



On the completion of five years of National Rural Health Mission (NRHM) in 2010, Union Ministry of Health & Family Welfare awarded three states for best implementation of NRHM, Rajasthan was one of them. But the public health system of state faces several issues that deter the quality service delivery. Although the scheme is well designed to achieve the improved status of health in rural areas and also includes the component of community monitoring to engage the relevant stakeholders in the process of scheme to hold public servants accountable. But the given space is not being utilised properly. In 2009-10, Consumer Unity & Trust Society (CUTS) in partnership with The Results for Development (R4D) Institute, supported by the Human Development Network (HDN) of The World Bank introduced a social accountability intervention in 30 primary health centres (PHCs) in Tonk district of Rajasthan to mobilise the community to monitor and provide feedback on delivery of various health services as well as on absenteeism of health service providers. This social accountability intervention triggered several changes at various levels of service delivery and generated pro-poor outcomes.

CASE STUDY

Improving the Service Delivery by Measuring Rate of Absenteeism and Initiating Community Monitoring in 30 Health Centres in Tonk District of Rajasthan, India

CONTEXT

The draft Approach Paper to Eleventh Five Year Plan (2006) by Nirupam Bajpai and R H Dholakiya entitled *Scaling up Primary Health Services in Rural Rajasthan: Public Investment Requirements and Health Sector Reform* clearly states that 'rural healthcare in most states including Rajasthan is marked by severe problems such as absenteeism of doctors/health providers, low levels of skills, shortage of medicines, inadequate supervision/monitoring, callous attitudes and poor community participation. These problems in healthcare delivery are leaving well-intentioned spending without any desired impact.

Health sector in India received increasing attention in 2005 and is clearly evident by the start of the National Rural Health Mission (NRHM) in India, for which the initial allocation made in the Indian Budget was ₹6731 crore (US\$1.45bn) in 2005-06 and that was increased to ₹14050 crore (US\$3.02bn) in 2009-10.

Along with allocating adequate funding for the health sector, equally important, is to ensure the function of the health systems for improved public expenditure outcomes. The approach paper by Nirupam Bajpai and R H Dholakiya clearly explains the need of improving service delivery in the health clinics, especially in the context of vulnerability of rural mass for which there is not much option except government-aided services.

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

CUTS' INTERVENTION

In 2009-10, CUTS in partnership with R4D Institute and the HDN of The World Bank introduced a social accountability intervention in 30 PHCs in Tonk district of Rajasthan to mobilise the community to monitor and give feedback on delivery of various health services, absenteeism of health staffs etc. and improving service delivery at PHCs by enhancing ownership among people. There are various reasons for choosing Tonk district. It is comparatively a progressive district with regard to health services, with the presence of several international development agencies and due to the proximity to the state capital, it is very much in the limelight.

The aim of the intervention was not only to look at the status of implementation of NRHM but also help the service providers to bring changes in the implementation process and policy makers in policy re-designing through dissemination of results and

consultation with government officials at various levels. This project also worked for evolving an innovative community-based model for monitoring public health services that can induce demand accountability of service providers and suggest the policy makers a replicable model of sustained accountability through civic engagement.

Social Accountability Process in Tonk District

A health services monitoring cell, consisting five educated and unemployed youth was constituted in the catchments area of each identified PHC through a local community-based organisation (CBO) for participatory absenteeism tracking process (PATP). The members of the cell monitored the presence of health officials at the PHCs during duty hours and also gathered information on delivery of services by frontline service providers for continuous 35 days (except on Sundays) for 30 PHCs selected on the basis of random sampling methods. Thus, 900 unannounced observations were made through the absenteeism tracking process using a community monitoring card (CMC).

Under the process of Citizen Report Card¹ (CRC), 902 health beneficiaries making exit from the PHCs were interviewed, with a field-tested questionnaire, mainly to get their feedback on various health service deliveries by a group of people chosen and trained from community monitors. The various components of the NRHM were taken into account. In general, the findings of the CRC are based on the perception of the service recipients, based on the services they get from the health facility in the vicinity of their localities.

Simultaneously, interviews of service providers, each of a Doctor (30), Adult Nurse Midwife (30), Accredited Social Health Activist (30) and a representative of Panchayati Raj Institutions (30) were conducted. The high level authorities at the district level, like the Chief Medical and Health Officer, the District Programme Manager, etc., were also interviewed for better clarity on certain issues.

On completion of the monitoring process, the competition and through analysis of data was done to get the findings. The findings and model developed for monitoring were disseminated through various dissemination and advocacy meetings at various appropriate policy forums to have desired impact.

KEY FINDINGS

Providers' Absence Rate

Provider's average absence rate for all categories of health officials was found to be 27 percent, which means

Table 1: Providers' Absence Rate

S.No.	Providers	Absence Rate (in Percentage)
1	Medical Officers (Doctors)	36
2	Lab Technicians	34
3	Lady Health Visitors	33
4	Adult Nurse Midwives	22
5	Male Nurses	12
	Average	27

out of 900 observations, on an average, health officials were found absent during 27 percent cases of observations. The rate of absenteeism² ranges from 12 percent for male nurses to 36 percent for doctors or medical officers. As described, there were 900 observations made of 30 PHCs for each category of employee.

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

Availability of Medical Facilities at PHC

Availability of few of the essential facilities and their quality was also checked during the PATP at the PHC. This was also reported by the community monitors on the basis of their observations. (Table 2)

Few of the infrastructural facilities which could be responsible for the presence of the service providers at the facilities were also counted during the process. (Table 3)

- 1 The *Citizen Report Card* (CRC) is a commonly used tool for participatory impact evaluation. The CRC is a survey instrument that taps information on users' awareness, access to, and satisfaction with publicly provided services. It contains information about the key constraints the poor face in assessing public services, their views about the quality of services, and their experiences in interacting with public officials.
- 2 In calculating absence rates, a provider was coded as absent if he or she was not found in the premises of PHC at the time of observation because of any reason like leave, official duty outside like training or monitoring visits to the sub-centres and absent without information.

Table 2: Facilities Available (%) at the PHC

Response	Immunisation	Drug Distribution	Blood Test	Delivery
Yes	44	73	51	63
No	55	26	35	33
Can't Say	1	1	14	4

Table 3: Availability of Infrastructural Facilities

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

integrated management of neonatal and childhood illness, exclusive breast feeding and timely introduction of complimentary feeding, immunisation, Vitamin A supplement, etc., are key strategies for attaining better child health in the country.

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

The figure related to immunisation was found to be very enthusiastic in case of child health. 93 percent parents said that their children are immunised. However, intensive work is needed in case of providing Vitamin A supplement and also in case of gaining confidence of people. (Table 4)

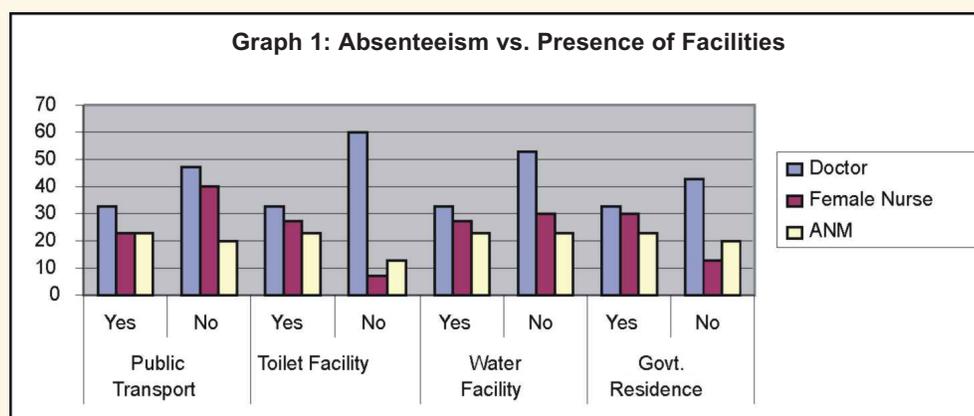
Table 4: Questions Related to Certain Services at PHCs for Better Child Health

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

Absence Rates of the Service Providers: Some Simple Correlations

Simple correlations between providers' absence and facilities connected to the healthcare centre are briefly reviewed. These correlations suggest that all facilities such as public transport, toilets, water and government residences matters in context of the providers' absence at the health facility. (Graph 1)

Graph 1: Absenteeism vs. Presence of Facilities



Janani Suraksha Yojna

The JSY, under the overall umbrella of the NRHM, integrates the cash assistance with antenatal care during the pregnancy period, institutional care during delivery and immediate post-partum period in a health centre, by establishing a system of co-ordinated care by field level health worker. It is a

Child Health

Child Healthcare services are also given a wide importance under the NRHM. Essential new born care,

100 percent centrally-sponsored scheme. The CRC was conducted to know the status of the provisions of the JSY from which the findings reveal both positive and negative feedbacks.

Table 5: Questions Related to the Provisions/Entitlements under JSY

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

It is evident from the data gathered that 10-20 percent of pregnant women are not having proper awareness about the JSY, which is weakening the demand-side of the service delivery. If we take the first question, all the women are registered under JSY, but are unaware of their registration. Poor awareness leads to poor demand and hence poor service delivery. It is surprising that 12 percent of the people said they have not got any economic help after pregnancy. (Table 5)

Awareness Generation

Awareness generation on various health needs, provisions and entitlements under the NRHM is vital to trigger the demand of services, which ultimately generates success of any scheme. To know the status of awareness among people about the general health practices, feedback from the respondents was taken. Table 6 denotes the status of awareness among the people.

Family Planning and Curative Services

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

Grievance Redressal Mechanism

Complaint Handling Mechanisms (CHMs) are critical tools for promoting transparency and accountability, reducing corruption, improving service delivery and enhancing overall effectiveness in public expenditure. But, the condition of CHM was found very abysmal. 82 percent of people reported that that they do not know any existing grievance redress mechanism.

Table 6: Gauging the Awareness Level on Health Needs

S. No.	Questions Related to the Awareness Level	Completely Aware	Partially Aware	Totally Unaware
1	On breast feeding	55	16	28
2	Introduction of complementary feeding	49	22	29
3	Spacing between the children	60	15	25
4	Legal age of marriage	67	8	24
5	Registration of birth/death	52	15	32

Outlook on PHC

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

However, most of the respondents had a good perception about building of the PHC and the availability of the health officials. They said that they like going to the hospital, but in case of medical facilities present at the PHC and the availability of medicines, a significant percentage of the respondents did not have a good opinion. (Table 7)

Table 7: People's Opinion about PHCs

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

Community Participation

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

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

Accessibility and Availability of the Health Services

Under the NRHM, the government has shown commitment to improve the availability of and accessibility to quality healthcare by people, especially for those residing in rural areas. To get a feedback on the accessibility of health services, few questions were asked to the respondents.

96 percent of the respondents³ said that PHCs are in their easy access and 94 percent are heavily dependent on the services provided by the PHC. However, 83 percent said that they find health officials at the PHC when they go, but 69 percent say that they get either no medicines or only few from PHCs. When their suggestions were sought to improve the services at the PHC, 11 percent said the supply of medicines should be improved and more medicines should be added to the list of medicines being provided.

Service Providers' Response

Interviews of 58 service providers were conducted particularly to know the reasons behind the absenteeism and also other factors responsible for their unavailability.

It was found that only 22 percent of respondents use government-provided residences. However, 72 percent of the personnel reside within the periphery of 1 km. Among the respondents, 60 percent travel on foot, 12 percent by bus and 14 percent on bikes.

It was found that 95 percent of service providers like their jobs and 82 percent of them are not willing to do any other job on the same salary, but 69 percent of them want to change their

PHC. At the same time, 12.5 percent of the respondents were found dissatisfied with their jobs and 25 percent say that they do not get leave on demand. 41 percent of the service providers reported shortage of staff.

Findings of Focus Group Discussions

- *Services:* Although there is benefit of having a PHC nearby, there is lack of many facilities like pathological tests, injections, lady doctors, proper medicines, delivery facility at night, etc., especially there is no facility at PHC for the first time delivery. Generally, one male and one female nurse executes most of the work at the PHC. In some instances, when patients come from a far away place after spending a lot of money in travelling, they found the doctor absent or gone on training or on leave.
- *Availability of Staff:* Villagers do not know the number of staff at the PHC. Many times, only few of them are present at the PHC. Some are reluctant to perform their duties. They do not stay at the PHC, even if the government has provided them residence. The need for help of a doctor can come at any time, so they should be always available.
- *Medicines:* Medicines provided by government are in meagre quantity. Few medicines available with the PHC are given to anyone, irrespective of the patients' ailments. Health officials say that because of unavailability of medicines, they sometimes give the medicines which are not meant for the purpose. They do it because of the fear that if they do not give any medicine, people will react negatively.

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

Because of unavailability of medicines at PHCs, villagers are bound to visit quacks, which is costly and sometime hazardous.

- *Awareness:* People below poverty line (BPL) are entitled for BPL card and other service delivery absolutely free of cost, but many BPL people are not made aware of the provisions/entitlements.
- *Complaint Handling:* People do not know where to complain about the poor services and there is no discussion over the poor services at the PHC. People who are capable enough to demand services and accountability from the health officials are provided better services and the poor and the marginalised keep on suffering.
- *Location of PHC:* At many places, the building of the PHC is out of the village. Women are not able to visit the PHC at night. Lot of political clout is also responsible for the placing of the PHC.

VICIOUS CIRCLE OF POOR SERVICE DELIVERY

Primary Health Centre

- Medicine comes once or twice in a year. Out of listed 35 medicines, only 10-15 medicines are provided. Most of the PHCs do not have any medical shop nearby.
- There is no proper infrastructure for health officials to stay near PHCs. At many of the places, even proper drinking water is not available. The problem of road, electricity, government quarters, market, etc., exists at many PHCs.
- No proper monitoring is done to identify the problems to improve service delivery.
- There is a poor demand of services due to negative perception of the people about the PHCs, their staff, facilities, etc.
- The PHC is not located in the centre of the village, but it is at a distance from it.
- In some cases, officials at PHCs have to fill the OPD list with fake names to show that the PHC is functional as there is criteria of a minimum number of patients for a PHC to run.

Health Officials

- They do not have required medicines to treat the patients. They also cannot prescribe as there is no medical shop. Sometimes, they do not have the medicines even for first aid. They manage to buy the first aid medicines from the money collected through the patient registration charges. The community

blames the health officials for non-availability of medicines. For BPL people, doctors are provided with money to buy medicines on the rate given by the department, but the rates are old and do not match with the market price.

- They have to be involved in data-related work and the quantum of this work is very high sometimes. Many a times, they are called to the department to execute certain work without even taking them on deputation. The officials keep on signing the register.
- Doctors have to play various roles like inspection of the sub-centres, running immunisation camps, family planning camps, meetings at district level, training, etc. When somebody asks where the doctor is, some reasons are given for the absence of the doctor. In some cases, it was also found that fresher join the PHC for money and experience and also keep preparing for higher studies and do not come to the PHC.
- In the absence of doctors, the male nurse becomes the head of the centre and he performs most of the jobs at the PHC. Since the number of staff members per patients is very high, they manage to come one day and abscond the next day, with some understanding among them. Many people prefer to call the male nurse at home, where he does the check ups and provide medicines brought from some medical store of nearby town and charge money. This generally happens during free hours between the two shifts of the day.
- The trainings imparted to them are also of no use, mostly.
- Many a times, the health officials, especially doctors, have not been sanctioned leave.

Community

- The community members do not show the ownership to the PHC because of absence of their engagement in the functions of PHCs as envisaged under NRHM.
- They also do not have faith in the medicines provided at the PHCs.
- They also encroach/steal/damage, sometimes, the property of the PHCs.
- Lack of medicines at PHCs leads them to quacks, where they get the medicines for their ailments.

Health Department at District Level

- There are not enough doctors available with the Department ready to work in the rural areas and stay there at the remuneration given by the government.
- The supply of medicines is less due to poor mechanism for medicine procurement and delivery.

- Under the NRHM, lot of data is to be provided, for which staff is not sufficient.
- There is political interference in transfers, selection of the location of the PHCs, etc., and more people try to get postings in PHCs nearer the city/their homes, etc.

RECOMMENDED SOLUTION

Strengthening Village Health and Sanitation Committee (VHSC)

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

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

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

Awareness Generation among the users

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

- Intensive awareness generation on the entitlements through rural means of communication must take place.
- The number and name of the staff should also be made public somewhere at all PHCs and they should strictly write down the purpose of leaving the hospital during duty hours and the probable arrival time.
- The availability/non-availability of medicines/facilities should also be proactively disclosed.
- The community should be made aware that the health officials at PHCs are well qualified and provide better treatment to them.

Availability of Medicines

- Sufficient availability of all the listed medicines at the PHC should be ensured. A minimum buffer stock should be maintained at each PHC. A shop for generic medicines could be opened at each PHC, either on a contract basis or by the government. A medicine van can move every month to each PHC for medicine delivery. People other than the BPL should be charged for medicines.
- The RPRIs need to oversee the delivery of medicines to the BPL.

Facilities at the PHCs

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

Deployment of Health Service Providers

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

Grievance Redressal Mechanism

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

delivery. This will solve several problems of grievance redress, information dissemination and awareness generation.

Monitoring by Officials

Regular monitoring (with increased frequency) and vigilance by various different level officials and RPRIs should be made mandatory.

Public-Private Partnership

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

GLIMPSES OF CHANGE

Improved Service

Delivery: Regular community monitoring of PHCs has helped in improving service delivery. According to the reports from the partner organisations, the availability of medicines and officials at the health centres have increased. The supply of medicines is also better this year, according to a doctor. It was decided to list down the names of the officials on the wall of PHCs, so that any one visiting the PHC can monitor the absenteeism and report in the VHSC to take appropriate action. Prior to this, people were not even aware about the number of staff in this PHC.

क्र.	नाम	कर्मचारी	पद
1	डॉ. विजय सिंह मीणा		M.O.I/C
2	श्री रामस्वरूप सेनो		MN II
3	श्री मुकुण्ड गोगवाल		MN II
4	श्रीमति नफीस अख्तर		LHV
5	उमिता जैन		ANM
6	श्री हमीद नूर		MPHW
7	केदार नारायण जाट		GNM
8	आशीष शर्मा		GNM
9	देवकरण गुजर		W/B
10	सुनील गौर		W/B

Enhanced Involvement of PRIs:

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



Increased Vigilance of State Government:

After the state level dissemination meeting, the state government has increased its vigilance to PHCs for quality service delivery and the absenteeism. The Principal Secretary, Health & Family Welfare has suspended few officials because they were found absent from health centres during duty hours without any information. This increased vigilance has also helped in restricting absenteeism at PHCs.

Govt suspends 2 doctors in city

HT Correspondent
in nagpurhindustianews.com

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

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

On the basis of the probe report, doctors Sunita Vishnoi

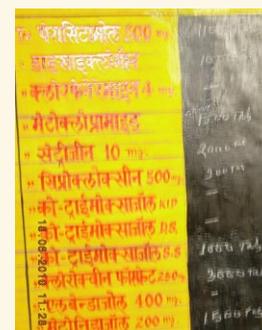
essential action for effective implementation by visiting their respective districts and inspecting the preparations of prevention and control of seasonal diseases.

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

These officers will look into the arrangements of sufficient quantity of vaccinations, medicines and other resources for

Display of Stock of Available Medicine:

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



More Absenteeism Study:

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

Mazdoor Satyagrah seeks accountability panel

TIMES NEWS NETWORK

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

The demand follows alleged measures by the government to penalise MGNREGS workers and its own employees coming late to offices, alleged activists. "It is a follow-up of an exercise we did on Thurs — one moves up the day. Having visited various government offices between 9:30 am and 10:30 am we found that only 30% of the employees were present on their seats. In some offices people reported for work even two hours or so late. Therefore,

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

They said while empty seats greet them at most places, there were also offices where all reported for work sharp at 9:30 am. "And the interesting part is that in all such offices the staff boys were always punctual. But as

for work increases," he said.

Explaining the work of the accountability commission, he said it would not only determine who is supposed to work here, but spell out in de-

This note has been prepared by Om Prakash Arya, Amar Deep Singh and George Cheriyan of and for CUTS Centre for Consumer Action, Research & Training (CUTS CART) as part of the project entitled 'Improving Service Delivery through Measuring Rate of Absenteeism in 30 Health Centres in Tonk District of Rajasthan, India' in partnership with The Results for Development (R4D) Institute, supported by the Human Development Network (HDN) of The World Bank.