

Knowledge and Research Programme on Improving Efficiency of Pro-poor Public Services



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**Croatia National Report
November, 2005**

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Published by:



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Department for International
Development Knowledge and Research Programme
on
Improving Efficiency of
Pro-poor Public Services

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Overview

About the research:

Despite considerable investment, public services in most developing countries are widely perceived to be unsatisfactory and deteriorating. The poor and disadvantaged in developing countries suffer in relation to delivery of public services. Firstly, they lack access to those services due to physical, financial, informational, political and other barriers. Secondly, they lack effective mechanisms for feeding back their complaints, views and requests in relation to those services. As a result, public services to the poor lack transparency, accountability and quality. The poor and the disadvantaged are particularly vulnerable as they rely completely on the state for accessing critical services like drinking water, health and education.

To address this gap, OneWorld South Asia, representative office of OneWorld International (OWI) was entrusted by the Department for International Development (DFID) to conduct a KaR programme on improving quality, effectiveness and transparency of pro-poor public services through the use of ICTs.

The study period was January 2004 –June 2005. Transparency International (TI) country chapters in Croatia, Pakistan and Nigeria and OneWorld South Asia in India were chosen as the four implementing agencies for this action research.

The project, focused largely on access to information and on identifying ways to improve the effectiveness of delivery of public services to the poor and vulnerable sections and the opportunities for ICTs to strengthen those mechanisms.

Research objectives:

The research objective was to design and implement an appropriate ICT led model to improve the transparency, quality and effectiveness of pro-poor services and to identify an effective niche for integrating ICTs in the traditional public services domain.

It sought to use the appropriate ICT to disseminate information to service providers and users and provide an appropriate means by which the poor can provide feedback to governments on the service provided.

Research Methodology:

The common core of this project was to combine ICT with participatory techniques.

These were used to gather views from the poor about various public services. This bottom up approach is in contrast to traditional ICT approaches (and indeed, public service provision) which tend to be top down and are unresponsive to user needs.

The research method used to address the problem was 'participatory action research' that involved an in-depth study of the system to comprehend the existing problems, and then, strove to change it towards a desirable direction in close association with community members. The distinguishing feature of this research was the use of ICTs to bring about positive changes in access to pro-poor public services. Most of the participatory action research techniques, such as surveys, interviews, Focus Group Discussions (FGDs) were used in all stages of the project. These included the selection of the sector for research, the choice of the ICT tool/intervention and monitoring and evaluation of the intervention.

The project was designed to facilitate peer to peer learning among the participating country teams. These teams met at various stages of the project to share their learnings.

Research outcomes:

The research has demonstrated that appropriate and relevant use of ICTs can help break the traditional wall of mistrust and apathy between the people and the service providers. The project has exhibited how ICTs can be neutral catalysts, acceptable to both sides as platforms for information exchange and communication.

Production of pro-poor services improvement packs are an important factor in this respect.

These information packs published by the three country teams and the international pack contain learnings from the project, would inform relevant interventions. These packs would provide specific guidance to government and civil society institutions on how to implement/improve ICT enabled-feedback/grievance redress systems for public services to the poor. Public sector organisations will benefit from this information with increased capacity in designing appropriate pro-poor programmes. This in turn, is hoped would contribute substantially to poverty alleviation and improved livelihoods.

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1. Choice of the Public Service Problem

During the international inaugural project workshop that took place in Zagreb from February 5 to 8, 2004, hosted by Transparency International Croatia, TI Croatia team members have selected the **health and social care sector** as the sector in which the project would be implemented. The health and social care sector was chosen based on the agreement of the team members that health and social services for the poor are in the most urgent need of improvement in terms of quality, effectiveness and transparency of the work of public health and social care institutions. As the poor are highly susceptible to contraction of chronic diseases due to their living conditions, transparent and efficient work of public health institutions, namely hospitals, are crucial for this particularly vulnerable group.

The health sector was selected based upon the conviction that health care services are the most essential public service for all segments of the society and particularly for the poor. Living conditions have a significant effect on people's health and well-being and hence, the poor are particularly vulnerable to long-term and chronic diseases as it was stated above. They often suffer from health problems typically associated with poverty, including malnutrition, infectious diseases and psychosocial stress, most of which are the result of inadequate diet and poor housing conditions. The poor tend to live in dilapidated houses with a high degree of humidity and insufficient heating, which increases their vulnerability to contraction of chronic diseases. Although mortality may not be directly related to an individual's social status, people living in conditions of poverty are more likely to suffer from chronic illnesses and therefore seek medical assistance on a more frequent basis.

In light of the fact that the poor and socially vulnerable citizens are completely dependent on public health care institutions for the provision of services since they cannot afford alternative, private care, the quality and accessibility of public health care services is of particular importance to them and it cannot be compromised. Out of all areas of public life, health care services have the most immediate effect on the quality of life of the poor and the impact of any inefficiency in the work of public health care institutions will be most strongly felt by socially vulnerable citizens.

Apart from subjective opinion of TI Croatia team members about the clear need to conduct the project within the sector of health and social care, available recent surveys revealed that Croatian citizens perceive health among the most corrupt sectors. In the light of that, Transparency International Corruption Barometer for 2004 showed that Croatian citizens believe health, political parties and judiciary to be the most corrupted sectors. Domestic research done by Transparency International Croatia in 2003 showed that more than 90% of the interviewed citizens believe corruption is spread or widely spread. The similar data were exposed by the identical research done this year in which more than 80% people perceive health sector as the most corrupted one.

Having in mind what research says about citizen's perception and taking into account contemporary discussions in the media concerning the misuse of waiting lists within the hospitals and other health and social welfare institutions, TI Croatia team members have detected lack of transparency and information about waiting times in hospitals and nursery homes as an area of public interest that could be improved. The improvement needs to be done by making waiting lists for diagnostics and surgeries as well as application for nursing homes public, which was pronounced the final objective of the project. Bearing in mind, privacy laws and laws that regulate protection of personal data, it was agreed that the lists could be published using codes or assigned numbers instead of patients' names. One hospital in the area of the city of Zagreb was selected for the implementation of pilot project due to its advanced level of computerization of services and on-going ICT projects.

Implementation of the project in public health institutions requires obtaining permission from the Ministry of Health, which TI Croatia project team managed to obtain with several months of delay due to Government and consequently, administration staff changes in the winter of 2004. As an alternative solution, liaison was established with the City of Zagreb City Office for Health, Labour and Social Welfare in order to examine the possibility of publicizing waiting lists for nursing homes which are in the domain of the City Office.

2. Choice for the Location of National Project

As it was stated earlier in the report, the team members have chosen the city of Zagreb to be the geographic location of the project. The city of Zagreb is the capital of the Republic of Croatia and the largest city in the country with the highest percentage of poor population.

The most recent study (January 2005) about being poor in Croatia done by Croatian Caritas and Croatian Catholic Church revealed that the largest portion of poor population live in the Northern Croatia where Zagreb is situated.

By choosing Zagreb as an area of work, we were certain that targeting poor population will be done without major problems, communication with other pro-poor organizations will be established and access to service providers will be easier.

Another reason for choosing particularly the capital resides in the fact that all governmental institutions are located there, health and social care institutions as well.

The criteria for choosing Clinical Hospital Dubrava (here and after, CH Dubrava) was the level of computerization within the hospital. CH Dubrava is the most sophisticated hospitals in the country in terms of computer usage, Internet and Intranet communication and medical equipment. Apart from that, CH Dubrava is one of the largest hospitals in the country with the capacity of 750 beds, 1592 employees and annual turnover of around

18,000 hospitalized patients. More than 280 000 citizens receive medical treatment within the hospital's policlinic system annually.

With regard to elderly people homes waiting lists, the same location has been chosen. The lack of capacity and misuse of waiting lists for getting a place in the home for elderly has been found to be a Zagreb specific problem. The city of Zagreb owns ten homes which makes far less than the capacity needed to accommodate people that requested a place in the home. The data concerning these elderly homes say how there are people that applied for position during the 80s and still did not get their accommodation, among many are poor and vulnerable citizens. It can be easily said that one is never too young to apply for his/her position in the home! However, it has to be emphasized that the poor and vulnerable groups have disadvantage in getting the accommodation in the homes which is the reason why most of the decisions made by commission for approval of accommodation remain unknown to the public.

This bureaucracy mentality leaves citizens without possibility to scrutinize it, which again creates an atmosphere which provides a certain level of corruption being constantly in process. Our aim was to create opportunities in which the civil society will have access to the lists and decisions made by the approval commission. We believe that being present as the third party in the process; the local government with its institutions will minimize situations in which corruption might occur.

3. Choice of ICT Tool

From the very beginning of the project, the team members have agreed to use ICTs in a broad sense. Available data about Internet usage in Croatia was little encouragement to make Internet media or Information kiosk as a center of the project. A different approach had to be taken: an approach that combines both, conventional and advanced information and communication technologies. Therefore, we have concluded to use existed advisory phone line system in the Transparency International Croatia and link it with CH Dubrava Internet site and Database of all nursing homes in the Zagreb.

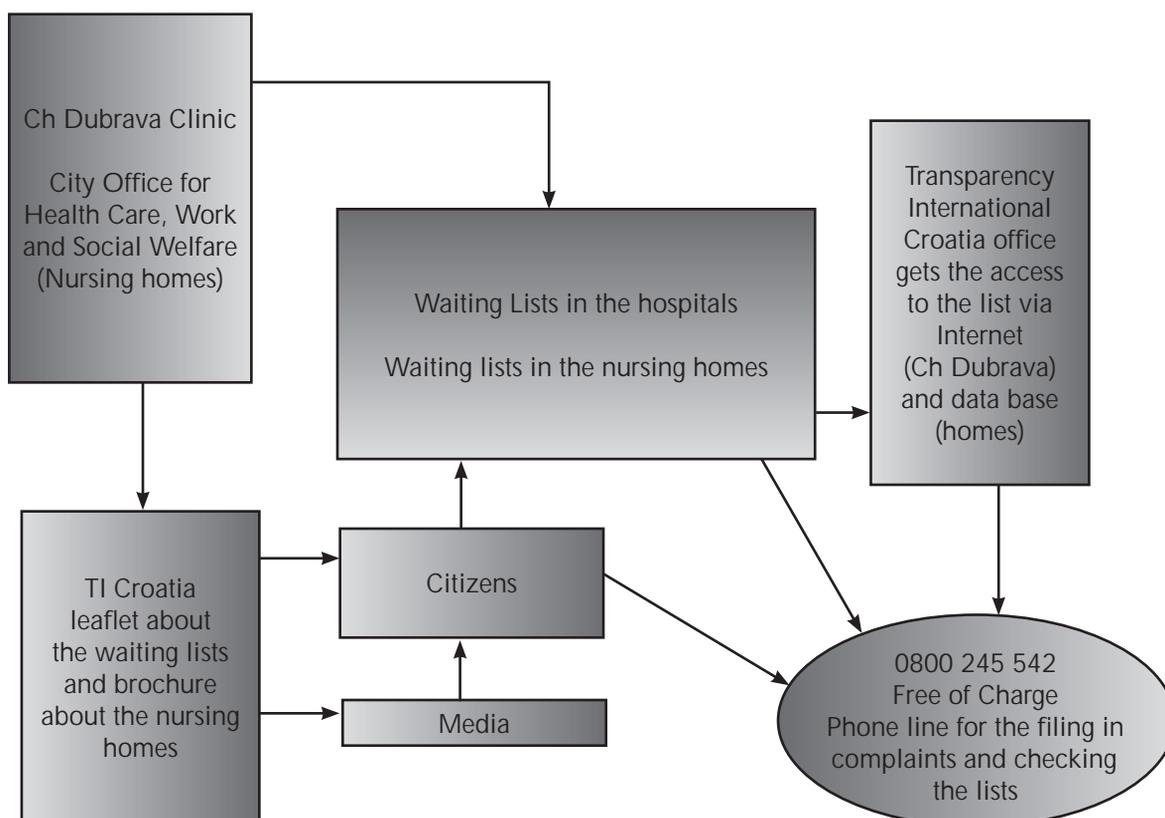
Since the required outcome of the project has to be increase of transparency (of the waiting lists), effectiveness and quality of public services using ICTs, we were at first puzzled how to, consequently, monitor the increase of effectiveness and quality only by making lists public. Here, we successfully created a system in which building sustainable phone line as a complaint mechanism could be linked to waiting lists. By this, we actually offered our users both advisory and advocacy service which is crucial for the poor population whose silent voices are for the most part, neglected with the nonexistent financial capacity to get advice from experts.

4. Development of the Tool

Our quest started with the advocacy campaign in the Ministry of Health and Social Welfare, City Office for Health, Labour and Social Welfare and CH Dubrava about the project benefit. After serious discussions about personal data protection, it was concluded that CH Dubrava should post waiting list from gastro-enterology department online. Patients will be placed on the list under the health insurance code number. This list will provide information about the date of designated medical treatment and date when the patient was given information about his/her hospitalization. The community will have unlimited access to this list via Internet and for those who do not have Internet access, TI Croatia will provide the monitoring service via free of charge phone line. Apart for monitoring service, it was agreed how TI Croatia will offer to its users, a possibility to file in the complaint for possible case of misuse of the list or any other unfair treatment in the hospital. TI Croatia keeps the right to seek the official answers about the malpractice in the CH Dubrava. For that

purpose, TI Croatia developed a specialized database to keep the complaints record and to monitor and evaluate the project outcomes. The database is user friendly, and can be easily understood within the process of training. It contains various personal data that need to be filled out, such as name, surname, birth date, residence, status and level of their inquiry, or complaint. In this way, we could then sort our lists of clients by their inquiry, date of their call, place of residence, institution, and name. Most importantly, the software is installed with the feature of generating percentages of the variables. In case, the person wants to remain unacknowledged when reporting a complaint, their wish is granted by listing them as "ANONYMOUS". They are later on tracked by the date of their call. The software used for this application was created by TI's administrator - it requires minimum hardware capacity, and is easily used by people who lack extensive computer knowledge. Waiting lists for surgery and medical tests, as well as for nursing homes will be given to us either in electronic format or as in hard copy format. Those lists will be

The elements of Croatian ICT model:



coded in order not to deviate law on Legal Protection on Private Information. Lists will be kept in TI Croatia office as in case 2 or on TI Croatia web site as in case 1. TI Croatia team-members and volunteers will disseminate this information via phone line and radio and local TV announcements.

One of the outcomes of the first focus group was possibility of developing the brochure for elderly social welfare users that will guide them about their rights to

be accommodated in the elderly homes with special care and treatments in case, they are ill. Since the brochure fits into the conventional information dissemination, techniques that are easily accessible by older poor people, we have decided to make this brochure as a final integral part of ICT model.

After the whole ICT model was rounded, the implementation started in October last year.

5. Maintenance of the Tool

With certain changes, TI Croatia project team consists of 4 members, two of them having operational roles and two of them acting as advisor and spokesperson.

The team members who were involved in daily operations were also in charge of maintenance of the tool.

From October onwards, each working day both lists were checked up and the brief record was written about the state of the list. In case of any changes or, indeed, suspicious situations (i.e. the list had not been updated, the access

has been denied, the Internet site of CH Dubrava on which the list is placed has been experiencing an error), the project coordinator immediately consulted contact persons. It is important to mention that we had contact persons in homes, CH Dubrava and in City Office for Health, Labour and Social Welfare. On the other hand, volunteers that handled free of charge citizens' advisory line worked in the shifts from 9:00 – 13:00 and 13:00 – 17:00. In that period, patients were able to check the list, request the information or file in the complaint. All phone calls were recorded in to the database, which was weekly examined by the project coordinator.

6. Monitoring and Evaluation

As it was emphasized earlier in the report, monitoring was done through phone call records database and or personal examination of the lists.

Volunteers in charge for handling the phone line were trained how to use the database by project coordinator. The training on handling users' complaints was done by project advisor.

Every phone call was recorded immediately upon the end of phone conversation. Volunteers were trained to provide concise, argumentative and clear description of the problem.

One of the most important tasks of volunteers was preparing the file for project coordinator who was in charge to take action steps toward resolving the case.

In terms of lists monitoring, the access to homes database was installed on the project coordinator computer. Only the project coordinator has access to it due to the security reasons.

Upon citizen's request, the project coordinator checked the position using the application code.

The users' satisfaction with our service was done by a phone call questionnaire, that is, the volunteers followed up the communication with the users by asking to rate their satisfaction with our response, quality of advice, velocity of answers, thoroughness etc.

As for the evaluation, due to limited financial resources, it was not possible to hire external evaluator for the project rather we had to rely on the internal possibility to objectively evaluate our work.

One of the strategies used was number of press materials issued during the media campaign. During the length of the media campaign, more than a dozen articles were issued. After we launched the brochure (information pack) for social welfare users on the rights and possibilities for accommodation and special treatment in the homes, we asked all heads of social welfare centers to give their evaluation

and assess if the brochure served its purpose and helped poor elderly population. The brochure was evaluated as highly positive by a substantial number of users.

The last approach used was the final focus group in which we managed to get together different types of vulnerable groups: disabled people, single mothers, refugees and Croatian nationals from Bosnia and Herzegovina, poor people suffering from rare diseases etc. Based on our presentation and project description, they positively evaluated outcome effectiveness.

The user's feedback information about the ICT model

The users have positively commented about the brochure especially about the nursing homes in the city of Zagreb emphasizing the informative aspect of it. The most feedback comments were given throughout the social centers in the form of letters.

The ICT users that were checking their place at the list or filing in the complaints evaluated this service as a useful and necessary one. The feedback comments on lists were given over the personal contact or over the phone. It was emphasized on several occasions by the users that transparent public lists have positively impacted the work of the hospital by creating the culture of fairness and accountability.

The service providers feedback on the ICT model:

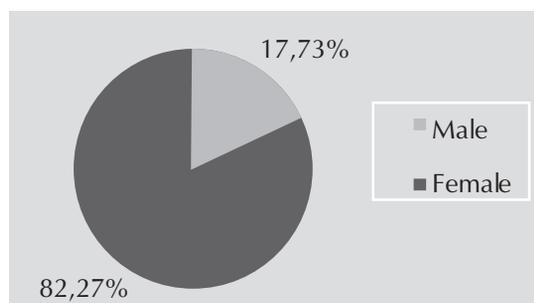
As for the service provider, the positive feedback about the ICT model was present, as well. Particularly positive comments were provided by the branch offices of the Centre for Social Welfare. The brochure was found useful as a guideline for the better understanding of the law, rules and procedures in the system of nursing homes.

The benefits of publicizing the lists were recognized by the hospital, as well. However, it should be noted that in April this year, the contact persons within the CH Dubrava were less cooperative about the model maintenance with the argument that the project is taking too much of their time for which they are not paid. TI Croatia pursued to resolve this situation on

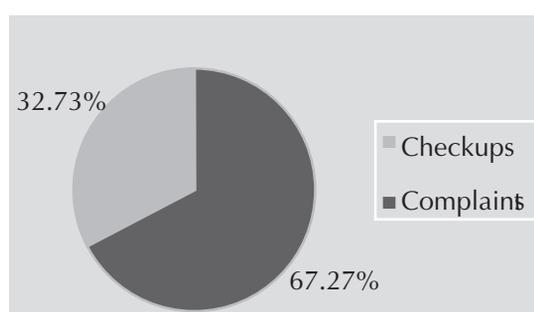
the mutual satisfaction having in mind that the satisfaction of the patients has to be in the first place, both to the hospital and civil society community.

Statistical data collected from the database	
Gender	
Total Male:	17.73%
Total Female:	82.27%
Total lists check pps and filed in complaints	
Total check ups:	27%
Total complaints:	32.73%
Check up: Waiting list in CH Dubrava	22.27%
Check up: Application Lists – Nursing homes	44.55%
Check up: Health and social welfare sector	0.46%
Complaint: Waiting list in CH Dubrava	1.36%
Complaint: Application Lists – Nursing homes	1.82%
Complaint: Health and social welfare sector	29.55%
Level of complaint	
Total complaints for CH Dubrava:	91.18%
Total complaints for nursing homes:	8.82%
Level of complaints: CH Dubriava:	
Waiting list:	4.84% [4.41%]
The head of hospital:	0.00% [0.00%]
Ministry of health and social welfare:	14.52% [13.23%]
Others:	80.64% [73.53%]
Level of complaint: Nursing homes	
Application list:	33.33% [2.94%]
Approval commission decisions:	16.67% [1.47%]
The decision of the nursing home board:	0.00% [0.00%]
The decision of social welfare centers:	33.33% [2.94%]
Ministry of health and social welfare:	0.00% [0.00%]
City office for health, labour and social welfare	0.00% [0.00%]
Others:	16.67% [1.47%]
Status of requests and complaints	
Accepted	89.55%
Denied	0.00%
Unknown	10.46%

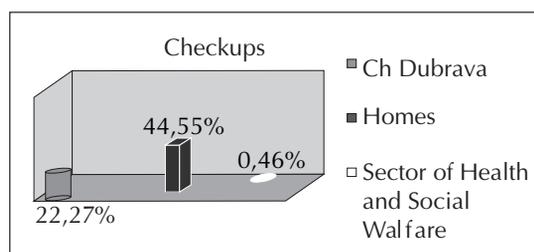
Graphical overview	
Total male:	17.73%
Total female:	82.27%



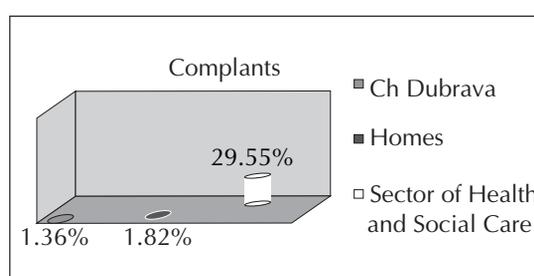
Total check ups:	67.27%
Total complaints:	32.73%



Checkups: Waiting list in Dubrava	22.27%
Checkups: Entrance list for homes	44.55%
Checkups: Health care and social welfare sector	0.46%



Complaints: Waiting list CH Dubrava	1.36%
Complaints: Waiting list for nursing homes	1.82%
Complaints sector of health and social care	29.55%



Focus Group Discussion I

On April 8, 2004 Transparency International Croatia Research Team members organized two focus group discussions with users of Center for Social Welfare "Trešnjevka" (branch office). This event has been organized in cooperation with Center for Social Welfare "Trešnjevka" with official approval of Ministry of Health and Social Welfare of Republic of Croatia. The Focus Group Discussion has been held in the premises of "Trešnjevka" Center for Social Welfare.

Focus groups have been conducted separately for men and women, as this suggestion came from the Head Research Advisor in this project, Dr. Gopakumar Krishnan.

In each of the group, there were 7 participants and discussions lasted for 60 minutes. The female focus discussion group was moderated by Ms. Ana First and male focus discussion group was moderated by Ms. Selma Rojnica. Afterwards, answers from both of the focus discussion groups were discussed and compared among team members. Twenty-one questions were discussed among users of the Center for Social Welfare "Trešnjevka". The same questions were discussed and analyzed in both of the groups.

Analysis of female FGD

Number of participants: 7

Age of participants: Between 40 and 70 years of age

Marital status: 5 married
2 single

Education: 1 elementary school
5 secondary school
1 MA degree

Social & economic status:

Women on Welfare benefits (welfare checks) and dole.

Three out of seven women lost their jobs during the early 90' as a labour force surplus. One is 100% disabled, hence never been employed, two are single mothers without jobs.

Six out of seven women are tenant of state owned apartments and only one participant inherited an apartment as a family property.

Monthly financial support given by center for social welfare for the household:

- 890.00 HRK (approximately 80.00 GBP)
Two persons per household
- 1770.00 HRK (approximately 160.00 GBP)
Four persons per household
- 800.00 HRK (approximately 72.00 GBP)
Two persons per household
- 1500.00 HRK (approximately 136.00 GBP)
Two persons per household
- 2000.00 HRK (approximately 181.00 GBP)
Five persons per household
- 1200.00 HRK (approximately 109.00 GBP)
Three persons per household
- 700.00 HRK (approximately 63.00 GBP)
A single person

Health condition of the participants:

- cerebral palsy
- cardiovascular diseases
- hearing problems – deafness
- diabetes
- impairment of the colon (100% disability)
- kidney failure
- osteoporosis

Quality of health services in the hospitals in Zagreb area:

Participants have agreed that the quality of health services at Zagreb hospitals is poor.

They have identified several areas where prompt improvement is needed:

1. The time needed for getting the appointment arranged.
2. Waiting lists in the hospitals should be public and patient should have opportunity to check his/her position on the list.
3. Obsolete and inconvenient equipment within some of hospital departments such as Gynecology Department.
4. Lack of hospital beds which makes waiting time for surgeries even longer.
5. Inappropriate accessibility, especially for disabled people – only one hospital in Zagreb area is accessible by tram, others are accessible by buses which are not frequent or by car that participants do not have.
6. Availability of gadgets for disabled people (wheel chairs, crutches, hearing aides...)
7. Double standards in treatments of patients. Respondents strongly believed that poor and socially excluded people have different treatment than employed middle class or upper class citizens. It is in their opinion, that poor people are often stigmatized for being poor and that doctors and nurses are in favour of those who bring them small presents as coffee, sweets and flowers.
8. Arrogance of doctors towards patients. It has been said that older doctors treat them better in comparison with younger ones who are usually arrogant and haughty.

The behaviour of staff in the hospitals:

It has been said that most well behaved staff in Zagreb hospitals are nurses. It is general opinion that older doctors have more understanding for their problems and that they treat them better with more compassion and kindness. They had complaints on the behaviour of desk receptionists who treat them in an inappropriate manner.

The treatment procedure in hospitals:

The participants had no significant complaints on treatment procedures in the hospitals. However, they have agreed that referrals should be open for a minimum of one year. Currently, they are open only for a month,

which repeatedly causes botheration for those who are disabled.

Possibility of choosing doctors:

Respondents have said that even if there is possibility of choosing the doctor for particular treatments, they are not aware of that. When a moderator explained them that the patient has right to chose specialists, they were doubtful about the fact that they could fulfill that right. Again, the moderator has faced a problem of apathy.

The quality of services at center for social welfare "Tre'njevka":

It was said that social workers couldn't do much since their hands are tightened with insufficient legal system in the country. According to the opinion of respondents, social workers could do much better if laws were flexible enough. Good cooperation between social workers and employment officers is missing. Social workers should be more involved in educating beneficiaries about their rights.

Accessibility of information:

Respondents have said that most of the time, they informed themselves about health services trough radio announcements or through word of mouth in the Centers.

Some of them knew that Ministry of Health and Social Welfare have free of charge citizen's advisory phone line but they said that most of the time, the line is busy.

They have identified TV as a best communication tool together with radio programmes for informing patients about health services. It has been suggested that either CSOs or Centers for Social Welfare create leaflets written in a simple and understandable manner about patient's rights, especially for those who are social welfare users. Those leaflets should be disseminated in the soup kitchens, centers for social welfare, ER, hospitals and shelter for homeless.

Grievance redress mechanisms:

Respondents were not familiar with grievance redress mechanisms apart from phone line established by Ministry of Health and Social Welfare. They do not have faith in grievance redress mechanisms introduced recently (Moderator has informed them about that)

as they said that most of the institutions introduce those mechanisms only because of self-promotion and nothing concrete has ever been done about citizen's complaints. It is common belief that all decisions are made at the top of executive power and even if someone shows initiative to help them, he or she faces obstacles either in the existing laws and procedures or within the system that is, according to their opinion, corrupted.

Issue of medicines that should be available free of charge:

Even though this question was not explicitly asked, participants felt free to present the case of medicines that were free of charge but recently withdrawn from the list of free medicines. Those medicines are essential for the normal life of participants, therefore needed on a daily basis. With the introduction of the paid medicines, Centers for Social Welfare and Croatian Caritas are covering part of the expenses for chronic diseases but still some medicines remain uncovered. It is obvious that socially excluded and poor people cannot afford to pay those medicines, which leaves them with no exit option.

Respondents have said that civil society organizations should be more involved in lobbying among decision-makers for finding good solution for this problem that could work in the interest of both sides.

Analysis of male FGD:

Number of participants: 7

Age of participants: Between 25 and 50 years of

Marital status: 2 married
5 single

Education: 4 elementary school
3 secondary school

Social & economic status:

Men on Welfare benefits (welfare checks) and dole. All unemployed, four of them without any job qualifications. One of them lost his job in the factory at the end of 80'. One person is living in a shelter for homeless, two are living in state owned apartments, and four of them still live with their parents, brothers and sisters.

Monthly, financial support given by center for social welfare for the household:

- 900.00 HRK (approximately 81.00 GBP)
Two persons per household

- 900.00 HRK (approximately 81.00 GBP)
Seven persons per household, only two of them are on dole

- 600.00 HRK (approximately 54.00 GBP)
A single person

- 900.00 HRK (approximately 81.00 GBP)
Two persons per household

- 900.00 HRK (approximately 81.00 GBP)
Five persons per household, parents are getting welfare checks for each of the children.

- 1500.00 HRK (approximately 136.00 GBP)
Three persons per household

- 600.00 HRK (approximately 63.00 GBP)
Single person.

Health condition of the participants:

- diabetes
- kidney failure
- PTSP

Quality of health services in the hospitals in Zagreb area:

Quality of health services in the Zagreb hospitals is rated relatively satisfactory. Major complaints were about long waiting time for surgery and medical tests. Majority complained about availability of doctors/specialists. Quality of treatments was rated high.

The behaviour of staff in the hospitals:

All respondents have agreed that most well-behaved staff in Zagreb hospitals that they are visiting frequently, are nurses. Since majority of respondents have serious diseases they have their own specialists which behave in the correct manner. They have complaints about the behaviour of desk receptionists.

The treatment procedure in hospitals:

Same as in female discursion group, the male participants had no notable complaints on treatment procedures in the hospitals. Nonetheless, they have mentioned that referrals should be more flexible. At the

moment, they face problems reaching doctors within the month, which is duration time of referral. After a month, they have to ask for new referral which is issued by general practitioners. All of this slows procedures of getting the doctor's appointment.

Possibility of choosing doctors:

Respondents have said that in case they, want to see a particular doctor, they have to wait even longer hence, possibility of choosing doctors is really not applicable or significant to them.

The quality of services at the center for social welfare "Trešnjevka":

Two out of seven FGD participants said that they are satisfied with quality of services at the center for Social Welfare Branch Office "Trešnjevka". They have emphasized that welfare checks always come on time. Others have said that quality of service needs improvement. Again, like in female FG, they have said that cooperation between Center and Office for the Unemployed is not as good as it should be. Three of them are attending career advisory in Office for Unemployed for five years and nothing happened, since.

Accessibility of information:

Respondents have said that most of the time they informed themselves about health services through word of mouth in the Centers from social workers or around friends.

They showed lack of faith in the advisory phone line system established by Ministry of Health and Social Welfare and Croatian Institute for Public Health.

They have identified radio programmes as the best mean for accessing the information about health services. In terms of health side benefits for poor population, male respondents believed that best possible way to inform them is through leaflets or billboard announcement posted in the Centers for Health and Social Welfare.

Grievance redress mechanisms:

As in female FG, respondents were not familiar with grievance redress mechanisms apart from phone lines established by, Ministry of Health and Social Welfare and written complaints that could be filled to Head of Hospitals.

They said that it is much wiser not to complain at all as retaliation situations are not rare in Croatia according to them.

They would like to see the ombudsman office more involved in protection of rights of poor people. According to them, ombudsman could act as a mediator between complaints of the poor patients and executive power in the country.

Disability assessment panel:

Among male respondents, one of them was a war veteran suffering from PTSP, diabetes and kidney failure. Since he is a beneficiary of social welfare Disability Assessment Panel, he is entitled to decide to what extent he needs help. A help that he is getting is not enough for proper treatment, especially since he needs more markers for diabetes per month than he is getting at the moment. If he asks for more, he gets response from DAP that according to existing law, he is entitled only to those given to him.

Focus Group Discussion II

The project team has again organized focus group discussion on the 6th of May 2005 consisting of six people – users of national social welfare programme. This event has been organized in close cooperation with Centre for Social Welfare “Novi Zagreb” and Association for Disabled People.

The three groups of questions have been given to the participants to give their insights about them. The project team has conceptualized 19 questions out of which 7 were related to the social welfare programmes, 7 were related to the area of health services, 2 questions were related to the grievance redress mechanism and 3 questions were investigating the most suitable means of communication with the social welfare users.

The number of participants: 6

Female: 4

Male: 2

Age: Between 36 to 59 years

Marital status: 5 married
1 single

Education: 1 elementary school, 3 high school and 2 undergraduate

Social status: social welfare users

Housing: 4 with own properties, 1 in a rented place, 1 in nursing home

Health conditions: chronic diseases (liver transplantation, heavy hip conditions, multiple sclerosis, paraplegic, heart diseases)

Due to serious health conditions, participants need permanent health and rehabilitation services including orthopaedic accessories.

Some of them are users of the pension found for the disabled people. All of them are users of the welfare programme (monthly welfare

paychecks). One of them is a single mother who got fired from the job during her second pregnancy which is serious violation of the Labour Law in the Republic of Croatia.

The paychecks vary from 1000 – 2600 kn (from 96 GBP up to 250 GBP) per month. For those who have physical disability, up to additional 200 kn (20 GBP) is available. Single mother gets 1200 (120 GBP) for both children.

Social welfare services and rights:

Analysis of the questions related to social welfare services and rights:

All participants agreed that the accurate information about the social care rights is not fully available to the users. Most of the time, they depend on the internal communication spread between users itself. Their social welfare officers and workers rarely visit them in their own premises. Most of the time, social workers do not have enough time and patience for listening users' inquiries over the phone. All of the FGD participants have bad experiences in getting the right information. Some of the experiences are rather disturbing and horrific. An FGD participant with multiple sclerosis when seeking for additional help considering her terrible and complicated situation has been advised by the social worker not to push as patient suffering from multiple sclerosis do not live long. This example clearly shows that the workers within the state institutions violate human and patients, rights as well as jeopardize user's overall health.

The users' perception about the work of the Social Welfare Centers is strongly negative. The FGD participants find employees of the Centre not interested in the issues of social welfare users. On the top of it, in the situations when a user asks for the explanation of the law or some other documents, the social workers use professional language that is hard to understand.

Overall, the FGD participants criticized the social public sector. A just paraplegic person who happens to live in the nursing home said that the staff in the home is very cooperative, supportive and helpful.

The quality of the health services:

The opinions about the level of quality of the services in CH Dubrava, CHC Rebro and Hospital Sv. Duh have been different.

Some of them have very good experiences in the aforementioned hospitals and some experiences are bad. However, all of them have identified Hospital Sv. Duh to be the worst when it comes to the level of service quality.

Concerning the publicized waiting lists, the FGD participants have not been aware that such lists exist. Only one participant has said that she has read about it in the local newspaper. Though they heard about the waiting list for the first time, FGD participants have agreed that transparent waiting lists are one of the main factors for combating corruption in the hospitals.

The major criticism was reserved for waiting time inside the hospitals for surgery or diagnostics. They emphasized the situation where it is not possible to make a hospital appointment via telephone but in person. This situation is rather difficult for the disabled people.

FGD participants are very often faced with the situation where levels of authorities have been changed without any public notice. This cause additional transport difficulties and expenses when trying to get much needed information.

In the situation when they have certain rights, the realization of it is very slow demanding lots of energy and efforts. Therefore, they rather give up instead of waiting for the long time for

the process start.

They are not aware of the right for second opinion and consequently, they never asked for it. It is their belief that practitioners should work more on patients' education.

Availability of information:

The FGD participants have agreed that most of the time they depend on internal communication (spreading the words between welfare users). Beside difficulties in assessing the right information within the public institutions, they are unsatisfied with the work of their own associations which should protect their rights and provide them with all necessary information.

They identified TV and radio as the best means of communication. FGD participants would like to see more brochures about the welfare programmes or health services.

Since they read free of charge city newsletter, they would like to see more topics related to social and health care in it. Those newsletter pages could be used as an information board for them.

FGD participants have agreed that civil society organizations should work more carefully in protecting the rights of poor and vulnerable. They welcome the idea of having the free of charge phone line complaint mechanism.

APPATHY – the majority of FGD participant's reaction as a consequence of inability to fulfill the rights.

Focus Group Conclusion

The FGD participants consider availability of the right information as a priority. The right information about the social and health care benefits or programmes provided in a timely manner can save their lives. The transparent waiting lists have been identified as a valuable contribution to the increasing effectiveness, quality and transparency of public sector.

Their suggestion for the improvement is connected to development of guides or manuals for using the services defined in the Law of Social Welfare Protection. As a concrete measure, they said that the City of Zagreb should find the resources for covering the phone bills (up to a certain extent) for disabled people, since they are dependant on it.

7. Project Obstacles

Taking in to consideration, limiting situations and factors in the project, like the length of the project, financial resources, time consuming process of establishing partnerships with national and local governments, we may say that the project delivered satisfactory results. However, throughout the project implementation period, certain obstacles were present.

Let us begin by mentioning those obstacles on which we could not influence much. The personnel changes threatened the project from the very beginning. Originally, the partner organization Association for Democratic Society Development appointed a project coordinator in January 2004. After a month and a half, the project coordinator had to be replaced due to her illness. A new project coordinator formed a team that again had to be changed because one team member left the organization in December 2004. At the end, in May this year the project coordinator left and the project was given to current staff in TI Croatia office and Project Advisor to lead it until its end. These changes, though managed very well, slowed down project actions.

Another obstacle relates to governmental members and administration staff changes in winter 2004 which grounded major shortcomings of the project plan, that is project re-planning in order to obtain all permission

and still start with ICT implementation in October.

Ensuring media presence was difficult during the life of the project. Since the media exercise was undertaken by TI staff (people without PR experience), we spent a vast amount of energy and effort trying to get our story in reputable daily papers and magazines.

At the end, we can conclude that media coverage was present during the life time of the project but in depth analysis of the core problems and our solution to it was not sufficiently done by press.

The inadequate media campaign was the major reason for the declineing curve of the phone calls, which was later on slightly improved.

At the end, it has to be noted that research component of the project experienced a level of minor difficulties. Our phone calls database faced technical backlash of which we were not aware at the time, but it continued to be in the procedure of development. The most of the complaint in CH Dubrava fall in to the category "others" (meaning other levels within the hospital) which does not enable us to deal with the problem other than naming it and advocacy for improvement.

8. Lessons Learned

This project brought us all important lessons for the planning of future activities and projects. First, from its very beginning, it emphasized the importance of building partnership relations with both, national and local governments. More over, it stressed out that verbal communication with decision makers within the state institution is not enough. Cooperation has to be carefully and exhaustively described in the binding document that we called Memorandum of Cooperation and Understanding. We have learned that insisting on nomination of contact persons from the institutions in charge for communication with us was crucial.

The media presence is of great importance for the delivery of desired outcomes, therefore more “out of box” thinking while preparing the media campaign should be present.

Before creating the project action plan, detailed discussion with service users in the form of focus groups should be done. In our case, hypothesis was chosen in February based on the existing researches and opinions of team members and focus group was organized

in April aimed at checking up the hypothesis. The good thing was that the hypothesis was proven to be correct but active presence of service users from the start might have shaped the project action plan differently.

The research component is quite important. We have learned that additional attention and financial resources have to be invested in to the software that monitors project deliverables in order not to end up in a situation where your data is not accurate. Good software support has to be installed for transferring the qualitative data in to the quantitative one.

However, TI Croatia managed to start the process of transparent waiting lists. This process has not been started anywhere in our neighborhood and yet we prove, that it is possible. The sustainability of the project is not questionable as the Ministry of Health and Social Welfare invited us to continue cooperation of publicizing the lists in other Zagreb and Croatian hospitals. More precisely, they included this initiative in the most recent reform activities within the upcoming four years.

9. Selection of Cases for the Database of the Projects

Throughout the timelines of the project, we received a number of calls and inquiries about the waiting lists for surgeries and medical procedures. We provided this information as promptly as possible. In some cases, we received words of gratitude from clients who claimed to have received the needed information only after mentioning their plans to contact the TI Croatia office in Zagreb.

Beside the regular number of calls we received to deliver the waiting list numbers and the possibilities of accession, a number of calls were directed in order to complain or report instances when our citizens evidently perceived possibilities of corruption but also evident mistreatment.

One of our calls, for instance, was from an anonymous mother who took her child into a health center near Zagreb where the doctor insisted that she should receive a vaccine which would be ordered from the medical supplies of the center. The parents soon found out that the vaccine can be purchased in various numbers of the local drugstores and cost half the price of what doctor planned to charge them. While pursuing their right to

provide the drug in the cheapest manner, one of the parents called to report the doctor, and the misuse of the position while making all parents pay the double price. We found out about the case, and instructed the client to report it to the Ministry of Health, and also the "White telephone", a toll-free number that serves particularly for reporting corruption and mistreatment within the health centers and institutions under the authority of the Ministry.

A similar situation happened when we received a call from M.E. from Dalmatia regarding a doctor who was providing sick days and entries to recovery centers only to people who in some ways helped him around his own house, be it gardening, painting or repairing furniture.

We continuously tried to provide, promptly and effectively, all the information regarding the institutions and departments the client should contact when mistreated or pursuing his/her entitlements. Simultaneously, we had numerous clients who received information about their waiting list status only after they contacted Transparency International. The gratitude of the people who phoned back to thank us was an honour and privilege in itself.

DFID KaR Pro-poor ICT Research - Project Team

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Transparency International, Croatia

Transparency International Croatia is a civil society organization founded in 2000, devoted to combating corruption, bringing civil society, media and government together in a coalition against all forms of corruption. TI Croatia does not expose individual cases; rather, in an effort to make long-term gains against corruption, TI Croatia focuses on prevention and reforming systems.

So far, its main interest were: conflict of interest of public officials, accessibility of information, promoting of ethics in judiciary, promoting the role of media in the fight against corruption, development of National Integrity System Study, conduction of research on citizen's corruption perception and development of Advocacy Legal Advisory Centre.

Till date, the three most important projects were "Increased Accountability in the Western Balkan" – regional project on conflict of interest and access to information, ALAC project and project "Improving the transparency, quality and effectiveness of pro poor public services using Information Communication Technologies (ICTs)".

For more details on the project, please visit,
<http://propoorict.ekduniya.net>

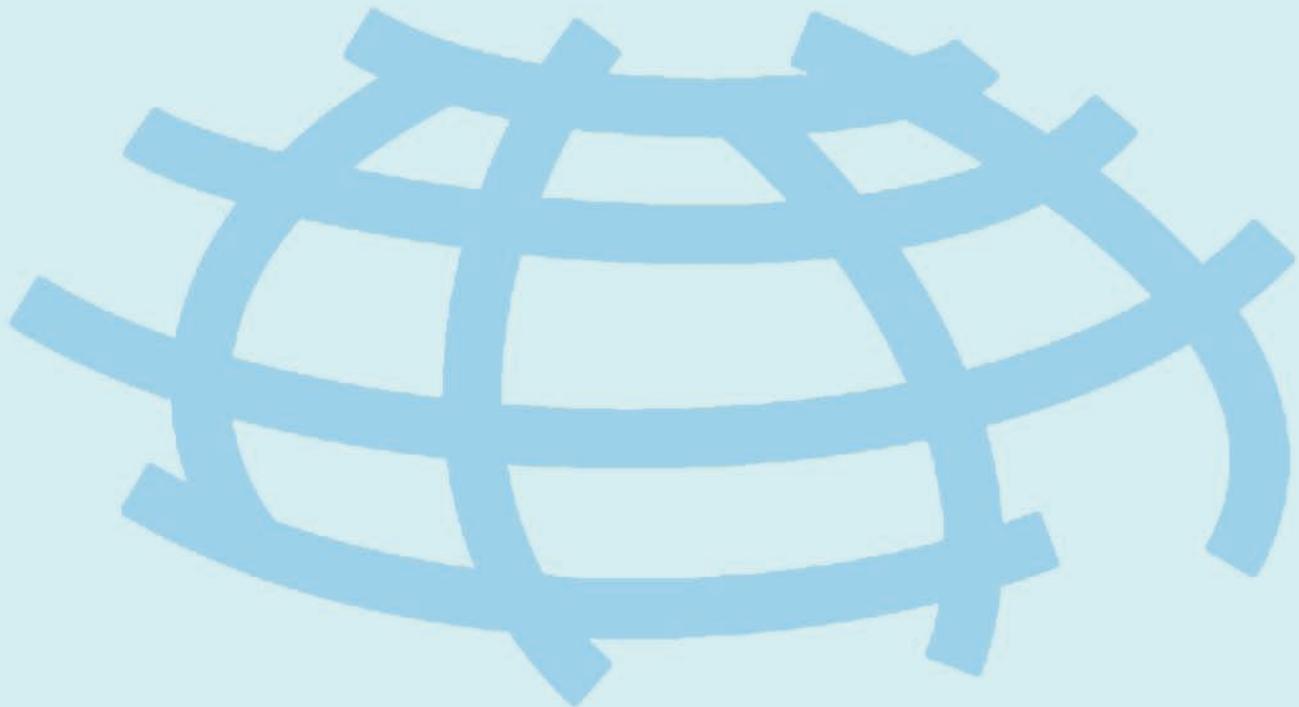
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OneWorld South Asia

OneWorld South Asia – the South Asian Centre of OneWorld Network with independent and autonomous governance structure – works towards use of Information, Communication and Technology (ICT) for promoting sustainable development and human rights, in India and in all the five south Asian countries and a few other countries in the West and East Asian regions such as Myanmar, Maldives, Afghanistan, Vietnam and Cambodia. The core focus of OWSA activities is to strategically position ICT tools — ranging from the internet, mobile telephones to community radio — enabling the poor to communicate on developmental issues and work towards realisation of Millennium Development Goals (MDG).

With a strong network of more than 700+ civil society organisations as partners, OneWorld South Asia (OWSA) works symbiotically to achieve these goals through four major programme areas: "voice the voiceless" through grassroots communication; channelise knowledge for development efforts; advocate for inclusive and pro-poor ICT policy; and enhance partners' capacity to communicate and advocate for affirmative policy change and public action.

These programme areas function as focused operational units with organic inter-linkages within a larger conceptual level strategic framework. Two anchoring division – Partnerships and Programme Co-ordination (PPC) and Capacity Building and Technical Services (CBTS) actively support and feed into the outcome of these programme areas.



A development organisation working with poor and marginalised communities and facilitating processes for achieving the Millennium Development Goals

- Advocating for inclusive and pro-poor ICT policy
- Enhancing partners' capacity to campaign for affirmative policy change and public action
- Giving a voice to the voiceless through grassroots communication
- Promoting communication for development



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