EXECUTIVE SUMMARY

The Rajasthan Health Systems Development Project (RHSDP) has been launched in the State with the goal of improving the overall health scenario in the State. As a part of its overall operational framework, the Project seeks to increase equitable access to quality health care for the under-served populations, particularly, the BPL, tribals, nomadics and women.

In order to design effective interventions for improving the access to public health facilities among the poor, the Project has aptly decided to start by conducting an in-depth review of the two major schemes already running in the State for the purpose. Accordingly, AMS Consulting (P) Limited, Jaipur was commissioned to undertake an in-depth review of the two schemes, namely, the BPL Medical Card Scheme and the OERT Scheme.

Methodology

As per the terms of reference given to us, the study was to be conducted in three districts of the State. Keeping in mind the three distinct regions of the State, Sawai Madhopur, Banswara and Jodhpur were selected to represent plains, tribal and desert regions, respectively.

In each district, all the Government health facilities upto the level of CHC, were covered— 2 DHs, 1 SDH and 24 CHCs. Besides the in-depth interview of the Facility In-charges and collection of secondary data, exit interviews of 1220 patients were conducted. At each level, both BPL as well as APL patients were covered so as to assess if there existed any discriminatory practices against the BPL patients. Further, due representation was given to both outpatients as well as inpatients.

Since the household survey entailed assessment regarding both the BPL Medical Card as well as the OERT Scheme, the procedure for household selection was decided keeping this fact in mind. In the first stage, 10 OERT villages were selected in each sample district. Considering the fact that the OERT Scheme had been implemented in limited number of villages in the State, it amounted to covering a fairly large proportion of the total OERT villages (between 10-17 percent) in each sample district. Due care was taken to ensure that the sample villages were geographically spread over the entire district. In the second stage, in each sample village, a random sample of 30 households (15 BPL and 15 APL) was drawn from amongst those where a delivery had taken place during the last one year. In all, 900 households were covered under the study.

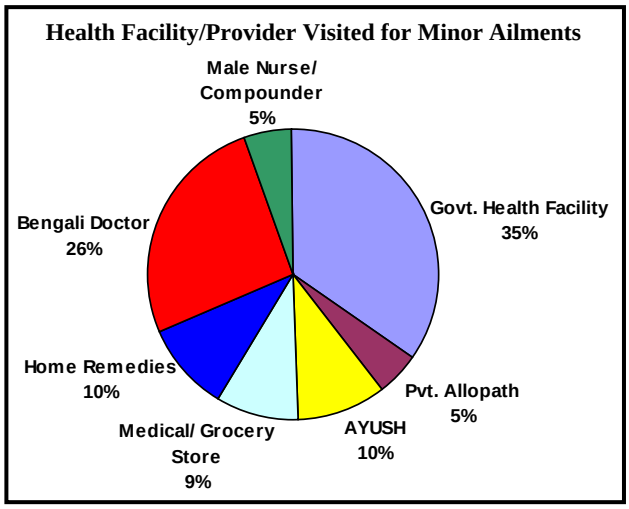
In each sample village, in addition to conducting the survey of households, the investigators also conducted in-depth interviews of the local functionaries, namely, ANM, AWW and village *Sarpanch*. Besides getting their suggestions for strengthening the schemes, it also helped us in triangulating the information obtained from the household survey and drawing conclusions with confidence.

A. BPL Medical Card Scheme

A1. Major Findings

A1.1 Health Facility/Provider Visited for Minor Ailments

The households who reported an incidence of minor illness (that is, those which did not require a hospitalization) during the last 3 months preceding the survey, were probed about the health service provider/ facility visited by them for seeking treatment. Overall, only 1 out of every 3 (35 percent) households reported having visited the Government facilities for the treatment of minor ailments. Out of these, a sizable 9 percent had approached the local ANM/ Sub-Center, while the rest had visited a PHC, CHC, SDH or DH. A sizeable 26 percent of the households had sought treatment from the Bengali Doctors, all of whom are unqualified quacks.



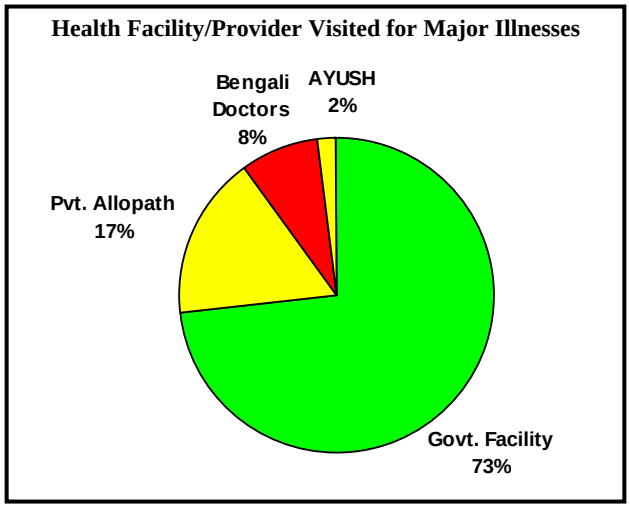
District-wise analysis of utilization pattern of health facilities reveals that the proportion of households visiting the Government health facilities in Sawai Madhopur is only about 21 percent, while a sizeable 39 percent of the population approaches Bengali Doctors for the treatment of minor ailments. In Banswara, nearly half of the households visit the Government facilities while, one-fourth visit the Bengali Doctors. In Jodhpur, the level of utilization of Government health facilities is lower than that in Banswara, however, an important finding is that, when it comes to visiting the Bengali Doctors, the proportion is much lower than that in the other two districts.

District-wise Utilization Pattern for Minor Ailments		
Sawai Madhopur	Banswara	Jodhpur
Govt. Facility (21%)	Govt. Facility (46%)	Govt. Facility (36%)
Bengali Docs. (39%)	Bengali Docs. (27%)	Bengali Docs. (14%)

Cost of treatment is one of the key determinants of health seeking behaviour of the population, especially the poor and marginalized sections of the society. The BPL households reported to have spent as much as Rs. 219/- for seeking treatment of a minor ailment from a Government facility. Most of it (82 percent) was spent on procuring medicines, 5 percent on diagnostics and the remaining 13 percent on transportation.

The study reveals that the average cost incurred in seeking treatment from Bengali doctors works out to almost the same as that incurred in a Government facility. In spite of this, a large number of households are seeking treatment from Bengali doctors, primarily on account of their easy accessibility.

A1.2 Health Facility/Provider Visited for Major Illnesses



A marked deviation was observed in the health seeking behaviour of households in the event of major illnesses *(those requiring hospitalization)*, as compared to that in case of minor illnesses. It is found that 3 out of every 4 households, regardless of their economic or literacy status, preferred the Government health facilities in the event of major illnesses. Out of the remaining, a good majority approached the private allopathic doctors. Understandably, the community prefers seeking treatment from qualified doctors only, rather than going to quacks in case of serious ailments.

District-wise Utilization Pattern for Major Illnesses		
Sawai Madhopur	Banswara	Jodhpur
Govt. Facility (76%)	Govt. Facility (59%)	Govt. Facility (85%)
Pvt. Allopath (17%)	Pvt. Allopath (21%)	Pvt. Allopath (13%)
Bengali Docs. (3%)	Bengali Docs. (19%)	Bengali Docs. (1%)
AYUSH (4%)	AYUSH (1%)	AYUSH (1%)

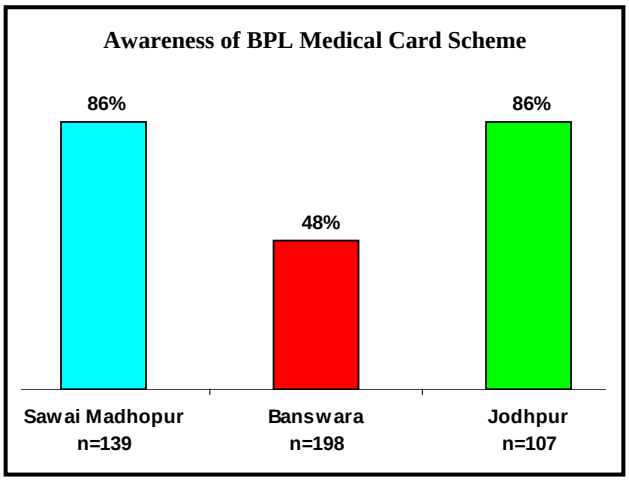
District-wise analysis reveals significant variations between districts. While the proportion of households who reported to have gone to a Bengali Doctor is just around 1 to 3 percent in Sawai Madhopur and Jodhpur districts, it is as high as 19 percent in Banswara. This may be attributed to the very high illiteracy among the tribals, accounting for almost three-fourth of the total population in the districts.

For the BPL households, the average expenditure incurred on per day of hospitalization at any Government facility works out to Rs. 740/-. Further, their average length of stay at Government facilities was found to be 2.9 days, indicating a total expense of Rs. 2145/- per episode of major illness. More than two-third of this amount was spent on buying medicines, while 8 percent on seeking the diagnostic services from outside. Ideally all these facilities should have been provided to them free of cost, as envisaged under the BPL Medical Card scheme.

A1.3 Main Source of Funds for Treatment of Major Illnesses

Capacity for funds mobilization determines largely the health seeking behaviour among the poor. The plight of the poor can be gauged from the fact that 2 out of every 3 BPL households reported to have borrowed money, in order to meet the expenses for the treatment of major illnesses. A few (2 percent) had to even sell/mortgage their assets for this purpose. It becomes amply clear that the benefits envisaged under the BPL Medical Card scheme have largely remained a distant dream.

A1.4 Awareness of Scheme among the BPL Households



One of the most significant and critical determinants of effectiveness of any intervention is its awareness among the target beneficiaries. An overwhelming majority (86 percent) of the BPL households in Sawai Madhopur and Jodhpur districts were found to be quite aware about the BPL Medical Card scheme. However, in Banswara, more than half the BPL households were found to be unaware, mainly because of lower literacy levels as also the predominantly tribal population in the district. It is indeed an irony, for these are the people who need the Scheme the most, and yet are the least aware about it.

All the three districts combined, 69 percent of the BPL households were found to be aware about the Scheme. However, as discussed above, a much smaller percentage (only 37 percent) reported the Government facilities to be their first point of contact for health problems. If one excludes the local Sub-Centre, this proportion drops to a mere 26 percent. This behaviour may be attributed primarily to two reasons — firstly, the actual experience of the BPL households regarding the implementation of the Scheme at the Government health facilities and secondly, easy accessibility and comparable cost of treatment at alternative facilities (Bengali Doctors, etc.).

A1.5 Experience of BPL Patients at Govt. Health Facilities

It was found that an overwhelming majority of the BPL patients was indeed getting exempted from paying registration fee at the Government facilities. However, only 60 percent of them were able to get all the prescribed medicines, free-of-cost. Around one-third (31 percent) had received some medicines, but not all. The rest (9 percent) reported that they had not received any medicines at all. District-wise analysis revealed that the proportion of BPL patients receiving all the prescribed medicines, was much lower in Banswara (only 41 percent) as against 63-64 percent for Sawai Madhopur and Jodhpur.

As regards the diagnostic services, overwhelming majority of the BPL patients were able to get them free-of-cost through the Government facility. In Banswara, availability of the prescribed diagnostic services through the Government facility was found to be cent percent for the BPL patients, while the similar proportion was 91-93 percent in Sawai Madhopur and Jodhpur. As regards the behavior of health functionaries at Government facilities, the BPL patients were found to be less satisfied in comparison to their APL counterparts, in all the three districts.

A1.6 Medicare Relief Societies

Majority of the Facility In-charges reported that the MRS meetings were not being held every month as envisaged. In maximum number of cases, these were being held after a gap of 3 to 4 months. When probed, most of them stated that the scheduled meetings could not be held at regular intervals because of absence of some of the members of the Society, resulting in delayed decision making for long period of time. A number of CHC In-charges stated that Dy. CMOs posted elsewhere at sub-district level, were made members of their MRS. More often than not, these officials were unable to come for the meeting.

As per facility records, at most of the places, the share of BPL in total patients was found to be much lower than their actual representation in the population of their catchment area. Further, wide fluctuations were noted in the share of BPL, for which no cogent explanations could be provided by the Facility In-charges. It appeared that their MRS never paid any attention to the share of BPL in the total patients coming to their facility.

Inadequate revenue generation by the MRS, coupled with inadequate supply of medicines, emerged as the chief constraint in serving the BPL Medical Card holders in a satisfactory manner. As a matter of fact, 2 out of every 5 Facility In-charges candidly admitted that they were not in a position to supply all the required medicines to the BPL Medical Card holders, free-of-cost. In a few instances, even the diagnostic services were not being provided free-of-cost to the BPL Medical Card holders.

A2. Recommendations for Strengthening BPL Medical Card Scheme

A2.1 Ensuring Availability of All the Prescribed Medicines

In order to ensure equitable access to quality health care for the poor, it is extremely crucial that all the prescribed medicines are made available to the BPL Medical Card holders. At present, due to inadequate revenue generation by the Medicare Relief Societies and insufficient supply of medicines from the State Government, it is almost impossible to provide all the required medicines to the BPL Medical Card holders, free of cost.

The State Government may consider providing a grant to the Medicare Relief Societies for enhancing the availability of medicines for the BPL Medical Card holders. To encourage the Societies to focus more on the BPL patients, the amount of grant to various Societies should be proportionate to the actual amount spent by them on the BPL patients. Initially, this system may be funded by the RHSDP and piloted in a few selected districts where the share of BPL population is comparatively higher. Later on, after evaluating its impact, it may be incorporated in the Government's budgetary mechanism and expanded to the entire State.

Simultaneously, it must be emphasized upon the Medicare Relief Societies that without focusing on the poor, it will be impossible to realize the Health Vision-2025 set out by

the State. They must make all out efforts to raise their revenue by efficient utilization of all the available resources so as to be able to provide all the required medicines to the BPL Medical Card holders.

Further, our study has revealed that certain drugs (mostly the ones for common ailments) are being supplied to the Government health facilities in such a large quantity that these are being given free-of-cost even to the APL patients. *The amount being spent on the excess supply of these drugs may be saved and utilized to enhance the availability of drugs for the BPL Medical Card holders.*

A2.2 Simplifying the Procedural Bottlenecks

At present, if a medicine prescribed to a BPL patient is not available in the facility, a lengthy procedure is followed for making the local purchase. First of all, the Pharmacist prepares an indent in triplicate and sends it to the prescribing doctor for his/her signature. After that, it is sent to the Facility In-charge for his approval. The medicines are then purchased from outside, taken into stock and then disbursed to the patient. It entails a considerable amount of time. During the study, many patients, especially those coming from remote villages, complained about the inordinate delay in getting all the prescribed medicines. A few reported that they had to come to the facility again on the next day for getting their medicines.

Further, at some of the facilities, it was observed that whenever some medicines were to be purchased from outside, the BPL Medical Card holders were required to furnish a photocopy of their Card. Wherever a photocopy shop was not available in the vicinity, it really became a hassle for the patient to get the photocopy done, besides the cost involved.

Since, ultimately it is the Pharmacist who is responsible for certifying that certain prescribed medicines are not available in the stock and need to be purchased from outside, what purpose does it serve to get the signatures of the prescribing doctor and the Facility In-charge? The RHSDP may take up this issue with the Directorate of Medical, Health and Family Welfare to issue stringent guidelines so that unnecessary procedural delays are eliminated. Further, the BPL patients should not be subjected to the hassle of furnishing a photocopy of their Medical Card.

A2.3 Ensuring Availability of All the Required Diagnostics

During the survey, it was found that almost 30 percent of the APL and around 10 percent of the BPL patients had gotten some or all the prescribed diagnostic tests done elsewhere at any private facility. When probed, maximum number of such patients complained about the inordinate delay in getting the test reports at the Government labs. Further, sometimes the doctors themselves were asking the patients to get the tests done from outside because either the required diagnostic facility was just not available at the hospital (such as sonography) or the Government lab had closed for the day while the report was needed urgently.

The RHSDP may commission a work-study of the diagnostic services at the Government health facilities for minimizing the delays and developing Standard Operating Procedures (SOPs). Further, the Project should motivate the Medicare Relief Societies to tie-up with private diagnostic facilities to provide such services that are not available with the MRS as also to cater to the urgent needs at odd hours. The RHSDP can play a pro-active role by evolving operational modalities for such tie-ups.

A2.4 Introducing Incentive Schemes for High Performers

Lack of motivation is a serious problem that plagues the public health system in the State and incentives, in general, are important motivators. It would be worthwhile to introduce an incentive scheme at the Government facilities to improve the utilization of BPL Medical Card scheme. The incentive will be linked to the achievement of a pre-negotiated benchmark in respect of the number of BPL patients utilizing the particular facility.

A2.5 Reviewing the Functioning of MRS

At most of the MRS facilities, the share of BPL in total patients has been found to be much lower than their actual representation in the population of their catchment area. Further, even the scheduled meetings of MRS are not being held at regular intervals due to the absence of some members of the Society. It results in delayed decision making for long period of time.

T*he RHSDP may like to introduce a system of monitoring to ensure that not only the Medicare Relief Societies meet regularly, they also review, on a regular basis, the share of poor in total patients visiting their facility. Further, the Project may put forward a proposal to the State Government to review the composition of the MRS at various levels. Considering the crucial role played by the paramedics in the delivery of health care services, it may be considered to include one of their representatives in the Executive Committee of the Society.*

A2.6 Focused IEC Campaign for Promoting the Scheme

The study has revealed that a sizable 30 percent of the BPL households are not aware about the BPL Medical Card scheme. Even amongst the aware lot, only one out of every three has reported to be using the Government facilities as his/ her first point of contact for health problems. Majority of the BPL households are found to be approaching the local unqualified providers for treatment. While these providers may be able to solve the current problem, their treatment may lead to severe consequences in the long run. Sometimes, they may spoil the condition to such an extent that it goes completely out of hand even for a qualified provider.

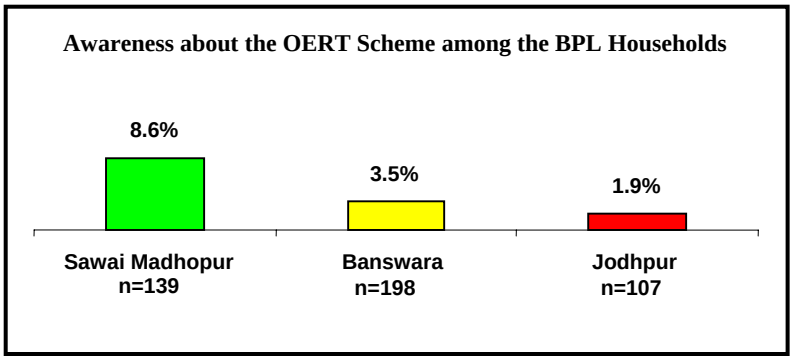
In order to improve the health status of the poor in the State, the RHSDP may launch an IEC campaign for inculcating appropriate health seeking behavior among them. The poor households should be motivated to avail the benefits of the BPL Medical Card

scheme from the Government health facilities and desist from approaching the unqualified providers. Simultaneously, it will be necessary to sensitize the health functionaries to give due cognizance to the BPL Medical Card holders, otherwise the IEC campaign will become counter-productive. As part of the campaign, the Project may also consider supporting a Social Worker at the Government health facilities to ensure that the BPL Medical Card holders coming there are indeed provided the benefits envisaged under the scheme.

B. OERT Scheme

B1. Major Findings

B1.1 Awareness about the Scheme



The awareness regarding the OERT scheme in the community is found to be abysmally low. Even among the BPL households who are the target beneficiaries of the scheme, the level of awareness is observed to be a dismal 4.7 percent. District-wise analysis indicates that the proportion of BPL households aware about the OERT Scheme is as low as just 1.9 percent in Jodhpur. The highest level of awareness was found in Sawai Madhopur, which is again a poor 8.6 percent.

Even among the *Sarpanchs* who were supposed to be the implementers of the OERT scheme at the village level, around one-third were found to be absolutely clueless about the Scheme. In Jodhpur, the share of unaware *Sarpanchs* was found to be more than half. Even among the ANMs who have the primary responsibility of ensuring safe motherhood at the village level, one-third were found to be completely unaware about the Scheme.

Pregnant women, specially from the disadvantaged poor families, are an important target group of the ICDS programme. Unfortunately, even among the Anganwadi Workers, a majority (2 out of every 3) was found to be unaware about the OERT scheme. As a matter of fact, in Jodhpur, none of the AWWs was found to be aware about the scheme. It is no wonder that in this district, not even 2 percent of the BPL households were found to be aware about the scheme.

B1.2 Utilization of the Scheme

Under the scheme, the *Sarpanchs* were provided Rs. 5000/- to be given to pregnant women from BPL households, in amounts of Rs. 300/- to 700/- for the purpose of emergency transportation. As already stated, one-third of the *Sarpanchs* were found to be completely unaware about the scheme. Even amongst the aware ones, a few could not give us any details about the utilization of funds received under the scheme. In all, we could see the pertinent records in only 17 out of 30 villages visited by us. Out of these 17, in only 6 villages, the sum of Rs. 5000/- was found to have been fully utilized, with an average of 10 beneficiaries per village. While in 4 villages, the utilization was found to be nil, partial utilization was seen in the remaining 7 villages.

Utilization of OERT Funds

Village	No. of Beneficiaries	Total Amt. Disbursed
Sawai Madhopur		
Bucholai	9	Rs. 4500/-
Naugaon	2	Rs. 1000/-
Talawada	6	Rs. 4880/-
Kawad	10	Rs. 5000/-
Banswara		
Devgarh	17	Rs. 5100/-
Moti Timbi	14	Rs. 4200/-
Miasa	13	Rs. 4900/-
Falwa	8	Rs. 5000/-
Jeeva Khunta	10	Rs. 5000/-
Nahli	4	Rs. 1800/-
Randia Para	14	Rs. 4375/-
Jhikli	0	NIL
Padla	0	Cheque Lost
Devgarh	17	Rs. 5100/-
Jodhpur		
Bada Koteja	7	Rs. 5000/-
Kheri Salwa	0	NIL
Bastwa	0	NIL
Himmatpura	10	Rs. 5000/-

B1.3 Problems Faced in Implementation

The OERT Scheme was designed to be implemented through the village *Sarpanchs*. Accordingly, the *Sarpanchs* who were found to be having some experience of implementing the Scheme, were probed about the problems faced by them during its implementation. The three major problems faced by them emerged as under :

- Those *Sarpanchs* who were able to utilize the first installment of OERT funds (Rs. 5000/-) complained that this amount was not adequate enough to meet the demands for the eligible beneficiaries coming under their area. They stated that all households having a case of institutional delivery had started demanding money. It became difficult for the *Sarpanchs* to deny the benefits of the Scheme, especially to those households who were poor but did not have a BPL Card.

- In the villages where the first installment had been fully utilized, the households continued demanding the benefits of the Scheme while no further funding was released to the *Sarpanchs*.

- Some of them felt that the documentary requirements for availing the benefits were a little too much, especially for the illiterate BPL households. Many of the ANMs and AWWs also expressed a similar sentiment.

B1.4 Current Delivery Practices in the Study Area

Place of Delivery : As per the directives received from RHSDP (No. SPC/2005/ 1231 dated 12/7/05), Sub-Centre villages were selected for the study. It was found that in majority (two-third) of the cases, the delivery had taken place at home, despite the fact that all the sample villages were Sub-Centre villages. District-wise analysis of the place of delivery revealed that as compared to Sawai Madhopur and Banswara, the share of institutional deliveries was much lower (only 15 percent) in the Sub-Centre villages of Jodhpur district. Interestingly, the proportion of institutional deliveries in the BPL households (37 percent) was found to be a little higher in comparison to their APL counterparts. Possibly, because of poorer health and nutritional status, the share of women encountering obstetric emergencies was higher in BPL households than the APL ones, and needed to be rushed to a medical institution.

Current Delivery Practices : Place of Delivery

District	n	At Home (%)	Sub-Centres / Govt. Inst. (%)	Private Inst. (%)
Sawai Madhopur	300	58.7	35.0	6.3
Banswara	290	51.0	40.0	9.0
Jodhpur	280	85.0	13.6	1.4
Total	**870**	**64.6**	**29.8**	**5.6**

Assistance during Domiciliary Deliveries : Overall, only 11 percent of the domiciliary deliveries were found assisted by a health professional— ANM in all the cases. In overwhelming majority (88 percent) of the cases, the home deliveries were assisted by a *Dai*, half of whom were reportedly trained ones. District-wise analysis reveals that the share of domiciliary deliveries assisted by untrained persons was much higher (66 percent) in Jodhpur as compared to the other two study districts. It may be recalled that in Jodhpur, the share of domiciliary deliveries was as high as 85 percent. When viewed together, the maternal health scenario in the district appears to be alarming.

Assistance during Domiciliary Deliveries

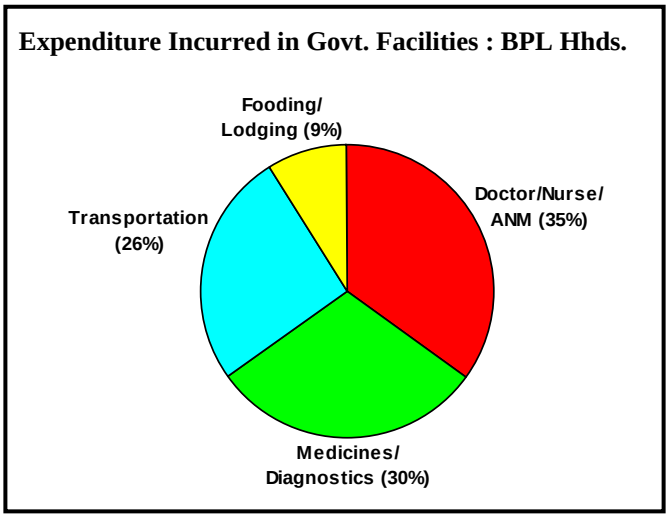
District	n	ANM (%)	Trained Dai (%)	Untrain-ed Dai (%)	Family Women (%)
Sawai Madhopur	176	16.5	50.6	32.4	0.5
Banswara	148	8.8	64.2	26.4	0.6
Jodhpur	238	8.0	25.6	65.5	0.9
Total	**562**	**10.9**	**43.6**	**44.8**	**0.7**

B1.5 Reasons for Preferring Domiciliary Deliveries

The households reporting domiciliary deliveries were further probed for the reasons behind this practice. More than half of them stated that this was normal practice in the village and they had been doing so for ages. According to them, hospitals were meant only for emergencies. Further, the perception about the high cost of institutional delivery emerged as another major reason for preferring domiciliary deliveries. These views were echoed by a majority of the local functionaries — *Sarpanchs*, ANMs and AWWs.

B1.6 Expenditure Incurred on Delivery

During the study, the households were also probed about the expenditure involved in the delivery. As expected, the expenditure incurred in institutional deliveries was found to be much higher as compared to that in domiciliary deliveries. Even in the Government facilities, the average expenditure incurred has been reported to be as high as Rs. 882/- even for the BPL households. Nearly one-third of the total expenditure was incurred in buying medicines/ diagnostic services from outside. This was quite in line with the observations made during the exit interviews conducted at the Government health facilities. Further, the BPL households reported that they had to spend a sizable sum in reaching their pregnant woman to the Government facility for getting the delivery conducted there. Almost one-fourth of the total expenditure was reported to have been incurred on transportation. This underscores the importance of providing transportation assistance to the BPL households, at least for the emergency cases.



B2. Recommendations for Improving the Maternal Health Scenario

B2.1 Referral Transportation for BPL Households

The OERT Scheme has now been subsumed into the *Janani Suraksha Yojna* (JSY) as a major component. Nevertheless, in view of the experiences of the OERT Scheme, it is imperative to address the following issues :

(a) Effective Communication Strategy : First and foremost, the target beneficiaries must be made aware about the *Janani Suraksha Yojna* and its benefits. Considering their socio-economic profile, inter-personal communication should be adopted as the main channel for propagating the Scheme. In addition, locally preferred and effective folk media may be considered as another option for creating awareness among the target beneficiaries. It would be apt to mention that a professional agency, with expertise in developing effective communication strategies, should be hired for the purpose.

(b) Sensitization/Training of Functionaries : Village level functionaries, namely, ANMs, AWWs and ASHAs need to be adequately trained on various aspects of the Janani Suraksha Yojna besides building their behavior change communication (BCC) skills. This would enable them to effectively communicate with the target beneficiaries on relevant issues. Further, considering their ability to influence and mobilize the community, role of the local PRI members, especially the village Sarpanchs, can hardly be over emphasized.

Accordingly, it is suggested that they may also be adequately sensitized about JSY and their role in influencing the target beneficiaries.

(c) Regular Availability of Funds : Review of the OERT Scheme has revealed that even those *Sarpanchs* who had taken interest and implemented the Scheme in their village, never received any further funds after the first installment was fully utilized. Having created due awareness about the Scheme but not being able to provide any financial assistance due to non-availability of funds, they became the target of community's ire which thought that they (*Sarpanchs*) were withholding the funds. It is therefore imperative to ensure regular availability of funds with the implementers of JSY, otherwise the entire exercise of propagating it among the target beneficiaries and training of functionaries will not only go in vain but, will in fact, become counter-productive.

(d) Procedural Simplicity : During the review of the OERT Scheme, it was found that the poor households were required to provide a number of documentary evidences in order to claim the benefits under the Scheme. In view of this, it is suggested that to the extent possible, the referral transport funds under the JSY should be made available to the target beneficiaries with minimum procedural formalities.

B2.2 Tracking of High Risk Pregnancies

The ultimate objective of the *Janani Suraksha Yojna* is to reduce the maternal mortality in the State. It is envisaged that the ASHA and AWW will register all the pregnancies in their area while the ANM shall provide comprehensive ante-natal care to all of them. Although the Scheme includes a major thrust towards promoting institutional deliveries, it will take a long time before it becomes a common phenomenon in the State.

Complications associated with pregnancies are often not predictable. Nevertheless, it would be a worthwhile strategy if the ANMs identify the well known high risk cases (adolescent mothers, short stature mothers, anemic mothers and the like) and the ASHAs/AWWs make an all out effort for ensuring the institutional delivery of at least such high risk cases. They should make an advance identification of the delivery institution and the means of transport for each such case, besides preparing the households for the institutional delivery.

The RHSDP may pilot a project in a few blocks wherein a database of all the identified high risk cases will be maintained at the block PHC. Based on the information provided by the ANMs, the progress of each case as regards the status of ante-natal checkups, TT vaccination, IFA supplementation, delivery and the post-natal care provisions, will be regularly updated on a monthly basis.

To ensure the authenticity of information, there should be a provision of sample verification through any external agency. The proposed system is expected to ensure comprehensive ante-natal care to all the high risk cases, their institutional delivery and proper post-natal care, and thus, lead to reduction in the maternal mortality rate in the State.

B2.3 Enhancing IFA Compliance

Nutritional deficiencies in women are often exacerbated during pregnancy because of the additional nutrient requirements for foetal growth. Iron deficiency anaemia is the most common micronutrient deficiency in the world. In Rajasthan, nearly half of the women are anaemic. It is a major threat to safe motherhood and to the health and survival of infants because it contributes to low birth weight, lowered resistance to infection, impaired cognitive development, and decreased work capacity. Under the RCH program, there is a provision for giving 100 IFA tablets to the pregnant women. However, there is a serious problem in ensuring their actual consumption due to their bad taste and side effects such as nausea, constipation, etc. In view of this, the RHSDP may pilot an innovative project for enhancing IFA compliance on the lines of the DOTS Project.

Compliance (actual consumption) of IFA tablets is to be monitored during the second trimester of the pregnancy. It is estimated that for every 1000 population, around 10-12 pregnant women will need to be monitored at any given point of time. It is proposed to identify two adolescent girls per 1000 population so that each can easily monitor 5-6 pregnant women. The girls will visit these pregnant women on a daily basis for 100 days and ensure that they consume the IFA tablet in their presence. The girls will also ensure that IFA tablets are not taken with certain food items such as milk which inhibit the absorption of iron in the body.

The selection of girls will be on voluntary basis and they will not be provided any monetary incentive. However, they shall be continuously motivated through appreciation of their work. These girls will be selected for a period of two years so that more and more adolescent girls get this useful exposure. Thus, besides targeting at the pregnant women, this intervention will have the unique advantage of improving the adolescent health in the area.

After their selection, the girls will be provided three-day training on safe motherhood with special focus on iron deficiency anaemia. Based on the successful ICDS training model, it is proposed that this training will be organized at the block level through mobile training teams and will be non-residential to ensure their convenience. Afterwards, there will be a one-day training session every month wherein the girls will be continuously motivated, besides monitoring their progress/achievements.

> *This pilot may be tried in several variants—replacing the adolescent girls with older women who have themselves taken IFA during a recent pregnancy, using the local dais/ASHAs and so on.*

The proposed intervention is expected to reduce maternal mortality rate in the long run by way of reducing the incidence of nutritional anaemia in the women during pregnancy.

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