2nd Common Review Mission (CRM): RAJASTHAN

under

National Rural Health Mission (NRHM)

(15th-22nd December 2008)

Organised by:

NRHM Division
Ministry of Health & Family Welfare
Government of India

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Content

Abbreviations

ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ARC	ASHA Resource Centre
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga, Unani, Siddha, Homeopathy
BPM	Block Programme Manager
CBR	Crude Birth Rate
CDR	Crude Death Rate
CHC	Community Health Centre
CMHO	Chief Medical and Health Officer
CRM	Common Review Mission
DD	Deputy Director
DH	District Hospital
DHS	District Health Society/Director Health Services
DMC	Designated Microscopy Centre
DOTS	Direct Observation Therapy – Short-course
DPM	District Programme Manager
DRDA	District Rural Development Agency
EC	Eligible Couple
EC-SIP	European Commission Sector investment Porgramme
EDL	Essential Drug List
EmOC	Emergency Obstetric Care
EMRI	Emergency Medicine and Research Institute
ENT	Ear Nose Throat
FBNC	Facility Based Newborn Care
FNGO	Field NGO
FRU	First Referral Unit
FW	Family Welfare
GOI	Government of India
GoR	Government of Rajasthan
Hb	Haemoglobin
HMIS	Health Management Information System
ICDS	Integrated Child Development Scheme
IDD	Iodine Deficiency Disorder
IDSP	integrated Disease Surveillance Project
IMNCI	Integrated Management of Neonatal and Childhood illnesses
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
IPP	India population Project
JNU	Jawaharlal Nehru University
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
LLFS	Life-Line Fluid Store
LT	Laboratory Technican
MCHN	Maternal and Child Health, and Nutrition
MLALAD	Member of Legislative Assembly Local Area Development (fund)
MMR	Maternal Mortality Rate/Ratio
MMU	Mobile Medical Unit
MNGO	Mother NGO

MO	Medical Officer
MOHFW	Ministry of Health & Family Welfare
MPLAD	Member of Parliament Local Area Development (fund)
MRS	Medicare Relief Society
NCD	Non-Communicable Diseases
NDCP	National Disease Control Programmes
NFHS	National Family Health Survey
NGO	Non-Government Organisation
NHSRC	National Health Systems Resource Centre
NIPI	Norway-India Partnership Initiative
NRHM	National Rural Health Mission
OPD	Out Patient Department
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PMU	Programme Management Unit
ppm	particles per million
PPP	Public Private Partnership
PRI	Panchayati Raj Institution
PTS	Pregnancy Tracking System
RCH	Reproductive and Child Health
RCHO	RCH Officer
RDK	Rapid Diagnostic Kit
RHSDP	Rajasthan Health Systems Development Project
RKS	Rogi Kalyan Samiti
RMRS	Rajasthan Medicare Relief Society
RNTCP	Revised National Tuberculosis Control Programme
RSACS	Rajasthan State AIDS Control Society
RSBY	Rashtriya Swasthya Bima Yojana
SC	Sub Centre/Scheduled Castes
SDH	Sub Divisional Hospital
SDP	State (Gross) Domestic Product
SHC	Sub Health Centre
SHRC	State Health Resource Centre
SIHFW	State Institute of Health and Family Welfare
SLO	State Leprosy Officer
SMO	Senior Medical Officer
SNGO	Service NGO
SPMU	State Programme Management Unit
SRS	Sample Registration Survey
TFR	Total Fertility Rate
TSP	Tribal Sub Plan
TT	Tetanus Toxiod
UC	Utilisation Certificate
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee

Chapter 1: Introduction

1(a) Rajasthan: An Introduction to the state

Rajasthan, with a geographical area of 3.42 lakhs square kilometres is the largest state, constituting 10.43 percent of the total area of the country. Geographically, Rajasthan can be divided into three distinct regions: (i) southern hill zone, (ii) north-eastern plains and (iii) western dry zone. The north-eastern plains are better endowed with natural resources, such as water and productive land. The physical environment of the southern region is marked by a sub-humid climate, thick forests and rugged and ravine topography. Tribal people mainly inhabit this region. The tribal area in the state constitutes 5.85 per cent of the state landmass with a population of 12.44 per cent of the total state population.

The population of the state is 56.5 million according to 2001 census, which is 5.49 percent of the national population. The ratio of the rural and urban population is 77:23. The population of scheduled caste and the scheduled tribes according to 2001 census are 17.15 and 12.56 percent respectively of the state's total population, as against the national average of 16.2 and 8.2 percent. The growth rate of population in the state (28.41 %) was higher than that of the country (21.34 %). Population density was 165 as compared to 325 for India according to Census 2001.

Table 1: Demographic Profile of Rajasthan and India

Indicators	Rajasthan	India
Population (2001) in million	56.5	1028
Decadal population growth rate, 1991-2001	28.41	21.34
Sex ratio (females per thousand male)	921	933
Population density (persons per sq km)	165	325
Per cent urban	23.39	27.8
Percent 0-6 yr.	18.85	
Literacy rate total	60.4	64.8
Literacy rate male	75.70	75.3
Literacy rate female	43.9	53.7
Per cent Scheduled Cast	17.15	16.2
Per cent Scheduled Tribe	12.56	8.2
Total fertility rate *	3.2	2.7
Crude birth rate **	28.6	23.8
Crude death rate **	7.0	7.6
Infant mortality rate **	68	58

Sources: *Census of India 2001, * NFHS-III 2005-2006*
***SRS-2005*

The age distribution of the population in the Rajasthan is typical of high fertility populations, with a high proportion of the population in the younger age groups: 39.89 percent are below 15 years of age and 4.84 percent are age 65 or older. The sex ratio defined as the number of females per thousand males is 921 females for every 1000 males as per Census 2001 for Rajasthan. The Sex Ratio was found to be lower in urban (890) than the rural (930). An important reason for the rural urban differential is migration of rural men to urban areas in search of education and livelihood.

Rajasthan has made significant gains in literacy by achieving literacy rate of 60.41 in 2001 as against 38.55 percent in 1991. Rajasthan has got a distinction in achieving the highest decadal difference of literacy rate of 21.86 percent from all the states of India. Rajasthan has made a fourfold progress in the field of literacy during the last decade especially among females. Among males, the literacy rate has increased from 54.99 percent in 1991 to 75.70 percent in 2001, which is higher than that of all India average i.e. 75.30 percent. In case of females, it has increased more than double from 20.44 percent to 43.85 percent from 1991 to 2001 respectively, which is still lower than the all India average of 53.7.

Rajasthan is heavily dependent on low-productive agriculture, which depends upon the vagaries of monsoon, and coupled with skewed land distribution. The backwardness is more profound in Scheduled Caste and Scheduled Tribe people. Indicators on poverty, work participation rate, and development indices, further reveal the poor socio-economic profile of the state. Rajasthan has one of the largest concentrations of Scheduled Castes and Tribes in the country. According to 2001 census, the Scheduled Caste and Scheduled Tribe population constituted 17.15 percent and 12.56 percent of the total population of the state respectively. At the district level Banswara (72.27%), Dungarpur (65.13%), Udaipur (47.86%) and Dausa (26.8%) districts have a high proportion of Scheduled Tribe population, whereas Ganganagar (33%) and Hanumangarh (25%) districts have a high proportion of Scheduled Caste population

Net State Domestic Product at constant (1993-94) prices, in the year 2000-01 has been estimated at Rs. 45,267 crore as against Rs. 46,574 crore in 1999-2000, and Net State Domestic Product at current prices works out to Rs. 70,211 crore for the year 2000-01 as compared to Rs. 69,491 crore during 1999-2000. A significant feature of SDP for Rajasthan has been its year-to year fluctuations mainly due to the behaviour of the monsoon since the primary sector (agriculture, animal husbandry, forestry, fisheries, etc.) contributes about 45-50 percent to total SDP. The per capita income for the year 2000-01 at current prices works out to Rs. 12,570 as against Rs. 12,765 during 1999-2000, registering decrease of 1.52 percent during the year.

Administratively, the state has been divided into 7 divisions, 33 districts comprising 9188 village panchayats, 39753 inhabited villages and 183 municipalities. Rajasthan was the first state to implement provision of *Panchayati Raj* in which *Panchayat Samities* (village level elected bodies) and *Zila Parishads* (district level elected bodies) have been formed for decentralisation of administrative power to the locally elected bodies. One-third seats in these bodies are reserved for women representatives.

1(b) Public Health System in Rajasthan

i. Infrastructure

The public health infrastructure in the state of Rajasthan shows a near adequacy in terms of numbers, but also shows a lot of scope of improvement in terms of functionality. Various health projects and programmes in the state, since the 1990's had brought in a substantial improvement in the health infrastructure, especially with projects like IPP-VIII and IPP-IX focussing on FRUs and the RHSDP focussing on district and sub-district/block level health facilities. Also, programmes like EC-SIP had invested heavily on upgrading a large number of Sub Health Centres and PHCs in selected districts. The present scenario of health infrastructure in Rajasthan is shown in the table below.

Table 2: Public Health Infrastructure in Rajasthan

No.	Facility	Required (as per 2001 Census)	Sanctioned	In Position (on 31/12/07)
1	Sub-centres	11323	10742	10742
1.1	Sub-centres functional			10333
2	Primary Health Centres	1780	1503	1503
2.1	PHCs offering 24 hour services			129
2.2	Block PHCs functioning as FRUs			NA
3	Community Health Centres	438	349	349
3.1	CHCs functioning as FRUs			18
4	Sub-divisional Hospitals	-	12	12
4.1	SDHs functioning as FRUs		12	12
5	District Hospitals	-	33	28
4.2	DHs functioning as FRUs		33	28

The above table highlights the requirement of various health facilities State per 2001 census, based on norms for establishing sub centers, PHCs and CHCs. Out of 10,742 Sub-Centres in the State only 8970 Sub-Centers have a building of their own. The rest of 1772 Sub-Centres are running in rented buildings. The construction of new Sub-Centre buildings will be taken up as per IPHS norms under NRHM Additionalities. During the year 2007-08 construction of 116 new Sub-Centre buildings shall be undertaken. Out of 1503 Primary Health Centres in the State only 1292 PHCs have a building of their own. The rest of 211 PHCs are running in rented buildings. Out of 349 Community Health Centres in the State only 289 CHCs have a building of their own. The rest of 63 CHCs are running in rented buildings.

ii. Human Resource for Health

As everywhere else in India, the state of Rajasthan is also facing acute shortage of skilled health human resources to provide quality healthcare to the rural people in the state. The shortage of staff exists across all levels, including doctors (including specialists), nurses, paramedical staff and outreach workers. The Rajasthan State gazette's figures of the state's health staff, as on April 2008, are given in the table 3 below.

Table 3: Health Administrator's staff position in Rajasthan (April 2008)

S.No	Name of the Post	No. of Post Sanctioned	In position	No. of Posts Vacant	Vacancy %
1	Director	4	1	3	75%
2	Ad. Director	8	7	1	12%
3	S.L.O.	1	0	1	100%
4	Joint Director	21	5	16	80%
5	Dy. Director & Equal	93	64	29	32%
6	Senior Specialist	281	175	106	38%

S.No	Name of the Post	No. of Post Sanctioned	In position	No. of Posts Vacant	Vacancy %
7	Junior Specialist	1869	1220	649	35%
8	S.M.O & Equal	871	692	179	20%
9	DY CMHO	52	15	37	71%
10	S.M.O. {Dental}	12	2	10	83%
11	Medical Officer	3846	4148	302	9%
12	M.O. {Dental}	111	88	23	21%

The shortage of critical health staff is faced more at the peripheral level, seriously affecting the quality of care, especially at the first referral level. The inadequacy of doctors and specialists at the CHC/FRU level is shown in the table 4 below.

Table 4: Staff in 367 CHCs in Rajasthan against the IPHS norms

S.No	Specialty	No. of Post Sanctioned	No. of Posts as per IPHS	Gap	Gap %
1	Anaesthesia	81	381	300	79%
2	ENT	17	77	60	78%
3	Gynecology	154	381	227	60%
4	Medicine	360	381	21	5%
5	Ophthalmology	69	135	66	49%
6	Forensic Medicine	0	77	77	100%
7	Pediatrics	97	381	284	75%
8	Superintendent (DD)	-	77	77	100%
9	Pathologist	-	14	14	100%
10	Radiologist	1	91	90	99%
11	Dermatologist	-	77	77	100%
12	Surgeon	364	381	17	4%
13	Dental Surgeon	63	367	340	93%
14	Sr. Medical Officer	383	304	-79	20% extra available
15	Medical Officer	806	2307	1501	65%

As clearly seen in the table 4 above, the state is facing huge problems to obtain adequate manpower to meet the IPHS norms.

iii. Health and Performance Indicators

The CBR was 37.1 live births per thousand populations in 1981 and it steadily declined to 28.6 in 2005. In rural areas it declined from 38.3 to 30.2 and in urban areas from 31.2 to 23.8 during the same period (SRS 2005). The CDR declined sharply over the same period. The estimated CDR for the state was 14.3 deaths per thousand populations in 1981 and it declined to 7.0 in 2005. The IMR for the state was 108 per thousand live births in 1981 and declined to 84 in 1990 and further to 68 in 2005.

Table 5: Current Status of RCH Indicators and Future Goals

OUTCOMES	STATE			INDIA		
	Current Status (2005)	Goal		Current Status	Goal	
		2008-09	2011-12		2008-09	2009-10
MMR	445 (SRS 03)	323	148	301 (SRS 03)	200	<100
IMR	68 (SRS 05)	55	32	58 (SRS 05)	45	<30
TFR	3.2 (NFHSIII)	3.0	2.1	2.7 (NFHSIII)	2.3	2.1

Some more health indicators for the state of Rajasthan is given in the table 6 below.

Table 6: Health Indicators of Rajasthan

Indicators	Source		
Health Indicators		**Rajasthan**	**India**
1. CBR (per 1000 population)	SRS 2007	27.9	23.1
2. CDR (per 1000 population)	SRS 2007	6.8	7.4
3. IMR (per 1000 live births)	SRS 2007	65	55
4. MMR (per 100,000 live births)	SRS 2003	445	301
5. TFR (per Woman, age 15-49)	NFHS-III (2006)	3.2	2.7
6. Sex Ratio (females per 1000 males)	Census 2001	921	933
7. Unmet need (of Eligible Women)	NFHS-III (2006)	14.7%	13.2%
8. Institutional deliveries	NFHS-III (2006)	32.20%	40.70%
9. Fully immunised (0-5 years)	NFHS-I (1993)	NFHS-II (1999)	NFHS-III (2006)
Rajasthan	21.1%	17.3%	27.0%
India	35.4%	42.0%	43.5%

It may be noted that as per the table 6 above, the institutional deliveries in Rajasthan is reported to be 32% only (as per household level data of NFHS in 2006), but the state government reports

approximately 70% institutional deliveries (of the ANC cases registered). Also the immunisation levels showed a decline from 1993 to 1999, which although showed a increase in 2006, is still much less than the national average. Other indicators are also poorer than the national average.

iv. Status of PRI framework in the state

Rajasthan has the three-tier PRI structure, as per the 73rd Constitutional Amendment Act and *panchayat* elections are held regularly. Two points worth noting with reference to NRHM is that there is no *panchayat* level set up at the village (Revenue Village) level and there may be one or more ward-*panch's* in one village. Secondly, the *Zila Parishad* chairman is junior to the District Collector and so all *panchayat* plans and schemes need sanction from the Collector. Also, the District Planning Committee of the *Zila Parishad* exists but is mostly non-functional. Across the all the three-tiers of the PRI system, there is a separate standing committee for sanitation and health, but that is not yet functionally integrated (institutionally) with the NRHM structures like VHSC.

v. Special constraints

As described in the background section on Rajasthan, the state has three distinct geographical divisions. The northern and north-eastern plains are relatively fertile and densely populated. But in this region lies the districts of Karauli and Dholpur, which has broken country-side and is sparsely populated with difficult communication, affecting transportation in medical emergencies and also discourages skilled health staff to be posted to the interiors. Similarly, the western desert region is devoid of any vegetation, humidity, is thinly populated with vast distances amongst habitations and poor communication, affecting reach. The desert region is also inhabited by shifting/nomadic population (*Banjaras*) making it difficult to track, especially for ANC and immunisation. The southern hills have thick jungles and inhabited by tribal population with less penetration of the public health system and the population relying more on faith healers and traditional systems of medicine. These difficult terrains limit the reach of the health workers and staff and also hinder timely transportation of serious patients to referral centres.

vi. List of facilities visited by the CRM team

The CRM team had four members for the field visit in the state of Rajasthan and they split into two groups of two members each and visited health facilities and interacted with health staff, officials, key stakeholders and community in two districts of Rajasthan. Team-A, comprising Dr. Gian Chand (ex-DHS, Himachal Pradesh) and Mr. Sanjay Saxena (NIPI-UNOPS) visited the facilities in Jaipur districts; and Team-B, comprising Dr. Rajib Dasgupta (JNU) and Mr. Gautam Chakraborty (NHSRC) visited the tribal district of Dungarpur. Between them, the CRM team visited 7 Sub Health Centres, 7 PHCs, 6 CHCs, 2 District Hospitals, 2 VHSC meetings, and 2 MCHN Days (VHND). The details of the facilities visited are given in the table 7 below.

Table 7: List of facilities visited by the CRM team

2nd Common Review Mission				
15th to 22nd December 2008				
Name of State			RAJASTHAN	
Names of Districts visited				
Sno	Name	District HQ	Name of DM	Name of CMO
1	JAIPUR	Jaipur		
2	DUNGARPUR	Dungarpur		

Health Facilities visited			
Sno	Name	Address / Location	Level (SC / PHC / CHC/other)
1	Mohanpura SC	Jaipur	SC
2	Bagrana SC	Jaipur	SC
3	Meghtalab SC	Dungarpur	SC
4	Bedsa SC	Dungarpur	SC
5	Narniya SC	Dungarpur	SC
6	Malikheda SC	Dungarpur	SC
7	Karauli SC	Dungarpur	SC
8	Kaladera PHC	Jaipur	PHC
9	Vatika PHC	Jaipur	PHC
10	Tunga PHC	Jaipur	PHC
11	Vidyadharnagar Urban RCH Centre	Jaipur	Urban RCH Centre under PPP
12	Kanba PHC	Dungarpur	PHC
13	Bhiluda PHC	Dungarpur	PHC
14	Dudhiabara PHC	Dungarpur	PHC
15	Govindgarh CHC	Jaipur	CHC
16	Chomu CHC	Jaipur	CHC
17	Bassi CHC	Jaipur	CHC
18	Sagwada CHC	Dungarpur	CHC
19	Simalwada CHC	Dungarpur	CHC
20	Bichhiwada CHC	Dungarpur	CHC
21	Janana Hospital	Jaipur	DH
22	District Hospital	Dungarpur	DH
23	SIHFW	Jaipur	SIHFW
24	District ANM Training Centre	Dungarpur	ANM Training Centre
25	Vijaypura village	Jaipur	VHSC Meeting
26	Bedsa village	Dungarpur	VHSC Meeting
27	Ramratanpura village	Jaipur	VHND
28	Meghtalab village	Dungarpur	VHND
29	Static Centre	Adarsh nagar, Jaipur	Static Centre
30	JK Lone Hospital	Jaipur	FBNC centre
31	EMRI Centre	SIHFW Campus, Jaipur	EMRI Centre
32	Medical College	Udaipur	School Health unit and Paediatric facility

Chapter 2: Mandate of CRM

The National Rural Health Mission (NRHM) was launched in April 2005 to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. Under the NRHM, the difficult areas with unsatisfactory health indicators were classified as special focus States to ensure greatest attention where needed. The thrust of the Mission was on establishing a fully functional, community owned, decentralized health delivery system with inter sectoral convergence at all levels. From narrowly defined schemes, the NRHM was shifting the focus to a functional health system at all levels, from the village to the district.

The Common Review Mission (CRM) has been set up as part of the Mission Steering Group's mandate of review and concurrent evaluation. The CRM provides occasions for state review, sharing of experiences across the states, discussions with wide range of stakeholders and an opportunity for mid course corrections by the Mission at all levels. The CRM seeks to undertake spot appraisal of the health system and reflect on success of the strategies and policies with an aim to identify mid course corrections which may be needed. The 2nd CRM is an opportunity to undertake detailed analysis of how successful/implementable is the strategies of the Mission. It is also an occasion for collating and documenting the evidence in support of (or against as the case might be) the policies and the efforts of the state in implementing them.

The 2nd CRM is being undertaken with the following overall mandate:

a) To review the changes in health system since launch of NRHM through field visits and spot examination of relevant records.
b) To document evidence for validating the key paradigms of NRHM including decentralization, infrastructure and HR augmentation, communitisation and others,
c) To identify the key constraints limiting the pace of architectural correction in the health system envisaged under NRHM
d) To recommend policy and implementation level adaptations which may accelerate achievement of the goals of NRHM?

Apart from the above mentioned general mandate of the 2nd CRM, certain state specific mandate for the state of Rajasthan were also evolved at the state level briefing meeting at the start of the field visits by the CRM team in Rajasthan. The additional state specific mandate for the 2nd CRM for Rajasthan were as follows:

a. Look into ways of integrating ASHA Sahyoginis (who are presently under ICDS) into mainstream NRHM structure.
b. How to strengthen micro health planning at the VHSC/panchayat level?
c. How to balance the commitment to social protection while ensuring economic viability of public health facilities and systems (through subsidised insurance schemes)?
d. Address the shortage of specialised healthcare providers.
e. How much has the state of Rajasthan been able to build on innovations that existed before the launch of NRHM in the state (like RMRS, MCHN Days, Jan Mangal Couples, etc.)

Overall, the state of Rajasthan expected the 2nd CRM to not only look at the implementation issues at the state level but also design related issues at the national level, especially related to planning, monitoring, financial management systems, communitisation and convergence related issues.

Chapter 3: Findings

3(a) Progress on Institutional Framework under NRHM

The NRHM had created various new institutions for better management of the public health system and the existence and functionality of these institutions are critical for the success of the NRHM objective of architectural corrections in the health system. The status of these institutions in the state of Rajasthan, as observed by the CRM team is mentioned below.

i. State/District Health Mission

The Rajasthan State Health Mission is constituted and functional, with at least two meetings per year being conducted under the chairmanship of the Honourable Chief Minister. District Health Missions, on the other hand, are non-existent/non-functional.

ii. State/District Health Society

The previously existing state and district level Health & FW Societies (under RCH-I and II) have been converted into State/District Health Societies, where all the other programme societies are also merged functionally (except RSACS), but the accounts of the vertical programmes are still managed separately. The accounts of RCH-I, and Family Welfare are merged with the Society account.

iii. PMU at State/District/Block level

The state and district level PMUs are adequately staffed and functional, playing a key role in planning, monitoring and assistance with NRHM additionalities as well as in coordinating the special drives/schemes like VHNDs. Rajasthan has also recently recruited block level programme managers and accountants to further strengthen the programme at sub-district level.

iv. Hospital Societies/RKS

Rajasthan has a history of hospital autonomy through the society mode with the creation of Rajasthan Medicare Relief Societies (RMRS), which is similar to RKS. Under NRHM, the RMRS had been extended from the secondary level health facilities (at district, sub-district and bloc levels) to the PHC levels. Each RMRS has also been provided with additional accounts staff under contract with the respective RMRS.

v. Sub Centre Committees

Sub Centre committees had also been created with separate bank account, and is functional. It has addressed the maintenance and upkeep of the Sub Centre to a large extent and the ANMs are feeling sufficiently empowered. But this has not taken off in Sub Centres which are located in difficult areas or located outside habitations resulting the ANM not residing in the Sub Centre.

vi. Village Health & Sanitation Committee (VHSC)

Team visited the Vijaypura Panchayat and met *Sarpanch* Shri Babulal Meena. The VHSC has been constituted but it has yet to/ start functioning. The Untied funds at VHSC are kept at Sub Centre level. During discussion with *Sarpanch* it was told that the Gram panchayat has some income from

land transfer, selling of trees produce besides grants from DRDA, MPLAD & MLALAD. They were willing to contribute out of Panchayat income for the purpose of health and sanitation.

vii. Additional institutions (SHRC/SIHFW/ARC)

The SIHFW in Rajasthan has adequate infrastructure, but is now facing problems as the EMRI call centre located within their campus, occupying a large space. SIHFW has minimal routine support from the government and sustains purely of project/training programme basis. Therefore, it is facing serious problems in taking in additional faculty and support/research staff.

The state of Rajasthan has decided to charge SIHFW with additional tasks of State Health Resource Centre (SHRC), but as SIHFW is already facing shortage of faculty for training and course development, it will be an additional burden on the scope of SIHFW. The state had already advertised 3 times for various consultants to be recruited under SHRC but had failed to find any suitable candidate.

As NRHM has created a huge army of filed level functionary in the form of ASHA, it needs dedicated monitoring and support, for which NRHM has the provision for ASHA Resource Centre (ARC). Here too, the state had decided to charge SIHFW with the task of managing the ARC. The state has taken cabinet approval for creating a separate monitoring structure for ASHA comprising of District ASHA Coordinator, Block ASHA Supervisor and PHC level ASHA Facilitator. This supervisory structure will be managed by the state level ASHA coordinators that presently form part of the SPMU. This might do away with the requirement of a separate ARC.

3(b) Progress on key aspects of health delivery system under NRHM

i. Assessment of the case load being handled by the Public System at all levels

- Increase in institutional deliveries
- Almost all PHCs reporting institutional deliveries
- Some SHCs also conducting institutional deliveries
- SDH (Sagwara) attracting increased caseload, even malnutrition and large numbers of NCDs. Performing large number of surgeries

ii. Preparedness of health facilities for patient care and utilization of services

- The SCs have in general begun to conduct institutional deliveries. Nearly 10% of SCs in Dungwara district are conducting deliveries, which is a positive development. Construction of labour rooms are in progress and nearly a third of the SCs in the district are planned to start institutional deliveries.
- The SDH, Sagwara is functioning very well and attracting increasing case-load. It is a unique model of PPP (through charity and managerial participation) but may be difficult to be replicated. However, this has also meant meagre case-loads at adjoining PHCs. An analysis of 'C to E' forms reveal that many minor case are being treated at Sagwara and the DH, Dungarpur which can be adequately treated at CHCs and PHCs. Minor wounds constitute a large load at these institutions, much of which can be tackled at SCs, PHCs and CHCs.
- Both the SDH and DH are conducting a large number of surgeries and that is a positive trend.
- Significant numbers of non-communicable disease including heart disease, diabetes mellitus, cancers and degenerative disorders are being identified and treated at primary and referral levels.
- Most CHCs and PHCs have registered increase in institutional deliveries though there are some with low figures.

- OPD attendance at some PHCs range from 25 to 30 per day. In well functioning PHCs and most of the CHCs it averages at about 100 per day. Of the two districts covered in the 2nd CRM, these institutions in Jaipur district seemed to be relatively better functioning than Dungarpur district; however, the latter is a tribal district with relatively less and sparse population

iii. Quality of services provided

- About a third of the SCs are being strengthened for conducting institutional deliveries.
- All PHCs have at least one allopathic medical officer. About 40% have an additional AYUSH doctor.
- AYUSH doctors are not adequately trained in managerial and public health functions.
- Optimal case mix of allopathic and AYUSH doctors are often absent. AYUSH doctors generally have too few patients.
- About 15% of PHCs have 3-4 beds in Dungarpur; in Jaipur, the number of beds is optimal.
- Some CHCs have less than 30 beds. However, owing to increased load due to the JSY, additional wards are being constructed at some CHCs.
- At most CHCs and PHCs, mothers were reported to be staying in the institution for 24-48 hours after delivery; enquiries with mothers during visits to the institutions seem to bear this out.
- Most institutions (including SCs) have being 'face lifted'. Toilets were clean and functional and many CHCs had functioning power backup systems.
- Despite these improvements, the following critical functional are still missing in FRUs/CHCs :
    - caesareans-sections
    - blood transfusion services
    - management of complicated APH/PPH cases
    - routine surgeries
- Several CHCs have licence for blood storage; personnel have undergone training, but are yet to operationalise this service.
- Waste segregation and facility level disposal are being done at most institutions; pits were found to be constructed and in use; bio-medical waste was reportedly being brought back from outreach sessions.

iv. Utilisation of diagnostic facilities and their effectiveness

- Owing to lack of pathologists and/or microbiologists at DH, Dungarpur laboratory services are seriously compromised.
- Some PHCs, particularly in Dungarpur district, have to no Laboratory Technicians (LTs).
- In several PHCs, 2 LTs are posted without adequate workload. In addition, if the CHC is a designated microscopy centre (DMC) for the RNTCP, there is an additional LT whose workload is about 5-8 slides per day.
- Rapid diagnostic kits (for malaria) IDD kits and haemoglobin testing kits available with ANMs. ANMs were not confident of their application/use; utilisation is therefore very low. On random testing by the CRM team in Dungarpur district, more than 15 ppm iodine was detected in edible salt.
- *Nischay* kits available with ANMs and ASHAs for detection of pregnancy are being better utilised; their independent validation requires to be done.
- Rapid diagnostic kits for malaria have been provided at PHCs; utilisation remains poor.

v. Drugs and Supplies

The Sources of Drugs & Supplies as observed during the visit are the following: Public Health, Family Welfare, RHSDP NRHM (kits), and Local Purchase (under MRS funds)

Generic Drugs

- Available in institutions (PHC/CHC/DH) through Cooperative Store and LLFS – 30-50% cheaper than MRP.
- List of Generic drugs and price (of both Cooperative Drug outlet and LLFS) displayed in all public health facilities.

Kits (under NRHM)

- ASHA Kit – ASHA received kit only once, resupply as and when required from Sub Centre/PHC (no systemic kit refilling).
- Pregnancy testing Kit (Nishchay kit) supplied to ASHA – not observed with all ASHA and not every ASHA trained to use it.
- Hb Testing Kit – supplied to ANM, not all ANM trained in using it (not seen in Jaipur).
- RDK (for malaria testing) not found below PHC.

Drug List

- Essential Drug list (EDL) available at state level (under RHSDP), not seen in health facilities.
- List of medicines as per IPHS for all levels of institutions (SC/PHC/CHC/DH) – booklet not found, Storekeeper/Pharmacists at PHC not aware of such a list.

Quality Control

- Drug Inspector posted, but in-charge of public health facilities not aware of drug sample and testing procedure.
- Sample from public health facilities not regular.

Inventory Management

- Re-supply and indenting as per need and availability
- Stock (in store and in pipeline) allowed to fall below average monthly consumption level, till inventory reaches zero level, before fresh indenting
- Many drugs, especially costly Antibiotics are out-of-stock for 2 weeks to 4-5 months. Number of "stock-outs" more in higher level facilities (DH/SDH)
- No system of knowing current balance of drug inventory in OPD (where daily consumption of tablets is high)
- Injectibles/fluids do not show "stock-outs

vi. Health Human Resource Planning

- There is acute deficiency of specialists at FRU/CHC; three-fourths of posts are vacant in Dungarpur.
- In DH, Dungarpur there are no dentists, ENT surgeons, orthopaedic surgeons, dermatologists, eye surgeons, radiologists and pathologists at; less vacancies at SDH, Sagwara.
- The Rural Medical Officer (RMO) cadre has greatly increased availability of MOs at PHC level and this is a positive step. There are several key weaknesses:
    - No induction training has been conducted; training is being taken up in a phased manner, in small batches, *after* induction.
    - The RMOs lack adequate programme management experience and remains a critical weakness
- There is an acute shortage of Lady MOs.
- Multi-skilling training is in progress. However, their utilisation and operationalisation is inadequate. In Dungarpur, multi-skilling training (anaesthasia) has been given to 4 MOs.

Shortage of other specialists (surgeons/obstetricians), equipments and support services (transfusion) have been obstacles to these trained personnel to deliver the services.

- In Dungarpur, most SCs have two ANMs, the second ANM being recruited under TSP by the state government. The second ANM is generally located at an under-served area, and not at the Sub Centre itself. These are positive developments. Under the NRHM, a third ANM needs to be appointed. While one ANM can be located at an under-served area, the state may consider locating the third ANM at the SC, to support institutional delivery and other functions.
- ANMs under TSP are contractual; drawing hardship allowance under NRHM in tribal/desert areas. Contractual LTs (under RCH II) not drawing hardship allowance. The allowance is not available to DPMs and BPMs either. These 'anomalies' were reported to the CRM.
- The recently appointed LHVs (senior-most ANMS were promoted) are yet to be fully trained for their new role.
- Discussions with the faculty at the ANM Training School, Dungarpur revealed that very few refresher courses were being organised for ANMs. The curriculum content of the ANM training courses have not been updated since long.
- Frequent transfers can adversely affect a district since they may lose trainers. In Dungarpur, 2 of the 4 Master Trainers of IMNCI have been recently transferred severely affecting their training schedules.
- Some posts of BPMs still vacant, most have joined in last one month. BPMs play a critical role in programme management. This level needs adequate attention from state and district level administrators.
- Individuals with diverse backgrounds and experiences are joining the programme management units at district and block levels. There is a lack of clear guidelines for fixing of salary of DPMs and BPMs leading to perceived anomalies and discontent.
- The State Institute of Health and Family Welfare (SIHFW) is located at Jaipur. It is gearing up to the increased training load under the NRHM and has been conducting a large number of training courses with a pre-defined schedule. However, the SIHFW is currently under *ad hoc* funding.
- The Regional Institutes at Jaipur and Ajmer are under the Directorate and are not under the SIHFW. Further, both these institutes being located in adjacent districts, including the state capital there is hardly any 'regional' distribution about them.
- The schools for LHV and ANM training are operating under the RCH. In short, all of these are lacking in institutional synergy.

Table 7: Status of contractual staff under NRHM

Position	Target	Position	Gap	Gap %
SPMU position	16	16	0	0%
DPM	33	33	0	0%
DAM	33	33	0	0%
DA	33	33	0	0%
BPM	237	181	56	24%
Accountant CHC / PHC	1087	985	102	9%
Data Entry Operator	305	252	53	17%
ANM / GNM	7502	2500	5002	67%
Staff Nurse – PHC / CHC	3704	3704	0	0%
Ayush MO	750	589	161	21%
Ayush compounder	750	647	103	14%
Specialist	45	0	45	100%
Pharmacist	500	0	500	100%

vii. Infrastructure

- Most of the civil works at DH/SDH/CHC level handled by RHSDP civil wing and is proceeding according to the schedule.
- Emphasis is being given to construction of staff quarters particularly at PHCs and CHCs; this is a positive step. In Dungarpur, progress was found to be slow at a few institutions.
- In small districts like Dungarpur, getting bidders for major jobs have sometimes been difficult.
- Referral transport is being mostly hired by patients from the market; utilisation of 102 ambulance service is limited. In some cases, payment is being made from untied/VHSC funds. Families are still incurring out-of-pocket expenditure on this account.
- Inter-institutional referral transport arrangements are working well; however, referral funds with MOs remain under-utilised in many institutions.

viii. Empowerment for effective decentralization and flexibility for local action

- Utilisation of untied grants by all levels of health institutions, but level of utilisation low (20-30%).
- MRS formed and functional down to PHC level. No LLFS at DH.
- Block level health "Society" not formed, but Block Health Plans exists
- VHSC being formed, not fully active yet. Their money lying with SHC, mostly unused. VHSC members need greater orientation/training to absorb the untied funds.

ix. ASHA

In Rajasthan, the ICDS Department appointed an additional tier called Sahayoginis to strengthen outreach services and social mobilisation. She received a fixed honourarium of Rs. 500 per month. When the NRHM was launched, the state cabinet decided to converge this human resource with the newly proposed Accredited Social Health Activists (ASHAs). In addition to the honourarium of Rs. 500, the Health Department fixed an amount of Rs. 450 per month. She would continue to receive all the incentives under the NRHM.

Observations/Issues

- The ASHA-Sahayogini experiment though launched with a promise has not translated to significant 'output' till date. Institutional deliveries accompanied by ASHA- Sahayoginis remain low at an average of about 20% for the state; in some districts, it is about 30-35%. Their contribution to other RCH activities including immunisation and sterilisation also remain below expectations. Their
- participation in MCHN (Mother, Child Health and Nutrition) Days is inconsistent across districts. In many cases, the nutrition component was found to be weakest.
- The ASHA-Sahayoginis are reporting for routine purposes to the Anganwadi Worker (AWW). Coordination with ANMs remains variable. Most of the follow-up actions of ASHA-Sahayoginis involve close coordination with the ANMs. This remains to be sorted out. Mentoring and hand-holding The initial one to one-and-a-half years since the initiation of the scheme has been weak and is responsible for most of these operational weaknesses.
- ASHA Diaries are not being regularly checked by ANMs. These diaries are being checked by ICDS functionaries though. As a result, action-taking is often weak. Malnutrition seems to be the greatest victim with no clear operational guidelines for referral to Anganwadis / PHCs / MTCs (Malnutrition Treatment Centres.

- Compensation to ASHA-Sahayoginis has been reportedly erratic. Lump sum payments are not uncommon. Of the promised fixed compensation of Rs. 450, all are currently getting Rs. 350. The irregular payment was confirmed by some providers.
- The training of ASHA-Sahayoginis has been modified in the state to 15 days, in two rounds. An in-depth evaluation of this modification needs to be carried out by the state and/or the NHSRC. In case, this is found to be a suitable option, national guidelines may be suitably modified to offer states an option. Else, the training system in Rajasthan shall need to be modified.
- 'Competitive entrepreneurship' among ASHA-Sahayoginis was reported by ANMs in some areas. Some of them were reporting disproportionately higher number of institutional births (accompanied) while others in the adjoining areas were reporting too few. It is possible that caste and other social alliances may explain this phenomenon.

x. Systems of financial management

- The finance team has been strengthened by providing additional staff at district, district hospital, CHC and blocks level.
- The process has been initiated to place one accountant at the sector PHC to cover 50 % initially. Therefore total strengthen of the finance staff at all the level will appear as under:

	Post	Joined
State	7	6
Districts	33	33
CHC / PHC (50%)	1087	985
Blocks	237	148

- Approval of district PIP and release of funds using flexi pool mechanism has been initiated from 2008-2009. This has really helped in reducing the no. of transactions and also providing flexibility at the district level.
- Electronic transfer of funds from State to districts to blocks has commenced.
- Monthly financial reporting from blocks to districts, districts to states and quarterly from state to GoI has been instituted.
- Financial guidelines under NRHM has been formed, printed and distributed to all districts. The guidelines prescribe the formation of Financial Management group at the state and district level.
- The tally software package has been introduced at State / district / block level but its implementation is at nascent stage.

Although the state efforts in strengthening the financial management in the project is commendable but there is need to consolidate the gains so that the benefits of these proactive steps can be sustained for further improvement of the overall programme management. This is detailed out in the following paras.

Finance Staffing and training

State level:

- The staffing at the State office is appropriate however it need further strengthening by induction of (i) IT technical support to facilitate receipt, validation and consolidation of the accounting data from the districts electronically and (ii) Finance Analyst to support the SPMU for planning, tracking, analyzing variance, determining bottleneck and recommend solutions for expenditure of Society as well as state directorate budget.

- Staff at the state office received the training organized by FMG at central level; however FMG has not been regularly visiting the state for mentoring / monitoring purpose. However in the mean time for resolving the operational issues proactively, FMG may create a blog as most of the issues are common in nature.

District level:

- State finance manager position is vacant; however Accounts Manager works with the FA posted through the system.

Sub district level:

- At block one accounts staff is recruited as part of block program management unit consisting of block manager. The accounts staff is also provided at CHC / PHC. The work load in a block is tremendous due to JSY transactions but it is handled by the accountant at CHC / PHC level. State has also initiated process of recruiting accountant at Sector PHC with in the block. The process is likely to be completed soon. 6) The accountants are now posted at Block PMU, CHCs and PHCs level. The Block PMU mainly acts as is a funds transfer unit, where as accountants at CHC / PHC acts final disbursal point. An analysis of transaction load reveals load with Block accountant is approx 250 – 300 transactions per month which is reasonable at all standard.. In a block there are about 10 – 12 accountant including at CHCs and PHCs. In addition to this there are cashiers who are posted through the system. Similarly, load at PHC accountant is approx. 150 – 200 transactions per month.

Accounting and reporting

- The funds are released to the districts and blocks under RCH flexi pool and Mission flexi pool instead of against each particular activity. The UCs are submitted on monthly basis or on incurring 50 % of the expenditure. The outstanding advances at the field level are of two natures- a) For regular activities like JSY, Immunisation, contractual staff, ASHA meetings etc. and b) For Annual maintenance and Untied Funds provided on yearly basis. The Society, for monitoring of outstanding advances has fixed a limit Rs two crores each district before releasing the subsequent tranche.
- At state level accounts are being maintained in Tally and on excel.
- The outstanding advances between block / district / state level are need be reconciled immediately and thereafter balances be confirmed on quarterly basis.
- At district level, analytical work such as variance analysis, tracking of low / high level of expenditure, appropriate provisioning at the time of PIP preparation must be initiated.

Audit and Internal controls:

- In Jaipur District the auditor has refused to comment on the financial statement for the year 2007-2008 and qualified the audit report with serious observations. In the management report dt. 28/8/2008 the auditor has observed: (i) non reflection of cash withdrawn from bank in the cash book of Dy. CMHO (FW), (ii) Maintenance of heavy cash balance, (iii) non confirmation of the some of the o/s balances etc.
- We have examined the procedure followed for maintenance of the books of accounts and bank operation in O/o the DHS, Jaipur and observed as under:

  a) Earlier three different bank accounts were maintained at DHS, Jaipur. In addition to the CMHO bank account, another two bank accounts were individually handled by Addl. CMHO, RCHO. From Aug,08 onward these two additional bank accounts were closed to comply with the guidelines issues by the MOHFW, GOI.

b) Now though only one bank account is maintained, funds are drawn in cash by Addl. CMHO & RCHO from the CMHO bank account. The three different cash books are maintained by addl. CMHO, RCHO & CMHO.

c) RCHO handles funds pertaining to: 7 day mobility support, Routine immunization, RCH camps and Dai training. Additional CMHO handles funds pertaining to: NSV, Sterilization & quality of camps. The CMHO handles directly funds pertaining to NRHM flexi pool & RCH flexi pool.

d) The funds drawn by Addl CMHO & RCHO are settled through submission of UCs to CMHO accountant instead of submitting the original vouchers. UCs are not meant for adjusting advances releases to the officials.

f) It was explained that funds are needed in cash for holding sterilization camps. These camps are conducted at the facility – CHC / PHC.

- At few places, accountants are not handling cheque book but it is kept by duty staff (CHC – Bassi). The accountant is maintaining books of accounts.
- The **age-wise analysis** of the pending advances is done on quarterly basis so that any advances of more than one year old can be followed more rigorously.
- The funds transferred to MRS are under ` maintenance grant 'and ` untied funds'. It is felt that the transfer of funds under the two heads does not add to any value. Therefore it is suggested that possibility be explored to club theses two heads and funds to RKS can be transferred under one common head.
- Bulks of the miscellaneous transactions are generated through untied funds at VHSC/ Sub Centres / PHC (MRS) etc. In addition to expenditure, it is essential to have financial controls in place. This can be attained through communitization of audit process i.e. involvement of community through public dissemination of financial information, participation of locals in decision making. Once this in place, accounting policies of `expenditure recognition' can be simplified.

In total state has 1100 accounting personnel in place and an additional layer of accountants at sector PHC is also in process and will be completed soon. The internal and external auditors are also available at state and district level. With this skill set available within the system, a more IT enabled solutions, focus on internal controls, further rationalization of delegation of powers, communitization of audit process of VHSC / RKS through dissemination of information will help in establishing the robust financial management system .

xi. HMIS and its effectiveness

Integrated HMIS

- Integrated modules for RCH, NDCP, IDSP
- Both aggregated and disaggregated information, by facility, levels of facility, and area
- Web-based
- Data validation built into the system for error tracking while data-entry
- Testing phase over, to be expanded in the state in nest financial year (2009-10)
- Training of users to be organised in-house, parallel to implementation of HMIS across the state

Pregnancy Tracking System (PTS)…Dungarpur

- System capturing individual record of identified pregnant mother (after ANC registration, based on EC register) at Block level
- Excel based system, web-based
- Sorting possible by age of mother, existing number of children, village, no. of ANC check-up done, no. of TT doses received, etc.
- PTS Cell in the Collectorate, manned by 4-member team
- Follow-up by PTS Cell with LHVs via phone
- Work-list generated for ANC Micro-tasking at village/Sub Centre level

xii. Community Processes under NRHM

- Rajasthan has begun involving the VHSCs in micro-planning, but the planning is focussed around achievement of health and family planning targets for the village population. Moreover, as there is no administrative unit at the village level, the funds for VHSC lies with the Sub Centre account.
- Involvement of the community representatives in the management structures of health societies and RKS/RMRS is minimal, which is dominated by the administration and health officials.
- Community monitoring had strated in some pilot districts but the result is not very encouraging as there is minimal participation from the health officials, and they view it threateningly as if a public trial/*Jan Sunvai*. The health officials also do not feel sufficiently oriented and empowered to handled such crowds.
- The MNGO/FGO/SNGO scheme is coming to a standstill with long delays in NGO selection and grant of funds for operations. This is caused mainly because of lack of clarity of NGOs' role within the NRHM ambit.

xiii. Assessment of non-governmental partnerships for public health goals

- Rajasthan has undertaken various partnerships for operating ambulance services (EMRI), MMUs, undertaking social marketing of sanitary products (with HLL), for running Urban RCH centres, etc.
- The partnerships is institutionally supported by RHSDP in terms of design and NRHM officials and consultants (in the SPMU/DMPU) support the actual contracting and implementation.
- The state has clearly spelt out PPP and NGO partnership policy and guidelines, which were originally developed under SCOVA before the launch of NRHM.
- There is serious lack of understanding and capacity to manage partnership contracts at the district level.

xiv. Thrust on difficult areas and vulnerable social groups

- Tribal Area Sub-Plan (under the treasury, outside the NRHM) has substantial effect in the tribal areas with additional funds for construction of Sub Centres and also additional salary support for the 2nd ANM. Most of the Sub Centres in Dungarpur (TSP district) has two ANMs.
- MMUs are functional in all districts but presently limited to holding health check-ups and OPD at PHC sites in the interior areas. C and D category villages are not yet covered by the MMUs.
- Social protection scheme includes *Rajasthan Swasthya Bima Yojana*, which involved premium subsidy provided from NRHM, and government hospitals reimbursed by the state insurance department for free treatment given to BPL card holders. This scheme was stopped by the launch of RSBY under the Ministry of Labour, under which smart cards are printed, but the scheme is presently non-functional with no payment made to the Insurance Company (ICICI-Lombard). Meanwhile the GoR launched a comprehensive social insurance scheme, which included health called *Bhamashah* scheme, but that was also stopped

because of the issue of non-compatibility of cards (with software support from Infosys) with the RSBY software. So presently the health insurance for protecting the poor from catastrophic expenditure is non-functional.

xv. Effectiveness of the disease control programmes including vector control programmes

- Rajasthan is a Malaria endemic state with recurrence of malaria every year. The slide collection and active search was found to be working and no shortage of malarial drugs was noted. The RDKs were found to be used by the lab Technicians at the PHC level and not used in the field/community level with ANM/ASHA.
- TB detection and cure rates were above the targeted level, although the District TB Officers reported many cases of relapse after 1-2 years of being declared sputum positive after DOTS.
- IDSP formats were observed at the district and CHC/FRU level. Staff under IDSP is being provided currently.

xvi. Performance of Maternal Health, Child Health and Family Planning Activities seen in terms of availability of quality of services at various levels.

Maternal Health

Though the outlay / expenditure has increased manifold for the RCH interventions but within that investment in CH sector has not increased proportionately. To address neonate mortality, the team felt the need of (a) Designing a incentive based intervention to cover home based visits during crucial neonate period (JSY plus); and (b) observed that there is a potential for us to convert A specific killer of new born in a focused program - National Newborn Infection Control Program. This has a potential to convert Skills of Anganwadi, ASHA in recognition of Danger signs of Pneumonia and giving a timely referral through Facilities developed as EmOC. We need to start connecting Skills of recognition of signs to effectively stopping Pneumonia. Disease treatment studies reveal that facility based and home based outcomes are same in both settings. PNC visits and AWC settings can be a good platform for these services. Addressing the other two major contributors to neonate deaths, prematurity and Asphyxia require different strategy.

Janani Suraksha Yojana

- The State has accredited institutions in the private sector for ensuring delivery under JSY. It is observed that vaccine supplies are not given to accredited institution for O dose vaccination.
- The register kept at the institution does not record a) Weight of the newborn b) condition at the time of discharge. It is extremely difficult to track pre mature / mal nourished neonate subsequently due to inadequacy of data.
- To improve the quality care in the labour room, the team felt the need for provision of birthing kit.

Immunization

- The district has reported severe stock out of vaccines during the year.
- On MCHN days vaccines are delivered either through courier or through MO who delivered the vaccine while on supervision. The reports are also collected on the very day however there is no mechanism of analysing reports at blocks to take corrective action. (Ramratanpura MCHN day , Block – Bassi)
- The field functionaries express hesitation of opening vaccine vial for fewer child due to fear of Vaccine wastage factor. The team felt that the one session one vial policy of GOI be

communicated effectively and also the same norms be applied while supplying vaccines to State.

- The immunization status of different districts in the state are skewed in nature. The tribal districts such as Udaipur, Dungarpur has higher immunization coverage as compared to the densly populated district such as Alwar and Bharatpur. One of the reason cited is due to provision of additional ANM in tribal districts.
  The team felt the need of (i) having more sites / sessions to cover the entire population, (ii) engaging more vaccinators for the session. At PHC a list of vaccinators (retd. Nurses, ANM, practitioners in pvt sectors) be drawn who can be deployed for the sessions.
- The tracking of pregnant woman and child would ensure improved RCH services in the field (Dungarpur)

Chapter 4: Recommendations

4(a) Recommendations on Institutional Framework under NRHM

Village Health & Sanitation Committee (VHSC)

- For the effective functioning of VHSCs it is felt that
  a) GPHSCs be constituted and co-terminus with GP.
  b) Different VHSCs to act as working committee under GPHSC.
  c) The VHSC will have the representation of respective ASHA, Panch and another representation from community.

Additional institutions (SHRC/SIHFW/ARC)

- SIHFW is already facing shortage of faculty for training and course development, and it will be an additional burden on the scope of SIHFW to manage the additional task of SHRC.
- The Strategic Planning Cell of RHSDP may be merged with SHRC under the SHS, after the RHSDP ends in September 2009.s
- Regional Training Centres may be expanded to all the administrative divisions and brought under SIHFW.
- SIHFW may look at curriculum development as well as faculty development programmes of the district level ANM Training Centres.

4(b) Recommendations on key aspects of health delivery system under NRHM

i. Case load being handled by the Public System at all levels

- Full range of services at CHCs should be urgently operationalised. In particular, transfusion services should be started urgently.
- The emerging trend of non-communicable diseases needs to be epidemiologically tracked; medicines and laboratory support will need to be augmented.
- While caseloads have increased in many institutions, lack of manpower remains a problem. It is hoped that recruitments of Rural Medical Officers (RMOs) will ease the situation to some extent.
- While energising Sub-Centres is a positive step, human resources and logistics shall need to be augmented to provide adequate services.
- Vacancies need to be filled up in single-doctor PHCs to improve quality of services.
- Non-functioning beds in PHCs and CHCs (to a lesser extent) should be urgently made operational.
- The vacancies and workload of LTs should be urgently rationalised.
- Utilisation of various diagnostic kits with the peripheral health workers is low and needs to be improved. Rapid diagnostic kits for malaria need to be located with health workers and not at the health institutions where laboratory facilities are available.
- As the tenure of the RHSDP comes to a close, the state shall need to plan for alternate delivery vehicles to take up the large range of functions of the Project.
- Construction of staff quarters are expected to be completed shortly. The state needs to ensure that they are allotted promptly and health care personnel stay there to improve the availability and quality of services.
- Tender criteria may need to be suitably altered for smaller towns for major tasks, with adequate safeguards.

- EMRI ambulance services have just been introduced; the cost and feasibility considerations need to be worked out for the state.

ii. Drugs and Supplies

- Single vs. Multiple channel of supply – avoid duplicity in supplies under Directorate, family Welfare, NRHM, RHSDP and RMRS/LLFS
- More clarity is needed on EDL for different levels of health facilities (SC/PHC/CHC/SDH/DH)
- Quality testing of drugs in stock to be undertaken routinely.
- Prescription Audit needs to be introduced (sample/periodic vs. regular basis)
- Inventory management
    - Need a computerized application for inventory management at stores.
    - Buffer/safety stock needs to be calculated and adhered to in light of average consumption,
    - Inventory tracking, and daily consumption registers needs to be maintained
    - Re-order quantity and frequency in light of lag time needs to be estimated and adhered to

iii. Health Human Resource

- To meet with the deficits in specialists at FRUs and hospitals, contractual appointments are being made. This should be scaled up fast in order to fill up the vacancies. The state needs to make a realistic assessment of the prospects for filling up these posts given the HR situation in the difficult areas.
- The vacancy of posts in lady medical officers is a matter of concern. While contractual appointments can be tried out, a realistic assessment is also necessary.
- The new RMOs need to be oriented and skilled in public health functions including programme management. Though many of them had been under contractual appointment for varying periods prior to this appointment, these skills have not been built.
- The districts need to build micro-plans, by institutions, for multi-skilling. Mere deputation of doctors to these courses will not enable FRUs to begin the services since it requires several deficiencies to be corrected in a synergistic manner.
- A cogent transfer policy of medical officers should be practiced.
- The state needs to take a view on recruiting the third ANM, perhaps in a phased manner, and deploying them in areas that need them most.
- The state / concerned districts may take a view regarding hardship allowances to different categories of contractual employees including DPMs and BPMs.
- Steps need to be taken to fill up vacant posts of BPMs and retain them.
- 'Pay bands' may be defined for DPMs and BPMs, to accommodate varied profiles of the candidates. The state may also consider an annual increment structure that may be built in. Hardship allowance (as applicable) may also be considered.

iv. ASHA

- An in-depth assessment of the functioning, supervision and incentive structure of ASHA-Sahayoginis is required.
- The working relationship between the peripheral functionaries of Health and ICDS departments need to be evolved. The CRM feels that the following steps are necessary:
    - The ASHA diaries be monitored by ANMs daily or on alternate days.
    - The MCHN day is energised with full cooperation of ANMs, AWWs and ASHA-Sahayoginis. The supervisory cadres – Lady Supervisors (ICDS) and lady Health Visitors (Health) should also participate regularly to make this exercise more meaningful.

  - The ANM and AWW co-ordinate regularly on fixed day activities such as immunisation.
  - The LS attend the monthly meeting of the MOs.
  - The CDPOs attend some of these meetings in their respective blocks/PHCs.
- The payment being made to ASHA-Sahayoginis be made regularly.
- The state has already proposed for an ASHA supervisory cadre; recruitment is in progress. The selected supervisors should be adequately trained and standard weekly/monthly monitoring protocols developed.
- ANMs and ASHA Supervisors should ensure that ASHA-Sahayoginis work only in their areas and 'poaching' is avoided
- Home visits by ASHA-Sahayoginis, and, identification and management of malnutrition needs sustained efforts.

v. HMIS

- Extension of PTS to PCTS (Pregnancy and Child Tracking System) to track the child born, till school enrolment
- Incorporating "C-to-E" forms into the Integrated HMIS
- Move from MIS (Management Information System) to DSS (Decision Support System) based on Decision Algorithms built around critical values and ranges of key indicators
- Move to Evidence-based Planning and Supervision

vi. Maternal Health, Child Health and Family Planning Activities, in terms of quality of services

- Within RCH
  - Investment in CH sector has not increased proportionately
  - Big disconnect between the AWW, ASHA and ANM
  - Underweight / malnourished neonate identified by ASHAs have no follow up by ANM or referral to institution due to lack of established treatment protocol (Village - Purana Bagrana)
  - PNC visits are not recorded in the dairy – no cross verification by ANM / supervisor.
- To address neonate mortality -
  - Design incentive based intervention to cover home based visits during crucial neonate period (JSY plus);
  - Design pneumonia control programme - with referral for sepsis management.
- Janani Suraksha Yojana
  - Supplies are not given to accredited institution for O dose vaccination
  - The register kept at the institution does not record a) Weight of the newborn b) condition at the time of discharge – difficult to track pre mature / mal nourished neo-nate.
  - Need for provision of birthing kit ensuring quality care.
- Immunization
  - Irregular supplies of vaccine
  - No mechanism of analysing reports at blocks received after MCN days
  - Vaccine wastage – a fear
  - The tacking of pregnant woman and child.

Chapter 5: State Specific Issues

(a) *ASHA Sahayogini* Scheme

In Rajasthan, the ICDS Department appointed an additional tier called Sahayoginis to strengthen outreach services and social mobilisation. She received a fixed honourarium of Rs. 500 per month. When the NRHM was launched, the state cabinet decided to converge this human resource with the newly proposed Accredited Social Health Activists (ASHAs). In addition to the honourarium of Rs. 500, the Health Department fixed an amount of Rs. 450 per month. She would continue to receive all the incentives under the NRHM.

The state has taken cabinet approval for creating a separate monitoring structure for ASHA comprising of District ASHA Coordinator, Block ASHA Supervisor and PHC level ASHA Facilitator. This supervisory structure will be managed by the state level ASHA coordinators that presently form part of the SPMU. This might do away with the requirement of a separate ARC.

(b) Rajasthan Medicare Relief Societies (RMRS) and Life-Line Fluid Stores (LLFS)

Rajasthan has a history of hospital autonomy through the society mode with the creation of Rajasthan Medicare Relief Societies (RMRS), which is similar to RKS. Under NRHM, the RMRS had been extended from the secondary level health facilities (at district, sub-district and bloc levels) to the PHC levels. Each RMRS has also been provided with additional accounts staff under contract with the respective RMRS.

Rajasthan had created RMRS mainly to generate revenue for the hospitals through user charges. To create additional source of revenue for the hospitals with RMRS, the state also encouraged hospitals to run Life-Line Fluid Store (LLFS), which are basically drugs and consumables stores within the hospitals, run the RMRS at below MRP rates.

The provision of untied funds and annual maintenance grants to RKS/RMRS under NRHM is slowly shifting the focus of RMRS away from resource generation to patient care and quality andequity. It may be noted that under the guidelines, each RMRS is mandated to to spend at least 50% of its revenues on BPL and other exempt category patients in terms of the value/rate of tests provided free and the medicines provided free/purchased from local market for the BPL and other exempt category patients.

(c) Pregnancy Tracking System (PTS)

The name-based tracking of RCH services (ANC, Delivery and PNC) through a Pregnancy Tracking System was observed in district Dungarpur. The System captures individual record of identified pregnant mother (after ANC registration, based on EC register) at Block level. It is an Excel based system and is web-based. Sorting of records is possible by age of mother, existing number of children, village, no. of ANC check-up done, no. of TT doses received, etc. PTS Cell is functional in the Collectorate, manned by 4-member team. Follow-up is done by the PTS Cell with LHVs via phone. Work-list generated by the PTS Cell for ANC Micro-tasking at village/Sub Centre level. The state has decided to extend the PTS to other districts in a phased manner and also extend to PTS to PCTS (Pregnancy and Child Tracking System).

(f) *Rajasthan Swasthya Bima Yojana & Bhamashah* Scheme

Social protection scheme includes *Rajasthan Swasthya Bima Yojana*, which involved premium subsidy provided from NRHM, and government hospitals reimbursed by the state insurance department for free treatment given to BPL card holders. This scheme was stopped by the launch of RSBY under the Ministry of Labour, under which smart cards are printed, but the scheme is presently non-functional with no payment made to the Insurance Company (ICICI-Lombard). Meanwhile the GoR launched a comprehensive social insurance scheme, which included health called *Bhamashah* scheme, but that was also stopped because of the issue of non-compatibility of cards (with software support from Infosys) with the RSBY software. So presently the health insurance for protecting the poor from catastrophic expenditure is non-functional.