OneWorld South Asia

Improving Transparency, Quality and Effectiveness of Pro-Poor Public Services through the use of ICTs

Assessment Report

India Country Chapter

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People need to have a say in the decision process in areas that will have a direct bearing on their lives. Any policy or programme aimed at their empowerment and development should then be designed to be responsive to their needs. This is essential, not only to secure their commitment but also to make the programme, sustainable and successful.

*The **DFID KaR** project on **Improving Transparency, Quality and Effectiveness of Pro-Poor Public Services, using ICTs**, seeks to showcase this through action research.*

*__OneWorld South Asia__, implementing the **India chapter** of the project, has chosen the **health sector** and within it, the **India Population Project**, focusing on Maternal and Child Health as the area for this action research. The project site - the Badarpur Maternity Hospital and a slum cluster near it -- is located in a peri-urban area close to the Delhi border with neighouring Haryana. .*

What makes this project unique is that it involves active participation of the key stakeholders –the government service provider and the beneficiaries i.e. the people that these services are meant for. The civil society organizations play the role of facilitators to bring these stakeholders on a common platform, to interact and relate to each other.

The willingness to participate in the action research programme by the stakeholders has been viewed as an important factor in selecting the sector. The selection process was an intensive two-month exercise, of study of the sectors and sequential elimination till one – health- was chosen. The other sectors under consideration were education, power and police.

An assessment survey in the project area, using participatory methods, has thrown up a complex set of data on the problems in the effective delivery of the health services. These problems, from the perspective of the service provider and the community, range from systemic and attitudinal problems to lack of education and awareness on health issues.

However, given the timelines and resources of the DFID project, it would not be feasible to address all these issues. 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.

It is recommended that the following issues be taken up for implementing the ICT model:

- *Inadequate communication about the services of the hospital to the people in the slum cluster*
- *Lack of interface between people and the hospital staff leading to attitudinal problems.*
- *Inadequate outreach from the hospital staff (besides **Basti Sevikas**) to the community*
- *No proper MIS to check the availability of staff, in the hospital to provide better services*
- *Low coverage of target beneficiaries on delivery of health services*

The proposed ICT model, therefore, could be a dedicated, toll free telephone line, installed at both ends – the community and the hospital. In the community the phone line could be installed either in a PCO booth or in the house of a locally accepted community leader, where women and adolescent girls would have easy access.

This line could open a two-way interaction between the community and the hospital to provide information relevant to the community and feedback to the hospital authorities.

Such a system may be supported by relevant software that 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.

Also, the Basti Sevika, a crucial link between the people and the service provider, could be supported in her role through an ICT tool. This could be a mobile phone facility to help her convey the people's needs to the hospital authorities. Likewise, she could use this phone to get latest information of about services at the hospital and keep the community informed about these, without having to travel back and forth.

Based on the monitoring and evaluation of the model, and the lessons learned, the model could be strengthened or changed as the case may be. 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 the Maternal and Child Health care services.

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1 INTRODUCTION

1.1 JUSTIFICATION

Social development involves more than merely changing development investment decisions. It is a way of thinking about development in which people, rather than economics or technology are the central focus. It calls for a new culture and methods of planning and development that are participatory and involve people.

The planning systems therefore need to be responsive to people, not only because they have the relevant information which otherwise would not be available to the planners but also because their involvement is essential to gaining their commitment.

The success of any planning or project aimed at social development would then be possible if it adopts the bottom up approach to community participation as against the more traditional and prevalent top down approach commonly followed by most government agencies.

The project justification statement of the DFID KaR Project on 'Improving the transparency, quality and effectiveness of pro-poor public services using ICTs' clearly states how, despite considerable investment, public services in most developing countries face tremendous operational challenges in effectively reaching to the target beneficiaries.

"The poor and the 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. There is no 'exit' option available to these users to seek an alternative provider in case of dissatisfaction with the service provided. (Gopakumar K et al 2002)"

This pro-poor action research project therefore focuses largely on access to information and 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. It seeks to identify and use the appropriate ICT to disseminate information to service providers and users and provide an appropriate means by which the poor can give their feedback to the government on the service provided.

However, the project will use ICTs in the broadest sense of the term and technology and encompass a variety of different mediums including telephone, Internet, television, film and radio. Also, ICTs will be viewed and used as a means and not an end in themselves. So the common core of the project would be to combine ICT with participatory techniques such as Focus Group Discussions, to gather views from the poor about various public services. This bottom up approach, as discussed at the outset, is in contrast to the traditional ICT approaches (and indeed public service provision), which tend to be top down and unresponsive to user needs.

Given this backdrop, international development organizations promoting pro-poor development policies and programmes were selected for this action research project in four countries.

These include the country chapters of reputed International NGO, Transparency International, in Croatia, Pakistan and Nigeria. Transparency International is the only international non-governmental organization devoted to combating corruption. It is a pioneer in promoting transparency in government and other key institutional set-ups.

In addition, OneWorld South Asia, the regional chapter of the UK-based NGO network, OneWorld International, was chosen for the project in India. OneWorld South Asia is one of the 12 centres of OWI, contributing to both regional international initiatives in ICTs to promote human rights and sustainable development.

OneWorld South Asia is focused on tackling poverty and ensuring people's rights and towards this has four programme areas of partnership, development communication, capacity building and research and advocacy.

The Digital Opportunity Channel, managed and edited by OWSA, is a strong advocacy platform to lobby for pro-poor ICT policies. Also, OWSA is a key collaborator in a grassroots ICT initiative, the Open Knowledge Network that uses the bottom-up approach to create a grassroots network, keeping local information needs in mind.

1.1.1 Why India

According to the National Sample Survey (NSS) of India, the poverty rate in India in 2000 stood at 260 million, a sharp decline from the 320 million figure of 1994. Nevertheless, the fact is that India still has more poor people than any other country in the world.

By the World Bank standard of $ 1 per day per capita, 52.5 per cent of India's population which was poor, accounted for 35 per cent of the world total in 1992 – far more poor people than all of sub-Saharan Africa. So if the total number of people living in poverty in the world is to be reduced, India is the obvious place to begin.

India's high level of poverty exists despite a half-century during which the overarching objective of India's development strategy has been the eradication of mass poverty. Accordingly throughout the period of independence, government policy has operated to favour the poor. One of these has been through the concept of Welfare state where the state accepts the responsibility for the provision of comprehensive and universal welfare for its citizens. These include a wide variety of subsidies, food distribution, and employment programmes aimed at the poor.

The pro-poor government services in India extend to a wide range of sectors from water and sanitation and power to health, education and public distribution system.

However, most of these services are prone to a systemic spread of corruption that has been well documented and articulated over the years, through various surveys and media exposé.

As a result of this rampant corruption, the services fail to reach the target beneficiaries, due to lack of information or inefficiency or inadequacy of these provisions. In many cases, the people become apathetic, seek alternative sources of services and do not raise their voices to demand better services.

Some of the typical problems that hamper effective delivery of these public services are:
➢ They are planned with a top-down approach with little or no consultation with the end users/target beneficiaries.
➢ The government has a monopoly as service provider, making its accountability to the users very low.

- The lack of accountability of government servants makes them prone to negligence, inefficiency and delivering low quality service.
- Multiplicity of local authorities offering these services leads to passing the buck among them as far as quality of service delivery is concerned.
- Information is power. But there is almost no dissemination of information about these services or their usage among the target beneficiates so the services remain under utilized.
- There is no effective monitoring/feedback mechanism in place for these services so the shortcomings either remain unnoticed or are never worked upon.
- The grievance redressal system is either non-existent or very weak.
- Corruption- retail and grand, percolates down to various levels of the government service chain. So be it hidden costs of services or bribery/extortion or scams, these are the order of the day.
- Lack of literacy, basic empowerment and access to information about these services has led to their under-utilization.
- People, due to lack of awareness and empowerment, don't seek redressal of grievances. They either accept the services, no matter what the quality, for lack of any exit options. Where there are options, they are forced to accept them.

1.1.2 A case for ICTs

The advent of Information and Communication Technologies as a highly leveraged enabling tool for delivery of services in the public and the private sector has by now been universally recognized. This has redefined the fundamentals and has the potential to change the institutions as well as the mechanisms of delivery of services forever.

In India, the government has already initiated several measures to usher in e-Governance. For the delivery of public services through IT, the government has already approved the policy of allocation of 2 to 3 percent of the budget of such departments for IT. In order to have an impact of the use of IT in government for citizen service, the government has taken up on a priority basis, computerization of services, which have a direct interface with the public.

These include interfaces for public grievances on services such as electricity, water, telephone, ration card, sanitation, public transport and police. Then there are social services

such as pension, registration of licenses and certificates, school and university registration, driving license and commercial services such as filing of tax returns, house tax, electricity, and water and telephone bills.

However, despite many visible efforts to bring about such an IT interface between the government service provider and the citizens, the efficacy and transparency of such systems is yet to be established through verified means.

1.2 ABBREVIATIONS USED

Abbreviation	Description
ICTs	Information and Communication Technology
OWSA	OneWorld South Asia
OWI	OneWorld International
DFID	Department for International Development (of United Kingdom)
NSS	National Sample Survey
TI	Transparency International
CSO	Civil Society Organisation
SHO	Station House Officer
FIR	First Information Report
MCD	Municipal Corporation of Delhi
DEO	District Education Officer
CRY	Child Relief and You
IEC	Information Education Communication
PCO	Public Call Office
IUD	Intra-Uterine Device
OT	Operation Theatre
ANM	Auxiliary Nurse Midwife
MTP	Medical Termination of Pregnancy
IPP	India Population Project
NDMC	New Delhi Municipal Corporation
SMO	Senior Medical Officer
CMO	Chief Medical Officer
OPD	Out Patient Department
PRA	Participatory Research Appraisal
M&E	Monitoring and Evaluation
FGD	Focus Group Discussions
MLA	Member Legislative Assembly
JJ	Jhuggi Jhompri (Slum clusters in hutments)
MCH	Maternal and Child Health
CEDPA	Centre for Development of Population Policies
DGHS	Director General Health Services
IT	Information Technology

1.3 STRUCTURE OF THE REPORT

This document consists of five sections and three appendices.

Section 1: Introduction: Provides Justification and rationale for action research project and use of ICTs

Section 2: Sector Identification: Process of selection of sector for research

Section 3: Sector Assessment: Details of sector, methodology for assessment problems faced and the ICT model to be applied.

Section 4: Problem Identified: Lists problems from perspectives of service provider and people. Identifies problems to be addressed by this research

Section 5: Proposed ICT Model: Identifies the ICT tool to be used for the research

2.1   SELECTION METHODOLOGY:

The project clearly states that participatory methodologies would be used at all stages of the project, right from sector selection to project design and implementation. The India chapter of the project therefore adopted this approach in the first stage of the project - sector Assessment, which began in January 2004 and continued till March.

Delhi, where the office of OneWorld South Asia is based, was chosen as the city for this research. The rationale for Delhi as a good location for such a project has been discussed in the India Country Paper presented at the Zagreb Planning Workshop in February 2004.

A combination of primary and secondary research was used to assess various sectors based on certain parameters, before short-listing one sector for the research.

These parameters are based on:

➢ Level of awareness of the service among target beneficiaries
➢ Perception, level of satisfaction among the target beneficiaries of such services
➢ Transparency in working, delivery mechanisms of the service provider
➢ Quality of service delivery, based on views of both provider and recipients
➢ Availability of options available to people in seeking such services
➢ Existence of feedback, grievance redressal mechanism
➢ Level of accountability of government service providers

In addition, the following parameters were kept in mind for the perceived challenges and methodological constraints in implementing the project:

➢ Willingness of the stakeholders to work on the project.
➢ Presence of a strong NGO working with the community to help facilitate people's participation in the project
➢ Readiness of local government functionaries to use the ICT tool and be open to the idea of receiving feedback from the people

➢ The stakeholder being open to the idea of using an ICT communication tool for information and feedback.

Face to face meetings were held with key stakeholders in the project – the government as service provider, the community (poor, underprivileged) and Civil Society Organizations (CSOs). This was combined with secondary research based on Internet and media sources as part of the exercise to select a sector for this project.

Four services, Police, Power, Education and Health were taken up for Sector selection. These services were identified by a recent Transparency International (TI) Survey, as the most corrupt government services in India.

The TI survey, titled *Corruption in South Asia, Insights & Benchmarks from Citizen Feedback Surveys in Five Countries*, was taken as peoples/citizens perspective on government services.

Face to face meetings held with the senior and local government officials and representatives of the NGOs corroborated what the TI survey had pointed towards – rampant systemic corruption.

Here are some details of the sector-wise findings:

2.1.1 Police

According to the TI Survey, Police was voted as the most corrupt service in India. A majority of the respondents, who interacted with the police, admitted paying bribes and many said that money was demanded for making a FIR (First Information Report).

While much of this applies in toto, to Delhi, there are other problems as well, that distances people from the police who are seen, not as a protector but as perpetrator and intimidator. Many of these problems have been listed in detail in the India country paper presented at the Zagreb Planning Workshop.

There have been several reports of policemen detaining people illegally or beating them up to extort money. According to estimates quoted in a BBC report, 1,440 cases of beating or torture, 269 of extortion and 726 of illegal arrests or detention were registered against the police in June and July, last year.

According to a senior police official, there are too many pressures that make the policemen succumb to the lure of bribes and extortion's. Long duty hours (12-hour shifts, six days a week) low salaries, vulnerability to and pressure from superiors make them susceptible to corruption.

"Given the temptation for bribes from the people who violate the law and norms in daily life, the policeman has little choice but to fall to the lure. After all, he is only human," remarked the official.

The Police officials and the CSOs felt that bringing in a change in the attitude of the policemen and rooting out institutional corruption would be a challenging task but felt the need to make a beginning. Unless there was a change in the people's perception of police the chasm between the people and the police would remain. They said many publicity and PR exercises, some of them using new and traditional ICTs have been undertaken to improve the image of the police but these have largely been viewed as cosmetic measures.

Despite such a view, the question of accessibility and willingness of the police officials to be associated with the project, told another story.

The India chapter got in touch with a local NGO run by a former police official, to identify areas and locale where such a project could be taken up. The NGO, Prayas, works for underprivileged communities residing in slums and resettlement colonies in Delhi. Its work is focused on juvenile justice and street children.

After two weeks of discussions with *Prayas,* the *Khanpur Slum Cluster*, in South of Delhi, was explored as an area for study. The slum cluster, with a population of more than 10,000 comes under the jurisdiction of the Ambedkar Nagar Police Station. Petty crimes, violence against women and domestic violence are rampant and people live in virtual fear of the police.

Discussions were held with the youth and women in the cluster to ascertain their views on the police service. The discussions began from general problems to specific issues, so that they felt comfortable and shared their thoughts freely. However, when the issue of police was brought up in the meetings, the youth and women, who had been quite vociferous about problems of water, sanitation, education, health and alcoholism, simply clamped up. The

general response was "We have never dealt with the police, so we can't say anything" or "what can we poor say about the police? Who listens to us, we have nothing to say."

Any amount of prodding and cajoling did not yield specific responses from the people, except general comments such as, "The police is not for the poor, but only those who have power and money."

Such was the fear and sense of awe among the people that they refused to talk about their experiences or even impressions about the police and started feeling uncomfortable with the questions.

To find out more about this attitude among the people, I tried approaching the Station House Officer (the police officer in charge) of the Ambedkar Nagar Police Station. The After nearly 10 phone calls over a period of three days, I finally got to speak to the SHO. A meeting was fixed for 1600 hrs the following day. However, the next morning, I got a call from the police station, saying "SHO sahib wont be able to meet you today, we will let you know when he is available next." Patient waiting and follow-up yielded another meeting. However, this time the SHO himself called to say he had to go to court and we should meet another day. For the fourth such appointment, (there were no phone calls this time to cancel the meeting) I went to the police station, along with two community volunteers of Prayas.

The meeting was fixed for 1600 hours. We reached well before time and were served tea and biscuits by the police staff, as we waited patiently. At the end of it all, we were told we wont be able to meet the SHO. "Sahib has had to rush for a VIP duty. The Deputy Prime Minister is visiting Lajpat Nagar, which is under our jurisdiction, so he had to report on site."

As we walked back, hoping for another meeting, the Prayas volunteer, said with a smile, "I have never been inside a police station and could have never imagined that I would visit one and even be served tea and biscuits by police officers!"

Subsequent calls to the SHO yielded no more meetings. We took them to be polite indications of his unwillingness to hear us out and work on the project

The unwillingness of the people, borne out of a sense of fear and awe of the police, and of the police to get involved with daily interface with the people, made me move on to another sector for selection. *Changing the attitude of the people and the police to be open to such experiments, one realized was a project in itself.* The DFID project timeline was not sufficient for such an attempt.

2.1.2 Power

The generation and transmission of power is a state monopoly in Delhi. However the distribution of power was handed out, barely a year ago, to private agencies in an effort to decentralize government control over this crucial service sector.

This measure was taken to improve the perception of this service, which is largely viewed as corrupt, inefficient and unreliable due to inadequate and erratic supply of power. According to the TI survey, 'improper supply of electricity and payment of excessive bills' by the consumers was the norm of the day. Bribes were a very common feature in dealings with the local officials.

One of the major challenges that the power sector faces is the theft of power. According to a senior official of the private power distributor, more than 50 per cent of the power produced in the state is stolen and this theft is rampant in the slum clusters. However, it should be mentioned that the rich middle class accounts for the greater part of the theft.

The distribution agencies, then, (the main interface of the power sector with the people) are working on various fronts to reduce the quantum of this theft. Also, a variety of traditional and new ICT interventions are being used to provide better power distribution and check corruption among the officials. People are also being sensitised against thefts.

Unlike other services, there is almost no convergence with other service sectors or the NGOs in these efforts.

Consultations with the slum dwellers revealed that most of them had no direct interaction with the power department, as they were using power illegally. Issues related to power tariff was of little relevance to these people.

2.1.3 Education

Primary Education has been a key focus of various government programmes in the country and especially so in the national Capital. With India active on the worldwide Education for All Campaign, primary education targets are a priority.

For the poor, the fees in private schools are way beyond their means. So the government school, where primary education is meant to be free, is the sole viable option for these people.

In Delhi, education facilities are provided by the local municipal (Municipal Corporation) and state government (Delhi Education Directorate). The primary schools up to Class V are run by the MCD and are located in many of the slum clusters as part of the *Sarva Shiksha Abhiyaan* (Education for All campaign).

 For this sector, it was decided to follow the service chain thread from the bottom beginning with the slum dwellers as the recipients of the service and then on to the school, the education department and so on.

Detailed discussions were held with women of the *Harijan Banjara Camp* at *Khanpur*, again in South Delhi. Most of the camp dwellers send their children to the MCD-run RPS Primary School and said they were unhappy with the school and the teachers. Fees charged unduly for various services, rude behaviour, absenteeism, and lack of quality education were some key grievances of the women. They accused the teachers of pilfering food, books and uniforms meant for the students. Some even said their children had refused to go to school for fear of being beaten up by the teachers.

There was reluctance from the school principal and her staff to agree to a meeting, when approached. Finally, after several attempts, through the intervention of a local NGO, Prayas, working in the area, she relented. But again, when the question of transparency and quality of education was broached, the staff refused to speak up. They said at this point, that one would have to seek permission from the District Education Officer (DEO), before they could speak up.

What followed was a week of phone calls to the DEO, who was never available on her seat. After the 11th phone call, the DEO's assistant, finally said that one could "take a chance and hope to meet the officer during the lunch hour."

With no other option available, I took the chance and managed to meet the DEO in her chamber, only to be told that "the project sounds very good, but these days, there are too many NGOs approaching us for various projects. These interfere with our programmes so you will have to seek permission from the Director of Primary Education..."

What then followed was an attempt to get the Director's office number. I was told that before I could get a meeting, I would have to fax a request to her and would be given an appointment in 'due course.' The fax sent, the wait for the appointment continues...

2.1.4 Health

There is a multiplicity of authorities that deliver health services to a population of millions in Delhi. Some of these authorities are the Directorate of Health Services, the Family Welfare Department, the Municipal Corporation of Delhi, the New Delhi Municipal Corporation and the Delhi Cantonment Board. There is also a large presence of private/commercial health service providers.

Primary and secondary health services such as running dispensaries and hospitals and nursing homes, immunization clinics and implementation of various national and state level programs for health care and prevention and cure of major diseases are the main services provided. However, the quality, access and information about these services are woefully inadequate, forcing the people, mainly the poor, to turn to private service providers for their health needs.

According to estimates, there are about 40,000 quacks, 1,600 illegal nursing homes and a Rs 100 crore spurious drugs industry operating in Delhi.

According to a project coordinator working on Health project of Child Relief and You (CRY), a leading Indian NGO working for under-privileged children said most of the health facilities were insensitive to the needs of the poor.

For instance, most of the primary health care centres providing post and antenatal care to women and their children operate during hours when the women from the poorer sections are away at work as daily wagers. As a result, they are unable to visit these dispensaries and chose instead to go to local quacks, who are available all through the day.

The multiplicity of authorities was also a hindrance in the way of effective delivery of services. All the government departments blame each other for the inadequate and inefficient services. This inherent tendency of passing the buck combined with lack of commitment among the health care staff has deprived many people of this basic service.

A typical case in point is the immunization clinics and primary health care centres. According to a senior health functionary in the Capital, one such immunization had to be closed for over a month, as the refrigerator for storing the vaccines had developed a fault due to erratic power supply. Requests to the power department to help proved futile. The doctor did not have the authority to order a new machine and the procedural formalities (running into weeks) in acquiring a replacement, with the sanction of his superiors, who sat in another corner of the city, led to the temporary closure of the clinic, depriving hundreds of children of timely immunization.

> *As a CMO of one such clinic, specifically meant for the slum dwellers, remarked, "My staff knows well that as government employees, their service is secured and there are no performance benchmarks. So why would they bother to stay late to attend to patients or go out to the slums to serve the people?"*

Civil Society representatives, working in the slum clusters, feel that there is a need to change the mindset of the government officials, and make them more accountable and diligent towards their duties. Also, they feel the services provided by the health department are not adequate to provide basic health care or sensitive to the needs of the poor. Convergence with other departments, sectors, for provision of clean drinking water, proper sanitation and food distribution system is necessary to provide basic health care.

2.2   SECTOR SELECTION

Secondary research and references on selecting a suitable health project led to India Population Project (IPPVIII). In Delhi, the local municipal body, the Municipal Corporation of Delhi (MCD), is now running this project. At the outset, it made a good area for this action research because unlike many government services targeting the citizens, this was

specifically designed for the slum population. It faced the formidable task of bringing family welfare and basic health to the doorstep of the urban poor.

A series of 'sensitisation' meetings were held with the project officials, where it was emphasized that the research would seek to help improve the services and delivery of the health care being provided through the maternity homes and health centres being run under this programme the project head agreed to work with us on the action research. The project head pointed out that there were constraints -- severe systemic problems combined with attitudinal problems of the staff that were hampering the effective delivery of health service to the target beneficiaries – the inhabitants of the slum clusters. She stated emphatically that the research would have to address the problems of both the community and the service provider, and not just one of the two.

The buy-in from the government service provider was viewed as crucial to the effective running of this action research. So with this critical buy-in secured, a decision was taken to take up research in the health sector.

The next step was to identify the NGO partner that would have good relations with the slum dwellers in the areas where these Maternity Homes or Health Clinics were being run. Three NGOs in three separate locations were approached for a feasibility study.

These are:

➢ **Navjyoti,** an NGO working for basic health, education and life skills in slum clusters in Delhi. Navjyoti's centre in Jehangirpuri, a resettlement colony and slum cluster, on the outskirts of Delhi was approached. The settlement, one of the largest in Delhi, has an IPP-VIII Health Post that people barely know about. Consultations with the IPP-VIII department, the Health Post workers and the NGO showed that such a project would be more relevant in a location where a larger gamut of services such as out patient department were being provided.

With these parameters in mind, the Badarpur Maternity Home cum Health Centre, located on the Delhi-Haryana border was chosen for a survey. Consultations were held with the hospital staff. The discussions showed that the hospital was suitable for the research as there was scope to improve the service delivery and outreach with the hospital staff and the community as the key players.

> *However, despite readiness of the Project Head, there was cautious scepticism in the hospital staff, including the head doctors, to the idea of being chosen for the project. There was a feeling among the staff that the project was aimed at exposing their `inefficiency' or adding to their already heavy workload." A series of meetings were held, over a period of a month to convince the team, about the objectives of the project to help them serve their target beneficiaries better. Finally with some bit of persuasion and cajoling, the hospital team agreed to work on the project in principle.*

The next step was to identify an NGO working in the slum clusters that the hospital caters to.

➢   **Two NGOs Prayatan and Prerana,** working on health and reproductive rights issues, were approached for collaboration on the project.

Prayatan is an NGO working on integrated community development projects since 1991but had shifted its operation to a new location on the outskirts of the city, at *Madanpur Khadar*, where most slums of Delhi are being re-located. But since its area was outside the purview of the IPP-VIII project, the collaboration had to be ruled out.

Prerana, an associate of US-based Centre for Development of Population Policies (CEDPA), was then identified and approached for partnership, as it has been working on reproductive rights issues for nearly two decades. Prerana has self-sustaining community models in six peri-urban areas of Delhi, including the slums covered by the Badarpur Maternity and Health Centre.

A MoU was signed between Prerana and OneWorld South Asia on the project.

With Prerana's help, a survey of the sites was undertaken in seven slums and resettlement colonies covered by the Maternity Hospital. These included *Sapera Basti*, *Khan*, *Mohan Baba Nagar*, *Puran Camp*, *Subhash Camp*, *Bilaspur Camp* and *Molar Band*. Together, the total population in these camps was about 1.5 lakh.

> *In-depth meetings were also held with representatives of the community, mainly women and adolescent girls. Based on their feedback about the lack of responsiveness and effective service from the hospital and even their lack of awareness of such a service, we selected Mohan Baba Nagar, a slum cum resettlement colony near the Badarpur Hospital, as the location for our project.*

With these buy-ins secured from the stakeholders, it was decided to take up the IPP-VIII Project of the MCD as the sector for this research in Delhi.

However, there was no formal agreement drawn up between OWSA and the IPP-VIII project, and if feasible would be drawn up at a later stage in the project.

An appointment was sought from the head of the MCD, the Commissioner, to seek his approval for the project. However, after a meeting was fixed, the Commissioners office without any reasons being attributed cancelled it at the 11th hour.

We are hopeful to involve the Commissioner and other key stakeholders in the project in due course.

3.1 INDIA POPULATION PROJECT (IPP-VIII)

The past few decades have witnessed an enormous growth in the population of major Indian cities. Employment opportunities in cities have attracted large-scale migration from rural areas and smaller towns. However, these metropolitan cities have not been able to cope with such a large influx of people or provide civic amenities to the burgeoning population. So be it safe drinking water, sewage disposal, water supply or healthcare system, the civic departments have been unable to cope with the influx.

The result has been the growth of slums in the metros. In Delhi alone, the slum population in 1991, according to the Food and Civil Supplies Department, stood at 1.2 million. (According to fresh estimates, it now stands at 4 million).

Most of these people on entry try to settle down near the point of entry in the city and later on shift as per work opportunities, thus resulting in quick migration within the city limit. A majority of these slum dwellers are illiterate and have little or no access to mass media like newspapers, radio or television and the only way to approach them is through the word of mouth, in their own time, in the evening.

Primary Health care in the Capital is being provided by a host of authorities - - the MCD, NDMC, Cantonment Board, DGHS, Delhi Administration, Central Government Health Service, Railways and Autonomous bodies. So while there is a large infrastructure available for provision of primary health care in Delhi, the Urban poor living in various squatter settlements and slums have been unable to effectively utilize the health services and so the health status of these slum dwellers has remained poor.

Previous studies on services utilization have shown that almost 40% couples were protected, half of them with sterilization, 85% births taking place in homes were attended by untrained persons, mostly neighbours or relatives. Diarrhoea incidence rate was high because of multiple factors such as illiteracy, lack of personal hygiene, inadequate water supply, lack of adequate storage and unhygienic surroundings.

The World Bank assisted India Population Project Eight (IPP VIII) was originally approved for implementation in four Metropolitan cities – Bangalore, Kolkata, Delhi and Hyderabad for improvement of health and family welfare status of urban slum population in these cities for a period of five years from August 1993. The project, after several revisions finally took off in 1998 with a project cost of Rs 429.40 crore and an expanded reach in smaller towns and cities as well. The project was called the 'India Population Project for Urban Slums.'

The project, on which Delhi spent nearly Rs 73 crore, finally came to an end in June 2002. The Municipal Corporation of Delhi took over the management and sustenance of the project.

The objectives of the project were:

➢ To improve Maternal and Child Health Care (MCH) through a specially targeted programme for slum dwellers
➢ To reduce fertility rate among the slum population through improved Family Welfare Services
➢ To improve the utilization rate of MCH and Family Welfare Services.

The target, through these programmes was:

➢ To raise the contraceptive prevalence rate to 60%
➢ Achieve universal coverage of immunization
➢ Provide ante-natal and post natal care
➢ Have 98% of deliveries conducted by trained personnel
➢ Reduction in proportion of third and higher birth order

The core of the strategy of the programme was to strengthen the outreach services for the population of JJ (*Jhuggi&Jhompri* (squatter settlements)) clusters by identifying a *Basti Sevika* (Outreach worker) from the community. This BS would serve a population of 2000 by essentially acting as a Health educator and motivator of the community. She would be a crucial link between the health services and the community and also provide minimum curative care to the community.

3.1.1 Information, Education and Communication (IEC) Component

Unlike most other health programmes in the state, IEC formed an integral part of this programme. Its objective is to educate, motivate and mobilize the population in general and

the target beneficiaries in particular to adopt small family norm and preventive and promotive health care.

The major emphasis of IEC in IPP-VIII is to create awareness among the slum dwellers to enable them to gain access to the health services provided under the project. The stresses are on interpersonal communication through the network of *Basti Sevikas* working in the clusters covered by the project. The IEC has the two-fold objective of strengthening the capacity of the communication infrastructure and widening the frequency of contact between the service providers and the community in order to encourage a more horizontal and spontaneous dissemination of messages leading toward behavioural change.

The IEC activities of IPP VIII project include interpersonal communication through groups meetings, health talks, and mass media activities such as theatre activities, school health programme, exhibitions, IEC van, Posters, handbills and National TV spots.

The project has clearly outlined the IEC strategy to be followed to propagate the message and also bring about attitudinal changes among the dwellers for whom health is never a priority but also a requirement in emergency situations or acute illness.

So the key elements of the IEC strategy are:

- Message are to be associated with Planned Parenthood
- Thrust to be on quality of life
- Strengthen women's organization, cooperatives
- Stress on inter-personal communication
- Development of material in decentralized manner

The project also has a component for roping in NGOs for mobilizing the community, capacity building and providing IEC activities.

A study of the low performing areas of the project highlighted the following:
➢ There is an urgent need for emphasis on interpersonal communication b ANMs, *Basti Sevikas* (outreach workers working in slum clusters), *Dais* and NGO volunteers with al the beneficiaries.
➢ Enhance IEC activities to increase coverage of beneficiaries and the community
➢ Evening capsule for male participation and involvement

- Participation of community based organizations in planning, monitoring and implementation
- Need for campaign mode through word of mouth
- Emphasis on availability of frontline workers in JJ clusters for a considerable time suitable to the beneficiary
- Training of ANMs, *Basti Sevikas*, *Dais* and NGO volunteers in critical areas of inter personal communication after ascertaining training needs
- Mass media approach useful in creating general awareness of the programmes
- Electronic media like Audio-visual vans and programmes through cable channels more useful in spreading the messages of health programmes
- Traditional media like puppets shows, street plays and magic shows should be made sensitive to the needs of the slum population and their socio-economic and cultural background.
- Print media (pamphlets, booklets banners, wall posters, display boards, wall paintings) needs more of visual elements with bright colours
- There is no ownership of programme by the community. So community participation in planning, implementation and monitoring has to be increased.

Disha, a voluntary organization commissioned by IPP-VIII to suggest a strategy for an effective IEC programme made the following observations about IEC programmes:

- Information about the area under the health post/centre needs to be displayed prominently.
- Field staff do not have full information about IEC activities taking place in their area in advance, ensuring their presence and involvement
- *Basti Sevikas* need to be involved in IEC through individual contacts with target groups for total coverage, linkage and follow-up
- Field staff do not generally carry or use the IEC materials during their field visits in the *Basti (slum clusters)*
- Prior information about IEC activities, venue and timing not properly disseminated to the community
- Time schedule of shows not as per convenience of the target groups
- No audio system used during puppet shows, so the messages are not very audible
- Key messages during IEC activities need to be frequently repeated
- Very little audience participation and interaction in IEC activities as field staff is seldom involved in these

- ➤ Key influencers in the community need to be given specific responsibilities to ensure male participation
- ➤ Early acceptors and couples whose Behaviour has changed as a result of the programme interventions should be felicitated and projected as role models

According to estimates provided by the Project Coordination Cell, about Rs 10 Crore were spent on IEC activities to create awareness and demand about the project activities among the communities. NGOs were involved in the IEC programmes, and local community level cooperatives, such as '*Mahila Mandal* ' (Women's Collectives)   *Purush Mandal*' (Men's Collectives) were set up to galvanize the people into community work groups. Vocational training was also imparted to women and adolescent girls, as part of the IEC activities, to ensure that the health messages were imparted for a lasting impact, while providing the people with livelihood skill such as tailoring and stitching, beauty care courses.

With the MCD taking over the management and sustenance of the project, there was a big cut in the IEC budgetary allocations and activities, impacting the programmes awareness among the floating, shifting, and slum population.

3.1.2 Organization Structure of IPP-VIII

For providing health services to these groups three types of health units viz.health   posts, one each for a population of 10,000 and health centres, one each for a population of 50,000 and maternity homes covering a population of 2, 00,000 have been established.

The project has been providing health care services for a considerable period of time now. According to latest records, there are 105 health posts, 26 health centres and six maternity homes cum health centres catering a JJ clusters in Delhi. When the project began, it was proposed that this programme would cover 929 JJ clusters of Delhi, with an estimated population of 1.25 million.

According to the project guidelines, the health centres were to be located preferably near the largest slum cluster. In case no space was available for such a construction, any other suitable cluster or nearby area would be chosen for the construction of the health centre.

ANMs manage each health centre. Each health centre monitors and supervises activities of 5 health posts. One ANM posted at the health post is assisted by five *Basti Sevikas* and five-trained *Dais* (midwives). Each ANM is to look after a population of 10,000 and is assisted by five *Basti Sevikas* who in turn cater to a population of 2,000 each.

> *According to the project guidelines, the preventive, promotive and curative health services are to be provided through this programme. Towards this, the doctors are supposed to visit the health posts and the JJ clusters for direct supervision of preventive and promotive services at least twice a week.*

For the purpose of this study, here is a brief on some units /roles of the project:

Maternity Home cum Health Centre:

Caters to a population of 200,000. It has to carry out the functions listed for a health centre such as to provide antenatal and postnatal care, immunize eligible children and women, identify couples eligible for family planning and motivate them to accept suitable methods, motivate local leaders for involvement in healthcare of community, finalise monthly programme of IEC unit and supervise the work of health posts and centres.

In addition, it is to provide outdoor and indoors services and have a provision of 15 beds, labour room and operation theatre. These also have to conduct institutional confinement and deliveries; provide facilities for terminal methods of family planning and MTP, Normal and high-risk deliveries and non-surgical care for children needing specialist's attention. For this services of paediatricians and gynaecologist are made available at these units.

Operative vaginal deliveries and minor gynaecological procedures such as D&C are meant to be conducted at these Maternity homes. However, patients with abdominal deliveries and children needing surgical interventions would be referred to higher-level institutions.

Staffing: Headed by the SMO (Senior Medical Officer) the Maternity Home cum Health centre is to have the following staff:
SMO, RMO, Gynaecologist, Paediatrician, Anaesthetist, *Safai Karamchari* (sweeper), Public Health Nurse, ANM, Statistical Assistant, Staff nurses, Ward *Ayah* (attendant), Health Worker (male) Lab Technician, Lab Assistant, Pharmacist, Clerk and OT Attendant, driver, *Chowkidar* (gatekeeper), warden and dresser.

***Basti Sevikas*:**

Selected from the clusters act as main link between the health workers & members of the community. They are paid an honorarium of Rs 500 a month and are meant to work three hours daily. She is given a health kit and carries out health education, promotes preventive care and motivates for immunization and allied services. She also works closely with the local trained *Dais* in the community to ensure proper ante and post natal care of pregnant women and refer high-risk cases identified by the *Dais* to the hospital.

One of her roles is to identify and refer to the IPP-VIII dispensary/hospital, women and children from the community needing institutional health care.

ANM:

Appointed specifically for the outreach programmes and is meant to visit the community every day. Her role is to guide and help the *Basti Sevikas* under her and help in providing ante and postnatal care to the women in the clusters. She is also meant to identify high-risk cases and refer them for supervision to a doctor.

Management Structure:

The management structure of the project has the *Basti Sevikas* at the bottom and the MCD Commissioner at the top of the organizational hierarchy. The Project Director who heads the Coordination cell in the MCD is the key management in charge of the project. The flow chart in **appendix C** explains the reporting pattern of the project under the Project Director.

3.1.3 Project site:

As mentioned in the section on Sector Selection, the Badarpur Maternity Hospital was chosen as the service provider and *Mohan Baba Nagar*, a slum and resettlement cluster of about 9000 population was chosen for this action research.

A. Government Service Provider: Badarpur Maternity Hospital:

The hospital is meant to cater to a population of 200, 00 as per project guidelines. It is looking after a population of 50,000 spread over a radius of eight KM. Unlike most such hospitals, which are meant to be located close or in the slum cluster, this hospital has a unique location, due to lack of availability of land for its construction, on any other site in the area. As a result, the slum population it is meant to cater to is spread over a radius of 8 km, *Mohan Baba Nagar*, being the closest area.

Picture I: Badarpur Maternity and Child Health Care Hospital

It started off as a health centre and assumed the status of a full-fledged hospital 1-½ years ago. However, it is yet to become fully operational. It is currently understaffed and its OT is not operational. Listed below are the areas and population covered by the Bardarpur hospital and its staff strength.

Clusters covered by IPP-VIII, Badarpur

S. No	Health Post	Cluster	Population	Remarks
1	A	Sonia Camp I	1790	
2		Sonia Camp II	400	
3		Mantoori camp	850	
4		Sahansi Camp	500	
5		Kachi Colony (Molarbundh)	2675	Under Survey
6		B/W Camp	1355	
		Total	**7570**	
1	B	Bilaspur	5755	
2		Sapera Basti	1200	
3		Bhat Camp	1400	
		Total	**8355**	

1	C	Kachhi Colony (Molarbundh)	3715	Under Survey
		Total	**3715**	
1	D	Indra Camp	1400	
2		Muslim Camp	1674	
3		Azad Camp	2400	
4		Rajeev Camp	2200	
5		Priyanka Camp	1800	
		Total	**9474**	
1	E	M B Nagar	5926	
2		Khan Camp	1200	
3		Subhash Camp	1500	
		Total	**8626**	

Staff Position

Sl. No.	Category of staff	Posted	Vacant
1	Gynaecologist	1	1
2	Anaesthetist	1	0
3	Paediatrician	1	0
4	Staff Nurse	8	0
5	Nursing Sister	1	0
6	OT Technician	1	1
7	OT Assistant	1	0
8	Lab Technician	1	0
9	Lab Assistant	1	0
10	Ward Ayah	6	2
11	Driver	1	0
12	Chowkidar	2	1
13	Safai Karam chari	6	3

*Voluntary Link Workers (*Basti Sevikas*) : 18

Diagram I: Clusters covered by IPP-VIII, Badarpur with population

Over the past six months, the hospital has shown improvement in its service delivery (*see table below*). However due to its unique location, on the Delhi-Haryana border, away from the clusters it is meant to serve, the hospital is serving only 30 per cent of the target beneficiaries. The rest of the people availing its services are from the neighouring states

or from other economic groups. According a hospital staff, "We are not supposed to turn away anyone who comes to our door for health care. So we end up catering to 70 per cent of the people from outside the target areas as there is not much demand from the slums."

Maternity Home Cum Health Centre Badarpur	
Population	**37740**
Eligible Couples	**6513**
Protected Couples	**1676**
Started Service Delivery from Temporary Accommodation	Jul-97
Started Providing Services from own Building	Sep-01
Maternity Home Quarterly Performance (July 2002 Onwards)	

Period	Deliveries Conducted
(Jul 02 - Sep 02)	56
(Oct 02 - Dec 02)	93
(Jan 03- Mar 03)	45
(Apr 03 - Jun 03)	61
(Jul 03 - Sep 03)	119
(Oct 03 - Dec 03)	148

Health Centre Performance		
Indicators	**2002-2003**	**2003-2004 (Dec 2003)**
Total ANC Registration	1230	1303
1st Trimester	545	496
TT Immunisation	415	585
IFA Prophylaxis	379	337
Total Deliveries	894	902
BCG	890	821
DPT 3	860	520
Measles	514	445
IUD	76	87
Sterilisation	95	78
OP	106	0
CC	76	22
OPD	31290	45047

Diagram II: *Performance detail of Maternity Home Cum Health Centre Badarpur*

B. Slum cluster: *Mohan Baba Nagar*:

Mohan Baba Nagar is a resettlement colony, closest to the Maternity hospital, with a very busy interstate, heavy traffic highway road separating it from the hospital.

Picture II: Mohan Baba Nagar

Mohan Baba Nagar is located on an incline with the main road touching the top of the locality. It is spread over a large area in Badarpur along Delhi's border with the Fardiabad Township of the neighouring Haryana. The colony has a population of about 20,000 in its seven blocs. Blocks A to E which are closer to the highway have people from a mixed economic background – from affluent to middleclass and lower middleclass. At the bottom of the steep incline, lies G bloc, a squatter settlement of migrants from northern and central Indian states.

A majority of the migrants are from the backward states of UP, Bihar, Rajas than and MP who do not have a good record of acceptance of family welfare programmes due to socio-economic and cultural barriers.

The people of this block live in near squalor conditions with no water or sanitation facilities. There is no health centre or any civic service available in the area, except a Balwari (Primary school and crèche for children)

Picture III: squalor in slum: Mohan Baba Nagar

Most of the about 6,000 people of this block, work as daily wagers, labourers, mill workers and petty vendors, to eke out a living. The average income of a household of five people is Rs 2,500. Literacy levels are low. Most of them are illiterate or have studied up to primary classes. Men are more literate than women.

No demographic profile has been prepared either by the Hospital authorities that are meant to conduct a survey of the areas they serve, or by local NGOs.

The only health and education facilities in the area are being provided by the project, and two NGOs – CaspPlan and Prerana.

The area lacks any strong community leadership. A few inhabitants have been designated as local leaders by virtue of their proactive stance in galvanising the community for basic amenities such as drinking water and electricity. In fact there is no strong community leadership in the cluster, except when it comes to issues like water supply.

Water supply is a major concern among the slum dwellers. The hand pumps installed in the area are contaminated by the dirty and polluted water of a '*khan*' (traditional pond) in the area full of industrial effluents and human waste. So their only reliable source of drinking water is through water tankers of the Delhi Jal Board, sent by the local MLA. When there is a delay of over three to four days in the water tankers supply, the community leaders make a representation to the MLA. Water shortage has often led to fights among the residents, bloodshed and police intervention.

The power situation presents a better picture as the people have regular power connections and pay a sub-contractor for the services. Also, as is the case, many of the slum dwellers have also taken the easy option of stealing power.

Health however is not a priority with the slum residents. The people address their health needs only in case of emergencies. Awareness about the preventive aspects of health care is non-existent among the people. They would turn to a doctor or hospital only in case of emergencies or major aliments. For smaller ailments, again, the preferred choice of the people is a private practitioner or a local 'anytime, always available' quack. Government hospitals are preferred only in case of major ailments as these are the only affordable options.

Information seeking behaviour: Given the low literacy levels, most of the people rely on the word of mouth and interpersonal communication for information on any service or development around them. Most of the houses have electricity and TV and cable connections, which are also a source of information about the world around them. Information from newspapers is only confined to some select shops where the people gather to read and share the news. Telephones are used commonly, more by men, and there are several PCOs in the locality.

However, the community is not proactive in seeking information and instead waits for information to come to them. The *Basti Sevikas*, the field staff of NGOs operating in the area and local community leaders, are their sources. It is only when some crucial concerns, for

instance delay in water supply through the water tankers, do they actually 'seek' information and take steps to redress the situation.

3.2 METHODOLOGY FOR ASSESSMENT

Picture IV: Focus Group Discussion Meeting

Action Research is viewed as a complex, dynamic activity involving the best efforts of both the members of communities and professional researchers. It is holistic and action bound to produce practical solutions and actions that can help transform the situation in democratic directions.

In the context of the DFID project, we chose the PRA methodology, so as to directly involve and consult those whom it is designed to benefit.

Face-to-face meetings using a combination of Focus Group Discussions (FGDs) and in-depth face-to-face interviews with the stakeholders, right from the Sectoral selection process to the assessment stage. In addition to these, secondary research was conducted to include relevant data and media viewpoint on the programmes. In addition to the face- to-

For the assessment stage, nine focus group discussions and in-depth interviews were conducted with the hospital staff, the IPP-VIII Coordination cell, and the community people and with the outreach workers. For the community FGDs were held separately with the men and women and given the women-centric nature of the health service the project is focusing on adequate representation of women in these consultations.

A chart below lists the location and sections with which these discussions were held. Since the National Project Coordinator is the only resource working on the project, paid volunteers were hired for assisting in the FGD's and note taking. The field staff of the partnering NGO, Prerana, were instrumental in organising the meetings with the community people.

The research team comprised of two members. While one asked the questions and conducted the FGD, the other took down notes for reapportioning. A tape recorder was also used for most of the FGDs, with full knowledge and consent of the group being interviewed. The participants were told about the project and the purpose of the discussion. The funnel approach of questioning, from the general to the specific was used for both the FGDs and In-depth interviews. Also, the questions were designed to veer from the general to the specific.

Given the quantity and type of data emanating from these interactions, the Soft Systems Methodology was used to derive a structured approach to deal with the soft problems, such as this project, that involves human interactions. This included an attempt to draw the 'Rich Picture,' a geographical representation of our understanding of the problem situation.

Details of FGDs and In-depth interviews:

S.No.	Method of discussion	Participants	No. of participants	Age group (yrs.)	Area/location
1	FGD	Women	12	23-45	Mohan Baba Nagar Badarpur
2	FGD	Adolescent girls	10	13-18	Tajpur Pahari, Near Mohan Baba Nagar, Badarpur
3	FGD	Community leaders	5	45-70	Mohan Baba Nagar
4	FGD	Men	9	24-50	Mohan Baba Nagar
5	FGD	Women	6	22-55	Sapera Basti Badarpur
6	FGD	*Basti Sevikas* (Outreach workers)	3	30-35	Mohan Baba Nagar
7	FGD	Hospital Staff – CMO, Head Nurse, ANMs, Paediatrician	5	-	Badarpur Maternity Hospital
8	In-depth Interviews	CMO, Badarpur Maternity Hospital	1	-	Badarpur Maternity Hospital
9	In-depth interviews & FGDs	IPP-VIII Coordination Cell – IPPVIII- Project Head, MIS, IEC, Training and Procurement In charges	5	-	Civil Lines Secretariat, North Delhi

***Diagram III:** Details of FGDs and In-depth interviews*

4.1 PROBLEM IDENTIFICATION

The FGDs and in-depth interviews threw up a vast amount of data pointing to a complex web of problems that were hampering the effective delivery of the family health care services to the slum population through the IPP-VII I project.

Contrary to generally perceived notion of service not being up to the mark due to laxity or inefficiency on the part of the service provider, problems, faced both by the local service provider and the community have contributed to low performance and demand of service. To quote the CMO of the hospital, the performance of the hospital has improved manifold in the past few months, in terms of the number of institutional deliveries. However the percentage of target beneficiaries getting these services was very low, just 30 per cent as against people from neighbouring states or outside the target group, which stood at 70 per cent. In case of OPD services, this ratio stood at 50-50.

A listing of the key problems faced by both the service provider and community is provided below. There after an attempt at addressing some of the problems that this project, given its timeline, resources and budget can address have been listed. The Rich Picture of the project and the problem situation, gives an idea of the problems at the two ends.

4.1.1 Problem identification: Community

The FGD'conducted with the community over a period of one month, with a cross-section of the community threw up a near unanimity of views from the target beneficiaries of the IPP VIII project about quality of services rendered.

Almost 80 per cent of the participants felt that the services at the hospital were not sensitive to the needs and requirements of the poor. The people felt the infrastructure facilities, the awareness drive, the accessibility and above all the behavioural attitude of the staff was highly unsatisfactory.

As a result, most of the people said they 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 being done at homes, through the traditional midwives.

Only in case of major ailments where the costs were very high, they had no exit option and went to larger government hospitals such as Safdarjung Hospital and All India Institute of Medical Sciences.

Perceptions of community:

➢ **Awareness/Outreach**:

Nearly half of the respondents said they were aware of the Maternity Hospital (MH) from the experiences of those who had been there or from the outreach workers who came once in a while to give immunization to the children. Almost all said they had 'heard' about the hospital by word of mouth but had never seen any doctor or medical practitioner, come to the community. The only community interface with the hospital for them was the *Basti Sevika*, "who comes for polio and immunization and some health messages." Also, most people did not have any clear idea of the timings or services provided at the hospital. Many of the women who went to the hospital after finishing their housework, had to return without any medical care, as the registrations close at 11 a.m.

> *"How would I know that they stop accepting patient at 11 a.m in the morning? As housewives, with children to look after, it is difficult for us to make it before 11 at times. The hospital timings should be more flexible" a mother of two in Sapera Basti.*

➢ **Infrastructure**:

A majority of the people who had been to the hospital, said they were not happy with the infrastructure facilities. They pointed out that the hospital lacked a basic service like an ambulance. Also, there was a water and electricity shortage in the hospital. The people also felt that the hospital was not a hospital in the real sense, as it did not even have an operational OT. As a result, even the simplest of delivery cases were referred to other hospitals for lack of proper infrastructure. They also felt that the hospital staff used lack of infrastructure as an excuse to turn them away.

> *"As patients, we have to arrange for our own water and medicines. There is no ambulance available for the pregnant women who have to be taken there for delivery. What kind of a hospital is it?" An elderly man whose daughter-in-law was taken for delivery to the hospital.*

> **Services**

Here again, most of the people (about 80 percent) felt that the services available at the hospital were not adequate. The people said the hospital was providing very basic services that were mainly geared for OPD patients. Medicines were never available and most of the out patients and those admitted, had to make their own arrangements. They also pointed out that the hospital was unable to take care of slightest complications. Also they said the doctors were not always available and often when they went to the hospital, they had to return without treatment as the doctor was away.

The residents also complained that in case of institutional deliveries, a majority of them who went to the hospital for deliveries or MCH related services were referred to other hospitals for deliveries. (The *Basti Sevika* also corroborated this view,) This according to them was to discourage them from seeking services of the hospital, which catered more to people from the neighbouring Haryana state, than to them.

"How come there are never any medicines available for us poor? Surely, the medicines must be there, sometimes at least. But we never get them. So God only knows what happens to the stocks" A 50-year old man whose wife was treated at the hospital."

> **Behavioural:**

This was one of the major grievances of the people said the hospital staff was very rude to them and that this itself had become a deterrent for them not to go to the hospital. The doctors rarely went to the community to meet the people. They would be shouted at if they asked any questions and were often threatened with being thrown out of the hospital "if we asked too many questions or complained about a service."

"They are not happy treating us or even touching us, as we are poor and filthy. This is the feeling that is given to us by the hospital staff through their attitude and behaviour. So why should we go there?"

"When I asked too many questions about why my baby's eyes were watering constantly, she (a hospital staffer) shouted at me and said if I was that worried about my child, I should take him to another hospital." A young mother whose baby was born in the hospital.

➢ **Cost-benefit analysis:**

The people felt that though the hospital services were meant to be free, they turned up paying much more to avail of its services by way of transport costs, money spent on medicines and losing a days' daily wages by not being able to go to work. As against these hidden costs of availing a free service, they found it cheaper to seek help from a quack, who was available, all day long, in their vicinity and was much cheaper.

> *"If I have to take my wife to this or any government hospital, I have to forgo a days work, as it takes a long time to reach the hospital and get the treatment. So I prefer to go to a private doctor and also manage to earn by days bread." A small time vendor and a father of two.*

➢ **Accessibility:**

The people felt that the hospital's location was not very convenient, as it was across a very busy highway. So even if they went there, they were not sure of getting medical attention, because of long queues or unavailability of doctors. This made many of them turn to local practitioners for their health needs.

➢ **Alternative systems:**

As mentioned earlier, almost 80 per cent of the people said they preferred to go to the local medical practitioner for treatment of minor ailments, as they were easily available and affordable. The people were aware that these practitioners could be quacks and not qualified doctors. But they said given the lack of services in the govt. hospitals, these quacks were their affordable choice. Next came MBBS (qualified doctors) who were a bit more expensive but still better than the government hospitals where the hidden cost of treatment was much more. Only in case of major ailments did they choose to go to bigger government hospitals for treatment, as the cost of treatment was very high.

Picture V: *Private Doctor's Clinic. Mohan Baba Nagar*

> **Grievances /Feedback:**

Almost 90 per cent of the people said they were neither aware of any grievance redressal mechanism nor were they interested in making any complaints. The general attitude was that since they were poor, no one would hear or pay heed to his or her complaints. Also, they said they had other pressing problems, such as water scarcity to bother about, rather than get involved in seeking redressal for lack of medicines or rude behaviour by doctors or even wrong diagnosis. Some of the people who said they did try complaining, said it was of no use as they were either threatened that they would not be treated or there was no follow-up or action on their complaints.

4.1.2 Problem Identification: Service Provider

The hospital and project officials, stated endless demands of the slum population, which 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 systemic problems, attitudinal problems and lack of accountability among the staff and non-negotiable project conditions, laid down by the World Bank were largely responsible for the low level of service delivery to the target beneficiaries.

Picture VI: *Empty waiting room at 1 pm. At a Maternity & Child Health Care Centre*

Perceptions of problems:

➢ **Systemic Problems:**

The management and sustenance of the IPP-VIII Project was taken over by the MCD, the local governing body of Delhi, in 2002, after the World Bank support to the project ended. The project, that had hitherto enjoyed a special status as a funded project, came under rules and procedures of the MCD.

The result has been long drawn procedures for hiring and recruitment of personnel to man the hospitals and more importantly of timely spending of funds to address pressing needs.

The complexity of governing agencies, providing health and other civic amenities has further aggravated the problem. The result is that due to these procedures, for instance the hiring of personnel, which is managed by various departments of the Municipal Corporations, has become long-drawn. Many of its important posts, such as doctors for round the clock duty, OT attendants, watchmen, nurses, and ayahs, have been lying vacant, leading to server resource constraints.

> *"As there are no doctors round the clock, we are unable to provide support for institutional delivery cases at night. Since there is no watchman, the residential nurses face the ire of angry relatives if they have to turn away a patient at night." Hospital staffer*

> **Infrastructure:**

The hospital faces severe infrastructure constraints such as water and electricity supply sewage facilities and provision of a canteen or a chemist shop. The location of the hospital, on the Delhi-Mathura highway and the Delhi-Haryana border, is another problem poser for the hospital, which does not come in the municipal limits. The result, it falls outside the municipal water limits of the city and has no regular water supply, except for submersible pumps. The shortage of water in the hospital makes it difficult for the staff to carry on its operations effectively. Similar problems hold true for electricity and sewage facilities. One of the reasons for this state of affairs is the multiplicity of agencies providing health services and lack of coordination among the departments providing civic amenities.

> *"Often after IUD insertions, we have no water in the room to wash our hands. So we have to walk across to the other side of the hall where there is some water stored, to clean our hands." A hospital doctor.*

> **Lack of accountability:**

The security of tenure and lack of accountability based on performance indicators has made the hospital staff, specially the doctors, very lax in their attitude and commitment to the job. The project clearly states that the doctors too would go out to the community to create awareness and monitor the services being provided. But except for some visits by the CMO and the paediatrician, no other hospital doctor had visited the clusters. Also, they were absent from duty on some pretext or the other, and were not seen in hospital in the afternoon hours.

> *"If the staff is pressurized to go out to the field, there is the option to seek transfers to other hospitals or health posts, where they may not have to go out to the slums." Hospital staffer.*

➢ **Behavioural:**

The hospital staff felt that there was not much demand for their services in the slums as there health is not a priority among the dwellers. Health is only seen as a need that has to be addressed in case of emergencies. Also, the low literacy levels and hygiene consciousness among the people, makes it difficult to make them take preventive measures, which was also a focus of the project.

On the attitude of the doctors, nurses and other staff, some of the project officials, admitted that this was a problem and said it had a bearing on fact that they had a security of tenure and their performance was not linked to goals and targets. As for the field staff, such as ANMs and *Basti Sevikas*, they felt that they faced a lot of challenges in the field from the people who were not very receptive to them. Also monetary incentives, especially for the *Basti Sevikas*, their main outreach workers, were very low.

➢ **Lopsided resource allocation**:

The IPP-VIII project allocation under the World Bank grant was lopsided to the extent that it involved expenditure to the tune of crore of rupees on infrastructure and building costs. However, the *Basti Sevikas*, one of the most important links between the community and the hospitals were provided a very meagre stipend. Given the importance of their role in creating an awareness and demand and of being informants of the hospital staff, they should be motivated with better working conditions.

The high infrastructure costs came in for a mention in the World Bank final report on the project, which found Delhi's performance, a mere 'satisfactory' as against the 'Highly Satisfactory' grades given to Hyderabad, Kolkata and Bangalore.

> *"While designing urban primary care centres, the need to develop permanent infrastructure should be carefully assessed, particularly in case of migratory populations like residents of JJ clusters in Delhi."*
>
> *In cities, where the beneficiary population is essentially migratory or floating in nature, as in the case of Delhi slums, investment in permanent constructions should be minimized - World Bank's report on completion of IPP-VIII project.*

➢ **Project Conditionality:**

The World Bank's cumbersome procedures, particularly relating to procurement of civil works and procedures required for approval was one of the main factors that have affected implementation of the project.

For instance there are very strict procurement guidelines, for medicines, equipment, land, construction material etc. The system has continued and in fact become more cumbersome under the MCD. So if the Chief Medical Officer of a maternity home has to procure a new refrigerator, the procedures of seeking the quotations and the right permissions and sanctions from a whole chain of project officials, could take months. The result could be that the health centre or Hospital would be unable to store medicines and provide the required services such as immunization facilities due to this problem.

> *"How can we expect our health centres and maternity homes to provide services to the people if they are not supplied the medicines on time because of bureaucratic procedures and delays?" IPP-VIII Coordination Cell.*

➢ **IEC Activities:**

The IEC activities of the project were basic to creating awareness and generating a demand for the health facilities in the community. However, since the World Bank funding ended, the IEC component of the project has shrunk considerably, leading to gaps in the awareness about these facilities in the floating, shifting slum population of Delhi.

4.1.3 **Problem Identification for action research**

From the above list of problems from the worldviews of the community and the service providers, it is clear that the low performance is not due to only lack of transparency, efficiency on the part of the service provider.

The Rich Picture of the problem below shows a much complex situation where systemic, behavioural, bureaucratic, infrastructure problems and lack of communication between the community and the service providers are at some of the key factors, affecting the delivery of the service to the target beneficiaries.
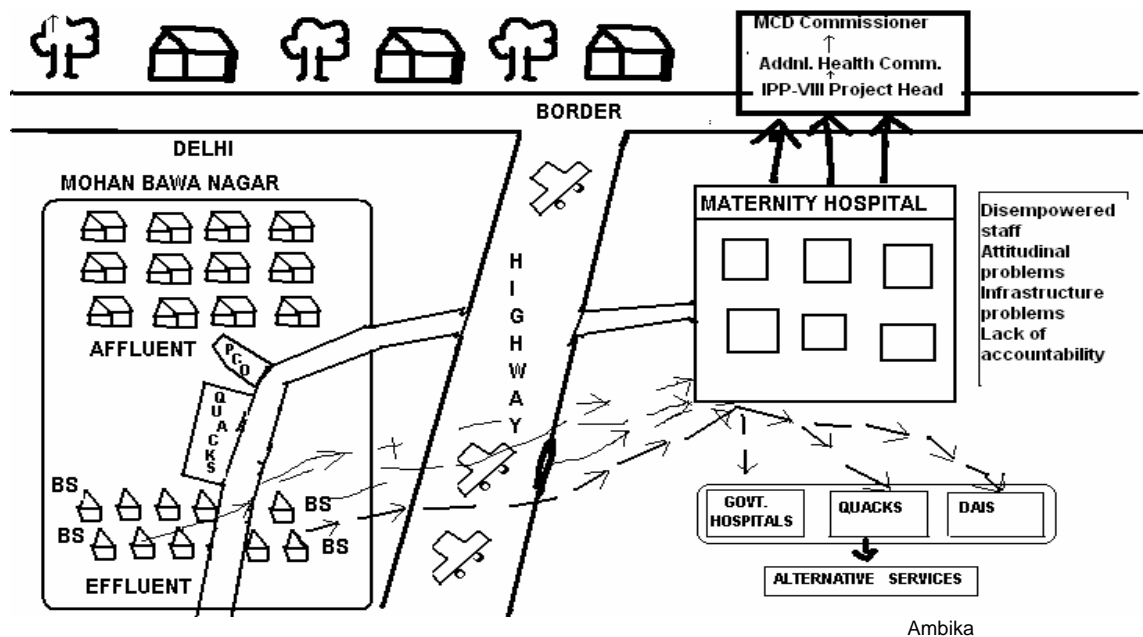

Diagram IV: Rich Picture of Mohan Baba Nagar

Given the time, resources and focus of this action research project, it would not be possible to work on improving/changing the entire gamut of challenges posed. However, since the action research is based on the PRA methodology and seeks people's ownership and participation, the following set of problems/challenges, could be addressed through the use of an ICT tool and supporting activities in the project period.

➢ Lack of proper communication about the services of the hospital to the people in the slum cluster
➢ Lack of interface between the people and the hospital staff leading to attitudinal problems among them
➢ Inadequate outreach from the hospital staff (besides *Basti Sevikas*) to the community

➢ No proper MIS to check the availability of staff, in the hospital to provide better services

The aim of these activities, using an ICT tool, would be to create awareness among the people about the service, meant specifically for them and empower and enable them to demand this from the hospital.

It would also create, parallel, on the part of the service provider, within the present infrastructure and constraints, better and more efficient service to the people who come to them from the slum clusters. This, way, it is hoped that the ratio of the target beneficiaries of the hospital, would increase from the 70- 30 ratio as of now (the latter indicates the slum population) in the months to come to 60.

This of course would not mean that services to the people outside the slum clusters, should be brought down, but lead to an increase in the services to the target beneficiaries for whom it is meant.

Given the profile of the people living in the selected site in 'G' block of *Mohan Baba Nagar* and their information seeking habits and literacy levels, a standalone ICT model, would not be a solution.

A combination of traditional and new communication tools would need to be used to bring the two stakeholders together on a platform. Such a platform would where they can communicate and share information, feedback and grievances. These would lead to better delivery of services that would serve the target beneficiaries and also help the service provider, in this case, the Maternity Hospital in its target of reaching the intended beneficiaries.

Consultations with the community people and the hospital authorities showed that traditional means of information sharing, such as word of mouth (*Basti Sevikas*) and posters, street plays, magic shows, would help create information about the services available at the hospital. For more specific information released through Cable TV could help.

However, since most people are not comfortable with the written word and neither take daily newspapers or read much, a voice device would be the best interface which allows for a two way communication.

The proposed ICT model, therefore, could be a dedicated, toll free telephone line, installed at both the ends – the community and the hospital. In the community the phone line could be installed either in a PCO booth or in the house of a locally accepted community leader, where women and adolescent girls would have easy access.

This line could open a two-way interaction between the community and the hospital to provide:

- ➢ Basic, updated information to the people on the days, time and types of services provided
- ➢ Schedules and availability of medicines and doctors, launch of any special health camps and drives
- ➢ Provide some tips on health and hygiene

> Provide a mechanism for people to lodge their feedback, grievances to the appropriate hospital authority.

Such a system would be supported by relevant software that would allow easy recording and updating of information about services in the hospital. Importantly, it would also maintain a log of complaints received so that the follow-up action on these could be monitored and evaluated.

This system could be tracked for about two months to test the efficacy of this system. Alongside, traditional communication tools could be used to create awareness about the availability of the tool and the hospital and its services in the community. The recommendations on making effective use of IEC in section 3.1.1 would need to be followed while using any traditional or new communication tools.

Further consultations with a software developer and the community and project authorities would need to be held to see if a **mobile phone component** could be added to this approach keeping the *Basti Sevikas* in mind.

As mentioned earlier, the *Basti Sevika* is a crucial link between the people and the service provider. Her role in creating awareness about the hospital facilities and motivating women to go to the hospital could be strengthened through the use of a mobile phone and SMS facilities. This would give her easy access to get the latest information from the hospital and also to keep the hospital for updated information and follow-up of cases referred by her from the community to the hospital.

Based on the outcome of the M&E, the ICT model could be either strengthened or changed.

The end objective of the proposed tool would be to bring about better communication; awareness and interaction between the target beneficiary and the service provider for effective delivery of the Maternal and Child Health care services.

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B. USEFUL LINKS

Transparency International	**:**	http://www.transparency.org/
OneWorld South Asia	**:**	http:// oneworldsouthasia.net/
OneWorld International	**:**	http://www.oneworld.net/
Digital Opportunity Channel	**:**	http://www.digitalopportunity.org/
Open Knowledge Network	**:**	http://www.openknowledge.net/
World Bank	**:**	http://worldbank.org/
Prayas	**:**	http://prayaschildren.org
Prerana	**:**	http://prerana.org
Sarva Siksha Abhiyan	**:**	http://ssa.nic.in

C. FLOW CHART IPP-VIII STRUCTURE

Flow chart 2.1

UNIT	INCHARGE	COVERAGE
Coordination Cell in MCD	Project Director	12,50,000
Health Centre	Medical Officers	50,000
Health Post Type 'B'	ANM-1	10,000
Jhuggie Jhomprie Bastee	Bastee Sewika-1 Trained Dai-1	2,000