RAKSHAK FOUNDATION

Relevance & Efficacy of National Rural Health Mission – at the grassroots level

JULY 2013

Submitted by:

Ravi Kiran Bachu

IIT Madras

Mentored by:

Dr. Manju Singh

Consultant & Family Planning Program Manager, Kota division, UNFPA

Preface

Pursuing engineering at IIT Madras, I have always been engrossed in matters related to engineering and science. Although I am interested in social issues, I really have not been able to do much about it apart from reading newspaper and having discussions with my like-minded friends.

Rakshak Foundation and its internship programme focusing on public policy research caught my eye and I chose to join it with the sole objective of bringing about an improvement in the society and governance!

I have always been an avid supporter of 'Right to Health' for everyone. Since I am interested in the health sector, I am working on a project that deals with an evaluation of National Rural Health Mission and finding its loopholes.

I thank Rakshak Foundation for giving me the opportunity to participate in public policy issues while being a student.

Acknowledgements

I wish to express my sincere gratitude to Dr. Manju Singh, Consultant and Divisional Program Manager, United Nations Population Fund, for being my mentor and extending her valuable guidance with incredible patience all the time. Also my thanks to Mr. Sunil Kumar, Group General Manager, Internet Ticketing Center, IRCTC (H/o Dr. Manju Singh), for extending help during the field visit. I also thank Mr. Swarup Pal for guiding me and providing key insights into the health scenario at the grassroots. And most importantly, Mr. Satendra, Block Program Manager, for being with us throughout the field visit and extending all sorts of help, without whom, this report couldn't have been made. I finally thank Rakshak Foundation for giving me a platform to involve myself in public policy research.

Contents

List of Acronyms.....5

List of Tables.....7

List of Figures.....7

EXECUTIVE SUMMARY 8

1. INTRODUCTION 11

1.1 Background of National Rural Health Mission (NRHM): 11

1.2 Goals and Objectives of Project 16

2. METHODOLOGY 17

2.1 Literature Search 17

2.2 Scope of the project 29

2.3 Field Visits, Surveys and Interviews 29

3. RESULTS AND DISCUSSIONS 40

3.1 Findings from the literature 40

3.2 Finding from the fields 42

3.3 Gap analysis 46

4. RECOMMENDATIONS, SCOPE AND STRATEGY FOR IMPLEMENTATION... 51

5. CONCLUSION 62

6. REFERENCES 63

APPENDIX 65

List of Acronyms

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy
BEmOC	Basic Emergency Obstetric Care
BPM	Block Programme Manager
BPMU	Block Programme Management Unit
CHC	Community Health Centre
CRM	Common Review Mission
D. A.	Dearness Allowance
DH	District Hospital
DPM	District Programme Manager
DPMU	District Programme Management Unit
ECS	Eligible Couple Survey
ECTS	Eligible Couple Tracking System
FRU	First Referral Unit
HFD	High Focus District
ICDS	Integrated Child Development Scheme
IFA	Iron & Folic Acid
IMNCI	Integrated Management of Newborn and Childhood Illness
IMR	Infant Mortality Rate
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
LPS	Low Performing States
LSAS	Life Saving Anaesthetic Skills
MCH	Maternal and Child Health

MDG	Millennium Development Goal
MIS	Management Information System
MMR	Maternal Mortality Rate
MO	Medical Officer
MPHW	Multi-Purpose Health Worker
MPW	Multi-Purpose Worker
NHSRC	National Health Systems Resource Centre
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
PCTS	Pregnancy and Child Tracking System
PHC	Primary Health Centre
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti
RMNCH +A	Reproductive Maternal Newborn Child Health +Adolescent
RMP	Rural Medical Practitioner
RMRS	Rajasthan Medicare Relief Society
SDR	Sub-centre Data Register
SHC/SC	Sub-Health Centre/Sub Centre
T. A.	Travel Allowance
TFR	Total Fertility Rate
VHND	Village Health and Nutrition Day
VHSC	Village Health & Sanitation Committee
VHSNC	Village Health Sanitation & Nutrition Committee
WCD	Women and Child Development
WIFS	Weekly Iron & Folic acid Supplementary Scheme

List of Tables

Page No.

Table 1: Present status of RCH indicators 17

Table 2: Other health indicators 21

Table 3: Findings on VHSC 28

List of Figures

Figure 1: Decentralisation of NRHM 14

Figure 2: Comparison along continuum of care in Rajasthan 18

Figure 3: Trends in institutional Deliveries 22

Figure 4: VHND at Aanganwadi of Maanpura village, Bundi district, Rajasthan 35

Figure 5: Multi-Purpose Worker, ASHA and ANM at Maanpura on VHND 35

Figure 6: ANM and ASHA administering vaccines to a newborn 36

Figure 7: ASHA at Bhandeda village, Nainwa block, Bundi district, Rajasthan 37

Figure 8: Register maintained by the VHSNC at Bhandeda village 38

Figure 9: PHC Basi, Nainwa block, Bundi district, Rajasthan 39

Figure 10: Strategy for a stronger ASHA system 52

Figure 11: Strategy for better functioning SHCs 53

Figure 12: Flowchart for capacity building of Medical Officers 54

Figure 13: Strategy for better community involvement 56

Figure 14: Strategy for expanding the scope of MIS 58

Figure 15: Strategy for better functioning grievance redressal mechanisms 59

Figure 16: A step towards population control 60

Figure 17: Conflicting ideas regarding inter-sectoral convergence 61

Figure 18 Need for convergence of funds 61

Executive Summary

This report looks into the National Rural Health Mission that was flagged off in 2005 and is named as one of the most ambitious programmes in the country.

Since 'Health' is a state issue, this report has focused upon NRHM activities in only Rajasthan.

The goals and objectives of this project has been

- To analyse the current situation of NRHM in rural regions in India.
- To study on whether NRHM is able to provide "accessible, affordable and quality" healthcare.
- To find out the loopholes in its delivery mechanism and suggest better ways for implementation.

The scope of this project is broadly divided into four components:

1) Target of NRHM in Maternal and Child Health – Reduce MMR and IMR through the implementation of JSY and JSSK.
2) Infrastructure and human resource to provide the services.
3) Community involvement and ownership.
4) Use of MIS and Grievance Redressal Mechanism

The report covers the literature search, the details of the field visits undertaken, the key findings and recommendations for improvement. Field visits were conducted to areas under Nainwa block of Bundi district, Rajasthan.

Key findings

The key findings with respect to the loopholes in the delivery of NRHM are:

Regarding implementation of JSY and JSSK:

- There is a significant delay in payment of cash incentives to ASHAs.
- Support system for ASHA is poor. ASHA supervisors are either absent or busy in other work.
- Counselling services imparted by ASHAs and ANMs in VHNDs are poor.

Regarding infrastructure and manpower:

- There is an acute shortage of staff in many health centres. Doctors with specializations are a rare sight.
- Lab equipment is poor.

- Many CHCs are not functioning as FRUs due to HR problem or infrastructure problem.

Regarding community involvement

- VHSNCs are poorly oriented towards utilization of untied funds. Hence misuse of funds occurs.
- Interest levels of PRI representatives in VHSNCs are low.
- No forum exists for people of villages to reach out to the higher authorities.
- Community based planning is almost NIL.
- Inter-sectoral convergence in terms of drinking water is not seen at the village level.

Regarding MIS and Grievance Redressal:

- Scope of HMIS is limited to PCTS, ECTS. And it is not under public domain.
- There exists a grievance redressal cell under the DPMU but is not at all widely known.

Recommendations

Suggested recommendations are:

Regarding implementation of JSY and JSSK:

- Specialised counselling and communication workshops for ASHA, ANMs & MOs.
- Increasing performance based incentives of ASHAs and removal of 1-5% of non-performing ASHAs.
- Performance evaluation of ASHA/Health Supervisor based on ASHA's performance and grant of allowances to ASHA/Health Supervisor for helping ASHAs in field visits. Follow up mechanism for ASHA's payments by BPM and entry in MIS.
- Analysing the situation of every SHC in every block – operational status, operational timings, area of coverage, staff posted and staff operational.
- Opening more SHCs based on the criteria that every SHC should not cover more than 2-3 villages. Marking the SHCs on a priority scale based on the distance and accessibility of the SHC from the nearest town. If the SHC is comparatively nearer to the town, then the SHC should be marked as low-priority SHC and if it is remote, it should be marked as a high priority one.
- Not allowing deputation of ANMs to other health centres at any cost and making sure that the ANM posted to the SHC stays there. High priority SHCs should be given special focus.
- Allocation of areas in the villages to the ANMs. The ANMs should be individually responsible for their respective section of the village.

Regarding infrastructure and manpower:

- Capacity building of doctors by **compulsory** training in specialised services like LSAS, BEmOC, etc.
- Performance tracking of doctors after training and follow-up training if required.
- Introduction of a supply chain manager at the district level.
- Non-monetary incentives for staff posted in difficult areas like speedy promotions, preference for children in academic institutions, special quota in post graduate studies for young doctors willing to serve in difficult areas, etc.

Regarding community involvement

- Quarterly meeting at the block level inviting members from VHSNC: One to two members from each VHSNC under the block should be invited for a quarterly meeting with the block officials and get their voices heard.
- Immediate orientation of VHSNCs on a large scale.
- Increasing number of members of VHSNCs and community consultation for appointing new members instead of ANM's discretion.
- Encouraging NGO participation in VHSNC even from outside the village.
- Arranging compulsory meetings with the Panchayat.
- Feedback from every village and SHC for funds required for the next year.
- Reintroducing community based monitoring.

Regarding MIS and Grievance Redressal:

- Bringing PCTS, ECTS under public domain to increase accountability and keep a check on fraudulent entries.
- To include inspection/monitoring records in the MIS under public domain.
- To include performance tracking related data in the MIS under public domain.
- To form a grievance redressal cell at the block level under the BPMU and to clearly lay down the issues to be handled at the block level and district level.
- To provide adequate publicity to the cells under DPMU and BPMU.
- Discussion of grievances to be a compulsory agenda of DHS meetings.

Other recommendations

- Free transport for sterilization cases should be provided.
- Incentives for sterilization should be increased and be more than that of the incentives under JSY.
- Fund pooling at a single platform in the village. Funds from different departments for the same purpose should be pooled and channelized.
- A programme should be developed for integration of drinking water and sanitation with health.

1. Introduction

1.1 Background of National Rural Health Mission (NRHM):

Prior to the launch of NRHM, many health policies like the National Population Policy, 2000 and the National Health Policy, 2002 governed the health issues of the nation. The Millennium Development Goals (MDGs) also served as an aim to achieve health targets.

The following MDGs were used as health targets:

Millennium Development Goal no. 4) Reduce Child Mortality

Millennium Development Goal no. 5) Improve Maternal Health

The National Population policy 2000 [1], focused on many aspects including reducing infant mortality rate to below 30 per 1000 live births, reducing maternal mortality ratio to below 100 per 100,000 live births, disease control and immunization.

The National Health Policy 2002 [2] set out to increase access to the decentralized public health system by establishing new infrastructure in deficient areas and by upgrading the infrastructure in the existing institutions. It aimed at improving the public health delivery system.

The health policies in place after 2002 were not able to achieve their goals and were widely considered a failure. The need and importance of a successful health policy was strongly felt and NRHM was launched in April 2005 by UPA-I government with a goal to "*Provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance.*"

The objectives of NRHM are:

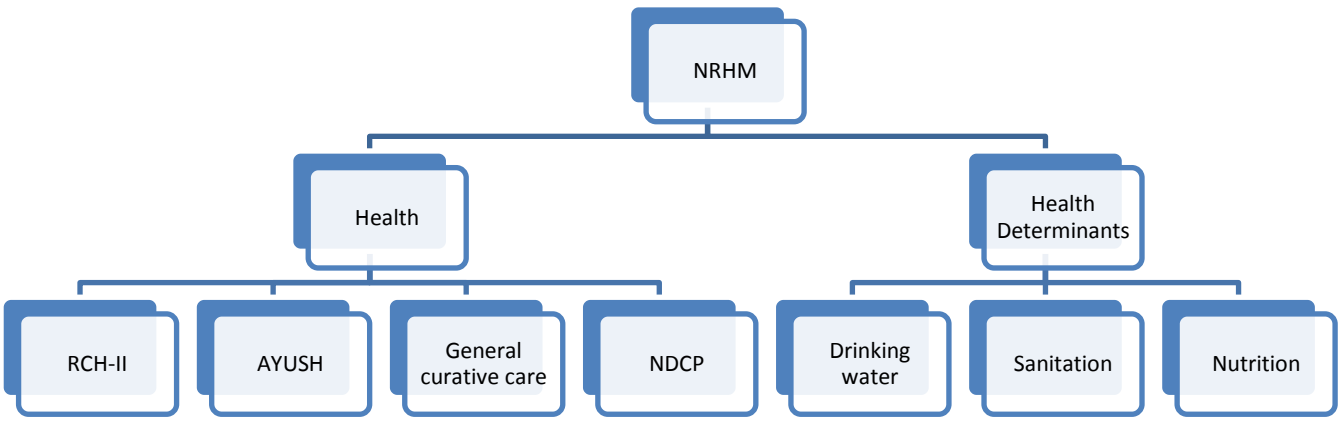
1) Reduction in IMR & MMR.
2) Universal access to public services for food and nutrition, sanitation and hygiene and Universal access to public health care services with emphasis on services addressing women's and children's health and universal Immunization.
3) Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.

4) Access to integrated comprehensive primary health care.
5) Population stabilization, gender and demographic balance.
6) Revitalize local health traditions and mainstream AYUSH.
7) Promotion of healthy life style.

- NRHM covers the entire country with an emphasis on 18 high-focus states Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Orissa, Uttaranchal, Jharkhand, Chhattisgarh, Assam, Sikkim, Arunachal Pradesh, Manipur, Meghalaya, Tripura, Nagaland, Mizoram Himachal Pradesh and Jammu & Kashmir.

- **Omnibus, umbrella approach** of NRHM– subsumes all health programmes such as RCH II, Disease Control Programmes, NRHM initiatives, Disease Surveillance Projects, etc.
- NRHM emphasizes on **decentralization, intra & inter-sectoral convergence and community ownership.**
- Proposes broad policy guidelines with **flexibility** to each state to draw their action plans to attain NRHM goals.
- Follows **outcome based budgeting** approach.

- NRHM uses the umbrella approach which is depicted by the following:



What is new in NRHM?

1) Decentralised Planning : Planning has been decentralised to the district level. Even village level planning is been focused upon.
2) Preparation of District Plans: As a part of the planning process, the district health plans are given prime importance and followed and reviewed by the state.
3) Community ownership of Health Delivery Systems: Community ownership is a key agenda of NRHM which focuses on the local community to own and operate the health systems. Facility based committees and village based committees including the ASHAs are a part of the community based ownership.
4) Inter-sectoral convergence: Intersectoral convergence between health, women and child development and drinking water has been aimed for in NRHM for

effective use of resources and horizontal cooperation between the relevant departments.

The organizational framework adopted in NRHM is given below:

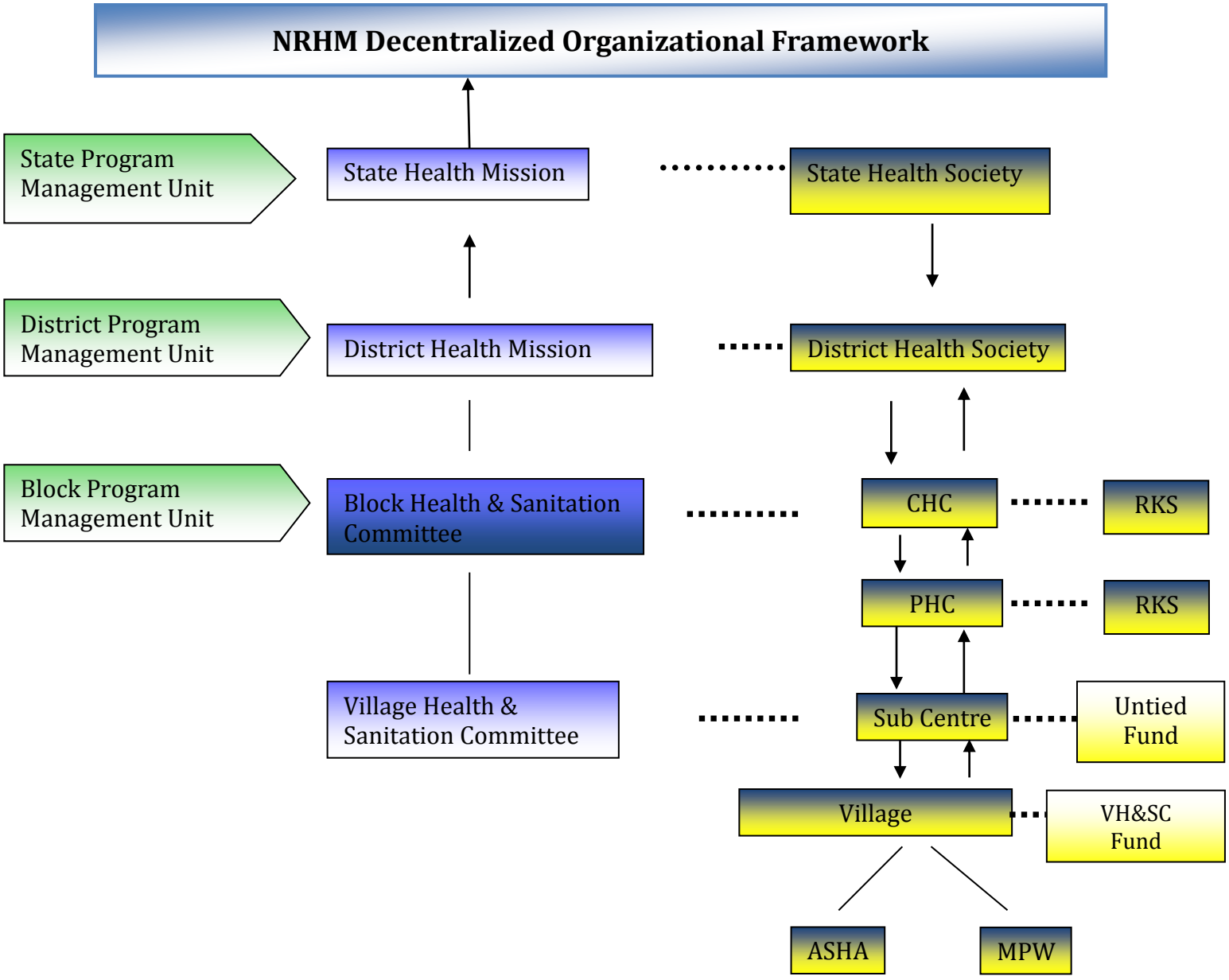


Figure 1: Decentralisation of NRHM || Source – Govt of Rajasthan Presentation on NRHM

The core strategies of the Mission are:

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through better human resource development, clear quality standards, better community support and an untied fund to enable local planning and action and more Multi-Purpose Workers (MPWs).
- Strengthening existing (PHCs) through better staffing and human resource development policy, clear quality standards, better community support and an untied fund to enable the local management committee to achieve these standards.
- Provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard. (IPHS defining personnel, equipment and management standards, its decentralized administration by a hospital management committee and the provision of adequate funds and powers to enable these committees to reach desired levels)
- Preparation and implementation of an inter sector District Health Plan prepared by the District Health Mission, including drinking water, sanitation, hygiene and nutrition.
- Integrating vertical Health and Family Welfare programmes at National, State, District and Block levels.
- Technical support to National, State and District Health Mission, for public health management
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of human resource for health.
- Developing capacities for preventive health care at all levels for promoting healthy life style, reduction in consumption of tobacco and alcohol, etc.
- Promoting non-profit sector particularly in underserved areas.

The supplementary strategies of the mission are

- Regulation for Private sector including the informal Rural Medical Practitioners (RMP) to ensure availability of quality service to citizens at reasonable cost.

Source – Framework of Implementation of National Rural Health Mission

- Promotion of public private partnerships for achieving public health goals.

- Mainstreaming AYUSH – revitalizing local health traditions.
- Reorienting medical education to support rural health issues including regulation of medical care and medical ethics.
- Effective and visible risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

The key components of NRHM are:

- Strengthening of systems: Mobile Medical Units (ambulances), infrastructure and HR.
- Schemes: Prominent schemes like Janani Suraksha Yojana, Janani Shishu Suraksha Karyakram, Weekly Iron Folic acid Supplementary schemes, etc.
- Community involvement: By creating committees such as Rogi Kalyan Samitis and Village Health & Sanitation Committees.
- Management Information Systems: To collect data and coordinate.

1.2 Goals and Objectives of Project

The goals and objectives of this project are:

- To analyse the current situation of NRHM in rural regions in India.
- To study on whether NRHM is able to provide "accessible, affordable and quality" healthcare.
- To find out the loopholes in its delivery mechanism and suggest better ways for implementation.

Source – Framework of Implementation of National Rural Health Mission

2. Methodology

The methodology for this research project has been in the following order:

- Literature Review
- Field visits and interviews
- Key findings
- Gap Analysis
- Recommendations

2.1 Literature Search

The literature review of this project has mainly been through evaluation reports and case studies of NRHM and its associated programmes and schemes.

2.1.1 Did NRHM achieve its targets in Maternal and Child Health?

NRHM had the following targets by the end of 2012[3]:
- Reducing Infant Mortality Rate (IMR) to 28 per 1,000 live births
- Reducing Maternal Mortality Ratio (MMR) to 100 per 1,00,000 live births
- Reducing Total Fertility Rate (TFR) to 2.1

The latest data collected (pertaining to Rajasthan) shows that

- The IMR stands at 63 per 1000 live births [5]
- The MMR stands at 264 per 1000 live births[6]
- The TFR stands at 3.1[7]

Present Status of Reproductive Child Health (RCH) Indicators

Table 2

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

Table 1: Present status of RCH indicators – Source: Annual Household Survey 2010 and 6th CRM

The AHS 2011 survey states that the MMR in Rajasthan declined by 67 points, which is highest among the nine states surveyed. This is a positive sign as state's MMR is usually above the national average.

In 2011-2012, the MMR in the state reduced to 264 per 100,000 live births. It was 331 per 100,000 live births in 2010-11. [6]

This also shows that NRHM has to go a long way in achieving its targets.

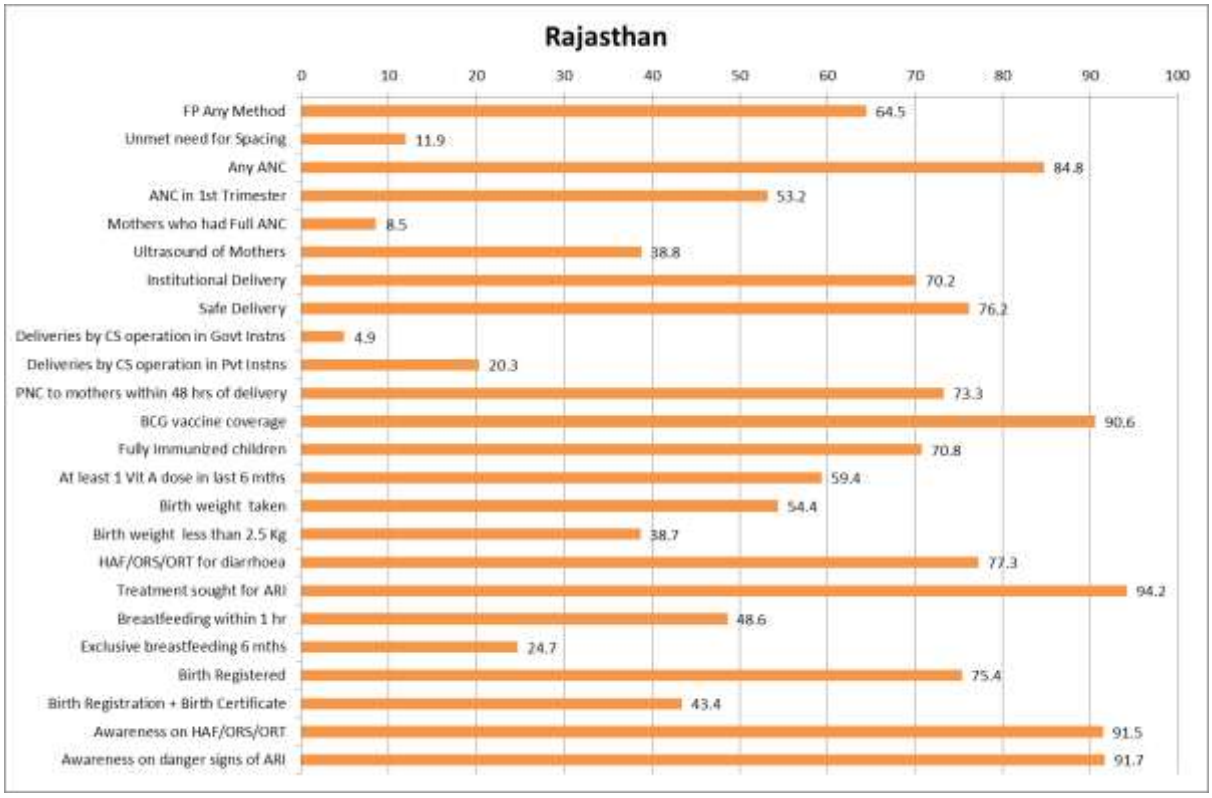


Figure2: Graph showing Comparison along continuum of care in Rajasthan – AHS 2010

This graph shows the extent of continuum care in Rajasthan. This shows that mothers who had full ANC are a minor fraction. Also, it shows that there is a large unmet need for spacing methods.

Let us look at some of the innovations by the state of Rajasthan in healthcare[4]:

1) **Yashoda Scheme [4]**

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

paid a performance linked incentive; acts as a catalyst and supports the nursing staff.

2) **Dhanwantri Comprehensive Emergency Response Services**

To provide comprehensive emergency response (health, police, fire) services to the people of Rajasthan the Dhanwantri Scheme was launched in 2008 on the lines of the EMRI 108 in Andhra Pradesh.

3) **Mobile Medical Unit (MMU)**

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

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

Key strategies of MMU:

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

4) **Malnutrition Treatment Centres**

In December 2000, the Rajasthan Department of Women and Child Development, and UNICEF jointly initiated Anchal Se Angan Tak (ASAT) strategy as a community based care model in seven districts. Under ASAT, Special Plan of Action for Management of Severe Child Malnutrition was initiated in 2005 in 14 blocks of seven districts using WHO standards based on a two pronged strategy viz. Hospital Based and Community based care of malnutrition.

Source – 6th Common Review Mission Report on Rajasthan

The Department of Medical and Health Services, Department of Women and Child Development, Government of Rajasthan, and UNICEF took the lead in addressing acute undernourishment in children, by operationalizing Malnutrition Treatment Centres (MCTs) as a pilot initiative in 2005. [4]

Malnutrition treatment centre (MTC) is a unit for the management of SAM children where they are kept under observation and provided with medical and nutritional care. The MTC first checks the children's height, weight and appetite and shortlist those in need of treatment. The children will then have to undergo a diet therapy, drug therapy and investigation. Thereafter, s/he will be admitted, along with the mother, at the MTC. The treatment process will take 15-20 days to complete depending on the severity of malnutrition. Not only the MTCs, ASHA and Aanganwadi workers in the district are equipped with a special measuring tape to measure the arms of a child to judge whether s/he needs help. [4]

Table 3

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

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

Table 2: Other health indicators – Source – 6th CRM

This table shows the ANC has to be focused on. Also, breastfeeding and sanitation should be emphasized on. Unmet demand for contraceptives is also reflected.

2.1.2 Implementation of JSY and JSSK:

The Institutional deliveries in the State have improved during the NRHM period. The institutional deliveries have increased from 24.5 % in 2005 -06 to 70.4 % in 2010-11 and there is a corresponding decline in maternal mortality.[4]

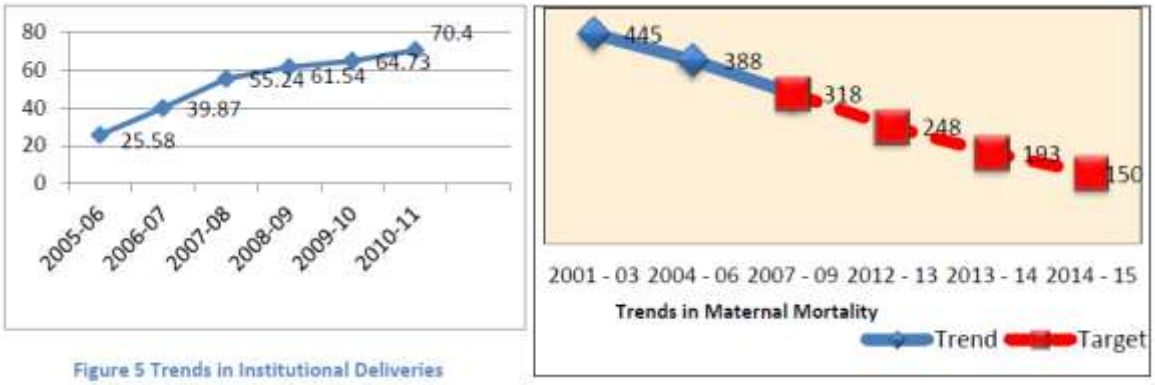


Figure 3: Trends in institutional Deliveries – Source – 6th CRM

This graph shows that institutional deliveries have increased since the onset of NRHM/RCH-II and MMR has shown a positive trend.

The number of OPD and IPD across CRMs have increased from 24650705 to 37761207 (upto Oct 2012) and from 1209720 to 1903994 respectively, indicating greater utilization of health facilities across CRMs.[4]

Referral Transport and the number of emergency cases have increased from 4593 to 597505 and from 42343 to 79536 respectively indicating the improvement in reach and accessibility to services in case of need. [4]

Despite the increase in institutional deliveries, the study finds persistence of home deliveries, which was about 40% in most districts studied, with a wide range- from 7.7% to almost 63%. Women who deliver at home had higher proportions of SC/ST and non-literate or primary school drop outs. The JSY excludes a significant proportion of women by virtue of the criteria, and these women who are excluded are those under 19 years, multiparous, poor women, often with no access to a BPL card, all of whom are at higher risk of maternal and perinatal outcomes, the first two directly and the third as a proximate determinant. Many of these women are not counted even in the HMIS, although their infants are recorded as receiving BCG vaccination.[8]

The State has a long way to go before it achieves the goals set forth.

2.1.3 Infrastructure and Manpower

2.1.3.1 Human Resource

Though there is a dearth of doctors and specialists, there has been an increase in the recruitment of doctors and specialists during the NRHM period. The number of Specialists have increased from 1089 to 1602 (Surgeons from 488 to 635; O & G from 271 to 402 from 2nd to 6th CRM; Anesthetist's from 82 to 231; Pediatricians from 192 to 332), however the number of specialists on contractual has decreased from 37 to 29 from 2nd to 6th CRM. The number of Medical Officers have increased across CRMs, from 3739 to 4933; ANM (regular) from 12122 to 14222 and ANM (contractual) from 1321 to 3163, however the number of AYUSH Doctors have decreased from 1092 to 917 from 2nd to 6th CRM. [4]

The number of pharmacists have increased from 15 to 1336, Lab Technicians from 2079 to 2303, Nurse Grade II from 10565 to 11112, however Nurse Grade I decreased from 1979 to 1782 from 2nd to 6th CRM.[4]

The number of ASHAs has increased from 42496 to 51500 from 2nd to 6th CRM.

The total strength of staff for SPMU across CRMs has increased from 10 to 20 and the number of DPMU has increased from 129 to 268 and that for BPMU from 1539 to 3280 from 2nd to 6th CRM. [4]

However there are vacancies at district and block level management positions.

HR Policy should include non-monetary incentives - **non-monetary incentives** for example posting in better districts after serving for a certain period of time in difficult districts, preference /reservation quota in academic and professional institutions for children whose parents have served for long in HFD, letters of appreciation, additional weightage for each year spent in HFD district during promotion , special quota in post graduate studies for young doctors willing to serve in difficult areas are some of the suggestions that must be given due consideration.[4]

2.1.3.2 Training

Training has been generally weak across CRMs. Training status is very poor in the State. The aggregate figures for training in Phase 1 of NRHM for SBA are 7 %; BEmOC 25 % and LSAS is 31 %. [4]

The only good progress is the implementation of IMNCI training in all the 33 districts.

Training of ASHA for module 5 is 67.61 % complete. ASHAs are escorting pregnant women to facility for Institutional deliveries. [9]

Training of module 6 & 7 has been completed only for 46 % of ASHAs.[9]

According to a review of the ASHA programme, staff at delivery points appeared to have been trained in SBA, field staff was generally familiar with ANC and other outreach based MCHN services such as immunization (but not HBNC).[9]

There exist no MPHW training schools in the State.[8]

2.1.3.3 Infrastructure

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

As of now the State has the following health facilities in place. [4]
(i) 108 FRUs (including DH),
(ii) 382 CHCs, 1528 PHCs,
(iii) 37 UHCs, 11487 SCs,
(iv) 196 dispensaries/ health posts,
(v) 13 City aid posts and
(vi) 118 Mother and Child welfare centres.

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

If the Rural Health Infrastructure norm of coverage of population is taken (population covered by each health centres) for the state, it is observed that the coverage by population (4487 for the State) is well within the national average (5624) for Sub Centres, Primary Health Centres (33975 for the State to national average 34876) and Community Health Centres (1, 37,075 for the State to national average of 1, 73,235). [4]

2.1.3.4 Coverage of Health centres

It is seen that in Rajasthan, the area covered by a Sub Centre (29.32 Sq. Km to national average of 21.05 Sq. Km) - the distance covered is much more; Similarly for the Primary Health Centre (222.02 Sq. Km to national average of 130.54 Sq. Km) – the distance covered is much more and the same is the case for the Community Health Centre (895.77 Sq. Km to national average of 648.43 Sq. Km). The area covered by each health centre is much larger than the National Average leading to a need for reassessing the area covered by health facilities norm for Rajasthan; otherwise the accessibility issue will always remain.[4]
Health centres labelled as 24×7, generally provide facilities only for deliveries.[3]
People spend large amounts of money on travelling long distances to access basic health services.[3] Though MMUs are becoming operational, their number and outreach is limited.[3] Local Rural Medical Practitioners (RMPs), who are available round the clock close to peoples' homes, continue to provide their services as usual. [3]

2.1.3.5 Diagnostic services [4]

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

2.1.4 Community involvement

The ASHA programme and formation of VH&SCs were seen as major steps towards community involvement and empowerment.

2.1.4.1 Profile of ASHA

In Rajasthan, ASHAs were found to be mostly young and literate. [9]
Number of ASHAs coming from poor households and the proportion of ASHAs who are SC or ST is equal to or more than the proportion of the SC/ST population in most states. [9]
In the CRM, of those who stated that there were marginalised sections in that area, a significant percentage also said that it was difficult for ASHAs to access these marginalised households- whether due to distance or due to social barriers.
Marginalised communities were defined for the purpose of this evaluation as – SC/ST households, hamlets, houses of migrants, economically backward, households with disabled women, women headed households having a problem with access/utilisation of services. [9]

'Why did you become an ASHA?' – this question was asked to ASHAs during the evaluations. It turned out that serving the community, financial aspect and a govt. job were the key driving factors. [9]
It was also seen that the selection process has been biased- based on ANM or the Panchayat head. [9]

2.1.4.2 Role of ASHA

ASHA's role as an activist is very limited.

ASHA's four major activities: [9]
a) Home visits: Especially for those homes with a pregnant woman or a newborn or a child below two years or a malnourished child or a child below five who is sick.
b) Attending the immunisation session or Village Health and Nutrition Day (VHND).
c) Periodic and regular visits to a health facility for training, for programme review or for escorting a woman for delivery, or a sick child.

d) Holding village level meetings.

Dimension of activism is missing in the present ASHA system. [9] The activist component should be understood primarily as reaching out to marginalised sections with a greater effort, and ensuring that people are mobilised at the village level to utilise services and undertake collective action needed to safeguard health, including access to health related entitlements.

2.1.4.3 Efficacy of ASHAs

Even in the best of situations, even for care in pregnancy which is one of the most emphasised aspects of the whole programme, upto 11% of potential users are being missed by the ASHA. [9]

76% of pregnant women were met by the ASHA and of these 93% opted for institutional delivery, but DLHS III home delivery figures are in the range of 50% indicating that all the 24% who were not met even once by ASHA during their pregnancy were all those who opted for home delivery. In Rajasthan, 56% of pregnant women who opted for institutional delivery named ASHA as the motivator. [9]

A high skill level will not result in better services if the supply side is not in place (For example, non-availability of the ANC card or IFA tablets). [9]
However a high skill level and an adequate supply side will not lead to better outcomes if the ASHA is not functional in this area.

It was widely observed that counselling for family planning services is low in all high focus states. [9]

It is observed that ASHAs have high knowledge about nutrition - The higher knowledge and functionality on nutrition in Rajasthan is accounted for by the fact that the ASHA were part of the ICDS system, and probably had been trained with more rigour in nutrition topics. [9]

2.1.4.4 Incentives to ASHA

After convergence with ICDS, ASHA sahyoginis (as they are so called in Rajasthan) are paid an honorarium of Rs. 1100 from Women and Child Development Department. [4]
The ASHAs are able to manage an income ranging between 1500 and 2500; thanks to the monthly honorarium of 1100. To insure the regular payment of ASHA state planned to integrate all ASHA incentives for paying in monthly meetings of PHC level. For Motivation of ASHAs, state planned to give award to three best ASHAs in every district on the lines of ANM based on their performance indicators. [4]

2.1.4.5 ASHA support system and monitoring

To monitor the work of ASHA the State has implemented the performance monitoring tool. ASHA has a support system right from the sector level to the national level.

Almost 60% of the Block Health Supervisor (earlier called Block ASHA supervisor) and 27% of PHC Health Supervisor posts are lying vacant. [4]

Monthly review meetings of District ASHA co coordinator are organized at state level. Many instances of District ASHA co coordinator being given the additional charge of DPM were observed hampering the programme implementation. [4]

Acute shortage of Master Trainers exists and most of them have other administrative duties as most of them are district level officers.
Almost all the ASHA trained till module 5 have received training in IMNCI. No career path has been designed for ASHA.

2.1.4.6 Village Health & Sanitation Committee

The VHSC is constituted at revenue village level. Two VHSCs are formed in Villages with more than 3500 population with total number of VHSCs in the state being 43437. Ward Panch/(Sarpanch in some places) is the president & ASHA is the Convener. Funds are kept in Sub Centre's untied funds account and Sarpanch and ANM are joint signatories. 7 members of each VHSC were trained. [10]Village Health Planning and Community Needs Analysis are being done. [10] ASHAs are coordinating the VHSNCs. However attendance of ASHA in meeting is very poor. [4]
State has made significant efforts to bring about the convergence between the health and health related sectors, like sanitation and drinking water etc. [4]

Use of indigenous low-cost technology, for example, water purifiers based on the Ganiyari model in Bilaspur, could be encouraged to kick-start health and sanitation interventions in an affordable way in the remotest areas. [3]
Observance of VHNDs, joint micro planning at the sub centre level (for immunisation, health checkups) are found to be effective in bringing functionaries of two departments (health & ICDS) together in addressing common issues. [4]

Field assessment of functioning of VHSNCs through NGO support is required.
NGOs can take up exercise of gradation of functional VHSNCs based on certain criteria such as Monthly meetings, Village Health Plan Status, Activities implemented, record maintenance, health bulletins and statement of expenditure submission. [4]

Table 1A: Findings on VHSC from ASHA Evaluation in eight states					
	% of ASHAs who reported functional VHSC	% of ASHAs who reported a functional VHSC and VHSCs providing support in promotion of institutional deliveries	% of ASHAs who reported a functional VHSC and VHSCs providing support in promotion of immunization	% of ASHAs who reported a functional VHSC and VHSCs providing support in Health awareness campaigns	% of ASHAs who reported a functional VHSC and VHSCs providing support in eliminating water clogging to prevent vector borne
Andhra Pradesh	58.5	65	79.5	65	45.3
Assam	93.5	55.6	67.9	50.8	16.6
Jharkhand	84.3	45.8	51.8	38	42.2
Kerala	97	27.8	53.6	71.6	82.5
Orissa	82.5	52.7	58.2	67.9	59.4
Rajasthan	77	48.1	64.3	39	44.8

Table 3: Findings on VHSC[10]

This table reflects the dismal situation of VHSCs in Rajasthan in terms of VHSCs providing support for institutional deliveries, promotion of immunization, health awareness campaigns and sanitation problems.

2.1.4.7 Community based monitoring

The Community Monitoring process was carried out in 180 villages, 36 PHCs and 12 blocks. In the first phase of monitoring, four districts were chosen, Alwar, Chittorgarh, Jodhpur and Udaipur in Rajasthan (National Report on Community Monitoring, NHSRC 2009). [4]

After the first round of monitoring it was observed that there was a significant improvement in health services delivered in all the four districts. However after the first phase of implementation this community monitoring was discontinued. [4]

The process of community monitoring should be reintroduced and scaled up to the entire state.

2.1.5 MIS, grievance redressal

No proper and functional Grievance redressal mechanism in place. There is a provision for a grievance redressal cell to be set up under DPMU in the implementation framework of NRHM primarily to address grievances related to delay in payments of incentives under JSY.

A Health Management Information System is in place in Rajasthan which has PCTS and ECTS under it.

2.1.6 National Health Mission (NHM) [3][11]:

A proposal of NHM encompassing NRHM and NUHM is being acted upon.

The midterm appraisal of 11th Five Year Plan suggested that models should be evaluated and developed for delivery of urban healthcare, especially focusing on

establishing an efficient primary health system and providing adequate coverage to the urban poor. Since rural and urban healthcare converges at the secondary and tertiary levels, and both are part of the same supervisory and management structure at the state government level, the ministry could contemplate establishing an Integrated National Health Mission.
Also, a new strategy "RMNCH +A" is being formulated for the high focus districts in which more funds are pumped, more ASHAs are appointed and newborn care is being prioritized.

2.2 Scope of the project

The scope of this project is broadly divided into four components:

1) Target of NRHM in Maternal and Child Health – Reduce MMR and IMR through the implementation of JSY and JSSK.
2) Infrastructure and human resource to provide the services.
3) Community involvement and ownership.
4) Use of MIS and Grievance Redressal Mechanism.

2.3 Field Visits, Surveys and Interviews

Interactions with mentor:

- Discussions on doing a literature review.
- Discussion on filing an RTI application.
- Discussion on narrowing down the scope of the project and setting up goals of the project
- Discussions on conducting field visit.
- Discussions on findings from field visit and literature review.
- Discussions on suggested recommendations.

Refer Appendix for more details.

Interviews with others:

Date	Name	Designation	Institution	Topic of Discussion
12-06-2013	Mr. Kailash	Store Incharge	CHC Nainwa	CHC operations
12-06-2013	-	ANM	CHC Nainwa	CHC operations
12-06-2013	Mr. Meena	RCHO, Bundi		RCH-II
13-06-2013	-	ANM	PHC Dugari	General
13-06-2013	-	ASHA	PHC Dugari	General
13-06-2013	-	ANM	PHC Baasi	General
13-06-2013	-	ASHA	PHC Baasi	General
13-06-2013	-	BCMO, Nainwa	CHC Nainwa	General
13-06-2013	-	MO Incharge	Dugari	General
13-06-2013	-	MO Incharge	Baasi	General
14-06-2013	-	BPM	Nainwa	General

Refer Appendix the below section for details

Details of field visit:

Block level meeting at CHC Nainwa

During the field visit to Nainwa Block of Bundi district of Rajasthan, the monthly Block level meeting of the health workers was held at CHC Nainwa. This meeting was attended by ANMs and Male nurses presided over by the BPM, BCMO, Asst. Statistical Officer, Bundi Distt., RCHO, Bundi Distt. and Medical officers of Nainwa Block.

The meeting served as an official method of communication between the district authorities and the block authorities as well as the ANMs and GNMs. Various points relating to general health and health programmes were discussed. Some of the key points that were discussed are:

1) Mukhyamantri Shubh Dhanlakshmi Yojana – A flagship programme by the Health Department of Govt. of Rajasthan which ensures incentives to parents on the birth of a girl child.
2) Problems regarding data entry by the ANMs and MOs – There was an evident misunderstanding between the block program management unit and the people responsible for data entry regarding data entry procedures. This was one of the causes of wrong data entry.
3) A reminder by district officials to ANMs to enter correct numbers in the registers. ANMs tend to write incorrect numbers in the register so as to get close to the target number assigned.
4) A brief discussion over the immunization status of the block and some villages under it and what steps to be taken to ensure the increment of % immunized.
5) A special Immunization week to cover up left over kids.
6) Emphasis on maintaining cold chain for the vaccines.
7) A discussion over the formats of registers, reports, stock registers.
8) Booster doses of TT injections to school children and DPT 2nd booster
9) An Arm band to be tied around a child's arm to identify malnourished children. This was to be used by the ANMs in the VHNDs.
10) Introduction of RMNCH + A – new strategy for the implementation of second phase of NRHM. It was informed that Bundi district has come under the list of high-priority districts and so RMNCH +A was being implemented. Targets of RMNCH+A were also discussed. Highlights of RMNCH +A were described to be 30% more funds and population criteria for ASHAs relaxation.
11) Weekly Iron & Folic acid Supplementary scheme (WIFS) for adolescents to be started under RMNCH +A.
12) It was informed that a new facility based monitoring mechanism is being developed by a new facility based committee.
13) Emphasis on every facility to have an NBCC (New Born Care Corner) was discussed.
14) The objectives and indicators of Annual Health Survey were discussed and brushed upon –

- Maternal Health – MMR, Safe Delivery
- Child Health – IMR, Immunization %
- Family Planning – TFR, CPR (Couple Protection Rate)

15) Objectives and indicators of Non-Annual Health Survey were discussed upon -

- Maternal Health – Safe Delivery, 3 ANCs
- Child Health – Breast Feeding
- Family Planning – No. of children > 3 not acceptable

16) Suggestions by ANMs on disease control were taken. This was the only interactive discussion in the meeting.

Inferences out of the Block Meeting :

1) The block level meeting was attended by only the health officials and no one from the community.
2) There exist communication gaps and misunderstandings relating to data entry.
3) Some manipulation exists to show better results and meet targets.
4) No. of cases of "*Nasbandi"* (or sterilization) was treated as an important indicator.

Discussion with an ANM during the block meeting:

The intern also had a brief discussion with one of the ANMs during the block meeting. She gave an insight into the situation at the SHCs.
Some inferences out of the discussion:

1) Sub-centers (SHCs) are not operational to the extent they should be. They are mostly operational for a very few hours in the morning.
2) Some SHCs lack basic facilities like water supply. Power cut is a common problem everywhere.
3) ANMs face difficulty in mobility. They have to cover large areas and find it very inconvenient.
4) ANMs are alone in SHCs. So, ANMs don't prefer posting in a SHC.
5) Lack of sweepers in SHCs. So the ANM has to do everything by herself.
6) Medicines are available for normal delivery and first aid in SHCs. So only first-aid and normal delivery facilities available in SHCs.
7) Immunization problems – the ANM tells that the villagers are very non-cooperative in getting the kids immunized.
8) The ANM insists that posting of the ANM should be only in the locality where she belongs.

Field visit to CHC Nainwa

The intern visited Community Health Centre, Nainwa, and looked at the health facilities being offered. Interviews were carried out with the store incharge and an

ANM present there. It was hard to find the MOs and approach them for interviews.

The questionnaire is attached in the appendix.

Inferences out of the interview with the store incharge and ANM at CHC Nainwa:

1) Regarding ANC checkups: ANC checkups mostly happen at VHNDs. If there is any problem, the woman comes to PHC/CHC.
2) Regarding obstetric services offered: Due to non-availability of doctors with specializations, only normal deliveries happen at the CHC. C-section is not done at the hospital.
3) Regarding nearest referral centre: In case of pregnancy related complication and/or C-section, the patient is referred all the way up to the District Hospital in Bundi.
4) Regarding drug store: The general availability of drugs is good and no problem is faced w.r.t. shortage of drug supply. Even if there is a shortage, they have enough funds to buy drugs from the market. A comprehensive database (named "e-Aushadhi") of drugs is maintained at the hospital. First-in-first out system of drugs supply is followed. A computer operator does the job of a pharmacist due to shortage of staff.
5) Regarding JSY & JSSK benefits: Cash incentives are being handed out as cheques in time and free transport and food are given to the beneficiaries. No problems are experienced in this aspect. Benefits are handed out to deliveries at a place other than the place of residence. However, cross-state delivery is ambiguous.
6) Regarding infrastructure: There was no awareness of Indian Public Health Standards (IPHS). Equipment problems were not prominent in the CHC. However, the staff says that other CHCs have a lot of equipment problems.
7) Regarding functioning as a First Referral Unit (FRU): CHC Nainwa does not function as an FRU as there is no functional blood facility and no team of doctors to perform emergency obstetric services.
8) Regarding shortage of manpower: HR problem was clearly evident. There was shortage of doctors with specializations, shortage of lab technicians, shortage of pharmacists and other workers.
9) Regarding ambulance services: There is a provision of one 104 ambulance and one 108 ambulance. The 108 ambulance was non-functional.
10) Regarding Rogi Kalyan Samiti (RKS): Untied funds, JSY funds and Annual Maintenance Grants given to the RKS a.k.a. RMRS are adequate. The RMRS has the flexibility to decide the expenditure out of these funds. No problems are experienced in this aspect.

Field visit to Maanpura and Bhandeda villages

Interaction with ASHAs

The intern visited the VHNDs happening at Maanpura and Bhandeda villages falling under Nainwa block. The objective was to interview ASHAs, ANMs and the

women coming to the VHNDs. The questionnaire for ASHAs is attached in the appendix.

Inferences out of the interviews with ASHAs at Maanpura and Bhandeda villages:

1) Regarding ANC: ASHA tracks down the pregnant women and bring them for ANC checkup to the VHNDs at the Aanganwadis. If there a problem arises, the woman goes to the nearest health centre and ASHA accompanies her if required. ASHA insists for 3 ANC checkups. TT injections, IFA tablets, etc. are given in the ANC checkup at VHND. ASHAs complain that sometimes it gets difficult to persuade the women to come for VHND.
2) Regarding institutional deliveries: No deliveries happen at home nowadays. Almost all deliveries happen at the health centers and ASHA counsels them for the same.
3) Regarding escorting a woman for delivery: ASHAs allege that sometimes the family members don't inform them about the delivery and so ASHA has to go alone later to the health centre to collect her incentive. This results in out-of-pocket expenses incurred by ASHAs for transport charges and also non-payment of incentives in some cases. This also shows the communication gap between ASHAs and the people. Ambulances like 104 and 108 are used for the purpose of transport and are said to be prompt. If the ambulances don't arrive, they hire private vehicles and the rent is paid by the health centre.
4) Regarding delays in cash payments: There is often delay in getting ASHA's package. This is a prime reason for demotivation of ASHAs.
5) Regarding role in VHSNCs: ASHA is a permanent member of VHSNC. Based on the discussion held with the ASHAs, the intern inferred that ASHAs don't have much say in the decisions taken by the VHSNC a.k.a. Village Health Committee a.k.a. Gram Swasthya Samiti.
6) Regarding ASHA's kit: ASHAs have a good kit comprising of oral pills, condoms, ORS sachets, paracetamol and other basic medicines. This refilled from time-to-time at the PHC.
7) Regarding out-of-pocket expenses of ASHAs: ASHAs end up spending for transport during visit to the hospital for sterilization cases.
8) Regarding satisfaction levels of ASHAs: Out of pocket expense was a major cause of dissatisfaction. ASHAs also look up to ANMs and desire permanent salaries but this is contrary to the whole concept of ASHAs.
9) Regarding counseling services provided by ASHAs: It was observed that ASHAs don't provide counseling on VHNDs which is a major drawback. This reflects the poor counseling services provided by the ASHAs or ANMs.
10) Other inferences: It was observed that ASHAs don't give importance to spacing methods as they get no incentive on it. Also, there was no evidence of wall posters or paintings which depicted good health practices at the Aanganwadis.

Figure 4: VHND at Aanganwadi of Maanpura village, Bundi district, Rajasthan.

Figure 5: Multi-Purpose Worker, ASHA and ANM at Maanpura on VHND

Figure 6: ANM and ASHA administering vaccines to a newborn

Field visit to PHC Dugari:

The intern visited the Primary Health Centre at Dugari which falls under Nainwa block. The purpose was to interview the MO at the PHC and also look at the health facilities being offered. ANM of PHC Dugari was interviewed in the VHND at Aanganwadi of Maanpura.

Inferences out of the interaction with the health officials at PHC Dugari:

1) Regarding ANC checkups: ANC checkups mostly happen at VHNDs. If there is any problem, the woman comes to PHC.
2) Regarding obstetric services offered: Due to non-availability of doctors with specializations, only normal deliveries happen at the PHC. C-section is not done at the hospital.
3) Regarding nearest referral centre: In case of pregnancy related complication and/or C-section, the patient is referred all the way up to the District Hospital in Bundi.
4) Regarding drug store: The general availability of drugs is good and no problem is faced w.r.t. shortage of drug supply. Even if there is a shortage, they have enough funds to buy drugs from the market. First-in-first-out system is followed w.r.t. drugs.

5) Regarding JSY & JSSK benefits: Cash incentives are being handed out as cheques in time and free transport and food are given to the beneficiaries. No problems are experienced in this aspect.
6) Regarding infrastructure: There was no awareness of Indian Public Health Standards (IPHS). There was no lab facility. There was a temporary arrangement of lab testing in the labour room. Inspite of the govt. sanctioning funds for Radiant warmers, no radiant warmers were seen.
7) Regarding shortage of manpower: HR problem was clearly evident. There was shortage of doctors with specializations, shortage of lab technicians, shortage of pharmacists and other workers. Posts of accountant, pharmacist and supervisor were vacant. The PHC operates with nearly 50% of the required staff.
8) Regarding ambulance services: There is one 108 ambulance functional in the area of the PHC.
9) Regarding Rogi Kalyan Samiti (RKS): Untied funds, JSY funds and Annual Maintenance Grants given to the RKS a.k.a. RMRS are adequate. The RMRS has the flexibility to decide the expenditure out of these funds. No problems are experienced in this aspect. However, the RKS did not spend the funds for sanitation purposes.

Figure 7: ASHA at Bhandeda village, Nainwa block, Bundi district, Rajasthan.

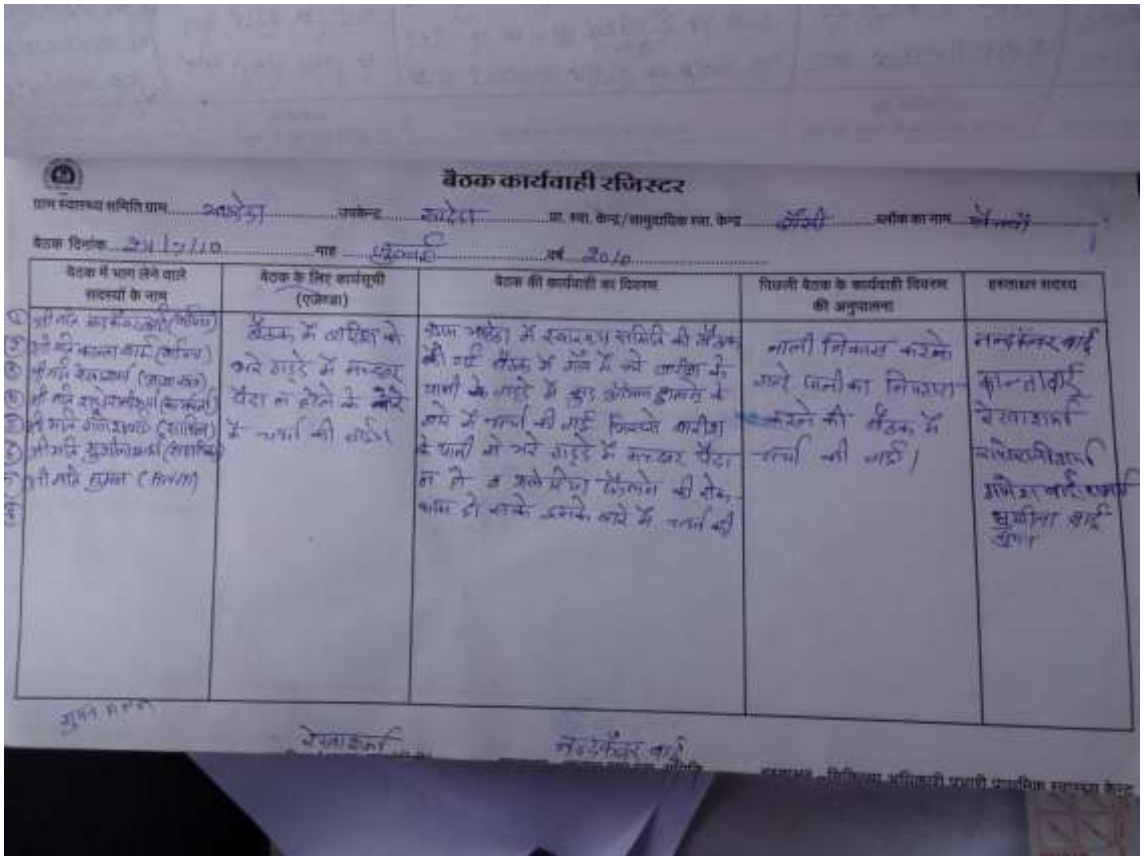


Figure 8: Register maintained by the VHSNC at Bhandeda village.

Field visit to PHC Basi:

The intern visited the Primary Health Centre at Basi which falls under Nainwa block. The purpose was to interview the MO at the PHC and also look at the health facilities being offered. ANM of PHC Basi was interviewed in the VHND at Aanganwadi of Bhandeda.

Inferences out of the interaction with the health officials at PHC Basi:

1) Regarding ANC checkups: ANC checkups mostly happen at VHNDs. If there is any problem, the woman comes to PHC.
2) Regarding obstetric services offered: Due to non-availability of doctors with specializations, only normal deliveries happen at the PHC. C-section is not done at the hospital.
3) Regarding nearest referral centre: In case of pregnancy related complication and/or C-section, the patient is referred all the way up to the District Hospital in Bundi.
4) Regarding drug store: The general availability of drugs is good and no problem is faced w.r.t. shortage of drug supply. Even if there is a shortage, they have enough funds to buy drugs from the market. First-in-first-out system is followed w.r.t. drugs.

5) Regarding JSY & JSSK benefits: Cash incentives are being handed out as cheques in time and free transport and food are given to the beneficiaries. No problems are experienced in this aspect.
6) Regarding infrastructure: There was no awareness of Indian Public Health Standards (IPHS). Inspite of the govt. sanctioning funds for Radiant warmers, no radiant warmers were seen. However, the basic infrastructure of this PHC was good. This, they said, was possible due to the untied funds given to the PHC.
7) Regarding shortage of manpower: HR problem was clearly evident. There was shortage of doctors with specializations, shortage of lab technicians, shortage of pharmacists and other workers. Post of pharmacist was vacant. The supervisor does the job of a computer operator. The govt. is about to send more staff for "Mukhyamantri Nishulk Dawa Yojana".
8) Regarding ambulance services: There is one 104 ambulance functional in the area of the PHC.
9) Regarding Rogi Kalyan Samiti (RKS): Untied funds, JSY funds and Annual Maintenance Grants given to the RKS a.k.a. RMRS are adequate. The RMRS has the flexibility to decide the expenditure out of these funds. No problems are experienced in this aspect. Funds were never utilized for betterment of drinking water situation.

Figure 9: PHC Basi, Nainwa block, Bundi district, Rajasthan.

Apart from this, the intern also analyzed the situation of the community/facility based committees. The details are included in the key findings of the report.

3 Results and Discussions

3.1 Findings from the literature

Findings from the literature are mostly based on the Common Review Mission Reports (CRM reports) and the critical evaluations on NRHM conducted by others.

3.1.1 Findings regarding implementation of JSY and JSSK

1) NRHM had the following targets by the end of 2012:
- Reducing Infant Mortality Rate (IMR) to 28 per 1,000 live births
- Reducing Maternal Mortality Ratio (MMR) to 100 per 1,00,000 live births
- Reducing Total Fertility Rate (TFR) to 2.1

The latest data collected (pertaining to Rajasthan) shows that

- The IMR stands at 63 per 1000 live births
- The MMR stands at 264 per 1000 live births
- The TFR stands at 3.1

2) The Institutional deliveries in the State have improved during the NRHM period. The institutional deliveries have increased from 24.5 % in 2005 -06 to 70.4 % in 2010-11 and there is a corresponding decline in maternal mortality. Despite the increase in institutional deliveries, the study finds persistence of home deliveries, which was about 40% in most districts studied, with a wide range- from 7.7% to almost 63%.

3.1.2 Findings regarding infrastructure and manpower

1) Though there is a dearth of doctors and specialists, there has been an increase in the recruitment of doctors and specialists during the NRHM period.
   During the NRHM period the State has concentrated in filling the critical gap in terms of recruitment and availability of health personnel in the health system. The State has increased the number of sanctioned posts for specialists from 1089 in 2007 to 1602, an increase of 513 sanctioned specialists' positions (47 % increase).[4] Human resource allocation (hiring, allocation, transfers) needs to be aligned with the actual existing requirements keeping in view the attrition due to retirement and transfers. Frequent changes in crucial management positions should take place.[4]
2) The number of pharmacists, Nurses and ASHAs have increased which is clearly indicated by the 6th CRM report on Rajasthan.
3) Training has been poor (apart from IMNCI training)[4]

4) Infrastructure has improved. Although the human resource required to utilize the infrastructure is a challenge.
As of now the State has the following health facilities in place. [4]

(i) 108 FRUs (including DH),

(ii) 382 CHCs, 1528 PHCs,

(iii) 37 UHCs, 11487 SCs,

(iv) 196 dispensaries/ health posts,

(v) 13 City aid posts and

(vi) 118 Mother and Child welfare centres.

Making the required human resources (doctors/nurses/ANMs/Lab Tech, etc.) available at these facilities is a concern that has to be addressed.

5) Poor coverage of health centres in Rajasthan.
The area covered by each health centre is much larger than the National Average. This clearly shows a need for reconsidering the area covered by health facilities norm for Rajasthan to address the accessibility issues. [4]
Health centres labelled as 24×7, generally provide facilities only for deliveries.[3] People spend large amounts of money on travelling long distances to access basic health services.[3] Though MMUs are operational, their number and outreach is limited.[3]

6) IPHS guidelines are not being followed in many health centres.
Most of the equipment in the PHCs was found to be not following Indian Public Health Standards in the CRM's field visits.

3.1.3 Findings regarding community involvement

1) Home based care is being taken up by ASHA is praiseworthy. During the various ASHA evaluation reports, it was reported that ASHA's work in door to door visit as a part of home based care has been commendable. Not only in Rajasthan, this job of ASHA has been a success in almost all the states of India.

2) Role of ASHA as an activist is very limited.
ASHA stands for Accredited Social Health Activist which clearly defines that ASHA is an activist. But this role of activist of an ASHA is lagging behind.

3) Upto 11% of the potential users are being missed by ASHAs. The efficacy and coverage of ASHA has been discussed at various stances. Improving the coverage of ASHA system is essential to achieve the health targets.

4) ASHAs get a monthly honorarium of Rs. 1100 under Integrated Child Health System.

5) ASHA has a good support structure in design. But many posts of ASHA facilitators are vacant. And many others are busy doing other work.
6) Village Health Plans are prepared and implemented by the VHSNC in its meetings.
7) Field assessment of VHSNCs through NGO support is required.
8) Community based monitoring was introduced and stopped.

3.1.4 Findings regarding MIS and grievance redressal

1) Management Information System (MIS) is in the form of Pregnancy and Child Tracking System (PCTS) and Eligible Couple Tracking System (ECTS). PCTS has details of ANC, delivey and PNC of a pregnant woman and also the immunization status of the children. ECTS has details of every couple in the village and their medical and family history.
2) No functional grievance redressal in place. The need of a grievance redressal has been expressed in many evaluation reports. According to the reports, there is no well-known redressal mechanism in place which could solve the grievances related to NRHM's activities.

3.1.5 Other findings

1) National Health Mission (NHM) to encompass NRHM and National Urban Health Mission (NUHM). NRHM is more or less seen as a success and urban healthcare lacks the improvement when compared to rural areas. So a need for a National Urban Health Mission was realised and is about to be flagged under National Health Mission encompassing NRHM and NUHM.
2) RMNCH +A strategy for high focus districts. RMNCH +A stands for Reproductive Maternal Newborn Child Health +Adolescent and brings adolescent care also under focus. High focus districts have been identified and special attention is being given. More funds are being pumped in and more ASHAs are being appointed.

3.2 Finding from the fields

Key findings from the field are broadly classified under five categories:

3.2.1 Findings regarding the implementation of JSY and JSSK.

In this section, the key findings with respect to the implementation of Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram are elaborated.

NRHM's main goals have always been to decrease IMR, MMR and TFR. The manjor cause of maternal deaths and infant deaths was the lack of a reachable health institution for getting the delivery done. The key focus of NRHM has been on

increasing the number of institutional deliveries in the first phase of NRHM (2005-2012). To increase the institutional deliveries, the health systems present in 2005 went through a massive restructuring. Janani Suraksha Yojana, the flagship programme of NRHM launched in 2005 was crucial in encouraging pregnant women to get their deliveries done at govt. institutions instead of at home. Janani Suraksha Yojana provided cash incentives to women for delivery at health centres. This was instrumental in decreasing the financial burden on the families during deliveries.

To ensure that the women have zero out-of-pocket expenses, Janani Shishu Suraksha Karyakram was launched in 2011 which ensures free treatment food, and transport to & fro for the woman and also to sick newborns.

These two programmes showed a significant rise in the number of institutional deliveries. The key observations regarding the programmes from the fields are as follows:

1) Payment of cash incentives to beneficiaries under JSY: Since Rajasthan has been marked as a Low Performing State (LPS), the incentive offered to beneficiaries in rural regions is Rs. 1400. While the ASHA package is Rs. 600 which includes Rs. 300 for 3 ANCs and Rs. 300 for delivery. The woman gets her incentive as soon as she is discharged in the form of a cheque. The health centres claim that there is no delay in giving incentives to either the women or the ASHAs. However, ASHAs do not get the incentive in the form of cheques and get it from the MO or the ANM sometimes immediately after the delivery and sometimes a little later. ASHAs often complain of delays in payments up to 6 months. The exact cause of delay in payment is yet unknown.

2) Free transport, food and treatment to the beneficiaries: Free food and treatment is being given to all the women admitted for delivery. Transport services are provided by ambulances like 108 in Rajasthan. Also, exclusively for maternity service, "Janani Express" (104) is also in place and functioning. However, if the ambulance is not available on time, private vehicle is hired and the rent for that is paid by the health centre immediately. No significant problems are experienced in this aspect.

3) ASHA: Accredited Social Health Worker (ASHA) is an important and integral part of these two programmes. It is the responsibility of ASHAs to bring the pregnant women for ANC checkups and delivery to health centres. ASHAs are found to be doing a commendable job in improving the institutional deliveries and taking health to every doorstep. ASHA facilitators/Health supervisors in every PHC have the job of facilitating ASHAs in their works. But they don't assist ASHA in the fields as they are not paid T.A. and D.A. for going into the fields. They do many other purposes but neglect the primary purpose of providing help to the ASHAs.
   However, one major flaw was found w.r.t. counselling services provided by the ASHAs and the ANMs. For good health practices to percolate at the grassroots, good counselling services are a must. Communication and a good rapport

between the ASHA/ANM and the women were missing. There was no counselling imparted by the ASHA/ANM at the VHNDs the intern visited. This might be a very important reason for NRHM to not achieve the targets that it aimed for.

3.2.2 Findings regarding infrastructure and manpower to provide the services.

For improving the health scenario of rural India, the main challenge has always been to strengthen the infrastructure and manpower in place to provide health services. To improve the manpower, various positions were created and filled up on contractual basis. To improve the infrastructure, funds were pumped and ambulance services were improved. The key observations regarding the infrastructure and manpower from the fields are as follows:

1) Manpower/Human resource problem: Human resource problem was clearly evident everywhere in the field visits. There was shortage of staff in the SHCs, PHCs and CHCs. Many of the contractual positions were filled but many were vacant. Due to this, the male workers had to do the jobs of the people whose posts were vacant. Many posts of doctors with specializations were vacant due to which surgeries couldn't be done. Many of the PHCs operate with around 50% of the staff. Many subcentres remain closed all the time as the ANM posted there goes for deputation to some health centre which is less remote. CHCs fail to function as FRU either due to lack of infrastructure or due to shortage of staff. However, in Rajasthan, more staff is being brought in to serve the flagship programmes of "Nishulk Dawa Yojana" and "Nishulk Jaanch Yojana".

2) Infrastructure problem: Lab equipment was found to be of poor quality even in the CHCs. In the PHCs, the lab equipment present was almost non-functional and all the lab tests were forwarded to the CHC. There were no radiant warmers present in PHCs. There is just one functional radiant warmer in CHC Nainwa. Basic equipment like microscope, Hb meter, BP instrument, weighing machine are not functional in many places.

3.2.3 Findings regarding community involvement and ownership.

One of the key agenda of NRHM has been to focus on community involvement in the health system and community ownership of the health services. The steps taken towards this are setting up of ASHAs, setting up Village Health Committees and Facility based committee (RKS). The key observations regarding community involvement are:

1) Village Health Sanitation and Nutrition Committee (VHSNC): VHSNC was setup in every village to look after the health, sanitation and nutrition needs of the village. Guidelines were prepared for the functioning of the committees and untied fund of Rs. 10000 every year was granted to them. This was excluding

the Rs. 10000 granted to the SHC. The ANM was incharge of setting up the committee which compulsorily includes herself, the ASHA, the AWW, the Saathin and a member of the Panchayat. A clear disinterest was observed in the members of Panchayat towards the health and sanitation affairs of the village. The involvement of NGOs is rare but wherever there is an involvement, it is active. A register is maintained with the ASHA which includes the minutes of meeting of the committee and also the development works undertaken. The ASHA and the ANM claim that the meeting happens on the VHND itself but no such meeting was observed.

Misuse of the untied funds was apparent as they used the funds to buy basic infrastructure like tables, chairs, boxes, etc. The funds were not utilised for solving the sanitation issues, drinking water issues of the village. In fact, there was no awareness regarding legitimate use of the funds due to poor orientation of the VHSNC. Also, the untied fund is hardly enough to carry out any major developmental activities like drilling another bore for getting cleaner water.

2) Rogi Kalyan Samiti: Rogi Kalyan Samiti (RKS) a.k.a. Rajasthan Medicare Relief Society (RMRS) in Rajasthan is a facility based committee set up in every PHC and CHC to look at the overall affairs of the health centre. Untied funds of Rs. 50000 and Annual Maintenance Grants is given to tis committee to utilise it for the betterment of services in the health centre. The RKS claim to get adequate funds and face no problems in this aspect. The untied funds are being used for minor repairs and solving running water and drinking water issues. There doesn't appear to be major discrepancies in fund utilization.

3) Community participation in planning: The existing VHSNCs are not empowered and oriented enough to involve in planning of health services at the village level. Also, there is no feedback mechanism from the VHSNCs to the block officials as to what their health needs are and which health services need to be given priority and which services need not. There exists no forum for the people of villages to reach out to the higher authorities and express their views. There exists zero planning by the community.

3.2.4 Findings regarding use of MIS and Grievance Redressal.

1) Use of Management Information System (MIS): The Pregnancy and Child Tracking System (PCTS) and Eligible Couple Tracking System (ECTS) serve as the two major components of MIS in Rajasthan. The data collected by the ANMs in the Sub-centre Data Register (SDR) is stored in PCTS and the data collected by the ANMs/ASHAs in the Eligible Couple Survey (ECS) is stored in the ECTS. These two databases used to monitor the health scenario in any part of Rajasthan. The data entry is being done in many health centres and is starting in many of them. The formats that are being used in the collection of data are very relevant and user friendly.

However, the scope of this MIS is limited to data entry and monitoring by higher authorities for the health status. There is no provision for performance

tracking of the health officials on a regular basis or even after a module of training. There is no provision for inclusion of inspection or monitoring records.
Apart from this, the data is not in public domain and can be accessed only by the health centres and higher authorities at block, district and state level. This decreases the scope for accountability of the health centres to the public.

2) Grievance Redressal: There should be a functional grievance redressal cell beneficial to all the stakeholders. There exist following provisions for grievance redressal:
   a) State Control Room with a state helpline number: They claim to address all grievances. The existence of such a helpline is little known to people.

   b) District Control Room under the CMO/CMHO with its helpline number: This is mainly used for alerting the authorities in case of epidemics. This does not act as a grievance redressal cell.

   c) District Project Management Unit: Comprising of DPM, District ASHA facilitator and District IEC coordinator, they claim to address grievances of all kinds. Their job is to notify the concerned authority for taking action. This was set up mainly to address grievances related to payment delays of JSY beneficiaries. Although this is functional, they hardly get 2-3 calls per month. The main reason for this is the lack of publicity of the contact numbers of the DPMU at every health centre.

3.3 Gap analysis

A comprehensive gap analysis has been done on the health services offered by NRHM. They are divided into five categories based on the scope of this project.

3.3.1 Gaps related to implementation of JSY and JSSK

3.3.1.1 Gap #1

ASHAs are getting demotivated to carry on their services.

Reasons:

- ASHA's payment is delayed many a times by the MOs and ANMs.
- Out-of-pocket expenses: ASHAs incur out-of-pocket expenses when they take a woman for sterilization to the hospital. ASHAs end up paying for commuting.
- Low incentives: ASHAs strongly feel that the incentives that they receive is hardly enough for the service that they give.

3.3.1.2 Gap #2

Sub-Health Centres (SHCs) are not operational to the extent they are supposed to be. Many model SHCs are not operational for deliveries.

Reasons:

- Lack of basic facilities: Basic amenities like water supply and electricity are an issue. Some SHCs face a problem with getting basic medicines and supplies.
- Mobility issues: ANMs face mobility problems and have to manage everything by themselves in the SHCs. So they don't prefer a posting in SHC. In many cases, ANMs are posted at a particular SHC on paper but the SHC remains closed throughout the year. Staying of ANMs in the SHC building is a very rare phenomenon.
- Political biases: Many SHCs are opened due to political bias and are not opened based on requirement.

3.3.2 Gaps related to infrastructure and manpower

3.3.2.1 Gap #3

Between the number of skilled manpower required and no. available.

Reasons:

- Lack of training to the general physicians for conducting surgeries: The MOs in PHCs and CHCs are all general physicians and doctors with specializations are a rare sight. Even the MOs on govt. duty since long have not been given training for conducting surgeries related to maternal health.
- Lack of facilities to doctors in rural areas: Doctors are not willing to serve in rural areas as they are not satisfied with the facilities that they get. They face mobility issues, water supply problems, power cuts, etc.
- Lack of incentives to the doctors when compared to private hospitals: Doctors with specializations have a provision of getting upto Rs. 80,000 per month under NRHM. Even then, specialised doctors are not willing to serve in CHCs as private hospitals offer more salaries and perks.
- Contractual positions are not preferred: People working on contractual posts in hospitals have lot of permanent govt. employees around and this leads to demotivation if the contractual positions are not made permanent soon. Due to this, contractual posts are filled and get vacant in no time again.

3.3.2.2 Gap #4

CHCs are not functioning as First Referral Units.

Reasons:

- No doctors with specialization to treat emergency obstetric cases: Doctors lack skills like administrating anaesthesia required to carry out surgeries. Doctors with obstetric skills are not present in CHCs.
- No functional blood bank: Either a blood storage facility doesn't exist or the staff required to operate it doesn't exist.

3.3.2.4 Gap #5

Equipment related problems.

Details:

- Radiant warmers are not present in PHCs: Even though government sanctioned funds to have radiant warmers in all the PHCs, there were no radiant warmers present.
- Basic lab facility is absent in some of the PHCs: Basic tests like haemoglobin count, malaria test is missing in many PHCs.
- Basic equipment like microscope, Hb meter, BP instrument are not functional in many health centres.

3.3.3 Gaps related to community involvement

3.3.3.1 Gap #6

Untied funds to VHSNC are not being utilized for the right purposes.

Reasons:

- Poor orientation of the VHSNCs: VHSNCs were oriented just once for a 2-day training. The committees are not clear as to what a legitimate use of the funds is and what is not.
- Disinterest of PRIs: Members of the panchayat, who are the most empowered in the village, do not involve in the health affairs of the committee. They do not attend any training sessions. The people who attend the orientation sessions are not empowered enough to take decisions in the committees.

3.3.3.2 Gap #7

Lack of community level (village level) planning. Lack of community involvement.

Reasons:

- Poor community empowerment: The community is not empowered enough to question the health officials and actively participate in the health affairs. Ignorance adds to the problem.
- No forum for community participation: There exists no means for the people of the village to get their voices heard to the higher authorities at the block or the district.
- NGOs are not encouraged: NGOs do not receive good support for involvement into the health affairs either by the villagers or the health officials. So the NGOs are active in only a few villages where they are encouraged. They desire a good support from the higher authorities as well.

3.3.4 Gaps related to Use of MIS and Grievance Redressal

3.3.4.1 Gap #8

No grievance redressal mechanism for patients.

Details:

- The government has sanctioned a Grievance Redressal Cell under District Project Management Unit but has not been implemented. However, there is a helpline number for the entire state. But there is no awareness regarding it.

3.3.4.2 Gap #9

No feedback mechanism from the village to the health officials.

Details/Reasons:

- No transparency in MIS: PCTS and ECTS are not in public domain. So if the data entered is wrong for a particular village, there is no possibility of the people of that village to challenge the officials.

3.3.5 Other gaps observed

3.3.5.1 Gap #10

Unsuccessful inter-sectoral convergence.

Reasons:

- No policy/programme: There exists no well-defined policy to integrate drinking water under NRHM. This is a major reason for the failure of inter-sectoral convergence.
- Coordination issues: No coordination with other government bodies like Public Health Engineering Department (PHED) for drinking water purposes in Rajasthan. The departments of WCD, PHED and Health operate in a vertical fashion and horizontal coordination with other departments does not exist.
- Limited coordination with PRIs for sanitation purposes.
- Funds received for the same purpose under different departments.

3.3.5.2 Gap #11

Good health practices are not percolating into the grassroots.

Reasons:

- Poor counselling by ASHAs/ANMs: ASHAs and ANMs are not imparting counselling services to the women on VHNDs which is very important for achieving results.
- Poor counselling by the Medical officers: During the health checkups by the doctor, the MO does not counsel the patient on good health practices and dos and don'ts.
- Poor IEC activities: No evidence of IEC material like wall posters was observed. IEC is vital for achieving any health target.

3.3.5.3 Gap #12

No feedback taken from villages/SHCs on the funds required.

Details:

- At present, the funds allotted to the VHSNCs and the SHCs are a result of utilization certificate issued by the district authorities averaged out on the entire district. This system does not take into account every village and SHC.
- This results in some villages/SHCs having more funds than required and some having fewer funds than required.

4 Recommendations, Scope and Strategy for Implementation

A set of recommendations are here provided which can be used for the betterment of health services pertaining to NRHM. The recommendations are broadly classified into 5 categories based on the scope of this project.

4.1 Recommendations related to implementation of JSY and JSSK

4.1.1 Recommendation #1

A step towards a stronger ASHA system:

Steps to be taken:

1) Compulsory Counseling and Communication workshops for ASHAs (and ANMs): This is of prime importance as counselling services are crucial to instill good health practices into the people.

2) Increase incentives to ASHAs: ASHAs work equivalent to ANMs and other paramedical staff. Inspite of that, their monthly earnings are quite poor. The incentives of ASHAs should be increased. Monthly honorarium need not be increased.

3) Performance tracking of ASHAs and removal of 1-5% of non-performing ASHAs: This is to ensure the quality of services provided by ASHAs.

4) Performance evaluation of ASHA/Health Supervisor: The performance of ASHA supervisor/health supervisor at every PHC should be based on the performance of ASHAs under him/her along with the ACR by the MO. This will ensure that he/she takes care that ASHAs are doing their duty.

5) Grant of T.A and D.A to ASHA/Health Supervisor: ASHA/Health Supervisor does not get T.A and D.A. to carry out field visits and monitor/guide the ASHAs. The Supervisor should attend atleast the VHNDs for which certain allowances need to be given.

6) Follow-up mechanism for ASHAs payment: Follow-up by the ASHA facilitator/BPM at the block level should be made compulsory at the block level for all the ASHAs in the block. The same should be updated online with the follow up status of the Facilitator/BPM. This will ensure that the Facilitator/BPM reminds the MO in-charge regarding the payments and that there are no delays in payments to ASHAs.

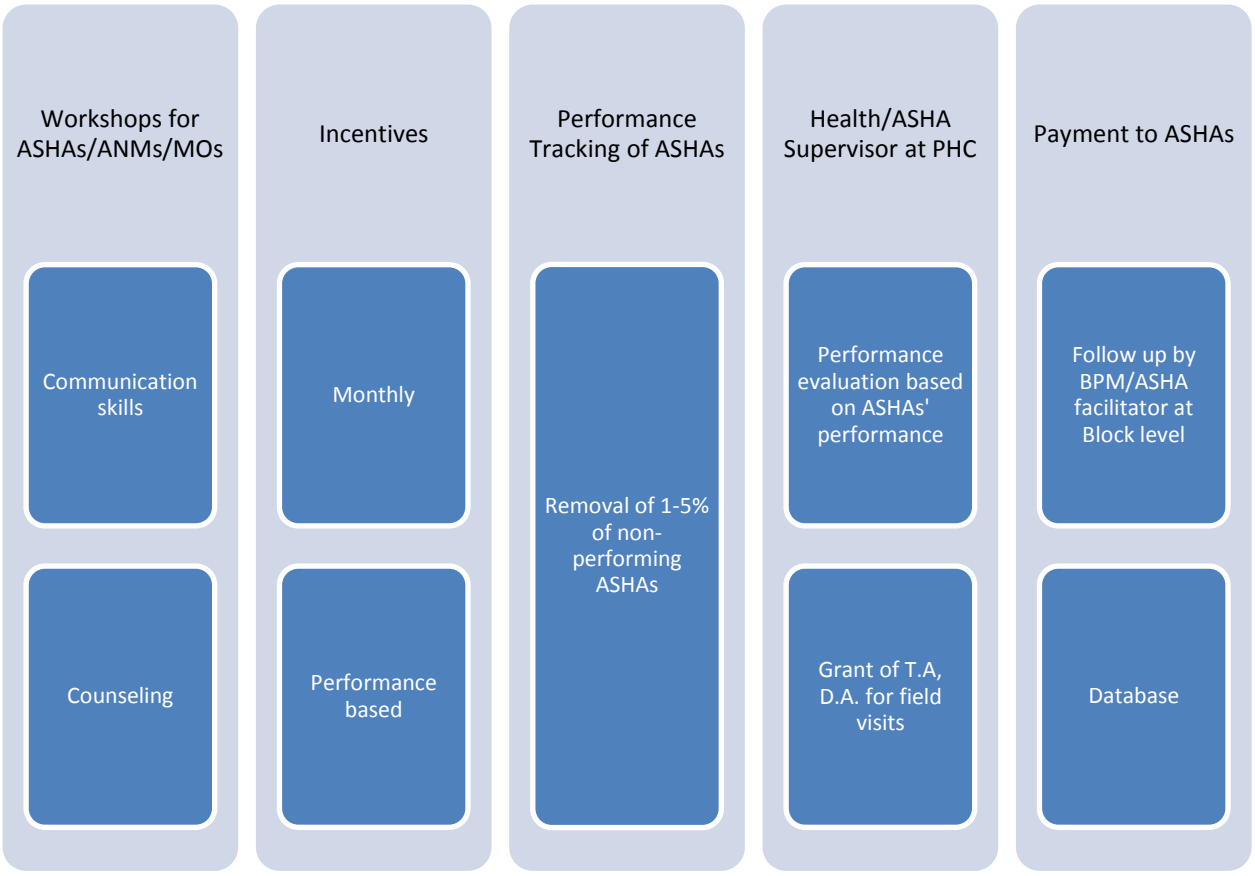


Figure 10: Strategy for a stronger ASHA system

4.1.2 Recommendation #2

A step towards better functioning SHCs.

Steps to be taken:

1) Analysing in every block the situation of every SHC – operational status, operational timings, area of coverage, staff posted and staff operational.
2) Opening more SHCs based on the criteria that every SHC should not cover more than 2-3 villages.
3) Marking the SHCs on a priority scale based on the distance and accessibility of the SHC from the nearest town. If the SHC is comparatively nearer to the town, then the SHC should be marked as low-priority SHC and if it is remote, it should be marked as a high priority one.
4) Not allowing deputation of ANMs to other health centres at any cost and making sure that the ANM posted to the SHC stays there. High priority SHCs should be given special focus.
5) Allocation of areas in the villages to the ANMs. The ANMs should be individually responsible for their respective section of the village.

Rationale: The existing SHCs have been created more or less based on political will and favour. The SHCs in the remote areas are hardly operational and the non-model SHCs are hardly giving maternal services. Also, the ANMs in a particular SHC split up the work and take leave on many days according to their mutual understanding.

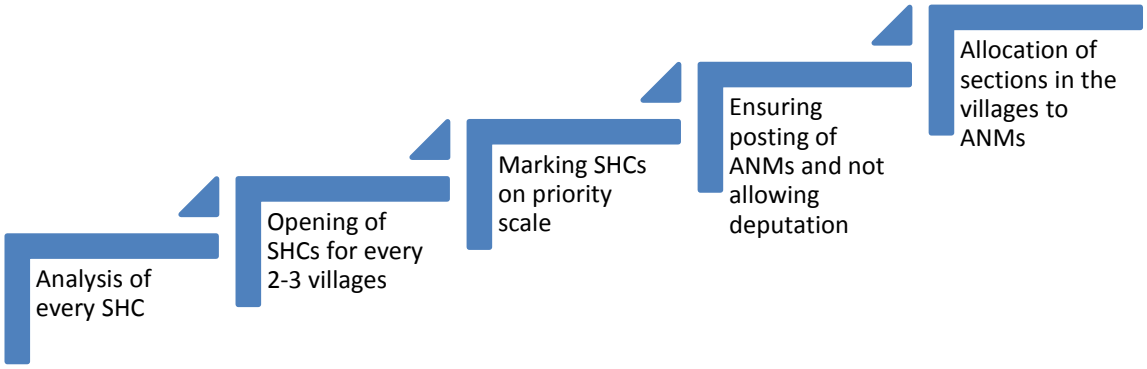


Figure 11: Strategy for better functioning SHCs

4.2 Recommendations related to Infrastructure and Manpower

4.2.1 Recommendation #3

Focus on capacity building of doctors by imparting training for maternal health.

Steps to be taken:

1) Imparting necessary training like LSAS training to the existing MOs so that they can perform basic surgeries related to maternal health.
2) There should be performance tracking of the doctors and follow up training if the performance is not satisfactory.

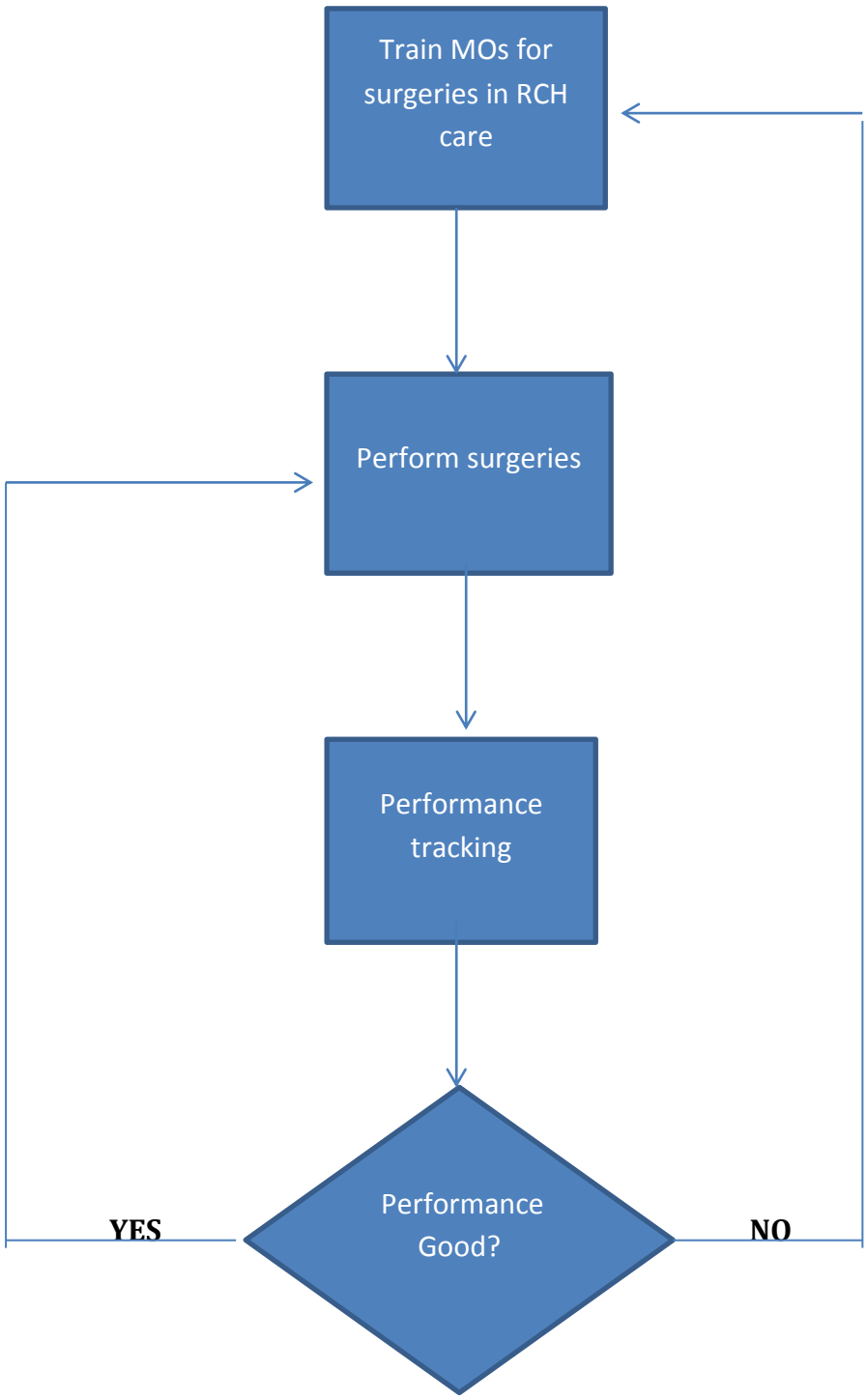


Figure 12: Flowchart for capacity building of Medical Officers

4.2.2 Recommendation #4

Introduction of a supply chain manager at the district level.

Rationale: There exist huge irregularities in the supply of drugs and other supplies to the different health centres. While some health centres receive regular supply, many receive interrupted supply or excess supply at once or no supply at all. This calls for a stronger supply chain management at least at the district level to give regular flow of supplies to all the health centres as per requirement.

4.2.3 Recommendation #5

Non monetary incentives

HR Policy should include non-monetary incentives - **non-monetary incentives** for example posting in better districts after serving for a certain period of time in difficult districts, preference /reservation quota in academic and professional institutions for children whose parents have served for long in HFD, letters of appreciation, additional weightage for each year spent in HFD district during promotion , special quota in post graduate studies for young doctors willing to serve in difficult areas are some of the suggestions that must be given due consideration.

4.3 Recommendations related to Community involvement

4.3.1 Recommendation #6

A step towards better community involvement and ownership

Steps to be taken:

1) Orientation of VHSNCs: Training/orientation sessions of VHSNCs should be held at regular intervals. This is of utmost importance as the committees are unclear about legitimate use of funds granted to them.

2) Increasing the number of members in VHSNCs: In Rajasthan, the number of permanent members is 7 of which 4 are from governmental sector excluding the PRI representative. This provides limited scope for participation of people belonging to non-governmental sector. The number should be increased to at least 11 to make it more active. Involvement of NGOs has to be given importance notwithstanding the participation of others.

3) Community consultation for making new members of VHSNC: Community consultation has been done by the Public Health Resource Network in Chhattisgarh to form the committee. Similar consultation has to be carried out

in every village so as to involve more people from the non-governmental sector. Representatives of NGOs working in adjoining areas of the village should also be encouraged to involve in the committee.

4) Forming a relationship between VHSNC and Panchayat: There exists a lack of support from the Panchayat to the VHSNCs. There needs to be a healthy relationship built between the VHSNC and the Panchayat. This can be done by arranging meetings with the panchayat, etc.

5) Feedback from every village and SHC for funds required: At present, the funds allotted to the VHSNCs and the SHCs are a result of utilization certificate issued by the district authorities averaged out on the entire district. This system does not take into account every village and SHC. This results in some villages/SHCs having more funds than required and some having fewer funds than required.

6) Reintroduce community based monitoring: Community based monitoring should be reintroduced as it improves accountability of the health centres.

7) Quarterly meeting at the block level inviting members from VHSNC: One to two members from each VHSNC under the block should be invited for a quarterly meeting with the block officials and get their voices heard. This will be a significant step towards community involvement and empowerment.

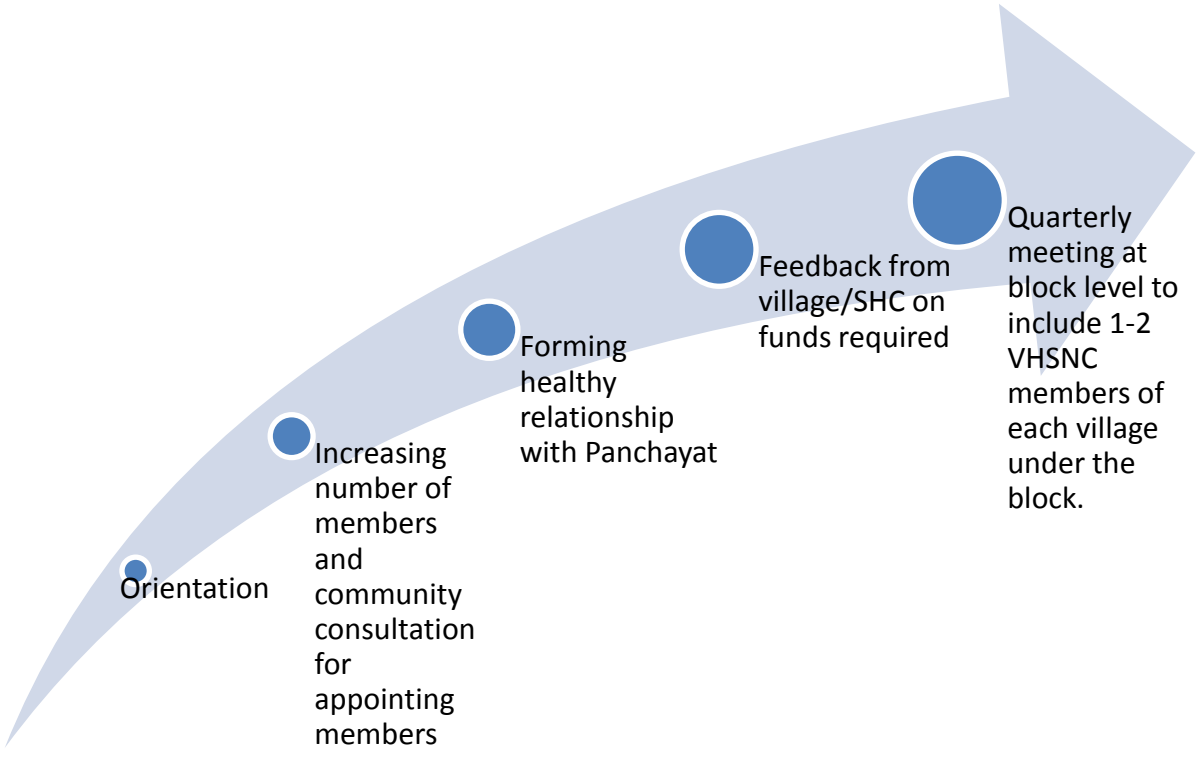


Figure 13: Strategy for better community involvement

4.4 Recommendations related to Use of MIS and Grievance Redressal

4.4.1 Recommendation #7

A step towards transparency and accountability:

Steps to be taken:

1) Bring PCTS and ECTS under the public domain: This would ensure transparency and increase accountability of the officials to enter correct data. In this way, we could impose a check on fraudulent entries as the public could challenge the data. This can again act as a fuel for community involvement.

Expanding the scope of the present MIS:

2) Inspection/Monitoring records should be of a specific format and should be entered in the database. This should again be in the public domain. In this way, every health centre will try to provide good services so that it does not get a bad reputation.
3) There should be a database which provides for performance tracking of different health officials like MOs, ANMs, ASHAs, etc. Payment status of ASHAs should also be included.

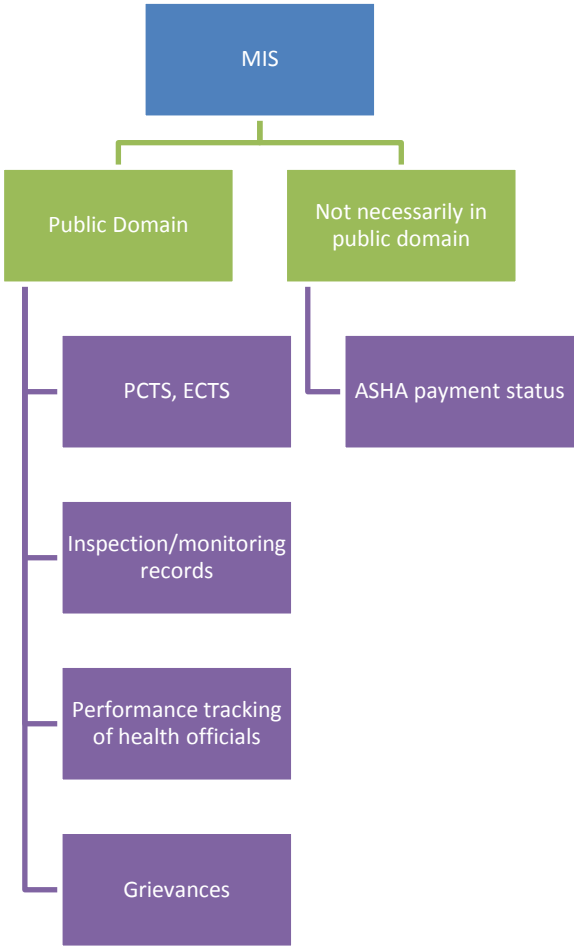


Figure 14: Strategy for expanding the scope of MIS

4.4.2 Recommendation #8

A step towards a better functioning grievance redressal mechanism.

Steps to be taken:

1) Set up a Grievance Redressal Cell at the Block level: Composition of the grievance redressal cell at the block level:
   a) Block Program manager
   b) Block ASHA facilitator
   c) An NGO representative (to maintain pressure on the above two officials)

   This team should display their phone numbers at every health centre in the block. The team should be incharge of an online database which handles the complaints and their statuses.

2) Create awareness of the grievance redressal cell under DPMU: Display the phone numbers of the members of the grievance redressal cell in the DPMU (the DPM and the District ASHA facilitator) at each and every health centre

under the district. People having grievances should have the freedom of calling up either the grievance redressal cell under the block or the district.

3) Clearly lay down the issues to be handled at the block level and at the district level. This is necessary to avoid the blame game.

4) The discussion of grievances registered should be a compulsory agenda of the DHS meeting.

5) Increase the responsibilities of the District IEC coordinator with respect to the grievance redressal cell.

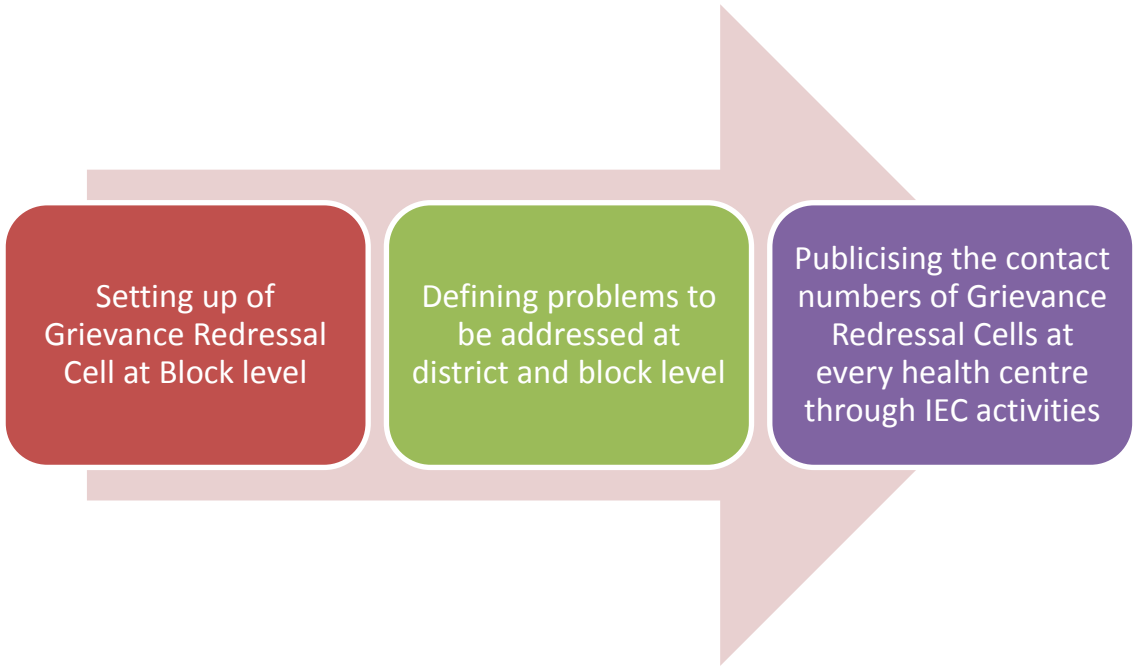


Figure 15: Strategy for better functioning grievance redressal mechanism

4.5 Other Recommendations

4.5.1 Recommendation #9

A step towards achieving better results in population control.

Steps to be taken:

1) Free transport must be given to men/women who go to health centres for sterilization purposes on similar lines of JSSK in addition to the cash incentives being provided.

2) Increase the incentive provided for sterilization: The incentive provided for sterilization should be atleast 3 times that of provided for delivery. This is necessary so as to make sterilization look more rewarding than giving birth to another child.

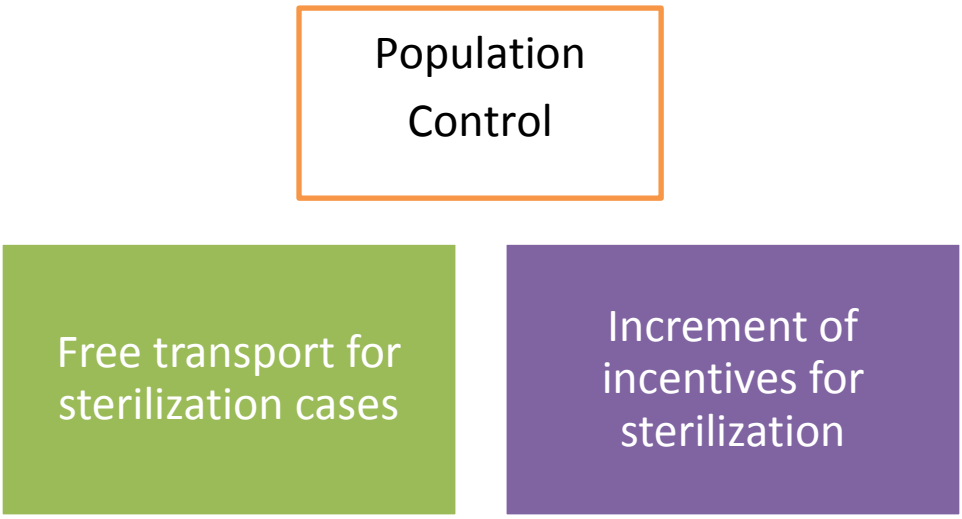


Figure 16: A step towards population control

4.5.2 Recommendation #10

Focus on inter-sectoral convergence.

1) Funds allocated for the same purpose to different departments need to be converged: For example, funds received by the standing committee of Panchayat for health should be converged/integrated with the funds received by the VHSNC. Similarly, the funds received for women and child development by the WCD department can be integrated with similar funds. All the funds received by the village under different programmes/schemes and departments must be brought to a common platform like the Panchayat.

2) Develop a programme for integration of drinking water and sanitation with health: There is a need for a policy and a programme by the Govt. of India to integrate health with drinking water at the village level. Inter sectoral committees should be formed at the state and district levels to coordinate the activities. Adequate help should be provided to the village health committees.

Conflicting ideas

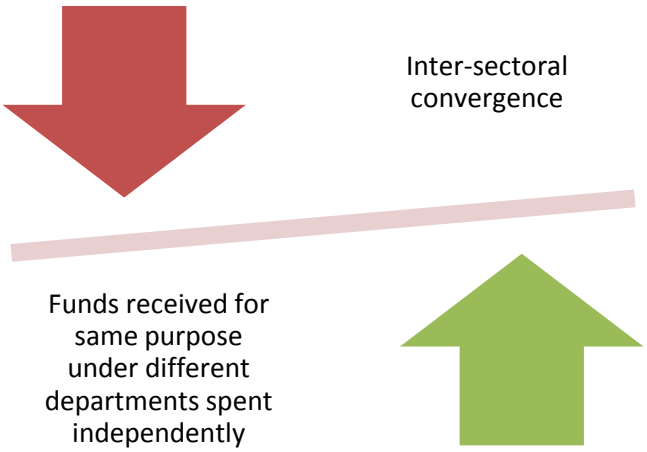


Figure 17: Conflicting ideas regarding inter-sectoral convergence

Need for converging and channelizing the funds

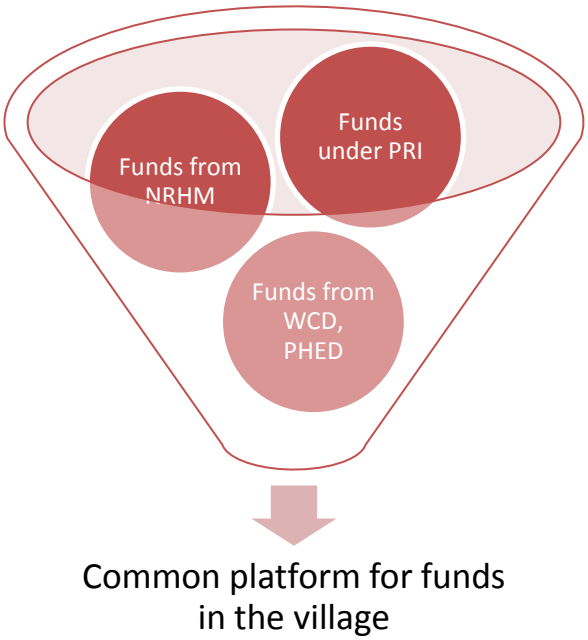


Figure 18: Need for convergence of funds

5 Conclusion

Bringing reforms in the health sector especially in the rural areas has always been challenging as all social changes take a lot of effort and time. Prior to NRHM, the health scenario in rural India was clearly tragic and people faced innumerable problems. The health indicators support this fact.

The analysis of certain branches of NRHM shows that NRHM has been vital in bringing a lot of positive reforms in the health sector in rural India. A lot of success stories of NRHM can be seen and heard.

The concept of ASHA for health to reach households was a very successful one and so were the programmes like JSY and JSSK. Capacity building took place on a large scale. Institutional deliveries increased significantly and health indicators improved. On careful observation, it can be seen that the various components of NRHM have been judiciously designed and policies framed are on the right track. The Govt. of India and the state governments have done and are doing a commendable job in improving the health scenario.

However, there is a lot more to be achieved and a lot more challenges to be faced and addressed. There is a need for health authorities to look at the problems at the grassroots and plug the loopholes in the implementation of the programmes. The author has brought out some of the issues and suggested recommendations with a hope that they could bring about further improvement.

Let us progress towards a more prosperous and healthier India!

6 References

1) Document of National Population Policy in www.india.unfpa.org (United Nations Population Fund India) http://india.unfpa.org/drive/NationalPopulation-Policy2000.pdf
2) Document of National Health Policy in the MoHFW website. - http://mohfw.nic.in/showfile.php?lid=113
3) 12th Five Year Plan document on Health.
4) 6th Common Review Mission report on Rajasthan.
5) Sample Registration Survey 2011
6) Article in Times of India on reduced MMR in Rajasthan according to AHS 2011 - http://articles.timesofindia.indiatimes.com/2013-05-07/jaipur/39089594_1_mmr-maternal-deaths-survey-report-states
7) Annual Health Survey 2010, Rajasthan.
8) Programme Evaluation of Janani Suraksha Yojana by NHSRC.
9) "ASHA – Which way forward?" – by NHSRC.
10) Update on ASHA programme, July 2011 – by NHSRC
11) Press Information Bureau news on National Health Mission - http://pib.nic.in/newsite/erelease.aspx?relid=95385
12) NHSRC presentation on NRHM evaluations.
13) A Primary Evaluation of Service Delivery under the National Rural Health Mission (NRHM): Findings from a Study in Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan – Kaveri Gill for Planning Commission
14) Concurrent Assessment of JSY Scheme in selected states of India, 2008
15) "Status and Role of AYUSH and Local Health Traditions, under National Rural Health Mission" – by NHSRC
16) 6th Common Review Mission report on India.
17) Article in Hindu on NRHM - http://www.thehindu.com/opinion/lead/for-a-new-and-improved-nrhm/article2333819.ece
18) Article in Business Line on Rural Health - http://www.thehindubusinessline.com/opinion/mixed-report-card-on-rural-health/article3446322.ece

19) PIB news on failure of NRHM in achieving targets- http://pib.nic.in/newsite/erelease.aspx?relid=51322

20) Article in live mint on accountability failures in NRHM - http://www.livemint.com/Opinion/f6WeAMMIDy6SYXj1VCItBI/Accountability-failures-mar-NRHM.html

21) Guidelines available on official website of NRHM on

a) WIFS
b) Incentives to ASHAs
c) Janani Suraksha Yojana
d) Janani Shishu Suraksha Karyakram
e) PHC workforce management
f) Possible PPP projects
g) Village Health & Nutrition Days
h) Upgrading CHCs to FRUs
i) Untied funds to health committees
j) Usage of untied funds
k) Working of health committees at different level
l) Upgrading to IPHS in all PHCs and CHCs

General References

1) www.nrhm.gov.in - The official website of the National Rural Health Mission, Ministry of Health and Family Welfare, Government of India.
2) www.rajswasthya.nic.in – Official website of Department of Health & Family Welfare, Govt. of Rajasthan.
3) www.nrhmrajasthan.nic.in
4) Website of State Institute of Health and Family Welfare – www.sihfwrajasthan.com
5) Website of National Health Systems Resource Centre – www.nhsrcindia.org
6) www.pctsrajmedical.raj.nic.in – portal of PCTS.

Appendix

Questionnaire for ASHAs

	Question	Yes/No/Subjective
1.	Your first task w.r.t. MCH is to identify expectant mothers	
2.	Do you register the pregnant woman for an MCH card?	
3.	Do you register the pregnant woman for a JSY card?	
4.	Any difficulties in registering?	
5.	Do you escort the woman for ANC check-ups to a health centre?	
6.	How many times do you take the woman for ANC check-up?	
7.	What is included in the ANC check-up? (TT injections, IFA tablets)	
8.	Any difficulties during ANC check-ups?	
9.	How do you convince the woman to go for an institutional delivery?	
10.	What do you suggest in general to a woman? Delivery in a govt health centre or in a private centre?	
11.	Is a health centre for delivery pre-determined?	
12.	Where do you preferably/often take women for delivery? (Name of health centre)	
13.	Do you escort the woman for delivery?	
14.	Mode of transport?	
15.	Your preferred mode of transport?	
16.	Is the mode of transport pre-determined?	
17.	Is the mode of transport easily available?	
18.	Any difficulties in taking the women for deliveries?	
19.	If the mode of transport is an ambulance, are the ambulances well equipped with trained staff and equipment?	
20.	Do you handle cash disbursements to the beneficiaries?	
21.	When do you get your cash incentive? Is there any delay?	
22.	Who hands over cash incentives to you?	
23.	Any problems regarding your cash incentives?	
24.	Satisfaction?	
25.	When do you make a post-natal visit?	
26.	How many post-natal visits do you make?	
27.	What do you do when the woman has a pregnancy	

	related complication? (referral cases)	
28.	Which is the nearest health centre for emergency obstetric services?	
29.	What are the problems in the cases when a woman is referred to another health centre?	
30.	Do you insist on immunization of newborn?	
31.	Immunization of newborn till what age? (14 weeks)	
32.	Do you insist on breastfeeding?	
33.	How effective is it? (good/poor, etc.)	
34.	Do you insist on family planning methods?	
35.	How effective is it? (good/poor, etc.)	
36.	When is vaccination to eligible children given?	
37.	Are pregnant women given ANC services in village health nutrition day (VHND)?	
38.	Is vitamin A given in VHND?	
39.	Are IFA tablets given to children with clinical anaemia?	
40.	Is supplementary nutrition provided to underweight children?	
41.	Is collection of data done in VHND?	
42.	Who collects the data?	
43.	Are all children under the age of 5 tracked by you and AWWs? How effective is it? How is it ensured?	
44.	Suppose a family which has a child under the age of 5 and has diarrhoea approaches you for help, what do you advise?	
45.	Do you counsel on balanced diet?	
46.	What is your role in planning for health delivery?	
47.	What is the role of VHSNC in planning process?	
48.	How flexible are your finances? (finances from ANMs, etc.)	
49.	What kind of financial decisions are you free to take?	

50.	Flexibility of funds allocation at which level?	
51.	Do you like the training sessions?	
52.	How frequently are you trained?	
53.	How effective is it?	
54.		
55.		

Questionnaire for Health centres (to be answered by ANM/MO/staff)

Sl.no.	Question	Yes/No/Subjective
1.	How often does a woman come for ANC to the health centre?	
2.	Do you insist on atleast 3 ANCs?	
3.	How many times does a woman come for PNC?	
4.	Is a C-section done here? If not, which is the nearest referral centre?	
5.	Are emergency obstetric services done here? If not, which is the nearest referral centre?	
6.	How is the availability of drugs in general?	
7.	Is the first-in-first-out system of drugs followed?	
8.	Are you able to give cash incentives to everyone on time?	
9.	What are the problems?	
10.	Are you able to give free transport to every pregnant woman?	
11.	What are the problems?	
12.	Are you able to give free diet to everyone?	
13.	What are the problems?	

14.	Are there enough experts available?	
15.	Do you need any more experts?	
16.	If there is a pregnancy related complication, what do you do? (referral, etc.)	
17.	Do you issue referral slips to women who go to their mothers' place for delivery?	
18.	An account of Rs. 10000 made available with the ANM?	
19.	Do you (ANM) maintain a certain amount with the ASHA/AWW?	
20.	What do you do with the money?	
21.	Is it sufficient?	
22.	Any problems?	
23.	IPHS (Indian Public Health Standards) being followed for PHCs/CHCs in emergency obstetric services? (not applicable for Sub centres)	
24.	Any problems?	
25.	Are monthly meetings organised by ANM for other health workers like ASHAs and AWWs?	
26.	Is a monthly work schedule prepared in those meetings?	
27.	Are AYUSH doctors available?	
28.	Do AYUSH doctors prescribe allopathy drugs?	
29.	How is the equipment status?	
30.	Are you in requirement of more equipment?	

31.	Transport problems?	
32.	What is the extent of flexibility of funds allocated to you?	
33.	Who has the flexibility of funds allocation?	

Meetings and Interviews

Date: May 24, 2013

Time: 9:30 PM

Duration of Discussion: 25 minutes

Discussion [Please use bullets]:

1) The mentor explained to me the different important components of NRHM.
2) Asked me to concentrate on basic health indicators like IMR, MMR, etc. and not think of cancer or HIV/AIDS.
3) Asked me to choose a place for field work according to my convenience. Suggested Bundi district in Rajasthan as it is the worst performing district in Rajasthan.
4) Guided me on what questions I can ask in the RTI application.
5) Guided me to narrow down on topics like JSY or ASHAs or something related where the results could be fruitful.
6) Guided me to look for utilization of services, equipment status, improvement, etc. during field visit.
7) Asked me to send a .doc format of the report so that she could type a few comments in it.

Action Items before next discussion:

1) Decide on detailed purpose of field visit.

2) Need to prepare a good plan and strategy of what to do in the field visit.

Date: June 4, 2013

Time: 10:28 AM

Duration of Discussion: 9 minutes

Discussion [Please use bullets]:

1) Discussed about field visit to Bundi district.
2) The tentative plan is to reach on 10th of June to Bundi and stay there for around a week.
3) To interact with DLOs, CMHOs and other field officers on reaching there.
4) The mentor will review my questionnaire on 6th of June and will further discuss about the field visit.

Action Items before next discussion:

1) To prepare different questionnaires for health workers as well as beneficiaries.

Date: June 4, 2013

Time: 10:28 AM

Duration of Discussion: 9 minutes

Discussion [Please use bullets]:

1) Approval of field visit
2) Discussion of who all to meet in the field visit

Date: June 11, 2013

Time: 10:00 AM

Duration of Discussion: 60 minutes

Discussion [Please use bullets]:

2) Approval of questionnaires
3) Discussion of who all to meet in the field visit.
4) Discussion of organizational structure in Nainwa.
5) Discussion of grassroot problems.

Date: June 2013

Time:

Duration of Discussion:

Discussion [Please use bullets]:

1) Discussion regarding key findings
2) Discussion regarding recommendations
3) Discussion regarding more literature review
4) Discussion on final report.

Field Visits

During the field visit to Nainwa Block of Bundi district of Rajasthan, the monthly Block level meeting of the health workers was held at CHC Nainwa. This meeting was attended by ANMs and Male nurses presided over by the BPM, BCMO, Asst. Statistical Officer, Bundi Distt., RCHO, Bundi Distt. and Medical officers of Nainwa Block.

At CHC Nainwa, the staff reported that the main problems were lack of manpower to operate the equipment and meet the demand.

At the Aanganwadis of Maanpura and Bhandeda, it was clearly observed that counselling and communication between the health workers and the beneficiaries was missing. Also, the functioning of VHSNCs was found to be not satisfactory. Poor orientation and facilitation of VHSNCs were the main reasons.

At the PHCs Baasi and Dugari, it was observed that funds received under NRHM had improved the health facilities over there. Lack of manpower was observed. Equipment problems were observed. There was no awareness about IPHS.

"The highest measure of democracy is neither the 'extent of freedom' nor the 'extent of equality' but rather the highest measure of participation."
- A.D. Benoist

Rakshak Foundation creates awareness domestically and internationally about the rights and responsibilities of citizens towards the society and state. Rakshak engages in and supports social and scientific research on public policy and social issues.

GET INSPIRED

IDENTIFY YOUR PASSION

GET INVOLVED

Disclaimer: This report is an outcome of a student project and the content of this report represents the views of its author. Neither the report nor any of its parts represent the views of Rakshak Foundation and/or any of its affiliates and officials in any capacity whatsoever. The figures and facts used in the report are only suggestive and cannot be used to initiate any legal proceedings against any person or organization. However, the author shall be extremely grateful to acknowledge any inaccuracies in the report brought to author's notice.
Please email your suggestions or concerns to: hr@rakshakfoundation.org]

Contact:

Email: secretary@rakshakfoundation.org
Website: www.rakshakfoundation.org

