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Drivers of Primary Healthcare and Elementary Education Initiatives in Rajasthan (2014–2024)

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Designed by Umesh Kumar

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The study was initiated in the wake of the district reorganisations in Rajasthan, and field research—which involved detailed interviews with the state-level bureaucracy—became complicated and unpredictable. The support of Rajasthan's bureaucracy at the state and district level was critical to the completion of this report.

Like any study that takes a political economy approach, this study too was dependent on the introduction and support of senior bureaucrats and researchers. I would like to thank senior bureaucrats in Finance, Health, and the Jaipur district administration, Ajay Mehta, Abhimanyu Singh, and Susmita Singla, for their immense patience with our questions and their generosity in providing me with connections at the state level.

Qualitative field research on policymaking can become challenging without the support of state-level bureaucracy. Senior bureaucrats in the education and health sectors and the district bureaucrats in our study districts have been kind with their time and insights; without their input, this report would remain incomplete.

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Abbreviations

3ie	International Initiative for Impact Evaluation
AB–MGRSBY	Ayushman Bharat-Mahatma Gandhi Rajasthan Swasthya Bima Yojana
AKS	Akal Sangharsh Samiti
ANC	Antenatal Care
ANM	Auxiliary Nurse and Midwife
ARAVALI	Association for Rural Advancement through Voluntary Action
ASER	Annual Status of Education Research
ASHA	Accredited Social Health Worker
AWW	Anganwadi Worker
BPL	Below Poverty Line
BSBY	Bhamashah Swasthya Bima Yojana
CAG	Comptroller and Auditor General
CAGR	Compound Annual Growth Rate
CBGA	Centre for Budget and Governance Accountability
CCE	Continuous and Comprehensive Evaluation
CET	Common Entrance Test
CHC	Community Health Centre
CSO	Civil Society Organisation
CSR	Corporate Social Responsibility
CWSN	Children with Special Needs
DH	District Hospital
DoE	Department of Education
DSPRUD	Delhi Society for Promotion of Rational Use of Drugs
DTNT	Denotified Tribes and Nomadic Tribes
EBB	Educationally Backward Blocks
GDP	Gross Domestic Product
GoI	Government of India
GoR	Government of Rajasthan
GP	Gram Panchayat
GSDP	Gross State Domestic Product
HR	Human Resource
HWC	Health and Wellness Centre
IAS	Indian Administrative Service
ICT	Information and Communication Technology
IIHMR	Indian Institute of Health Management Research
IMR	Infant Mortality Rate
IPD	Inpatient Department
JC	Janta Clinic
JSA	Jan Swasthya Abhiyan
JSSY	Janani Shishu Suraksha Yojana
JSY	Janani Suraksha Yojana
KGBV	Kasturba Gandhi Balika Vidyalaya
KII	Key Informant Interview
MAA Yojana	Mukhya Mantri Ayushman Arogya Yojana
MCH	Maternal and Child Health
MCHN	Mother and Child Health and Nutrition Days
MG English Medium Schools	Mahatma Gandhi English Medium Schools
MKSS	Mazdoor Kisan Shakti Sangathan
MLA	Member of Legislative Assembly
MMCSBY	Mukhyamantri Chiranjeevi Swasthya Bima Yojana
MMR	Maternal Mortality Rate
MMU	Medical Mobile Units
MNDY	Mukhyamantri Nishulk Dava Yojna
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Scheme
MNJY	Mukhyamantri Nishulk Jaanch Yojana
MNNRY	Mukhyamantri Nishulk Nirogi Rajasthan Yojana
MO	Medical Officer
MoE	Ministry of Education
MoHFW	Ministry of Health and Family Welfare
MP	Member of Parliament
NAS	National Achievement Survey
NEP	National Education Policy

NFHS	National Family Health Survey
NFP	National Fluorosis Control and Prevention Programme
NFSS	National Food Security Scheme
NGO	Non-governmental Organisation
NHM	National Health Mission
NHP	National Health Policy
NIC	National Informatics Centre
NMHP	National Mental Health Programme
NOHP	National Oral Health Programme
NRHM	National Rural Health Mission
OBC	Other Backward Classes
OOPE	Out-of-pocket Expenditure
OPD	Out-patient Department
PAB	Project Approval Board
PCI	Per Capita Income
PCTS	Pregnancy and Child Tracking and Health Services Management System
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PM-ABHIM	Pradhan Mantri Ayushman Bharat Health Infrastructure Mission
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PPP	Public–Private Partnership
PRI	Panchayati Raj Institution
RAS	Rajasthan Administrative Service
RBI	Reserve Bank of India
RBSK	Rashtriya Bal Swasthya Karyakram
RGHS	Rajasthan Government Health Scheme
RHS	Rural Health Statistics
RIHMR	Rajasthan Institute of Health Management Research
RJSSY	Rajasthan Janani Shishu Suraksha Yojana
RMSCL	Rajasthan Medical Services Corporation Limited
ROP	Record of Proceedings
RSBY	Rashtriya Swasthya Bima Yojana
RSCERT	Rajasthan State Council of Educational Research and Training
RSPRUD	Rajasthan Society for Promotion of Rational Use of Drugs
RTE	Right to Education
SA	Sambalan Abhiyan
SBC	Special Backward Class
SC	Scheduled Caste
SCERT	State Council of Educational Research and Training
SD	Shala Darpan
SDMC	School Development and Management Committee
SEIMAT	State Institute of Education Management and Technology
SIQE	State Initiative for Quality Education
SRS	Sample Registration System
SSA	Sarva Shiksha Abhiyan
ST	Scheduled Tribe
U5MR	Under-5 Mortality Rate
U-AAM	Urban Ayushman Arogya Mandir
U-DISE	Unified District Information System for Education
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UPHC	Urban Primary Health Centre
WHO	World Health Organization

Project Overview

This paper is part of a three-state study on the drivers of state-level initiatives in primary health care and elementary education in urban areas during the decade of 2014 to 2024. The selected states are Karnataka, Rajasthan, and Odisha.

The states were selected to represent three different types of contexts with regard to state-level initiatives. The first is a well-resourced state (indicated by per capita income [PCI]), with health and education indicators above the national average (Karnataka). The second is a poorly resourced state that has done well and improved health and education to reach above the national average (Rajasthan). The third state is also a poorly resourced one but has rapidly improved both its fiscal position and some of its health and education outcomes, even though they remain below the national average (Odisha).

Effective social welfare, whether in the areas of education, health, sanitation, water, or nutrition, is dependent on how well existing programmes are implemented and governance systems function and the extent to which social welfare is prioritised by state and national governments. Prioritisation is reflected in forms such as increased budget allocation, mission-mode implementation, or the development of new initiatives that solve specific challenges. In certain instances, the prioritisation of social welfare shapes the commitment of actors such as political leaders, bureaucrats, civil society actors, and professional associations in addressing the challenge. It is widely understood among the community of practitioners as well as researchers that whenever an initiative is implemented in mission mode (i.e., when clear, time-bound targets are set for specific indicators with accountability frameworks), the highest levels of political and bureaucratic commitment are given to achieve the project goals (see Kapur et al., 2010, p. 39).

As a first step to understand the prioritisation of social welfare, we need to trace the pathways through which new initiatives are created. This project aims to highlight them. The overarching study question is why and when a state undertakes new initiatives for primary health care and elementary education in urban areas. This question is examined in the context of each of the three study states and discussed in three separate state reports. This is followed by an overarching synthesis paper in which we analyse the common drivers of the initiatives across all three states. We also examine whether the nature of the initiatives differs across the states due to differences in the drivers. Lastly, we examine if the initiatives address the critical ground-level challenges that elementary education and primary health face. For example, would the introduction of an English medium of instruction address the low uptake of urban primary schools? Would the provision of free medicines make government care preferable to private clinics in urban areas? The project does not attempt to do an evaluation of new programmes. It aims to see if the solution proposed by the initiative is sufficient to solve ground-level challenges.

This paper focuses on the second state in the study, Rajasthan. Our first state, Karnataka, is shown as a progressive state with strong social indicators and a high PCI. However, gaps exist in both the performance and provision of elementary schools and primary health facilities.

Rajasthan is a large state with low PCI, but it has significantly improved its performance in health and education. It has had strong civil society-led movements for progressive legislation in health and education, the most recent one being the Right to Health Act. Rajasthan offers an interesting case for examining the role that civil society groups may be playing in leading the development of new health and education initiatives at the state level.

The overall findings highlight what drives state-level policymaking in diverse settings and the key stakeholders in state-level policymaking. It tells us whether there is something inherent in the nature and process of state-level policymaking that leads some states to adopt active and engaged roles in making social welfare policies aligned with grassroots-level realities, while others do not. Broadly, across the three states, the project employs the following methods:

a) Analysis of key government policy documents and knowledge reports, such as the state's economic survey reports and finance commission reports.

b) Key Informant Interviews (KIIs) with bureaucrats at the state, district, and facility levels (schools and Primary Health Centres [PHCs]), civil society leaders, researchers, academics, journalists, and engaged citizens.

c) Analysis of health and education datasets, which include the Unified District Information System for Education (U-DISE), National Achievement Survey (NAS), Sample Registration System (SRS), and National Family Health Survey (NFHS).

Executive Summary

This study examines the drivers of state-level initiatives in primary health care and elementary education in Rajasthan during 2014–2024, focusing on urban areas.

Rajasthan has made impressive strides in improving health and education outcomes. During 2014–2024, on many critical indicators such as Infant Mortality Rate (IMR), Under-5 Mortality Rate (U5MR), and class VIII language and mathematics outcomes, Rajasthan pulled itself up into the above-the-national-average category. It is a poor state whose PCI has consistently remained below the national average during this decade. Moreover, growth in the average net PCI of Rajasthan was lower than that of India during 2014–2024. Yet, Rajasthan continued to improve its health and education status.

Rajasthan's case is insightful because it has had a long history of progressive social movements. These took up some of the most entrenched social issues, such as the empowerment of women, tribal groups, Dalits, and rights-based demands for food, work, and accountability. These movements contributed to key national-level legislations. For example, the Supreme Court's Vishakha Guidelines, the Right to Information, the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGA), and most recently, the Right to Health have benefitted from movements originating in Rajasthan. Were civil society groups the key actors driving the improvements in Rajasthan's health and education outcomes in recent years? We explore these issues through our research question: Why and when did Rajasthan undertake state-level initiatives for primary health and elementary education in urban areas during 2014–2024?

Our study is broken into three broad sections. First, we examine the number and nature of initiatives. We selected initiatives that have been either funded or ideated by the state. We also discussed stock of the trends in the budget allocation to the health and education departments during this period. Second, we examine the objectives and the strategies of the initiatives and see whether they align with the ground-level challenges facing Urban Primary Health Centres (UPHCs) and elementary schooling. Third, we examine the drivers of initiatives, which include identifying the actors who led them.

Our findings highlighted that in Rajasthan, health and education budget allocations and expenditures, state-level initiatives, problems prioritised by the initiatives, and the challenges that the schools and UPHCs face at the ground level are not aligned with each other. For example, declining expenditures coexist with a high number of initiatives in education. To understand how these components connect and explain why and when Rajasthan undertook state-level initiatives, we identify four constructs: Policy Universe, Policy Priority, Policy Focus, and Policy Action.

Policy Universe refers to the set of institutions and potential mechanisms through which policy operates. It has five components: (a) health and education budget allocations; (b) state-level initiatives; (c) routine but large infrastructure upgrades and hiring across a majority of facilities; (d) specific problems or challenges that the initiatives focus on; and (e) the challenges that the facilities face in their everyday. The Policy Universe can exist in one of the three ways, namely, Policy Focus, Policy Action, and Policy Prioritisation, which are discussed below.

Policy Focus is when new initiatives, budgets, and routine activities undertaken by the state-level bureaucracy (such as hiring and infrastructure upgrades) are aligned with solving important ground-level challenges. This makes the Policy Universe aligned and convergent.

Policy Action refers to a situation in which many new initiatives, budget increases, and/or routine activities are being undertaken by the state-level bureaucracy, but they are less important in solving critical challenges related to the on-the-ground functioning of UPHCs/schools. This makes the Policy Action misaligned and divergent.

Policy Priority happens when (a) budgets align with health and education services at the ground level; (b) health and education services and facilities tap into the expanding needs of the population that are either being serviced by the private sector or remain unexpressed; (c) new initiatives emerge that tackle the difficult problems of quality of care/teaching and training; and (d) there is an ongoing vision of the role of public provision of health and education for all strata of society, one that is implementable and owned by all stakeholders in the system, such as bureaucrats, political leaders, and civil society groups.

In Rajasthan, the policy universes of primary health and elementary education are fundamentally different. Expenditure for both health and education has declined between 2014 and 2024, but there have been initiatives in both these domains.

In primary health, out of a total of 11 state initiatives for the health sector, two focused exclusively on urban primary health: Urban Ayushman Arogya Mandirs (U-AAM), which were known as Janta Clinics (JCs) when they were established in 2019. The second initiative was the outsourcing of select UPHCs, which were facing staffing challenges, to external agencies in a Public–Private Partnership (PPP) mode. This initiative is no longer in operation. Additionally, UPHCs have received prominent infrastructure upgrades and staff hiring drives during the study period. Mukhyamantri Nishulk Dava Yojana (MNDY) and Mukhyamantri Nishulk Jaanch Yojana (MNJY)—two initiatives that look at the health sector as a whole—have improved the uptake of UPHCs. They provide free medicines and tests across public health facilities, including UPHCs. They have tackled the critical problem of high out-of-pocket expenditure (OOPE) for medical treatment.

In education, out of the 14 initiatives, none have focused on urban elementary schools. Many have focused on the education sector as a whole or on elementary education for both rural and urban areas together, such as the State Initiative for Quality Education (SIQE), Free Uniforms, and Free Textbooks. Initiatives that focus on education include model school initiatives, such as Adarsh Schools, Mahatma Gandhi English Medium Schools (MG English Medium Schools), Shala Darpan (SD), and Gyan Sankalp.

We find that Rajasthan's Policy Universe in primary health is one of Policy Focus; it is convergent and aligned. In contrast, the Policy Universe in elementary education is one of Policy Action, and it is divergent and misaligned.

The policy universes of both primary health and elementary education are driven by an interplay of contextual factors and key stakeholders. Rajasthan's socio-economic context is such that, historically, health has been considered more important than education within policy circles. COVID-19 reinforced the focus on publicly provided health care. For elementary education (particularly in urban areas where the poor who lost livelihoods sent their children to government schools), COVID-19 could not rebuild that trust.

The key actors driving the initiatives during 2014–2024 are the senior-most state-level bureaucrats and political leaders. Civil society organisations (CSOs), particularly those that have focused on community mobilisation, have been less prominent. The incentives and ambitions that drive the senior bureaucracy and political leadership are not always about solving the most critical education and health challenges. For senior bureaucrats, it is the professional dynamics—that is, the pressures they face within the bureaucracy on the one hand and their relationship with senior political leadership on the other—that shape their role in initiative-making. Professionally, senior bureaucrats often have very little time in the health and education departments, and they have to distinguish their tenure with distinctive contributions. These contributions have to align with the vision of the senior political leaders, which in turn has to align with the political imperatives of the day. Bureaucrats also have to work within the constraints of departmental capacity. They take up ideas and problems that can be addressed in a clear, visible manner. They need access to implementable solutions whose outcomes are not complex and are observable to all stakeholders and partners, who can support them in this process. This limits the scope to tackle the deeper, structural challenges that impact primary care and elementary education, for example, quality of care.

The incentives driving political leaders are related to the creation of brand identity and political capital during non-election periods and visibility during election times. Political leaders use health and education initiatives to create a brand for themselves as supporters of social welfare, which is a critical aspect of being seen as a leader. They also use these initiatives to build coalitions with groups that can help them during elections. Creating visibility of their own efforts, therefore, is an important political objective during the electoral period. Each of the initiatives that we found to be important meets this matrix of incentives of senior bureaucrats and political leaders. The alignment that has happened in primary health is a result of the benefits that some initiatives gave to the political leadership. Health and education do not win or lose elections, but they are important enough to generate responsiveness among senior political leaders during non-election periods. If a good initiative is discontinued or marginalised, elected political leaders have to take note based on the feedback they have received from the ground level. Curiously, in health, the initiatives have been such that successive regimes have not discontinued useful initiatives such as MNDY; however, this has not occurred in education.

We make four policy recommendations to improve the drivers of state-level policy initiatives. First, the limited focus on health and education in urban areas, particularly in education, is because a defined policy agenda on the challenges in urban areas—including those "distinct" and those "shared" with rural areas—is missing. It is important to understand what it is that the initiatives need to solve. Therefore, Rajasthan needs to define the agenda for urban health and education. For this, we recommend that a government-appointed commission be set up that would have

clear, implementable outputs. The commission would define the urban health and education agenda and provide measurable steps and initiatives in the short run (1.5 years, which is the usual tenure of a health and education secretary), medium run (5 years), and long run (10+ years).

Second, one pathway that drives policy is demands from citizen constituents, particularly users of schools and UPHCs. In the present policy design, government primary care and elementary education facilities are primarily imagined as options of the last resort for the poorest of the poor, particularly in urban areas. In fact, large sections of the users of primary health and education facilities also come from this section of the population. It is important that these facilities should be used by a large section of the non-poor in the catchment areas of the facilities and have the resources to demand better quality services and drive more initiatives. However, within this stratum, government facilities are seen as being of poor quality. To address this, legitimacy needs to be created for both UPHCs and elementary schools beyond that of the urban poor. For this, the local UPHC and its services need to be advertised aggressively within its catchment area. Specific emphasis should be given to audit, quality, and performance reports and to highlighting the cost savings and quality of care to be gained by households if they access UPHCs.

In education, the requirement for school principals to raise funds should be removed, as this indicates to people that the state has given up on urban schools. Additionally, a hierarchy of basic requirements for school strengthening should be created. The weaknesses of the schools should be publicised with an action plan of what needs to be done in a phased manner and then accomplished. This process must be a widely publicised one. Once the key problems for urban elementary education are identified, they must be matched with solutions that can be implemented by the State machinery. It is most important that the State machinery is seen as the key and the only implementation pathway.

Third, there is a small cohort of actors, particularly for urban areas, that ideates policy: namely, the senior bureaucrats and political leaders. This limits both the range of ideas and partners on health and education for policymaking. It is important to invigorate CSOs that have historically played a defining role in highlighting challenges and policy ideas. There is already a model for engaging with civil society in Rajasthan. The Association for Rural Advancement through Voluntary Action (ARAVALI) is a state-supported platform that engages with non-governmental organisations (NGOs), research organisations, private sector bodies, and Panchayati Raj Institutions (PRIs) to address socio-economic challenges impacting rural areas. It particularly supports NGOs with capacity development and engages them to work in partnership with government initiatives. We need to replicate this model for urban areas as well.

Fourth, health and education outcomes are not the political responsibility at any level of government in Rajasthan. While providing formal roles for Members of the Legislative Assembly (MLAs) and Members of Parliament (MPs) may lead to over-politicisation, providing a pathway through which the state of schools and UPHCs in assembly and parliament areas is made visible to users, CSOs, and other actors can drive new initiatives. Creating assembly and parliamentary constituency-level profiles with data on the availability of health and education facilities and outcomes is one way to link political leaders with health and education outcomes in their areas.

We used qualitative methods in this study, conducting KIIs and reviewing government reports (Economic Survey, Project Approval Board [PAB] minutes, National Health Mission [NHM] Record of Proceedings [ROP]) and policy documents (state-level task force reports, Comptroller and Auditor General [CAG] Reports, Finance Commission Reports). Our analysis was conducted at four levels: state, selected districts, sub-district (i.e., taluka), and school/PHC. The study districts included one district in Central Rajasthan and another in South Rajasthan, each with a prominent urban centre under a municipal corporation. The two districts include one below and one above the state average in select health and education indicators. Key informants included state-district- and frontline-level health and education bureaucrats, civil society leaders, academics, policy researchers, journalists, engaged citizens, and ordinary users of health and education facilities.

This report is divided into five sections. In Section 1, we discuss Rajasthan's social and economic indicators and its performance in health and education. In Section 2, we outline the questions this study addresses and argue for a focus on primary health and elementary education in urban areas. In Section 3, we detail the key methods used in this study, the study sites, and the analytical framework. In Section 4, we present the main findings of this study in four subsections. In the final section, we synthesize the arguments and discuss their implications for policymaking in health and education in Rajasthan, offering policy recommendations.

1. Rajasthan: A Story of Improving Health and Education

Rajasthan is not a rich state. Its PCI for 2021–2022 was ₹80,545, which is below India's average PCI of ₹94,054 (PIB, 2023). Rajasthan was ranked 20th out of 33 states and union territories. Its economic position has improved, no doubt. Over the years, its Gross State Domestic Product (GSDP) annual growth rate increased from 7% in 2014–2015 to 8% in 2023–2024. But it continues to hover at the national average (Table 1). Another indicator of its moderate economic growth is its compound annual growth rate (CAGR).[1] From 2014–2015 to 2023–2024, this was 5.6% for Rajasthan, at par with India's GDP CAGR at 5.9% (Reserve Bank of India [RBI], 2024).

Despite its economic situation, Rajasthan has steadily improved many of its social indicators, with health being particularly notable. Until 2012, Rajasthan was categorised as a "High Focus State" needing financial and technical assistance in improving its health indicators (National Rural Health Mission [NRHM] Mission Document, 2005–2012, 2005). Table 2 highlights the improvement in Rajasthan's critical health indicators between 2004 and 2019–2020 (a 15-year period). Table 3 highlights Rajasthan's improved performance in comparison with the all-India averages in two important health indicators that link with services provided at UPHCs.

Table 1: Annual Growth Rate of GSDP/GDP from 2014–2015 to 2023–2024

	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019	2019–2020	2020–2021	2021–2022	2022–2023	2023–2024
Rajasthan	7.3	8.0	5.9	5.2	2.4	5.4	-1.8	9.0	7.8	8.0
India	7.4	8.0	8.3	6.8	6.5	3.9	-5.8	9.7	7.0	8.2

Source: MoSPI (2025a, 2025b).

Note: GSDP and GDP are at constant prices with base year 2011–2012.

Table 2: Health Indicators as per National Family Health Survey (NFHS) Rounds 3–5 for Rajasthan

Indicator for Rajasthan	NFHS 3 (2004–05)	NFHS 4 (2015–2016)	NFHS 5 (2019–21)
Infant Mortality Ratio	65	41	30
Under Five Mortality Ratio	85	51	37
Neo-Natal Mortality Ratio	NA	30	20
Maternal Mortality Ratio	318*	186**	137***
*SRS bulletin 2007–2009; **SRS Bulletin 2015–2017; ***SRS Bulletin 2018–2020.			

Source: NFHS-3 (2006), NFHS-4 (2016), NFHS-5 (2021), SRS, (2011, 2019, 2021).

[1] As annual growth rate may not give the entire growth trajectory of the state, CAGR demonstrates the state's aggregated growth for a decade of performance. Among the other states, Rajasthan's CAGR from 2014–2015 to 2023–2024 is ranked 11 out of 22, showcasing moderate growth in GSDP.

Table 3: Comparative Performance Between Rajasthan and India on Important Primary Care Level Indicators

	NFHS-4	NFHS-5
Rajasthan (IMR)	41	30
India (IMR)	40	35
Rajasthan (U5MR)	50	37
India (U5MR)	49	41

Source: NFHS-4 (2016), NFHS-5 (2021).

In education, Rajasthan has also been noted for strong improvements. The NAS, which is the only learning assessment survey that covers both urban and rural schools, has completed two rounds of surveys: 2017 and 2021. In both rounds, Rajasthan is among the top performers. In Table 4, we highlight Rajasthan's performance in comparison to other states in language scores.

Table 4: Language Score of Class VIII Students in Government Schools

Rank	State	2017 Score	State	2021 Score
1	Rajasthan	329	Punjab	338
2	Gujarat	325	Haryana	316
3	Kerala	323	Rajasthan	313
4	Karnataka	318	Chandigarh	303
5	Jharkhand	316	Lakshadweep	303
6	Chandigarh	315	West Bengal	303
7	Maharashtra	313	Madhya Pradesh	301
8	Himachal Pradesh	312	Kerala	300
9	Uttarakhand	309	Gujarat	298
10	Andhra Pradesh	308	Maharashtra	292

Source: NAS (2017, p. 101, 2021, p. 63).

It must be noted that Rajasthan's performance on NAS 2021 has fallen in comparison with NAS 2017 scores. This trend was observed across all Indian states due to learning losses caused by COVID-19 and was not specific to Rajasthan. Table 5 highlights that learning levels fell between 2017 and 2021 for both Rajasthan and India, but learning levels in Rajasthan remained above the national average in both years. The fact that Rajasthan has remained among the top performers in 2021 indicates that the systems and processes it had put in place to improve learning in government schools in 2017 have sustained even during COVID-19.

Table 5: Learning Levels of Class VIII Students

Indicator	State/National	2017	2021
Language	Rajasthan	67	63
	India	57	58
Mathematics	Rajasthan	54	42
	India	39	37

Source: NAS (2017, p. 6, 2021, p. 27).

Note: The figures represent the percentage of correct answers given by students in urban areas in the concerned subject.

Furthermore, despite having a smaller economic pie, Rajasthan allocates more than the average budget allocations by other states to health and education. On average, Rajasthan's estimated expenditure was 7% (health) and 19% (education) between 2019–2020 and 2023–2024. It is higher than the average allocation by all states on health (6%) and education (15%) (PRS Legislative Research, 2024).

Rajasthan's case is also particularly insightful for our research questions because of its long history of prominent social movements. These movements resulted in progressive national-level legislation. For example, the Sati Agitation in 1987 in Rajasthan led to the promulgation of the Sati (Prevention) Ordinance in 1987 (Saxena, 2023). Subsequently, national legislation was brought in to prevent the practice of Sati and the construction of sati temples. The Vishakha guidelines against sexual harassment in the workplace were laid down by the Supreme Court in 1997 as a response to civil society mobilisation against the rape of Bhanwari Devi in Rajasthan (Ministry of Women and Child Development, 2015). The Mahatma Gandhi National Rural Employment Guarantee Act was implemented in 2005–2006 in response to a campaign by many CSOs based in Rajasthan, led by the Mazdoor Kisan Shakti Sangathan (MKSS), who were building on the Maharashtra State Employment Guarantee Act (1977). In the area of the Right to Food, Akal Sangharsh Samiti (AKS), an umbrella organisation consisting of 50 bodies, led a movement to address the acute drought situation in Rajasthan in the early 2000s, demanding the Right to Food. Their actions led the Supreme Court to order drought relief and the provision of food across India. It also mandated Rajasthan to implement the existing eight food-related public policies with commitment (Srinivasan & Narayanan, 2007). These included Antyodaya Yojana, the Integrated Child Development Scheme, and Mid-Day Meals. In education, Rajasthan has had some prominent civil society-led

government programmes such as Shiksha Karmi (1987) and Lok Jumbish (1992), which contributed some of the prominent ideas in school education. These ideas included community-based school monitoring groups, para-teachers, and parallel structures for the implementation of donor-funded programmes. In health, civil society agitation contributed to the running of Free Drug clinics and later the free medicine scheme. More recently, it was civil society agitation that led to the enactment of the Right to Health (Pachauli, 2023) amid huge protests from doctors' organisations.

Mobilisations have happened with CSOs forming large collectives of NGOs across the state. This highlights the capacity to come together and build alliances towards a common cause and mobilise a large segment of the population beyond the individual catchment areas of NGOs. Furthermore, several progressive agitations across sectors, from health to gender, have been led by a common set of civil society leaders, which demonstrates that the leadership had wide legitimacy and deep understanding across sectors. For example, Kavita Shrivastav, who participated in the Mahila Atyachaar Virodhi Jan Andolan in the 1987 agitation against Sati, has remained engaged in other social issues, such as the Right to Food and Work. Some of India's most prominent CSOs in education and health are in Rajasthan. These include Sewa Mandir, Bodh Shikshan Sansthan, Doosra Dashak, PRAYAS, and BASICS. These organisations have remained within the social development space for decades now. This highlights the presence of a historically rooted, bottom-up understanding of social development challenges, the strategies taken to address them by the state and NGOs, and why and when they worked.

This unique history of civil society action resulting in policy initiatives indicates that we can expect four things in our study. First, some of Rajasthan's state-level initiatives in urban primary health and elementary education would be led by CSOs or emerge from social movements. Second, due to the long history of civil society-led community mobilisation, users of urban schools and health facilities would be active in demanding better services and holding the bureaucracy and political leadership to account. Third, there could be channels through which ground-level challenges facing urban schools and urban primary care facilities would reach state-level policymakers. And lastly, organisations championing the cause of urban primary care and elementary education would have a continued and long-standing engagement with state-level decision-makers.

2. Drawing the Study Scope

Within health and education, this study is limited to four focus areas.

1. Primary health and elementary education
2. Urban areas
3. Government-run schools and UPHCs
4. Initiatives undertaken by the state, i.e., state-level initiatives

Primary health and elementary education: While good-quality public provision of health and education at all levels—primary, secondary, and tertiary—is foundational for human development, primary health and elementary education are particularly critical.

Primary health care is provided by trained health professionals and refers to the provision of immediate health services in which minor illnesses and the first level of care in cases of injury or sickness are diagnosed and treated. Primary care also supports managing long-term and chronic health conditions. Additionally, primary health care goes beyond curative services and includes preventive and promotive health services, such as whole-body checks and health advice to people seeking support and ongoing care. Proximity to the community, quick time to care, affordability, and a whole-body approach to health care are other distinctive features of primary care. In India, primary care is provided at three levels: sub-centre, PHCs—which in urban areas are called UPHCs—and Community Health Centres (CHCs). Each of these facilities covers a certain range of health services and population. Population norms are the same across the country. In urban areas, a PHC is established for a population of 50,000 people. Health services provided at UPHCs are set in national guidelines, but different states have variations in the specific combination of health services provided at the PHC level. For example, some PHCs provide 24/7 care; others close at around lunchtime. Services provided at a PHC also differ between rural and urban areas. In this study, we are focusing on UPHCs. The presence of sub-centres and CHCs varies widely across states, particularly in urban areas; therefore, we have not included them here. For example, West Bengal has no CHCs. For sub-centres, nationally comparable data for urban areas are not available in

Rural Health Statistics (RHS), which provides data on primary care health infrastructure.

Elementary education covers grades I to VIII and ages 6 to 14. Key health and education indicators, such as IMR/Maternal Mortality Rate (MMR) and foundational literacy and numeracy, are typically addressed by PHCs and elementary-level education. However, due to the poor quality of these services and facilities, users bypass them and turn to higher-level institutions. In the case of health, users go to private clinics or to district hospitals (DHs). In the case of school education, parents turn to private tuitions where they can afford them, or students continue to have poor functional literacy even at higher class levels.

Urban focus: We have focused on urban areas for two reasons. First is the increasing rate of urbanisation in India. According to the last census (2011), 25% of Rajasthan's population resided in urban areas; this is projected (2031) to increase to 28% (National Institute of Urban Affairs, 2022). Second, focusing on urban areas presents the toughest test of a government's role in prioritising primary health and elementary education. Private providers are dominant, and historically, government action has been limited because the urban poor have largely been invisible in policy discourse. The assumption has been that urban areas offer a better quality of life and government does not need to provide services. In rural areas, the government tends to be the sole provider, and competition from the private sector is not as severe. Improving the standard of living in rural areas has also been a focus within policy discourse for a longer period compared to urban areas. Therefore, if a state has managed to focus on urban areas in recent years, it indicates a high level of interest and commitment to ensuring good health and education for its people, including those who have remained in the policy shadows—that is, urban residents. It is also important to note that urban areas have certain unique challenges that impact schools and PHCs. For example, the availability of land to expand school infrastructure is more difficult in urban areas. In contrast, in rural areas, staffing challenges are acute. Urban postings are preferred by doctors and teachers, while rural ones, particularly those far from urban centres, face staff shortages. Community mobilisation in rural areas is easier because villages have their own social identities. In urban areas, it is unclear what the social identity of administrative units is; are municipal wards an independent unit, or are neighbourhoods formed around caste and language groups? All of this means that state-level initiatives that are designed and developed keeping rural areas in mind cannot be implemented in urban areas without recognition of urban challenges. It also means that urban areas need dedicated state-level initiatives in health and education.

Government UPHCs and Schools: We have also chosen to focus on state government-run facilities. According to NFHS-5, 70% of urban residents seek general health care in public facilities (NFHS-5, p. 156). NFHS-5 data present a challenge to our selection of UPHCs as the focus area. The uptake of government-run UPHCs is poor. NFHS-5 highlights that it is only 3% in urban Rajasthan, compared to 29% for private clinics.[2] An important possible conclusion that could emerge is that UPHCs are not important for providing for the health care needs of urban areas and that government policy has not succeeded in improving UPHCs in order for people to use them more often. We, however, see value in focusing on UPHCs. The NFHS data only records which health facility is utilised as the first port of call for an illness. There are many reasons why, in urban areas, UPHCs may not be the first port of call as per this survey. The low uptake could just be an indicator that the facilities are not sufficient or are not covering enough health services that users would reach out to them as the first level of health care. There is another reason why this data point does not cover all the aspects that make a UPHC critical in the health system. Primary care includes curative, preventive, and promotive services. This complete package of primary care is exclusively provided by the state, while private clinics primarily provide curative care. Lastly, even though existing UPHCs cater to 3% of first-level care, for the UPHCs themselves, they may be operating at full capacity. This can indicate that the health needs of the population are way beyond what the existing UPHC network is able to provide.

As per the most recently released U-DISE dataset, 65% of all schools in Rajasthan are government schools (UDISE+, 2024). The latest U-DISE data (2024) is based on the new schooling structure proposed by the National Education Policy (NEP) 2020,

[2] The public facilities by urban residents include government/municipal hospitals, government dispensary, CHC, rural hospital, block PHC, UPHCs, and sub-centres (See NFHS-5 Rajasthan, p. 157).

in which elementary years of schooling are merged with pre-primary classes and called preparatory years. So, it is difficult to isolate the share of elementary government schools in the overall dataset. But according to the U-DISE 2021–2022 dataset, a majority of government schools in Rajasthan are elementary schools. This further reinforces the need to study state-level initiatives for elementary education (EE). More importantly, it is the elementary years of schooling that have witnessed the longest and deepest engagement by civil society movements in Rajasthan. Starting with the Shiksha Karmi project in 1983, and later the Lok Jumbish in 1992, improving elementary education by providing teachers, community ownership and accountability for local schools, learner-centred curriculum, and inclusion of girls in education has been a critical priority for CSOs working in education.

State-level initiatives: We have limited our examination to those initiatives in Rajasthan that are funded, ideated, or designed at the state level. These include any policy, programme, scheme, regulatory mechanism, or budget allocation that focuses on the elementary years of schooling or the primary care years. We do not focus exclusively on initiatives that involve new budgetary allocations or new implementation structures, but also on those that do not involve an increase in budgets. Budgetary allocation is assumed to demonstrate the highest form of government commitment to meet stated objectives. An exploration of why and when budget allocations are increased to improve health and education reveals the material terms by which the state prioritises social welfare. This tends to receive significant attention in policy discourse and academic writing (Kundu & Bhuta, 2021; Kundu & Rastogi, 2020).

However, we argue that budgets only provide a partial understanding of the Policy Focus on social welfare. This is primarily because new initiatives may introduce new ways of addressing health and education challenges without involving additional budgetary commitments. Many government initiatives involve improved administrative efficiency (for example, utilising test scores in teacher recruitment) or are part of partnerships with non-governmental actors such as NGOs or philanthropists. A stakeholder analysis of the interest groups involved in policymaking (Ansell, 2010; Corrales, 1999; Singh, 2015) and exploration of specific successful or failed policies, programmes, and schemes (Lahariya, 2020) are some of the other approaches taken in research studies to understand why certain sectors have not been the Policy Focus. We argue that these approaches provide only a partial insight into why and when social welfare receives policy attention.

3. The Methods

The existing rich literature on primary health and elementary education in Rajasthan provides limited insights into why certain state-level policy initiatives were designed in health and education.

A state's commitment to health and education can be gauged in two ways: One is through investment in health and education, highlighted by (a) increased resource allocation, (b) improved utilisation of budgets, and (c) accountability. The second is through initiatives undertaken by the state in specific sectors (Venkateswaran et al., 2021).

Studies on budget allocations and utilisation tend to focus on amounts allocated and the efficiency of their utilisation. For example, Ahmed et al. (2019) examine the expenditure on the Bhamashah Health Insurance scheme of Rajasthan and highlight that while the health budget increased by 36% between 2015–2016 and 2019–2020, the insurance budget surged by 600% within the same time frame. What principles determine resource allocation and who leads these decisions within the policymaking system are less clear in the existing literature. Why budgets increase in some years and not others, and what determines which programme will get higher allocations, say insurance, are questions we know less about. The Centre for Budget and Governance Accountability (CBGA) employs a budgeting approach to dissect the state's spending on education and highlights that the largest share of the education budget goes to elementary and secondary education, yet the funds remained underutilised, creating perpetual issues such as a lack of teacher training and teacher vacancies (Kundu & Bhuta, 2021).

Studies on state-level programmes and policies often focus on examining the impact of the initiative on ground-level challenges. For example, Rajasthan's free medicine and diagnosis scheme was the focus of the analysis of a recent paper by Dreze, Khera, and Malhotra (2024) and earlier by Selvaraj et al. (2014). Dreze et al. (2024) argue that the free medicine and

free diagnostics scheme[3] led to double the utilisation between 2013 and 2022. Selvaraj et al. discovered similar findings in 2014. But we know little about why this widely praised initiative was developed. What factors drove its inception in the first place? In education, existing studies have examined the impact of the school consolidation programme (Bordoloi & Shukla, 2019), free books and uniform initiative, and state-level interventions to improve learning levels in Rajasthan. Kundu (2017), for example, highlights that despite the Right to Education (RTE) mandate and various measures by the Rajasthan government, education is not free. Parents end up spending on tuition and exam fees, school uniforms, books, stationery, and conveyance, incurring heavy OOPE even when using government schools. Kundu (2017) estimates that the OOPE on a child's education in urban areas is at least twice as high as that for their rural counterpart. Other writings focus on specific challenges in elementary education, such as poor learning outcomes (Bhattacharjea et al., 2013; Chakrabarti et al., 2018; Govinda & Bandopadhyay, 2010; Goyal, 2007) or lower enrolment of women in secondary schools (Kundu & Bhuta, 2021; Sinha et al., 2019), and the impact of poor infrastructure in schools on learning levels (Janu, 2020).

We seek to examine which initiatives were made for primary care and elementary education, particularly for urban Rajasthan; what problems they aimed to solve and how; and what drove these initiatives. Instead of focusing on specific initiatives, we take a decadal approach and attempt to identify policy ideas, their link with ground-level challenges, and the pathways and stakeholders that led to their emergence.

Study methods: This qualitative study employs three types of methods.

- Mapping of state-level initiatives between 2014–2024 through a review of the yearly economic survey of the state and web-based searches of government websites, cross-checked through qualitative interviews with bureaucrats in the health and education departments at the state and district levels, as well as researchers and journalists.
- Review of official policy, programme, and scheme documents to understand their objectives, scope, and design. Documents reviewed included the State Economic Survey (2014–2024), Common Review Mission of NHM, Programme Implementation Plan reports (PIP), PAB Reports, and CAG audit reports.
- KIIs were conducted with 11 categories of respondents across state, district, and sub-district levels, which are presented in Table 6. For a detailed summary of the methods used, including probe areas, policy documents reviewed, and the number of interviewees and UPHCs and schools visited, please see Appendix 2.

[3] As of November 2024, the state had 33 districts which were subsequently being demarcated into 41 districts.

Table 6: Categorisation of Key Informants According to Their Role in State-level Initiatives

Type of Informant	Category	Rationale
Minister: health, education, finance, planning	State-level political decision-makers	They determine which policy to implement, allocate budgets, decide on the location of facilities, and establish timelines for project implementation.
Secretary: health, education, planning, finance, statistics	State-level bureaucracy decision-makers	They determine which policy to implement, offer technical input on the design and implementation structure, budgets, locations, and timelines, and manage the education and health systems on a day-to-day basis.
Commissioner: education, health, State Council of Educational Research and Training (SCERT)	State-level bureaucracy decision-makers	Provide technical input in policymaking, make final decisions on which policy ideas to pursue, participate in policymaking commissions, and handle budget requests.
District-level officers in health, education; collector	District-level implementers	Implement the programme at the district level, raise budget requests, and provide technical inputs on areas of policy gaps and strengths.
Block-level officers in health and education	District-level implementers	Implement the programme at the block level, raise budget requests, and provide technical inputs on areas of gaps and strengths in policy.
School principals, teachers, MO of PHCs, Accredited Social Health Workers (ASHAs) and auxiliary nurses and midwives (ANMs)	Frontline-level bureaucracy	Implement the programme at the facility level, as they are closest to the hard realities of running PHCs and schools, and have the best understanding of the programme's functioning.
Non-governmental organisation (NGO) leader	Civil society partners	Works with the state government and district level, providing ideas, technical inputs, and occasionally funding for schools and PHCs.
Researchers, university professors	Academic experts	Members of state-appointed government commissions provide technical insights on health and education and shape popular perceptions through public writings.
Journalists: Health, education, politics	Policy influencers	Influence policy by tracking and observing the implementation of health and education initiatives.
Local journalists	Engaged citizens	May not be working on Health and education but know the locality enough to have a sharp understanding of the functioning of local schools and PHCs
Users of schools and PHCs	Ordinary residents	They have no role in policymaking or implementation, but can raise demands for services.

Temporal scope of the study: Policy-related initiatives need to be studied over long periods because the capacities and resources required to develop new initiatives take time to mature. This consideration applies more to landmark initiatives that reform or reorient the system than to routine, regular-level initiatives that emerge during government operations. Furthermore, the status of an initiative as a landmark one emerges over time. This study focuses on identifying what factors propel a state to introduce new initiatives in general, rather than on what leads to the emergence of a specific initiative that eventually becomes an iconic one. Therefore, the scope of this study has been limited to the last 10 years, from 2014 to 2024. It includes only those initiatives that focus on the overall elementary education or primary health system. Initiatives that address small and specific aspects, such as curriculum reform or outcome-tracking software, are not included in the analysis. From an operational perspective, access to documents and stakeholders involved in the creation of the initiatives is critical for this kind of study, and a more recent time frame enables this more easily.

Geographical scope of the study: The number, design, and scope of new initiatives need to be studied at the state level, but their origins need to be traced from the grassroots up. This will allow an exploration of grassroots-level challenges that are best articulated by actual users of schools and PHCs, frontline state officials, and district- and sub-district-level bureaucracy and civil society leaders. The study operates at three levels:

- At the state level, the focus is on mapping reform initiatives, the officially stated reasons for their implementation, and the key issues in health and education that the bureaucracy considers challenging.
- At the district level, the focus is on how district-level bureaucracy, civil society, interest groups, and political leadership engage with the initiatives, particularly their role in shaping state-level initiatives and their understanding of challenges in health and education.
- At the grassroots and non-elite levels, the focus is on CSOs, NGOs, and concerned citizens and understanding the ideas surrounding the uptake of health and education among non-elites and the actors who shape and influence policymaking.

Study sites: Two urban municipal corporations in south and central Rajasthan were selected, one with strong and one with weak performance on health and education indicators.[4] Each of these corporations corresponds to one or two assembly constituencies. The study sites did not include the very best-performing or worst-performing ones, as such extremes often result from a long history of successful or failed state action, an enabling or restrictive social context, and local-level political mobilisation and leadership, which can give a skewed understanding of the realities of policy.

Data gathering and analysis parameters: Our study gathered data on five questions:

- What were the key initiatives in improving the quality of elementary education and improving services and outcomes in health between 2014–2024 in urban Rajasthan?
- Why were these initiatives conceptualised?
- Who were the key actors in bringing these initiatives?
- What kinds of policy challenges are focused on by the initiatives, and how do they relate to the everyday functioning of PHCs and schools?
- What factors led to the development of these initiatives?

A detailed summary of the methods, including sub-research questions, probe areas, data sources, and analysis framework, is available in Appendix 2.

[4] Health indicators included for this analysis were four ANC visits and child vaccination rates because these indicators relate to health services provided at the PHC level. We used NFHS-4 and NFHS-5 data. For education, we used NAS 2021 data on the indicator called "Performance," which measures the percentage of correct responses in math and language. We compared the data points for each district with the state-level. For health, we divided the districts into two categories: those that were above the state average and those below it on data for four ANC visits and child vaccination rates. Then for each category, we further narrowed the list to those that had improved their performance from NFHS-4 to NFHS-5 and those that hadn't. In the remaining districts in the two categories, we selected districts that had the largest urban areas. In education, we created two categories: those which performed better than the state average and those that were below the state average in the data point for the performance indicator in NAS 2021. We chose to use NAS over Annual Status of Education Research (ASER) because NAS covers urban areas as well. This analysis was conducted by project research assistant Prajakta Shukla.

4. The Insights

The marked improvement in health and education outcomes in Rajasthan during 2014–2024 suggests that we would find at least three kinds of insights. Firstly, budgets and expenditures, and/or the total number of initiatives focused on primary health and elementary education, would have increased. Secondly, the initiatives would focus on improving critical challenges impacting elementary education and primary health facilities at the ground level. Thirdly, important stakeholders (for example, civil society groups, professional associations such as teachers' associations, frontline bureaucracy, etc.) connected with the elementary and primary health sectors would be involved in the making of new policy initiatives. It can be argued that improvement in health and education outcomes is not necessarily dependent on the inclusion of different stakeholders. But in Rajasthan's case, this becomes important as historically, civil society groups and professional associations have played a defining role in the making, implementation, and oversight of crucial initiatives. They have mobilised communities to support and, at times, oppose government actions. Several examples can illustrate this point; the mobilisation around the Right to Health Act is a recent one. Mobilisations by the doctors' association against the act led to a significant dilution in the provisions of the act. In education, civil society groups such as Sewa Mandir have long worked with marginalised groups to enhance their participation in government programmes on education.

We examine each of these arguments in this section. We start by discussing the trends in budget allocations and expenditures during the study period from 2014 to 2024. This is followed by a discussion of key initiatives that Rajasthan has undertaken in primary health and education and the challenges that they attempt to solve. This is followed by a discussion on the extent to which the objectives of the initiatives align with the ground realities of the functioning of UPHCs and elementary education schools. In the last section, we discuss what was driving Rajasthan's initiatives in primary health and elementary education.

Before we begin the discussion, we would like to define an important conceptual category that we use in our data analysis. It is called the Policy Universe. It consists of four components: (a) budget allocations and expenditure; (b) new initiatives by the State and the Central government; (c) prominent large-scale upgrades to infrastructure and the hiring of human resources (HR); and (d) ground-level realities that impact the uptake of UPHCs and schools. Each of these components can operate in disconnected ways. While budgets may increase, no new initiatives or hiring may be happening. The opposite is also true. Both budgets and initiatives may increase, but they may target the wrong problem. Therefore, this paper argues that all these need to be examined together if we are to understand the initiatives.

4.1 Mapping the Policy Universe: State of Budget Allocation and New Initiatives Between 2014–2024

The Budgets: The Policy Universe in elementary education and primary health does not fully align with the improved health and education outcomes. On the one hand, Rajasthan has been well recognised for allocating higher budgets for health and education in comparison to other states (PRS, 2024) (Table 7).

Table 7: Allocation of Health and Education Budget in Proportion to Total Expenditure of Rajasthan

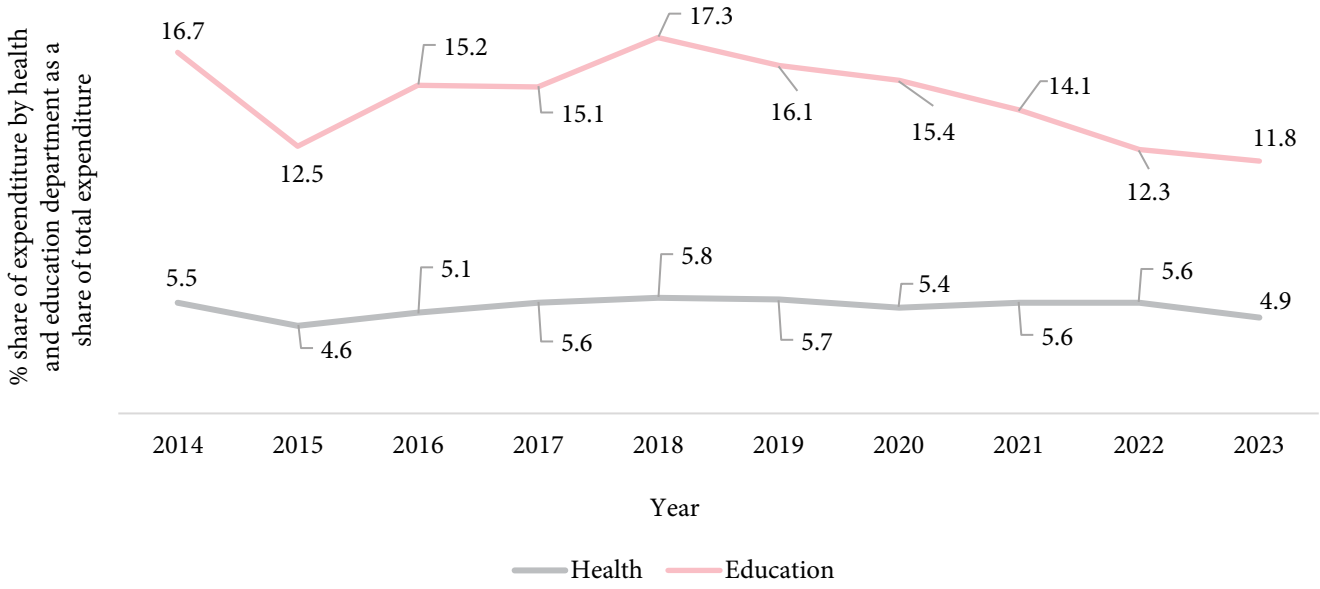
Year	Health (%)	Education (%)
2019–2020	6.2	19.0
2020–2021	7.1	19.3
2021–2022	7.0	19.1
2022–2023	7.4	18.0
2023–2024	7.4	19.5

**Compiled through collating data from PRS analysis of various years of state budgets by project research associate, Prajakta Shukla.*

Source: PRS Legislative Research(2019, 2020, 2021, 2022, 2023)

But the share of health and education expenditure in the total state expenditure has declined during this period (Figure 1).

Figure 1: Expenditure on Health and Education as a Proportion of Total Expenditure



Source: Rajasthan budget documents.[5]

Elementary education Initiatives: While the trend in budget allocations is similar in both elementary education and primary health, when we examine state-level initiatives, the trend diverges significantly between the two sectors.

In education, it was found that during 2014–2024, 14 new state-level initiatives were undertaken, which focused on the entire schooling years, from Nursery to XII standard (i.e., pre-primary, elementary, and secondary education) (Table 8 contains the full list of the initiatives). Of these, only three focus exclusively on elementary education, and these apply to both rural and urban areas, but none focus exclusively on elementary education for urban areas. The three initiatives are SIQE (2015), Free Books (2017),[6] and Free Uniforms (2022).[7] The Free Books and Uniforms initiatives aimed to reduce school-related expenses borne by parents. They provide books, fabric for uniforms, and the cost of stitching the uniform for children attending classes I to VIII in government schools.[8] The SIQE initiative aimed to improve learning levels in primary classes in secondary and senior secondary schools under the Rajasthan state board exams. SIQE focused on a limited set of schools. Its main strategy was to introduce child-centred teaching and learning methodology, Continuous and Comprehensive Evaluation (CCE) in primary grades, and strengthen teacher training.

We found four other initiatives that impact elementary education in urban areas because they cover

[5] The health and education budget calculated for the state of Rajasthan considers the actual expenditure of the state. The figures are drawn from the state's budget document. The expenditure is for education, sports, art and culture (education occupies the largest component in this), and health department (especially for the department of Health and Family welfare). The data are taken from a budget document titled "Budget study," which is part of the many documents released along with the state budget. It provides a consolidated overview of the state revenue and expenditure across all major categories and schemes. The expenditure for health and education includes both revenue and capital expenditure. This document does provide the expenditure for school education and medical services (minus non-allopathic treatments), which gives a more accurate representation of education/health expenditure, but this is only the revenue expenditure. Capital expenditure figures are only available under the consolidated head of "Education, Sports, art and culture" and are not available only for education (Department of Finance, Government of Rajasthan, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021).

[6] Free textbook scheme was being implemented as part of the SSA programme with contributions from both the State and Central government. It is also included in the Economic Review (Economic Review, 2019, p.99; 2020, p.117).

[7] The free uniforms scheme was implemented as part of the "Back to School" programme in 2021 and this also included free books for classes VI and VIII. Free books were being provided at a much smaller scale under SSA (Bordoloi, & Shukla, 2019; PAB Minutes, 2017).

[8] Two other initiatives, Language mapping (2024) and Utkrisht schools (2016), are exclusively for elementary education classes, but only for rural areas. Language mapping initiative aims to teach primary classes in government schools in the local dialect. The initiative focuses on rural and tribal areas where children do not speak Hindi but local dialects at home and are hence unable to follow classroom instruction (Jhingran, 2024; Language and Learning Foundation and UNICEF, 2025).

Utkrisht schools aim to create "model schools" in upper primary classes—one per panchayat—in those areas where other model schools such as Adarsh schools, are not present.

the entire schooling years from classes I to X or XII, not just the elementary years (I–VIII). Of these, two initiatives fall in the model school category, and the other two are essentially online data portals.

The "model school" initiatives: These initiatives include the Adarsh or Utkrisht Schools (2016) and the Mahatma Gandhi (MG) English Medium Schools (2019).

Adarsh schools are primarily rural institutions and part of the larger school consolidation programme that began in 2014 in Rajasthan. The programme was undertaken across Rajasthan but focused mainly on rural areas (Bordoloi & Shukla, 2019; Varghese, 2022). The programme aimed to consolidate schools that have zero or low enrolments with other schools (either with other elementary schools or other secondary and senior secondary schools) so that enrolments would increase and resources could be used effectively. It is particularly meant to target the problem of single-teacher schools and multi-grade teaching. As per policy documents such as government orders,[9] Adarsh schools were first set up in gram panchayats (GPs). Later, Adarsh schools were also opened in urban areas, though in fewer numbers. It is unclear whether there are specific norms for urban areas. Adarsh schools consolidate students, teachers, and physical infrastructure in one school in each GP that is selected because it meets RTE norms and has better enrolment.[10]

Mahatma Gandhi (MG) English Medium Schools are premised on the idea of providing English-language teaching to children. This initiative also focuses on select schools that are upgraded and provided with English-speaking teachers, better infrastructure, and a composite schooling experience till class XII in one school compound.

Both Adarsh and MG English Medium Schools have a limited scope. To highlight the limited reach of Adarsh schools, as per U-DISE 2021–2022 data, Ajmer has 1,957 government schools. Of these, there are only 407 Adarsh schools, a mere 20%. In urban areas, Adarsh schools are fewer. Urban Ajmer has only 42 Adarsh schools. MG English Medium Schools began as a small initiative, with one school each in 33 district headquarters and 301 block headquarters in Rajasthan from the 2019–2020 session onwards.[11] As of 2024, there were only 3,737 MG schools in Rajasthan. Given that the total number of government schools in Rajasthan is 71,547 (U-DISE+ 2021–2022), MG schools account for a mere 5% (Government of Rajasthan [GoR], 2023).

The "online portal" initiatives: The Shala Darpan initiative (2015) focused on creating an online portal in which all data related to schools, such as the number and the varied types of government and private schools, teachers, school activities,[12] and enrolment, are collated and available to ordinary citizens, schools, teachers, bureaucrats, and policymakers. The Gyan Sankalp initiative (2017) focuses on creating an online portal to channel Corporate Social Responsibility (CSR) funds and other philanthropic funds.

To summarise, for elementary education in Rajasthan, during the study period 2014–2024, there were no initiatives that focused exclusively on elementary education in urban areas (Table 8 details the descriptions of the key initiatives provided).

[9] For example, see Government order 9-5/2017 dated May 9, 2017 and 4(6) dated May 12, 2015. (Ministry of Human Resource and Development, Government of India [GoI], 2015; Ministry of Human Resource Development, GoI, 2017).

[10] In 2014, the GoR announced the Rajasthan Adarsh Yojana, under which one Adarsh school was to be established in each of the 9,895 GPs across the state. This model government school is to serve as a "role-model" for other nearby schools and ensure that at least one fully equipped, integrated school is accessible to the area's children (The Bridgespan group, 2018). Following the norms of RTE, all primary or upper primary schools with less than 30 children, were merged with the schools situated within the 1 km range and having higher enrolments. Total 17,000 schools in 2016 were ordered to be consolidated (Jolad, 2018). Assessment of the school consolidation programme in Rajasthan demonstrates that although basic infrastructure and teachers have increased in the merged schools, the enrollment remains lower in consolidated schools. Moreover, the process lacked due deliberation with local communities, authorities, and stakeholders such as teachers, headmasters etc. (Bordoloi & Shukla, 2019). MG English Medium schools were formed in 2019, with one school in every district. News reports highlighted the immense demand for English medium schools. In Bhilwara, as the report states, the admission applications were three times the available seats , (Express News Service, 2021).

[11] Government order 04(15) Education- 1/ 2019 dated June 16, 2019 (Directorate , Secondary School Education, 2019).

[12] School activities include preparation for exams through mock test and quiz for various classes, information on various scholarships and awardee list, on student's performance, their assessments in various classroom tests, etc.

Table 8: State Government Initiatives Focusing on or Impacting Elementary Education in Rajasthan, 2014–2024

S. No.	Initiative	Details	Problem Focused On
1	State Initiative for Education Quality (2015)	Announced as part of the school consolidation programme in 2015, the initiative focuses on grades I–V to improve learning levels through changing and improving pedagogy (CCE, child centred learning, etc.), capacity building of teachers and school principals, and district and block level planning and monitoring.	Low learning levels in Grades I to V in secondary schools.
2	Adarsh Schools (2015)[13]	Adarsh Schools were announced in 2015–2016 and established in three phases over three years. Among the existing schools, district collector had to nominate one school as 'Adarsh' (model) school which was to be developed as the "Centre of Excellence." Every GP was mandated to have one Adarsh school, equipped with furniture, Information and Communication Technology (ICT) labs, classes up to X or XII, toilets, laboratories, etc. These schools were to mentor other schools within the GP. The schools were to form School Management Committee for class V to class VIII (Shaladarpan Portal, 2025).	Falling enrolment in government schools and resource inefficiencies.
3	Utkrisht Schools (2016)	Aligning with the Adarsh schools, Utkrisht Schools were announced in 2016, where one primary (I–V) or upper primary school (I–VIII) was to be designated as Utkrisht schools and located in villages where Adarsh schools were not formed. The Utkrisht schools were also to be developed as "Centres of Excellence" and mentor other primary and upper primary schools (Rajasthan Council of School Education, GoR, 2025).	Falling enrolment in government schools and resource inefficiencies.
4	Mukhyamantri Nishulk Uniform Vitran Yojana	Launched in November 2022, the scheme provided two sets of uniforms to students of classes I–VIII. The students included all female students and male students of Scheduled Castes (SC), Scheduled Tribes (ST) categories as well as students from the Below Poverty Line (BPL) class. The amount allocated was ₹290 crore in the ratio of 60:40, where the Centre paid 60% and the state paid remaining 40%. Additionally, the state allocated ₹119 crore for the other students, disbursing ₹200 per head through direct benefit transfer. This amount was meant for stitching charges (Rajasthan Council of School Education, n.d.).	OOPE for parents on school uniforms.
5	MG English Medium Schools (2019)	The schools were launched in all 33 districts of Rajasthan. It was envisaged to reduce dependence on private schools. By 2020–2021, 205 government schools were converted into English medium schools (Secondary Education Department, GoR, 2024).	Lack of English language skills among government school students.
6	Shala Darpan	This is an online portal in which data on all aspects of primary and secondary education pertaining to students, schools, and academic and non-academic staff is collated 'live' and made available to staff and public.	Online portal for improved monitoring of schools through live data collection.
7	Gyan Sankalp Portal	An online portal which channels CSR/Philanthropic donations to state government programmes/ schemes or to individual schools (GoR, 2021). These donations are according to norms detailed in the Bhamasha guidelines.	Raising, consolidating, and channelling financial resources for improving school systems particularly in infrastructure and facilities.

Source: Author's compilation.

[13] The norms for developing Adarsh schools focus on the rural local government architecture.

Janata Clinics (JCs) in Rajasthan (2019)

JCs are IT-enabled health centres in underserved/slum areas of Rajasthan. Till 2021, 13 JCs were established in the State. JCs are based in urban areas, providing affordable and accessible health care to the underserved, slum areas with a target of 20,000 population. JCs are also expected to reduce crowding at tertiary hospitals by providing primary health care services along with referrals to secondary and tertiary facilities. The services provided by the clinic include health screening, immunisation, ANC services, provision of free diagnostic tests, and medicines (Department of Medical and Health, Government of Rajasthan, 2022). Each clinic is linked to the nearby PHC/UPHC and provides health services in hard to reach areas (Rajasthan Foundation, n.d.). JCs are built on the land that is donated or under CSR. Each JC needs ₹20 lakh to establish and another ₹25 lakh per year to run it. Till May 2023, Udaipur had four JCs, Ajmer had three, and Jaipur had 14.

Primary health care: In health, the total number of initiatives is 11, but only two focus exclusively on primary health for urban areas. Of these, only one is ongoing. The JC initiative, which is funded by the Central government's 15th Finance Commission under the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) programme,[14] is the only ongoing one and has been designed and ideated by the state. JCs are extensions of UPHCs and aim to provide additional primary care coverage in dense slum areas that are left out or which cannot be covered by existing UPHCs. In 2024, JCs were renamed U-AAM. The second initiative involved outsourcing of select UPHCs in a PPP mode to private organisations on a not-for-profit basis (Department of Health and Family Welfare & State Health Society, 2017). This initiative aimed to address staffing shortages of doctors and paramedics at the UPHCs for a period of three years. As of 2021, this scheme has been stopped, and the UPHCs have been returned to the GoR. We have included two other initiatives that do not focus exclusively on primary health care. Their focus is on a general health problem of high OOPE due to medicines and tests. One of these initiatives began before our study period. But both initiatives have had an immense impact on UPHC uptake; thus, they have been included in the study. These initiatives are the Mukhya Mantri Nishulk Dawa Yojana (MNDY) (2011) and Mukhya Mantri Nishulka Jaanch Yojana (MNJY) (2017). These schemes made selected medicines and tests available free of cost at any Public Health Facility, and PHCs were included within the definition of a public health facility. Both initiatives were started, designed, and funded by the Rajasthan government.

Studies (for example, Selvaraj et al., 2014) highlight that MNDY significantly improved the footfall at PHCs. Though the focus of these studies is on rural PHCs, a few UPHCs were also included, and preliminary conclusions can be drawn that the two initiatives would have had a similar impact on UPHCs[15] as well.

[14] PM-ABHIM is a centrally sponsored scheme with central sector components with an outlay of ₹64,180 crore. The measures under the PM-ABHIM focus on developing capacities of health systems and institutions across the continuum of care at all levels, primary, secondary and tertiary, to prepare health systems in responding effectively to the current and future pandemics /disasters (PIB, 2021).

[15] While MNDY and MNJY focused on improving diagnostics and free medicines, the absence/lack of pharmacists and technicians at UPHC may not result in effective uptake of facilities. More than 50% of lab technicians and pharmacists positions in UPHC are vacant as per RHS 2020–2021.

Table 9: Initiatives That Impact PHCs and Do Not Focus Exclusively on Them

Initiative	Details	Problem Focused On
MNDY—2011	MNDY is a flagship health care initiative launched by the GoR to provide free essential medicines to the residents of the state. It was launched in 2011 by then chief minister of Rajasthan, Ashok Gehlot. The objective of the scheme was to ensure that free medicines were available to every individual seeking treatment, thereby reducing OOPS. All residents of Rajasthan are covered under the scheme. Medicines are distributed through a robust supply chain managed by the Rajasthan Medical Services Corporation Limited (RMSCL).	High OOPE due to medicines.
MNJY—2017	MNJY was launched in 2017 with the dual objective of strengthening diagnostics services and providing free diagnostic care in the state. The scheme is functional in all state health facilities including PHC, CHC, medical colleges, and covers up to 90 diagnostic tests (at the tertiary level). Up to 1,50,000[16] tests are known to be conducted every single day (Annual Progress Report—Health Department 2021–2022). By January 2022, ₹2.12 billion[17] was allocated for the scheme, out of which 71% (₹1.23 billion) has been utilised.	High OOPE due to the share of diagnostic tests.

Source: Author's compilation.

It is important to note that while the MNDY and MNJY benefitted UPHCs, they did not focus on the primary care level. They were not designed to ensure that primary care facilities have the required infrastructure, staff, supplies, equipment, and governance mechanisms, and that the bouquet of services that they deliver is aligned with the health needs of the community. Shortages in both facilities and staff continue in Rajasthan's UPHCs, even though they have reduced over several years. RHS 2021–2022 shows that there is a 35% UPHC deficit, which has marginally decreased from 37% in 2020–2021.[18] The vacancy gap in HR has reduced in comparison to 2019–2020, yet remains high. Barring nursing staff and doctors, over half of the positions of lab technicians, pharmacists, and ANMs in urban primary care remained vacant in 2021–2022 (RHS, 2022) (Table 11, which shows a prominent reduction in vacancies and the continued HR shortages in Rajasthan). Therefore, we categorise MNDY and MNJY as initiatives that "impacted" urban primary care. U-AAM and PHCs in PPP mode are the only initiatives that focus on urban primary care because they were exclusively designed for UPHCs.

In addition to state-level initiatives, two important developments happened during the study period. Firstly, significant improvements have been made in the infrastructure provisions in UPHCs. These include the relocation of UPHCs into new government buildings, upgrading the quality of the buildings, and the provision of designated waiting areas with sitting spaces and separate rooms for dedicated public health-related activities such as vaccination, out-patient department (OPD) visits, and tests. Secondly, large HR recruitment drives have been undertaken along with the strengthening of monitoring and supervision of certain cadres of UPHC staff. As a senior state-level bureaucrat in the health department stated, "we have completed recruitment for six out of eight categories of HR across health facilities in Rajasthan, and additional recruitments will be made in the coming months."[19] Improvements in monitoring mechanisms include the development of the Pregnancy and Child Tracking and Health Services Management System (PCTS) and biometric attendance for frontline staff such as ASHAs and Anganwadi Workers (AWWs).

[16] 1.50 lakh tests.
[17] 212 crore.
[18] There is some data discrepancy in reporting for UPHC shortage. In 2019–2020 RHS there is a 7% shortage of UPHCs in Rajasthan. The 2020 RHS data (shows 37% UPHC shortage) seem to suggest that 200+ UPHCs were shut down. There has been no reported large-scale shutting of UPHCs or a spike in urban population or sanctioned UPHCs. This is unlikely and was not found in field visits.
[19] Translation by the author.

While not all UPHCs benefitted from the infrastructure and HR upgrades, they covered sufficient numbers across the state to be acknowledged by a cross-section of respondents. For example, interviewees in our study, such as civil society leaders and district-level bureaucratic health functionaries, stated that UPHCs in Rajasthan have significantly improved infrastructure and HR during the last few years. Most importantly, this has given the idea at the ground level and within communities that money is being spent on urban primary care.

In conclusion, as far as initiatives for primary health go, there is only one initiative that focuses exclusively on urban primary care, which is the U-AAM (formerly Janta Clinics). The PPP for UPHCs was a small component of a larger initiative aimed primarily at rural PHCs and has been discontinued.

4.2 Mapping the Challenges Facing Elementary Schools and UPHCs

In this section, we examine the initiatives from the perspective of the grassroots functioning of elementary schools and UPHCs. This section highlights that in primary care, the initiatives align with a defined, critical challenge at the ground level. The solution provided also addresses the challenge. In elementary education, however, while the initiatives do align with ground-level challenges, they are not necessarily the ones reducing the uptake of government schools. Further, the solution does not solve the challenge effectively. We have two different types of policy universes in primary health and elementary education in Rajasthan. For primary health, the Policy Universe appears to be one of consolidation of policy gains; in elementary education, it seems the Policy Universe is fragmenting and disjointed from the everyday functioning of schools.

Urban Elementary Schools: The Absent School at the Grassroots and Misaligned Initiatives

Infrastructure and land: Urban schools face challenges around the basic components of the structure of the school. These are land, infrastructure, and staff. Land availability is a particular challenge in urban areas, and many schools run in old buildings, often haveli-style houses donated by local philanthropists. These houses lack a sufficient number of playgrounds and even well-ventilated rooms for primary grades. Many lack classrooms to cover all classes. As a schoolteacher and a member of the state-level teachers' association, told us:

"Urban areas—schools challenges, infrastructure, in big cities…, no place to sit, fewer rooms, students come a lot, enrolment, no place, building, playground, library, for all these things, and in rural this thing is not there, there is a lot of space with the person, other than that, enrolment is low. Urban enrolment is good, infrastructure is weak, particularly in cities; many schools are rented, in two rooms. The city of Jaipur."

Even schools with better infrastructure suffer from a similar problem. The principal of one of the MG English Medium schools in study site, Radha,[20] shared with us the many infrastructural challenges facing the school. Her school had been selected as a Mahatma Gandhi school in 2019. As part of that scheme, the school received additional funding and teachers trained in the English language. Enrolments improved significantly, and the children of many government officials wanted to get admission to the school. However, classroom availability remained a challenge. She used donations from local philanthropists to repair a broken part of the school and made additional classrooms available to science students. She told us:

"We received an extra ₹5 lakh apart from grants, to strengthen, nursery has helping staff/peon, caretaker, etc. HR improved; we have a guard, which was not possible earlier. Teachers also increased. The other building was dilapidated; I used the funds to repair the building and use it for the science block."

As members of the district-level education bureaucracy told us in one angst-filled conversation, "40% of urban schools in our district are in rented buildings. They are under litigation because the landlords of the buildings have filed cases against the education department. Due to the stay orders on the buildings, no additional investments can be made for upgrading the infrastructure either via the education department or the MLA local area development funds." Land challenges manifest themselves in other ways, too. At times, when land/building is available and a school from an old building is relocated, it ends up being in an area that does not need another government school and loses the connection with its earlier community.

[20] Name changed for anonymity.

Other basic school resources need strengthening as well. The sitting arrangement in classrooms is often limited to rugs, and walls are dark and unpainted—not an ideal environment for first-generation learners. More worryingly, particularly from the perspective of state-level initiatives such as Free Textbooks and Uniforms, the supply chains for school supplies are fractured at the grassroots level. At times, there is a mismatch between the needs of children in urban schools versus those in rural areas. There is a long delay in textbooks reaching schools, even for time-sensitive initiatives such as remedial learning workbooks during the post-COVID-19 period. The free mid-day meals scheme in urban areas faces an additional challenge. Cooking the meals on the school premises is difficult due to space limitations, and pre-cooked meals are distributed. The pre-cooked meals do not align with the diet preferences of students and are therefore not taken up by them.

Teachers and staff: Staff, both teaching and non-teaching, are the other prominent challenging area. Rajasthan is among the top five states that have single-teacher schools, has the highest dropout rates at the primary care level in India (3.6%) (Lok Sabha Question 2096, 2024) and among the top 10 states with the highest teacher vacancies (Loksabha Question 1719, 2023). The availability of teachers in urban areas is not challenging, as working in an urban school is aspirational for most teachers. Many teachers use political connections to secure these postings. The key challenge for urban teachers is that postings are disproportionate, with some schools facing shortages and others having excess teachers. Schools with adequate teachers also have staff shortages in other forms. Teachers have many non-teaching duties, such as census and elections, for which they have to be away from the school. This reduces the time they are available in the school, furthering the popular image that in government schools, consistent teaching attention to students is not provided. One of the school principals we spoke with told us that out of the nine teachers in her school, four are away on government duties.

A related but less recognised challenge is that of frequent data reporting for online portals, in addition to separate requests for data from the education department. While the live updating of data on online portals was intended to reduce the need to maintain hard copy records and multiple data requests, what has actually happened is the opposite. Schools are maintaining both online and office records, and requests for additional information over and beyond these records are also made. Adding to this is the use of school premises to conduct various competitive exams. For example, during the study period, in one of the study districts, government schools were closed for several days because they were the venues for the state-level Common Entrance Test (CET) exam.

Deputation-based posting is another challenge that impacts teacher availability and teacher cadre morale. Teachers are posted in urban schools on deputations, and preferred schools/locations end up having an excess of teachers. We were given examples of urban schools that had low enrolment and an excess number of teachers on deputation. Even active teachers' union members highlighted the problems with deputation-based posting to us. Usually, teachers' union members tend to be less critical of the actions of their fellow teachers. Political influence is often used to secure these positions, which creates dissension among teachers, many of whom do not have this influence. A mathematics teacher in an old, high-enrolment school in one of the study districts told us that because he did not have the required political influence, he had not received his posting in his home district in Jhunjhunu.

The misaligned job allotment process extends to the non-teaching staff. School principals and senior teachers told us that the lack of computer operators, accountants, peons, and other support staff significantly impacts the day-to-day functioning of the schools, particularly the implementation of the new initiatives. For example, in schools that do not have a computer operator or if the appointed computer operator is not skilled at the task, other teachers with computer skills are often asked to fill the gap. This reduces their teaching time. A lack of accountants means that financial reporting becomes a challenge. The headmistress of a well-functioning and financially well-provided MG English Medium School told us that she prefers local philanthropists to donate directly to the school rather than use the online CSR portal. Donations made via the online system add to her reporting and responsibilities, and she does not have a strong accountant. She highlighted that she and other headmasters worry about allegations of financial mismanagement because of poor accounting practices at the school level.

Overlaid on this weak infrastructure and poor HR are activities that schools have to do as part of the state-level initiatives. The result is a peculiar kind of mis-

alignment. While the initiatives do focus on important grassroots needs related to elementary education, the lack of a functioning school system invariably ends up derailing them. The Free Textbooks and Uniforms initiatives aim to reduce out-of-pocket educational expenses incurred by parents. However, if textbooks do not reach schools on time, it pretty much makes the initiative redundant. The Free Uniform scheme sought to ensure that parents do not spend on school uniforms and that students go to school well-dressed, which is an expectation that parents had shared with the teachers we interacted with. But the financial amount allocated for stitching uniforms appears to be low for urban areas, and there were delays in the fabric reaching the schools, due to which either the uniforms were not ready in time for the school session or could not be stitched at all. Some children had left the school, and teachers had to track down the parents and transfer the amount to them.

Competition from low-cost private schools: Government schools target only the poorest of the poor and compete with low-cost private schools that provide the basic semblance of a school, i.e., just about sufficient infrastructure such as classrooms, desks, and chairs, a well-painted school building, and the required number of teachers. Teacher qualifications in low-cost schools are often lower than in government schools, and learning outcomes are not necessarily higher. Parents also have to bear additional OOPE on textbooks and school uniforms when they send their children to low-cost schools, but the decline in enrolment continues in favour of the low-cost schools.

Teachers, headmasters, and district-level education department functionaries with whom we spoke shared that parents find these schools attractive because of regular teacher attendance, smart uniforms, and well-maintained infrastructure. The capacity to pay for such things signals that the parents have a higher social standing. Government schools remain the option of last resort for the poorest of the poor. The popular narrative around government schools was well captured by an autorickshaw driver who said that "We send all the children in our family to private. There are no studies in government," even though he acknowledged that some government schools in his city were good.

Limitations of the "model school" approach: Similarly, MG English Medium Schools, while performing well during their first phase, now face a shortage of trained, English-speaking teachers. The shortage in the recently opened schools has further eroded the credibility of a government school. Overall, the creation of model schools versus strengthening the school system as a whole appears to signal in urban areas that public schools can only function in small islands. The model school approach to school system strengthening has not translated into an overall ecosystem for improving city schools. While they most certainly demonstrate how attractive and well-functioning a government school can be if the basics are in place, they remain disconnected islands of excellence. Their excellence does not have a ripple effect in either strengthening other public schools or creating a demand or movement among the members of the bureaucracy for better public schools.

Negative connotation of seeking philanthropic support: Schools are encouraged to seek financial support from local philanthropists, which adds to the image that public schools are sliding away. The Gyan Sankalp (CSR) portal does little to stem this decline. What was previously an expression of community support for local schools in the form of the purchase of school resources such as tables and desks, in some cases laptops, financial support to construct classes, or, in rare instances, the donation of land, no longer takes place. All donations have to be routed through the Gyan Sankalp portal. This formalisation signals that public schools need to be rescued.

Table 10: Private School Enrolments in Rajasthan and Sample Districts with High Share of Urban Areas

Indicator (2021–2022)	Ajmer	Udaipur	Rajasthan	India
Share of enrolments in private unaided recognised schools in class I in urban (%)	75	77	45	61
Share of private unaided schools with class I-VIII in urban areas (%)	41	34	26	22
Language score for class VIII in urban areas (%)	66	62	63	58
Mathematics score for class VIII in urban areas (%)	40	37	42	37

Source: UDISE and NAS (2021).

Urban PHCs: Delayed, Disjointed System Strengthening with Aligned State-Level Initiatives

Infrastructure of UPHCs: Many of the challenges that we have discussed in the context of elementary education are also present in urban primary health. These include land, location, infrastructure, and staffing. Overall, there is a 35% UPHC shortage in Rajasthan as per RHS 2021 (Ministry of Health and Family Welfare [MoHFW], 2022, p. 165).

Table 11: Shortfall of Human Resources and Infrastructure in UPHCs in Rajasthan

Staff Category	2019–2020 (%)	2021–2022 (%)
Doctor	No Shortfall	No Shortfall
Nursing Staff	40	No Shortfall
Lab Technician	76	51
Pharmacists	79	56
ANM	67	50
Urban-PHC Functioning in Rented Building	14	6
Urban-PHC Buildings that Need Reconstruction	22	17

Source: Rural Health Statistics (2020, 2022.

Land, location, and infrastructure: These challenges are being addressed in a staggered, at times in a disjointed manner, but one in which the value of UPHCs is not depreciating. Many of the UPHCs visited as part of this study had been moved to new buildings. Those that had not been moved have been upgraded. UPHCs benefited from more HR recruitments and an improved visual look. This is not the experience of all UPHCs in the state, but as the RHS data also highlight in Table 11, only 6% of UPHCs are now operating out of rented buildings. This has come down from 14% in 2019–2020.

In more densely populated parts of old cities, UPHCs are located in small buildings with limited capacity for infrastructural upgrades. Some even share the building with other government facilities (Ajmer city is among those facing this challenge). Moving these UPHCs to new areas either means that the government has to acquire new land and construct a new building, or take over another building. In some instances, as told to us by a district-level bureaucrat, primary health facilities like U-AAM (JC) clinics could not be created because the identified building was being used by the local community, and they did not want to give up the building for a U-AAM. In such cases, infrastructure in the existing buildings is strengthened and aligned with the services that the UPHC is supposed to provide. For example, the provision of sitting areas and segregating areas through visual markings for vaccination, OPDs, etc.

This infrastructure strengthening and building improvement, though a work in progress, has given the sense at the ground level that some spending is happening in UPHCs. There is no policy push that UPHC staff should seek out local philanthropists for contributions to improve the infrastructure of UPHCs. The responsibility of running and managing the primary care facilities is squarely seen as resting with the state health bureaucracy. A senior civil society leader who has worked in the primary health sector for decades shared with us that primary care in Rajasthan has historically performed better than in other states, with a higher presence of facilities. Overall functionality has improved manifold in recent years.

Staffing in UPHCs: In terms of staffing, both medical and non-medical, the strongest link for a UPHC is its Medical Officer (MO). A strong MO, who builds a connection with the community and ensures effective coordination across many of the different functions and staff of the PHC—curative and preventive—is critical. The uptake of the UPHC and the implementation of the initiatives depend on the MO. In this regard, urban PHCs score well. A district health official in one of the study districts informed us that in Rajasthan, urban postings are sought after by doctors, and usually the senior and seasoned doctors are posted in UPHCs. Therefore, MO staffing is usually not a challenge in urban Rajasthan. Deputation-based posting, due to which higher numbers of staff are posted in certain UPHCs, does happen. But many district-level bureaucrats told us that this is not a prominent problem. Additionally, recruitments had been done in six out of eight categories of health staff, as a senior state health bureaucrat told us. Due to this, chronic staff shortages and disproportionate staffing were not rampant, even though vacancies in some categories at the facility level remain. This is also reflected in the fact that there was wide recognition that in urban areas, the uptake of UPHCs is strong, with a figure of 250–300 OPDs per day repeatedly mentioned by health bureaucrats at the facility, district, and state levels.

Staffing challenges, particularly with regard to ANMs and pharmacists, are prominent, which impact preventive services undertaken by UPHCs (Table 12). To address some of these, such as spraying neighbourhoods during the malaria and dengue season, short-term on-contract posts are created to support ASHAs and ANMs. In UPHCs with high OPDs, a second part-time doctor is provided. Further, doctors and medical staff rarely perform non-medical government duties and are not away from the UPHC facilities for election duty or census work, like school teachers in Rajasthan. As members of a district-level health staff informed us, doctors are a powerful group and are able to preserve their service rules far better than elementary teachers.

Demands for an increase in staff were repeatedly made by both UPHC-level staff members and district-level health bureaucrats. This included the demand to fill all vacant posts against sanctioned positions and to increase the sanctioned posts themselves. This demand was made because more staff were needed to cover the enhanced services provided at UPHCs after they were upgraded to Health and Wellness Centres (HWCs). It was also meant to address high OPDs in UPHCs and the demand for more tests and specialists. OPD timings also do not fully align with the working routines of people in the UPHC catchment area. OPD timings during summers are 8 a.m. to 2 p.m. and in winters are 9 a.m. to 3 p.m., both of which restrict the uptake by the working segment. To increase OPD timings, additional staff working in multiple shifts is required, which has not happened so far.

Table 12: Shortage of Lab Technicians and Pharmacists in UPHCs in Rajasthan

	2019–2020 (%)	2021–2022 (%)
Lab Technician	76	51
Pharmacists	79	56

Source: Ministry of Health and Family Welfare (2019, 2022).

Monitoring: Other tech-based initiatives from before 2014 (prior to the study period) have also addressed specific challenges related to UPHC-based monitoring. These were highlighted by members of the frontline bureaucracy. Some of these include biometric attendance and the PCTS to track health outcomes. The biometric attendance software has addressed the challenge of absenteeism among field staff and the role of political influence in hiring. Before the use of biometric attendance, political connections were sometimes used to hire field workers. Some individuals who were hired from this category would delegate their jobs to others for a small payment or be absent from the job. The PCTS software, developed and implemented across health facilities in Rajasthan in the early 2000s, has enabled the linking of services provided at the UPHC level with defined health outcomes, thereby making the tracking of health outcomes effective.

In response to these challenges**,** the new initiatives undertaken during our study period, namely, U-AAM (JC) Clinics, MNJY, and UPHCs in PPP mode, focus on specific critical challenges impacting primary care in urban areas. U-AAM clinics were dedicatedly focused on urban primary care and on covering unreached areas that do not have a UPHC or have a high load of everyday OPDs. MNJY and UPHCs in PPP mode focus on health system-wide challenges, in which UPHCs are also nested. These challenges are the high costs of health tests and the poor availability of staff in PHCs.

UPHCs in PPP mode sought to address chronic staff shortages in PHCs. Though it must be highlighted that the number of UPHCs covered under this initiative was small, and it faced significant civil society opposition (Nandi et al., 2020). The PPP partners asserted that the backlog of payments from the government for their services was huge and this was impacting their capacity to continue providing staff at the PHCs. The revocation of the initiative reinforced that the responsibility of primary health care lies with the state, and the governing regime, which led the revocation of the initiative, sought to address the staffing challenges via fresh recruitment.[21]

[21] The State government had handed over 75 PHCs in rural and 37 in urban areas to private entities under the "Run a PHC" scheme. Prayas, in its fact-finding report on the PHCs run in PPP mode in Pratapgarh found staff being absent on duty. Upon further enquiry, they were told that the staff is severely underpaid and often the pay structure is below minimum wage. Additionally, the report also found that the basic hygiene and sanitation of the PHC was compromised and the existing staff lacked the ability and know-how to run medical equipment (Prayas, 2019). News reports also highlighted additional limitations in the efficacy of the scheme. District-level assessment of PHCs were undertaken under the court's directive where 36 PHCs were found to be performing poorly and unable to meet the delivery norms prescribed by the government (The Hindu, 2020). These PHCs were not popular, as reportedly, PHCs run under the PPP scheme faced high turnover of health care employees on account of lower wages. In the absence of health staff, utilisation rate of PHC would have likely declined. Moreover, the private led PHCs failed to address preventive care functions as it massively focused on selected few indicators (Rao, 2017).

4.3 Mapping the Policy Universes for Urban Primary Health and Elementary Education

Previously, we had introduced the concept of Policy Universe. It consists of four components: (a) budget allocations; (b) policy initiatives; (c) routine but significant HR and infrastructure drives; and (d) challenges that impact the uptake of UPHCs and elementary education schools at the ground level. The alignment between these components determines how UPHCs and EE schools operate and the extent to which they are prioritised by the state leadership.

Budget expenditures and initiatives together must address ground-level challenges. Ground-level challenges must shape the extent of budgets allocated and the number and kinds of initiatives undertaken by the state. When all these align—i.e., budgets, initiatives, and challenges—it signifies that the primary health and elementary education are a Policy Priority. But this is not happening in the case of Rajasthan. In Rajasthan, primary health and elementary education have two distinct policy universes. We define the two policy universes as one of Policy Focus in primary health, and Policy Action in elementary education.

Urban Primary Health: A Sector Receiving Policy Focus

The Policy Universe in urban primary health in Rajasthan has witnessed three distinctive developments during the study period. Due to these developments, we argue that the Policy Universe is a convergent and aligned one in which initiatives are linked with ground-level issues and successive policy initiatives build on the previous ones. Much of this has happened in a disjointed and staggered manner, but the primary care system has benefitted from the developments. We define this state of the Policy Universe in urban primary care as one having "Policy Focus."

Firstly, while budget expenditures have declined and stagnated during the last decade, there is still a sense among important grassroots-level actors that spending is happening on UPHCs. This was shared with us by district-level bureaucrats, facility-level staff, and civil society leaders. Secondly, there are very few initiatives that have focused exclusively on urban primary care. In terms of ongoing ones, there is only U-AAM (formerly JCs). Previously, there was the UPHC-under-PPP mode, which covered a few UPHCs. MNDY and MNJY have impacted primary care facilities immensely and resulted in increased uptake. All these initiatives have added to the existing urban primary care system. None have undercut each other's design or goals. Thirdly, additional recruitments and infrastructural upgrades have happened across many UPHCs in Rajasthan.

These developments have emerged in a disconnected and staggered manner over the last 15 odd years and have had important limitations. For example, both MNDY and MNJY were developed over several years (2011–2017) without a specific focus on UPHCs. UPHCs in PPP mode failed to provide a clear staffing solution, and U-AAM clinics are extensions to UPHCs and not a mechanism to strengthen them. Recruitments and infrastructure upgrades are taking place in waves and do not include all facilities or all posts. Yet, despite the limitations, these developments have ended up solving some important challenges that were reducing UPHC uptake. Together, they have made the Policy Universe of urban primary health care a convergent and aligned one in Rajasthan. The urban primary care sector has therefore received Policy Focus in Rajasthan.

We further argue that the Policy Universe is such that urban primary health is not a Policy Priority, for which four things need to happen. Firstly, budget allocations must be increased to provide more resources for infrastructure and staff to cover the new services that UPHCs are providing as HWCs. Secondly, plans to expand the reach of UPHCs need to be undertaken. The study highlights that wherever UPHCs are well-provisioned, they have a strong uptake, so clearly there is a pent-up health demand. Thirdly, more initiatives need to be developed to tackle the "wicked" problems of quality of care, staff training, and reaching newer segments of the population. Lastly, a vision of how primary care connects with the overall goals of Universal Health Coverage (UHC) needs to be developed at the state level. Insurance is an important mechanism for achieving UHC, but as one senior civil society member told us, the connection of UPHCs with the insurance framework has not been thought through. Ideas on how this can be done have been discussed in policy circles, but they have not been implemented. One such idea is that UPHCs could be facilities where post-operative care is provided for insurance-supported procedures such as hernia. These ideas need a holistic imagination of the health system as a whole and the role of primary care in it. This has not yet happened.

Urban Elementary Education: A Sector Receiving Policy Action

The Policy Universe in urban elementary education in Rajasthan has witnessed what we call Policy

Action. Many new initiatives have tried to address the challenge of declining uptake of public schools in urban areas in a limited, scattered, and conflicting manner. Elementary education has not received Policy Focus like urban primary health and is definitely not a Policy Priority. We make our argument on the basis of four observations.

Firstly, budgets have declined and stagnated over the last decade. Furthermore, cripplingly, there is a perception that no money is being spent on schools. Many members of the frontline bureaucracy we spoke with told us that they have been pushed to raise money from local philanthropists. Another funding challenge stated by many frontline and state-level members of the bureaucracy is that funds are allocated to schools based on increasing enrolments. This makes the challenge of increasing uptake even more entrenched. If schools do not have good facilities, how can the uptake be increased?

Secondly, there are no initiatives that focus exclusively on elementary education in urban areas, which indicates that there is limited policy recognition of the unique challenges that urban areas face for example, the availability of land, lopsided teacher distribution, or the availability of an easy opt-out option for parents in the form of low-cost private schools.

Thirdly, the problem prioritisation within existing initiatives is misaligned with the challenges actually impacting urban elementary schooling. For example, the Free Books, Free Uniforms, and SIQE initiatives, which are being implemented for elementary classes in both urban and rural areas, have had a limited impact on improving uptake. This is because the out-of-pocket costs borne by parents is not a major challenge that is preventing parents from sending their children to urban government schools. They are willing to spend that money on low-cost schools and pay for books and uniforms. The SIQE initiative is implemented across all schools in Rajasthan, and it does not solve the more fundamental problems of infrastructure, teachers, and funding. The other initiatives—model schools (Adarsh, Utkrisht, and MG Schools) and online portals (SD and Gyan Sankalp)—are also not solving the challenges that impact uptake across urban schools. Model schools are mostly in rural areas. The few located in urban areas, by their nature, target select schools only. The portals improve administrative oversight of schools. They help the bureaucracy, but as we highlighted earlier, the data collected through these portals do not necessarily feed into policy, nor are they used by the schools themselves. In fact, as discussed previously, data uploading to these portals eats into the teaching time available to the teachers.

Fourthly, the solutions proposed in the initiatives are also at odds with the ground-level realities. For example, poor supply and distribution chains for books and uniforms make it challenging to deliver the Free Textbooks and Uniforms initiative. Alternatively, the idea of a "model" school based on school consolidation further exacerbates the image of weak urban schools because the average school with elementary classes is clearly not on the policy radar.

The policy universes of primary health and elementary education that we have discussed so far are driven by an interplay between legitimacy, policy opportunity, and the dynamics of the bureaucracy–political leadership.[22]

4.4 Drivers of the Urban Primary Health Policy Universe

The Context: Moral Legitimacy and Policy Opportunity: The overall context in which urban primary health exists is one where, between health and education, health is considered more important and is seen as having a significant impact on reducing poverty. The initiation and later success of important initiatives such as MNDY and MNJY, and even of the insurance programmes in Rajasthan,[23] underline how important the cost implication of health services

[22] There are many approaches to understand drivers of policymaking and even success of policy initiatives. We draw out several of these existing framework such as (Khemani et al., 2022; Kingdon & Thurber, 2011; Venkateswaran et al., 2022).

[23] BSBY was launched in Rajasthan under the leadership of then CM, Vasundhara Raje in December, 2015. The Insurance Programme provided coverage to beneficiaries under the umbrella of National Food Security Scheme (NFSS) and Rashtriya Swasthya Bima Yojana (RSBY). The insurance provided coverage of up to ₹30,000 for general illness and upto ₹3 lakh per household, providing free and seamless treatment in public as well as private health facilities in the state (Directorate, Medical, and Health Services, 2015). Rajasthan's 9 million people were covered under BSBY (Ahmed,2019). Mukhya Mantri Chiranjeevi Swasthya Bima Yojana was launched in May 2021, it provides coverage to all the registered families with the expanded health coverage of ₹25 lakh on health care treatments in public or empanelled private facilities in the state. The benefits of the scheme extends to non-backward households as well, who are allowed to enrol by paying a premium of ₹850 per annum (Department of Health and Family Welfare, 2023). Subsequently, in February 2024, Mukhya Mantri Chiranjeevi Swasthya Bima Yojana was renamed as Mukhyamantri Ayushman Aarogya Yojana in Rajasthan, by the current CM of the state, Bhajanlal Sharma (Kumar, 2024).

is for people. Several civil society leaders[24] we spoke with during the study told us that in Rajasthan, historically, health services are considered more important than education.

The COVID-19 pandemic further strengthened this understanding and created a kind of legitimacy for the health system in several ways. Firstly, the public health system performed effectively at the hour of duty, and it demonstrated to state-level political and bureaucratic leadership that there are few alternatives to the public provision of these services. Among the citizens, it created greater respect for the public system in terms of the quality of medicines and tests that were being provided under the free medicines and free tests schemes. Secondly, it also created a context of political validity for the provision of health services. Political leaders were intensely involved and engaged in addressing the COVID-created health crisis. Across interviewees, we were told that political leaders could see the political gains to be made by the effective provision of health services. Thirdly, under the pressure of the COVID-19 pandemic, the primary care system and its critical role became particularly evident. It was the frontline staff members who led the neighbourhood battles against COVID-19, and not just the well-established doctors. Rajasthan's strong performance in COVID-19[25] management also underscored the legitimacy created for the health system.

In addition to this moral, issue-based legitimacy created for the public health system, primary care also got a policy push from the central government. Under the 15th Finance Commission and the PM-ABHIM programme, dedicated funds had to be spent on urban primary care by the states. U-AAM (JC) clinics, just like the Namma Clinics in Karnataka, are initiatives under this Central government programme.

The stakeholders: The stakeholders driving the Policy Universe in primary health are senior state-level bureaucrats and political leaders. At times, civil society leaders approach political leaders or senior bureaucrats with new ideas, give implementation support, or raise issues with regard to increasing budgets. But whether a particular problem is prioritised, and what an initiative should solve for, is a decision taken by the bureaucracy and senior political leadership. Other pathways, such as civil society action and internal bureaucratic feedback, have been less prominent in shaping the Policy Universe for urban primary health.

The bureaucracy: The role of the senior bureaucracy is shaped by three factors, which need to converge for an initiative to come together: firstly, the formal relationship with the political leadership; secondly, professional constraints within the bureaucracy, including those related to their own careers; and thirdly, the availability of legitimate and doable policy ideas and partners for implementation during their tenure.

The bureaucracy has to work within the political vision set by the governing regimes, specifically by the senior political leadership at the state level, led by the chief minister. A retired senior bureaucrat from the health department told us that during her tenure in the health department, strong support from the chief minister of the state was given, due to which experiments with new initiatives focusing on persons with disabilities could be done. She said, "I had kind of a dream run, as people would say. Not everyone has a dream run. That might have been coloured by their own perception to catch the eye of the big boss. That's how you get praise and postings." The initiatives taken by this bureaucrat took off because they aligned with the priorities of the political regime. The bureaucrat demonstrated the type of action that the governing regime wanted to see.

Relatedly, an important incentive for bureaucrats to drive new initiatives is career progression within the bureaucracy and the relationship between senior bureaucrats and political leaders. The professional dynamics within the senior bureaucracy impact which problems are selected, which solutions are provided, how they are implemented, and which areas are prioritised within the state for implementation. State-level bureaucrats are under intense pressure to demonstrate unique activities that they have taken during their tenure. This means that the senior bureaucrat's own initiative in identifying problems

[24] This does not mean that more budget has been allocated or that the government has necessarily emphasised health. This just highlights that in popular understanding, implications of poor or good provision of health services is more impactful than that of education.

[25] Rajasthan developed several good practices for effective management of COVID-19 (Niti Aayog 2021; Pareek & Sole, 2021). Rajasthan also ranked as the fifth best state in a Health System Resilience Index created by Mona et al (2022). The index ranks states on performance of their health system for COVID-19 based on indicators such as medical infrastructure, health profile, COVID-19 related health outcomes.

and seeking solutions—either by working with external partners such as NGOs, identifying high-performing people within the department, or engaging with central government political leadership—is the most critical.

This specific bureaucracy–political leadership relationship means that there is no consistent leadership of the health department that develops and implements a vision for the health sector. Both the political and the bureaucratic leaders move around significantly. Who holds the health department and health system vision together remains unclear.

Our respondents among civil society, engaged citizens, and the state-level bureaucracy shared with us that the bureaucratic culture in Rajasthan during the study period has become one of frequent transfers. Senior bureaucrats are moved out of the department with alarming frequency, at times within a year. During the study period, a new secretary had taken over the health department. The tenure of one of the former health secretaries was 16 months (GoR, 2025a). She had significant experience (over five years between the late 1990s and early 2000s) in the health sector, both with the Central and State government before she became the health secretary. Many others in the bureaucracy do not have this advantage when they take up new posts.

Due to these pressures, deeper structural challenges, at times, are ignored or addressed in a staggered manner. They are difficult to solve and do not yield immediate results that can be presented to the political leadership. In each of the initiatives that we discussed, these dynamics play out. U-AAM (JCs) were implemented because of a policy push from the central government in the context of the 15th Finance Commission. The knowledge that the urban primary health system needs additional support has been prominent at the state level. But it was only when the senior bureaucracy was provided with the funds and the mandate from the Central government that the initiative came about. MNDY began as a pilot initiative in one district (Jhalawar) and was scaled up across the state. It was the initiative of the senior bureaucracy working in partnership with CSOs. Once the feasibility, utility, and financial viability of the idea were demonstrated to the bureaucrats and later to the political leadership, the initiative was adopted. The challenges of high OOPE due to medicines and the need for free medicines with an essential medicine list had been around for a long time;[26] however, these concerns did not necessarily translate into an initiative until an interested bureaucrat, acting within the professional framework of the bureaucracy along with support from the political leadership, advanced the idea.

Bureaucrats and political leaders routinely get feedback from within the bureaucracy about the challenges and the requirements of primary care facilities. These feedback channels include the annual updates on staff vacancies, meetings between bureaucrats and political leaders on health outcome data, and meetings of senior bureaucrats with field functionaries such as ASHAs. But the internal bureaucratic feedback system does not result in new initiatives or problem prioritisation at the state level. The mere presence of problems facing UPHCs is not sufficient to create new initiatives. The challenges must align with the priorities set by political and bureaucratic leaders.

Political leaders: They are the other key stakeholder driving the Policy Universe in primary health. Elected leaders (MLAs/MPs) do not have a formal role in the workings of the primary health system. But their informal role is influential. As shared with us by the officers in the district health department and staff at UPHCs, political leaders in Rajasthan are an important link between the people and the health bureaucracy. They receive petitions from the people for various aspects of a UPHC, such as opening a new UPHC or moving it to a bigger building, infrastructure upgrades, staff hiring, or even the provision of additional facilities. Leaders take these petitions forward to the district/state-level bureaucracy and raise important issues in the state legislature. Political leaders are also consulted by the state and district-level bureaucracy when new UPHCs are opened, particularly for their input on land and location. Another role of political leaders concerns the transfer of medical staff and distribution of contracts

[26] For an important discussion on the historical developments which led to the free medicine scheme (See, Gurbani, 2017). The efforts to provide low-cost medicines took form in Chittorgarh when the district collector working in cooperation with the state bureaucracy and other players in the district in 2009. But during this period, many other states in India were already providing low-cost drugs. These included Tamil Nadu, Gujarat, etc. By 2010, the importance of providing low-cost medicine was recognized in national policy circles. The Central government called all states to develop low-cost medicine procurement and distribution based on the model developed by Tamil Nadu through NRHM and this provided an important base of legitimacy.

for construction activities and medical supplies. As shared with us by several civil society leaders in our study districts, political leaders recommend transfers of medical professionals and enable preferred partners to attain construction contracts. In return, these favoured partners support the political leaders in monetary and non-monetary ways during and outside of elections.

An important driving motivation for political leaders in their informal role is "branding" and "political capital creation" during non-electoral periods and "visibility" during the electoral period. New initiatives have to make "political sense" for the leaders, more than just solving grassroots challenges. The problems and the solutions they provide have to be linked with the political careers of senior state-level leaders. For example, U-AAM (JCs) are used by local leaders as an example of their commitment to improving the lives of the poor.

Political leaders are involved in the UPHC system for "branding" themselves as supporters of social welfare for their constituents. While they cannot and are not held accountable for welfare outcomes, in their individual professional capacity, they cannot be seen as anti-welfare (by both the poor and the non-poor in the constituency). Health facilities (and, as we will see in the foregoing discussion, education facilities too) provide political leaders with this opportunity. By opening new facilities, supporting hiring, and enabling construction, they can signal to the electorate their morally valuable credential of being supporters of social welfare. Simultaneously, health facilities also support political careers by helping "create political capital." Monetary contributions, the support of local chapters of professional organisations, and the professional medical community itself are valuable to build political careers.

During election periods, political leaders highlight improvements in primary health facilities as individual accomplishments of chief ministers or those of the political party and its ideology. New initiatives end up being those that focus on defined, measurable challenges, such as OOPE, which can be addressed visibly. These initiatives are also easily brandable, and their credit can be clearly ascribed to a political leader/party/ideology. They create visibility for the party and political leaders during elections, even though the initiatives do not help them win elections. As multiple interviewees across categories remarked, the political culture in Rajasthan is one where the governing regimes at the state level alternate between elections. The introduction of valuable initiatives and speaking of health initiatives, such as MNDY or MNJY, do not move elections one way or the other. However, they help create the branding of specific political regimes or leaders as supporters of certain kinds of policy ideas (free provision of health essentials, insurance) or as addressing specific types of health-related challenges (high OOPE for the poor). Electoral pressure by itself is not sufficient for political focus on health or specific sectors within health. However, popular responsiveness, which is not just with regard to voting but overall political support and identity, is an important consideration that political leaders must keep in mind when introducing new initiatives or supporting and strengthening old ones.

Health initiatives such as MNJY and MNDY solved the particular problem of high OOPE among the people. These initiatives created a distinctive image of the political leadership as supporters of social welfare. It is noteworthy that political leaders across regimes had to strengthen both MNJY and MNDY. Reports that the initiatives were not supported by the bureaucracy and the governing regime in later years after they were initiated were shared with us by civil society leaders, researchers, journalists, and frontline bureaucracy. But it appears that the new regimes received ground-level reports that withdrawing these initiatives would impact people adversely. The state political leadership was responsive towards this feedback, and the initiatives have continued. We would like to underline that this example of political responsiveness is unique to these initiatives. It is not electoral responsiveness. It is not driven by a knowledge that elections can be lost if social welfare measures are withdrawn. It is non-electoral responsiveness where people reveal their preferences outside of elections/their vote. It highlights that MNJY and MNDY as health initiatives were useful to the governing regimes, not just because of their worth for elections but also outside elections.

CSOs and other stakeholders: The role of other actors, such as CSOs, professional bodies, and experts/researchers, varies significantly with regard to proposing new initiatives, both in terms of problem selection and solution proposition. CSOs, and in the case of the initiatives discussed in this paper, have been at the forefront of proposing new ideas to strengthen primary care. However, civil society groups have also had to work within the professional and cultural contours of the bureaucracy and polit-

ical regimes. In the case of MNDY, it was not the mere advocacy by CSOs that resulted in the policy initiative, though the advocacy role was prominent. It was the uptake of the initiative by a district-level bureaucrat who was committed to the idea of reducing OOPE. Being a trained doctor with a significant understanding of the workings of the hospital and the health system, the bureaucrat was able to work with important stakeholders in Jhalawar and Chittorgarh, develop a workable system for low-cost medicines, and then engage the state-level bureaucracy and political leadership. MNDY started as a district-level pilot in Jhalawar and aligned with a national-level policy narrative around the free provision of essential drugs during the late 1990s.[27]

Nationally, under NRHM, in 2010, there was a thrust to ensure easy access to medicines, and states were called upon to develop systems on the lines of the Tamil Nadu Medical Services Corporation. In other words, MNDY was a product of national-level Policy Focus as well as the leadership of a committed bureaucrat. Its translation into a state-wide policy initiative was a result of its alignment with the political leadership and its value for political branding, capital, and visibility.

Other actors, such as professional bodies and experts/researchers: These have a much lesser role in driving new initiatives. Doctors' associations do act as conduits for presenting the preferences and positions of doctors around new initiatives. For example, doctors' associations did share their reservations about the quality of medicines at the time that MNDY was implemented. However, in terms of overall public health-related initiatives, they are not prominent actors. Experts and research bodies may work on specifically commissioned projects/initiatives, but these also happen due to the initiative of bureaucrats and political leaders. An illustrative example is the Khushi Baby app. This initiative is a technology solution to improve maternal and child health (MCH) via tracking through a wearable device and a mobile-based app.[28] This initiative was developed by a Yale master's student working with initial funding from Yale and subsequent funding from 3ie[29] and the Gavi alliance.[30] Later, in partnership with a doctoral fellow at the Indian Institute of Health Management Research (IIHMR) in Jaipur, he conducted randomised control trials on beneficiaries and co-developed the initiative with frontline health workers in Udaipur. The founders of Khushi Baby engaged the state government bureaucracy for scale-up across the state. But it was only after the app's solution was noticed by the health secretary that it was implemented in selected places in the state (it is presently focused in rural areas as per the Rajasthan digital health platform). The scope and scale of the initiative are still limited[31] compared with other e-health initiatives in Rajasthan (Joshi et al., 2021).[32]

4.5 Drivers of the Urban Elementary Education Policy Universe

As mentioned earlier, the elementary education Policy Universe is defined by Policy Action, not Policy Focus. There are many new initiatives, but the initiatives and the budgets do not converge to solve critical problems which limit the uptake of facilities. This is due to several factors. Briefly, to capture the key arguments here, the context of urban elementary education is one in which public facilities have become "purposeless" in the eyes of the average parent. The stakeholders driving the Policy Universe are unable to focus on addressing important challenges that are specific to urban public schools. Their engagement

[27] In fact, "under the encouragement of Delhi Society for Promotion of Rational Use of Drugs (DSPRUD) initiative, 'WHO- India Essential Drugs Programme,' Rajasthan Society for Promotion of Rational Use of Drugs (RSPRUD) was formed in 1999, which started series advocacy workshops. This facilitated 'Rajasthan State Essential Drugs List' in 1999, followed by 'Rajasthan State Standard Treatment Guidelines' in 2008" (Gurbani, 2017). Nationally, under NRHM, in 2010, there was a thrust on ensuring easy access to medicines, and states were called upon to develop logistics and supplies system on lines of Tamil Nadu. MNDY, first as a pilot in Jhalawar, which was then scaled up to 17 districts in Rajasthan, was a product of national-level Policy Focus as well as the leadership of a committee bureaucrat. Its translation into a state-wide policy initiative was a result of its alignment with the political leadership and its value for political, branding, capital and visibility.

[28] The initiative has three components: a "pendant" (tech wearable) for the beneficiary, a mobile app for the frontline worker, a dashboard for health bureaucrats, and automated voice recording, WhatsApp groups/chatbots for follow-up. Those using the Khushi baby initiative are given a wearable device, "a pendant" which records the beneficiary's health history. This is scanned and accessed by frontline health workers to track health indicators and health bureaucracy at the district level.

[29] 3iE stands for International Initiative for Impact Evaluation. It is an international non-profit organisation which is provides evaluation and synthesis services.

[30] GAVI, the Vaccine Alliance is a public-private partnership founded in 2000 to improve access to immunisation in poor countries.

[31] According to Rajasthan government website, it is limited to certain blocks in rural India (Department of Health and Family Welfare, GoR & Khushi Baby, n.d.).

[32] At the time this paper was written, the Khushi Baby app was not present at scale. Therefore, it is not included in the study.

in the overall schooling system is also particularly inconsistent. The demands of their professional commitments further limit their capacity to consistently provide high-quality governance to urban elementary education.

The Context: The context driving the Policy Universe for elementary education in urban areas is one where the value of public schools is unclear. Respondents among the frontline bureaucracy, engaged citizens, and ordinary residents highlighted to us that government schools in urban areas are in a poor state and that private schools provide better schooling. Two important developments during the study period could have changed this understanding, but this has not happened. First is the implementation of various model school initiatives—Adarsh, Utkrisht, and MG English Medium Schools—and second is the COVID-19 crisis.

Our observations of urban schools and discussions with the frontline bureaucracy, civil society leaders, and engaged citizens suggest that the creation of model schools—Adarsh, Utkrisht, and MG English Medium Schools—has also not altered the image of urban public schools. "Model" schools are present in much smaller numbers in urban areas but many have high enrolments. They present a model of what higher funds and better facilities can do for the quality of schools and how urban parents would respond to such schools. Unfortunately, this has not translated into an articulated demand for improving the "non-model" urban schools.

COVID-19 provided a brief interlude where enrolments in government schools increased because parents faced steep income loss. But this did not create legitimacy for government schools. The schooling system could not prove to the parents that their children were getting an improved learning experience. As soon as parents' income positions improved, enrolments began to fall in government schools (see Table 13, which highlights the decline in enrolments in private schools from 2019–2020 to 2022–2023 in two sample districts that had high levels of enrolments).

The challenges of urban areas and the high density of low-cost private options dampen the demand for better schools for parents and local stakeholders (political leaders, community leaders). A sense of resignation is prominent even among civil society leaders as well as district-level bureaucrats that, in urban areas, public schools are weak and neglected. This furthers the focus on resource efficiency and consolidation, which is a prominent policy idea in the elementary education Policy Universe. As Rajesh, a district-level bureaucrat, told us:

"There are no more elementary schools in Rajasthan. All schools are I–X or I–XII; very few schools are elementary. Either all schools are upgraded or merged. Teachers are engaged in running various schemes such as Mid-day meals, the provision of milk scheme, etc., that the teachers are unable to teach as the irrelevant work is so much. The schools lack sufficient HR to get these works done."

Stakeholders: Just like primary health, the Policy Universe within elementary education is also driven by state-level bureaucrats and senior political leadership. Their role in the running of urban elementary schools and the incentives for initiative-making are not aligned with the challenges of high-quality urban public schooling.

Table 13: Change in Class I Enrolment Before and After COVID-19 in select Urban areas in Rajasthan

District	Enrolment Figures	2019–2020	2022–2023
Ajmer	Enrolment in class I in urban areas	20861	19320
	No. of enrolment in class I in private, unaided schools	17113	14549
	% of enrolment in class I in private, unaided schools	82	75
Udaipur	Enrolment in class I in urban areas	10314	8707
	No. of enrolment in class I in private, unaided schools	8850	6675
	% Enrolment in class I in private, unaided schools	86	77

Source: UDISE+ (2024).[33]

[33] COVID-19 lockdown was implemented in India from March 2020 till March 2022, with severe restrictions on individual and institutions being removed in stages from 2021.

Bureaucrats in education are also working under the same professional constraints discussed in the context of primary health. The pressures of managing a professional career within the bureaucracy are an important guardrail for the kinds of initiatives that end up being proposed. Embedded structural challenges can be addressed by senior bureaucrats only if their tenure in the department is secure. Our respondents among the state-level bureaucracy and civil society told us that the standard tenure for senior bureaucrats in the education department is a little over a year. For example, the current education secretary has been in the post since March 2024. At the time of the field visit, he had been in office for eight months. In his previous position, he was the secretary for Women and Child Development and Panchayati Raj for three months (January 2024–March 2024).[34]

During the brief period that bureaucrats head a department, they must distinguish their tenure with initiatives that can be identified as their contribution. This needs solutions that can be undertaken within shorter periods. One of our respondents, a senior civil society leader who had been working within the area of education since the 1980s, shared a story that is illustrative of this situation. He told us that when he proposed a programme for teacher training to a senior bureaucrat in the education department, he was told that the programme should be such that it would be completed during the tenure of the bureaucrat, as he needed to demonstrate performance at his end. To demonstrate their own unique contribution, often initiatives are undertaken in a rushed manner or ones that bypass the deeper structural challenges. For example, during the short tenure of a senior member of the education bureaucracy (nine months), an important initiative was undertaken by the education department called the No-Bag Day in government schools. As part of the initiative, every Saturday was declared as a day for extra-curricular activities that focused on the personality development of students. The initiative was prominent as it was announced by the then chief minister.[35]

District-level bureaucrats and school principals told us that the initiative in the first round was not carefully thought through. No-Bag Day significantly reduced teaching time. School teachers already spend time away from classes due to non-teaching duties. At times, schools in urban areas are shut because they function as exam centres. All of these already reduce the teaching time, and a No-Bag Day four days a month reduces it further. Civil society leaders and teachers among our respondents highlighted that it is possible that this initiative was borrowed from private schools in Rajasthan. But private schools do not have the pressures of non-teaching duties and extra school holidays due to public examinations. The initiative was revoked after protests from teachers and replaced with a new policy of No-Bag Day only twice a month. Despite this policy idea–implementation mismatch, the initiative was talked about as a notable achievement of the senior education bureaucrat of the department.

Political Leadership: Just like in primary health, the role of political leaders in elementary education must align with their political careers in important ways. During non-election periods, their activities with regard to public schools build their brand and create their political capital. During the election period, front-ending the initiatives and their own activities around elementary education creates visibility for them. But during the last decade, in elementary education, the role of politics in Rajasthan has been centrifugal and divergent.

Just like in primary health, political leaders do not have a formal role in the functioning of schools in their constituencies. Schools are the responsibility of the bureaucracy. However, political leaders have an important informal role in the everyday functioning of schools, particularly in two areas: (a) teachers and (b) school infrastructure. Political leaders receive petitions for teacher transfers and requests for teacher appointments, and they can use funds from the MP and MLA quotas to contribute to constructing school buildings and give informal and at times formal clearances to land allocation for new school buildings in their constituencies.

When new initiatives related to schools are implemented, say a new Adarsh or MG English school is set up in an MLA constituency, they use it to enhance their own "branding." Political leaders also play an

[34] This information has been taken from the website of the Department of Personnel (GoR, 2025a) which is a good source of understanding the history of the department (Health, Education, and Finance), administrative posts (Health Secretary/Commissioner etc.) and the posting of individual officers (IAS/IPS/Rajasthan Administrative Service [RAS]). A prominent exception to this was the tenure of Naresh Gangawar, who part of the education department in various senior positions (commissioner, secretary) from 2013 to 2018 during the Vasundhara Raje government. See the Department of Personnel Civil list (GoR, 2025b).

[35] No-Bag Day was already being implemented in a few other states such as Andhra Pradesh and Manipur before it began in Rajasthan.

active role in teacher transfers. Given the strong position of teachers' associations in elections and in mobilising political opinion, supporting teachers aids the political capital of political leaders during non-election periods.

During election periods, initiatives that provide visibility and individual credit are valued and useful. Therefore, ideas like the MG English Medium Schools, which clearly respond to a significant anxiety among parents of public-school children that they must learn English, are useful to political leaders. Again, much like primary health, the initiatives themselves do not win or lose elections, but they aid in creating a brand impact for the leaders and their associated parties. Political visibility created by new initiatives tracks back to senior political leaders at the state level or the political party and ideology, but rarely to the individual MLA or MP in a constituency.

In elementary education, channels for political responsiveness are broken to the extent that successive political regimes do not necessarily build on the initiatives created by previous regimes. In health, successive regimes could not stop MNDY or MNJY. They built on the initiatives because they got feedback from the constituents that stopping the initiative would impact their everyday life. The MG English Medium School initiative was initiated or implemented by different regimes, but the programme suffers from a lack of English teachers to support the expansion of the scheme, and subsequent regimes have not been able to address this.

Other stakeholders in education, such as CSOs and professional associations, in the course of the study period, were not prominent in driving new initiatives. CSOs focusing on grassroots mobilisation have played a very impactful role in driving some of the more path-breaking initiatives in education; however, during the study period, their role in leading new initiatives was no longer prominent. Important national and international development organisations, such as United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), and Pratham, work in partnership with state-level bureaucrats on initiatives that have been designed and developed by the state leadership, such as textbooks and curriculum design. These organisations do not take a grassroots mobilisation route and focus on defined, technical aspects of the EE system, rather than focusing on strengthening the school as a unit and enhancing its uptake within the community.

Professional organisations such as teachers' associations play an important role in communicating the needs and challenges of teachers. But they have not been able to promote the emergence of important teacher-strengthening initiatives such as a teacher transfer policy, the rationalisation of teachers across urban areas, or the inclusion of a hard-duty allowance for teachers working in difficult-to-reach areas.

5. The Implications

Urban primary health care and elementary education have not been policy priorities in Rajasthan. But where Rajasthan's outcomes are impressive is in the urban primary health care sector. We say this despite the prominent limitations. Budget expenditures have declined, new initiatives for urban primary care are limited, and the few that are there have emerged in a staggered and disjointed manner, with sporadic waves of infrastructure upgrades and hiring. Yet, the Policy Universe of urban primary care has been one of what we describe as Policy Focus. It is a convergent and aligned one. The Policy Universe has addressed some of the problems of the uptake of urban PHCs. These include reducing high OOPE due to medicines and tests, making senior doctors available at UPHCs, and provisioning UPHCs well with infrastructure, equipment, and medical supplies. Two things stand out about the Policy Universe of urban primary care. There seems to be some "universality" built into the initiatives and the budgets. Declining budgets are a reality that applies to all UPHCs. It is not that some UPHCs are getting preferential, higher funding, or better staff. New initiatives such as U-AAM (JC) or the now-stopped UPHCs in PPP mode did target a few UPHCs only. But they were aimed at enhancing the reach of the entire urban primary care system, not to concentrate resources in a few facilities. All initiatives—MNDY, MNJY, U-AAM (JCs)—exist in a somewhat complementary manner. They did not undercut each other and were implemented across regime changes at the state level, consolidating the gains over a period.

Urban elementary education in Rajasthan over the last decade is an illustrative contrast in important ways. Budget expenditures have declined here, too, and there are no new initiatives that focus on urban elementary education. Several new initiatives were implemented during the study period, focusing on school education in general, all of which include urban schools to varying degrees. But again, there

was no targeting of specific challenges to elementary schooling in urban areas. The key policy ideas have been of "model" schools and monitoring systems that do not sufficiently solve the key challenges impacting the uptake of urban schools. The initiatives have given a sense that the overall urban public school system cannot be supported by the state. As regimes changed, the support for the initiatives changed, and there is a consistent push for school leadership to raise funds from local resources. Over a period, the Policy Universe for urban elementary education for Rajasthan has become misaligned and divergent from the ground realities.

What drove this state of affairs in Rajasthan? Why is the Policy Universe for primary health convergent and that for elementary education a divergent one? Primary health benefited from the legitimacy created by the COVID-19 pandemic for public health facilities. The Central government policy push as part of the 15th Finance Commission was another important contextual development. In education, COVID-19 demonstrated to parents that government schools have not improved the learning environment enough, and once livelihood issues were resolved, parents sent their children back to private schools. The already weak legitimacy of public elementary schools in urban areas became weaker. These developments provided a defining context, the impetus, and the incentive for the key actors in shaping the Policy Universe. These actors are primarily senior bureaucrats and political leaders for both elementary education and primary health. Local CSOs, which had been so prominent in Rajasthan in setting the social policy agenda and driving new initiatives, had a less clear role during the study period. Global consulting firms and pan-national NGOs have been more active in working with the state bureaucracy and political leadership. But again, their role was defined by the contours set by the bureaucracy and the political leaders. It seems that during the decade we focus on in this study, 2014–2024, urban elementary education and primary health have not witnessed prominent civil society leaders setting the state-level agenda.

Senior bureaucrats and political leaders in both primary health and elementary education sought to shape the policy universes, working with somewhat identical incentives. In both areas, bureaucrats have to manage the professional pressures of working within the bureaucracy, including the culture of frequent transfers and the low capacity of support staff. In short periods of time, they have to demonstrate action and create their unique legacy. This impacts the kinds of challenges that are selected for new initiatives and how they are implemented. Bureaucrats also must work within the vision and priorities set by the political leaders and have limited scope to set the agenda outside of this perimeter. On the other hand, political leaders want to do those things in urban primary care and elementary education through which they can develop their "brand" as supporters of social welfare and build social capital during the non-election period. During election time, the chosen initiatives must yield "visibility" for political leaders.

This particular bureaucratic–political relationship is the matrix for the development of state-level initiatives. New initiatives, budget decreases, increases, and status-quo, and other prominent developments in the Policy Universe happened during the study period when the professional pressures and resources available to senior bureaucrats aligned with the political priorities set by state-level leaders. The presence of challenges by themselves is not sufficient for new initiatives.

Our analysis shows that to change the drivers of the health and education universes and enable the emergence of new initiatives and higher budgets, four limitations need to be addressed. Firstly, the policy universes for health and education indicate that there is no clear policy agenda for either of the sectors in urban areas, not even for primary health where the initiatives are somewhat aligned with the ground-level challenges. Secondly, the Policy Universe for both sectors remains limited to keeping the facilities focused on the poor, both in terms of the number of facilities as well as their quality. The poor not only have limited resources to demand better services, but this also means that government expenditure on public facilities at the elementary and primary level does not have wider legitimacy. What then will drive new initiatives? Thirdly, the pathways and stakeholders for the emergence of new initiatives are limited to the senior-most state-level leaders within the bureaucracy and politics, and their incentive structures are not always connected with ground-level needs. We make four policy recommendations to address these limitations.

Define the agenda: UPHCs in Rajasthan, where they are working well, are fulfilling a defined health need. They are providing a basic medical service, and it seems that they are being accessed by a cross-section of the local catchment area, not just the poorest of the poor. There is much more that UPHCs can and

must do. To start with, they must be open for longer hours and have more staff to provide UPHC services to all within their catchment area. Even within this limited scope, they are fulfilling clear needs. This is not happening in most of the government elementary schools in urban areas, and low-cost private schools are the beneficiaries.

To address this, in both health and education, the urban agenda needs to be delineated from the remaining system in health and education in Rajasthan. For health, this is slightly clearer. UPHCs are catering primarily to urban slum populations and migrants. This kind of catchment area is not clear for schools. First and foremost, we need an answer to the question: What is the purpose of government elementary schools in urban Rajasthan? Is it to provide schooling to the poorest until they move up the economic ladder? Or is it to provide high-quality, affordable education with certain distinctive features unique to a public system, for example, socio-economic and cultural diversity in the classroom and a standardised teaching–learning system? Underlying this question is what kinds of challenges urban public schools face and what sorts of initiatives they need. For example, an urban school needs to be an infrastructurally strong entity, not just because parents have the choice of low-cost private schools but because in the larger urban context, people's standard of living, exposure, and expectations are different from rural areas. The presence of adequate teachers who teach regular classes and school principals who are accountable and responsive in building their schools is critical. When teachers and principals appear to be responding to the needs of other stakeholders in the education system, the integrity of an elementary school is compromised, as parents can see that the school is not aligned with teaching and learning but with other criteria.

For health, defining the urban context has somewhat different requirements. UPHCs meet the health needs of a small segment of the population. Even with this, UPHCs had a high OPD load, as many frontline and state-level bureaucracy members told us. UPHCs are also being bypassed to in favour of hospitals, and alongside this, low-cost private providers are also being accessed. This highlights that health needs are diverse and complex but the UPHC is an important part of the health service provision at the grassroots. After all, all primary care health functions are provided only by the government systems. Without them, preventive and promotive services in health would be largely neglected. Thus, there is an urgent requirement to define the health needs that should be provided by the urban PHC system. To illustrate, in rural areas, PHCs have facilities for childbirth, and hence they are open for longer hours. This is not the case in urban areas. Yet, as an MO at a UPHC informed us, her tenure in a rural PHC was significantly easier than in an urban one. In UPHCs, the patient flow is non-stop, and there is a greater diversity of cases too, as migrants from different parts of India seek medical care. Therefore, UPHCs need additional resources and dedicated strengthening.

The agenda-setting responsibility has to be given to a government-appointed commission that would have a clear, implementable outcome. The commission would define the urban health and education agenda and provide measurable initiatives in the short run (1.5 years, which is the usual tenure of a health and education secretary), medium run (five years), and long run (10+ years). The commission would remain in action until all the goals are achieved and would submit its report to the CAG. The commission would have its own secretariat and would use existing data and studies and commission new ones (all of which must be publicly available). Its members would include the health/education/finance/planning secretaries and ministers at the state level, leaders of professional bodies (teachers'/doctors' unions), private sector body representatives, and civil society leaders.

Build legitimacy: UPHCs are seen as valuable, while the role of urban elementary schools is less clear (see pp. 30–32 of this paper for a detailed discussion on the challenges faced by elementary schools). There is a legitimacy problem, and the first step is to create that legitimacy. Once the urban health and education agenda is clear, some part of this legitimacy will emerge organically. But building legitimacy still needs deliberate thinking and actions on the part of the state bureaucracy and political leadership. Legitimacy creation for UPHCs and urban elementary schooling is different, in part because they face different sets of challenges. Starting with UPHCs, they do not have to struggle to create basic legitimacy because they have a high uptake, but they need to expand the range of their services and their target population. They need to be seen as good PHC facilities and not poor people's health facilities in urban areas. For this, we need to advertise local UPHCs and their services more actively within their catchment areas. In particular, we need to emphasise audit, quality, and performance reports and highlight the cost savings

and quality of care to be gained by households if they access UPHCs. We need independent private bodies to audit UPHCs, and their results should be widely published. Including doctors' associations in this process will also help. As an example, when the low-cost medicine model was being developed in Chittorgarh, the bureaucrats leading the project actively used local media and advertising channels to disseminate information about the quality of low-cost medicines and make people aware. This strategy was effective in ensuring the awareness and uptake of the medicines (Singh, 2009).

In elementary education, the challenges are more fundamental. The first step is to remove the requirement for school principals to raise funds, as this indicates to the people that the state has given up on urban schools. Second, a hierarchy of basic requirements for school strengthening must be created. For example, is providing mid-day meals or the English language more important than regular, outcome-oriented teaching? It is necessary to identify the catchment of students attending low-cost schools and examine what they need in an urban public school. Strong infrastructure and teaching will likely emerge as prominent. The weaknesses of the schools should be then widely publicised with a phased action plan and accomplished. More effective monitoring of schools through online portals, free books, and textbooks are not the reasons students will go to an urban public school. Good teaching and a good school environment are. But it is most important that the sequence of actions is thought through clearly and implemented in a sustained manner. It is when initiatives are not linked to the real challenges impacting school uptake, and when they fail, that a legitimacy crisis appears.

Include more stakeholders: At present, in both health and education, the drivers of policy initiatives are led by the senior bureaucracy and political leadership. It is important to invigorate CSOs that have historically played a defining role in prioritising challenges and policy ideas. Many CSOs are active across a whole range of issues: education among the tribal population, adult education, women's education in rural areas, the right to health, and MCH in rural areas. But a focus on urban challenges or driving state-level initiatives for improving urban primary health care or elementary education has not been prominent. This is an important area where Rajasthan can lead by example for the rest of India. Urban areas have not witnessed the kinds of community mobilisation that rural areas have benefitted from for decades. The idea of a "community" in urban areas is diffuse. Is it based around a ward, a neighbourhood, or the catchment of a school or a PHC? But this also opens up immense opportunities for the state to support civil society groups to emerge and become a link between the state and the users of UPHCs and schools. There is already a model for engaging with civil society in Rajasthan. ARAVALI is a state-supported platform that engages with NGOs, research organisations, private sector bodies, and PRIs to address socio-economic challenges impacting rural areas. It particularly supports NGOs with capacity development and engages them to work in partnership with government initiatives. We need to replicate this model for urban areas as well. While the role of ARAVALI is primarily focused on implementation, in urban areas, we need the platform to work in partnership with the health and education departments to propose new initiatives.

Create institutional structures for ownership: Health and education outcomes are not the political responsibility at any level of government in Rajasthan. Bestowing a formal role on political leaders can have unintended consequences of overt politicisation at the facility level. What is needed is for health and education outcomes to trickle into political contestations at the constituency level. So, alongside voters talking about the community identification of the candidates, they should be able to talk about the state of health and education outcomes, and the availability of facilities and services. The first step towards this is to make the relevant information available: In how many schools at the primary, secondary, and higher education levels in a constituency are learning levels poor, and how many UPHCs do not have pharmacists? The selection of data points has to be such that mobilisation around them can produce demonstrable action. For example, curing diabetes ought not to be tracked, but coverage of diabetes testing can be. One pathway to address this is to create assembly and parliamentary constituency-level profiles with data on the number of health and education facilities and achievement of outcomes. Each constituency profile should also be matched with the right district and sub-district-level bureaucratic authority.

Second, there needs to be some continuity in bureaucratic leadership in the health and education departments. Short tenures make long-term planning challenging and compromise accountability within the department. It is unclear who is in charge of what and where exactly the challenges lie. Who holds the health and education agenda together?

One suggestion for this would be to create a matrix of institutions and key senior members within the health and education bureaucracy at the state level who hold longer tenures. Institutions such as the counterpart of ARAVALI, which we suggested above, and government-appointed commissions can play this role. So can education- and health-focused organisations such as the Rajasthan State Council of Educational Research and Training (RSCERT), the State Institute of Education Management and Technology (SEIMAT), and the Rajasthan Institute of Health Management Research (RIHMR). But for this, their governance structure has to be revamped, and well-established and recognised leaders in the field have to be appointed at leadership levels, and not Indian Administrative Service (IAS) officers. Financial resources have to be provided, and their role and responsibilities in proposing new initiatives and implementation have to be clearly laid out and actioned. If RSCERT is not used to develop the curriculum and if that role is bolstered by hiring external organisations, such as consulting firms or international development organisations, then the organisation does not become strong enough to provide the continuity of leadership to the sector.

Rajasthan has much to offer in terms of learnings to other states. Its strength is to offer solutions that highlight how a poor, socially backward state improved standards of health and education. Rajasthan is also an example for itself. Education has much to learn from health. Our analysis in this paper has highlighted that while deliberate action to improve primary health was perhaps absent in the case of Rajasthan, it has surely highlighted that public facilities can indeed meet the requirements of the urban population and what needs to be done for this to happen. Careful analysis and diligent action are all that is required to replicate this in other areas, starting with education.

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Appendix

Appendix 1: Summary of Health and School Education-Related Initiatives

Here, the key health and education-focused initiatives undertaken by the Rajasthan government between 2014–2024 from two approaches have been highlighted. The first table presents a year-wise listing of initiatives highlighted in the economic survey report of Rajasthan. This listing includes ongoing and new initiatives at the state and national level.

Table A1: Summary of Key Health and Education Related Initiatives in Rajasthan, 2014–2024, as per The Economic Survey Reports

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
2014–2015	**PCI:** ₹72,156 **PCI Ranking:** 21st among all states in India **GSDP:** ₹5.74 lakh crore **GSDP Growth Rate:** 11% **GSDP Ranking:** Eighth among all states in India	**Janani Suraksha Yojana (JSY):** The goals of JSY are reduction in maternal and IMR as well as an increase in the institutional deliveries of BPL and SC/ST families. JSY started in 2005. **Janani Shishu Suraksha Yojana (JSSY):** JSSY provides free services to pregnant women and sick newborns in public health institutions, in order to reduce their OOPE. JSSY was launched in 2011. **Rashtriya Bal Swasthya Karyakram (RBSK):** Under RBSK programme, newborn to 18-year-old children are medically screened and provided surgical treatment (if necessary) at district level. **Mukhya Mantri BPL Jeevan Raksha Kosh:** Free treatment facility is being provided to various families (including BPL) since 2009 under the scheme. The beneficiaries can avail free treatment in any of the government run health facility in the state. Alternatively, in the absence of the medical facility, patients can also be referred to AIIMS, New Delhi or PGMERI, Chandigarh **Mukhyamantri Nishulk Dava Yojana (MNDY):** MNDY began in 2011. Rajasthan Medical Services Corporation (RMSC) procures drugs through tendering and then supplies the drugs to district warehouses. These drugs, including surgicals and sutures, are provided free of cost to the OPD and Inpatient Department (IPD) patients seeking health care in government facilities in the state.	**Kasturba Gandhi Balika Vidyalaya (KGBV):** To promote girls' education in the state, especially among dropout girls as well as never-enrolled girls, KGBV were established with the assistance of the centre. The girls are provided with a condensed course including basic competencies, to prepare them to catch up with learning levels of class VI. As of 2014–2015, 200 KGBVs are functioning in the state. **Mewat Balika Awasiya Vidyalaya:** Ten Mewat Balika Awasiya Vidyalaya are established in the state to promote girls' educations, especially the dropout girls of Mewat region i.e., Alwar district. The enrolment for 2015–2016 has been 419 against the capacity of 500 girls. **Meena Manch:** Meena Manch is a group consisting of class VI to class VIII girls from over 9000 nodal schools and 200 KGBV. Meena Manch not only motivates parents to send their girls to school but also creates awareness on issues of child marriage, dowry and so on. **Adhyapika Manch:** Adhyapika Manch provides a conducive and friendly environment to female students in schools, thereby improving their academic performance. One Adhyapika Manch has maximum 100 teachers.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
		Mukhyamantri Nishulk Jaanch Yojana (MNJY) MNJY was introduced in 2013. It not only provides free health diagnostics and investigations to the patients in government facilities, but also strengthens existing laboratories and diagnostic facilities of public health institutions. **National Medical Mobile Units (MMU):** MMU is a combination of two vehicles—staff van and diagnostics van with equipment such as ECG machine etc, provide health facilities in remote, desert and tribal areas. MMU has been functional since 2008 in the state. **108 Toll-Free Ambulance Service:** At present 683 emergency ambulances known as "108" are operational in 248 blocks of 33 districts of the state. "108" ambulance was launched in 2008. Dedicated to the transportation of pregnant women and to promote institutional deliveries, 600 Janani Express vehicles are operational in the state. **BPL Five-Litre Desi Ghee Scheme:** Five litres of desi ghee coupon given to women of BPL families upon their delivery in government institution. The scheme is functional since 2009. **Mother and Child Health and Nutrition Days (MCHN):** Emphasising the need for routine immunisation along with awareness on nutrition, sessions on MNCH days are organised in the state.	**Shala Darshan (SD):** SD has been implemented to collect basic information and statistical data from elementary schools. The data includes number of teachers, students, physical infrastructure etc. In 2016, SD was replaced by SD—a portal created by National Informatics Centre (NIC). **Sambalan Abhiyan (SA):** Since 2012–2013, SA supervises teaching learning process and learning outcomes especially in subjects such as Hindi, English, and mathematics. Remedial teaching is undertaken, where learning gaps are identified. SA also reviews the school environment, HR, and physical infrastructure. The reading campaign providing remedial learning was organised by the state for classes I–VIII students, as it found gaps in reading abilities of children under Sambalan Abhiyan. **Activities for Children with Special needs (CWSN):** CWSN were provided with polio corrective and sight restoration surgeries, where required. Additionally, braille books, large print books and transport as well as escort allowance is given to CWSN to improve their accessibility to school.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
2015–2016	**PCI:** ₹83,423 **PCI Ranking:** 21st among all states in India **GSDP Growth Rate:** 10% **GSDP:** ₹6.7 lakh crore **GSDP Ranking:** Eighth among all states in India	**National Medical Mobile Units (MMUs):** MMU has been operational in the state to provide basic health care facility in the tribal, desert, and inaccessible areas of the state. Additionally, to improve health access 741 emergency ambulances known as "108" and 600 Janani Express are operational in the state. **Mukhya Mantri BPL Jeevan Raksha Kosh:** The scheme provides OPD and IPD care facilities free of cost to 16 categories of families and BPL families in the state. **Mukhyamantri Nishulk Dava Yojana (MNDY):** MMND began in 2011. Rajasthan Medical Services Corporation (RMSC) procures drugs through tendering and then supplies the drugs to district warehouses. These drugs, including surgical and sutures, are provided free of cost for OPD and IPD patients seeking health care in government facilities in the state. ₹224 crore was spent under MNDY till December 2015. **Mukhyamantri Nishulk Jaanch Yojana (MNJY):** MNJY was introduced in 2013. It not only provides free health diagnostics and investigations to the patients in government facilities, it also strengthens existing laboratories and diagnostic facilities of public health institutions. Over 90 million investigations were conducted in 2015–2016. (December, 2015) Janani Suraksha Yojna, Janani Shishu Suraksha Yojna, and RBSK are few other schemes implemented in Rajasthan to provide better health care facility to women and children.	**Sambalan Abhiyan:** SA monitors school and has been introduced since 2012–2013. It aims at supervision of status of physical and HR, school environment, teaching-learning process, and learning levels of students. **Shala Darshan:** SD is a database that collects information from schools run by government at village, block or district level. It is a digital system where schools enter the necessary information through login. **Activities for Children with Special needs (CWSN):** CWSN were provided with braille books, large print books, various aids appliances, corrective surgeries and also given transport or escort allowance to improve their accessibility to school. To promote girls' education in the state, 200 KGBVs are functional. Dropout girls as well as never-enrolled girls, are provided with a condensed course including basic competencies, to prepare them to catch up with learning levels of Grade VI. Ten Mewat Balika Awasiya Vidyalaya are running in Alwar district, emphasising education of girls and the schools run in Alwar district, which is part of Mewat region, which is educationally backward region. Similarly, Meena Manch, Adhyapika Manch, and Academic Mela have been successfully implemented in for improving the learning quality and providing conducive school environment.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
2016–2017	**PCI:** ₹90,447 **PCI Ranking:** 21st among all states in India **GSDP:** ₹7.49 lakh crore **Growth Rate:** 11.5% **GSDP Ranking**: Eighth among all states in India	**National Mental Health Programme (NMHP):** NMHP, launched in 2014–2015, is now implemented in all 33 districts of Rajasthan of 2016–2017 and it provides health facilities through OPDs and camp modes to the patients. Capacity building of health staff has been also undertaken under NMHP. **National Oral Health Programme (NOHP):** NOHP is implemented in all 33 districts of Rajasthan and emphasises on improving oral health of people. **Family Welfare Programme:** With the objectives of population stabilisation and reduction in maternal and child deaths, population stabilisation and family welfare programmes is being implemented in the state. **Immunisation Programme:** To reduce IMR and to provide safeguards to infants and pregnant women against serious diseases, an intensive immunisation program is being implemented throughout the state **Mukhyamantri Nishulk Dava Yojna (MNDY):** Under the scheme, all outdoor and indoor patients are provided essential medicines, free of cost. **Bhamashah Swasthya Bima Yojana (BSBY):** BSBY was launched in December 2015 in Rajasthan, providing free health coverage to 9.7 million families. These families were identified under National Food Security Act (2013) providing them coverage of ₹30,000 to ₹3 lakh per family annually. One of the unique features of BSBY is absence of Third-party administrator in the scheme.	**Sarva Shiksha Abhiyan (SSA):** SSA is being implemented in the state to provide education to children in the age group of six to 14 years. This also includes activities to bridge social, regional and gender gaps with the help of public participation in school management. **Utkrishta Vidyalaya Yojana:** One primary/upper primary school in every GP is designated as "Utkrishta Vidyalaya," to be developed as "centre of excellence" for elementary education. Adarsh Schools acts as resource centre for Utkrishta Vidyalaya. **Activities for Children with Special needs (CWSN):** CWSN were provided with braille books, large print books and also given transport or escort allowance to improve their accessibility to school. **Kasturba Gandhi Balika Vidyalaya (KGBV):** To promote girls' education in the state and bring back dropout girls as well as never enrolled girls, KGBV were established with the assistance of the centre. The girls are provided with a condensed course including basic competencies, to prepare them to catch up with learning levels of class VI. To promote girls' education in the state, 10 Mewat Balika Awasiya Vidyalaya are running and similarly Meena Manch, Adhyapika Manch, and Academic Mela have been successfully implemented.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
		Nishulk Sanitary Napkin Distribution Scheme: Rajasthan has started a scheme for free distribution of sanitary napkins to all school going girls of classes IV–XII of rural areas and non-school going girls of 10 to 19 years age of BPL families. The scheme will not only benefit adolescent girls by improving their school attendance, but would also reduce IMR and MMR in rural areas long-term. **Mukhyamantri Nishulk Jaanch Yojana (MNJY):** MNJY not only provides free health diagnostics and investigations to the patients in government facilities, it also strengthens existing laboratories and diagnostic facilities of public health institutions. **Adarsh PHC:** The Adarsh PHC scheme has been launched in 2016, to facilitate quality care in rural areas. Accordingly, 295 PHCs are marked as "Adarsh," with every block having one Adarsh PHC. The scheme intends to fill the HR, equipment and supplies gap, as through e-Aushadi portal, all the data at is integrated and monitored at state level. **PHC on PPP Mode:** Seventy-seven PHCs out of the 243 PHC's listed in tender are functioning on PPP mode in the state. The PHC's contract renewal is based on their performance. Apart from PHCs, in selected few district and sub-district hospitals facilities such as CT scan, MRI, and haemodialysis are also functioning on PPP mode.	

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
2017–2018	**PCI:** ₹1,00,551 **PCI Rank:** 21st among all states in India **GSDP:** ₹8.4 lakh crore **Growth Rate:** 11% **GSDP Rank:** Eighth among all states in India	**The National Health Mission (NHM):** NHM is a national intervention for ensuring provisions of effective health care through a range of interventions at individual, household, community, and critically at the health system levels. The mission focuses on rural as well as urban health. **Bhamashah Swasthya Bima Yojana (BSBY):** Launched in December 2015 in Rajasthan, BSBY completed its first phase on December 2017. The Phase 2 of BSBY provides expanded coverage of disease packages, beneficiaries and empanelled hospitals providing free health coverage to eligible families MNDY are being implemented in the state with the aim of providing free medicine in the government health facilities. Medicines are available for outdoor patients according to OPD timings and 24 hours for indoor and emergency patients. **Mukhyamantri Nishulk Jaanch Yojana (MNJY):** Similarly free diagnostics facility is available in the state under MNJY. **Adarsh Primary Health Centre:** Along with 295 Adarsh PHCs identified in first phase, additionally 286 PHCs are identified and transformed into Adarsh PHC in 2017, catering to the health care needs of rural population. **Health Services in PPP Mode:** As of December 2017, 52 PHCs were running in partnership with private entities. In tertiary care facilities, along with MRI, CT scan and Haemodialysis, IVF facilities are also introduced in PPP mode. With the objectives of population stabilisation and reduction in maternal and child deaths, family welfare programmes are being implemented in the state.	**Sarva Shiksha Abhiyan (SSA):** SSA is being implemented in the state to provide education to children in the age group of six to 14 years. This also includes activities to bridge social, regional, and gender gaps with the help of public participation in school management. Right to Free and Compulsory Education Act, 2009 is being implemented in the state since April 1, 2010. Twenty-five per cent seats are reserved in private schools for boys/girls of weaker sections and disadvantaged groups. 5.35 lakh children including 1.17 lakh new admissions have been upgraded and newly admitted on free seats of private schools in the year 2017–2018. **Swami Vivekanand Government Model Schools:** In 134 Educationally Backward Blocks, Swami Vivekanand Government Model Schools have been setup which are CBSE affiliated in English medium schools. **Adarsh School:** In every GP, at least one secondary/senior secondary Adarsh school is being established. While 9,895 Adarsh Schools will be created in rural areas, 281 Adarsh Schools will also be developed in urban areas. Adarsh school act as "mentor schools" to Utkrisht Vidyalaya. **Utkrishta Vidyalaya Yojana:** 62 schools under Utkrishta Vidyalaya Yojana were merged. In 2017–2018, 9,659 schools were functioning against 9,631 schools in the year 2016–2017. Nine Mewat Balika Awasiya Vidhalaya and 200 KGBV are functional in the state benefitting over 10,000 female students. Similarly, Meena Manch, Adhyapika Manch and Academic Kishori Mela are successfully running in the state.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
2018–2019	**PCI**: ₹1,09,105 **Ranking**: 21st among all states in India **GSDP**: ₹9.2 lakh crore **Growth Rate**: 11% **GSDP Ranking**: Eighth among all states in India	**Rajasthan Janani Shishu Suraksha Yojna (JSSY):** To reduce the IMR and high mortality rate of women during childbirth, GoR is implementing the scheme in the state. It provides various medical facilities for pregnant women and newborn children. **Mukhyamantri Nishulk Dava Yojana (MNDY):** Essential drugs comprising of 608 medicines, 77 sutures, and 147 surgical items are being provided free of cost across government hospitals/public health institutions in the state. Under this scheme, medicines are available for outdoor patients during OPD timings and are available 24 hours for indoor and emergency patients. Additionally, medicines for the treatment of critical and severe disease are also available. **Mukhyamantri Nishulk Jaanch Yojana (MNJY)** MNJY not only provides free health diagnostics and investigations to the patients in government facilities, it also strengthens existing laboratories and diagnostic facilities of public health institutions. Nearly 120 million people benefitted under MNJY in 2018–2019. **Nishulk Sanitary Napkins Distribution Scheme:** The scheme is being implemented in the state which provides free distribution of sanitary napkins to all school going girls of classes VI –XII of rural areas and non-school going girls of 10–19 years age. Under this scheme, there is a provision to distribute 12 sanitary napkins free of cost to each girl per month. Population stabilisation and reduction in maternal and child deaths. Population stabilisation and family welfare programmes are being implemented in the state. Under this scheme Intrauterine devices (IUDs), Post Placental IUCDs (PPIUCDs) and oral contraceptives are provided along with facility for sterilisation. BSBY is being implemented in the state to provide cashless health care services to the poor families of Rajasthan.	**Free Textbook Distribution Scheme:** The State government is providing free textbooks to the students studying regularly in classes I–VIII in all government schools through the State Textbook Board, Jaipur. **Anganwadi Integration:** 37,444 anganwadi centres are linked with government schools, providing pre-primary education and health facilities for children aged three to six years old. According to Right to Free and Compulsory Education Act, 2009, 25% of seats in private schools are required to be reserved for boys/girls of weaker sections and disadvantaged groups. To promote education of girls, 318 KGBVs and 10 Mewat Balika Awasiya Vidyalaya are functional in the state. Pre-matric scholarship is being provided to SC, ST, Other Backward Classes (OBC), Special Backward Classes (SBC) and Denotified Tribes, and Nomadic Tribes (DTNT) of marginal areas (OBC). In 2018–2019, scholarships worth ₹3,828 lakh were given to students. **Transport Vouchers:** To improve access to schools for rural children, transport vouchers are provided to children of classes I to VIII. **Utkrishta Vidyalaya Yojana:** In 2018–2019, 8,839 Utkrishta schools were running in the state against 9,659 schools in 2017–2018 and 9,631 schools in the year 2016–2017.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
		Adarsh Primary Health Centre: Along with 295 Adarsh PHCs identified in first phase, in Phase 2 i.e., by 2018–2019 596 PHCs were transformed into Adarsh PHCs treating over 120 million patients every month and conducting 8,000–9,000 deliveries. The number of PHC's running under PPP mode has expanded to 84 PHC in 2018–2019, previously there were 52 PHCs under PPP.	**Adarsh Schools:** 5,590 schools in rural and 197 schools in urban areas have been developed as Adarsh schools. Activities for CWSN during the year 2018–2019, apart from providing books, transport allowance, the State government provided training to the children to operate mobiles and laptops. **Akshay Patika:** Akshay Patika is a platform established in over 59,000 schools where teachers, parents and donors can donate the money for school's routine work. The use of grants under Akshay Patika needs approval of School Development and Management Committee (SDMC) or SMC.
2019–2020	**PCI:** ₹1,18,159 **PCI Ranking:** 21st among all states in India **GSDP:** ₹10 lakh crore **Growth Rate:** 8.32% **GSDP Ranking:** Eighth among all states in India	**Ayushman Bharat–Mahatma Gandhi Rajasthan Swasthya Bima Yojana (AB–MGRSBY)** AB–MGRSBY has been launched on September 1, 2019 in the state with the objective of providing cashless health care services to the poor families (under NFSA-2013 and selected families of SECC 2011) of Rajasthan. Under the scheme, Health Insurance cover of 30,000 (for general illnesses) and of ₹3 lakh (for critical illnesses) per family per year is provided on floater basis. A covered family can avail IPD treatment in any of the empanelled private facility (996 private) or government facility (519 government health facilities) under the scheme. **Nirogi Rajasthan Abhiyan:** GoR has launched Nirogi Rajasthan Abhiyan on December 17, 2019, on the first anniversary of the State government. The scheme focuses on improving the health of all the citizens of Rajasthan. It aims to improve adolescent, geriatric health as well as emphasise on reduction of non-communicable diseases.	**Mahatma Gandhi (MG) English Medium Schools** The State government converted English medium schools into Mahatma Gandhi Government Schools for Classes I–VIII in the first phase, which began on October 2, 2019. Initially, 33 schools were launched, with one MG English Medium school in every district. **Utkrisht Schools:** Formed as "centre of excellence" on the lines of Adarsh Vidyalaya, in 2019–2020 the state has 8,839 Utkrisht Schools.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
		Nishulk Sanitary Napkins Distribution Scheme: It is being implemented in the state which provides free distribution of sanitary napkins to all school going girls of classes VI–XII of rural areas and non-school going girls of 10 to 19 years of age. Under this scheme, there is a provision to distribute 12 sanitary napkins free of cost to each girl per month. By December 2020, the state had distributed sanitary napkins worth ₹12 crore to the girls. **Adarsh PHC:** In 2019–2020, the state has over 800 clinics facilitating quality care in rural areas. The scheme intends to fill the HR, equipment and supplies gap. The year 2019–20 saw 5% rise in OPD patients availing health services at the clinic. **Janta Clinics (JCs):** On December 18, 2019, the first JC was opened in Jaipur, whereas 11 more JC were to be operational in state capital and 3 in Jodhpur by 2019–2020. JC provides access to primary health (PH) facilities in densely populated urban areas. **PPP:** In 2019–2020, 73 PHCs were running on PPP mode in the state, which is decline from 84 in the previous year. The state continues to provide CT scan and haemodialysis facility as well as IVF treatment on PPP mode, the is provided at reduced rate for general people and free of cost for poor people. Besides above health schemes, MNDY and MNJY provide free of cost medicines and diagnostic facilities in any government health institution in the state. To reduce the IMR and MMR, Rajasthan JSSY is implemented in the state providing free medical and other facilities to pregnant women and newborn children.	**Akshay Patika:** This platform established for receiving donation to schools by donors, teachers, and parents is operational in more than 62,000 schools of the state. **Gyan Sankalp Portal:** It in an online platform that enables donor or CSR funds to be donated in Mukhyamantri Gyankosh. The donations are channelised in primary and secondary schools. The portal was initiated since 2017. **Shala Darpan** This is an online platform, where every government school feeds information on students, working personnel, scholarships, distribution of laptops, etc. The state is endeavouring to achieve the objective of total literacy and quality education through various programmes/schemes like Samagra Shiksha Abhiyan, Continuing Education Programme & Saakshar Bharat Mission. Right to Free and Compulsory Education Act, 2009 is being implemented in the state since April1, 2010. As per the provisions of the Act, 25% seats are reserved in private schools for boys/girls of weaker sections and disadvantaged groups. **Free Textbook Distribution Scheme:** Under the scheme, the State government is providing free textbooks to the students studying regularly in classes I–VIII in all government schools through the State Textbook Board, Jaipur. In 2019–2020, textbooks worth ₹45.66 crore were distributed in government schools. Pre-matric scholarship is being provided to SC, ST, OBC, SBC, and DTNT marginal area (OBC) students. To promote girls' education in the state, 319 KGBVs are functional and 10 Mewat Awasiya Balika schools operate in Alwar district.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
2020–2021	**PCI:** ₹1,09,386 **PCI ranking:** 21st among Indian states **GSDP:** ₹9.5 lakh crore **GSDP Growth rate:** -4.11% **GSDP Ranking:** Eighth among all Indian states	**Ayushman Bharat-Mahatma Gandhi Rajasthan Swasthaya Bima Yojana (AB–MGRSBY):** AB–MGRSBY was launched on September 1, 2019 in the state. The new phase of the scheme started from January 30, 2021. An MoU has been executed between Rajasthan State Health Assurance Agency and The New India Assurance Agency on January 14, 2021. Around ₹1,750 crore per annum will be spend on the scheme. Sum insured has been increased from ₹3.30 lakh to ₹5 lakh per family per year in the new phase. This cover shall be segmented into ₹50,000 fwor secondary illnesses and ₹4.50 lakh for tertiary illness per family per annum on family floater basis. **Nishulk Sanitary Napkins Distribution Scheme:** GoR started Nishulk Sanitary Napkins Distribution Scheme for free distribution of sanitary napkins to all school going girls of classes VI–XII of rural areas and non-school going girls of 10 to 19 years age. Under this scheme, there is a provision to distribute 12 sanitary napkins free of cost to each girl per month. Sanitary napkins worth ₹12 crore were distributed by State government between 2020–2021 (Up to December 2020). **Rajasthan Janani Shishu Suraksha Yojana (RJSSY):** To reduce the IMR and high mortality rate of women during childbirth, the State government is implementing the Rajasthan JSSY in the state. Under the scheme, free medical and other facilities are being provided to pregnant women and newborn children. **Measures for Mitigating COVID-19:** For COVID-19, various measures for prevention, control, treatment, investigation (contact tracing), and dissemination of information in the state were taken up. As part of active and passive surveillance, door-to-door surveys were conducted and OPD in clinics were screened since March 2020. There were 60 labs across all the districts in the state which had RTPCR testing facility for detection of COVID-19, which had a cumulative daily testing capacity of 65,886 tests. A total of 117 RTPCR machines were available for testing. In state labs, COVID-19 was being tested for free and the department set a ceiling amount of ₹800 for testing in private labs.	**Right to Free and Compulsory Education Act:** During the financial year 2020–2021 income limit has increased ₹1 lakh to ₹2.50 lakh for admission of 25% seats in private schools under section of 12(G) under RTE Act 2009. An amount of ₹226.48 crore has been reimbursed in year 2020–2021 upto December 2020 to these schools by the State government. **Samagra Shiksha:** Under Samagra Shiksha, universalisation of Elementary and Secondary Education is envisioned a time bound manner. It supports states to implement RTE. **Free Textbook Distribution Scheme:** During the financial year 2020–2021, a total amount of textbooks worth ₹38.70 crore has been distributed successfully in the State government schools. **Mid-Day Meal Scheme During COVID:** Under the Mid-day Meal Scheme, it has been decided to distribute food grains (wheat/rice) and chana dal to the Parents/Guardians of students studying in classes I–VIII in government schools, Madrasas and Special training centres for the period of school closure due to COVID-19. **Digital Classes:** In view of the adversity of circumstances created by COVID-19, a unique initiative has been taken by the department for a stable provision to facilitate education to the students by conducting digital online classes for the students of classes VI–XII across the state as an innovative action. **WhatsApp groups for CWSN:** Various WhatsApp groups were created such as "State Resource Group for Online Learning of CWSN," "District Online Learning Group of CWSN," and "Block Online Learning Group of CWSN" were created to connect special teacher/resource person (CWSN) to the CWSN.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
		Provisions were made to provide incentive amount by the State government to the doctors (₹5,000), paramedical staff (₹2,500), and other personnel (₹2,500) engaged in tracing and treatment of those infected and suspected of the COVID-19. **PPP:** 70 PHCs in 2020–2021 were running under PPP mode. Facilities such as CT scan and Haemodialysis as well as IVF treatment are provided in PPP mode by the state. 891 Adarsh PHCs are functional in rural areas providing high quality primary care to the rural population, whereas in Urban, 12 Janata clinics, caters to the needs of the urban poor population. Under State governments' MNDY and MNJY, people can avail free medicines and diagnostics facilities. In 2020, every day 0.125 to 0.15 million free investigations were conducted in the state. Apart from above health schemes, the state continues to operate National Oral Health and NMHP in the state. The state has high presence of fluoride in water, therefore National Fluorosis Control and prevention programme (NFP) is also functional in 30 districts of the state.	Similarly, Shikshadarshan program was telecasted daily for three and a quarter hours (12:30–2:30 p.m. and 3:00 to 4:15 p.m.) for all classes on Doordarshan Rajasthan and during lockdown period, audio teaching material was broadcasted for 55 minutes daily through "Akashvani" till June 30, 2020. **Shala Darpan:** Shala Darpan, an integrated school management online platform, provides information on students, working personnel, scholarships, distribution of laptops, pre-metric scholarships etc. **Gyan Sankalp:** Gyan Sankalp facilitates smooth transfer of funds from donors to 64,000 schools in the state through Mukhya Mantri Gyankosh. **No-Bag Day:** To enable overall development of child and making the learning joyful, Saturdays are observed as "No-Bag Days" in schools. In December 2020, there were 134 Swami Vivekanada English Medium Schools and 1,680 MG English Medium Schools in the state. Similarly, 10,175 Adarsh Schools and 8,592 Utkrisht schools are functional in the state. **Activities/Scheme for Female and Marginalised Students:** 37,554 girls (dropouts and never enrolled) are studying in 319 KGBV schools in the state, whereas 395 female students continue to be educated in nine Mewat Balika Vidyalaya. Pre-Matric Scholarship worth ₹580 lakh was distributed to the students of SC, ST, OBC, SBC, and DTNT marginal areas (OBC) up to December 2020. CWSN studying in government or government aided schools are provided with transport and reader allowance, female students are provided with a stipend. All CSWN students, in the above schools are trained in using laptop.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
2021–2022	**PCI:** ₹1,35, 218 **PCI ranking:** 21st among all Indian states **GSDP:** ₹11.96 lakh crore **GSDP growth rate:** 18.04% **GSDP ranking:** Eighth among all Indian states	**Mukhyamantri Chiranjeevi Swasthya Bima Yojana (MMCSBY):** Launched on May 1, 2021 in Rajasthan, MMCSBY envisages to provide health insurance coverage to the entire population of the state. Under the scheme families of NFSA, SECC, small and marginal farmers, contractual workers and beneficiaries of COVID-19 ex-gratia scheme have been given free of cost health insurance. The rest of the population can avail the scheme by paying a small amount of ₹850 per family per year which is 50% of the premium cost to the government. The remaining 50% premium cost is being borne by the State Government. **Nirogi Rajasthan Abhiyan:** GoR launched Nirogi Rajasthan Abhiyan on December 17, 2019, emphasising improvement in the health of all the citizens of Rajasthan. Under Nirogi Rajasthan Abhiyan, a female and male volunteer person is identified as "Swasthya Mitra" in every urban ward and revenue village. Swasthya Mitra will encourage the public to attend Chiranjeevi health camps and avail health facilities related to NCDs, CDs, geriatric, gynaecological issues, vaccination, immunisation, etc. **Mukhyamantri Nishulk Dava Yojana (MNDY):** Launched in 2011, MNDY provides free medicines in all government health facilities including medical colleges. RMSCL, a state-level procurement agency, purchases medicines, surgical and sutures, supplying it to District Drug Warehouses located in every district of the state. Along with the already listed medicines, COVID related medicines were also distributed under MNDY. In 2021–2022, ₹760 crore was spent under the scheme. **Mukhyamantri Nishulk Jaanch Yojana (MNJY):** Under MNJY, everyday up to 0.125–0.15 million free health diagnostics and investigations are undertaken. Till December 2021, over 17 crore people in the state benefited from the scheme.	**Model Schools:** Apart from Utkrishta and Adarsh Vidyalaya schools, out of 186 economically backward blocks (EBBs) of Rajasthan, in 136 blocks Swami Vivekananda Schools are functional. These are also English Medium Schools launched in 2015–2016. **No-Bag Day:** To enable overall development of child and making the learning joyful, Saturdays are marked as "No-Bag Days" in schools. **Creating a Safe School Environment:** The State government in 2021–2022, endeavoured to make school spaces safe for children by using IEC display, that will provide information on "safe touch and unsafe touch" as well as "child crime." Every school Is allocated with ₹1,500 for the activity. Similarly, the efforts have been also made to provide training on "online safety and digital learning" in schools. **Mid-Day Meal Scheme:** As the schools were closed due to COVID-19, food grains (wheat/rice) were distributed to the parents/ guardians of students studying in classes I–VIII in government schools, madrasas and Special training centres. Combo packets (spices, pulses and oil) were distributed to the Parents/Guardians of students in a phased manner under mid-day meal scheme. **Right to Free and Compulsory Education Act:** In financial Year 2020–2021 income limit has increased from 1 lakh to 2.50 lakh for admission of 25% seats in private schools under RTE Act 2009. An amount of ₹125.66 crore has been reimbursed in year 2021–2022, to these schools by the State government. **The Free Textbook Distribution Scheme:** In the year 2021–2022, textbooks worth ₹64.40 crore has been distributed successfully in all the state government schools up to December 2021.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
		Adarsh Health Centres: While JCs catered to the urban population, Adarsh PHC provide high quality health services in rural areas. Along with providing regular health treatment, these centres also conduct 8,000 deliveries per month. For rural PHCs, 37% were converted into Adarsh Health centres, whereas 199 CHCs are identified to be transformed as model CHCs. **Public-Private Partnership (PPP):** Apart from 39 PHCs running under PPP mode, 29 DHs and one sub-DH have Haemodialysis and CT scan facility, operated by private partners under PPP model. MRI testing facility and IVF facilities are also provided under PPP model in selected DHs of the state. **IM Shakti Udaan Scheme:** Under the Udaan Scheme, menstrual health and hygiene is prioritised for women in reproductive age by providing them with free sanitary napkins, creating awareness around menstrual health and encouraging SHGs, CSOs and NGOs to uptake Menstrual health and hygiene management activities. **National Flurosis Control and Prevention Programme:** All 33 districts of Rajasthan are affected by Fluorosis, where 30 districts are covered under NFP. The investigation and treatment of fluorosis in the state has benefited over 30,000 potential patients. **National Mental Health Programme (NMHP):** Ninety-five lakh rupees were spent on NMHP in the year 2021–2022, where patients were screened through OPD clinics, health camps and in different health facilities. To improve capacity of doctors and para medics training session were also undertaken. **National Oral Health Programme (NOHP):** The GoI is supporting the state of Rajasthan for running NOHP since 2014–2015. In the year 2021–2022, ₹115 lakh were allotted to the state. The idea is to reduce inequality primary health care services, in rural and urban areas. In view of the outrage of COVID-19 being declared as an international public health emergency by the World Health Organization (WHO) and subsequent guidelines pertaining to the pandemic being received from Ministry of Health, GoI, various measures for prevention, control, treatment, investigation (contact tracing), and dissemination of information in the state were adopted.	**Mahatma Gandhi (MG) English Medium Schools:** The State government converted English medium schools into Mahatma Gandhi Government Schools for classes I–XII, since 2019–2020 onwards. In 2021–2022, a total of 551 MGGS (English Medium) schools were functioning in the state. **Health Education Programme:** Under this program, the health check-up of students studying in government and non-government schools is conducted in co-ordination with Department of Health and Family Welfare. A separate programme of anaemia control for teenage girls (10–19 years), is run by UNICEF in the state. **Shala Darpan:** Shala Darpan portal provides information of all government schools, educational offices, education related schemes, list of beneficiaries, details of all activities conducted in schools, etc. **Gyan Sankalp Portal:** Gyan Sankalp portal enables CSR funds and donors to streamline their donation for the government schools. In 2021–2022, ₹28 crore was donated through this portal. **Kasturba Gandhi Balika Vidyalaya (KGBV):** 316 KGBVs are functional in state providing education to over 38,000 girls. **Pre-Metric Scholarship:** Students belonging to SC, ST, OBC, SBC, and DTNT marginal area (OBC) received scholarship of ₹170.51 lakh by December 2021. Along with pre-metric scholarships, the state runs various programmes/ schemes like Samagra Shiksha Abhiyan, Continuing Education Programme, and Saakshar Bharat Mission for promoting total literacy and quality education.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
2022–2023	**PCI:** ₹1,56,149 **PCI ranking:** 21st among all Indian states **GSDP**: ₹14.13 lakh crore **GSDP growth rate:** 16.04% **GSDP ranking:** Eighth among all Indian states	**Mukhyamantri Chiranjeevi Swasthaya Bima Yojana (MMCSBY):** Moving towards achieving the goal of Universal Health Care, as defined by Sustainable Development Goals, Rajasthan launched MMCSBY in May 2021 which provides health insurance coverage to the entire population of the state. **Adarsh PHC/CHC:** On the lines 750 Adarsh PHCs functioning in rural areas, 180 CHCs are also developed as Adarsh CHC in the year 2022–2023. **Janta Clinics (JCs):** JCs provide high-quality primary health care services to urban poor's & vulnerable population of the state in the proximity of slum areas. Twenty-five JCs are operational in the state and an additional 47 clinics were approved under Prime Minister-Ayushman Bharat Health Infrastructure Mission, 2022. **Mukhyamantri Nishulk Nirogi Rajasthan Yojana (MNNRY):** MNNRY has been started from May 1, 2022 as an expansion of the MNDY and MNJY. Under this scheme, all indoor and outdoor patients visiting Medical colleges attached Hospitals, DHs, CHCs, PHCs and Sub-Centres are provided essential medicines and check-up facilities free of cost. Apart from the above schemes, 27 PHCs are being operated in the state on PPP mode. In selected district and sub-district health facilities, MRI, CT scan and IVF is also provided under PPP mode. The state is also focusing on reducing food adulteration under Shudh ke liye Yudh Abhiyan since 2020.	**Right to Free and Compulsory Education Act, 2009:** The Act is being implemented in the state since April 1, 2010. In this Act, 25% seats are reserved in private schools for boys/girls of weaker sections and disadvantaged groups. An amount of ₹416 crore has been reimbursed to these schools by the State government for the first and second instalment of 2021–2022 (up to November 2022). **Mukhyamantri Free Uniform Distribution Scheme:** Students of classes I–VIII are provided with two sets of uniform fabric along with stitching charges. The scheme was introduced in 2021–2022. **Workbooks:** To enable students to catch up post COVID-19, workbooks for of all subjects were provided to students in classes I–II, and Hindi, English and Mathematics workbooks for students in classes III–VIII by the Rajasthan Council of School Education. **Model Schools:** Swami Vivekanand government model schools are functional in 134 EBB in the state. In 2021–2022, there were 136 model schools. Activities for CWSN— CWSN of classes I–XII are actively included into the mainstream education by providing them Medical, Functional and Educational assistance. The activities encourage students to learn while the focus is on prevention. As of December 2022, 40,460 girls were studying in 316 KGBVs. In November, 2022, pre-metric scholarships worth, ₹305.08 lakh were provided to the students belonging to SC, ST, OBC, SBC, and other tribal groups. Under Free Textbook Distribution Scheme, students studying regularly in classes I–VIII in all government schools of the states were provided with textbooks. By November 2022, textbooks worth ₹50.53 crore had been distributed.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
		Rajasthan Janani Shishu Suraksha Yojana (RJSSY): Under the RJSSY, free medical, lab-tests, food, blood facilities, referral transport, etc. are provided to pregnant women and newborn children. During the year 2022–2023, over 2.3 million pregnant women availed free medicine, and 0.9 million pregnant women availed lab tests, 0.4 million pregnant women were picked or dropped through free transport facility and 48,000 pregnant women availed blood transfusion services. Similarly, over 0.3 million children benefitted by blood transfusion and other services under the scheme.	
2023–2024	**PCI**: ₹1,67,964 **PCI ranking:** 21st among all Indian states **GSDP:** ₹15.28 lakh crore **GSDP growth rate:** 12.56% **GSDP Ranking:** Eighth among all Indian states	**Ayushman Arogya Mandir:** As per National Health Policy (NHP)-2017, to strengthen the primary health care services, GoI transformed all the sub- health centres and PHCs into Ayushman Arogya Mandirs under Ayushman Bharat Yojana. As of March 2024, 9,391 Ayushman Arogya Mandir are operational in the state which includes 292 UPHC and 246 U-AAM. **Mukhya Mantri Ayushman Arogya Yojana (MAA Yojana**): This scheme, which began in January 2023, provides health coverage to families against high health care costs by offering cashless treatment to eligible beneficiaries at government as well as private empanelled hospitals for a wide range of medical services. Cashless treatment amounting to ₹25 lakh per family per year is being provided under the scheme. **Rajasthan Government Health Scheme (RGHS)**: Cashless medicine facility is provided under RGHS to all RGHS registered beneficiary on all CONFED medical stores and at more than 4,000 private empanelled pharma stores. The scheme includes ministers, ex-MLAs, all state government employees, etc.	**Right to Free and Compulsory Education Act, 2009:** The Act is being implemented in the state since April 1, 2010. In this Act, 25% seats are reserved in private schools for boys/girls of weaker sections and disadvantaged groups. The State government has developed a web portal for effective monitoring and timely reimbursement for 25% free admissions in private schools (as per state norms). **The Free Textbook Distribution Scheme:** Under the scheme the State government provides free textbooks to the students studying in classes I–VIII of government secondary and senior secondary schools, all girls studying in classes IX–XII, SC/ST boys, and to the students of low-income households, whose parents do not pay income tax. **Mukhyamantri Free Uniform Fabric Distribution Scheme:** In alignment with budget announcement for 2023–2024, two sets of free uniform fabric and stitching charges are provided to all the students studying in government schools up to class VIII. **Residential/Non-Residential Special Training:** Camps are organised for children aged 7–14, in a small group of 15–29. Students who have never enrolled in schools, have dropped out, or require special training to develop appropriate competency levels benefits from the camps.

Year	Per Capita Income (PCI), GSDP and their rankings	Primary Health Care Initiative(s)	Elementary Education Initiative(s)
		Rajasthan Janani Shishu Suraksha Yojana (RJSSY): The scheme provides free medical and transportation services to pregnant women and sick newborns in public health institutions, to reduce their OOPE. Under this scheme, apart from free-medicines and consumables, lab-tests, food, blood facilities, etc. are being provided free of cost. **Shudh ke Liye Yudh Abhiyan:** To ensure that people of the state can consume pure, unadulterated food, a state-wide campaign Shudh ke Liye Yudh Abhiyan is being conducted by the Rajasthan government since October 2020. As of 2023–2024, the state had 684 Adarsh PHCs functioning in rural areas, Shudh ke Liye Yudh Abhiyan, MNNRY, national scheme against AIDS, Flurosis, and mental health continues in state. However, the PPP in health is limited to CT scan, MRI, and IVF facility as no PHCs were running in PPP mode in 2023–2024.	**Hostels:** Similarly, seasonal hostels are established for the students to pursue their studies, whose parents migrate in search of livelihoods. Additionally, children who are poor, homeless, or orphans can avail education, living in government-run residential hostels. These are for the areas where population is scattered and does not fulfil norms of minimum population for schools. Aligning with the objective of promoting education, pre- metric scholarship is being provided to the students of SC, ST, OBC, SBC, and from other marginal communities. To bring back dropout and never enrolled girls back to school, 316 KGBVs were operating in the states. From the health point of view, Department of Health and Family Welfare also conducts health checks for primary and upper primary schools and anaemia control programme for girls.

Source: Economic Review reports of Rajasthan, 2014–2015 to 2023–2024. The PCI and GSDP represent the current prices. The details provided in this table are the Health and Education programmes underway in Rajasthan during this period and include a mix of new and ongoing state and national-level initiatives. Developed by research team member Sitara Gupta.

Appendix 1.1: Key Health-Focused State-Level Initiatives in Rajasthan, 2014–2024

This listing has been developed through KIIs with state-level bureaucracy and web search.

Table A1.1: Key Health-Focused State-Level Initiatives in Rajasthan, 2014–2024

S. No.	Name	Nature of Initiative	Years Enacted	Aims and Objectives
1	Mukhya Mantri BPL Jeevan Raksha Kosh	Government scheme	Launched in 2009	The scheme provides OPD and IPD care facilities free of cost to 16 categories of families, including BPL families in the state.
2	MMDY	Government scheme	First implemented in 2011	MNDY provides free medicines in all government health facilities, including medical colleges. RMSCL, a state level procurement agency purchases medicines, surgical and sutures, supplying it to District Drug Warehouses located in every district of the state. It intends to strengthen health systems in the state and reduce OOPE.
3	MNJY	Government scheme	First started in 2013	Similar to MMDY, free diagnostics facility is available in all State government led health facilities and intends to reduce OOPE on diagnostics and strengthen health system.
4	BSBY	Government scheme	First Implemented in 2015, the scheme was subsumed in AB–MGRSBY in 2019	The scheme provides free health coverage to 97 lakh families. These families are identified under National Food Security Act (2013) and RSBY provides health coverage of ₹30,000 to ₹3 lakh per family annually. One of the unique features of BSBY is absence of third-party administrator in the scheme.
5	Adarsh PHC	Government institution	Set up since 2016	The Adarsh PHC scheme facilitates quality care in rural areas. Every block has one Adarsh PHC. The scheme intends to fill the HR, equipment, and supplies gap.
6	'Run a PHC' scheme	Government scheme	Launched in 2016, the scheme was wrapped in 2022	To address the issue of shortage of HR in health, the State government decided to run 243 PHCs on PPP mode, where the private entity will provide HR and state would facilitate the functioning of the PHC by providing medicine, diagnostics, space, etc. Seventy-seven PHCs out of the 243 PHCs were functioning in the PPP mode in the state in the first year of the scheme.
7	Nishulk Sanitary Napkin Distribution Scheme	Government scheme	First started in 2016–2017	To offer free sanitary napkins to school going girls of classes VII–XII, in rural areas and non-school going girls of 10–19 years age of BPL families. Subsequently the scheme was expanded to all teenage girls, irrespective of the income quintile. In 2021, IM Shakti Udaan scheme was launched in the state, that provides free sanitary pads to all the women of reproductive age through schools, college and anganwadis. The nodal department of the Udaan scheme is directorate of women empowerment and implemented in collaboration with several other departments such as medical, tribal etc.

S. No.	Name	Nature of Initiative	Years Enacted	Aims and Objectives
8	AB–MGRSBY	Government scheme	September 2019 (Integrated with Pradhan Mantri Jan Arogya Yojana [PM-JAY] in September 2019)	AB–MGRSBY is a combination of AB–PMJAY and BSBY scheme. It has expanded the health coverage from ₹3 lakh to ₹5 lakh, where ₹50,000 would be for secondary illness and remaining amount for tertiary illness.
9	Nirogi Rajasthan Abhiyan	Government campaign	Launched in 2019	It endeavours to improve adolescent, geriatric health as well as emphasise on reduction of non-communicable diseases with the help of health volunteers called as Swasthya Mitra.
10	Janta Clinics	Government Institution	Set up in December, 2019	To provide primary care to citizens of Rajasthan and improve access to basic medicines and diagnostics. JCs serves the poor and vulnerable population of the state. The JCs were renamed as U-AAM in 2024.
11	Shudh ke Liye Yudh Abhiyan	Government campaign	Launched in October, 2020	To ensure that people of the state can consume pure, unadulterated food, a state-wide campaign Shudh ke Liye Yudh Abhiyan is being conducted by the Rajasthan government since October 2020.
12	Mukhyamantri Chiranjeevi Swasthaya Bima Yojana	Government scheme	May 2021	Aligning with the goal of UHC under SDG, and on the backdrop of Corona led crisis, MMCSBY was launched providing universal health insurance coverage to the entire population of the state. The health treatments initially upto ₹5 lakh and later expanded to ₹25 lakh can be availed through any of the government health facility or in private empanelled hospitals. The scheme is free for selected categories of the people, such as those under NFSA Act, marginal farmers, etc., other can avail the scheme by paying a subsidised premium of ₹850 annually per family.
13	Bike Ambulance Services	Government scheme	December, 2021	In densely populated areas of Jodhpur and Ajmer, Bike ambulance service is set up. People avail service by calling on '108' tollfree number. Bike Ambulance enables quick and easy transportation of patients to the health facility.
14	Model Immunisation Centres	Government infrastructure	2022–2023	Model immunisation centres are open in UPHC, providing child friendly environment for immunisation of children. The immunisation centres will also promote vaccination of children.
15	MAA Yojana	Government scheme	Began in January 2023	MAA Yojana provides health coverage to families against high health care costs by offering cashless treatment to eligible beneficiaries at government as well as private empanelled hospitals for a wide range of medical services. Cashless treatment amounting to ₹25 lakh per family per year is being provided under the scheme.
16	MAA vouchers	Government scheme	2024	Offers three vouchers to pregnant women, through which they can avail free sonography from a test facility in the empanelled private hospitals of the state. The MAA vouchers are expected to improve antenatal care (ANC) in women.

Appendix 1.2: Key Education-Focused State-Level Initiatives in Rajasthan, 2014–2024

This listing has been developed through KIIs with state-level bureaucracy and web search.

Table A1.2: Key Education-Focused State-Level Initiatives in Rajasthan, 2014–2024

S. No.	Name	Type	Years of Implementation	Aims and Objectives
1	Adarsh Vidyalaya Yojana	Government programme	Implemented since 2015–2016	Adarsh Vidyalaya are model schools, with one secondary or senior secondary school in every GP. While 9,895 Adarsh School were to be created in rural areas, 281 Adarsh School were to be developed in urban areas.
2	Utkrishta Vidyalaya Yojana	Government programme	Implemented since 2015–2016	One primary/upper primary school in every GP is designated as Utkrishta Vidyalaya, and is developed as "centre of excellence" for EE. Adarsh Schools acts as resource centre for Utkrishta Vidyalaya.
3	Swami Vivekananda Model schools	Government programme	Implemented since 2015–2016	In 134 Educationally Backward Blocks of the state, Swami Vivekanand Government Model Schools have been set up which are CBSE-affiliated English medium schools.
4	Textbook revision	Change in existing policy	Initiated in 2015–2016, revised in 2019	Under the recommendation of committee formed the state, the school textbooks were revised in 2015–2016, the new State government formed in 2019 reversed the previous changes.
5	SD	Government portal	Launched in 2016	SD, an existing portal that collected basic information and statistical data from elementary schools, was replaced by Shala Darpan in 2016. Darpan is created by NIC and has information ranging from teachers, students, physical infrastructure, scholarships, distributed books, laptops, activities conducted in schools, assessment reports of students etc. Every school feeds information in the portal, which is available to be reviewed and monitored at district and state level.
6	Gyan Sankalp portal	Government portal	Initiated since 2017	Gyan Sankalp Portal in an online platform that enables donor or CSR funds to be donated in Mukhyamantri Gyankosh. The donations are channelised in primary and secondary schools.
7	Anganwadi integration	Government policy	Began in 2018–2019	Active anganwadis are integrated with the campus of primary/secondary/senior secondary school. government schools are linked with 37,444 anganwadi centres, providing pre-primary education and health facilities for children aged three to six years old. Anganwadi integration is envisioned to smoothen the transition of children to school.
8	MG English Medium Schools	Government programme	Launched in 2019–2020	The State government converted English medium schools into Mahatma Gandhi Government Schools for classes I–X. Over 500 MGEM schools are functioning in the state.

S. No.	Name	Type	Years of Implementation	Aims and Objectives
9	NISHTHA 2.0 and 3.0	Government programme	Began in 2021–2022	To maintain the excellence in teaching, regular training of teachers is undertaken. In view of NEP 2020, online sessions were organised for primary (NISHTHA 2.0) and secondary (NISHTHA 3.0) school teachers.
10	Mukhyamantri Free Uniform Fabric Distribution Scheme	Government policy	Introduced in 2021–2022	Students of classes I–VIII are provided with two sets of uniform fabric along with stitching charges of ₹200 per head.
11	No-Bag Day	Change in existing policy	Launched in 2021	No-Bag Day initiative motivates students to come to school and engage in various activities, including health awareness and check-ups, sports, etc.
12	Mission Buniyaad	Government programme	Started in 2021	Mission Buniyaad intends to reduce the dropout rate among female students of classes VIII–XII and improve their learning outcome by providing them personalised reading learning material through ICTs.
13	Rajasthan ke Shiksha me Badte Kadam	Government programme	Launched in 2022	Under the remedial learning programme post COVID-19 an effort was made to improve learning outcomes and enhance teacher motivation. The students are provided competency-based workbooks, which ensures to brush-up their knowledge and skills of previous years as well.
14	Model libraries	Government programme	Began in 2022–2023	The State government provided 8.2 million books in over 67,000 elementary and secondary schools, inculcating habit of reading among students.
15	Free textbook distribution scheme	Government policy	Began in 2022–2023	The State government is providing free textbooks to the students studying regularly in classes I–VIII in all government schools through the State Textbook Board, Jaipur.
16	Mission START	Government programme	Launched in 2023	Improve access to education, especially in remote areas, and providing access to ICT labs and tech especially in schools with not enough teachers.
17	Language mapping	Change in existing policy	Introduced in 2024	Following the guidelines of NEP 2020, the RSCERT has identified 18 dialects that will be integrated into classroom teaching for classes I–V in state schools in the 2024–2025. Often, teachers speak a different language than that of children. To support such students, dictionaries and resource material is created by RSCERT and provided to teachers in Garasia, Mewari, Wagdi, etc.

Source: Collated through web-search of education and health department websites in Rajasthan, KIIs with members of the bureaucracy, research experts, and annual reports of relevant departments such as the Department of Education (DoE) and the Department of Health and Family Welfare.

Appendix 2: Detailed Methods Framework

To understand why and when Rajasthan undertook new initiatives, the following framework was employed for data collection and analysis.

Table A2.1: Data Collation and Analysis Framework

Question	Probe Area	Data Source
1) What kind of health and education initiatives were undertaken in the state between 2014 and 2024? 2) Further, analysing if the initiatives have attempted to address any specific urban primary health/education related challenge? What were the challenges that the initiative was responding to?	*Mapping the initiatives. *Origin of intent underlying the initiatives. *Objective of the initiative.	*Web search. *Review of Economic survey documents. *Review of policy documents on each of the selected initiatives. *Department annual reports in which details of initiatives are provided. *Key informant interviews (KIIs).
Identifying the origins of the initiative. Which stakeholders led it?	*Mapping of stakeholders involved in the initiative and their role in it.	*KIIs. *Listing of participants in commissions through review of commission reports.
Why was the initiative undertaken?	*Mapping of the process through which the government undertakes new initiatives. *Mapping of the process through which the specific initiatives included in this study were undertaken. *Role of stakeholders in the initiative. *Key factors which led to initiatives such as social movement pressure, instruction from political leadership, routine bureaucracy work, stand-alone bureaucratic interest, civil society/expert committee interest.	*Program and scheme .implementation documents. *KIIs.

- *Policy documents examined as part of the study:*
  - *Education: Swami Vivekananda Government Model School Guidelines, Adarsh Vidyalaya Yojana Guidelines.*
  - *Health: Policy documents on MNDY and Model Immunisation Centre.*
- *Budget documents, annual economic review documents, and other documents examined as part of the study:*
  - *Budget documents for the last 10 years.*
  - *Annual progress reports of the DoE and Department of Health and Family Welfare for three years, NHM PIP and ROP reports for 10 years, NHM's Common Review Mission's report from 2012 to 2021.*

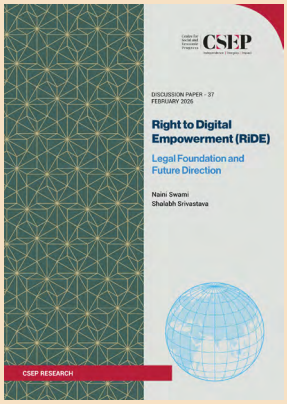
Data collection for this study was undertaken between August 2024 and October 2024. A total of 70 interviews were completed. Interviews were conducted in different phases, which included senior and junior bureaucrats in the health, education, planning, and statistics departments; district-level health and education officers; headmasters; teachers; and MOs of six PHCs. Similarly, academics, researchers, journalists, civil society leaders, local activists, and members of teacher unions also formed part of the key informants. Key questions across the categories of respondents emerged from the probe areas listed. Some of these questions included: (a) Key initiatives focused on PH/EE in recent years, (b) purpose of the initiative, (c) where did it come from, (d) key challenges in PH/EE in your understanding, (e) measures to strengthen PH/EE, and (f) most influential leader (politician, bureaucrat, NGO, etc.) in health and education.

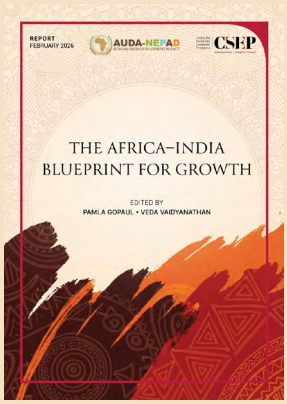
About the author

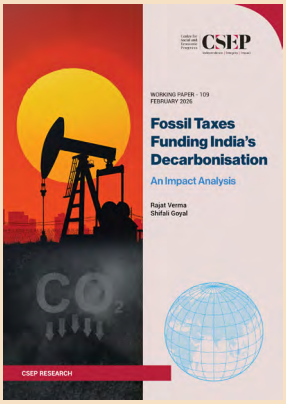
Priyadarshini Singh is a Fellow with the Human Development research program at CSEP. She has previously worked with the Centre for Policy Research, New Delhi, Ashoka University and PwC-India. She completed a PhD at the Department of Politics and International Relations at SOAS, University of London as a Felix Scholar. Her research work focuses on political economy of policy making with a focus on education, history of public institutions and grassroots political ideas and politics.

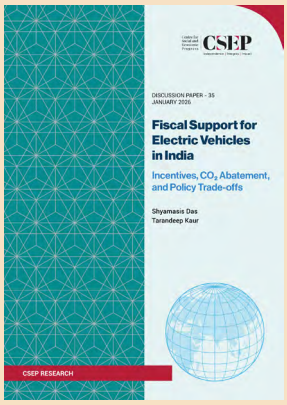
Priyadarshini is a member of the Karnataka State Education Policy Commission (2024 onwards).

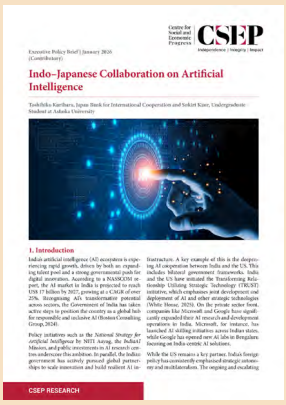
Other publications

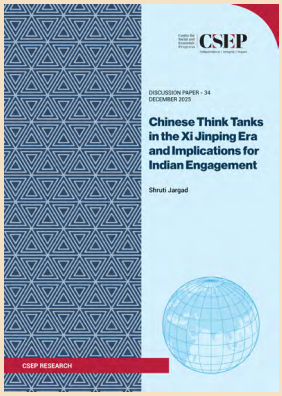


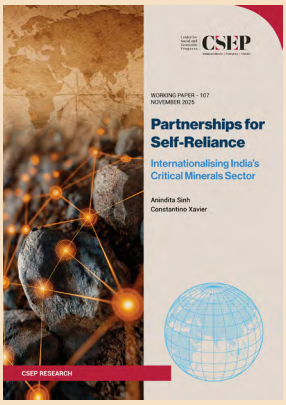


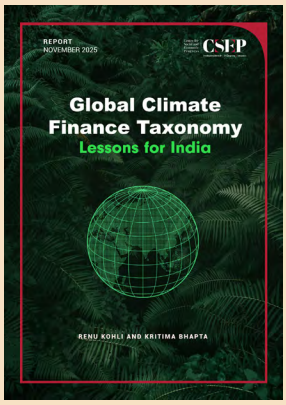


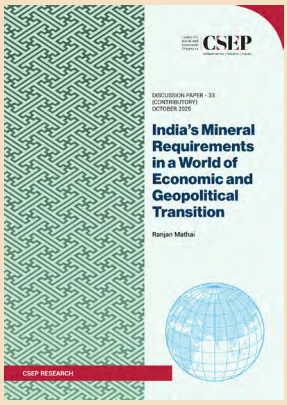


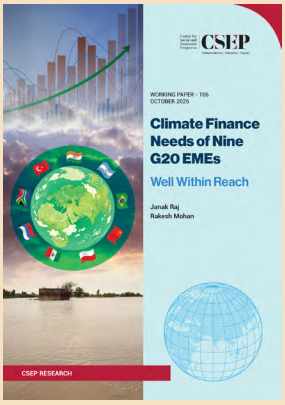


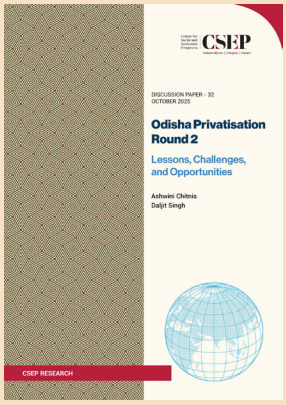


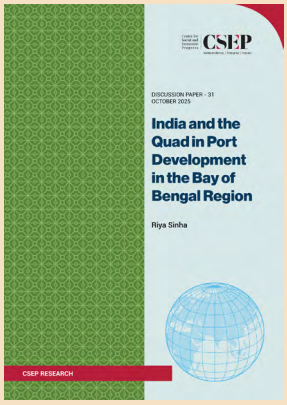


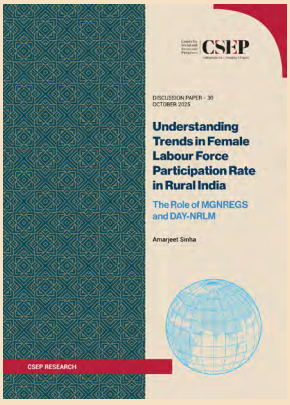












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