Summer Placement in NRHM Rajasthan

(April 8-June 8, 2013)

A Report on

Reproductive Maternal Neonatal Child Health + Adolescents in Rajasthan

Name of Student(s)

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Under Guidance Of Dr. Nutan P Jain

Post-graduate Programme in Health Management 2012-2014

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CERTIFICATE

This is to certify that **Dr. Tonmoy Dutta** student of the 17th batch of the Post Graduate Diploma in Health and Hospital Management (PGDHM) at Institute of Health Management and Research, Jaipur underwent the summer training at **National Rural Health Mission (NRHM)** Rajasthan from April 8th to June 8th 2013 and worked on **A Report on Reproductive Maternal Neonatal Child Health + Adolescent in Rajasthan**

The candidate successfully carried out the study assigned to him during summer training and his approach to the study was sincere, scientific and analytical.

We wish him success in all his future endeavours.

Dr Ashok Kaushik
Dean(academics and student affairs)
IIHMR,JAIPUR

Prof. Nutan Jain
Professor
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Acknowledgement

We extend our sincere thanks to Mrs. Gayatri Rathore Secretary Health-cum-Executive Director, NRHM Rajasthan for the faith shown upon us and guidance given to us without which the assignment would not have been possible.

Without the guidance & blessings of **Dr. S.D. GUPTA**, Director, IIHMR, Jaipur and Institute of Health Management & Research, Jaipur summer internship would not have been possible for us.

We are also highly thankful to **Nutan Jain** at IIHMR Jaipur & **Anuradha Aswal** NRHM Rajasthan, our guide for this summer internship program, for the guidance, support, facilitation & coordination which we have received from them and also an opportunity given to us to have a look of health system at various levels.

We would also like to convey our heartfelt gratitude to all State Programme Officers for making us familiar with various programs and also for arranging field visit which has helped us tremendously to enhance our knowledge and understanding.

We would like to extend our thanks to the Heads of developmental partners (if any write the name) for the support and help they have provided to us for the field trip as well as orientation.

Last but not the least almighty God who gave us courage & strength to perform our duties efficiently. We thank everybody again.

Dr. Tonmoy Dutta
Dr. Vikram Singh
Students – PGDHM (Batch- 2012-14) IIHMR, Jaipur

Acronyms

ANC	Antenatal Care
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
BPM	Block Project Manager
CHC	Community Health Center
DH	District Hospital
DLHS	District Level Health Survey
DPM	District Project Manager
IEC	Information education and communication
IFA	Iron and folic acid tablet
IMR	Infant Mortality Rate
IT	Information technology
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Surakhya Yojana
MMJRK	Mukhyamantri Jeevan Raksha Kosh
MMR	Maternal Mortality Ratio
MSLY	Mukhyamantri Subh Laxmi Yojna
NGO	Non-governmental organizations
NHSRC	National Health Systems Resource Centre
NRHM	National rural health mission
PHC	Primary health centre
PNC	Post natal care
PPP	Public–private partnership
RCH	Reproductive and Child Health
SC	Sub-center
SHRSC	State Health Systems Resource Centre
SNCU	Sick Newborn CareUnit
TFR	Total Fertility Rate
TT	Tetanus Toxoid

Content

Background

Summer internship is an integral part of the PGDHM currriculum.As a part of the course;students of the first year are required to undergo summer training at an organization to get in depth exposure of various departments in the organization and better understanding of the health care delivery system.

The major objectives of the summer training programs are as follows:

1) To better understand the existing health delivery system including public and private sectors.
2) To observe the implementation of various National Health Programmes at National/State/District levels.
3) To understand various functions of health systems by interactions with key stakeholders,policy makers, programme managers,academicians and researchers
4) To work on the project/task assigned by summer training organizations.

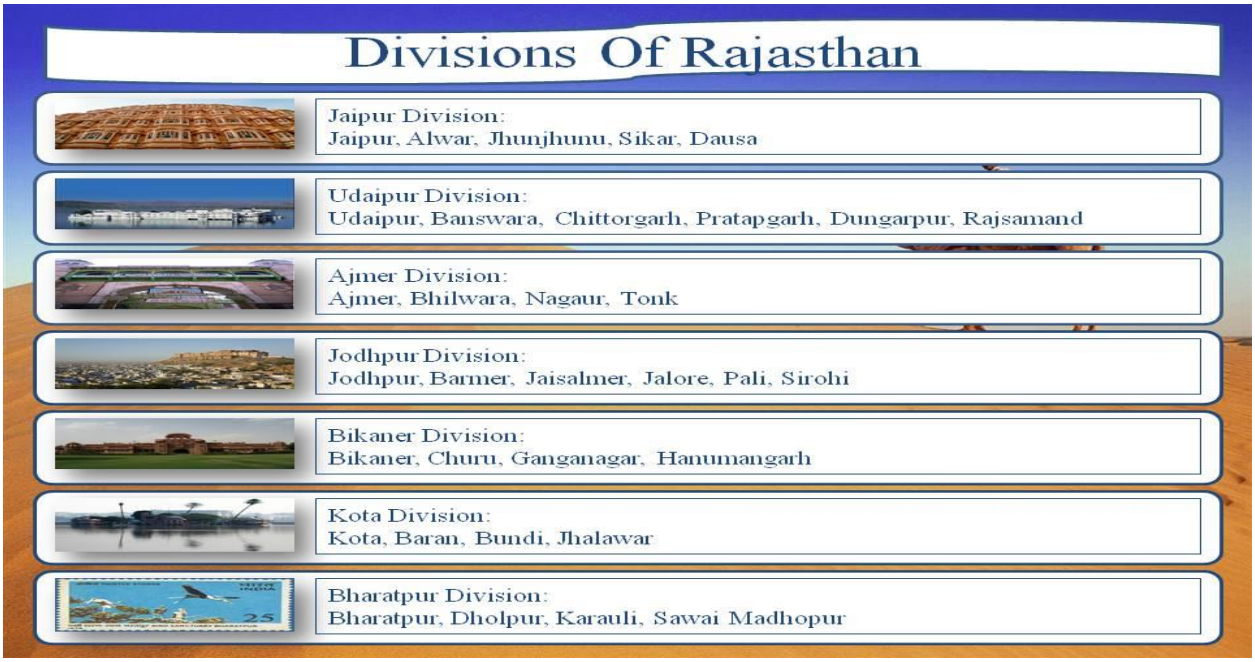
Tasks Assigned

During the summer training at National Rural helath Mission, Jiapur, Rajasthan the following tasks were assigned:

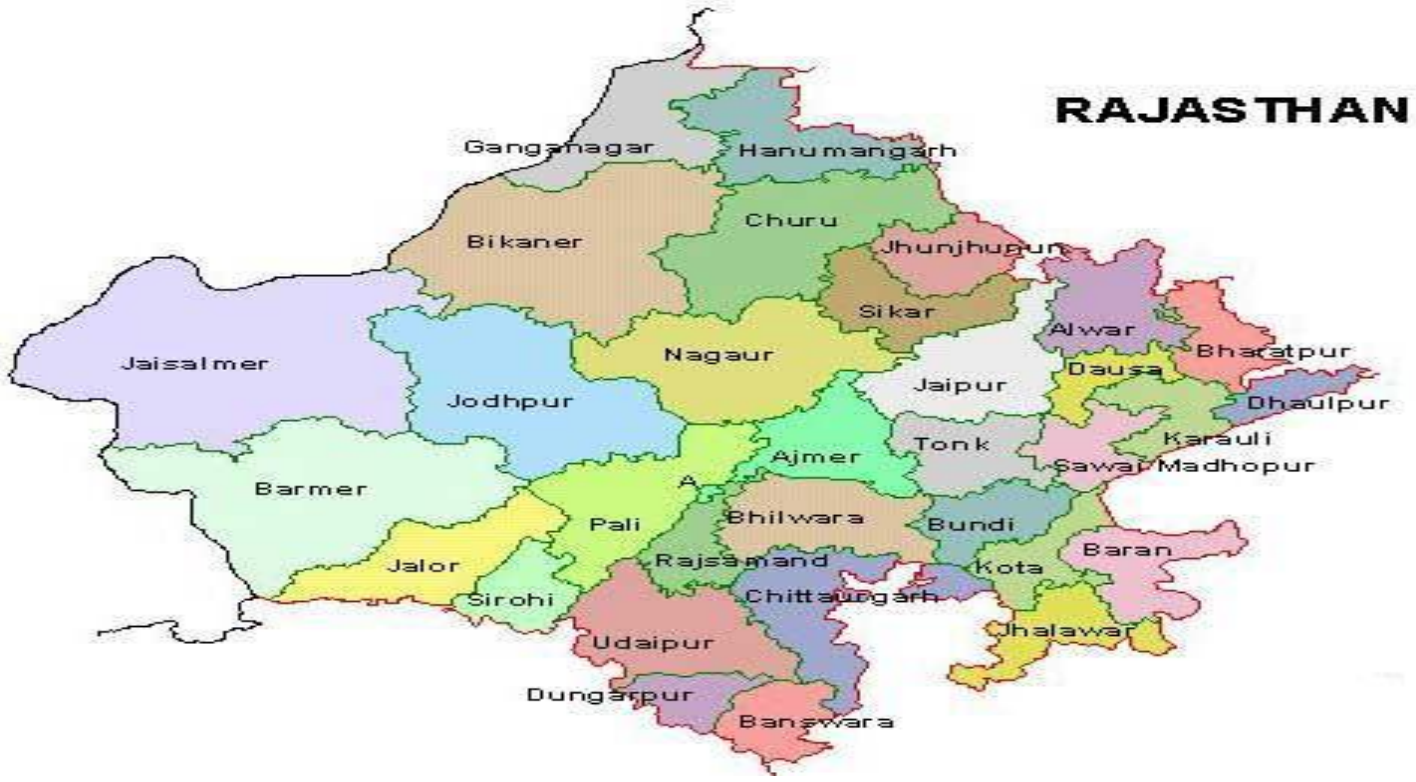
- Analysis of 16 dashboard indicators given by GOVERNMENT OF INDIA (GOI) in the state: A Presentation.
- Ranking of districts by 16 indicators.
- Analysis and presentation of different parameters in RMNCH+A for Udaipur and Kota zones.

Rajasthan

Rajasthan is the largest state of the Republic of India by area and was established on 1st November 1956. Rajasthan, physically the largest state in the Indian Union is situated in the North-west part of the country, and has 56 million (or 5per cent) of the country's population. The population density is 165 persons per sq. km. (as against the national average of 312). Rajasthan covers 10.4% of India, an area of 342,239 square kilometers (132,139 sq mi). The Population of Rajasthan is 6,86,21,012 comprising of 5,15,40,236 rural and 1,70,80,776 urban population as per the Census 2011.



Rajasthan is divided into 33 districts and seven divisions:



Health Indicators of Rajasthan

Demographic data- Rajasthan (Census of India, 2011)

Health Indicators

Indicators	India	Rajasthan
Total Population	1,21,01,93,422	6,86,21,012
- Male	62,37,24,248	3,56,20,086
- Female	58,64,69,174	3,30,00,926
- Urban	37,71,05,760	1,70,80,776
- Rural	83,30,87,662	5,15,40,236
Population Density		165/km
Breakup of Religion		Hindus - 88.8% Muslims - 8.5% Sikhs - 1.4% Jains - 1.2%
CBR	22.1* 22.5**	26.7* 24.7**
CDR	7.2* 7.3**	6.7* 6.6**
Decadal Growth Rate		21.44
Sex Ratio		926 (Females/1000 Males)
Child Sex Ratio (Age 0 – 6 Yrs)		883
Literacy Rate	74.04%	67.06%
- Male	82.14%	80.51%
- Female	65.46%	52.66%
TFR	2.7#	3.2#
IMR	47* 50**	55* 60**
MMR	212***	318***

Source: Census of India, 2011

Source:* SRS Dec.2011** AHS 10-11*** SRS2007-09#NFHS III.

National Rural Health Mission, Rajasthan

Background

The National Rural Health Mission (NRHM) was launched on 12 April, 2005 throughout the country with special focus on 18 States, viz. eight Empowered Action Group (EAG) states (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Rajasthan, Uttar Pradesh and Uttarakhand), eight North Eastern States and the hill States of Jammu and Kashmir and Himachal Pradesh which had poor health indices.

The aim of the Mission is to provide *accessible, affordable, accountable, effective and reliable* healthcare facilities in the rural areas of the entire country, especially to the poor and vulnerable sections of the population. The key strategy of the NRHM is to bridge gaps in healthcare facilities, facilitate decentralized planning in the health sector, provide an overarching umbrella to the existing programmes of Health and Family Welfare including Reproductive and Child Health-II, Vector Borne Disease Control Programme, Tuberculosis, Leprosy and Blindness Control Programmes and Integrated Disease Surveillance Project. It also addresses the issue of health in the context of a sector wide approach encompassing sanitation and hygiene, nutrition etc. as basic determinants of good health and advocates convergence with related social sector departments such as Women and Child Development, AYUSH, Panchayati Raj etc.

The NRHM seeks to provide health to all in an equitable manner through increased outlays, horizontal integration of existing schemes, capacity building and human resource management. The Mission envisages increasing expenditure on health, with a focus on primary healthcare, from the level of 0.9% of GDP (in 2004-05) to 2-3% of GDP over the mission period (2005-2012).

The National Rural Health Mission (NRHM) is a national effort at ensuring provision of effective healthcare through a range of interventions at individual, household, community, and critically at the health system levels.

Objectives of the NRHM:

The main objectives of the NRHM are:

- Reduction in child and maternal mortality;
- 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;
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases;
- Access to integrated comprehensive primary health care;
- Population stabilization, gender and demographic balance;
- Revitalize local health traditions & mainstream AYUSH; and
- Promotion of healthy life styles.

IMPACT OF N R H M

Since its launch

Indicators		Status at launch	Current status	Achievement
Maternal Mortality Ratio	Rajasthan	388 (SRS-2004-06)	264 (AHS, 2011) 318 (SRS-2007-09)	↓ 124 ↓ 70
	India	254 (SRS-2004-06)	212 (SRS-2007-09)	↓ 42
Infant Mortality Rate	Rajasthan	63 (SRS-2008)	52 (SRS-2011)	↓ 11
	India	53 (SRS-2008)	44 (SRS-2011)	↓ 9
Full Immunization	Rajasthan	26.5 (NFHS-2005)	53.8 (CES, 2009) 70.8% (AHS, 2010)	↑ 27.3 ↑ 44.3
	India	43.5 (NFHS-2005)	61.0 (CES, 2009)	↑ 17.5
Institutional Delivery	Rajasthan	32 (NFHS-2005)	70.4 (CES, 2009), 77.34 Dept. Data	↑ 38.4
	India	41 (NFHS-2005)	71.9 (CES, 2009)	↑ 30.9

Year-wise Targets for the State

Indicators		Year-wise Targets (As recommended by Govt. of India)		
	SRS 2009-10	**2012-13**	**2013-14**	**2014-15**
Maternal Mortality Ratio	318 (SRS 07-09)	248 (2011-13)	193 (2013-15)	150 (2015-17)
Under 5 Mortality	68 (SRS 2010)	51	45	39
Infant Mortality Rate	55 (SRS 2010)	37	31	25
Neonatal Mortality Rate	40 (SRS 2010)	28	24	20
Early Neonatal Mortality Rate	33 (SRS 2010)	24	21	18
Total Fertility Rate	3.1 (SRS 2010)	2.9	2.8	2.6

NRHM: A Management Perspective

NRHM is a drive which worked on the managerial aspect of the health sector and brought out the need of involving so to this sector. NRHM redefined the tasks and made it clear to the people that management to this sector can make a difference to the society which was far behind in health care which was among the main priority for the government. Following are few managerial aspects which can be seen in NRHM.

1. **Division of work**

During our learning process, we experienced that NRHM is a classic example of division of work. Work is divided according to the hierarchy systematically. From bottom to top level, lower cadre is reporting to higher cadre in their respective order.

2. **Authority**

In NRHM, every individual completes their responsibilities obediently. SPM (State Program Manager) coordinates the work with their respective PD (Project Directors). Project Directors from different programme are responsible for their respective programme running under them. Similarly, every individual in NRHM is responsible for their duty.

3. **Discipline**

In NRHM, we found that there is proper discipline in their work and their responsibilities are completed in their desired time. Every individual respect the harmony of others work and their effort. There is Code of conduct for every work and it is maintained.

4. **Unity Of Command**

Mission Director communicates the order to the State Program Manager(SPM) and the order is uniformly conveyed to the project directors and the same pattern is followed throughout the hierarchy.

5. **Unity Of Direction**

The aim of NRHM is to improve the social health of the country and the every individual is working for the same to achieve these goals.

6. **Subordination of Individual Interest to General Interest**

The aim of NRHM is being generalized and every individual works specifically for these aim.

7. **Remuneration**

Recruitments are done for contractual and permanent posts. At present more contractual staff is there than the permanent staff. Accordingly the pay scale and its breakup vary between the two. Also the State Government has proposed to the Union Health & Family Welfare Ministry that the sharing of burden of salaries of permanent posts between the Centre and the State would be in the ratio of 85:15 as mandated under the programme. In the event of NRHM's termination, the entire burden of salaries will be taken over by the State Government.

8. Centralization

De-centralization was there as each department is headed by a Project director who is in charge of all the required planning decisions and reports to the State Program Management Unit. Also all the districts have their own District Program Management Units.

9. Scalar Chain

Timely UI Notes were issued to the department from Mission Director to State Program Manager (SPM) following the chain. Orders from Central government are conveyed to the respective departments and their official. In same manner, Information and the data collected from the different field and the places are delivered to the respective higher authority.

10. Order

Persons working in the same programme work harmoniously, following the same order with equal integrity.

11. Equity

All employees should be treated as equally as possible.

12. Stability of Tenure of Personnel

In NRHM, Majority of higher hierarchy employees are permanent and the employees which are on contractual basis are working since many years, as their contracts are renewed and good salary hike is given every year. Hence they are continuing their job and thus the stability of tenure of personnel is maintained.

13. Initiative

The State Program Unit Management takes steps to encourage worker initiative, each Project Director is encourage to take new steps to improve the ongoing schemes and also to propose any new additions to them.

14. Espirit De Corps

Harmony and general good feelings among employees are developed through various incentives, leadership trainings, and get-togethers and other recreational activities.

NRHM and Millennium Development Goals

Millennium Development Goals (MDGs) are eight international development goals set by the United Nations which member countries, including India, have agreed to achieve by the year 2015. MDGs directly pertaining to Health Sector and the progress made by India is as under:

Goal 4: Reduce Child Mortality: Target is to reduce Under Five Mortality Rate (U5MR) by two thirds between 1990 & 2015. In case of India, it translates into a goal of reducing U5MR to less than 39 per 1000 live births by 2015

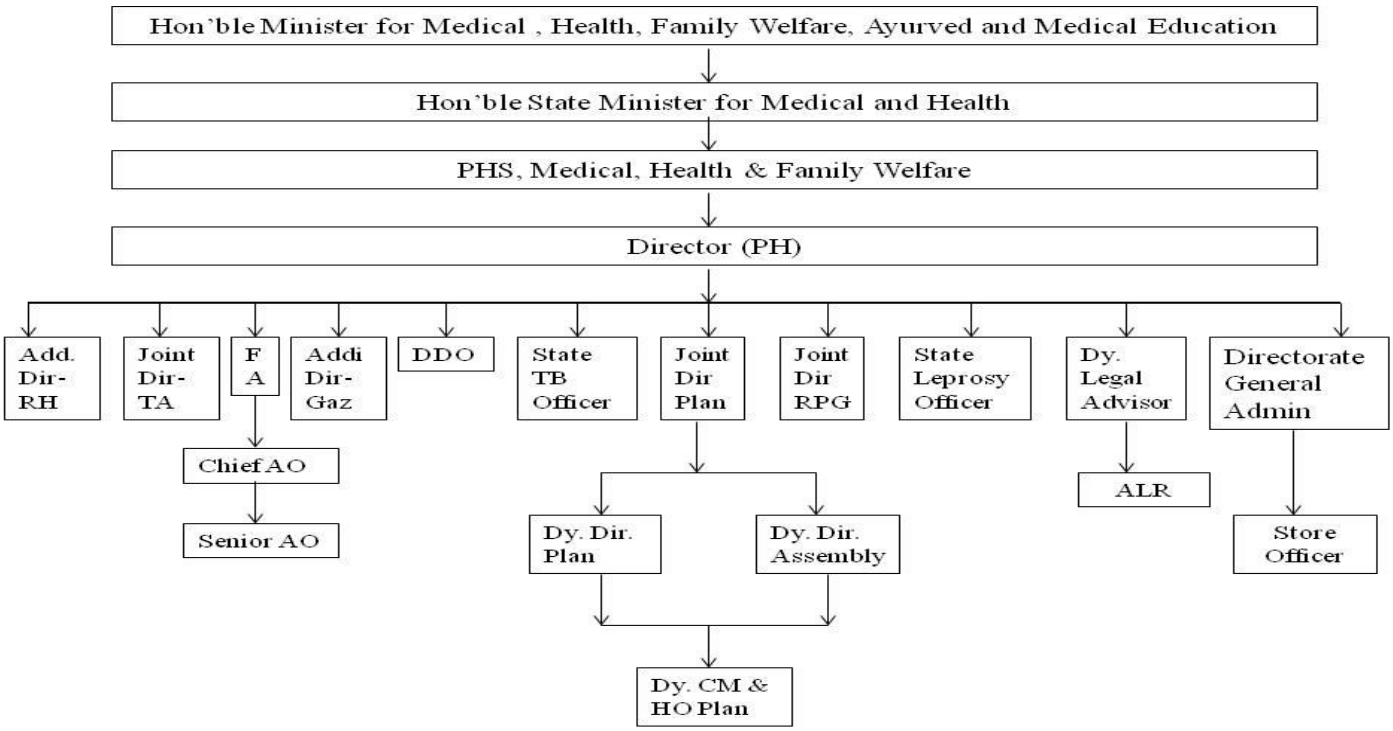
The steps taken include Integrated Management of Neo-natal & childhood illness, training of ASHAs (Accredited Social Health Activist) in Home based new born care, Navajat Shishu Suraksha Karyakram, setting up of sick new born care units at district hospitals, promoting exclusive breastfeeding and complementary feeding, strengthening routine immunisation programme, focussing on reduction in morbidity and mortality due to Acute Respiratory Infections (ARI) and Diarrhoeal Diseases, name based tracking of pregnant women and children, etc.

Goal 5: Improve Maternal Health: : Target is to reduce Maternal Mortality Ratio (MMR) by three quarters between 1990 & 2015. As per the estimates of MMR released by the WHO, UNICEF, UNFPA and the World Bank, India requires to reduce MMR from 600 in 1990 to 150 per 100,000 live births in 2015.

The steps taken include promoting institutional deliveries, strengthening of infrastructure, Strengthening of Essential and Emergency Obstetric Care services, Strengthening Referral Systems, launching of Janani Shishu Suraksha Karyakaram, Maternal Death Review, organising village health and nutrition days, engagement of ASHA at community level, introduction of integrated mother and child health card, etc.

Goal 6 : Combat HIV/AIDS, malaria, and other diseases. Target is to halt by 2015 and begin to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases.
The steps taken to control diseases like HIV / AIDS, Malaria and Tuberculosis include early diagnosis and treatment, improving monitoring and evaluation, strengthening human resources, involvement of NGOs, Private sector and community, providing services near to the doorstep of community, etc.

Organogram – DM & HS (Rajasthan)



Introduction to RMNCH+A

Improving the maternal and child health and their survival are central to the achievement of national health goals under the National Rural Health Mission (NRHM) as well as the Millennium Development Goals (MDG) 4 and 5. A substantial increase in the availability of financial resources for Reproductive and Child Health (RCH), healthcare infrastructure and workforce as also the expansion of PROGRAM management capacity since the launch of NRHM in 2005 provides an important opportunity to consolidate all our efforts.

In order to bring greater impact through the RCH Program, it is important to recognize that reproductive, maternal and child health cannot be addressed in isolation as these are closely linked to the health status of the population in various stages of life cycle. The health of an adolescent girl impacts pregnancy while the health of a pregnant woman impacts the health of the newborn and the child. As such, interventions may be required at various stages of life cycle, which should be mutually linked. The reasons for adopting such a strategy can be understood when the available data is taken into account and the close inter-linkages between different stages of life cycle are recognized. In India, 22% babies born each year have LBW, which has been linked to maternal under-nutrition and anemia among other causes. Also half of adolescents (boys and girls) have below normal body mass index (BMI) and almost 56% of adolescent girls aged 15–19 years have anemia. The poor nutritional status of adolescent girls and young women is inextricably linked to the birth weight of their children and subsequently to child survival. Adolescents (15–19 years) contribute about 16% of total fertility in the country and 15–25 years age group contributes 45% of total maternal mortality. There is evidence to show that in developing countries, the risk of premature delivery and LBW doubles when conception occurs within six months of a previous birth. The use of contraceptive has the potential to improve perinatal outcomes and child survival by widening the interval between successive pregnancies.

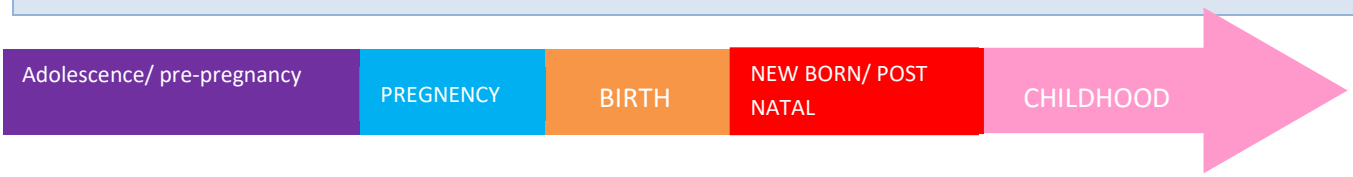
Just as different stages in the life cycle are interdependent so are the aspects of where and how healthcare is provided. This Continuum of Care approach of defining and implementing evidence-based packages of services for different stages of the lifecycle, at various levels in the health system, has been adopted under the national health PROGRAM. This strategic approach to Reproductive, Maternal, Newborn, Child plus Adolescent Health (RMNCH+A) is described further in the document. The 'Plus' in the strategic approach denotes the (1) inclusion of adolescence as a distinct 'life stage' in the overall strategy; (2) linking of maternal and child health to reproductive health and other components (like family planning, adolescent health, HIV, gender and Preconception and Prenatal Diagnostic Techniques (PC&PNDT); and (3) linking of community and facility-based care as well as referrals between various levels of health care system to create a continuous care pathway, and to bring an additive /synergistic effect in terms of overall outcomes and impact.

The empowerment of women, is therefore key to achieving MDG 4 and 5. A cohesive action by the Government integrating cross-sectoral efforts is needed to tackle these challenges. While recognizing the need for wider action, this RMNCH+A strategic approach focuses on what the Health Delivery System can do to help achieve maternal and child health goals.

It must be recognized that the set of interventions are those that are shown to have high impact on reducing mortality and improving survival, and most of them have been part of the previous phase of NRHM. The effectiveness of these interventions is determined by the coverage achieved among the affected fragment of the population as also the availability, accessibility, actual utilization of services and quality of service delivered. Therefore, it is important that 'Bottleneck Analysis' be carried out at various levels of planning, including the state and district level in order to priorities attention to address specific gaps in the delivery of a particular intervention or a set of interventions.

Continuum of care across life cycle and different levels of health system

	REPRODUCTIVE CARE	PREGNANCY AND CHILD BIRTH CARE	NEWBORN AND CHILDCARE	
CLINICAL	• Comprehensive abortion care • RTI/STI case management, • Postpartum IUCD and sterilization; interval IUCD procedures • Adolescent friendly health services.	• Skilled obstetric care and immediate newborn care and resuscitation • Emergency obstetric care • Preventing Parent to Child Transmission (PPTCT) of HIV • Postpartum sterilization.	• Essential newborn care • Care of sick newborn (SNCU, NBSU) • Facility-based care of childhood illnesses (IMNCI) • Care of children with severe acute malnutrition (NRC) • Immunization.	
	Reproductive health care	**Antenatal care**	**Postnatal care**	**Child health care**
OUTREACH/ SUB-	• Family planning (including IUCD insertion, OCP and condoms) • Prevention and management of STIs • Peri-conception Folic acid Supplementation.	• Full antenatal care package • PPTCT	• Early detection and management of illnesses in mother and newborn • Immunization.	• First level assessment and care for newborn and childhood illnesses • Immunization • Micro-nutrient Supplementation.
FAMILY AND COMMUNITY	• Weekly IFA supplementation • Information and counseling on sexual reproductive health and family planning • Community based promotion and delivery of contraceptives • Menstrual hygiene	• Counselling and preparation for newborn care, breast feeding, birth preparedness • Demand generation for pregnancy care and institutional delivery (JSY, JSSK)	• Home-based newborn care and prompt referral (HBNC scheme) • Antibiotic for suspected case of newborn sepsis • Infant and Young Child Feeding (IYCF), including exclusive breast feeding and complementary feeding, • Child health screening and early intervention services (0–18 years) • Early childhood development • Danger sign recognition and care-seeking for illness • Use of ORS and Zinc in case of diarrhea	
Inter-sectoral: Water, sanitation, hygiene, nutrition, education, empowerment				



Continuum of care cycle shown above is representing the stages of life in which how health plays an important role and the interventions done. It shows how an adolescent female reaches to pre-pregnancy phase and later crosses the pregnancy by giving birth in which new born and post natal care is seen and that reaches to childhood and again a female child reaches to adolescent age and the cycle continues.

ADOLOSCENT HEALTH

Priority interventions

1. Adolescent nutrition; iron and folic acid supplementation
2. Facility-based adolescent reproductive and sexual health services (Adolescent health clinics)
3. Information and counseling on adolescent sexual reproductive health and other health issues
4. Menstrual hygiene

PREGNANCY AND CHILD BIRTH

Priority interventions

1. Delivery of antenatal care package and tracking of high-risk pregnancies
2. Skilled obstetric care
3. Immediate essential newborn care and resuscitation
4. Emergency obstetric and new born care
5. Postpartum care for mother and newborn
6. Postpartum IUCD and sterilization
   Implementation of PC&PNDT Act.

NEW-BORN AND CHILD CARE

Priority interventions

1. Home-based newborn care and prompt referral
2. Facility-based care of the sick newborn
3. Integrated management of common childhood illnesses (diarrhea, pneumonia and malaria)
4. Child nutrition and essential micronutrients supplementation
5. Immunization
6. Early detection and management of defects at birth, deficiencies, diseases and disability in children (0–18 years).

THROUGH THE REPRODUCTIVE YEAR

Priority interventions

1. Community-based promotion and delivery of contraceptives.
2. Promotion of spacing methods (interval IUCD).
3. Sterilization services (vasectomies and tubectomies).
4. Comprehensive abortion care (includes MTP Act).
5. Prevention and management of sexually transmitted and reproductive infections (STI/RTI).

THE 12TH FIVE YEAR PLAN HAS DEFINED THE NATIONAL HEALTH OUTCOMES AND THE THREE GOALS THAT ARE RELEVANT TO RMNCH+A STRATEGIC APPROACH AS FOLLOWS:

HEALTH OUTCOME GOALS ESTABLISHED IN THE 12TH FIVE YEAR PLAN

- Reduction of Infant Mortality Rate (IMR) to 25 per 1,000 live births by 2017.
- Reduction in Maternal Mortality Ratio (MMR) to 100 per 100,000 live births by 2017
- Reduction in Total Fertility Rate (TFR) to 2.1 by 2017

In order to achieve these goals, that are ambitious, yet potentially feasible few objectives are in the target. For achieving the under-five mortality are of 33 per 1000 live births , corresponding to infant mortality rate of 25 per 1000 live births in 2017 (as articulated in 12th Five Year Plan), variable increases in the coverage levels for key interventions are required. They are as follows.

Coverage targets for key RMNCH+A interventions.

i. Increase facilities equipped for Perinatal care (designated as 'delivery points') by 100%
ii. Increase proportion of all births in government and accredited private institutions.
iii. Increase proportion of pregnant women receiving antenatal.
iv. Increase proportion of mothers and newborns receiving postnatal care.
v. Increase proportion of deliveries conducted by skilled birth attendants.
vi. Increase exclusive breast feeding rates.
vii. Reduce prevalence of under-five children who are underweight.
viii. Increase coverage of three doses of combined diphtheria-tetanus-pertussis (DTP3) (12–23 months).
ix. Increase ORS use in under-five children with diarrhea.
x. Reduce unmet need for family planning methods among eligible couples, married and unmarried.
xi. Increase met need for modern family planning methods among eligible couples.
xii. Reduce anemia in adolescent girls and boys (15–19 years).
xiii. Decrease the proportion of total fertility contributed by adolescents (15–19 years).
xiv. Raise child sex ratio in the 0–6 year's age group.

LEARNING

Summer training at NRHM (Rajasthan) was a great learning; working under SPM NRHM, Rajasthan guidance was a smooth experience as she provided a great learning through various assignments and projects during the training program. She exposed us to much new learning.

- Exposure to the planning process of the State Project Implementation Plan (PIP) 2013-14
    - Participated in the meetings, and provided suggestions
- Exposure to RMNCH+A introduced in March 2013
- Exposure to various departments/ units, namely Child health department, ASHA, ARSH, PLAN Unit, HR department, SPM Cell, 108 Ambulance were the various departments we got our departmental postings
- Data collection from the district coordinators over telephone
- Analysis of secondary data using 16 indicators for 34 districts in Rajasthan, a detailed presentation on different parameters of RMNCH+A for Kota and Udaipur Zone
- Prepared graphical power-point presentations
- Organizational communication

Annexure

List of Contacted Persons

SN	Name	Designation
1	Smt. Gayatri A. Rathore	Secretary MH&FW and Mission Director, NRHM
2	Dr. Samit Sharma	Managing Director, RMSC
3	Shri Kan Singh Rathore	Director IEC
4	Dr. Nupur Atheya	Project Director, Maternal Health
5	Dr. A.N. Mathur	Project Director, Child Health
6	Dr. Anuradha Aswal	State Program Manager
7	Mr. Sujan Kumar Saha (Addl Charge)	Assistant State Program Manager
8	Mr. Nirmal Prajapat (Addl Charge)	State Data Officer
9	Dr. Giriraj Sharma	Nodal Officer, JSY and MSLY
10	Mrs. Archana Sharma	Consultant NGO & ARSH
11	Ms. Veena Sharma	Consultant ASHA and Programme Officer SARC
12	Mr. D.P. Kanungo	Consultant, MMJRK
13	Mr. Manoj Kumar Swarankar	State Coordinator, SNCU
14	Mr. Sumesh Singh	Consultant, IT
15	Sh. Kishna Ram Esharwal	Deputy Director RCH and In-charge State PCPNDT Cell
16	Dr. RamBabu Sharma	Medical Officer (Ayush)
17	Dr.R.P. Jain	Project Director, Immunization

Ranking of Districts by 16 Indicators

As per review of GOI 16 Indicators Reports (Overall Ranking)

Month-Upto February, 13

S. No.	Name of Districts	Maternal Health								Child Health							Family Planning		Over all Marks	Over all Ranking	Ranking Jan., 13
		ANC registered within Ist trimester (12 weeks)	No. of PW received 3 ANC checkups	Pregant women given TT_2 & Booster	Pregnant women having severe anaemia (Hb<7) treated at institution	SBA attended home deliveries	Women discharged under 48 hours of delivery	Institu-tional deli-veries	Women receiving post partum check-up with in 48 hours after delivery	No. of new borns visited with in 24 hours of home deliveries.	Live birth	New born weighed at birth	New born brest fed within 1 hour	New born given OP V_0 at birth	New borns given BCG		Vasec-tomies out of Total Sterili-zation	Tubec-tomies out of Total Steri-lization			
1	TONK	3	1	1	-2	2	3	4	3	2	-1	3	2	1	-1		-4	3	20	1	1
2	BUNDI	2	1	-1	4	1	-3	4	4	-2	-2	4	3	4	-1		-4	3	17	2	2
3	PRATAPGARH	-1	2	4	2	-2	3	3	1	-1	-4	1	1	3	1		-4	4	13	7	3
4	JHALAWAR	1	1	-3	-3	2	4	2	4	4	-3	3	3	3	-4		-4	4	14	4	4
5	BARAN	1	-1	1	-2	1	-1	4	4	1	-1	4	4	4	-1		-2	-1	15	3	5
6	BHILWARA	4	1	3	-2	2	1	3	2	4	-1	-1	-1	-2	1		-3	2	13	5	6
7	KOTA	2	1	-2	-4	2	2	3	2	2	-1	1	-1	4	2		1	-1	13	6	7
8	KARAULI	1	1	1	1	-1	4	2	1	-1	2	2	2	1	-4		-4	4	12	8	8
9	CHURU	4	1	2	1	-4	1	1	1	2	2	2	2	-2	-3		4	-4	10	9	9
10	BANSWARA	-1	-1	2	2	2	1	2	1	-2	-4	3	3	3	-2		-4	4	9	10	10
11	JAIPUR I	2	4	-2	4	2	-3	4	-3	2	3	-2	-4	1	-1		1	-1	7	11	11
12	JAIPUR II	1	2	1	-2	-2	2	3	-1	-1	3	-2	-2	2	3		-4	3	6	12	12
13	DUNGARPUR	-1	-1	1	1	-1	3	2	4	-4	-1	1	-1	1	1		-4	4	5	15	13
14	JHUNJHUNU	-1	-2	-3	1	3	-1	4	1	3	4	-2	-2	-2	4		1	-2	6	13	14
15	AJMER	2	2	2	2	-4	-2	3	2	1	-3	-1	-2	2	2		-2	1	5	14	15
16	BHARATPUR	2	-1	3	-3	4	-2	-2	-3	2	3	1	2	1	-3		-4	4	4	16	16
17	SIROHI	2	1	4	-3	-4	-1	3	2	2	-4	2	1	-3	1		-4	3	2	19	17
18	DHOLPUR	-2	-4	-2	-3	-2	2	-1	1	4	1	4	4	2	-1		-4	4	3	18	18
19	CHITTORGARH	2	1	2	-2	-4	3	2	-1	2	-3	3	2	-1	-4		-1	-1	0	22	19
20	RAJSAMAND	1	1	2	-3	-4	4	-1	1	-2	2	2	2	2	-2		-1	-1	3	17	20
21	NAGAUR	1	-1	-1	-4	1	2	2	1	-2	2	1	2	-2	2		-2	-1	1	20	21
22	HANUMANGARH	3	1	-1	1	2	-1	3	-1	-3	1	-2	-2	-1	1		1	-2	0	21	22
23	DAUSA	-2	-2	-1	-4	3	2	-1	-2	4	2	-1	-1	3	-3		-4	4	-3	23	23
24	ALWAR	-1	-1	2	1	-2	2	-2	-1	-1	-1	2	1	-1	1		-1	-1	-3	24	24
25	GANGANAGAR	2	2	-4	-2	-2	-2	2	1	2	-2	2	2	-1	-1		-2	-1	-4	25	25
26	JAISALMER	-3	-3	-2	-2	1	3	-4	2	1	-4	2	2	1	1		-3	3	-5	26	26
27	SIKAR	-1	-3	-3	-3	1	1	4	-3	1	4	1	1	-3	-		-3	1	-6	27	27

															1					
28	PALI	-2	-3	-1	-3	-2	2	2	1	-1	-3	1	2	-1	-1	-1	-1	-11	28	28
29	UDAIPUR	-2	-1	-2	3	-1	-2	-1	1	-4	-2	2	-1	1	-1	-3	2	-11	29	29
30	S.MADHOPUR	-1	-3	-3	-2	1	-3	2	-2	3	3	-3	-4	2	-2	-4	4	-12	30	30
31	BARMER	-4	-4	-4	-4	-2	1	-4	1	2	-2	2	2	-3	2	-1	-1	-19	33	31
32	JODHPUR	-2	1	1	-4	1	-4	-2	-4	-2	4	-4	-3	1	1	-4	4	-16	31	32
33	BIKANER	-3	-1	1	-4	1	-2	-2	-3	-1	-1	1	2	-2	-2	-2	-1	-19	32	33
34	JALORE	-2	1	-1	-2	-1	-3	-1	-2	2	-2	-2	-1	-4	-2	-4	4	-20	34	34
Rajasthan		-1	-1	-1	-1	-2	3	3	1	-1	-1	-2	1	-1	-4	-2	2	-7	24	23

DISTRICT WISE RANKING IN TOTAL STERLIZATION (MALE + FEMALE)

S. No.	District	Total sterilization	Male	%Male sterlization	Female	% Female ster.
1	JAIPUR I	18109	536	2.96	17573	97.04015
2	ALWAR	15171	336	2.21	14835	97.78525
3	UDAIPUR	14220	130	0.91	14090	99.08579
4	JODHPUR	12477	39	0.31	12438	99.68742
5	NAGAUR	12140	191	1.57	11949	98.42669
6	SIKAR	11326	134	1.18	11192	98.81688
7	AJMER	10749	160	1.49	10589	98.51149
8	JALORE	9901	18	0.18	9883	99.8182
9	BHARATPUR	9691	31	0.32	9660	99.68012
10	BIKANER	9669	169	1.75	9500	98.25215
11	JAIPUR II	9456	62	0.66	9394	99.34433
12	CHITTORGARH	8589	168	1.96	8421	98.04401
13	GANGANAGAR	8481	152	1.79	8329	98.20776
14	BHILWARA	8477	84	0.99	8393	99.00908
15	BANSWARA	8040	25	0.31	8015	99.68905
16	KOTA	7954	209	2.63	7745	97.37239
17	CHURU	7826	649	8.29	7177	91.70713
18	HANUMANGARH	7774	258	3.32	7516	96.68125
19	DAUSA	7447	20	0.27	7427	99.73144
20	JHALAWAR	7329	24	0.33	7305	99.67253
21	JHUNJHUNU	7079	248	3.5	6831	96.49668
22	TONK	7047	37	0.53	7010	99.47495
23	KARAULI	6985	18	0.26	6967	99.7423
24	BARAN	6831	104	1.52	6727	98.47753
25	PALI	5918	109	1.84	5809	98.15816
26	BARMER	5756	106	1.84	5650	98.15844
27	DUNGARPUR	5466	7	0.13	5459	99.87194
28	S.MADHOPUR	5359	22	0.41	5337	99.58948
29	BUNDI	5058	32	0.63	5026	99.36734
30	DHOLPUR	4939	23	0.47	4916	99.53432
31	SIROHI	4735	33	0.7	4702	99.30306
32	RAJSAMAND	3368	76	2.26	3292	97.74347
33	PRATAPGARH	2989	13	0.43	2976	99.56507
34	JAISALMER	2468	20	0.81	2448	99.18963
Total		278824	4243	1.52	274581	98.47825

District wise ranking in male sterilization

S. No.	District	Total sterilization	Male	%Male sterlization	Female	% Female stererlization
1	CHURU	7826	649	8.29	7177	91.70713
2	JHUNJHUNU	7079	248	3.5	6831	96.49668
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32	KARAULI	6985	18	0.26	6967	99.7423
33	JALORE	9901	18	0.18	9883	99.8182
34	DUNGARPUR	5466	7	0.13	5459	99.87194
Total		278824	4243	1.52	274581	98.47825

Conclusion

In 16 GOI indicators Tonk is ranked no. 1 inn all the other 34 districts. There are different parameters like ANC registrations, 3ANC checkup received, TT 2 and booster injections, sever anemia Hb < 7 treated at institute, SBA attended home deliveries, discharged under 48 hrs or delivery, institutional deliveries, post partum checkup within 48 hrs of deliveries, newborn visited withing 24 hrs of home deliveries, live birth, wt of new born, breast feed within one hr, OPV at birth, BCG to newborn, vasectomies out of total sterilizations, tubectomies out of total sterilizations.

These parameters were considered and then these districts were ranked accordingly. Jalore is the district which was at the bottom of the list and it needs attention to get it in a better state.

As we can see in the above tables for district wise ranking in total sterilization, there are 34 districts in the list and the list is topped by Jaipur 1 followed by Alwar district, whereas Jaisalmer ranks the lowest in total Sterilization.

When we specifically see the male sterilization among the districts Churu district with 8.29 percent and Dungarpur district is at lowest in male sterilization with 0.13 percent. The table suggests that there needs a lot effort to be put in promoting male sterilization and males are far behind in going for sterilization.

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The candidate successfully carried out the study assigned to him during summer training and his approach to the study was sincere, scientific and analytical.

We wish him success in all his future endeavours.

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