Closing the Loop
Inclusion of the urban poor in maternal health service delivery in Bangalore

Prarthana Rao • Meena Nair • Poornima G. R • K. Prabhakar
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Inclusion of the Urban Poor in Maternal Health Service Delivery in Bangalore

Prarthana Rao • Meena Nair • Poornima G.R. • K. Prabhakar

Prepared by

Funded by

Study Partners
Closing the Loop – Inclusion of the Urban Poor in Maternal Health Service Delivery in Bangalore

Study done by Prarthana Rao, Meena Nair, Poornima G.R. and K. Prabhakar for International Budget Partnership

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Public Affairs Centre (PAC) is a not for profit organization, established in 1994 that is dedicated to improving the quality of governance in India. The focus of PAC is primarily in areas where citizens and civil society organizations can play a proactive role in improving governance. In this regard, PAC undertakes and supports research, disseminates research findings, facilitates collective citizen action through awareness raising and capacity building activities, and provides advisory services to state and non-state agencies.

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<tr>
<td>APSA</td>
<td>Association for Promoting Social Action</td>
</tr>
<tr>
<td>BBMP</td>
<td>Bruhat Bengaluru Mahanagara Palike</td>
</tr>
<tr>
<td>BIDS</td>
<td>Budget Information Data Sheet</td>
</tr>
<tr>
<td>BoV</td>
<td>Board of Visitors</td>
</tr>
<tr>
<td>BPL</td>
<td>Below Poverty Line</td>
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<tr>
<td>BWSSB</td>
<td>Bangalore Water Supply and Sewerage Board</td>
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<tr>
<td>CFAR</td>
<td>Centre for Advocacy and Research</td>
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<tr>
<td>CRC</td>
<td>Citizen Report Card</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
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<tr>
<td>CSC</td>
<td>Community Score Card</td>
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<tr>
<td>ESI</td>
<td>Employees, State Insurance</td>
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<tr>
<td>GoK</td>
<td>Government of Karnataka</td>
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<td>IBP</td>
<td>International Budget Partnership</td>
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<tr>
<td>IPP</td>
<td>India Population Project</td>
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<tr>
<td>JSY</td>
<td>Janani Suraksha Yojane</td>
</tr>
<tr>
<td>MH</td>
<td>Maternity Home</td>
</tr>
<tr>
<td>MHMC</td>
<td>Maternity Home Monitoring Committee</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>MTP</td>
<td>Medical Termination of Pregnancy</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>OPD</td>
<td>Out Patient Department</td>
</tr>
<tr>
<td>PAC</td>
<td>Public Affairs Centre</td>
</tr>
<tr>
<td>PET</td>
<td>Public Expenditure Tracking</td>
</tr>
<tr>
<td>RHMC</td>
<td>Referral Hospital Monitoring Committee</td>
</tr>
<tr>
<td>SPAD</td>
<td>Society for People’s Action for Development</td>
</tr>
<tr>
<td>UFWC</td>
<td>Urban Family Welfare Centre</td>
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</table>
Acknowledgments

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- The officials at the BBMP health department including Chief Health Officer and the Health Officers for all their support in providing access to information and also for letting us interact closely with the Maternity Home staff.

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While we are indebted to the individuals mentioned above for their contribution, we the authors are solely responsible for the opinions expressed and any errors therein.

Ms. Prarthana Rao, Dr. Meena Nair
Ms. Poornima G.R., Dr. K. Prabhakar
Public Affairs Centre had conducted a Citizen Report Card study of maternal health services offered by the Bangalore City Corporation in its Maternity Homes and Urban Family Welfare Centres in the year 2000 and found that the quality of service delivery was far from satisfactory. Together with other NGOs in the city, certain reform measures were recommended. Some of them were implemented too like setting up a helpdesk, coming out with a citizen’s charter, introduction of User fee etc. After a decade, PAC decided to study the quality of service delivery once again in these Maternity Homes to understand the impact in ten years. With the help of financial support from the International Budget Partnership, a Citizen Report Card study was conducted in 12 out of 24 Bruhat Bengaluru Mahanagara Palike (BBMP) Maternity Homes in the city. The quality of service still remained poor. Corruption was still rampant and entitlements like Madilu Kits were not reaching the beneficiaries. There were lots of hurdles in availing the benefits of the Janani Suraksha Yojane. Basic facilities like drinking water, clean toilets, and ambulance facilities were missing in many of these Maternity Homes.

PAC decided to investigate this further to understand if lack of funds were responsible for poor quality of services and took up detailed budget analysis of BBMP maternal health budgets. Some initial efforts on tracking some of the funds like User Fee, free food for inpatients were also made in selected Maternity Homes to understand the issues further. These exercises revealed that there were some gaps in supply of medicines, issue of receipt for User fee collected, procurement of sufficient quantities of milk for in-patients etc.

In order to address some of these issues, PAC decided to partner with local NGOs and mobilize communities to demand for better services. Through the use of Community Score Cards in selected Maternity Homes, the users of these health units were empowered with knowledge on their maternal health entitlements through massive information sharing workshops. Informed communities were asked to rank the services and prioritise the service delivery gaps that need immediate, mid-term and long term attention. An informal platform called Maternity Home Monitoring Committees (MHMC) consisting of these users was
created for each of these Maternity Homes. The members of these committees regularly interact with users of the Maternity Homes and record their experiences. They visit the Maternity Homes periodically and observe the facilities extended at these units, behavior of staff and cleanliness of the premise. The observations and experiences of users gathered during interactions are presented to the Officials of BBMP health department in a formal meeting that happens once in every 2 months at the Maternity Homes and joint actions are taken for improvement. The project which started with 3 MHMCs today has spread further and such committees exist in 6 Maternity Homes and 2 Referral hospitals today.

The partner NGOs are continuously supporting the members of the committees in carrying out their activities. BBMP health department also recognizes this body as an informal link between the service provider and the user and are working jointly with the members to improve the quality of service delivery at the Maternity Homes.

A repeat Score Card was conducted to understand the impact of the advocacy efforts by the committees. It is observed that there is significant improvement in the behaviour of doctors and other staff at the Maternity Home. Issue of receipt for the user fee collected has improved drastically. Users are more aware of the fee structure and demand receipts for the amount paid. There has also been some improvement in distribution of iron and folic acid tablets to pregnant women and in food distribution for in-patients.

The results have been encouraging. This is a continuous change process and what is presented here in this report is only the beginning of the change process. There is still a long way to go. This example demonstrates that empowered communities can stand up and demand for better services and put enough pressure on the system to deliver better.
INTRODUCTION

TOWARDS IMPROVED MATERNAL HEALTH SERVICE DELIVERY

This chapter details the background, objectives and methodology adopted by Public Affairs Centre in carrying out the study.
Inclusion of the Urban Poor in Maternal Health Service Delivery in Bangalore

1.1 Background

BRUHAT BENGALURU MAHANAGARA PALIKE (BBMP) or Greater Bangalore Municipal Corporation is responsible for providing basic civic facilities to the citizens of Bangalore city which include water supply, sanitation, roads, street lights, health facilities, etc. BBMP currently manages and operates 24 Maternity Homes (MH).

The services provided by these MHs are:
- Delivery
- Immunization
- Antenatal care
- Postnatal care
- Family welfare services – Permanent and temporary

Public Affairs Centre (PAC) undertook a unique Citizen Report Card (CRC) Study of Maternity Homes, India Population Project Centres (IPP) and Urban Family Welfare Centres (UFWC) in partnership with five city-based NGOs in 2000. A total of 500 patients and 77 staff members of these facilities were interviewed. The purpose of the survey was to get corroborative evidence on the poor quality of services provided and the widespread corruption in the maternity homes to strengthen the advocacy work of Civil Society Organizations (CSOs).

A recent paper publication has revealed that four of these maternity homes have ceased to function leaving only 20 maternity homes managed by BBMP.

Public Affairs Centre (PAC) is a non-profit organization dedicated to the cause of improving the quality of governance in India. The Centre is globally known for pioneering Citizen Report Cards (CRCs). The Citizen Report Card (CRC) is a simple and credible tool to provide systematic feedback to public agencies about various quantitative and qualitative aspects of their performance. CRCs elicit information about users' awareness, access, usage and satisfaction with public services thus bringing in the dimension of a 'bottom-up' assessment of public services.
The findings showed:

- Poor service delivery in Maternity Homes;
- High levels of corruption in the delivery of services in Maternity Homes;
- Absence of effective accountability mechanisms.

In 2010, PAC undertook another study to measure changes that may have happened over the last decade in the quality of service delivery in these Maternity Homes and to use tools such as Community Score Card (CSC) to take up issues related to service delivery and budgets in order to implement an effective advocacy process. The study report proposed the following Impact Plan:

**Figure 1: Impact Plan**

- **Project Objectives**
  1. Established partnerships btw community groups and BMP to improve quality of maternal health services
  2. Maternal health budgets in BBMP based on evidences from the Service user and providers

- **Short term Objectives**
  1. Training of community groups on reading budgets related to Madilu Yojane
  2. Develop evidence based indicators to assess changes in the maternal health service delivery
  3. Influence budget allocations for Madilu Yojane

- **Changes to Budgets**
  Evidence based budget preparation at the unit level

- **Decision Makers**
  1. Commissioner, BBMP
  2. Mayor and Council, BBMP
  3. Standing committee for Health in BBMP

- **Changes to Policy**
  Unit level budget preparation
  Evidence based allocations to Madilu

- **Activities/Methods**
  1. Secondary data
  2. Partnership with NGO Partners
  3. CRC
  4. Budget analysis
  5. First CSC
  6. Follow up community
  7. Repeat CSC
  8. Develop relevant indicators and toolkits

- **Decision Makers**
  1. Commissioner, BBMP
  2. Mayor and Council, BBMP
  3. Standing committee for Health in BBMP

- **Changes to Rules**
  Amendment in BoV composition guidelines–to incorporate actual users from the community

- **Ultimate Goal**
  Improved participation and transparency in budget formulation and delivery of maternal health care services in the selected BBMP maternity homes

**Figure 2: Approach to Achieving the Impact**
1.2 Phase 1 Study Highlights

Three major activities were carried out to identify and address service delivery and budget-related gaps in phase 1 of the study:

1. The study initially began with an attempt to carry out Public Expenditure Tracking (PET) for specific themes like user fee, food for in-patients, procurement of medicines, infrastructure facilities and salaries for employees in three selected Maternity Homes. In due course of time, it was realized that the record-keeping in Maternity Homes and the systems and procedures followed by the health department of BBMP were not supportive enough to carry out the PET exercise. Hence, it was decided to look at budget documents and information related to expenditure on these themes in Maternity Homes to conduct a Budget Analysis study instead of PETS. However, important pointers regarding corruption practices and absence of accountability mechanisms came up in the process which was used as issues to be addressed through the following exercises.

2. A Citizen Report Card (CRC) was carried out in 12 of 24 Maternity Homes as a benchmarking exercise. The findings reinforced the point that even after 10 years, the issues and service delivery gaps remained.

3. The Community Score Card (CSC) exercise was carried out in three out of the 24 Maternity Homes by selecting one Maternity Home in each of the three health zones of Bangalore. The exercise followed a three-step approach that forms its mandate.
   i. Input tracking and performance score card which included sharing of entitlements and building awareness about maternal health and health care among urban poor women who were users of the services of the three Maternity Homes. This was followed by a performance scoring exercise on a scale of 1 to 5 by the users – on the services of the Maternity Homes, the infrastructure facilities available and about the behaviour and availability of staff at the Maternity Homes.
   ii. This exercise was followed by a self-evaluation exercise by the Maternity Home staff on the same scale against the same set of indicators.
   iii. As a concluding step to this, an interface meeting was held in all the Maternity Homes, which created a platform for service providers and the users to engage in a dialogue and come up with an action plan to improve the quality of services of Maternity Home. The CSCs were carried out in the same sequence for each of the three Maternity Homes separately in collaboration with local NGOs that had direct access to community members and community groups.

As an outcome of 18 months of such rigorous activities, both with the community groups as well as BBMP health officials, the following were achieved:
1. Maternity Home Monitoring Committees (MHMC) were constituted at the three Maternity Homes. These committees consist of 8-10 members who have availed its services in the past and continue to do so and are living in the vicinity of these Maternity Homes.

2. Consent was obtained from the committee members and the MH staff to work together in improving the quality of services provided by the MHs, for which a joint action plan for improving service delivery was drafted.

3. The Action Plan is being implemented through continuous monitoring by the MHMC members and then through regular internal information sharing exercises and quarterly meetings with the MH staff. The key features of the action plan include:
   a. Visiting the MHs on a regular basis (once in 10 days) by different members of the committee and monitoring of progress as per checklists provided to them.
   b. Meeting of MHMC members to share or update information on observations on the implementation of the action plan and other changes related to quality of services is taking place every fortnight.
   c. Meeting with the MH staff once in three months to discuss improvements and areas for improvement.
   d. Building awareness among users in the community on maternal health and entitlements from the MH, through small informal meetings between MHMC members and users in their respective localities, mobilizing community members to participate and take advantage of the various awareness camps, health camps, etc. organized by BBMP in these areas.

4. The tangible follow-up activities to prevent corruption and lack of accountability have been the introduction of User Fee charts and Grievance Redress process charts by PAC, which are displayed in the Maternity Homes.

With these efforts PAC realized that there is definite scope for deepening the work in the following areas:

1. **Strengthening the community monitoring mechanisms to improve the quality of services in Maternity Homes:** This process had just begun through two sets of activities for the MHMC members – monitoring service delivery improvements or its lack thereof in the MH and raising awareness in the communities on maternal health and entitlements. This would then be followed by exercises related to building awareness regarding the importance of understanding budgets, the role MHMC members can play towards finalizing budgets and then working with the service providers for its effective implementation.

2. **Deepening partnerships with current and potential NGO partners:** The current project has witnessed good partnerships with three project partners, SPAD (Society for
Key findings from the CRC

Medical and other infrastructure

- Though scanning was advised to most respondents, 85 percent of them had to go to private labs or the Referral Hospital.

Delivery Services

- Only 56 percent of the respondents have gone for deliveries to the Maternity Homes and the rest to government hospitals.

JSY and Madilu

- Only 26 out of the 120 respondents were aware of the Janani Suraksha Yojane (JSY or Safe Motherhood Scheme)
- Fifteen (15) out of the 26 received the cheque of Rs. 600 under the Yojane.
- Twelve (12) percent of the 120 respondents who were from the BPL (Below Poverty Line) category did not receive this benefit.

Key Findings from the Budget Analysis

- 50 to 60 percent of the user fee spent by the MHs is on medicines.
- Deposit of user fee cash is not happening on a daily basis in some cases.
- The number of cases registered in the OPD register and the number of receipts issued in the bill book do not tally.
- The date of issue of receipt and registration of case in the OPD register does not match.
- Quotations from private drug houses have some discrepancies.
- A constant amount of milk is being received by the MHs every day irrespective of the number of in-patients.
- The quantity of medicines supplied is less than what is requested in most cases.

Key points for advocacy from the CSC (common to three selected MHs)

- Scanning facility must be introduced.
- Streamlining of milk procurement for in-patients.
- Display eligible criteria to obtain JSY benefits and stock of Madilu kits.
- Display of User Fee charts and Grievance Redress Information charts (for all 22 MHs).
- Provision of safe drinking water and hot water for patients.
- Formation of Maternity Home Monitoring Committees to monitor service delivery and work for improving awareness in the locality.

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4 Madilu scheme was started by the government to provide post-natal care for the mother and child. The objective of this scheme is to encourage poor pregnant women to go for institutional deliveries in order to considerably reduce maternal and infant mortality rates in the state. Under the scheme, every woman who delivers in a Government institution is entitled to receive a kit worth Rs 1250 containing 18 essential commodities such as wrappers, towels, napkins, etc.
People’s Action for Development), CFAR (Centre for Advocacy Research) and APSA (Association for Promoting Social Action). There is scope to continue this partnership while expanding the scope of the study (six MHs) and deepening those that are currently in place.

3. **Improved allocations for Madilu Yojane:** Initial assessment in this phase of the study showed that there are some issues with allocations and disbursements related to Madilu Yojane. Since the PAC team felt that this scheme was a big help for urban poor women, specific budget advocacy strategy needs to be developed to increase the allocation for the same.

4. **Testing the replicability of the knowledge product (the draft toolkit):** Through the three existing partner-NGOs, the draft toolkit developed could be tested by replicating the exercises in other Maternity Homes.

### 1.3 Phase 2 of the Study

In order to build upon the success that PAC has achieved so far, it was proposed to expand the scope of its work as well to deepen the process. Accordingly, phase 2 of the project began with additional funding from IBP.

The second phase of the project was designed to build on the initiatives from phase 1. Hence, it was decided to expand the scope of the intervention by replicating the toolkit in two Referral Hospitals and two Maternity Homes with the help of NGO partners. Detailed analysis of budgets, allocations and fund flow systems related to Madilu Yojane was taken up. Extended handholding and training were offered to the current MHMC members. A repeat CSC was conducted in the three MHs of phase 1 to understand the impact of MHMCs and other interventions of phase 1. A repeat CRC was also conducted as a feedback assessment on the initiatives.

### 1.4 Chapter Format

This report details the activities and outcomes during the second phase of the project. The report consists of five chapters. Chapter 1 talks about the repeat CRC, Chapter 2 gives the details from the repeat CSC, Chapter 3 is about experiences of NGO partners in replicating the toolkit. Chapter 4 identifies the gaps in budget allocations, expenditures and fund flow and Chapter 5 draws Conclusions and suggests the Way Forward.
WHAT DOES THE CITIZEN REPORT CARD REVEAL?

THE SECOND CRC IN BBMP MATERNITY HOMES

This chapter captures the experiences of users of Maternity Homes and their staff members about the quality of services provided in these institutions based on the Citizen Report Card approach. The study was conducted in 2011 as an impact assessment exercise to understand the outcomes of the various advocacy activities carried out by PAC in partnership with SPAD, CFAR and APSA to empower the communities to demand better service delivery in these Maternity Homes.
2.1 Introduction

In order to continue the user-provider engagement, PAC was provided with additional support by IBP to strengthen the Maternity Home Monitoring committees (MHMC) and also to replicate the exercise in a few more Maternity Homes. Thus PAC decided to replicate this exercise in 4 more health units comprising of 2 Maternity Homes and 2 Referral Hospitals by using the toolkit that was developed based on the phase 1 experience. Through the two existing partner NGOs; the draft toolkit was tested by replicating the exercises. Another very important component of this exercise was to understand the fund flow and functionality of procurement and distribution of Madilu kits which is being extended at the BBMP hospitals as an incentive to encourage institutional delivery.

With these exercises being implemented it was necessary to understand the impact of the activities in order to plan further interventions or to make necessary changes in the process. Thus it was decided to conduct a second Citizen Report Card (Repeat CRC) before the conclusion of the project period (around September-October 2012) to test the effectiveness of the exercises and the efficacy of the toolkit. Based on the feedback from the CRC the knowledge product was finalized. This report gives the outcomes of the repeat CRC.

2.2 Sample and Methodology

The survey comprised 50 percent of the Maternity Homes (MH) managed by the BBMP. These are the same set of Maternity Homes that were chosen for the initial CRC in 2009. Every Maternity Home that was selected for the survey was observed for basic infrastructure facilities. In each of these Maternity Homes, the Assistant Surgeon who is in charge was interviewed. Along with the Assistant Surgeon, the empanelled gynaecologist was also interviewed wherever available. Ten (10) users who had availed all or at least a few of the facilities in these Maternity Homes in the past 2 years were interviewed to get their feedback on the services provided. These
respondents were selected from the catchment areas of these Maternity Homes. The sample size for the study is given in Table 1.

Table 1: Sample Size for Survey

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<tr>
<th>Sl.No</th>
<th>Details of Interviews</th>
<th>Numbers</th>
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<tr>
<td>1</td>
<td>Observation of Maternity Homes</td>
<td>12</td>
</tr>
<tr>
<td>2</td>
<td>Interview with Medical Personnel</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Medical Officers / Asst. Surgeons</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Doctors</td>
<td>12</td>
</tr>
<tr>
<td>3</td>
<td>Interview with Users</td>
<td>120</td>
</tr>
<tr>
<td></td>
<td>Users per Maternity Home</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td><strong>Total Interviews</strong></td>
<td>156</td>
</tr>
</tbody>
</table>

2.2.1 Questionnaire Design

Similar to the earlier CRC, data collection encompassed not just the users but also the implementers and the instruments were accordingly designed to suit the purpose. Three sets of data collection instruments were designed, which included observation schedules and interview schedules. These were:

- Observation Schedule for Maternity Homes;
- Interview Schedules for Users of Maternity Homes;
- Interview Schedules for Assistant Surgeons and Gynaecologist.

All the data collection instruments included the aspects that are covered in a CRC, which are:

- Availability;
- Access and usage;
- Service quality and reliability;
- Problem incidence, responsiveness and problem resolution;
- Costs, including corruption, and
- Satisfaction and suggestions for improvement.
2.2.2 Field Work and Quality Assurance

An experienced team of investigators was selected to carry out user interviews. A one-day training programme, which involved briefing on data collection instruments and mock call exercises, for this team was conducted in Bangalore. The user interviews started soon after and completed in 15 days. Observation study and staff interviews were conducted by PAC study team members.

During the course of user interviews, PAC study team consistently monitored the field work through field visits and carried out spot checks and back checks and onsite scrutiny of filled-in questionnaires. The team supervisors also kept in contact with the PAC study team for updates on a daily basis. Another round of random scrutiny was carried out once the questionnaires reached PAC but before data entry.

2.2.3 Data Entry and Analysis

Data entry for the 156 questionnaires (including observation) was carried out in-house at PAC by engaging the services of a data entry operator. Thus there was constant quality check to ensure that or genuine data were available for analysis.
USER FEEDBACK

2.3 Background

A total of 120 women were interviewed through household surveys to get their feedback on the services provided by the BBMP Maternity Homes. These respondents were carefully selected from the catchment areas of the 12 Maternity Homes. The criterion for selection was that the user should have availed all or most of the maternity health services from the respective Maternity Home in the last two years.

2.3.1 Profile of Respondents

The respondents who were all women were in the age group of 19 to 35 years. Nearly 80 percent of them were Hindus with 54 percent of them belonging to the Scheduled Caste background. Around 73 percent of them had formal education but was limited to SSLC or less than that. They were mostly women belonging to the non-agricultural labour class (38 percent) or self-employed (39 percent). The average monthly income of the respondent families was Rs. 4724. Around 82 percent of them belonged to BPL families but only 60 percent of them had their BPL cards. On an average the respondents have been using the Maternity Homes for the last two years and 9 months. Most of the users (77 percent) have used the services of the Maternity Homes on their own.

2.3.2 Antenatal Services

All users have reported that their names were registered and cards were issued after their pregnancy was confirmed at the MHs.

Only 75 percent of them got the Thayee card immediately after registration. Around 18 percent of the users have not received the Thayee card. It was the hospital nurse who issued the most of the cards as reported by 74 percent of users. Only 9 percent of them have received the cards from the link workers. A majority of them (88 percent) have reported that the card was issued free of cost and there were no incidental expenses related to this.

Almost all users (99 percent) have reported that they were advised to come for regular checkups after their pregnancy was confirmed. Realising the importance of regular checkups, a good number of them (99 percent) have gone for regular checkups. Nearly 90 percent of them have reported that they were examined by the doctor every time they went for a checkup. For a small percentage of people (10 percent) it was the head nurse who examined them in the absence of the doctor.
More than 90 percent users have said that every time they went for a checkup during their pregnancy, their weight gain and blood pressure were recorded. Along with this, they were physically examined to monitor the growth of the baby.

Over 90 percent of pregnant women that they were advised to take folic acid and iron tablets regularly. These tablets were mostly provided at the Maternity Homes free of cost.

Scanning was advised to all pregnant mothers. More than half of them (62 percent) underwent scanning in a private laboratory.

It was observed that lab facilities were being utilized by a majority of the users. However, a lot of cases were reported where people had to spent money to avail these facilities but have not been issued receipts. Table 2 summarises the responses.

Table 2: Details on Utilisation of Laboratory Facilities at the Maternity Homes

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<thead>
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<th>Sl.No.</th>
<th>Laboratory Services</th>
<th>Users who have availed service at the Maternity Home (%)</th>
<th>Users who have paid for the service at Maternity Home (%)</th>
<th>Average amount paid (Rs.)</th>
<th>Users who have obtained receipts for the full amount paid from Maternity Home (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Blood test</td>
<td>90</td>
<td>76</td>
<td>63</td>
<td>27</td>
</tr>
<tr>
<td>2</td>
<td>HIV test</td>
<td>89</td>
<td>39</td>
<td>41</td>
<td>21</td>
</tr>
<tr>
<td>3</td>
<td>Urine Test</td>
<td>92</td>
<td>55</td>
<td>54</td>
<td>25</td>
</tr>
</tbody>
</table>

Most pregnant mothers have been given anti-tetanus injections with more than half of them reporting two injections. Around 81 percent of them have reported the use of disposable syringes every time.

A quarter of the respondents have paid for the syringe, around 18 percent have paid for the injections between Rs. 10 and 50 and none of them have received receipts for the amounts paid.

2.3.3 Delivery services

When we examined the delivery services at Maternity Home, 80 percent of the users reported that they had visited the Maternity Home for delivery; however, only 58 percent of them delivered at the Maternity Home. Ninety (90) percent of those who did not deliver at the Maternity Home were referred to other government hospitals for delivery and the reason cited to most of them for referral was ‘lack of facilities’ at the MH to conduct delivery.

The compliance to referral protocols was checked. Only 11 percent reported that ambulance facilities were given during referral; 65 percent reported that referral slips
were given. And only 3 percent reported that a staff member from the MH accompanied them. About two-thirds of those referred reported that they were not told as to why they were being sent to other hospitals for delivery.

**Figure 3: Reasons for not following the referral protocol completely**

- Nearly 93 percent of those who delivered at the Maternity Homes had a normal delivery. None of them reported that they were made to wait for a long time for allotment of bed.
- Nearly 21 percent of those who delivered at the Maternity Homes were asked to pay money to get a bed during admission time. Three-fourths of those who paid money did not get receipt for the money paid.
- Most people have reported that the doctor, nurse and other staff were available during their delivery.
- Nearly 57 percent of them reported that hot water was given when they were admitted. However, 18 percent of them had to pay for this facility for which no receipts were given.
- Fifty-four (54) percent of the users who delivered at the Maternity Homes have paid for their delivery. Of them, 73 percent did not get receipts. People have reported paying up to Rs. 1500 for a delivery in these Maternity Homes. The disturbing fact is that people even had to pay to see their newborn child.

### 2.3.4 Schemes and Benefits

#### a. Janani Suraksha Yojana (JSY)

Sharing of information about the scheme is low with only 9 percent of the users reporting that they were told about the scheme.
Encouraging is the fact those who had availed the benefits under the scheme received Rs.600 by cheque and nearly 75 percent of them have received them at the time of discharge from the MH.

Most people (98 percent) who received the benefits under the scheme did not pay money to receive the same.

b. Madilu Yojane

Only 48 percent of those who delivered at the Maternity Homes were told about the Madilu Yojane by the hospital staff and 45 percent received the kit under the scheme. Around 96 percent of them have received the kit at the time of discharge.

Most people (93 percent) who received the benefits under the scheme did not pay any money to receive the same.

2.3.5 Food for inpatients

Every in-patient in the BBMP Referral Hospital and Maternity Home is entitled to a pound of bread, 500 ml milk and an egg/banana per day for the entire duration of stay there. Users who were admitted at the BBMP Maternity Homes were asked if they got bread, milk and banana as per the norms during their stay. Their responses are tabulated below:

<table>
<thead>
<tr>
<th>Days</th>
<th>Bread (n=13)</th>
<th>Milk (n=13)</th>
<th>Egg/Banana (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Received as per norm (%)</td>
<td>Did not receive (%)</td>
<td>Received as per norm (%)</td>
</tr>
<tr>
<td>1</td>
<td>73</td>
<td>13</td>
<td>45.5</td>
</tr>
<tr>
<td>2</td>
<td>68.5</td>
<td>15</td>
<td>43</td>
</tr>
<tr>
<td>3</td>
<td>64</td>
<td>20</td>
<td>46</td>
</tr>
</tbody>
</table>

The table clearly shows that at least one-third of the in-patients still do not get adequate food that they are entitled to at the Maternity Homes.

It is interesting to note however that those who got the food items at Maternity Homes did not any money for this entitlement.

Though a majority of the users (89 percent) reported that they were satisfied with the quality of services related to food for in-patients, only 40 percent of them were fully satisfied.
2.3.6 Immunisation

A majority (98 percent) of the mothers reported that they were told about the different vaccinations that have to be administered to the newborn child and a card was also issued giving the immunization schedule.

Most of them (98 percent) reported that they followed the immunization schedule that was advised.

Close to one-third of them had to pay either for the syringe or for the vaccination. The amount paid ranges from Rs. 10 to 20. None of those who paid money received receipts for the amount paid.

Though a majority of the users (98 percent) reported that they were satisfied with the quality of immunization services provided at the Maternity Homes only 41 percent of them were fully satisfied.

2.3.7 Family planning

Around 68 percent of users reported that they were advised on the family planning methods by the Maternity Home staff; however, a majority of them (82 percent) have not followed any method.

Only 17 out of the 30 women who delivered at the Maternity Home have undergone sterilization operations. Around 30 women of them had to pay an average of Rs. 380 for the operation. Out of the 17, only nine of them received any incentive and not all of them received the incentive of Rs. 600. It varied from Rs. 150 to Rs. 600 as reported by the users. None of the women reported that their husbands had undergone the operation.

Only 31 percent of users are completely satisfied with the family planning services offered by the Maternity Homes.

2.3.8 MTP

Only one user reported that she had undergone a MTP at one of the Maternity Homes. Since the sample size is very small further details on this section is not reported.

2.3.9 Medicines and drugs

A majority of the users were prescribed medicines at the Maternity Homes. One-third of them received all the prescribed medicines at the Maternity Home while 7 percent received some of the medicines from the Maternity Home.

Though 80 percent of respondents were aware that they were entitled to free medicines at the Maternity Homes, around 12 percent of them did not get any free medicines.
2.3.10 Display of information

From the graph it is clear that a majority of the users have not observed the display of information in the form of charts at the Maternity Homes. Of those who have observed, more than 80 percent reported that the list of available services and the immunization schedule have been displayed and is visible to the patients.

Figure 4: Display of information at the Maternity Homes

Note: Others include responses for ‘displayed but not visible’ to all and ‘not displayed’

A majority of the users (87 percent) reported that TV shows are not held on ANC days.

2.3.11 Availability of basic infrastructure

Around 84 percent of users reported that the Maternity Homes have drinking water facility. Many reported that the containers used for storing drinking water are clean (80 percent).

More than 80 percent of users said that the toilets are clean and have water facility.

2.3.12 Satisfaction with availability and behaviour of staff

From the graph below it can be seen that only a quarter of the users are completely satisfied with the availability and helpfulness of staff at the Maternity Home. Doctors have been rated high with more than 60 percent reporting complete satisfaction with availability and behaviour of these doctors.
2.3.13 Community monitoring and oversight

Around 96 percent of users were not aware that there was a committee responsible for monitoring the functioning of the Maternity Homes. The minority who were aware of the community monitoring thought that it was the NGOs that monitor service delivery.

2.3.14 Grievance redress

Around 50 percent of the users noticed the availability of complaint boxes in the Maternity Homes. One-third of the users also observed the display of contact numbers of officials for lodging complaints and their redress. However, only two percent have lodged complaints about their dissatisfaction of service delivery at the Maternity Homes.

2.3.15 Overall satisfaction of service delivery and suggestions for improvement

Only 30 percent of users are completely satisfied with the overall quality of services provided at the Maternity Homes, however as many as 70 percent of them are partly satisfied with the services, indicating that though the service delivery is not disheartening, there is definitely scope for improvement. Most of the users are partly satisfied due to lack of information, existence of corruption and behaviour of staff. Availability of essential services like scanning is also quoted as an important area for improvement.
Inclusion of the Urban Poor in Maternal Health Service Delivery in Bangalore

Figure 6: Complete satisfaction with services of Maternity Homes
STAFF FEEDBACK

2.4 Staff Profile

Medical Officers and panel gynecologists\(^5\) of 12 Maternity Homes were interviewed on various aspects of their work. All of them were qualified doctors who had completed their MBBS degrees. All were females except for one male medical officer. Most of them have been working in the health department for four or more years. The panel gynecologists are new to the system with less than a year’s experience. A majority of them have been working in the same Maternity Home for less than two years.

All Medical Officers have reported that most of the facilities like antenatal services, delivery, post-natal services, immunization, family planning advice and minor ailment treatment are provided at all the Maternity Homes. They have also reported that weight measurement, BP measurement and physical examinations are done during every routine checkup.

Regarding scanning and other lab tests, it was found that basic blood and urine tests were done in all Maternity Homes including for HIV/AIDS. Scanning is usually not done at the Maternity Homes due to non-availability of radiologists. The patients are generally referred to Referral Hospitals or government hospitals for scanning. One of the Medical Officers suggested that it would be useful if BBMP could certify the existing gynecologists by training them to perform the functions of a radiologist and issue reports after scanning.

All Medical Officers reported that iron and folic acids as well as tetanus injections are given to all pregnant women during their pregnancy.

All Maternity Homes provide delivery services 24 hours except one where facilities for delivery do not exist.

All Maternity Homes reported that some of the cases are referred to government hospitals for delivery. The main reason for doing so seems to be high risk cases that cannot be handled at the Maternity Homes. More than 95 percent of the MOs reported that referral protocols (ambulance facility, issue of referral slips) are followed. Staff accompaniment is also offered if BBMP ambulances are used.

All Maternity Homes provide immunization to the newborn babies and have a specific immunization day in a week (Thursday).

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\(^5\) BBMP Maternity Homes earlier only had medical officers who were performing both the medical as well as administrative responsibilities at the Maternity Homes. This however was exerting a lot of pressure on the doctors and was a deterring factor in their performance. BBMP was exploring the option of introducing panel gynecologists in order to reduce the burden on the medical officers. PAC along with its partners took up this aspect during the first phase of the study and advocated strongly for enrolling gynecologists as a panel.
All Maternity Homes where delivery services are extended reported that they are empowered to extend Janani Suraksha Yojane and Madilu Yojane benefits. All these Maternity Homes also reported that they extend these facilities to all eligible patients.

2.4.1 Status of Human resources in Maternity Homes

The following table shows the current strength of human resources in the surveyed Maternity Homes as reported by the concerned Medical Officers.

Table 4: Status of Human Resources at the Maternity Homes

<table>
<thead>
<tr>
<th>Staff</th>
<th>Sanctioned</th>
<th>Shortage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asst Surgeon</td>
<td>12</td>
<td>25</td>
</tr>
<tr>
<td>Jr. Health Asst (Nurse)</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>Aaya</td>
<td>39</td>
<td>23</td>
</tr>
<tr>
<td>Peon</td>
<td>33</td>
<td>52</td>
</tr>
<tr>
<td>Pourakarmika</td>
<td>30</td>
<td>43</td>
</tr>
<tr>
<td>Dhobi</td>
<td>6</td>
<td>83</td>
</tr>
</tbody>
</table>

It can be seen from the table above that many of the sanctioned posts in BBMP Maternity Homes are vacant. In addition to this, there have been requests for additional posts to be sanctioned in some of the Maternity Homes as reported by the Medical Officers.

An interesting fact is that some of the posts such as that of the staff nurse and clerk are sanctioned in only some Maternity Homes. It was also observed that in a few Maternity Homes, where some of the posts were not sanctioned at all, people had been brought on deputation and were working there full-time and their salaries were drawn from their parent departments. For example, in some of the Maternity Homes, the post of peon is not sanctioned; however, there is a peon working in the Maternity Home. Some of the essential posts such as that of an Asst. Surgeon, who is vital for any Maternity Home was shared among Maternity Homes in some cases. Administrative assistants such as clerks were also being shared by Maternity Homes. It is very interesting to note that in one of the Maternity Homes an MO suggested that the posts of Aayas (cleaners) be removed as their roles and responsibilities are being fulfilled by the Pourakarmikas (municipal sweepers).

2.4.2 Budget preparation, allocation and utilization

All MOs reported that they are consulted during budget preparation and allocations by BBMP. All of them reported that they were aware of Budget Information Data (BID), and had used...
them to provide budget estimates required for Maternity Homes. Most of the information that was shared in the BIDS was related to electricity charges, telephone charges, water supply charges, salary details, user fee collection and JSY incentives. None of them have reported at which hierarchy level actual budget allocation decisions are taken. More than 95 percent of the MOs felt that this existing system of budget preparation was robust.

All Maternity Homes reported that they submit the actual expenditure details on a monthly basis usually to the Superintendent of the concerned Referral Hospital (as reported by more than 90 percent of Maternity Homes).

2.4.3 Medicines and Equipments

All vaccinations and tablets for the mother and child are reportedly bought from the Central Drug Store of BBMP. In case of shortage, the medicines are either borrowed from concerned Referral Hospitals or purchased from drug stores using the user fee that was collected. Such purchases have been permitted by a circular issued by the BBMP Commissioner.

Generally, it was reported that medicines were received from the central drug store in a day (50 percent) or two (42 percent) of placing the request. The Medical Officers also suggested that it was best to purchase all drugs from the Central Drug Store since it consumes less time and is cost-effective because medicines are purchased in bulk at wholesale rates. None of the Maternity Homes reported of instances where expired drugs were supplied from the store. All Medical Officers reported that they submit the drug utilization details to the Superintendent of the respective Referral Hospitals every month.

All Medical Officers reported that they had all necessary equipments. However, 16 percent of them reported that some of these equipments were not in working condition like the baby warmer and NST machine. These machines and equipments were maintained using the User Fee in 82 percent of the cases. In nearly 33 percent of Maternity Homes, the equipments were on Annual Maintenance Contracts (AMC), which made it easier to maintain or repair the equipments in time.

2.4.4 Food for Inpatients

Medical Officers of 10 out of 12 Maternity Homes reported that they provided food for inpatients. In six Maternity Homes, milk was given to all inpatients. In all 10 Maternity Homes one pound of bread and one banana were given to patients once a day. In three Maternity Homes, a fixed quantity of milk (three litres) was procured every day and distributed to all the patients. The food items were all procured from suppliers approved by BBMP. All MOs opined that the food was of good quality and the quantity was sufficient for the patients. Suggestions for improving this aspect of service delivery include providing milk regularly as per the norms, supply of eggs, introduction of Akshaya Patra food distribution for lunch, etc.
2.4.5 User Fee

It was found that all Maternity Homes collect User Fee stipulated by BBMP for lab tests and other services such as delivery and MTP. In all cases, the Medical Officers reported that receipts were given to the users for the fee paid. The details of amount collected and spent from the User Fee were submitted to the Superintendents of the respective Referral Hospitals on a monthly basis.

Every Maternity Home and Referral Hospital is allowed to spend a sum of Rs.20,000 and Rs. 1,00,000 respectively per month from the User Fee (reported by all Medical Officers) based on the circular issued by the BBMP Commissioner. The User Fee is mostly utilized for purchase of emergency medicines, repair of equipments, stationery and for photocopying as reported by more than 90 percent of the medical officers. All Medical Officers felt that this sanctioned sum was sufficient to meet the emergency requirements.

Many Medical Officers (66 percent) were of the opinion that all medicines should be supplied by the central stores at all times instead of buying it using the User Fee.

2.4.6 Maternity Home Monitoring Committees

Five (5) out of 12 MOs were aware of the existence of Maternity Home Monitoring Committees. Of them three had met the committee members and felt that it was useful to have such committees as they serve as messengers within the user community apart from building a good relationship between the users and the staff. In their opinion the committees should continue the work they are currently doing and similar committees have to be set up in other Maternity Homes and Referral Hospitals as well.

2.4.7 Work-related

All Medical Officers reported that they work for seven hours at the Maternity Home and were always available on call during emergencies. Ten (10) out of 12 MOs also worked in more than one Maternity Home. All of them performed several duties at the Maternity Home, apart from medical work which included advisory role, administrative work, counselling, awareness-building, organizing health camps, etc. The main motivation for joining the medical service in government hospitals seemed to stem from a sense of public service as reported by 70 percent Medical Officers followed by job security as reported by 50 percent. Some of them (30 percent) also mentioned the non-transferable nature of the job as a reason.

All, except one, of them reported that they were not aware of any of their colleagues having private practices or working in any private hospitals. A lot of them (84 percent) were satisfied with the support they got from seniors, juniors and colleagues at the workplace. Two of them who reported dissatisfaction, were mostly dissatisfied with the support of the seniors/superiors. Many of them suggested that the administrative burden has to be reduced and administrative support in the form of clerks and assistants have to be provided in all Maternity Homes and Referral Hospitals.
2.4.8 Corruption

Nearly 75 percent of the Medical Officers reported that it was not customary in BBMP Maternity Homes to receive gifts in cash or kind for the services offered. They also reported that they were not aware of any instance where any of their staff or their colleagues demanded any gift from the patients. The 25 percent of MOs who reported that demands for gifts did exist said that it was prevalent among Group D staff.

2.4.9 Public Grievance Redress System

Medical Officers of all Maternity Homes reported the presence of a public grievance redress system. All of them had information of their Citizen’s Charter painted on their walls near the entrance which was clearly visible to all patients. Most (83 percent) complaints were registered in written form by dropping them in the complaint box. There were a few instances (20 percent) where patients had complained over telephone. Also, feedback formats were given to be filled in by the in-patients during the time of discharge wherein they could spell out the problems they faced during their stay.

Nearly 30 percent of the Medical Officers reported that there were instances when patients had approached them directly for lodging complaints against the staff. In such cases, both parties were brought together and the issue was discussed and resolved.

2.4.10 Satisfaction with the Job

It is seen that only 25 percent of the Medical Officers were completely satisfied with their job and another quarter of them completely dissatisfied. Some of the reasons reported for...
dissatisfaction related to lack of infrastructure facilities such as poor building and lack of water facility in toilets; they also related to work environs such as insufficient rest, work pressure, and therefore the inability to avail leave due to them and poor pay.

2.4.11 Changes observed during the last three years and suggestions for further improvement

It has been observed that nine out of 12 Medical Officers who responded to this aspect of the survey reported only improvements related to improvement of infrastructure such as like provision of NST Machine, better building conditions and improved cleanliness in and around the Maternity Homes.

However, all 12 Medical Officers who were interviewed were of the opinion that there is scope for further improvement especially with regard to increasing staff (especially radiologists and anesthetists) and for upgradation of infrastructure to offer C-section and scanning facilities. Existing staff should also be trained on other emergency care such as accident management, heart attacks, etc. Some of them have even asked for basic facilities such as drinking water and uninterrupted power supply.
2.5 Conclusions

1. Quality of services such as antenatal care, post-natal care, immunization and family planning services are reasonably good as was the scenario during the previous survey. Antenatal checkups are done regularly, iron and folic acid tablets are given to most pregnant women, tetanus injections are administered and basic clinical tests are conducted which include blood and urine tests. However, scanning facility still does not exist in Maternity Homes which is a point of concern. Issue of Thayee card also seems to be a problem which needs to be streamlined as there is a sense of passing the buck between the staff at the health units and the link workers.

2. Awareness levels are still low when it comes to beneficiary schemes among the users. It is observed that some of the eligible mothers have not received the benefits of both JSY and Madilu schemes. In case of Madilu, it has been reported that the kits are not in stock most of the time and, when in stock, all the 19 items are not given properly which clearly indicates signs of leakage.

3. Immunization programmes continue to be regular and effective in all Maternity Homes and Referral Hospitals. Thursday continues to be the stipulated day of the week when the infants are vaccinated as per the vaccination schedule. In some Maternity Homes where the patient load is high, immunization services are offered two days in a week.

4. Most of the medicines are supplied by the central drug stores as reported by most of the Medical Officers. With the increase in the User Fee that can be spent for essential purposes from Rs. 5,000 to Rs. 20,000, it is observed that its utilization towards purchase of essential medicines in case of emergencies has gone up. In spite of this, many of the users have reported that all medicines are not given at the Maternity Home which implies that the forced expenditure by the patient continues to exist as she has to purchase the prescribed medicines from private drug stores.

5. Availability and behaviour of staff at the Maternity Homes has improved as compared with the earlier survey. However, there is still a scope for improvement with the lower level staff as complete satisfaction with their behaviour still seems to be low.

6. Corruption is found to be rampant in all Maternity Homes and Referral Hospitals. Both the Medical Officers as well as the users agree on this point. Users continue to report instances of paying extra money at every stage of maternal health care in Maternity Homes starting from registration to medicines to syringes for immunisation to allotment of bed for delivery and getting benefits of various schemes.
7. General awareness among users and staff about the Maternity Home Monitoring Committees is low. Users and staff from the three Maternity Homes where the committees were constituted during phase 1 of the project seem to know about the committees and their functioning. The users and staff of these three Maternity Homes find the committees useful and insist that they continue to perform their role in future.

8. The following tables show some of the improvements in user experiences before and after the establishment of Maternity Home Monitoring Committees in GG Halli, Nandini Layout and Cox Town Maternity Homes.

### Table 5: Measuring the Influence of MHMC on Some Indicators

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Indicator</th>
<th>Name of the Maternity Home</th>
<th>Before MHMC (%)</th>
<th>After MHMC (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ambulance facility for referral cases</td>
<td>GG Halli</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>2</td>
<td>Staff members sharing information about family planning</td>
<td>GG halli</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>3</td>
<td>Obtained receipts for the user fee paid</td>
<td>Nandini Layout</td>
<td>32</td>
<td>58</td>
</tr>
<tr>
<td>4</td>
<td>Reporting of instances of paying extra money</td>
<td>GG halli</td>
<td>56</td>
<td>66</td>
</tr>
<tr>
<td>5</td>
<td>Display of information – List of services</td>
<td>Nandini Layout</td>
<td>56</td>
<td>100</td>
</tr>
<tr>
<td>6</td>
<td>Behaviour of nurse – Satisfied</td>
<td>Nandini Layout</td>
<td>60</td>
<td>90</td>
</tr>
<tr>
<td>7</td>
<td>Behaviour of other staff members – Satisfied</td>
<td>Cox Town</td>
<td>50</td>
<td>80</td>
</tr>
<tr>
<td>8</td>
<td>Overall satisfaction with services</td>
<td>Cox Town</td>
<td>70</td>
<td>100</td>
</tr>
</tbody>
</table>

Note: % of users reported ‘YES’ to the indicator
WHAT DOES THE COMMUNITY SCORE CARD REVEAL?

REPEAT SCORE CARD IN GAVIPURAM GUTTAHALLI, NANDINI LAYOUT & COX TOWN MATERNITY HOMES RUN BY BBMP

The score card exercise was repeated in the three Maternity Homes where the Maternity Home Monitoring Committees had rigorously worked for a year and half to improve the quality of service delivery. This exercise was conducted to understand the impacts of the MHMCs which will aid the process of its replication and functioning as a sustainable model across all BBMP health units in Bangalore, and if possible in other urban health systems as well.
What Does the Community Score Card Reveal?

3.1 Background

In 2010, based on the learnings from the Citizen Report Card (CRC) exercise and the budget analysis, it was felt that a more detailed intervention is required to facilitate the change process for improved service delivery. Hence the Community Score Card (CSC) approach was adopted and this social accountability tool was implemented in three Maternity Homes one in each health zone as delineated by the BBMP – East, West and South. The CSC helped assimilate local knowledge and arrive at local solutions. This tool as such provides,

1. A forum for direct and constructive engagement between the service user and the service provider;
2. An opportunity for joint decision making;
3. Immediate feedback to the provider on areas for improvement;
4. Towards quality, efficiency and effectiveness of service delivery; and
5. A platform to promote good governance (accountability, transparency, participation) in the process of public service delivery.

The three CSCs were carried out in collaboration with NGOs who have a strong field presence in the catchment areas of these Maternity Homes. The NGOs were instrumental in identifying local leaders who could play an active role in advocating for better services through repeated Focus Group Discussions (FGD) with the community members in the catchment areas of these Maternity Homes. A total of 12 indicators were used in this exercise.
3.2 Key points for advocacy that emerged from the CSC (common to three selected MHs)

- Scanning facility to be introduced.
- Streamlining of milk procurement for inpatients.
- Display of information about JSY and stock of Madilu kits.\(^6\)
- Display of User Fee charts and Grievance Redress Information charts (for all 22 MHs).
- Provision of safe drinking water and hot water for patients.

As an outcome of this exercise, Maternity Home Monitoring Committees (MHMCs) were formed in these Maternity Homes. These committees consist of 8–10 members who are selected from the catchment areas of these Maternity Homes who have availed services from the Maternity Home in the past and are availing services currently as well. Consent was obtained from the committee members and the Maternity Home staff to work together in improving the quality of services provided by the Maternity Homes, for which a joint action plan for improving service delivery was drafted. Action plan is being implemented through continuous monitoring by the MHMC members and then through regular internal information sharing exercises and quarterly meetings with the Maternity Home staff. The key features of the action plan include:

- Visiting the MH on a regular basis (once in 15 days) by different members of the committee and monitoring of progress as per checklists provided to them;
- MHMC member meeting for sharing of/updation on observations on the implementation of the agreed action plan and also other changes related to quality of services taking place in the MH, on a fortnightly basis;
- Meeting with the MH staff once in three months to discuss improvements and areas for improvement;

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\(^6\) Madilu scheme was started by the government to provide post natal care for the mother and the child. The objective of this scheme is to encourage poor pregnant women to go for institutional deliveries in order to considerably reduce maternal and infant mortality in the state. Under the scheme, every lady who delivers in a Government institution is entitled to receive a kit worth Rs. 1250 containing 18 essential commodities like wrappers, towels, napkins, and others for both the mother and the baby.
• Building awareness among users in the community on maternal health and entitlements from the MH through smaller informal meetings between MHMC members and users in their own respective localities, mobilizing community members to participate and take advantage of the various awareness camps, health camps, etc. organized by BBMP in these areas.

• Tangible follow-up activities to prevent corruption and lack of accountability have been the preparation of User Fee charts and Grievance Redress process charts by PAC and display of these charts in the Maternity Homes.

These committees have been functional in these Maternity Homes for the last one year and have been working both with the staff as well as the users as per the action plan. In order to understand the impact of these MHMCs, the score card exercise was repeated in the three Maternity Homes using the same set of indicators and applying the same methodology as was done in the earlier exercise (Input tracking, scoring and interface meeting).

### 3.3 Beginning of change process

From Table 6 on page 44, it can be observed that three trends of change can be observed in the scoring pattern:

1. Scores have improved in areas such as distribution of Iron and Folic tablets; scores have gone up from zero to five in GG Halli Maternity Home and behaviour of staff has improved from zero to four in Nandini Layout Maternity Home. These clearly indicate improvement in service delivery matching the expectations of the Users.

2. Scores have reduced, for example in medical services provided at Nandini Layout Maternity Home, where it has gone down from four to three which means that either the expectations of users have increased due to awareness of their rights or entitlements or some of the areas have been neglected which need to be further strengthened.

3. Scores remain same as in the case of scores from users and staff on the delivery facilities at Cox Town Maternity Home which means that the quality of service has been maintained at acceptable standards.
### Table 6: Comparative Score Sheet

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Indicators</th>
<th>Gavipuram Guttahalli Maternity Home</th>
<th>Cox Town Maternity Home</th>
<th>Nandini Layout Maternity Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical Services</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Other facilities</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Delivery facility</td>
<td>5</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Distribution of Iron and Folic tablets</td>
<td>4</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Food for inpatient</td>
<td>5</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Family Planning services</td>
<td>4</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td>7</td>
<td>Madilu scheme</td>
<td>5</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>JSY scheme</td>
<td>5</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>Doctors behaviour with the Users</td>
<td>4</td>
<td>0</td>
<td>4.5</td>
</tr>
<tr>
<td>10</td>
<td>Other staffs’ behaviour with Users</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>Users Fee collection and issuing receipts</td>
<td>5</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>Display of information</td>
<td>–</td>
<td>–</td>
<td>4</td>
</tr>
</tbody>
</table>

Note: Display of information was added as one of the indicators during the second CSC as there was a lot of initiative taken by PAC and its NGO partners along with MHMC members to spread awareness about the information charts that are on display at the Maternity Homes. PAC has also designed, printed and circulated some of these charts like User Fee details, Grievance redress mechanism, details on JSY and Madilu to all the Maternity Homes. NA – Not Applicable; SS – Staff Score; CS – Community Score
3.4 Changes observed from the user perspective

1. Significant improvement in the behaviour of doctors and other staff at the Maternity Home is observed.

2. Issue of receipt for the user fee collected has improved drastically. Users are more aware of the fee structure and demand receipts for the amount paid. This, indirectly, has reduced the corrupt practices in the Maternity Homes of taking money in the name of fee and not issuing receipts for the amounts taken.

3. There has also been some improvement in distribution of iron and folic acid tablets to pregnant women and in food distribution for in-patients.

3.5 Changes observed from the staff perspective

1. The doctors’ behaviour has improved and has been rated better this time.

2. Information sharing about schemes especially Janani Suraksha Yojane (JSY) has been streamlined. The ANMs and nurses are entrusted with the task of sharing relevant information about the schemes with the pregnant women during their ANC checkups.

3. There has also been some reduction of scores on certain indicators like medical facilities, other facilities, etc. by the staff members. This could be because of lack of sufficient number of staff and problems related to maintenance of buildings. The point to be noted here is that, staff members have realized the expectations of users in terms of quality of service and have begun to introspect. They have also started putting in place small reforms which is a change for good.

3.6 Learning from the exercises

1. The use of Community Score Cards has been useful in creating effective dialogue platforms for users and service provider engagement.

2. The process of conducting the score card has been useful in knowledge generation and sharing among the users. This has ensured that the women are now more empowered with relevant information on their rights and duties and are in a position to demand better services.

3. The Score Cards which were initiated in Maternity Homes have been replicated in higher order health units such as Referral Hospitals and has been effective. Hence it can be derived that the tool is useful to find local solutions at various levels to address issues of different complexities and magnitudes.
CONTINUING TO INCREASE
THE SCOPE OF GOVERNANCE

REPLICATION OF TOOLKIT

The maternal health toolkit developed during phase I of the project was tested in a few other Maternity Homes and at the higher order health units – Referral Hospitals, by NGO partners. This chapter summarises their experiences in replicating the toolkit.
Continuing to Increase the Scope of Governance

4.1 Background

PAC undertook an exercise of testing the replicability of the toolkit developed in the first phase of the project with two of its partners, Centre for Advocacy and Research (CFAR) and Society for People’s Action for Development (SPAD). CFAR and SPAD had partnered with PAC in conducting Community Score Cards (CSCs) in Phase 1 of the project.

During this phase they agreed to replicate the exercise in one Maternity Home and one Referral Hospital each. Accordingly, SPAD decided to replicate it in Azadnagara Maternity Home and in JJR Nagara Referral Hospital and CFAR in Yeshwanthapura Maternity Home and Sriramapura Referral Hospital.

The toolkit developed by PAC based on the experience in Phase 1 was shared with both the partners. Regular training and field accompaniments were done at every stage of toolkit implementation.

Partners successfully completed the replication exercise by conducting Citizen Report Card, Budget Analysis and Community Score Card exercises and constituted Referral Hospital Monitoring Committees (RHMC) and Maternity Home Monitoring Committees (MHMC) respectively. The RHMC and MHMC members have been oriented on the maternal health entitlements and have also been given extensive training on their roles and responsibilities. The committees have been monitoring the services at the health units as well as interacting with the users in the catchment areas of these health units regularly.

In order to understand the efficacy of the toolkit and to make changes that might be necessary to make the toolkit more comprehensive and user-friendly, PAC sought feedback from the partners on the toolkit based on their experiences in this replication exercise.

The following section gives the summary of the feedback on the toolkit.
Closing the Loop

4.2 Tool 1 – Citizen Report Card

The Citizen Report Card approach gave good insights into the service delivery status and served as a good benchmarking exercise. The approach was useful in the systematic understanding of the strengths and weaknesses of the system in a holistic manner as it provided the experiences of users and providers at the same time.

**Easy steps in the tool**

- CRC was easy to understand and implement.
- The process of sampling for survey was also easy and it helped get feedback from actual users in a particular area.
- The design of the data collection tool in the toolkit was comprehensive and it read well; questions were linked properly to cover all aspects of different services methodically.

**Difficult steps in the tool**

- Identification of actual users according to the sample plan was difficult because of incomplete postal address provided by the Maternity Homes and Referral Hospitals.
- Convincing the users regarding the purpose of the survey was another difficult task. Most users felt threatened to open up and answer some of the questions, especially those related to user fee and corruption as they feared repercussions from the staff in their later visits to the hospital. However, this was dealt with by explaining to them that the data collected would be confidential and respondent details will not be shared with the service providers.
- The questions on the ‘Citizen Charter and schemes’ were difficult as the community had no information on these.

**4.2.1 Pointers for improving the toolkit**

1. The data collection instrument is designed well and has to be retained as it is.
2. Certain sections in the data collection tool like the one on ‘Citizen Charter and schemes’ may have to be simplified further or additional information about these can be included as show/flash cards which will help the investigators to explain this section better.
3. The design of the tool on sampling seems to be comprehensive and self-explanatory.
4. Data analysis module in the tool can be improved to make it easier and could have a more hands-on approach.
5. Training programme design and implementation in the toolkit seems to be satisfactory and hence may be retained as such.
4.3 Tool 2 – Community Score Card

The tool helped bring awareness to vulnerable communities about rights and entitlements. It was a new activity and a good learning experience. The indicators used in CSC were practical and relevant to the users of the Maternity Home services. Interface meeting where community and service providers come to a common place and negotiate for better delivery of services is very good. This approach is essential for the organizations who are working with the community as it is non-confrontational and based on facts.

**Easy steps in the tool**

- Mobilising community was easy as the partners work at the grassroots level.
- Awareness-building about entitlements was easy as detailed charts were prepared in the toolkit which gave all useful information in the form of simple bullet points.

**Difficult steps in the tool**

- Consensus-building among the users for scoring the indicators was challenging. It required a good facilitation.
- Obtaining a suitable date for interface meeting from the service provider was extremely difficult and time-consuming. However, this process did help in building the necessary rapport with officials for further advocacy and follow-up work.

4.3.1 **Pointers for improving the toolkit**

1. Some tips on facilitation should be included in the toolkit.
2. Instead of a lecture mode using charts, if the entitlement sharing exercise can be developed into a group activity, which will encourage greater participation of the community members, the receptive ability will be increased to a larger extent.
3. Training programme design and implementation in the toolkit seems to be satisfactory and hence may be retained as it is.

4.4 Tool 3 – Budget Analysis

It provided a good understanding of how budgets can be used as a means of advocacy to improve service delivery. It also gave a deeper insight into the budget process, record maintenance and expenditures with regard to maternal health services. Implementation of the tool was difficult and challenging due to lack of unit level budget information.

**Easy steps in the tool**

- None of the steps were easy.
• On a comparative scale though, analysis of data was simpler than data collection.

**Difficult steps in the tool**

• Data collection was very difficult. This was due to many reasons including lack of staff, improper record maintenance, long waiting hours, etc.

• Data collection and analysis of the budget is very time-consuming and laborious.

**4.4.1 Pointers for improving the toolkit**

1. A Q&A exercise sheet at the end of every theme for budget analysis should be included as it will serve as a refresher and as an easy guide.

2. Basics of budget terminologies, cycles, procedures, etc. have to be included in the introduction.

3. Training programme design and implementation in the toolkit seems to be satisfactory and hence may be retained as it is.

4. The language used in the toolkit can be further simplified. Some of the terms are difficult to understand and are not self-explanatory.

**4.5 About replicability of the toolkit**

The partners feel confident to replicate the exercise in other health units as well as for other services after this exercise. The partners will continue to mentor the community monitoring committees that have been set up and build their capacities further so that these hospitals become accountable to the community.

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**A spin off of this exercise**

A small NGO called Munnade, working with garment factory workers in Bangalore, approached PAC showing interest in replicating the toolkit to understand the quality of service delivery in ESI (Employees’ State Insurance Corporation) dispensaries. PAC agreed to help the team in customizing the toolkit for services at ESI dispensaries.

Munnade followed the steps in the toolkit and replicated the exercise in two dispensaries run by ESI in Bangalore. Based on this experience, this is what they had to say about the toolkit:

Even though Munnade has been working with garment factory workers and their rights under ESI for several years and were aware of the problems, the CRC approach threw light on several small aspects that remained unnoticed. This systematic approach helps one understand the problem holistically and not go by anecdotal evidences. However, this being a statistically driven tool, need certain technical skills within the team for replication which is a big limitation for small groups like ours.

The Community Score Card approach has been a new learning to the team and is extremely useful in dialoguing with the service provider. The whole design and approach in the CSC is non-confrontational. For the community it is an empowering exercise. This also helps in organizing people into small groups for effective advocacy work.
This chapter looks at the implementation of the madilu yojane in BBMP Maternity Homes by looking at the budget allocations, expenditures, fund and functional flow analysis.
Towards Better Implementation of Schemes

5.1 Background

Madilu scheme was started by the Government of Karnataka (GoK) to provide post-natal care for the mother and the child. The objective of this scheme is to promote institutional delivery by encouraging poor pregnant women to deliver in health centres and hospitals in order to considerably reduce maternal and infant mortality in the state.

The beneficiaries are:

- All mothers who deliver in Government Institutions.
- For first two live births.

Under this scheme, a kit which has 19 essential items for the newborn and the mother such as mosquito net, carpet, bed sheet, bathing soap, washing soap, sanitary pads, diaper, etc is given as an incentive to the mother.

Findings from the Citizen Report Card survey conducted in 2009 clearly showed that Madilu kits (mother and baby care kit) were not given to all users. Among two-thirds of women who received the mother and child kits, only half of them received the full kit with 19 items in it.

The Community Score Cards clearly showed that the kits were “Out of Stock” very often due to which all eligible mothers were not receiving the kits. Initial investigations showed that the budget allocated for procurement of these kits were inadequate. The allocations seemed to have been done randomly and not based on evidences like current / expected number of eligible deliveries.

In order to understand the bottlenecks in the process of distribution of madilu kits, PAC collected documents related to budget allocations and expenditures including details of procurement of kits by BBMP, their distribution to health units, issue of kits at the Maternity Homes and Referral Hospitals for the last three years (2009-10, 2010-11 & 2011-12) and analysed the same to
find out the gaps. Several rounds of discussions were also held with concerned officials at BBMP to understand the fund flow and functionality flow.

5.2 A Look at the BBMP budgets

A review of BBMP budget (2009-10) reveals some interesting facts. The health component of the budget comes to about 1.6 percent of the total budget amount. Within this there are two classifications, namely, Health General and Health Medical, the funds being allocated in the ratio 60:40, respectively. The health medical component of the budget is only 0.6 percent of the overall budget. This has been constantly decreasing since 2002 when it was 1.4 percent of the overall budget.

Within the health medical budget, nearly 39 percent of the budget amount is set aside for salaries. The budget for Maternity Homes comprises about 17 percent of the health medical budget. The proportion of deliveries taking place in these Maternity Homes (against the total number of patients visiting these Maternity Homes) has gradually been coming down.

Figure 8: Budget allocation for health medical budget within BBMP

BBMP health budgets have a separate line item, “Post-natal care kits for deliveries in BBMP hospitals” to extend benefits under the Madilu yojane. The allocations under this line head for the last three years has been around Rs. 1,00,000.

5.3 Allocations and expenditures on Madilu Kits

The allocations for procuring Madilu kits is approximately Rs. 1,00,00,000. During the year 2011-12, the estimated budget for Madilu kit was Rs. 3,00,00,000. However, in the revised budget it came down to Rs. 1,00,00,000. The unit rate for procurement of the kit has been Rs.

7 Please see website – http://www.bbmp.gov.in/index.php?option=com_content&view=article&id=50&Itemid=161
1,250 for the year 2009-10 and 2010-11 while it is Rs. 1,403 in 2011-12. The number of kits procured during 2009-10 and 2010-11 is 7,800 and during 2011-12 it is 13,000. Some items for the kits have been procured from Karnataka Handloom Industries Corporation Limited and the remaining from the Mysore Soaps and Detergents Limited. The following table gives the snapshot of the allocations and expenditures during the last three years.

**Table 7: Allocation and expenditure details for Madilu Yojane**

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Particulars</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Revised budget (Rs.)</td>
<td>1,07,25,000</td>
<td>1,00,00,000</td>
<td>1,00,00,000</td>
</tr>
<tr>
<td>2</td>
<td>Unit rate of procurement (Rs.)</td>
<td>1,250</td>
<td>1,250</td>
<td>1,403</td>
</tr>
<tr>
<td>3</td>
<td>No. of Kits ordered (No.)</td>
<td>7,800</td>
<td>7,800</td>
<td>13,000</td>
</tr>
<tr>
<td>4</td>
<td>Cost of procurement (Rs.)</td>
<td>97,50,000</td>
<td>97,50,000</td>
<td>1,82,39,000</td>
</tr>
</tbody>
</table>

The guideline of the scheme clearly states that all mothers above the age of 18 years are eligible to get the benefit under this scheme for first two live births. The total number of deliveries during these three years, according to the records of BBMP, is 38,312. A sub-set of this is eligible for the benefits under the scheme as this is applicable only for the first two live births. Since a centralized data base of the number of first and second deliveries was not available, 50 percent of the deliveries have been assumed as ‘eligible’ based on the CRC surveys carried out in 2009 and 2011. Accordingly, 19,156 mothers were eligible to get Madilu kits in the last three years. The total number of kits procured as shown in Table 7 is 28,600. This, in absolute terms, means surplus procurement. However, the CSC and CRC findings reveal that close to half of those who delivered at the Maternity Homes did not receive the kits.

**Table 8: Details of deliveries at the Maternity Homes eligible for Madilu**

<table>
<thead>
<tr>
<th>Sl.No.</th>
<th>Particulars</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of deliveries at Maternity Homes</td>
<td>9090</td>
<td>15527</td>
<td>13695</td>
</tr>
<tr>
<td>2</td>
<td>No. of deliveries eligible for Madilu yojane (50% of total deliveries)</td>
<td>4545</td>
<td>7764</td>
<td>6848</td>
</tr>
<tr>
<td>3</td>
<td>No. of Kits ordered by BBMP</td>
<td>7800</td>
<td>7800</td>
<td>13000</td>
</tr>
</tbody>
</table>

The consolidated data on deliveries at the Referral Hospitals was not available. The number indicated here is a sum total of the deliveries recorded at 23 Maternity Homes run by BBMP.
5.4 Procurement procedure for Madilu Kits

1. Since the guidelines mention ‘first two live births’ it becomes absolutely necessary to maintain this data. It is observed from records that at the unit level this is maintained in a manner which cannot be compiled to get a sum total of number of eligible cases. The in-patient register has a dedicated column to record this data; however, the manner in which the details are filled as shown in the picture below, makes it almost impossible to collate and compile.

2. Though the number of deliveries has been varying, a constant amount of money has been allotted for the scheme in the last three years.

3. During 2011-12, a significant rise in the budget estimate is observed (from rupees one crore in the previous year to three crore); however, the revised budget has dropped it back to rupees one crore. This rise and fall in numbers do not seem to have any logical reasoning in terms of evidence or data.

4. In 2011-12, the number of kits ordered and the unit cost of the kit have increased. The allocation remained the same at Rs. 1,00,00,000. In absolute terms, there has been a
budget deficit of Rs. 82,39,000. Hence one wonders if these kits were procured at all or not. If so, where did the remaining amount come from?

5. Drug house distributes the stock equally among all six Referral Hospitals, which is untenable as some Maternity Homes have higher patient load than others.

6. Though the number of kits ordered seem to be higher than those required, the ‘No Stock’ boards in most Maternity Homes during a few months in the year are both surprising and shocking. The shocking factor is that all the kits are procured in one consignment once in a year and distributed to the Referral Hospitals soon after procurement. This means that in theory, there should not be a situation where one needs to put up a ‘No Stock’ display.

5.6 Conclusion

Allocations are clearly not based on evidences such as number of deliveries, number of eligible mothers, etc. Record-keeping needs to be immediately streamlined to be able to maintain and analyse data which can be used as evidence for allocations. Random distribution of kits from drug store down the line is creating bottlenecks and is probably the main reason for “No Stock” even though the purchase of kits seems to be surplus.
STOCK-TAKING AND PREPARING THE WAY FORWARD

LEARNINGS FROM THREE YEARS OF WORK

This chapter summarises the learnings from three years of work that PAC and its partners have put in to understand the process of maternal health service delivery in BBMP Maternity Homes and Referral Hospitals. The initial steps that the team has taken towards improving the services, the experiences in creating dialogue platforms for communities to interact and demand for better services from BBMP and the next steps to continue this effort and spread it wider.
Stock-Taking and Preparing the Way Forward

6.1 Background

The project, over the last three years, has carried out several activities. Some of them have been very effective in achieving the set objectives and some have not been so effective. The following chapter will list the activities and its accomplishments.

PAC’s main advocacy strategy for bringing about change in the system was the use of different tools at different levels. Use of CRC and budget analysis led to sensitizing the community issues related to lack of budget allocations and expenditures resulting in poor quality of services, denial of benefits under schemes and lack of accountability at the unit level to the higher officials within the BBMP health department.

Use of CSC has led to the creation of dialogue platforms between service providers at the unit level and direct beneficiaries of the services. This has led to a process of constructive engagement leading to service quality improvement. For example, in Nandini Layout Maternity Home, drinking water facility which was not available for out-patients is now available. The construction and repair work at the Maternity Home have received some momentum with the representation of the committee members at the Joint Commissioner’s office in BBMP. Community members are more aware of their entitlements now. There is reasonable improvement in the behaviour of staff members at Maternity Homes where MHMCs have been formed. Corruption levels have also come down noticeably.

6.1.1 Understanding the quality of maternal health service delivery in BBMP Maternity Homes

PAC had undertaken a Citizen Report Card study of maternal health services offered by the then Bangalore Mahanagara Palike (BMP) in 2000 and had found certain gaps in service delivery including lack of community oversight, lack of accountability and rampant corruption. Certain
reform measures were also put in place by the city administration to address these gaps. In 2009, almost a decade later, the CRC study was repeated again to assess the improvements in the service quality. It was shocking to discover that the gaps continued to remain in alarming proportions. Hence, PAC decided to take up pilot projects using the Community Score Card method to take some actions to reduce these gaps.

### 6.1.2 Formation of Monitoring Committees

As an outcome of the Score Card exercise in three Maternity Homes, Maternity Home Monitoring Committees were constituted comprising users of those Maternity Homes who served as an informal link between the users and the service providers. The entire process of score card empowered the communities with relevant knowledge about their maternal entitlements and created a dialogue platform where these empowered communities could raise their concerns and demand for improved service delivery.

The committee members have been monitoring service delivery improvements or lack thereof in the Maternity Home and raising awareness in the communities on maternal health and their entitlements in the catchment areas of the Maternity Home that they visit.

This process also forged strong partnership between three grassroots organizations and PAC who have been very useful in the follow-up and advocacy work and have taken the ownership of the process.

### 6.1.3 Budget analysis and advocacy for improved allocations for Madilu Yojane

It was observed from the findings of the Report card and the Score card exercises that the incentives under the Madilu yojane, being implemented by the government to encourage institutional delivery was not reaching the beneficiaries for various reasons, including insufficient budget allocations. Hence PAC, along with its partners, studied the process of procurement of Madilu kits, budget allocations and expenditures and prepared a detailed working paper. The paper clearly identifies the gaps and bottlenecks in the system. This has been shared with the higher-level functionaries of BBMP for necessary action.

### 6.1.4 Sharing knowledge

In order to spread the experience of using these social accountability tools to improve the quality of service delivery, a toolkit was developed. This is a valuable output from the project which will help in capacity development of NGOs and other groups who would like to adopt this methodology and work towards improving the accountability in public service delivery.

Another tangible output is various charts that have been produced carrying essential information for the users such as User Fee details, Grievance redressal procedures, details on availing the benefits of JSY and Madilu Yojane, etc. and displayed in all the Maternity Homes and Referral Hospitals.
6.1.5 Testing the replicability of the knowledge product (the draft toolkit)

Through partner-NGOs, the draft toolkit has been tested by replicating the exercises in two other Maternity Homes and two Referral Hospitals. The partners have found the toolkit very useful and felt capacitated to independently undertake such studies in other health units.

6.1.6 Integration of budget analysis into PAC’s domain of tools

A budget analysis component has been included in all CRCs and CSCs that PAC undertakes currently. A new tool called the CRC+ has been evolved based on the experiences gained in this project and few other experiments that PAC undertook in the recent past.

CRC+ takes the diagnostic power of CRCs forward by using specific internal data of governments to pinpoint those discrepancies in fund flows and functional responsibilities, which when rectified can improve governance outcomes.

6.2 Way Forward

6.2.1 Ensuring budget transparency at all levels within BBMP

Lack of access to unit level budgets in BBMP health system is a main hurdle in understanding the allocations and expenditures. This is a serious threat in establishing accountability on the part of the service provider. Hence it is very vital to demand for access to unit level budgets. However, based on the experience of studying and understanding BBMP health budgets, making unit level budget information available has some major roadblocks.

One is that the mindset of the concerned staff starting from the unit level to the Chief Health Officer has to change for them to understand the usefulness of preparing unit level budgets using their own BIDS. They should realize that unit level budget information and the obligation that they have towards citizens in following transparency and accountability principles go hand in hand. PAC, through the project, has been able to sensitize concerned staff members on this to a reasonable extent and the higher officials are considering the matter very seriously. However, the lower level officials still consider this as an additional administrative burden.

The second obstacle in this process is that a lot of capacity development and process re-engineering have to be made within the health department of BBMP to enable them to prepare budget estimates, keep records of the expenditure, audit these records and prepare balance sheets. These processes are both time-consuming and fund-intensive. PAC has been working with the Joint Commissioner of Health and the Chief Health Officer to persuade them to bring in the required systemic changes to be able to achieve this.

The third obstacle is that the community members and the MHMC members at the moment are not in a position to understand the important link between non-availability of services and
budgets. They also find the number game a little too technical and are not able to relate to it spontaneously. Hence they have not involved themselves actively in the budget advocacy as much as they have in monitoring the quality of service delivery. PAC has currently built the capacities of its partner-NGOs to understand the budgets, who, in turn, in the future with their direct engagement with members of MHMC will slowly build the capacities of these community workers on understanding and demanding access to budgets at the unit level.

### 6.2.2 Effective Grievance Redress mechanism

The grievance redress mechanism in the Maternity Homes and Referral Hospitals is weak. There is a definite need for strengthening this system. BBMP health department can dedicate a day in a month as grievance redressal day and make sure that the grievances of the people are heard and addressed by all concerned officials within the department. There are successful models in other government institutions such as the Employees State Insurance Corporation (ESIC), Bangalore Water Supply and Sewerage Board (BWSSB) and so on.

### 6.2.3 Institutionalisation of monitoring committees to ensure sustainability

The existing Board of Visitors (BoV) is inactive in all the Maternity Homes. The idea of community monitoring to improve the service delivery is defeated with the board of visitors being non-functional. It is a known fact that in most of the government-driven community participation forums, the composition essentially has a representative from the government. This curbs the idea of third party monitoring as these representatives quite often behave very defensively. Also, the ownership of such mechanisms is a challenge as there is no representation of actual users.

On the other hand, a committee such as MHMC has demonstrated the ability to perform as effective third party monitors. It would be very useful to bring some of these members on board and make them a part of the BoV to ensure greater ownership.

When governance fails, citizens have no option but to collectively demand for good governance, accountability and transparency. But this collective demand, if backed with knowledge and not mere rhetoric, can yield sustained results as seen in the case of Maternity Home Monitoring Committees!
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57. Towards Green Karnataka (Public Affairs Centre), 2013.

PAC Books by other Publishers

Recent Releases

Improving Governance the Participatory Way
Meena Nair, K. Prabhakar, Prarthana Rao and Poornima G.R.

This publication records the implementation of a successful initiative by Public Affairs Centre (PAC), in partnership with grassroots organizations like Centre for Advocacy and Research (CFAR), Society for People’s Action for development (SPAD), and Association for Promoting Social Action (APSA) in creating an effective participatory citizen-provider engagement model which helped improve the quality of service delivery in selected Maternity Homes run by the Bruhat Bengaluru Mahanagara Palike (BBMP or Greater Bangalore Municipal Corporation).

The initiative which began in the form of a study of the quality of services in these Maternity Homes by using well known Social Accountability Tools such as Citizen Report Cards (CRC), Budget Analysis and Community Score Cards (CSC), led to the formation of Maternity Home Monitoring Committees (MHMCs) in the catchment areas of three Maternity Homes. These MHMCs not only monitor services at the Maternity Homes, but also undertake awareness building activities on maternal health entitlements during their regular interactions with community members in the Maternity Home catchment areas, in cooperation with Maternity Home staff members and BBMP officials.

Phase II of the project attempts to replicate the model in more Maternity Homes and Referral Hospitals along with budget advocacy on better implementation of incentive schemes.

The publication has been translated into Kannada for wider circulation.

Public Distribution System in Karnataka – A Study of the Effectiveness of its Monitoring Mechanisms
Sreedharan S., Venugopala Reddy A. Prabhakar K., Srikant P., Harish Poovaiah

PAC implemented a project to empower citizens to access entitlements under PDS in four districts of Karnataka from 2008 with its four network partners. While implementing the project, the PDS system was found wanting in addressing deficiencies such as eligible families not getting the cards and families with cards not getting the right quantity and quality of ration in right time for long periods of time. This brought about the question of effectiveness of four monitoring mechanisms (grievance redress mechanisms) that existed in the system. Hence this study, PDS in Karnataka - Effectiveness of Monitoring Mechanisms using the CRC tool.

The exercise was carried out in 15 districts with network partners. While scrutinising the situation the exercise also created awareness about the mechanisms in scale. The evidence generated with over 7,500 stakeholders was validated with them for accuracy. The conclusions and recommendations were presented to the Minister of State and to the Commissioner of Food, Civil Supplies & Consumer Affairs.
Citizens Fighting Corruption – Results and Lessons of an Innovative Pilot Programme in India

Vinay Bhargava, Indira Sandilya, Alexander Varghese and Harish Poovaiah

The Citizens Against Corruption (CAC) project on which this report is based is an innovative pilot project started in 2009 with support from the Department for International Development, UK through its global Governance and Transparency Fund. CAC is implemented in South Asia by a partnership of the Public Affairs Centre (PAC), Bangalore, India and the Partnership for Transparency Fund (PTF) – a US-based international NGO committed to helping citizens fight corruption.

This report shows that there is hope in curbing corruption. It presents efforts and results achieved by 14 grassroots Non-Government Organizations (NGOs) spanning four diverse states in India (Odisha, Karnataka, Rajasthan and Uttarkhand) in helping citizens engage to produce positive results to reduce corruption and improve service delivery.

Tools for Improving Maternal Health Service Delivery – An Implementation Manual

This manual was developed by Public Affairs Centre based on the experiences of a pilot project in Bruhat Bengaluru Mahanagara Palike Maternity Homes. It is a combination of three well-known social accountability tools used in a particular manner to achieve specific objectives for the improvement of maternal health service delivery. This manual can be used by community groups, NGOs and research institutions working in the health sector and is very specific to maternal health service delivery.

Social Audit of Public Service Delivery in Karnataka

M. Vivekananda, S. Sreedharan, and Malavika Belavangala

This publication offers an insight on how citizens at the receiving end view the public services delivered to them by the service providers. The social audit, by using the citizen report card methodology, was carried out in Karnataka by the Public Affairs Centre, Bangalore as desired by the Department of Planning, Programme Monitoring and Statistics, Government of Karnataka covering seven services, namely, public bus transport, food and civil supplies through public distribution system, veterinary health care, pension schemes, services of primary health centres and district hospitals, government high schools and nemmadi kendras.

The social audit was carried out through a random sample survey of the users of selected public services in eight selected districts of Karnataka using a mix of household and exit interviews. In addition, a few case studies, based on the opinions and comments received from the stakeholders on the services surveyed, are also presented, in order to enlighten the quality aspects of these services.
Closing the Loop
The community participation model – ‘Maternity Home Monitoring Committees’ (MHMCs) - where common users of Maternity Homes come together to advocate for improved maternal health services offered by the city municipality was one of the outcomes of a two-phased study carried out by Public Affairs Centre (PAC) in Bangalore. The model has been successfully implemented in five Maternity Homes and one Referral Hospital. The process of putting these MHMCs in place came through a three-and-half-year study done in partnership with three local NGOs in Bangalore with funding and support from the International Budget Partnership (IBP).

This report demonstrates a successful example of ‘Closing the loop’ - with evidence based research and concerted advocacy efforts, it is possible to empower communities who then can stand up and demand for better services by putting pressure on the system.