Summer Training at
National Rural Health Mission (NRHM),
Government of Rajasthan
(April 9-June 1, 2012)

Utilization of ANC Services in Urban Slums of Jaipur along with an Overview of Various Components under NRHM

By
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Under the guidance of
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Post Graduate Diploma in Hospital and Health Management
2011-2013

Institute of Health Management Research,
Jaipur
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CERTIFICATE

This is to certify that **Mr. Vijay Kumar Agarwal,** student of PGDHM 2011-2013, has undergone Summer Training in **National Rural Health Mission, Rajasthan** from April 9 to June 1, 2012. The title of the summer internship project was "***Utilization of ANC Services in Urban Slums of Jaipur along with an Overview of various components under NRHM***".

The candidate carried out all the studies related to the summer training. His approach to the studies has been sincere, scientific and analytical.

This summer training as partial fulfilment of the course requirement is recommended for the award of Post Graduate Diploma in Health and Hospital Management (PGDHM).

We wish him success in all future endeavours.

Dr. P. R. Sodani
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Certificate

This is to certify that Vijay Kumar Agarwal, student of PGDHM 16th batch, institute of Health Management and Research, Jaipur has successfully completed his summer internship at NRHM, Rajasthan from 9th April to 1st June, 2012 and studied the various components of NRHM with a special focus on "Utilization of ANC Services in Urban slums of Jaipur" at various levels of health care, under the guidance of Dr. Noopur Prasad, Project Director, M.H.

He has been sincere and curious learner during his internship period.

We extend our good wishes to him for a bright and successful career ahead.

(Dr. Pradeep K Sarda)
Director (RCH)
Medical, Health and F.W. Services
Govt. of Rajasthan

1324
31/8/2012

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I owe a great debt to **Smt. Gayatri Rathod (IAS),** *Mission Director NRHM* for having permitted me to do my summer training with Government of Rajasthan. She was a constant guiding support and inspiration throughout the training period. I would also like to thank **Dr. P.K. Sarda,** *Director RCH* and **Dr. Nupur,** *Joint Director RCH* without whom this training could never have been accomplished.

This training wouldn't have been completed without a substantial support from a great number of people and so I would like to thank all the consultants in various departments and other staff members at NRHM for being so helpful all the time and making this summer training project an unforgettable.

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Most importantly I would like to thank my mentor **Dr. Susmit Jain** (IIHMR) for his able guidance and useful suggestions, which helped me in completing the project work, in time able experience.

Finally, most importantly, I would like to express my heartfelt thanks to my beloved parents for their blessings, my friends/classmates Priyanshu, Priyanka, Pawan, Hemlata, and Garima for their help and wishes for the successful completion of this training.

Vijay Agarwal

List of Abbreviations and Acronyms

ANC	Ante-natal care
ANM	Auxiliary nurse midwife
ASHA	Accredited social health activist
AWC	Anganwadi centers
AWW	Anganwadi worker
AEFI	Adverse Events Following Immunization
AAO	Assistant Accounts Officer
AIDS	Acquired Immunodeficiency Syndrome
ARSH	Adolescent Reproductive And Sexual Health
ART	Anti Retroviral Therapy
BCG	Bacillus Calmette Guerin
BCMO	Block Chief Medical Officer
BPL	Below Poverty Line
CBD	Community Based Distribution
CBFP	Community Based Family Planning Programme
CCC	Community Care Centers
CMC	Concurrent Monitoring Cell
CMHO	Chief Medical & Health Officer
DIO	District Immunisation Officer
DLHS	District Level Health Survey
FRU	First Referral Unit
FSW	Female Sex Worker
HRG	High Risk Group
ICDS	Integrated Child Development Services
MDG	Millennium Development Goals
MH	Maternal Health
MDR	Maternal Death Review
MVA	Manual Vacuum Aspiration
NFHS	National Family Health Survey
NIC	National Informatics Center
OCP	Oral Contraception Pill

OPV	Oral Polio Vaccine
PLHIV	People Living With HIV
PPTCT	Prevention Of Parent To Child Transmission
RI	Routine Immunization
RIMS	Routine Immunization Monitoring System
RMRS	Rajasthan Medicare Relief Society
RSBY	Rashtriya Swasthya Bima Yojna
RTI	Reproductive Tract Infection
SARC	State ASHA Resource Center
STI	Sexually Transmitted Infection
UIP	Universal Immunization Program
VPD	Vaccine Preventable Disease

Preface

Summer internship is an integral part of the PGDHM curriculum. As a part of the course; students of first year are required to undergo summer placement 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 major objectives of the summer training programme 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 Components 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 organization.

During our training period we had an **Overview of various Components** undertaken in National Rural Health Mission, Rajasthan including the current status of the components and our observations regarding the same. We also carried out a small study on the different topics assigned to us.

Part -1

About NRHM…

The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure. These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP. It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country. It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and Funds for optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare. It seeks to revitalize local health traditions and mainstream AYUSH into the public health system. It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health. It seeks decentralization of programmes for district management of health. It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure. It shall define time-bound goals and report publicly on their progress. It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective.

Part-2

Report on Specific Assignment:

(UTILIZATION OF ANTE-NATAL CARE (ANC) SERVICES IN URBAN SLUMS OF JAIPUR)

2.1. OBJECTIVES:

1. To assess the utilization of ANC services in urban slums of Jaipur and to identify the reasons for Under-utilization / No Utilization of ANC services by the community, if any.
2. To identify the Gaps in health delivery system related to ANC service utilization

2.2. METHODOLOGY:

The descriptive cross-sectional study was carried out in Jawahar nagar urban slum, Jaipur during the period from May 21, 2012 – May 28, 2012. The sampling procedure adopted was convenient sampling. 30 females were chosen as primary respondents who were registered for ANC services during the period October'2011 to March'2012. These women were interviewed with the help of semi structured schedule.

In addition to this, secondary data was also collected from the Anganwadi centres and dispensary in that area regarding ANC services. Also, a formal meeting was conducted with ASHAs, ANMs and AWWs to develop the understanding of the health delivery system and community behaviour regarding the ANC services in the slum. The minutes of meeting were recorded.

The total population of the Jawahar nagar slum divided in seven Tela was 33, 630.

2.3. FINDINGS:

2.3.1. ANC Services

The secondary data of women who were registered during october1, 2011 to March31, 2012 for ANC services was collected from the Anganwadi centres. The Data comprises of total ANC registrations, registrations in first trimester and the total number of completed ANCs as shown in the Table 1.

In the given data the complete ANC include registration and two doses of TT with interval of one month.

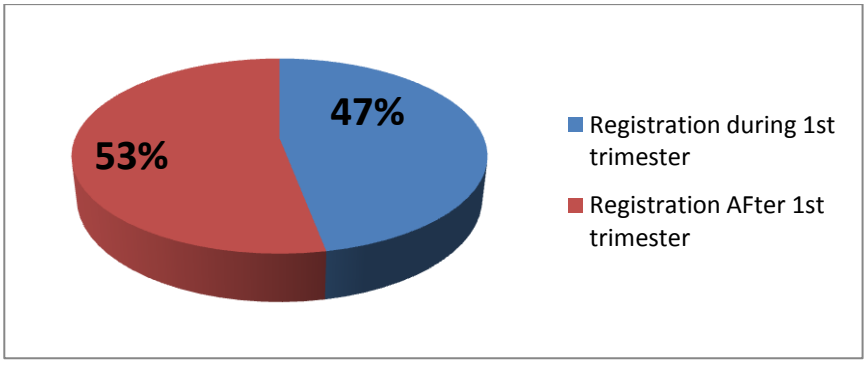
Table 1: Profile of ANC Services in the study area

	ANC Registered	Registration in 1st Trimester	Complete ANC*
OCT'11	39	22	31
Nov'11	47	20	31
Dec'11	41	15	30
Jan'12	47	18	35
Feb'12	67	30	38
March'12	104	57	60
Total	345	162	225

***** For this study Women with Complete ANC were those had been registered and had been administered two doses of TT

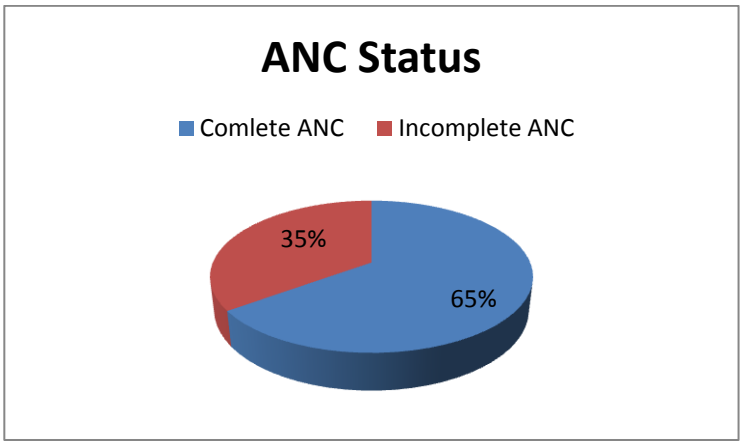
It was found that the registration in first trimester (Early registration) was almost half (47%) of total registration as shown in the Graph 2.

Graph 1: ANC registration during October'11-March'12



The data also exhibit that the dropout rate was high as complete ANCs were only 35% in comparison of total registrations as shown in the Graph 3. The reasons for the high dropout rate was that women registered for ANCs were not accepting the TT dose due to various reasons and few of them were going to other health facilities for checkups as said by the health workers during the meeting with them.

Graph 2: ANC Status during October'11-March'12



2.3.2. Resources :

During the study, the health facilities were visited which includes Anganwadi centres in Jawahar nagar slums and D-health post(It is a dispensary dedicated to Jawahar nagar slum). The availability of the resources such as manpower, drugs and equipments were checked and they were found to be inadequate to cater the needs of the community.

There were only 7 ASHAs and 3 ANMs working in the population of around thiry three thousand which is quite less.

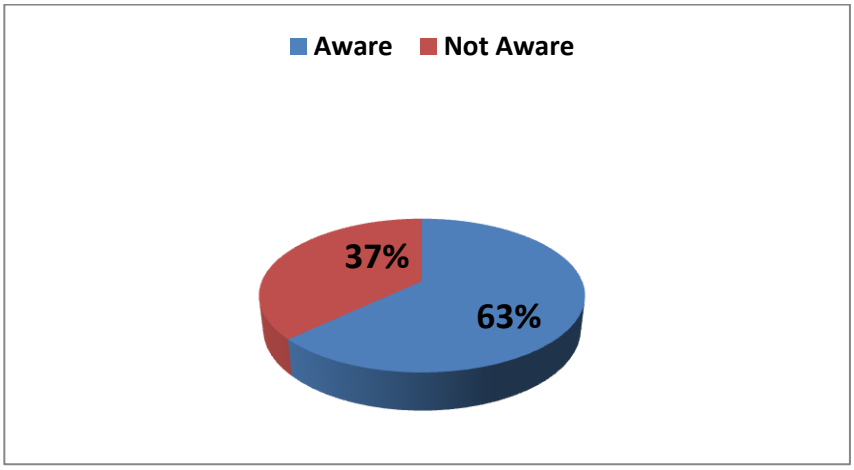
After formal discussion with health workers, it was found that they don't have adequate space to conduct MCHN day smoothly as the size of Anganwadi centre was too small. Alternate Vaccine delivery system is not functional in slums so ANMs are facing difficulties in getting the vaccines at right time and right place, they added.

It was also found in the discussion that there was no weight machine in the Anganwadi centre since last two years.

2.3.3. Community awareness and behaviour

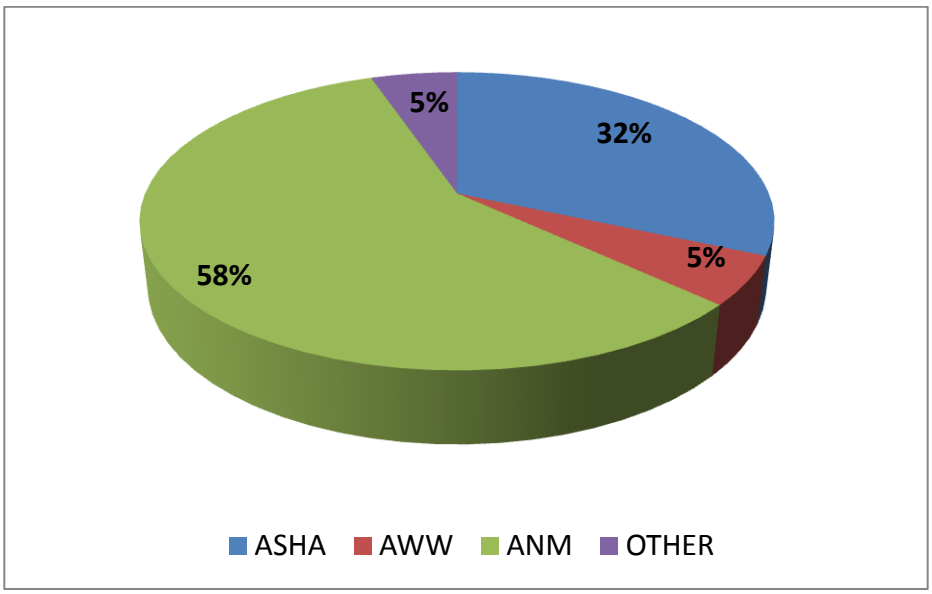
A face to face interview was conducted with 30 women with the help of semi structured schedule who were registered for ANC services during Oct'11-March'12. The purpose was to find out the common reasons for under utilization of the ANC related services, if any. Community behaviour plays a major role in availing the health services. It can be seen in the Graph 4 that awareness level regarding ANC services is around 2/3rd (63%) which is quite satisfactory among community

Graph 3 –Awareness Level of respondents regarding ANC Services



Health worker plays a major role in increasing the awareness level of community. Respondents who knew about the ANC services were asked about the source of information. Around 60% respondents said that awareness is due to ANM as shown in Graph 5. Thus, we can say that ANM played a major role in increasing awareness level in community than any other health worker.

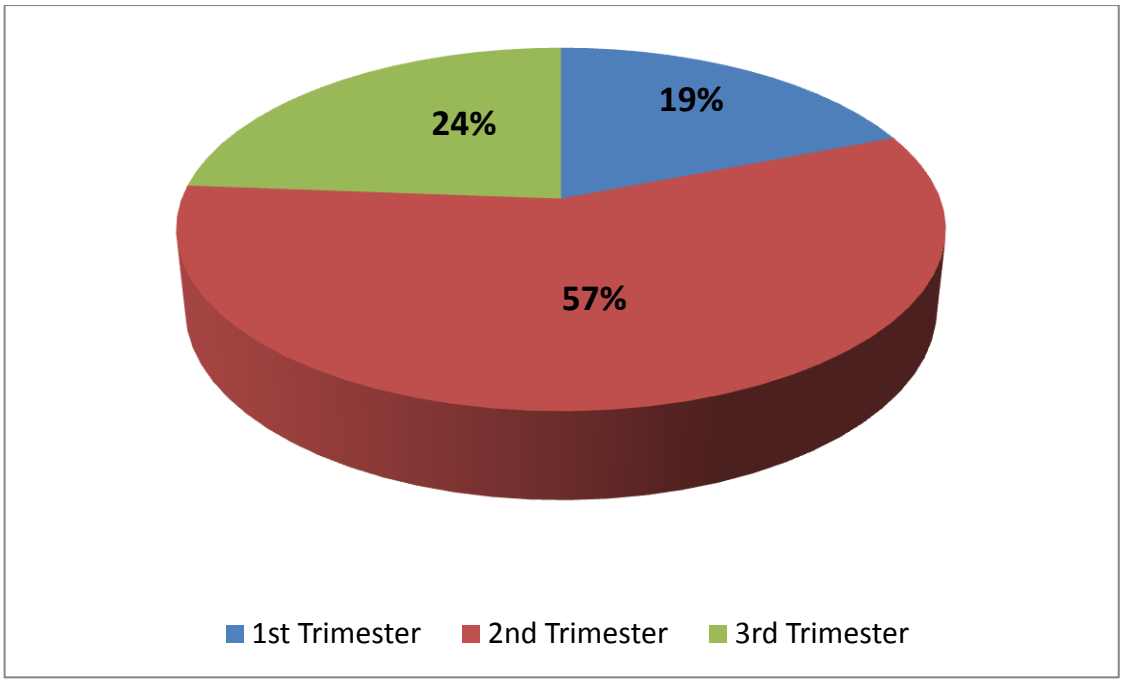
Graph 4 - Awareness provided by Health worker



Though ASHA is the first link between community and the health system and she is primarily responsible for awareness and behaviour towards ANC services utilization in the community but she contributed only one third (around 33%). The reasons for contributing less in providing the awareness in the community could be that they are not sensitised and also not trained. ANM told that no training of ASHAs in Jawahar Nagar Slum has been conducted till now except the first Induction programme of fifteen days so this could be the reason for incompetency in their work.

Early registration is the registration within first trimester of the pregnancy. It was found that only there were 20% registrations in first trimester. Majority of the registrations took place in Second trimester. It is interesting to note that about 1/4th registrations were during the last trimester of pregnancy(In 6-8 months of pregancy) as shown in the graph below

Graph 5 - Time of Registration for ANC

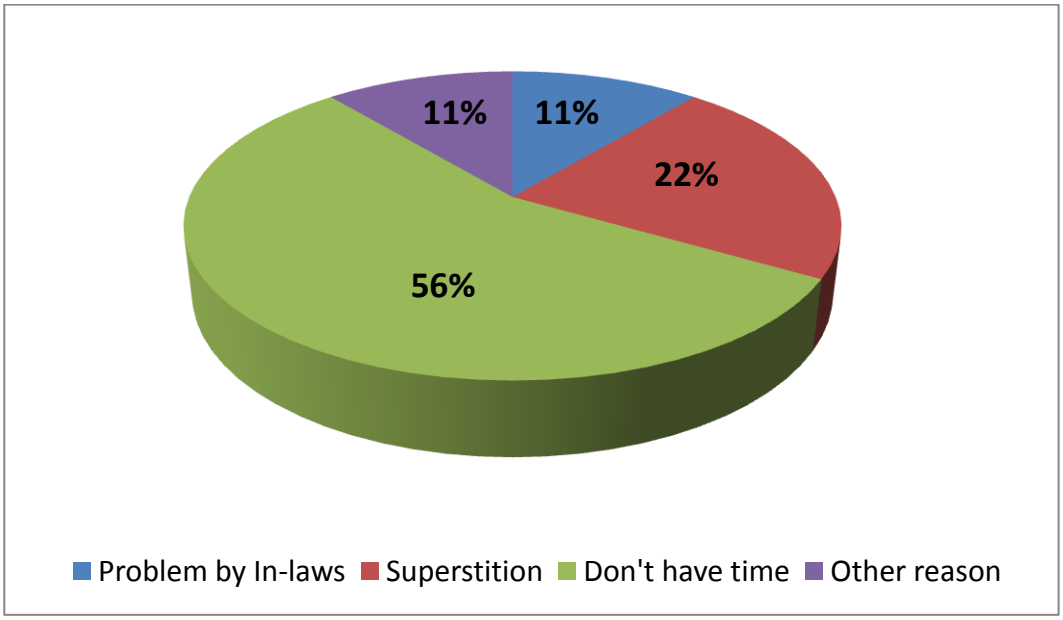


Superstition appeared to be one of the main reasons for not registering the pregnancies early. It is considered inappropriate to reveal the prganacy status in the first trimester. This also seems to be an important reason for underutilization of ANC services as shown in Graph 7. Around 22% respondents told this reason for underutilization of ANC services.

The time problem was the main reason for underutilization of ANC services in slums.

This reason was responded by around 56% of the women as shown below in Graph 7.

Graph 6 - Reasons for underutilization of ANC services



The Women leave their houses early in the morning and come late by evening. This was also the major reason for Left outs. Superstitions followed by Problem by in laws especially mother in laws are also the important reasons for no registrations in the Slum community as shown in the above gr

Part-3

Learning's from Summer Internship:

During summer internship, following components under NRHM were studied. Reproductive and Child Health Programme (RCH), Janani Surkasha Yojna (JSY), Janani Shishu Suraksha Yojna (JSSSY), Immunization, ASHA, Village Health and Sanitation Committee (VHSC), Pregnancy and Child Tracking System (PCTS), Pre Conception and Pre-Natal Diagnostic Techniques (PCPNDT), Rajasthan State AIDS Control Society (RSACS), And Mukhya Mantri Jeevan Raksha Kosh (MMJRK). A brief description of these components/ Programmes is given below.

3.1. REPRODUCTIVE AND CHILD HEALTH (RCH):

The overall goal of RCH programme was to reduce infant and maternal morbidity and mortality in the state. These goals are being achieved through improvement in quality, enhancing accessibility and availability, and coverage with the reproductive and child health services. The programme emphasized empowerment of women and communities for enhancing health service. RCH includes Maternal Health, Child health, And Maternal Death Review which are described below.

3.1.1. Maternal Health

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. Every year, in India, 28 million pregnancies take place with 67,000 maternal deaths, 1 million women left with chronic ill health, and 1 million neonatal deaths.

There are three main strategies Provision of Quality Antenatal Care, Ensure Access to a Skilled Birth Attendant, and Functional Facilities to Provide Institutional Deliveries for improvements in maternal health.

3.1.2. Child Health

Child health component mainly includes Integrated Management of Neonatal and Childhood Illness (IMNCI), Home Based Post-natal Care (HBPNC), and Malnutrition Treatment Center (MTC).

Integrated Management of Neonatal and Childhood Illness (IMNCI) is a strategy for improving neonatal and child health and reducing infant mortality in the state. This strategy aims to improve neo-natal and childhood survival in the state through regular and appropriately timed home visit for newborns (3 visits are recommended for the newborns- on Day 1,3 and 7). If there is a low birth weight child(less than 2.5 kg) than 3 additional visits on day 14, 21, and 28.

The agencies which are jointly responsible for implementing IMNCI in the districts are Department of Medical, Health & Family Welfare and Department of WCD and UNICEF provides technical support for the program.

Home Based Post-natal Care (HBPNC) has been initiated by Rajasthan in the three NIPI focus districts of Bharatpur, Alwar and Dausa. Under this initiative, mothers delivering at home are visited and monitored by ASHA-Sahyoginis wherein she visits her at least six times within 42 days, first visit is within 24 hrs; second visit on 3rd day, third visit on 7th day; fourth visit on 14th day, fifth visit on 28th and last visit on 42nd day of the delivery and provide Post Natal Care to the those women who delivered at Home. For complete Post Natal home visits, ASHA is getting incentive of Rs 200 per home delivery (six visits) and Rs 100 per institutional delivery (five).

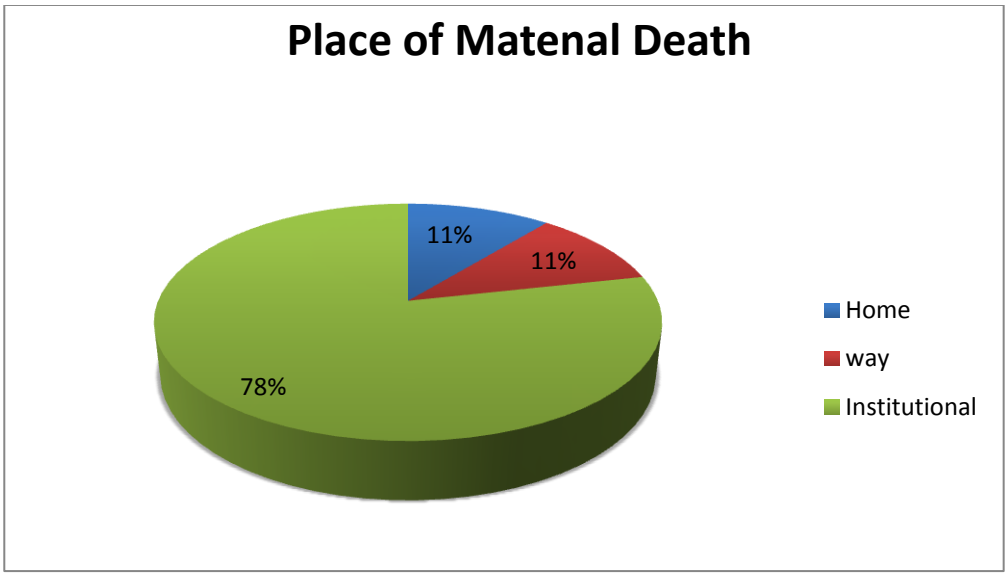
Malnutrition Treatment Center (MTC) are for Severely malnourished children where they are referred to the center by AWWs and ASHAs for rehabilitation. For care of sick children & severe malnutrition children 6 bedded MTC has been established in 36 DH & in 3 selected CHCs.

3.1.3. Maternal Death Review (MDR)

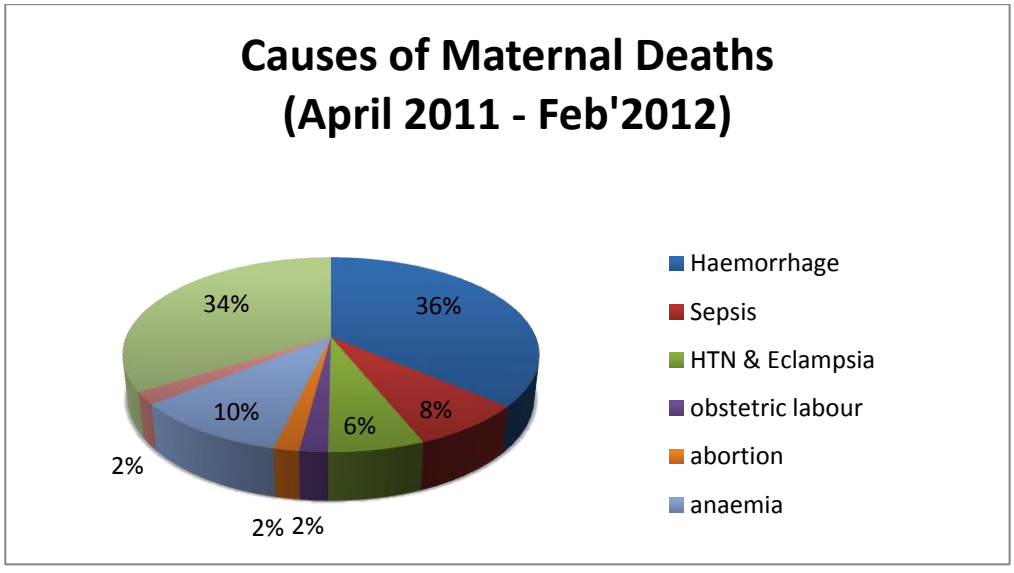
In MDR all the deaths of women between from 15 to 49 years of age and infant (up to one year of age) are reported by Accredited Social Health Activist (ASHA), Anganwadi Worker etc. and being verified by a team of Medical officer and Lady Health Visitor. If death is a maternal death then it is investigated by the Block team. After investigation block team send the report to CMHO and collectors where cause of death is analyze by the team of expert. The cause of death then review in DHS and Block level meeting and also share in simple language with community. In year 2010-11this program is initiated as a Maternal Death Review in all districts. On reporting of each maternal death incentive of Rs. 50 is given to ASHA, AWW.

During the training the place and probable causes of maternal death were studied. The graphical representation of the both is shown below.

Graph 8: Place of Maternal Death



Graph 9: Causes of Maternal Deaths



Recommendations: A separate e-mail id for reporting maternal death from districts should be there.

3.2. Janani Suraksha Yojna:

Janani Surakha Yojana (JSY) is a centrally sponsored scheme under NRHM umbrella to benefit pregnant women & certified poor families. The objectives of JSY are to decrease maternal mortality rate & infant mortality rate and to increase Institutional deliveries amongst BPL & poor families.

Under JSY programme ASHA has some duties viz. Registration of eligible beneficiary, Antenatal checkups(3 times), Arrange referral transport, Escort her to health facility & facilitate cash assistance from PHC/CHC/DH, and Post natal checkups (2times).

A JSY report has been prepared for the period of April 2011 to March 2012 in which number of JSY beneficiaries (total and BPL) and no. of JSY beneficiaries before delivery is mentioned in seven division of Rajasthan state.

Table 2: JSY Report – April'2011-March'2012

S.no.	Division	**No. of JSY Beneficiaries**		**No. of JSY BPL Beneficiaries before delivery**
		Total	**BPL**	
1	Ajmer	133792	6313	319
2	Jaipur	167818	5800	180
3	Kota	83694	10493	84
4	Jodhpur	159420	5358	700
5	Udaipur	163402	31941	758
6	Bikaner	95228	8808	837
7	Bharatpur	106609	7207	92
	State Total	909963	7207	92

Source: DM&HS, Rajasthan

3.3. Janani Shishu Suraksha Yojna (JSSY)

Janani Shishu Suraksha Yojna was started on September 2011 in Rajasthan. The main objectives were Entitlements and elimination of out-of pocket expenses for pregnant women and sick neonates, Enhancing access to public health institutions, and to Reduce MMR & IMR.

There are some entitlements for pregnant women under JSSY like:

1. Free Delivery & C –Section

2. Free Drugs & Consumables before, during and till 6 months after the delivery

3. Free Diagnostics (Blood, Urine, USG etc)

4. Free diet during stay (up to 3 days for normal delivery & 7 days fro C-Section

5. Free transport: home institution, between health institution in case of referrals

6. Exemption from all kinds of user charges

Also there are some entitlements for Sick Newborn till 30 days after birth like:

1. Free and zero expense treatment

2. Free drugs & consumables

3. Free diagnostics

4. Free provision of blood

5. Free transport from home health institution, between health institution in case of referrals

6. Exemption from all kinds of user charges

Status of JSSY for pregnant women and sick newborn till 30 days after birth in current financial year was studied and tabulated below.

Table 3: JSSY Status for Pregnant Women (From 12 Sep -31st Dec-2011)

S.NO.	SERVICES	NO. OF BENEFICIARIES
1.	Total Deliveries	254995
2.	No. of pregnant women provided free medicine	443820
3.	No. of pregnant women provided free lab tests	244108
4.	No. of pregnant women availed free hot food	338497
5.	No. of pregnant women provided free transportation from Home to facility	126975
6.	No. of pregnant women provided free transportation from Facility to Home	158990
7.	No of Pregnant women provided free blood	11335

Source:-DM&HS Rajasthan

Table 4: JSSY Status for Sick Newborns till 30 days after birth (From 12 Sep -31st Dec-2011)

S.NO.	SERVICES	NO.OF BENEFECIERIES
1.	No. Sick Neonates (30 days) received free medicine	75102
2.	No. Sick Neonates (30 days) received free lab tests	22413
3.	No. Sick Neonates (30 days) received Free referral transport from Home to facility	5526
4.	No. Sick Neonates (30 days) received Free referral transport from Facility to Home	8131

Source:-DM&HS Rajasthan

3.4. Immunization

Routine Immunization in India

Delivering effective and safe vaccines through an efficient delivery system is one of the most cost effective public health interventions. Immunization programmes aim to reduce mortality and morbidity due to vaccine preventable diseases (VPDs).

India's Immunization Program is one of the largest in the world in terms of quantities of vaccines used, numbers of beneficiaries, and the numbers of immunization sessions organized, the geographical spread and diversity of areas covered. Under the immunization program, seven vaccines are used to protect children and pregnant mothers against Tuberculosis, Diphtheria, Pertussis, Polio, Measles, Tetanus and Hepatitis-B.

Some components of Immunization are monitored at state level like: Immunization & Vitamin A, Vaccine supply, VPD surveillance, Status of Cold Chain Equipment, and AEFI (Adverse Event following immunization).

Adverse events can also occur as a result of inappropriate storage, handling, preparation and administration of vaccines. The most common program error is infection as a result of nonsterile injection or poor injection technique. These can be prevented through training of health workers, regular supervision and an adequate supply of equipment for safe immunization injections.

In **Immunization** Programme there are some challenges like: Improving vaccine use and reducing wastage Safe injections, Reduce Adverse event following immunization, Alternate vaccine delivery system, and Left outs and Drop outs.
For left outs and dropouts some common reasons were identified like: Parents not motivated to immunize children because of their poor understanding of its purpose and importance, Session site too far away, Cultural or Religious reasons for refusal of vaccination (myths, rumours and misconceptions, Financial or gender barriers to immunization (e.g. husbands disallow wives to attend sessions because of time/lost labour, expense and/or fear of side effects), and AEFI in the community discourages parents to immunize their children.

3.5. Accredited Social Health Activist (ASHA):

The new band of community based functionaries, named as Accredited Social Health Activist (ASHA) was proposed in the NRHM who is serving the population of 1000 and 500 in hilly and desert terrene.

ASHA is the first port of call for any health related demands of deprived sections of the population, especially women, children, old aged, sick and disabled people. She is the link between the community and the health care provider.

In each Anganwadi Centre apart from Anganwadi Worker one additional worker named 'Sahyogini' is envisaged to provide door to door information and services of Nutrition, Health, preschool education. Her role

is quite similar to the role of ASHA under NRHM. So to avoid duplication of workers providing same types of services in the same area, the decision was taken at State level, that there will be only one worker coterminous with Anganwadi, who will work with DWCD and DMHS. This worker is called as 'ASHA Sahyogini', selected by the community through Gram Panchayat and responsible to the community.

Criteria for selection of ASHA Sahyogini

- One ASHA Sahyogini for each Anganwadi Center.
- Woman resident of that area, Married/ Widow/ Divorcee
- Age between 21 to 45 years
- ASHA Sahyogini should have effective communication skills, leadership qualities and be able to reach out to the community.
- ASHA Sahyogini should be literate woman with formal education up to eighth class, In Tribal and desert areas the educational qualification may be relaxed if the 8th pass Candidate is not available. This is permitted only after the approval of State level Committee.
- Adequate representation from disadvantaged population groups.

ASHA gets a monthly honorarium of 1000/-Rs from WCD department and from NRHM she gets incentives according to her performance. An incentive plan is given below.

Table 5: Incentive plan for ASHA:

S.NO.	Activity By ASHA	Incentive
1.	Reproductive and Child Health	
1.1.	Early registration and complete ANCs	100/-
1.2.	Institutional delivery	
1.3.	Complete PNCs	100/-
1.4.	Home Based PNCs (HBPNC)	100/-
2.	Immunisation	
3.	Family Planning	
3.1.	Social Marketing	1/- Per condom 1/- Oral pills 2/- ECP
3.2.	Sterilisation	150/- Male 200/- Female
4.	National Programmes	
4.1.	Cataract Operation	175/-
4.2.	RNTCP	250/-(After sputum –ve)
4.3.	Malaria	50/-(After 14 days)
4.4.	NLEP	300/-PB 500/-MB
5.	VHSC Meeting	100/-
6.	MCHN Day	150/-
7.	Sector Meeting (At PHC)	100/-

Source: DM&HS, Rajasthan

3.6. Village Health and Sanitation Committee (VHSC)

The NRHM framework support decentralized planning & monitoring up to the grass root level. Therefore it was decided to entrust village level committees of the users group, community based organization for the planning monitoring & implementation of NRHM activities into the 41000 revenue villages of the State.

VHSC feed such groups, which is the fifth committee (Development Committee) of the Gram Panchayat. The VHSC is the key agency for developing Village Health Plan & the entire planning of village Panchayat for NRHM. This committee comprises of Panchayat representatives, ANM, Anganwari workers, Teachers, Community health volunteers, ASHA.

The State is presently having 9189 Gram Panchayats where such committees exist. It is planned to organize the training of at least 25 % of these committees on village health need identification & local action under NRHM. It is also proposed to provide Rs.10000/- to all VHSC for supporting their efforts in developing Village Health Plans.

Table 6: Data of VHSC of seven zone of Rajasthan State

The data of VHSC was studied and information regarding VHSC has been tabulated below.

S.no	Zone	No. of VHSCs to be constituted	No of VHSCs constituted till current month	No of VHSCs trained till Feb 2012	Total funds Alloted	Amount expenditure	Percentage utilization
1	Ajmer	5691	5689	5382	53329300	5608000	10.52
2	Bikaner	6342	6277	6215	45621100	5608000	40.12
3	Bharatpur	3895	3895	3455	35432300	2594000	7.32
4	Jaipur	7761	7624	6060	72836100	7374000	10.12
5	Jodhpur	7332	7318	6139	70333400	17855000	25.39
6	Kota	4318	4316	4229	35416100	20512000	57.92
7	Udaipur	8404	8321	6131	88096900	47080000	53.44
Grand Total		43743	43440	37611	401065200	119326000	29.75

Source: DM&HS, Rajasthan

3.7. Pregnancy & Child Tracking System / Pregnancy, Child Tracking & Health Services Management System (PCTS)

Pregnancy, Child Tracking & Health Services Management System is online software used as an effective planning & management tool by Medical, Health & Family Welfare department, Govt. of Rajasthan. The system maintains online data of more than 13000 government health institutions in the state.

The System facilitates Online tracking of pregnant women, Online tracking of infants & children, Better health surveillance, Better monitoring of immunisation programme, Monitoring of institutional delivery, Identification of cases for sterilization, Better management of health institutions, Online directory of health institutions , Line list of infant deaths ,and Swasthya Sandesh Seva (SMS Alerts to Citizen and Health Workers).
There are four main components of PCTS viz. Master reports, Activity reports, Reports on line list, a Monitoring Desk.

There are some challenges in the system like, Data entry problem at PHC level, Lack of staff to operate the software, and planning to provide this facility at Sub centre level.

3.8. THE PRE-CONCEPTION AND PRE-NATAL DIAGNOSTIC TECHNIQUES ACT (PCPNDT):

This is an act to provide for the prohibition of sex selection, before or after conception and for regulation of prenatal diagnostic techniques for the purpose of detecting genetic abnormalities or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex-linked disorders and for the prevention of their misuse for sex determination leading to female feticide and for matters connected therewith or incidental. Misuse of modern diagnostic facilities like ultra-sonography, amniocentesis, chorionic villi examination etc for the purpose of female feticide which is against the female sex and affects the dignity and status of women, therefore it was necessary to bring a legislation to regulate use of diagnostic techniques and to provided punishment to stop the misuse of diagnostic techniques. It also prohibits advertisement of PNDT for detection & determination of sex.

The key objectives of state PCPNDT cell are Collection & monitoring of various data related with PCPNDT Act, 1994 through district PCPNDT Coordinators, Awareness programme through Government agencies/NGO to lawyers, Judiciary, PRI etc, To evaluate the local causes of female feticide in various districts, To involve NGO for effective implementation of PCPNDT Act, 1994, Online submission of Form "F" & Quarterly report with complaint loading, Up gradation of ultrasound machines for the purpose of storing various images, To identify unregistered centers & doctors engaged in unlawful activities, Registration of manufacturers of ultra sound machine suppliers, and Organizing various meetings of advisory committee in the state.

After observing the data related to PCPNDT, it was found that there are some requirements of improvement like need for community awareness regarding use of complaint registration software, need for Inter Departmental Cooperation for 'Save the Girl Child' campaign like involving Department of Education, Police department and others, more IEC activities should be promoted, along with the NGOs, involvement of all Panchayati Raj Institutions, Educational institutions, Farmer-Peasant related organizations and all Sectoral organizations must be considered, and Asha sahyogini, Anganwadi worker, ANM should be the major components in implementation of the act.

3.9. Rajasthan State AIDS Control Society (RSACS):

National AIDS Control programme (NACP) is being implemented by RSACS formed under the Directorate of Medical and Health Services, Govt. of Rajasthan, Jaipur. NACP third phase has been completed on 31-3-2012.

The AIDS cell receives all the AIDS funds from the National AIDS Control Organization (NACO), Ministry of Health and Family Welfare, Govt. of India in form of grant aid.

The main objectives of NACP are: To prevent HIV transmission and to control its spread, To reduce morbidity and mortality associated with HIV infection, To coordinate and strengthen STD/HIV/AIDS surveillance, To enhance community awareness, specially knowledge, attitude and practice of high risk groups, To develop health education material for distribution and use by agencies working in AIDS prevention, To promote safety of blood and blood products and encourage voluntary blood donation, To provide facilities and to strengthen Sexually transmitted diseases services in Government and private medical

institutions, practitioners and NGOs, To develop counseling services, and Implementation of the policies formulated by National AIDS Control Organization, Govt. of India.

General prevalence of HIV in Rajasthan is 0.19%, Prevalence in STI patients is 2.33%, and in FSW it is 3.86%.

RSACS provides various services for HIV control and prevention. It includes ICTCs, STI and RTI control, Blood Safety, Care, Support and Treatment, Targeted Interventions, and Sentinel Surveillance.

Integrated Counseling & Testing Centers are the gateway to HIV prevention a treatment. ICTC is a public health strategy that aims at reducing HIV transmission by Increasing access to knowledge and understanding of HIV, Facilitating early uptake of services for HIV-positive and negative people, Providing tools for the adoption of safe behavior, Reducing and removing stigmatization and discrimination, Increasing access to knowledge and understanding of HIV, Facilitating early uptake of services for HIV-positive and negative people, Providing tools for the adoption of safe behavior, and Reducing and removing stigmatization and discrimination.

Current facility based distribution of ICTS centers in the Rajasthan state.

	Medical Colleges	**District Hospital**	**CHC/Sub District Hospital**	**24x7**	**PPP**
Total No of ICTCs	14	50	118	46	24

In Blood Safety programme there are 87 Blood banks, 21 blood component separation units.
The services which are provided at care, support and treatment centers includes In-patient admission for 15 days, Counseling Services, Food and recreation facility, Nutritional Counseling and support for inpatients, Treatment and Patient Management, Referral and Outreach services, and Drugs for opportunistic infections.

Targeted intervention as a strategy for prevention has proved to be an effective means to contain the prevalence of HIV in the state of Rajasthan. Currently there are 34 TIs working with core groups. Three TI are

working with MSM & 3 with IDUs, 28 are working with FSW population and 7 are core composite intervention. 9 TIs are working with migrant population. Similarly, two TIs are working with truckers. Thus total number of TIs is 52.

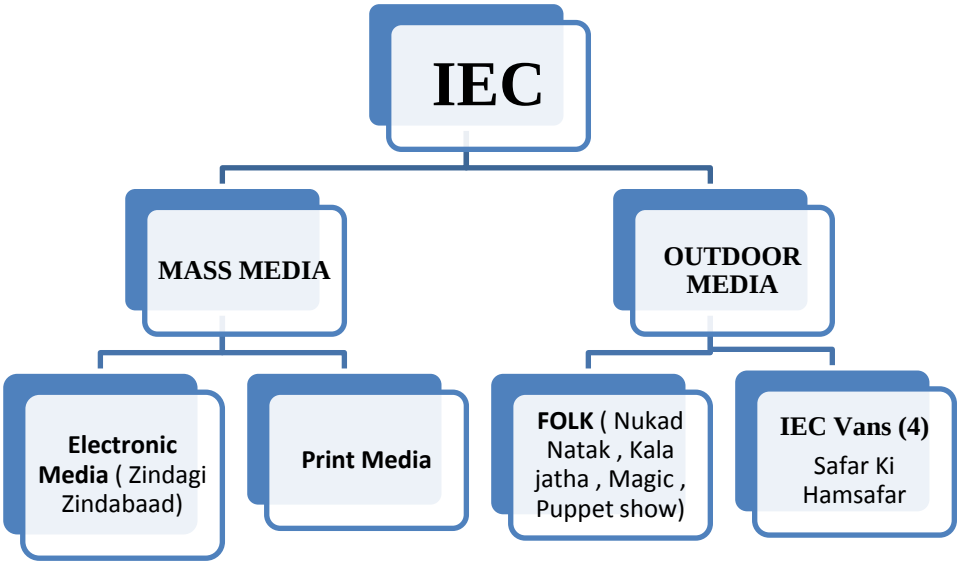
Districts of Rajasthan have been categorized according to HIV positivity/ prevalence in four categories.

Table 7: Categorization of districts according to HIV positivity

Category	Districts	Criteria (Prevalence)
Category A	Ganganagar	More than 1%
Category B	Ajmer, Alwar, Barmer, Jaipur, Udaipur	0.5-1%
Category C	Banaswara,Bharapur,Bhilwara, Chittaurgarh, Daulpur, Jalawar, Jodhpur, Karauli, Kota, Rajasmand, Sirohi	.25-0.5%
Category D	Baran, Bikaner , Bundi, Churu, Dausa, Dungarpur, Hanumangarh, jaisalmer, Jalore , jhunjunu, Sawai Madhopur, Sikar	Less than 0.25%

There are various IEC strategies for educating people about HIV/ AIDS.

Figure 10.1- Various IEC Strategies for HIV/ AIDS



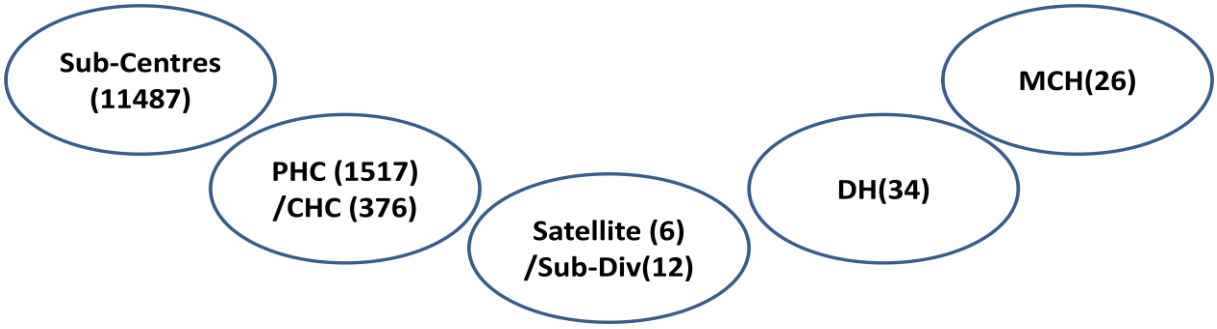
3.10. Mukhya Mantri BPL Jeevan Raksha Kosh (MMBJRK):

"Mukhya Mantri BPL Jeevan Raksha Kosh Yojna" was launched on 1st January 2009 to provide Free OPD Services, Free IPD Treatment, Free treatment at Higher centers, Free Investigations, Free Referral Transport and Free implants/appliances for BPL, State BPL, Aastha Card Holders, and HIV/AIDS.

69 rivate Hospitals have been empanelled and have been allotted land on concessional rates.

Salient Features of MMBJRK are: Every health institution at Primary, Secondary & Tertiary should have a signage having the details of the scheme mentioning the categories and BPL counter, both in yellow color, If the Facility is not available at the Tertiary level, the patients are referred to AIIMS New Delhi and PGI Chandigarh for which the cost is borne by RMRS, A web portal http://cmbpljrk.raj.nic.in has been developed by NIC, having following features, Unique ID No. for each patient, Monthly report generation of physical and financial progress; institution wise, category wise, caste wise, 25% of the OPD expenditure is borne by MRS and rest by MMJRK, Medicare relief society of every institute does a rate contract with the outside retailers and thereby procures medicines at lower discount. These medicines are made available to the BPL patients by the personnel at the BPL counter.

Figure 10.1-Network of Public HealthCare Institutions in Rajasthan



The figure shows the total number of public health institutions in Rajasthan where the services of the scheme are provided.

A comparison among MMBJRK with RSBY and Rajiv Arogyasri (Andhra Pradesh) is given below to show differences among them.

Table 8:- Comparison of MMBPLJRK with major Health Insurance Schemes

S. No.	Head	RSBY	MMBPLJRK Rajasthan	Rajiv Arogyasri Andhra Pradesh
1	Insurance Limit (Annual)	General illness limits Rs.30, 000 on floater basis per year.	No limit of expenditure on treatment of individual as well as on a family.	2 Lakh/ year on a family floater basis
2	Premium amount	Rs 750 per family per year (Rs 644 according to tender)	Not Applicable. This is not an insurance scheme.	Rs 450/- per family per year –borne by the State
3	Family members Coverage	Family size is limited up to 5 members	No limit of family size	No limit of family size
4	OPD facility availability	No	Yes	Only consultancy through camps

5	**Beneficiaries Coverage**		•	**BPL families**
6	**Beneficiaries Contribution**	**Rs. 30/- per family**	**No charges**	**No charges**
7	**Follow Up treatment**	**Only till 10 days**	**All kind of follow up services available**	**Follow up available for an year for 125 identified procedures**
8	**Identity Proof**	**RSBY smart card (process involved)**	**BPL, Astha, Annapurna, Ration, Pensioners card etc. (proof of relevant category)**	**White ration card with photograph /age of all members**
9	**Amount allocated (FY 2010-11)**	**Rs. 350 cr. (GoI)**	**Rs. 65 cr. (State) Rs. 20 cr. (GoI) under NRHM**	**Rs. 925 cr. Revised to 1200 cr. (State)**
10	**Network Hospitals**	**Facility available in limited government and private Hospital**	• **AIIMS, New Delhi & PGI, Chandigarh along with all Government Hospitals in the State** • **Treatment of 5 BPL patients per Hospital per month in 32 Super Specialized private Hospitals**	**Facility available in limited Government (92) and private (250) Hospitals**
11	**Counters/ Manpower available**	**Counter and man-power at each facility**	**Counter and manpower at each facility**	**Arogyasri mitra and Counter available at each facility.**
12	**Online/ Manual reporting**	**No manual backup**	• **Scheme is online in 445 Facilities, CHC up to MCH level** • **manual backup available at all facilities**	**All network Hospitals are reporting online**

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4. Pre-Conception & Pre-Natal Diagnostic Techniques Act, 1994 and Rules with Amendments, Ministry of Health and Family Welfare, Government of India, 2006.

List of Persons Interacted during the Training Period

S.No.	Name	Designation	Place
1.	Smt. Gayatri Rathod	Mission Director NRHM	NRHM, Swasthya Bhawan
2.	Dr. P. K. Sarda	Director RCH	NRHM, Swasthya Bhawan
3.	Dr. Nupur	Joint Director RCH	NRHM, Swasthya Bhawan
4.	Dr. Giriraj Sharma	Consultant Maternal Health	NRHM, Swasthya Bhawan
5.	Dr. Indra Gupta	Nodal officer- RTI/STI/SBA/MDR	NRHM, Swasthya Bhawan
6.	Shikha Sharma	Consultant Urban RCH/Quality Control Assurance/Anaemia Control Program	NRHM, Swasthya Bhawan
7.	Nalini Khatri	Programme officer (IMEP)	NRHM, Swasthya Bhawan
8.	Vaishali Sharma	Consultant IEC	NRHM, Swasthya Bhawan
9.	Kishanaram Esharwal	Project Director, MMBPLJRK	NRHM, Swasthya Bhawan
10.	Priyanka Kapoor	Consultant MMU	NRHM, Swasthya Bhawan
11.	D.P.Kanungo	Consultant MMJRK	NRHM, Swasthya Bhawan
12.	Ashok Dutt	Statistical Inspector (PCTS)	NRHM, Swasthya Bhawan
13.	Sushrita Roy	Consultant ASHA	NRHM, Swasthya Bhawan
14.	Vaidehi Agnihotri	Consultant VHSC/ARSH	NRHM, Swasthya Bhawan

15.	Naresh Kumar	Nodal Officer, JSY	NRHM, Swasthya Bhawan
16.	D.K.Shringi	Drug Controller	Swasthya Bhawan
17.	Anuja Agrawal	Procurement & Drug Warehouse Incharge, RHSDP	Swasthya Bhawan
18.	Dr. J.P.Dhamija	Director AIDS, Director(RSBTC), PD(RSACS)	Swasthya Bhawan
19.	Dr. R.S.Rathore	State Immunization Officer	Swasthya Bhawan
20.	Jimeevas	Technical Support person for RSACS	RSACS
21.	Reshma Azmi	Team Leader Capacity Building	RSACS
22.	Dr. Pradeep Choudhary	Joint Director IEC	RSACS
23.	Dr. Ravi Gupta	PPTCT Consultant	RSACS
24.	Dr. Raja Chawla	Deputy Director RTI/STD	RSACS
25.	Sanjay Singhal	Quality Manager	RSACS
26.	Ashish Verma	Programme Officer, State Mainstreaming Unit	RSACS
27.	Prakash Narvani	M & E Officer	RSACS
28.	Dr. L.L.Dautonia	Deputy Director Immunization	NRHM, Swasthya Bhawan
29.	Hardayal Singh	Deputy Director PCPNDT	NRHM, Swasthya Bhawan
30.	Archana Sharma	Health Manager, PNDT Cell	NRHM, Swasthya Bhawan
31.	J.P.Jat	State Demographer FW	NRHM, Swasthya Bhawan
32.	Prem Sharma	Statistical Inspector (Demographic cell)	NRHM, Swasthya Bhawan
33.	Vibha Sharma	Assistant State Demographer	NRHM, Swasthya Bhawan
34.	Dr. Ashok Panagariya	Member State Planning Board	Swasthya Bhawan, Yojna Bhawan

35.	Dr. Ramdhan Jat	Health Manager	Kanwatiya District Hospital
36.	Dr. D.B.Gupta	PMO	Satellite Hospital, Sethi Colony
37.	Dr. G.S.Khatri	Joint Director (Blindness)	Swasthya Bhawan
38.	Dr. Madhuri	Deputy CMHO	Swasthya Bhawan

List of activities performed during the training period

Date	Activity
09/04/2012	Discussion on the objectives and Mission document of NRHM
16/04/2012	Discussion on the operational guidelines on maternal and newborn health
17/04/2012	Assisted Dr. Giriraj sharma(consultant-MH) in the monitoring of FRUs of Rajasthan – Monthly monitoring of State FRUs is done and Report is sent to GOI
18/04/2012	A brief study on implementation of Janani surakha yojna (JSY)
20/04/2012	A detailed analysis on number of maternal Deaths and their major causes in the financial year 2011-12
25/04/2012	A discussion on Alternate Vaccine Delivery System (AVDS) and gave some recommendation.
27/04/2012	Reviewed the Training modules of ASHA and suggested some improvements in the Modules for the next edition.

Date	Activity
19/04/2012	Kanwatiya hospital, Shastri nagar , Jaipur
15/05/2012	PHC Sundlak, Dist. Baran
16/05/2012	SC and AWC Melkhedi, Dist. Baran
17/05/2012	SC and AWC Ranwasi, Dist. Baran
18/05/2012	PHC koyla, Dist. Baran SC Badagaun, Dist. Baran
18/05/2012	CHC Amer, Dist. Jaipur
23/05/2012	CHC Sanganer , Dist. Jaipur

Meetings / Workshops attended

Date	Meetings / workshops objective
27/04/2012	Vitamin A campaign from 30-04-12 to 31-05-12