not been created in all the villages. If the structures are there, the community members have not been trained or made aware of their roles and responsibilities, resulting in low and ineffective participation of the community members. Another limiting factor is the presence of substantial vacancies among the grassroots cadres of health workers. Despite the large numbers of ASHAs, AWWs, Sathins and ASHA Sahyoginis recorded on official documents, the field reality is that there is a large turnover, attrition and poor retention of these workers. This is important as the cultural and social barriers in Rajasthan make it difficult at times for women to work in the community.

The participation of the Panchayati Raj institutions (PRIs) is also marginal and only beginning to emerge. In most sub centres, the health functionaries continue to play a predominant role. In sub centres where the health functionaries are proactive, efficient and aware of utility of untied funds, meetings are being organized periodically. In such centres, records of meetings, documentation of expenditures incurred and of follow up activities approved by the committee are being maintained. Though the untied funds are supposed to be utilized with the consensus of the community, this seldom happens and Sarpanch and other PRI functionaries play a marginal role confined to financial approvals for disbursement of grants. In many places the process of utilisation of untied funds is yet to begin.

In isolated instances of proactive PRI involvement, VHSC heads and members have a sense of community ownership of the health care agenda in the community and are involved in raising resources for physical improvement, renovations, purchase of equipment and for maintenance and repair of the health care facilities.

Medical Relief Societies (MRS) are functional at all levels – PHCs, CHCs and District Hospital; but their role and nature of their participation has not been fully understood at the institutional level. The stakeholders appear to have limited understanding of their role in enabling devolution of responsibilities of health care to local government. MRSs are perceived by stakeholders essentially as a mechanism for enabling utilization of user charges and other facility revenues. The meetings of MRS as of VHSC are generally limited to budgetary approvals, purchase of equipment and supplies, contract renewals etc.

Roles and Responsibilities

Generally health providers are oriented towards provision of medical services, with little understanding or inclination to address the broader determinants of health. More often than not, there is a disconnect between the interest and priorities of health providers and PRIs, usually resulting in poor involvement and ownership by the community based stakeholders.

Suggestions to improve community participation and ownership

Mobilization, formation and strengthening of VHSC/PHC and block level committees; community level enquiry and sharing of reports and planning have to be ensured for effective community participation and ownership of the NRHM.

Establishing Community Based Structures

The foremost requirement is that all the mandated community based structures such as VHCs, and MRSs should be in place. The committees at the village, PHC and block have to be formed where such committees have not been formed. Similarly, the government should be committed

to filling all vacancies in the different cadres of grass root workers through extensive mobilization of the community.

Use of Existing Structures and Programs

Rajasthan has a very active nongovernmental sector. There have been several government programs and schemes which have involved NGOs and community at the grassroots level. Within health sector also, there is a pre-existing presence of community participation in health care system, which pre-dates NRHM in the form of Medical Relief Societies (MRS). MRSs are functional across all facilities, big or small, urban or rural, peripheral or central. Regular meetings of MRS happen though the periodicity varies. As mentioned earlier, such structures and past experiences should be leveraged for effective involvement of the community in the NRHM.

Ensuring a Broad Based Community Representation in Committees

The community participation should be broad based. It is important to involve stakeholders representing different social groups including the representation of marginalized groups – women, Dalits, tribal populations and offering different services. This has to be taken care of by leaders of the community and the health department has to make it a priority. Participation of stakeholders, who have a fair understanding of functions, roles and responsibilities such as youth, teachers etc. should be emphasized.

There is potential for tapping into the community resources and many PRIs are willing to increase their participation but are limited due to poor understanding of health issues and of their own roles and responsibilities.

Capacity Enhancement and Hand Holding of the Community Stakeholder

For successful devolution of authority and responsibility to the PRIs, stakeholders will have to be trained to understand their role and responsibilities for taking the ownership of the health programs and systems at village, block and district levels. Hence, capacity building at village, block and district levels for very large numbers stakeholders has to be factored in for greater involvement and proactive participation in planning the health activities, managing the health services and monitoring of timely and quality delivery of services at various levels.

Health providers at PHC level can facilitate dissemination of success stories of PRI functionaries supporting health care functionaries thus motivating all others to contribute in the same manner. There is also a need for all stakeholders to recognise community health workers as dignified community representatives and not the last link in the health care delivery chain. Ultimately, PRIs will need to be oriented to shift their focus from problem identification to finding solutions at the community level.

Transparency and Accountability in Systems

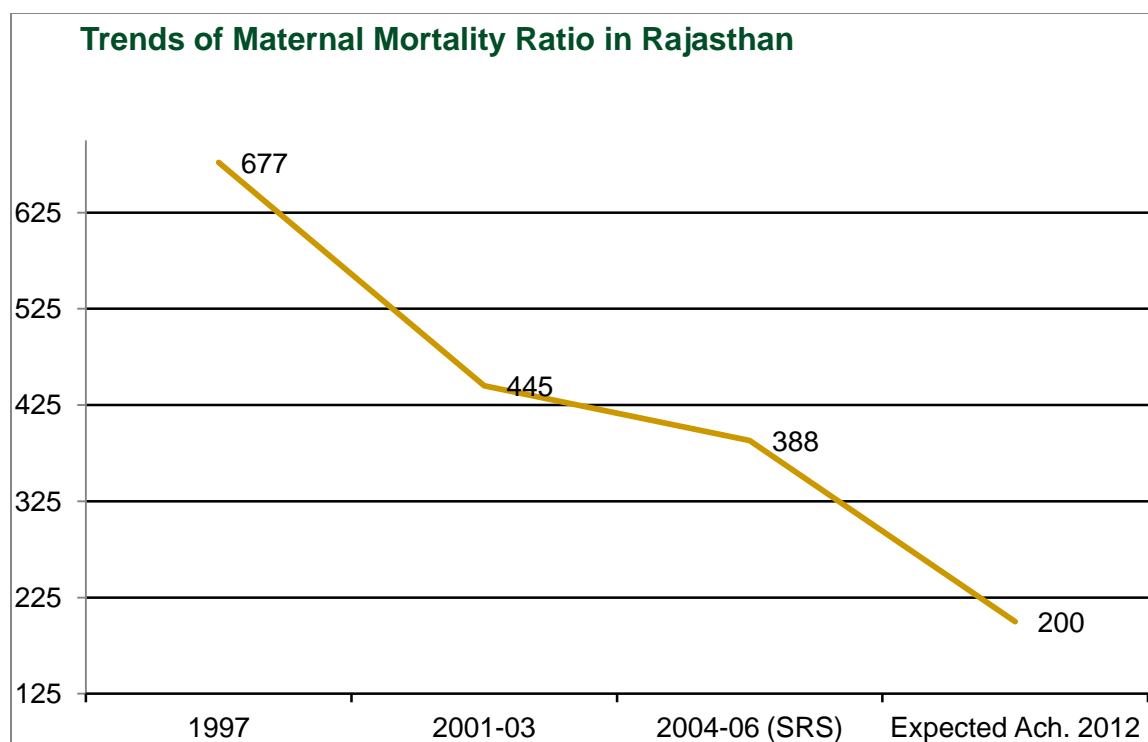
Transparency and accountability in planning, managing and evaluation of the NRHM at the community should be treated as a central principle to ensure trust and ownership of the community. The programme strategies, schemes, reports and budgets should be duly publicized and made available to one and all. Meetings should be held periodically. Minutes should be written down along with the follow up on decisions and responsibility centres.

Facilitating the Balance of Power between Stakeholders

Community stakeholders and service providers come from different backgrounds. They have different understanding of their respective roles and responsibilities. Hence, they have different attitudes and perspectives. PRIs have capacity to mobilise resources, generate revenue, and improve community involvement while health care functionaries bring in their technical skills for improving health care. It is vital to institutionalize mechanisms to facilitate a proper power balance between stakeholders so that both can capitalize on their individual strengths for achieving better outcomes.

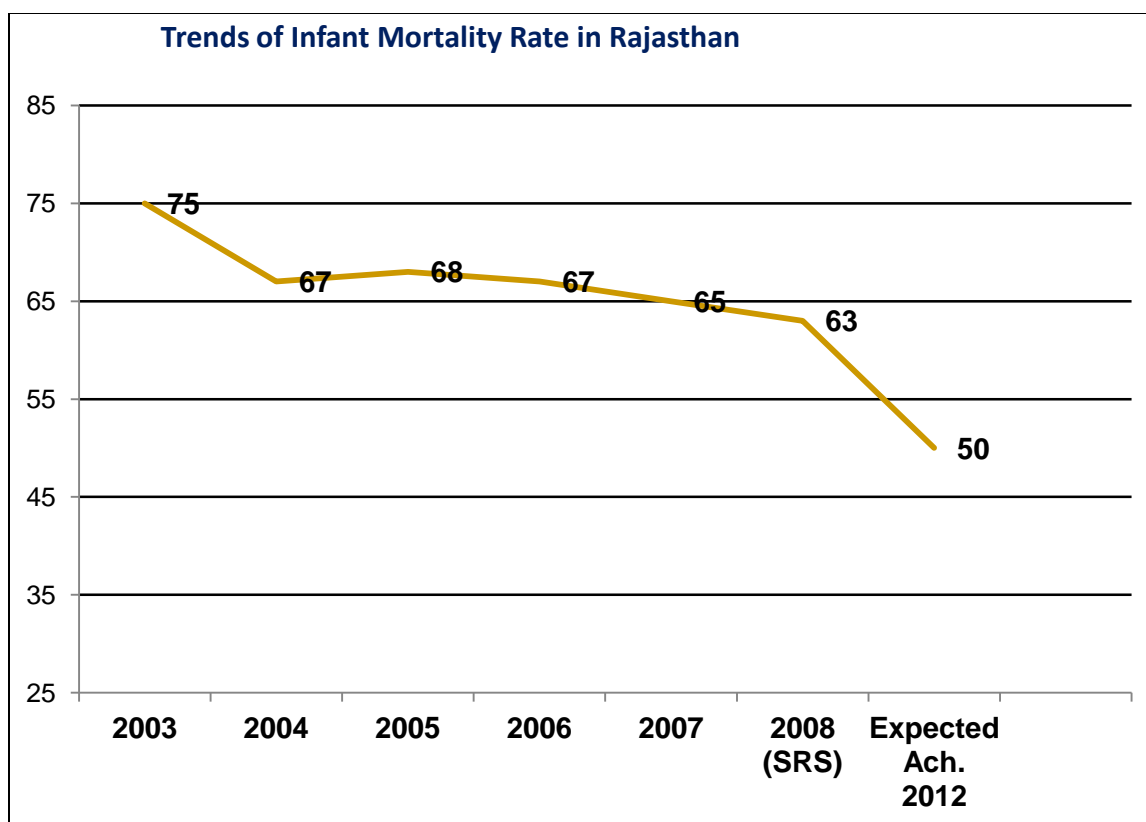
Status of the progress of State against Specific Objectives and Expected Outcomes of NRHM

Figure-7: Declining Trends in Maternal Mortality Ratio in Rajasthan



Note: Planning Commission has commended the rate of reduction in the major health indicators of Rajasthan, which is better than the all India average.

Figure-8. Declining Trends of Infant Mortality Rate in Rajasthan



4. Recommendations and Conclusion

A team consisting of 7 members constituted the 4th Common Review Mission of the NRHM for the State of Rajasthan. Following induction of the team in New Delhi on 15th December 2010, the team left to visit Rajasthan between 16th and 22nd December 2010. During this period, the CRM team met with the Principal Health Secretary GOR, Mission Director NRHM Rajasthan, Executive Director of RSHDP and other senior officials of the DOHFW, GOR in Jaipur. The team then divided into two smaller groups and visited two districts – Ajmer and Pali in the State over the next four days. At the district level, the two teams interacted with district level health officials, medical officers, ANMs, laboratory technicians, accountants, district and block project management team members and grassroots workers (ASHA and AWWs). They visited a total of 23 health facilities and two VHNDs spread over the two districts. On completion of field visits, each team debriefed the respective district teams on the last day of their district visit. After returning to Jaipur, the CRM representatives met with and debriefed the PHS on 21st December 2010. On 22nd December, the CRM team met with representatives of NRHM and DOHFW GOR and shared the debriefing and recommendations, requesting feedback from the assembly.

The following key recommendations were shared by the CRM team with representatives of DOHFW-GOR representatives, Rajasthan State Health Service Development Project representatives and representatives of the State NRHM team at a debriefing session held in Jaipur on 22nd December, 2010 at the State Swasthya Bhawan.

- With regards planning of MCH centres, the CRM team suggested that the state needs to review and plan MCH centres (including planning the HR mobilization) more rationally. Mentioning that too many centres been brought under the L1 in the State, the CRM

suggested that planning MCH centres should be minimally based on numbers of institutional deliveries and on access of communities for normal delivery services within 2 km, and emergency services within 1 hour.

- The CRM recommended that a MCH task force would need to oversee the process and provide substantive follow up.
- There seemed to be a good deal of coordination and collaboration between all stakeholders. However, PRI and health department will require close coordination to make this operational.
- With respect to improving access to and utilisation of family planning services in the State, differential strategies for young couples focusing on delaying their first birth and spacing their second baby required state-wide implementation.
- District-level health action planning (DHAP) needs to move from the current practice of budget template-based planning to evidence-based planning that uses both epidemiological data and service statistics. The CRM in other words, strongly recommended that NRHM planning in the state should be based on denominator populations, quality of services and on outcome tracking.
- To address State-wide childhood malnutrition, the CRM recommends innovative thinking such as community-based management. The WCD department, ICDS at blocks and AWW need to be involved for active tracking of severe/Grade-III malnutrition and for their referral to MTCs.
- Training: each district needs to develop a district-level training calendar based on the need of the district. Training has to be a priority, and requires dedicated staff. Utilisation of training budget needs to be done.
- On issues of finances, in addition to recommendations already given under review of financial activities, the CRM recommends that the State speedily clears the RCH-I fund balances that are still showing from its books.
- With respect to utilising of VHSC funds, in addition to using the funds as per established pattern, newer ideas for addressing community's health requirements need to be funded.
- With respect to payments to ASHAs, the CRM recommends that a bank account should be opened for each ASHA immediately after she completes her training. All payments to ASHAs should be through account payee cheques only. Lastly, after hearing the voices of ASHAs from the field, the CRM recommends that appropriate local-level solutions may be organized so that ASHAs can get their incentive payments periodically (e.g. monthly) rather than as piecemeal small amounts.