DFID Department for International Development

OneWorld South Asia
Connecting Communities, Empowering People

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

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India National Report
November, 2005

Published by:

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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.

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 for 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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Executive Summary

The basic tenets of democratic governance have underlined the need for participatory, inclusive approach to all governance processes. In today's information age, this tenet becomes even relevant as information combined with knowledge sharing have become key to the true empowerment of people, especially the poor.

However, the fact remains that public services in most developing countries face several operational challenges and often do not reach the target beneficiaries. The poor and disadvantaged in developing countries are unable to access these services due to physical, financial, informational, political and other barriers.

To address this gap, OneWorld **International (OWI)** was entrusted by **the Department for International Development (DFID)** to conduct a **Knowledge and Research (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 the four implementing chapters of this action research.

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

OWSA, as implementer of the India chapter of this action research, selected the health sector and within that, zeroed in on maternal and child health care for an ICT based intervention to improve the quality, transparency and effectiveness of services in this area.

Most of the participatory action research techniques, such as surveys, interviews, Focus Group Discussions (FGDs) were used in all stages of the project. These were to select the sector, i.e., health that needed intervention, the project site (Badarpur, in a peri-urban area bordering Delhi and Haryana); the project partners (IPPVIII run maternity hospital); the socio-economic profile and health needs of the community and their access to pro-poor health services; the choice of the ICT tool and to evaluate the impact of the ICT intervention on enhancing the out reach of the hospital to the community and the community's increased utilisation of hospital facilities.

Voice communication was identified for the ICT intervention and a toll free telephone line was installed at both ends the community and the hospital. The line was installed to open a two-way interaction between the community and the hospital to provide information relevant to the community and feedback to the hospital authorities.

A major outcome of the project was increased utilisation of hospital facilities by the slum dwellers and sincere efforts by the hospital authorities to enhance their outreach to the community. It also brought about positive changes in the health seeking behaviour of the people and hospital staff's perception towards their health related needs and demands. There were limitations and challenges as well, such as the uncertainty caused by delay in eliciting responses from the service providers, issues over ownership and maintenance of the ICT tool and the slow responses from both sides on being a part of the intervention.

This notwithstanding, the project has gone on to demonstrate how 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 shown that ICTs can be neutral catalysts, acceptable to both sides as platforms for information exchange and communication.

The research has also shown how people's participation in the design and development of programmes meant for them, can be more effective than those that follow a top down approach. The same goes for technology applications which need to be designed with the inputs of the end users to be usable and sustainable. This intervention has also exhibited the effect of increasing citizen participation and it represents a move towards empowering both individuals and CSOs and increasing their capacity to hold governments and public

services to account. Better feedback and transparency will also increase the quality and reduce the costs of public services to the poor.

The project has spawned new projects and research initiatives that that use VOICE as a mechanism to share information and knowledge to benefit the people.

We hope that the learnings from this intervention, shared through a tool kit to improve delivery of public services, would be used for designing appropriate programmes for delivery of public services to the poor.

1. Structure of the Report

1. About the Pro Poor Action Research
2. Project Goal and Research Framework of the Indian Chapter
3. Project Implementation
4. Project Evaluation
5. Project Outcomes
6. Dissemination
7. Conclusion

2. About Pro-poor Action Research

There is a demonstrated need for mechanisms that will enable voices of the poor to be heard, and provide guidelines to design better procedures that will, in turn, enable governments to effectively respond to the needs and demands of the poor.

The pro-poor ICT Research Project, titled, "Improving Transparency, Efficiency and Effectiveness of Pro-poor Government Services using ICTs as a Tool", conceived by Dr. B. Shadrach, Director, OneWorld South Asia, is one such endeavour towards researching the feasibility of such a mechanism.

According to him, the main purpose of pro-poor action research is to focus on access to information and identify ways to improve the effectiveness of public service delivery to the poor and vulnerable sections of the society and the opportunities for ICTs to strengthen those mechanisms. It seeks to identify and use the appropriate ICT to disseminate information to service providers and users and provide appropriate means by which the poor can give their feedback to the government on these services.

However, the project seeks to use ICTs in the broadest sense that encompasses a variety of audio-visual mediums including telephone, internet, television, film and radio. Moreover, ICTs are viewed and used as a means and not an end in themselves. So, the aim of the project is to combine ICT with participatory techniques, such as Focus Group Discussions (FGDs), interviews, to gather views from the poor about various pubic services. This bottom up ICT approach, as discussed at the outset, is in contrast to the traditional ones (and indeed, public service provision), which tend to be top down and unresponsive to user needs.

Given this backdrop, international development organisations promoting pro-poor development policies and programmes were selected for this action research project in four countries. These included the country chapters of a reputed International NGO, Transparency International, in Croatia, Pakistan and Nigeria. In addition, OneWorld South Asia (OWSA), one of the 12 regional chapters of the UK-based NGO network, OneWorld International, was chosen for the project in India. OWSA leads international initiatives using ICTs to promote both human rights and sustainable development in the South-Asian region.

3. Project Goal and Research Framework

Goal: To deliver better health services to the poor.

Purpose: Improving the transparency, quality and effectiveness of pro-poor public health, especially MCH services using ICTs.

Duration: January 2004-June 2005.

Project timelines tables:	
1. January-March 2004	1. Sector selection
2. April-September 2004	2. ICT tool identification and preparation
3. October-December 2004	3. ICT tool implementation phase I (IVRS)
4. December-March	4. UCT tool implementation phase II (Real Time)
5. April-June 2005	5. Evaluation

The 18-month action research was divided in four main phases:

Project phases:

- Preparatory phase
- Research phase
- Implementation phase
- Evaluation phase

Methodology: Participatory action research

This project was conceived necessarily as **participatory action research** that **seeks** to achieve positive social change through ICT intervention. The guiding principles of this research method were participation and reflection, empowerment and emancipation of the community seeking to improve its social situation. To put it simply, action research is "learning by doing". It involves dual commitment as it requires an in-depth study of the system to comprehend existing problems, and then, strives to change it towards a desirable direction in association with its members. Accomplishing this twin goal requires active collaboration of researcher and client, thus stressing on the importance of co-learning as a primary aspect of the research process.

Participatory action research derives its methodology from participatory research, which involves a systemic inquiry, with the collaboration of those affected by the issue being studied, for the purpose of education and taking action or effecting change. Several other quantitative and qualitative research methods, such as secondary data review, interviewing, case studies, participant and direct observation, are generally used to increase the reliability and credibility of such research.
Stakeholder involvement is essential for proper implementation of participatory research projects. It seeks to bring together all stakeholders to facilitate participation and negotiations in focus group discussions and workshops. In the present project, this **participatory methodology** informed each stage of the research from sector and ICT selection to tool installation and implementation and evaluation. While the **stakeholder participation** was more evident in the sector selection stage, the post selection stage was marked by community and service providers' participation.

Some participatory highlights of the research are:

- Active involvement and participation of key stakeholders the government service provider and the beneficiaries, i.e., the community for whom these services are meant.
- Facilitator role of civil society organisations in bringing these stakeholders on a common platform, to interact and relate to each other.
- Prominent role of key players: the community and the service providers in decision making related to project implementation and evaluation.

Data collection:

The primary data for this participatory action research was collected through surveys, interviews, focused group discussions (FGDs), workshops and participant and direct observation methods. Secondary sources, such as government reports, online resources, etc. were consulted to delineate the methodology of the study and understand the status of pro-poor services in the Indian context.

Scope:

The scope of the project involved the following steps:

- **Selection of the research sector: OneWorld South Asia (OWSA),** the Civil Society Organisation (CSO) responsible for implementing the India chapter of the project, has chosen the health sector and within it, the **India Population Project VIII (IPPVIII)**, focusing on **Maternal and Child Health (MCH)** as the sector that needed intervention through appropriate ICT tools to enhance delivery of its services.

  About 25 hospitals and dispensaries were opened under the IPPVIII project in various parts of Delhi to provide MCH facilities to the slum population in and around the city. However, various reports and appraisals have shown little use of these services by the people or the real stakeholders. (for details, refer to the Sectoral Assessment Report)

- **Project site:** The **Badarpur Maternity Hospital** and a slum cluster named Mohan Baba Nagar, which is a peri-urban area close to the **Delhi-Haryana border** was chosen as the project site**.**

- **Project partners/stakeholders:** The key project partners involved in the imple mentation of the project are:

OneWorld South Asia: The main project implementing and facilitating agency responsible for conducting the action research.

Prerana: A local NGO focusing on reproductive health issues in the Badarpur area. Project partner to provide community outreach and contact.

IPPVIII: The IPPVIII Project Head as the lead support/collaborator from the government/service provider side.

OneWorld International: International organisation responsible for providing overall project management support.

Badarpur Maternal & Child Health Hospital: The local service provider that has the mandate to provide MCH health care, including pre and antenatal checkups, childbirth, immunization, and birth control services.

G-Block Community, Mohan Baba Nagar, Badarpur: The target beneficiaries. Within the community, the **specific target beneficiaries** availing the MCH services include women in the reproductive age group, i.e., 25-40 years; adolescent girls in the age group of 15-25 years; and 0 6 years old children and infants.

Stakeholder composition

Key Project Players	Role
1. G Block, Mohan Baba Nagar	Key Beneficiaries in the community
2. Badarpur Maternity and Child Health Hospital	Key Player from Govt. side
3. IPPVIII Department (Municipal Corporation of Delhi)	Catalyst from Govt. side
One world South Asia	Project implementer & Catalyst
Prerana	Community baded organization partnering with the project implementer.

The project partners collaborated due to mutual understanding and commitments to the project objectives. There was no formal agreement between OWSA and the IPPVIII authorities, representing the Municipal Corporate and the project implementers, despite best and sustained efforts by OWSA. A presentation made to the MCD commissioner, in September 2004, yielded little success. However, the project continued due to the support and interest shown by the IPPVIII project authorities. The only formal agreement in the project was between OWSA and Prerana, a project partner.

4. Project Implementation

The implementation of this participatory action research was achieved in stages that included:

a) **A baseline survey** in the selected community to understand the problems related to the availability, delivery and quality of health services and the attitude of the service providers towards their health needs and their infrastructural constraints in delivering health services effectively.

b) **ICT intervention** to improve the situation. Its main components were selection of an appropriate ICT tool, its embedding/ popularization in the community, acceptance of the tool by the community and its wide spread usage.

c) **Evaluation** of the impact of intervention on the community and the service provider.

Baseline survey:

The baseline assessment survey conducted in the project area in April-May 2004 and again in October 2004 (soon after the intervention) using participatory methods, such as focus group discussions (FGDs), interviews and face-to-face meetings, had thrown up a complex set of data on the problems related to effective delivery of health services to the community. Following are the main findings reflecting views of key stakeholders like the community and the service providers on this issue.

Community: The FGD conducted with the community, the target beneficiaries of the IPP VIII project provided near unanimous views about the quality of services rendered by the service providers. Almost 80 per cent of the respondents felt that the services at the hospital were not sensitive to the needs and requirements of the poor. The community felt that they were not able to access the hospital services because of:

- Their own health seeking behaviour,
- Lack of proper awareness and outreach,
- Lack of proper infrastructure and services,
- Hidden costs of free medical services,
- Behavioural and attitudinal issues,
- Exit options,
- Absence of any feedback mechanism.

As a result, most of the people preferred to go to local medical practitioners (quacks), Dais (midwives), and private hospitals for their health needs. Almost 70 per cent of the deliveries in the community were performed at home through the traditional midwives. Only in case of major ailments, where the costs were very high and they had no exit options, they would go to larger government hospitals, such as the Safdarjung Hospital and All India Institute of Medical Sciences.

Service providers: The hospital and project officials found the endless demands of the slum population, who wanted every facility free and at their doorstep, not according any priority to health, specially the preventive aspects, and responding to health only in emergency situations, as major impediments in effective delivery of services.

Both the hospital authorities and the project coordination cell, however, admitted that the non-negotiable project conditions laid down by the World Bank, in addition to the following problems, were largely responsible for the low level of service delivery to the target beneficiaries:

- Systemic issues
- Lack of infrastructure
- Low accountability
- Behavioural & attitudinal problems
- Improper resource allocation
- Project condition laities
- Health seeking behaviour of the community
- Beneficiaries considering free services as service at doorstep.

(Refer to annexure I for the details of the baseline survey)

Thus, the baseline survey revealed that the hospital faced some genuine infrastructure and staffing problems, which were impeding its efforts to provide services as per its mandate. In fact, the authorities sought support from the project team to address these issues before committing to be part of the project. They had clearly stated that in addition to the needs of the people, their needs too had to be addressed by such a project.

However, the Sector Assessment Report, brought out in the initial stages of the project, suggested that given the timelines and resources of the DFID project, it was not feasible to address all these issues and challenges that the report had thrown up.

Many of these, such as systemic problems, need to be addressed through an advocacy platform, which can be taken up after the completion of the project.

So, the baseline survey revealed that prior to the ICT intervention, the target beneficiaries were not availing the services provided by the hospital mainly because of:

- Lack of any communication channel between the community and the hospital staff, leading to inadequate information dissemination regarding hospital services to the community.
- Lack of interface between people and the hospital staff leading to attitudinal problems.
- Inadequate outreach from the hospital staff (except Basti Sevikas) to the community.
- Lack of proper MIS to check the availability of staff in the hospital to provide better services.
- Low coverage of target beneficiaries requiring the health services.

This situation necessitated some kind of intervention, preferably, an ICT tool that could provide a neutral, yet interactive space for the two sides to:

- Exchange information and create relevant awareness.
- Understand each other in a better way.
- Demand services (community from hospital, and hospital from MCD/relevant authorities).
- Promote better services for the poor.

ICT intervention:

The actual ICT intervention began in October, 2004 and lasted till June, 2004. The key stages of ICT intervention were selecting of an appropriate ICT model, embedding the tool in the community and the hospital, popularising and promoting the usage of the tool among the beneficiaries, acceptance of the tool by the community and the hospital staff and the outcomes of this intervention.

Selection of appropriate ICT model:

The selection of appropriate ICT tool was achieved in a participatory manner through consultations and FGDs with the stakeholders, the community and the hospital staff. It revealed that within the community:

- People were not comfortable with any intervention involving written text (people don't even read newspapers).
- New or evolved technology tools would not be very successful, as people were not acquainted with their use.
- Any familiar conventional ICT tool that they were already using would be acceptable.
- They had neither the ability nor the willingness to pay for any service.

At the same time, the service providers:

- Were reluctant to shoulder any added responsibility associated with a 'complicated tool'.
- Were not too keen to undergo extensive training for using and maintaining a tool.
- Were not keen to handle a tool that involved recording or maintaining data constantly.
- Were not keen to get into written communication/documentation/data collection/sharing.

Initially, the research team also considered using wireless to gather and relay the information through audio and video means and appropriate models were also developed. However, owing to budgetary and time constraints, instead of wireless and broadcast options, it was decided to use use VOICE based ICT tool that would allow free of cost two-way interaction and interface between the community and the hospital staff for information communication and dissemination. Such a tool would provide relevant information to the community about the hospital services and entitlements and feedback to the hospital staff on the needs of the community.

Thus, the simple phone line, an older form of ICT technology emerged as a tool that required little literacy or technical training and was easy to use by all members of the community as well as the hospital authorities. Such a tool supported by relevant software would allow easy recording and updating of information about services in the hospital. Importantly, it would also maintain a log of complaints received by the hospital so that the follow-up action on these could be monitored and evaluated. The proposed ICT model, therefore, was a dedicated, toll free telephone line to be installed at both ends the community and the hospital.

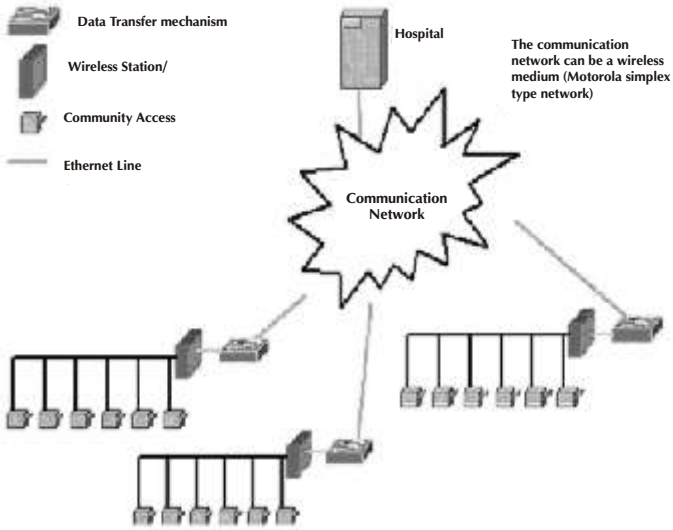
Accordingly, an ICT tool was developed based on the needs and abilities of the community and the hospital authorities to improve the interface between the hospital staff and the community it served. The tool constituted of a point-to-point phone line between the Badarpur slum and the local maternity hospital, connected to a computer that recorded and stored the voice data between the two points. The tool was designed and structured as an Interactive Voice Recording System (IVRS).

The steps involved in the utilisation of this facility were:

- The women/ adolescent girls would visit the access point and communicate their query/problem to the hospital through the telephone.
- The reader software at the hospital end would capture the data (the number and information).
- It will be updated on a daily basis through a central Management Information System (MIS).
- The hospital would respond to the queries or update information regarding the hospital services using the voice mode on the telephone.

The information so provided would be further disseminated through the common access point in the community.

Schematic diagram of the ICT model



The project team decided to use Hindi as the language to be used in the IVRS facility since it was the mother tongue of majority of the target beneficiaries. In order to make the beneficiaries understand and relate to the language and the voice, several tests and versions were prepared in consultation with the community. The queries made through the IVRS tool were recorded in a computer at the OWSA office to check the usage of the tool and estimate the progress of the project. Through this kind of monitoring and evaluation of the ICT model, and the lessons learned; efforts would be made to strengthen or change the model. The end objective of the proposed tool would be to bring about better communication; awareness and interaction between the target beneficiaries and the service provider for effective delivery of Maternal and Child Health care services.

Embedding the ICT tool in the community and the hospital:

The installation of the ICT tool and its successful embedding in the community was an important step in determining the future course of the research. It was important that in the community, the phone line should be installed at a focal point, preferably at the house of a community leader where women and adolescent girls, the target beneficiaries, would have easy access. The procedure of ICT tool installation and embedding was led by a participatory approach involving the key players- the community and the hospital staff through consultations.

The key variables that emerged from consultations with the community for locating the phone line were:

- Prominent/visible location
- Easy access for all including women
- Proper maintenance and control
- Ownership by the community
- Pro-activeness/voluntary participation
- Acceptability to community members

So, based on the above parameters, the tool was installed in October 2004 at a grocery shop, run by a community leader and his wife, through a community led-launch event. The fact that the community leader's wife also helped him in operating the shop and that many women and children frequented it for their daily purchases, made it acceptable to the community.

At the hospital end, after much deliberation, it was finally decided to install the tool at its maternity ward, which operated round the

clock. The key factors determining its installation in that ward were:

- Constant and continued staff availability,
- Security and safe and monitored use of the tool,
- Facilities for proper maintenance (eg., charging of the telephone instrument),
- Trained and aware staff to handle tool/queries,
- Willingness of the relevant hospital staff/section to take ownership of the tool.

Information education communication (IEC) measures to generate awareness about the tool and its usage:

Although NGOs, such as Prerana and CASP had been working on health issues in the community for many years, IEC measures were essential to popularise the tool and its usage, given the limited use of such interventions in the community. At the same time, the floating nature of the migrant population was a key factor why sustained interventions had limited recall in the community.

Soon after the installation of the tool, the catalysts- OWSA and Prerana volunteers undertook IEC, as both the community and the hospital staff needed a lot of hand-holding support in terms of the technical usage of the phone and prodding to use the phone line. Such measures took the form of:

- Pamphlets and leaflets to promote awareness about the tool;
- Door to door campaigning and training to use the tool;
- Regular group meetings by Catalysts (OWSA and Prerana staff) to promote the use of the tool;
- Community volunteering to promote use of the phone;
- Tie ups with Basti Sevikas and Auxiliary Nurses and Midwives (ANMs) to promote usage and interaction;
- Street plays;
- Media (especially television and print media) coverage of the event during the course of the project.

Usage/acceptance of the tool:

As a result of sustained IEC measures, there was a quick **acceptance of the tool by the community** as it gave them a hitherto non-existing, direct communication link with the hospital staff, although during the IVRS phase of tool implementation, the technique did not give them the option to speak directly to the hospital staff. But, when after a couple of months, the novelty value wore off, it had to be sustained through IEC measures, often with the use of community volunteers to enhance its impact.

On the other hand, the hospital's attitude to the tool ranged from cautious skepticism to indifference during this initial phase. Still, the initial hype created by the installation of the tool provided a good impetus to the hospital staff to take upon the responsibility of the phone line and attend the training sessions provided by the project team.

Stages of tool implementation:

The ICT Tool intervention was implemented in two stages over a period of nine months from October 2004-June 2005. For the purpose of this study, the first stage was the **IVRS: information phase** that lasted from October to December, 2004. The second stage was the **Real Time: information and communication phase** (December, 2004 to June, 2005).

1. IVRS: Information phase: October to December, 2004.

In the initial stage, the installation of the ICT tool provided only IVRS facility. It enabled the people to pick up the phone and get an IVRS update from the hospital on the services offered by it and the hospital timings. At the hospital end, the staff updated the information and also answered queries, feedback from the people, if any. The IVRS provided information related to basic hospital services, health advice and tips as well. The information about health services included details about the availability of doctors, the days and time of specific health facilities and also the lack of services. At, this stage, it provided little scope for interaction between the service providers and the beneficiaries.

2. Real time: Information and communication phase: December 2004- June 2005.

The Second stage was the Real time phase that was characterised by information and direct communication between the two stakeholders. Most significantly, the implementation of this stage was borne out of the demands generated by the community after it was armed with relevant information on their health services entitlement.

The project team and community volunteers encouraged the people using the phone to seek information before visiting the hospital for any health service to carry a green card/coupon (to

be provided to them by the grocery shop owner). This card had to be deposited at the hospital counter to help keep track of the number of people seeking services from the hospital after using the ICT tool. However, over a period of time, tracking of the coupon could not happen as either the grocery shopkeeper forgot to give it, or the people did not ask for it or did not take it with them, or the hospital staff did not keep track of the cards received. It hindered effective monitoring and evaluation of ICT intervention that also reflected on the ownership issue linked to the use of the tool for accessing hospital services.

Analysis of the IVRS phase (October-December 2004):

After the installation of the ICT tool, the beneficiaries made a total of 86 calls in just two months from October to December, 2004. Though the IVRS did not give immediate and ready answers to the queries of the community people, it was the first step in creating an interface between the hospital and the community. The people became informed about the services and timings of the hospital. The benefit of the tool was not limited to the community alone; the hospital staff also got a clearer picture of the community's specific health needs. Despite the fact that the phone did not give instant replies or help in emergencies, it brought the community closer to the service provider, and made them aware of their health needs. Data analysis during this phase included the analysis of data pertaining to the queries on the IVRS tool as well as the responses to these queries.

(Refer to annexure 2 for transcript of IVRS script)

Analysis of data pertaining to the QUERIES on the IVRS tool

In the early days of tool installation, no queries were recorded. This was mainly because the people were getting used to handling the phone and the IVRS instructions and were also shy and hesitant. The analysis of the data pertaining to the queries on the IVRS tool revealed that more than half (55 per cent) of the total queries were wasted, of which 7% wastage was due to technical problems and 16 per cent because beneficiaries picked up the phone, but made no query. A large number of them were also test queries because the tool and its usage were novel experiences for the beneficiaries. They needed handholding in using it effectively. Test queries were also made to check the working of the tool. Some of the incomplete and test queries could also be attributed to technical problems. These were:

- Initially, the time allotted to record a query was just 20 seconds, which was too short.
- The battery back up of the phone was very low.
- Initially, phone buttons, especially the star and the zero buttons, were not functioning.
- Voice recording was not clear.

Following is the categorisation of the total calls recorded in the database.

Total number of calls recorded in the system **86**

Test queries -22: These were related to testing of the tool at OWSA, Vendor, Community and hospital ends.

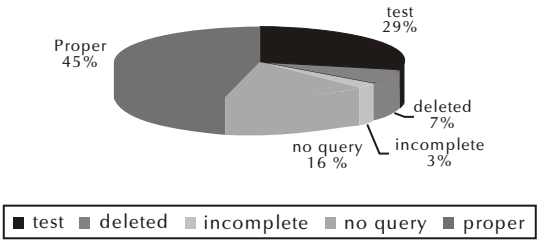
Deleted queries -5: These were queries deleted at the hospital end because either they were not clearly audible or because they were not related to hospital services.

No queries-12: There were no queries because people picked up the phone, but started chuckling instead of asking questions or they wanted to know just the hospital timings. It happened only during the early phase of IVRS implementation, as the people did not know how to ask questions, were shy and hesitant.

Incomplete queries-2: It happened because the asked questions did not fit in the given time or the hospital staff could not understand the question because of lack of complete information.

Proper queries-35: These were clearly audible, contextual and properly fed queries

Pie Chart- I: Types of Queries



Since the primary beneficiaries of this project were women, adolescent girls, and infants and children, all the proper queries were related to their problems. These can be broadly classified into two groups, gynecological and paediatric problems.

Gynaecological problems:

Group	Age	Nature of the problem			
Group - A		Menstrual/ related	Pregnancy/ delivery	Family planning	General health/ Menopausal
Group - B	Adols-25	4		1	1
Group - C	>25-35	3	3	7	
Group - D	>35				5
Group - E	Age not mentioned	1	2	2	3

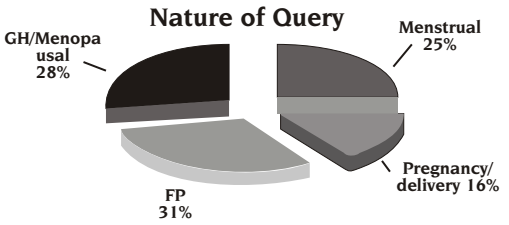
Table I: Nature of Problems: Gynaecological

The above table shows that these problems were basically age specific. So, the adolescent age group asked queries related to menstrual problems. FGDs with this age group showed that in cases of complications, they preferred to visit local quacks instead of going to the hospital. As this age group comprised young girls and girls of marriageable age in the community, it should become the potential target group for awareness generation. It would lead to a positive attitude towards sexual and reproductive health needs in the future.

Usually, adolescent girls were married early in the community, often soon after reaching puberty; hence, this group needed greater awareness on family planning. They also required more attention and sensitisation about MCH health services and the tool.

As the women in the reproductive age group comprise the largest target beneficiaries of the hospital, efforts should be made by the hospital to meet their specific needs. It should have a fully operational O.T. along with the presence of a resident doctor to attend to emergency deliveries. The third group's queries were generally related to menopausal complications.

Out of the total proper queries, those related to Family Planning were the most numerous, followed by those on menstrual problems, general health or menopause and pregnancy. The questions on family planning were mainly related to family planning methods or complications arising due to it. This indicates that the women knew about such methods and are also willing to adopt them. It reveals that the women of this low income community are keen to know about family planning. Thus, the hospital should strive to fulfill this need effectively by providing them proper guidance and counselling.



Pie Chart- II: Nature of Queries

Interestingly, queries related to pregnancy and deliveries were lower compared to others. This can be attributed to the fact that the dais (traditional midwives) and traditional family practices in the community are the first and preferred choice for such services. They are also able to deal with this problem. But the latter are not equipped to deal with other women-related health issues.

Pediatric problems: Queries on paediatric problems were markedly less than those on gynecological ones. In this case too, the queries were age group specific. Gastro-intestinal problems were the most common disease amongst the children. Lack of sanitation in the area coupled with water problems was primarily responsible for the predominance of this disease among the children.

Age	Nature of the problem			
	General	Growth related	Gastro-intestinal	Special
0-2	2			
2-4	1	1	1	
>4	1		3	2

Table II: Nature of the Problems: Paediatric

The service provider should, therefore, focus not only on the curative aspects, but also on the preventive ones. The ANMs and Basti

Sevikas can spread awareness about hygiene and related issues. Interestingly, there were no queries on vaccination.

Analysis of data pertaining to RESPONSES on IVRS tool:

Reciprocation from the hospital side was satisfactory. However, the responses were limited in nature and they communicated only basic information, such as the time and day when a particular service was available. But, it helped demolish the first wall: a near total lack of communication between the beneficiaries and the service providers. The staff now seemed approachable, accountable and reachable. The fact that all services were not as reachable was another issue to be addressed.

The responses to the queries were delayed given the system set up wherein the hospital staff would check the queries entered at a designated time of the day and respond when the information sought was available. This could easily take a day, which in medical/health scenario would translate into a big delay. For instance, if a person asked about the availability of a medicine or doctor, they would not get an instant response. As the answer to the problem could not be provided instantly, people continued to approach alternative health providers.

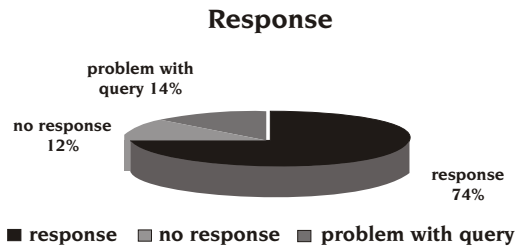
Following is the classification of the responses to the queries provided by the hospital staff:

Total number of responses- 32

No responses without known reason- 05

No responses due to technical problem- 06

Cases, in which there was no response to queries, were diverse in nature. In some cases, the queries were incomplete, so the hospital staff found it very difficult to answer them without understanding the query properly.



Pie Chart- III: Response

Community perception regarding IVRS and its usage:

During the initial phase after the installation of the ICT tool, the beneficiaries were skeptical in using this facility, as they:

- Were not too clear about the technical aspects of using the IVRS.
- Found it difficult to appreciate the IVRS as a phone interaction. So, as they did not get any voice based response from the hospital side, they often thought that nobody was listening to them. So, they preferred to go to the hospital directly than use the phone. Also, very few of them used the green card/coupon provided at the time of making a call when visiting the hospital.
- Found feeding of queries in a non responsive mode a bit awkward and would often start laughing.
- Could not follow or keep up with all the instructions provided by the IVRS. For instance, if the IVRS required them to feed in their query in a minute, they would often exceed the time limit, leading to incomplete queries being recorded.
- Found the phone of hardly any use in case of emergency, they could not get any immediate advice from the hospital end.
- After a few days, most of the beneficiaries became aware of all the services available in the hospital and their timings. After that, they hardly found any sense in making calls to the hospital. This attitude led to decrease in the number of people using the IVRS facility.

Impact and outcomes of the ICT intervention:

The installation of the ICT tool, the telephone, proved to be a catalyst in bringing about behavioural changes among the target beneficiaries, the women. It enabled:

- The women to seek answers to their health related questions from the hospital staff through a neutral, faceless facilitator, a telephone. Earlier, they had inhibitions in approaching the hospital staff for seeking any kind of medical or health related advice because of their sour experiences with them.
- The women to explain their gynaecological problems, such as irregularity in menstrual cycles or fears and doubts associated with menopause, etc., without any inhibitions through the phone. Otherwise, they would feel shy telling at length the doctor, especially the male doctor, about these problems.
- The adolescent girls to seek advice on sexual rights and needs through the telephone. Often, they were not comfortable in discussing these issues even with their closest kin.
- The pregnant women, who often depended on the elderly ladies in the house for seeking advice on matters related to

pregnancy and childbirth. These elderly ladies also influenced all decisions related to this key stage in a woman's life.

Challenges faced:

- Despite continued negotiations and interventions by the project implementers, it was difficult to motivate the hospital authorities to add more information to the IVRS. Partly, it could be attributed to their apprehensions about transparency, and partly, it was due to systemic resistance to being transparent about the limitations and shortcomings. They were skeptical about being open to review and criticism and provide explanations for services that were not available at the hospital. This trust building with the service provider or opening their minds to be part of such a review or transparency, as mentioned in the Sector Assessment Report, was another project in itself. The current research framework and timelines do not provide the timeframe to address this aspect.
- Also, the project authorities were categorical about not taking up any grievances related to hospital services or staff through this channel. It was, therefore, agreed that the service provider would entertain only queries of general nature and those requiring tele-health advice or counseling would be avoided.
- The IVRS tool had little relevance in case of emergencies. For example, if a patient in severe pain recorded her query, she would not get any immediate advice from the hospital authorities. She would have to wait for a certain period of time. Though she needed immediate attention, the tool could not facilitate it. The hospital clearly stated at the outset that it was not equipped to deal with medical emergencies and often referred such cases to bigger hospitals.
- The IVRS phase also demonstrated that a period of learning and familiarisation should precede the actual operationalisation of any non-traditional tool. It was essential for the successful embedding of sophisticated tools. This could ensure the successful utilisation of the installed technology by all cross sections of the population irrespective of socio-economic differences.
- The ownership of the ICT tool was a critical issue. The fact that the tool was installed at the house of an individual and not in a community space, led to some limiting problems. The owner of the grocery shop started developing proprietary attitude and even saw the telephone as a means to demand remunerations in various forms (charging of phone batteries, providing volunteer support for IEC to encourage people to make calls).
- The grocery shop owner, depending on the rapport/remuneration from the project staff, started spreading his own views on the project intervention within the community and to external agencies (media, visitors). This points to the need for installation of such a tool at a community space where one individual cannot dominate or monopolize the tool.
- More time is required, from this catalyst intervention, to give the people the confidence to demand their rights and services and the hospital authorities to strive to provide these more efficiently and in a transparent manner.

Key learnings of the IVRS phase:

The analysis of queries and responses enabled the project team in understanding the main health needs of the community. These, along with the problems encountered in day-to-day life, revealed that:

- Health needs of the beneficiaries are age specific. The most common health related queries are related to gynaecological and paediatric problems.
- Women in the community are neither unfamiliar with nor averse to family planning norms.
- Lack of sanitation was a major area of concern.
- Health services should also take into account the preventive aspects along with the curative ones.
- Mediation of the tool provided information about the services and contributed in creating awareness in the community. Also, it made the hospital aware about the real and specific needs of the community.
- The phone served as a catalyst to bring the community and the hospital staff closer to each other in terms of communication and understanding of specific needs, situations.
- Information about their service entitlements from the hospital through the tool and IVRS generated the demand for Real Time interaction.

Real time interaction: Information and communication phase (December, 2004 to June, 2005):

The IVRS phase of the implementation of the ICT tool exemplified project objectives of empowering the people to demand

information and also provide proper communication channels to disseminate such information. Parallely, it also signified a relative readiness of the service provider to respond to the demands of the community and be part of a direct interface for communication with the people. However, this did not signify any change in the nature and value of information being provided. The broad information structure and content remained the same.

The IVRS basically provided information on the hospital services and this became known to the people in two months time. Therefore, there was little that they could use the phone for except for recording their queries, which too were not answered instantly. The limited and set information provided through the IVRS facility and its declining use led to increasing demand from the community for real time interaction with the hospital authorities through the ICT tool, the phone line. This demand was voiced through ongoing FGD's and meetings with the stakeholders during the implementation phase of the tool.

When this proposal for real time interaction with the hospital staff through the phone line was presented before the hospital authorities, they were not initially open to the idea. They saw it as an additional burden on their limited staff and a source of pressure for services from the people for which they did not have the infrastructure.

Finally, interventions by the Project facilitators (OWSA) and constant lobbying with the IPPVIII project head yielded results **and the CMO agreed in December 2004 to a set, limited one hour of real time interaction** wherein people from the community can make a call directly to the hospital and talk to the staff and get the health information then and there on the phone. However, this was a fixed hour interaction and the people had to be informed and encouraged to use the phone at that hour (1400-1500 hrs).

Again, a lot of IEC followed to encourage people to use the phone facility during this time slot. Given the community profile, the people did not always understand the time frame limitations for making the call or reaching out to the hospital authorities. **The IEC measures taken to popularise the use of the tool for real time interaction included:**

- Display of several new posters at strategic locations within the target community.
- Distribution of printed leaflets and handbills in the community. These were written in simple Hindi language using bright colours, so as to attract attention.
- Two street plays were also organised in February, 2005 on women and child health issues. Prerana, the partnering organisation helped through its female volunteers to identify issues and script the street plays.

Month wise break up of calls made to the hospital

No. of Calls Per Month	
Dec 7, Real Time started	
December 68	
January 46	
Jan 16, a volunteer was appointed to galvanize the community people to make calls	
February 17	
In February, Phone was out of order for many days due to technical reason	
March 53	
Phone was out of order from 7th March to 12th March due to technical reason	
April 86	
May 49	
On 2nd and 7th May, Phone could not be charged due to power failure throughout the day	
June 41	

Considering the limitations of one-hour real time interaction, the people continued to demand full time access for real time interaction with the hospital staff. The project team also found it difficult to ensure phone usage during the one-hour time. Consequently, the one hour real time interaction was converted into full time (0900 hrs- 1600 hrs) real time interaction from March 2005, when the hospital authorities finally agreed to extend the timings. This was a major development in the project, as it demonstrated the willingness of the authorities to listen to the community people and address their queries.

This development could be attributed to a host of factors:

- Persistent demand from the community members;
- Constant lobbying by the project implementers with the hospital authorities;
- Practical considerations of handling of the tool (constant charging, locking of phone as

against, keeping it on all day for use);

- Better comfort levels with handling of phone calls by the hospital staff who no longer considered it as an additional workload or threat.

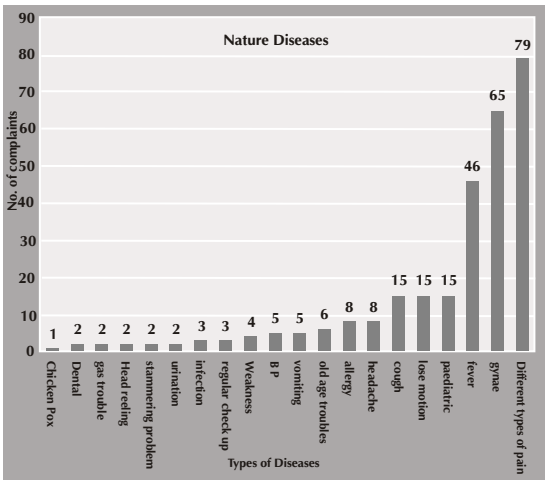
A record total of 360 phone calls were made during the real time interaction between December 7, 2004 to July 4, 2005.
Since the complaints had to be logged in manually in registers at both ends, the research team decided to use paid volunteers from the community to foster community interest and ownership. The first volunteer was a woman from a neighbouring area (Tajpur Pahari) who had generated a lot of good response and interest from the community. However, there were personality differences between the volunteer and the community leader supporting the tool, which led to constant complaints and bickering that threatened to deflect attention from the tool.

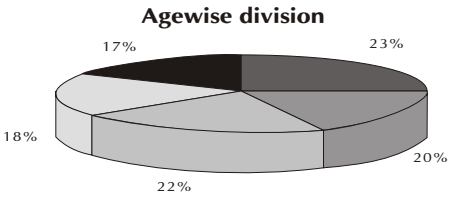
OWSA and Prerana, therefore, decided to try the local leader's wife as the volunteer. This generated good results in the initial months (the highest no. of calls in a month were registered in April during her tenure) but again slackened over the months.

Analysis of data pertaining to the QUERIES/ COMPLAINTS made by the community:

Nature of complaints: Analysis of the data related to the queries made through the telephone by the beneficiaries revealed that most of them sought information on minor health problems. These were related to illnesses caused by change of season, waterborne diseases, lack of sanitation facilities besides pregnancy and gynaecological problems. The following chart shows the diseases people complained about and the number of calls per category of disease.

Age wise distribution of the complaints: Most queries, almost 23% of the calls, were regarding paediatric problems. The second highest number of queries was regarding different gynaecological problems pertaining to the age group 21 to 30. Queries made for problems related to children and adolescents between the age group of 11 to 20 occupied the third place. These were followed by queries regarding problems of people above 40 years of age. The least number of queries were made by people in the 31 to 40 age group.





Analysis of data pertaining to the RESPONSES given by the hospital staff:

Analysis of the two registers kept at the hospital and community leader's house showed that in most of the cases, both the versions of queries or complaints registration were almost the same. It reflected that people in the community were aware of their problems; and they communicated these appropriately. Though there were segments that understood the specialty service provided by the hospital, for many, it still remained a general hospital and they sought information on all general health needs.

The responses provided by the hospital staff showed that they gave considerable time to understanding the community's health related problems and gave useful advice and information.

The interactions between the two sides showed an evolved change in the way each side perceived the other. The hospital's perception of the people being uncouth, rude and inarticulate changed to that of being polite, smart and keen to seek information. The community's perception regarding the hospital staff changed from one of being indifferent, insensitive and rude to that of being concerned about and sensitive to their health needs and problems.

As mentioned earlier, though no additional information was provided during the real time interaction phase, the fact that the same or relatively a little more information was being

given by a person (and not a mere voice) at the other end, helped add value and enhance the confidence levels of the people.

In most of the cases, they received information regarding which day of the week they should visit the hospital for a particular problem, but in a few cases, they were given useful, ready solutions to the problems. Since it was a specialty service hospital (MCH), when people asked about general health problems or services, which were complicated, the nurses referred them to other hospitals/ clinics.

Some examples of these value added information are listed below:

Case 1

Suman, 2, was suffering from diarrhoea. Her mother called up the hospital when the OPD was closed for the day. The nurse who picked up the phone told her mother to visit the hospital with her child next day and also gave her instructions on how to make ORS at home so that she can start giving it to the child.

Case 2

Shakeela, 34, had two children and she was pregnant for the third time. She wanted medical termination of pregnancy, which was not available at the hospital. The nurse from the hospital end told her to go to Safdarjung hospital, which was the next nearest hospital from the community.

Case 3

Charu, 3, was bitten by a dog. Her mother called up the hospital to ask for a solution, but the hospital did not have the required injections to treat the case. The nurse on duty referred Charu to Safdarjung hospital.

Case 4

A 15 years old girl, Nilu's eyes used to water whenever she got up from sleep. She called up the hospital to seek advice in this regard. The nurse on duty told her to wash her eyes with lots of water and visit the OPD the next day.

Case 5

Kusumlata, 40, complained about cough and cold. She also mentioned that she felt feverish in the evening. The nurse assumed that it might be a case of malaria and referred her to go to Gandhi Dispensary for malaria check up.

Case 6

Prerana, 25, was nine months pregnant and had been visiting the hospital for regular check ups. One day, she called up the hospital and complained of swelling and pain in legs and face. The nurse asked her to attend the gynaecology OPD on Tuesday at 9 am (gynaecology OPD day). She also suggested her to record her Blood Pressure on a daily basis and maintain a chart, to keep her feet raised occassionally, and take bed rest on her left side.

Legal information services vs people's advocacy:

The project envisioned, if necessary, legal information and services to the target beneficiaries to:

- Give information about the services to the community and the target beneficiary groups.
- Develop a complaint registration system and catalyse the target beneficiary groups to register complaint through the ICT model.
- Explore the possibility of using the tool to analyse the complaints.

Given these specific desired outputs through the implementation of the ICT model, the project also recognized that ICTs would not have served any purpose by merely generating demands for the services. The assumption that there would be certain proportion of demands that would be unmet, provided the rationale for exploring options/alternatives to legitimise the various sets of demands in each country. This would also require the presentation of complaints in a fashion that attracted the attention of the service providers. Legal experts associated with the present project suggested that these assumptions and realities could provide a solid ground for legal advisory services to be drawn upon during the course of the implementation of the project.

However, in the Indian context, the need for any legal intervention was not felt given the nature of the tie up with the service providers. A formal tie up with the service provider could not take place despite best and sustained efforts. So, there was no MoU or Letter of Intent, just an informal understanding and promise of support and cooperation from the hospital authorities to be part of the action research.

Traditionally, the poor and the marginalised never strove to organise themselves to take legal recourse or seek legal help for their grievances or complain against the system. So, expecting them to do so under the time and scope of the project might not be feasible. It emerged from the community meetings that the people were keener for the project to help them build information and communication channels with the service providers instead of

confrontation. This, however, did not mean that the people were not keen to address the issues or problems in service delivery. **People's advocacy emerged as the alternative to legal interventions.**

In one particular instance, the tool and its usage proved to be a catalyst for people to take affirmative action and bring about positive change. In a particular case, when the people did not get the desired response or service owing to water shortage in the hospital, they were disappointed at the efficacy of the initiative. However, with some prodding from the project facilitators, they decided to launch a signature campaign demanding provision of water supply in the hospital. This people's advocacy initiative yielded tangible results and water supply was restored. So, people's advocacy replaced the need for recourse to legal advise/interventions in this project.

Database of local government services:

A key project deliverable was to provide the people, in their local language, a database of government services and entitlements in their area. The purpose was to enable the people to be informed and armed with this knowledge, so that they could access these services and where that was not the case, seek appropriate grievance redress for the same.

Accordingly, based on a needs assessment of the community, a database of services was developed. The information was sourced from the government website (the Delhi government had already enacted the Right to Information Act, and in this context, made information online), local municipal and government offices, books and directory services.

The information collated was to be translated into Hindi language and put on a CD. It had to be regularly updated through online access (when that became available in the community).

The set of services, useful for the people were identified as:

List of basic utility services:

Water supply

Hospitals & Dispensaries

Schools and colleges

Power supply

Police

Welfare schemes and helpline services

List of important phone numbers

Documents linked to registrations and licenses:

Birth & Death registration

Driving License

Ration Card

Passport

Special Categories Certificates (senior citizens, handicapped)

Permits for livelihood needs:

Hawkers license

Cycle-rickshaw license

Small scale and cottage industries

Loan facilities

Special schemes and entitlement for unemployed, marginalised sections

Initially, the **Prerana** centre in the vicinity of the project site was chosen for establishing people's advocacy centers. A local scrap dealer on voluntary basis lent out space for this centre to the NGO. However, given the experience of putting a public access facility at a privately owned space, as witnessed with the ICT tool, the project team agreed to look for another viable option. It was decided to defer the development of the database till the issue of community owned space for installing such a database was ready. It was felt that the community had to be ready for provision of such a space and information. The people were given the option of providing alternate solutions.

5. Project Evaluation

As the project was guided by a participatory, bottom up approach that puts people centre stage in every aspect, its evaluation was also based on it. So, instead of resorting to conventional techniques of project evaluation through external evaluators or project teams, efforts were made to include stakeholders and beneficiaries of the project in this exercise.

The project team/implementers, in fact, tried to play the role of facilitators and not evaluators, as the conventional evaluation approach is geared more towards donor or project management needs as against project specific needs and learnings. It was equally important to avoid making the evaluation a linear reporting to the donor on the project goals and outcomes, but one that informed the project through its learnings and lessons. Therefore, it was necessary to seek the views of all stakeholders to understand the dynamics of this ICT project, its successes, failures, shortcomings and proposing solutions for overcoming the obstacles. Project evaluation included the following exercises:

a) Developing the questionnaire:

The first task was to draw up a questionnaire or interview script for focus group discussions. So, keeping with the spirit of the evaluation, a FGD with a cross section of the community, representing women, adolescent girls, community leaders and men was held to frame a questionnaire, so as to ensure that it was not a top down or a project team guided exercise. Through this exercise, **several important issues were identified for framing the questionnaire, such as:**

- Most common health needs
- Health seeking behaviour of people
- Awareness about the hospital
- Awareness about Hospital Services
- Extension of Hospital Services
- Awareness and knowledge of the ICT tool
- The tool, its use
- Impact of the tool
- Extension of the tool to other services

The FGD helped to view the project from a dimension that the project staff as well as the community itself could not have understood or perceived. So, the questions contributed by the community members for the evaluation exercise were padded up with another set of questions (called the shadow questionnaire) as it included questions that needed information from the project deliverables point of view.

(Refer to annexure 3 for FGD questionnaires)

b) Identifying the target groups:

The first step in this direction was the identification of focus group participants from among the beneficiaries and service providers for carrying out project evaluation. The service providers (the hospital and IPPVIII authorities) for FGDs were identified in terms of their access to people on a daily basis and also the level of their medical expertise. The identified group comprised three to four categories of people. Separate sets of FGDs and face-to-face meetings were organised with them. These included doctors, nurses, ANMs, basti sevikas and midwives or dais.

The beneficiaries' group included men, women, adolescent girls and community leaders. Various age groups and sections of the community were identified based on project specific intervention (Maternal and Child Health care). They were classified in terms of gender, age and user groups. Men and the community leader were also included in the FGD to capture the perceptions of the community in general, and of those who were not direct users of the hospital services. The women were divided into two groups; adolescent girls in the age group of 12-20 years and women in the reproductive age group of 20-45 years.

Each focus group comprised 15-20 people representing all the above mentioned identified categories.

c) Planning the meeting:

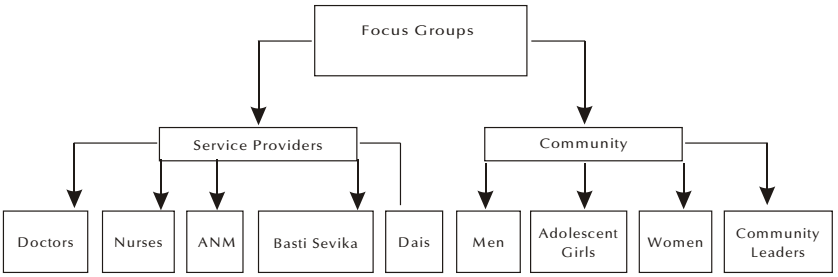
Instead of the project staff leading or holding the FGDs, volunteers from the community led the way in organising the meetings. The project team attended as mere facilitators and observers.

d) Conducting the focus group meetings:

Most of the meetings were held in the community and the hospital premises. In the brainstorming meeting itself, the date and time for holding all meetings with specific target groups were decided. A few people from the community were selected as catalysts, to

organise and coordinate the meetings. The project team provided only the outline questions and backend support for the meeting. This approach was adopted, as it was likely that more people of the community would be more comfortable in talking to someone from among themselves. Their houses served as the venues for these meetings

The main focus groups are represented in the following diagram:



Meetings with the community

No.	Place of Meeting	Date	Target Population	No of Attendees
1	Community Leader's house	30th April	Men	8
2	Prerana Centre	3rd May	Adolescent girls (20 yrs of age and below)	15
3	Prerana Centre	3rd May	Women (above 20 yrs of age)	20
4	Community volunteer's house	4th May	Women (above 20 yrs of age)	5
5	Community volunteer's house	6th May	Adolescent girls (20 yrs of age and below)	20
6	Community volunteer's house	16th May	Women (above 20 yrs of age)	20
7	One Community leader's house	1st June	Community leaders	6

Meetings with the service providers

No	Place of Meeting	Date	Target Population	No of Attendees
1	MCH Hospital	2nd May	Staff Nurses and Head Nurse	7
2	Prerana Centre	5th May	Basti Sevikas	2
3	MCH Hospital	9th May	ANM	3
4	At respective houses	25th May	Local Dais	2
5	Civil Lines Office of IPP VIII	25th May	Project Director, IPP VIII	1

Findings of project evaluation/ the impact of ICT intervention:

Several common points emerged from the analysis of the deliberations carried out during these FGDs. After collating all the data, it emerged that the responses were similar for some questions, but different in case of a few others. Based on the similarity in responses, three groups have been formed:

Direct service providers: The staff of the MCH, CMO, the staff doctors, staff nurses and ANMs.

Supplementary service providers: The hospital-trained dais, the Basti Sevikas.

The target beneficiaries: People of G Block, Mohan Baba Nagar, Badarpur, New Delhi.

The ICT intervention had considerable positive impact on different aspects of pro-poor public service delivery in the project site. Besides making the target beneficiaries aware of the services provided by the hospital, it also improved the outreach of the hospital to the community.

Following are the main outcomes of the ICT intervention.

Views of different focus groups regarding the health seeking behaviour of the community:

The ICT intervention helped in creating a positive change in the health seeking behaviour of the target population, the women in the reproductive age group and the adolescent girls. They became well informed about the various MCH services provided by the hospital and many of them were encouraged to avail of relevant health services and medical advice from the hospital. The increased inflow of OPD and delivery cases in the hospital after the intervention emerged as a strong indicator of the community's willingness to change its health seeking behaviour.

Community:

From the community angle, the impact can be judged from two perspectives: impact of the ICT intervention on the awareness level of people and their health priorities; and impact of the ICT intervention on enhancing the level of interface between the hospital and the people. Focus group discussions with the community revealed that after the installation and use of the telephone line:

- People have become more aware and conscious of their health needs.
- They often carried the green coupon, so that the doctors could understand that they have come from G-block.
- People could also threaten the hospital staff that they will complain to their higher authority.
- It has improved mutual relationship between the hospital staff and the community to some extent. The hospital staff is more civil and polite and "even provides medicines".
- People who would often go to the local/ traditional doctors, were willing to try out the hospital services, given the awareness generated by the tool.

Basti sevikas:

Focus group discussions with the Basti Sevikas and Dais revealed that though they did not find any significant change in the attitude or behaviour of the community people, they have definitely become more assertive in asking for the services they are entitled to. While a few of the dais thought that the phone made little impact on people on the delivery of health services, others opined that it was good and benefited the people. Its impact could be more properly realized if this initiative was continued.

The service providers:

Among the service providers, different groups had different views about the impact of the tool.

- Some of them thought that project intervention has only helped create awareness about the hospital services; it hasn't changed community's health seeking habits.
- The staff nurses observed a significant change in people's confidence levels and information seeking skills and articulation. Earlier, they used to pick up the phone and start chuckling, or the community leader at whose house the phone was installed would ask the questions on behalf of all the women. But now, the women themselves started asking these after a polite namaste.
- They felt more comfortable answering these questions and the interactions on the phone helped in breaking the communication barrier between the community and the hospital.
- More and more people from different backgrounds are coming to know about the phone.
- The Chief Medical Officer thought that the fact that people were coming out of their houses to make calls proved that people had become smarter, were aware of their rights and had the courage to ask for information.

Other behavioral and attitudinal changes:

Post the intervention; both the sides feel a discernible change in their attitude towards each other:

- The hospital staff felt that the beneficiaries had become articulate and confident in asking questions. (They actually picked up the phone, said a confident Namaste, and asked well-framed questions. Earlier they would hesitate or simply laugh nervously after picking up the phone: Staff Nurse)
- They have become smart and ask for the specific services as against general questions and especially for services that are free. So, they have become more aware of their rights and entitlements
- The community people now preferred to check about a particular health service through the telephone than visiting the hospital uninformed on any day.
- The community people also felt that because of the telephone, their importance had increased and they are entitled to ask for the services. They even warned the hospital staff for negligence in their duties.
- The community and the hospital people, mutually believed that the people felt

empowered by the ICT intervention. They found it a convenient way of demanding and ensuring the services from the hospital authorities. According to them, the service providers felt that if they don't respond to the people's health needs, they would complain against them to higher authorities.

- This mutual feeling made the hospital staff more accountable to the community they were serving. The people also considered the tool as a means of filing grievances about the lack of hospital services and hence a means to ensure proper services from the hospital. Though there were no official complaints by the people, the tool interestingly served as a deterrent from sulking responsibilities by the hospital staff.

Awareness about the hospital and its services: Both the community and the hospital staff felt that the phone line/intervention had helped in creating awareness about specific services rendered by the hospital and the people, to a considerable extent, were able to access the same. The phone line and the activities generated around it, created awareness and curiosity about the hospital among the people. People learnt about the services, timings, days and limitations of the hospital through the installation of the phone line.

After the intervention, two community perspectives emerged regarding the quality of health services provided by the hospital:

People, who were aware of the intervention and had used the tool, opined that:

- There had been some improvement in the hospital services after the intervention mainly owing to the pressure from the people demanding proper services from hospital.
- The hospital staff became more responsive as they felt that people might complain to their superiors or that they might come under a scanner if they do not deliver/provide the services.
- Visiting the hospital was easier and less time consuming now. They went exactly on that day when the doctor for that particular service would be available.
- People were more informed and therefore more confident about seeking information on the hospital services.
- The community people felt that the phone line helped in giving them a clearer and realistic picture of the hospital and the limitations of its services and infrastructure.

Another mixed section of the community felt that:

- The hospital services were still very bad.
- The introduction of the tool had not shown any impact on the attitude and behaviour of the service provider. Neither the doctors nor the nurses behaved properly.
- The doctors referred most cases to bigger hospitals often without proper checkup.
- Did not provide medicines and if they gave some, these were the inexpensive ones.
- Project intervention did not change anything.
- However, they now felt empowered to threaten or question the staff if they did not provide the services and the hospital staff too was aware of this possibility.

Both the community link workers, Basti Sevikas and ANMs, who have a presence in the community felt that:

- The intervention and the ICT Tool had helped generate more awareness and interest about the hospital services.
- Many people who did not know about the hospital earlier, came to know about it and its services through the phone.
- It can be attributed to the activities associated with the phone line and its usage, which had a wider reach as against their focused reach to the target beneficiaries: pregnant women and infants.
- They felt that the number of patients visiting the hospitals had increased since the intervention.
- For the first time, people were asking about specific services and timings, which was not the case earlier. So the concept of set of services, days, timings, was better appreciated and understood by the people. It also led to planned visits to the hospital for the right kind of services.

With respect to the health services offered by the hospital, its staff felt that:

- Since the intervention, the hospital was taking more care to provide relevant information and services to the people.
- The hospital staff observed considerable increase in the number of patients attending the OPD and those who were coming for delivery.
- The average monthly delivery cases increased to 40-50 from 12-14 in the last 8-9 months. Though the hospital staff does not accept it explicitly, they cannot suppress the positive tone in their voice either.

- The intervention helped them provide some essential services, such as water, which was not earlier available in the hospital.
- Made the hospital strive for and demand better facilities and infrastructure (staff, OT facilities).

Demand for extension of hospital services:

All the three groups of respondents thought that the hospital services should be extended to a few other fields. Being part of the community, the dais and the Basti Sevikas share the same view as the community. In this regard, they wanted:

- Some services for the men in the hospital so that they have an incentive to seek health care and bring their women folk to the hospital.
- It can provide other health facilities besides MCH, such as providing general health care for elderly, men, and children above 12 years, (who are currently outside the realm of the hospital).
- OT facilities should be provided to avoid referrals to other hospitals.
- Ambulance services should be provided to bring patients to the hospital and not merely to take referral patients to other hospitals.

Awareness about the tool and its usage:

Most of the people consulted in the evaluation were aware of the tool and had either used it themselves or knew people/neighbors who used it. It was more convincing and satisfying for people to call up and get direct answers from the hospital. But its awareness and usage varied from group to group. The tool, in a way, served as a preparatory ground for the people to try, test and then develop the confidence to demand information on services, provide feedback on the same and seek redressal of grievances. FGDs revealed that utilising the facility of making phone calls was not a strong indicator of the level of awareness about the phone.

Community leaders: They had the highest level of awareness as they were part of the process to introduce the tool to the community. Meetings were organised through their participation and support and they played a key role in promoting the tool in the community.

Other members of the community also know about the phone. The ratio would be around 60:40. The women were the next most aware persons, as they were the key target beneficiaries and the project involved them in some way or the other.

The adolescent girls were the least aware about the intervention. As they were not the direct target population group catered to by the hospital, they hardly used the phone or the hospital facilities. This also pointed to the health seeking behaviour and decision taking abilities of this reproductive care group, which was dominated and influenced by the elderly women in the family.

The OWSA field teams, and Prerana community volunteers were the key people who were providing information about the tool in the community through IEC measures and face-to-face meetings.

Regarding the ICT intervention, the community people thought that:

- Any initiative that sought to help and empower poor people was good and helped them in one-way or the other. The phone also helped people to generate the demand, for the first time, from the service provider, as against going for other options.
- Many people knew about the phone, but never needed to call for the last eight months.
- Often, men instead of women made calls to ask about children's problems.
- They also came to know whether the doctor for a particular service was available or not. It meant less wastage of time and more efficient use of time and hospital services.
- Created a better understanding of the hospital services than before. Earlier perceptions were based on what they had heard or their general impression of a government service/utility.

The Basti Sevikas thought that they benefited from the phone, as it made their work easier. Now if people asked something they could not answer, they could guide such people towards making a call to the hospital. The midwives felt that the phone line was not too relevant, as many people either had phones at home or had access to public phones. However, they felt that it did help the poor people in emergency cases and for seeking general health advice.

Extension of the tool to other services:

Having realised the potential of the tool in facilitating access to information and, consequently, to avail pro-poor health care services, all the focus groups demanded the extension of the tool to other services as well. Following are their observations in this regard:

Community:

- Water shortage being a major concern in the community, the community wanted the

phone service to be extended to provide information on water supply and register grievances on water shortage (Water, in fact, was a cross cutting need that was flagged by all the groups).

- The municipality water tanker came only once in 2-3 days to provide water. This often led to fights over accessing it, the community felt that prior information on its arrival, through the phone line, could help people queue up and avert fights.
- Information on starting small enterprises was another need of community members who preferred self-employment. They required information about licenses for opening and operating small shops, public telephone booth, hawker's thela, or license to run a rickshaw, auto-rickshaw or license for a porter, etc.
- Information on government /social services, such as schools, crèches, voter and ration cards and driving licenses was also required.
- It could provide access to police helpline (100) to curb crime and sexual abuse.

Dais and basti sevikas:

- In addtion to water supply information, they sought links to sanitation and garbage collection departments to curb the spread of diseases in the community.
- This facility could be used for disseminating Health and Hygiene awareness in the community, which had low literacy levels and knowledge about basic cleanliness.

Hospital staff:

Although, they were not aware about the community needs, but on the basis of interaction with the patients, they felt that:

- Water and sanitation facilities can be extended to the community as most health related problems stemmed from these.
- Introduction of hotline for garbage collection can help in overcoming the problem of unhealthy environment.

Evaluation findings:

Thus, project evaluation revealed that the introduction of ICT intervention through the installation of a telephone line had considerable positive impact on the delivery of pro-poor health care services to the community. Even the hospital authorities realised that though it's difficult to establish where the people are coming from (G block or another locality), but there had been a change in their attitude and awareness levels. The following observations made by the beneficiaries and the service providers further illustrated the positive outcomes of this participatory action research project:

> Once I took my neighbor to the hospital. She was nine months pregnant. She was a regular visitor to the hospital and was also a hospital card holder. The nurse said that my neighbours, case is complicated and referred us to Safdarjung. She had been visiting the hospital for such a long time and at that critical moment, the nurse refused to check her up. Then I threatened her that I would complain to her higher authority about your negligence . First she was quite reproachful, but then she turned defensive and spoke to us properly. She came to know we are from G-Block."
>
> Chandini, Mohan Baba Nagar

> I have noticed that more people have started visiting the hospital lately. It may be due to our campaign or for the phone. I have been working in the community for the last three years. I have never seen so many women visiting the hospital. This induces me to think that it is due to the phone that more women are going to the hospital.
>
> Basti Sevika who works in G-Block, Mohan Baba Nagar

> The fact that people have accepted the tool and are coming out of their houses to make calls indicate that they have become aware and particular in using the services they are entitled to. People have definitely become smarter.
>
> CMO, MCH, Badarpur

> Earlier, when we used to go to the hospital, the staff would treat us badly and even complain to the doctors about us. But now, they behave properly and lend us their ear. We now even get more medicines than we used to get before.
>
> Resident, Mohan Baba Nagar, G-Block

Project head:

The Head of IPP VIII, also felt that there had been a change in the behaviour of both the parties. She felt that the tool empowered the people to launch people's advocacy through the signature campaign to demand water supply in the hospital. This helped her as the project head and the hospital to get the water facility restored.

As a member of the service providers and head

of the hospital, she could definitely see a change in the attitude and behaviour of the hospital staff, which she herself was unable to bring about. So, the tool, according to her, was a catalyst in bringing this about. She believed that the tool helped to improve the accountability of the hospital staff which had become more responsive to the people.

> "I feel that the hospital staff has become more accountable than ever before. I have been trying to get this accountability from them for a long time, but I have never seen them behave like this. No measure would have given me this accountability except for the fear of people complaining against them for their careless action or behaviour."
>
> IPPVIII Project head.

Improving outreach from the hospital staff to the community:

- In terms of improvement of outreach from the hospital staff, there had not been any significant change. They attributed this to the norms they had to follow as a government hospital.
- The only change was that they had started a door-to-door immunization programme in the community and held some additional health camps in the community.
- The hospital being a government one had some protocol, which they could not possibly alter.
- The Basti Sevika's role did not expand as they were not trained for immunization and medical check up; they were trained for distribution of a few essential medicines like ORS, contraceptives, etc. The ANMs being outreach workers at the community level, their role was extended only to provide immunisation besides the weekly /monthly checkups. Their main task was to galvanise people to attend the weekly health camps where they go to conduct check up and immunisation.
- One positive outcome of the project was the building of a good relationship between the people and the staff nurses who answered the phone since the people started interacting with them, more frequently.
- The staff and the people became more appreciative of each other's attitude and behaviour and openly acknowledged the changes therein. With this, the tool/ intervention was able to provide a communication platform for each side to understand the other, and improve and even acknowledge behavioural improvements.

Monitoring and improving accountability of the hospital staff:

- The intervention could not bring about any strict MIS to check the availability of hospital staff as to whether they were in the hospital during the OPD or they just signed and went out. Being a government establishment, the accountability was low owing to the perception that they had no fear of losing their job.
- However, the intervention helped ensure better availability of the hospital staff.
- Compared to the IVRS phase, it was the real time phase that brought about this transparency. The real time facility gave the people a chance to call up in the morning to check about the doctor's availability and then visit the hospital. This demand made the hospital ensure that there were doctors available on most days to cater to the people.

6. Project Outcomes

One of the major outcomes of the project was increased utilisation of hospital facilities by the slum dwellers and sincere efforts by the hospital authorities to enhance their outreach to the community. It also brought about positive changes in the health seeking behaviour of the people and hospital staff's perception towards their health related needs and demands.

This project has also shown the effect of increasing citizen participation and represents a move towards empowering both individuals and CSOs and increasing their capacity to hold governments and public services to account. Better feedback and transparency will also increase the quality and reduce the costs of public services to the poor.

The outcomes were not confined to the project area/consitutuency alone, they also provided the ideas and seeds for other initiatives to benefit poor and marginalised communities.

The use of **VOICE** as the main means of communication and information dissemination to the community who had low literacy levels but high information needs, provided the inspiration for another initiative. Known as **the BT lifelines project**, a OneWorld and British Telecom initiative, too used telephone based voice mechanism to provide Question and Answer (Q&A) service on livelihood issues to farmers in several states of India.

Also, the efforts to spread value added information to the people through community efforts led to the induction of Prerana Volunteer and **project support team member**, Ms. Asha Sharma, as a **Grassroots Academician of the Jamshetji Tata National Virtual Academy for Rural Prosperity [NVA**] She was felicitated, along with 125 other grassroots academicians, as a fellow by the President of India in a national level convocation ceremony. The fellowship recognises the grassroots workers as knowledge workers and the torchbearers of the knowledge revolution in the country.

7. Dissemination of Lessons

Strategies to disseminate the lessons learned in implementing this research, were an inherent part of the initial design of this project. This was done keeping in mind the general trend where the learnings derived from pro-poor development initiatives are not as widely and as effectively distributed, as they should be. These learnings remain confined to donor reports or academic and research journals. The result is that mistakes are often repeated and useful ideas need to be rediscovered time and again.

Also, even if these are shared, many a time they do not reach the intended beneficiaries. Therefore, project-guides, tool kits or information packs that present the findings in a simple format, (such as this pack) are a good way to share such information

Accordingly, in addition to this report, a handy tool kit on the varied ways of improving the delivery of pro poor government services has also been produced. This handbook/ information pack has been worded in a simple manner. Graphics, cartoons and relevant illustrations have been used to add value to the message and make it more user friendly at the same time.

While the information packs and other forms of dissemination would help in reaching out to the CSOs, service providers and policy makers; the grassroots and the poor would need to be reached as well. Towards this end, experiences on how ordinary citizens can ensure that their voices are heard by the authorities as also seen in the case of this particular project, may be shared in the capacity building programmes designed for empowering the poor.

A website, highlighting various stages of the project including the information packs was also created (http://propoorict.ekduniya.net). This was to enable worldwide sharing of the project.

8. Conclusion

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

The participatory interventions made during the 18-month project have shown how just mere provision of services is not a guarantee of their effective delivery to the target beneficiaries. Enabling mechanisms that can break the traditional communication and behavioural patterns between the people and authorities also must be established at the ground level to make the service delivery effective and transparent.

Similarly, the development and design of delivery programmes meant for the poor need their participation, if these programmes are to be effective and sustainable. A top down approach will not suffice in ensuring that people can access these services.

Importantly, the research has also demonstrated the need for a bottom up approach, as against the top town policy and programme approach for e-governance or service delivery programmes. This is especially relevant to developing countries where the social exclusion of the poor and marginalised is acute due to low literacy and awareness. A bottom up approach then would help design policies that are sensitive to the limitations and the needs of these people and thereby ensure their participation and access to such services.

The learnings and recommendations from this project may be referred to for drawing up similar interventions in the future. These are listed with respect to the three sets of stakeholders:

Community:

- Proper information, communicated in the right way can generate the right demand.
- People's involvement while designing the programmes and services is essential to secure their informed participation.
- Seeds of empowerment can be sown only when people are informed and aware. This is the first step to give them the confidence to demand services and make the service providers accountable.

Service provider:

- If one has to work or take along the service provider in collaboration (as against confrontationist approach), the provider's needs/limitations should be taken into account.
- Making the service provider open to transparency may require longer intervention period and confidence building.
- The intervention should seek to benefit both the ends: the community and the service provider.
- The buy- in of the service provider from the highest to the ground level could help determine the success levels of the intervention.
- A right balance needs to be struck in being sensitive to the limitations and needs of the service provider and the community.

Project partners:

- The participation of the project partner should provide strong support, not just a commitment on paper.
- Proactive involvement of the partner in the project is necessary.
- Selection of partnering NGOs should be based on strong commitment to the project.
- Project partner should have strong interventions in the community.
- Project intervention period needs to be longer to be able to inform, empower the people to demand services and seek grievance redress.
- Strong NGO led development work in the community could help integrate the intervention in the community. It should not be a stand alone or one-off project.

It is hoped that the experiences and learnings of this research and the tool kit developed from its learnings would be used by the stakeholders mainly the NGOs, the government agencies and policy makers. This, we hope will result in public service delivery programmes and accompanying technology tools that see the poor, not just as recipients, but also as equal stakeholders who need to be consulted in decisions that affect their lives.

Annexures

Annexure 1 A : Details of the Baseline Survey

Most common health problems & needs of the community:

During the baseline survey, both the community and the hospital staff reported that water borne diseases were the most common health problems that afflicted the community, especially the children. Most of the queries made by the incoming patients were also related to these ailments. These diseases, such as dysentery, cholera, typhoid, etc. were rampant mainly due to lack of water and sanitation facilities and availability of only polluted water. Mosquito bred diseases, such as Malaria and Dengue were also common.

Besides these common problems, some other key health services that were required urgently by the community people were related with dental and eye problems and health facilities for men and elderly people.
The hospital staff opined that among the MCH related services, most of the needs were regarding delivery, paediatric problems like diarrhoea, anemia, allergies, for antenatal (ANC), postnatal (PNC) check ups, and birth control measures.

The baseline survey indicated that prior to the intervention of the ICT tool, the nature and quality of the pro-poor public health services in and around the project site left much to be desired. This, coupled with behavioural and attitudinal problems of the beneficiaries and the service providers also affected the delivery of these services. Following are the main findings of the baseline survey:

Availability and status of pro-poor public health services:

The Badarpur MCH hospital is the only hospital in the vicinity of the community. But, it provides only specialty health care services for women, adolescent girls and children/ infants. Besides the Badarpur hospital, people from the community also go to the Badarpur dispensary. A mobile van provided by CASP Plan, an NGO, where health checkup and medicines are available for Rs. 10 is another easy option. The people also seek the services of quacks, private doctors, traditional and trained dais.

There is no facility to cater to the health needs of men and elderly people. They have to go to the nearest government hospital (Safdarjung), which is 16 kms away from their site, to seek any health advice or check up. Besides these, there are Basti Sevikas from Badarpur hospital and Anganwari-Balwari workers from the Badarpur dispensary, who provide medicines and door-to-door health counseling to the community.

Health seeking behavior of the community:

The community, dais, Basti Sevikas and the hospital staff admitted that the health seeking behaviour of the community is very poor as they fail to prioritize health for their well being or spend time and money for it. They seek help from the hospital only in case of an emergency. All of them believe that the main reasons for their poor health seeking behaviour are: poverty, cheaper, affordable and easily available exit options, such as quacks, local doctors, traditional and trained dais, etc. Other reasons that deterred the beneficiaries from seeking health care from a government facility are:

The community attributed the following reasons to the low utilisation of pro-poor public health services:

- The general attitude and behaviour of the hospital staff;
- Low quality of service delivery;
- Non availability of doctors;
- Non availability of medicines.

The dais and basti sevikas think that:

- Since the hospital is situated at a distance from the community, people prefer to go to private doctors or nursing homes located in the vicinity of the community and pay larger amounts.
- The community people don't like to waste their time standing in a big queue at the hospital; they want everything quick.
- Moreover, the local doctor is always available, whereas in the hospital, they can meet the doctor on a specified day and time.
- After the hospital decided to carry out door-to-door check up and immunisation, community's health seeking behaviour seems to have worsened. Now, they wait till the ANM and Basti Sevikas come for immunisation even if it is too late for the child.

The hospital staff:

- Health care from hospitals is the last option in case of emergencies or serious cases after other local /traditional remedies and means have been exhausted.

- Low education levels and strong belief in traditional healing methods are hard to change.
- Low comprehension level of hygiene and health related advise.
- Decisions on health care in families is dominated by men, elderly women who are guided by traditional notions; not by younger women.

Other behavioural and attitudinal problems:

Prior to the intervention, there were marked behavioural problems among the service providers and the beneficiaries.

Major behavioural and attitudinal problems associated with the hospital staff were:

- The staff was not very amenable to the community people.
- The staff was often rude to the people.
- The people were afraid of asking too many questions for the fear of being snubbed.
- The hospital staff often turned them away to other hospitals.
- They never provided medicines.
- Often, they prescribed general medicines without conducting proper checkups.
- They treated the people shabbily as they were poor and 'dirty'.

Major behavioural and attitudinal problems associated with the community were:

- People had low level of comprehension of the services provided by the specialty hospital.
- Were not educated enough to comprehend health and hygiene advice.
- Were not articulate enough and were not open to listening to or following health advice.
- Did not understand simple instructions on hospital timings and services and landed on the wrong days.

Awareness about the hospital services:

Both the community and the hospital staff felt that prior to the intervention, there were limited channels of communication between the hospital and the community, thereby leading to little or limited awareness about the health services provided by the hospital. This was mainly due to:

- Presence of a heavy, floating migrant population in the community.
- No steady way to spread continuous awareness about the hospital services. Lack of IEC efforts, such as posters, pamphlets in the community to remind its floating population about the hospital and its services.
- No proactive interface between the hospital and the community, except for Basti Sevikas, who conduct door to door surveys and send reports about pregnant women to the hospital and distribute primary health care medicines and contraceptives; and ANMs, who conduct antenatal checkups in the community (through their rounds and check up sessions in the community) are the only faces of the hospital in the community.

Quality of hospital services:

Regarding the quality of the hospital services, the community, dais, Basti Sevikas and the hospital staff unanimously agreed that it was not good, which was mainly due to lack of proper infrastructure and life saving and emergency facilities, such as fully operational OT, ambulance service and resident doctors, in the hospital. The community and the Basti Sevikas and dais also felt that the doctors and nurses referred most cases to Safdarjung, often without proper check up and requirement. Many referral cases were actually not complicated. This was the main reason why the hospital ward was not as crowded as it should be.

In this respect, some of the local dais, trained by the hospital and provided medical kits for working in the community, opined that the hospital staff misled the patients and provided wrong notions about their pregnancy related problems. One of them felt that the hospital had impacted her livelihood, while another one felt that it had helped. With respect to the health services offered by the hospital, its staff felt that:

- The hospital provides best care and services given the limited facilities and infrastructure, as the workload is less and patient nurse ratio is almost 1:1.
- The hospital functions round the clock.
- Unlike other hospitals where 2-3 patients share a bed, here each patient has a separate bed.
- Hospital has good quality of nurses.

The beneficiaries also felt that the hospital should have the following facilities as well:

- The hospital should provide all services that an MCH should provide.
- There should be a nursery, drinking water, 24 hrs gynaecologist and paediatrician.
- It should have the required number of staff.
- Proper power and water supply should be provided.

Annexures

Annexure 1B : Questionnaire for Community Members

1.1 Age of respondent

a) 20 -30 yrs.....01
b) 31 40 yrs.....02
c) 41 -50 yrs.....03
d) 50 and above.....04

1.2 Educational qualification

a) Class 1- 5.....01
b) Class 6-9.....02
c) Tenth pass.....03
d) Class XII.....04
e) Graduation and above.....05

1.3 Occupation

a) Unskilled Labourer.....01
b) Shopkeeper.....02
c) Housewife.....03
d) Other.....04

1.4 Marital status

a) Married.....01
b) Unmarried.....02

1.5 Occupation of husband

a) Labourer.....01
b) Shopkeeper.....02
c) Business.....03
d) Other.....04

1.6 Family type

a) Nuclear.....01
b) Joint.....02

If "a" then skip to Q 1.8

1.7 No. of family members

a) Only 2.....01
b) 3-5.....02
c) 6 -9.....03
d) 10 or more.....04

1.8 No of children

a) Boys
b) Girls
c) None

If none skip to Q 2.1

1.9 No. of children below 2 years

a) One.....01
b) Two.....02
c) Not applicable.....98

Present health status

2.1 Presently, are you pregnant?

a) Yes.....01
b) No.....02

If no, skip to 3.1

2.2 How many months

General awareness about health facilities

3.1 Are you aware of any health facility near your locality, where you can avail medical care services?

a) Yes.....01
b) No.....02

If no, skip to 3.3

3.2 If yes, where?

Probe

Yes 01, No 02, DK/CS -99, NA -98

If No to option C, skip to 3.3

a) Govt. hospital.....
b) PHC .....
b) MCH Badarpur .....
c) Pvt. Nursing homes
d) RMPs .. ..
e) Local quacks..... .....
f) Mobile Vans .....
g) Others .....

3.3 How did you come to know about MCH Badarpur?

a) ANM.....01
b) Neighbours.....02
c) Basti Sevika.....03
d) Others.....04

3.4 What kinds of services are provided in Badarpur MCH?

Probe

Yes 01, No 02, DK/CS -99, NA -98

a) OPD services..... .
b) Family planning..... .

c) Immunization . .....
d) Surgeries. .....
e) Emergency .....
f) Medicines .....
g) ANC .....
h) Normal delivery .....
i) PNC . .....
j) Health camps .....
k) Others .....

Patient experiences

4.1 How has been your experience in accessing care in Badarpur MCH?

a) Good 01
b) Not very good 02
c) Bad 03

4.2 If you faced any problems in accessing services, it was related to…

Probe

Yes 01, No 02, NA -98

a) Medical treatment .....
b) Behaviour of doctors.....
c) Behaviour of nurses .....
d) During registration.....
e) Non availability of medicines . .....
f) Non availability of doctors
g) Defunct OT .....
h) Referrals without any specified reason .....

4.3 What steps did you take to address these ... problems

a) Report to CMO .....
b) Report to Head nurse .....
c) Report to higher authorities .....
d) No reporting .....
e) Other .....

Intervention specific

5.1 What all services do you wish that the Badarpur MCH would provide?

a) Operation facilities
b) Facilities for all people
c) Others

5.2 Would you like some health camps to be organized in your community?

a. yes .....
b. no .....

5.3 If yes, dealing with which component?

a) ANC check ups
b) Family Planning
c) Immunisation
d) Others . .....

Annexures

Annexure 1C: Guidelines for Health Card workers

1. **Health needs of the community**
   - Deliveries
     - i Normal
     - ii Complicated cases
   - Surgeries
   - Family planning operations
   - Problems during menopause
   - Health Camps
     - i ANC Check up
     - ii Family planning
     - iii Immunization
     - iv General

2. **Health seeking behaviour**
   - Govt. hospital
   - Private maternity homes
   - Local Quacks
   - RMPs
   - Traditional dais/midwives

3. **Awareness about government hospital – MCH Badarpur**

4. **Care and treatment services at MCH Badarpur**
   - Time of registration
   - Ward experience
   - OPD experience Doctors - Medicines
   - Availability of doctors
   - Availability of Medicines
   - Availability of water
   - Operation theatre facilities
   - Ambulance services
   - Hidden costs in accessing services at Badarpur MCH
   - Behaviour/Attitudes of doctors and Nurses
   - Referral case experience

5. **Institutional linkages - Role of basti sevikas in the community**
   - Health Information
   - Vaccinations
   - Immunization
   - ANC Check ups
   - Post hospital visit experience
   - Distribution of essentials ORS and Contraceptives

6. **Information accessing mechanisms – emphasis on hospital info.**
   - Family
   - Televisions
   - Basti Sevikas
   - Neighbourhood
   - From other NGOs
     - i. CASP Plan
     - ii. Balwadi

7. **What improvements/changes would you like to see in the care services provided by in Badarpur MCH?**

8. **Grievance redressal mechanism**
   - Report to CMO
   - Reporting to higher authorities
   - Report to Basti Sevikas /ANMs at community level

9. **Any suggestions /comments?**

Annexure 1D: Baseline Survey Compilation: Interim Analysis

Project launch events	Interventions made	Calls registered	Findings	Remarks
9th Oct 2004	1. IVRS tools was developed in Hindi-language, was kept simple so that the genre understands it better and is able to relate to whatever given in the IVRS System.	(Recorded Calls) **9th Oct 2004 till 6th December 2004** 91 - calls made 16 - wasted calls	There were technical problems with the phone, some of which are listed below. Initially, the time allotted to record a query was 20 seconds which is too less.	The problems pertaining to the tool was brought to the notice of the Vendor and Aman. 1. The timing for recording the query was increased to

Project launch events	Interventions made	Calls registered	Findings	Remarks
9th Oct 2004	1. IVRS tools was developed in Hindi-language wase kept simple so that the genre understands it better and is able to relate to whatever given in the IVRS System. 2. Signboards were placed in strategic locations in the community so that people are able to where the phone is kept and that its usage is free. 3. Spreading awareness about the launch event of the tool 4. Advocating the usage of the phone-how to make calls and how it get registered. In this people were explained in group meetings and also on one to one basis as how to make calls and get answers for it.	(Recorded Calls) **9th Oct 2004 till 6th December 2004** 91 - calls made 16 - wasted calls 31- response given 30 - test queries 5 - deleted queries 2 - incomplete queries 7 - pending queries	There were technical problems with the phone, some of which are listed below. Initially the time allotted to record a query was 20 seconds which is too less. Battery back up of the phone was very low. Initially phone buttons especially the star and the zero buttons were not functioning. Voice recording not clear. **Other** Due to the above one day a lady was not able to make call (*Refer- Story-G -BLOCK-28th October 2004) Grievances from the people that hospital lacks water facility, mostly the cases are referred.	The problems Pertaining to the tool was brought to the notice of the Vendor and Aman. 1. The timing for recording the query was increased to 1 minute, which is sufficient. 2. The phone requires constant charging and one more reason for batteries being exhausted so fast is the usage of the speaker phone. 3. The service provider has been changed. Earlier it was Tata Indicom and now it is Reliance. 4. The community has been asked to pick up the receiver and then put forth their query instead of using the speaker phone. 5. The changes have been made and conveyed to the Vendor so that he can incorporate all of them. 6. The Vendor has been told about this and he is working on it.
Signature campaign	The IVRS tool installed in the community has created a lot of awareness among the community members about the existence of the MCD hospital in the nearby vicinity and the		Frequent interactions with the community brought forth these following issues: 1. Need for improved health care services especially operation theatre to be activated.2.Since	The director has assured that she would try her best to solve the issues relating to the provision of operation theatre facilities to the residents of the nearby community.

Project launch events	Interventions made	Calls registered	Findings	Remarks
Signature campaign	services that they are entitled to receive. This was done after a series of meetings with the Local cable network people who agreed to display the message of the tool installation in the community free of cost. 2. A signature campaign was initiated in the G-block community by the residents who demanded the provision of water and operation theatre facilities from the Badarpur MCH. 3. 15 volunteers were identified from the partnering organization Prerana, who could help in spreading awareness about the IVRS tool in the community as well as galvanize people to give their signatures and show their solidarity through the campaign for accessing better services from the hospital. 4. Out of 15, 12 were trained in the functions and usage of the tool. Finally 8 volunteers helped in doing the actual work of spreading awareness about the tool as well as the signature campaign. 5. A meeting was held with the MLA of the local constituency to inform him of the signature campaign and		the water crisis has been finally taken care of at the hospital end so operation theatre facilities should be started.3. The community members are demanding that their queries should be taken care of immediately by the hospital authorities and that they should have a one-to-one conversation with the doctor (the need to have real time interaction with the health service provider). 2. Water crisis issue should be resolved so that they don't have to fetch water for deliveries to be done in the hospital. Calls answers which were provided were of very generalized nature.	The water problem that existed in the hospital since the last couple of years had finally been looked into by the hospital authorities. A new pump has been installed to ensure that water supply is there for 24 hours. This will help the patients up to a great extent and with the provision of water all, the other necessities can be put in place.

Project launch events	Interventions made	Calls registered	Findings	Remarks
Signature campaign	discuss about issues relating to water and operation theatre facilities in the hospital and seek his support and cooperation for improving services. 6. Large group meetings (each group comprising 25 members) and 15 small group meetings (3-5 members) were held with women of the community where they were explained about the usage and functions of the tool. After that, the women were informed about the signature campaign and with their consent, their signatures were obtained. 7. A total of 522 signatures were obtained from the G block community. 8. Three members presented to the IPP VIII Director and to the hospital CMO the letter accompanying the signatures campaign from the community. OWSA team facilitated the whole process to bring in the voice of the voiceless			
Real time calls.	1. Meetings were held with the MCD hospital authorities and the CMO to inform him that the community members feel that the information provided by the hospital staff in	**7th December 2004-31st December 2004** 74 - calls made	With the IVRS phone usage gearing up in the community, people were demanding for real time interaction between them and the hospital authorities. This was been	1. Initial response to this service was been positively received by the community as well as from the hospital authorities. It's a good learning from the hospital staff

Project launch events	Interventions made	Calls registered	Findings	Remarks
Real time calls.	response to their queries is useful but generalized in nature. The community is expecting much more beyond this information and feels that the queries should be taken care of in real time which will take care of the problems arising in case of emergencies. This will enable the community people to seek information as well as get care services from the doctors. 2. The CMO agreed to keep the phone in real time between 2.00 - 3.00 pm. This added a lot of value to the phone. Awareness was done in the	**1st January 2005-10th January 2005** 6 - calls made Community group meetings and through follow ups that real time calls has been activated.	achieved this month. The hospital authorities agreed for REAL TIME interaction for an hour (where in the people from the community can make a call direct to the hospital and talk to the staff and get the health information then and there on the phone). Than what comes through IVRS Recording.	that they are also happy that people are now making calls to them and are asking response to their queries directly & it was an added piece of information from them that calls are coming more in number in this one hour duration. 2. The usage decreased. Interaction with the people brought out the community dynamics and there was lack of willingness to make calls on their own by the people. To bring in change in the behavioural attitude of the people which has been made from past so many year is difficult in such a short span of time. Attitude of dependence on the spouse depicts a culture in the community. Women at times don't come forward to speak about their own health till they take permission from their male counterparts to ask the solution over phone. This shows how the society is weaved and how women are happy to keep themselves in the shells. (*detail refer file - Analysis lack of willingness amongst the G block).

Annexures

Annexure 2: Script of IVRS Recording

Welcome to Badarpur Maternity and Child Health Care Hospital

- **Information about the hospital:**

Namaskar. Do you want to know about the services available in this hospital? Please listen to the questions after the bip.

- What are the health facilities available in this hospital?

In this hospital, ANC and PNC check up facilities for pregnant ladies, vaccination for pregnant ladies and children and family planning consultation and operation facilities for ladies are available.

- When can one come for an ANC check up?

Wednesday and Friday, from 9 am to 1 pm

- When can one come for PNC check up?

This facility is available everyday, from Monday-Friday from 9am to 4pm

- Is blood testing facility available here?

Yes, it is available for pregnant ladies, ladies with new born baby and children

- When can one register on name for check up?

One can register name from 9 am to 1 pm for that same day

- Where is the registration done?

It is done at the entrance gate of the OPD

- Is there any medicine shop inside the hospital?

According to government rules, no private medicine shop can be opened inside the hospital.

- Is any medicine available in the hospital?

Yes, general medicines are available for mother and children. The pharmacy remains open from 9 am to 2:30 pm everyday. The pharmacy is situated at the room 6 of the OPD building. Schedules and times are subject to change.

- Is ambulance facility available in the hospital?

Yes, ambulance facility is available for the patients who are already admitted in the hospital

- Is the hospital open for 24 hours?

Yes, this facility is available for pregnant ladies and who need to be admitted for delivery

- Is MTP (Medical Termination of Pregnancy) facility available in the hospital?

No, it is not available right now. But it will soon be available.

- Can we get token no. or phone no. of the hospital for appointment?

Token no is not given for appointment, but if you ask a question, you will be given a token no.

- Is it possible to get information about a doctor's availability on a particular day?

Yes, it is possible to get information about a doctor's availability on a particular day.

- What kind of delivery facility is available here?

The patient can come at any time of the day for delivery as the hospital remains open for 24 hours a day. Right now, only normal cases are handled here. In case of complicated cases, the patient would be referred to other hospitals.

- Is OT facility available here?

Yes, but right now, it is not functioning. It will take a little time to be functional.

If you want to know anything else, then feed in your query after the bip and after you complete your query, please press 0.

Thank you

- **Essential precautions about health:**
- Pregnant ladies need to do at least three medical ANC check ups.
- All children under the age of five should be given all vaccines. Immunization is done for free in this hospital.
- Children should not be fed with bottled or powdered milk. Breast feeding is necessary and best for health and nutrition of the children.
- For proper up bringing and care of the children, there should be at least a 3 years gap between two children.
- Family Planning facility, both operation and medicines is available in this hospital for free.
- **Information on general health and hygiene**
- Boil the water for 20 minutes before drinking, or add chlorine tablets in the water which is available free in the hospital.
- Always cover the food and drink items.
- Do not shit or pee in the open place.
- Wash your hands with soap before having food.
- Do not allow water to get stagnated in one place. This will prevent dengue, malaria to spread etc.

Annexures

ANNEXURE 3: FGD QUESTIONNAIRES FOR EVALUATION EXERCISE

Annexure 3.1: FGD Questionnaire: for Community

I. Awareness

- Are you aware of the health facilities/ health centres in the vicinity?
- How did you come to know about the Badarpur MCH?
- Are you aware of the services provided at Badarpur?
- How did you come to know about the Badarpur facility?
- Despite knowledge of the Badarpur MCH facility, do you choose to go elsewhere for you health needs (for instance, private doctors/ hospitals, Bangali doctors, dais)?

II. Hospital services

- Have you/ your family availed of any services at the MCH?
- If not, why?
- If yes, what are the nature and range of services that you and your family have chosen to access at the MCH?
- What is your experience of service delivery at the MCH?
- What are the constraints that you have faced in accessing these services?
- How have you tackled these problems?

III. The tool, its use

- Did you know that there is a phone line that has been provided to the community to enable them to talk to the medical staff whenever required?
- When/how did you come to know of this facility?
- Do you think this connectivity between the hospital and the community was required?
- Have you made any calls from this phone?
- If yes, how many times? For what purpose? Was the purpose served?
- If not, what are the reasons, or constraints to making use of the telephone?
- Do you believe this service to be useful? In what ways has it benefited the community? (what did you expect of the green coupon, was it justified)
- Do you believe that the telephone has enabled community access to the MCH?
- Have you/you family visited the MCH after the installation of the phone line?
- What nature of services did you/your family avail?

IV. Impact of the tool

- Has the telephone has any impact on the wider concern of health in the community?
- If yes, in what way?
- Has the telephone had any impact on the relationship between the community and the hospital?
- Has there been any impact on the attitude or behaviour of the hospital staff?
- What are the problems that you have faced with the telephone or the hospital; and how have you dealt with these problems? What role can you further envision for yourself as part of the community?
- Has the use of this phone enabled/ inspired you to demand other services (for instance the demand and subsequent campaign for water supply at the hospital)?
- Would you like to take a similar kind of initiative for an OT service at the hospital, or medical services for men at the hospital?

V. Extension of the tool to other services

- With the understanding that there are certain valuable services that are being provided by the MCH (can also bring in the comparison with the CASPLAN van, and the dispensary), what more would you want of the hospital in terms of additional services, infrastructure, and medical supplies?
- With the understanding that the phone has proved to be a tool of some use, do you believe that it can be linked to other government/ public services?
- Are there other tools that you are aware of that can also prove useful?
- What are the services that you believe can be linked with an information tool to enhance public service delivery to benefit your community and other communities like yours?
- What do you understand/ think of a project like this?
- What is your understanding of the role of volunteers, community leaders, the community itself in such an undertaking?

Annexures

ANNEXURE 3: FGD QUESTIONNAIRES FOR EVALUATION EXERCISE

Annexure 3.2: Shadow Questionnaire for ANM and Basti Sevika

1. What do you think are the most common health needs of this community?
   - Deliveries
     i Normal
     ii Complicated cases
   - Surgeries
   - Family planning operations
   - Problems during menopause
   - Health Camps
     i ANC Check up
     ii Family planning
     iii Immunization
     iv General

Awareness

2. What is your opinion on the health seeking behaviour of the community women?

3. what is the level of awareness amongst community about Government hospital MCH Badarpur

4. Despite knowledge of the Badarpur MCH facility, do people choose to go elsewhere for their health needs (for instance, private doctors/ hospitals, Bangali doctors, dais)?

Services within the hospital:

5. What is your opinion on the care and treatment of services at MCH Badarpur?

In terms of

- Availability of doctors
- Availability of Medicines
- Availability of water
- Operation theatre facilities
- Ambulance services
- Are the patients asked to pay for any of the services
- Refusal at the time of registration
- Referral cases

6. How would you rate your hospital's ability to cater to the needs of the nearby residents? (%age)

7. What are the constraints that you think you are facing in providing proper services?

8. How would you tackle these problems as part of the hospital staff?

9. What are the areas you think hospital needs to improve it?

The tool, its use

10. Telephone line is intended to link the community with the hospital. How would you rate the relevance of this connection to your work with the community?

11. Has the telephone line made any difference to the traffic to the hospital (since October)?

12. What other factors might have influenced the level of traffic during this period?

13. Do you perceive any difference in the community's attitude to the wider concern of general health since the tool was made available?

14. If the telephone has altered the relationship between the people of the community and hospital staff, how has this happened?

15. How important was the community role in securing water supply for the hospital?

16. Given that the community did exhibit a degree of proactiveness in this matter, do you believe that this proactiveness can be harnessed to support you work with them?

17. If yes, in what ways and to what end?

Impact of the tool

18. To what extent have you been able to associate the use of the phone with your work?

19. How has the phone affected your work and output?

20. Do you think it could prove useful to extend the facility of the telephone to the wider population of your area?

21. Are there any other tools that you think could be employed?

22. Are there other services that you as hospital staff believe could be facilitated through the use of this and other information and communication tools?

23. Are there any changes, on the basis of this project, that you and you colleagues would like to see to enhance service delivery by the hospital?

Extension of the tool to other services

24. With the understanding that there are certain valuable services that are being

provided by the MCH, what more do you think hospital can provide in terms of additional services, infrastructure, and medical supplies?

25. With the understanding that the phone has proved to be a tool of some use, do you believe that it can be linked to other government/ public services?

26. Are there other tools that you are aware of that can also prove useful?

27. What are the services that you believe can be linked with an information tool to enhance public service delivery to benefit the community and other communities like this?

28. What do you understand/ think of a project like this?

29. What is your understanding of the role of doctors, nurses, ANMs, Basti Sevikas and the community itself in such an undertaking?

Project:

30. What is your opinion of the project that provided the telephone?

31. Do you think that projects like this are a good way to improve services or should the initiative come from somewhere else

Comments:

32. Are there any changes that you or your colleagues would like to see to improve the care provided by the hospital

Annexures

ANNEXURE 3: FGD QUESTIONNAIRES FOR EVALUATION EXERCISE

Annexure 3.3: Shadow Questionnaire for Nurses

1. What do you think are the most common health needs of this community?
   - Deliveries
     i Normal
     ii Complicated cases
   - Surgeries
   - Family planning operations
   - Problems during menopause
   - Health Camps
     i ANC Check up
     ii Family planning
     iii Immunization
     iv General

Awareness

2. What is your opinion on the health seeking behaviour of the community women?

3. What is the level of awareness amongst community about Government hospital MCH Badarpur

4. Despite knowledge of the Badarpur MCH facility, do people choose to go elsewhere for their health needs (for instance, private doctors/ hospitals, Bangali doctors, dais)?

Services within the hospital:

5. What is your opinion on the care and treatment of services at MCH Badarpur?

In terms of

- Availability of doctors
- Availability of medicines
- Availability of water
- Operation theatre facilities
- Ambulance services
- Are the patients asked to pay for any of the services
- Refusal at the time of registration
- Referral cases

6. How would you rate your hospital's ability to cater to the needs of the nearby residents? (%age)

7. What are the constraints that you think you are facing in providing proper services?

8. How would you tackle these problems as part of the hospital staff?

9. What are the areas you think the hospital needs to improve it?

The tool, its use

10. The telephone line is intended to link the community with the hospital. How would you rate the relevance of this connection to your work with the community?

11. Has the telephone line made any difference to the traffic to the hospital (since October)?

12. What other factors might have influenced the level of traffic during this period?

13. Do you perceive any difference in the community's attitude to the wider concern of general health since the tool was made available?

14. If the telephone has altered the relationship between the people of the community and hospital staff, how has this happened?

15. How important was the community role in securing water supply for the hospital?

16. Given that the community did exhibit a degree of proactiveness in this matter, do you believe that this proactiveness can be harnessed to support your work with them?

17. If yes, in what ways and to what ends?

Impact of the tool

18. How has the phone affected your work and output?

19. How has the phone been integrated into you daily work schedule?

20. Do you think it could prove useful to extend the facility of the telephone to the wider population of your area?

21. Are there any other tools that you think could be employed?

22. Are there other services that you as hospital staff believe could be facilitated through the use of this and other information and communication tools?

23. Are there any changes, on the basis of this

project, that you and you colleagues would like to see to enhance service delivery by the hospital?

Extension of the tool to other services

24. With the understanding that there are certain valuable services that are being provided by the MCH, what more do you think hospital can provide in terms of additional services, infrastructure, and medical supplies?

25. With the understanding that the phone has proved to be a tool of some use, do you believe that it can be linked to other government/ public services?

26. Are there other tools that you are aware of that can also prove useful?

27. What are the services that you believe can be linked with an information tool to enhance public service delivery to benefit the community and other communities like this?

28. What do you understand/ think of a project like this?

29. What is your understanding of the role of doctors, nurses, ANMs, Basti Sevikas and the community itself in such an undertaking?

Project:

30. What is your opinion of the project that provided the telephone?

31. Do you think that projects like this are a good way to improve services or should the initiative come from somewhere else?

Comments:

32. Are there any changes that you or your colleagues would like to see to improve the care provided by the hospital?

Annexures

ANNEXURE 3: FGD QUESTIONNAIRES FOR EVALUATION EXERCISE

Annexure 3.4: Shadow Questionnaire for Doctors

1. What do you think are the most common health needs of the community?
   - Deliveries
     - i Normal
     - ii Complicated cases
   - Surgeries
   - Family planning operations
   - Problems during menopause
   - Health Camps
     - i ANC Check up
     - ii Family planning
     - iii Immunization
     - iv General

Awareness

2. What is your opinion on the health seeking behavior of the community women?

3. what is the level of awareness amongst community about Government hospital MCH Badarpur

Services within the hospital:

4. What is your opinion on the care and treatment of services at MCH Badarpur?

In terms of

- Availability of doctors
- Availability of Medicines
- Availability of water
- Operation theatre facilities
- Ambulance services
- Are the patients asked to pay for any of the services
- Refusal at the time of registration
- Referral cases

5. How would you rate your hospital's ability to cater to the needs of the nearby residents? (%age)

6. What are the constraints that you think you are facing in providing proper services?

7. How would you tackle these problems as part of the hospital staff?

8. What are the areas you think the hospital needs to improve in?

The tool, its use

9. Do you think this connectivity between the hospital and the community was required?

10. Do you believe this service to be useful? In what ways, do you think, has it benefited the community?

11. Do you believe that the telephone has enabled community access to the MCH?

12. Has the telephone had any impact on the wider concern of health in the community?

13. If yes, in what way?

14. Has the telephone had any impact on the relationship between the community and the hospital?

15. Do you feel the phone has been able to help you in your work?

16. If yes, how the phone can be used further to supplement to your work?

17. Has there been any impact on the attitude or behaviour of the community?

Impact of the tool

18. Have you discerned any change in the behaviour of the people in the community?

19. What are the problems that you have faced with the telephone or the community?

20. How have you dealt with these problems?

21. What role can you further envision for yourself as part of the hospital closely working with the community?

22. Has the use of this phone enabled/ inspired you to demand services in your community?

Extension of the tool to other services

23. With the understanding that there are certain valuable services that are being provided by the MCH, what more do you think the hospital can provide in terms of additional services, infrastructure, and medical supplies?

24. With the understanding that the phone has proved to be a tool of some use, do you

believe that it can be linked to other government/ public services?

25. Are there other tools that you are aware of that can also prove useful?

26. What are the services that you believe can be linked with an information tool to enhance public service delivery to benefit the community and other communities like this?

27. What do you understand/ think of a project like this?

28. What is your understanding of the role of doctors, nurses, ANMs, Basti Sevikas and the community itself in such an undertaking?

Comments:

29. Are there any changes that you or your colleagues would like to see to improve the care provided by the hospital?

Annexures

ANNEXURE 3: FGD QUESTIONNAIRES FOR EVALUATION EXERCISE

Annexure 3.5: Shadow Questionnaire for Project Head, IPP VIII

1. What do you think are the most common health needs of this kind of a community?

2. What is your opinion on the care and treatment of services at MCH Badarpur?

In terms of

- Availability of doctors
- Availability of Medicines
- Availability of water
- Operation theatre facilities
- Ambulance services
- Are the patients asked to pay for any of the services
- Refusal at the time of registration
- Referral cases

3. How would you rate the hospital's ability to cater to the needs of the nearby residents? (%age)

4. What are the constraints that you think you are facing in providing proper services?

5. How would you tackle these problems as part of the head of IPP?

6. What are the areas you think the hospital needs to improve in?

7. Do you think this connectivity between the hospital and the community was required?

8. Do you believe this service to be useful? In what ways, do you think, it can benefit the community?

9. Do you believe that the telephone has enabled community access to the MCH (from the account of the hospital staff)?

10. Has the telephone has any impact on the wider concern of health in the community (from the account of the hospital staff)?

11. If yes, in what way?

12. Has the telephone had any impact on the attitude of the hospital staff?

13. What role can you further envision for the hospital closely working with the community?

14. Has the use of this phone enabled/ inspired you to demand services in your community?

15. With the understanding that there are certain valuable services that are being provided by the MCH, what more do you think the hospital can provide in terms of additional services, infrastructure, and medical supplies?

16. With the understanding that the phone has proved to be a tool of some use, do you believe that it can be linked to other government/ public services?

17. Are there other tools that you are aware of that can also prove useful?

18. What are the services that you believe can be linked with an information tool to enhance public service delivery to benefit the community and other communities like this?

19. What do you understand/ think of a project like this?

20. What is your understanding of the role of doctors, nurses, ANMs, Basti Sevikas and the community itself in such an undertaking?

21. Are there any changes that you or your colleagues would like to see to improve the care provided by the hospital?

22. What are, in your opinion, the other areas where this tool or an ICT tool of this kind can be used to work with the community?

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Acknowledgements

We would like to convey our gratitude to following for their support and participation in this project:

The people of Mohan Baba Nagar, Badarpur

The IPPVIII Project team of MCD

Badarpur MCH Hospital Team

Prerana, our partnering NGO

Tina Rajan, our illustrator

Project Consultants and Advisors

DFID for funding the project

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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.

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

For project related queries, write to
geeta.sharma@oneworld.net

OneWorld South Asia
Connecting Communities, Empowering People

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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