Summer Training at

Assessment of CM free Medicine Scheme in Chittorgarh District

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

Institute of Health Management Research,
Jaipur
2012

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CERTIFICATE

This is to certify that Mr. Kshitiz Sisodia has undergone summer training in Prayas, Jaipur from 9th April to 1st June, 2012

The candidate carried out all the studies related to summer training himself. His approach to the studies has been sincere, scientific, and analytical. This summer training in partial fulfillment of the course requirement is recommended for the award of Post Graduate Diploma in Hospital & Health Management.

I wish him success in all future endeavors.

Dr .P. R.Sodani

(Dean Academics and Student Affairs)

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Index

Abbreviations Used

1. DTCA - Direst to-consumer advertising
2. SPSS - Statistical Packet for Social Sciences
3. O.P.D - Outdoor Patient Department
4. I.P.D - Indoor Patient Department
5. PHC - Primary Health Center
6. CHC - Community Health Center
7. SC - Sub-Center/ Schedule Caste
8. DH - District Hospital
9. ST- Schedule Tribe
10. OBC- Other Backward Castes
11. DDC- Drug Distribution Center
12. HMIS- Health Management Information System
13. RMSC- Rajasthan Medical Services Cooperation

LIST OF TABLES, GRAPHS & FIGURES

About the Organization

Prayas (Endeavour) is a voluntary organization working for social, political and economic development in Chittorgarh district of Southern Rajasthan. Established in 1979, Prayas, as its name suggests, is distinguished primarily by its evolving orientation. It has taken up many kinds of issues and undertaken a variety of projects with several, sometimes divergent approaches. The unity that underlines this diversity has been provided by Prayas`pro-people and pro-empowerment orientation, continuous effort to respond to people`s voices and changing circumstances, and the priority given to concrete experience over conceived theory or received dogma. Over its more than two decades, Prayas has been characterised by creative efforts and experimental, open-ended attitudes. Diverse adventures and turbulent events, therefore, have filled these years

Centre for Health Equity

During the end of 2005, Prayas set up an advocacy and research unit in Jaipur called Centre for Health Equity. This centre carries out equity related research in health systems and engages in various legislative and executive advocacy. It serves as secretariat for some campaigns viz. against pre-birth elimination of girl children, coercive population control measures, access to treatment, quality assurance in health services and to have a state health policy. The centre has been working on creating evidence based research, action and policy advocacy on different dimensions of health and health inequities in local, regional and national context. In past sometime it has been actively involved in advocacy campaign and collective action against the problem of sex selection in Rajasthan and in different parts of the country. It has been leading and hosting the secretariat for state level campaign against sex selection and declining sex ratio in Rajasthan. This centre also publishes newsletters to feature contemporary health issues

Centre for Labour Research & Action

Prayas Centre for Labor Research and Action is a unit of Prayas that works with workers in unorganized sector. The Centre anchors a multi state and multiple partner initiative that seeks to organize vast mass of workers in the unorganized sector in the state of Gujarat. The Centre is currently working in the work streams of cottonseed production, brick kilns, cotton ginning factories, and construction. Majority of the workforce in these streams comprises of seasonal migrants who come from the tribal pockets of Gujarat and from neighboring state of Rajasthan, Chhattisgarh, UP, and MP. The Centre also works in the source areas from where workers come. It has field presence in all the states from where seasonal migrants are coming. Prayas Centre began working in Gujarat in the year 2006 when it started work with seasonal tribal migrants from South Rajasthan working in cottonseed production. It also works with the local workers mainly in cotton ginning mills, and construction work. Its philosophy and approach is to create a supportive environment for setting up and strengthening workers` organizations/Unions. The Centre has promoted a number of Unions viz. Dakshini Rajasthan Majdoor Union, Int Bhatta Majdoor Union**,** Gujarat Ginning and Other Mill Workers Union, and Majdoor Adhikar Manch. The Unions have led struggles for higher wages and better work conditions. The workers' struggles over the last four years have led to significant wage hikes in cottonseed production and brick kilns – resulting in additional payments of millions of rupees in wages.

Policy advocacy with the Government is a key component of Centre's work. The Centre has good credibility with the Government. It has given memorandum on key issues related to workers' welfare. Prayas Centre has organized public hearings, seminars and symposium with active support of the State and Central Government and statutory bodies, and multi stakeholder participation on the issues of child labour in Bt Cottonseed farms, cotton ginning factories and other sectors of work in Gujarat and Rajasthan, and on the issues of brick kiln workers. Centre's efforts have led to evolution of anti child trafficking administrative apparatus in the states of Guijarat and Rajasthan. The Union promoted by the Centre is a member of the Task Forces set up to prevent child labor in the state of Rajasthan. The Centre is set up as a separate Unit within Prayas with substantial financial and administrative autonomy.

EXECUTIVE SUMMARY

Building up a system of Citizen based monitoring of Health Services in the state was the major task after the government of Rajasthan announced the scheme of free distribution of medicines. Questionnaires were prepared, one for patients or the beneficiary's interview, second was prepared to interview hospital authorities at the medicine distribution centre. The questionnaires were field tested in Chittorgarh block (15 Centers and 81 patients) and records were maintained.

When the results were analyzed the findings were:

- Only 64% people were aware about the scheme. The essential medicines mentioned in the list were not available at medicine distribution centre because of which patients could not get all the prescribed medicines free of cost from the government distribution centre,
- Only 65% medicines were available at one time of the total prescribed medicine to a patient, and thus, patients had to purchase it from the outside medical shop for which they had to pay a lot more.
- Perception that low cost medicines are ineffective and duplicate. Strongly believed in both urban and rural parts.

A summary sheet was also prepared to document the results of the two questionnaires. It was also recommended that more awareness should be spread about the scheme by the way of lectures in schools, kala jattha etc. The survey data is depicted through pie charts with inferences. Then findings and recommendations are followed by annexures of the checklists and other necessary attachments.

BACKGROUND

The Indian economy has done well in recent years. The average rate of growth of the economy in the last five years has been 8.5 per cent. During the three year period 2005-06 to 2007-08, the annual growth rate exceeded 9 per cent. But the feel good factor is still lacking. Despite high growth rate millions of Indians are bearing the brunt of poverty. India markedly registered high GDP in recent years but laggard behind in reducing underweight children, decreasing maternal mortality Millions of Indians are under BPL category and do not have access to barest needs of day to today life. So there is an urgent to rectify the situation. What India needs is inclusive growth.

Inclusive growth as you all know is an attempt to bridge the various divides in an economy and society, between the rich and the poor, between the rural and urban populace, and between one region and another. That is a formidable task. The process of growth has to be such that all sections of society benefit from the growth process and that is the essence of inclusive growth. The task ahead of India is to sustain the present level of growth if not accelerate it to higher levels. India needs to translate growth into poverty reducing growth, a process of growth to which the poor can contribute and from which the poor can also benefit.

One aspect of inclusive growth is financial inclusion. Financial inclusion can be defined as the delivery of credit and other financial services at an affordable cost or free of cost to the vast sections of the disadvantaged and low income groups. The various financial services include savings, credit, insurance and payments and remittance facilities. Schemes like RSBY; Rajiv Aarogyasri has covered lot many people since the inception. But many are left to come under such umbrellas. So meanwhile we can help poor by reducing their burden through financial inclusion. One such financial service can be free medicines made available to poor section of India.

Promoting 'Health for all' Government of Rajasthan on 2nd October 2011 introduced a new scheme named "Chief Ministers free medicine distribution scheme" in which around 400 necessary medicines will be available free of cost at medicine distribution centers at the hospital. Being a developing country India is bearing the brunt of double burden of diseases. More badly, resources are restricted to richer sections of the society but diseases not. So this scheme could be proved as a boon to rural India as Healthcare expenditure is the second greatest cause of rural indebtedness in India today. As of 2008, 72% of total healthcare expenditure was privately funded, 89.5% of which was paid out of pocket by patients. In year of 1999-2000, 32.5 million patients fell below poverty line after a single hospitalization. WHO estimates that 65% of Indian population lack access to essential medicines.

The cost of medicines is one of the main factors contributing to the breach of human dignity. Medicines account for 70% of out-of-pocket expenditure. Though patients receive free check-up at government hospitals but they have to purchase medicines from local chemist as government medicines centers always run short of essential medicines. And at local chemist they have to pay two to forty times more the cost as compare to govt. medicines centers.

INTRODUCTION

The goal of medicine as a profession dedicated to healing and caring of the sick in a dignified manner depend very much on a stable and trusting doctor-patient relationship. A patient comes to a doctor with trust to act best in interest of their patients. But they are unaware of the fact that the doctors will act best on interest of themselves, not their patients. Doctors make most of this ignorance on patient side. To earn favor from Pharma companies they prescribe medicines up to the eyeballs of patients which they do not need, at the prices they even need much less.

Indian Pharmaceutical Industry is one of the most vibrant sectors of Indian Industry. It has been growing at the rate of 11-12%. It is the 3rd largest in the world by volume and 13th in value. It is 8% of global production and 2% of world pharma market. The estimated worth of the Indian Pharmaceutical Industry is US$ 6 billion and by 2015 it is going to be worth of US$ 20 billion. Pharma industry plays a major role in high GDP of India. Pharma companies spend heavily on marketing of drugs. Though direst to-consumer advertising (DTCA) is banned their primary targets are medicine professional for promoting their sales.

On patient's side, their prevailed many myths like costly medicines are much effective, medicines at government stores are not good and unaware of the difference between generic and branded medicines.

Generic verses branded medicines:
When a company launched a new drug in the market, it is marketed and sold under its brand name and company got a patent on the brand name of the drug. After the patent period expires, other pharma companies can produce their own generic version of the medicine. Thus a generic version is out of patent. Generics can be marketed under an agreed international name –not owned by anybody. There are no therapeutic differences between generic and branded medicines.

The unscrupulous behavior of doctors and unregulated marketing by pharma companies are the result of loose reigns of Indian government. Regulatory authorities in India are slow to protect consumers from drugs that have been banned, withdrawn, or marketed under restrictions in North America, Europe, and many other Asian countries. For example, Rofecoxib, the internationally recalled antiarthritis drug sold by Merck & Co. as Vioxx, Ceoxx and Ceeoxx, was among some of the controversial drugs available in the domestic market in 2005.8 the drug was officially banned in India, in October 2004, a month after Merck recall.

Cost of access to medicines:
No doubt pharma companies exercised a significant role through R&D and employ drugs to fatal ailments. There are drugs to cure almost every disease. Pharma companies spent huge money in developing new drugs. They reimburse the spent money by charging high prices for the drug under the patent period. As patent period expire other companies are allowed to produce a generic version of the drug which can be available at low prices in market. But the companies who produce the drug slightly modify the medicine which add minimal or no therapeutic value and try to gain a patent for another 20 years on new drug. This is called 'ever greening'. This practice is harmful for as cost to access that medicine is again very high. Drugs are available but cannot be accessed due to high cost by poor patients.

RATIONALE

To orient members of civil society organizations about the basic concept of right to free treatment and its significance in context of right to health and universal access to health care and to subsequently prepare and organize them for setting up systems of citizen based monitoring to ensure that free medicines are available to all as a matter of their right.
It is a Citizen-based monitoring system to sustain and strengthen chief minister free medicine scheme, which will keep a check on the proper implementation of the scheme.
Study has done to identify the gaps in the planning and actual implementation. Purpose of the study is to provide a regular feedback about the scheme. It is an independent non-biased assessment through a civil society organization. This study will help to make decisions for amelioration of the scheme. The scheme needs to be monitored in order to know the barriers and bottlenecks in the scheme which hinders the scheme's proper implementation.

METHODOLOGY

- It is a descriptive study to define the current scenario of the scheme. This study is done to ensure the efficient distribution of medicine, it has done to make sure that people are getting the free medicines from the govt. medicine stores or still they have to pay for the medicines.

Tools & Techniques- A monitoring tool was designed to keep track of the progress of the scheme, two questionnaires were developed, one for the beneficiary's (demand side) and the other for the hospital authorities at the medicine distribution centre (supply side) and then an analysis sheet was prepared to document the findings.

(i) Demand side- This questionnaire gives the data for awareness among the people, availability of medicine and grievance redressal by direct interview.
(ii) Supply side- This Questionnaire gives the data for the availability of drugs in the store, drug warehousing facility, drug distribution facility, record maintenance and final results of the scheme by direct interview.

- Sample Size- (100 demand side and 14 supply side) Purposive Sampling
- Tool for analysis- SPSS is the only tool used for analysis in the study.

Scope of the Project

Chittorgarh Block was chosen as the area for the project and field testing. In Chittorgarh block, visit to several hospitals were made and data was collected from the patients and the Hospital Drug Distribution Centre.

Patients coming out of the O.P.D. section from the above mentioned health centers were interviewed about the:

- awareness about the free medicine scheme,
- how much time did it take to get the free medicines
- quantity of medicines freely available,
- money spent in buying unavailable medicines,
- Asked to give their opinion about the current scheme and the generic drugs.

Besides this, the stocks of the medical centre were checked in terms of the number of free medicines available, lag in supply of medicines, maintaining record in outgoing stock registers, condition of store rooms, etc. Number of patients during October-November for 2010 and 2011were also recorded to compare the change in patient load after the initiation of this scheme.

Profile of the respondent

Sex (Table-1)

Sex	Frequency	Percent
MALE	47	47.0
FEMALE	53	53.0

Out of total respondent, (i.e. 100), 47 were males and 53 were females. So the study will more or less give the depiction of both the genders. Out of total number of respondents, male and female are approximately same in number that will help our study to make accurate inferences for both the genders.

Type of Health facility

Type of Health facility	Frequency	Percent
PHC	30	30.0
CHC	50	50.0
SC	4	3.0
DH	16	15.0
Total	100	100.0

Out of total people probed, 80% people were probed in PHC and CHC together, while SC and DH consists just 20% of it. This shows that the interpretation we will make, give us more insight of CHC and PHC rather than other two health facilities.

Category (Table-3)

	Frequency	Percent
GENERAL	35	35.0
SC	8	8.0
ST	15	15.0
OBC	42	42.0
Total	100	100.0

Out of total respondents, the category of the people probed majorly consists of general and OBC category, so the data might be inclined a little towards both these category. 77% of population consists of these two categories; rest 23% consists of the other categories.

FINDINGS ON DEMAND SIDE

Category-wise awareness about the scheme (Table-4)

CATEGORY	UNAWARE	AWARE
GENERAL	23%	77%
SC	43%	57%
ST	47%	53%
OBC	41%	59%

From the above table it can be implied that general category people are more aware than the other categories people. It means that still dissemination of information needs to be done among the people in the given area.

Sex-wise awareness about the scheme (Table-5)

SEX	UNAWARE	AWARE
MALE	23%	77%
FEMALE	47%	53%

This can be interpreted from the data that males are much more aware than the female population, since they are more exposed to the external environment and on the other hand females are not exposed to the external environment as compared to males.

Awareness spread by media among the masses (Table-6)

MEDIA	AWARE	PERCENTAGE
TV	17	27%
OTHERS	2	3%
NEWSPAPER	16	25%
POSTER	6	9%
HEALTH WORKER	20	31%
PAMPHLATE	1	2%
FRIEND	2	3%
Total	**64**	**100%**

Above table deduces that the most common and effective medias to communicate and disseminate the information in the given area are Television, newspaper & health worker.

Awareness spread by media sex-wise (Table-7)

MEDIA	SEX	
	MALE	FEMALE
TELEVISION	33%	18%
RADIO	0%	0%
NEWSPAPER	25%	25%
POSTER	11%	7%
HEALTH WORKER	31%	32%
PAMPHLET	0%	4%
FRIEND	0%	7%
FAMILY MEMBER/RELATIVE	0%	0%
HOARDING/BANNER	0%	0%
OTHERS	0%	7%

In the above table it is quite evident that heath workers are playing quite an important role in disseminating the information about the scheme, newspapers is the source which is commonly prevalent between both the sexes. Apart from these sources, television is also a big source of information, especially for males. Pamphlet, friends and posters are the other sources which are contributing to disseminate the information in the given area.

Getting free medicines (Table-8)

Getting free medicines	Frequency	Percent
<50% FREE	17	17.0
>50% FREE	11	11.0
>75%FREE	7	7.0
100% FREE	65	65.0
Total	100	100.0

It is revealed from the table above that 35% of people are not getting their medicines for free, so there are some loopholes in the system which is hindering the distribution of the free medicines, there might be several reasons like doctors not writing generic medicines, inadequate supply of medicine in comparison of demand etc.

FINDINGS ON SUPPLY SIDE

1. Availability of Medicine

Total Availability of Medicine (Table-9)

Type of Health Facility	Total Availability of Medicine			Total
	>50% available	>75% available	100% available	
PHC	1	2	4	7
CHC	1	4	1	6

From the above mentioned data and diagram, it is quite clear that availability of medicine in PHC is better than CHC; apart from it there are still some health facilities where availability of medicines is even lower than 50%. That is one of the big reasons that people have to buy the medicines from the private stores on very high rates.

Days taken to make the medicines available (Table-10)

Type of Health Facility	Days taken to make the medicines available				Total
	more than 7 Days	6-7 days	4-5 days	1-3 days	
PHC	0	0	1	6	7
CHC	2	1	2	1	6

Days taken to make the medicines available (FIGURE-10)

The above mentioned information clearly implicates that days taken to make the medicine available are much higher in PHCs than CHC, the reason maybe because of the fact that CHCs has much more patients than PHCs, so the preference is given to CHC before PHC. But still the days in which the medicines are made available should certainly be decreased.

2. Drug warehouse

Availability of Drug warehouse in Health Centre (Table-11)

Type of Health Facility	Drug ware house available		Percentage Of Availability
	Yes	No	
PHC(7)	7	0	100.0
CHC(6)	6	0	100.0

The above diagram shows the availability of drug warehouse in health centers among Chittorgarh health facilities and it is clearly implied from the above mentioned diagram that every health facility i.e. PHC and CHC has 100% availability of drug ware house.

Availability of Racks in drug warehouse (Table-12)

Type of Health Facility	Racks available in drug ware house		Percentage Of Availability
	Yes	No	
PHC(7)	7	0	100.0
CHC(6)	6	0	100.0

The above diagram shows the availability of racks in drug warehouses and the availability of racks is 100% which means almost every CHC and PHC has 100% availability of racks to keep drugs, which is a good indication, since every health centre has racks in its drug warehouse to keep the medicines.

Medicines kept in alphabetical order (Table-13)

Type of Health Facility	Medicines kept in alphabetical order		Percentage for Yes
	no	yes	
PHC	3	4	57.1
CHC	1	5	83.3

The above diagram shows what percentage of drug ware houses keep their drugs in alphabetical order in chittorgarh and it is a very common method among health centres in order to make them easy to sort among the piles of drugs. But 43% of drug in PHC and 17% of drugs in CHC warehouses do not keep their medicines in alphabetic order, which implies either they put the drugs without any order or they have some other methods to sort the drugs, for e.g. keeping them according to their use or type. But it is quite evident from the above that this method is more common in CHC and since they have a lot of storage for drugs in comparison of PHC, and this maybe the reason for the higher number of CHC storing their drugs in alphabetical order.

Is Drug Warehouse Clean? (Table-14)

Type of Health Facility	Is Drug warehouse Clean?		Percentage for Yes
	no	yes	
PHC	1	6	85.7
CHC	0	6	100.0

The above diagram shows that what percentage of drug warehouse in PHC and CHC is clean and it clearly shows that almost all the PHCs are fairly clean which is a sign of good infrastructure in health facilities provided by government.

Availability of Fridge for keeping medicines

Type of Health Facility	Availability of fridge		Percentage Of Availability
	Yes	No	
PHC(7)	7	0	100.0
CHC(6)	6	0	100.0

The diagram above depicts that the availability of fridges in PHC and CHC are 100% and all of them are in working condition too. So, the medicines which need to be kept in lower temperature are kept in fridge in order to keep them intact.

3. Drug Distribution Centre

Drug distribution center board outside the DDC room (Table-16)

Type of Health Facility	DDC board outside the DDC room		Percentage for Yes
	no	yes	
PHC	0	7	100.0
CHC	0	6	100.0

The table above holds the data of having a Drug distribution centre board outside the DDC room and every DDC room has a board outside of it to make people informed about the DDC room, so that they can easily see and reach there to get the medicines without any trouble. All of the health facilities are having written DDC outside the room.

Notice for free medicine outside the room (Table-17)

Type of Health Facility	Notice for free medicine outside the room		Percentage for Yes
	no	yes	
PHC	1	6	85.7
CHC	1	5	83.3

Above mentioned data is about the health facilities having a notice for free medicine outside the drug distribution centre. Approximately 85 % of total health facilities have it written outside the room in order to disseminate the information about the scheme. But not all of them are having it written there.

4. Record Updation

Consumer registration updation daily (Table-18)

Type of Health Facility	Consumer registration updation daily		Percentage for Yes
	no	yes	
PHC	0	7	100.0
CHC	1	5	83.3

This is the data about updating the register daily, which turns out to be quite good but still it is not being done in some health centres which is not good because this risks the authenticity of the data as a person might lose or cannot remember the data afterwards.

Is drug distribution centre computerized? (Table-19)

Type of Health Facility	Is drug distribution centre computerized?		Percentage for Yes
	no	yes	
PHC	7	0	0
CHC	5	1	16.7

Almost none of the health centers in Chittorgarh are computerized except a few, which indicates that they are not using HMIS which is a very important tool to record and interpret data and it also saves time. But it is good enough that at least they are being maintained daily.

5. Results

(i) Change in OPD

Change in OPD October (Table-20)

	Change in OPD October				
	0-24	25-49	50-100	More than 100	Total
PHC	2	2	0	2	6
CHC	0	3	3	0	6

Change in OPD November (Table-21)

	Change in OPD November				
	0-24	25-49	50-100	More than 100	Total
PHC	1	2	2	1	6
CHC	0	2	4	0	6

The above deduces that change in OPD is taking place more in PHC rather than CHC because even if they are not severely ill, they go to PHC since the medicines are free now and they don't have to pay for them and their health seeking behavior has drastically change but in a positive way, which avoids any forthcoming severe disease which they could have suffered from, if they had not gone for early treatment.

(ii) Change in IPD

Change in IPD October (Table-22)

	Change in IPD October				
	0-24	25-49	50-100	More than 100	Total
PHC	2	2	0	2	6
CHC	1	2	2	1	6

Change in IPD November (Table-23)

	Change in IPD November				
	0-24	25-49	50-100	More than 100	Total
PHC	1	2	2	1	6
CHC	1	2	2	1	6

The table above shows the data of change in IPD which implicates that the IPD is increasing in CHCs more than PHCs because of the fact that the people who previously could not afford to seek the treatment, started seeking the health care facilities and as CHCs has a most people coming for severe cases rather than mild ones, so the burden on IPD in CHCs is increasing and OPD is decreasing that is a positive sign that people are getting the health care facilities that they needed.

Recommendations

- The scheme should be promoted at grass root level as only 64 % of the patients surveyed are aware about the scheme.

- Routine submission of medicine stock records by every health centre to its higher level, thereby compelling them to regularly maintain records as well as easy collection and verification of data.

- Centralized computer system may be helpful in monitoring and recording the supply of medicines timely and according to our data almost no health facilities had computers, so HMIS should be used to make the data recording more effective.

- Advertising should be done by the ways of lectures, banners, E-group on social networking sites, posters, plays on stages, word of mouth etc.

- At the same time monthly monitoring should be done at all the centers in order to know the actual results or feedback so that scheme works effectively.

- Not only rural people, but urban people also need to be made aware about the generic and the branded medicines.

- An effective and efficient grievance redressal system should be designed which gives quick decision and proper dissemination of information should be spread about the system.

- Medicines should be made available at health facilities as soon as they demand in order to make sure that everybody is getting free medicines.

- Medicines at DWC should be kept in alphabetical order to avoid the chaos and to easily find the medicines out of the big piles of medicines.

- More people should be hired at DDC to distribute the medicines in order to reduce the waiting time, since the burden on OPD and IPD has significantly increased.

Learning

- The whole Summer Internship has given me a very deep insight about NGO's.
- I worked on a very basic level of community and interacted with many people during survey, this somewhat has given me an idea of how to deal with the people.
- Statistical Packet for Social Sciences (SPSS) was one of a major tool used in a study, so, working with it as a tool has enhanced my knowledge about the analyzing software and make some meaningful interpretation from the data collected.
- Overall it helped me to understand about the whole process of problem solving, starting from the identifying problem and very little insight of implementation of the scheme.

ANNEXURES

AA-1 Beneficiary's interview or feedback form (Demand Side)

<u>लाभार्थियों से साक्षात्कार एवं दवा पर्ची का अवलोकन</u>

चिकित्सा संस्थान : उप स्वा. केन्द्र/प्रा.स्वा.के./सा.स्वा.के./उप जिला/जिला चि. .....

विकास खण्ड ..... दिनांक ..... समय .....

रोगी का नाम : ..... आयु ..... लिंग..... वर्ग .....

निवास स्थान का पूर्ण पता : .....

..... संपर्क फोन नं. .....

रोग/लक्षण : ..... चिकित्सक का नाम .....

साक्षात्कार देने वाले का नाम: ..... आयु ..... लिंग..... वर्ग ..... .

रोगी से सम्बन्ध : ..... संपर्क फोन नं. .....

निवास स्थान का पूर्ण पता : .....

क्र. सं.	***प्रश्न (अधिकतम अंक : 12)***	***जवाब***	***अंक***	***स्पष्टीकरण/टिप्पणी***
01	*क्या आपको मुख्यमंत्री निःशुल्क दवा योजना के बारे में जानकारी हैं ?* *यदि हाँ तो कैसे जानकारी प्राप्त हुई ?* *1. टी.वी. 2. रेडियो 3. अखबार* *4. पोस्टर 5.स्वास्थ्य कार्यकर्ता 6. पम्पलेट्स 7. मित्र 8.सदस्य परिवार 9.होरडिंग/ बेनर* *10. अन्य .....*	*हां : 1* *नही : 0*		
02	*क्या डॉक्टर द्वारा आपको लिखी गई दवाइयों की पर्ची दो प्रति (कापी) में दी गयी ?*	*हां : 1* *नही : 0*		
03	*क्या आपको दवा देते समय समझाया गया कि कौनसी दवा कितनी बार तथा किस तरह से सेवन करना है ?*	*हां : 1* *नही : 0*		
04	*क्या आपको बताया गया कि आपको लिखी सभी दवाइयां निशुल्क चिकित्सालय से ही मिलेगी ?*	*हां : 1* *नही : 0*		
05	*निशुल्क दवा वितरण केन्द्र से दवा प्राप्त करने में कितना समय लगा ?*	*दवा तुरन्त मिल गई : 3* *10–15 मिनट : 2* *16–30 मिनट : 1* *30 मिनिट से अधिक : 0*		
06	*आपको पर्ची मे लिखी दवाइयों में से कितनी दवाइया निशुल्क और कितनी क्रय करनी पडी ?* *पर्ची में अंकित कुल दवा .....* • *निशुल्क .....* • *क्रय .....*	*100 : निशुल्क : 3* *झ75 : निशुल्क : 2* *झ50 : निशुल्क : 1* *ढ50 : निशुल्क : 0*		
07	*आपको पर्ची मे कितने दिन की दवा लिखी ..... उसके एवज में निशुल्क दवा केन्द्र से आपको कितने दिन की दवा मिली ... .*	*100 : प्राप्त की : 2* *झ50 : प्राप्त की : 1* *ढ50 : प्राप्त की : 0*		
कुल अंक				

8. दवा क्रय करने में कितनी राशि व्यय हुई ?

जैनरिक दुकान ..... रू0, निजी दुकान ..... रू0 कुल राशि ..... रू0

9. *क्या आप सरकारी अस्पताल में उपलब्ध मुफ्त दवाओं को बाहरी दवाओं के समान असरकारक मानतें हैं ? हां अथवा नही स्पष्टीकरण देवें*

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10. *निशुल्क दवा योजना के कार्यक्रम पर आपकी टिप्पणी :*

AB-1 Hospital authority at distribution centre's interview and Supply side observations

<u>स्वास्थ्य केन्द्र अवलोकन प्रपत्र</u>

चिकित्सा संस्थान : उप स्वा. केन्द्र/प्रा.स्वा.के./सा.स्वा.के./उप जिला/जिला चि. .....
विकास खण्ड ..... दिनांक ..... समय .....

✶ *निःशुल्क दवा वितरण केन्द्र पर नियोजित स्वास्थ्य सेवा प्रदाता का विवरण :*

क्र.सं.	***स्वा 0 सेवा प्रदाता का नाम***	***पद***	***कार्यभार की जिम्मेदारी***

' स्वास्थ्य केन्द्र पर नियोजित कुल सेवा प्रदाता ..... उपस्थित सेवा प्रदाता .....
अवकाश पर ..... प्रतिनियुक्ति पर ..... कार्यालय कार्य से अन्यत्र .....

A. ***दवाईयों की उपलब्धताः (अधिकतम अंक : 09)***

क्र. सं.	***प्रश्न***	***जवाब***	***अंक***	***स्पष्टीकरण/टिप्पणी***
01	*स्वास्थ्य केन्द्र पर दवाईयों की उपलब्धताः* • *कुल कितनी प्रकार की दवाओं की मांग की गई..... .....* • *मांग के विरूद्ध कितनी दवाईयां उपलब्ध कराई गई ....*	*100 : उपलब्ध : 3* *झ75 : उपलब्ध : 2* *झ50 : उपलब्ध : 1* *ढ50 : उपलब्ध : 0*		
02	*मांग के कितने दिवस पश्चात् दवाईयां उपलब्ध कराई गई .... मांग कब की गई .....* *मांगी दवाईयां अंतिम बार कब उपलब्ध करवाई गई थी ....*	*1 दिन : 3* *2 दिन : 2* *3 दिन : 1* *4 दिन या ज्यादा : 0*		
3.	*संस्थागत स्तर पर दवाइयां क्रय करने हेतु व्यय :* *उपलब्ध बजट .....* *व्यय राशि .....*	*100 : व्यय : 3* *झ75 : व्यय : 2* *झ50 : व्यय : 1* *ढ50 : व्यय : 0*		
कुल अंक				

ठ्ण दवा भण्डारण :(अधिकतम अंक : 13)

क्र. सं.	अवलोकन बिंदू	जवाब	अंक	स्पष्टीकरण/टिप्पणी
01	क्या दवा भण्डारण के लिए अलग से कक्ष है ? यदि नहीं तो दवा भण्डारण कहाँ किया जा रहा है स्पष्ट करें ?	हां : 1 नही : 0		
02	क्या दवाईयां रखने के लिए रैक्स की व्यवस्था है ? यदि नहीं तो क्या व्यवस्था है स्पष्ट करें ?	हां : 1 नही : 0		
03	क्या दवाईयों को रैक्स में अंग्रजी वर्णानुक्रम में रखा गया है ?	हां : 1 नही : 0		
04	क्या दवाईयों के डिब्बे जमीन पर रखे पाए गए हैं ?	नही : 1 हां : 0		
05	क्या भण्डारण गृह साफ-सुथरा है ?	हां : 1 नही : 0		
06	क्या कमरे में कहीं किसी प्रकार की नमी/आद्रता पाई गई हैं ?	नही : 1 हां : 0		
07	क्या कमरे में कहीं किसी प्रकार की टूट-फूट पाई गई हैं ?	नही : 1 हां : 0		
08	क्या कमरे में अथवा रैक्स में कहीं दीमक पाई गई ?	नही : 1 हां : 0		
09	क्या कमरे में कहीं चूहे या अन्य जानवर पाए गए ?	नही : 1 हां : 0		
10	क्या कम तापमान में भण्डारण की जाने वाली दवाईयों के लिए फ्रिज/प्स्ट की व्यवस्था है ?	हां : 1 नही : 0		
11	यदि हाँ तो क्या वह चालू अवस्था में है ?	हां : 1 नही : 0		
12	क्या विशेष दवाईयों के भण्डारण के लिए लौकर की व्यवस्था है ?	हां : 1 नही : 0		
13	क्या आग बुझाने के साधनों की व्यवस्था है ?	हां : 1 नही : 0		
कुल अंक				

ब्ण दवा वितरण केन्द्र : (अधिकतम अंक : 02)

क्र.सं.	अवलोकन बिंदू	जवाब	अंक	स्पष्टीकरण/टिप्पणी
01	क्या दवा वितरण केन्द्र के बाहर स्पष्ट व बड़े अक्षरों में ''दवा वितरण केन्द्र'' का बोर्ड लगा हुआ है ?	हां : 1 नही : 0		
02	क्या दवा वितरण केन्द्र के बाहर निःशुल्क उपलब्ध दवाईयों की सूची लगी हुई है ?	हां : 1 नही : 0		
कुल अंक				

क्ण रिकॉर्ड संधारण : (अधिकतम अंक : 04)

क्र.सं.	अवलोकन बिंदू	जवाब	अंक	अंतिम संधारण दिनांक
01	क्या उपभोग रजिस्टर प्रतिदिन एवं नियमित संधारित किया जाता हैं ?	हां : 1 नही : 0		
02	क्या स्टॉक रजिस्टर प्रतिदिन एवं नियमित संधारित किया जाता हैं ?	हां : 1 नही : 0		
03	क्या पासबुक नियमित संधारित की जाती है ?	हां : 1 नही : 0		
04	क्या दवा वितरण केन्द्र कम्प्यूटरिकृत हैं ? यदि हां तो क्या समस्त कार्य कम्प्यूटरिकृत हैं ?	हां : 1 नही : 0		
कुल अंक				

म्ण परिणाम : (अधिकतम अंक : 06)

(अ)	*बाह्य रोगी*			*जवाब*	*अंक*	*स्पष्टीकरण/टिप्पणी*
माह	*2010*	*2011*	*: बदलाव*	*>100 : : 3*		
अक्टुबर				*> 50 : : 2*		
नवम्बर				*> 25 : : 1*		
कुल				*< 25 : : 0*		
(ब)	*अन्तरंग (भर्ती) रोगी*			*जवाब*	*अंक*	*स्पष्टीकरण/टिप्पणी*
माह	*2010*	*2011*	*: बदलाव*	*झ100 : : 3*		
अक्टुबर				*> 50 : : 2*		
नवम्बर				*> 25 : : 1*		
कुल				*< 25 : : 0*		
कुल अंक						

AC-1 Summary sheet

अवलोकन सारांश प्रपत्र

चिकित्सा संस्थान : उप स्वा. केन्द्र/प्रा.स्वा.के./सा.स्वा.के./उप जिला/जिला चि. .....

विकास खण्ड ..... दिनांक ..... समय .....

क्र.सं.	*विवरण*	*कुल अंक*	*कुल :*	*मुख्य कमियां*	*सुधार के लिए सुझाव*	*सुधार के लिए जिम्मेदार मुख्य व्यक्ति*
I	*दवाईयों की उपलब्धता (अधिकतम अंक 9)*					
ठ	*दवा भण्डारण (अधिकतम अंक 13)*					
ढ	*दवा वितरण केन्द्र (अधिकतम अंक 2)*					
क	*रिकॉर्ड संधारण (अधिकतम अंक 4)*					
म	*परिणाम (अधिकतम अंक 6)*					
ध	*लाभार्थी साक्षात्कार एवं दवा पर्ची अवलोकन (अधिकतम अंक 12)*					
कुल अंक (अधिकतम अंक 45)						

अन्य विशेष बिन्दु : .....

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- Out of pocket expenditure study.