5th CRM Report Rajasthan

National Rural Health Mission

Ministry of Health & Family Welfare

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Chapter 1

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5th Common Review Mission				
8th November to 15th November, 2011				
Name of State		RAJASTHAN		
Names of Districts visited				
S.No.	**Name**	**District HQ**	**Name of DM**	**Name of CMO**
1	Barmer	Barmer	Dr. Veena Pradhan	Dr. Ajmal Hussain
2	Chittaurgarh	Chittaurgarh	Mr. Sumit Jain	Dr. R. P. Sharma
Health Facilities Visited				
Barmer District				
S.No.	**Name**	**Address/Location**	**Level (SC/PHC/CHC/other)**	**Name of the person in Charge**
1	CHC, Kalyanpur	Village Kalyanpur, Block Balotra,	CHC	Dr.Rasa Ram Sukhar
2	Sub Centre, Mangta	Village Mangta, Block Dhorimanna,	Sub Centre	Raashi Parmar, ANM
3	SHC Mukne Ka Tala	Vill. Duddu, Block Dhorimanna	Sub Centre	Munni Devi, ANM
4	CHC, Dhorimanna	Block Dhorimanna	CHC	Dr. Hanumana Ram Choudhary
5	Sub Centre, Alamsar	Village Alamsar, Block Chhotan	Sub Centre	Suman Kumari, ANM
6	PHC, Dhanau	Village Dhanau, Block Chhotan	PHC	Balbir Singh Male Nurse
7	PHC, Sata	Village Sata, Block Chhotan	PHC	Dr. Shivraj Bishnoi
8	PHC, Bhakasar	Village Bhakasar, Block Chhotan	PHC	Dr. Babu Lal Meena
9	CHC, Sheo	Village Sheo, Block Chhotan	CHC	Dr. Chanda Ram
10	District Hospital, Barmer	Barmer	District Hospital	Dr. Maheshwari, PMO
11	Sub Centre, Majiwala	Village Majiwala, Block Balotra	Sub Centre	Sindhumole Joseph, ANM
12	District DrugWarehouse	Barmer	Drug Warehouse	District Project Co-ordinator

Health Facilities Visited				
Chittaurgarh District				
S.No.	**Name**	**Address/Location**	**Level (SC/PHC/CHC/other)**	**Name of the person in Charge**
1	DH Chittorgarh	Chittorgarh	DH	Dr. Rajendra Aggarwal, Dr. Jaishing Meena
2	Nimbahera SDH	Nimbahera	SDH	Dr. Nitin Mali
3	Mandphiya CHC	Bhadesar	CHC	Dr. Anit Jatav
4	Rawatbhata CHC	Rawatbhata	CHC	Dr. G.J.Parmar, Dr. Kamal Bhargav
5	Badisadri CHC	Badisadri	CHC	Dr S.C.Gupta
6	Ghosunda PHC	Chittorgarh	PHC	Dr. Surendra Srivastava
7	Bhadsoda PHC	Bhadesar	PHC	Dr. Mukesh Kalera,
8	Boraw PHC	Rawatbhata	PHC	Dr. Kamalesh
9	Nikumbh PHC	Badisadri	PHC	Dr.Puspendra Gupta
10	Umand PHC	Kapasan	PHC	Dr. Narendra Singh Deval,
11	Sowania SC		SC	Ms. Anita Chodhury, ANM (Regular) Ms. Lakhi Devi, ANM (Contractual)
12	Badolia SC		SC	Ms. Bina Sharma, ANM
13	Lasravan SC		SC	Mrs. Saraswati Devi, ANM
14	Karunda SC	Chotisadri	SC	ANM-Asha Rani
15	Uchnarkhurd SC	Kapasan	SC	ANM-Smt Vimla Tripahti
16	Pind SC		SC	ANM--Shyam kaur ASHA-Nirmala devi Aanganwadi worker--Hem Kanwar, Aanganwadi Sahayika--Wardi bai
17	Purnamani SC	Badisadri	SC	ANM Snehlata

Chapter 2

State Profile

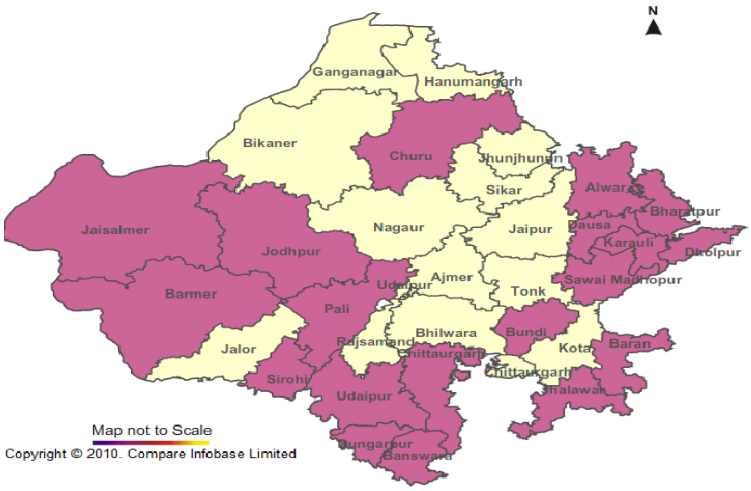


Figure 1: District map of Rajasthan

The Population of Rajasthan is 6,86,21,012 comprising of 5,15,40,236 rural and 1,70,80,776 urban population as per the Census 2011. The State has recorded 21.44% growth in last 10 years. The rising population in Rajasthan also reflected in the population density that now stands at 201 persons per sq km against figures of 165 and 129 in 2001 and 1991 respectively. The total population growth in this decade was 21.44 percent while in previous decade it was 28.33 percent. The population of Rajasthan forms 5.67 percent of India in 2011. In 2001, the figure was 5.49 percent.

Table1: Demographic data- Rajasthan (as per 2011 Population Census)

Population	6,86,21,012
Population Density	165/km
Sex Ratio	920
Breakup of Religion	Hindus - 88.8% Muslims - 8.5% Sikhs - 1.4% Jains - 1.2%

As per the census report 2011, Rajasthan has also recorded an improvement in the female literacy rate that now stands at 52.66 against that of 43.9 in 2001. But even this figure stands way below the national average of 65.46.

Administratively, the state has been divided into 7 divisions, 33 districts divided into 237 blocks comprising 44672 villages. The state has a network of 34 district hospitals, 12 sub district hospitals, 5 satellite hospitals, 376 community health centers, 1517 primary health centers and 11487 sub health centers

Status of Health Indicators: the following is the status of basic health indicators of Rajasthan as compared to the country as a whole.

Table 2: Health Indicators of Rajasthan

Sl. No	Indicators	Rajasthan	India
1	Infant Mortality Rate (SRS- 2009)	59	50
2	Maternal Mortality Rate(SRS 2007-09)	318	212
3	Total Fertility Rate (SRS 2009)	3.3	2.6
4	Institutional Deliveries (In Lakhs) 2011-12 (upto June) (MIS)	2.53	32.98
5	Full immunisation (In thousands) 2011-12 (upto June) (MIS)	391	4651

District Profile:

Barmer

The total population of Barmer is 26,04,453 as per the Census 2011 figures with 15.7% Scheduled Castes and 6.0 % Scheduled Tribes population. At present the districts has 2464 villages and the geographical area of the district is 28, 387 square kilometers.

As per DLHS – 3 Barmer has 21.3% Institutional deliveries, and a 51.0% full immunization rate. The total unmet need for family planning is 18.0%. The District has 8

blocks with 1 DH at Barmer, 1 SDH at Balotra, 14 CHCs, 63 PHCs, and 545 SC. In addition, a GNMTC at Barmer and an ANMTC at Balotra are functional.

Chittaurgarh

The population of Chittaurgarh is 15, 44,392 with Scheduled Castes making up 13.9% and Scheduled Tribes 21.5% of the population. As per DLHS- 3 data, institutional deliveries in Chittaurgarh are 45.1% of the total deliveries; full immunization is at 69.0 % while the total unmet need for family planning is 10.0%.

The district has 11 blocks with 1 DH at Chittaurgarh, 14 CHCs, 38 PHCs, and 302 Sub Centres.

Infrastructure Development

Table 3: Status of health facilities in the state:

Number of Sub-Centres functioning	**11487**
Number of PHC functioning	**1504**
Number of CHC functioning	**368**
Number of DH functioning	**34**

(As on March 2010; RHS 2010)

Table 4: Block-wise Availability of Health Facilities in Barmer

Sl. No.	**Name of Block**	**No. of Sub Centres**	**No. of Health facilities above SC but below block level other than PHCs (may include APHC etc.) RFWC**	**No. of PHCs**	**No. of CHCs**	**No. of Sub-Divisional Hospitals and other hospitals above CHC but below District Level**	**No. of District level hospitals if any**
1	Baitu	63	1	8	2	0	0
2	Balotra	81	0	8	2	1	0
3	Sheo	52	1	7	2	0	0
4	Siwana	56	1	8	2	0	0
5	Sindhari	72	1	7	1	0	0
6	Dhorimanna	77	1	8	2	0	0
7	Chhotan	70	0	11	1	0	0
8	Barmer	74	1	6	2	0	1
	Total	**545**	**6**	**63**	**14**	**1**	**1**

Table 5: Block-wise Availability of Health Facilities in Chittaurgarh

Sr. No	Name of Block	No. of Sub Centres	No. of Health facilities above SC but below block level other than PHCs (may include APHC etc.)	No. of PHCs	No. of CHCs	No. of Sub-Divisional Hospitals and other hospitals above CHC but below District Level	No. of District level hospitals if any
1	Bhadesar	30	0	2	2	0	0
2	Begun	34	0	7	1	0	0
3	Dungla	23	0	2	1	0	0
4	Rashmi	25	0	2	1	0	0
5	Rawatbhata	27	0	4	1	0	0
6	Nimabahera	34	0	4	2	0	0
7	Gangrar	23	0	2	1	0	0
8	Bhupalsagar	20	0	3	1	0	0
9	Barisadri	23	0	4	1	0	0
10	Chittaurgarh	42	0	5	2	0	1
11	Kapasan	21	0	3	1	0	0
	Total	**302**	**0**	**38**	**14**	**0**	**1**

Positive points:

- The health infrastructure in both districts was found adequate and well maintained in most facilities especially in Chittaurgarh district but there is room for improvement in Barmer.

- Sufficient equipment was available in the health facilities visited. Sub Centre Majiwala in Barmer was a model SC that had good infrastructure and equipment.

- Many sources of funds are being used for creation of health infrastructure in the State like BADP, donation by the community/trust/business houses, corporate, donor funds.

- AYUSH wings have been constructed in 27 PHCs in Chittaurgarh district. However, the AYUSH wings were found underutilized.

Figure 2: Model Sub Centre Majiwala

Figure 3: CHC Rawatbhata

<u>Areas for improvement</u>:

- Integration between the infrastructure wing established at the State level and the health department at district level in Rajasthan needs strengthening. There is no coordination between civil wing and CMHO at the district level. The assistant engineers posted in the districts do not report to the CMHO and there is no involvement of the Medical Officer in charge of a facility in supervision of the construction work. As a result, in many places the construction was found to be of poor quality such as the labour room constructed in Sub-Centre Alamsar in Barmer and PHC Bhagsoda in Chittaurgarh.

Figure 4: labour room at SC Alamsar, Barmer

- It was observed that new infrastructure was being planned without taking into account availability of existing infrastructure, gap analysis and prioritization leading to vast redundancy especially in district hospital, CHCs and PHC. For example, CHC Sheo in Barmer is huge, beautifully designed and flooded with equipment but hardly utilized. Similarly, at PHC Ghosunda in Chittaurgarh, a room was enlarged and converted to a big hall for out-patient waiting area despite the fact that the facility did not have a high case load. In addition, the same facility did not have a separate female ward. If the construction had been planned taking into account the need and utilization, separate male and female wards could have been constructed ensuring privacy for the female patients. Further, 155 new labour rooms had been constructed in Barmer but were not being used.

- In addition, equipment is supplied at health facilities without taking into account availability of manpower to use the same. Unused autoclaves were found in many facilities visited in Barmer. In addition, fully equipped Operation Theatres were not being used in CHCs Dhorimanna and Sheo in Barmer district. In CHC Sheo, complete FRU equipments have been lying unused since 1996.

Figure 5: unused equipment at CHC Sheo *Figure 6: unused Autoclave at DH Barmer*

- There is a need to improve space management at health facilities especially in district hospitals. It was seen that female wards were overcrowded while male wards and wards for malnourished children highly underutilized both in Barmer and Chittaurgarh. Further, there were no rooms earmarked for ASHAs at any delivery point. Thus the ASHAs and Yashodas do not have proper accommodation while they are assisting/accompanying the beneficiaries at the hospital. In addition, in view of the high case load at DH Chittaurgarh, waiting areas are required for the patients' attendants and for the JSSK beneficiaries found waiting in the corridors for transportation to be dropped back home after being discharged from the facility.

- It was observed that there is no system in place for safety inspection of old structures and demolition of abandoned infrastructure in both districts. For instance, the PHC Sata at Barmer was old and unsafe for use but continued to function and had an average OPD of 30 per day and 40-50 deliveries were being conducted per month. Further, PHC Nikumbh in Chittaurgarh was newly constructed adjacent to the old building which was lying unused and had not been demolished.

- The teams also found that the health facilities were poorly maintained especially in Barmer district. The account books revealed that the Annual Maintenance

Grants and untied funds provided were not being utilized for regular maintenance and upkeep of facilities.

Figure 7: lack of maintenance at PHC Dhanau

- The teams also observed that regular electricity supply was not available in facilities in both districts. This mandates the provision of generators especially in facilities which are delivery points or cold chain points. In addition, it is recommended that solar lights may be considered in facilities where electricity supply is a concern. In addition, telephones were not functioning in many facilities visited in Chittaurgrarh. Further, running water supply was not found in many health facilities visited especially delivery points in Barmer. However, in both districts the facilities visited were well connected by road with the exception of PHC Bhakasar in Barmer which was located near the international border with Pakistan.

Health Human Resources

Availability of Human Resources and Gap analysis

There is acute shortage of health human resources including Doctors, Specialists, Nurses, Pharmacists, X-ray technicians, especially in hard to reach areas.

Table 6: Status of Human Resources in Chittaurgarh

Designation	Sanction	Working	Vacant	% Vacant positions
1. Junior Specialists				
Surgeon	15	04	11	73.33
Gynecologist	11	03	08	54.50
Pediatricians	10	03	07	70.00
Anesthetists	6	00	06	100
2. Medical Officers				
SMOs at CHCs	11	4	7	63.64
MOs at CHCs	37	24	13	35.10
MOs at PHCs	38	32	6	15.79
AYUSH MO	38	23	15	37.80
3. Paramedical				
ANMs	359	359	0	0
Male Nurse	175	156	19	10.90
LTs	57	54	03	5.70
MPWs	46	24	22	47.80

Table 7: Status of Human Resources in Barmer

(As on 12.11.11)

Designation	Sanction	Working	Vacant	% Vacant positions
1. Junior Specialists				
Surgeon	14	1	13	92.85
Gynecologist	6	0	6	100.0
Pediatricians	6	1	4	66.7
Anesthetists	2	0	2	100.0
Medicine	14	3	11	78.5
Ophthalmology	2	1	1	50.0
Chest & TB	1	0	1	100.0
2. Medical Officers				
SMOs at CHCs	9	3	6	66.67
MOs at CHCs	30	19	11	58.0
MOs at PHCs	71	57	14	19.71
AYUSH MOs	30	21	9	30.00
3. Paramedical				
ANMs (regular + contractual)	1259	1072	187	15.0
GNM (NRHM)	173	169	4	0.58
SMPWs	18	5	13	72.22
MPWs	95	62	33	34.74
LTs	82	67	15	18.30
Pharmacists	2	0	2	100
AYUSH Pharmacists	30	26	4	13.33

At present, 18593 contractual staff has been recruited at different levels out of the total 20,335 sanctioned posts in Rajasthan. Out of this total contractual manpower, 100 are

Medical Officers, 44 are Specialists, 5648 are ANMs, and 7069 are GNMs. Besides 585 paramedics, 1014 AYUSH Medical Officers and 401 AYUSH Compounders are also working on contract in the State. For better programme management and strengthening of health infrastructure, around 500 management professionals, 1100 Accounts professionals and 600 IT/Computer professionals have been also taken on contract under NRHM.

2757 AYUSH Doctors are posted under Ayurveda Department and 1014 AYUSH Doctors posted at PHCs, CHCs and DHs under NRHM in Rajasthan. However the utilization of their skills is poor. The outdoors at AYUSH wings ranges between 5-10 per week at facilities visited in Chittaurgarh. Also at many facilities they are given the charge of MO of that facility. At present 162 AYUSH doctors have been given the charge of Medical Officers (In charge). These skilled manpower may be utilized in convergence programmes such as School health, Adolescent programmes etc.

Areas for improvement:

- Acute shortage of specialists and medical officers is the biggest human resource challenge in the State. The lack of skilled health human resources is a huge obstacle in terms of service delivery in Rajasthan and this was also the situation found in the districts visited by the CRM team. Over 70% of the specialist posts in Chittaurgarh and 80% specialists positions in Barmer were found vacant with no anesthetists available in either district. With 7 FRUs planned in Barmer and 11 in Chittaurgarh the shortage of specialists and medical officers needs to be urgently rectified with innovative policy and regulatory measures.

- Rational deployment of available staff was another area of concern. It was found that many facilities with high case load were without a medical officer. For instance, PHC Dhanau in Barmer was functioning without a MO since June 2011 but has a high delivery load with 83 deliveries being conducted in October 2011.

Few PHCs at Begu and Rawatbhata block in Chittaurgarh were also functioning without MOs.

- In Chittaurgarh, it was reported that two doctors who were trained in LSAS were posted outside the district despite the shortage of specialists in the district. Further, it was observed that many MOs were given dual responsibility of CHC MO i/c and BCMO which is a tremendous workload and results in compromised service delivery. This was the case in CHC Sheo where the MO i/c was also given the charge of BCMO.

- The teams also found that a large number of male nurses were posted at health facilities but they were not being optimally utilized. In addition, GNMs were posted at SCs/PHCs but were not conducting deliveries. Further, MPWs were not available at sub centers, which was a condition for providing 2nd ANM at the sub-centres.

- Another issue that was flagged to teams was about the de-motivation among the contractual staff working under NRHM both at state and district level. It is to be noted that the salary package, which is being provided to these professionals, is low as compared to the salary packages in other states. In Barmer, the salary of contractual doctors is Rs. 16600/- per month which is very low especially for the remote areas leading to high attrition rate in the district. Therefore, it is essential that state pay special attention towards retention of skilled professionals.

- The teams also noted that there was no plan in place for supervision and performance review of the staff. Thus, proper orientation is required for supervisory cadre to motivate and improve performance of staff in health facilities.

- There is shortage of support staff at facilities, especially in facilities with huge caseload. At DH Chittaurgarh the Yashodas informed that they were being

utilized for cleaning the wards in the absence of cleaners. The State has a policy that the facility can recruit support staff as per requirement and the funds from AMG/Untied funds could be used for the same. This policy needs to be implemented in the districts visited nad in other districts of the state.

Pre-Service Training Capacity

In Chittaurgarh district, the availability of training facility at district level needs strengthening. The ANMTC at Chittaugarh was facing severe dearth of adequate infrastructure like residential quarters for the ANM trainees and required human resource for. The ANMTC is not registered since it has not paid its registration fee to NIC at Delhi since 2000. In view of this the ANMs trained are de-motivated since they are unable to find employment outside the state. There is also a backlog in fund payment to ANMs. Such needs are not prioritized while preparing the DHAPs. In absence of training material, study material, nursing articles, projectors etc the quality of training is highly compromised.

Skills in available Health Human Resources

- Training capacity needs to be strengthened at the district level. Training calendars are maintained in Chittaurgarh district but not followed, however no such planning is done in Barmer district.

- The State also needs to plan for rational deployment of trained staff. It was observed that doctors trained in LSAS and BemOC were not posted in facilities where their skills could be optimally utilized inspite of the severe shortage of specialists.

- Multi–skilling of existing staff must be prioritized in the State to mitigate the scarcity of specialists and doctors. In addition, SBA training of ANMs, GNMs, IMNCI training should also be strengthened. Since the State Institute of Health

and Family Welfare is the nodal agency for training in Rajasthan it should look into the matter.

- The block level program management units need strengthening in terms of the understanding of the programme. It was observed in Barmer that the block accountants and the accountants placed at facilities did not have adequate knowledge of financial management of the programme with the result that accounts were mismanaged in most facilities visited. Therefore, there is urgent need to train the financial management staff on the guidelines and procedures for proper fund management.

Positive Points:

- Adequate numbers of ANMs, GNMs, Lab Technicians are available in both districts.

- The CMHOs of Barmer and Chittaurgarh were aware of the human resource issues, receptive to the suggestions of the team and keen to improve the situation.

- The health department in both districts had good coordination with district administration with the Collectors of both districts taking interest in health issues.

- DPMs of both the districts were found to be competent with superior knowledge of the programme.

- The State authorities informed the team about the recent recruitment of 130 Medical Officers who were to be posted in remote rural areas in order to augment the existing health human resources. In addition, 904 MOs were to be recruited by 25th November the majority of whom would be posted at rural PHCs. In addition, the state has also provided for special allowances and incentives for staff working in remote, hard to reach areas as a measure to retain skilled HR.

Health Care Service Delivery

Overall, increased funding in the past decade has translated into reanimation of government health care service delivery. The assured services - OPD services, round the clock emergency services, referral services, inpatients, Maternal and Child Health Care including family planning, minimum laboratory services, Medical Termination of Pregnancies using Manual Vacuum Aspiration (MVA) technique, (wherever trained personnel and facility exists) Management of Reproductive Tract Infections / Sexually Transmitted Infections, Implementation of NDCPs were seen in the health facilities .

Promotion of Safe Drinking Water and Basic Sanitation, Disease Surveillance and Control of Epidemics, collection and reporting of vital events, education about health/ Behaviour Change Communication (BCC), as envisaged in GOI guidelines are not uniformly provided at all the PHC/CHCs level.

In Chittaurgarh district, 20 out of total 38 PHCs are functioning as 24*7 facilities. 13 CHCs are operational, one SDCH and one DH fully functional. Out of 302 SCs, 85 SCs are model SC having delivery services.

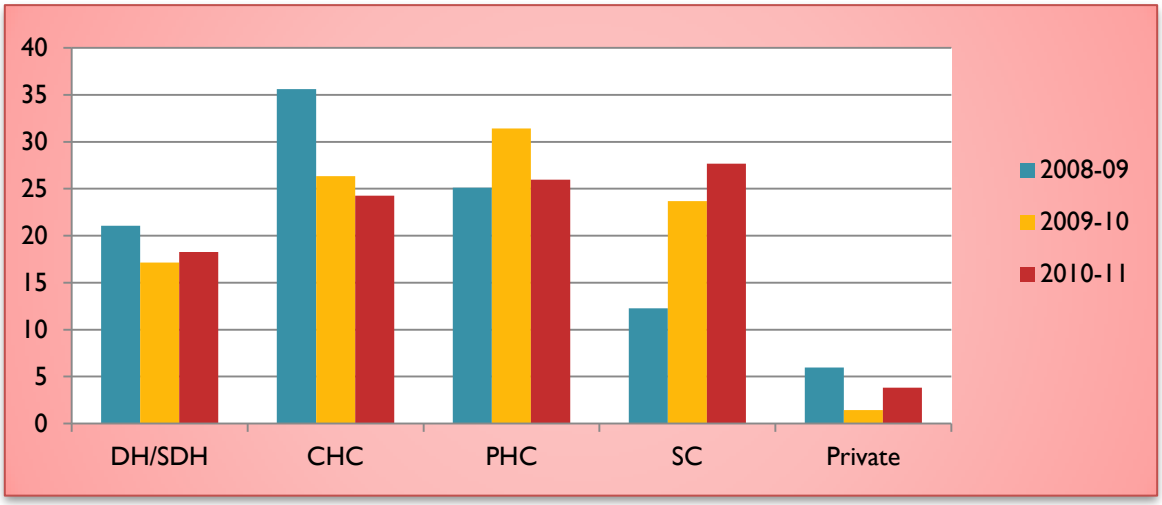
In Barmer, 7 CHCs are listed as FRUs in Barmer however none of them can be considered as functional FRU as the team of required specialists (Gynaecologist, Pediatrician, Anaesthetist) and blood storage unit is not available in any FRU.

Positive Points:

- There has been an increase in IPD, OPD and delivery load at public health facilities over the years since the inception of NRHM but the quality of service provision remains a concern. With the launch of the free generic drug scheme in the State on October 2nd, 2011 the availability of free drugs has further increased the flow of patients to public health facilities. It was also observed that upto the CHC level, most of the inpatient admissions were for deliveries with treatment of

snake bites being the other main reason for in-patient care in Barmer. Further, public health facilities are the primary source of health care services in Barmer with very few private providers and people go to Gujarat to seek private health care.

Table 8: Change in Institutional Delivery Load- Barmer



- The above graph shows a gradual shift in institutional deliveries from DH/SDH and CHC towards PHC and SC in Barmer which are taking up more of the normal delivery load over time – SC were handling 12.26 % of institutional deliveries in 2008-09 which increased to 27.68 % of institutional deliveries in 2010-11. This is a beneficial development for the goal of reducing MMR as it indicates a shift with lower level facilities taking up more of the uncomplicated delivery load with the result that higher centres can maximize the available resources for handling complicated cases.

- In Chittaurgrah, the utilization of the facilities for institutional services is showing an increasing trend in some of the facilities. For instance, in Boraw PHC, the numbers of deliveries conducted during 2011-12 is 33 till the CRM visit as compared to 48 during 2010-11. Rawat Bhata CHC conducts an average of 30-40

deliveries per month, DH has average 628 deliveries per month. There is a clear increase of institutional delivery in the district.

- The DH Chittaurgarh is functional with good utilization and the average OPD is around 600 per day. The DH Barmer has an average OPD of 400 per day and inpatient admissions of around 600 per month. However, only female ward is adequately utilized with other wards being underutilized.

- Overall, the health facilities do have an OPD registration counter and adequate waiting area with proper sitting arrangements in the districts visited.

- 15 bedded SNCU was found fully functional at Chittaurgarh whereas in Barmer SNCU with 12 beds is operational but quality of care was found compromised with little attention being paid to infection control and poor maintenance of patient records.

- The SNCU of the Chittaurgarh DH has an average case load of around 200 cases a month, out of which outborn case load is around 32%. Referral rate is around 7%. Management success rate is pretty good; only 42 babies expired out of total admission of 1398 during April to October 2011 which is around 3%.

- The SNCU at DH Barmer has an average case load of 70 patients a month with 63% outborn case load and a referral rate of 27%. Most patients are referred to the medical college at Jodhpur. However, the case management rate is low with almost 10% deaths pointing to the poor quality of care being provided at the SNCU.

Figure 8: well equipped SNCU at DH Chittaurgarh

Figure 9: SNCU at DH Barmer

Areas for improvement:

- Doctors are allowed private practice in Rajasthan which can impact service delivery at public health facilities. In Barmer, the team observed instances of doctors calling patients at their private clinics and prescribing drugs and tests on their private prescription slips but subsequently using government facilities for surgical interventions. This results in high out of pocket expenditure on drugs and diagnostics for the patients.

- It has been observed that the IPD services needs to be further strengthened in the health facilities. In most facilities visited, the maternal wards were found overcrowded while the male wards were lying unused. The Chittaurgarh District Hospital Maternity wing was overcrowded with patient lying in corridors. It has only 50 functional beds though average daily occupancy was 75-80 per day. The wards were full and the all corridors of the hospital were occupied by Antenatal and post natal mothers.

Figure 10: Overcrowded Maternity Ward of DH Chittaurgarh

- The facilities visited in both districts had functional labour rooms but the quality of care was found highly variable. In addition, the required set of equipments/ infrastructures for conducting delivery in the health facilities needs to provided in all the health facilities. Labour rooms in many facilities did not have adequate privacy and there was an absence of separate toilets for the mothers. In Barmer, most labour rooms did not have New Born Care Corners while in Chittaurgarh the new born care equipment had been supplied recently.

Figure 11: labour room toilet at PHC Dhanau

- The lack of privacy for female patient was a concern in both districts. In Ghosunda PHC there were only 6 common beds and there was no separate ward or separate toilets for male and female patients.

Figure 12: Common Indoor Ward of Gosunda PHC, No Privacy for Female Patient

- Laboratory facilities: The minimal laboratory services are available in the facilities visited. Hb% estimation, TLC, DLC, Urine – RE, Urine – Sugar, Blood sugar tests, MP examination and sputum examination are being done routinely. The other diagnostic services need to be strengthened. The X- ray and other diagnostic services have been outsourced in Nimbahere SDCH under Chittaurgarh, but the unit is not functioning as per the stipulated guidelines. No Thermo-Luminescent Dose badge (TLD badge or dosimeter) was seen both in Nimbahere SDCH and Mandophia CHC under Chittaurgarh. In DH Barmer and CHC Sheo radiography equipment was available but was lying unused due to the absence of radiographers.

- Biomedical Waste Management: No system for biomedical waste management, sterilization of equipment, infection control exists in Barmer. The facilities visited had poor arrangements for Bio medical waste disposal systems. Some facilities had been provided with colour-coded bins but the staff was not found to be

trained in the use of the bins. At PHC Bhagsoda these bins were kept adjacent to the casualty area. At PHC Ghosunda in Chittaurgarh and PHC Dhanau in Barmer the waste was disposed in the open are just adjacent to the facility.

Figure 13: Medical waste dumped outside PHC Dhanau, Barmer

Utilization of Untied funds/AMG/ RKS corpus grants:

- Untied funds for the year 2011-12 had very recently reached the blocks, and were not received by the CHCs, PHCs, or SCs yet. In the past, facilities (such as SC Mangta) mentioned that they had utilized untied funds for whitewashing, purchasing BP apparatus, weighing machine, stethoscope, table and chair for SC. In comparison to the NREGA, NRHM untied fund of Rs. 10,000 at village level seem very less to the Sarpanch/ Pradhan to make significant efforts to strengthen local health initiatives. ANM, who holds a joint account with the Sarpanch needs to spend considerable time to convince him/her to co-sign for utilization of untied funds. Due to frequent change of MO I/Cs in some CHCs, the staff had little information on utilization of RKS funds or maintenance grants.

- No Grievance redressal mechanism was found in the facilities visited in the districts and the CMHO Barmer also did not know about the system of Grievance redressal under NRHM. Facilities in Chittaurgarh district had citizens charters displayed but without the NRHM logo. However, the charters were not found in most facilities in Barmer.

Emergency and Referral Transport:

108 services have been operationalized in the State but it was found that the call centre is located in Jaipur and the people managing the call centre take lot of time to understand the location where the ambulance is to be sent. 108 service is confined to 35 KM of block headquarter which is a concern in far flung areas like Barmer district. There was a lack of awareness about 108 services among people and the teams found that most of the patients use hired vehicles to come to health facility. Mock drill for 108 conducted in Barmer district where the ambulance was called to Majiwala village. However, the ambulance did not reach the location even an hour after the call was made.

Outreach services

Aanganwadi centres in the districts were found functional with MCHND services being provided. However, no micro plans for immunization services or MCHND were found in sub-centres visited in Barmer.

In addition, service delivery at most sub-centres was found to be focused on maternal health and immunization with only the model sub-centre Majiwala having comprehensive service delivery including ARI and diarrhoea management functionality.

In Barmer district, new MMUs reached the district about 2 months before the CRM visit but were lying idle due to non selection of operator. One Medical Mobile unit (MMU) was positioned centrally at CHC Balotara and only 16 days medical camps were held per month by the MMU. This had been set up as a PPP with an NGO called Bhandari Trust, based in Jodhpur and it was found that the MMU was stationed in Jodhpur and travelling to the camp area every day of operation. There was no involvement of the Block Medical Officer in planning the MMU camps. Currently district has 2 MMUs, and some more are in the process of getting sanctioned by the State.

ASHA Programme

There are about 43000 ASHAs in the state of Rajasthan. In Rajasthan ASHA's role is also recognized by the Department of Women and Child Development and they are involved in mobilization and service provision under ICDS program with the Anganwadi workers. And because of ASHA's expanded role they are called as ASHA Sahyogini in Rajasthan. ASHAs are given a fixed incentive of Rs. 1,000 per month from the ICDS for their work.

Many of the ASHAs in the districts visited by the CRM team were found to be well qualified. They were found to be active, enthusiastic and had reasonably good knowledge of their work. ASHAs appear empowered through various training offered to them and they have gained social status in the community. During the discussions with the villagers it was found that they are aware of ASHAs role in the community, and have come in contact with ASHAs for one or the other health service.

There is a support structures for ASHAs functioning at a state level, district level and at the block level. At the state level there is a state level ASHA Coordinator and an ASHA Resource Center under State Institute Health and Family Welfare(SIHFW). At the district level there is a District ASHA Coordinator under the DPMU and at the block level there is a Block Health Supervisor under the Block Management Unit and at the PHC level every PHC has a Health Supervisor. This structure provides mentoring, supervision and facilitates training for ASHAs. The state has also established a system of performance indicators to determine functionality and effectiveness of ASHAs. The attrition rate of ASHAs in the districts visited reported as 2% to 3%. On average ASHAs are able to earn a monthly performance based income of Rs.1350 including the fixed incentive of Rs. 1,000 from ICDS.

Some of the areas of Improvement in ASHA program for the state of Rajasthan are as follows:

- Overall, there is shortage of ASHAs. Due to very low female literacy in the state, few ASHAs have been identified who were educated till 8th std. The State has revised eligibility criteria to include women educated till 5th standard to be positioned as ASHAs. The ASHA modules from 1-4 have been combined into 15-days crash course to orient ASHAs to conduct their duties responsibly.

- Training of all ASHAs in 5th Module and maximum number of ASHAs in 6th and 7th Module should be completed

- It was found that ASHAs are not trained for malaria activities under the program, therefore they need to be trained for malaria activities.

- There is no career path for ASHAs. As most of the ASHAs are qualified in the state, it is suggested that ASHAs can be considered for promotion to ASHA supervisors, preferential admission for better performing and qualified ASHAS for ANM and GNM training schools.

- Amount of incentives per month is low. Most of them get about only Rs 300 to 400 per month from health department.

- As ASHAs given incentive only for ANC and PNC are not getting incentive for escorting the women for delivery, and due this ASHAs are reluctant to accompany the women to hospital for delivery.

- ASHAs need to be provided with certain job aids for counseling as they will not miss on any important information while counseling the women.

- A focused group discussion was held with the ASHAs at PHC Bhakasar, and the CRM teams was satisfied with their knowledge on MCH issues, and learn about their daily coordination with the ANMs and AWWs, and beneficiaries. Anecdotally, ASHAs in Barmer cover anywhere between 60 to 300 houses per month. Most ASHAs, the CRM team met, had completed this training (modules 1 to 4), and were aware of their roles. Their key roles included accompanying

women for deliveries at the facility, immunization, and community mobilization for ANC, PNC, Family planning and childhood illnesses. They indicated that the incentives they get for getting women sterilized is too little, and doesn't even take care of their travel expenses. However, post natal care visits at home, after discharge from the facility, were still ignored. An ASHA works anywhere between 1 to 4 hours per day. ASHAs have been successful in creating demand and referring/accompanying beneficiaries to facilities for MCH services, especially institutional deliveries. Incentives attached to this service could be the driving force. They are most actively providing services which have direct significant incentives attached to them. One of the major challenges in desert districts such as Barmer was accessibility. Vastly scattered hamlets across arid desert lands allow no other means of home visits except on foot, which makes it almost non-existent. ASHAs did not complain of caste based discrimination affecting their duty.

Reproductive and Child Health

Maternal Health:

- ANC services are being delivered at MCHN days, but provision of good quality and complete ANC (including counseling on identification of danger signs and nutrition, abdomen check, urine examination etc.) is still very low.

- Institutional births: In Barmer, quality of Institutional births at the PHCs and SCs remain very poor. Facilities where deliveries were being conducted, such as SC Mukne ka tala, SC Alamsar, and PHC Dhanau, were observed to lack the basic infrastructure such as running water, electricity (available only 6 hours in a day), clean toilets, and clean delivery rooms (including linen). In addition, facilities lack a regular waste disposal mechanism after deliveries. Also, there is shortage of Class IV employees to sweep and clean the SCs and PHCs after delivery.

- At PHC Dhanau in Barmer, the labour table was broken and rusted and the team was informed that it was being used to conduct deliveries. The delivery load at PHC Dhanau is high with 83 deliveries being conducted in October 2011. In contrast, the facilities in Chittaurgarh district had well – maintained, clean equipment.

Figure 14: labour table at PHC Dhanau, Barmer

- Overall, microplans seem to be made annually by the ANMs under the supervision of BCMHOs. But the ANMs don't seem to be using these regularly, as they couldn't show the CRM team any sample. In Barmer, very limited facilities were practicing use of partographs in the labour room. A significant proportion of women found at facilities were staying 48 hours after delivery at CHCs. Though, this was not the case in DH or PHCs or SCs where deliveries were taking place. In DH, women who had normal deliveries were staying only for maximum 24 hours after delivery, and in PHC and SCs even less.

- Nutrition: Most PHCs visited seemed to be providing regular cooked meals, through the State initiated 'kalewa' yojana. Here, representatives from the self help groups (SHG) are providing nutritious home cooked meals to the mothers

after delivery and during their stay at the hospital. However, payments made to the SHG were not yet streamlined.

- **JSY** payments are being made through checks at the institution of delivery. The check disbursement process was observed to have variable levels of time lag due to some facilities setting specific days in a month for all JSY checks to be disbursed. In PHC Dhanau, checks are disbursed once in every 20 days, due to lack of a medical officer in position. The accounts manager has to ensure all official documents are in place before checks are cleared. Patients come mostly after a month of discharge to collect the checks. At the same PHC, it was also observed that the original Mother and Child cards were being filed as ID proof, rather than a photocopy of the card. This could potentially affect immunization coverage record of the mother and the child.

- **MCH centers:** The State has made considerable progress in identifying MCH centers. Facility mapping has been completed for the following: L3 FRUs—172; L2 CHCs and 24X7 PHCs—635; and L1 PHCs 2250. However, the State faces acute shortage of skilled manpower. In Barmer, 70% posts of specialists are vacant, and 187 ANM posts are vacant.

- JSSK was launched in Rajasthan on Sept 12, 2011. Drop back home facility has been made available through the JSSK. And patients visited at CHCs (Dhaurimana and Shiv) and 24X7 PHCs were utilizing this service.

Child Health

- Though SNCU has been established at the DH, they lacked adherence to quality standards and appropriate monitoring and care by the paediatrician on duty and other supporting staff. In CHCs, essential newborn care corners were not adequately developed. In some facilities the equipments had been bought, but staff was not trained to use or maintain the same.

- Essential newborn corners and stabilization units have been established in the CHCs and block PHCs, but they are not being effectively used by the staff due to lack of training, and lack of specialists (esp. paediatricians) at the block level and below.

- Presence of Yashodas at DH, introduced by Norway India Partnership Initiative (NIPI) and further scaled up by GOR, seems to reflect Govt's focus on facility based postnatal care of mothers and newborns, and early initiation of breastfeeding. They are trained in kangaroo mother care and essential newborn care.

Immunization

- There was shortage of vaccines particularly BCG, OPV and Measles in the districts. No extra stock being kept at district level in Barmer.
- In PHC Dhanau, all children were shown vaccinated with BCG and OPV in the reports even when vaccine was not available in the ILR.
- It was observed that requirement of vaccines not generated from the field. In Barmer, all blocks are given the same number of doses of a vaccine regardless of population. Cold chain needs to be better maintained with proper temperature charting, use of stabilizers.
- Mixing of vaccines with HIV test Kits and Anti Snake venom was found in some facilities in Barmer

Family Planning

The TFR of Rajasthan is 3.3. The state has made improvement in the TFR in the last 5 years, TFR in 2006 was 3.5. The state has prioritized family planning in their health agenda and it is evident in innovative schemes that have been launched for family planning such as Jan Mangal Programme, Balika Sambal Scheme and Family Welfare Award Scheme for good performing districts, panchayats samitis, gram panchayats, Govt. health facilities & private hospitals and NGOs. Many of the facilities that were visited

during the review in Chittaurgarh and Barmer have received award for achieving higher number of sterilizations. Family Planning services are being offered at PHCs and CHCs fixed day basis. At all the sub centers ANMs are providing IUCD insertions. The state has also introduced PPIUCD services at the district hospitals, which is another positive initiative in family planning. Supplies of condoms and oral contraceptive pills are available at all the facilities and it is being made available through ASHAs at the community level.

Family planning coverage (modern method) is around 55% in Rajasthan, and 52% in Barmer (Source: DLHS 3). Female sterilization continues to be the most common method of practicing family planning in the rural areas. Spacing and temporary methods are not used regularly (such as IUDs or Condoms). With increasing awareness of the JSY benefits (Rs. 1400), and the immediate compensation being double the sterilization incentive (Rs. 600), FP has taken a temporary hit. ASHAs are actively accompanying mothers to the facilities for sterilization, since there is an incentive attached for them as well.

Some areas of improvement in family planning are as follows:

- Counseling for family planning during ANC and institutional delivery needs to be strengthened, as there is an increased institutional delivery it a good opportunity to counsel the women and provide family planning services.

- Counseling for exclusive breast feeding is being done at the district hospitals by the Yashodas, but this should be clubbed with counseling for Locational Amenorrhea Method (LAM) as a method of family planning which is effective for six months after delivery. And LAM counseling can be done by ANMS and GNMs in PHCs, CHCs and Sub centers.

- PPIUCD service is being provided at the district hospital only, it can be offered at CHCs and FRUs also, as the number of institutional delivery is increasing in these

facilities in the wake of JSSY scheme. Providers in CHCs and FRUs should be trained on PPIUCD.

- Quality Assurance committee is not functional in the districts visited for the CRM. Quality assurance committees should be made functional at the district hospitals and also should establish quality assurance mechanism at the PHCs, CHCs and Sub Centers. Family Planning quality assurance committee should include maternal health and child health also.

- Family Planning clinical trainings can be provided at the district hospitals. Training for NSV can be provided at district hospital. There are very few NSV providers in the state. Medical Officers in peripheral facilities should be considered for NSV training and service provision.

- Contraceptive Technology Updates (CTU) is not happening in the state. SIHFW should plan for regular CTUs at the district level.

- Staff (especially ANMs and ASHAs) needs to be trained in the newer contraceptive methods to inform eligible couple on the various temporary methods now available. More information needs to be provided on use of oral pills and IUCDs. During discussions with ASHAs, it appeared that they have been emphasizing on sterilization after the 2nd or 3rd child is delivered.

- Home Delivery of Contraceptives scheme by ASHAs is not yet rolled out in the state though the supplies have reached at the district level. During the CRM visits in Barmer district, the contraceptive social marketing by ASHAs was launched on November 12th at CHC Sheo by the CMO Barmer, Director NRHM and other officials.

Figure 15: Launch of Home Delivery of Contraceptives by ASHAs at CHC Sheo

Preventive and Promotive Health Services including Nutrition and Inter Sectoral Convergence

During the visit of the 5th CRM to Rajasthan, it was found that Nutrition is provided through ICDS programme at Aanganwadi Kendras run by the State Government to children between 3 to 6 years and mid day meal programme to children to classes I to VIII in primary and upper primary government schools in the state. ASHA workers who work under NRHM and mostly at sub-centers and villages impart nutrition education to adolescent girls also. Otherwise, not much nutrition education or awareness was found among the school children and adolescents.

The following visits were made to the schools:

Upper Primary School at Bhadesar Block :

Upper primary school at village Bhadsora was celebrating Education Day on 11th November, 2011. Mid Day Meal is served in most of the Schools of Chittaurgarh through Centralized Kitchens run by Nandi Fundation. The team tasted the meal for the day (Lapsi) and the same was found to be nutritious and tasty. However, on further inquiry it was found that IFA tablets have not been given to boys of the school. Upon enquiring from primary health Center Bhadsoda why micro nutrients have not be served to the boys school, the team was informed that micro nutrients are sent but they are thrown away by the children. The District Education Officer, Chittaurgarh and the Director, Mid Day Meal, Government of Rajasthan were of the opinion that IFA tablets are not to be given to the boys. As a result both physical and mental growth of the boys was stunted. In the adjacent school which was Upper Primary Girls school in the same village the full nutrition education was imparted to the girls. Micro nutrients were also provided to them. As a result they were found to be intelligent and well built.

Block Bari Sadari, Village Nikkunj :

Though the schools were claiming that they are giving IFA tablets regularly along with the de-worming medicines, the records do not prove that. The schools informed that the

nurses from health centers come and administer the medicines. On checking whether medicines were provided by the Health Centers it was found that they had not provided any medicine except where de-worming medicine was given to 8 students for complaining of stomach ache. School Health Programme is, therefore, the weakest link.

Government Primary School, Nayion ki Dhani, Village Sanau, Barmer

Interacted with the students and teacher, Mrs. Banesh. The team was informed that health check-up is being conducted once a year and De-worming tablets are provided to the students. However, during a group discussion with school going adolescents girls in Sanau Village the team was informed that IFA tablets were not being distributed to adolescent girls and regular school health checkups were conducted only for the primary students. This was also the situation in case of adolescent boys. Thus, the health needs of adolescent children were being ignored in the school health programme.

Figure 16: students at Govt. Primary school Nayion ki Dhani

The outreach services provided by the ASHAS are very encouraging. They are fully trained to handle any nutrition / health related matters pertaining to ladies. A part of the team sat and conversed with the village ladies in village Suvaniya on day 3 and they were very happy with the guidance given by the ASHAS. The ASHAS accompany the

pregnant ladies to the hospitals or delivery centers. They also help new mothers in breast feeding and lactation.

There is confusion between the Health Department and Education Department in the State regarding administration of micronutrients. Education Department is of the view that micronutrients like IFA tablets are not to be administered to boys but only to girls. There is no clarity in this, which was admitted by the State Government and the District Administration, Chittaurgarh in de-briefing meetings. Even six monthly dose of de-worming tablets are not being given regularly to the school children. Only when children complain of stomachache, these tablets are administered. The Health Centers are least concerned about the school children. They examine the school children only on a reference from the school and they are given ordinary treatment. The only thing, which is done regularly, is a visit to the school by the nearest Health Centre at the beginning of the academic session to take measurement of height and weight of the children and physical examination of eyes, teeth and throat. To decide whether a child is anemic only cursory glance through eyes and nails are done.

Gender Issues & PCPNDT

The team observed that gender issues are not given due importance in the state. There is hardly any toilet facilities attached to labor rooms or female wards. Privacy in the labor room is very critical and that has not been looked into. The team found labor room with broken glass-windows without any curtain. Both male and female patients are kept in same hall. Availability of running water is always an issue in Rajasthan. The female staff also pointed out this issue.

Regarding PCPNDT in Rajasthan:

- Advisory Committees have been constituted at State, District and Sub-district Level.
- Dedicated PCPNDT Cell has been established at State and District level.
- Total, 4494 inspections, 196 suspension and cancellation, 298 Seal and Seizures have been done and 192 Complaints and 22 FIR have been filed in the court by the Appropriate Authorities
- Department has started auditing of form-F as a separate activity in all 34 districts through District PCPNDT Co-ordinators.
- Quarterly Reports are being received from district through the District Nodal Officer.
- 192 complaints and 22 FIR have been filed in the Court, which are under process.

Initiatives taken:

- Hon'ble CM Rajasthan has taken an initiative that NGOs will be ensured in the Inspections & Public Awareness activities to prevent Female Foeticide. The Department has selected 342 NGOs.
- Government will start "Hamaribeti Express" at Jaipur & Jodhpur for IEC activities. The basic objective behind this express is to make people aware about this problem of Sex-Selection & the solution to stop Sex-Selection through Film show and other activities.
- For the "Save the Girls Child Campaign" this year Department will propose to appoint a Brand Ambassador.

Areas for Improvement

- All labor rooms and female wards should have attached toilets with availability of water.
- Privacy in the labor room is very critical. This should be properly maintained.
- Separate wards for male and female patients should be provided.

Training

- No training calendar was found in Barmer district. However, in Chittaurgarh, training calendar has been prepared but it is not being followed.

- There is no follow up plan after training. In Barmer district, 8 MOs have been trained in BeMOC but not deployed in facilities where they may be utilized. In Chittaurgarh district 2 MOs were trained in LSAS and then posted outside the district

- Many SBA trained ANMs are not posted in sub centres which are the delivery points and have been posted to the facilities where no deliveries are being conducted.

- Midwifery was not included in GNMTC course till 2003. Therefore these GNMs are not conducting delivery and need training.

- Training infrastructure was found to be poor in both the districts.

- NSSK training has not been completed.

- Training of staff is a very week area. Training needs assessment should be done immediately and conduct of trainings needs to be expedited.

- Training capacity at district level needs strengthening in both the districts as well as in other districts of the State.

National Disease Control Programmes

National Vector Borne Diseases Control Program

- VBD Society received an amount of Rs.1.54 lakhs in current financial year out of which an amount of Rs.30, 000/- has been spent.

- Funds are being spent on procurement of Pyrethrum, Temephos, Spray pumps, RDK for Malaria and on wages of contractual staff. Antimalarial medicines, bednets etc. are procured by the state.

MALARIA

- Chittaurgarh district has an API of less the 2 and ABER above 12%. A total of 718 Pv cases and 11 Pf cases have been reported from the district in current year. No death due to malaria has been reported.

- It was seen that the labs had good quality microscopes and JSB stain was being used for staining smears. Labs had trained lab technicians. All health facilities visited had RDK for malaria which was used in emergency and during field visits. All facilities had ACT and the same was being used for treatment of Pf cases. It was informed that in case any Pf case is reported in an area, IRS with Pyrethrum was carried in surrounding 50 houses, Mass fever survey was carried out, MLO was put in pits and Temephos and Bti were put in fresh water collections. Also all health facilities visited had hatcheries for Gambusia.

- It was also observed that in most of the facilities doctors and paramedics were giving presumptive treatment to suspected cases of malaria which had been discontinued in the programme**.**

DENGUE

- District has reported only 3 dengue cases so far. No hospital has been identified as SSH in the district. None of facility visited had ELISA reader. All CHCs and DH had card test for detecting IgM and IgG which is not supplied in the programme.

CHIKUNGUNYA

No Chikungunya case has been reported in the district.

BLINDNESS CONTROL PROGRAMME

- Chittaurgarh received an amount of Rs.10 lakhs in current financial year out of which an amount of Rs.6.06 lakhs had been spent under the programme. An amount of Rs.750 per operation case is paid to NGOs/hospitals under the programme. Against a target of 8600 cataract surgeries, the district had performed 1514 surgeries mainly through camp approach.

- Other than the district hospital, none of the facility had operative facility for Eye surgery.

NATIONAL LEPROSY ERADICATION PROGRAMME

District received an amount of Rs.1 lakh in current financial year and no expenditure has been carried out till date.

Funds are utilized for IEC activities, mobilization etc. Posts sanctioned under the programme are lying vacant.

IDSP

- District received an amount of Rs.1.68 lakhs in current financial year against an opening balance of Rs.3.41 lakhs. District has spent an amount of Rs.1.56 lakhs on wages of contractual staff, IEC activities and office expenses.
- All the facilities visited were using the recommended SPL forms. Sub centres, PHCs and CHCs were sending the data to the Block office where data entry was

done on IDSP portal by the DEO. Data from District hospital was being entered at CMHO office. As per the claim of the district, data of 298 out of 302 sub centres, 25 out of 38 PHCs and all CHCS was being entered on the portal. However on scrutiny it was seen that large numbers of facilities were defaulting on data entry. Further media alert on IDSP portal was being used rarely.

RNTCP

- The district TB committee had received an amount of Rs 17.8 lakhs in the CFY and an expenditure of Rs 9.3 Lakhs had been incurred till date on wages, procurement of lab consumables, IEC and other miscellaneous activities.

- District has one STS and one STLS at District TB unit. At rest of the facilities, Govt.lab technicians are carrying out sputum testing. Lab technicians were trained and Microscopes in good condition were available at all facilities inspected. DOTS treatment and follow up was provided by the GNM/ANM posted at the facilities. Adequate treatment courses were available at the facilities. ASHAs were being given Rs.250 for each completed course. On scrutiny of record it was seen that treatment success rate was nearly 85% and drop rate was around 5%.

- It was however observed that HIV testing for AFB positive cases was not being done at most of the centres due to absence of ICTC.

Procurement System

The State Govt. has constituted **Rajasthan Medical Services Corporation Limited (RMSCL)** for procurement and free distribution of medicines to all patients visiting govt. health institutions through Drug Distribution Centres (DDCs). Drugs and surgical consumables are directly supplied at District Drug Warehouse. All Health institutions in the state/district are allocated fixed budget for indent of medicines and surgical consumables viz: Rs.10,000 for sub centres, 1.5 lakhs for PHCs, 5 lakhs for 30 bedded CHCs, 10 lakhs for 50-70 bedded CHCs, 20 lakhs, 30 lakhs and 40 lakhs for 100, 150 and 200 bedded, district hospitals respectively, 50 lakhs for dental college, 10 crores for medical colleges and associated hospitals and 30 crores for SMS medical college.20% additional budget provision has been kept in case of any shortfall. Health institutions are provided with Passbooks to keep track of expenditure on drugs and consumables. One copy of the passbook remains with the institution and the other copy is kept at the district warehouse.

RMSC procures medicines and consumables from open market through tendering. Upto 25% of total procurement is from Govt. firms/Small scale industries.

419 medicines (200 have been procured in the first stage) and 160 surgical consumables are proposed to be procured in the system. Only generic Medicines are procured in the system.

10% of institution budget can be utilized for making local purchases for items not included in the list or in case of non-availability of listed medicines.

Medicines and consumables received at the warehouse come with test reports. However a secondary random testing is done from govt.lab at Jaipur.

<u>Tendering process (Two bid):</u>

Technical bid/Financial bid—selected through L1-Supply order cum Rate contract (F.O.R.) issued.

Drugs are procured directly from the manufacturers. Only those companies that have an annual turnover of above 20 crores and have GMP certificate can participate in the tender.

DPC (District Project Coordinator) in charge of the DDW under the overall leadership of CMHO.

Drug distribution is controlled through a software *e-aushadhi*. All DDWs are connected with central server through the software. The software calculates the cost of drugs/consumables issued to a facility and the cost is entered in the passbook.
District monitoring committee under the chairmanship of the District collector holds regular meetings and inspects DDW and DDCs. At block level, monitoring committee under the chairmanship of SDM monitors the working of DDCs.

Procurements at District and CHC Level

District hospitals and CHCs make procurements for Life Line drug stores (stores operated at the hospitals by the hospital staff from where generic drugs are sold to the patients after adding an amount of 10% on purchase price), for drugs and consumables from 10 % of allocated fund for institution, and equipments. These procurements are made on L1 by inviting bids from reputed firms which are shortlisted by a duly constituted committee of officers. Smaller institutions follow the R/c of district hospital. In some cases DGS&D R/C or State R/c are used for procurement.

Observations on State Drug Procurement and Distribution

Procurement

- No separate supply procurement and distributions system is there for centrally sponsored decentralized items as a result they are subjected to budget ceiling imposed in state budget allocation

- PROMIS software is not being used for central supplies

- It was observed that the drugs and consumables supplied to the health facilities from allocated budget were grossly inadequate leading to shortage of essential items in the hospitals. It is recommended that the allocation of amount for PHCs, CHCs, and District Hospitals etc. should be upwardly revised after discussion with the facility incharge**.**

SHORTCOMINGS AT DDWS

a. Standard Storage maintenance guidelines are not being followed.

b. Record keeping is inadequate.

c. There is substantial delay in updating of passbooks.

d. In some places passbook system is yet to be started.

e. Pharmacists are not available at DDCs.

f. Cold storage facilities are inadequate for storage of vaccines and other injectables and drugs that require specific temp.

g. At Barmer district, Central Govt.RCH supplies are stored in a make shift room

h. No expiry record register is maintained.

I. Regular inspections are not being carried out by monitoring committee.

J. *e-aushadhi* software is not being used in Barmer district.

K. No security surveillance system is in place.

l. At Barmer district no cleanliness is maintained in the store

Financial Management

a. **Human Resource Positions**

The status of availability of work force for financial management including key posts is as below

Table9: Details of Human Resources for Financial Management

Sl. No.	Name of post	Sanctioned	Filled in	Remarks
A	**State Level**			
1.	Financial Adviser	1	1	-
2.	Chief Accounts Officer	1	1	-
3.	Sr. Accounts Officer	2	1	-
4	Asstt. Accounts Officer	4	3	-
5	Junior Accountant	4	4	
5	State Finance Manager	1	1	-
6	State Accounts Manager	1	Vacant	Court stay in filling the post of SAM
7	Accounts Manager (in place of State Accounts Manager)	1	1	
8	Accounts Clerk	2	2	
9	Accountant	2	2	
B	**District Level**			
8.	District Accounts Manager	34	33	One Position, DAM-Dausa is Vacant due to resignation

C	Block level & below			
D	Accountants	1098	1098	

However, at PHCs and CHCs, deficits of skilled work force were seen. Financial management at PHC/CHC level is very poor and medical Officers are managing funds with the help of nurses, Lab. Tech. and LHV's. Post of accountants is lying vacant, which hampers the smooth flow and quality work of accounts and finance in the State.

b. **Electronic Fund Transfer**

Electronic funds transfer system is being used for transfer of funds from state to districts and districts to blocks in about 230 Nos. (out of 237 blocks). At state level e-transfer is being done through Bank of Baroda and ICICI Bank & PNB & From only those blocks where transfer of fund is not possible by E-Transfer because of certain connectivity/technical issues, hence Cheque/DD are using for transferring the fund. In other periphery like PHCs and CHCs and sub centres, the cheques are used to transfer the funds for AMG, Untied Grant and other respective grants.

c. **Customized version of Tally ERP 9**

The customized version of Tally ERP 9 software has been installed at state, district and block level but it is not implemented in most of the blocks due to lack of training and some technical issues as well.

d. **Funds are being utilized for the approved activities**

Funds released are being mostly utilized for the approved activities as per approved PIP provisions and committed liabilities of the previous years but we found one instance in Barmer district like:

- In 2010-11, a budget was sanctioned for the post of Hospital Manager under code A.11.4.1 (Strengthening of Directorate of Hospital Administration). In the year 2011-12, the same has not been approved under PIP but in Barmer district the payment has been made and booked under Programme Management. This shows the diversion of funds.

e. **Multiplicity of Audits**

- Audit parties of Medical & Health Department and Indian Institute of Public Auditors of India are undertaking internal audit. Concurrent audit in vogue in districts excepting four districts. Audit by Chartered Accountant is being done annually. C&AG has undertaken Performance audit for the years 2005-06 to 2007-8 and regular audit of C&AG is going on for the period from 2005-06 to 2009-10 at present. Besides this on practical grounds following are the facts for the visited district Barmer:

- Statutory Audit for the Financial Year 2010-11 in the district Barmer has completed but still the Audit Report for the same has not been received at district level.
- Concurrent audit is still in process for last 2 quarters (April-September 2011) and informed that the delay has occurred due to late appointment of auditor as per letter no. DRHS/2011/6747 dated: 23.09.2011.

f. **Delegation of Financial & Administrative Powers**

Delegation of Financial & Administrative down the level has been adopted as per GoI guidelines.

g. **Training measures adopted by the State**

- Due to day-by-day increasing workload and diversification of activities, trainings & refresher courses to accounts personnel are needed. Till now no such measures have been adopted by state and it is strongly recommended to prepare a training plan for the same and extend it to the PHCs and CHCs level primarily focused on general bookkeeping and record maintenance. The other points, which need to be undertaken, are:

- The implementation of model accounting system should start and call for comprehensive training to accounts personnel.

- There should be a proper orientation and training programme for sarpanch and ANM to make them clear about the guidelines prepared for utilization of untied fund.

h. **Financial status under HMIS by the State and Districts**

It has informed that there are significant differences of budget heads of the approved PIP of 2011-12 from budget heads of PIP 2010-11, hence the changes in the formats of HMIS is required to update the portal. As of now district are sending information by FMR & State is reporting to GOI regarding monthly & Quarterly Expenditure.

i. **Records, their timeliness and accuracy, submission of MIS, Statement of Expenditures at various levels**

There are some shortfalls in time bound accurate maintenance of proper records at district and below levels. There are no inordinate delays in disbursements. However, at places where facility of e-transfer is not available, funds are transferred through cheques /demand drafts, which take reasonable time receipt of funds at the designated institutions. Secondly, it was observed that most of the delays occurred in between PHCs, CHCs and blocks because of different bank accounts. Mostly in blocks, the accounts are being

maintained in State Bank of Bikaner and Jaipur where as PHCs and CHCs maintains their accounts in Jaipur Thar Gramin Bank.

j. **Integration of financial management processes with NDCPs**

The National Disease Control Programmes are being implemented under umbrella of NRHM. Presently separate bank accounts for the programmes are maintained. As regards integration of financial management, the procedure of consolidated balance sheet of RSHS including NDCPs is being done for the year 2010-11.

k. **Implementation of the Model Accounting Handbooks for sub-district level**

The Model Accounting Handbooks have been sent upto block level with the objective to bring about uniformity in books of accounts but still the Model Accounting Handbooks have not reached at PHC/CHC and Sub Centre level. Although the implementation of model accounting system might take some time and state may call for through training to accounts personnel.

l. **Procurement Manuals and its guidelines.**

Any separate procurement manuals have not been framed. Procurements are being made as per guidelines of GoI/Financial rules of Govt. of Rajasthan.

m. **Utilization Certificate (UCs) Status**

The Utilization certificates from 2005-06 to 2009-10 have been submitted to GoI. & there is no pendency of UC's for the year 2005-06 to 2009-10. Now Rs. 40.44 crores under RCH Flexipool and Rs. 66.99 crores under Mission Flexipool are pending for the financial year 2010-11.

n. **Reasons for longstanding advances to implementing agencies**

Non-availability of old records and lack of timely monitoring due to lack of sufficient work force at various levels is the main reason for longstanding advances to implementing agencies pending for settlement.

Following advances are still lying with the implementing agencies in Barmer District up to 31.10.11:

1. PWD Block Baitu : 8,48,000.00
2. PWD Block Balotra: 4,00,000.00
3. PWD Block Gudamalani : 43,000.00
4. PWD Block Sindhari: 3,50,000.00
5. BDO Block Dhorimanna : 3,90,410.00
6. BDO District Barmer: 2,50,000.00
7. BDO Block Baito : 3,75,000.00
8. BDO Block Choutan: 2,00,000.00

o. **Expenditure against untied funds and AMG to District Hospitals, CHCs, PHCs, SCs, and VHNSCs,**

- Lack of proper maintenance of books of accounts like cash books, ledgers in PHCs and CHCs, so it becomes difficult to track the head wise expenditures and their balances.

- There is a system of tracking expenditure of Untied Funds & AMG to District Hospital, CHCs, PHCs & SCs, by Utilization certificates.

- In the case of VHNSCs untied fund, the same are treated as expenditure as per sanction letter no. NRHM/Accounts/ 2008/841 dated: February, 19 2009 provided the fund have been credited in the bank account of VHNSC. Now from the year 2011-12 they have changed the system of booking of the expenditure on the basis of actual expenditure.

p. **Reason for low utilization of funds**

Table 10: Fund Utilization of Barmer (upto October 2011)

(Rs. in Lakhs)

S. No.	*Particulars*	*Amount / Percentage*
1.	*Total PIP 2010-2011*	*2341.23*
2.	*Unspent Balance on 31.3.11*	*439.37*
3.	*Fund Released during the Year Up to October 2011*	*912.31*
4.	*Total Fund Available (2+3)*	*1351.68*
5.	*Expenditure during the financial Year*	*864.20*
6.	*Unspent Balances as on 30.09.2011*	*475.64*
7.	*Utilization % against fund available*	*64%*
8.	*Utilization % against PIP*	*36.91%*

Following reasons have been identified for the low utilization for Chittor and Barmer:

- The main reason of low utilization of fund is the shortage of staff and lack of training for the existing staff.
- Delayed receipt of UCs & SOE from different implementing agencies hence the expenditure is booked less.
- Shortage of Medical Officers is also a big challenge and need innovative policy and regulatory measures, which certainly affects the decision making consequently it, hampers the flow of utilization.
- Many MOs given dual responsibility of CHC MO I/C and BCMO which is a tremendous workload.
- Program Management units need strengthening, especially at block level.

- Substantial amount of advances (Rs. 89.35 Lakhs) were lying up to 31.10.11 with sub centres and VHSCs associated to untied fund due to lack of understanding and coordination between ANM and Sarpanch.

q. **RKS constitution**

Rajasthan Medical Relief Societies have been formed at district; sub-district, CHC & PHC level health institutions and most of the RMRS are registered under Rajasthan Society Registration Act. 1958. NRHM funds are being utilized through these societies. Some of the main points of the RMRS (RKS) constitution in Rajasthan:

1. 15 Members committee whose chairman is District Collector and Co-Chairperson is CEO-Zila Parishad
2. The meetings of the governing body shall be held twice a year.
3. The Governing Body will have full control of the affairs of the society and will have authority to exercise and perform all the powers, acts and deeds of the society consistent with the aims and objects of the society.
4. The account of the society shall be opened in nationalized bank and approved by the executive committee or in a scheduled commercial bank as may be specified by the MoHFW, Government of India.

r. **Fund flow- the process of receipt, disbursement, expenditure, accounting and submission of utilization certificates**

GoI releases funds in bank account of RSHS. GoR releases its share in PD account of the RSHS. This fund of PD account is transferred in bank account of the society. RSHS releases funds to DHSs and DHSs to Block CM&HOs & other agencies. Block CM&HOs release funds to CHCs/PHC/Sub-Centres. Each health institution maintains its accounts and submits utilization certificates to the authority from which funds received.

s. **Lack of funds for essential programme components**

As per state, Budget Head of A 10.7 Mobility Support of BMO/MO/Other amount proposed Rs. 1019.42 Lakh but no amount is approved, hence state has facing very much problem to deliver vaccines in the field. Secondly, it was observed that Training for accounts personnel is requisite and was not incorporated in the PIP and it is now proposed to put the same in next State Action Plan.

t. **State Share Contribution. Whether these activities commensurate with NRHM activities?**

State is contributing its share on release basis. State contribution is used for running RCH & NRHM Additionalities activities. In addition, Specific state share is received for MMJRK scheme. In initial years, the scheme is based on health insurance scheme running in NRHM Additionalities. The current State Share outstanding is 116.64 crores.

u. **Compliance with instructions with reference to i) income tax, b) unspent balances under RCH-I and EAG schemes, c) interest earned against NRHM funds d) diversion of funds.**

In respect of Income tax, the state has filled income tax returns. As per state, continues efforts are being made to reduce the unspent balance of RCH 1 and EAG schemes & will submit Utilization Certificates for the same.

v. **Monitoring & Evaluation**:

State has weak financial monitoring as a result of which there was defalcation in the year 2008-09 in Udaipur district and in the year 2009-10 cash defalcation of Rs.34 lakhs in district of Jaipur. Further, the auditor has certified the accounts of Bharatpur district negatively. During CRM visit to Barmer district it was found that cash book has not been

authorized by incharge of the facility i.e Dhorimanna CHC and Bakhasar PHC which is again a precedent of serious negligence.

Recommendations:

- The implementation of Model Accounting Hand Books should start and state should call for comprehensive training to accounts personnel.

- There should be a proper orientation and training programme for sarpanch and ANM to make them clear about the guidelines prepared for utilization of untied fund.

- Ensure proper maintenance of books of accounts like cash books, ledgers and Bank Reconciliation Statements (BRS) in PHCs and CHCs, so it becomes easy to track the head wise expenditures and their balances

- It was observed during CRM that VHSCs untied fund being credited in Sub Centres account which hampers the smooth flow of decentralization. As per guideline, VHSCs should operate their Untied Grants through their separate bank accounts. State should take necessary steps to open a separate bank account for respective VHSCs so that the motive of decentralization could be fulfilled.

Effective Use of Information Technology

Presently, Rajasthan state has its own Pregnancy, Child Tracking & Health Management online System (PCTS). On the PCTS the data entry is being done by name based tracking of pregnant women and children as per the GoI guidelines.

Although state has instructed to complete all backlog entries in all columns of MCTS, it has observed few months delay in initial entry and huge gap in subsequent updates. Therefore, timely tracking for dropouts is not seen. The system is generating SMS for beneficiaries as well as for respective ANMs for due events, but effective of the system is yet to be seen.

- **Three types of SMS are being sent to the ANM**

SMS type 1-Information (List of Pregnant Women expecting delivery in 1st and 2nd Fortnight of the month) to ensure the Institutional Delivery, which will help the reduction of MMR.

SMS type 2-Information (Immunization schedule of the month) to ensure to immunized the new born or child which will help in the reduction of IMR

SMS type 3-Information (Vaccination reminder on regular basis) is being provided to Beneficiary, which will improve the status of full immunized children.

The excellent system for service tracking needs some finer improvement in terms of rapid entry to ensure timely reminder.

Health Management Information System (HMIS):

PCTS is facility based data reporting system. Monthly data up to Sub-center level is being entered at block and some PHC level.

Areas of concern:

- At present the Pregnancy, Child Tracking & Health Services Management System (PCTS), which is slightly different from GoI owned MCTS, and the GoI HMIS

are not fully integrated. For example, number of pregnant women registered in recent months does not tally with individual's pregnancy information in PCTS. There are high possibilities of errors during this manual data transfer. Immediate entry and update is required for integration.

- There is also need for analysis and utilization of the data at the local level. This needs to be promoted. The MIS system track the performance of District and below based on based on state level target fixation at the beginning of the year. Bottom up participatory planning needs to be integrated with the HMIS. Right now performance is seen only against top-down targets.

- The CRM team noted that the Integrated MIS Format for flow of physical performance data were found at all levels including the lowest (ANM). But feedback mechanism is not used adequately to inform planning and responsive corrective action.

Programme Management

- DPMU is operational at HQ
- Critical position of BPM for high focus blocks vacant
- PHC accountant not available in many PHC/CHC
- Data Entry not being done for facility level reporting
- Block PMU is maintaining Accounts for PHC/CHC

Decentralized Local Health Action

- District Health Action plan submitted
- Approval of State as per NPCC to district communicated
- Reconciliation of DHAP after approval not done at district
- Block Plan only for MH, Immunization and Family planning
- Holistic Block plan not available
- PHC Plan not done and SC Plan for only MH, CH and FP

Community Ownership

- VHSCs formed in all villages. However, funds for all VHSCs under a Gram Panchayat are being operated through a single account.
- Meetings of RMRS are limited just for fund utilization and are not happening regularly. RMRS members are unaware of the guidelines.
- Decision to appoint BDO as chairperson of RMRS is cited as a hurdle in meetings since BDOs are not giving enough time for RMRS meetings and not signing cheque.
- AMG is not provided to some SC
- Money is being deducted from Untied Fund for various activities like training and communication expense.

Monitoring and Evaluation

- No plan and system for regular monitoring especially for high focus districts and blocks.

- CMHOs and BMHOs not provided funds for monitoring.

- Need to take into account size and number of facilities while deciding monitoring budget.

- State level monitoring officer has been appointed but no action is taken on the reports submitted by him.

Overall Outcomes

- Increase in institutional deliveries and immunization observed in the districts.
- Community involvement through PRIs, VHSNC and RMRS was observed by the teams.
- ASHAs emerged as symbol of women empowerment and torch bearers of health issues in remote areas
- Improved infrastructure, equipment and HR at sub centre level
- Improved utilization of health facilities.

Other Observations:

- No citizen charter displayed
- IEC display poor
- No information boards about use of NRHM funds for creation of infrastructure and no NRHM logo
- Maternal death review not started in Chittaurgarh district.