Summer Training at
NHM, Rajasthan
(April 3 to June 2, 2017)

- **Analysis of Parameters and Monitoring Framework to assess the Effectiveness of the Pradhan Mantri Surakshit Matritva Abhiyan**
- **Study on Online Payment Module of JSY and Rajshree Scheme**
- **To assess the effectiveness of online JSY and Rajshree payment module in Tonk, Jaipur, and Jaisalmer districts, Rajasthan**
- **To assess the reports of indicators related to JSY Scheme in the above three districts of Rajasthan**

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INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that **Dr. Harshita Jain** student of **MBA in Hospital and Health Management, 2016-18** has undergone summer training in **National Health Mission, Rajasthan** from 3rd April to 2nd June 2017.

The candidate herself completed the project assign to her during summer training. Her approach to the project was sincere and proactive. This summer training is in partial fulfillment of the course requirement recommended for the award of MBA in Hospital and Health Management.

I wish her success in all her future endeavors.

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CERTIFICATE

This is to certify that **Ms Harshita Jain**, student of MBA Institute of Health Management Research (IIHMR, Jaipur) has successfully completed her Summer Training Program at NHM, Rajasthan from 3rd April, 2017 to 2nd June 2017. She has worked on the project- **Analysis of indicators and monitoring framework of Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) and study on Online JSY payment (OJAS).**

Her performance was found satisfactory. We extend her good wishes for a bright and successful career ahead.

Director RCH

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ACRONYMS/ABBREVIATIONS

ABBREVIATIONS	Meaning
ASHA	Accredited Social Health Activist
ANM	Auxiliary nurse midwife
AWW	Anganwadi Workers
BPL	Below poverty line
CHC	Community health Centre
DPM	istrict Programme Manager
DH	District hospital
EMT	Emergency medical technician
FRU	First Referral Unit
HRP	High risk pregnancy
Hb	Haemoglobin
IEC	Information Education and communication
IFA	Iron folic acid
JSY	Janani Suraksha Yojana
JSSK	Janani Shishu Suraksha Karyakram
MMR	Maternal mortality ratio
MH	Maternal Health

MDR	Maternal Death Review
MCP	Maternal child Protection
NBCC	New born care corners
NBSU	New born stabilisation unit
NPR	National Population registration
NRHM	National Rural health mission
NHM	National health mission
OJAS	Online just accessible seamless software
OBGY	Obstetric Gynaecology
OJSYPM	online JSY payment module
OPD	outpatient department
PCTS	Pregnant mother child tracking system
PMSMA	Pradhan mantri Surakshit Matritva abhiyan
PPP	Public private partnership
QAC	Quality assurance committee
QAU	Quality Assurance unit
QA	Quality Assurance
PHC	Primary health Centre
PW	Pregnant women
RSY	Rajshree Yojana
RSOC	Rapid survey on children
SCNU	Special new-born care unit
SLY	Shubhlaxmi Yojana
TBA	Traditional birth attendance
TT	Tetanus Toxoid

PREFACE

Summer internship is an integrated part of the PGDHM candidates. As a part of the curriculum students are required to undergo summer training at any reputed organization to get in depth exposure of various departments in the organization and better understanding of the health care delivery system and its functions.

The objectives of the summer training program are as follows:

1. To understand the health care delivery system including private and public sectors.
2. To observe the implementation of various National Health Programs and policies at National/State/District level.
3. To understand various functions of health systems by interaction with the key stakeholders, policy makers, program managers, academicians and researchers.
4. To complete the project assigned by summer training organization.

During our training period we had an Overview of the various programs undertaken in National Health Mission, Rajasthan including the current status of components during the period. We also carried a small study on the project assigned to us.

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RAJASTHAN

Health is important to human resource development and State Government is committed to ensure that Rajasthan's health indicators catch-up with the all India averages. The success of the programs taken in the public health field are determined by the progressive improvement of various demographic/ epidemiological indicators over time. This improvement is the outcome of specific initiatives as well as other supplementary initiatives in the developmental sector.

The government stress the importance of developed healthcare infrastructure and provision of quality health care services. Although many initiatives have been implemented to uplift the health status of the people of the State to comply with the mainstream of National averages but much still remains to be focused.

COMPARATIVE HEALTH INDICATORS OF INDIA AND RAJASTHAN

S. No.	Indicators	India	Rajasthan
1.	Total Population(census 2011) In millions	1210.1	68.6
	- Male	62.3	3.56
	- Female	58.6	3.30
	- Urban	37.7	1.70
	- Rural	83.3	5.15
2.	Crude Birth Rate (CBR) (SRS 2013)	21.4	25.6
3.	Crude Death Rate (CDR) (SRS 2013)	7.0	6.5
4.	Infant Mortality Rate (IMR) (SRS 2013)	40	47
5.	Maternal Mortality Ratio (MMR) (SRS 2011-13)	167	244
6.	Total Fertility Rate (TFR) (SRS 2013)	2.3	2.8
7.	Couple Protection Rate (CPR) (Any method)	54.0 (DLHS-III)	70.2 (AHS-2012-13)
8.	Sex Ratio (census 2011)	943	928
9.	Total Literacy Rate (%) (Census 2011)	66.10	73.00
10.	Male Literacy Rate (%) (Census 2011)	79.20	80.90
11.	Female Literacy Rate (%) (Census 2011)	52.10	64.60

Figure: 1 Demographic and health profile of Rajasthan and India

OBSERVATIONAL LEARNING

About NHM Rajasthan

The National Health Mission (NHM) is a national intervention for ensuring provision of successful healthcare services through a range of interventions at various levels and most importantly at the health system levels. In the first phase, NRHM was started in the year 2005 and completed in 2012. In the next phase, NHM will be continued till year 2017. The mission has focus on rural as well as urban health hence, National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM) are working as Sub-missions of NHM.

Objectives of the National Health Mission.

- Reduction in Infant Mortality Rate and Maternal Mortality Ratio by at least 50% from existing levels in next seven years
- Universal access to public health services for Women's health, Child health, water, hygiene, sanitation and nutrition
- Access to integrated comprehensive primary healthcare
- Ensuring population stabilization, gender and demographic balance.
- Revitalization of local health traditions and mainstream AYUSH
- Promotion of healthy life styles
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.

To attain these objectives, various activities are being implemented under NHM under 5 major sub heads-

- NRHM + RMNCH plus A
- NUHM
- National Disease Control Programme
- Non-Communicable Disease Control Programmes including injury and trauma
- Infrastructure maintenance

DEAPARTMENT WISE/PROGRAMME WISE LEARNINGS

1.1 ASHA (Accredited Social Health Activist) Programme

Since inception of NRHM in 2005, ASHA (known as ASHA Sahyogini in Rajasthan) has played critical and an important role in implementation of health activities under NRHM. The ASHA programme was introduced as a key component of the community process intervention and now it has emerged as the largest community health worker programme in the world. It is considered a critical contribution to enabling people's participation in health.

ASHA is a community level worker whose role is to function as a health care facilitator, a service provider and to generate awareness on health issues. Besides delivering key services to maternal child health and family planning, she also renders important services under National Disease Control Programme.

1.1 a) ASHA Soft – To improve the system for effective monitoring and their performance on 26 parameters, this software was launched. It is a huge accomplishment for the Rajasthan government as it required no investment in any manner and no new HR were hired. It reduced the burden on ASHA and staff as the need to compile information manually demolished.

Objectives:

1. To ensure timely and transparent online payment to ASHAs.
2. To monitor performance of each and every ASHA every month.
3. To identify the gap area and assessment
4. Assess the quality in vulnerable areas
5. Timely payment of incentives of ASHA to maintain their motivational level.

Main activities – It involves the Verification of ASHA Claim Form; Online data entry of ASHA Claim Form and its verification on ASHA Soft; Release of payment; SMS sent to ASHA for information of online payment.

1.2 INTEGRATED AMBULANCE PROJECT

This comprises the combined services of 108, 104 and medical advice service.

1.2 a) 108: EMERGENCY SERVICE RESPONSE (EMS)

Emergency Response Services, also known as 108-Ambulance Services are run in the PPP mode in the State. It is known that a patient who is transported to the nearest healthcare facility within 15-20 minutes of an emergency and receives basic care from trained professionals has the greatest chance of survival. Thus, EMS is an important part of the overall healthcare system as it saves lives by providing immediate care.

Objectives

1. To provide comprehensive Emergency Response Services to everyone.
2. To increase the access to health services, police and fire service, particularly attending emergency situations, serious ill health and all other emergencies in the general population.
3. To provide 24hours pre-hospital emergency transportation /ambulance services to everyone.

Procedure

The dispatch of ambulance services works on the unique procedure of Sense – Reach – Care along with the GPS tracking systems for locating active ambulances.

Figure 2: working of 108 emergency ambulance services Source: NHM Rajasthan Portal, Ambulance page

Sense

- It applies that any person can dial a toll-free number 108 from in need of emergency help and the call is attended by specially trained communications officers who connect the caller to the dispatch division after understanding the nature of emergency

Reach

- The ambulance nearest to the site is identified and the driver is contacted and guided to the mishap site.

Service

- The ambulance reaches the site and takes the patient to the nearest hospital. During the trip, pre-hospital care is provided to the victim by EMT.

1.2 b) The Janani Express Yojana

The Janani Express Yojana provides emergency transportation facility to all the expectant mothers, sick infants and BPL families and help them to reach government health facilities and avail healthcare facilities on time.

1.2 c) 104(Medical Advice service)

104 Medical Advice Service has been started in 2011 and formally launched on January 16, 2012.The service is centralized, and 104 Call Center is established which is active 24 x7. This Medical Advice Service helps people to get all the health-related information by dialing a toll free number ‘104’

1.3 MATERNAL HEALTH

1.3 a) Janani Suraksha yojana (JSY)

JSY was launched in 2011 and it is a centrally sponsored scheme under NHM which was started to provide benefits to pregnant women.

Objectives

1. To decrease MMR.
2. To increase institutional deliveries amongst BPL and poor families.

1.3 b) JSSK

Janani Shishu Suraksha Karyakram was launched on 1st June 2011. It was started in Rajasthan on 12 September 2011 in all 33 districts. It aims to provide benefits to both pregnant women and sick new born till 30 days after birth such as:

- Entitlements for pregnant women
- Free and zero expense treatment (delivery and C section)
- Free drugs and consumables till 6 months of delivery.
- Free diagnostics
- Free provision of blood
- Free diet during stay (up to 7 days in case of c section and 3 days in normal delivery)
- Free transport from home to health institution, between facilities in case of referral, Drop from institutions to home
- Exemption from all kinds of user charges
- Entitlements for sick newborn till 30 days after birth.

1.4 CHILD HEALTH

1.4 a) Facility Based Newborn and Child Care

facility based newborn care services at health facilities have been implemented to address the issues of high neonatal and early neonatal mortality, This includes setting up facilities for care of Sick Newborn such as Special New Born Care Units (SNCUs), New Born Stabilization Units (NBSUs) and New Born Baby Corners (NBCCs) at different levels .

a) Special Newborn Care Units: They are set up with at least one SNCU in each district. SNCU is 12-20 bedded unit .Services provided for sick newborn are:
    - Management of LBW infants>1800gm

- Immunization services
- Free Referral services
- Follow up of babies discharged from units and high risk newborns.

b) Newborn Stabilization Units: they are established at Community Health centres /FRUs. These are 4 bedded units with trained doctors and nurses for stabilization of sick newborns.
Services provided for sick newborn:
- Management of LBW infants>1800gm, with no complication,
- Management of newborn sepsis
- Referral services
- Stabilization of referral and sick newborns and those with very LBW

c) New Born Care Corners: These are one- bedded facility attached to the labor room and Operation Theatres for provision of essential newborn care. NBCC at each facility where deliveries are taking place should be established.
Services provided for sick newborn:
- Identification and prompt referral of at risk and sick newborn.

1.4 b) Home Based New Born Care (HBNC): It is a new scheme that has been launched for providing Home Based Newborn Care by ASHA. ASHA has to visit to all newborns according to specified schedule up to 42 days of newborn birth and they would be paid after 45 days of delivery all together.

1.4 c) Malnutrition treatment centre (MTC)

Established in all the district hospital of state. Severely malnourished children are referred to the centre by AWW and ASHAs for rehabilitation. After discharge from MTC of the children, their tracking and follow ups are done at AWCS.

1.5 BHAMASHAH BIMA YOJNA

It is a scheme to provide cashless facility to the IPD patients for the identified families covered under National Food Security Act (NFSA) and Rashtriya Swasthya Bima Yojana (RSBY) by the Government through an Insurance Company New India Assurance Company on a fixed premium per family per year.it was launched on 13 December 2015.

Objectives of the Scheme

1. To manage Govt. money for healthcare services.
2. To provide quality health care that avoids large out of pocket expenditure
3. To provide financial security against illness
4. To improve health status of the State.
5. To create a data base which could be used to make policy level changes in Healthcare.

6. To bring a revolution in healthcare in rural area – by providing stimulus to Private Sector to open hospitals in rural areas and reducing the increasing burden on Government facilities.

Bhamashah Scheme, provides a service delivery platform for the transfer of cash and non-cash benefits to the beneficiaries in a transparent manner, and was relaunched in the year 2014 with broader objectives. The Scheme provides a 'Bhamashah Card' issued to the family. The Card is linked to a bank account that is in the name of lady of the house who is the head of the family. The card has an advantage of bio-metric identification. Multiple cash benefits can be accessed through the Bhamashah Card and those benefits will be directly transferred to bank accounts of the beneficiaries. Non-cash benefits would be given directly to entitled beneficiaries.

1.6 Rashtriya Bal Swasthya Karyakram (RBSK)

Rashtriya Bal Swasthya Karyakram was started in the year 2015-16. It is an initiative which aims at early identification and intervention of the 4 'D's viz. Defects at birth, Deficiencies, Diseases, Development delays including disability for children from birth to 18 years. Early management of diseases will help in preventing the progress of diseases into more severe form. This will reduce mortality rate.

Following are the Target groups under Child Health Screening and Intervention Service.

Categories	**Age Group**
New born at public health facilities and home	Birth to 6 weeks
Preschool Children in rural and urban slum areas	6weeks to 6 years
School going Children from class 1st to 12th In government and government aided schools	6yrs to 18 years

1.7 The preconception and pre-natal diagnostic techniques (prohibition of sex selection) Act 1994, (PCPNDT)

State level PCPNDT

Objectives

- Collection and monitoring of various data related with PCPNDT Act
- Awareness program through Government agencies/NGO to lawyers, judiciary etc.
- To evaluate the local causes of female feticide.
- To involve NGO for effective implementation.
- To identify the unregistered centres and doctors engaged in unlawful practices.
- Online submission of form f and quarterly report with compliant loading.
- Registration of manufacturers of ultra sound machine suppliers
- Upgradation of ultrasonography machine for purpose of storage of various images.
- Organizing various meetings of advisory committee in the state.

Tracking of individual case of ultras sonography undertaken at any health institution whether in government or in private sector. To help the government in establishing such a system in Rajasthan, an online monitoring and surveillance system IMPACT (Integrated Monitoring system for PCPNDT ACT) has been developed and implemented for Medical Health & Family Welfare department by NIC. It facilitates monitoring of each case of sonography of pregnant women at any of the sonography facility registered in the state.
All sonography centres in the state have been enrolled with the department. The information is available on line on the system. Details of each of the diagnostic facility including the machines and the involved (Doctors and Radiologists) are available online. System facilitates capturing of information for each sonography case in real time which is prescribed by the PCPNDT Act.

1.8 QUALITY ASSURANCE AND KAYAKALP

QACs have been formed at state and district levels. Their initial goal was to ensure quality in male and female sterilization services. Now it has been expanded beyond family planning and includes all services under the RMNCH+A, disease control programmes and other hospital services.

1.8 a) State level quality assurance committee

They are formed to oversee the quality assurance activities across the state in accordance with the guidelines, and ensure regular and prompt reporting of the various key indicators. Following are the functions:

1. Composition of QACs and QAUs the state and district: The primary role is to provide overall guidance and monitoring of QA efforts in the districts
2. Ensuring attainment of the Standards for Quality of Care by Public Health Facilities by developing a checklist for achieving the national standards and assessment of needs of Technical Assistance by the facilities and its mobilization.
3. Mentoring the state/district level units

4. Periodic Review of Quality scores, attained by different categories of Public Health Facilities and take decisions for improving and maintain those scores.
5. Review and adjudicate compensation claims under the National Family Planning
6. Support the quality improvement process.
7. Reviewing Key performance indicators of quality for District Hospitals and assessment of Performance of health facilities.

1.8 b) Kayakalp: District hospitals are awarded with kayakalp with first prize of 50 lac, second of 20 lacs, and constellation prize to two institutes of 3 lacs. Also, this will motivate all CHCs in the upcoming years for the maintenance of their quality and infrastructure and hygiene.

ORGANOGRAM (MATERNAL HEALTH DEPT.)

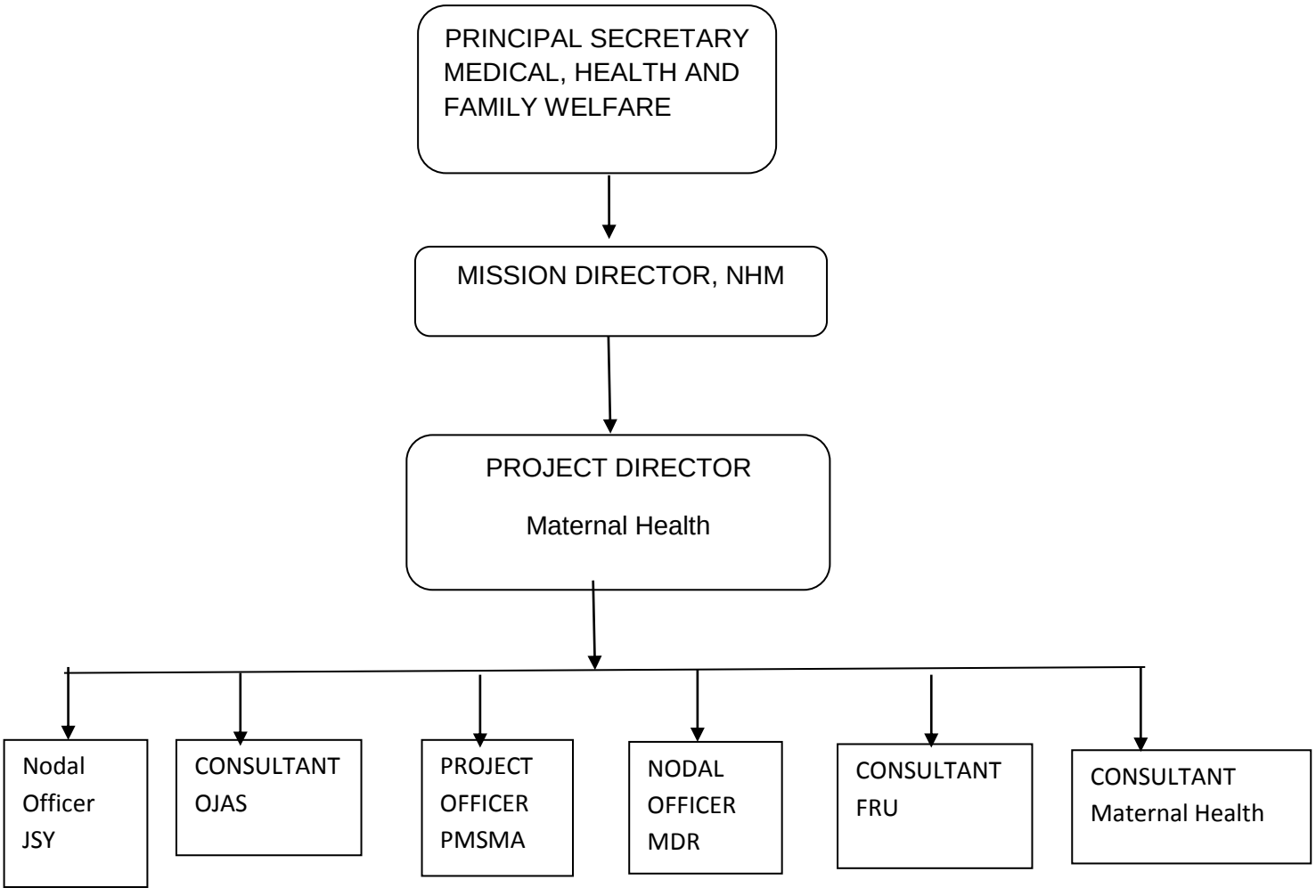


Figure 3

ANALYSIS OF PARAMETERS AND MONITORING FRAMEWORK TO ASSESS THE EFFECTIVENESS OF THE PRADHAN MANTRI SURAKSHIT MATRITVA ABHIYAN

Rajasthan and India at a glance.

Government of India under Ministry of Health & Family Welfare (MoHFW), launched the Pradhan Mantri Surakshit Matritva Abhiyan scheme in July 2016. The program aims to provide free of cost assured, comprehensive, quality antenatal care, universally to all pregnant women on the 9th of every month across the country. In India, Rajasthan holds second positon in terms of total number of volunteer registered till April 2017 with a total of 533 private doctor volunteers and a total of 27,561 number of women who have received antenatal services under this scheme. In the country, total number of volunteer registered are 3,689 and No. of Facilities providing PMSMA services are 11,471 till April 2017.

PMSMA is held every month, wherein all the essential maternal health services are provided at identified public health facilities. If the 9th day of the month is a Sunday/ a holiday, then it is organized on the next working day. OBGY specialists/ Medical Officer /physicians with support from private sector doctors to supplement the efforts of the government sector, provide Antenatal checkup services. This is an additional ANC routine at the health facility. Under the campaign, a minimum package of antenatal care services would be provided to the beneficiaries at the PMSMA Clinics to ensure that every pregnant woman receives at least one checkup in the 2nd and 3rd trimester of pregnancy.

Operational definitions

Full Antenatal care: All those women who have completed 4 visits to the facility for routine checkup had 2 doses of TT immunization (1 dose in prior immunization) and about 200 IFA tablets and will have undergone physical and abdominal examination in all 4 visits would be considered.

Partial antenatal care: all those women who had visited the health facility at least once for routine checkup will be considered partially covered.

High-Risk Pregnancy

Definition

A high-risk pregnancy is a type of condition which puts the mother, the developing fetus, or both at higher than normal risk for complications during or after the pregnancy and at birth. High Risk Conditions of pregnancy that are not to be missed by the health care provider during an ANC checkup are as enumerated below:

- severe anemia i.e. HB less than 7gm./dl
- Pregnancy induced hypertension, pre-eclampsia, Pre-eclampsia, toxemia, preterm labor
- Hypothyroidism
- Young primi (less than 20 years) or Elderly gravida (more than 35 years)
- Twin / Multiple pregnancy
- Malpresentation
- Low lying placenta, Placenta Previa
- Positive Bad obstetric history (History of still birth, abortion, congenital malformation, obstructed labor, premature birth etc.)
- Rh negative
- Patient with History of any current/ past history of systemic illness.
- Mother having a health problems, such as Diabetes, Cancer, High blood pressure, Kidney disease, Epilepsy, rheumatoid arthritis.
- Height less than 140 cm
- Baby with a genetic condition, such as Down syndrome, or a heart, lung, or kidney problem.
- Mother taking certain medicines, such as lithium, phenytoin (e.g.: Dilantin) etc.

Diagnosis: A woman with a high-risk pregnancy requires a closer monitoring than other pregnant woman. They require more number of ultrasound tests, regular blood pressure checkups, urine tests to look for protein and urinary tract infections. Tests for other problems may also be done, especially if mother are more than 35 years or if she had a genetic problem in a past pregnancy. Such tests are developed to track the original condition, survey for complications, verify the adequate growth of fetus and make decisions regarding the health of mother or baby's health at risk. It may also require the need to have induced labors or pre term delivery.

Prevention

- A visit during pregnancy period and before pregnancy period for a woman who has a medical problem. The doctor can counsel women with any condition the precautions during pregnancy.
- Woman can need medicines to control a pre medical condition which may cause problems for the baby. There may be other substitute available which is safer for

use. In some cases if there is no other medication, a woman must consider the risks to the baby when deciding to become pregnant.

- A woman who did not had a pre-pregnancy visit should contact a healthcare provider as soon as she learns she is pregnant. Schedule of the first prenatal visit within few days, instead of waiting until eight to 10 weeks of pregnancy. This is necessary as certain medical conditions can increase the risk of miscarriage. The provider makes sure that any medication is adjusted properly to safe delivery.

INTRODUCTION

Pradhan Mantri Surakshit Martitva Abhiyan visualize to improve the quality and coverage of Antenatal Care, Diagnostics and Counselling services. Many of the deaths are preventable and many lives can be saved if quality antenatal care is provided to pregnant women and high risk factors such as severe anemia, pregnancy-induced hypertension etc. are detected on time and managed well.

Despite the availability of various treatment centres, regular training of health care providers at different levels, monitoring, and the functioning of outreach platforms like Village Health and Nutrition Day, there is still insufficiency of the desired coverage and quality of maternal health services.

MMR in India still remains high at 167/ 1, 00,000 live births as per RGI- SRS (2011-13), with improved access to maternal health care services and considerable progress in the reduction of maternal and infant mortality reduction in MMR. In Rajasthan, there is a reduction of 144 points in MMR from 388 (SRS, 2004-06) to 244 (SRS 2011-13) and rise in institutional delivery from 28 per cent in 2005 to 78 per cent (AHS 2012). In 2007-08, India had 47% institutional deliveries only (DLHS 3). With the implementation of different schemes, significant progress was observed in the maternal health care service indicators like institutional deliveries and Ante Natal Care coverage within a short span of time. However, as per latest data of the Rapid Survey on Children (2013-14) (RSOC), the institutional deliveries in India are 78.7%.

With massive increase in the number of pregnant women coming to institutions for delivery, till date only 61.8% women receive first ANC in first trimester (RSOC) and the coverage of full ANC (provision of 100 IFA tablets, 2 tetanus toxoid injections and minimum 3 ANC visits) is as low as 19.7% (RSOC)

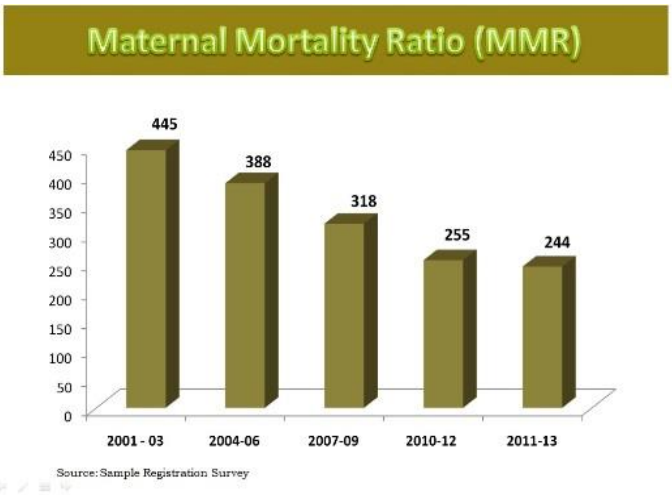


Figure 4: Maternal mortality Ratio trends in Rajasthan, source: sample registration survey.

PROBLEM STATEMENT

Reducing MMR is an important challenge for India as it strives towards achieving the Sustainable Development Goals. This can be possible if complete range of the required services is accessed by the pregnant women which is linked with a minimum package of antenatal care services provided to the beneficiaries. There is a notable decrease in the maternal death but still we are not able to save pregnant women. Lives are lost even today during the time of delivery. The causes include blood deficiency, infection during delivery, high blood pressure. Timely detection and treatment of the complications and causes can prevent the death of mother and newborn. So to understand and assess the functioning of PMSMA Programme along with finding out what is the effectiveness of indicators and monitoring parameters through primary data collection by Rapid Situational analysis, in Jaipur District of Rajasthan this study is done.

REVIEW OF LITERTAURE

- Implementation of Various health programmes have been done in the country in order to improve maternal health; however, yet the desired outcome has not been achieved due to ineffective strategies of implementation ,slow implementation due to the lack of use of available resources, or lack of effective governance by departments. [1]

- Factors such as higher literacy and socio economic status have been found linked with increased percentage of antenatal check-up, and specific components of diagnostic and laboratory tests. Thus, pregnant women from poor and uneducated backgrounds with at least one child were less likely to receive proper antenatal check-ups and services. [2]

[1] . Sharad D. Iyengar ET all, 2009 maternal health: a case study of Rajasthan
[2] Saseendran Pallikadavath,et all, 2004 Antenatal care: provision and inequality in rural north India

- Network of ANMs, ASHAs and Medical officers are crucial to provide the benefits of the established public health system. However, implementation challenges prevent people from accessing these services and health personnel from providing them.[3]

- Along with birth preparedness, covering of the health information and counselling for pregnant women should be emphasized. Relevant information, education, and advice regarding appropriate nutrition and rest, promotion of early and exclusive breastfeeding, feeding options for HIV-positive also should be encouraged. [4]

Information Education & Communication (IEC), Inter-personal Communication (IPC) and Behavior Change Communication (BCC) activities are the key focus areas. Extensive use of mass media in raising awareness is an integral part of IEC/BCC campaign. Special focus is given to IEC activities in order to sensitize pregnant women about the programme and encourage voluntary participation of private doctors. ANM, ASHA and AWW plays a major role in mobilization of the community and potential beneficiaries in both rural and urban areas for availing of services.

[3] Esha sheth et all 2015, Understanding Barriers to Antenatal Care and Institutional Delivery-Focus Groups

[4] Ornella Lincetto et all Antenatal Care ; Who publication

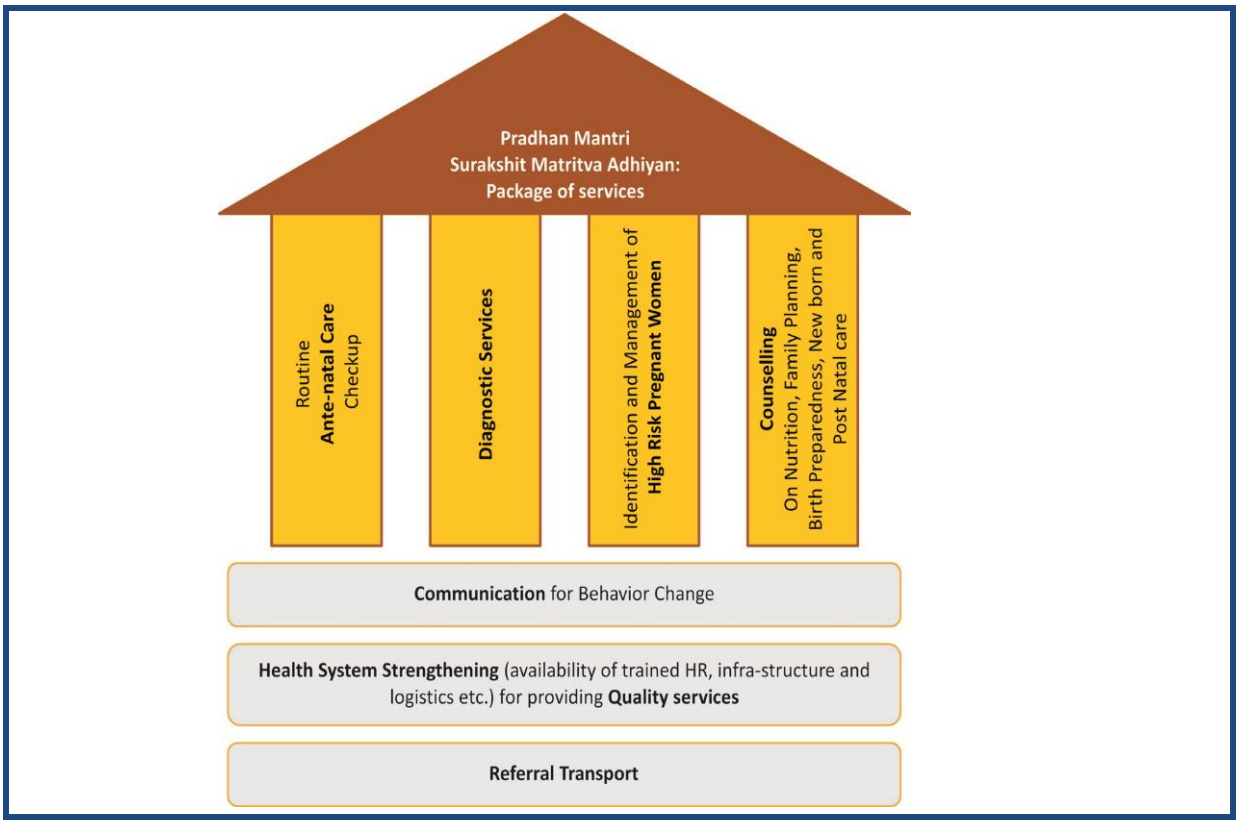


Figure 5: services and components of PMSMA, source: pmsma guidelines

Following are the objectives of the program:

● to ensure that a physician/specialist provides care in at least one ante-natal visit in the second or third trimester.

● To improve the quality of care during ante-natal visits of pregnant women by ensuring following services:

a) All the diagnostic services at the center.
b) Screening for applicable clinical conditions
c) Proper management of any existing clinical conditions.
d) Proper counseling services
e) Proper documentation of services and its records.

● To Offer an additional opportunity to pregnant women who have missed their previous ante-natal visits.

● To Identify and record high risk pregnancies. And planning of birth who are found with a risk factor condition.

●To give early diagnosis services, management of conditions like Anemia, etc. Care will be provided during these clinics. Special focus to be given to early and adolescent pregnancies, as they require specialized care.[6]

Target Beneficiaries: The program aims to reach out to all Pregnant Women who are in the 2nd or 3rd Trimesters of pregnancy.

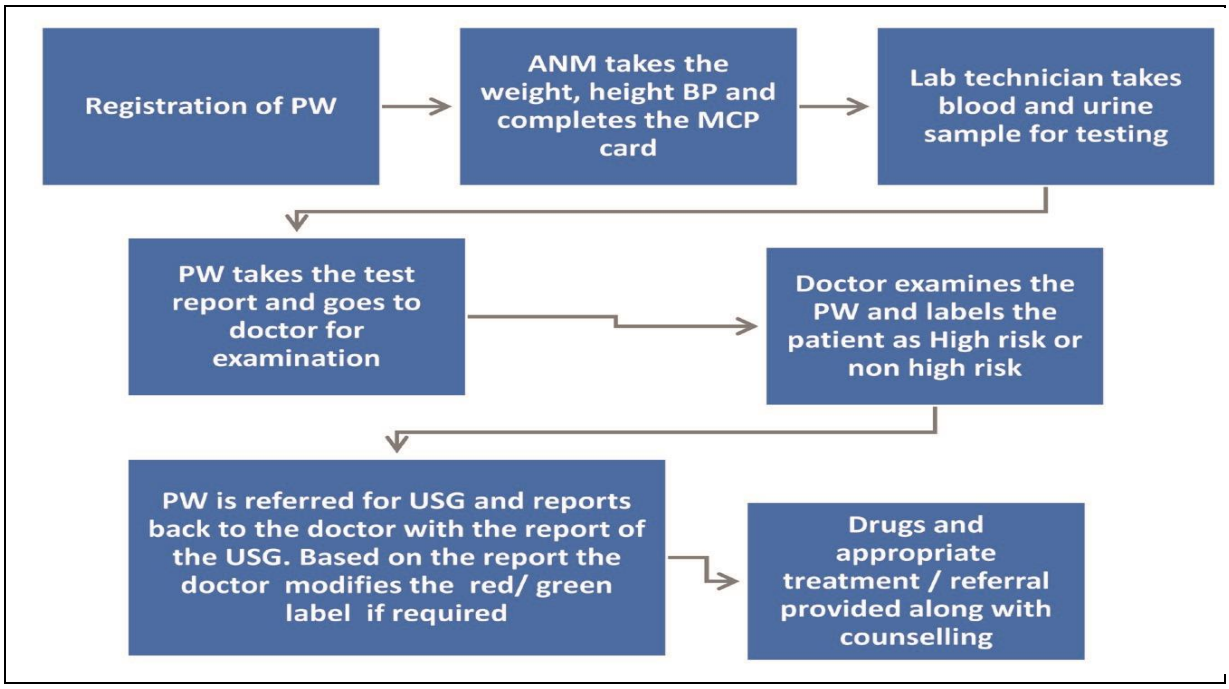


Figure 6: Procedure of flow of beneficiaries on the day of PMSMA camp, Source: PMSMA guidelines.

a**. Registration**: The ANM/ Staff nurse would register the pregnant woman coming to the PMSMA Center and provide her a MCP card and safe motherhood booklet.

b**. Examination**: The Staff Nurse/ANM will take the height and weight of the PW, check her pulse and BP and record the findings on the case sheet and send the mother to the laboratory for diagnostics.

c. **Diagnostics**: Following the registration, the woman should be provided with a printed list of investigations. All tests should be done by the Laboratory technician before the doctor examines the pregnant woman. If all tests are not available in the public facility the technician from the outsourced laboratory should be present in the facility. Blood sample should be collected at one go for all tests to be done irrespective of the place of testing. Once the samples are drawn, the pregnant woman should be conveyed the time when the report is to be collected. Women should not be called the next day for results of the lab investigations. The reports should be handed over on the same day to the beneficiaries to ensure that the doctor is able to see the reports during the examination of the PW and is able to categorize the PW into a high risk / non high risk category and initiate appropriate treatment.

d. **Examination by Obstetrician/ Medical Officer**: All PMSMA beneficiaries who registered would visit the Obstetrician/ medical officer with the report of their investigations. Examination by ANM/ staff nurses and lab investigations of beneficiaries should be started at least an hour before the Obstetrician/ medical officers starts examining the beneficiaries.

The doctor would reconfirm the findings noted down by the nurses, by systemic (especially BP checkups) and obstetric examination, followed by prescription of necessary drugs. The doctor would then refer the woman for USG and ask her to report again with USG findings. Based on the examination of the PW and reports of investigations & USG reports a red sticker / stamp would be put on to the MCP card of women who are found to be high risk.

During this campaign, trained service providers and ASHA should focus on identifying and reaching out to pregnant women who have either not registered for ANC or left out/missed ANC along with dropout cases as well as High Risk pregnant women. It will ensure that not only all pregnant women complete their scheduled ANC visits but also undertake all essential investigation. While 9th of every month will be organized as a special day, it is reiterated that the existing, routine and planned services such as ANC, PNC etc. will be delivered at all the facilities as scheduled.

Mandatory filling out the MCP cards at these clinics and marking with a sticker indicating the risk factor for each visit.
Green Sticker- for women with no risk factor detected; Red Sticker – for women with high risk pregnancy.

Stickers	**Condition**
Red Sticker	For women with high risk pregnancy.
Green Sticker	for women with no risk factor detected

Figure 7: Stickers and color for high risk and no risk pregnancy.

RATIONALE

MMR is one of the major focus issue among health indicators for India. Challenges in India for mother for high risk pregnancy has always been found. If all the pregnant woman are examined by a physician and undergo required tests at least once during the PMSMA camp and then followed up — this can result in decrease in the number of maternal and infant deaths in our nation. PMSMA is a newly launched program by govt. of India. Though the government of India has well planned and implemented and has a monitoring and evaluation system for the scheme for their program, still a rapid situational analysis was done to find the gaps in the effectiveness and functioning of PMSMA and for gaining knowledge and skills.

OBJECTIVE

1. To Carry out a rapid situational analysis to assess effectiveness of PMSMA camp in the community through observational study

2. To assess the awareness of beneficiaries in the PMSMA camp

3. To assess the awareness and practice level of ASHAs regarding ANCs services.

RESEARCH METHODOLOGY

Study Design: The study is Cross-sectional analytic in nature

Sample size- 48 pregnant women, 10 ASHAs

Study duration: one month

Study tool: The survey comprised semi-structured questionnaires for pregnant women and health staff in the sampled district and observation checklists. Convenience sampling was used for selecting Sanganer block, Jaipur district.

Study location: CHC Sanganer, Sanganer block, district Jaipur, Rajasthan

Study respondents: mothers pregnant 1-9 months who came for ANC checkup and ASHAs

Sampling method: Purposive sampling. The study is confined to one CHC only.

Data collection: A rapid situational analysis was done at the Centre and a tool in the form of questionnaire was prepared for beneficiaries and health workers in the area and responses were recorded.

The questions were closed ended so as to reach the target population and intent to find probable answers.

Data entry: All the responses were entered into Microsoft excel.

Data analysis Procedure: Different **responses from the respondent were coded numerically for the closed ended questions and entered into MS excel. The data is interpreted and analyzed with help of diagrams and graphs.**

OBSERVATIONS FROM VISITING THE FACILITY

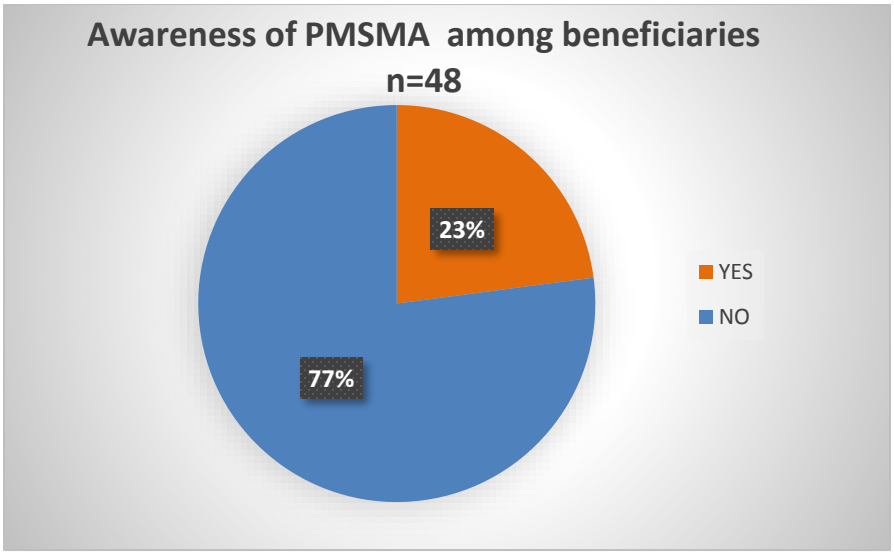
S NO	PARAMETERS	AVALIABILITY		FUNCTIONALITY	
		YES	NO	YES	NO
1.	TT INJECTION	☑		☑	
2.	IRON FOLIC ACID TABLETS	☑		☑	
3.	IV IRON	☑		☑	

	SUCROSE				
4.	HIV KIT	☑		☑	
5.	SYPHILLIS TEST KIT	☑		☑	
6.	B.P. MACHINE	☑		☑	
7.	WEIGHING SCALE MACHINE	☑		☑	
8.	TAB ALBENDAZOLE	☑			☑
9.	USG MACHINE		☑		☑
10.	THERMOMETER	☑			☑
11.	FETOSCOPE	☑		☑	
12.	SUGAR TEST	☑		☑	
13.	SITTING FACILITY		☑		☑
14.	DRINKING WATER AVAILABILITY	☑		☑	
15.	IEC AT FACILITY	☑			☑
16.	HRP STICKERS		☑		☑

RESULTS:

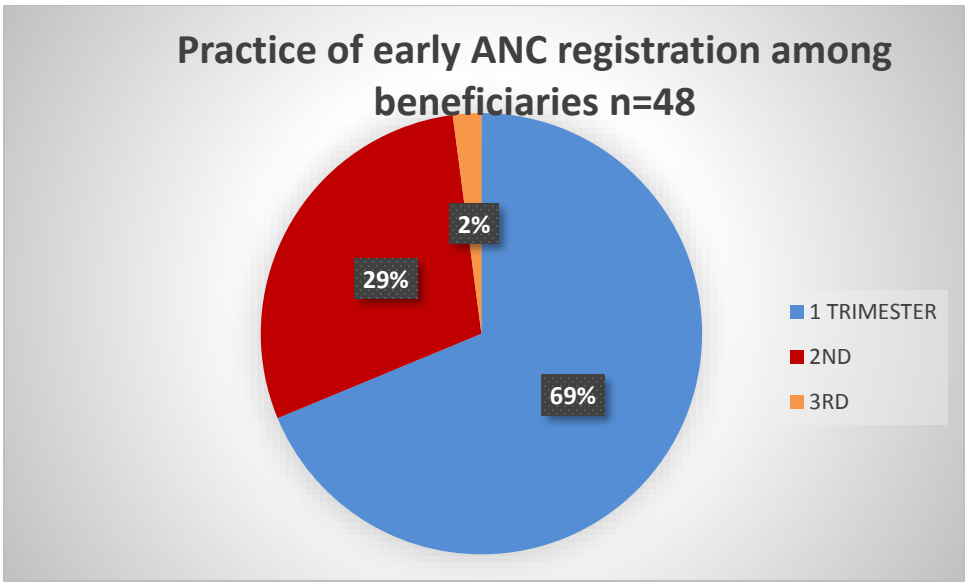
Questions based on knowledge and practice of pregnant women and health workers were asked, Following are the result of some of the indicators:

1. Awareness about PMSMA camps among the beneficiaries.



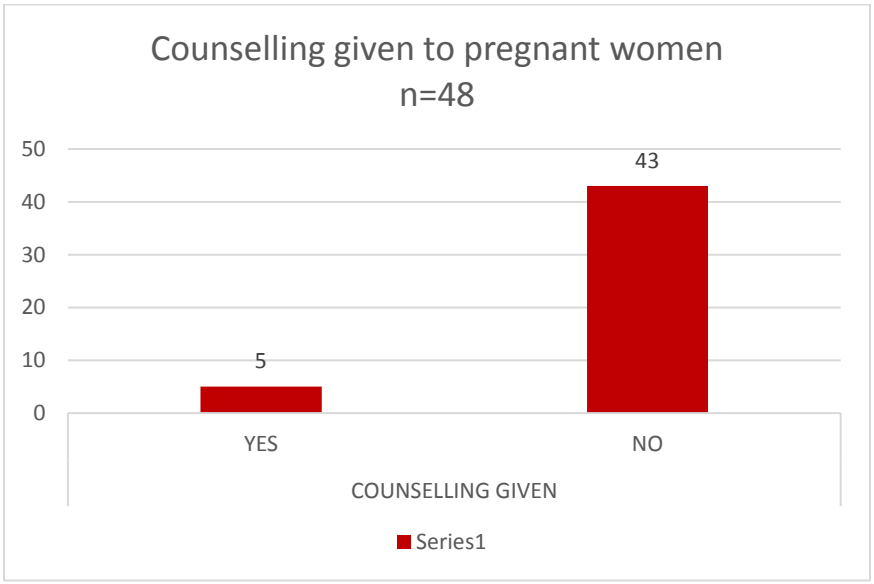
INFERENCE: only 23% out of the total visited pregnant women knew that every month on 9th PMSMA camp is conducted at health facility, 77% were not aware about the camp, which emphasizes the use of IEC material and its prominent placement at health facilities. Also a relation was seen with more educated women being aware about the scheme and lesser uneducated women being unaware. The study demonstrated the positive relationship between the utilization of antenatal care and socioeconomic background of mothers in terms of literacy status and household standard of living.

2 Practice of Early ANC registration



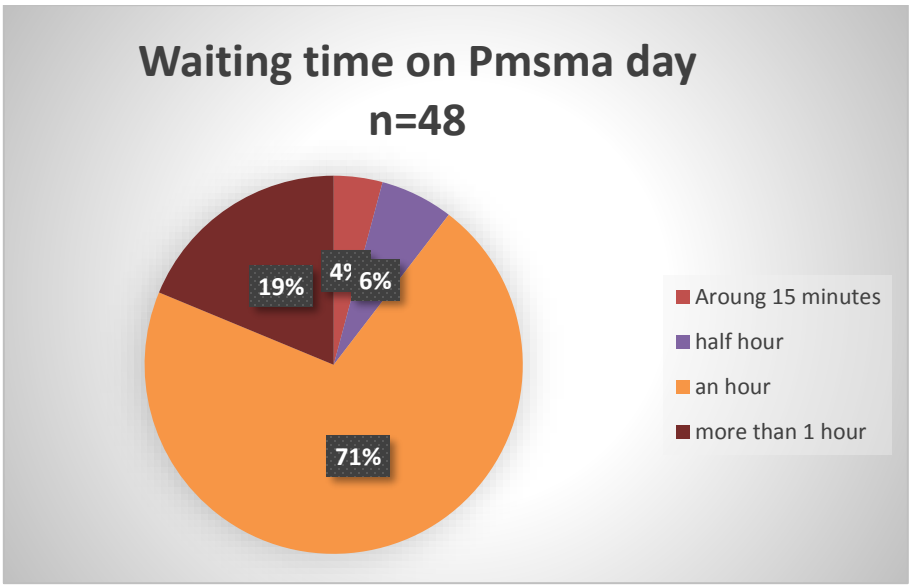
INFERENCE: early registration is the registration of the pregnancy within first trimester.69% had them registered in their first trimester while 29% in second trimester and 2% in third trimester. This shows that even today there is delay in early registration among pregnant women and few get registered late in their pregnancy period. ASHA and ANMs plays a major role in getting them registered early.

3 Practice of Counselling



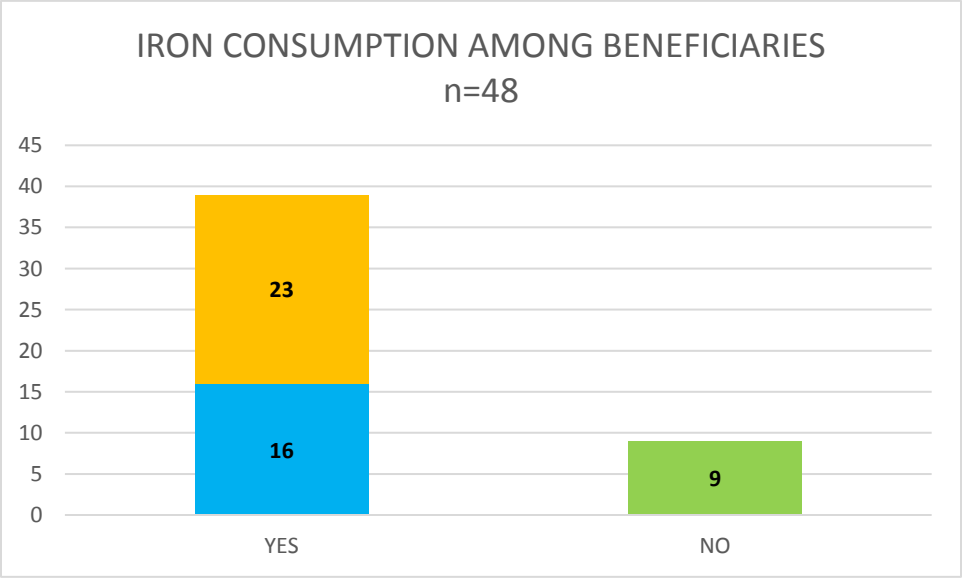
INFERENCE: one of the major components of camps is providing counselling to the women regarding delivery, health complications, breastfeeding, nutrition which was lacking. It was observed ¾ th of the patients were not counselled. Major reason included large number of patients and lack of staff which rendered no time for counselling.

4 Waiting time for pregnant women in PMSMA clinic.



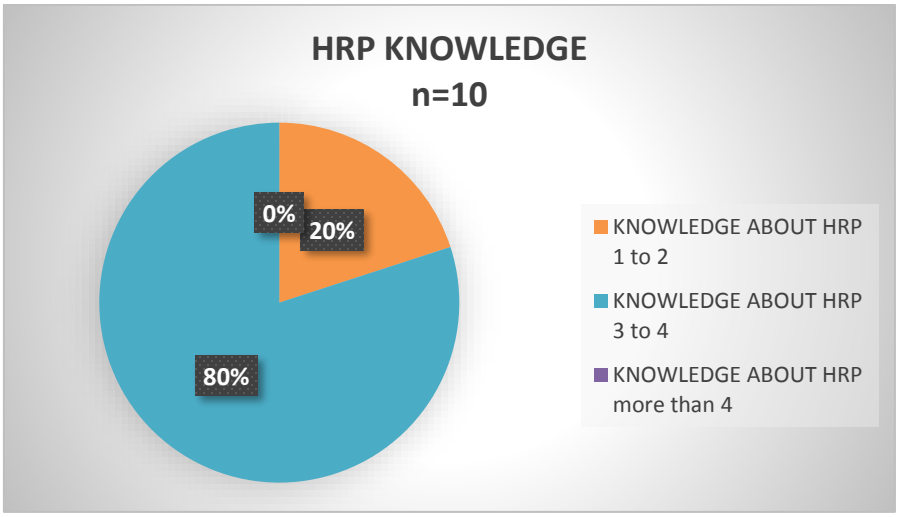
INFERENCE: 71% of the respondents said that their waiting time is around an hour and 19% said more than hour .This makes the pregnant women uncomfortable in the hot summer and the person escorting them on the camp. The major reason for delay was due to large number of OPD. This time can be utilized for counseling activities, which were lacking at the CHC.

5 IFA consumption among pregnant women



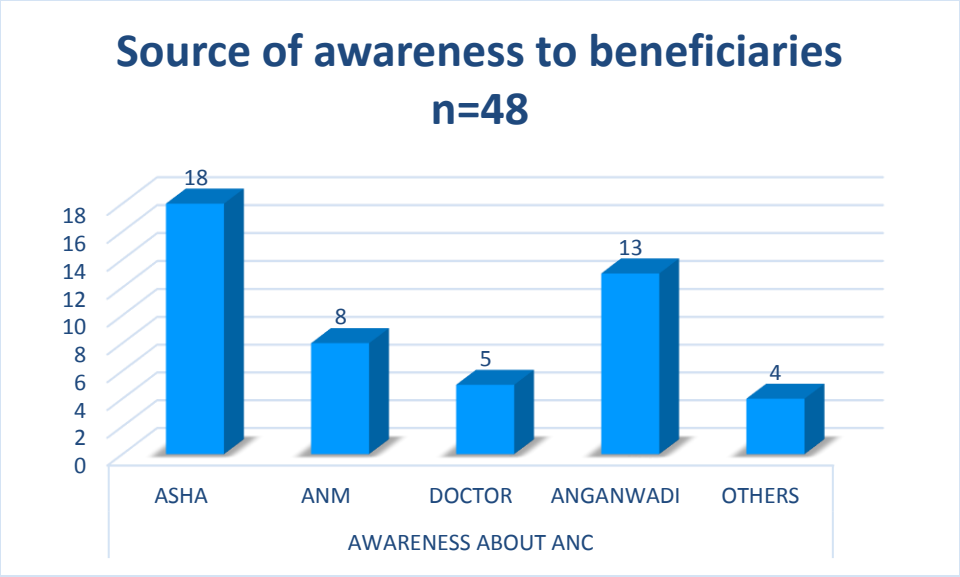
INFERENCE: Even though three-fourth women suffer from anemia and it is compulsorily advised to take iron supplements during pregnancy, only 16 out of 48 i.e. 33% of total consumed on a regular basis ,rest 23 women i.e. 48% did not take the supplements regularly. Most of the women who came to the camp were taking iron tablets as advised by the gynecologist. Reasons for not taking medicines were-some of them came for the 1st time and others due to various reasons like taste factor or did not considered it as an important measure.

6 knowledge of High risk pregnancy factors among ASHAs



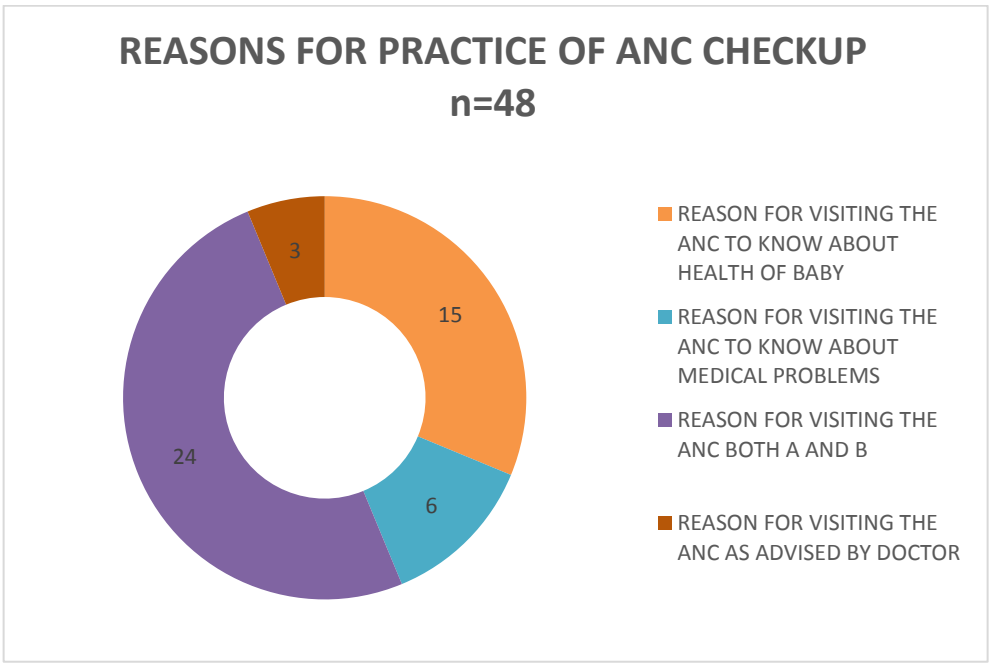
INFERENCE: While most of the ASHA and health workers had knowledge about high risk pregnancy, 80% of them were not aware about more than 4 high risk factor criteria. This shows a need to provide adequate training on knowledge about high risk pregnancy criteria and its management.

7 Source of ANC awareness among community



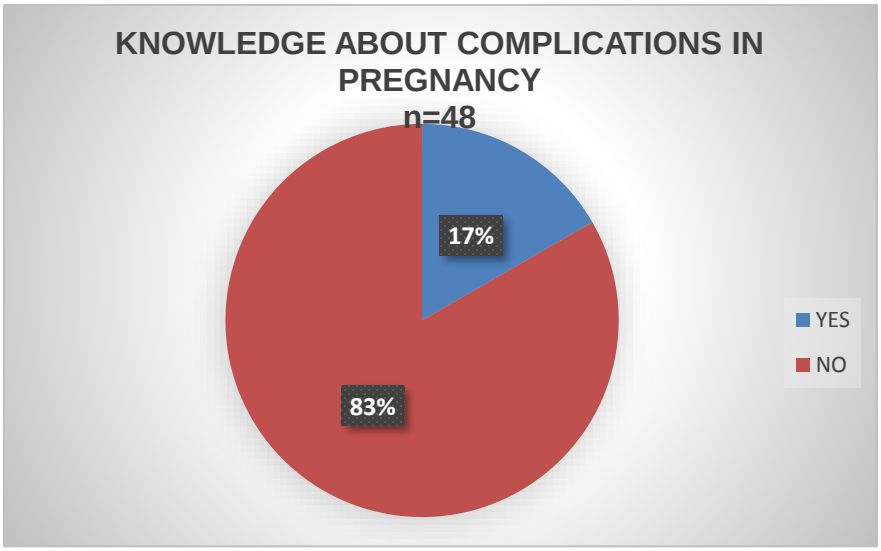
INFERENCE: ASHA is the first line of communication between the community and health system and is primarily responsible for awareness about ANC and change of behavior towards the health services utilization. The graph shows most women were informed by ASHAs and Anganwadi workers while few were also informed from friends, relatives through word of mouth. The reasons for less contribution are because they are not sensitized about the importance of ANC properly.

8 Knowledge for ANC among beneficiaries



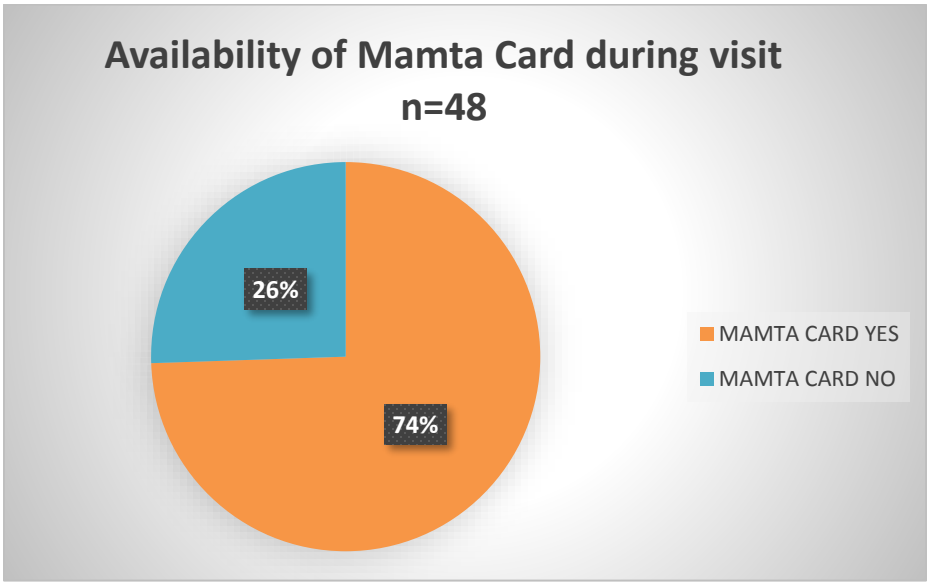
INFERENCE: among the respondents, it was observed that they had adequate knowledge and were aware that ANC is necessary for both mother and child health and care. 50% responded that is necessary to get ANC done for both mother and baby while 31 % agreed it is important for the developing fetus health.

9 Knowledge about the complications among beneficiaries



INFERENCE: It was surprising that pregnant women were not sensitized regarding the symptoms or knowledge about the pregnancy complications. This is due to lack of counselling at grass root level. Few women knew because of the problems encountered /earlier experiences in the previous pregnancies.

10. Mamta card for ANC



INFERENCE: Even though it is mandatory to get mamta card after their ANC registration, as it helps marking high risk pregnancies and their follow up, one-fourth of the respondents did not have the card. This was due to lack of documents submission at their Anganwadi centre or delay in seeking ANC care**.**

LEARNINGS

1. Gained knowledge about the program through the literature review.

2. Field visit learning:

The purpose was to provide field exposure and learn about the Pmsma program and do rapid analysis. Various parameters/indicators are used to measure maternal health.

PMSMA takes place at PHC and above level where line listing of pregnant women is done. Learned monitoring and evaluation skills of health workers at CHC level.

It was a great experience visiting CHC, Anganwadi Centre and households, the effectiveness was measured only by interacting with beneficiaries personally.

Key observations:

- Lack of proper placement of IEC materials and knowledge, among the pregnant women of the PMSMA camp
- Unavailability of the few basic amenities like carpet which was noticed and sufficient number of chairs causes inconvenience to the HRP's. Lack of sitting facility for the pregnant women and the person escorting them. This limited availability even causes the hustle-bustle and unwanted confusion in the camp.
- The Waiting time period for the whole procedure was 1 hour or more.

- Knowledge among staff regarding the criteria of High Risk Pregnancy was not satisfactory.
- non availability of coolers in scorching summer and heat was noticed and frequent power cuts not only causes suffering for HRP's and their relatives but also causes job dissatisfaction among the health care providers which further reduces the serving standard of the care by them.
- The Absence of facility of sonography at the centre which are mandatory according to the guidelines of the camps. This not only causes discomfort to the HRPs but also out of pocket expenditure in sonography and transportation of the HRP's to the higher centre will discourage the women to avail the proper diagnosis in appropriate time, causing already risky pregnancy even more dangerous.

LIMITATIONS

- One month study is a short period for the study.
- There was a scope for more in depth probing of various components making the study more interesting.
- Sample size taken is small and size might not represent the entire universe of the study.
- Bias may be present depending on the location used for data collection.

ETHICAL CONSIDERATIONS

- Confidentiality of the respondents will be maintained to ensure anonymity.
- Information received from respondents will not be misused in any form.
- Respect and dignity of the respondents were taken care during study and clear explanation of study intention was offered.

CONCLUSION

- People don't have knowledge of these camps so it hinders the success of these camps to some extent.
- The IEC material for the camps are inadequate at the CHC
- The ANM and ASHA had a good knowledge about high risk pregnancy and were trained well for their part in the implementation of the program.
- The arrangements for the camps are not up to the mark.
- There is no proper counselling of the high risk pregnancy women.
- All the criteria for the detection of HRP are not taken into consideration.

RECOMMENDATIONS

- Ensuring availability of USG and HRP stickers and conducting regular annual audits for the materials availability at the facility.
- Limited opening hours, large distances and waiting times, causes inconvenience to the beneficiaries. Therefore, proper sitting arrangements, and ensuring comfort to pregnant women when they visit the facility.
- Involvement of ASHA and ANM to increase the awareness about the camps. Training session can be kept in six months/yearly to keep the health workers updated about the newly launched health programs.
- Time for service delivery should be checked. To reduce the waiting time, involving more staff members on PMSMA day. Few tasks can be given to other cadres, for saving the time and giving them higher impact tasks. Rotation of staff members to enhance the knowledge and decrease the workload on limited health workers.
- Utilization of the waiting time for counselling of pregnant women, either in groups or individually.
- Scheduled Timings of the camps should mandatorily be followed.
- Use of more IEC material and its placement at commonly visited public places and health facilities like in the examination room etc. along with use of inter- personal communication to increase the reach of PMSMA. Recommending women to come for free checkup on 9th of month on her next due appointment. Irrespective of the antenatal camps attended previously, focus should be on that they should attend at least one additional ante-natal care clinic conducted as a part of PMSMA, during their second or third trimester.
- USG Test facility should be preferably made available at the Centre instead of referring the patients.
- Health workers must motivate pregnant women to attend the maternal and child health clinics. Increasing literacy levels and raising the standard of living may fall in the domain of development planning.
- Fortified food for treating iron deficiency and prescreening of childbearing women for anemia during their reproductive age 19-35 years will help in monitoring iron deficiency an its proper treatment.

STUDY ON ONLINE PAYMENT MODULE OF JSY AND RAJSHREE SCHEME

Introduction:

- Online JSY Payment Module is an online system for direct benefit transfer to JSY scheme, Rajshree Yojana and Shubhlaxmi Yojana beneficiaries. Under the active leadership of Mr. Naveen Jain(MD, NHM),OJAS was launched in Rajasthan on 1st August, 2015 for online transparent payment of incentives to beneficiaries under JSY, Shubhlaxmi Yojana, Rajshree Yojana at public health facilities up to CHC level to overcome the gaps and lag in payment to beneficiaries.
- From 1st August, 2015 to 31st March 2016, 4.42 lakh pregnant women benefitted under the scheme for JSY and payment of `62.57 crore has been transferred. 2.19 lakh benefited under SLY and payment of 46.40 crore has been transferred. In the first phase of OJAS was started covering all the medical colleges, District hospitals, sub district hospitals and CHCs In the second phase, it was launched for all PHCs in December 2016.
- It facilitates to get all the details of beneficiary of payment for after due eligibility at PHC. "OJAS Software is online web portal .The software is integrated in PCTS.

Objectives of OJAS: -

To ensure the timely and seamless online payment for JSY, RY, SLY beneficiaries. The OJAS Software has been conceptualized with following objectives:-

- To make timely online payments for JSY ,SLY, RY
- To monitor the performance of every delivery
- To identify the Gaps and need assessment at facility level and community level.

OJAS was started because of the following reasons**:-**

- There was Cheque based mode of payment for JSY, SLY
- There was no timely encashment of cheques by beneficiary
- Lack of Transparency in the payment system
- Lack of Data base hub through addition of various features like transportation, weight of babies, etc.
- Lack of details at the time of delivery for the C-section, sex at birth, twins, less than 2.5kg
- Large amount of money wastage/leakages in scheme.
- For various reports to monitor the progress of the programme and health information.

Thus, Rajasthan is the first state to start online payments of JSY, RSY, SLY. Due to the system, various reports are possible now from OJAS. They are as follows:

- Improved transparency in the online payment system.
- simplification of payment system
- Daily delivery status at health institutes
- Assessment of the various health reports which were not available earlier like death of women during the stay in institutes, Weight of LBWs babies, hospital stay duration of women.
- Ratio of birth of girl child can be monitored at district and state level.
- Referral transport reporting can be watched.
- Easy monitoring of the physical and financial progress under the programme.
- Beneficiary deposit the document once and need not come repeatedly at institution.
- Launch of Shubhlaxmi Yojana which was availed till 1 June 2016 and Rajshree Yojana on 1st June 2016 for the female child as beneficiaries.

PCTS

Health & Family Welfare department, Govt. of Rajasthan designed Pregnancy, Child Tracking & Health Services Management System which is an online software and act as an effective management tool The system maintains all the data of various government health institutions in the state which ease in monitoring of data.

Challenges for the system.

- Data problem at PHC level.
- Planning to provide this facility at sub centre level but huge investment is required.

Operational definitions:

Cash transfer: Cash transfers can be described as a class of instruments that transfer cash with or without conditions, directly to poor households

Conditional cash transfer: they provide cash directly to poor households on the condition that those households make pre- specified investments in the human capital of the health of mother and newborn. Specific conditions may be attached to these transfers like institutional delivery and /or attendance at health clinics, participation in immunization etc. Such schemes create incentives for households to enhance their behavior towards achieving the social goals.

PRE-REQUISITES FOR CASH TRANFER SYSTEM

The design of any cash transfer has many elements, all of which need to be assessed for the cash transfer system to operate smoothly**.**

1) A unique-identification card is necessary to cover all the recipients of any cash transfer under a unique identification system. This is being done under the UIDAI's Aadhaar scheme.
2) The bank account to be jointly or individually held by the beneficiary.
3) Universal access to banking- everyone should have access to the banking system in one form or the other within a reasonable distance.
4) Along with having access to the banking system, everyone must have a bank account.
5) Data Bases for transfers and link with Unique I.d. - a Cash Transfer System requires a database of beneficiaries. These databases have a correspondence with the unique ID so that there is a common platform for money transfers. The Implementing Agency should ensure that the database has the details of the Unique ID number while the Banking system should have the mapping of Aadhaar numbers to the bank accounts.
6) Transfer Procedures/ Checks/ Mechanism – they should have inbuilt checks and balances for traceability, preventing fraud and audit of transactions.

The online payment process: -

OJAS was developed in a short time span because of the keen interest displayed by the government to solve the major issues, which were being faced at grass root level. The software has been developed by NIC, Rajasthan state unit headed by the Mission Director, NHM, Rajasthan. This online payment process has been implemented across the state from 1 August 2015 at CHC and higher govt. health institutions with the addition of PHCs from December 2016.

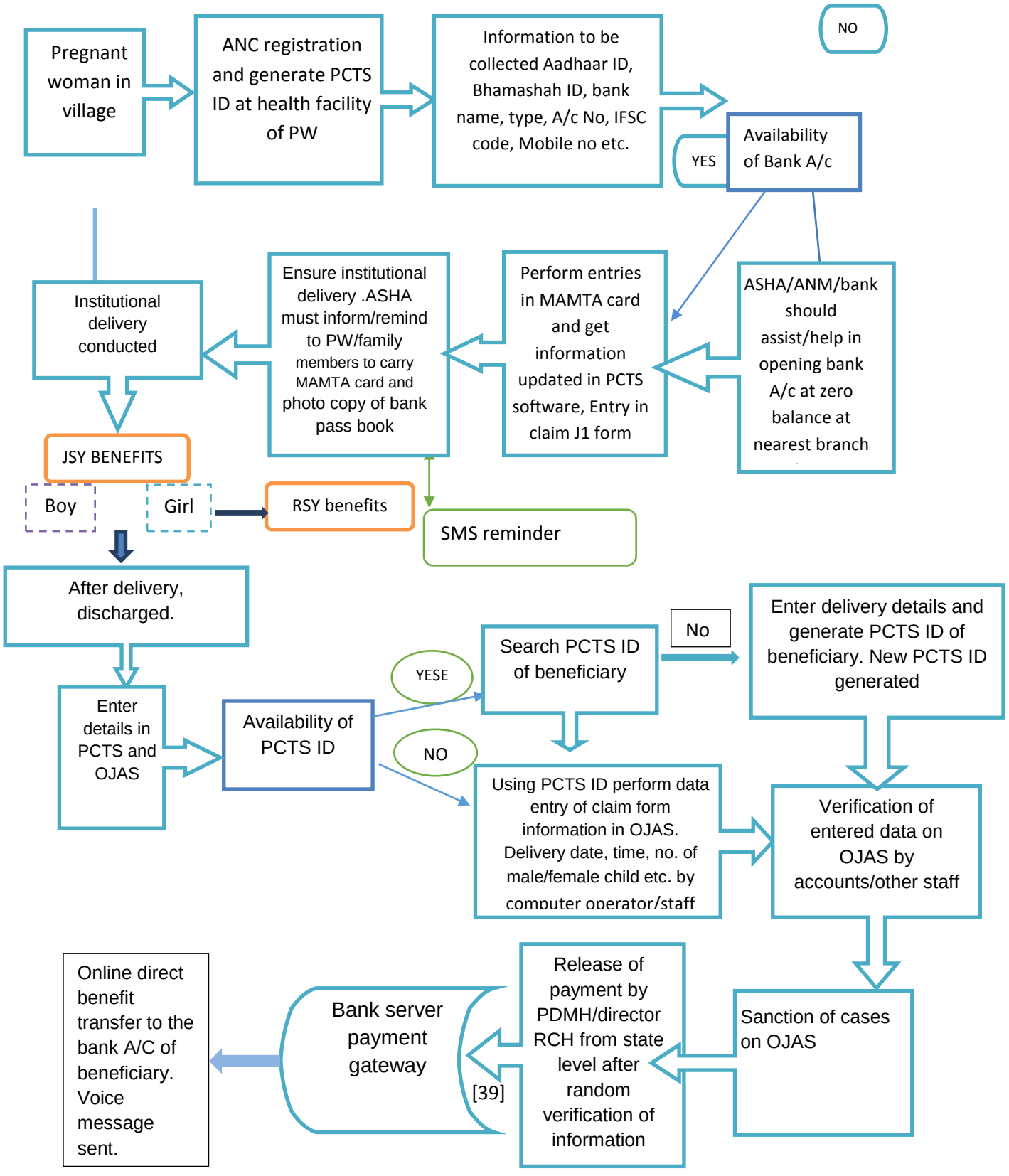

Pregnant woman in village
ANC registration and generate PCTS ID at health facility of PW
Information to be collected Aadhaar ID, Bhamashah ID, bank name, type, A/c No, IFSC code, Mobile no etc.
NO
YES
Availability of Bank A/c
ASHA/ANM/bank should assist/help in opening bank A/c at zero balance at nearest branch
Perform entries in MAMTA card and get information updated in PCTS software, Entry in claim J1 form
Ensure institutional delivery .ASHA must inform/remind to PW/family members to carry MAMTA card and photo copy of bank pass book
Institutional delivery conducted
JSY BENEFITS
Boy
Girl
RSY benefits
SMS reminder
After delivery, discharged.
Enter details in PCTS and OJAS
Availability of PCTS ID
YESE
NO
Search PCTS ID of beneficiary
No
Enter delivery details and generate PCTS ID of beneficiary. New PCTS ID generated
Using PCTS ID perform data entry of claim form information in OJAS. Delivery date, time, no. of male/female child etc. by computer operator/staff
Verification of entered data on OJAS by accounts/other staff
Sanction of cases on OJAS
Release of payment by PDMH/director RCH from state level after random verification of information
[39]
Bank server payment gateway
Online direct benefit transfer to the bank A/C of beneficiary. Voice message sent.

Figure 8: process flow of online JSY payment through OJAS

AIM: The Study is done to assess the online JSY payment module and find the high, average and low performing districts of Rajasthan.

LITERATURE REVIEW

Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana launched by the NRHM, is a safe motherhood program with the major objective of reducing maternal and infant mortality and promoting institutional delivery among the poor pregnant women. It has been improvised in all states with special focus on low performing states. It is a conditional transfer of cash that ensures quality maternal care. JSY is sponsored by the center government .This Scheme has majorily contributed in increasing the Institutional deliveries among the low socio-economic groups.

The Yojana is implemented by recognizing ASHAs as an important link between the Government and the beneficiaries in 10 low performing states. In other eligible states and UTs, AWW and TBAs have also been engaged for the same.

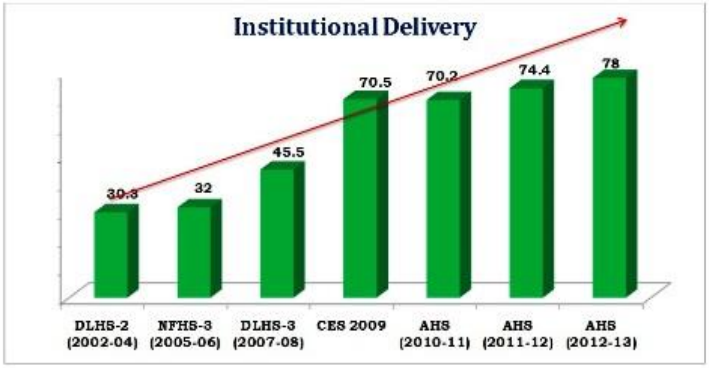


Figure 9: Institutional delivery trend in Rajasthan, Source: Health indicators, NHM Rajasthan site.

Key Features of JSY:

- The states named as Low Performing States (LPS) are the ones having low institutional delivery rates and the remaining states are named as High performing States (HPS).
- Cash assistance for home delivery

  BPL Certification is required in all HPS states. BPL pregnant women, who are not able to deliver at institute, are entitled to a cash benefit of Rs 500 per delivery regardless of the age of pregnant for up to two live births. However, at some places where BPL cards are not issued or available, the gram Pradhan or ward member will provides help.
- Eligibility: All women delivery delivering in govt. institute and marked private health centres. For beneficiary outside state, benefits given on providing the ANC card.
- Each beneficiary registered have a JSY card along with a MCH card. This will help in Tracking all the pregnancies and monitoring Antenatal Check-up, and the post-delivery care effectively.
- Outlay of Cash Assistance it is verified and sanctioned at the delivery institution itself as the cash assistance to the mother is given to meet the cost of delivery. Beneficiaries who deliver at institutions, entire cash entitlement is released in one go specifically at the time of delivery and before getting discharged. After verification, payment is released and transferred to women bank account within seven days of delivery.[5]

Category	Rural Area		Urban Area	
	Amount given to mother	Amount given to ASHA	Amount given to mother	Amount given to ASHA
LPS	1400	600	1000	400
HPS	700	600	600	400

4

Figure 10: Cash Assistance for Institutional Delivery (in Rs.), source: JSY guidelines

RAJSHREE YOJNA

The mortality rate of the girl child is one of the stigmas for the society and to address this serious issue, the Government of Rajasthan formulated a scheme which not only encourages the birth of girl child but also makes them empowered through good education.Criteria for availing the scheme are:

[5] [5] https://www.nhp.gov.in/janani-suraksha-yojana-jsy-_pg

4 **Guideline for Janani Suraksha Yojana (JSY)**

1. Only girl children are eligible for this scheme
2. Girl child must be born in Rajasthan state
3. Girls born on or after 1st June 2016 will be eligible for benefits under Mukhya Mantri Rajshree Yojana
4. Scheme eligible for up to two girl child born.

Key Features:

Every parent will be benefitted with Rs. 50,000 for education and health of girl child. This amount is divided into different steps:

1. At the time of birth- Rs **2500** will be given**.**
2. In the first year of vaccination- Rs **2500**
3. At the time of admission in Class 1st – Rs **4000**
4. At the time of admission in Class 6th – Rs **5000**
5. At the time of admission in Class 10th– Rs **11,000**
6. At passing in Class 12th– Rs **25,000**

SHUBHLAXMI YOJNA

In order to check the maternal mortality ratio and to encourage the birth of a female child this scheme was launched on 1st April 2013.
Under this scheme on or after 1st April 2013 till 31st may 2016, if a female child is born in any Govt. Health Facility and accredited private hospital under JSY, the mother will be paid an amount of Rs 2100/- after her discharge. This amount will be in addition to the payment under the JSY scheme.
After the completion of 1st year and all the scheduled vaccination to the child the mother will be paid an additional amount of Rs 2100/-.
After the child is 5 years old and after she takes admission in a school the mother will be paid an additional amount of Rs 3100/-
Payment of 2nd installment given only when first criteria is fulfilled.

OBJECTIVE:

1. To assess the effectiveness of online JSY and Rajshree payment module in Tonk, Jaipur, and Jaisalmer districts, Rajasthan

2. To assess the reports of indicators related to JSY Scheme in the above three districts of Rajasthan.

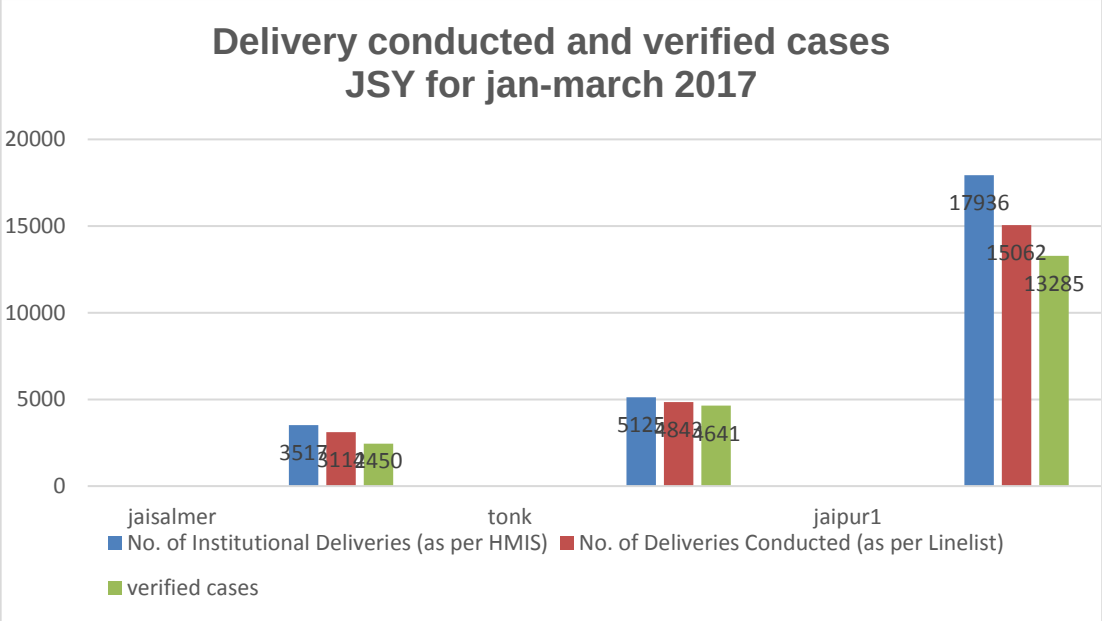
RESEARCH METHODOLOGY

Research design – research design for this study is quantitative research.
Study type- retrospective and analytical.

Data collection – data type is secondary data.
Sampling unit- all beneficiaries who delivered during the month of Jan –march 2017.
Study Location- District Jaipur 1, Tonk, Jaisalmer, Rajasthan
Data analysis procedure: The data is interpreted and analyzed with help of diagrams and graphs in MS Excel.

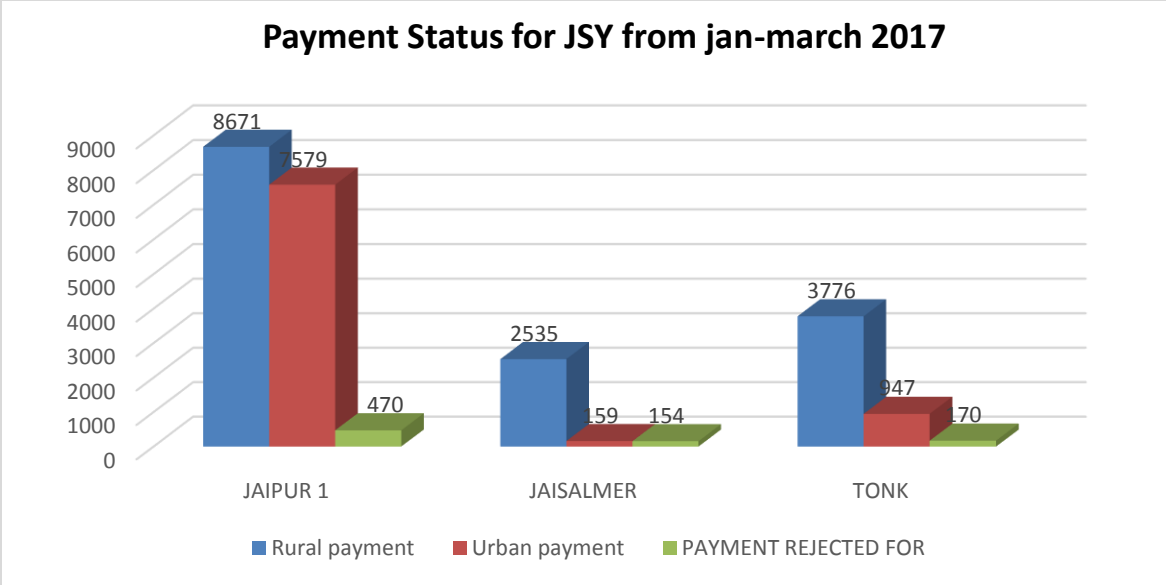
DATA ANALYSIS

1. Discharge and payment status for delivery cases in three districts during the 4th quarter of financial year 2016-17



INFERENCE: the graph shows that the difference in the number of deliveries conducted and the verification status is very less which signifies the use of online payment module efficiently. Jaipur shows the largest number of cases due to large population size while Jaisalmer shows the least number of cases.

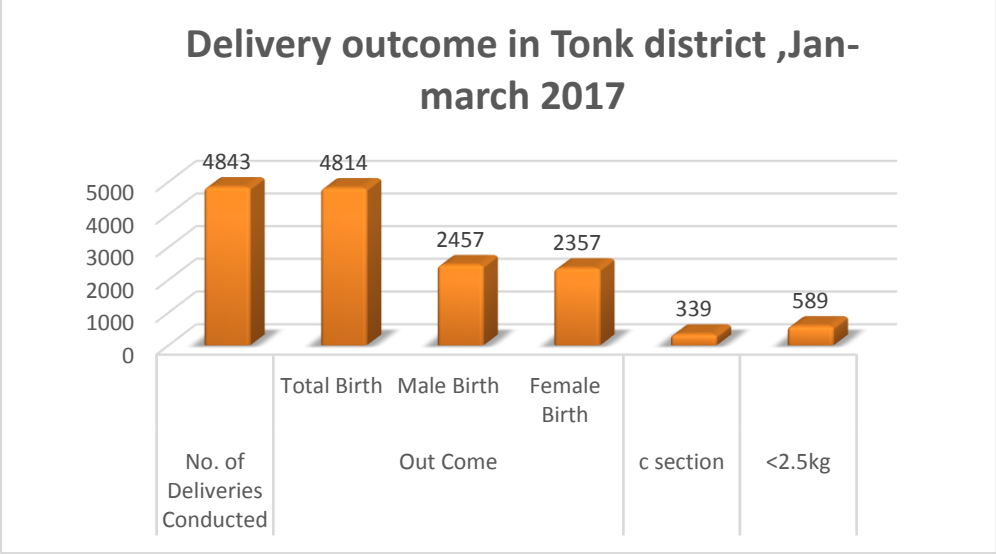
2. JSY Payment status in urban and rural area of the three districts.



INFERENCE: the analysis shows that the payments among the verified and rejected cases in the rural and urban area, rural cases are more as compared to urban population. This shows good awareness of the JSY scheme among the rural population. The reasons for payment rejection include lack of submission of documents on time or absence of bank account details of the beneficiary.

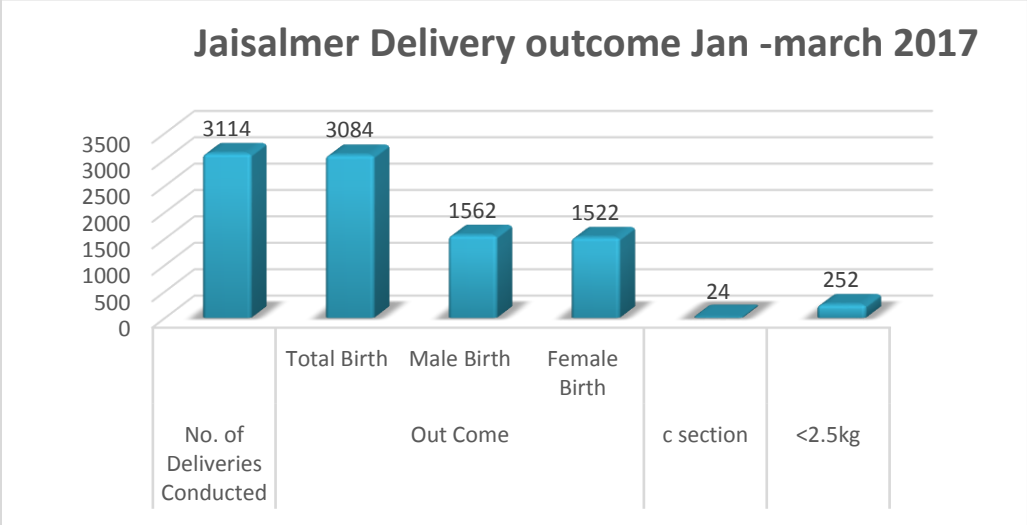
The total number of rejected cases is least for Jaisalmer i.e.154 and highest for Jaipur i.e. 470

3. Delivery outcome in Tonk district



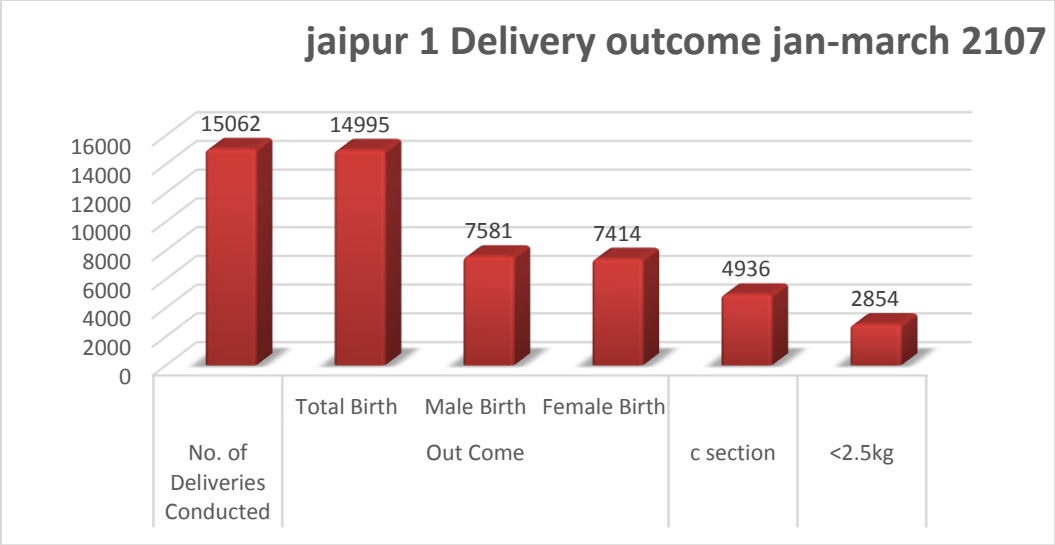
INFERENCE: the analysis shows that the proportion of LBW and C section deliveries are still there in spite of efficient JSY implementation. The reasons may be malnutrition and lack of proper monitoring and counselling of cases.

4. Delivery outcome in Jaisalmer district



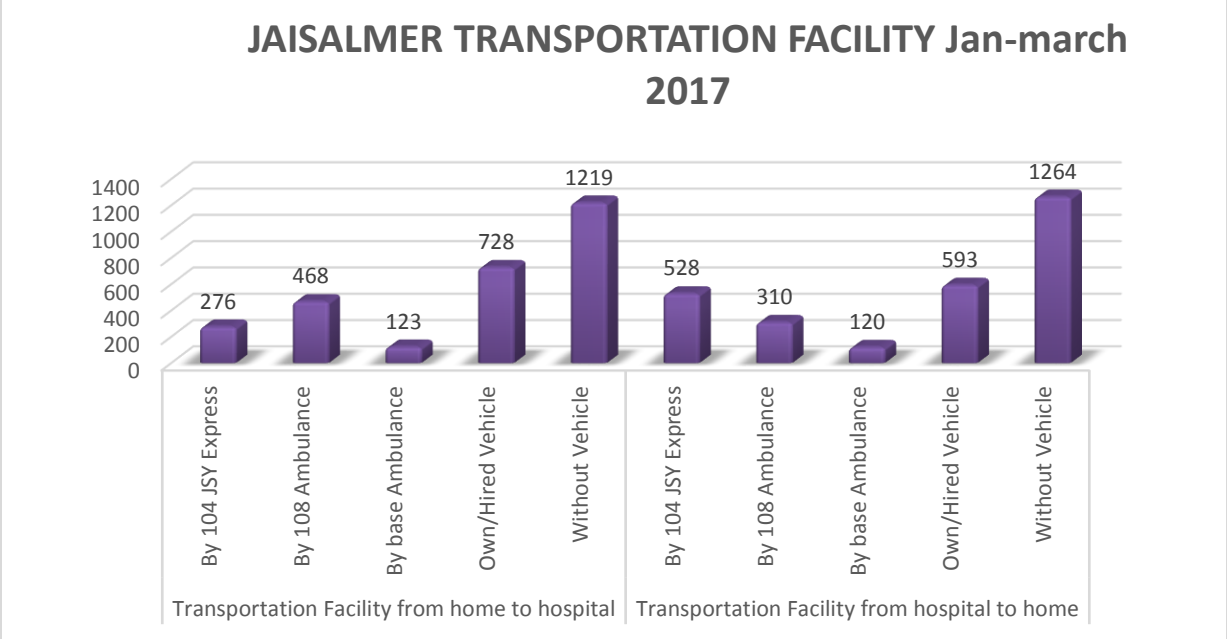
INFERENCE: the analysis shows that the proportion of LBW and C section deliveries are less as compared to other districts. This shows efficient monitoring of mother and newborns in the district.

5. Delivery outcome in Jaipur district



INFERENCE: the analysis shows that the proportion of LBW and C section deliveries are more than other districts. The reasons may be malnutrition, lack of proper monitoring of cases, ANC registration in the district and more number of references to the capital from other districts.

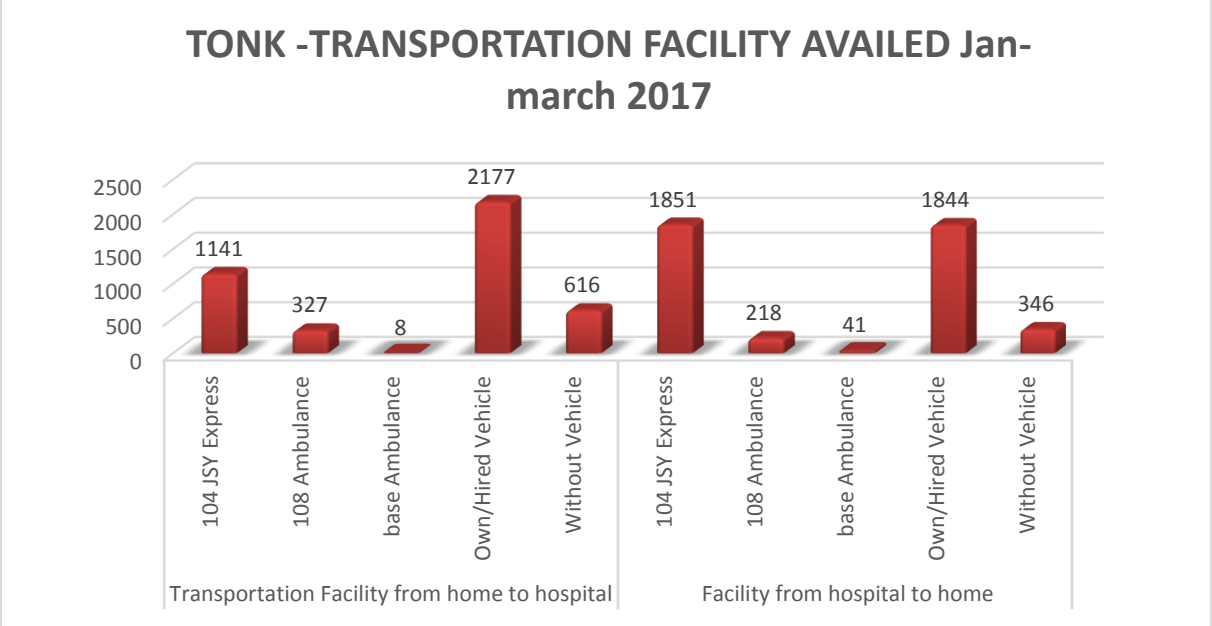
6. Utilization of Transport facility indicator in JSY scheme in Jaisalmer



INFERENCE: the analysis shows that the utilization of free transportation facility is less and 1219 people do not use any service. The use of 108 facilities is more than 104 ambulance

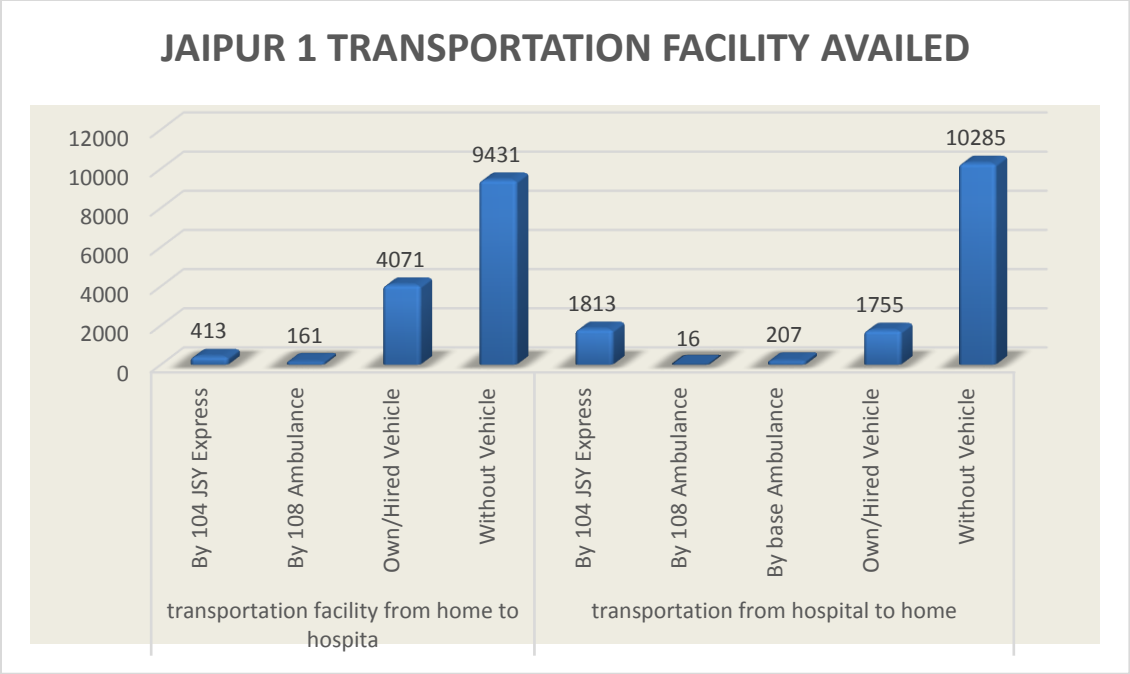
services which signifies lack of 104 awareness among population during home to health facility.

7. Utilization of Transport facility indicator in JSY in Tonk



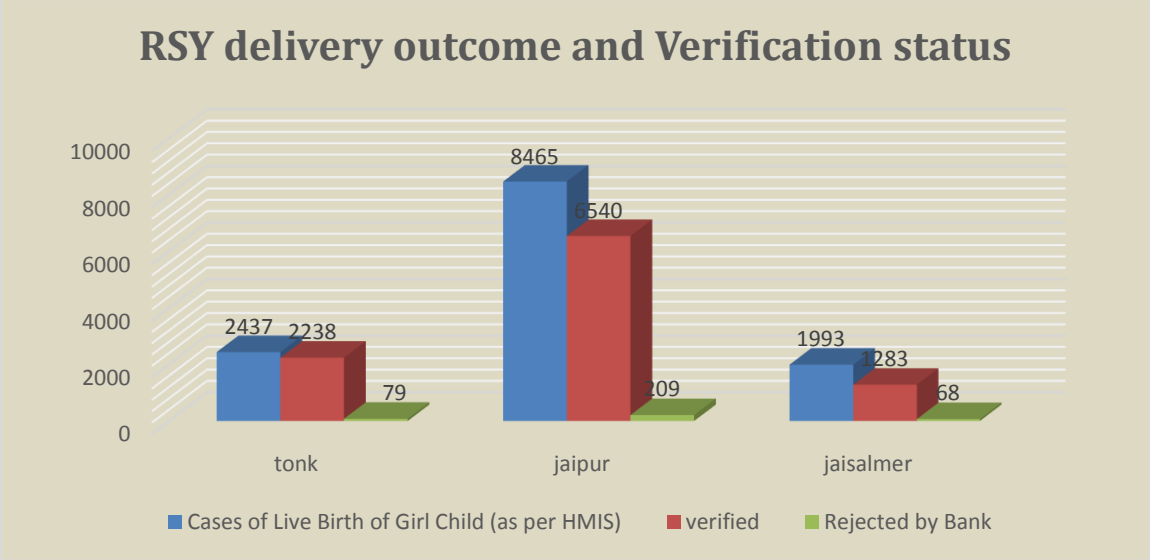
INFERENCE: the analysis shows that the utilization of free transportation facility more than Jaisalmer and 616 people do not use any service. The use of 104 facilities is more than 108 ambulance services which signifies there is awareness about 104 ambulance services among the population.

8 Utilization of Transport facility indicators in JSY scheme in Jaipur



INFERENCE: the analysis shows that the utilization of free transportation facility is quite insignificant as compared to delivery conducted in the district and 9431 people do not use any service. The use of both 104 and 108 ambulance services is very negligible which means awareness and utilization is low in the district.

9. RSY delivery outcome and payment status in the three districts from January to March 2017



INFERENCE: The analysis shows that the number of rejected cases for RSY is lowest for Tonk and highest for Jaipur 1. The difference in number of cases reported and verified is highest for Jaipur 1 and lowest for Tonk. The cases of pendency for cash payment is due to rejection by bank which is comparatively very less for all the three districts.

DISCUSSION AND OBSERVATIONS

- From the month of January to march 2017, district of Tonk, Jaipur, Jaisalmer cases of delivery reported and verified taken into account. After analysis, it shows that Tonk is high performing (90%), Jaipur is average (74%) performing and Jaisalmer is a poor performing districts in the State. (69%)
- Tracking of delivery outcome, low birth weight in all the districts is feasible.
- It was observed that almost all beneficiaries had received the cash amount within a week of delivery.
- Difference in HMIS reporting cases and line listing cases is present.
- Utilization of ambulance services from home to hospital is low in Jaipur and Jaisalmer.
- Delivery conducted and live birth rate is good for Tonk.
- A lot of people go for the benefits of the scheme but many of them cannot get the benefits because either do not opt for institutional deliveries which is mainly seen in rural areas, or people from rural areas do not have bank accounts so they cannot get the benefits of the scheme.
- Pending cases are due to lack of documents 98% and 1% due to technical errors.
  For JSY (account no, Aadhaar card) are not there with the beneficiaries, for RSY (Bhamashah card) is not there, which are mandatory documents.

CONCLUSION

The payment through OJAS is convenient and it directly goes to the beneficiary so it's a transparent system.

- Data entry level at PHC level not always available.
- Some people do not have bank accounts.
- If the operator commits a mistake during verification, it delays the payment to the beneficiary. But there are some challenges.
- No tracking of payment status for the beneficiary if the payment does not get sanctioned. Sometimes the entry gets duplicated. So quality of data gets hindered.
- Chances of error are there during the whole process.

Recommendations

- Giving deadlines to beneficiaries to submit the documents required within time frame.
- Maintenance of quality of data records and prevention of duplication.
- People should be encouraged to have bank accounts.
- Awareness about the utilization of Ambulance services.
- Absconding cases/migratory cases should be given benefits.

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ANNEXURE

1.1 List of people interacted during internship period.

S. No.	Name	Designation
1.	Mr. Naveen Jain	Mission Director, NHM.& Secy.to Govt. of Rajasthan
2.	Dr. Jalaj Vijay	SPM NHM
3.	Dr. Tarun Chaudhary	Project Director, Maternal Health
4.	Dr. Suva Lal	Project Director-RBSK
5.	Ms. Anju Rajpal	Project Director NHM & Add. Director IEC
6.	Ms. Shakunta Choudhery	State Demographer
7.	Ms. Nalini Khatri	Program officer IMEP
8.	Mr. Hemendra Baplawat	Consultant, (JSY) Janani Suraksha Yojna
9.	Dr. Anurodh Tiwari	Consultant, (MH), Maternal Health

10.	Dr. R. K. Jat	Nodal Officer (JSY and MSLY)
11.	Dr. Rommel Singh	Child health
12.	Ms. Priyanka Kapoor	Consultant (MMU and 104-MAS), (ISC-108) and 104 (Janani Express)
13.	Mr. R C Rawat	Social Scientist
14.	Dr. Khushboo Jain	Consultant cum Technical Officer, Public Health (QA)
15.	Sh. Prem Shankar Sharma	Asst. Statistical Officer
16.	Ms. Shikha Sharma	Consultant IAP
17.	Dr. Kapil	Consultant, Child Health
18.	Sh. M P Jain	State Nodal officer .BSBY
19.	Sh. Nirmal Prajapat	Data Officer ISC
20.	Ms. Vatsala Sharma	Program officer, SPM unit
21.	Ms. Aparna Jha	Health manager, PNPDCT
22.	Dr. Dinesh Sharma	CMO, CHC Amer
23.	Dr. Abha Sethi	Specialist, CHC Sanganer
24.	Dr. Shashi	JSY Officer, Kanwatiya Hospital, Jaipur

25.	Dr. Vijay Daya	Jsy nodal officer, Zenana hospital.
26.	Ajita T.	LHV, CHC Sanganer

1.2 WORKSHOP ATTENDED

DATE	MEETINGS/WORKSHOP ATTENDED
13/04/2017	District level urban health Planning, NUHM

1.3 PICTURES

Picture 1 Examination room in PMSMA camp visited at the CHC

Picture 2 Measurement of blood pressure and records of OPD at the camp

Picture 3 measurement of weight of pregnant women at the facility.

Picture 4 Pregnant women who came for ANC check up in the camp

Picture 5: I.v. Sucrose Folic acid dose given to anemic women with hb less than 7 gm%

Picture 6: Lack of sitting facility for the pregnant women

Picture 7 Abdominal checkup of the pregnant woman

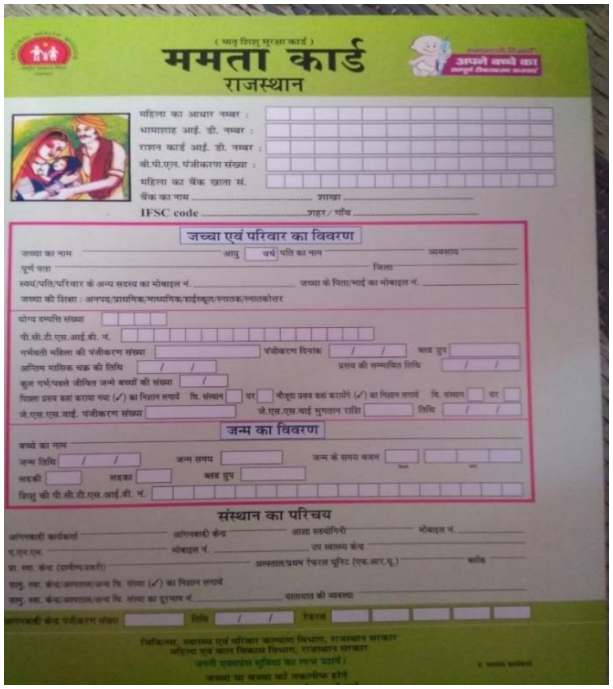
Picture 8 Field visit to CHC by intern

Picture 9.1

picture 9.2

Picture 9.1, 9.2: IEC materials at the CHC

Picture 10 Visit to Anganwadi centre



Picture 11 Mamta card issued to mother on ANC registration

1.3 Questionnaire

Questionnaire for ASHA

1. What is the education level of ASHA?
   A) Middle school b) high school c) degree d) post-graduation
2. Are you identifying all pregnant women before 12 weeks i.e.in first trimester?
   a) Yes B) no (why?)
3. Do you think these camps are useful for normal and high risk pregnant women?
   A) Yes b) no c) can't say
4. Do you escort the HRP women for the follow ups to CHCs?
   A) Yes b) no
5. If no, why not?
   1. Pregnant women not willing
   2. Family not willing
   3. Others
6. Are the HRP stickers marked for HRP?
   a. a)Yes b) no
7. What are the problems do you face in Motivation and referral of High risk mother for Higher Health Services?

8. Are the following supplies available with you at your center?

	Availability	Functionality
a. Weighing scale	Yes/No	Yes/No
b. B.P machine	Yes/No	Yes/No
c. HB meter	Yes/No	Yes/No
d. Sonography machine	Yes/No	Yes/N
e. HIV/Syphilis Kit	Yes/No	Yes/No

9. How many women are getting registered for ANC in one month in the village?
10. How many pregnant women went for institutional delivery among them?
11. Knowledge about HRP of health worker. What are the HRP criteria you know?
    A 0

B 1-2

C 3-4

D>4

12. Are reporting format/ ANC register available?

A) Yes b) no

13. Does your ASHA kit has all tests?

A) Yes b) no

14. If no which is not available?

a) Urine kit b) blood kit d) drugs c) others

Questionnaire for Pregnant Women

Name of the women- Age-
Address-

I. Till when you have taken education.

a) Illiterate b)primary school c)middle school d)high school e)degree f)post-graduation

II. How many months pregnant are you?

A) 3 months b) 3-6 months c) 6-9 months

III. When did you register for 1st ANC.?

A) 1st trimester b) 2nd trimester c) 3rd trimester

IV. How many ANC have you visited?

a) 1 B)2 c)3 d)4

V. How did you come to know about PMSMA camps?

A) ASHA b) ANM c) FAMILY d) TV e) POSTER/hoarding f) others

Awareness about ANC provided by

a) ASHA
b) ANM
c) AWW
d) OTHER

VI. Who facilitated or motivated you to avail antenatal care?

a. DOCTOR B. ANM C. ANGANWADI WORKER D. ASHA E. RELATIVES / FRIENDS F.SELF G. Others

VII. How many of PMSMA camps have you attended?

VIII. Do you have your Mamta card?

a) Yes b) no

IX. Do u know which injections are given?

X. How many times Taken TT Injections?

a.0

b.1

c.2

D.3 or more

XI. Are you taking the iron tablets?

a) Yes b) no c) irregularly

Why not?

XII. Do u know how to take iron tablet

A) Yes b) no

XIII. If yes taking IFA, how many iron tablets you have consumed?

A)>50

b) 50-99

C) 100-149

D) 150-200

XIV. Ultra sounds examination performed in first trimester? Yes/no

XV. How many ultra sounds examination have you gone through? No/1/2

XVI. Are you being asked for the follow ups? Yes/No

XVII. If not able to come for follow-ups, why not?

a) Distance

b) Time

c) Cost

d) Not necessary

XVIII. Do you think privacy is maintained here?

a) Yes b) no

XIX. Are you being provided by the proper information in understandable language?

A) Yes b) no c) can't say

XX. How much you have to wait for check up in the camp?

a) 15 minutes

b) Half hour

c) 1 hour
d) More than one hour

XXI. Was the Antenatal check-up done with :
a) enough time
b) somewhat enough time
c) Hurriedly by health personnel

XXII. Would you suggest visiting this camp to your relatives/friends?
a) Yes b) no

XXIII. Should 1st ANC be done in 3 weeks?
A) Yes
b) No
c) Can't say

XXIV. Are you regular for your ANC visit?
If Yes, main factor for visit
A) To know about baby
b) As medical advised by doctor
c) To know about medical problems
d) both A and b
If No, reason for not visiting
a) Superstition
b) In laws/family refusal
c) Don't have time
d) Not necessary
e) Poor quality service
f) Lack of knowledge
g) distance
h) Other

XXV. During (any of) your antenatal care visit (s), did anyone tell you about the following signs of pregnancy complications?
a) Vaginal bleeding
b) Convulsions
c) Prolonged labor
d) others

XXVI. Did anyone tell you, where to go (health facility) if you have any pregnancy complications.

a) Yes b) no

XXVII. During (any of) your antenatal visit (s), did you receive advice at least once?

A yes B no

XXVIII. If yes, did you receive advice on the following at least once?

a) BREASTFEEDING
b) KEEPING BABY WARM
c) CLEANLINESS
d) SPACING
e) NUTRITION
f) INSTITUTIONAL DELIVERY