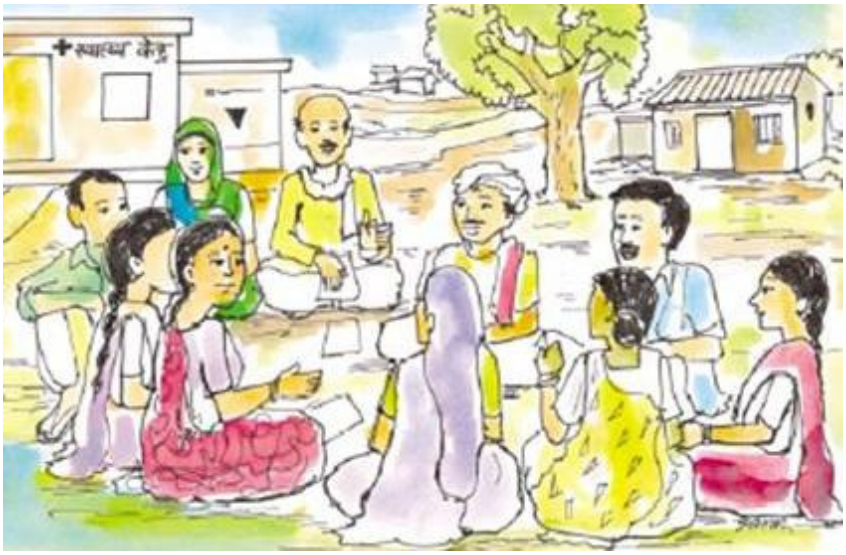
Improving Service Delivery through Measuring Rate of Absenteeism in 30 Health Centres in Tonk District of Rajasthan, India

Final Analytical Report



CUTS Centre for Consumer Action, Research and Training (CUTS CART)
in partnership with
the Result for Development (R4D) Institute

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List of Acronyms

ASHA	Accredited Social Health Activist
ANM	Adult Nurse Midwife
BPL	Below Poverty Line
CMHO	Chief Medical & Health Officer
CRC	Citizen Report Card
CHC	Community Health Centres
CMC	Community Monitoring Card
CHM	Complaints Handling Mechanisms
CUTS CART	Consumer Action, Research & Training
DPM	District Programme Manager
DLHS	District Level Household & Facility Survey
FGD	Focused Group Discussions
GO-NGO	Government Organisations-Non-GOs
JSY	Janani Suraksha Scheme
MDGs	Millennium Development Goals
NMBS	National Maternity Benefit Scheme
NRHM	National Rural Health Mission
OPD	Outpatient Department
PATP	Participatory Absenteeism Tracking Process
PHC	Primary Health Centre
R4D	Result for Development Institute
RPRIs	Representative of Panchayati Raj Institutions
PRIs	Panchayati Raj Institutions
SHGs	Self-Help Groups
VHSC	Village Health and Sanitation Committee
WHO	World Health Organisation

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EXECUTIVE SUMMARY

1.1 ABSTRCT

Delivery of various services through welfare schemes takes huge allocation of budget and expenditure in India, but the outcome is not proportionate and far below than expected. To break this phenomenon of low public expenditure outcome, which exhausts a big chunk of the taxpayers' money in vain, the Government of India is taking development as a mission. The situation is improving, but the speed is still slow. Apart from many other impediments, absenteeism is one major obstacle, especially in the area of health and education, which hampers effective delivery of services.

India is implementing the National Rural Health Mission (NRHM) for improving the health service delivery in rural areas, for which the expenditure was Rs 14000 Crore (US$3.02bn) for the financial year 2010-11. The scheme is well designed to achieve the improved status of health in rural areas and also includes the component of community monitoring to engage the relevant stakeholders in the process of scheme to hold the public servants accountable.

This community monitoring project executed in Tonk district of Rajasthan aimed at improving and ensuring service deliveries at Primary Health Centres (PHCs) by measuring absenteeism of the health officials through developing a community-based monitoring model, reasoning out the factors responsible for such behaviour through interviewing the service providers, assessing the satisfaction of the citizens through Citizen Report Card (CRC), and after all doing evidence based advocacy for bringing changes.

The objective of the study was to evolve a community-based model of monitoring absenteeism in public health centres that can induce demand accountability of service providers, along with measuring the rate of their absenteeism and the satisfaction of the

beneficiaries, and to do evidence-based advocacy for adopting the model and improving the service delivery.

1.2 STRATEGY ADOPTED

The Investigation was conducted in a partnership mode. Ten local grass-roots organisations, showing keen interest in the project activities, were identified and selected from various blocks of the district, called partner organisations. They were made responsible for the activities related to few particular PHCs.

Five unemployed educated youths were selected from the catchment area of each PHC, with the help of local partners, and trained in executing monitoring of absenteeism. They were given the CMC, the tool for monitoring the absenteeism, in advance to test and practice it. Later, on a fixed date, all the monitors started to make unannounced visits to the PHCs to record absenteeism. Since there were five monitors for each PHC, the 1st monitor got his next chance to record absenteeism on sixth day and again on next sixth day

The head of the partner organisations conducted the interview of service providers and beneficiaries were surveyed with the help of surveyors identified each for a particular to PHC from the team of community monitors. All of them were trained rigorously for conducting the interviews.

Several other methods of research like secondary data collection, focus group discussions, interface meetings etc were also adopted to get the real picture of service delivery at the PHCs. Information regarding the progress of the activities was provided to the local and state level administration to build an ownership of them in the project and its findings. RPRIs were also kept in the loop from the beginning.

1.3 KEY RESEARCH FINDINGS

Participatory Absenteeism Tracking Process (PATP)

The PATP found that absenteeism among all categories of health officials exists on an average at the rate of 27 percent. However, the range of absenteeism was found to be between 12 percent in case of the male nurses and 36 percent for the Doctors or the Medical Officers.

The health officials were considered as absent if they were not found at the health centre, for whatever reason. Therefore, to get the actual absenteeism data, the attendance record of the officials was collected and it was found that there is an average 10 percent difference between the data obtained through community monitoring and the attendance record.

The study also tried to establish a simple correlation between the quality of infrastructural arrangements at the PHC and absenteeism and found that non-availability and quality of the facilities like public transport, toilet, water and government residence affects the presence of health officials at the health facility.

Citizen Report Card (CRC)

902 beneficiaries were surveyed using the CRC questionnaires on the health services provided at PHCs. 96 percent of the respondents said that the PHCs are easily accessible to them and 94 percent of the respondents are heavily dependent on the services provided by PHCs. 69 percent of the respondents said that they get either no medicines or only few from the PHCs. Reporting on the satisfaction, only 56 percent of the respondents found to be satisfied. More than 90 percent of the respondents like going to PHCs, like building of the PHCs, like the way they are looked after by the health officials, but in case of facilities and medicines, around 20 percent respondents do not like the service.

Only 35 percent of the people confirm the availability of health service at night at the PHC and 82 percent of the respondents don’t know where to complain about any problem

regarding poor service delivery at the PHC. Only two percent of the respondents paid money for getting the services and 34 percent of the respondents reported that nobody visits their village regularly to know their health status.

Interviews

Interviews of 58 service providers were conducted particularly to know the reasons behind the absenteeism and also the other factors responsible for their non-availability. It was found that only 22 percent respondent use government residence, however 72 percent of the personnel reside within a periphery of 1 km. Among the respondents, 60 percent travel on foot, 12 percent by bus and 14 percent on bikes.

The average number of training the service providers have received was found to be 5.4 and the average age of employment of the service providers is 9.1 years and the average time spent on the current PHC was found to be 3.9 years.

It was found that 95 percent of the service providers like their jobs and 82 percent of them are not willing to do any other job on the same salary, but 69 percent of them want to change their PHC. At the same time, 12.5 percent of the respondents were found to be dissatisfied with their jobs and 25 percent of the respondents say that they don't get leave on demand. 41 percent of the service providers say there is shortage of staff and 12 percent of the respondents reported somebody having left a job recently.

Interface Meetings

Interface meetings between service providers and recipients were conducted to develop more understanding between them. The following facts were revealed from the interface meeting:

- ✓ Medicines to the PHC come once or twice only, not round the year.
- ✓ Only 10 out of 35 listed medicines are made available and when they get exhausted, nothing can be done.

Focused Group Discussions

- SERVICES: However, there is lack of many facilities like pathological tests, injections, lady doctors, proper medicines, delivery facility at night, etc. Especially, there is no facility at PHC for the first time delivery.
- AVAIABILITY OF STAFF: Villagers do not know how many staff members are there at the PHC. Many times, only few staff members are present at the PHC. Some are reluctant to do their duty.
- MEDICINES: Medicines provided by the government meagre in quantity.. The few medicines available at PHC are given to any one, irrespective of the ailments to the people.
- AWARENESS: People below poverty line are entitled for BPL card and other service delivery absolutely free of cost, but many people below poverty line are not made aware of the provisions/entitlements.
- COMPLAIN: People don't know where to complain about the poor services and there is no discussion over the poor services at the PHC.
- PLACE OF PHC: At many places, the building of the PHCs is out of the village. Women cannot visit the PHC at night. Lot of political clout is also responsible for the placing of the PHC.

1.4 POLICY IMPLICATIONS

Awareness Generation

Lack of information about the entitlements/facilities/staffs at the centre among the villagers has emerged out as a severe problem during interface and community meetings.

Intensive awareness generation, proactive disclosure about the number and name of the staff members and purpose of being outside, availability/ non availability of medicines and the community should be made aware that the health officials at the PHCs are well qualified and will provide better treatment to them.

Strengthening Village Health and Sanitation Committee (VHSC)

In most *Village Health and Sanitation Committee meetings,* the participation is either low or they do not take place. Lack of information about the meetings or about the committee itself is the prime cause for this.

A day should be fixed for the VHSC meetings and it should be made known to every villager through various means of communication suitable to and available in the area. The *Sarpanch* and other *RPRIs* at the local level should be empowered and the process of community monitoring of the PHC that is inbuilt in NRHM should begin and continue.

Availability of Medicines

Sufficient availability of all listed medicines at the PHC should be ensured. A minimum buffer stock should be maintained at each PHC. A shop for generic medicines can be opened at each PHC, either on contract basis or through the government. A medicine van can move every month to each PHC for medicine delivery. People, other than the BPL, should not be provided medicines free of cost. The RPRIs need to oversee the delivery of medicines to the BPL.

Facilities for Service Providers at the PHCs

Provision of additional financial allocation is needed for bringing facilities at the local level to make the PHCs functional.

Deployment

Deployment of the health officials should be optimum in quality and quantity. Along with the optimum deployment, there should be optimum arrangement of health related facilities at the PHC, so that they can perform and provide better services.

Grievances Redressal Mechanism

Use of telecommunication can be very well incorporated by setting up a local helpline on call centre model, with toll free number, and should be made known to all the villagers. The villagers will be able to register their complaint about the service delivery at the PHC and possible steps can be taken for improving the quality of the service delivery.

Monitoring by Officials

Regular monitoring (with increased frequency) and vigilance by various different level officials and PRI representatives, who should be particularly trained for monitoring, inspecting and investigating service delivery, should be made mandatory.

Others

A public-private partnership (GO-NGO collaboration) for monitoring of the service delivery should be established for bringing transparency and accountability.

INTRODUCTION

2.1 BACKGROUND

The availability of human resources for health is an important indictor for the outreach of health service delivery. India lies at 124th position in case of availability of doctors among 200 countries, according to the World Health Organisation (WHO), having six doctors per 10,000 people. The number becomes critical when it comes to rural areas, as the distribution of doctors is heavily skewed towards urban areas. According to an estimate,[4] the urban physician-to-population ratio is almost six times the rural concentration of physicians. The situation becomes more worrisome when the component of absenteeism is added to this scenario of scarce availability of health workforce.

The other side of the coin is the allocation and expenditure of money for the health sector. Despite improving considerably on its health status since the Independence, the country's absolute per capita expenditure is lower than most other developing countries, according to an Icra report on the Indian health care sector. India's total expenditure on health amounts to 5.10 percent of the gross domestic product (GDP), while its per capita total expenditure on health is US$80, compared to an average of over US$220 spent by many other developing countries. However, allocations for health have increased from Rs. **10,040** crore in FY 2005-06 to Rs. **22,641** crore in FY 2009-10 – a rise of **125** percent, but it still needs to be increased and spent properly.

2.2 CONTEXT OF THE STUDY

Improving human capital in reaching the Millennium Development Goals (MDGs) and raising living standards has been the focus of investments in the social sectors and, in particular, health. This sector has received increasing attention and is clearly evident by the start of the

[4] The Centre for Enquiry into Health and Allied Themes

NRHM in India, for which the initial allocation made in the Indian Budget was INR 6731 crore (USD1.45bn) in financial year (FY) 2005-06 and that was increased to INR 14050 crore (USD3.02bn) in FY 2009-10.

Adequate funding for the health sector is needed but, equally important, is to ensure the function of the health systems for improved public expenditure outcomes. The draft Approach Paper (2006) by Nirupam Bajpai and R.H. Dholakiya clearly states that "rural healthcare in most states including Rajasthan is marked by several severe problems like absenteeism of doctors/ health providers, low levels of skills, shortage of medicines, inadequate supervision/monitoring, callous attitudes and poor community participation. These problems in health care delivery are leaving well-intentioned spending without any desired impact.

This clearly explains the need of improving service delivery in the health clinics, especially in the context of vulnerability of rural mass for which there is no much option except government aided services.

Rajasthan is one among the few backward states of India where public health indicators are very low and this is the reason why it is put among 18 states of India identified by NRHM for special focus in providing effective health care. Rajasthan is one because it is weak in both public health indicators and infrastructure. The problem of access of people to such basic services is more severe in rural areas.

The figures below reveal the status of the health indicators in Rajasthan against India and the year-wise increase in expenditure of Rajasthan in the NRHM:

S. No.	Item	Rajasthan	India
1	Total Population (Census 2001) (in million)	56.51	1028.61
2	Decadal Growth (Census 2001) (%)	28.41	21.54
3	Crude Birth Rate (SRS* 2007)	27.9	23.1
4	Crude Death Rate (SRS 2007)	6.8	7.4

5	Total Fertility Rate (SRS 2007)	3.4	2.7
6	Infant Mortality Rate (SRS 2007)	65	55
7	Maternal Mortality Ratio** (SRS 2004-06)	388	254
8	Sex Ratio (Census 2001)	921	933

* Sample Registration System ** Pregnancy related deaths per 100 thousand mothers

2.3 ABOUT THE PROJECT

This study report consolidates the results of certain social accountability tools such as Community Monitoring Card (CMC) utilised for participatory absenteeism tracking process (PATP), CRC utilised for getting the feedback of service recipients and the interviews of service providers executed for reasoning out the factors responsible for absenteeism.

Absenteeism leads to waste of both financial and human resources and there is very less research done in this area in India. The policy makers are also very much aware of the severity of absenteeism of medical personnel, but they do not have much evidences collected scientifically and reasons for that. This lack of information restricts the government to find a way out.

Keeping all these aspects in mind, all these tools were utilised mainly for measuring absenteeism of health officials and for deriving the highlights and gaps in the delivery of health services at Primary Health Centres (PHCs) running in Tonk district of Rajasthan, India. This district is adjacent to the capital of the state and has made significant progress in health indicators after the implementation of the NRHM. This district was chosen to identify what makes the district successful in achieving good health indicators and what is the status of the rate of absenteeism in such a progressive district.

Under the participatory absenteeism tracking process (PATP), the presence and absence of health service providers were recorded for 30 PHCs for the period of 30 days in continuity, through unannounced and secret visits to the health centres during working hours.

The calculation of absenteeism is based on direct physical verification of employees' presence, rather than relying on attendance registers of the health officials, as it is very easy to manage the attendance register, especially in the rural areas, and so attendance registers not provide the right picture about absenteeism. There are various tactics being adopted by the service providers to remain absent from the health centre without taking leave. These tactics were revealed during the execution of various activities under the project. At the same time, several genuine reasons were also found for absenteeism that must be corrected for reducing such cases.

Under the process of CRC, 902 health beneficiaries were interviewed, with a field-tested questionnaire, mainly to get their feedback on the various health service deliveries by a group of people chosen from community monitors. The various components of the National Rural Health Mission (NRHM) were taken into account. Special focus was given to *Janani Suraksha Scheme* (JSY) – a scheme to improve maternal and neonatal health – which is a component of the NRHM to improve maternal mortality rate, through increasing institutional delivery, and child health for improving the infant mortality rate. This scheme also caters to one of the Millennium Development Goals (MDGs). In general, the findings of the CRC are based on the perception of the service recipients, based on the services they get from the health facility in the vicinity of their localities.

The summary statistics on the absence of health officials includes statistics on average level of provider absence, cadre-wise distribution of absenteeism rate among various service providers, presence/absence of various medical facilities at the centre and the infrastructural facilities connected to the health facility. The analysis of interviews could also bring the reported reasons for absence and the distribution of absences among providers. It also examines the correlation of service provider absence between a wide range of potential

determinants like the distance of the facility from the town, their engagement in other official works and many more.

The summary statistics about the perception of the service recipients is on the basis of their feedback about various components of the health service delivery at the PHCs. The feedback collection will take various entitlements given to the people through various schemes and programmes into account.

2.4 NATIONAL PROGRAMME

The NRHM was launched in April 2005 to effect an architectural correction in the health care delivery system with the convergence of various health programmes. Accordingly, special emphasis has been given to the health sector in terms of financial allocations during later years of the 10th Plan and also in the 11th the Plan. It is an effort to improve public health services, with a special focus on states with weak public health infrastructure and indicators. The Goal of the Mission is to improve the availability of, and access to, quality health care for people, especially for those residing in rural areas, the poor, women and children, thereby bridging the urban-rural disparities.

The vision statement of the NRHM, as described on the NRHM website and its documents, is as follows:

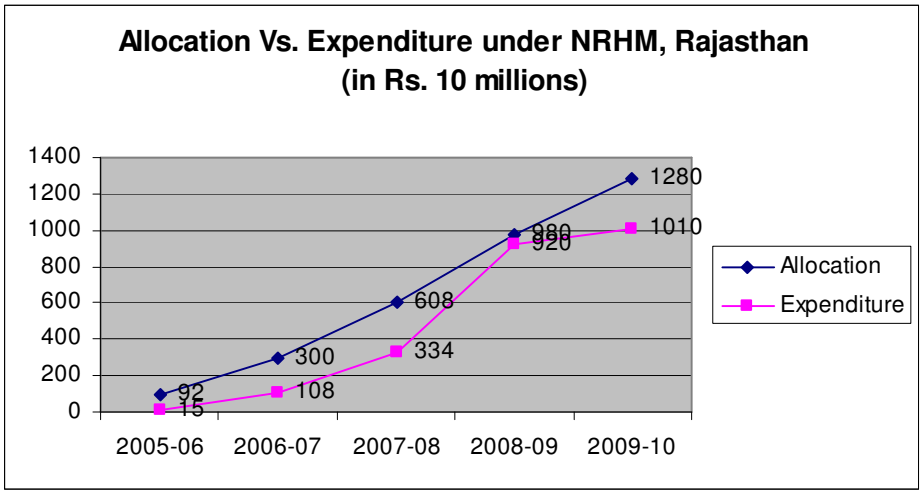
- Provide effective health care to rural population throughout the country;
- Commitment of the Central Government to raise public spending on health from 0.9 percent of the GDP to two to three percent of the GDP;
- Undertake architectural correction of the health system to enable it to handle effectively increased allocations;
- Promote policies that strengthen public health management and service delivery in the country;
- Revitalise local health traditions and mainstream Ayurveda, Yoga, Unani, Sidha and Homeopathic (AYUSH) treatments into public health systems;

- Decentralise programs for district management of health;
- Define time bound goals and report publicly on their progress; and
- Improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary health care.

The “accountability” component for the service providers becomes very crucial for achieving the goals of the NRHM. In the past, there have been numerous programmes for improving the national health status. But, most of them were not effective enough in addressing the poor health status of the country. Also, the needy were not even aware about most of the programmes and schemes. However, Information, Education and Communication (IEC) activities are one of the major components under the NRHM for providing health-related schemes and programs to the people, which is around 2.5 percent of the total budget.

The accountability framework proposed in the NRHM is a three-pronged process that includes internal monitoring, periodic surveys and studies and community-based monitoring. Community Monitoring is also seen as an important aspect of promoting community-led action in the field of health. The provision for Monitoring and Planning Committees has been made at the PHC, Block, District and State levels. The adoption of a comprehensive framework for community-based monitoring and planning at various levels under the NRHM places people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.

NRHM Year-wise Allocation vs. Expenditure in Rajasthan (in 10 millions)



But, unfortunately, even after four years of the completion of the mission, the wheel of community-based monitoring is still not set in motion and no data is available with the department even after laying down the framework for the implementation of community-based monitoring of 36 selected districts of nine states of the country. Apart from gathering data on absenteeism, this project aims at developing a community-based monitoring model and showcasing the acquired evidences from field to advocate for setting up the community-based monitoring in motion. This will further improve the service delivery at health centres and public expenditure outcomes.

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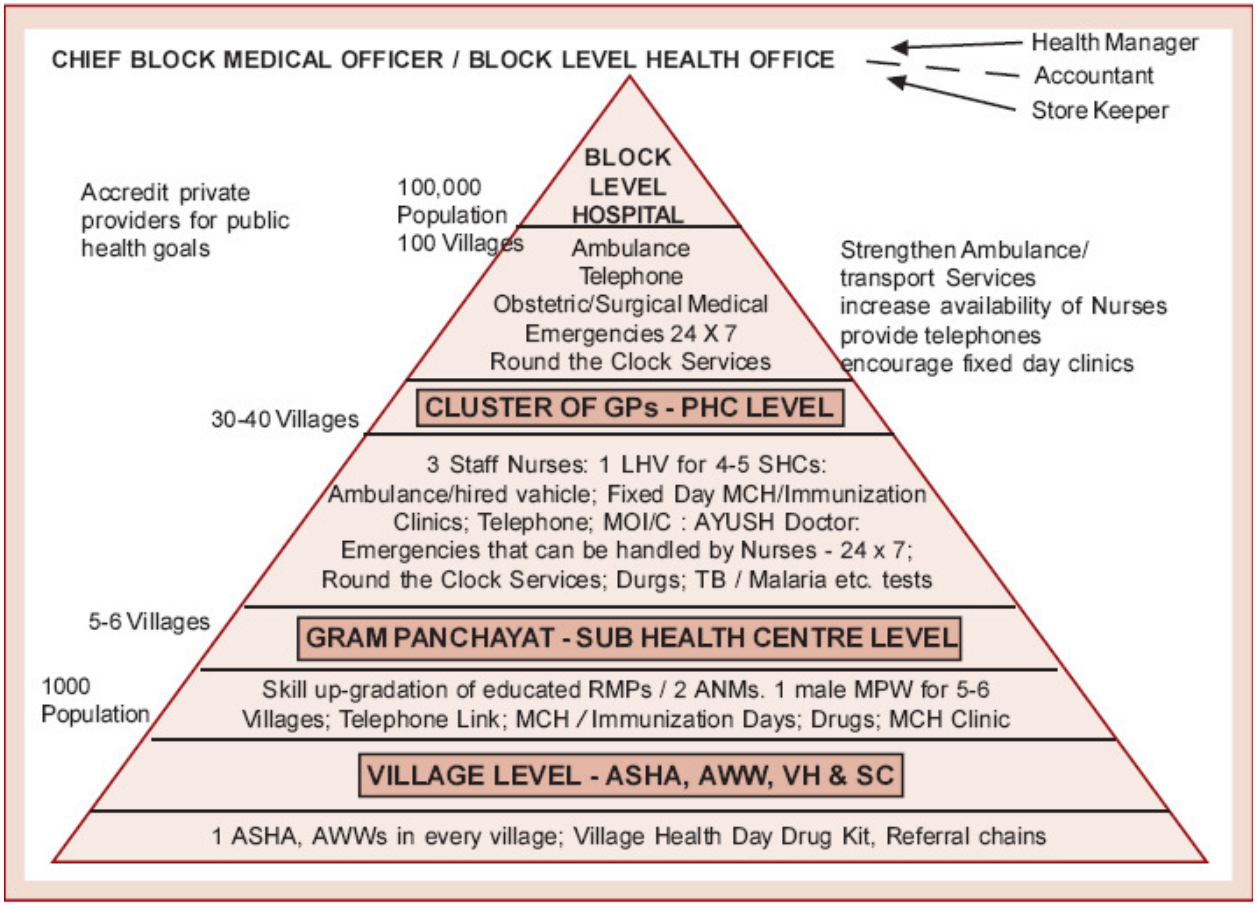
2.5 IMPLEMENTATION MECHANISM IN RAJASTHAN

Structure of Health Care System under NRHM in a District

An illustrative structure of providers at various levels below a block, 5-6 of which jointly constitute a district, is given below. Therefore, a PHC is responsible for the health of a cluster of nearly 30-40 villages, or around 10,000 people. There are 45 PHCs in the Tonk district that take care of nearly a 120-thousand population.

Figure 1.1 : NRHM - Illustrative Structure



Source: NRHM, Framework for Implementation, 2005-12, Ministry of Health and Family Welfare, Government of India, New Delhi.

2.6 PROFILE OF PROJECT AREA: DISTRICT OF TONK

The district of Tonk is situated in the north eastern part of the state, with area coverage of 7,194 sq. km. Tonk has a population of 1211671, comprising of 626436 men and 585235 women. The district has 59.93 percent of cultivators, having total 1100 villages, approximately. Tonk is a small district, located at a distance of 96 kms from Jaipur.

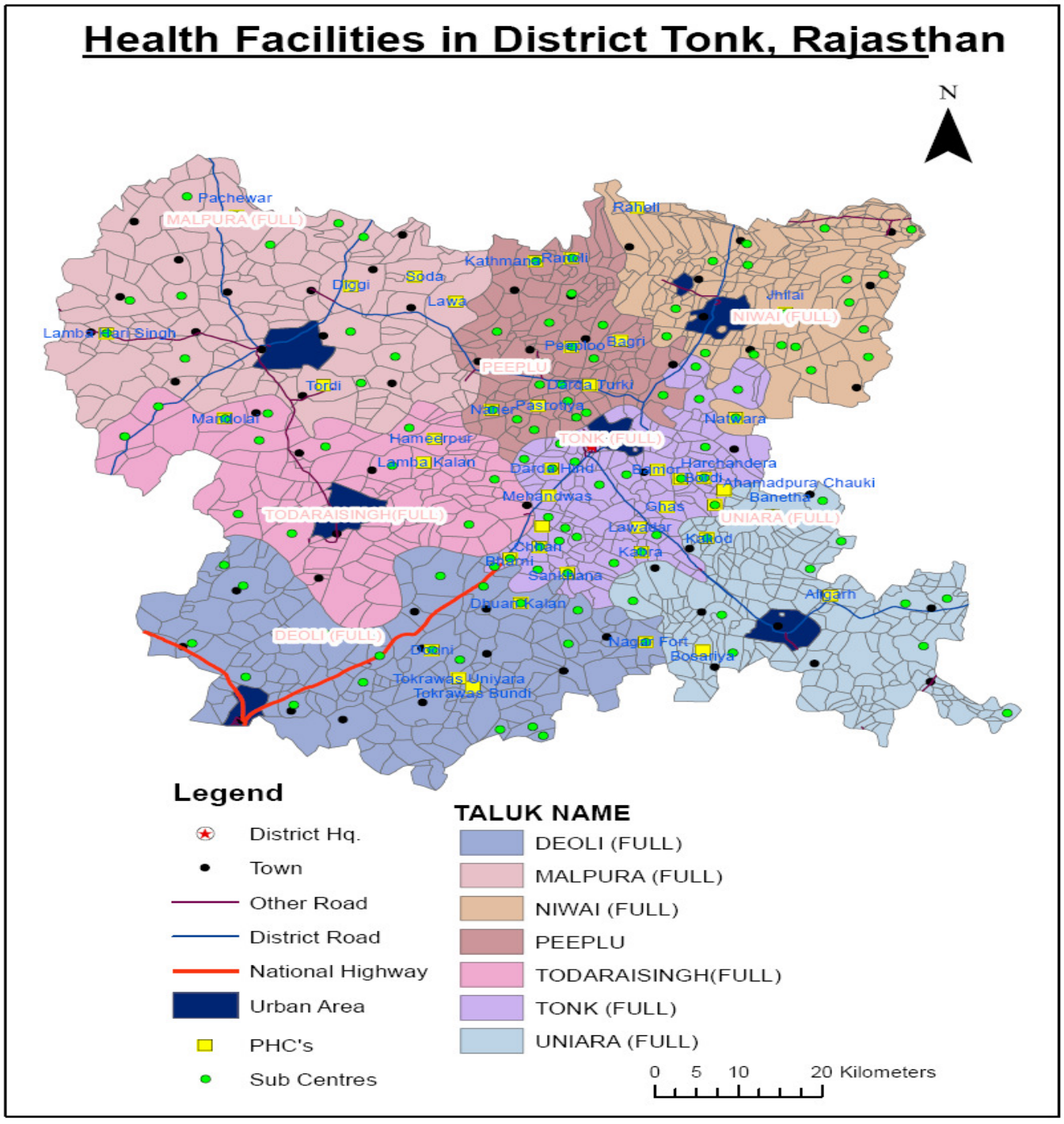
This is a district which is adjacent to the capital of the state and has made significant progress in health indicators after the implementation of the NRHM. DLHS, which gathered the data in 2007-08, keeping in mind the intentions of the NRHM, showed good progress in case of few indicators presented in the Table below. This district has also been under constant observation because of certain reasons like proximity to the state capital, plethora of agencies, including the UN and the World Bank, working in the district, etc. This district was chosen to identify what makes the district successful (or is it really successful?) in achieving good health indicators. This is a district, where many agencies including UN are working intensively in the health sector, so what changes the common man feels and reports about the status of

services and their satisfaction. What is the rate of absenteeism in the district and how is it affecting the delivery of health services?

S. No.	Indicators	*DLHS-2	**DLHS-3
1	Percentage of girl's marrying before completing 18 years	7.1.9	61.7
2	Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)	37	38.5
3	Institutional births (%)	24.7	47.3
4	Children (12-23 months) who have received BCG (%)	64.2	94.8
5	Children (12-23 months) who have received 3 doses of DPT Vaccine (%)	34	53.9

***District Level Household Survey -2 (2002-04) **DLHS-3 (2007-08).**

Health Facilities in District Tonk, Rajasthan



As denoted in the picture above, in Tonk district, number of Community Health Centres (CHC) is 7 and the number of PHC and Subcentres are 45 and 249 respectively.

RESEARCH DESIGN

STUDY APPROACH and METHODOLOGY

The NRHM primarily aims at access of health services to rural people and PHCs are the backbone of the service delivery to the rural people under the mission. Hence, the study mainly focuses on service delivery at a PHC. First and foremost, a series of visits were made to build acquaintance with the area, build rapport with the government officials, see the implementation of schemes at the grass roots, understand the dynamics of the place and identify the local organisations as a part of scoping visit under the project.

An NGO consultation meeting was conducted for around 20 NGOs, in order to make the organisations familiar with the project, its goal and the activities. After a rigorous screening of their interests and credibility, 10 local organisations (Annexure 1) were selected as partners to implement the activities in the area. Simultaneously, a district co-ordinator was also appointed to co-ordinate with the partners. Each partner was made responsible for the activities of a few particular PHCs.

PARTICIPATORY ABSENTEEISM TRACKING PROCESS

Random sampling method was utilised to select 30 PHCs (Annexure 2) to avoid any kind of bias. Tonk district has the characteristics of both rural and urban area as it borders the state capital and thus PHCs selected for the study will have all characteristics of rural, urban, remote etc. This will help in drawing conclusions for whole state.

Five unemployed youths were selected for each PHC from its catchment area, with the help of the local partner organisation, to monitor the presence/absence of the health officials. They were stationed for an hour at each PHC to record the data on all the 30 randomly selected PHCs at various points of time during duty hours. The providers' presence was recorded for 30 consecutive days, except Sundays. The presence of the health officials was

recorded at three different points of time according to chart A (Annexure 3). Thus, five community monitors for 30 days collected 900 observations for eight categories of the health workers working at the 30 PHCs in the district, through the use of Community Monitoring Card (Annexure 4).

The categories of the health workers are Doctor, Doctor Ayush (Ayurvedic), Male Nurse, Female Nurse, Lab Technician, Lady Health Visitor, Pharmacist and Adult Nurse Midwife. The observers did scoping of the PHC before starting the monitoring. The observers monitored the presence at three points of time (10.00 am, 11.30 am and 5.00 pm). To avoid any kind of disturbances due to the monitoring process, monitors were strictly instructed to do monitoring on every 6th alternate day and not in sequence. This project paid token honorarium to every monitor for conduction the monitoring.

CITIZEN REPORT CARD

30 service recipients from each PHC were randomly selected for conducting the CRC from among the people coming to the PHCs for availing any kind of service. Earlier, it was attempted to do a random sampling on the basis of Outpatient Department (OPD) list, but the same was not found properly maintained. Thus, 902 people were asked to provide their report on the service delivery on the basis of questionnaire (Annexure 5). The survey work was executed by one community monitor best out of five related to the particular PHC.

Simultaneously, interviews of the service providers, each of a Doctor, Adult Nurse Midwife (ANM), Accredited Social Health Activist (ASHA) and a representative of *Panchayati Raj* Institutions (RPRIs) for every PHC, were conducted. The high level authorities at the district level, like the Chief Medical and Health Officer (CMHO), the District Programme Manager (DPM), etc., were also interviewed for better clarity on certain issues. The interviews of the service providers were either done by the head of the partner organisation or by the member of project management team.

Category of Respondents	Sample Size	Actual Interviews Done
Beneficiaries	**900**	**902**
Doctors	30	29
Adult Nurse Midwives	30	29
ASHAs	30	30
RPRIs & VHC Members	30	30
Total	**1020**	**1020**

Other than the PATP, the CRC and the interviews, several focused group discussions (FGDs) with service providers and service recipients were conducted during the course of the investigation.

SECONDARY DATA COLLECTION

Constant watch was kept on the local newspapers of the project area and also the leading newspapers to gather the relevant news related to the project. Simultaneously, the Internet was also used for the purpose of collecting secondary data.

APPROACH TOWARDS SUSTAINABILITY

The project was partnered by ten local grass-roots organisations showing keen interest in the project activities and goals. These partners already have rapport built in the areas where the PHCs were located. This helped in getting the community monitors. Since partner organizations were based locally, the monitoring of the monitors and other survey work remain easy for them in true sense. The project was able to initiate this process of community monitoring with the involvement of local partners, because they were familiar with the PRIs and the SHG groups in the particular area. Initially, a community meeting was organised in several PHC catchments to select the volunteer monitors. Several interface

meetings between the service providers and recipients were also conducted to improve the understanding between them and also to devise ways to improve the service delivery at the health centres.

The sustainability of this model depends on two points: first, if government adopts this community-based monitoring model and institutionalises the process and, second, if the RPRI and community jointly take the decision to carry the model forward through its revenue.

All the work of data collection and civic engagement at one of the PHCs was deliberately done by the district co-ordinator appointed for the project area, mainly to understand the dynamics of the PHC and people availing services, in order to enrich the research work.

SUMMARY STATISTICS

4.1 Participatory Absenteeism Tracking Process

Providers' Absence Rate

Provider's average absence rate for all categories of health officials was found to be 27 percent, which means out of the 900 observations, on an average, health officials were found absent during 27 percent cases of observations. The rate of absenteeism[5] ranges from 12 percent for Male Nurses to 36 percent for Doctors or Medical Officers. As described, there were 900 observations made of 30 PHCs for each category of employee.

To know the amount of cases where the health officials manage to sign the register without visiting the health centre, the team obtained Xerox copies of the attendance sheets and a comparison was done. It was found that an average difference of 10 percent exists. This means, on an average, on 10 percent days health officials do not come to the PHC, but manage it to sign. This was found highest in the case of Lab Technicians and lowest in case of Male Nurses.

De-segregation of Absenteeism by Key Health Care Cadre

S. No.	**Medical Providers**	**Absence Rate (in Percentage)**	**Absence Rate (in %) Obtained through Attendance Sheet**	**Difference**
1	Medical Officers (Doctors)	**36**	**31**	**5**
2	Lab Technicians	34	14	20

[5] In calculating absence rates, a provider was coded as absent if he or she was not found in the premises of PHC at the time of observation because of any reason like leave, official duty outside like training or monitoring visits to the sub-centres and absent without information.

3	Lady Health Visitors	33	15	18
4	Adult Nurse Midwives	22	15	7
5	Male Nurses	**12**	**12**	**0**
	Average	**27**	**17**	**10**

Day-wise Doctors' Absence

While analysing the day-wise absence in order to know the concentration of absenteeism for any particular day, it was found that slightly higher rates were found for Mondays and Wednesdays. The overall absence rate varies between 32 to 41 percent for Doctors. The hypotheses behind this investigation was that the health officials remain absent more on Saturdays and Mondays, as they move out of station and take a day or two extra in joining the duty again. This proved true in case of Mondays, where absenteeism was found highest, however, in case of Saturdays, it did not hold true. Instead of Saturday, Wednesday was found the day when maximum absenteeism found.

Days	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Absenteeism (in %)	41	35	39	35	35	32

Status of the Availability of Medical Facilities at PHC

Availability of few of the essential facilities and their quality was also checked during the Participatory Absenteeism Tracking Process at the Primary Health Survey. This was also reported by the community monitors on the basis of their observations. Information on the availability of these facilities and their quality was also asked for in the same monitoring card used for absenteeism tracking purpose.

Response	**Immunisation**	**Drug Distribution**	**Blood Test**	**Delivery**

Yes	44	73	51	63
No	55	26	35	33
Can't Say	1	1	14	4

Few of the facilities which can be responsible for the presence of the service providers at the facilities were also counted during the process.

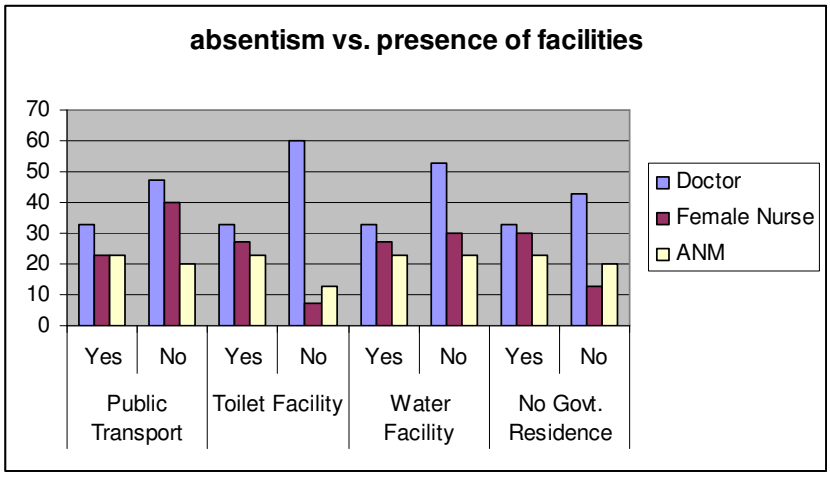
Availability of Infrastructural Facilities

S. No.	Infrastructural Facilities at the Health Centre	Yes (%)	No (%)
1	Public Transport to the PHC	80	20
2	Toilets	90	10
3	Water	83	17
4	Electricity	87	13
5	Government Residences	73	27

Quality of Infrastructural Facilities

S. No.	Quality of Infrastructural Facilities at the Health Centre	Good (%)	Average (%)	Bad (%)	No Response (%)
1	Public Transport to the PHC	50	37	7	20
2	Toilets	37	43	17	10
3	Water	40	43	13	17
4	Electricity	37	47	13	13
5	Government Residences	37	27	20	27

Absence Rates of the Service Providers: Some Simple Correlations



We review briefly the simple correlations between providers' absence and facilities connected to the health care centre. These correlations suggest that all facilities like public transport, toilets, water and government residences matters in context of the providers' absence at the health facility.

Cost of Absenteeism

For Doctors Only in Whole Rajasthan

- Salary of a doctor at entry level: INR 16,800 + 6000 (200 per day allowance)
- Number of doctors in Rajasthan: 1,542
- Financial loss in Tonk (for 45 PHCs): Rs. 4.4 million per annum (USD0.1mn)
- Total loss in Rajasthan: Rs. 150 million per anum (USD3.33mn)

For Various Cadres in Tonk District

S. No.	Medical Providers	Absence Rate (in Percentage)	Salary with Allowances per Month	No. of Officials (in Tonk)	Loss of Resource
1	Medical Officers (Doctor)	36	22800	42	4136832
2	Lab Technicians	34	8000	36	1175040
3	Lady Health Visitors	33	8000	35	110800
4	Adult Nurse	22	5200	47	645216

	Midwives				
5	Male Nurses	12	12900	73	1356048
	Total				**8421936**

It is evident from the from the above Table that total financial loss due to absenteeism in five prominent cadres for service delivery at PHC in Tonk is nearly INR 8 million.

4.2 CITIZEN REPORT CARD

Respondents' Demographics

Out of the total 1020 respondents, 902 were the recipients of the services from the PHC, 88 were the service providers at the PHC and 30 were the representatives of the Panchayati Raj Institutions.

Out of 902 respondents from service recipients section:

- 52 percent were males and 48 percent were females;
- 95 percent were from Hindu community and five percent were from the Muslim community;
- 79 percent were APL and 20 percent were BPL and one percent were unclear about their status;
- 39 percent were from nuclear families, 59 percent were from joint families and two percent were not clear.
- 64 percent were from the age group of 19-40, 17 percent from 41-60 years, that together constitutes 81 percent; and
- 76 percent people were below the monthly income of Rs. 5000.

Key CRC Findings

Janani Suraksha Yojna (JSY)

The Janani Suraksha Yojna (JSY), under the overall umbrella of the National Rural Health Mission (NRHM), is a modified version of the earlier National Maternity Benefit Scheme (NMBS). The JSY integrates the cash assistance with antenatal care during the pregnancy period, institutional care during delivery and immediate post-partum period in a health centre,

by establishing a system of co-ordinated care by field level health worker. It is a 100 -percent centrally-sponsored scheme.

The CRC was conducted to know the status of the provisions of the JSY from which the findings reveal both positive and negative feedbacks. The findings are compiled in form of a Table.

S. No.	Questions Related to the Provisions/Entitlements under JSY	Yes	No	Can't Say
1	Are you registered under JSY?	80	5	14
2	Were you given the iron tablets during pregnancy period?	76	8	16
3	Was any lab test done at the PHC during pregnancy?	75	11	14
4	Does government encourage institutional delivery in your opinion?	82	5	13
5	Do health workers come to patient's home for delivery purpose?	50	35	14
6	Whether your ANM has required skills for delivery?	87	9	4
7	Was economic help given after delivery?	68	12	20
8	Does your hospital have 24–hour delivery facility?	63	24	13

It is evident from the data gathered that 10-20 percent of pregnant women are not having proper awareness about the JSY, which is weakening the demand-side of the service delivery. If we take the first question, all the women are registered under JSY, but are unaware of their registration. Poor awareness leads to poor demand and hence poor service delivery. It is surprising that 12 percent of the people said they have not got any economic help after pregnancy.

Child Health

Child Health Care Services are also given a wide importance under the NRHM. Essential new born care, integrated management of neonatal and childhood illness, exclusive breast feeding and timely introduction of complimentary feeding, immunization, Vitamin A supplement, etc., are key strategies for attaining better child health in the country.

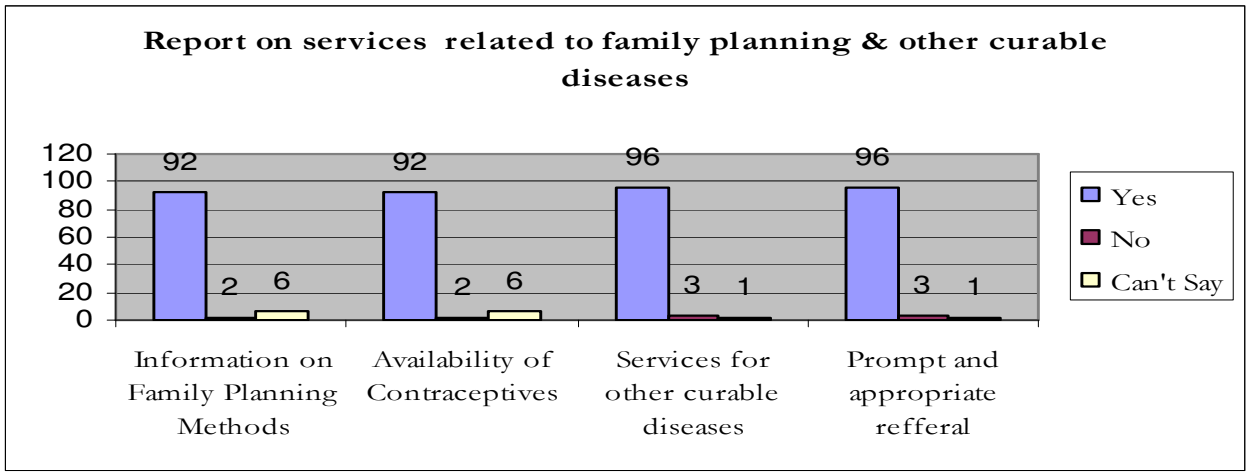
Keeping these strategies in mind, the CRC gathered the feedback on certain activities implemented for better child health.

S. No.	Questions Related to the Certain Activities Implemented for Better Child Health	Yes	No	Can't Say
1	Is your child immunized?	93	3	4
2	Has your child been given Vitamin A supplement?	81	14	4
3	Were you told for exclusive breast feeding to your child?	88	7	5
4	Does your PHC provide your child security against malnutrition and other infectious diseases?	78	17	5

The figure related to immunisation was found to be very enthusiastic in case of child health. Ninety-three percent parents said that their children are immunised. However, intensive work is needed in case of providing Vitamin A supplement and also in case of gaining confidence of people.

Family Planning and Other Curative Services

It was found that the percentage of the people visiting the PHC in connection with availing the curative services is as high as 50 percent and becomes 56 percent after including the people coming for family planning services. The percentage of respondents informed about the family planning methods was found to be 92 percent and 92 percent respondents confirmed the availability of contraceptives and other family planning methods. At the same time, 95 percent of the respondents reported the availability of services for other curative diseases and 96 percent of the respondents are happy with prompt and appropriate referral.



Complaint Handling Mechanism

Complaint Handling Mechanisms (CHMs) are critical tools for promoting transparency and accountability, reducing corruption, improving service delivery and enhancing overall effectiveness in public expenditure. But, the condition of complaint handling mechanism was found very abysmal. Eighty-two percent of the people reported that they do not know where to complain about any fault in the service delivery at the PHC.

Awareness Generation

Awareness generation on various health needs, provisions and entitlements under the NRHM is vital to trigger the demand of services, which ultimately generates success of any scheme. To know the status of awareness among people about the general health practices, report from the respondents was taken. The Table below denotes the status of the awareness among the people.

S. No.	Questions Related to the Awareness Generation	Completely Aware	Partially Aware	Totally Unaware
1	On breast feeding	55	16	28

2	Introduction of complementary feeding	49	22	29
3	Spacing between the children	60	15	25
4	Legal age of marriage	67	8	24
5	Registration of birth/death	52	15	32

Opinion on PHC

The CRC also tried to find out the general opinion about the PHC and the services provided there. It was found more people are having positive opinion about their respective PHCs and the service provided there.

S. No.	**Items**	**Yes**	**No**	**Can't Say**
1	Like going to a PHC nearby	97	1	2
2	PHC has a good building	93	6	1
3	Health officials are present continuously	90	9	1
4	Health officials do quality diagnostics	93	5	2
5	Good medical facilities are available in the PHC	74	21	5
6	Medicine are available free of cost	77	19	4

However, most of the respondents had a good perception about the building of the PHC and the availability of the health officials and they said that they like going to the hospital, but in case of medical facilities present at the PHC and the availability of medicines, a significant percentage of the respondents did not have a good opinion.

Community Participation

Community-based monitoring of health services is a key strategy of the National Rural Health Mission (NRHM) to ensure that the services reach those for whom they are meant, especially for those residing in rural areas, the poor, women and children. Community monitoring is also seen as an important aspect of promoting community-led action in the field of health. Formation of Village Health and Sanitation Committees (VHCs) was one of the strategies to enhance civic engagement.

Respondents were simply asked about their knowledge about the VHC. Only 53 percent of the people accepted that they know about such a committee and only 46 percent of the respondents accepted that they have ever met any VHC member.

Accessibility and Availability of the Health Services

Under the National Rural Health Mission (NRHM), and the government has shown commitment to improve the availability of and accessibility to quality health care by people, especially for those residing in rural area. To get a feedback on the accessibility of the health services, few questions were asked to the respondents.

96 percent of the respondents[6] said that the PHCs are in their easy access and 94 percent of the respondents are heavily dependent on the services provided by the PHC. However, 83 percent of the people said that they find health officials at the PHC when they go, but 69 percent of the respondents say that they get either no medicines or only few from the PHCs. When their suggestion was asked to improve the services at the PHC, 11 percent of the people said the supply of medicines should be improved and more medicines should be added to the list of medicines being provided.

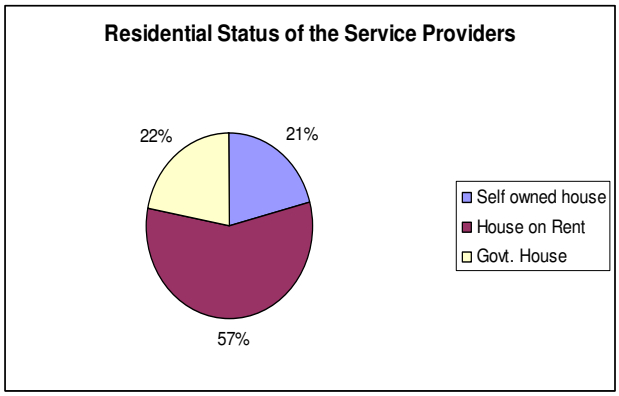
[6] The questionnaires were filled with the people coming to the hospital. Since CRC is done with the actual user of the services and when we tried to get the list of actual users. The OPD list is not maintained with the names and addresses of the beneficiaries. At the same time, it also needs to be taken into consideration that most of the respondents do not have any choice other than the government hospitals.

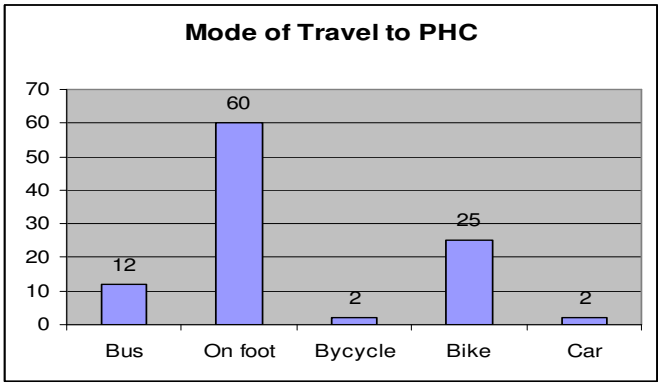
Some General Findings/Facts

1. Average distance of the PHC from respondents home: 2 km;
2. Average time in journey to PHC and check up for a respondent: 1.3 hours;
3. Only 56 percent of the people are satisfied with the service delivery at PHC;
4. 90 percent of the people said that they never paid any money to avail the health services;
5. Only in 35 percent cases respondents affirm health service delivery at night at PHCs; and
6. Only 63 percent respondents accept that some body visits their village regularly.

4.3 Interview of Service Providers

The interviews of the 58 service providers were conducted particularly to know the reasons behind the absenteeism and also the other factors responsible for their non-availability. It was found that only 22 percent respondents use government-provided residence. However, 72 percent of the personnel reside within the periphery of 1 km. Among the respondents, 60 percent travel on foot, 12 percent by bus and 14 percent on bikes.





Average number of training the service providers have received was found 5.4 and the average age of service of the service providers is 9.1 years and average time spent on the current PHC was found 3.9 years.

It was found that 95 percent of the service providers like their jobs and 82 percent of them are not willing to do any other job on the same salary, but 69 percent of them want to change their PHC. At the same time, 12.5 percent of the respondents found dissatisfied with their jobs and 25 percent of the respondents say that they do not get leave on demand. Forty-one percent of the service providers say there is shortage of staff and 12 percent of the respondents reported about somebody leaving job recently.

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A doctors says not sufficient medicines are given to the PHCs because of which we are unable to provide proper services. We need to manage with the situation. One list of medicines with rates is given to us. We are allowed to buy only those listed medicines on the given rates. But, many of them are not found on medical shops even. People after seeing the list ask for the medicines which are listed and blame us for not providing. The rates given for the medicines are also old and do not match with the market rates.

I am a doctor and my duty is to provide treatment to the patients, but I am doing the data feeding work at the PHC. If I am found at the PHC on Wednesday, then the authority will ask why I am here. If we raise more questions in the monthly meetings, the monitoring of the PHC becomes more. Quality of the training is also not fine. The training is nominal and there is no benefit of the training. There is a gap of three hours in between the two shifts, which is useless for us. There should be change in timings. Travel allowance and better facilities like lab instruments, etc., should be given. During interview, a female came with pain in her ear. She was given paracetamol. After her departure, the interviewer told the doctor that it was not the medicine for pain in the ear. The doctor said that the required medicine is not here and if any medicine was not given to the person, she would have cried and said that you people eat the medicines.

4.4 Other Observations

Several other findings were gathered through various interface meetings and focused group discussions with service providers which provided insights to understand the problems in service delivery.

- Deficiency of medicine was one of the major obstacles found for poor service delivery, according to service providers and service recipients as well. In many cases, the villagers reported that very few medicines are available with the PHC and the doctor or other staff gives the same medicines irrespective of the problems they have. The

villagers said that they do not have faith in government-supplied medicines. Since there are no shops available at the Gram Panchayat level, people prefer to go to the community health centre at the block level or the district hospitals so that they can buy medicines from the shop, if not available at the hospital.

- Due to lack of medicines and other facilities, generally, people do not go to the hospital and they also do not take much interest in the hospital affairs. Because of the poor demand of service delivery and less monitoring by the authorities, the health officials manage to remain absent. People also are hesitant to come to the service point, when they find poor or no services at the PHC. The high deficiency of medicine was supported by several medical officers that medicines are provided only once or twice. The incidence of filling the OPD list by fake names was also mentioned by few service providers, mainly to increase the number, as actual number of patients is very low. In many cases, it was found that the health officials carry purchased medicines and provide to the patients at villages. It was also found that staff like male nurses, etc., keep general medicines with them and visit the village to provide services on a private basis.

- It was also found in some cases that villagers are not supportive of the service providers. They excrete near the hospital and even steal some property of the hospital. In one case, the garage built in the hospital was encroached by the villagers for their use.

- It was also found that because of the regular absence of doctors in some PHCs, the villagers do not know whether a doctor is appointed at the PHCs or not.

- Since doctors do not stay in the village, people do not have the confidence whether, when they come, he or she will get the treatment.

- At some PHCs, posts are vacant and not filled quickly.

- Generally, the poor and illiterates come to the PHC and those who have money call the doctors at home and take treatment by paying fees. People also prefer the treatment by male nurse, as he carries the medicines with him, whereas doctors write medicines, which they need to bring from the district level, as no medical store is there at the GP level.

- Pregnant women are given good care, but they are demanded money to get the baby delivered in the hospital.. The delay is made in delivery of cheques to the mother under Janani Suraksha Yojana to get bribe.

- Most of the doctors are deputed to the head office for official work.

4.5 Focused Group Discussions

- SERVICES: Although there is benefit of having a PHC nearby, there is lack of many facilities like pathological tests, injections, lady doctors, proper medicines, delivery facility at night, etc., especially there is no facility at PHC for the first time delivery. Generally, one male nurse and one female nurse execute most of the work at the PHC. In some instances, when patients came from a far away place after spending a lot of money in travelling, they found the doctor absent or had gone on training or was on leave.

- AVAIABILITY OF STAFF: Villagers do not know how many members of staff are there at the PHC. Many times, only few members of staff are present at the PHC. Some are reluctant to do their duty. They do not stay at the PHC, even if the government has provided them residence. The need for help of a doctor can come at the any time, so they should be available at any time.

- MEDICINES: Medicines provided by government are in meagre quanitity. The few medicines available with the PHC are given to anyone, irrespective of the patients' ailments. Health officials say that because of unavailability of medicine, they sometimes give the medicines which are not meant for the purpose. They do it because of the fear that if they do not give any medicine, people will react negatively. Because of unavailability of medicines at PHCs, the villagers are bound to visit quacks, which is costly, villagers said.

- AWARENESS: People below poverty line are entitled for BPL card and other service delivery absolutely free of cost, but many people below poverty line are not made aware of the provisions/entitlements.

- COMPLAINT HANDLING: People do not know where to complain about the poor services and there is no discussion over the poor services at the PHC. People who are capable enough to demand services and accountability from the health officials are provided better services and the poor and the marginalised keep suffering.

- LOCATION OF PHC: At many places, the building of the PHC is out of the village. Women cannot visit the PHC at night. Lot of political clout is also responsible for the placing of the PHC.

4.6 Individual Cases

The building of the **Ghaad** PHC is small. The government had provided money to extend the building, but the money got lapsed because of the lacklustre approach of the RPRI. This Gram Panchayat, where this PHC is located, is a small town and several small villages are connected to this PHC. Only three members of staff – one male doctor, one male nurse and one female nurse – run this PHC and they do not complete the duty hours and nobody stays at the PHC at the night. The villagers feel that the doctor is not competent, because of which people do not visit the hospital for delivery. The male nurse is very rude and comes to the

PHC from outside and the time of his arrival and departure is not known. If somebody asks any question or information, he says bring order form CMHO (Ghaad).

The building of **Aanava** PHC is new, but is situated at the outskirts of the village, nearly 1 km from the village. People face problem in visiting hospital at night and is nearly impossible to visit PHC at night, if need arises. Most of the medicines are not available at the PHC and no staff stays at the PHC at night. One male and one female nurse handle the major work of the hospital.

A medical store is available nearby **Naner** PHC and people around are well aware. This PHC witnesses the availability of staff all the time, as the doctor stays in the government-provided residence, but the post of ANM is vacant.

The building of **Kathmana** PHC is in good shape, but the doctor does not stay at night for the reason of unavailability of the government residence and also lack of drinking water facility and electricity. People have complained of unavailability of capsules, injections and other life-saving drugs.

There is no medical store nearby, no drinking water, electricity and residence facility for the PHC at **Arania Kedar,** which leads to poor service delivery at the PHC.

Most of the cases are referred to the CHC Niwai, because the Medical Officer is not there at the PHC of **Dangarthal.** The Medical Officer is on leave for the last six months due to personal reasons, but no alternative arrangements have been made yet.

The doctor of the **Pachewar** PHC does private practice during the duty hours. There is no ANM at the PHC and pregnant ladies need to travel either to Bhavda, 9 km, or to Malpura, 22 km. Mostly, there is dearth of medicines and staff at the centre and health facilities.

The doctor of **Kharera** PHC comes not more than twice in a month and other staff also does not remain present at the centre regularly. Because of lack of medicines and staff, there is poor service delivery at the PHC.

No timely opening of the PHC, no sanitation facilities, not sufficient beds, broken beds, unwashed covers, no drinking water facility, no functional BPL counter, the doctor remains outside mostly at his home – this is the case of **Datwas** PHC.

4.7 Secondary Data Findings

PHC Population Density

It was found that in some areas the density of PHCs is very high, whereas in some, it is very low. On discussion, it was found that due to political clout of one health minister in the area, she was able to get maximum PHCs in the area of her vote bank.
Distance mapping was done for every PHC and found long distance variation among the PHC location.

S. No.	Distance of the nearest PHC	Number
1	Below or equal to five kilometres	6
2	Below or equal to ten kilometres	27
3	More than or equal to fifteen kilometres	15
4	More than or equal to twenty kilometres	7

Post Sanctioned, Appointed and Vacant in all 45 PHCs in Tonk

The average number of posts vacant for five cadres for all PHCs in Tonk is nearly 12 percent, as evident from the Table below.

S. No.	Medical Providers	Posts Sanctioned	Appointed	Vacant	% Vacant
1	Doctors (MO)	47	42	5	11
2	Lab Technicians	42	36	6	14
3	Lady Health Visitors	47	35	12	25
4	Adult Nurse Midwives	50	47	3	6
5	Male Nurses	77	73	4	5
	Average				**12**

VICIOUS CIRCLE OF POOR SERVICE DELIVERY AT PHCs

Primary Health Centre

- Medicine comes once or twice in a year. Out of listed 35 medicines, only 10-15 medicines are provided and most of the times when requisition goes to the department, message of medicines not available comes. Most of the PHCs do not have any medical shop nearby.

- There is no proper infrastructure for health officials to stay near PHCs. At many of the places, even proper drinking water is not available. The problem of road, electricity, government quarters, market, etc., exists at many PHCs.

- No proper monitoring is done and monitoring is not done keeping service delivery in mind. Monitoring is not done to identify the problems to improve service delivery.

- There is a poor demand of services because of the negative perception of the people about the PHCs, their staff, facilities, etc.

- The PHC is not located in the centre of the village, but it is at a distance from the village.

- In some cases, officials at the PHCs have to fill the OPD list with fake names to show that the PHC is functional as there is criteria of a minimum number of patients for a PHC to run.

Health Officials

- They do not have required medicines to treat the patients. They also cannot prescribe as there is no medical shop. Sometimes, they do not have the medicines even for first

aid. They manage to buy the first aid medicines from the money collected through the patient registration charges. The community blames the health officials for non-availability of medicines. For BPL people, doctors are provided with money to buy medicines on the rate given by the department, but the rates are old and do not match with the market price.

- They have to be involved in data-related work and the quantum of this work is very high sometimes. Many times, they are called to the department to execute certain work without even taking them on deputation. The officials keep signing the register.

- Doctors have to play various roles like inspection of the sub-centres, running immunisation camps, family planning camps, meetings at district level, training, etc. When somebody asks where the doctor is, some reasons are given for the absence of the doctor. In some cases, it was also found that fresher join the PHC for money and experience and also keep preparing for higher studies and do not come to the PHC.

- In the absence of doctors, the male nurse becomes the head of the centre and he performs most of the jobs at the PHC. Since the number of staff members per patients is very high, they manage to come one day and abscond the next day, with some understanding among them. Many people prefer to call the male nurse at home, where he does the check ups and provides medicines brought from some medical store of nearby town and charge money. This generally happens during the free hours between the two shifts of the day.

- The trainings imparted to them are also of no use, mostly.

- Many times, the health officials, especially doctors, are not sanctioned leave.

Community

- The community members do not show the ownership to the PHC because of absence of their engagement in the functions of PHCs as envisaged under NRHM.

- They also do not have faith in the medicines provided at the PHCs.

- They also encroach/steal/damage, sometimes, the property of the PHCs.

- Lack of medicines at the PHCs leads them to quacks, where they get the medicines for their ailments.

Health Department at District Level

- There are not enough doctors available with the Department ready to work in the rural areas and stay there at the remuneration given by the government.

- The supply of medicines is less due to poor mechanism for medicine procurement and delivery.

- Under the NRHM, lot of data is to be provided, for which staff is not sufficient.

- There is political interference in transfers, selection of the location of the PHCs, etc., and more people try to get postings in the PHCs nearer the city/ their homes, etc.

RECOMMENDATIONS

Most of the beneficiaries appeared positive towards the scheme and its implementations, as evident from the data. However, there is lack of awareness on entitlements. People are happy as they are having a PHC nearby under the NRHM.

Strengthening Village Health and Sanitation Committee (VHSC)

Mostly the VHSC meetings are either not well attended or do not take place. Lack of information about the meetings or about the committee itself is the prime cause for this.

For effective functioning of the VHSC, following needs to be taken into account:

- A day should be fixed for VHSC meeting and it should be made known to every villager through various means of communication suitable to and available in the area.
- The *Sarpanch* and *other RPRIs* at the local level should be informed about their rights and duties in order to make VHSC meetings function properly by involving people, discussing the problems related to the particular health centre and sorting them out.
- The process of community monitoring of the PHC that is inbuilt in the NRHM should begin and continue. The use of telecommunication can be very well incorporated for community monitoring of the PHC, like a system of community monitoring through SMS, etc., can be developed.

Awareness Generation

Lack of information about the entitlements/facilities/staff at the centre among the villagers has emerged as a severe problem during interface and community meetings.

- Intensive awareness generation on the entitlements through rural means of communication must take place.

- The number and name of the staff should also be made public somewhere at all the PHCs and they should strictly write down the purpose of leaving the hospital during duty hours and the probable arrival time.
- The availability/non availability of medicines/facilities should also be proactively disclosed.
- The community should be made aware that the health officials at the PHCs are well qualified and will provide better treatment to them than quacks.

Availability of Medicines

- Sufficient availability of all the listed medicines at the PHC should be ensured. A minimum buffer stock should be maintained at each PHC. A shop for generic medicine can be opened at each PHC, either on contract basis or through the government. A medicine van can move every month to each PHC for medicine delivery. People other than the BPL should not be provided medicines free of cost.
- The RPRIs need to oversee the delivery of medicines to the BPL.

Facilities at the PHCs

- The health officials face several difficulties in staying at the PHCs because of lack of facilities. Functional toilets and drinking water must be available at every hospital.
- The provision of additional financial allocation is needed for bringing facilities at the local level to make the PHC functional.
- Medical facilities should also be enhanced, in order to provide better service delivery at the centre. This will lead to the re-generation of the faith of the community in the health centre.

Deployment

Deployment of the health officials should be optimum. There are PHCs which run for 24 hours of all seven days [24*7] with one doctor and that is impossible. The PHCs should be well equipped with the personnel as well as the health facilities. A lab technician is of no use if there are no facilities of lab at the PHC. At several places, lack of lower grade staff, like sweeper, etc., was found and also there are PHCs which are overstaffed. There are PHCs which, because of their proximity to the city, have more staff than required. The staff needs to be present during the duty hours and if this not possible, there should be alternative arrangements. This is needed for building up the faith of the community in the hospital. The Health Department should not be inhuman in cancelling the leaves of the health officials and there should be separate arrangement for data collection.

Grievance Redress Mechanism

Use of telecommunication can be very well incorporated in setting up a local helpline on call centre model, with toll free number, and should be made known to all the villagers. The villagers will be able to register their complaint about the service delivery at the PHC and possible steps can be taken for improving the quality of the service delivery. It will be very helpful for illiterate people to demand for better service delivery. This will solve several problems of grievance redress, information dissemination and awareness generation.

Monitoring by Officials

Regular monitoring (with increased frequency) and vigilance by various different level officials and PRI representatives, who should be particularly trained for monitoring and inspection and investigating service delivery, should be made mandatory.

Others

A public-private partnership (GO-NGO collaboration) for monitoring of the service delivery should be established for bringing transparency and accountability.

PROBLEMS ENCOUNTERED

- Delays due to 'code of conduct' in place for *Panchayat* and Municipal Elections

  Due to code of conduct in place for two kinds of elections and one village health campaign, the district administration showed their inability to participate in the events and support for any activity under the project.

  Action Taken: The project team postponed the activities, where the participation of district administration was needed, and, in the meantime, other activities under project were completed.

- Change of leadership in the *Panchayati Raj* Institutions (PRIs)

  Representatives of the RPRIs are one of the key stakeholders, who are given proper space in the NRHM and most of them are replaced by others after elections. The new RPRIs will take time to understand their role in the NRHM and its community monitoring component.

  Action Taken: The project team has taken both new and old RPRIs in to consideration for the purpose of community engagement in the scheme and also helping in building community based monitoring model.

- Frequent transfers of relevant government officials at various levels

  Transfers of the key officials at the district and state levels proved to be a big constraint for the implementation of the project. Officials, who assumed the position were also found not capable of supporting and guiding, since they were taking too much time to understand about the functions of their own department. .

Action Taken: The project team has started communication from the scratch each time.

- Non-responsiveness of the local level authorities

  Even after taking the officials on board from the beginning, the local level authorities are reluctant to provide the required support, as they are not convinced that the absenteeism data will not affect them negatively.

  Action Taken: The project team is still in search of champions at various levels of administration.

- Sensitivity of the issue of tracking absenteeism

  There is fear among the service providers at various levels that the data collected will be used against them for initiating some disciplinary action and hence they are reluctant to share any official records.

  Action Taken: The project team member keep reiterating at various platforms that the study is not meant for fault finding, but it is a fact finding process and wants to highlight the problems in service delivery. They will also get the insight by the study.

EVIDENCE-BASED ACTION AND ADVOCACY

(A) Project Launch Meeting

Tonk, Rajasthan, December 22, 2009

Introduction

CUTS Centre for Consumer Action, Research & Training (CUTS CART) in partnership with Results for Development (R4D) organised launch meeting of the project entitled, 'Ensuring Health Service Delivery through Community Monitoring in PHCs of Tonk, India' at *Jila Parishad* Conference Hall, Tonk, on December 22, 2009.

Objective

The objective of the meeting was to launch the project formally and to inform about its objectives to the concern government officials and the relevant stakeholders. It was also aimed to create a platform for various stakeholders to discuss health issues and work together in order to improve the health service deliveries.

Participation

More than 70 participants including officials from district health departments, medical officers, doctors, health workers from various primary health centres (PHCs), partnering organisations, selected community monitors, representatives of civil society organisations (CSOs), media and other individuals working on health issues attended the meeting.

Proceedings

The meeting commenced with screening of a documentary film 'Social Accountability in Action' narrating the experiences from grassroot level of using social accountability tools in getting better service delivery. **Amar Deep Singh**, Project Officer, CUTS welcomed all participants and guests.

George Cheriyan, Director CUTS International while delivering the introductory remarks mentioned that success of any public programme largely depends on the community involvement. Under the project, two aspects of National Rural Health Mission (NRHM) is being focused, i.e. community monitoring; and enhancing the capacity of *Panchayati Raj* Institutions (PRIs) to manage and control the functioning of health services.

He stated that the objective of the project is to provide feedback to the government on the status of the service deliveries in the PHCs through the community involvement. Social accountability tools will be utilised to assessing the services. As part of activities, 30 PHCs are selected in Tonk district and 150 monitors are selected and trained to monitor these PHCs. Support of district administration is expected for better implementation of the project, which is being implemented for fact-findings not for fault-findings. The success of this model can be replicated to other districts of the state.

He also provided brief about CUTS and its 25 years long journey from grassroots to international level. In conclusion he iterated that adequate support is required from the government, district administration, CSOs, media, PRIs, health officials and others for the successful implementation of the project.

Om Prakash Arya, Project Coordinator, CUTS presented the overview of the project through power point presentation. He stated the goal of NRHM which is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. But there is lack of community ownership in public health

programmes, which impacts the level of efficiency, accountability and effectiveness. Under NRHM, NGOs can be involved in monitoring, evaluation and social audit.

He said that CUTS have utilised three social accountability tools in Mid-day Meal Scheme (MDMS), National Rural Employment Guarantee Scheme (NREGS) and now going to utilise it in another flagship scheme NRHM.

Community Monitoring Card (CMC), Citizen Report Card (CRC) and Interview of Schedule are three selected tools of social accountability for the project. He told that CRC is a simple but powerful tool to provide public agencies with systematic feedback from users of public services. It helps in identifying issues that constraint the poor from assessing and using the services like availability, ease of access, quality, reliability and cost. He informed participants about the objectives, activities and expected outcome of the project.

Ramvilas Choudhary, *Jila Pramukh*, Tonk while delivering special remarks opined that Rs 11 crores have been provided to Tonk district under the NRHM. Due to participation of the community only, outcome of the programme is very poor. Involvement of the people is equally important for the success of any government scheme. There are several other factors, i.e. lack of proper system and coordination behind the poor implementation of public programmes. Civil society groups and media can play a key role in the proper implementation of these programmes.

He told that district administration would provide all the necessary support for the better implementation of this fair study conducted by CUTS in Tonk district.

Dr. RK Jawa, Additional Chief Medical & Health Officer appreciated CUTS for implementing this project in Tonk, which will provide a clear picture of the gaps in the NRHM implementation. He also said that involvement of the community

is also very important for better implementation of any health programme. He assured to provide necessary support for the implementation of the project in Tonk district.

Subbur Khan, District Programme Manager, NRHM talked about the implementation of NRHM in Tonk district. He mentioned that institutional deliveries were 20 percent in 2005, which increased by 64.40 percent in 2009. The target for 2010 is 70 percent which is the success of the *Janni Suraksha Yojna* (JSY). But still there is a need to improve services under NRHM. The gaps in these programmes need to be identified through such studies/projects. He assured to provide necessary support from district programme for CUTS study in Tonk.

During open discussion, participants showed their active participation. Devraj Singh, Block Programme Manager, NRHM urged on the need for the community to play an effective role in the health related programmes. Some of doctors of PHCs disclosed the lack of facilities like water, electricity in the PHCs, which affects the services. Asking on the reason of absenteeism, one doctor pointed out the reason as rare availability of leave for health officials. Auxiliary Nurse Midwives (ANMs) provided their feedback and said that they are only representatives in the field and working under difficult conditions. Representatives of the CSOs mentioned that there is need of better coordination between the community and service delivery. PRI members can also play important role in the health programmes.

Amar Deep Singh thanked all the guests and participants. In sum, he urged the participants to be part of the activity to find out the gaps in the services, which can be filled up through effective community participation.

Outcome

- Created the ground for effective awareness and marked the beginning of the campaign under the project.
- Government assured to provide necessary support in future activities of the project in the Tonk.
- Open discussion helped to understand the common problems faced by PHC staff and field workers.
- Wider media coverage helped in introducing the project, its objectives in a large context.
- Successful in terms of getting the government on board from the initial stage of the project.

(B) District Level Dissemination Meeting

State Institute of Agriculture Management

Tonk, Tuesday, 30 June 2010

Introduction

CUTS Centre for Consumer Action, Research & Training (CUTS CART), in partnership with the Results for Development Institute organised a District Level Dissemination Meeting (DLDM) under the project 'Improving Service Delivery through Measuring Rate of Absenteeism in 30 Health Centres in Tonk District of Rajasthan, India', being implemented in Tonk District of Rajasthan, at State Institute of Agriculture Management, Jaipur on June 30, 2010

Background

Good governance is one of the pathways to achieve the vision of Consumer Unity & Trust Society (CUTS) and so it has been continuously working for improving status of governance at all levels of government through the use of various methods and approaches. CUTS center for Consumer Action, Research & Training (CUTS CART) has been utilizing various social accountability approaches in various flagship schemes of GoI for enhancing client power and engagement in the processes of implementation.

CUTS CART is implementing a project 'Improving Service Delivery through Measuring Rate of Absenteeism in 30 Health Centres in Tonk District of Rajasthan, India' in partnership with Results for Development (R4D) institute under its Transparency and Accountability Programme (TAP). Through the implementation of various research activities and use of social accountability tools like Citizen Report Card and Community Monitoring under the project for the duration of 10 months now, the project has come up with concrete findings related to the delivery of health services in Tonk district and the findings as well as the advocacy points drawn out of evidence were disseminated through DLDM

Objective

The overall objective of dissemination was to advocate for making changes and engaging community in the implementation procedure for the improved service deliveries at the PHCs and also to show the effectiveness of community monitoring done as a project activities for better outcomes and cooperation among the service providers and service recipients.

Participants

The event experienced participation of around 80 relevant stakeholders including Dr. Ramawatar Jaiswal, Deputy Director, Department of Health & Family Welfare, Dr. R. P. Meena, Chief Medical & Health Officer (CMHO), Dr. R. K. Jawa, Dy. CMHO, Dr. Gopal Saini, RCHO, Tonk, District Programme Manager, Suboor Khan, Chief Planning Officer, B. L. Bairwa, Block CMHOs, Block Programme Managers, Doctors from PHCs, Representatives of PRI, Media and others.

Courtney Tolmie (CT), Senior Programme Officer from Results for Development Institute came down to Jaipur to be part of DLDM

Details of the Proceeding

Screening of the Film

A film 'Social Accountability in Action: Experiences from Grassroots' showing the experiences from grassroots of using the tools of Social Accountability in getting better service delivery was shown to the participants.

Welcome, Amar Deep Singh

At the outset, Amar Deep Singh, Project Officer, CUTS welcomed the distinguished participants and presented the overview of the project in brief

Introductory Remarks, George Cheriyan

George Cheriyan, Director, CUTS International, started with saying about the objective of the dissemination meeting of the project findings is to ensure maximum benefits of the health services in the primary health centres of Tonk by providing recommendations based on the evidences collected through various research activities and the use of social accountability tools to the district administration.

He further added that this project was not a fault finding mission but an effort to suggest certain measures based on citizens' report on the quality and quantity of service delivery entitled to poor and marginalized under NRHM. He said that huge budget is allocated for the National Rural Health Mission and is increasing every year as focus of government is to provide quality health service delivery to the people of this country so it should be made sure that the money is used in a proper and transparent way. He said this is possible when community monitoring aspect of NRHM is emphasized and implemented correctly.

He also added that out of all 33 district of Rajasthan, Tonk was selected to understand what is working well in the district as it is known as one of the progressive district under NRHM in Rajasthan. The idea behind considering Tonk is to see whether things are really working well and if working, then what is working well, so that it can also be replicated in other district of Rajasthan. At last he thanked Results for Development Institute and Courtney Tolmie for providing support to CUTS to do this study and also for coming down to Tonk to participate in the DLDM.

Opening Remarks, Courtney Tolmie

Courtney Tolmie (CT), Senior Programme Officer from Results for Development Institute started with her comment on the presence of all kind of stakeholders in the meeting and said that such mix groups are rarely seen in the US. She appreciated the CUTS works being done in the area of research and advocacy and said that she is very excited about the findings emerged out of the study done here in Tonk district of Rajasthan. Stating about the work done by Results for Development Institute, she said that it works in the area of transparency and accountability mainly in health and education sector. She said that R4D supports the organizations in the countries who know their country best instead of working directly.

She further added that the problem of absenteeism is rampant all over the world and it has major financial implications. She reiterated that her organization is committed to identify problems of service delivery in the countries of Asia, Africa etc to identify problems and come out with solution

Release of communiqué-Engaging Eyes by Courtney Tolmie

A communiqué based on the findings of the project was released by Courtney Tolmie during the DLDM and distributed to the participants.

This communiqué will work further as an advocacy tool during the project and later for bringing changes in the health service delivery. The electronic version of it will be circulated among a wider audience

Presentation of the findings, Om Prakash Arya

Om Prakash Arya, Project Coordinator, CUTS, presented the key findings emerged out of the various research activities and information gathered through the use of social accountability tools like Citizen Report Card and Participatory Absenteeism Tracking Process. A few of the key findings and recommendations are enlisted below.

Key findings

Absenteeism among all categories of health officials exists on an average at the rate of 27 percent. However, the range of absenteeism was found to be between 12 percent in case of the male nurses and 36 percent for the Doctors or the Medical Officers.

Medicines to the PHC reach once or twice in a year only, not round the year. Only 10 out of 35 listed medicines are made available and when they get exhausted, nothing can be done. Few medicines available at PHC are given to any one, irrespective of the ailments to the people.

Lack of faith in community towards Services at PHCs, Poor awareness on entitlements, People don't know any grievance redress mechanism, Negligible VHSC meetings, community monitoring, Low OPD Count (Fake names),Villagers are not sure about the services available at the PHCs

People do not know about any grievance redress mechanism under NRHM. Lack of Infrastructural facilities for a healthy life style for health officials, Doctors are given lot of other work, Not given leave, 24*7 hospitals have one doctor, PHCs are not located centrally, not evenly distributed

Community do not cooperate with health official of PHCs sometimes, Political interference in transfers, selecting PHCs location. Uneven distribution of staff, Poor availability of doctors to work in rural areas

Report card on JSY and Child health

S. No.	Provisions/Entitlements under JSY	Yes
1	Are you registered under JSY?	80
2	Were you given the iron tablets during pregnancy period?	76
3	Was any lab test done at the PHC during pregnancy?	75
4	Does government encourage institutional delivery in your opinion?	82
5	Do health workers come to patient's home for delivery purpose?	50
6	Whether your ANM has required skills for delivery?	87
7	Was economic help given after delivery?	68
8	Does your hospital have 24–hour delivery facility?	63

RESPONSES

Dr. Ramawatar, Dy. Director, DoFHW, GoR

Dr. Ramawatar Jaiswal praised CUTS by saying that its interventions in various areas are very effective. He further said that he is ready to accept recommendations and it will certainly help in improving the quality of service delivery at health centers. He added that the issue which is presented by Geroge Cheriyan is very relevant that budget is not an issue now but the issue is how to implement effectively the budget allocated under NRHM. He was remembering the days when due to lack of funds, CMHOs had to make visits to the PHCs on bicycles. He ordered the district health administration to make visits to the PHCs to look into their condition.

Dr. R. P. Meena, Chief Medical & Health Officer, Tonk

Dr. R. P. Meena was not agreeing with few of the findings related to the availability of medicines at the PHCs. He said that he will share the findings presented over here in the meeting of doctors and will see how medicines are not reaching to the health centers. According to him the medicines are not reaching because of lack of demand by the medical officers. Quoting the positive findings on service delivery, he said that the effort is visible through the reports of people and wherever there are problems, he will try to find out and rectify it.

Dr. R. K. Jawa, Dy. Chief Medical & Health Officer, Tonk

Dr. R. K. Jawa congratulated CUTS for the wonderful work it is doing and he said that it is very true that real development takes place when there is true community participation as

evident in the findings of the project. He also pointed out that community should also come forward and send their children to the schools especially girls

Md. Suboor Khan, District Programme Manager, NRHM, Tonk

Md. Suboor Khan, in response to the presentation of findings says that it needs to be investigated again by the department that the cash assistance is reaching the people properly or not because according to his report, most of the people are availing cash assistance under JSY. He further said that the name and mobile number of CMHO is written on the wall of the PHCs and if it is not there, then he will make arrangements for that. He also said that few of the recommendations presented here is already taken in to account. Facility mapping is started in the Tonk where all the villagers know about where to go in different phases of the deliveries to get the better services. At last he added that he is pleased that CUTS has done such study and the information provided by it will be used for further planning.

Dr. C.D. Vyas, Rrepresentative of Doctors at PHCs

Dr. C.D. Vyas told that it is very true that the PHCs are not located at right place. Generally it is outside the village. Before selecting the place to construct it, it should have been discussed in the Panchayat. He said that presently anyone is given position or made members in the Village Health & Sanitation Committee (VHSC) and they don't own the VHSC. The members of the PHCs should be selected cautiously and made responsible for its activities. He also pointed out the problem of electricity and water supply. He said, to reach timely at the PHC, He had taken bath at PHCx for 66 days in last financial year, as the water supply does not come on time.

Murli Dhar Sharma, Representative, Partner NGOs, Tonk

Murli Dhar Sharma told in his response that the Participatory Absenteeism Tracking process (PATP) was completed quietly without any information to the health officials. Later on when we went to the PHCs and told about the process of PATP is done and it will

continue further by the community membes, the service delivery and the presence of health officials increased at the PHCs. Now, we get the phone calls from many community members about the availability of services and staff. The health officials are also getting cooperation from the villagers and representatives of PRI. He also mentioned about one of the incidences, when community helped the doctor in one fake charge of corruption on doctor that was sabotaged by a quack near by because doctor was very helpful to community in context of providing health facilities.

Open Session & Vote of Thanks

Several other participants responded on the findings relating to their experiences and responded accordingly by the project team members. Madhu Sudan Sharma, in his concluding remarks, pointed out that the project aimed at finding out the highlights and gaps in the implementation of the scheme, which it has succeeded in and resulted in drawing recommendation for improvement at all levels.

He also proposed the vote of thanks. He thanked all the distinguished guests and participants, who attended District Level Dissemination Meeting from various places and gave special thanks to the partner NGOs and other officials of Tonk, who helped in the study for their efforts in various ways in supporting the project activities and showing their active presence in the meeting. He also thanked the team members like Shyam Sunder Vijay, Dharmendra Chaturvedi and Nikita Srivastava who helped in organizing the event.

Highlights

- Majority of the expected policy influencing government officials arrived to the meeting and showed their interest in finding of the study and also announced few decisions in order to improve the health service delivery
- Most of the findings were endorsed by officials and few of the problems found in study were taken seriously by the concerned authorities to look in to and find solutions
- Good electronic and print media coverage certainly drew attention of other relevant stakeholders who were not present in the meeting.

(C) State Level Dissemination cum Advocacy Meeting

Hotel Jaipur Palace, Jaipur

Thursday, 29 July 2010

Introduction

CUTS Centre for Consumer Action, Research & Training (CUTS CART), in partnership with the Results for Development Institute organised State Level Dissemination cum Advocacy Meeting (SLDAM) at Hotel Jaipur Palace Hotel in Jaipur on July 29, 2010 after incorporating the feedback gathered in the District Level Dissemination Meeting organized at Tonk under the project 'Improving Service Delivery through Measuring Rate of Absenteeism in 30 Health Centres in Tonk District of Rajasthan, India', being implemented in Tonk District of Rajasthan.

Background

Good governance is one of the pathways to achieve the vision of Consumer Unity & Trust Society (CUTS) and so it has been continuously working for improving status of governance at all levels of government through the use of various methods and approaches. CUTS center for Consumer Action, Research & Training (CUTS CART) has been utilizing various social accountability approaches in various flagship

schemes of GoI for enhancing client power and engagement in the processes of implementation.

CUTS CART is implementing a project 'Improving Service Delivery through Measuring Rate of Absenteeism in 30 Health Centres in Tonk District of Rajasthan, India' in partnership with Results for Development (R4D) institute under its Transparency and Accountability Programme (TAP). Through the implementation of various research activities and use of social accountability tools like Citizen Report Card and Community Monitoring under the project for the duration of 10 months now, the project has come up with concrete findings related to the delivery of health services in Tonk district and the findings as well as the advocacy points drawn out of evidence were disseminated through SLDAM

Objective

The overall objective of dissemination was to advocate for making changes and engaging community in the implementation procedure for the improved service deliveries at the PHCs and also to show the effectiveness of community monitoring done as a project activities for better outcomes and cooperation among the service providers and service recipients.

Participants

The event experienced participation of around 100 relevant stakeholders including the Mr. Rao Rajendra Singh, MLA, Rajasthan, Ms. Shyama Nagarajan (Health Specialist, World Bank, New Delhi and In-charge of Rajasthan Health System Development Project), Dr. Shiv Chandra Mathur (Executive Director, Rajasthan Health System Resource Centre), Ramawatar Jaiswal, Dy Director, Deparment of Health and Family welfare, Priyanka Singh (Seva Mandir, Udaipur) were the key respondents. The

representatives of CSOs, media and PRI and various other stakeholder groups attended the meeting and shared their experiences and responded on the presentations.

Details of the Proceeding

Screening of the Film

A film 'Social Accountability in Action: Experiences from Grassroots' showing the experiences from grassroots of using the tools of Social Accountability in getting better service delivery was shown to the participants.

Welcome, Amar Deep Singh

Amar Deep Singh, Project Officer, CUTS, welcomed the distinguished participants present on dias and other stakeholders present in the auditorium at the outset. He also presented the overview of the project in brief and said that the study was taking place in the Tonk district of Rajasthan for last one year and the major aspect, which was studied under the project was the status of health service delivery and community monitoring, which is an integral part of NRHM. After conducting district level dissemination meeting at Tonk and incorporating the comments, we will be presenting the key findings of the study today in this SLDM, he said.

Context Setting, George Cheriyan

George Cheriyan, Director, CUTS International, started with welcoming the distinguished guests and participants and shared about the objective of the dissemination meeting of the project findings is to ensure maximum benefits of the health services in the primary health centres of Tonk by providing recommendations based on the evidences collected through various research activities and the use of social accountability tools.

He further added that public expenditure management for better outcome is thrust of government now as we have huge

allocation and beautifully designed schemes and programmes. He informed that in the financial year 2010-11, government has allocated 37 percent of the outlay on the social sector which is unprecedented. He said that government had the mechanism of health service delivery but the reason behind inaugurating NRHM was to provide quality health service delivery for poor and marginalized for which community was given better space to engage themselves in the implementation of schemes and also to monitor the delivery of services.

He also talked about the existing accountability framework in the NRHM and the provision of internal monitoring, periodic survey and community based monitoring model. Further he said that education and health are the two sectors, which are human resource oriented, so this study has also tried to see the rate of absenteeism through community monitoring. At last he ensured emphatically that this was not a fault finding mission but an effort to suggest certain measures based on citizens' report on the quality and quantity of service delivery to policy makers. At the end he congratulated the whole team involved in the study for their rigorous and meaningful work.

Presentation of the findings, Om Prakash Arya

Om Prakash Arya, Project Coordinator, CUTS, presented the key findings emerged out of the various research activities and information gathered through the use of social accountability tools like Citizen Report Card and Participatory Absenteeism Tracking Process. He said that we come across with many astonishing news and information but we remain un-shocked. The cost of health services is so high that it brings down the people under poverty line from above poverty line and in such a scenario if public health facility is not working, we can imagine the people who are poor and marginalized. Refering to a WHO data, he said that in India, 72 percent of total healthcare expenditure is privately funded and 89.5 percent of which is paid by out-of-pocket patients.

A few of the key findings and recommendations are enlisted below.

Key findings

'36 per cent absenteeism was found in doctors and on an average 27 per cent of it was observed in 5 categories of health providers including doctors'. The male nurses were found at lowest at 12 percent. The financial loss due to this absenteeism was INR 8.4 million in a year while considering only five categories of health service providers.

while talking about methodology, he said that 900 unannounced on-spot observations were made for 35 consecutive days except on Sunday by 150 monitors selected from the catchment of the PHCs. One of the reasons behind absenteeism can be the poor infrastructure facilities for which interesting correlation was found. Other than that absence of medicines and other medical facilities at the centre and also poor implementation of community monitoring, which are integral part of NRHM, were found poor.

Along with the participatory absenteeism tracking, Citizen Report Card were utilized for 902 people to know their perception about the status of health service delivery in the district. In this project titled 'Ensuring service delivery through community monitoring of health services in 30 health centers in Tonk district of Rajasthan' CUTS kept civic engagement and community monitoring aspect of National Rural Health Mission (NRHM) as a central point

- 69 % of respondents say that they either get no medicines or only few medicines
- 47 % reports that they don't know about VHSC and only 54 % says that they have never met any VHSC member.
- 82 % of the people reported that they do not know any existing grievance redress mechanism.
- 44 % of the respondents found not to be satisfied with health service delivery.
- 32 % of respondents says that they have not received any cash assistance under JSY
- 37 % says that 24-hour delivery facility is absent at their PHC
- 34 % says that no one has visited their home to know their health status

- 24 % of JSY beneficiaries were not given iron tablets and 25 % were not done any lab test

To understand their viewpoint, the service providers were also interviewed and found that 69 percent of them want to change their PHC. At the same time, 12.5 percent of the respondents were found to be dissatisfied with their jobs and 25 percent of the respondents say that they don't get leave on demand. 41 percent of the service providers say there is shortage of staff and 12 percent of the respondents reported somebody having left a job recently.

Key Responses

Ghanhshyam Gurjar , Sarpanch, Gram Panchayat Pachewar

The *Sarpanch* of *Gram Panchayat Pachewar,* Ghanhshyam Gurjar shared that the PHCs in his village has neither lady doctor nor ANMs. He said that Pachewar Gram Panchayat is the largest in Tonk and several GPs are dependent on Pachewar PHCs but the position of ANM is vacant since last so many years. He further added that even the sub centers are not functional as they lack the presence of nurse and other support staff. He said that due to intervention of CUTS community monitoring initiative, the situation is improving but we request the govt. officials to look into the matter seriously.
Mohan Lal Meena

Mohan Lal Meena, Local Supporting NGO, Tonk

Mohan Lal Meena, representative local supporting NGOs in study in Tonk from Shri Kalyan Sewa Sansthan described about the implementation of various tools for absenteeism tracking and community based monitoring model in the project area briefly. He stated that lot of effort was made to obtain the authentic data and there were several levels of monitoring for absenteeism data collection.

Priyanka Singh, Seva Mandir, NGO, Udaipur

Ms Priyanaka Singh, In-charge, Education and Health Programme from Seva Mandir, Udaipur, congratulated CUTS for this initiative as such kind of absenteeism study is not done generally.. She further commented on the research methodology of the project and said that she could not understand how the authenticity of the data collected by the researchers was ensured. She added that she found Tonk as a very good district as in one such exercise, Seva Mandir found that the rate of absenteeism is as high as 60 percent in some cases. Commenting on the recommendation part of the study she said that IEC activities are not able to ensure awareness in the community and thus continuous and long term involvement with the community is needed to create awareness and sustain it.

(From L to R: George Cheriyan, Shyama Nagarajan, Rao Rajendra Singh, Shiv Chandra Mathur, Priyanka Singh)

Dr. Shiv Chandra Mathur, Executive Director, Rajasthan Health System Resource Center, (RHSRC), Government of Rajasthan

Dr Shiv Chandra Mathur, Executive Director, RHSRC in his response congratulated CUTS for taking such an initiative. He further threw light on the work on RHSRC and NRHM. Responding to the problem of PHCs not being situated centrally, he said that the allocation of PHCs is done on the basis of some norms and at times it's not possible to construct PHCs at central location due to various physical, geographical, political and social barriers. He further added that the 24*7 means that they must have a support staff (preferably ANM) present round the clock at the center and that the doctor of the PHC is not supposed to give duty at the center 24*7. He also stated that if there is any shortage in supply of drugs at the PHC the reason must be some sort of management problem, as there is no shortage in supply of such drugs.He further added that schemes like JSY must reach to the intended beneficiaries. On the matter of Village Health and Sanitation Committee (VHSCs), he said that there is 'silent revolution' taking place in the villages through the process of strengthening VHSC.

Ms. Shyama Nagrajan, Incharge, Rajasthan Health System Development Project and Health Specialist, The World Bank

Ms. Shyama Nagarajan, Incharge, Rajasthan Health System Development Project from World Bank, shared her views on the presentation. She stressed on the fact that there must be shared responsibilities of the individuals to ensure their accountability and thus contribute towards governance. She congratulated CUTS for its effort to mobilize communities and conduct such a vast study. She also shared her experiences of working in Rajasthan through RHSDP project and said that in the four years of programme she has noticed visible change in the attitude of communities in Rajasthan. They have started to come up with their response on the status of service delivery which shows the enhanced level of awareness among mass who asks for there entitlements.

Mr, Rao Rajendra Singh, Member of Legislative Assembly, Rajasthan Assembly

Mr Rao Rajendra Singh MLA, Rajasthan shared his valuable experiences on the study and related facts. He said that even after 60 years of independence we have people living below poverty line equal to the population of India at the time of independence. He also further stated that according to the report of Transparency International, corruption is in Health Department is maximum. Adding to the fact he stated that total immunization in Rajasthan is mere 27% according to the Rajasthan health survey. He stressed on the point that elected representatives bears of cost of poor service delivery and poor governance. He pointed out that India is a democracy having the biggest constitution and people who have to know the constitution are significantly illiterate, so how can they exercise their rights until they know them. He very strongly remarked on the poor status of Integrated Child Development Scheme (ICDS) and to ensure to Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) the services under ICDS need to be ensured, He said. He stressed on the fact that there must be a attendance system for public representatives too. At last, he questioned why the problems remain same every time when go for election even after having 6 public elected representatives for one person in India Until and unless there is spirit among us to ameliorate the things and be accountable, we will not be able to progress, he concluded.

Open Session

Mr Om Prakash from an organization CULP, asked that whether Tonk district can be representatives of the state. He further asked that the sampling method of this research must be

made clearer. He further inquired if the headquarter of the medical officers is PHC or the district where the PHC is located. He also raised the query why only 30 PHCs out of 45 were selected for the study and the scientific reason behind it, if any. Dr Shipra Mathur, Development & Communication Division, Rajasthan Patrika, Hindi Daily, asked to the present policy makers the way forward to move Mr. Brij Bihari Sharma, head of one of the partner organizations, answered few questions related to the methodologies and made it clear. Several other participants responded on the findings relating to their experiences and responded accordingly by the project team members.

Vote of Thanks

Madhu Sudan Sharma, in his concluding remarks, pointed out that the project aimed at finding out the highlights and gaps in the implementation of the scheme, which it has succeeded in and resulted in drawing recommendation for improvement at all levels. He also proposed the vote of thanks. He thanked all the distinguished guests and participants, who attended State Level Dissemination Meeting from various places and gave special thanks to the partner NGOs and other stakeholder of of Tonk, who helped in the study for their efforts in various ways in supporting the project activities and showing their active presence in the meeting as they were present in the SLDM to support the study findings in large number. He also thanked the governance team members Shyam Sunder Vijay, Dharmendra Chaturvedi and Nikita Srivastava who helped in organizing the event and making it successful.

Highlights

- policy influencing government officials arrived to the meeting in significant number and showed their interest in finding of the study
- Large number of relevant stakeholders including large number of media member remained present through out the meetings.

- Good electronic and print media coverage certainly drew attention of other relevant stakeholders who were not present in the meeting.

(D) Production of Documentary Film- A Tool for Advocacy

A documentary film titled Engaging Community in Health Services' of the duration of 10 minutes could be produced under the project .This documentary film shows the problems faced by the rural community in accessing the health services because of the poor functioning of the health centres at the primary health centres . This documentary could also show the benefits of community-based monitoring model created under the project in enhancing the service delivery at the PHCs.

This documentary film was released on August 25, 2010 by Roland Lomme, the governance advisor, The World Bank. This is being utilized as an advocacy tool by showing at different platform. This film can be viewed visiting this link: http://www.cuts-international.org/CART/Documentary-Engaging_Communities_in_Health_Services.htm

E) Presentation of 'Absenteeism Study'

World Bank, New Delhi

August 25, 2010

CUTS was invited to present 'Absenteeism Study' on August 25, 2010 at the World Bank, New Delhi. This seminar was attended by the governance and health staff team coordinated by Mr. Roland Lomme, Advisor, Governance & Institutional Development, The World Bank and Mr. Gerard M. La Forgia, Lead Health Specialist, South Asia Human Development Department, The World Bank.

The seminar started at 5.00 pm in the VC room with the opening remarks by Roland introducing CUTS and the governance work. Jerry introduced findings of the study. The presentation on study was made by Mr. George Cheriyan and Mr. Om Prakash Arya and it was concluded with a 10 minute documentary film based on the study. The participants asked lot of questions starting with the definition of absenteeism, methodology, process, findings, sustainability of the suggested community based monitoring model etc., which was answered Some interventions were suggestive in nature to make such studies more effective.

The discussions concluded by 6.45 pm with Jerry once again appreciating the study and (the health team) making a proposal to Roland (governance team) about their desire to engage CUTS for a 'stoke taking of successful working community based monitoring models in health

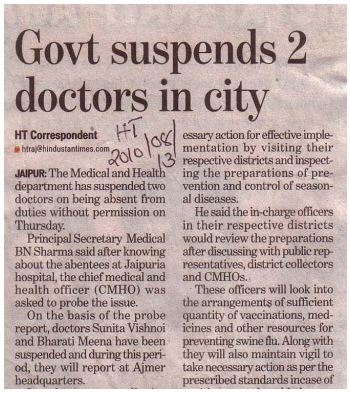
sector (it could be in other sectors as well) in various states (at least 10 states) in India' supported by the World Bank. The fund availability also was suggested. Prior to the seminar, CUTS members had separate meetings with Jerry and Roland. In the meeting, the focus was the study and some possible engagement of CUTS in the health sector.

INITIAL IMPACTS OF ADVOCACY AND COMMUNITY MONITORING

1) Regular community monitoring of the PHCs has helped in improving service delivery there. According to the reports from the partner organizations, the availability of medicines and officials at the health centers have increased. The supply of medicines is also better this year, according to a doctor. It was decided to list down the names of the officials on the wall of PHCs, so that any one visiting the PHC can monitor the absenteeism and report in the village health and sanitation committee to take action. Prior to this, people were not even aware about the number of staffs this Primary Health Centre.

2) The involvement of PRIs in the functioning of PHCs have helped in solving various problems related to the facilities at the health centre. One of the PHCs was facing the acute problem of drinking water as the tube wll water contains high level of fluride in it. In the interface meeting between service providers and recipients, it was decided to build a Tanker in the premise of the PHC. The head of the Gram Panchayat made this Tank there and now water is brought through tanker. This has been a great help for health officials as well as the patients of the PHC.

3) After the state level dissemination meeting, the state government has increased its vigilance to the PHCs for the quality service delivery and the absenteeism. The principal Secretary, Health & Family welfare, have suspended few officials because they were



Govt suspends 2 doctors in city

HT Correspondent
htraj@hindustantimes.com

HT 20/10/13

JAIPUR: The Medical and Health department has suspended two doctors on being absent from duties without permission on Thursday.

Principal Secretary Medical BN Sharma said after knowing about the abentees at Jaipuria hospital, the chief medical and health officer (CMHO) was asked to probe the issue.

On the basis of the probe report, doctors Sunita Vishnoi and Bharati Meena have been suspended and during this period, they will report at Ajmer headquarters.

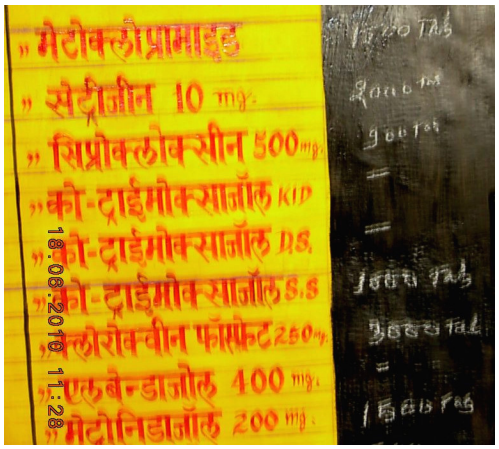
essary action for effective implementation by visiting their respective districts and inspecting the preparations of prevention and control of seasonal diseases.

He said the in-charge officers in their respective districts would review the preparations after discussing with public representatives, district collectors and CMHOs.

These officers will look into the arrangements of sufficient quantity of vaccinations, medicines and other resources for preventing swine flu. Along with they will also maintain vigil to take necessary action as per the prescribed standards incase of

absent from the health centers during duty hours without any information. This increased vigilance has also helped in restricting absenteeism at the PHCs.

4) Availability of medicines is now written on wall and updated regularly. This helps the visitors including higher authorities of health department to get to know the availability of medicines. The community can also put pressure on the health department to make the medicines available in sufficient quantity in this case.



5) The media coverage of the state level dissemination cum advocacy meeting have triggered the similar study of absenteeism in other department related to rural development. One organization named Mazdoor Kissan Shakti Sangathan have visited the offices responsible for implementing Mahatama Gandhi National Rural Employment Guarantee Scheme (MGNREGS) between 9.30 AM to 10.30 AM and found that only 30 percent officials were present on their seat.

Mazdoor Satyagrah seeks accountability panel

TIMES NEWS NETWORK

Jaipur: The on-going Mazdoor Satyagrah has demanded the setting up of an accountability commission in the state. Activists of the Satyagrah will be writing to CM Ashok Gehlot asking him to do this.

The demand follows alleged measures by the government to penalise MGNREGA workers and its own employees coming late to offices, alleged activists."It is a follow-up of an exercise we did on Thursday. Having visited various government offices between 9.30 am and 10.30 am we found that only 30% of the employees were present on their seats. In some offices people reported for work even two hours or so late. Therefore, we want to know what kind of action the government proposes to take against such employees as in case of MGNREGA workers even half an hour late for work means the entire day's wages are deducted," says Nikhil Dey, an activist of the Rozgar Evum Suchna Ka Adhikar Abhiyan.

CALL FOR TRANSPARENCY

as wages per day, as in the Gudaliya village of Tonk, the government has been saying that the villagers did not work and so their salary was deducted so what about those officers who come regularly late to various government offices," he asks.

Dey said while empty seats greeted them at most places, there were also offices where all reported for work sharp at 9.30 am. "And the interesting part is that in all such offices the office boys were always punctual. But as one moves up the hierarchy the delay in reporting for work increases," he said.

Explaining the work of the accountability commission, he said that it would not only determine who is supposed to work how, but spell out in detail the work of even a minister, a policeman, a bureaucrat and even a labourer. "It should also suggest the penalties for all the people concerned if they do not do their work," he said.

In the survey, the activists also came upon the fact that the mandatory Section 4 of the RTI is not all being ad-

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http://www.nrhmcommunityaction.org/media/documents/Managers%20Manual.pdf

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http://www.accountabilityindia.org/admin/uploads/vitalfiles/53_1268110455.pdf

Event Photographs

NGO Consultation Meeting at Tonk on September 10, 2009

Orientation Programme for NGOs & Monitors

Interactions & Meetings with community on various occasions

Interface Meetings in various *Gram Panchayats*

District Level Dissemination cum Advocacy Meeting at Tonk on June 29, 2010

Project area visit of Courtney Tolmie on June 29, 2010

State Level Dissemination cum Advocacy Meeting
at Jaipur on July 29, 2010

Documentry Film Production at project area

News Clippings

Project Launch Meetings

दैनिक भास्कर जयपुर · बुधवार, 23 दिसंबर 2009

स्वास्थ्य कार्यक्रम में जनसहभागिता जरूरी

टोंक. जिला परिषद सभागार में कट्स की ओर से आयोजित कार्यशाला में उपस्थित लोग।

कट्स की ओर से सामुदायिक निगरानी द्वारा स्वास्थ्य सेवाओं में सुधार विषय पर कार्यशाला

कार्यालय संवाददाता | टोंक

कट्स की ओर से जिला परिषद सभागार में मंगलवार को 'सामुदायिक निगरानी द्वारा स्वास्थ्य सेवाओं में सुधार' विषय पर कार्यशाला का आयोजन किया गया।

जिला प्रमुख रामबिलास चौधरी ने कहा कि किसी भी मिशन एवं योजना की कामयाबी उसके समय एवं सही दिशा में कार्य करने पर ही निर्भर है। कई योजनाएं आती है तथा कई गैर सरकारी संस्थाएं कार्य करती है। आवश्यकता के अनुरुप व समय पर कार्य को अंजाम नहीं देने के कारण उनकी सार्थकता सिद्ध नहीं हो पाती है। जिला प्रमुख ने सही समय पर सही दिशा में कार्य किए जाने पर जोर दिया। उन्होंने केंद्र व राज्य सरकार की ग्रामीण स्वास्थ्य योजनाओं की जानकारी देते हुए उसके सफल क्रियान्वयन में जनसहभागिता की जरूरत बताई। कार्यक्रम में कट्स के निदेशक जार्ज चेरियन, ओमप्रकाश आर्य, अमरदीप सिंह, मधुसूदन शर्मा आदि ने भी कट्स की गतिविधियों एवं कार्यप्रणाली पर प्रकाश डाला। कार्यक्रम में मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी, एसीएमएचओ डॉ. आरके जावा, डॉ. एसके गोयल, बृजबिहारी शर्मा, मुरलीधर शर्मा, नंदलाल चौधरी, नरेन्द्र शर्मा, इंदिरा शर्मा सहित स्वास्थ्य कार्यक्रम से जुड़ी महिलाएं मौजूद थीं।

राजस्थान पत्रिका
टोंक, बुधवार, 23 दिसम्बर 2009

संस्थागत प्रसव पर जोर

टोंक के जिला परिषद सभागार में मंगलवार को आयोजित कट्स संस्था की कार्यशाला को संबोधित करते अतिथि।

टोंक, 22 दिसम्बर (कासं.)। यहां कट्स सेंटर फॉर कन्ज्यूमर एक्शन रिसर्च (कट्स) एण्ड ट्रेनिंग के तत्वावधान व रिजल्ट फॉर डवलपमेंट के सहयोग से जिला परिषद के सभागार में मंगलवार को कार्यशाला हुई। कार्यशाला में जिला प्रमुख रामबिलास चौधरी ने स्वास्थ्य केन्द्रों में मरीजों को समय पर उपचार दिलाने पर जोर दिया।

उन्होंने कहा कि चिकित्सक सरकारी योजनाओं की क्रियान्वयन ठीक प्रकार से करें। कट्स के निदेशक जॉर्ज चेरियन ने संस्थागत प्रसव जच्चा-बच्चा को समय पर उपचार दिलाने को कहा। जिला परियोजना प्रबंधक सुबूर खान ने भी संस्थागत प्रसव व स्वास्थ्य केन्द्रों पर उपलब्ध कराई जा रही योजनाओं की जानकारी दी। कार्यशाला को अतिरिक्त मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी डॉ.आर के जावा, कट्स के मधुसूदन शर्मा तथा ओमप्रकाश आर्य ने भी सम्बोधित किया।

दैनिक नवज्योति जयपुर बुधवार, 23 दिसंबर, 2009 सच्चा हमसफर

टोंक में सामुदायिक निगरानी द्वारा स्वास्थ्य सेवाओं में सुधार परियोजना शुभारंभ कार्यक्रम को सम्बोधित करते हुए जिला प्रमुख रामबिलास चौधरी। फोटो- श्याम

परियोजनाओं में जनसहभागिता जरूरी : चौधरी

कट्स के स्वास्थ्य सेवाओं में सुधार का शुभारम्भ

न्यूज सर्विस

टोंक, 22 दिसम्बर। जिला प्रमुख रामबिलास चौधरी ने कहा कि एनआरएचएम स्वास्थ्य सेवाएं प्रदान करने के लिए एक महत्वपूर्ण परियोजना है, पर इसका लाभ लोगों को तभी मिल पाएगा, जब इसमें जनसहभागिता सुनिश्चितता की जाएगी।

चौधरी मंगलवार को जिला परिषद सभागार में आयोजित टोंक जिले में रिजल्ट फार डवलपमेंट एजेंसी के सहयोग से कट्स द्वारा चलाई जा रही सामुदायिक निगरानी द्वारा स्वास्थ्य सेवाओं में सुधार का शुभारंभ कार्यक्रम को सम्बोधित कर रहे थे। उन्होंने कहा कि टोंक जिले में एनआरएचएम के तहत 11 करोड़ रुपए का आवंटन है, परन्तु कार्य की समीक्षा करते समय उपयुक्त परिणाम नज़र नहीं आते। कट्स के निदेशक जार्ज चेरियन, परियोजना कर्मचारी ओमप्रकाश आर्य, अमरदीप, मधुसुदन शर्मा ने परियोजना के विभिन्न पहलुओं पर प्रकाश डालते हुए कहा कि इसमें जिला प्रशासन का सहयोग अपेक्षित है। यह परियोजना किसी दोषारोपण के ख्याल से नहीं बल्कि स्वास्थ्य सेवाओं में मिलजुल कर सुधार करने की परियोजना होगी। उन्होंने बताया कि कट्स द्वारा संचालित इस परियोजना का उद्देश्य प्राथमिक स्वास्थ्य केन्द्रों पर उपस्थित सुविधाओं में सामुदायिक निगरानी द्वारा सुधार लाना है, परियोजना से प्राप्त निष्कर्षों को सुझावों के साथ सरकार तक पहुंचाना एवं उन्हें लागू कराने की पैरवी कराना है। अतिरिक्त मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी डा.आर.के.जावा, जिला परियोजना प्रबंधक सुबूर खान, ब्लॉक परियोजना प्रबंधक और अन्य स्वास्थ्य कर्मचारियों ने भी सभा को सम्बोधित किया।

HINDUSTAN TIMES, NEW DELHI
THURSDAY, DECEMBER 24, 2009

Project launched

JAIPUR: A project titled 'Ensuring health service delivery through community monitoring in primary health centres (PHCs) of Tonk, Rajasthan' was launched at Zila Parishad Conference Hall, Tonk. The National Rural Health Mission was an important programme for providing better health services to rural people. But these services could be delivered only through community participation, said Zila Pramukh, Ramvilas Choudhary. CUTS International and Result for Development the US designed and implemented the project. The aim is to improve services at PHCs.

HTC

दैनिक ताज भारती 23 दिसम्बर 2009

स्वास्थ्य सेवाओं की योजना में जन सहभागिता सुनिश्चित हो-जिला प्रमुख

टोंक 22 दिसम्बर (कासं)। एनआरएचएम स्वास्थ्य सेवाएं प्रदान करने हेतु एक महत्वपूर्ण परियोजना है पर इसका लाभ लोगों को तभी मिल पाएगा जब इसमें जन सहभागिता सुनिश्चित की जा सकेगी। जिला प्रमुख रामबिलास चौधरी टोंक जिलें में कट्स द्वारा चलायी जा रही परियोजना 'सामुदायिक निगरानी द्वारा स्वास्थ्य सेवाओं में सुधार' के शुभारम्भ बैठक में बोल रहे थे। चौधरी ने बताया कि टोंक जिले एनआरएचएम के तहत 11 करोड़ रूपये का आवंटन है परन्तु कार्य की समीक्षा करते समय उपयुक्त परिणाम नजर नहीं आते। यह शुभारम्भ बैठक आज जिला परिषद सभागार में किया गया। कट्स के निदेशक जार्ज चेरियन, परियोजना ओम प्रकाश आर्य, अमरदीप सिंह और मधूसूदन शर्मा ने परियोजना के विभिन्न पहलुओं पर प्रकाशा डाला और कहा कि इसमें जिला प्रशासन का सहयोग अपेक्षित है।

यह परियोजना किसी दोषारोपण के खयाल से नही बल्कि स्वास्थ्य सेवाओं में मिलजुल कर सुधार करने की परियोजना होगी। जिले के अतिरिक्त मुख्य चिकित्सा एवं स्वास्थ्य आर.के.जावा, जिला परियोजना प्रबन्धक सुबूर खांन, ब्लॉक परियोजना प्रबन्धक और अन्य स्वास्थ्य कर्मचारियों ने भी सभा को सम्बोधित किया और कट्स को पूरा सहयोग देने का आश्वासन दिया। इसके अलावा विभिन्न संस्थाओं के प्रतिनिधियों ने भी अपना मत रखा। कट्स द्वारा संचालित इस परियोजना का उद्देश्य प्राथमिक स्वास्थ्य केन्द्रों पर उपस्थित सुविधाओं में सामुदायिक निगरानी द्वारा सुधार लाना है तथा परियोजना से प्राप्त निष्कर्षों को सुझावों के साथ सरकार तक पहुंचाना एवं उन्हें लागू कराने की पैरवी कराना हैं। उक्त परियोजना रिजल्ट फॉर डेवलपमेंट एजेन्सी के सहयोग से टोंक जिले में चलायी जा रही हैं।

खबरों की दुनिया

टोंक, 23 दिसम्बर, 2009

एनआरएचएम स्वास्थ्य सेवाएं प्रदान करने के लिए एक महत्वपूर्ण परियोजना: चौधरी

सामुदायिक निगरानी द्वारा स्वास्थ्य सेवाओं में सुधार के शुभारंभ कार्यक्रम

टोंक, 22 दिसम्बर (नि.स.)। मंगलवार को टोंक जिले में रिजल्ट फार डवलपमेंट एजेंसी के सहयोग से कट्स द्वारा चलाई जा रही परियोजना सामुदायिक निगरानी द्वारा स्वास्थ्य सेवाओं में सुधार के शुभारंभ कार्यक्रम को जिला परिषद सभागार में सम्बोधित करते हुए जिला प्रमुख रामबिलास चौधरी ने कहा कि एनआरएचएम स्वास्थ्य सेवाएं प्रदान करने के लिए एक महत्वपूर्ण परियोजना है, पर इसका लाभ लोगो को तभी मिल पाएगा, जब इसमें जनसहभागिता सुनिश्चितता की जाए। उन्होंने कहा कि टोंक जिले में एनआरएचएम के तहत 11 करोड़ रुपए का आवंटन है, परन्तु कार्य की समीक्षा करते समय उपयुक्त परिणाम नजर नहीं आते। कट्स के निदेशक जार्ज चेरियन, परियोजना कर्मचारी ओमप्रकाश आर्य, अमरदीप, मधुसुदन शर्मा ने परियोजना के विभिन्न पहलुओ पर प्रकाश डालते हुए कहा कि इसमें जिला प्रशासन का सहयोग अपेक्षित है। यह परियोजना किसी दोषारोपण के ख्याल से नही बल्कि स्वास्थ्य सेवाओं में मिलजुल कर सुधार करने की परियोजना होगी। उन्होंने बताया कि कट्स द्वारा संचालित इस परियोजना का उद्देश्य प्राथमिक स्वास्थ्य केन्द्रो पर उपस्थित सुविधाओं में सामुदायिक निगरानी द्वारा सुधार लाना है, परियोजना से प्राप्त निष्कर्षो को सुझावों के साथ सरकार तक पहुंचाना एवं उन्हे लागू कराने की पैरवी कराना है। अतिरिक्त मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी डा.आर.के.जावा, जिला परियोजना प्रंबधक सुबूर खान, ब्लाक परियोजना प्रबंधक और अन्य स्वास्थ्य कर्मचारियों ने भी सभा को सम्बोधित करते हुए कट्स को पूरा सहयोग देने का आश्वासन दिया। इसके अलावा विभिन्न संस्थाओं के प्रतिनिधियों ने भी अपना मत रखा।

अधिकार

टोंक, बुधवार, 23 दिसंबर, 2009

सिस्टम की कमियां जन सहभागिता से दूर करें : जिला प्रमुख

टोंक 22 दिसंबर (कासं)। राष्ट्रीय ग्रामीण स्वास्थ्य मिशन आमजन को स्वास्थ सेवाएं प्रदान करने की एक महत्वपूर्ण योजना है इसका लाभ तब ही मिल पायेगा जब इसने जन सहभागिता सुनिश्चित की जा सकेगी। उक्त विचार जिला प्रमुख राम विलास चौधरी ने यहां जिला परिषद सभागार में कट्स द्वारा चलाई जा रही सामुदायिक निगरानी द्वारा स्वास्थ्य सेवाओं में सुधार कार्यक्रम में कहे चौधरी ने बताया कि टोंक जिले में एन.आर.एच. एम के तहत 11 करोड रूपयों का आवटन है फिर भी परिणाम संतोश जनक नहीं आते है। कट्स के निदेशक जार्ज चोरियन ने कहा कि संस्थां द्वारा दोंनों पहलुओं पर निगरानी रख जाती है सेवा प्रदाता की समस्याओं तथा ग्रामीण जन की समस्याओं दोनों पहलुओं का सर्वे कर राज्य व केन्द्र सरकार को भेजा जायेगा।

दैनिक भास्कर

जयपुर · मंगलवार, 22 दिसंबर 2009

सेवाओं में सुधार को लेकर बैठक आज

टोंक. प्राथमिक स्वास्थ्य केंद्रों में सेवाओं में सुधार परियोजना की बैठक कट्स इंटरनेशनल जयपुर द्वारा रिजल्ट फॉर डवलपमेंट ऐजंसी के सहयोग से जिला परिषद के सभाभवन में मंगलवार सवेरे 11 बजे आयोजित होगी। बैठक में कई विभागों के प्रतिनिधि उपस्थित थे।

District Level Dissemination Meeting at Tonk

राष्ट्रदूत जयपुर, 30 जून, 2010

'स्वास्थ्य और शिक्षा के क्षेत्र में अनुपस्थिति का मामला विकासशील देशों में आम'

टोंक में कट्स की और से आयोजित कार्यशाला मे सीनियर प्रोग्राम ऑफिसर कर्टनी टॉलमी ने योजनाओं पर आधारित फोल्डर का विमोचन किया। फोटो-चावला

टोंक, (निसं.)। स्वास्थ्य और शिक्षा के क्षेत्र मे अनुपस्थिति का मामला विकासशील देशों में आम है जिसके गम्भीर वित्तीय परिणाम होते हैं साथ ही सेवाओं के वितरण भी निराशाजनक असर होते हैं। यह बात मंगलवार को यहां कट्स की आयोजित परियोजना प्रसार बैठक में बोलते हुए कर्टनी टॉलमी जो अमेरिका के एक गैर सरकारी संस्थान रिजल्ट्स फॉर डवलपमेन्ट्स में सीनियर प्रोग्राम ऑफिसर हैं। उन्होने कहा कि कट्स टोंक जिले में अध्ययन कर स्वास्थ्य सेवाओं में सुधार के लिए प्रयासरत हैं, यह खुशी की बात है।

इस अवसर पर प्रचार-प्रसार के लिए जिला स्तरीय योजना के फोल्डर का कर्टनी टॉलमी सहित अन्य पदाधिकारियों ने विमोचन किया। कट्स इन्टरनेशनल के निदेशक जॉर्ज चेरियन ने कहा कि राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के लिए काफी बजट आवंटन हो रहा है पर उस आंवटन का समुचित उपयोग पारदर्शी तरीके से सुनिश्चित किया जाना बेहर आवश्यक है। उन्होंने कहाकि यह अध्ययन राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के क्रियान्वयन में आने वाली समस्याओं का पता लगाने के लिए किया गया है ताकि उसमें सुधार किये जा सकें तथा इसमें सामुदायिक निगरानी और नागरिक रपट कार्ड जैसे सामाजिक जवाबदेहिता के उपकरणों का उपयोग किया गया है। ताकि सुशासन स्थापित किया जा सकें। उन्होंने कहा कि टोंक जिले में 30 प्राथमिक स्वास्थ्य केन्द्रों का वैज्ञानिक तरीके से चुनाव किया गया है। कार्यशाला में मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी आर.पी. मीणा, डॉ आर.के.जावा सहित स्वास्थ्य विभाग के अधिकारी व समाज सेवी संगठनों के पदाधिकारी मौजूद थे।

दैनिक भास्कर

जयपुर · बुधवार, 30 जून 2010

टोंक. कृषि विस्तार केंद्र में कट्स की आयोजित बैठक में योजनाओं के फोल्डर का विमोचन करते अतिथि।

कट्स की परियोजना प्रसार बैठक आयोजित

टोंक| कृषि विस्तार केंद्र के सभागार में मंगलवार को कट्स की परियोजना प्रसार बैठक आयोजित हुई, जिसमें जिले के स्वास्थ्य अधिकारियों सहित कट्स के प्रतिनिधि आदि मौजूद थे। इस बैठक में सरकार द्वारा स्वास्थ्य व शिक्षा पर अधिक ध्यान दिए जाने के बावजूद योजनाओं की सही क्रियान्विति नहीं होने सहित ग्रामीण क्षेत्रों में कई शिक्षक व स्वास्थ्य कर्मियों के नदारद रहने की बात भी सामने आई। कट्स इन्टरनेशनल के निदेशक जार्ज चेरियन ने कहा कि राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के लिए काफी बजट आवंटन हो रहा है। पर उस आवंटन का समुचित उपयोग पारदर्शी तरीके से सुनिश्चित किया जाना बेहद आवश्यक है। समन्वयक ओम प्रकाश आर्य ने निष्कर्षों के प्रस्तुतिकरण में कहा कि जिले में औसत रुप से स्वास्थ्य कर्मचारियों में 27 प्रतिशत की अनुपस्थिति दर्ज की गई है। दवाओं की अनुपयोगिता भी एक प्रमुख समस्या के रुप में सामने आई है। स्वास्थ्य विभाग के अधिकारी नदारद रहने की स्थिति से इनकार करते रहे, लेकिन अव्यवस्थाओं आदि को लेकर व कोई संतोषजनक जवाब नहीं दे पाए। राज्य के परिवार स्वास्थ्य एवं कल्याण विभाग के उपनिदेशक रामावतार जायसवाल, सीएमएचओ आरपी मीणा, उप सीएमएचओ आरके जावा, जिला कार्यक्रम प्रबंधक सुबूर खान ने भी विचार व्यक्त किए।

राजस्थान पत्रिका

टोंक . बुधवार . 30 जून 2010

कार्यशाला

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन की पुस्तक का विमोचन

मिशन के बजट का पारदर्शी तरीके से उपयोग जरूरी

अनुपस्थिति चिंताजनक

कार्यालय संवाददाता @ टोंक

चिकित्सा एवं स्वास्थ्य विभाग से जुड़े कर्मचारियों की कार्यालयों से अनुपस्थिति चिंताजनक है। यह विचार निजी संस्था कट्स ओर से टोंक के कृषि प्रशिक्षण केन्द्र में मंगलवार को आयोजित कार्यशाला में वक्ताओं ने व्यक्त किए। अमेरिका के एक गैर सरकारी संगठन की वरिष्ठ कार्यक्रम अधिकारी कर्टनी टॉलमी ने कहा कि स्वास्थ्य व शिक्षा के क्षेत्र में अनुपस्थिति का मामला विकासशील देशों में आम है। कट्स अन्तरराष्ट्रीय के निदेशक जॉज चेरियन ने कहा कि मिशन के बजट का पारदर्शी तरीके से उपयोग जरूरी है। परियोजना के समन्वयक ओमप्रकाश आर्य, सीएमएचओ आरपी मीणा, परिवार स्वास्थ्य एवं कल्याण विभाग के उपनिदेशक रामवतार जायसवाल ने भी विचार व्यक्त किए। इस दौरान अतिथियों ने सामुदायिक निगरानी मॉडल राष्ट्रीय ग्रामीण स्वास्थ्य मिशन की पुस्तक का विमोचन भी किया।

कार्यशाला आज

टोंक. सेंटर फॉर कन्जुमर एक्शन रिर्चस एण्ड ट्रेनिंग (कट्स) के तत्वावधान तथा एमएमएम शिक्षण एवं जनसेवा संस्थान की ओर से बुधवार को जिला परिषद सभागार में उपभोक्ता जागरूकता पर कार्यशाला होगी। संस्थान के सचिव गोपाल सैनी ने बताया कि कार्यशाला में मुख्य अतिथि जिला प्रमुख कल्लीदेवी होगी तथा अध्यक्षता सीएमएचओ आरपी मीणा करेंगे।

बाल विवाह के बताए दुष्परिणाम

मालपुरा. यहां राजीव गांधी सभागार में महिला एवं बाल विकास विभाग की ओर से बाल विवाह रोकथाम पर ब्लॉक स्तरीय कार्यशाला हुई। कार्यशाला में उपखण्ड अधिकारी एलएन मीणा ने कहा कि बाल विवाह सामाजिक बुराई है। इसकी रोकथाम के लिए सभी को मिलकर समाज में बदलाव लाने के लिए प्रयास करना होगा। यूनीसेफ के सलाहकार रणधीर सिंह ने बाल विवाह होने से वाले दुष्परिणामों की जानकारी दी। संदर्भ व्यक्ति अधिवक्ता छोटूलाल सोलंकी ने बाल विवाह अधिनियम की जानकारी दी। विकास अधिकारी रामकिशोर जांगिड़, महिला बाल विकास अधिकारी रमोला भटनागर एवं प्रधान रामगोपाल जाट ने भी विचार व्यक्त किए।

आदेश के बाद भी कार्यशाला स्थगित नहीं

निवाई. राज्य सरकार के निर्देशानुसार सरपंचों, उप सरपंचों व ग्राम सेवकों की छह दिवसीय आवासीय संयुक्त आमुखीकरण कार्यशाला को सोमवार को स्थगित करने के बाद भी निवाई में कार्यशाला चल रही है। इससे सरपंचों में रोष है।

सरपंच संघ के महामंत्री गणेश सिंह राजावत ने बताया कि आमुखीकरण कार्यशाला सरकार ने स्थगित कर दी।

उसके बावजूद भी निवाई में कार्यशाला चालू हैं। उन्होंने बताया कि नवनिर्वाचित जनप्रतिनिधियों व ग्राम सेवकों के और भी अनेक काम होते हैं, जो इस कार्यशाला से प्रभावित हो रहे हैं। विकास अधिकारी वीसी बंसल का कहना है कि अभी तक कार्यशाला स्थगित के आदेश प्राप्त नहीं हुए हैं।

टोंक के कृषि प्रशिक्षण केन्द्र में आयोजित कट्स की कार्यशाला में पुस्तक का विमोचन करते अतिथि।

मालपुरा में सोमवार को राजीव गांधी सभागार में बाल विवाह रोकथाम कार्यशाला में उपस्थित अधिकारी।

किशोरों को प्रशिक्षण

कठमाणा (पीपलू). कठमाणा में मंगलवार कोशिव शिक्षा समिति रानोली के तत्वावधान में किशोरों को जीवन कौशल प्रशिक्षण दिया गया। प्रशिक्षण में समिति सचिव शिवजीराम यादव ने प्रभावी संप्रेषण, वार्तालाप, कुशल कार्य, परियोजना समन्वयक पंकज तिवाड़ी ने ग्राहक व्यवहार, प्रबंधन के तरीके बताए।

टोडारायसिंह. विकास अधिकारी डीडी. गुप्ता ने कहा जनप्रतिनिधि अपने अधिकार व प्रदत्त शक्तियों का उपयोग कर पंचायतराज को मजबूत बनाएं। गुप्ता यहां आमुखीकरण कार्यशाला को संबोधित कर रहे थे। महिला एवं बाल विकास परियोजना अधिकारी मिथिलेश जैन, ब्लॉक शिक्षा अधिकारी रूपनारायण टेलर, इंदोकिया सरपंच धन्नालाल गुर्जर ने भी प्रशिक्षण दिया। इधर पुलिस ने सट्टे की खाईवाली करते ओमप्रकाश को गिरफ्तार किया।

दैनिक नवज्योति

जयपुर, बुधवार, 30 जून, 2010

टोंक में अमेरिका की गैर सरकारी संस्थान रिजल्टस फार डवलपमेंट के सीनियर प्रोग्राम ऑफिसर कर्टनी टॉलनी कट्स की परियोजना प्रसार बैठक में शोध परियोजना के प्राप्त निष्कर्षों की प्रस्तुति रिपोर्ट पेश करते हुए। फोटो : नवज्योति

निष्कर्षों की प्रस्तुति रिपोर्ट पेश

कट्स की परियोजना प्रसार बैठक आयोजित

न्यूज सर्विस

टोंक, 29 जून। अमेरिका की एक गैर सरकारी संस्थान रिजल्टस फार डवलपमेंट के सीनियर प्रोग्राम ऑफिसर कर्टनी टॉलनी ने कहा कि स्वास्थ्य और शिक्षा के क्षेत्र में अनुस्थिति का मामला ज्यादातर विकासशील देशों में आम हैं और इसके गंभीर वित्तीय परिणाम होते हैं और सेवाओं के वितरण पर भी निराशाजनक असर होते है। टॉलमी मंगलवार को राज्य कृषि प्रबंधन संस्थान में आयोजित कट्स की परियोजना प्रसार बैठक में एक साल से चल रही इस शोध परियोजना के फलस्वरुप प्राप्त निष्कर्षों का प्रस्तुति के मौके पर अपने विचार व्यक्त कर रहे थे। टॉलनी ने कहा कि कट्स टोंक जिले में अध्ययन कर स्वास्थ्य सेवाओं में सुधार के लिए प्रयास... कट्स इंटरनेशनल के निदेशक जार्ज चेरियन ने कहा कि राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के लिए काफी बजट आंवटन हो रहा है। उस आवंटन का समुचित उपयोग पारदर्शी तरीके से सुनिश्चित किया जाना बेहद आवश्यक है। उन्होंने कहा कि यह अध्ययन राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के क्रियान्वयन में आने वाली समस्याओं का पता लगाने के लिए किया गया है।

परियोजना के समंवयक ओमप्रकाश आर्य ने कहा कि जिले में औसतन रुप से स्वास्थ्य कर्मचारियों ने 27 प्रतिशत की अनुपस्थिति दर्ज की गई है। उन्होंने कहा कि जननी सुरक्षा ... अच्छा काम हुआ हैं। पर जनभागीदारी सुनिश्चित नहीं हो पा रही है और इसके कारण जनता में प्राथमिक स्वास्थ्य केन्द्रों के प्रति अविश्विास आदि जैसे गंभीर परिणाम सामने आ रहे है। एनआरएचएम स्वास्थ्य सेवाओं को सुनिश्चित करने की महत्वपूर्ण परियोतना है। 2005 में शुरु हुई परियोजना के क्रियान्वयन की वस्तुस्थिति का पता लगाने के लिए कंज्यूमर यूनिटी एण्ड ट्रस्ट सोसायटी कट्स द्वारा एक अध्ययन किया गया। जिसमें राजस्थान के टोंक जिले में 30 प्राथमिक स्वास्थ्य केन्द्रों का वैज्ञानिक तरीके से चुनाव किया गया और सामुदायिक निगरानी और सिटीजन रिपोर्ट ... उपकरणों का उपयोग करके वस्तुस्थिति का आंकलन किया गया, ताकि जहां-जहां सुधार की गुंजाइश हो, वहां उचित कदम उठाए जा सके। राज्य कृषि प्रबंधन संस्थान में आयोजित बैठक में एक साल से चल रही इस शोध परियोजना के फलस्वरुप प्राप्त निष्कर्षों का प्रस्तुति किया गया। प्रस्तुतिकरण की प्रतिक्रिया में राज्य के परिवार स्वास्थ्य एवं कल्याण विभाग के उपदिनेशक रामवतार जायसवाल, सीएचएचओ डॉ.आर.पी.मीणा, उप सीएमएचओ आर.के.जावा, जिला कार्यक्रम प्रबंधक सुबूर खान नें भी अपने विचार व्यक्त किए। इस मौके पर जिलेभर से स्वास्थ्य विभाग के अधिकारी, जिला प्रशासन, पंचायती राज प्रतिनिधि, स्थानीय नागरिक संगठन और दर्जनों प्राथमिक स्वास्थ्य ...री मौजूद थे।

खबरों की दुनिया — टोंक, 30 जून, 2010

स्वास्थ्य और शिक्षा के क्षेत्र में अनुपस्थिति आम : कर्टनी टॉलमी

टोंक, 29 जून (नि.स.)। स्वास्थ्य और शिक्षा के क्षेत्र में अनुस्थिति का मामला ज्यादातर विकासशील देशों में आम हैं और इसके गंभीर वित्ती परिणाम होते हैं और सेवाओं के वितरण पर भी निराशाजनक असर होते है। यह बात टोंक में कट्स की परियोजना प्रसार बैठक में बोलते हुए अमेरिका के एक गैर सरकारी संस्थान रिजल्टस फार डवलपमेंट के सीनियर प्रोग्राम आफिसर कर्टनी टॉलनी ने कही।

टॉलनी ने आगे कहा कि कट्स टोंक जिले में अध्ययन कर स्वास्थ्य सेवाओं में सुधार के लिए प्रयासरत हैं, यह खुशी की बात हैं। कट्स इंटरनेशनल के निदेशक जार्ज चेरियन ने कहा कि राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के लिए काफी बजट आंवटन हो रहा है। पर उस आवंटन का समुचित उपयोग पारदर्शी तरीके से सुनिश्चित किया जाना बेहद आवयक है।

उन्होंने कहा कि यह अध्ययन राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के क्रियान्वयन में आने वाली समस्याओं का पता लगाने के लिए किया गया है। ताकि उसमें सुधार किए जा सके तथा इसमें सामुदायिक निगरानी और नागरिक रपट कार्य जैसे सामाजिक जवाबदेहिता के उपकरणों का उपयोग किया गया हैं, ताकि सुशासन स्थापित किया जा सके।

परियोजना के समंवयक ओमप्रकाश आर्य ने निष्कर्षों का प्रस्तुतिकरण में कहा कि. जिले में औसम रुप से स्वास्थ्य कर्मचारियों ने 27 प्रतिशत की अनुपस्थिति दर्ज की गई है। उन्होंने कहा कि जननी सुरक्षा योजना और बाल स्वास्थ्य से संबंधित अच्छा काम हुआ हैं। पर जनभागीदारी सुनिश्चित नहीं हो पा रही है और इसके कारण जनता में प्राथमिक स्वास्थ्य केन्द्रों के प्रति अविश्विास आदि जैसे गंभीर परिणाम सामने आ रहे है। एनआरएचएम स्वास्थ्य सेवाओं को सुनिश्चित करने की महत्वपूर्ण परियोतना है। 2005 में शुरु हुई परियोजना के क्रियान्वयन की वस्तुस्थिति का पता लगाने के लिए कंज्युमर यूनिटी एण्ड ट्रस्ट सोसायटी कट्स द्वारा एक अध्ययन किया गया।

जिसमें राजस्थान टोंक जिले में 30 प्राथमिक स्वास्थ्य केन्द्रों का वैज्ञानिक तरीके से चुनाव किया गया और सामुदायिक निगरानी और सिटीजन रिपोर्ट कार्ड जैसे सामाजिक जवाबदेहिता के उपकरणों का उपयोग करके वस्तुस्थिति का आंकलन किया गया, ताकि जहां-जहां सुधार की गुंजाइश हो, वहां उचित कदम उठाए जा सके। राज्य कृषि प्रबंधन संस्थान में आयोजित बैठक में एक साल से चल रही इस शोध परियोजना के फलस्वरुप प्राप्त निष्कर्षों का प्रस्तुति किया गया।

समाचार जगत

जयपुर, 30 जून, 2010

स्वास्थ्य और शिक्षा के क्षेत्र में अनुपस्थिति आम : कर्टनी टॉलमी

टोंक (निसं.)। स्वास्थ्य और शिक्षरा के क्षेत्र में अनुपस्थिति का मामला ज्यातार विकासशील देशों में आम है और इसके गम्भीर वित्तीय परिणाम होते है और सेवाओं के वितरण पर भी निराशाजनक असर होते है। यह बात टोंक जिले में कट्स की परियोजना प्रसार बैठक में बोलते हुए कर्टनी टॉलमी ने कहा जो कि अमेरिका के एक गैर सरकारी संस्थान रिजल्ट्स फॉर डवलपमेंन्टस में सीनियर प्रोग्राम ऑफिसर है। आगे उन्होंने कहा कि कट्स टोंक जिले में अध्ययन कर स्वास्थ्य सेवाओं में सुधार ,के लिए प्रयासरत है, यह खुशी की बात है। बैठक को सम्बोधित करते हुए कट्स इन्टरनेशनल के निदेशक जॉर्ज चेरियन ने कहा कि राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के लिए काफी बजट आवंटन हो रहा है। पर उस आवंटन का समुचित उपयोग पारदर्शी तरीके से सुनिश्चित किया जाना जरूरी है। उन्होंन कहा कि यह अध्ययन राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के क्रियान्वयन में आने वाली समस्याओं का पता लगाने के लिए किया गया है। ताकि उसमें सुधार किए जा सकें तथ्वा इसमें सामुदायिक निगरानी और नागरिक रपट कार्ड जैसे सामाजिक जवाबदेहिता के उपकरणों का उपयोग किया गया है। ताकि सुशासन स्थापित किया जा सके। परियोजना के समन्वयक ओमप्रकाश आर्य ने निष्कषों के प्रस्तुतिकरण में कहा कि जिले में औसत रूप से स्वस्थ्य कर्मचारियों में 27 प्रतिशत की अनुपस्थिति दर्ज की गई है, जननी सुरक्षा योजना और बाल स्वास्थ्य से सम्बन्धित अच्छा काम हुआ है पर जनभागीदारी सुनिश्चित नहीं हो पा रही है और इसके कारण जनता में प्राथमिक स्वास्थ्य केन्द्रों के प्रति आश्वासन आदि जैसे गम्भीर परिणाम सामने आ रहे है। एनआर एचएम स्वास्थ्य सेवाओं को सुनिश्चित करने की महत्वपूर्ण परियोजना है। 2005 में शुरू हुई परियोजना के क्रियान्वयन की वस्तुस्थिति का पला लगाने के लिए कंज्यूमर यूनिटी एण्ड ट्रस्ट सोसायटी (कट्स) द्वारा एक अध्ययन किया गया है। जिसमें राजस्थान के टोंक जिले में 30 प्राथमिक स्वास्थ्य केन्द्रों का वैज्ञानिक तरीके से चुनाव किया गया और सामुदायिक निगरानी और सिटिजन रिपोर्ट कार्ड जैसे सामाजिक जवाबदेहिता के उपकरणों का उपयोग करके वस्तुस्थिति का आंकलन किया गया। प्रस्तुतिकरण की प्रतिक्रिया में राज्य के परिवार स्वास्थ्य एवं कल्याण विभ्नाग के उपनिदेशक रामअवतार जायसवाल, जिले के सीएमएचओ आर.पी.मीणा, उपसीएमएचओ आर.के., जावा, जिला कार्यक्रम प्रबन्धक सुबूर खान ने भी अपने विचार वक्त किए।

State Level Dissemination cum Advocacy Meeting
on July 29, 2010 at Jaipur

HINDUSTAN TIMES, NEW DELHI
FRIDAY, JULY 30, 2010

'Absentee rate of doctors 36 pc'

HT Correspondent
htraj@hindustantimes.com

JAIPUR: Absentee rate among health officials is as high as 27 per cent, a survey has found. While the rate was 12 per cent for male nurses, doctors and medical officers topped the survey with 36 per cent.

The finds of the survey, conducted by NGO CUTS Centre for Consumer Action, Research and Training (CUTS CART) in 30 out of 40 Primary Health Centres (PHCs) in Tonk district, were revealed at a state-level dissemination cum advocacy meeting of their project 'Ensuring Service Delivery through Community Monitoring of PHCs in Tonk, Rajasthan'.

The survey says 34 per cent laboratory technicians, 33 per cent lady health visitors, 26 per cent female nurses and 27 per cent pharmacist were found absent.

The NGO had launched a project last year to improve health services after realizing the need for community-based monitoring of National Rural Health Mission (NRHM), which had seen a sizable increase in budgetary allocation from Rs 92 crore in 2005-06 to Rs 1,280 crore in 2009-10 but no corresponding improvement in health care.

Rao Rajendra Singh, the MLA, said, "Nobody knows who is responsible so problems remain unsolved. Once aanganbari centres function well, PHCs will automatically follow the suit."

THE HINDU
SUNDAY, AUGUST 1, 2010

Absenteeism rampant in Tonk PHCs

'Respondents also complained of getting only a few medicines'

Special Correspondent

- Study was conducted by CUTS International in partnership with TAP
- 'Absence of governance and accountability major obstacle in the process of service delivery'

JAIPUR: On an average more than one third of the health services personnel was observed missing during duty hours in Primary Health Centres (PHCs) in Tonk district of Rajasthan according to a study. Absenteeism was as high as 36 per cent among doctors while in five categories of health service providers it was found to be 27 per cent on an average.

The study, conducted by CUTS International in partnership with Transparency and Accountability Programme (TAP) of the Results for Development (R4D), based in Washington DC, also found 69 per cent of respondents (citizens) complaining of either not getting any medicines or getting only a few.

The findings were presented in a State level dissemination cum advocacy meeting here in the presence of experts, policy makers and people's representatives including MLA Rao Rajendra Singh, Shyama Nagarajan, Health Specialist, and World Bank Shiv Chandra Mathur, Executive Director, Rajasthan Health System Resource Centre and Priyanka Singh, Seva Mandir, Udaipur.

CUTS employed the PATP (Participatory Absenteeism Tracking Process), along with the Citizens' Report Card (CRC) tool, among 902 people served by 30 of the total 45 PHCs in Tonk to know their perception about the status of health service delivery. In the study, civic engagement and community monitoring aspect of National Rural Health Mission (NRHM) were kept as the central point.

In all, 900 unannounced on-spot observations were made for 35 consecutive days except on Sunday from August 2009 by 150 monitors selected from the catchment of the Primary Health Centre (PHCs), Om Prakash Arya, the Project Coordinator who presented the key findings, said.

George Cheriyan, Director, CUTS International, while presenting the overview of the project, said that absence of governance and accountability was the major obstacle in the process of service delivery. One of the reasons behind absenteeism could be the poor infrastructure facilities in the area for the serving personnel, he noted.

The study observed that on average 12 per cent posts of health personnel in PHCs remained vacant. The unfilled posts ranged from 5 per cent in the case of male nurses to 25 per cent in Lady Health Visitors. The situation was of both service deliverers and the end users remaining unhappy and dissatisfied.

As for the end users, 44 per cent of the respondents were not found satisfied with health service delivery. As many as 47 per cent said they did not know about VHSC (Village Health and Sanitation Committee) while a whooping 82 per cent reported that they had no knowledge of any existing grievance redress mechanism. Thirty two per cent of them said they did not receive any cash assistance under Janani Suraksha Yojna (JSY).Thirty seven per cent complained of 24-hour delivery facility lacking in their PHC. Thirty four per cent said no one ever visited their home to know their health status.

The PHCs lacked facilities like clean drinking water and toilets. The study found that 30 per cent of the PHCs had either poor or no proper drinking water facility. A 10 per cent of the PHCs lacked toilets and 13 per cent, electricity. Perhaps to understand the level of satisfaction/dissatisfaction of the service providers one should consider theses findings of the study as well: 12.5 percent of them are unhappy with their jobs; 25 per cent of them complained of not getting leave on demand and 41 per cent pointed out that there is shortage of staff.

महका भारत
जयपुर, 30 जुलाई, 2010

सुशासन व्यक्तिगत जिम्मेदारी और जवाबदेहिता से ही संभव-श्यामा नागराजन

कट्स की राज्यस्तरीय बैठक

जयपुर, 29 जुलाई (कासं)। कट्स इंटरनेशनल द्वारा रिजल्ट फॉर डवलपमेंट, वॉशिंगटन के सहयोग से टोंक जिले के चयनित प्राथमिक स्वास्थ्य केंद्रों पर किए गए अध्ययन के दौरान 36 प्रतिशत चिकित्सक व औसतन 27 प्रतिशत अन्य चिकित्साकर्मी अनुपस्थित पाए गए। यह तथ्य कट्स द्वारा गुरुवार को सहकार मार्ग स्थित एक होटल में आयोजित राज्य स्तरीय प्रचार प्रसार व पैरवी बैठक में प्रस्तुत किए गए।

बैठक में विश्व बैंक की स्वास्थ्य विशेषज्ञ श्यामा नागराजन ने कहा कि सुशासन व्यक्तिगत जिम्मेदारी व जवाबदेहिता से लाया जा सकता है। केवल सरकारी प्रयासों से नहीं। हर एक नागरिक को सर्वजनिक सम्पत्तियों व सेवाओं की कीमत समझनी होगी। विधायक राव राजेन्द्रसिंह ने कहा कि असंतोषप्रद सेवाओं और व्यवस्थाओं की कमियों का शिकार जनप्रतिनिधियों को होना पड़ता है क्योंकि उन्हें हर पांचवें वर्ष चुनाव का सामना करना पड़ता है। सिंह ने परियोजना के अंतर्गत चिकित्साकर्मियों की अनुपस्थिति पर किए गए सर्वे पर प्रतिक्रिया करते हुए कहा कि जनप्रतिनिधियों की पंचायत, पंचायत समितियों व जिला परिषदों और विधानसभा में उपस्थिति सुनिश्चित करने की कोई व्यवस्थान नहीं है। उन्होंने अपने क्षेत्र व राज्य में स्वास्थ्य सेवाओं की कमी के बारे में बताया। राजस्थान हेल्थ सिस्टम डवलपमेंट रिसोर्स सेंटर के कार्यकारी निदेशक डॉ शिवचंद्र माथुर ने कट्स द्वारा प्रस्तुत सर्वे से निकली समस्याओं पर कार्ययोजना बनाकर कार्रवाई करने की आवश्यकता बताई और कहा कि राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के अंतर्गत जननी सुरक्षा योजना का लगभग नौ प्रतिशत लाभ ही बीपीएल परिवारों को मिल रहा है। मातृ मृत्यू दर के सरकारी आंकडे बहुत ही कम हैं। उदयपुर सेवा मंदिर से स्वास्थ्य विशेष प्रियंका सिंह ने भी अपने विचार प्रकट किए। कट्स के निदेशक जार्ज चेरियन ने टोंक में चलाई गई एकवर्षीय परियोजना के उद्देश्य व विभिन्न गतिविधियों के बारे में विस्तार से प्रकाश डॉलते हुए कहा कि भारत में धनराशि की कोई कमी नहीं है। पर सरकारी खर्चों के बेहतर प्रबंधन व वित्तीय सदुपयोग की जरूरत है। कट्स के परियोजना आधिकारी ओम प्रकाश आर्य ने सर्वे के तथ्यों को विस्तार से प्रस्तुति कियाऔर स्वास्थ्य सेवाओं में जनभागीदारी द्वारा सुधार लाए जाने व कट्स का जनभागीदारी मॉडल राज्य में लागू करने का सुझाव राज्य सरकार को दिया। परियोजनाअधिकारी अमर दीप सिंह ने आगंतुकों का स्वागत किया।

डेली न्यूज़
जयपुर, शुक्रवार
30 जुलाई, 2010

व्यक्तिगत जिम्मेदारी व जवाबदेही से ही सुशासन संभव

टोंक जिले के चयनित प्राथमिक स्वास्थ्य केंद्रों पर 36 फीसदी डॉक्टर व औसतन 27 फीसदी अन्य चिकित्साकर्मी अनुपस्थित पाए गए हैं। कट्स इंटरनेशनल की ओर से की गई स्टडी में यह खुलासा हुआ है। गुरुवार को कट्स की ओर से आयोजित राज्यस्तरीय प्रचार-प्रसार व पैरवी बैठक में विश्व बैंक की स्वास्थ्य विशेषज्ञ श्यामा नागराजन ने कहा कि सुशासन व्यक्तिगत जिम्मेदारी व जवाबदेहिता से लाया जा सकता है, केवल सरकारी प्रयासों से नहीं।

ANNEXURE 1: Partner Organizations

PHC wise List of NGO partners under TAP

Sr.	Partner Agency and contact person	Name of PHCs	Numbers of PHCs
1.	Ashrar Jahan, Secretary, Prerna Education & Welfare Society, Subhash Bazar, Tonk Phone: 941442 5102	Sitapura, Nagar Fort, Kharera,	3
2.	Braj Bihari Sharma, Gautam Rishi Gram Vikas Evam Shodh Sansthan, Paluko Ka Mohalla, Ashok Chowk, Tonk Mo: 94143-48448,	Rajmahal, Anwa, Ghar	3
3.	Mohan Meena, Shri Kalyan Seva Sansthan, House No: 38, Purana Bazar, Diggi- Malpura, Tonk Mobile: 099281 19827	Pachewar Lawa	2
4.	Gopal Swaroop Mishra, Secretary, Gyandeep Shiksha Evam Anusandhan Sansthan, Kasturba Colony, Brijlal Nagar, Malpura, Tonk- 304 502 Ph.: 01437-224177	Lambahari Singh Toradi	2

5.	Munna Lal Rao, Samuhik Vikas Sansthan, Patel Road, VP- Newai, Tonk Ph. 01438-224393	Siras, Raholi	2
6.	Ramesh Chand Gurjar Shri Dev Gramin Vikas & Prashikshan Sansthan, Karіriya, Niwai, Tonk Mob: 99501 01881	Dhangarthal, Datwas	2
7.	Kishan Gurjar, New Saraswati Welfare Society, Vill. Devari, Gelod, Peeplu, Tonk Mob.: 98878 73029, 94139 62626	Mandolai, Barwas Nasirda	3
8.	Maalchand Sharma, Saraswati Vidhya Niketan Siksha Samiti, Kalli Dungri Road, Shiv Nagar, Mahadevali, Tonk-304001 Ph: 01432-2450 06	Dardahind, Gahlod, Mendwas,	3
9.	Murlidhar Sharma, Sardar Patel Shiksha Samiti, Patel Marg, Mahendi Baag, Near Natraj Hotel, Tonk Ph: 01432-2450 06	Arniyadedar Naner, Bagri, Kathmara	4

10	Gopal Lal Saini, MMM Sikshan Evam Jan Seva Sansthan, Khoja Bawari, Near Police Line, Tonk Mob: 98293 47200, 92141 67972	Bharni, Bambor, Ahamadpura Chauki, Aligarh Banetha	5
11.	CUTS District Coordinator Shayam Sunder Vijay, C/o Kishan Lal Sahu, Teliyon Ki Gali, Mahendi Baag, Tonk (Rajasthan) Mobile: 96805 10921, 92520 63129 sanjpiyu@yahoo.co.in	Dardaturki	1
		Total	**30**

ANNEXURE 2: All PHCs in Tonk Vs. Randomly selected 30 PHCs

Districts	Blocks	PHCs		30 PHC selected through Random sampling		
Tonk	Tonk	Chhan	0.891713	Devli	Anwa	0.704374
Tonk	Tonk	Dardahind	0.574337	Devli	Nasirda	0.927844
Tonk	Tonk	Naner	0.775333	Devli	Rajmahal	0.00526
Tonk	Tonk	Prana	0.753067	Devli	Ghar	0.698294
Tonk	Tonk	Dardaturki	0.084457	Devli	Sitapura	0.513461
Tonk	Tonk	Bagari	0.665626	Devli	Nagarphot	0.165517
Tonk	Tonk	Ahamadpurachauki	0.327124	Malpura	Lava	0.720639
Tonk	Tonk	Ranoli	0.894271	Malpura	Lambaharisingh	0.730404
Tonk	Tonk	Kathmana	0.849706	Malpura	Pachewar	0.493689
Tonk	Tonk	Lawadara	0.171095	Malpura	Toradi	0.574402
Tonk	Tonk	Bharni	0.539842	Niwai	Biras	0.662665
Tonk	Tonk	Bambor	0.995145	Niwai	Raholi	0.684803
Tonk	Tonk	Sakhana	0.531718	Niwai	Dhangarthal	0.568223
Tonk	Tonk	Gahlod	0.211512	Niwai	Datwas	0.307248
Tonk	Tonk	Arniyadedar	0.472735	Todaraisingh	Kharera	0.864645
Tonk	Tonk	Pasrothiya	0.937743	Todaraisingh	Mandolai	0.867805
Tonk	Tonk	Kabra	0.784199	Todaraisingh	Banwas	0.982517
Tonk	Tonk	Mendwas	0.829101	Tonk	Dardahind	0.245633
Tonk	Niwai	Jhilay	0.815187	Tonk	Gahlod	0.570461
Tonk	Niwai	Biras	0.159912	Tonk	Bharni	0.732389
Tonk	Niwai	Chanani	0.707239	Tonk	Naner	0.604761
Tonk	Niwai	Raholi	0.003237	Tonk	Kathmana	0.966145
Tonk	Niwai	Datwas	0.002909	Tonk	Bambor	0.063105
Tonk	Niwai	Dhangarthal	0.780699	Tonk	Ahamadpurachauki	0.114332
Tonk	Devli	Nagarphot	0.455488	Tonk	Dardaturki	0.513482
Tonk	Devli	Anwa	0.557587	Tonk	Mendwas	0.160705
Tonk	Devli	Dhuankalan	0.277088	Tonk	Bagari	0.907277
Tonk	Devli	Nasirda	0.493052	Tonk	Arniyadedar	0.756417
Tonk	Devli	Sitapura	0.473931	Uniyara	Aligarh	0.888349

Tonk	Devli	Rajmahal	0.687118	Uniyara	Benetha	0.412391
Tonk	Devli	Ghar	0.400695			
Tonk	Uniyara	Aligarh	0.439511			
Tonk	Uniyara	Benetha	0.6463			
Tonk	Uniyara	Kakor	0.523854			
Tonk	Todaraisingh	Mandolai	0.985471			
Tonk	Todaraisingh	Kharera	0.525114			
Tonk	Todaraisingh	Banwas	0.359421			
Tonk	Todaraisingh	Hamirpura	0.081944			
Tonk	Malpura	Diggi	0.982521			
Tonk	Malpura	Pachewar	0.551699			
Tonk	Malpura	Lambaharisingh	0.45062			
Tonk	Malpura	Sara	0.752518			
Tonk	Malpura	Toradi	0.686417			
Tonk	Malpura	Lava	0.512365			
Tonk	Malpura	Chandsen	0.151989			

ANNEXURE 3: Community Monitoring Schedule

CHART A											
PHC Monitoring Schedule											
Day	**Monitor 1**	**Monitor 2**	**Monitor 3**	**Monitor 4**	**Monitor 5**	**Day**	**Monitor 1**	**Monitor 2**	**Monitor 3**	**Monitor 4**	**Monitor 5**
1	10:00					16	10:00				
2		11:30				17		11:30			
3			5:00			18			5:00		
4				10:00		S	U	N	D	A	Y
5					11:30	19				10:00	
6	5:00					20					11:30
S	U	N	D	A	Y	21	5:00				
7		10:00				22		10:00			
8			11:30			23			11:30		
9				5:00		24				5:00	
10					10:00	S	U	N	D	A	Y
11	11:30					25					10:00
12		5:00				26	11:30				
S	U	N	D	A	Y	27		5:00			
13			10:00			28			10:00		
14				11:30		29				11:30	
15					5:00	30					5:00

ANNEXURE 4: Community Monitoring Card (For Absenteeism and Facilities)

Name of Monitor: ----------Block ----------

Name & Address of PHC----------

Name of Coordinating CSO----------

(Please write Yes or No)

Sr.	Staff/Services	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
A.	***Date***							
1-	Medical Officer In charge							
2-	Doctor *Ayush*							
3-	Male Nurse							
4-	Female Nurse							
5-	Lab Technician *							
6-	Lady Health Visitor *							
7-	Pharmacist *							
8-	Adult Nurse Midwife *							

B.	***Services***							
1-	Medical Examination							
2-	Drug distribution							
3-	Immunizations							
4-	Dressing and Minor operations							
5-	Delivery							
6-	Blood testing *							
7-	Family planning operations *							
8-	Distribution of contraceptives *							

*** Optional**

(To be filled on last day)

Sr.	**Basic Information about PHC**	**Yes**	**No**	**Quality (Tick √)**		
				Good	**Average**	**Bad**

1-	Public transport to reach PHC					
2-	Functioning toilet					
3-	Regular Water Supply					
4-	Regular Electricity Supply					
5-	Telephone at PHC					
6-	Building for PHC					
7-	Quarters for Staffs					
8-	Six beds					
9-	Laboratory					
10-	Working Ambulance					
11-	Vaccine facilities					
12-	Waste Disposal					
13-	Normal Delivery kit					
14-	Chart and other information displayed					

ANNEXURE 5: Questionnaires (First Draft) for all categories for CRC

Questionnaire: Beneficiaries

Name of Investigator: _____ Starting Time: _____

Date: _____ Ending Time: _____

Investigator Introduction: [answers in legible handwriting in the spaces provided for responses.]

Section I. Demographic Questions

1] What is your name?

2] Gender of respondent 1- Male 2- Female

3] What is your age? ____Years

4] Location / Address: _____

5] Type of family 1-Nuclear 2-Joint

6] Number of adult males in the household- adult male----adult female------ Children------

7] How many members in the household are employed?

8] What is the monthly household income?

9] You come under 1-BPL 2-APL

10] Religion: 1-Hindu 2-Muslim 3-Other

Section II. Health Facility

General

11] Which of the following sources of health facilities are available in your neighborhood? (Multiple responses are possible)

1- Government Hospital 2- Private Hospital

3- Private Doctor 4- Quack 5- Other

12] Which of the following sources of health facility does you and your family use? (Multiple responses are possible)

1- Government Hospital 2- Private Hospital

3- Private Doctor 4- Quack 5- Other

13] What is your main source of health services 1/2 /3/4/5?

14] How far is the government hospital from your residence? _____

15] How long does it take to avail the government health facility from your residence? _____

16] When you visited GH in the month of December your ailment was related to

1- Maternal Health (skip to q. 16)

2- Child Health (skip to q. 22)

3- Family Planning (skip to q. 26)

4- Adolescent Health (skip to q. 30)

5- Curative Diseases (skip to q. 36)

6- Other (Please Specify) _____

Maternal Health

17] Have you been registered in hospital under JSY?

18] How many times were you investigated by hospital before delivery?

19] Have you been provided with the iron and folic acid pills before delivery?

20] Was there any laboratory check up? (Blood, Urine etc)

21] Is institutional delivery being promoted by government?

22] Does any body come to your home to provide delivery services if called?

23] Have you received any cash assistance from hospital? How much?

24] Does your GH provide 24 hour delivery facility?

GO TO QUESTION

Child Health

25] Does your child get immunization from the hospital?

26] Have your child been provided with Vitamin A supplement?

27] Have you been told for breast feeding for at lease 6 months?

28] Is your child protected from preventive diseases like malnutrition or any infection?

GO TO QUESTION

Family Planning

29] Are you provided with the counseling regarding family planning methods?

30] Are you provided with the various methods for family planning?

GO TO QUESTION

Curative Services

31] Does GH provide treatment for minor ailments? (Including accidents/emergencies)

32] Is health day organized at the Aanganwadi centers in the village?

33] Do you get appropriate and prompt referral?

Common Questions

34] Do you know about any village health committee in your village?

35] Do you know about its members?

36] Does doctor and other health officials present at the time of your visit?

37] Do you get medicine from hospital prescribed by doctor there?

38] Overall are you satisfied with the service provided at GH?

1- Satisfied 2- Partially Satisfied 3] Dissatisfied (skip to q)

39] What is the reason for dissatisfaction? _____

40] Have you paid any bribe for any service related to health facility in last one year?

41] Was the bribe demanded (or did you pay on your own)? 1- Demanded 2- Paid on my own

How much money you paid as bribe?

42] Have you made a complaint related to your health services in the past one year?

43] To whom did you complain?

44] What was the result of the complaint?

1- Prompt action taken 2- Delayed action taken 3- No action taken

45]

		Yes	NO
45.1	I like going to government hospital nearby		
45.2	The hospital building is in good shape		
45.3	Health officials remain present regularly		
45.4	Health officials takes care of the patients honestly		
45.5	The hospital has good medical facilities		

46] Level of awareness

		Correct	Incorrect
46.1	Exclusive breast feeding		
46.2	Time for initiating complementary feeding		
46.3	Spacing between the children		
46.4	Age of marriage		
46.5	Birth/ Death certificate		

47] Does any one make regular visit to your village to know about your health status?

48] If yes, How many days in a month?

49] Whether your ANM has required skill for delivery?

50] Your suggestion to improve the service delivery_____

Interview Schedule for Service Providers

Name of Investigator: _____ Starting Time: _____

Date: _____ Ending Time: _____

I: General Information

1. Block……

2.1 Name of the PHC: _____2.2 Your Designation _____

3.1 Place of stay: _____

3.2 Native place: _____

3.3 Distance from your residence to your PHC _____ in km

4. Residential status: 1.Owned 2.Rented 3.Government quarters

5. Marital Status: 1.Single 2.Married

6. Family size_____ members

7.1 Any other member/s in your family work

7.2 Place of working _____

8.1 Any other member/s in your family needs special health care _____

8.2 The members_____

II. Background Information of the Respondent

10.1 At what time you reach your facility? _____am

10.2 At what time you leave your facility? _____pm

11.1 What means of transport do you use to get to the facility?

1. Bus 4.Motor cycle
2. Walking 5.Personal car
3. Bicycle 6. Others (specify)_____
7. Don't know

12. What is your highest level of formal education attained? _____

13. Besides the formal training, have you attended any other training that may include in-service training etc?

14. If 'Yes' to above question,

14.1 How long was the training? _____days _____months _____ yrs

14.2 On what subject? _____

14.3 Who sponsored your further training?

1. Government 2.Self 3.Others (specify)_____ 4. don't know
2.

15.1 What is your work experience in health department? Years_____ Months_____

15.2 What is your work experience in this health facility? Years_____ Months_____

16. In general, how would you describe your physical health?

1. Very poor 2.Poor 3.Fair 4.Excellent

17. Compared to people of your own age, how is your physical health?

1. Very poor 2.Poor 3.Fair 4.Excellent

IV: Job satisfaction

		Agree	**Disagree**
19.1	Is your job at this facility usually worthwhile?		

19.2	Is your job usually interesting to you?		
19.3	Does your job suit very well in relation to the training?		
19.4	If you have a chance, at the same rate of pay at this facility, will you wish to change your job?		
19.5	If you have a chance, at the same rate of pay, will you wish to change to another health facility?		
19.6	Would you be satisfied with a different job at this facility than with your present job?		
19.7	Do you have over workload at this health facility?		

V: Wages and other incentives

22. Are you getting your salary on time?

23. Do you go to the bank personally to draw the salary?

24. Is your salary comparable to what is offered in private health facilities?

25. What other benefits/incentives are provided besides the salary?

1. Salary increment 4. Hardship allowance
2. House allowance 5.Rewards for consistency in attendance
3. Commuter allowance 6. Overtime payment

7. Others (specify)_____

26. Do you do any other work to supplement your income during non-official hours?

27. If yes to Quest 26, which specific work do you do, to supplement your income?

1. Local (Work on part time basis in another health facility)
2. Private practice (operates own clinic)

3. Other, (specify)_____

28. During the last 3 months, have you gone on leave?

29. If No, to Question 28, how many times were you absent from the facility?

Over the last 3 months? _____

30. What were the reasons for your non availability?

1. Health Problem
2. Family problem
3. Conducting Health Camps
4. Visiting sub Centers
5. Administrative work (court, on deputation, training etc.,)
6. In-charge duties at other PHC's
7. Festival
8. Meetings convened by superior officers
9. Anganwadi visits, school visits, training etc.,
10. 10.Others □, specify_____

31. How long were you on leave from the facility _____ months _____days

32. Is Non availability of medical/ para medical staff a problem in this health facility?

1. Yes 2.No

33.1 If Yes to the Q.No32, how do you grade that problem?

1. Serious 2.Moderate

33.2 Why is it a problem?

_____

33.3 Suggest few options to minimize that problem.

_____

34. Suggest any three additional incentives that you would wish to be given to make you more productive/ committed to working in this health facility.

1. _____
2. _____

If respondent is a Doctor

1] Are you provided with functional residence where PHC is located?

2] Does health facility have all necessary equipments for conducting (Y/N) and surgeries (Y/N)

3] DO you think after implementation of NRHM, there is improvement in?

1. Infrastructure(Y/N) 2. Manpower availability (Y/N)

3. In institutional deliveries 4. In Outdoor patients

4] Are the prescribed medicines available in health facility pharmacy?

5] Does the health facility get a regular supply of all the required medicines?

General (Y/N) Ayush(Y/N)

6] Is there any delay in getting funds under NRHM?

7] In your perception, is the Rogi Kalyan Samiti (RKS) playing an effective role in:

Applicable/ Not Applicable

- Addressing complaints of the patients (Y/N)
- Improvement of health facility infrastructure (Y/N)
- Improvement of Lodging/ Boarding facilities to patients and theirs relatives? (Y/N)
- Improvement in support services like cleaning, laundry, diagnostic, waste disposal? (Y/N)

8] How do you utilize the untied funds?

- Maintenance (Y/N)
- Seeking services from private doctors (Y/N)
- Repairs/Renovation (Y/N)

- Buying equipments (Y/N)
- Buying medicines (Y/N)
- Paying for services like cleaning, security etc (Y/N)
- Hiring contractual staffs (Y/N)

If respondent is an ANM

1] How many villages covered by your sub centre have ASHAs in position?_____

2] How often do you meet the ASHAs of your area weekly/fortnightly/monthly/rarely

3] How do you feel ASHA is contributing to NRHM by

- Mobilizing community to avail health services (Y/N)
- Identifying and accompanying complicated delivery cases (Y/N)
- Providing health information to the community (Y/N)
- Acting as depot holders (Y/N)
- Providing newborn baby care (Y/N)

4] Have you been provided the essential drug kit for your centre (Y/N)

5] What is there in the drug kit

ORS/ Chloroquine/ Antibiotics/ painkillers / TB Drug Kit / Disinfectant / DDK / Oral contraceptives / Condoms

6] How often does you drug kit get replenished? Weekly/fortnightly/monthly/Rarely

7] Do you conduct deliveries (Y/N) 7.1 At home (Y/N) 7.2 At Sub centres

8] How many deliveries you conduct in a month, on an average?_____

9] How many TBAs are there in your area?___

10] Are they given any incentives to conduct deliveries?

ASHA Questionnaire (Draft-1)

Village: _____ Block: _____

Date: _____ Investigator: _____

Starting time: _____ Ending Time: _____

General Information of ASHA

1. Age of ASHA: _____
2. Caste: SC/ST/OBC/General:
3. Education: _____
4. Marital Status: unmarried/married/widowed/divorced/separated?
5. Month and year of joining as ASHA _____
6. Does the ASHA work for the same village/ village panchayat where the stays? (Y/N)

Selection:

7. Where there any focused group discussions (FGDs) held in your village before selection of ASHA? (Y/N)
8. Who held the FGDs? _____
9. Did the FDGs involve awareness about concept and roles of ASHA among the village community? (Y/N)
10. Was there any kind of short listing of candidates done as per your knowledge for selection of ASHA? (Y/N)
11. Was there a 'Gram Sabha' meeting held during the selection process of ASHA/ (Y/N)
12. Before joining as ASHA did you work as community based worker? (Y/N)

Training:

13. As the ASHA worker received any training after joining? (Y/N)

14. How many days of training has the ASHA received? _____

15. How many times in last one year? _____

16. Did you receive any compensation for the attending training? (Y/N)

17. How much? Rs. _____

18. Do you received regular 'on the job training' at your village? (Y/N)

19. Who provides on the job training? ANM/NGO/Others _____ (specify)

Role and Responsibilities:

20. Have you been given a drug kit? (Y/N)
21. Does your drug kit contain?

ORS (Y/N): Iron tables (Y/N) Oral Pills (Y/N)
Condoms (Y/N) Disposable delivery kit (DDK) (Y/N)

22. Is the ASHA clear about her roles for:

22.1 Provide information about existing health services? (Y/N)
22.2 Creating awareness to the community on health, hygiene and nutrition? (Y/N)
22.3 Escort/accompany pregnant women or sick children to the nearest health facility? (Y/N)
22.4 Informing the sub-centre/ PHC/CHC about: Births and deaths in the village? (Y/N)
22.5 Promoting construction of household toilets? (Y/N)

23. How many pregnant women did you escort to HF in the last one year? _____

24. How much money are you given to accompanying a mother to a health facility?

Rs. _____

25. Do you have to spend anything over and above of what you are reimbursed? (Y/N)
25.1 How much? Rs. _____

Payment and Incentives:

26. Do you receive any performance based incentive? (Y/N)

26.1 How much? Rs. _____ (Average per month)

27. How do you get these incentives?
(As advance or direct payment from the ANM's/From the Sarpanch/From the PHC Medical Officer)

28. Are you happy with the incentives given under the programme? (Y/N)

29. For which activities do you get performance-based incentive?

30. Any other incentives? (Y/N) Details: _____

31.How do you remember the work done by you in a month? _____

32. Do you report it to the ANM/Sarpanch/PHC Medical Officer?

33. Do you have a Bank account/ Post Office account/ No account?

Coordination:

34. Are you recognized by the people of your village? (Y/N)

35. Do they support you for your roles and responsibility as an ASHA worker? (Y/N)

36. Are you actively involved with the local Panchayat Raj Institution (PRI)/ Village health committee (VHC) in your village? (Y/N)

37. Do you receive proper support from the PRI and VHC? (Y/N)

38. Do you have any difficulty in functioning? _____

39. Why do you feel people trend not to avail public health services?

1. Quality of service 2. Not aware 3. Services not available
4. Have to pay extra money 5. Other _____ (specify)

40. Would you like to work as an ANM later one? (Y/N)

41. Is there increase in the institutional deliveries in last two-three years? (Y/N)

42. If so what are the reasons according to ASHA? _____

Questionnaire for VHC/PRI/RKS Members (Draft-1)

Village: _____ Bock: _____

Investigator: _____

General Information

1. Are you a member

    1. VCH member ( ) 2. PRI Member (Y/N)

2. Caste: SC/ST/OBC/General

3. Month and Year of Joining as member _____

4. Education: _____

Program Interventions

5. Are you aware of a program called NRHM or its Hindi version? (Y/N)

6. Were you given any orientation about the program by the health department workers or officials? (Y/N)

6.1 For how many days? _____

7. What is your role in the programme?

    1. Mobilizing Community (Y/N)
    2. Ensuring regular visits of ANM (Y/N)
    3. Selection of ASHA (Y/N)
    4. Proper functioning of SHC's (Y/N)

8. Is there any amount given to your sub centre so far? (Y/N)

8.1 How much? _____ p.a.

9. Have you received the untied fund for your sub centre so far? (Y/N)

10.When? _____

11. If yes, have you opened a bank account? (Y/N) Is it a joint account? (Y/N)

12. Do you feel through NRHM the government has decentralized decision making? (Y/N)

13. Do you feel more empowered after the launch of NRHM? (Y/N)

14. How often the meeting of VHC members held?

1. Weekly 2. Monthly 3. Quarterly 4. Annually

15. Where they are generally held?

1. Sarpanch's house 2. Panchayat office 3. Health facility

16. Do you feel that NRHM has improved the health service delivery in your area? (Y/N)

17. Where do you look for further information about NRHM?

Role as Rogi Kalyan Samiti (RKS) member

18. Are you a member of:-

18.1 Rogi Kalyan Samiti at the PHC (Y/N)
18.2 Rogi Kalyan Samiti at the CHC (Y/N)
18.3 District level (Y/N)
18.4 Not a member (Y/N)

19. If yes, what in your opinion is the function of RKS?

1. Addressing complaint of the patients (Y/N)
2. Improvement of health facility infrastructure (Y/N)
3. Improvement of health related equipments (Y/N)
4. Improvement of lodging/boarding facilities to patients and their relatives (Y/N)
5. Improvement in support services like cleaning, laundry, diagnostic, ambulatory, waste disposal etc. (Y/N)

20. What is the frequency of RKS meeting? _____ per year

21. When was the last meeting held? _____

22. Does the 'Rogi Kalyan Samiti' generate any funds? (Y/N)

22.1 If yes, how much amount: _____ (Rs.) per year

23. Person in charge of funds _____ (Designation)

24. Is there any audit of the fund (Y/N)

24.1 If yes, Internal-1 External-2

ANNEXURE 6: Health Facility in District Tonk, Rajasthan & its Distance from Block

Health Facilities in District Tonk ,Raj.						
S.No.	Block Name	Name of PHC	Nearest PHC	Distance from PHC	Distance from block	Distance from District
1	Tonk	***Chhan***	bharni	5	20	20
2	Tonk	***dardahind***	Mendwas	11	12	12
3	Tonk	***Naner***	hameerpura	6	25	25
4	Tonk	***Prana***	siras	8	27	27
5	Tonk	***Dardaturki***	bagri	7	22	22
6	Tonk	***Bagari***	Dardaturki	7	29	29
7	Tonk	***Ahamadpurachauki***	Banetha	5	17	17
8	Tonk	***Ranoli***	kathamana	4	35	35
9	Tonk	***Kathmana***	Ranoli	4	39	39
10	Tonk	***Lawadara***	kabra	2	20	20
11	Tonk	***Bharni***	Sakhana	6	25	25
12	Tonk	***Bambor***	Ahamadpurachauki	7	7	7
13	Tonk	***Sakhana***	Bharni	7	31	31
14	Tonk	***Gahlod***	Pasrothiya	11	5	5
15	Tonk	***Arniyakedar***	Siras	30	49	49
16	Tonk	***Pasrothiya***	Gahlod	11	16	16
17	Tonk	***Kabra***	Lawadara	2	22	22
18	Tonk	***Mendwas***	Chhan	6	12	12
19	Niwai	***Jhilay***	siras	15	13	42
20	Niwai	***Siras***	prana	8	22	41
21	Niwai	***Chanani***	Raholi	15	45	74
22	Niwai	***Raholi***	Chanani	15	60	89
23	Niwai	***Datwas***	siras	15	28	57
24	Niwai	***Dhangarthal***	Jhilay	28	13	42
25	Devli	***Nagarphot***	Anwa	7	38	55
26	Devli	***Anwa***	Nagarphot	7	31	48

27	Devli	***Dhuankalan***	Ghar	8	32	45
28	Devli	***Nasirda***	mandolai	25	40	95
29	Devli	***Sitapura***	Nagarphot	11	50	60
30	Devli	***Rajmahal***	bharni	18	25	50
31	Devli	***Ghar***	Dhuankalan	8	35	53
32	Uniyara	***Aligarh***	Banetha	10	10	45
33	Uniyara	***Banetha***	Aligarh	10	20	25
34	Uniyara	***Kakor***	Aligarh	18	20	18
35	Todaraisingh	***Mandolai***	Toradi	20	30	100
36	Todaraisingh	***Kharera***	Chhan	12	17	33
37	Todaraisingh	***Barwas***	Mendwas	10	25	25
38	Todaraisingh	***Hamirpura***	Naner	6	21	31
39	Malpura	***Diggi***	lava	10	10	60
40	Malpura	***Pachewar***	Chandsen	27	21	91
41	Malpura	***Lambaharisingh***	Chandsen	31	25	95
42	Malpura	***Soda***	diggi	10	20	70
43	Malpura	***Toradi***	Mandolai	20	10	80
44	Malpura	***Lava***	diggi	10	20	50
45	Malpura	***Chandsen***	diggi	8	6	64

ANNEXURE 7

http://chittorgarh.nic.in/Generic_new/generic.htm

PROBLEM STATEMENT

TOP

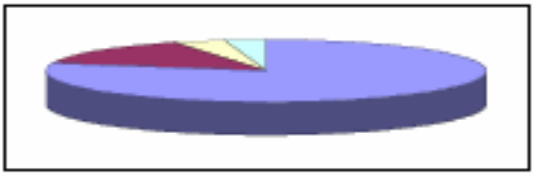
Huge gap in access to drugs

With a population of nearly 100 crores, India accounts for 16 per cent of the global population. Sizeable population lives below the poverty line and 48 per cent of the people are illiterate. India accounts for huge morbidity & mortality burden due to large number of deprived & extremely poor people. WHO says that 65% of the population still lacks regular access to essential medicines. With the rise in health care cost, over 23 % of the sick don't seek treatment because they are not having enough money to spend. A study by World Bank shows that as a result of single hospitalization 30 % of people fall below poverty line. Over 40% of those hospitalized, need to borrow money or sell their assets.

Healthcare costs are high and are increasing further. Expenditure on drugs constitutes about 50 % of the health care cost which increases up to 80 % in rural areas. (In fact expenditure on health care is the second most common cause for rural indebtedness in India)

Where does the money for health expenditure (in India) come from?

Private out of pocket expenditure	79%
State govt.	14%
Central govt.	4%
Private investment	3%
Private insurance	0 – 1%



India accounts for 22 per cent of the global illness with only 2 per cent of the global drug production of which only 0.7 per cent are essential drugs. Yet 1.3 per cent are non essential, profit-oriented formulations which are highly priced, irrational or useless. Crores of our people, living in abject poverty, can barely afford a square meal a day, can they afford to spend on costly medicines.

People are being pushed further into poverty, disability and death because of these costs. Completely irrational drugs, which do nothing but waste people's money, are widely sold. More and more drugs flood our markets every year. There are over 20,000 pharmaceutical units in the country producing over 1,00,000 (one lakh) formulations of drugs. It is paradoxical that while essential and life-saving drugs are in short supply, more and more drugs which are not therapeutically more effective, irrational and may be even dangerous, are being produced and pushed in the market with absolute disregard to the country's health needs. The problem becomes more acute in developing countries where resources for the purchase of drugs are scarce.

In the pharmaceuticals sector, the cost of manufacturing a drug is relatively low, compared to the price it is sold at. By selling drugs at inflated prices, big companies and retailers pocket a large share of the money paid out by the consumer. Retail prices of drugs show complete arbitrary variation between brands. There are abnormally high trade margins with wasteful, unregulated and unethical drug promotion. There is a nexus between drug companies, stockists, retailers, Medical Representatives (M.R.) & some medical practitioners which disproportionately inflates the cost of medicines & the overall treatment. Each

ANNEXURE:8

http://www.nrhmcommunityaction.org/media/documents/Managers%20Manual.pdf