Impact evaluation of Tribal Health Care Delivery Strategy

For

Rajasthan Health Systems Development Project

By:

State Institute of Health and Family Welfare, Jaipur

(An ISO 9001: 2008 Certified Institution)

Index

Prologue

Prologue:

Known for its History, Heritage and Hospitality; the State of Rajasthan, geographically the largest State (10.43% of the total area of the country) spread over 342000 sq. kms. de facto supported 56.5 million people (Census 2001) where 23.4% were restricted to Urban Rajasthan and at current growth rate is projected to have been supporting 68.16 million as on July 2009 (Dept. of Economics & Statistics, GoR). The State has 7 zones, 33 Districts, 237 panchayat samitis and 41353 inhabited villages and a reasonably large Health infrastructure with health care delivered through 34 District hospitals, 367 CHCs, 1503 PHCs and 10951 SCs.

The tribal districts also have a fairly reasonable 3 tier health infrastructure (Udaipur-DH/SDH-9, CHC-19, PHC-73, SC-551; Banswara- DH/ SDH-2, CHC-12, PHC-46, SC-338; Baran – DH-1, CHC-9, PHC-35, SC-210; Chittorgarh- DH/SDH-3, CHC-40, PHC-54, SC-394; Dungarpur-DH/SDH-3, CHC-7, PHC-38, SC-305; Sirohi – DH/SDH-2, CHC-6, PHC-22, SC-187)

The Human Development Index stands at 0.710 with a wide variation between districts (Dungarpur-0.409 and Sriganganagar- 0.809).

The tribal are, hunters, forestland cultivators and minor forest product collectors, live in isolation with near to nature hence, called son of soil. The impoverished economy affects population growth, literacy, sex ratio, pregnancy procedure and health care. The growth rate of tribal population was higher than the growth rate of total population of the state between 1991 to 2001. About 12.4% of the entire population of the state belongs to scheduled tribes. Bhils, the principal tribe of Rajasthan, comprise approximately 39% of the total tribal population in Rajasthan. Banswara area is dominated by this tribal group. The other tribes are Minas, Shariyas, Garasiyas, Damaors, Gadiya Lauhars, Rebaris, Kanjars, Sansi, Meo and Banjaras. Each tribe is distinguished by difference in their costumes, festivals and ornaments.

Five districts, Udaipur, Banswara, Dungarpur, Jaipur and Sawaimadhopur, together contributed two third of the state's tribal population.

Around 54.75 lakhs or 12.56% of the State population is Tribal and is spread over six districts. Primarily, Banswara with 72.27% and Dungarpur having 65.14% of population belonging to scheduled tribe are the main tribal districts besides Udaipur (47.46%), Sirohi (24.76%), Chittorgarh (21.53%) and Baran (21.23%) as per DLHS-3 data.

A tribal woman produces 4.3 children during her reproductive life but they want only 2.7 children and consider on an average 2.9 children as ideal in their family. The tribal maintain sufficient space between births of two children.

The geo-geographical and territorial punctuations at times make it a little difficult to reach the populace, particularly in the Tribal areas. Govt. of Rajasthan, through the World Bank assisted Rajasthan Health Systems Development project since 2004 had been trying to ensure to reach the tribal population in 6 Districts with specific strategy to make health services available involving key stake holders like ISM, ICDS, PRIs, NGOs and ilk with a strategy forged out of cultural context, utilization patterns, complemented by improving physical infrastructure on one hand, ensuring logistics on the other while taking care of demand generation through Village Contact Drives, extensive IEC efforts and RCH camps.

World Bank supported Health System Development Project is one of the key initiatives which has provided the opportunity and resources to the Government for improving its service delivery system. Focus of the state is to improve the health and nutritional status of the population, in particular the vulnerable groups such as the poor, women, children, scheduled castes, scheduled tribes (SC/STs), and nomadic populations.

State Health System Development Project in Rajasthan with support from the World Bank was expected to address issues related to performance of secondary level institutions by increasing efficiency in the allocation of health resources, through policy and institutional development, and developing functional linkages with primary and tertiary care.

To improve access and equity, to disadvantaged sections of society especially poor, SC and tribal population, is one of the key components of the project.

The strategic approach to address tribal health resulted into development of a Tribal Development Plan (TDP) including the following activities:-

a. Strengthening the service delivery in the selective hospitals in tribal areas with up-gradation of infra-structure and equipment along with drugs and supplies;
b. Improving human resource to ensure that adequate and appropriately trained staff would be available at facilities in tribal areas;
c. Increasing access to health care services through provision of mobile medical units;

d. Strengthening the linkages between primary and secondary health care levels by convergence with on-going health programs;
e. Creating awareness on health issues through NGO's;
f. Reducing barriers to accessing health care in tribal areas by holding RCH Camps;
g. Incentivizing doctors and other medical staff, from public and private sectors, to encourage them to work in these areas;
h. Contracting of local doctors to provide services in government facilities and at camps;
i. Integrating the tribal medical systems in providing essential health services;
j. Extensive IEC/BCC activities to influence the health seeking behavior of tribal population

Having established its credibility in the system over a period, State Institute of Health & Family Welfare, Jaipur was asked to share the responsibility of making an independent assessment of the impact that the Tribal Health care delivery strategy has made on the utilization of health services and key indicators, in the 6 Tribal Districts of the state, namely-

1. Banswara
2. Baran
3. Chittorgarh
4. Dungarpur
5. Sirohi
6. Udaipur

Study Objectives

Study Objectives:

1. To enlist activities planned under TDP and undertaken in the project.
2. To ascertain reasons for not undertaking a planned activity.
3. To undertake a detailed desk review of all available project documentation including aides memoire, studies, evaluations and reports to track the evaluation of the TDP, key decisions that were made regarding the design and planning of various intervention, and mid-course corrections, if any.
4. To assess the extent to which activities undertaken under the TDP have contributed to the Project Development Objectives (PDOs).
5. To estimate what proportion of project funds have been spent on the implementation of the TDP.
6. To elicit the view of all stakeholders
   a. Tribal community members and leaders,
   b. NGO partners,
   c. Field staff,
   d. Hospital staff,
   e. RHSDP officials,
7. To analyze the available data from the MIS, Health Camps, to understand changes in utilization of various RHSDP facilities by the tribal population.
8. To analyze the available data from the MIS, data from the Health Camps, NFHS, and RCH data, the RCH data on tribal communities, to assess the status of health care access amongst tribal.

Scope of Work

Scope of work:

The study TOR identified the scope of work for the study-

1. Conduct a survey with a pre-determined sample of beneficiaries in all tribal districts regarding
    a. Access to and utilization of RHSDP facilities
    b. Awareness and utilization of intervention under the TDP
    c. Satisfaction with both (a) and (b)
2. Develop a questionnaire focusing on the specific elements of the TDP and the objectives of this evaluation. Also use questions that had been used for the baseline Social Assessment, to enable a comparison.
3. Collate and develop baseline data from the
    a. baseline assessment
    b. baseline Social Assessment and
4. MIS data/Health Camp data
5. Devise an appropriate sampling plan and field test the draft questionnaire.
6. Orient and train data collectors.
7. Monitor data collection.
8. Analyze the data from the survey in conjunction with other available data, according to a plan agreed with RHSDP/World Bank.
9. Conduct a desk review of all available materials (aide memoires, studies, evaluations and other reports) of the implementation history of the TDP. Identify gaps in implementation, reasons for the gaps, new initiatives, key decisions taken with regard to the strategizing/planning/ implementation of the TDP.
10. Conduct stakeholder consultations with all key stakeholders based on a plan.
11. Document findings in the final report.
12. Conduct a Dissemination Workshop, after incorporating the comments of RHSDP/World Bank, of key stakeholder.

The Approach

The Approach:

The SIHFW did conceive the study and an inception report were submitted to the Project Director-RHSDP. The approach was engineered around the following areas-

a. Desk review of the dossier, including aide memoire, studies, project development objectives, strategy adopted, evaluation scale and parameters
b. Development of study tools in consultation with client organization and referring to scope of work and deliverables
c. Empanelment of Resource persons
d. Enlistment of investigators
e. Initiating dialogue with State and District officer
f. Getting the relevant information dossier from Project Directorate
g. Orientation of Resource and Investigators
h. Secondary data collection
i. Accessing primary data.

In consonance to the adopted approach a method mix was adhered for accomplishment of objectives within the scope of work ascribed.

Based on documents received, reports obtained and available literature; study findings and reports from various organizations were reviewed. Data from both published literature and a number of unpublished studies, conference papers, annual reports were reviewed, particularly Social Assessment Report, Patient Satisfaction Report, Report on BCC Training, RCH Guidelines, VCD guidelines, circulars regarding implementation of tribal strategy issued from State, aide memoires, State PIP-NRHM, Facility survey report by NRHM, UNICEF and SIHFW, the report on National Family Health Survey (NFHS-3) for Rajasthan 2002-03; Census of India Reports, DLHS-3, Rapid Household Survey under Reproductive and Child Health (RCH) Project for Rajasthan 2004-05. Apart from these reports, various state government publications/documents, i.e., Economic Review and annual reports of various years of Department of Medical, Health and Family Welfare were also reviewed.

Methodology:

I. Preparatory phase:

Getting the dossier on:

a. Aide memoire,
b. Studies conducted,
    1. Baseline study on social assessment by IIHMR ,
    2. Patient Satisfaction Survey report
c. TDP Plan and Strategies,
d. List of Facility in the districts (DH,CHC, PHC, FRU, Sub centers) covered under Project
e. Staff position in selected districts
f. HR support provided by RHSDP
g. Inputs provided by RHSDP for strengthening health care delivery in tribal districts since inception of project
h. Guidelines of RCH camps and progress of program in tribal districts for last 5 years
i. Supplies, IEC, equipments and drug supplies in tribal districts
j. Mobile health services provided under RHSDP in Tribal Districts
k. List of NGO and their work plan and progress so far
l. Initiatives under taken under Public Private Partnership basis
    1. List of private Doctors hired in tribal districts for health care services
    2. Guidelines for incentive package to the doctors
    3. Convergence activities/initiatives with ongoing programs
m. Promotional activities of Tribal Medical Health System
n. MIS Formats and Report
o. HMIS of Facility Report (238)
p. List of Facilities where BCC training undertaken
q. Indicators to be covered in Social Assessment

II. Desk review

a. Review of Literature and available secondary data.

III. Field work

a. In depth interviews with stakeholders
    1. Tribal community members and leaders
    2. NGO partners

3. Field staff of various health programs
4. hospital staff at all levels of hospitals
5. RHSDP officials (State and district level)

b. Exit Interviews
   1. Patients – Outdoor/ Indoor

c. Facility assessment
   1. Respondents:
      i. Facility in Charge
      ii. Doctors / Specialist
      iii. Patient Counselor
      iv. RMRS
      v. Store keeper
      vi. Laboratory In Charge
      vii. Statistical staff
      viii. Drug store keeper
      ix. Paramedics–Staff Nurse

d. Observations

e. FGD

IV. Time frame:

Priming and preparation: May 20-June 7, 2009
Field visits: June 8-15, 2009
Data entry: June 18-July 10, 2009
Analysis & Report writing: July 20-July 31, 2009

V. Sampling:

1. Districts: 6

Banswara
Baran
Chittorgarh
Dungarpur
Sirohi
Udaipur

2. Facilities : **60**

District Hospital: 6

CHC:

50 bedded: 5

30 bedded: 32

Referral hospitals: 5

PHC (for RCH Camps): 12

3. Respondents :

a. State level

Program Management Unit Stakeholders

i. Program Officer-In-charge Consultant- Tribal Strategy Implementation
ii. Finance Advisor –CEO
iii. Procurement Cell
iv. BCC-IEC Consultant
v. Civil
vi. HR Consultant
vii. In charge RCH Camps

b. District Level

i. CM&HO: 6
ii. DPC: 6
iii. MO/IC: 48
iv. NGOs: 10
Executing NGO: 2
Support NGO: 8
v. Program Officer: 14
(DPMs/RCHO)

Facility Assessment-

Sample:

a. Facility: 48

b. Exit Interview -

   i. Inpatient – (2 per facility): 96

   ii. Out Patent – (8 per facility): 384

c. Villages : 144

   (3 villages (1 from each category –ABC) x 48facility)

   a. Households : 1440

   (10 households from each village)

   (20%BPL, 30% General, 30% ST, 20% SC)

d. FGD: 18

   (3 per district)

   Participants: 10-12

   Women (pregnant & lactating, members of SHG, ASHA, AWW)

   Men of different age group (including community leader of different castes**)**

e. VCD Assessment

   Blocks: 4

   VCD not conducted in two districts

   Total villages covered 100 in each block

   Total sample village (10% village): 40

   (Selection Indicators for villages-Distance, Location and Population–ABC category)

   Number of Households: 400

   (10 households from each village)

   Selection Indicators of household-

   Economy (BPL-Non BPL)

   Social (representation of General, SC, ST population)

f. RCH Camp

   PHC: 12

   (2 per district)

   Village: (3 per PHC) 36

   (One per ABC category)

   Households :(10 per village) 360

   Beneficiaries: 5

Non beneficiaries: 5

Data Collection:

The data collection was tutored through

1. Quantitative Approach
   a. Interviews with stake holders at-
      i. State level- Officer In-charge, Consultant- Tribal Strategy Implementation, Finance Advisor, Additional Director, Procurement Cell, Additional Director, HR and Training, BCC-IEC Consultant, Chief Engineer –Civil, State Program manager, NRHM.
      ii. District- CMHO, Principal Medical Officer, DPCs
      iii. Facility- Doctors, LHV, LT, Drug Store in charge, RMRS In charge & exit interviews
   b. Survey
      i. household and beneficiary
2. Qualitative approach
      i. Focus group discussions
      ii. Discussions and consultations with the government health sector, NGO sector.

The study team in field could not contact all on account of reasons beyond control during the field visit. A summary of targeted as against actual contacted is presented below:

Name of District	State level		CM&HO and DPC		Facilities		Exit Interviews		Village		Household	
	T	A	T	A	T	A	T	A	T	A	T	A
Banswara	12	6	2	2	7	7	70	55	21	27	270	270
Baran			2	2	7	7	70	72	21	21	270	210
Chittorgarh			2	2	14	14	140	120	42	58	580	548
Dungarpur			2	2	5	5	50	50	15	28	210	251
Sirohi			2	2	5	5	50	47	15	24	310	240
Udaipur			2	1	10	10	100	97	30	41	460	432
Total	12	6	12	11	48	48	480	441	144	193	2200	1951

T-Target, A-Actual

Data Analysis and Final Report: The primary data collected through structured questionnaire on different variables besides the FGDs conducted during study was entered using software and analyzed subsequently.

Desk Review

Desk Review:

Relevant documents, records, and reports were reviewed to ascertain the activities implemented to achieve the goal of tribal development plan. HAF, RCH Camp Reports and Guidelines issued by department.

a. Aide Memoire

Based on the observations of Review Mission May 9 to June 2, 2005 and April 3 - 14 2006; with reference to the Project Development Objectives (improve the health status of Rajasthan, in particular the poor and un-served) it was placed for record that objectives would be addressed through -

(i) Increasing access of poor (BPL) and the underserved population to health care by upgrading health facilities in the remote areas, promoting public private partnership and improving health care seeking behavior through demand side interventions and

(ii) Improving the effectiveness of health care through strengthened institutional framework for policy development, program implementation and management capacity, and increase in the quality of health care.

For this a set of action were agreed to realign the activities to the PDO, in terms of -

A. Special IEC to increase information access by making BPL aware of availability of services and the free services that the card holders can claim when availing services.

B. Provision of health care and free ambulance services, where such services are not available through PPP for increasing physical access.

C. Posting a counselor (Social paramedical worker) at each institution to facilitate use of services by BPL to increase their social access.

D. BCC training for service providers to improve inter personal relations to increase their social access

E. Provision of adequate drugs on essential drug list at each at each institution to increase financial access and

F. Enabling the MRS to provide drugs to the BPL/STs that are not available in the hospital pharmacy normally, and use of private diagnostics services, if needed, through a subsidy from the Health Equity Funds created under the Project, as well as initiate Community Based Health Insurance pilots, to also increase financial access.

Further, to strengthen human resources, the mission recommended that the following actions should be taken in the immediate short term:

a. Assess the staffing gap for medical, paramedical and lab technicians/radiographers for each project supported institutions and agree on action to address these issues
b. Consider temporary posting of ANMs at the institutions to address shortage of female staff nurse
c. Ensure that at least one anesthetist is available in each district.

Estimated Average Population Coverage by Health Camps

SN	Districts	Population	OPD	Coverage
1	Baran	25000	535	2.1
2	Barmer	25000	1312	5.3
3	Bikaner	25000	1250	5
4	Chittorgarh	25000	1767	7.1
5	Dungarpur	25000	916	3.7
6	Jaisalmer	25000	949	3.8
7	Sirohi	25000	1920	7.9
8	Udaipur	25000	4257	17
	Total	225000	12906	5.7

Ref – Aide memoire-(7-15 October 2006)

Aide Memoire (March 3-12, 2008) commented that RCH Camps are being organized as per plan. Three follow up camps also being conducted. However, the mechanism of institutionalizing follow up of referral patients with support of ANM and counselors appointed by project as recommended during the MTR has not been institutionalized. No efforts have been made to develop a repertoire of crisp, sharply focused, well-packaged, consistent messages for delivery at the camp addressing free services for BPL and availability of specialist services at RHSDP hospitals. Clinical support to Outreach camps by specialists from satellite hospitals is not being mapped, despite it being a pre

requisite for providing equipment support to these facilities. It is recommended that RHSDP take up these issues on priority.

Data on agreed indicators for tracking of utilization of services by tribal population and staffing according to norms at project facilities in tribal areas has been reviewed. About 7.6% of all inpatients in tribal districts are tribal, compared to a target of 20% in 3 years of project. About 43% of doctors posted in tribal areas are in position, 52% of paramedics, including ANMs, and nurses and about 50% of laboratory technicians. This is better than over all targets for staff in place in tribal areas of 25% in third year of the project. The Mission is pleased to note the efforts made to track utilization of services by tribal and recommends that IEC targeting tribal population is expeditiously implemented to enhance utilization rates.

The Aide Memoire (March 2009) has annotated, as vow to Project Development Objectives (PDOs), the achievement made by the Project during Dec. 2006 to Dec. 2008, and indemnified the achievements in relation to increase in service utilization (IPD patients), CHCs with more than 10 deliveries a month, human resource in relation to norms, availability of essential drugs in all 48 tribal project facilities; marking the overall accomplishment as “Moderately satisfactory”.

With reference to Project Development Objectives, the observations of Bank have been summarized here-

Indicator	December 2006	December 2007	December 2008
Percentage of BPL populations among out patients seen at all project facilities i.e. district (DH) and sub divisional hospitals (SDH & CHC)	10.7 % (189)*	17.29% (235)	19.9% (238)
Percentage of BPL among inpatients seen at all project facilities	10.9 %	9.25%	12.9%
Percentage of ST populations among inpatients seen at all 49 project facilities in six tribal districts i.e. at district (DH) and sub divisional hospitals (SDH & CHC) in six tribal districts	**8.65%(33)**	**24.12 %(49)**	**13.51%(49)**

* Figures in brackets correspond to number of reporting facilities

ST- IPD & No. of facilities reporting %(no.)			
	2006	2007	**2008**
Jan	8.34%(49)	12.11%(49)	22.40%
Feb	10.97%(49)	16.68%(49)	3.43%
Mar	12.75%(49)	19.79%(49)	1.61%
Apr	11.45%(49)	14.34%(49)	5.27%
May	7.60%(49)	15.17%(48)	8.59%
June	21.05%(48)	19.39%(49)	13.4%
July	23.43%(49)	19.92%(47)	14.92%
Aug	23.01%(47)	17.67%(48)	17.48%
Sept	22.7%(47)	22.28%(48)	17.13%
Oct	22.9%(47)	23.15%(49)	13.42%

Nov	12.35%(36)	26.10(48)	13.73%
Dec	8.65%(33)	24.12%(49)	13.51%

b. Social Assessment Survey-

The "Social Assessment Survey" addressing to inclusion, empowerment and security, was undertaken by IIHMR to assess needs and suggest interventions to ensure:

i. Access to information and quality health care services for vulnerable groups, and
ii. Reduction in vulnerability, stigma and increase in social inclusion of tribal and nomadic population.

The assessment exercise focused on beneficiary assessment in relation to social, cultural and economic context that governs the health care seeking besides the existing government program and schemes were assessed.

The findings underlined that the burden of disease in tribal and desert areas is primarily on account of TB, Malaria, Leprosy, Sickle cell disease, Jaundice, Cholera, skin ailments, and Flurosis.

Vulnerability of newborn babies is a major issue leading to high IMR. Women suffer mainly from anemia, malnutrition, RTI and reproductive morbidities.

The well documented reasons for underutilization of health services were simply reiterated in this social assessment survey also as-

- Poverty
- Under-nutrition
- Poor environmental sanitation, poor hygiene and lack of safe drinking water
- Lack of access to health care facilities
- Social barriers preventing utilization of available health care services

For obvious reasons (access, rapport, low cost, convenient timings, availability, no waiting time, and no wage loss) people prefer traditional practitioners for health care in tribal districts factors.

On the contrary, timings, cost, and non-availability of health staff & medicines keep them away from the organized Health system.

The exit interviews had some interesting findings. The average wait time was 15 minutes. Those who had to wait for average 30 minutes (34 %), perceived it as "too long".

49% feel services are expensive, 25% expressed dissatisfaction with infrastructure, 14% had doubts about skills of staff, and 50% opined that equipments are not there while close to 90% complained about non availability of medicines.

c. Patient Satisfaction Report –

In an effort to bring in desired reforms into Health Care Delivery System, particularly so in wake of-

a. Rising costs,
b. Changing political situations, and
c. Social contexts (expectations of people from System);

The public sector health services are finding it difficult to sustain the services without extra inputs that need to be pumped in. Many of the functions of health care systems depend on adequate financing. If sustainable financing mechanisms are not put in place, innovative ideas for strengthening the primary health care base of health care systems will not yield results. The dynamics of health in view of-

a. New emerging diseases,
b. Changing disease profile,
c. Technical and diagnostic advances,
d. Longevity of life,
e. Expectations of people,
f. Subsidies and cross-subsidies
g. Increasing non-plan expenditure,
h. Competing priorities and
i. Improving awareness among people;

Increasing expenditure on health is further complemented by leakages, non-operative expenditures, and High revenue: capital ratio, and pressures from self-interest groups.

Increasing the effectiveness of health care system should lead to increase in utilization that should ultimately be reflected in Patient satisfaction. A study on this was undertaken by Hospihealth Consultants India Private Limited, Mumbai for RHSDP, with the following objectives-

A. To measure the level of patient satisfaction with project facilities in Rajasthan in terms of the following:
    a. Behavior of care provider and staff

b. Availability of services, facilities and equipment

c. Waiting and consultation time
d. Client friendly environment like cleanliness, comfort, signage, etc.
e. Perceived quality of health care received including client's privacy

B. To measure the level of patient satisfaction with similar levels of care in the private sector on the above mentioned parameters, for a public-private comparison.
C. Ascertain the barriers to services from the non-users of the project facilities and understand their views.

Additional objectives envisaged by Hospihealth to complete the study are:

- **Get Provider's perspective** that is the staff and doctors of the hospitals in terms of patient satisfaction levels and their difficulties in achieving that.
- Recommend the **strategies** to improve the patient satisfaction levels.

The study included both **patient survey** (at **24 government hospital** with **equal representation from desert, tribal and plain population** of Rajasthan as well as **project and non project hospitals** and **12 private hospitals**, selected from the project hospital areas) and **household survey** for those who did not use the hospital care in last one-year period. LAMA and death cases were also traced during the survey.

The study respondents were mainly the patients and where not possible the attendants were also subjected to customized version of the Patient Satisfaction protocol originally developed by RHSDP.

The key areas on which patient satisfaction was measured were- behavior of care provider and staff, facilities and equipment, waiting and consultation time, and No-Medical Needs (Water, Toilet, Signage and ilk).

Out of the total patient surveyed, 74.5% patients were from OPD and 25.5% patients were from IPD. In Project Hospitals, 51% and in Non Project Hospital, 39.4% patients were from tribal district.

The nature of service and facilities available at the facility decide the utilization of services, as observed in the study where close to 75% of patients did not mind travelling more than 10 kms for 150/100 bedded facilities. Interestingly all these facilities were project facilities with inputs from RHSDP.

The registration facilities in project facilities had a higher level of satisfaction compared to non project and private facilities. By and large, the people were happy with seating arrangements during wait

period in all the project facilities, of course higher the facility higher the satisfaction on accounts of higher inputs pumped into these.

Cleanliness, though a subjective phenomenon turned out to be the grey area and just close to 50% only appeared satisfied even in facilities with a bed compliment of 100/150. It is here where the private hospitals score over.

Availability and behavior of staff was relatively better in Project facilities though the 60% levels have a lot of scope for improvement.

Put to scale, medicine availability, surgery and other procedures, and over all cost were quite acceptable to people. The clients even pointed certain generic areas where improvements can be made like, better nursing behavior, more nurses, free medicine, reducing OPD waiting and availability of more specialists.

The percentage of responses on the same issues were not at par with those who were interviewed at their homes and that is quite acceptable as when in facility, the responses are expected to be a little biased.

The study did underline the strengths of private facilities as speed of registration, signage, cleanliness of waiting area & toilet, drinking water facility, lighting, doctors' availability, consultation timings, OPD waiting time, explanation regarding treatment & disease, staff behavior, skills of nurses and canteen facility.

Fortunately, none of these area needs any extra financial input and bit of concern and compassion can put the care at its best in Project facilities in particular and all public health facilities in general.

Further, all the recommendations made in the report are either capital intensive or quite generic and are far from prudence and purely subjective (e.g., landscaping, plantation, well designed diagnostic departments integrated with OPD, good waiting areas with proper sitting arrangement, proper drinking water facility preferably with coolers, well planned canteen facility, patients lift). Suggestions like **Corporatization of Hospital** is left to any body's intelligence in view of the understanding that health is a state subject and there is a constant decline in percentage of total plan expenditure on health on account of competing priorities.

One of the recommendations made by the consultant organization deserves special attention, i.e. **Management of Hospitals by professionally trained Hospital administrators** and earlier we implement it, better it would be.

d. Tribal Development Plan-

Under RHSDP, Tribal Development Plan was evolved in consultation with IIHMR. The plan was developed based on findings of different research studies and analysis of outcomes of existing programs being implemented in the state. The Plan was shared with NGOs working in tribal areas at a consultation meet held on January 16, 2003, in Udaipur. Feedback and suggestions of the NGOs were incorporated into the Plan. TDP, terse is succinctly reproduced here.

Awareness among the tribes of their entitlements, especially to government programs and schemes promoted to benefit them and how the benefits avail, is low. This makes them vulnerable to exploitation by others who misrepresent government programs and usurp the benefits. The reality of the life of the tribal is steeped in state of indebtedness and deprivation. There are a total of 12 scheduled tribes in the state.

Tribal Development Efforts in Rajasthan-

The Government of Rajasthan has long been engaged in formulating policies and strategies for tribal development. Programs and activities implemented for tribal welfare in the state are

A. Community Based Approach
B. Area Specific and Family Oriented Approach
C. Tribal Sub-Plan (TSP) Approach
D. Saharia Development Approach
E. Modified Area Development Approach (MADA)
F. MADA Cluster Area development

A Tribal Development Plan has been proposed, to address the issue of poor access to health care among the tribal in Rajasthan through strategic approach aimed at increasing the demand for health care services by tribal populations. The approach includes the following activities:

a. Strengthening service delivery in tribal areas, through

A. strengthening of hospitals in tribal areas by way of up-gradation of infrastructure and equipment and provision of drugs and supplies at the level of sub-district and district hospitals
B. Fully equipped PHCs, and sub-centres along with trained staff including doctors and paramedics
C. Provision of Mobile Services in tribal areas.
D. Strengthening linkages between primary and secondary health care levels

E. Convergence with on-going health programs.
   - Special study to find out the causes of malnutrition among tribal and develop a community-based intervention to address the problem.
   - Develop a plan within the first year for convergence with the National TB Control Program in tribal areas,
   - Develop a plan within the first year for convergence with the National Malaria Eradication Program
   - A series of workshops in the first two years of the project to orient all grass-root level functionaries, traditional practitioners and RMPs

F. **Contracting of NGOs**. NGOs with trained specialists among their functionaries would be encouraged to play an active role in the health delivery system. Their role, however, would not be limited to merely creating awareness on health issues but extend to contributing towards the implementation of project. NGOs would also help in establishing village-level committees to direct and oversee health care activities locally.

G. **Strengthening RCH Camps**. Reducing barriers to accessing health care in tribal areas by strengthening the health camps currently ongoing under the RCH Program and supplementing these services with an essential package of interventions and building in the referral linkages with static facilities. Strengthening of camp in tribal areas through:
   - Training of outreach workers in the provision of an essential package;
   - Strengthening a referral network between the camps and public health facilities at the primary and secondary level and ensuring adequate follow-up;
   - Strengthening the monitoring and evaluation of the impact of such camps;
   - Enhanced management and supervision of the quality of clinical services provided at such camps.

H. Developing an incentive package for doctors and other medical staff, from public and private sectors, to encourage them to work in these areas

I. **Contracting Local Private Doctors**. Another strategy proposed under the project for increasing access to health care services is the contracting of local doctors to provide services in government facilities, particularly in areas where the government has difficulty in placing their own doctors.

J. **Integrating the tribal medical systems in providing essential services**

   Traditional healers are to be involved for delivery of basic services at the community level.

   Pilot project in 2-3 tribal areas involving Local Village level midwife/MCH (Sevika)/Community Health Volunteers to fill the gap between the ANM and TBA and to provide skilled attendants for MCH care in difficult areas.

K. Increasing the appropriate utilization of non-tribal medical systems through appropriate BCC

L. Reducing the cost to tribal by publicizing the existing exemption/incentive based schemes.

M. **Training:** The training component needs to be carefully planned and put into place. The trainings need to be conducted at various levels:

- **Sensitization Training**. The sensitization training programs need to be organized for the medical officers, para-medical staff, sarpanch, ward panch.
- **Medical Officers**: Sensitizing the doctors to the issues and problems of marginalized groups.
- **Para-medical Staff**: There is a definite need to have a sustained dialogue with the male nurses, female paramedics and compounders who are available at the PHCs and CHCs and proxy for medical officers.
- **Sarpanch and Ward Panch**: They will be given a health sensitizing training to support and supervise the ANMs. They should also be provided information on BPL cards, and on approaches for strengthening of the overall delivery system.
- Apart from the already ongoing skill based training programs, the following new training modules are to be added:
  - Sahayika/Sevika will be provided 6 days sensitization training.
  - ISM & H Practitioners will be provided 3 days orientation training on "essential" package of services.
  - Traditional medicine (tribal) practitioners will be provided 6 days training.
  - PRI members, CBO/NGO at block, district and state levels should be oriented for the RCH program. The duration of awareness training could be 3 days.
- **Identify, train and equip the Local Tribal Traditional Birth Attendants (TBA)**. In many difficult areas the TBAs are the first contact RCH care provider for the tribal people. During the desk review incorporating Tribal Development Plan, these activities at point no. E, F. G, H, J and M were found to be part of TDP. However, during the study it became evident that these activities were not taken up under the RHSDP as the priorities and the available resources and time frame did not probably allow it.

b. Management Structure

The proposed structure will have a State Steering Committee on Tribal Health, a District level coordination committee, a Block level coordination committee and a Village health team/committee at sub center level comprising of ANM, village midwife (Sahayika/Sevika), and AWW, TBA, NGO, MSS and village panchayat member. This committee has now been formed under NRHM as VHSC

for each village with an untied grant of Rs. 10000 transferred. For the capacity building of VHSCs training of VHSC members are proposed in PIP.

c. Operations Research

- Study the effectiveness of mobile health services and develop a plan to expand the same.
- Alternative strategies to improve accessibility and utilization of health/RCH services in tribal areas.
- Improving skilled attendance in HCM care with special reference to deliveries.
- Nutritional status of tribals, and plan for addressing the issue of malnutrition.
- Innovative approaches for better inter-sectoral coordination, and convergence.
- Extent of use and effectiveness of traditional herbs for contraception and its role in RCH program.
- Tribal culture and practices vis-à-vis modern medicine and RCH program.
- Appropriate referral linkage and transport in tribal areas.

It was earlier envisaged to conduct certain Operations Research studies as mentioned above but these could not be accomplished under the project

d. Costing for Tribal Development Plan

The total cost for the Tribal Development Plan is Rupees 369.78 million, was to be set apart as per the suggestions given in reports by IIHMR, Details of which are put here under

	Cost for Tribal Development Plan (INR in millions)						
		Year1	Year2	Year3	Year4	Year5	Total
	Activities						
1.1	Strengthening SDH/DH	45.06	92.58	16.14	0.00	0.00	153.78
1.2	Strengthening Sub-centers	0.00	0.00	0.00	16.83	0.00	16.83
1.3	Provision of mobile services	1.00	8.00	3.00	3.00	3.00	18.00
2.1	Contracting NGOs	1.70	6.20	5.00	5.00	5.00	22.90
2.2	Strengthening RCH Camps	0.70	0.00	0.00	0.00	0.00	0.70
3.1	Contracting local private doctors	0.00	6.00	6.00	6.00	6.00	24.00
4.1	Sevika/Sahayaka for providing skilled attendants	0.00	20.90	20.90	20.90	20.90	83.62
5.1	Increasing appropriate utilization of non-tribal medical system through BCC	1.25	1.25	0.50	0.50	0.50	4.00
6.1	Reducing cost to tribal through strengthening the existing schemes of the government	5.70	3.90	3.50	3.50	3.00	19.60
7.1	Training	10.20	8.15	6.50	0.00	0.00	24.85
	Monitoring and Evaluation	0.10	0.10	0.60	0.10	0.60	1.50
	Total Cost (Rs. Million)	**65.71**	**147.09**	**62.15**	**55.83**	**39.00**	**369.78**

e. Evaluation of VCD conducted by RVHA

RHSDP has out sourced a study to RVHA for evaluation of the impact of VCD in selected areas. SIHFW research team reviewed the study report and compared the results of current findings. RVHA has conducted the evaluation in two round of the VCD for which in-depth interviews and FGDs were conducted. The key issues covered under the evaluation of VCD were, facilities available in the area at the CHC/PHC/sub-centers, health benefits and services for BPL & tribal people by CHC/PHC, (free medicines, free investigation facilities for BPL and tribal people), specialist services available at CHC, need and importance of seeking health services at the early stage of diseases, health messages, extent to which BPL and tribal people effectively use health services and facilities of CHC/PHC, behavior of health staff, participation level of the members of FGD in the health meetings organized by VCD team in the village, benefits received by villagers due to VCD.

75 to 80% villagers of selected blocks stated that VCD Campaign was organized in two phases in their villages in three rounds and during VCD Campaign.

Information about health services and facilities of concerned CHC were given by VCD team.

Villagers participated in various meetings organized by VCD team in villages during VCD Campaigns, but villagers expressed their feelings that **VCD activities were organized in main villages only,** and hamlets and other outreach areas of the villages were not covered under VCD Campaign.

70% villagers during focus group discussions stated that **BPL and Tribal groups of the area were clearly explained** about the health services and facilities of CHC, PHC and their use by these groups during VCD

75% villagers during FGDs mentioned that 25 to 30 households were visited and contacted every day in each village by VCD team and messages about the location, functioning and services of CHC & PHC were given in detail to the villagers. 75% villagers also mentioned that during VCD health messages about the health services, facilities, diagnostic facilities, indoor facilities of CHC, Benefits of BPL cards were provided to them.

90% Tribal (scheduled tribes) and 10% backward and general households were interviewed to assess the impact of VCD; 90% household respondents were aware about the health services and facilities of CHC ARNOD and its location and distance from their village.

The findings are generalizations drawn from an earlier study which was reviewed by the present study team, again as part of desk review. In no way they exclusively relate to one CHC; it is just to exemplify that a particular CHC has been referred here

80% household level respondents were aware about the curative (treatment of illness), diagnostic (Blood, Urine, X-ray examinations), surgical (minor operations) and immunization (Preventive) services of CHC ARNOD.

92 percent respondents were aware about location of CHC in their area but only 48 percent respondents were aware about the health services and facilities available at CHC, 48 percent family respondents were aware about curative and diagnostic services of CHC, only 31 percent were aware of immunization services provided by CHC.

73 percent respondents stated about the services of general doctors in CHC but only 25 percent respondents were aware about the specialist services in CHC, 2 percent respondents could not answer about the type of services of CHC.

71 percent respondents were aware about availability of free medicine and investigations to BPL families and they also knew about the benefits of BPL cards.

Villagers stated that VCD teams have effectively given health messages about the health services and facilities in their area especially in CHC.

f. BCC Training for Better Hospital services ("MHARO CHOKHO ASPATAL"-)

To address the objective of increasing access of the Below Poverty Line (BPL) and the underserved population to healthcare, and to improve the effectiveness of healthcare through strengthened programme implementation and management capacity, and increase in the quality of healthcare; BCC training for service providers were introduced in the project with the help of a professional agency Ma Foi Consulting Solutions Limited (MCSL).

A Training Need Assessment (TNA) was conducted in the State. The TNA recommended that it was necessary to build capacity of all categories of staff, i.e., administrators, district officials, specialists, doctors, nursing staff and technicians and Class IV staff to improve the hospital and health care facility's performance in the State.

A comprehensive training package on 'Behavior Change Communication for Performance Excellence' was developed for medical and paramedical staff. BCC training was conducted in two

phases. Selected facilities were covered in first phase and remaining facilities were taken up in II phase.

Activities carried out during the training:

The activities carried out during the First Phase of BCC included: Pre Sensing Exercise, training at all the covered facilities in three tiers – ***Seva bhav*** (Service Orientation), ***Aspatal Aapka Aur Hamara*** (Team Work) and ***Seva Sankalp*** (Determination to serve and Oath Taking).

Expected Outcomes

- A sense of ownership among the service providers to ensure smooth implementation of the process
- Institutionalization of Behavioural change process through systemic support to the individual employees
- The behavioural changes among the individual workers and the group is alive and constant

Approach and Methodology

Approach and methodology towards achieving the expected outcomes includes:

- Use of a multi-disciplinary team of professionals, including behavioural trainer, development consultants, project managers, monitoring and evaluation experts
- Constitute a resource pool of 35-40 persons drawn from the newly appointed HSIT consultants, members of the State training institutes, HSDP and the State Health department.
- Conduct a Situation Analysis for existing facilities and share with the Stake holders
- Preparing the resource persons (Including identified Internal Champions) through TOT on BCC training.
- Train the resource persons in training methodology so that they can take up BCC training in other locations of the State.
- Conduct BCC training in the 20 facilities in the same six districts with Internal Champions, Health Institute Professionals along with HSIT Consultants, which were not covered in the first round of BCC training.
- Conduct a capacity building workshop at Jaipur for all Internal Champions of 50 facilities.

- Based on learning the skills and enhancing their capacity as a trainer the resource person trains our Trainers and conduct training workshops at their respective facilities
- The last round of training for 30 facilities was conducted with select people at the facility. These people were selected after consultation with Internal Champions and PMO/MOIC at the facility level and also getting approval from District and State
- Develop monitoring and evaluation (M&E) mechanism to monitor the progress and evaluate the outcome of the BCC training, prepare the resource persons for using the M&E mechanism through-

    1. Stakeholders Meeting and Involvement
    2. Situation Analysis: Tool Development, Planning & Field Visit
    3. Training of Internal Champions
    4. Capacity Building Workshop
    5. Training at 6 districts with Internal Champions (R2)
    6. Training of select people for existing 30 facilities with Internal Champions (R 3)

The Five major components of the capacity building were:

1. Gender Sensitivity
2. Stress Management
3. Team Building
4. Ownership
5. Problem solving skills

Recommendations of Agency

a. Shortage of Staff is common across the 6 districts

b. The Security of the staff is of utmost importance and thus from RMRS fund high security to be put in place

c. Visiting hours for the Attendants is a necessity as it is creating nuisance for the Service providers

d. Dress Code / Uniform Code is to be enforced

e. Punctuality / Swiping of Attendance Card should be introduced as it is found that most of the staff members do not turn to facility on time

f. Strict action to be taken against Doctors who are doing Private practice during OPD timings

g. Empowerment to hospital administrators is required to make changes in the hospital

h. Introduction of HMIS in the health system will take it in a long way

i. Lot of medical Equipment and instruments were found idle / damaged and there is clear lack of getting these items repaired. It will improve the condition of the facility drastically if DPC/ PMO/MOIC gets involved directly.

j. Though capacity building was done in two TOT's for internal champions but it was found that neither DPC's nor chosen members who came for TOT wanted to take part in the training at their respective facilities. It is thus recommended that Internal Champions should be selected on participatory method and who are interested in conducting training.

Observations

Observations:

Following activities were executed which could be evaluated.

- Up gradation of infrastructure including – civil works (new construction and repairs) supply of equipments and drugs.
- Capacity building of service providers through conducting trainings on – HCWM, BCC, referral, clinical trainings on various subjects etc.
- Strengthening the linkages between primary and secondary health care levels by convergence with on-going health programs by organizing RCH camps at selected PHCs
- Create awareness of health issues by contracting NGO's; for village contact drive.
- To Strengthen the RCH Camps, in order to reduce barriers to accessing health care in tribal areas.
- IEC activities to influence the health seeking behavior of tribal's which aimed at developing Behavior change Communication (BCC) to provide information on the services available at various levels of hospitals and motivating the target groups to utilize these services.
- To strengthen the various existing exemption schemes of the government; MMJRK, Free service provisions for BPL card holders

Following activities could not be evaluated as not executed but need strengthening, henceforth.

- Incentive package for doctors and other medical staff, from public and private sectors, to encourage them to work in these areas;

- Contracting of local doctors of provide services in government facilities, particularly in areas where the government has difficulty in placing their own doctors.

- Integration of the tribal medical systems in providing essential health services;

Facility Assessment

Facility Assessment:

Under the project interventions, it was expected that secondary level institutions will be equipped with minimum facilities to render the first referral services to the community. Provision of effective and affordable healthcare services (curative including specialist services, preventive and promotive) for a defined population, with their full participation and in co-operation with agencies in the district that have similar concern was expected from an equipped facility in urban and the rural population of the area.

Essential Services (Minimum Assured Services) that were expected to be offered, referred to-

- OPD, indoor, emergency services.
- Secondary level health care services with regard to specialties like-

General Medicine, General Surgery, O&G, Pediatrics, Emergency/A&E, Critical care, Anesthesia Ophthalmology, ENT, Skin & VD for RTI/STI, Orthopedics, Dental care and AYUSH

- Diagnostic and other Para clinical services regarding:-Lab, X-ray, Ultrasound, ECG, Blood transfusion and storage, and physiotherapy
- Support services: Following ancillary services should be ensured:
- Medico legal/postmortem, ambulance services, dietary services, Laundry services, Security services, housekeeping and sanitation, waste management, Office Management (Provision should be made for computerized medical records with anti-virus facilities whereas alternate records should also be maintained).
- Counseling services for domestic violence, gender violence, adolescents, etc. Gender and socially sensitive service delivery be assured.

Under evaluation of tribal strategy, components covered under institutional strengthening by RHSDP were assessed. In the evaluation process all the parameters suggested in IPHS were used as check list point for evaluation. Out of total 77 health facilities including District Hospitals, Sub district Hospital and Community Health Centers in sample districts, total 48 Institutions (40 Project and 8 Non-Project facilities) were selected for assessment in this evaluation study. List of assessed facilities shown in Table F-1.

Table F-1: List of Facilities Assessed

S.No.	Name of Medical Institution	City/ Town	District	Beds	Project / Non Project
1	M.G.(District) Hospital	Banswada	Banswada	300	**RHSDP**
2	Community Health Centre	Kushalgarh	Banswada	50	**RHSDP**
3	Upgraded PHC	Bagidora	Banswara	30	**RHSDP**
4	Upgraded PHC	Chota Dungla	Banswara	30	**RHSDP**
5	Community Health Centre	Chotisarwan	Banswara	30	**RHSDP**
6	Upgraded PHC	Ghatol	Banswara	30	**RHSDP**
7	Upgraded PHC	Paloda	Banswara	30	Non Project
8	Government Districts Hospital	Baran	Baran	150	**RHSDP**
9	Community Health Centre	Chhabra	Baran	50	**RHSDP**
10	Referral Hospital	Antah	Baran	30	Non Project
11	Upgraded PHC	Atru	Baran	30	**RHSDP**
12	Referral Hospital	Chhipabarod	Baran	30	**RHSDP**
13	Upgraded PHC	Kishanganj	Baran	30	**RHSDP**
14	Community Health Centre	Mangrol	Baran	30	**RHSDP**
15	Government District Hospital	Chittorgarh	Chittorgarh	150	**RHSDP**
16	Government District Hospital	Pratapgarh	Chittorgarh	150	**RHSDP**
17	Upgraded PHC	Badi Sadri	Chittorgarh	50	**RHSDP**
18	Upgraded PHC	Bharawardha	Chittorgarh	30	Non Project
19	Upgraded PHC	Kapasan	Chittorgarh	50	**RHSDP**
20	Referral Hospital	Nimbaheda	Chittorgarh	50	**RHSDP**
21	Upgraded PHC	Arnod	Chittorgarh	30	**RHSDP**
22	Upgraded PHC	Chhotisadari	Chittorgarh	30	**RHSDP**
23	Upgraded PHC	Doongla	Chittorgarh	30	**RHSDP**
24	Upgraded PHC	Gangrar	Chittorgarh	30	**RHSDP**
25	Upgraded PHC	Bhopalsagar	Chittorgarh	30	**RHSDP**
26	Upgraded PHC	Mandphia	Chittorgarh	30	**RHSDP**
27	Upgraded PHC	Rashmi	Chittorgarh	30	**RHSDP**
28	Upgraded PHC	Kanera	Chittorgarh	30	Non Project
29	General (District) Hospital	Dungarpur	Dungarpur	150	**RHSDP**
30	Upgraded PHC	Sagwara	Dungarpur	105	**RHSDP**
31	Upgraded PHC	Aspur	Dungarpur	30	**RHSDP**
32	Upgraded PHC	Bichhiwara	Dungarpur	30	**RHSDP**
33	Community Health Centre	Saroda	Dungarpur	30	Non project
34	District Hospital	Sirohi	Sirohi	150	**RHSDP**
35	Upgraded PHC	Kalindri	Sirohi	30	Non Project
36	Upgraded PHC	Pindwara	Sirohi	30	**RHSDP**
37	Upgraded PHC	Reodar	Sirohi	30	**RHSDP**
38	Referral Hospital	Shivganj	Sirohi	30	**RHSDP**
39	Upgraded PHC	Vallabhnagar	Udaipur	50	**RHSDP**
40	Referral Hospital	Bhindar	Udaipur	50	Non Project
41	Upgraded PHC	Jhadol	Udaipur	50	**RHSDP**
42	Upgraded PHC	Salumbar	Udaipur	50	**RHSDP**
43	Upgraded PHC	Dhariawad	Udaipur	30	**RHSDP**
44	Community Health Centre	Kanod	Udaipur	30	Non Project
45	Upgraded PHC	Kurawad	Udaipur	30	**RHSDP**
46	Upgraded PHC	Mawali	Udaipur	30	**RHSDP**
47	Upgraded PHC	Rikhabhdevji	Udaipur	30	**RHSDP**
48	Upgraded PHC	Sarada	Udaipur	30	**RHSDP**

Health Facilities were assessed in terms of available basic amenities as well services provided through the institution. The areas covered were - availability of reception counter, cash counter, signage, availability of drinking water, sitting arrangement, OPD rooms or cubical with availability of equipment, privacy, washbasin with 24 Hour running water supply, Wards with nursing station, toilets etc. Availability and functionality was assessed for each area. All the observations have to be read in light of the fact that at places where the functionality was there it has been temporarily disrupted because of civil works in progress.

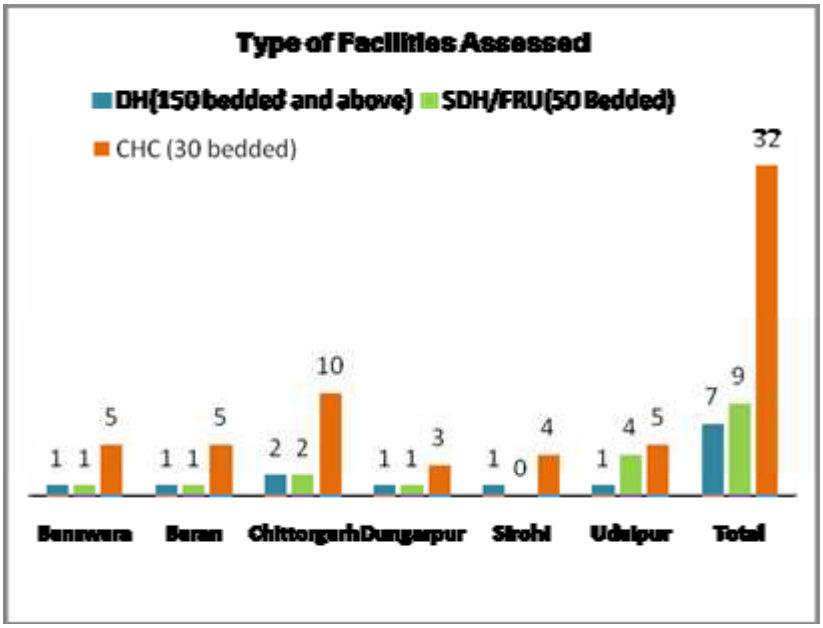


Figure 1: Type of facilities

Reception cum enquiry/Cash counter-

Out of total 40 Project facilities assessed, the registration cum enquiry counter was available at 36 (90%) Project facilities and cash counter at 35 (87.5%) centers. However, it was only at 33 and 32 facilities respectively that these were a functional. The construction in progress at some of the CHCs has led to functional disruption. Facilities where registration counters were not found are - Upgraded PHC Arnod, Bharawardha, Chhotisadari, Gangrar (Chittorgarh), Atru (Baran) and Community Health Centre Kushalgarh (Banswara), Saroda (Dungarpur).

Display of signage-

Display of signage on various information including timings of staff on duty, essential drug list, citizen charter, user charges etc., were observed and recorded during facility assessment. Out of total 40 Project facilities assessed hospital timings were displayed at 31 facilities. Name of the facilities(project as well as non-project) without displaying of timing are, upgraded PHC (Bagidora, Paloda, Kalindri, Atru Gangrar, Pindwara, Vallabhnagar, Salumber, Ghatol, Chhabra, Badi Sadri) Community Health Centre (Choti sarwan) District Hospital Banswara, Referral Hospital Chhipabadod, Binder) 28 Project facilities had a display of staff on duty. 12 Project and 4 Non-

Project facilities such as Upgraded PHC (Bagidora, Kalidri, Bichhiwada, Gangrar, Jhadol, Kurawad, Mawali, Pindwara,, Rishabhdev, Sagwada, Salumbar, Sarada, Vallabhgarh). Referral hospital Bhinder, Chhipabadod and District hospital Chittorgarh; did not have the display.

Display of citizen charter was observed at 25 (62.5%) Project facilities**, while facilities without display of citizen charters were** Referral Hospital (Antah) Upgraded PHC, (Arnod, Bagidora, Paloda, Kalindri, Bichhiwara, Gangrar Ghatol, Pindwara, Kanod Bhinder, Badi Sadri, Chhoti Sadri Jhadol, Mawli, Salumber, Saroda, Vallabhanagr CHC - (Chhoti Sarvan, Kushalgarh).

User charges-

User Charges were found displayed at 26 (65%) Project facilities. Facilities where user charges were not found displayed are Badi Sadri, Gangrar, Arnod, Bhopalsagar, Kanera, Sagwara, Pindwara, Kalindri - Mawli, Sarada, Kanod, Jhdole, Kurawad, Bagidora, Paloda (Upgraded PHC) Mangrol, Saroda (CHC), Nimbaheda, Bhider, Chhipabadod, Shivganj (Referral Hospital), Pratapgarh, Chittorgrh (DH).

Essential drug list-

Essential drug list was displayed only at 24 (60%) Project facilities; institutions without display of ED are CHC (Saroda, Mangrol) Upgraded PHC (Arnod, Bagodora, Nimbaheda, Bhopalsagar, Badi Sadri, Dhariyavad, Ghatol, Gangrar Kanod, Pindwara, Sagwara. Vallabhnagar, Sarada, Rishbhdev Salumber, Karera, Jhadol, Mawli, Pindwara) -Referral Hospital (Bhider, Antah).

IEC material-

IEC material was available at 36 (90%) Project facilities but it was displayed only at 29 (72.5%) places. A mandatory requirement of display of categories of patients, entitled for free treatment including drugs was derided at 19 (47.5%) facilities.

Incidentally these actions shall not cost a fortune; it is just a matter of aptitude.

Basic amenities at hospital -

35 (87.5%) Project facilities had seating arrangements for patients in waiting. Facilities without proper sitting arrangements were Upgraded PHC - (Bagidora, Gangrar, Vallabhnagar, Kalindri, Mawli, Sarada Dhariyavad, Kanod, Jhadol) CHC- Kushalgarh, Chittorgarh.

However, 35 Project facilities had water cooler and RO system installed, another 5 Project facility and 6 out of 8 Non-Project facilities had drinking water facilities. These facilities are, Upgraded PHC, (Pindwara, Kalindri, Kanera, Bharawardha, Ghatol, Gangrar, Sarada, Dhariyavad, Kanod, Mawali, Jhadol).

The display related issues probably will be taken care of when the construction activities are over.

Table F-2: Basic amenities at health facility

Basic amenities	Category of Facility	Baran N=7		Banswara N=7		Chittorgarh N=14		Dungarpur N=5		Sirohi N=5		Udaipur N-10		Total N=48	
		A	F	A	F	A	F	A	F	A	F	A	F	A	F
Reception cum enquiry	P	6	5	5	5	9	7	4	4	4	4	8	8	36	33
	NP	1	1	1	1	2	2			1	1	2	2	7	7
Cash counter	P	6	5	3	3	11	9	4	4	4	4	7	7	35	32
	NP	1	1	1	1	2	1	1	1	1	1	2	1	8	6
Display															
Signage	P	6	5	5	3	8	7	2	2	3	3	7	4	31	24
	NP	1	1			2	2					2	2	5	5
Timings	P	4	4	6	4	8	8	4	4	3	3	7	4	31	27
	NP	1	1			2	2	1	1			2	2	6	6
Staff on duty	P	5	5	6	6	10	11	3	2	3	3	4	1	28	28
	NP	1	1	1	1	2		1	1			1	1	6	4
Citizen charter	P	4	4	4	4	6	6	3	3	3	3	5	4	25	24
	NP	1	1			2		1	1			2		6	2
User charges	P	4	4	6	5	6	6	3	3	2	2	5	4	26	23
	NP	1	1			2						1		4	1
Essential drug list	P	1	1	6	6	9	10	3	3	2	2	3	1	24	23
	NP	1	1	1		1		1	1			1		5	2
IEC material	P	6	5	5	4	10	11	4	4	2	2	8	2	36	29
	NP	1	1	1		1		1	1			1		5	2
List of free category Patients	P	4	2	7	5	9	6	3	3	3	3	5	1	31	20
	NP	1	1			1		1	1			1		4	2
Facilities															
Sitting arrangement	P	6	5	5	5	11	12	4	4	4	3	5	4	35	33
	NP	1	1	1	1	1		1	1	1	1	2		7	4
Toilets	P	6	5	6	6	12	12	4	4	3	2	6	3	37	32
	NP	1	1	1	1	1		1	1	1	1	2		7	4
Drinking water	P	6	5	4	4	11	10	4	4	4	3	6	5	35	31
	NP			1	1	1		1	1	1	1	2		6	3
Stretcher trolley/ Wheelchair	P	6	5	6	6	12	12	4	4	4	3	7	4	39	34
	NP	1	1	1	1	1		1	1	1	1	1		6	4
Drug dispensing	P	6	2	6	6	12	12	4	4	4	3	8	3	40	33
	NP	1	1	1	1	1		1	1	1	1	1		6	4

P - Project, NP - Non-Project A - Availability, F - Functional

It is only with reference to 4 variables that Udaipur shows a relatively poor status but then an observant look will reveal that these are not amenities, it simply relates to display (Citizen charter, IEC material, User charges and Essential Drug List) in project facilities which has been thrown out of shape, for the ongoing civil works, temporarily.

Table F-3: Availability of Manpower

Manpower	Category of Facility	Baran N=7	Banswara N=7	Chittorgarh N=14	Dungarpur N=5	Sirohi N=5	Udaipur N-10	Total N=48
Superintendent/ PMO	P	2	1	1	2	1	0	7
	NP							
Hospital Administrator	P	2	0	1	2	0	1	6
	NP							
Medical Officer	P	5	5	7	4	2	5	28
	NP	1	1	2	1	1	2	8
Specialists	P	5	4	8	2	3	4	26
	NP			1			1	2
Patient counselor	P	2	2	5	2	1	3	15
	NP							
Nurse	P	6	5	10	4	3	4	32
	NP	1	1	2	1		2	7
Wards boys	P	6	6	11	4	4	4	35
	NP	1	1	2	1	1	2	8
Sweepers	P	6	6	10	2	4	5	33
	NP	1	1	2	1	1	1	7

P - Project, NP - Non-Project

The information specific to facilities under study are not made available by the System, District and State information is available but that shall not serve the purpose here.

Staff: Availability of service providers was assessed at 40 Project facilities, and it was observed that in defiance to IPHS, 14 Project facilities and 2 Non-Project facilities were functional without a specialist. Facilities without specialists are mostly Community health centers and Sub district Hospitals such as CHC- (Mangrol, Saroda,) Referral Hospital, (Shivganj, Chhipabadod, Bhindar Upgraded PHC (Reodar, Kalindri, Atru, Badi Sadri, Arnod, Bharawardha, Gangrar Paloda, Chota Dungla, Jhadol, Mawli, Dhariyavad, Salumber Bichhiwara, Aspur). Some of the facilities like CHC- Chhabra, Pindwara and upgraded PHC Kinshanganj have only one specialist which is the key indicator to assess the quality of services.

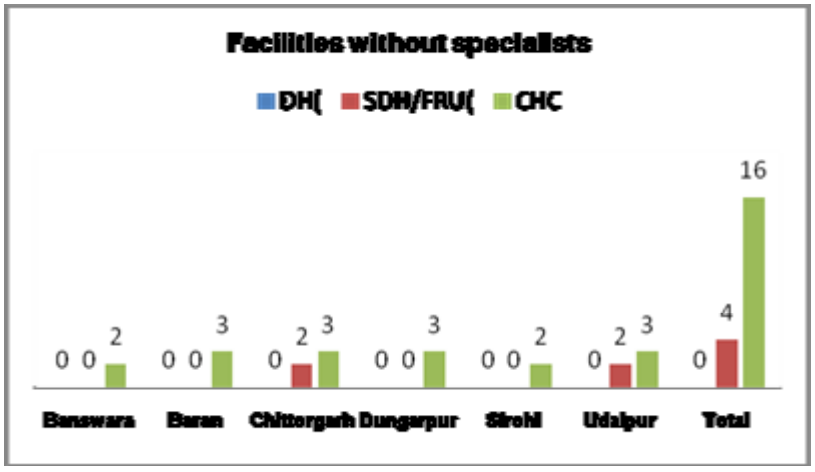


Figure 2: Facilities without specialist

It is difficult to justify the inputs through projects when the manpower is not in place which then tells on utilization and forces referrals. But then from where to get the specialist is again an unanswered question.

Only district hospitals were equipped with all specialists but most of the places were abandoned with the services of all the specialists. Presence of limited technical staff (one or two specialists) is the key problem to ensure the quality of care at facility level.

Out of total 48 facilities (thirty two 30-bedded facilities did not have a provision of patient counselor), 15 (93.75%) facilities (all these are project facilities) had patient counselors. This is because the project has placed counselors at only 50 bedded and above facilities. Facilities with Patient counselor were- DH- Pratapgarh, Sirohi, Banswara, Dungarpur, Baran, and Chittorgarh Sub District Hospitals – Kushalgarh, Chhabra, Sagwada, Kapasan, Nimbaheda, Salumber, Vallabhnagar, Jhadol.

Status of OPD-

As per IPHS, recommended and implemented under NRHM, it is expected that health facility should have a separate outpatient department for each specialty with minimum of equipment and privacy.

As per findings most of the facilities have equipped OPD with required equipments except Kanod, Kapasan and Pindwara (Up graded PHC). Some of the facilities under construction probably will have better working conditions at OPDs after civil works are done with.

Table F- 4: Status of OPD

Facilities in OPD	Category of Facility	Baran N=7	Banswara N=7	Chittorgarh N=14	Dungarpur N=5	Sirohi N=5	Udaipur N-10	Total N=48
Availability of equipments	P	6	6	11	4	3	8	38
	NP	1	1	2	1	1	1	7
Privacy	P	5	5	12	4	3	8	37
	NP	-	1	2	1	1	1	6
Wash Basin with 24 hour running water supply	P	3	6	11	5	2	6	33
	NP	1	-	-	-	1	-	2

P - Project, NP - Non-Project

A separate injection room was available at each facility where availability of syringe sterilizer, disposable syringes, and hub cutter was observed except - upgraded PHC- (Dhariyavad, Jhadol, Mawli, Sarada, Vallbhagarh, Atru). To ensure the health care waste management color coded bins have been supplied and systematic use of these bins found everywhere except at Upgraded PHC Dhariyavad (Udaipur) and Referral Hospital Chhipabadod (Baran).

Injection room-

Table F- 5: Status of injection room

Status of Injection Room	Category of Facility	Baran N=7	Banswara N=7	Chittorgarh N=14	Dungarpur N=5	Sirohi N=5	Udaipur N-10	Total N=48
Availability of syringe sterilizer	P	5	3	11	4	4	3	30
	NP		1	2	1	1	1	6
Availability of disposable syringes	P	6	6	12	4	4	8	40
	NP	1	1	2	1	1	1	7
Availability of needle destroyer, hub cutter	P	6	5	16	4	4	4	38
	NP	1	1	1	1	1	1	6
Color coded bins	P	6	5	12	4	4	7	38
	NP	1	1	2	1	1	2	8
Emergency tray	P	6	5	13	4	4	5	37
	NP	1	1	1	1	1	2	7
Wash basin with 24 hour running water supply	P	6	5	13	4	3	2	33
	NP				1	1	2	4

P - Project, NP - Non-Project

The study had no inbuilt questions on this issue so it is not possible at this juncture to respond to this issue.

Most of the facilities were equipped with dressing room but in 10 Project facilities and 2 Non-Project facilities, screen and curtains were not available. These facilities are, Mangrol, (CHC) and Upgraded PHCs (Arnod, Palod, Atru, Dhariyavad, Jhadol, Kapasan, Kurawad, Mawli, Pindwara, Salumber and Vallbhagarh).

Upgraded PHC (**Pindwara, Palod, Kurawad, Dhariyavad, Mawali, Kanod Kanera, Arnod) had Dressing rooms with no provision of washbasins and water**, contumacious to Hospital hygiene.

These frugal inputs, if thought and put in place, will certainly address to quality and aesthetics related issues but then it requires vision and ownership, money is not a punctuation here with flexi funding and RMRS in place.

Dressing room-

Table F-6: Status of dressing room

Facilities dressing room	Category of facility	Baran N=7	Banswara N=7	Chittorgarh N=14	Dungarpur N=5	Sirohi N=5	Udaipur N-10	Total N=48
Screen and curtains	P	5	5	10	4	3	3	30
	NP	1		2	1	1	1	6
Trolleys	P	5	6	11	4	2	3	31
	NP	1		2	1	1	1	6
Antiseptics & dressing material	P	6	6	11	4	3	6	36
	NP	1	1	2	1	1	2	8
Emergency tray	P	5	4	11	4	3	6	33
	NP	1	1	2	1	1	2	8
Wash basin with 24 hour running water supply	P	5	7	11	4	2	6	35
	NP	1		1	1	1	1	5
Color coded bins	P	6	5	11	4	3	7	36
	NP	1	1	2	1	1	2	8

P - Project, NP - Non-Project

Separate MOT was not there in the facilities such as Pindwara and Kalindri (Sirohi) Salumbar, and Dhariyavad (Udaipur) and Sagwada in Dungarpur.

MOT-

Table F-7: Status of MOT

Facilities in MOT	Category of facility	Baran N=7	Banswara N=7	Chittorgarh N=14	Dungarpur N=5	Sirohi N=5	Udaipur N-10	Total N=48
Lights	P	5	6	11	3	3	6	34
	NP	1		1	1		1	4
Oxygen	P	5	6	11	4	3	6	35
	NP	1		1	1		1	4
Instruments/ equipments	P	5	7	11	4	3	7	37
	NP	1		1	1		1	4
Emergency tray	P	5	7	10	4	3	5	34
	NP	1		1	1		1	4
Wash basin with 24 hour running water supply	P	5	7	11	4	3	4	33
	NP	1		1	1		1	4
Color coded bins	P	5	6	10	4	3	7	35
	NP			1	1		1	3

P - Project, NP - Non-Project

Most of the hospitals excluding District Hospitals were not equipped to deal with emergencies and surgery and had no separate observation rooms.

Observation room-

Table F-8: Status of observation room

Facilities in Observation Room	Category of facility	Baran N=7	Banswara N=7	Chittorgarh N=14	Dungarpur N=5	Sirohi N=5	Udaipur N-10	Total N=48
Beds	P	5	3	11	3	2	6	30
	NP		1	1			2	4
IV stands s	P	5	3	12	3	2	6	31
	NP		1	1			1	3
Emergency drug	P	5	3	12	3	2	5	30
	NP		1	1			1	3
Oxygen	P	5	3	12	3	2	5	30
	NP		1				1	2
Toilet	P	4	4	12	2	2	2	26
	NP			1			1	2
Color coded bins	P	5	3	12	3	2	6	30
	NP		1	1			2	4

P - Project, NP - Non-Project

Status of ward-

Only 28 (70%) Project facilities had nursing stations. Facilities without nursing stations are Referral Hospital – (Antha Chhipabadod Bhinder, Kushalgarh, Nimbaheda), Upgraded PHC (Palod, Kalindri, Bharatwada, Kurawad Ghatole, Jhodole, Kanera, Kapasan, Kishanganj, Pindwara, Rasmi, Sarada, Rishabhdev, Salumber Mawali). Windows and ventilation in wards was proper at most of the places, as the project (RHSDP) has taken care of these during renovation.

A simple intervention to maintain aesthetics, like exhaust fans in toilets, was not available in 12 (30%) Project facilities and 7 Non-Project facilities, to name, Referral Hospital Antah, CHC (Saroda) District Hospital Banswara Dungarpur, Upgraded PHC,-(Kanod, Badi Sadri, Bharawardha, Bhinder, Kapasan, Kurawad Mawali Rishabhdev, Saroda, Vallabhnagar, Kalindri, Paloda, Pindwara, Salumber, Jhadol)

Table F-9: Status of wards

Facilities in ward	Category of facility	Baran N=7	Banswara N=7	Chittorgarh N=14	Dungarpur N=5	Sirohi N=5	Udaipur N-10	Total N=48
Nursing station	P	4	4	9	5	3	3	28
	NP						1	1
Exhaust fans in toilets	P	5	5	10	4	3	1	28
	NP			1				1
Windows and ventilation	P	6	6	12	4	4	7	39
	NP			1	1	1	2	5
Color coded bins	P	5	7	11	4	4	5	36
	NP	1			1	1	2	5

P - Project, NP - Non-Project

Toilet facilities in labor complex were not available in 17 (42.5%) Project facilities and 2 Non-Project facilities including District Hospital Pratapgarh, MG Hospital Banswada, Referral Hospital, (Antah, Bhindar, Nimbaheda) Community Health Centre (Chhabra, Choti sarwan) and Upgraded PHC, (Pindwara, Kanod, Chota Dungla Dhariawad, Mawali, Rikhabhdevji, Badi Sadri Chhotisadari,Sarada, Rashmi.kanera, Ghtole, Choti sarvan).

Labor room-

Table F-10: Status of labor room

Facilities in labor room	Category of facility	Baran N=7	Banswara N=7	Chittorgarh N=14	Dungarpur N=5	Sirohi N=5	Udaipur N-10	Total N=48
Labor table	P	6	6	12	4	4	8	40
	NP	1	1	2	1	1	2	8
Lights	P	7	5	12	3	4	5	36
	NP		1	2	1	1	2	7
Privacy	P	6	6	12	4	5	6	39
	NP	1	1	2	1		2	7
Equipments	P	5	6	10	3	4	8	36
	NP	1	1	2	1	1	1	7
Toilets	P	3	4	6	4	3	3	23
	NP	1	1	1	1	1	1	6
Running water	P	5	6	11	4	3	7	36
	NP	1	1	2	1	1	1	7

P - Project, NP - Non-Project

Investigation facilities at health facilities were found available but some of the hospitals had only basic investigations done for want of trained staff and availability of equipments.

Laboratory-

Table F-11: Status of laboratory

Facilities in laboratory	Category of facility	Baran N=7	Banswara N=7	Chittorgarh N=14	Dungarpur N=5	Sirohi N=5	Udaipur N-10	Total N=48
Washbasin & water supply	P	5	7	12	4	3	3	35
	NP	1		1	1	1	1	5
Color coded bins	P	5	7	12	4	4	3	35
	NP	1		2	1	1	1	6
Disposal syringes & needle	P	5	7	12	4	4	6	38
	NP	1		2	1	1	1	6

P - Project, NP - Non-Project

Trainings: Capacity Building of Health Services Provider

Orientation of the providers was one of the inputs scripted under project for effective implementation of the project activities and a Training Needs Assessment (TNA) conducted, identified Clinical/Technical Training, Managerial Training, HMIS, Disease Surveillance, Waste Management, Equipment Maintenance, Rational Use of Drugs, Quality Improvement of Referral together with Behavior Change of Service Providers, as some major areas for Trainings. Status of training as per records of State PMU is reflected in Table F12 and F13.

Table F-12: Progress of Training in Tribal Districts

Sl. No.	Training Area	Participants						Total
		Udaipur	Dungarpur	Chittorgarh	Banswara	Baran	Sirohi	
1.	Rational Use of Drugs (SMOs/MOs)	11	18	10	14	10	6	69
2	Rational Use of Drugs (Nurses)	16	11	18	13	12	9	79
3.	Managerial Trg. (District Level Officers & SMOs)	18	2	5	8	4	11	48
4.	Foundation course (Newly recruited MOs/RMOs	6	6	11	5	4	4	36
5.	Managerial Training(Nurses)	8	6	5	3	2	2	26
6.	Quality Improvement (SMOs/MOs	7	7	15	7	10	5	51
7.	Equipment Management & Maintenances (LT/Radio-grapher/OT Assistant, ECG Technicians)	42	34	21	16	21	25	159
8.	Critical Care (Specialist Doctors-Gyn, Pead., Med, Sur.)	4	4	4 (Chittorgarh) 4 (Pratapgarh)	4	-	1	13
9.	BCC Phase I (All staff)	-	222	362	-	-	-	584
	BCC Phase II (All Staff)	-	573	1013	-	-	-	1586
	Total	112	883	1468	70	63	63	2651
Numbers of Clinical/Technical Trainings were organized at Zonal Level covering district also.								

Source –HMIS-RHSDP

As regards PRI sensitization training for supervision of ANMs, TBA training, traditional medicine practitioners training, NGO orientation training etc., they do not figure out in the PIP of RHSDP and probably that is the reason why these were not held

BCC trainings were organized in Chittorgarh and Dungarpur districts at selected facilities in first phase and second phase where 584 and 1586 were trained respectively.

Table F-13: List of facilities covered under BCC in tribal districts and participants trained.

S. No.	Name of District	Facilities covered phase I	Participants trained	Facilities covered phase II	Participants trained
1	Dungarpur	1. Upgraded PHC Aspur 2. General Hospital, Dungarpur 3. Upgraded PHC Sagwara 4. Upgraded PHC Bichhiwara 5. Upgraded PHC Simalwara	222	1. Dungarpur, 2. Similwara, Sagwara, 3. Aspur, 4. Bichiwara	1013
2	Chittorgarh	1. Govt. Hospital, Chittorgarh 2. Govt. Hospital, Pratapgarh 3. Upgraded PHC Chotisadri 4. Upgraded PHC Dungla 5. Upgraded PHC Rashmi	362	1.Upgraded PHC, Badi Sadri 2. Referral Hospital, Bengu 3. Upgraded PHC Kapasan 4. Referral hospital, Nimbahera 5. Upgraded PHC Bhopalsagar 6. Upgraded PHC Gangrar 7. Upgraded PHC Mandfia 8. Upgraded PHC Rawatbhata	573

Table F-14: Status OF HCWM Training in tribal districts - Phase- I and II

S No	Districts	Number of Trainee											
		Doctor		Nurses		Paramedical		Class IV		Others		Total	
		P-1	P-2	P-1	P-2	P-1	P-2	P-1	P-2	P-1	P-2	P-1	P-2
1	Banswara	32	31	131	105	9	61	93	68	17	37	282	302
2	Baran	23	28	59	48	6	22	44	24	7	21	139	153
3	Chittorgarh	38	34	105	96	13	40	55	65	6	13	217	248
4	Dungarpur	35	10	114	49	11	22	86	29	26	12	272	122
5	Sirohi	16	17	39	31	5	17	23	37	2	42	85	144
6	Udaipur		102		177		73		118		63		533
	Total	**144**		**448**		**44**		**301**		**58**		**995**	

Source -HMIS-RHSDP

It was observed in the field that at most of the places training of HCWM has been conducted and all the staff members involved in clinical procedures have been trained. As the clinical training is being organized at Zonal level, record of training in terms of batches and participants has not been maintained at district and facility level. Under RHSDP logistics has been taken care of, reasonably well. Other than equipments and furniture, drugs IEC material, reporting formats, referral slips etc., are provided to the facilities.

In view of the perennial shortage of staff across the country, one of the approaches adopted is to strengthen the Secondary level institutions for receiving referrals which is accepted to be a cost effective intervention in service delivery and utilization of services. Receiving Referrals at CHC was one variable under the study. Data on this gathered for preceding five years shows the increasing trends in numbers of referral cases each year. Many facilities in district Chittorgarh including Palaoda, Kanera, Kapasan, Nimbaheda, Rasmi, Chhotisaravan,Gangrar, Bhopalsgar, District Sirohi (Pindwara, Kalindri), and Udaipur (Sarada, Dhariybad, Salumber, Bhinder) could not make records available to the study team. This has to be interpreted carefully as the segregated record for last 5 years is not available with most of the facilities, in relation services to BPL/APL, marginalized population and other vulnerable groups.

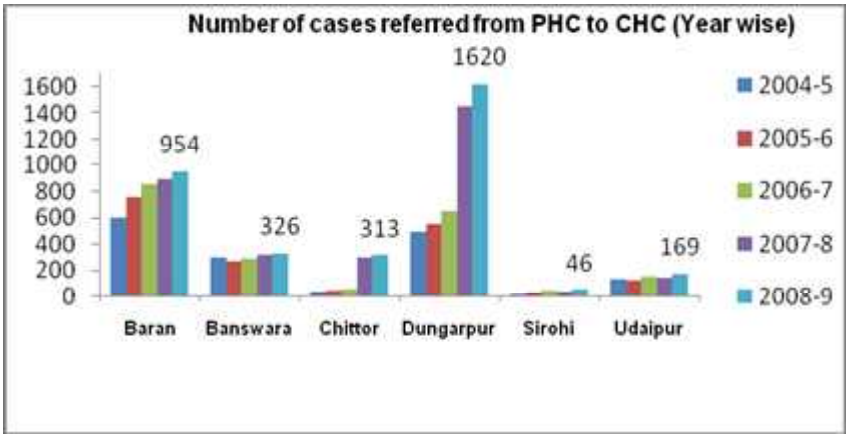


Figure 3: Referrals from PHC to CHC

***Table F-15: Referrals received at CHC/ DH from PHC**

District	Years				
	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009
Banswara	598	761	850	899	954
Baran	290	270	285	316	326
Chittorgarh	36	44	49	299	313
Dungarpur	492	549	651	1454	1620
Sirohi	12	16	37	30	46
Udaipur	131	121	150	142	169
Total	1559	1761	2022	3140	3428

Referral from CHC to higher facilities was also explored during study as shown in the table below.

The data on referral relates to the information available at the facility. However, the individual facility was not studied in this regard during the study. The comments had during FGD on why services are not utilized people have come out that there is no proper referral receiving at the Secondary, particularly District Hospitals**.**

Table F-16: Referrals from CHC to higher facility

Name of District	Years				
	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009
Banswara	429	464	615	6636	1062
Baran	1231	1407	1478	1677	1915
Chittorgarh	346	479	713	698	865
Dungarpur	698	806	1355	1741	1679
Sirohi	77	155	170	321	430
Udaipur	597	780	953	900	816
Total	3378	4091	5284	6000	6767

CHC are expected to be manned by a minimum of 7 specialists as per IPHS standards. In most of the institutions neither specialists nor blood storage facility is there; and that punctuates the utilization levels of these secondary level institutions. This is one area that needs to be addressed on priority at the earliest.

70% of the CHCs with no concerned specialist and 65% with no blood storage facility prompt these referrals. This is in contradiction to the earlier statement (35% of the institutions did not have specialists) and has to be read carefully as the specialist may be present but his specialty may not match the sickness with which the patient presented.

Table F-17: Reasons for referrals

Reasons for referral	Category of facility	Baran N=7	Banswara N=7	Chittorgarh N=14	Dungarpur N=5	Sirohi N=5	Udaipur N-10	Total N=48
Patient critical	P	5	5	9	3	3	6	31
	NP	1	1		1	1	1	5
Specialist not available	P	5	5	8	3	2	5	28
	NP	1	1	1	1	1	1	6
Blood bank facility not available	P	4	5	8	2	2	5	26
	NP	1	1	1	1	1	1	6
Patient did not improve	P	2	6	6		3	0	20
	NP	1		1	1	1		4
Relatives wanted	P	3	5	9		3	0	23
	NP	1	1		1	1		4

P - Project, NP - Non-Project

Service Utilization:

As an indicator of access and reach, data on service utilization speaks a volume. DLHS-3 data shows that number of institutional deliveries in each tribal district except Udaipur is higher than state average (DLHS-3) fully immunized children are more than state average (48%) in each district except Baran. For all other parameters tribal districts are far ahead.

Table F-18: Population and Reproductive Health Indicators in Tribal Districts (DLHS-3)

Indicators	Baran	Banswara	Chittorgarh	Dungarpur	Sirohi	Udaipur	Tribal Districts
Family planning (currently married women, age 15-49)							
Current Use :							
Any Method (%)	57.0	63.4	63.7	64.8	55.3	66.6	57.0
Any Modern method (%)	54.2	61.8	59.5	62.8	53.6	62.1	54.0
Unmet Need for Family Planning:							
Total unmet need (%)	17.8	8.7	10.0	10.2	18.3	11.7	17.9
For spacing (%)	6.9	4.1	4.3	4.7	7.1	4.9	7.7
For limiting (%)	10.9	4.6	5.7	5.5	11.2	6.8	10.2
Maternal Health:							
Mothers who had at least 3 Ante-Natal Care visits during the last pregnancy (%)	37.5	19.0	34.5	30.0	36.1	26.9	27.7
Institutional births (%)	58.4	46.7	45.1	46.2	46.5	39.4	45.5
Mothers who received post natal care within 48 hours of delivery of their last child (%)	41.0	44.6	45.3	47.4	39.6	40.1	38.2
Child Immunization and Vitamin A supplementation:							
Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%)	48.0	82.8	69.0	87.4	61.9	77.0	48.8
Children (9-35 months) who have received at least one dose of Vitamin A (%)	47.4	84.5	68.8	90.3	60.4	83.6	50.8

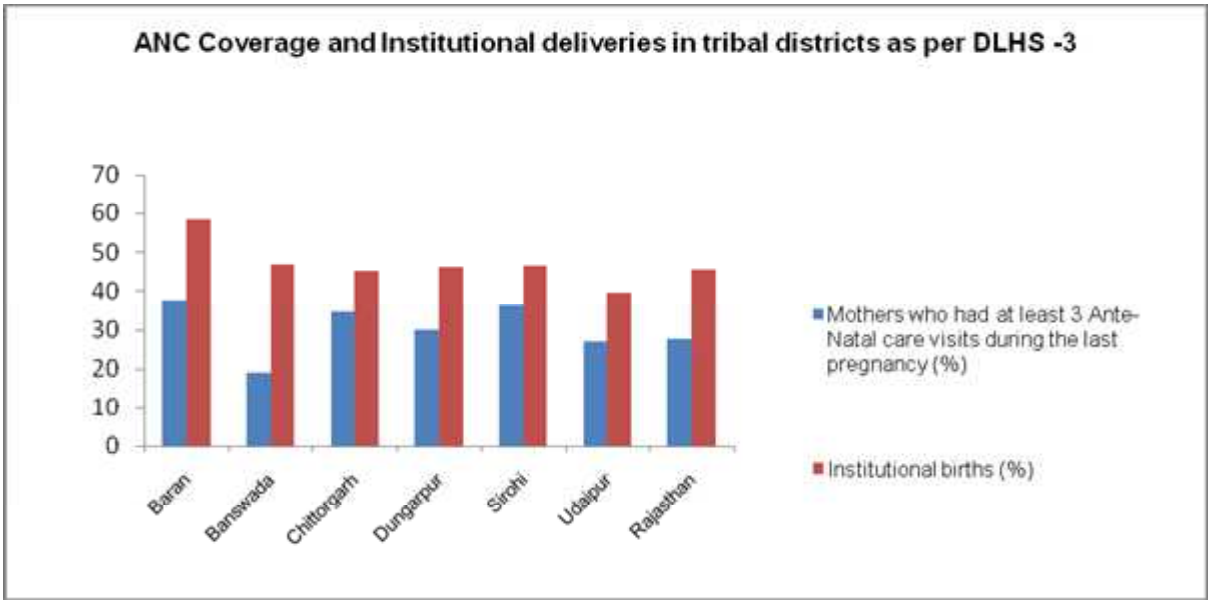


Figure 4: ANC coverage and ID

Service utilization data of last five years (RHSDP Project cycle 2004-2009) from each covered DH, SDH and CHC was obtained.

Some of the institutions could not provided the complete data such as Upgraded PHC Palaoda, Kanera, DH-Pratapgarh, Chittorgarh, Referral Hospital Nimbaheda, Upgraded PHC Rasmi, Chhotisaravan, Gangrar, Bhopalsgar (Chittorgarh), CHC - Pindwara (Sirohi) and Sarada, Dhariybad, Salumber, Bhinder (Udaipur) and that restricts the authentication of progress in the field.

Table F-19: Services provided by institution in last 5 years in sample districts

Name of services		2004-2005		2005-2006		2006-2007		2007-2008		2008-2009	
		DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs
ANC	P	4761	17209	14478	34329	22987	32208	21278	39317	16239	26859
	NP		3126		3136		3825		4811		4741
Institutional Delivery	P	6427	13298	14218	18858	17188	20082	17686	38246	19338	42471
	NP		2399		2705		3253		4657		5164
Normal delivery	P		20785		27170		31137		56688		56033
	NP										
Caesarian section	P	813	746	780	903	1093	697	1155	1407	1194	1479
	NP										
Sterlization –Female	P	1626	10583	3247	11831	3456	10475	3418	12363	3318	13537
	NP		1115		1575		1709		1854		1946
IUD Insers	P	1016	5810	1067	5424	1426	6739	1573	6155	1982	8047
	NP										
MTP-performed	P	671	830	817	951	813	1473	850	1342	373	1718
	NP										
Tretment of RTI-STI	P	1615	3844	1683	5639	1821	7059	1954	7811	2064	10625
	NP		977		978		1185		1675		1401
Immunizatio n	P	22663	29427	23324	43749	26345	39555	26928	39850	29289	42707
	NP		3320		4242		3396		4469		4764
Number of Diahorrea Cases	P	12525	21241	16068	19083	15614	23713	15798	24819	12807	22585
	NP		7420		6808		8050		8166		8584
ARI	P	19023	34931	15520	62654	18254	71911	11341	71213	16356	53619
	NP										
TB Patients Treated DOTs	P	214	6150	712	7399	721	6546	827	6706	661	6254
	NP										

P - Project, NP - Non-Project

Table F-20: services provided by institution in last 5 years (ANC)

Districts		DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs
		2004-2005		2005-2006		2006-2007		2007-2008		2008-2009	
Banswara	P (N=6)	3275	2019	3995	1902	4318	2857	4156	6390	4647	4625
	NP (N-1)	NA	NR	NA	NR	NA	505	NA	524	NA	NR
Baran	P (N=6)	NR	4376	8859	4674	6975	4520	5876	5604	6428	5308
	NP (N-1)	NA	213	NA	195	NA	315	NA	379	NA	566
Chittorgarh	P(N=12)	NR	4373	NR	6477	NR	5422	7810	7107	NR	7948
	NP (N-2)	NA	509	NA	517	NA	594	NA	1158	NA	1083
Dungarpur	P (N=5)	624	2179	980	1506	1648	262	2140	470	3461	813
	NP (N-1)	NA	874	NA	857	NA	872	NA	990	NA	874
Sirohi	P (N=4)	862	3509	644	3555	1066	4196	1296	4428	1703	4594
	NP (N-1)	NA	313	NA	319	NA	303	NA	352	NA	355
Udaipur	P (N=8)	NR	1066	NA	1737	NA	1247	NA	1850	NA	1771
	NP (N-2)	NA	1217	NA	1248	NA	1236	NA	1408	NA	1863
Total	P (N=40)	4761	17209	14478	34329	22987	32208	21278	39317	16239	26859
	NP (N=8)	NA	3126	NA	3136	NA	3825	NA	4811	NA	4741

P - Project, NP - Non-Project

Table F-21: ANC Coverage

District	2006-07	2007-08	2008-09
Udaipur	61766	65114	70825
Sirohi	19469	24564	26872
Dungarpur	16505	21438	27505
Banswara	32190	36280	34325
Baran	15983	20130	19644
Chittorgarh	39787	35151	36062
Tribal Districts	1124848	1337321	1421039

Source: DMHS-RCH HMIS-Progress Report 2008 & 2009

Banswara District hospital registered a 41% increase in ANC cases where as at FRUs and CHCs, the number has more than doubled over past 5 years.

By and large, the **ANC registrations have gone up by 241% in Tribal District Hospitals and by 56% in FRUs and CHCs of these districts, during the project period.** District Hospital **Baran, somehow, slipped by 27.44% in ANC services in last 4 years** though the FRUs and CHCs here registered a 20% growth in ANC registrations.

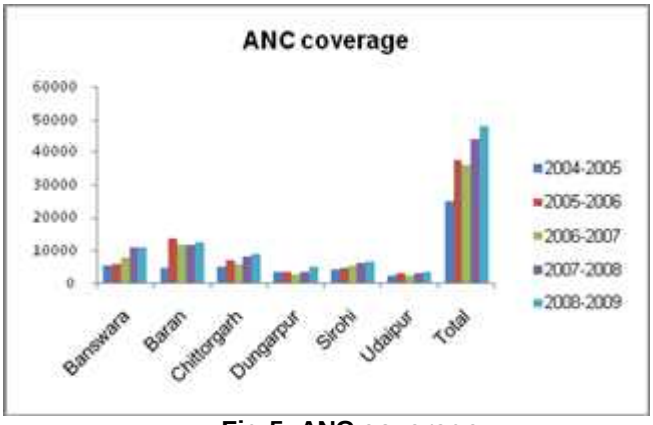


Fig 5: ANC coverage

Percentage of child immunization registered a moderate increase from 17.3% NFHS-1 to 26.5% NFHS-3 but here also tribal districts had a better coverage of Immunization against the State average.

However, DLHS-3 reported it as 48.8% for Rajasthan but in Tribal districts it is highest - 87% in Dungarpur, 82% Banswara, 77% Udaipur, 69% Chittorgarh, 61% Sirohi and lowest 48% in Baran. As per the State report of RCH 91.81% children are immunized. Though the data cannot be triangulated for obvious reasons, the project facilities have shown a 88% increase in immunization from 2004-05 to 2008-09.

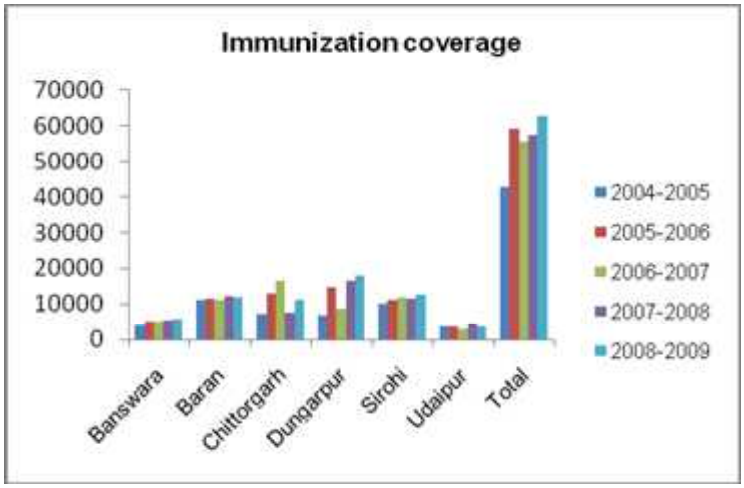


Figure 6: Children fully immunized

Table F-22: Services provided by institution in last 5 years (immunization)

Districts		DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs
		2004-2005		2005-2006		2006-207		2007-2008		2008-2009	
Banswara	P(N=6)	3270	522	3995	515	4311	623	4151	631	4530	723
	NP (N-1)				650				548		481
Baran	P (N=6)	12651	10041	12003	10311	13520	9857	13681	11067	13882	10457
	NP (N-1)		1079		1270		1279		1240		1365
Chittorgarh	P N=12)	NR	7337	NR	13040	NR	16374	NR	7329	NR	10837
	NP (N-2)								262		438
Dungarpur	P (N=5)	5448	569	6340	7629	7448	350	8198	7543	9320	7671
	NP (N-1)		855		866		811		833		824
Sirohi	P (N=4)	1294	8598	986	9975	1066	10370	898	10281	1557	10715
	NP (N-1)		290		267		256		297		325
Udaipur	P (N=8)	NA	2360	NA	2329	NA	1981	NA	2999	NA	2264
	NP (N-2)		1096		1189		1050		1289		1331
Total	P(N=40)	22663	29427	23324	43749	26345	39555	26928	39850	29289	42707
	NP (N=8)		3320		4242		3396		4469		4764

P - Project, NP - Non-Project

Table F-23: Services provided by institution in last 5 years (Institutional Deliveries)

Districts		DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs
		2004-2005		2005-2006		2006-2007		2007-2008		2008-2009	
Banswara	P(N=6)	3801	1955	4962	1695	5038	793	6923	7992	6485	8391
	NP (N-1)						32		82		47
Baran	P (N=6)	NR	3019	3394	8677	3593	6674	4761	5358	5431	5061
	NP (N-1)		1570		1657		1543		1740		1810
Chittorgarh	P N=12)	NR	4833	2768	4286	4851	6423	4305	11087	NR	15597
	NP (N-2)								525		692
Dungarpur	P (N=5)	2160	2456	2520	2581	3204	2956	4644	7128	5363	4907
	NP (N-1)						56		99		154
Sirohi	P (N=4)	466	627	574	640	502	1062	1358	1839	2059	2784
	NP (N-1)		43		64		50		177		219
Udaipur	P (N=8)	NA	408	NA	941	NA	2174	NA	5019	NA	5731
	NP (N-2)		786		1112		1572		2034		2242
Total	P(N=40)	6427	13298	14218	18858	17188	20082	17686	38246	19338	42471
	NP (N =8)		2399		2705		3253		4657		5164

P - Project, NP - Non-Project

*Udaipur does not have a District Hospital

Institutional delivery data from facilities under study show a gradual increase. At District Hospitals as well as FRUs and CHCs under Project the ID has shown more than 200% increase between 2004-05 to 2008-09. Out of total 48 facilities (Project and Non-Project) assessed in the evaluation, only 9 hospitals have the facility to conduct the Caesarian section at facility, these are mostly district hospitals, still increase in IDs is a simple validation of JSY efforts and convergence of NRHM with RHSDP inputs.

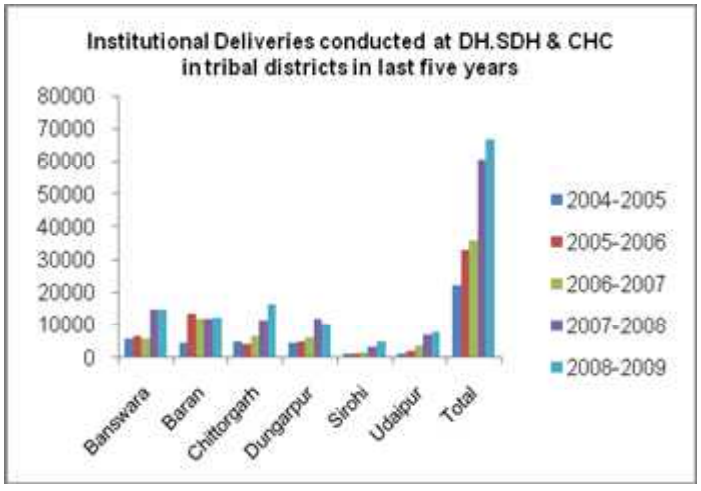


Figure 7: ID conducted in DH, SDH and CHC

Table F-24: Diahorrea cases treated in last 5 years

Districts		DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs
		2004-2005		2005-2006		2006-2007		2007-2008		2008-2009	
Banswara	P(N=6)	1197	2539	3615	4608	2468	4137	2434	5583	2120	6143
	NP (N-1)	NA	NR				91		72		70
Baran	P (N=6)	5520	3294	5435	2123	5851	1630	6110	1914	5981	1792
	NP (N-1)										
Chittorgarh	P N=12)	NR	1882	NR	2327	NR	4642	NR	4835	NR	5092
	NP (N-2)		381		392		448		306		105
Dungarpur	P (N=5)	1308	1384	1368	1279	1412	1398	1378	1587	1405	970
	NP (N-1)										
Sirohi	P (N=4)	4500	7722	5650	7242	5883	7245	5876	8547	3301	7679
	NP (N-1)		521		468		407		881		901
Udaipur	P (N=8)	NA	-	NA	1504	NA	4661	NA	2353	NA	909
	NP (N-2)		6518		5948		7104		6907		7508
Total	P(N=40)	12525	21241	16068	19083	15614	23713	15798	24819	12807	22585
	NP (N=8)		7420		6808		8050		8166		8584

P - Project, NP - Non-Project

* Udaipur does not have a District Hospital

Besides ID, Immunization and ANC coverage, data on diarrhea cases treated between years 2004-2009 were looked at from different study units. District Hospital Banswara registered a 77% increase whereas the FRUs and CHCs in the same district registered a 141.94% increase in number of diarrhea cases treated, reflecting on increased utilization of services in the tribal area and this largely could be attributed to RHSDP initiatives (Trainings, Logistics, Drugs and improved reporting). Epidemiologically there is no evidence to baptize it as true increase. However, CHCs & FRUs in Baran registered a negative growth (-45.60%).

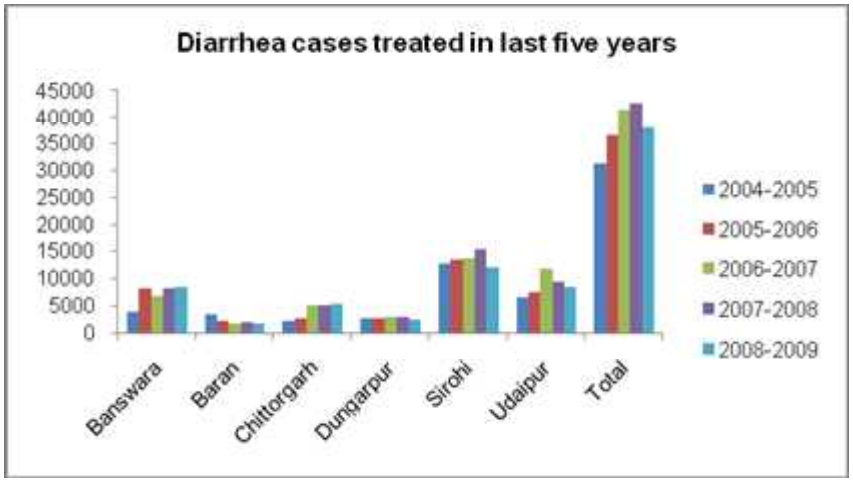


Figure 8: Diarrhea cases treated

Table F-25: Sterlizations performed in last 5 years

Districts		DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs
		2004-2005		2005-2006		2006-2007		2007-2008		2008-2009	
Banswara	P(N=6)	173	2425	381	2705	137	2300	424	3014	175	3076
	NP (N-1)	-	56	-	52	-	55	-	62	-	-
Baran	P (N=6)	NR	2195	644	2372	683	2325	781	2639	582	2660
	NP (N-1)		521		489		543		589		598
Chittorgarh	P N=12)	NR	2480	570	2800	889	2408	NR	2875	NR	4425
	NP (N-2)		147		124		185		245		210
Dungarpur	P (N=5)	1230	301	1390	301	1495	244	1842	427	2008	47
	NP (N-1)		91		97		110		137		166
Sirohi	P (N=4)	223	519	262	598	252	536	371	668	553	843
	NP (N-1)		41		31		34		72		69
Udaipur	P (N=8)	NA	2663	NA	3055	NA	2662	NA	2740	NA	2486
	NP (N-2)		259		782		782		749		903
Total	P(N=40)	1626	10583	3247	11831	3456	10475	3418	12363	3318	13537
	NP (N =8)		1115		1575		1709		1854		1946

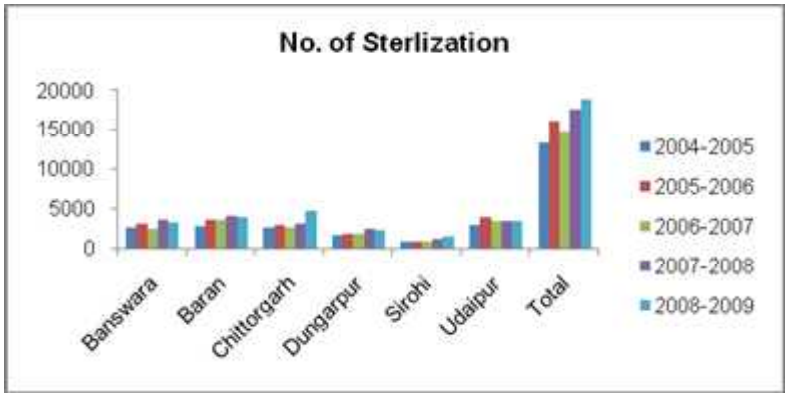


Figure 9: Sterilization performed

Table F-26: Treatment of RTI/STI in last 5 years

Districts		DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs	DH	FRU and CHCs
		2004-2005		2005-2006		2006-2007		2007-2008		2008-2009	
Banswara	P(N=6)	723	2581	727	3288	732	3937	735	4328	742	4531
	NP (N-1)		21		47		54		47		20
Baran	P (N=6)	NR	30	NR	38	NR	475	NR	480	NR	470
	NP (N-1)		679		647		792		940		915
Chittorgarh	P N=12)	NR	996	NR	1689	NR	1454	NR	2196	NR	5102
	NP (N-2)		54		56		102		86		45
Dungarpur	P (N=5)	808	97	848	111	970	165	1012	102	1108	161
	NP (N-1)		95		121		113		178		172
Sirohi	P (N=4)	84	140	108	187	119	31	207	259	214	264
	NP (N-1)		128		107		124		101		135
Udaipur	P (N=8)	NA	0	NA	326	NA	997	NA	446	NA	97
	NP (N-2)								323		114
Total	P(N=40)	1615	3844	1683	5639	1821	7059	1954	7811	2064	10625
	NP (N =8)		977		978		1185		1675		1401

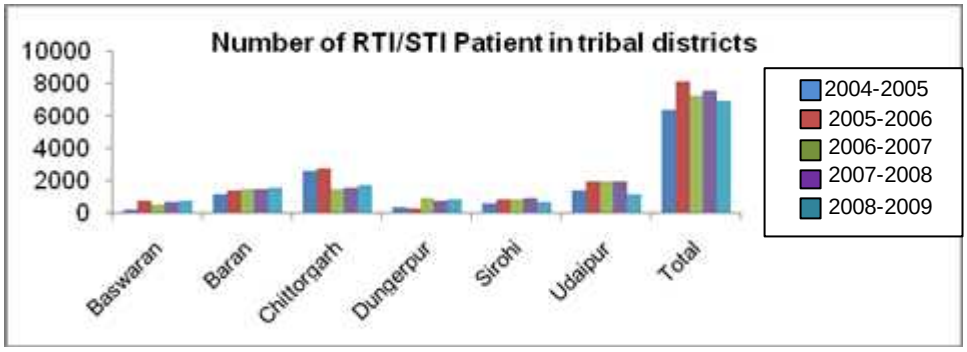


Figure 10: RTI/STI patients treated

State officials-response

Perceptions of State Officials:

As key artisans responsible for forging strategies and scripting policies, State officials were interacted to have their understanding on tribal development plan and its different components. Somehow, for the initial thought of number (12, 8 from RHSDP and 4 from NRHM), based on different activity areas, only 6 could be contacted and their responses scribbled. At RHSDP- PMU one person is responsible for 3 activities such as RCH camp, BCC, VCD so number of respondents further got reduced from 8 to 5. From NRHM, only SPM could be interacted (Director RCH and Additional Director NRHM could not be done).

State level authority/officers were interacted to get their opinion on project activities suggested under Tribal Development Plan. Out of total respondents interviewed, 83.3% respondents were aware about the component of strengthening of health facilities to improve the utilization of services and increase the satisfaction level of patients who visited the health facilities. RCH camps, BCC, contract hiring of specialists and PPP involving NGOs for VCD were known to 66.7% of respondents. Only 33.3% knew about capacity building of manpower and provision of special incentives to the manpower in TDP.

83.3% officials were aware of the fact that the human resource development issues have been addressed through contractual staff, hard duty allowance and rural medical care.

Mobile Medical Units

Under NRHM MMU has been introduced on Public Private Partnership basis. All the six tribal districts are covered under the scheme.

Table S-1: Status of MMU in Tribal Districts

SN	District	Operating NGIO	Number of MMU
1	Dungarpur	Bhoruka Charitable Trust	1
2	Banswada	Vagad Vikas Sansthan Gitanjali Medical College	2
3	Chittorgarh	Gitanjali Medical College	1
4	Sirohi	Nav Jeevan Seva Santhan	1
5	Udaipur	Trimurti Shiksha Santhan	1
6	Baran	AOES	1

Regarding the nature of services provided through MMUs, 33.3% state officials knew about the package comprising of ANC, PNC, Oral Contraceptive, RTI/STI, and treatment of minor ailments. Only 16.7% had the feel that IUD, ORS, IFA, Minor surgeries also are covered by MMUs.

On being asked as to how the linkages between primary and secondary care institutions can be improved, 83.3% favored improved referral system and BCC, while 66.6% thought patient counselors stationed at the facility could be the answer.

For an effective BCC, 83.33% feel print media, field publicity and mass media had been effective tools where as 66.6% felt that instrument of VCD has proved to be a pragmatic approach.

Under Tribal Development Plan, contracting of local private Doctors was envisaged for increasing access to health care services; **83% state officials voiced that it has not been implemented.** Non-availability of specialists and incentive being not lucrative enough were put as the punctuations in engaging private doctors. Only 16.7% officials (mainly from NRHM) said private practitioners are available under incentivized package.

None of the State Authority had any idea about integration of the **tribal medical system in health services as it has not been initiated under RHSDP due to medico-legal issues and adverse consequences on health seeking behavior community.**

For capacity building of service providers, 83.3% of State Officers feel that training component should be strengthened and this should be on a continuous basis. **The quality of induction training offered by State Institute of Health & Family Welfare was appreciated by everyone.**

Table S-2: Staff requiring additional training to provide health care services in tribal region

	State	
	No.	%
Yes	5	83.3
No	1	16.7
Total	6	100.0

83.3% of the state officials felt additional training should be provided to health care providers in tribal region. **Training of Community based functionaries as suggested in TDP could not be initiated reason being the concept of Sevika /Sahyika replaced by ASHA** and NRHM has taken the lead role to straightening of ASHA as key grassroots level functionary to motivate the community for obtaining the timely health services.

Table S-3: Status of procurement and supplies

	No. of respondents from State	
	No.	%
IEC material	3	50.0
Equipment	5	83.3
Drugs	5	83.3
Total	6	100.0

83.3% state officials were responding that the equipments and drugs supplied from state to the districts while only 50% respond for the IEC material supplied to districts from state.

As per the report received from RHSDP, between 2004-05 to 2008-09 14.8 million were spent on IEC activities under the Project for organizing the local specific IEC activities such as conducting folk shows and placing the hoardings. At district level sensitization workshops for the NGOs, PRI, and stakeholders were organized in each tribal districts.

Terse, the following suggestions emerged out of the interaction with State authorities.

The contacted State officials of NRHM categorically underlined the need to **put more manpower in place and put in a mechanism to ensure their stay at the facility** by infusing a little more incentive either monetary or in terms of recognition and opportunities towards career advancement. Alternately, the common suggestive remedy was to **have specialists contracted in and incentivized on job-work basis.**

The RHSDP mentors however felt that a **prudent Human Resource management**, **an effective monitoring system, a simple HMIS and incentivizing Medical Officers to cut on attrition rate and promote their stay, and increasing the reach through camps should be put in practice besides sustaining the achievements through rationalized logistic support, and continuous sensitization through trainings.**

District Officials-response

District Officials-response

Holding a pivotal role, DPC and CMHOs were expected to have a lot of say in implementation of the TDP and therefore, at the very beginning it was thought to seek their opinion on the components and strategy. CMHO Chittorgarh could not be contacted. The responses have been put collectively so as to avoid singling out of an officer.

More than 90% district officials were aware about tribal plan and strategy developed under RHSDP. Components of tribal strategy were also known to the district officials. 90% the officers knew that civil works and logistics were integral components of Tribal Development Plan. 81% were in knowledge of capacity building of man power, special incentive to staff was endorsed by 45.4% BCC by 36.3% and PPP through NGO for VCD by 27%, as the major components. The component knowledge on a closer look clearly establishes the priority that is further substantiated from the responses on the activities and sub activities planned to ground the implementation.

Synchronized with the objectives, a set of activities were enlisted for implementation. Somehow during the process, priorities got shuffled based on perception and “Strengthening of infrastructure (91%) and Capacity Building Trainings (81.8%)” only were registered with CMHO and DPCs in the district losing the focus on incentivizing specialists, BCC and PPP which were bullied (around 40% only could recall them as planned activities).

The sub activities under “Strengthening” which gained maximum currency were Repair-Renovation and New construction (72.7%) and RCH camps (91%). Incidentally RCH camps were already going on through the system and the financial inputs from RHSDP were simply clubbed with the kitty.

The Mobile Medical Units which were thought as an important tool to increase access and reach of the system in tribal areas which are already constrained on account of geo-geographical, cultural, equity, purchasing power parity, institutional network, communication & transport; could not be taken up under the project. NRHM, however, thought about and did try to place MMU under PPP in these areas, a little later during the project period.

The “Capacity building” was addressed through Trainings and Workshops and was recalled by 91% and 73% of officials, respectively.

Capacity building of staff has been initiated through organizing the training and workshops and conducting the exposure visits. In most of the districts, training of facility staff on HCWM under taken in all institutions. BCC training is conducted in Dungarpur and Chittorgarh districts.

Table D-1: Training areas and progress

Sr. No	Training Area	No. of Training programs						Total
		Udaipur	Dungarpur	Chittorgarh	Banswara	Baran	Sirohi	
1.	Rational Use of Drugs (SMOs/MOs)	11	18	10	14	10	6	69
2	Rational Use of Drugs (Nurses)	16	11	18	13	12	9	79
3.	Managerial Trg. (District Level Officers & SMOs)	18	2	5	8	4	11	48
4.	Foundation course (Newly recruited MOs/RMOs	6	6	11	5	4	4	36
5.	Managerial Training(Nurses)	8	6	5	3	2	2	26
6.	Quality Improvement (SMOs/MOs	7	7	15	7	10	5	51
7.	Equipment Management & Maintenances (LT/Radio-grapher/OT Assistant, ECG Technicians)	42	34	21	16	21	25	159
8.	Critical Care (Specialist Doctors-Gyn, Pead., Med, Sur.)	4	4	4 (Chittorgarh) 4 (Pratapgarh)	4	-	1	13
9.	BCC Phase I (All staff)	-	222	362	-	-	-	584
	BCC Phase II (All Staff)	-	573	1013	-	-	-	1586
	Total	112	883	1468	70	63	63	2651
Numbers of Clinical/Technical Trainings were organized at Zonal Level covering district also.								

Source –HMIS-RHSDP

RCH camp is one of the most important activities implemented in tribal areas in collaboration with RCH program. As per the response 90 PHCs are covered under the scheme and 397 (91.9%) camps were organized in the year 2008-09 against the planned target of 432; with 111183 cases attended (on an average 339 cases per camp, 43% tribal, 38.43% females and 45.44% BPL). Total 9.90 million (Rs. 24,959/- per camp) have been spent on the camp activities.

Table D-2: Status of RCH /RHSDP Camps (from April 08- March 09)

S. No	District	RCH Camps planned	RCH camps held	Total OPD	Total female patients	Total tribal patients	BPL	%	Patients referred	Total expenditure
1	Baran	72	72	21302	7396	1091	5089	23.89	141	2546700
2	Banswara	72	70	18260	7733	13106	10999	60.24	166	2291478
3	Chittorgarh	72	62	15502	5959	2295	2963	19.11	295	3070684
4	Dungarpur	72	72	18416	7270	11057	11941	64.84	75	1806822
8	Sirohi	72	49	10522	3620	862	1052	10.00	45	997649
6	Udaipur	72	72	27181	10755	19440	22291	82.01	180	2266000
	Total	432	397	111183	**42733**	47851	54335	48.86	902	9908649

Source- HMIS-RHSDP

Under the PPP approach, organizing Village contact Drives for a little better understanding of needs and expectations of community; was outsourced to NGOs and it was expected that these NGOs shall hold consultative meetings with client populace, have informative slogans written at prominent places to improve awareness on health issues and available services, organize counseling sessions, hold puppet shows and make house to house visits to have first hand feel of the facilitators and detriments so that timely actions can be taken.

In the process, under a pilot, VCD was undertaken in 4 Blocks of 4 Districts through NGOs.

The premier concerns converged to Family planning, Immunization, RTI/STI, Diarrhea & ORS, DOTS, Institutional Deliveries, PCPNDT & Sex selection, and VHSC.

The impact of VCD is said to have resulted in increased utilization of services and improved access to services according to 54.5% and 45.5% respondents respectively and earlier observation do notarize that.

RCH Camp (Outreach Camp): MO/IC's responses

Observation of Medical Officer In charge on RCH (Outreach) Camp:

In order to increase the access and reach it was thought to strengthen the ongoing camps under RCH program by providing financial impetus under the project.

12 PHCs in six districts were visited and from each PHC 3 villages (one each of A, B and C category) were selected. From each village 10 respondents (5 beneficiaries and 5 non-beneficiaries) were interviewed, the findings of which have been incorporated in this document under household survey results.

To have an understanding of the medical officers on RCH camps, 11 of the Medical Officers from 12 PHCs could be contacted.

All the Medical Officers are in knowledge of RCH camps. A total of 56 camps are recorded to have been organized between April '08 to March '09, viz. Banswara and Baran holding 11 camps each, Chittorgarh and Sirohi 10 each, Dungarpur (7) and at Udaipur only 6. 54.5% of the Medical Officers believed that the camps are supported by RHSDP alone whereas 45.5% knew that inputs from RCH have been gelled with RHSDP interventions (MOs from Dungarpur). 63.6% of the Medical Officers were aware of the administrative and financial guidelines for these camps.

RCH camps were well publicized in advance using mikes and 'nukkad natak'. But for emergency services, RCH camps are well arranged in terms of drinking water, place, toilets, privacy and medicines.

Medical Officers listed the services offered at RCH camps as ANC, PNC, distribution of oral contraceptives, IUD insertion, investigation and dispensing for tuberculosis, screening and treatment for RTI/ STI, routine vaccination along with dispensation of ORS and IFA. However no sterilization facilities were said to be offered. The number of cases per camp on an average was 47 and BPL counted for 33.9% of the total cases. The camp attendance figures for Baran could not be obtained.

Gynecologist, pediatrician and physician were the part of team, virtually in each camp, but only 63.6% of the Medical Officers verified that patient counselor was also present at camp site.

As regards role of patient counselor medical officers felt that informing about services, counseling on the prescription and facilitating free drug acquisition. Only 36.4% of the Medical officers had the knowledge regarding system's intent to integrate tribal medical system with the official health care delivery system. However 50% feel that such integration will increase the utilization of health care facilities while another 50% feel that the workload of facilities can be shared through this

integration. There is no dearth of money for drugs at RCH camps, feel all the Medical Officers interacted.

All the Medical Officers confirmed the monitoring of RCH camps by DPC and/ or CM&HO. 90% of the respondents (MOs) feel that RCH camps have led to increased influx, improved awareness and higher utilization of services. All the Medical Officers voiced that in order to ensure that the patients are not lost, an attempt is made to ensure that patients do turn up for follow up visits at the facility by telling them when to come next and where during the camp itself.

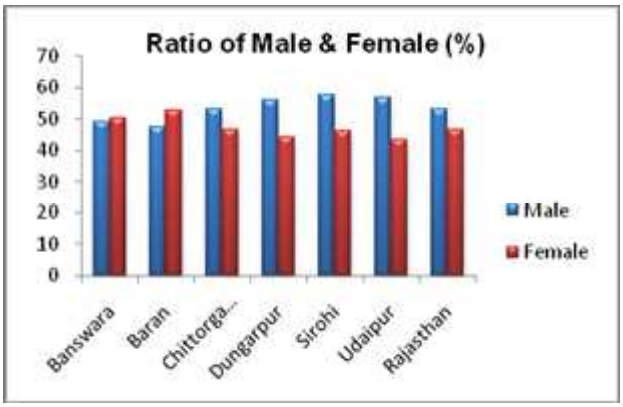
Exit interviews

Exit interviews

The time tested assumption that when you are done, you divulge the sharp and shooting critique reflecting on how it was, where it pinched, and what can fix it. The exit interviews are forged out of this postulate, with the single objective to assess client satisfaction, a driving force for utilization.

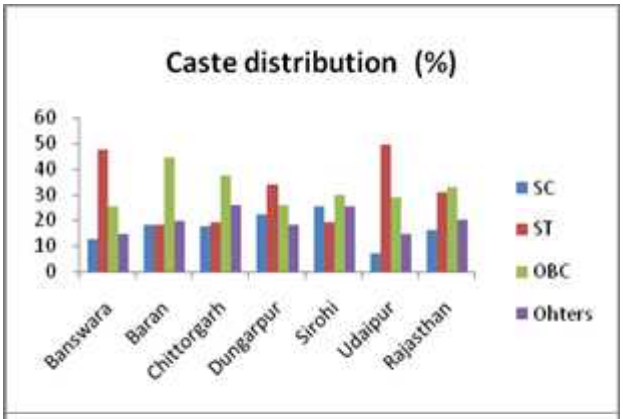
Randomly, from all the facilities, a total of 441 subjects comprising of 109 In-patients, 235 OPD patients and 97 attendants were interviewed on a structured questionnaire.

There were 235 male and 206 female respondents for the exit interview giving fair chance to both the sexes to voice their concerns and opinion.



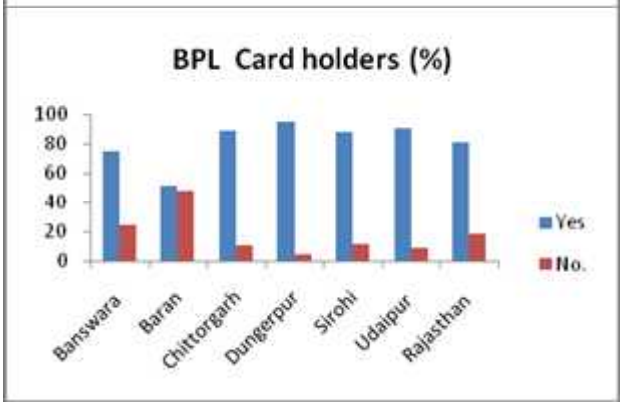
At two of the facilities – Paloda (Banswara) and Kanera (Chittorgarh) – exit interviews could not be done as there were no patients in the facilities at the time of visit.

57.4% were from APL category while 42.6% represented BPL category.Further, 16.1% were from SC, 30.8% ST, 33.1% from OBC populace and 20% represented general class.



Maximum number of ST representation was from Banswara (47.3%) and Udaipur (49.5%), whereas out of the total 146 OBC subjects, Baran (44.4%) and Chittorgarh (37.5%) dominated this universe.

The maximum number of respondents who had BPL cards for availing free services from health facilities was from Dungarpur (95.2%), Udaipur (90.2%) and Banswara (75%) and this was physically verified at the time of exit interviews.



When it came to illness, fever was the commonest condition for which 17.5% of the 441 respondents visited the facility, followed by pain abdomen (10.7%) and injuries (8.8%). Else the pregnancy (ANC and labor pains) was the reason for coming to the facility in 16.8% of respondents of exit interview.

The highest (19.1%) coming for pregnancy related reason were in Sirohi. Surprisingly, those who visited the facility for vaccination were just 1.4%.

89% of the respondents preferred to choose the particular facility as it was “easily accessible”, “facilities of investigation”, prompted 79.45% to verge in followed by “doctor always available” in 61.2% of cases.

The “drug availability” (43.1%), “inexpensive treatment” (38.1%)* and facility of emergency services (31.8%) were some other reasons voiced by the respondents for coming to a particular institution.

Table E-1: Reasons for choosing particular hospital

Reasons	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Rajasthan	
	No.	%	No	%	No.	%	No.	%	No.	%	No.	%	No.	%
Easily accessible	47	85.5	64	88.9	112	93.3	45	90.0	44	93.6	81	83.5	939	89.1
Good reputation	9	16.4	28	38.9	48	40.0	37	74.0	27	57.4	53	54.6	202	45.8
Low expenses	23	41.8	8	11.1	45	37.5	26	52.0	30	63.8	36	37.1	168	38.1
Facility of investigation	35	63.6	62	86.1	108	90.0	36	72.0	42	89.4	67	69.1	350	79.4
Availability of drugs	22	40.0	12	16.7	68	56.7	30	60.0	20	42.6	38	39.2	190	43.1
Doctors always available	36	65.5	29	40.3	83	69.2	33	66.0	38	80.9	51	52.6	270	61.2
Facilities for emergency	14	25.5	7	9.7	28	23.3	24	48.0	24	51.1	41	42.3	138	31.3
Total	55	100.0	72	100.0	120	100.0	50	100.0	47	100.0	97	100.0	441	100.0

Signage display for OPD was reasonably perceived by the respondents as close to 90% said that they had no problem in locating the respective OPD at the facility. **This was in response to the question put to respondents during exit interviews whether they could easily locate the desired service outlet. We feel that display of signage facilitates accessibility reducing waiting time and in turn reflects on patient satisfaction.**

Interestingly, the wait period as opined by 82.5% of the respondents was reasonably short (less than 30 minutes) and that is an achievement for public health facilities. However, the expectations are that it should be reduced to around 15 minutes. Close to 85% of respondents were satisfied with seating area, drinking water facility and toilets in the facility, but facilities at Banswara and Udaipur with satisfaction level of 75% need to improve further.

Contrary to the figment held about care providers in Public Health institutions, close to 60% of the respondents during exit interview held a positive opinion, rated as "Good", with reference to promptness, behavior, listening, and explaining. At places like Dungarpur, Sirohi, and Udaipur the ratings were expressed as "Bahut Accha" (Excellent) by 32%, 25.5% and 18.6% of the respondents respectively. These findings are analogous to the "Patient Satisfaction Report" wherein the overall patient satisfaction in relation to provider's behavior was rated as 60.4%.

Table E-2: Doctors attitude

Parameter of doctors attitude		Promptness in attending	Doctor's behavior	Patient Listening to problem	Maintaining privacy	Explaining about the problem	Explaining about the medicine	Total N
Banswara	E	9.1	10.9	9.1	9.1	5.5	7.3	55
	G	67.3	69.1	69.1	41.8	70.9	63.6	
	F	21.8	16.4	16.4	29.1	14.5	21.8	
	P	1.8	3.6	5.5	20	9.1	7.3	
Baran	E	1.4	2.8	1.4	1.4	1.4	0	72
	G	91.7	77.8	77.8	58.3	51.4	55.6	
	F	5.6	19.4	18.1	38.9	41.7	43.1	
	P	1.4	0	2.8	1.4	5.6	1.4	
Chittorgarh	E	5	12.5	9.2	5	3.3	3.3	120
	G	61.7	60.8	57.5	22.5	60.8	60	
	F	29.2	20.8	30	60	27.5	26.7	
	P	4.2	5.8	3.3	12.5	8.3	10	
Dungarpur	E	32	34	36	20	36	32	50
	G	60	54	48	46	46	52	
	F	8	12	16	22	16	16	
	P	0	0	0	12	2	0	
Sirohi	E	23.4	34	36.2	31.9	34	25.5	47
	G	59.6	63.8	53.2	55.3	53.2	63.8	
	F	17	2.1	6.4	10.6	10.6	6.4	
	P	0	0	4.3	2.1	2.1	4.3	
Udaipur	E	23.7	18.6	25.8	24.7	20.6	18.6	97
	G	54.6	62.9	52.6	44.3	58.8	53.6	
	F	13.4	14.4	16.5	18.6	13.4	22.7	
	P	8.2	4.1	5.2	12.4	7.2	5.2	
Total	E	14.1	16.8	17.5	13.8	14.1	12.2	441
	G	65.3	64.6	59.6	41.7	57.6	57.8	
	F	17.2	15.6	19.3	34	13.4	24.5	
	P	3.4	2.9	3.6	10.4	7.2	5.4	

E=Excellent, G=Good, F=Fair, P= Poor

Table E-3: Nurse Behavior rating

Districts	Rating									
	E		G		F		P		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Banswara	4	7.3	36	65.5	15	27.3	0	0.0	55	100.0
Baran	1	1.4	61	84.7	10	13.9	0	0.0	72	100.0
Chittorgarh	4	3.3	78	65.0	28	23.3	10	8.3	120	100.0
Dungarpur	9	18.0	38	76.0	3	6.0	0	0.0	50	100.0
Sirohi	7	14.9	33	70.2	6	12.8	1	2.1	47	100.0
Udaipur	8	8.2	61	62.9	19	19.6	9	9.3	97	100.0
Tribal Districts	33	7.5	307	69.6	81	18.4	20	4.5	441	100.0

Equally important in the process of health care, is the behavior of nursing staff. On an average 69.6% of the respondents rated the nurse's behavior as "good", with nursing staff at Baran (84.7%) and Sirohi (70.2%) scoring the highest. As the Baran and Sirohi government facilities are minimally utilized (interactions with households from these two districts are against the public facilities), it is difficult to understand the reactions of interviewees.

Institutions with patient Counselors

SN	Districts	Name of the institutions	Bed Strength
1	Baran	General Hospital Baran	150
		Chhabara	50
2	Banswara	General Hospital Banswara	300
		KushalGarh	75
3	Chittorgarh	General Hospital Chittorgarh	150
		Nimbaheda	50
		Kapasan	50
		Pratapgarh	150
		Chhoti Sadri	50
4	Dungarpur	Genral Hospital Dungarpur	150
		Sagwada	105
5	Sirohi	General Hospital Sirohi	150
6	Udaipur	Jhadol	50
		Vallabhnagar	50
		Salumber	50

Source: RHSDP

Table E-4: Role of patient counselor

Role of counselor	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Guidance	24	43.6	51	70.8	62	51.7	20	40.0	33	70.2	59	60.8	249	56.5
Explanation of treatment prescribed	22	40.0	17	23.6	67	55.8	21	42.0	27	57.4	36	37.1	190	43.1
Getting free drugs	8	14.5	12	16.7	46	38.3	19	38.0	16	34.0	28	28.9	129	29.3
User charges	15	27.3	10	13.9	9	7.5	18	36.0	22	46.8	21	21.6	95	21.5
Total	55	100.0	72	100.0	120	100.0	50	100.0	47	100.0	97	100.0	441	100.0

In realization to the fact that majority of the service care providers are too preoccupied with clinical dimensions and/or administrative chores it was rationally thought to put in patient counselors who can complement the care process through compassion, empathy and concern. The exit interview respondents found them friendly, particularly when it came to guiding the patients to appropriate facility/doctor (56.5%). Another perplexing area for care seekers is to get advice on the drugs prescribed (when, which, how much, with what, possible side effects, when to return). 43% found patient counselors useful in understanding the prescription.

Table E-5: Waiting time for consultation

Waiting time	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No	%	No.	%	No.	%	No.	%	No.	%	No.	%
Less than 30 minutes	52	94.5	33	48.8	108	90.0	44	88.0	42	89.4	85	87.6	364	82.5
More than 30 minutes	3	5.5	39	54.2	12	10.0	6	12.0	5	10.6	12	12.4	44	17.5
Total	55	100.0	72	100.0	120	100.0	50	100.0	47	100.0	97	100.0	441	100.0

82.5% of the respondents in exit interview had to wait for less than 30mins, and another 17.5% did wait for more than 30mins. The observations of the present study with reference to the waiting time at OPDs are in agreement with the findings of "Patient Satisfaction Report" (85%) by Hospihealth. Close to 57.1% of respondents said that the waiting time should match their endurance level which has been cited as 15mins. This is where the system needs to work either by putting in more

manpower or increasing the number of service delivery outlets or synchronizing the functioning of inter-related service components. However, maximum number of respondents (32%) feels disappointed with the amount of time that they had to spend at OPD for consultation.

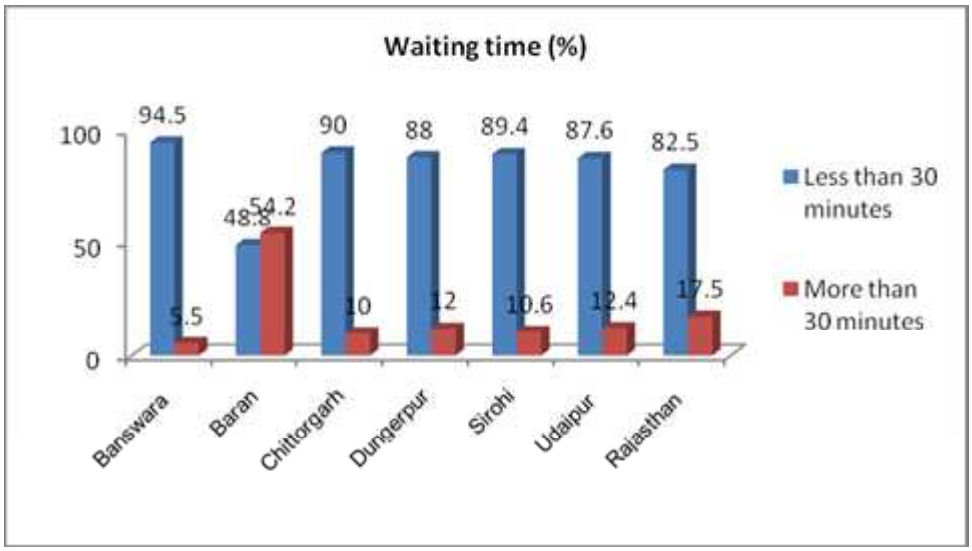


Table E-6: Opinion on time spent in obtaining the services at different places of hospital more than expectations

Time spent more than expectation in	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No	%	No.	%	No.	%	No.	%	No.	%	No.	%
registration counter	9	16.4	29	40.3	12	10.0	19	38.0	6	12.8	9	9.3	84	19.0
OPD	16	29.1	17	23.6	26	21.7	27	54.0	29	61.7	26	26.8	141	32.0
Lab	6	10.9	20	27.8	29	24.2	9	18.0	11	23.4	4	4.1	79	17.9
X-Ray	3	5.5	6	8.3	25	20.8	6	12.0	6	12.8	9	9.3	55	12.5
Injection room	2	3.6	10	13.9	12	10.0	5	10.0	6	12.8	6	6.2	41	9.3
Lifeline room	3	5.5	14	19.4	5	4.2	2	4.0	1	2.1	17	17.5	42	9.5
Total	55	100.0	72	100.0	120	100.0	50	100.0	47	100.0	97	100.0	441	100.0

Table E-7: Acceptable wait time

Waiting time	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
15 min	46	83.6	18	25.0	55	45.8	34	68.0	35	74.5	64	66.0	252	57.1
30min	8	14.5	35	48.6	57	47.5	6	12.0	7	14.9	17	17.5	130	29.5
1hr	1	1.8	19	26.4	8	6.7	10	20.0	5	10.6	16	16.5	59	13.4
Total	55	100.0	72	100.0	120	100.0	50	100.0	47	100.0	97	100.0	441	100.0

Table E-8: Facilities available

Facilities	Banswara	Baran	Chittorgarh	Dungarpur	Sirohi	Udaipur	Total
Drinking water	43 (78.2)	63 (87.50	111 (92.5)	46 (92.0)	44 (93.6)	72 (74.2)	379 (85.9)
Sitting arrangement	40 (72.7)	67 (93.1)	114 (95.0)	43 (86.0)	46 (97.9)	75 (77.3)	385 (87.3)
Toilets	44 (80.0)	66 (91.7)	109 (90.8)	41 (82.0)	42 (89.4)	72 (74.2)	374 (84.8)
Total	55	72	120	50	47	97	441

Close to 85% of all the respondents affirmatively said 'yes' regarding availability of drinking water, sitting arrangements and toilets at the facility.

Table E-9: Referred to another doctor within the facility

Opinion of referral within the hospital	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	3	5.5	31	43.1	54	45.0	9	18.0	3	6.4	33	34.0	133	30.2
No.	52	94.5	41	56.9	66	55.0	41	82.0	44	93.6	64	66.0	305	69.8
Total	55	100.0	72	100.0	120	100.0	50	100.0	47	100.0	97	100.0	441	100.

Once again, the fraternity particularly in secondary level institutions by and large is said to be averse to referrals or seeking second opinion.

The observations, somehow, are gainsaying. The exit interview reflected that 30.2% of the respondents had an intra-facility referral, highest being in Chittorgarh (45%) and Baran (3.1%). These could be for another associated ailment or for seeking second opinion (valid for district hospitals) in the interest of patient; whatever is the reason, this is a healthy sign.

Public Health facilities are expected to dispense free medicines to patients, particularly to BPL out of the essential drugs maintained under generic names at the facility. Incidentally the cohort had 46% BPL respondents. The exit interview respondents were asked to air their experience on free supply of drugs. Only 23.4% of the BPL respondents did not get free medicines from the facility. The respondent group had been censorious of public facilities in Baran for various reasons including free medicines but here the maximum number (40%) of respondents from BPL category said that they got free medicines from health facility.

Table E-10: Availability for medicine at facility

		APL			BPL			Total			**Total**
		All prescribed	Some of them	None of them	All prescribed	Some of them	None of them	All prescribed	Some of them	None of them	
Baran	No	4	14	17	8	5	7	12	19	25	55
	%	11.4	40.0	48.6	40.0	25.0	35.0	21.1	34.5	43.6	100
Banswara	No	5	11	21	8	15	12	13	26	33	72
	%	13.5	29.7	56.8	22.9	42.9	34.3	18.1	36.1	45.8	100
Chittorgarh	No	13	41	22	12	21	11	25	62	33	120
	%	17.1	53.9	28.9	27.3	47.7	25.0	20.8	51.7	27.5	100
Dungarpur	No	13	14	2	7	13	1	20	27	3	50
	%	44.8	48.3	6.9	33.3	61.9	4.8	40	54	6	100
Sirohi	No	5	14	11	5	8	4	10	22	15	47
	%	16.7	46.7	36.7	29.4	47.1	23.5	21.3	46.8	31.9	100
Udaipur	No	6	28	12	14	28	9	20	56	21	97
	%	13.0	60.9	26.1	27.5	54.9	17.6	20.6	57.7	21.7	100
Tribal Districts	No	46	122	85	54	90	44	100	212	129	441
	%	18.2	48.2	33.6	28.7	47.9	23.4	22.7	48.1	29.3	100

22.7% of the respondents said they got all the prescribed drugs while 48% got some of the prescribed drugs. 29.3% had their prescription disowned by facility pharmacy. Patients at Dungarpur were a little lucky (40% had 100% of the prescription dispensed). With increasing drug prices and relatively abated financing of health care, it is preposterous to think that public sector can continue with charity for all.

Findings from various studies have often seized the prescription ownership to a maximum of 50% in situations where the drugs have to be bought from the open market as health stands a neglected priority under cluttered concern and abdicated responsibility. Once again, of the total 341, 93.2**% of the unfortunate cohort who were either not dispensed or had their prescription partially owned by the system; still bought their pills from the market.**

Table E-11: Medicine bought from market

Response		APL		BPL		Total		**Total**
		Yes	No	Yes	No	Yes	No	
Baran	No.	31	0	12	0	43	0	43
	%	72.0	0.0	28.0	0.0	100.0	0.0	100
Banswara	No	32	0	25	2	57	2	59
	%	56.1	0.0	43.9	100.0	96.4	3.6	100
Chittorgarh	No.	55	8	27	5	82	13	95
	%	67.0	61.5	33.0	38.5	86.3	13.7	100
Dungarpur	No.	14	2	14	0	28	2	30
	%	50.0	100.0	50.0	0.0	93.3	6.7	100
Sirohi	No.	25	0	11	1	36	1	37
	%	69.4	0.0	30.6	100.0	97.3	2.7	100
Udaipur	No.	38	2	34	3	72	5	77
	%	52.7	40.0	47.3	60.0	93.5	6.5	100
Rajasthan	No.	195	12	123	11	318	23	341
	%	61.3	52.2	38.7	47.8	93.2	6.8	100

These are some of the reasons which keep the patients away from the organized health care delivery system, in turn resulting into poor utilization and seeking solace in the unfounded traditional practices. But then a positive derivate is that the people despite being restrained by their purchasing power; value health and that is a point which can be exploited for institutionalizing user fee charges provided the corpus so created is used for infusing quality and follow the postulates of cross subsidy.

Of those who did not get their medicine from the facility had to buy it from the market. Commonly assumed figures for prescription ownerships are 60%. Here, respondents had prescribed medicines purchased from the market that could be interpreted with many reasons like severity, awareness, concern for health, or purchasing power.

One of the Project Development Objectives was to strengthen the secondary level institutions in tribal areas so that facilities are available inviting people to use. The labyrinthine health care process is dependent to a large extent on the diagnostic support of laboratories, at least in relation to the basic pathological and bio-chemical tests. 66.4% of the respondents did avail the diagnostic facilities from the facility but 33.6% (corresponding percentage for BPL is 28.2%) had to cough out for the test done in the market. But then every facility has a limitation and could be that these tests were a little advanced for which facilities at the public units cannot be made available.

Table E-12: Diagnostic test done outside the hospital

Response		APL		BPL		Total		Total
		Yes	No	Yes	No	Yes	No	
Baran	No.	7	28	2	18	9	46	55
	%	20.0	80.0	10.0	90.0	16.4	83.6	100
Banswara	No	26	11	20	15	46	26	72
	%	70.3	29.7	57.1	42.9	63.9	36.1	100
Chittorgarh	No.	35	41	12	32	47	73	120
	%	46.1	53.9	27.3	72.7	39.2	60.8	100
Dungarpur	No.	4	25	9	12	13	37	50
	%	13.8	86.2	42.9	75.1	26	74	100
Sirohi	No.	6	24	1	16	7	40	47
	%	20.0	80.0	5.9	94.1	14.9	85.1	100
Udaipur	No.	17	29	9	42	26	71	97
	%	37.0	63.0	17.6	82.4	26.8	73.2	100
Tribal Districts	No.	95	158	53	135	148	293	441
	%	37.5	62.7	28.2	71.8	33.6	66.4	100

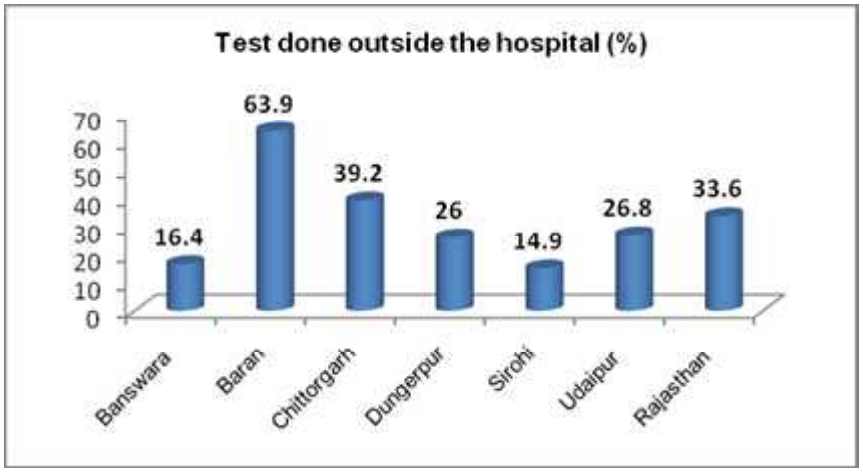


Table E-13: Doctors asking for consultation at home

response	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	3	5.5	13	18.1	15	12.5	1	2.0	3	6.4	12	12.4	47	10.7
No.	52	94.5	59	81.9	105	87.5	49	98.0	44	93.6	85	87.6	394	89.3
Total	55	100.0	72	100.0	120	100.0	50	100.0	47	100.0	97	100.0	441	100.0

At Baran, Udaipur and Chittorgarh, 18.1%, 12.4% and 12.5% respondents, respectively said that they were asked to seek consultation at home. By and large, 89.3% of the subjects said that the patients were examined and prescribed at the facility itself with no charges. This as such is not significant as it is deeply embedded in the psyche of the consumers that they would be treated a little better at home.

Table E-14: Doctor/Nursing staff asked for fee

Response	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	4	7.3	6	8.3	6	5.0	2	4.0	2	4.3	23	23.7	43	9.8
No.	51	92.7	66	91.7	114	95.0	48	96.0	45	95.7	74	76.3	398	90.2
Total	55	100.0	72	100.0	120	100.0	50	100.0	47	100.0	97	100.0	441	100.0

9.8 % of the subjects of exit interview said that they were asked to pay for services; Udaipur (23.7%) championing the list.

When asked "are you satisfied with the consultation/ examination", 91.2% of the respondents affirmatively said "Yes" with responses in the range of 87-95%.

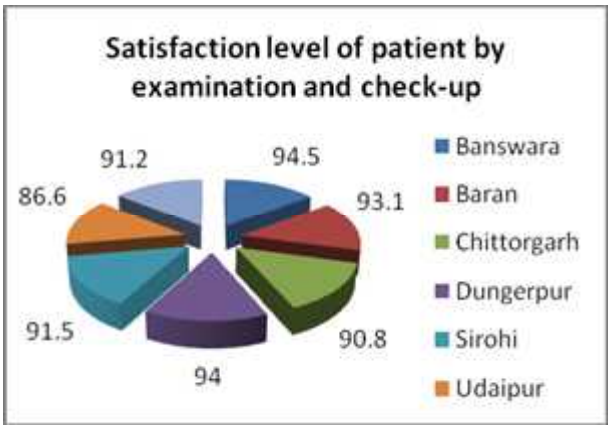


Table E-15: Hospital cleanliness

response	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	50	90.9	72	100.0	112	93.3	46	92.0	42	89.4	78	80.4	400	90.7
No.	5	9.1	0	0.0	8	6.7	4	8.0	5	10.6	19	19.6	41	9.3
Total	55	100.0	72	100.0	120	100.0	50	100.0	47	100.0	97	100.0	441	100.0

However, when segregated for project and non project facilities, observation hardly show any difference, a point in case here is reflected in the following table referring to hospital cleanliness

Cleanliness affirmed*	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
PF	50	90.9	61	100	102	92.72	36	90	33	86.84	67	87.01	349	91.60
NPF	0	0	11	100	10	100	10	100	9	100	11	55	51	85

*Non responses not included here

The respondents of exit interview who just had the experience of visiting/staying at the facility, when asked to express their views on overall cleanliness, close to 91% opined that hospitals are clean enough, Chittorgarh (93.3%) being rated as the cleanest facility.

Table E-16: Treatment matching expectations

Response	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Yes	51	92.7	44	61.1	102	85.0	49	98.0	43	91.5	84	86.6	373	84.6
No.	4	7.3	28	38.9	18	15.0	1	2.0	4	8.5	13	13.4	68	15.4
Total	55	100.0	72	100.0	120	100.0	50	100.0	47	100.0	97	100.0	441	100.0

84.6% of the subjects were satisfied with the clinical management and expressed that it matched with their expectations; Baran somehow had the least (61.1%) number of respondents whose expectations were met at the facility.

Once again segregated for project and non project facilities, observation do not reflect any tangible difference

Treatment matching expectations	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
PF	51	92.72	37	60.65	92	83.63	39	97.5	35	92.10	69	89.61	323	84.77
NPF	0	0	7	63.63	10	100	10	100	8	88.88	15	75	50	83.33

Table E-17: Recommendation about facility to family/ friends

Response	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No.	%	No.	%	No.	%	No	%	No	%	No	%
Yes	51	92.7	70	97.2	105	87.5	50	100.0	44	93.6	88	88.7	406	92.1
No.	4	7.3	2	2.8	15	12.5	0	0.0	3	6.4	11	11.3	35	7.9
Total	55	100.0	72	100.0	120	100.0	50	100.0	47	100.0	97	100.0	441	100.0

The personal experiences with reference to services and resultant satisfaction are the decisive forces for revisiting and/or recommending the facility to others which in turn is a qualitative tool for establishing credibility of the facility. In an attempt to know whether these 441 respondents would suggest the facility to their friends and relatives, 92.1% turned out with a positive nod.

It is difficult to make any interpretation as to why Baran (97.2%) scored over Chittorgarh (87.5%). As for all other parameters Chittorgarh was put at a relatively higher pedestal.

Table E-18: Improvement in facility in last five years

Response	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	51	92.7	66	91.7	105	87.5	49	98.0	44	93.6	88	90.7	403	91.4
No.	4	7.3	6	8.3	15	12.5	1	2.0	3	6.4	9	9.3	38	8.6
Total	55	100.0	72	100.0	120	100.0	50	100.0	47	100.0	97	100.0	441	100.0

The tribal development plan under RHSDP with Bank's support has made improvements in infrastructure besides taking care of logistics and the softer inputs.

This has been vouched by 91.4% of the respondents who in response to the question "has the facility improved", responded that the facility has shown a lot of improvement in preceding five years.

Treatment matching expectations	**Banswara**		**Baran**		**Chittorgarh**		**Dungarpur**		**Sirohi**		**Udaipur**		**Tribal Districts**	
	No.	**%**	**No**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
PF	**51**	**92.7**	**57**	**93.4**	**95**	**86.4**	**39**	**97.5**	**35**	**92.1**	**72**	**93.5**	**349**	**91.6**
NPF	**0**	**0**	**9**	**81.8**	**10**	**100**	**10**	**100**	**9**	**100**	**16**	**80**	**54**	**90**

Now that could have been a generic statement, so to have a feel of where, the respondents feel, the facility has improved; the subjects were asked to indicate the areas where the facility according to them has improved.

Table E-19: Improvement perceived in the facility by the respondents

Hospital facilities and services	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No	%	No	%	No.	%	No	%	No	%	No	%	No.	%
Sitting arrangements	37	67.3	63	87.5	101	84.2	41	82.0	45	95.7	66	68.0	353	80.0
Drinking water availability	36	65.5	56	77.8	100	83.3	45	90.0	40	85.1	45	46.4	322	73.0
Clean toilets	32	58.2	45	62.5	57	47.5	39	78.0	36	76.6	47	48.5	256	58.0
Proper beds	22	40.0	30	41.7	95	79.2	39	78.0	31	66.0	63	64.9	280	63.5
Proper sewerage system	4	7.3	14	19.4	33	27.5	20	40.0	20	42.6	30	30.9	121	27.4
Cleanliness of hospital	34	61.8	27	37.5	74	61.7	41	82.0	38	80.9	50	51.5	264	59.9
Staff in uniform	13	23.6	27	37.5	58	48.3	32	64.0	30	63.8	23	23.7	183	41.5
Diagnostic services	21	28.2	8	11.1	39	32.5	30	60.0	36	76.6	31	32.0	165	37.4
Availability of Ambulance	23	41.8	18	25.0	72	60.0	26	52.0	31	66.0	51	52.6	221	50.1
Total	55	100.0	72	100.0	120	100.0	50	100.0	47	100.0	97	100.0	441	100.0

Sitting arrangement (80.0%) followed by drinking water facility (73%) proper beds (63.5%) and clean toilets (58%) were some of the areas where the improvement was visible to exit interview respondents. Unfortunately an area which does not require a fortune (staff in uniform) did not make any appearance onto the improvement list.

Household Interviews

Household Interviews:

Against the original sample size of 1840 households, 1951 were visited to seek their comprehensive opinion on the services from the facility that they frequent incase of need.

Table H-1: **District-wise distribution of households**

Name of District	No. of facilities	No. of PHCs	No. of villages	No. of households	No. of FGDs
Banswara	7	2	27	270	5
Baran	7	2	21	210	5
Chittorgarh	14	2	58	548	7
Dungarpur	5	2	28	251	7
Sirohi	5	2	24	240	7
Udaipur	10	1	41	432	7
Total	48	12	193	1951	38

55% of the households belonged to APL while 45% were living below poverty line.

The class-wise distribution of subjects is-
SC- 14.4%,
ST-38.6%,
OBS-35.8% and
General 21.2%, with maximum ST subjects visited from Banswara (60.4%), as expected.

Further the respondents from households were categorized as OPD patients, IPD patients, relatives, and community leaders.

Table H-2: Type of Respondent

Respondent Type	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%
OPD	126	46.7	131	62.4	257	46.9	128	51.0	155	64.6	335	77.5	1132	58.0
IPD	56	20.7	33	15.7	53	9.7	98	39.0	45	18.8	54	12.5	339	17.4
Relative/ attendants	82	30.4	33	15.7	223	40.7	24	9.6	40	16.7	41	9.5	443	22.7
Community Leader	6	2.2	13	6.2	15	2.7	1	0.4	0	0.0	2	0.5	37	1.9
Total	270	100.0	210	100.0	548	100.0	251	100.0	240	100.0	432	100.0	1951	100.0

The healthcare seeking behavior and practices are prescript of factors including education, awareness, purchasing power, access, availability, faith in the system, gender and past experiences, besides the priority attached to health.

Findings of Social Assessment conducted by IIHMR clearly indicate that patients had to travel long distance in rural areas compared to urban areas for seeking health care at the government hospitals. More specialized the care longer would be the distance that the patient needs to travel, adding to the indirect cost of treatment.

Social Assessment study indicates distance from residence to facility is one of the reasons for non utilization of services, as besides adding to the cost, on account of the time consumed it forces the family members to keep away from labor market, further contributing to the poor purchasing power. The generalizations made by the study reflect that to reach a district hospital the rural folk have to travel 24 kms on an average, compared to the urban counterpart who would just commute 4 kms; for CHC the distances were 11 and 2 kms in rural and urban areas respectively.

Table H-3: Average distance traveled to reach facility by residence (Kms)

Facility	Rural	Urban
District hospital	24	4
Sub-divisional hospital	17	2
Community health center	11	2

Source: Exit Interviews at Government Health Institutions 2001.

The findings of the exit interview also suggest that people in tribal areas traveled a longer distance compared to desert and plain. Similarly, people in desert areas traveled long distance compared to plain area to reach the district hospital.

An attempt was made under the present study to have a feel regarding average distance that has to be traversed by sick and the family in tribal areas. Somehow like the earlier study, level of institution in the present study has not been accounted for. Irrespective of level of facility (DH/SDH/CHC) 54.3 percent of the beneficiaries traveled a distance of less than 5 kms, while 27.3 percent traveled more than 15 km to approach the facility.

Table H-4: Distance travelled to the nearest facility

Distance Traveled	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<5	111	41.1	142	67.6	277	50.5	216	86.1	116	48.3	148	34.3	1010	51.8
5-10	92	34.1	67	31.9	230	42.0	35	13.6	88	36.7	141	32.6	653	33.5
>10	67	24.8	1	0.5	41	7.5	0	0.0	36	15.0	143	33.1	288	14.8
Total	270	100.0	210	100.0	548	100.0	251	100.0	240	100.0	432	100.0	1951	100.0

Impact of RCH Camp –

Camps have been identified as an effective instrument to reach the underserved in difficult areas provided each camp gets a reasonable number of beneficiaries justifying the effort and the cost involved in. This simply means that people need to know the time and place and have to be mobilized well in advance.

RHSDP did bring in convergence with RCH-NRHM for holding RCH camps in remote and underutilized PHCs. An initiative is to dovetail efforts put in RCH camps under NRHM with outreach camps of RHSDP in nine selected districts.

Strengthening outreach services for people residing in remote areas in 9 selected districts (Baran, Banswara, Chittorgarh, Dungarpur, Sirohi, Udaipur (Tribal). Barmer, Bikaner & Jaisalmer (Desert) through “Health Camps”; was planned with the budgetary provision of Rs.40,000 for each camp (including follow-ups) from RHSDP and 10,000 from RCH committee for five collaborative camps and from the savings of each camp supported by RHSDP, if required, one additional camp was to be arranged by RHSDP.

Each camp is expected to provide specialist services, diagnostics, and national program interventions with special focus on BPL, women, children and cases screened for CM Medical relief fund.

The expenditure break up of Rs. 40,000/- from RHSDP (Medicine-25000, Referral transport-3000, POL/ Hiring-3000, Specialist /TA/DA-5000, Contingencies- 4000) and Rs. 10,000/- from RCH Camps arrangement- 4000, IEC (pre camp & during camp)-5000, Ayurvedic Medicine-1000) was explicitly specified.

Subjected to the question if they are in knowledge of RCH camp being held at places only 51% of households knew about it (for each camp there is a provision of Rs. 5000/- for IEC). Dungarpur (29.9%) and Sirohi (37.9%) respondents were the least informed about RCH camps. In District Baran on the date of camp at PHC- Paraniya even the people from nearby villages were ignorant of date, time, place and services at the camp and were there by default (finding that emerged during the FGD conducted). Out of total respondents who knew about RCH Camps (1005) only 433 (43.1%) did avail the services.

Table H-5: Distribution of households according to RCH services utilization

Districts		Male		Female		Total		Total
		Yes	No	Yes	No	Yes	No	
Banswara	No.	26	33	63	37	59	100	159
	%	44.1	63.0	55.9	37.0	37.1	62.9	100
Baran	No.	38	20	26	21	64	41	105
	%	59.4	48.8	40.6	51.2	61	39	100
Chittorgarh	No.	82	81	49	65	131	146	277
	%	62.6	55.5	37.4	44.5	47.3	52.7	100
Dungarpur	No.	16	19	20	20	36	39	75
	%	44.4	48.7	55.6	51.3	48	52	100
Sirohi	No.	16	37	7	31	23	68	91
	%	69.6	54.4	30.4	45.6	25.3	74.7	100
Udaipur	No.	86	134	34	45	120	179	299
	%	71.7	74.9	28.3	25.1	40.1	59.9	100
Tribal Districts	No.	264	354	169	219	433	573	1005
	%	61.0	61.8	39.9	38.2	43.1	57	100

Of the total 433 who came for ambulatory care during the camps 69.7% did get consultation for fever, maximum of such cases were at Baran (90.6%) followed by Chittorgarh (82.4%); another 57.3% had cough.

As the very objective of MCH services is to focus on women and children some basic indicators were picked up and the analysis of responses shows that 57.98% (225) of the total 388 women came for ANC check up while immunization services were availed by 56.8% of the respondents, another 46.7% had sterilization done at the camps. Respondents those who availed the RCH camps services were asked about the kind of services offered during the camp.

Table H-6: Services at the RCH Camp

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
OPD	No	%	No	%	No	%	No	%	No	%	No	%	No	%
a. Fever	24	40.7	62	90.6	108	82.4	18	50.0	16	69.6	74	61.7	302	69.7
b. Cough	5	8.5	58	10.9	95	72.5	14	38.9	14	60.9	62	51.7	248	57.3
c. RTI/STI	9	15.3	7	87.5	73	55.7	5	13.9	9	39.1	16	13.3	119	27.5
Total	59	100.0	64	100.0	131	100.0	36	100.0	23	100.0	120	100.0	433	100.0
MCH Services														
a. Mother														
ANC Checkup	10	16.9	56	87.5	106	80.9	10	27.8	11	47.8	32	26.7	225	52.0
IFA	14	23.7	17	26.6	72	55.0	12	33.3	10	43.5	31	25.8	156	36.0
TT	8	13.6	33	51.6	102	77.9	12	33.3	13	56.5	42	35.0	210	48.5
Screening	2	3.4	39	60.9	56	42.7	5	13.9	12	52.2	32	26.7	146	33.7
b. Child														
Screening for Malnutrition	7	11.9	43	67.2	54	41.2	6	16.7	11	47.8	26	21.7	147	33.9
Immunization	2	3.4	44	68.8	105	80.2	13	36.1	11	47.8	71	59.2	246	56.8
ORS	12	20.3	34	53.1	109	83.2	11	30.6	13	56.5	54	45.0	233	53.8
Vitamin A	15	25.4	40	62.5	63	48.1	6	16.7	13	56.5	28	23.3	165	38.1
Family Welfare Services														
a. OP/IUD	0	0.0	7	10.9	50	38.2	12	33.3	8	34.8	51	42.5	128	29.6
b. Sterilization	1	1.7	44	68.8	84	64.1	10	27.8	15	65.2	48	40.0	202	46.7
Total	59	100.0	64	100.0	131	100.0	36	100.0	23	100.0	120	100.0	433	100.0

Table H-7: Drugs and Investigation at RCH Camp

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Drug Dispensing	23	39.0	33	51.6	105	80.2	28	77.8	16	69.6	78	65.0	283	65.4
Investigation														
a. Blood	21	35.6	40	62.5	61	46.6	17	47.2	16	69.6	57	47.5	212	49.0
b. Sputum	9	15.3	7	10.9	56	42.7	4	11.1	10	43.5	37	30.8	123	28.4
Referral	6	10.2	37	57.8	63	48.1	5	13.9	9	39.1	63	52.5	183	42.3
Procedures-minor surgeries	0	0.0	31	48.4	33	25.2	6	16.7	13	56.5	55	45.8	138	31.9
Total	59	100.0	64	100.0	131	100.0	36	100.0	23	100.0	120	100.0	433	100.0

Table H-8 Service rating for RCH camps

		APL					BPL					Total				
		Excellent	Good	Fair	Poor	Total	Excellent	Good	Fair	Poor	Total	Excellent	Good	Fair	Poor	Total
Banswara	NO	6	19	4	1	30	3	16	10	0	29	9	35	14	1	59
	%	20.0	63.3	13.3	3.3	100.0	10.3	55.2	34.5	0.0	100.0	15.3	59.3	23.7	1.7	100.0
Baran	NO	1	24	2	2	29	0	31	2	3	36	1	55	4	5	65
	%	3.4	82.8	6.9	6.9	100.0	0.0	86.1	5.6	8.3	100.0	1.5	84.6	6.2	7.7	100.0
Chittorgarh	NO	1	40	9	8	58	2	49	14	8	73	3	89	23	16	131
	%	1.7	69.0	15.5	13.8	100.0	2.7	67.1	19.2	11.0	100.0	2.3	67.9	17.6	12.2	100.0
Dungarpur	NO	2	6	0	0	8	1	21	5	1	28	3	27	5	1	36
	%	25	75	0	0	100	3.6	75.0	17.9	3.6	100.0	8.3	75.0	13.9	2.8	100.0
Sirohi	NO	8	9	5	0	22	0	0	1	0	1	8	9	6	0	23
	%	36.4	40.9	22.7	0.0	100.0	0.0	0.0	100.0	0.0	100.0	34.8	39.1	26.1	0.0	100.0
Udaipur	NO	8	33	16	2	59	7	41	13	0	61	15	74	29	2	120
	%	13.6	55.9	27.1	3.4	100.0	11.5	67.2	21.3	0.0	100.0	12.5	61.7	24.2	1.7	100.0
Tribal Districts	NO	26	131	36	13	206	13	156	45	12	226	39	287	81	25	433
	%	12.6	63.6	17.5	6.3	100.0	5.8	69.0	19.9	5.3	100.0	9.0	66.4	18.8	5.8	100.0

The respondents were asked to rate the services as "excellent", "good", "fair" and "poor". With inherent punctuations narrated above it is a pleasant observation that 66.4% of the 433, who availed the services, did qualify these services as "good". **The visage responses from BPL (69%) rating the services as "good", is something that should be credited to the Project efforts.**

Impact of Village Contact Drive

To increase utilization of renovated CHCs for BPL, tribal and other marginalized populations, activity of village contact drive in 4 selected districts was organized. As per the guidelines VCD was organized in 100 villages of one block of the districts. The VCD was driven with the assumption that

- The tribal population prefers traditional medical practitioners.
- Health workers are not much familiar with the tribal culture/language and the different words and practices used by tribal people for indicating their needs.
- Tribal areas have difficult terrain restricting the reach of organized health care system.

The purposive VCD intended at increasing the awareness about the services available in the CHC and having the feel of extent to which tribal populace is willing to use them and the whole exercise was in conformance to the objectives of the tribal development plan.

NGOs were assigned the task under PPP mode, for a period of 3 months and as the major terms of reference it was expected that 20-25 families per village shall be contacted during the drive.

The village contact drives in renovated CHCs (Arnod, Aspur, Reodar, Jhadol) of Chittorgarh, Dungarpur, Sirohi, Udaipur districts, was undertaken and the criterion for village selection rested with population of village, location – one village in each direction and proportion of BPL/tribal/ marginalized families in the village.

Table H-9: Profile of Districts and Blocks for VCD

Sr.No.	Districts	Blocks	Total no. of Villages	Population	Households	Villages to be covered
1.	Chittorgarh	Arnod	179	1,19,837	23,967	100
2.	Dungarpur	Aspur	203	2,03,104	40,620	100
3.	Sirohi	Reodar	126	1,88,302	37,660	100
4.	Udaipur	Jhadol	256	2,06,681	34,240	100
Total			764	7,17,924	1,36,487	400

It was expected that the NGO shall, during the contact drive, inform the families about services available at renovated CHC, free services available to BPL card holders, and procedure to acquire

BPL card and the eligibility thereof, focus on women and children for ANC, institutional deliveries, & immunization, monthly health camps.

Further, it was conceived that the NGO shall take up follow up visits in second and third months and shall reinforce about the services available.

Confirming to the scope of work for the present study, the SIHFW study teams did try to know whether the respondents from these 379 households from 4 districts (visited during house to house contacts) know about the village contact drives held in their village. But for 29% (110) all knew that a VCD was held in their village.

Table H-10: VCD held in the village

	Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%
Yes	91	75.2	60	87.0	28	80.0	90	58.4	269	71.0
No	30	24.8	9	13.0	7	20.0	64	41.6	110	29.0
Total	121	100.0	69	100.0	35	100.0	154	100.0	379	100.0

75% of those who were in knowledge of VCD in villages could specifically point out that organizing a village meeting was the main activity followed by another 63% who recalled that puppet shows were organized. 53.9% said that distribution of leaflets was also done. As the prime activity- “house to house visits”, only 36.8% of the respondents could recapitulate. In order to be a little more objective, the investigators also explored the issues that were discussed during the meeting in house to house contacts.

Table H-11: Activities organized during VCD

	Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%
Meetings	86	94.5	50	83.3	22	78.6	45	50.0	203	75.5
Slogan Writing	58	63.7	25	41.7	3	10.7	10	11.1	96	35.7
Counseling	23	25.3	25	41.7	4	14.3	12	13.3	64	23.8
Puppet show/Street Play	64	70.3	54	90.0	10	35.7	42	46.7	170	63.2
Distribution of Pamphlets	49	53.8	47	78.3	17	60.7	32	35.6	145	53.9
House to house visit	12	13.2	29	48.3	15	53.6	43	47.8	99	36.8
Total	91	100.0	60	100.0	28	100.0	90	100.0	269	100.0

Family planning (83.6%) immunization (76.6%), DOTS (73.2%), malaria (75.5%) carried the premium tag and issues like institutional delivery, reasons for non-utilization of services, role of VHSC and sex selection were consigned to the back seat.

Table H-12: Issues Discussed during VCD

	Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No.	%	No.	%	No.	%	No.	%
Family Planning Services	86	94.5	55	91.7	26	92.9	58	64.4	225	83.6
Immunization	82	90.1	45	75.0	19	67.9	60	66.7	206	76.6
RTI/STI	44	48.4	42	70.0	16	57.1	43	47.8	145	53.9
TB patients put on DOTS	77	84.6	39	65.0	19	67.9	57	63.3	197	73.2
Diarrhea & ORS	59	64.8	51	85.0	21	75.0	50	55.6	199	74.0
Malaria	76	83.5	57	95.0	21	75.0	66	73.3	203	75.5
Institutional delivery	40	44.0	34	56.7	15	53.6	24	26.7	149	55.4
Role of VHSC	47	51.6	15	25.0	4	14.3	4	4.4	63	23.4
Satisfaction with services of health facility	6	6.6	21	35.0	7	25.0	31	34.4	106	39.4
Reasons for non utilization of health services	20	22.0	13	21.7	6	21.4	5	5.6	30	11.2
Sex selection & PCPNDT	0	0.0	50	83.9	13	46.4	17	18.9	100	37.2
Total	91	100.0	60	100.0	28	100.0	90	100.0	269	100.0

The cognizance of the results from the RVHA study has been taken while espying the findings of the present study. The study by RVHA puts the knowledge level as 70% but that is not endorsed here 71 % knew about VCD from the household interviews).

Why did people utilize the public health facilities, was the question and as expected easy access and approach (82.5%) was the answer apart from responses like past experience (43%), 24x7 staff availability (53%).

Free services to BPL were the reason to exult for 32% of the respondents. Once again only 7.6% subscribed to IEC/VCD as the facilitator for utilization.

Table H-13: Reasons for utilizing the services

Reasons for utilization of services	Banswara	Baran	Chittorgarh	Dungarpur	Sirohi	Udaipur	Tribal Districts
	%	%	%	%	%	%	%
Free services to BPL	28.9	42.4	34.3	45.4	17.1	26.6	32.0
Easy Approach	82.6	91.0	95.1	74.1	87.1	64.6	82.5
Convenient timings	24.1	81.4	65.0	38.6	30.8	47.9	49.7
Availability of doctor and staff 24x7	54.1	39.5	52.7	47.8	68.3	54.4	53.2
Personal attention by staff	8.9	22.9	21.7	40.6	22.1	20.8	22.3
Good investigation facility	40.4	97.0	36.9	37.1	55.8	23.4	33.7
Positive feedback friends & relatives	39.3	30.0	15.0	49.0	45.8	18.5	28.9
Information received through IEC/VCD	10.4	10.5	7.5	14.3	2.1	3.9	7.6
Was advised by PRI/ASHA/AWW	13.3	39.0	20.4	49.0	39.2	27.5	29.0
Good past experience	26.7	57.1	45.1	64.9	53.3	25.2	43.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Per se, health has a disarrayed concern and is a neglected priority particularly so when the reference is made to normal physiological processes. Minor ailments are nursed through home remedies or traditional healers. Studies on “Health seeking behavior and health care services in Rajasthan, India: A Tribal Community's Perspective”- Lakhwinder P Singh and Shiv D Gupta - IIHMR Working Paper No. 1; stand as testament to the statement.

Findings of a household survey conducted in Udaipur in the year 2003 by Abhijit Banerjee, Angus Deaton, and Esther Duflo also support that tribal community prefer to go to the private doctors or the Bhopa for the treatment of minor illnesses instead of government hospitals. (Ref. “Health Care Delivery in Rural Rajasthan”, Poverty Action Lab Paper No. 7, February 2004).

Under the present study a few dimensions of health seeking behavior of tribal communities were explored. The response to the question regarding who is approached when they fall sick, defied all the earlier postulates as 43.9% (857 households) of the 1951 households prefer to contact an ANM followed by a private doctor (42.5%). **Traditional healers were the choice for a minority of 22.1%.**

Substantial inputs and sustained efforts by RHSDP, looks, have made a dent on the cultural inheritance and traditional norms and people have reposed their faith in modern system of medicine.

Table H-14: Preferred practitioners/functionaries for minor ailments

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%
ASHA	15	5.6	118	56.2	80	14.6	123	51.0	46	19.2	87	20.1	474	24.3
ANM	151	55.9	68	32.4	136	24.8	205	81.7	121	50.4	176	40.7	857	43.9
Private doctor	77	28.7	88	41.9	309	56.4	75	29.9	111	46.3	170	39.4	830	42.5
Traditional healer	37	13.7	4	1.9	150	27.4	73	29.1	44	18.3	125	28.9	432	22.1
Total	270	100.0	210	100.0	548	100.0	251	100.0	240	100.0	432	100.0	1951	100.0

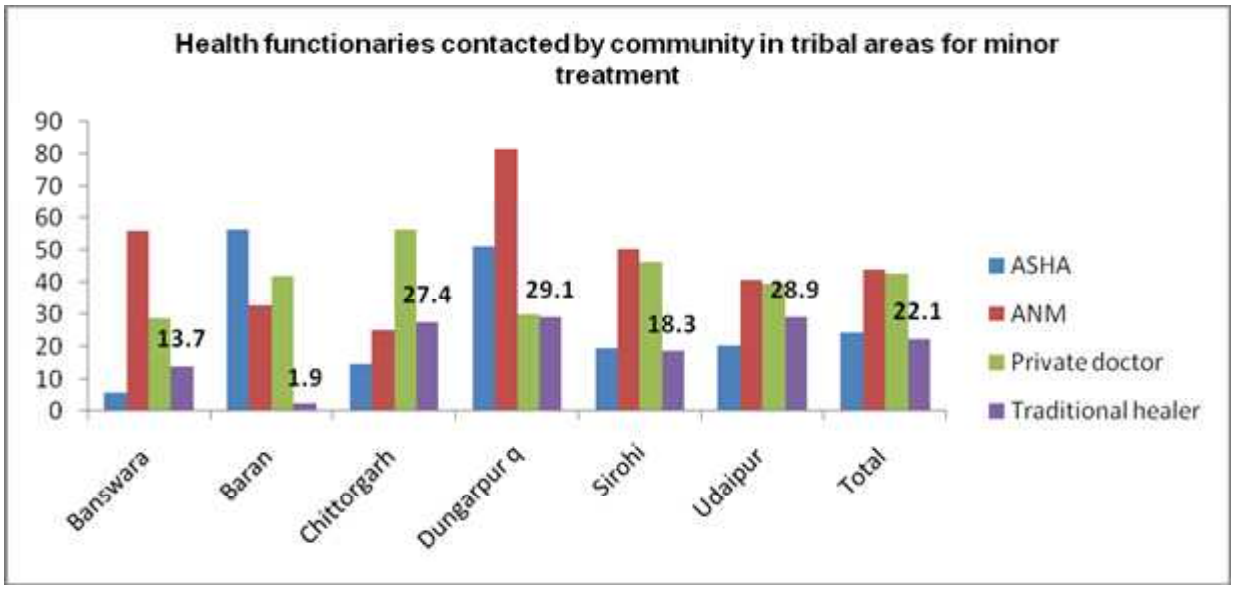


Table H-15: Reasons for preferring a Traditional healer

	Banswara	Baran	Chittorgarh	Dungarpur	Sirohi	Udaipur	Tribal Districts
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Faith	20 (54.1)	0 (0.0)	143 (95.3)	59 (80.8)	36 (81.8)	67 (53.6)	324 (75.0)
Inexpensive	10 (27.0)	0 (0.0)	83 (55.3)	40 (54.8)	29 (65.90	33 (26.4)	195 (45.1)
Culturally	5 (13.5)	1 (25.0)	55 (36.7)	60 (82.2)	38 (86.4)	57 (45.6)	215 (49.8)
Easy availability	15 (40.5)	3 (75.0)	108 (72.0)	37 (50.7)	22 (50.0)	34 (27.2)	219 (50.7)
Total	37 (100.0)	4 (100.0)	150 (100.0)	73 (100.0)	44 (100.0)	125 (100.0)	432 (100.0)

Though in minority, it was aptly thought to find out why people visit traditional healers. “Faith” (75%) turned out to be a predominant factor followed by “easy availability” (50.7%). For the same reason, 50% of the respondents feel that a little orientation about the system can make these traditional healers relatively more effective.

Table H-16: Can traditional healers be effective following orientation

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	13	35.1	4	100.0	128	853	24	32.9	23	52.3	28	22.4	220	50.9
No	24	64.9	0	0.0	22	14.7	49	67.1	21	47.7	97	77.6	212	49.1
Total	37	100.0	4	100.0	150	100.0	73	100.0	44	100.0	125	100.0	432	100.0

For their perennial presence, respect that they enjoy and the faith that the tribal community has in traditional healers the system is considering getting them into the main stream of health care with defined roles. Under this pretext, households were requested to visualize the possible role of traditional healers after their orientation.

Table H-17: Role of Traditional healer

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Timely referring patients	6	46.2	4	100.0	121	94.5	24	100.0	21	91.3	16	57.1	192	87.3
Counseling on family welfare	9	69.2	0	0.0	24	18.8	5	20.8	7	30.4	7	25.0	52	23.6
Depot holders for contraceptives & ORS	5	38.5	0	0.0	1	0.8	4	16.7	5	21.7	3	10.7	18	8.2
Increasing awareness about government scheme	5	38.5	0	0.0	22	17.2	14	58.3	11	47.8	5	17.9	52	25.1
Total	13	100.0	4	100.0	128	100.0	24	100.0	23	100.0	28	100.0	220	100.0

A whooping number of respondents (87.3%) hollered that at least they can timely refer the patients to an appropriate facility 87.3% of the 220 (who had faith in and availed services of a traditional healer) opined that they could “timely refer” and play an effective role in counseling on family welfare issues (23.6%).

Nothing comes free from the public health facilities is the commonest connotation annotated by the perception that has a strong lineage. The findings of the FGD done during “Social Assessment Study” by IIHMR endorsed the opinion of tribal communities that the system is virtually non-functional, the public hospitals are indifferent, the system lacks credibility, the poor dispensing of drugs, inconvenient timings, uncertainty of availability of doctor and medicines, long distances to be traveled to get care and difficulty in accessing transportation, and high cost of transportation.

Somehow, we fail to prefix any justification to the majority of the aforesaid findings, as the evidence compiled under “**Reasons for utilizing the services”** does not allow us to support their observations. Further, though 16.6% household admitted that consultation fee was asked for, 84% got the treatment absolutely free.

Table H-18: Payment made for services

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	34	12.6	47	22.4	79	14.4	22	8.8	15	6.3	126	29.2	323	16.6
No	236	87.4	163	77.6	469	85.6	229	91.2	225	93.8	306	70.8	1628	83.4
Total	270	100.0	210	100.0	548	100.0	251	100.0	240	100.0	432	100.0	1951	100.0

The two findings, one from "Social Assessment Study" report and the other from "Patient Satisfaction Report" are themselves contradictory as 97% of the respondents in the patient satisfaction report are believed to have said that the facilities are inexpensive though not free.

Table H-19: Awareness about health functionaries

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%
ASHA	202	78.4	164	78.1	426	77.7	220	97.6	152	63.3	280	64.8	1444	74.0
ANM	241	89.3	56	26.7	394	71.9	241	96.0	174	72.5	348	80.6	1454	74.5
AWW	258	95.6	142	67.6	506	92.3	232	92.4	233	97.1	394	91.2	1765	90.5
TBA	81	30.0	4	1.9	284	51.8	140	55.8	92	38.3	282	65.3	883	45.3
Total	271	100.0	210	100.0	548	100.0	251	100.0	240	100.0	432	100.0	1951	100.0

People need to know, who they can contact for seeking healthcare. In order to assess about whether they know of the health functionaries available in the village, 1951 respondent's responses were recorded. Presence of AWW is registered with 90.5% while ASHA and ANM are known to 74% each.

The respondents were asked to rate the facility that they frequent most, in terms of certain parameters on a scale ranging from excellent to poor. On an average "good" was the response for accessibility, registration, enquiry (58%), seating arrangements (49.5%) and drinking water (47.3%).

Table H-20: Rating of the facilities

		N-H-Interviewed	Registration/enquiry counter	Waiting time	Guidance/information	Signage	Seating arrangement	water	Toilets	Fans & lights
Banswara	E	N- 270	1.9	0.7	1.9	1.5	3	10.4	10.4	11.9
	G		59.3	36.3	35.6	23.7	47	46.7	47.4	47.8
	F		33	38.5	34.5	32.2	35.2	27.4	25.2	30
	P		5.9	24.4	28.1	42.6	14.8	15.6	17	10.4
Baran	E	N- 210	1.4	0	0.5	0	0.5	0.5	1	1.4
	G		72.4	31.9	12.9	9.5	41	37.6	24.8	56.2
	F		22.9	46.2	63.6	64.8	39.5	41.4	45.7	26.7
	P		3.3	21.9	23.9	25.7	19	20.5	28.6	15.7
Chittorgarh	E	N-548	2	2.2	1.3	1.3	2.9	2.7	1.8	2.4
	G		44.9	30.5	25.9	23	58	59.3	44.7	45.6
	F		47.6	55.3	53.8	55.3	29.4	29	41.4	42.5
	P		5.5	12	19	20.4	9.7	8.9	12	9.5
Dungarpur	E	N-251	4.8	7.2	9.6	29.5	34.7	40.2	33.1	22.7
	G		64.1	57.4	57.8	32.7	33.5	32.3	29.9	48.6
	F		28.7	30.3	27.1	21.1	27.9	19.9	19.9	19.5
	P		2.4	5.2	5.6	16.7	4	7.6	17.1	9.2
Sirohi	E	N=240	5.8	3.3	7.1	10.8	25.4	20	13.3	14.2
	G		54.2	55.8	47.1	30.8	57.9	56.7	47.1	61.7
	F		35.8	28.8	26.7	35.4	14.6	17.9	24.6	18.8
	P		4.2	12.1	19.2	22.9	2.1	5.4	15	5.4
Udaipur	E	N-432	7.4	3.7	15.7	17.4	21.5	21.1	14.4	16.9
	G		65.3	56	35.6	40.3	49.1	40.7	39.8	58.3
	F		19.7	26.2	31	30.8	22.2	23.1	26.9	18.3
	P		7.6	14.1	17.6	11.6	7.2	15	19	6.5
Tribal Districts	E	N-1951	39	2.9	6.3	9.5	13.6	14.6	11.2	10.9
	G		58	43.7	34.7	27.7	49.5	47.3	40.2	52.2
	F		32.9	39.1	40.3	40.9	27.7	26.3	31.6	27.8
	P		5.2	14.4	18.8	21.9	9.2	11.8	17.1	9.1

E- Excellent, G- Good, F- Fair, P-Poor

Put together there 8 variable based on which Tribal Health facilities were ranked by the respondents of Household survey. The summation of Excellent, Good and Fair ranking for toilets as well as signage are not that bad. Moreover these ranking have a subjective value only as people have different perception of them.

User Fee

In increasing demands and expectations, newer infections and resurrection of old ones, besides the rising health care costs unmatched with available resources in health sector it has become imperative for the exchequer to think of alternatives towards health care finances. Of the many options forged out during last twenty years, "user fee" stands out to be the most pragmatic one. To institutionalize user fee an instrument baptized as "RMRS" was barged in the state of Rajasthan in 1996 at SMS Medical College Teaching Hospital. The success paved for secondary and subsequently for primary care institutions who espouse with the idea.

The objective was to make institutions a little independent, raise the quality and ultimately become self-sustainable to a large extent. The approach was to cross subsidize by charging those who could afford and offering free care including drugs to sections of society like senior citizens, BPL, widows, destitute, accident victims, freedom fighters and retired government servants.

The user charges were levied on OPD registration, IPD, investigations and the accommodation in private wards.

Table H-21: Opinion of respondents on user charges

Name of the District	Category of user charges	Comfort level with User charges		
		Very Much,	to some extent,	should not be charged
Banswara	OPD Ticket	85.9	5.2	8.9
	IPD admission	76.3	11.1	12.6
	Investigation	74.1	6.3	19.6
Baran	OPD Ticket	62.9	14.3	22.9
	IPD admission	49.0	20.5	30.5
	Investigation	31.0	31.4	37.6
Chittorgarh	OPD Ticket	53.3	25.7	21.0
	IPD admission	49.1	24.8	26.1
	Investigation	45.6	10.0	44.3
Dungarpur	OPD Ticket	16.3	36.6	47.4
	IPD admission	15.9	33.9	50.2
	Investigation	13.1	33.5	53.4
Sirohi	OPD Ticket	41.7	27.5	30.8
	IPD admission	23.8	27.1	49.2
	Investigation	12.9	22.1	65.0
Udaipur	OPD Ticket	8.8	37.8	53.5
	IPD admission	8.8	37.0	54.2
	Investigation	8.6	31.9	59.5
Total	OPD Ticket	42.8	25.9	31.3
	IPD admission	36.5	26.6	36.9
	Investigation	31.6	21.2	47.3

During the household survey covering 1951 respondents in all the 6 districts, a viewpoint was taken on the institutionalization of user charges in public health facilities. For OPD charges 42.8% of the responding cohort felt comfortable while another 31.3% rejected the idea of subjecting the OPD registration to a fee. 47.3% did not agree that investigations should be charged for while 36.9% vocalized that IPD admission charges should be scrapped off.

In response to the question "do you get the medicine from facility", only 50% had positive experience; and this is in line with the observations of "Patient Satisfaction Report" by Hospi Health Consultants India, Mumbai. That is where the expectations cannot be matched on account of shrinking health care budgets as percentage of total plan outlay. The national health accounts also cannot support it.

Table H-22: Availability of free medicines at the facility

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%
Yes	157	58.1	85	40.5	338	61.7	159	63.3	79	32.9	159	36.8	977	50.1
No	113	41.9	125	59.5	210	38.3	92	36.7	161	67.1	273	63.2	974	49.9
Total	270	100.0	210	100.0	548	100.0	251	100.0	240	100.0	432	100.0	1951	100.0

81.4% of the respondents said that they did not pay a single penny during their stay at any of the facility and another 18.6% who did pay, paid for food, transport and accommodation besides some medicines and booked all these under the expenditure made for treatment.

Table H-23: Payment made for treatment during stay at the facility

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%
Yes	21	7.8	105	50.0	87	15.9	37	14.7	27	11.3	86	19.9	363	18.6
No	249	92.2	105	50.0	461	84.2	214	85.3	213	88.7	346	80.1	1588	81.4
Total	270	100.0	210	100.0	548	100.0	251	100.0	240	100.0	432	100.0	1951	100.0

The behavior of facility staff particularly the doctors on issues like listening, counseling and explaining was rated as "good" by 83.6% of the respondents. These figures have a 3% dip when

compared to the findings from exit interviews in the same study, but is still higher than the findings of "Patient Satisfaction Report" referred in the present study.

Table H-24: Behavior of staff

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
Doctor	No	%	No	%	No	%	No	%	No	%	No	%	No	%
a. Listening	184	68.1	200	95.2	451	82.3	223	88.8	209	87.1	365	84.5	1632	83.6
b. Counseling	186	68.9	100	47.6	182	33.2	194	77.3	204	85.0	280	64.8	1146	58.7
c. Explaining	165	61.1	122	58.1	368	67.2	200	79.7	199	82.9	207	41.9	1261	64.6
Nurses														
a. Listening	191	70.7	197	93.8	393	71.7	238	94.8	211	87.9	364	84.3	1594	81.7
b. Counseling	175	64.8	91	43.3	151	27.6	200	79.7	192	80.0	267	61.8	1076	55.2
c. Explaining	146	54.1	147	70.0	269	49.1	197	78.5	178	74.2	156	36.1	1093	56.0
d. Attending	161	59.6	173	82.4	269	49.1	215	85.7	212	88.3	342	79.2	1372	70.3
Ancillary staff														
a. Listening	121	44.8	142	67.6	381	69.5	197	78.5	155	64.6	125	28.9	1121	57.5
b. Attending	135	50.0	132	62.9	172	31.4	171	68.1	175	72.9	204	47.2	989	50.7
c. Helping	129	47.8	134	78.1	172	31.4	212	84.5	179	74.6	127	29.4	983	50.4
Total	270	100.0	210	100.0	548	100.0	251	100.0	240	100.0	432	100.0	1951	100.0

As far as investigation are concerned only 52.8% of the respondents were prescribed investigations, and that is where Indian practitioners, who believe that the important part of stethoscope is the one which lies between two ear pieces, score over others, and these findings validate it to a large extent. The Cassandra may think otherwise, "facility is not equipped, so investigations not prescribed"; for so long as respondents are happy there is no point to debate.

Table H-25: Investigations prescribed

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%
Yes	123	45.6	168	80.0	266	48.5	117	46.6	123	51.3	233	53.9	1030	52.8
No	147	54.4	42	20.0	282	51.5	134	53.4	117	48.8	199	46.1	931	47.2
Total	270	100.0	210	100.0	548	100.0	251	100.0	240	100.0	432	100.0	1951	100.0

Of those who were subjected to investigations (1030) only 30.9% had to have it from the market. Could be because the test was relatively advanced, doctor was abreast with advances, or the respondents belonged to APL category who could afford. These are all probable explanations as further probing into were not included in the scope of work for the study team.

Table H-26: Investigations at the facility

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%
Yes	101	82.1	71	42.3	189	71.1	97	82.9	98	79.7	156	67.0	712	69.1
No	22	17.9	97	57.7	77	28.9	20	17.1	25	20.3	77	33.0	318	30.9
Total	123	100.0	168	100.0	266	100.0	117	100.0	123	100.0	233	100.0	1030	100.0

For the 712 respondents who had the investigations done at the facility, 61.7% got their reports on the very same day, 23.9% on next day and 15.7% had to wait for more than three days. This could be justified as some of the investigations related to microbiology and histopathology take little longer for the process.

Table H-27: Report of investigation

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%
Same day	87	86.1	19	26.4	111	85.7	60	61.9	55	56.1	100	64.1	432	61.7
Next day	12	11.9	10	13.9	60	31.1	22	22.7	31	31.6	36	23.1	170	23.9
After 3 days	2	2.0	34	47.2	14	7.4	14	14.4	9	9.2	18	11.5	89	12.5
After 7 days	0	0.0	9	12.5	4	2.1	4	4.1	3	3.1	2	1.3	23	3.2
Total	101	100.0	72	100.0	189	100.0	97	100.0	98	100.0	156	100.0	712	100.0

To support timely referrals, mobility means are a must. The presence of an ambulance at the facility was witnessed by 59.7% of the respondents and of those who certified 10.2% had an opportunity to use it. Further 59.7% of those who used the ambulance services did pay for it. 50% of them did pay more than Rs.200 for ambulance services.

Table H-28: Availability of ambulance at facility

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%
Yes	125	46.3	160	76.2	396	72.3	89	35.5	150	62.5	244	58.5	1164	59.7
No	145	53.7	50	23.8	152	27.7	162	64.5	90	37.5	188	43.5	787	40.3
Total	270	100.0	210	100.0	548	100.0	251	100.0	240	100.0	432	100.0	1951	100.0

Table H-29: Use of ambulance

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%
Yes	12	9.6	18	11.3	55	13.9	6	6.7	10	6.7	18	7.4	119	10.2
No	113	90.4	142	88.8	341	86.1	83	93.3	140	93.3	226	92.6	1045	89.8
Total	125	100.0	160	100.0	396	100.0	89	100.0	150	100.0	244	100.0	1164	100.0

Table H-30: Payment for ambulance services used

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%
Yes	2	16.7	11	61.1	41	80.0	1	16.7	3	30.0	10	55.6	71	59.7
No	10	83.3	7	38.9	11	20.0	5	83.3	7	70.0	8	44.4	48	40.3
Total	12	100.0	18	100.0	55	100.0	6	100.0	10	100.0	18	100.0	119	100.0

Table H-31: Amount paid for ambulance

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%
<100	0	0.0	1	9.1	3	6.8	0	0.0	0	0.0	4	40.0	8	11.3
100-200	1	50.0	5	45.5	14	31.8	0	0.0	2	66.6	5	50.0	27	38.0
>200	1	50.0	5	45.5	27	61.4	1	100.0	1	33.3	1	10.0	36	50.7
Total	2	100.0	11	100.0	44	100.0	1	100.0	3	100.0	10	100.0	71	100.0

By and large, most of the households (81.4%) felt satisfied by the services as they said that they will recommend it to others. The reasons accorded to this are mentioned as availability of staff

(84.5%), cleanliness (67.7%), cost (79.2%) and staff behavior (56%). The overall satisfaction level figures are lower than what is reported in "Patient Satisfaction Report" (96%).

Table H-32: Recommend hospital to family & friends

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%
Yes	224	83.0	189	90.0	389	71.0	234	93.2	208	86.7	345	79.9	1589	81.4
No	46	17.0	21	10.0	159	29.0	17	6.8	32	13.3	87	20.1	362	18.6
Total	270	100.0	210	100.0	548	100.0	251	100.0	240	100.0	432	100.0	1951	100.0

Table H-33: Reasons for recommending

	Banswara		Baran		Chittorgarh		Dungarpur		Sirohi		Udaipur		Tribal Districts	
	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%
Availability of doctor/staff	173	77.2	162	85.7	362	931	209	89.3	184	88.5	253	73.3	1343	84.5
Rapid cure	72	32.1	14	7.4	188	48.3	144	65.1	122	58.7	212	61.4	752	47.3
Medicines are freely available	96	42.9	65	34.4	238	61.2	162	69.2	65	31.3	98	28.4	724	45.6
Cleanliness	135	60.3	127	67.2	258	66.3	178	76.1	150	72.1	196	56.8	1044	65.7
Diagnostic services	77	34.4	34	18.0	56	14.4	100	42.7	109	52.4	141	40.9	517	32.5
Inexpensive	177	79.0	180	95.2	292	75.1	211	90.2	200	96.2	198	57.4	1258	79.2
Good behavior of the staff	92	41.1	46	24.3	203	52.2	200	85.5	153	73.6	195	56.5	889	55.9
Total	224	100.0	189	100.0	389	100.0	251	100.0	240	100.0	432	100.0	1951	100.0

Table H-34: Changes observed in service delivery in last 5 years

Districts	Changes observed	HH Interviewed	Free medicines	Availability of doctor/staffs	Cleanliness	Diagnostic services	Behavior of the staff
Banswara	Improved	N =270	140 (51.9)	178 (65.9)	213 (78.9)	161 (59.6)	202 (74.8)
	Same		110 (40.7)	61 (22.6)	33 (12.2)	80 (29.6)	46 (17.0)
	Deteriorated		20 (7.4)	31 (11.5)	24 (8.9)	29 (10.7)	22 (8.2)
Baran	Improved	N =210	83 (39.5)	97 (42.6)	124 (59.0)	51 (24.3)	52 (24.8)
	Same		81 (38.6)	97 (42.6)	70 (33.3)	135 (64.3)	142 (67.6)
	Deteriorated		46 (21.9)	16 (7.6)	16 (7.6)	24 (11.4)	16 (7.6)
Chittorgarh	Improved	N=548	269 (49.1)	185 (33.3)	229 (41.8)	100 (18.2)	219 (40)
	Same		223 (40.7)	273 (49.8)	284 (51.8)	321 (58.6)	267 (48.7)
	Deteriorated		56 (10.2)	90 (16.4)	35 (6.4)	127 (23.2)	62 (11.3)
Dungarpur	Improved	N=251	121 (48.2)	139 (55.4)	173 (68.9)	104 (41.4)	161 (64.1)
	Same		113 (45.0)	104 (41.4)	61 (24.3)	131 (52.2)	85 (33.9)
	Deteriorated		17 (6.8)	8 (3.2)	17 (6.8)	16 (6.4)	5 (2)
Sirohi	Improved	N=240	86 (35.8)	162 (67.5)	178 (74.2)	132 (55)	171 (71.3)
	Same		140 (58.3)	74 (30.8)	59 (24.6)	103 (42.9)	61 (25.4)
	Deteriorated		14 (5.8)	4 (1.7)	3 (1.3)	5 (2.1)	8 (3.3)
Udaipur	Improved	N=432	105 (24.3)	150 (34.7)	218 (50.5)	164 (38)	174 (40.3)
	Same		196 (45.4)	179 (41.4)	164 (38)	190 (44)	198 (45.8)
	Deteriorated		131 (30.3)	103 (23.8)	50 (11.6)	78 (18.1)	60 (13.9)
Tribal Districts	Improved	N=1951	804 (41.2)	911 (46.7)	1135 (58.2)	712 (36.5)	979 (50.2)
	Same		863 (44.2)	788 (40.4)	671 (34.4)	960 (49.2)	799 (41)
	Deteriorated		284 (14.6)	252 (12.9)	145 (7.4)	279 (14.3)	173 (8.9)

Focus Group Discussions

Focus Group Discussions:

In all, 38 FGDs were held in 6 Tribal Districts with 10-15 participants between 20-55 years of age group. The heterogeneous group had participants from APL/BPL, SC/ST/OBC/General, and both the sexes. Majority were farmers with a few students, youth leaders, PRI members, ASHA, ANM, AWW and some shopkeepers.

The convergence areas for FGD were –

1. Facilities in the Facility
2. RCH camps, and
3. VCD

For the facility, service availability, staff presence & behavior, medicines, investigation, ambulance services, distance, referral and satisfaction level of the users were the key issues asked to be opined on by the participants.

Referring to RCH camps, the FGD facilitator touched upon areas like knowledge and information about camps, services at camp, drugs & Investigation and follow up.

Similarly, issues like knowledge, duration, frequency, activities and impact; were discussed during VCD.

Astonishingly, the participants waylaid and pulverized the set of positive observations that we had so far, from the study.

Why do people come to facility?

The question was responded with expected responses that are epidemiologically valid and indicate at the major burden of disease. Fever, malaria, cough & cold, diarrhea & dehydration, pain abdomen, vomiting, asthma, tuberculosis, pneumonia, joint pains, agricultural injuries; in general

were the conditions enlisted. The cohort at Banswara, Sirohi and Dungarpur also added STI/RTI to the list.

Surprisingly, pregnancy, labor, vaccination and contraception were not mentioned by any one. The only possibility is that the question hinted only at Disease and people have a fair understanding that these are not diseases.

Whom do they prefer for seeking Health care/ Treatment?

The responses rambled across Districts and were dictated by nature of illness (acute/chronic, routine/ emergency), time when illness gets attention (Day/ Night), service availability, distance, cost, service range, and staff behavior.

It was made explicitly clear by entire universe across all districts, by and large, that they prefer to visit the closest facility/service provider be it Govt./Private or even a Traditional healer. This simply means people have started valuing health and are willing to pay. That was the premise from where "user charge" concept under RMRS emanated and stays firmly grounded, hitherto. On the other hand the opinion expressed on user charges by the Household interviewed, asks to shelve the interpretation.

FGD participants from Baran, however, opted only for Private Hospital/ Practitioner which according to them is cheap as the charges for dispensed drugs are "inbuilt" and not separately charged.

For snake/ scorpion bite, the preference vote went to Traditional Healers.

Besides Baran, people prefer a Public Facility for seeking health care for staff availability, free drugs, investigation facility, skilled doctor, and for delivery. However, in Baran also Govt. facilities are preferred for delivery for the cash subsidy under JSY. Responses at Chittorgarh were a little mixed up; some said they prefer Private hospitals for good treatment and staff behavior while others favored the Govt. facility.

The tribal group in the cohort is the henchmen of traditional healers particularly in Udaipur and Banswara.

A concern that was raised unequivocally relates to free Drugs to BPL. BPL in Udaipur, Chittorgarh, and Baran district do not get free medicines regularly, while BPL from Sirohi, Dungarpur and Banswara said they almost get all the drugs from facility as "free" and it is only sometimes that they had to buy from market.

Cash benefits attached to JSY and Sterilization are almost universally known and availed too.

The referrals are not properly received was the observation at Udaipur. For the same, referred cases at Chittorgarh prefer to go to private hospitals.

Once again, but for Baran, staff behavior was rated good.

Presence of "108" was witnessed at Udaipur and Sirohi and was appreciated by discussants.

The improvements in infrastructure, services, drugs & diagnostics, behavior, cleanliness and facility as such are well perceived. The presence of ASHA, AWW and ANM also is endorsed universally by the FGD participants.

On account of increasing expectations and demands, problems shall continue to habitat sometimes as tangibles and at times feigned.

Common problems enlisted during FGD are, non availability of female doctor, non availability of beds, oxygen, doctor not available full time, lack of transportation facility, fresh BPL card are not made, costly medicines to be purchased from market (Udaipur); absence of doctors, poor diagnostic facility, no ambulance facility (Chittorgarh); unavailability of doctor and staff, poor toilets, no medicine for BPL patients (Baran); problem of transport, cost of treatment (Dungarpur);and shortage of medicines, near expiry medicines, ambulance available but not provided, poor diagnostics (Banswara). Majority of these are genuine and can be easily resolved with minimal cost to the project.

RCH camp

At Sirohi, Baran, Dungarpur and Udaipur; people from villages close to PHC knew about RCH camps but "C" category village inhabitants were unaware of such activity.

People know that besides treatment for common ailments, specialist's services are there; still they do not come to camps regularly, as they feel that camps are not the solutions since follow up camps are not held on a regular basis. The solution according to the cohort members is Mobile Medical Units that can visit on a weekly basis at a fixed place which initially if well publicized will not ask for the drill to be repeated every time.

VCD:

VCDs, which were taken up in 4 blocks of 4 Districts, covering 100 villages in each block through selected NGOS, aimed that the information about services and schemes should cascade down to the remotest village. In Udaipur and Sirohi, the FGD participants knew about VCD, the activities like nukkad natak, house to house visits, distribution of pamphlets, puppet show and village meetings and the issues discussed during VCD (cleanliness, FP & other diseases).

Discussants at Chittorgarh and Sirohi had no idea about VCD, while at Dungarpur, very few knew about VCD.

The human memory is often short-lived and the recall goes with strong punctuation on account of time lost down the memory lane. It would be pertinent here to recapitulate that the VCD activity was taken up almost three years back and the same might have betrayed the memory of FGD discussants. Moreover, the participant's cohort today may not have matched those who were there three years back. Just a point in case, the officials at RHSDP even had to stir their grey cells to recall the events in the past. With these limitations the findings of FGD related to VCD, need to be carefully interpreted.

Recommendations

Recommendations:

For years the marginalized population particularly the tribal, have been forced to sit at the fence of the system, particularly, the health care delivery system. The situation is all the more grim under impoverished economy, inaccessible terrain and traditional beliefs & customs. The poor health status (IMR, MMR & TFR) complemented by a meager purchasing power, lack of awareness have further restricted them to avail the health care.

A strategic approach coined as Tribal Development Plan was expected to address the issues of access and equity, in general. The study conducted by SIHFW for RHSDP to evaluate the implementation of tribal health care strategy with special focus on –

1. Assessment of health facilities in relation to the environment, infrastructure, services, charges, Supplies, trainings and staff attitude;
2. VCDs that aimed to increase awareness and ultimately utilization; The VCD were conducted only for a small population under the project and that too focused to main villages rather than reaching out to remote areas. That is why only 29% people knew about. We feel that a well planned VCD with a deep reach and more frequent approach it shall be able to deliver the desired. May be it proves to be a fiasco but then still it deserves a fair try.
3. RCH camps to address accessibility;

has come out with some startling and undeniable observations, which are the basis of these recommendations:

We feel, that these can be accomplished, provided concerted efforts with dogged determination are put in place; within next twelve months.

1. The areas like increasing the number of cash counters, display of essential drug list & the list of categories who are entitled for free treatment, should be addressed at the earliest.

2. The facilities which have a sizeable work load should, under relocation, get these specialists, the posting of which should conform to the facilities and equipments already available. This would help in churning out the maximum benefits from the skilled and specialized manpower besides rationalizing the hard inputs. We need to simply relocate the specialists. This explicitly means that the investments so far made shall not stay wasted for want of skilled man power and as a priority let us first match the available skilled manpower with the resources that have been created under the Project or by the system

3. Patient counselors who have a vital role should be an integral part of the facility. The system should ensure that they are placed at its earliest in view of the time constraint and the work load faced by direct care providers (only 15 facilities have Patient Counselors at present). The understanding is that there are just two more facilities left as on August 15th, 2009. The need is to have patient counselors at all the facilities, 30 bedded and above in tribal areas.

4. At a sizeable number of centers mundane provisions like, screens and curtains for privacy, wash basins with running water, exhaust fans in the toilets, toilets attached to labor room, windows and ventilation in the wards should be immediately installed. These thrifty interventions will certainly address to quality, aesthetics and infection control. This is where the civil wing has to wield.

5. With just 60% facilities having nursing stations, creation of a nursing station should be one of the priorities that should be antecedent to care.

6. BCC training which hitherto was restricted to only Chittorgarh and Dungarpur henceforth should be taken up in all the districts.

7. The soft component of HMIS has to be further strengthened with special reference to storage, retrievability and its application in decision making. This is where all the study facilities scored the least.

8. CHCs and FRUs to be strengthened either by relocation of staff and equipment or creation of posts (in conformance to IPHS standards) to reduce the referrals besides avoiding the loss of critical time (71% of the CHCs had no specialists).

9. Popularizing government schemes in relation to JSY and MMJRK should be emphasized particularly during VCDs.The patient counselors could be one of the ways but then not all patients do avail services of counselors and while in facility patients and attendants are more receptive to advice on their ailment rather than schemes

10. Contract hiring of specialists has emerged out to be a big limiting factor on account of poor compensatory mechanism. The incentives need to be little more rationalized for luring the qualified private practitioners; the issue requires address at policy level.

11. Training of community based functionaries, envisaged earlier in the TDP along with the orientation of traditional practitioners should be taken up immediately which would cut down the work load of health facilities besides facilitating timely referrals in case of emergency.

12. Service delivery component should be shouldered by system and NGOs should be assigned demand generation (this is prompted out of the observations on VCD and the opinion expressed during FGD) and VCDs should be more frequent and focused.

13. Generic drugs should be made available and the essential drug list should be re-casted to maximize the effectiveness of inputs besides increasing the dispensing capacity particularly to BPL.

14. More of the services should be brought under the domain of user chargers. However, the revenue so collected should be ploughed back to address “availability” and “quality”.

15. A strong referral system should be evolved and down referrals be addressed unequivocally. This draws the substance from the findings of the FGD and the responses from exit interviews as well as household survey where people for their referrals not being honored have preferred to go to a private practitioner.

16. RCH camps should be supplemented by services through Mobile Medical Units as it is virtually impossible to have a follow up mechanism only through a camp approach. The MMU should visit the area where a camp was held within the next seven days with detail record of camp beneficiaries to facilitate follow up.

17. The focus areas for RCH camps should be Category “C” villages to increase the reach of service delivery in tribal areas.

18. The sustainability of the efforts and the achievement thereof, after the Project is over has to be taken over by the system.