Practices of Unqualified Practitioners in Selected Urban Slums of South West Delhi: An Exploratory Study

Dissertation submitted to the Jawaharlal Nehru University
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MASTER OF PHILOSOPHY

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CERTIFICATE

I hereby declare that the dissertation entitled '**Practices of Unqualified Practitioners in selected Urban Slums of Southwest Delhi: An Exploratory Study**' submitted by me to Jawaharlal Nehru University, New Delhi, India for the award of the degree of Master of Philosophy, is my original work and has not been previously submitted in part or full to any other university or institution for any other degree or diploma.

Kriti Singh
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We recommend this dissertation to be placed before the examiner for evaluation for the award of the degree of Master of Philosophy.

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List of Tables, Maps and Graphs

ABBREVIATION

ANM	Auxiliary Nurse Midwife
AYUSH	Ayurveda, Yoga, Unani, Siddha and Homoeopathy
BAMS	Bachelor of Ayurvedic Medicine
BHMS	Bachelor of Homeopathic Medicine and Surgery
BUM	Bachelor of Unani Medicine
CHC	Community Health Centre
DDA	Delhi Development Authority
DHS	Delhi Health Services
DMC	Delhi Medical Council
DMA	Delhi Medical Association
GDP	Gross Domestic Product
GoNCTD	Government of National Capital Territory of Delhi
IMA	Indian Medical Association
IMC	Indian Medical Council
JJ	Jhuggie Jhopri
JNURM	Jawaharlal Nehru National Urban Renewal Mission
MBBS	Bachelor of Medicine, Bachelor of Surgery
MR	Medical Representative
NGO	Non Government Organisation
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
MCD	Municipal Corporation of Delhi
RMP	Registered Medical Practitioner
TBAs	Traditional Birth Attendants

CHAPTER 1

INTRODUCTION

Urbanisation in India

Rapid urbanisation and lopsided development patterns have resulted in migration of the rural population to urban settings. Although urbanisation is one of the indicators of development, unregulated growth of urbanisation in developing countries has created problems of proliferation of slums. India's urban population is second largest in the world after China. In 1999-2000, about 27 percent of the Indian population were migrants, According to the 55th of NSS round, the proportion of migrants to the total population was higher (33 percent) in urban areas than that (24 per cent) in the rural areas. As per the Census of 2001, 28.6 crore people live in urban areas which is expected to grow at the rate of 7 percent[1]. Among the male migrants, 52 percent in urban areas migrated due to reasons related to employment. The rate of urban growth has been unable to match housing, educational and health service facilities, including drinking water and sanitation.

According to R Ramchandran urbanisation is an outcome of industrialisation and economic development. Urbanisation is associated with conversion from traditional rural economies to modern industrial economy. Every nation undergoes this cycle of evolution from agrarian to industrial society. Gradually, dependence on primary sector reduces and investments in social overhead capitals including transportation, communication etc increases. An important feature of urbanisation in India is dualism with urban growth at the macro level actually decelerating, while in class I cities it is growing. The process of urbanisation in India has been large city oriented. It is associated with concentration of population and activities in urban centers especially in class I cities. As a result, its population has gone up to the extent that in 2001 it had increased to 69 percent of the countrie's urban population. In 1901 there were only 24 class I cities which in 2001 had gone up to 393.

The rapid growth of cities and urbanisation has been explained by two major hypotheses – 'the push factor' and the 'pull factor'. A rapid rate of growth of population and limited availability of agricultural land pushes the landless labourers to migrate to the

[1] NUHM (2008): *National Urban Health Mission draft for circulation*, urban Health Division, Ministry of Health and Family Welfare, GOI. http://mohfw. nic.in/NRHM/ NUHM%20%20March% 2009-08.doc (accessed on 15 March 2008)

cities. Cities become the hub of economic activities and hence attract migrants. Urbanisation process is not just lead by migration but is an outcome of demographic explosion due to natural increase. The rural out migration towards big cities leads to stretching of the already overburdened urban services.

The basic feature and pattern of urbanisation in India includes lopsided urbanisation leading to growth of classI cities; its characteristic being low industrialisation with no strong economic base and is a product of demographic explosion and rural urban migration. Use of capital intensive technologies in the class I cities is unable to generate employment for the migrants who end up in the informal sector. Because of the labour absorptive capacity of this sector requiring a low level of skill often employs large number of urban poor at low pay. This is evident from the fact that informal sector in urban areas has grown exponentially. In 1991-2001 workers classified as "marginal workers" registered an increase of 360 percent while the workers classified as "main workers" grew only by 23 percent. Slums being an effect of rapid urabanisation are accompanied with poor standard of living and little or no access to housing, water and sanitation. Migrants have to face poverty, unemployment, inequalities and exploitation in their day to day life.

This has led to a rise in the number of unregulated slums and one in three urban dwellers in India live in slums[2]. In effect, slums have become the unavoidable and ugly symbols of industrial and urban growth. Though slums vary greatly from each other, the universal characteristics are overcrowding, poor housing and congestion, extremely poor sanitation with choked drains, lack of garbage disposal facilities, absence of civic amenities, poor personal hygiene, and hygienic conditions. People migrating in search of employment inhabit these slums and live in abject poverty, sub-human conditions having a poor quality of life full of insecurity and social isolation.

Delhi is segregated along economic status which is evident from the geographic differentiation in terms of clustering of households belonging to different economic

[2] A slum is a compact settlement with a collection of poorly built tenements, mostly of temporary nature, crowded together usually with inadequate sanitary and drinking water facilities in unhygienic conditions. Such an area, according to the NSS is considered as "non notified slums" if at least 20 households lived in that area. Areas notified as slums by the respective municipalities corporations, local bodies, or development authorities are treated as "notified slums". The slum dwellings are commonly known as 'jhuggi jhopri' in Delhi. It may be noted that the definition of "slum" conforms to the one adopted in the NSS survey.

classes. Delhi slums are inhabited by people living below poverty lines. It is reported that in Delhi slums, 400,000 people live on one square meal. Even more alarming is the fact that urban poverty is often underestimated with many of the urban poor living in unrecognized squatter settlement[3] or on the pavement. Around 35 percent of Delhi population resides in the Jhuggi Jhopri (J.J) clusters and unauthorised colonies. Civic bodies are unable to provide required basic amenities as they are all settled in areas labelled as unauthorised by the authorities.

These in turn have resulted in high incidence of disease of poverty and thus high mortality and morbidity. To make it worse, the reach of essential health services and utilisation is very low among this section of the population.

Health Status of Urban Poor in India

As per Census 2001, 4.26 crores people lived in slums spread over 640 towns/cities with population of 50,000 or above. In cities with population of one lakh and above, the slum population is expected to reach 6.25 crore by 2008[4], putting greater strain on the infrastructure which is already overstretched[5].

A re-analysis of the data presented by National Family Health Survey (NFHS-III) and NFHS-II shows higher under five mortality rates among urban poor as compared to the urban average and is as poor as rural mortality rates. As per NFHS III data (table I), under 5 Mortality Rate (U5MR deaths per '000 children in the age group) among the urban poor at 72.7 is significantly higher than the urban average of 51.9 and slightly better than the overall rural figure of 81.9. Under nutrition figures among urban poor children are even worse than in rural areas. About 47.1 percent of urban poor children (under 3 years) are underweight as compared to the urban average of 32.8 percent and 45 percent among rural population.

These data brings to light the plight of the urban poor, most of whom have migrated to the urban areas in search of livelihood. The reach of essential preventive

[3] Squatter settlement: Sometimes an area develops into an unauthorized structures put up by "squatters". Squatter settlements were the slum like settlements which did not have the stipulated number of 20 households to be classified as a slum. Definition as used in NSS.

[4] -Ibid: 1

[5] - Ibid: 1

health services and utilisation is very low among this section of the population. Almost 60 percent of urban poor children miss total immunization before completing 1 year. Among the urban poor, 71.4 percent of the children are anaemic as against 62.9 percent in the case of urban average. Among the urban poor only 44 percent of deliveries are institutional as compared to the urban average of 67.5 percent. Poor environmental condition in the slums along with high population density makes them vulnerable to lung diseases like Asthma; Tuberculosis (TB) etc. Slums also have a high-incidence of vector borne diseases (VBDs) and cases of malaria among the urban poor are twice as much as other sections of the population many than other urbanites.

Only 18.5 percent of urban poor households have access to piped water supply at home as compared to the urban average of 50 percent. Among the urban poor, 46.8 percent women have received no education as compared to 19.3 percent in urban average statistics.

Table: 1.1 Reanalysis of NHFS-III Data Done by UHRC and SLI

Key Indicators for Urban Poor in India from NFHS-3 and NFHS-2	**Urban Poor**	**Overall Urban**	**Overall Rural**	**All-India**	**Urban Poor NFHS-2 (1998-99**
Child Health & Survival					
Mortality (deaths per '000 children in age group)					
Neonatal Mortality	34.9	28.7	42.5	39.0	45.5
Infant Mortality	54.6	41.7	62.1	57.0	69.8
Under-5 Mortality	72.7	51.9	81.9	74.3	102.0
Children completely immunized (%)	39.9	57.6	38.6	43.5	40.3
Nutritional status of children (6-59 months)					
Children under 3 years who are stunted (%)	54.2	39.6	50.7	48.0	52.5
Children under 3 years who are underweight (%)	47.1	32.7	45.6	42.5	48.0
Children with anaemia (%)	71.4	63.0	71.5	69.5	79.0
Maternal Health					
Women age 15-49 with anaemia (%)	58.8	50.9	57.4	55.3	54.7
Births in health facilities (%)	44.0	67.4	28.9	38.6	43.5
Births assisted by a doctor/nurse/LHV/ANM/other health personnel (%)	50.7	73.4	37.4	46.6	53.3
Environmental Conditions					
Households with access to piped water supply at home (%)	18.5	50.7	11.8	24.5	13.2

Households accessing public tap / hand pump for drinking water (%)	72.4	41.6	69.3	42.0	72.4
Household using a sanitary facility for the disposal of excreta (flush / pit toilet) (%)	47.2	83.2	26.0	44.7	40.5
Infectious Diseases					
Prevalence of medically treated TB (per 100,000 persons)	461	307	469	418	535
Women (age 15-49) who have heard of AIDS	59.2	76.1	62.9	66.4	61.4
Prevalence of HIV among adult population (age 15-49)	0.47	0.35	0.25	0.28	Na
Access to Health Service					
Children under age six living in enumeration areas covered by an AWC (%)	53.3	50.4	91.6	81.1	Na
Women who had at least one contact with a health worker in the last three months (%)	10.1	6.8	14.2	11.8	16.7

Source: NUHM draft : Appendix II.

Health Services

Healthcare is the responsibility of the state government according to the constitution of India but there are certain areas where the central government exercises its direct control. The central list of legislative functions include international health aspects, recommending and enforcing standards in medical education and research and also management of central health agencies and a few institutions of research. While the concurrent list includes programmes like the prevention of infectious and contagious diseases, mental health, regulation of births and deaths, control of adulteration of

foodstuffs etc. The provision of medical facilities and preventive healthcare is the direct responsibility of the state government. Apart from the state, local bodies and voluntary agencies also provide medical facilities. Hence, The Central government is involved in policy making, financing and monitoring. Since health is a state subject, planning, monitoring, regulation, coordination, finance and implementation of all health activities within the state is the responsibility of the state. It is also responsible for providing primary, secondary and tertiary health care. Water supply and sewage disposal also falls under the purview of the state government. Moreover, the local self governing bodies are also responsible for providing primary health care, public health, general sanitation and waste disposal.

Healthcare services to the people are delivered at three levels :-- i) the grass root or primary level; ii) the intermediate or secondary level and at the iii) apex or tertiary level. Healthcare at the grass root level are provided by various agencies which are the first point of contact between the individual and the primary health facilities and include primary health centres, sub-centres and dispensaries. From this level, patients are referred to agencies at the intermediate level where they are provided enhanced curative services and testing facilities. At the highest level, health institutions provide specialised care.

The health system in India consists of the public sector, private sector and an informal network of providers who operate within an unregulated environment, with no controls on the services provided, by whom they are provided and the cost of these services. In addition, there are no standards against which the quality of services measured by this segment of the private sector can be evaluated.

The Organization and Role of Plural Health Providers in India

India probably has the largest private health sector in the world (Duggal and Nandraj 1991 cited in Sunil Nandraj, 1994).[6] At the time of Independence, less than 8 percent of all medical institutions in the country were maintained by wholly private agencies (Bhore Committee 1946). By the early 1990s, this figure had reached close to 60

[6] Nandraj, Sunil (1994): 'Beyond Law and the Lord- Quality of Private Health Care', *Economic and Political Weekly, Vol.XXIX, No. 27, July 2 1994, pp. 1680-5.*

percent, and there are indications that it increased even further during the past decade.[7] Over the years, especially in the 1980s, the private players in health sector has gained a dominant presence in medical education and training, medical technology and diagnostics, manufacture and sale of pharmaceuticals, hospital construction and ancillary services and the provision of medical services where it is more focused on providing curative care. Three-quarters of the human resources and advanced medical technology, 68 percent of total of over 15,097 hospitals and 37 percent of over 623,819 beds in the country are in the private sector (Directory of Health Services, GOI 1996 cited in Sujatha Rao et al, 2005).[8] The share of the private health sector in India is between 4 to 5 percent of the GDP.

Public Health Facilities Available in Delhi

The Ministry of Health and Family Welfare of the Government of India is the highest authority responsible for setting standards of health facilities, implementation of national level health programmes and management of its health facilities. The Director General of Health Services (DGHS) is the technical wing of the Ministry and is responsible for implementing programmes on its behalf. The Central Government and its agencies that provide healthcare facilities include:-- i) Central Government/CGHS; ii) Railways; iii) Defence and iv) ESI.

Delhi has only a few Central government hospitals that provide medical facilities to the general public. These include Safdarjung Hospital, Ram Manohar Lohia Hospital, Sucheta Kriplani Hospital etc. The Central government also provides funds to few autonomous institutes involved in medical education and research and also dispense medical care as part of their research, for e.g All India Institute of Medical Sciences (AIMS) in New Delhi.

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[7] Radwan, Ismail (2005): *India- Private Health services for the poor*, Policy Note. http://siteresources.worrldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/RadwanIndiaPrivateHealthFinal.pdf, accessed on (Tuesday, April 14, 2009)

[8] Rao, Sujatha et al (2005) : Delivery of Health Services in the private sector, Commission on Macroeconomics www.who.int/entity/macrohealth/action/Report%20the%20National%20Commission.pdf accessed on (Thursday, April 16, 2009)

In Delhi there are multiple agencies involved with delivery of healthcare facilities which are being provided by various government and Non-Government Organisations. At the state level, the Department of Health and Family Welfare of the state government has a technical wing, the Directorate of Health Services (DHS) headed by a Director. Apart from the DHS, the following agencies are working in the area of health :-- Directorate of Indian System of Medicine and Homeopathy, Ayurveda, Unani and Homeopathy; Directorate of Prevention of Food Adulteration; Drug Control Department; Delhi AIDS Control Society.

The local self governance bodies working in the area of health include :-- i) MCD ii) NDMC and iii) Delhi Cantonment Board. The MCD plays a prominent role in providing primary care. It has maternity and child welfare centres and maternity hospitals. Its activity is also geared for the waterborne and vector borne diseases and has public health laboratory to support this. They are also responsible for sanitation and waste disposal.

The Directorate of Health services (DHS) of Government of NCT of Delhi is the major agency committed to delivery of healthcare and it co-ordinates with other government and non-government organisations for the improvement of the health of its citizens.

Services provided by the DHS include :-- i) co-ordinating the implementation of various National and State Health programmes ii) healthcare facilities at primary and secondary level in the national capital through dispensaries and health centres, hospitals, School Health Clinics and Mobile Health Clinics.

Delhi with an area: 1483 Sq Km and population of 17.72 million [9] (population estimate for 2009) has been divided into nine administrative districts- North, West, North West, South, South West, East, North East, Central and New Delhi District, each under a Chief District Medical Officer.

[9] Source: DHS

Table1.2 :Health Outlets Under DHS

S. No.	Health Outlets	1998-99	1999-00	2000-01	2001-02	2004-05	2006-07
1.	Number of Dispensaries	139	139	155	167	179	184
2.	Number of Hospitals	13	15	11	11	-	-
3.	Number of Mobile Health Clinics*	62	62	73	73	71	67
4.	Number of School Health Clinics	63	63	64	64	15	15

Source: Directorate of Health Services.

*This programme has been designed by the Government of Delhi to cater to the health demands of the growing population -- about 35 percent[10] -- living in J.J clusters and unauthorised colonies. Mobile Health Scheme provides primary healthcare to the residents at their door-step. The Delhi Government has invited the NGO sector to participate in the scheme due to paucity to resources and keen interest shown by some NGO's. As a result, a fleet of 68 Mobile Dispensaries provide healthcare to the J.J clusters.

Apart from these government agencies, private sector and NGOs are also prominent in providing health care facility.

Access to Health Care

Despite the supposed proximity of the urban poor to urban health facilities, their access to them is severely restricted due to socio economic, language and ethnic barriers and most important, prejudices and insensitive attitude of the health providers. Moreover, provisioning of healthcare is fragmented, with maladies such as lack of accountability, poor referral system, weak stewardship and poor staff quality acting as barriers for the

[10] According to the Delhi Health Survey

poor in accessing these services[11]. Presently, the number of health centers as per the norms is 16,137 sub centers, 2,913 PHCs and 3,239 CHCs according to the population as per Census 2001.[12]

Though the spending on healthcare is 6 percent of Gross Domestic Product (GDP), the state expenditure is only 0.9 percent of total spending. In effect, just 17 percent of all health expenditure in the country is borne by the state, and 82 percent comes as 'Out of pocket payment' by the people. A substantial financial burden of households is for meeting healthcare needs. This gains significance when we realise that nearly half of the country's population does not have enough resources to meet its food requirements. Compared to state expenditure on health, the private household expenditure is nearly four to five times more than that of the state (Duggal and Amin, 1989, cited in G Ingle and K, Nath, 2006).[13]

As a result of the inadequacies and poor functioning of the urban public health delivery system and ineffective outreach especially at the primary level, the access of urban poor to health care services remains limited.

The private health sector in many developing countries has expanded since the 1980s (Alailima and Mohideen 1984, cited in Sara Bennett, McPake.et al, 1997)[14]. Several studies conducted to examine the private sector, which varied from voluntary to not profit, for profit, corporate, trusts, stand alone specialist services, diagnostic laboratories, pharmacy shops and unqualified practitioners.[15] In India the private sector has a large presence at the primary healthcare level and includes practitioners from different systems of medicine who are both formally and informally trained[16]. Analysis of the 57th round of the NSS, covering 30,000 health providers, shows that there are an estimated 13 lakh private healthcare provider enterprises employing 22lakh people. Over one-third of them have no registration of any kind and 25 percent are AYUSH

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[11] Barua, Nupur (2005): *How to develop a pro-poor private health sector in urban India?*, presented at Global Forum for Health Research, Forum 9, Mumbai, India.

[12] Ingle, G and K, Nath. A (2006): 'Reaching Out to the Unreached: Health Care for the Poor in India', *Indian Journal of Community Medicine Vol. 31, No2, April- June 2006.*

[13] Ibid: 6

[14] Bennett Sara, McPake.et al (1997): *'Private practitioners in the slums of Karachi: professional development and innovative approaches for improving practice* ' by Inayat H. Thaver and Trudy Harpham in Private health providers in developing countries. Serving the public Interest. Zed Books, London and New Jersey, pp 71- 81

[15] Ibid: 8

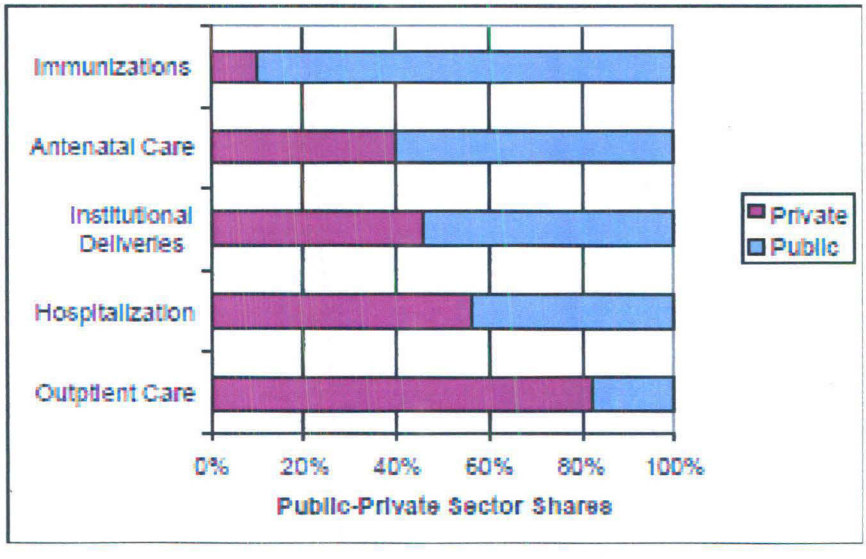
[16] Baru, Rama V (2003): 'Privatisation of Health Services, The South Asian Experience'. *Economic and Political Weekly*, October 18, 2003, pp 4433-4437

practitioners. An important subset of providers is the large number of unqualified providers.

"Studies have shown that private practitioners at the primary level consist of a variety that includes traditional healers, folk practitioners, herbalists, practitioners of indigenous systems of medicine, allopathic and those practicing allopathic without any formal training. There is some evidence to suggest there is considerable amount of cross practice between practitioners, institutions and systems of medicine in the private sector"[17]. In cities, it is increasingly evident that the urban poor are seeking health care from the private sector. (Yesudian 1994; Uplekar 1989a and 1989b cited in Sara Bennett, McPake.et al, 1997).[18]

Analysis on utilisation of outpatient services across the country based on the mid-1990s NSS survey shows that by the middle of the 1990s, over 80 percent of outpatient care was in the private sector in the rural areas and 81 percent in the urban areas, with the bulk of it provided by the private doctors (around 55 percent) in both rural and urban areas.[19]

Figure 1.1: Public and Private Sector Shares in Service Delivery



Source: 'The Poor and Health Service Use in India', Ajay Mahal, Abodo S. Yazbeck, David H. Peters, and G. N. V. Ramana 2001.

[17] Baru, Rama V (2007): '*Dynamics and Quality of private health services in India' Paper presented at the International Workshop " Public- Private Mix: A Public Health Fix?*" Strategies for health Sector Reform in South and South –East Asia' Naresuan University, Phitsanulok, Thailand.

[18] Ibid : 14

[19] Sen, Gita etal, (2002): 'Structural Reforms and Health Equity: A Comparison of NSS Surveys, 1986-87 and 1995 – 96', *Economic and Political Weekly*, Vol. XXXVII, No.14, pp- 1342-1352.

According to the *NSS Report No. 508: Level and Pattern of Consumer Expenditure, 2004-05,* the poorest 5 percent of the urban population of India (ranked by per capita spending levels) in 2004-05 belonged to households with monthly consumer expenditure per person in the range "Rs. 0-335" -- spending less than Rs 11 per person per day on consumption. Another 5 percent of the Indian urban population belonged to households with monthly per capita expenditure in the range "Rs-335-395" -- spending about Rs 11-13 per person per day on consumption. Medical expenses formed 7 percent of total consumer expenditure in rural and 5 percent in urban India.

Thus that healthcare needs form a substantial financial burden for families who do not have sufficient resources to meet its food requirement. Compared to state expenditure on health, the private household expenditure is nearly four to five times more than that of the state (Duggal and Amin, 1989, cited in Sunil Nandraj, 1994).[20] According to the 'National Council of Applied Economic Research (1992): Household Survey of Medical Care', 55 percent of the household expenditure on healthcare was spent on private doctors and only 39 percent on public institution.[21]

According to Jishnu Das and Jeffrey Hammer[22] the poor had access to worse providers than the rich in the area of competence.

Providers with less training and qualification were located in the poor areas, whereas the proportion of MBBS providers more than doubled when one moved from poor to rich neighbourhoods. The MBBS providers located in the poor region were less competent than those in the rich regions and the results were also similar for those without that degree.

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[20] Ibid: 6
[21] Ibid: 6

[22] Das, Jishnu and Hammer Jeffrey (2007): ' Location, Location, Location: Residence, Wealth, And The Quality Of Medical Care In Delhi,' *Health Affairs (Web exclusive), 26, no. 3(2007): w338-w351,*

Table 1.3: Distribution of Competence, By Area Income, Providers' Qualifications, And Institution, In Delhi, India, 2003-04

Income of neigh-bourhood	All providers	Private –sector providers				Public-sector providers		
		RMP/ other	BAMS / BHMS	MBBS	All	PHC	Hospit -al	All
All areas	0.01 (1.00)	-0.66 (0.51)	-0.37 (0.90)	0.58 (0.98)	-0.03 (1.02)	0.02 (0.87)	0.20 (0.98)	0.16 (0.93)
Low Income	-0.30 (0.88)	-0.64 (0.52)	-0.50 (0.91)	0.41 (0.78)	-0.31 (0.87)	-0.64 (0.55)	0.23 (1.14)	-0.21 (0.97)
Middle Income	-0.11 (0.80)	-0.89 (0.36)	-0.23 (0.73)	0.07 (0.66)	-0.26 (0.72)	0.38 (0.90)	0.16 (0.88)	0.28 (0.87)
High income	0.52 (1.12)	-0.28 (0.65)	-0.21 (1.17)	0.91 (1.09)	0.58 (1.18)	0.16 (0.77)	0.40 (1.03)	0.32 (0.93)

Source: Das. Jishnu, Hammer Jeffrey (2007): " Location, Location, Location: Residence, Wealth, And The Quality Of Medical Care In Delhi" *Health Affairs, 26, no. 3(2007): w338-w351.*

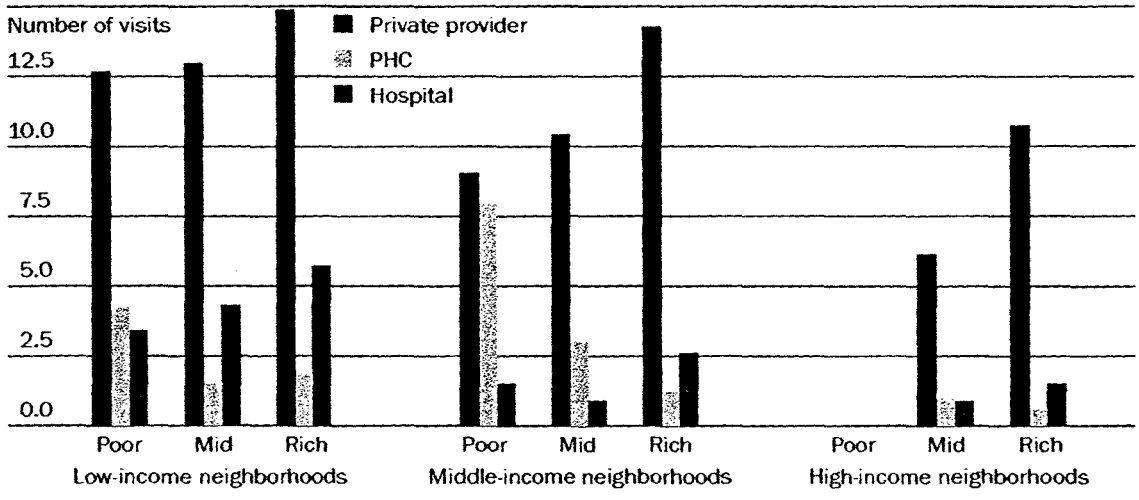
Notes: This table shows average competence and its standard deviation (in brackets) by neighbourhood, qualification, and institutional affiliation. It shows that the average competence is much lower in low income than in high-income areas, in both the private and public sectors. Even within qualification categories, the less competent go to lower-income areas. Thus, among only doctors with the Bachelor of Medicine and Bachelor of Surgery (MBBS) degree, the average competence of a private sector MBBS in a low-income area was 0.5 standard deviation less in a low than in a high income area. Among public-sector providers, this difference was close to 0.55 standard. RMP is registered medical practitioner, BAMS is bachelor of Ayurvedic medicine and surgery, BHMS is bachelor of homeopathic medicine and surgery. PHC is primary health center.

Jishnu Das's study clearly brings out the choices that households made among private and public providers, the latter separated into PHCs and hospitals. Here three important observations were made. First, all income groups and neighbourhoods overwhelmingly favoured the private over the public sector. Second, people in low-income neighbourhoods visited private providers more frequently than did those in high-

income neighbourhoods. Third, visits to public facilities by the poor were primarily to PHCs, and among the rich, to hospitals.

Figure 1.2

Provider Visits, By Neighborhood And Household Income, In Delhi, India, 2003-04



NOTES: Exhibit shows how visits to medical care providers over the thirty-five weeks of the survey were distributed across private- and public-sector doctors (the latter separated into primary health centers, or PHCs, and hospitals). Visits are disaggregated by the income of the neighborhood that the household is in and the income of the household itself (poor, mid, and rich).

Source: Das. Jishnu, Hammer Jeffrey (2007): " Location, Location, Location: Residence, Wealth, And The Quality Of Medical Care In Delhi" *Health Affairs, 26, no. 3(2007): w338-w351.*

Despite a large public and even larger private health sector, appropriate and affordable health care remains inaccessible to several hundreds of millions, particularly women and children. In the absence of any kind of regulations governing location, standards, pricing, private facilities are predominant in market places and residential colonies. Pharmacy shops have the freedom to provide all kind of services, of whatever quality and at exorbitant cost that varies from facility to facility. These factors greatly influence the quality of health services available to the poor who are constrained by factors like price, location, time as well as the kind of treatment meted out to them.

Health services in Delhi, with a population of 13 million (Census of India 2001), is provided by the unregistered practitioners in most of the poor urban neighbourhoods. The urban poor, in turn, resort to treatment in the private sector with both registered and unregistered practitioners, who have become the major players and are largely

unregulated, with their number in Delhi itself being estimated at 40,000, according to the DMC.

Though law has stopped the practice of RMPs[23], people still preferred going to them since they were easily accessible and often worked on credit. Most of them were from the same community. In Karchana district of Uttar Pradesh, they were popularly called 'Jhola chaps' since they carried their Jhola of medicines with them. The excessive use of injections was the characteristic of these practitioners. One of the reasons for their popularity was that they treated their patients with injections on demand. Since most of the people who came to them for treatment were on daily wages, they could not afford to stay at home during sickness and thus often insisted on injections[24].

These private practitioners resort to various malpractices, over-medication, random prescription of drugs and inappropriate treatment regimes. "These practitioners make regular headlines in the media in the aftermath of fatal accidents caused by misdiagnoses, and the Delhi government conducts raids in an attempt to shut their 'clinics'. Although the Supreme Court of India has deemed their operations to be illegal, the fact remains that most of them continue to practice. Our ongoing field research indicates that they have their own associations for internal support amongst its members; many of these practitioners operate out of 'clinics' that bear no signboards or placards. And it is they who are the backbone of the 'health service' for the urban poor."[25]

These unqualified practitioners are the first point of contact for the poor people seeking primary health care. A study conducted by R Bhat in 1999 of 49 unqualified private medical practitioners in 4 blocks, spread over 3 districts in West Bengal, showed that unqualified practitioners enjoyed close rapport with and the trust of the local community as they were a part of the community, were accessible at all times, provide treatment for several types of ailments, including antibiotics that gave quick relief.[26]

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[23] Registered Medical Practitioners, however it is a colloquial term for Unqualified Practitioners

[24] Deepti Chirmule & Gupte Anuradha (1997): *Study on Factors Affecting Health Seeking And Utilisation of Curative Health Care*, Unpublished . Bharatiya Agro Industries Foundation, Pune. http://www.cehat.org/

[25] Ibid: 17

[26] Ibid: 8

An Overview of Private Providers and Health Seeking Behaviour

The literature available on informal providers is scarce. Very few studies have been conducted on informal providers exclusively. Whatever information is available is in the context of studies conducted to assess the health seeking behaviour of the urban poor or the poor people in rural areas.

Sara Bennett, Barbara McPake discuss that while the performance of the public providers has been very well researched in the past decades, similar knowledge about the private providers do not exist and has only started emerging over the last few years. Despite neglect of private sector providers in some countries and outright abolition in others, emphasis has been placed on the potential for them to play a complementary role in the overall strategy defined by public interest. It has become evident from these researches that the public sector has failed to achieve low cost access to services for the population especially in the remote areas.

However, there has been much concern about equity with growing privatisation which is often overshadowed by arguments about efficiency. It has often been argued that privatisation will hurt the poor (Ugalde and Jackson 1995). This argument has been challenged by Stren (1998),[27] who while discussing urban services in Africa argue that the evolution of private markets led to overall welfare of the poor as they were able to procure access to essential services though at a cost, to which they had no access previously and hence enhanced equity. Here the preferability of 'health-threatening' private providers over none brings forth a lot of issues from the public health perspective.

Here it is important to note that the failure of the private sector is most glaring in the poor technical quality of care offered by unqualified providers at the lowest levels of the health system. Regulation of these is difficult as the number of providers is large and they are not registered. Though many countries have already banned the sale of drugs, treatment and health advice by non registered practitioners it had little or no effect on the problem.

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[27] Bennett Sara, McPake et al (1997): The public/ private mix debate in health care, Private Health Providers in Developing Countries. Zed Books, London and New Jersey, pp 1-18

The unqualified providers also neglect preventive measures as the consumers are ignorant and do not understand their efficacy. These encourage unethical behaviour on the part of the unqualified practitioners whose only motive is profit, which are in most cases based on supplier induced demand.

There are four major areas of concern which has been clearly brought out by the studies on the private sector from middle and low income countries (Benett et al). They are competition, regulation, equity and gains from improving the public sector. Apart from these, concerns are raised about healthcare system. "Clearly defined relationships between primary, secondary and tertiary providers are required in order for the sector as a whole to function efficiently, yet private providers frequently appear to have poor or non-existent relationships with other (particularly public) levels of health – care system" (Aljunid 1995, cited in Sara Bennett, McPake et al, 1997)[28].

A study of the role of individual private practitioners, public sector and other agencies in a cholera epidemic in urban slums of Delhi[29] showed that early detection of the problem was done by the public institution and private practitioners could not identify the early signs. The private practitioners also did not provide emergency care even though they were approached first with 43 percent of those affected sought their services for less serious conditions. The study found that 75 percent of those who were seriously ill resorted to the government hospital. Very few private practitioners prescribed the use of oral dehydration solution which was propagated by the government hospitals as a control measure.

The research showed that the private sector is not reliable for dealing with epidemics caused by infectious diseases. The public sector is crucial for public health surveillance and control of epidemics. The study recommended that local private practitioners should be involved in the early detection, treatment and management of epidemic like situations by giving them information on management of such epidemics.

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[28] Ibid: 27, pp 11

[29] Priya, R. et al (1989): *Sunder Nagari Mein Ulti-Dust Ki Prakop Va Uski Roktham (The Gastro-enteritis outbreak and its control in Sunder Nagari: An assessment at community level),* Mimeo, Sable Sangh with support from the ICSSR, New Delhi.

On similar lines, a study of the role of private practititoners in the treatment of malaria in urban slums of Mumbai[30] concluded that many practitioners in Mumbai and Navi Mumbai were poorly qualified. Hence, they could not play a supportive role in the efforts of the public health departments of the two cities to bring the epidemic under control. The diagnostic and treatment practices adopted by them were not consistent with the guidelines laid down by the WHO and India's National Malaria Eradication Programme (NMEP). Limited practitioners, especially those practicing in low-income areas, relied on a peripheral blood-smear test to make a diagnosis. Practitioners whose clientele were mostly the poor, commonly resorted to giving only one-day treatment and justified their mode of diagnosis by asserting that their clients could not afford a blood smear test or a full prescription and that they were only responding to the demands of their patients. These practitioners only exacerbated the health problems of their patients and also defeated the efforts of bringing the epidemic in the cities under control. This clearly shows that they practiced medicine that was unethical and dangerous.

Unqualified practitioners have been studied to some extent by Snehlata Gupta[31] (1990) in Delhi slums that shows the plurality of providers. The study provides some insight into the characteristics of the informal providers. Majority of the providers were unqualified and had picked up practice by working as assistants or apprentices to doctor, compounders and dispensers. They charged lesser fees, were easily accessible and gained popularity by displaying sympathetic attitude towards their patients. They used instruments like thermometer, stethoscope, tongue depressor as well as intra-venous sets and even treated people on credit. The study showed that those who could not afford qualified practitioners went to the unqualified one instead of government hospitals since they did not want to lose their daily wages or spend money or time on transport.

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[30] Kamat, Vinay (2001): 'Private Practitioners and their Role in the Resurgence of Malaria in Mumbai (Bombay) and Navi Mumbai (New Bombay), India: Serving the affected or Aiding an Epidemic?' *Journal of Social Science and Medicine vol 52* pg 885-909.

[31] Gupta, Snehlata (1990): *Socio-economic and Political Determinants of People's Responses to their Health Problems: A Case Study of New Seema Puri – A Resettlement Colony in Delhi*, Unpublished, M Phil Dissertation, Jawaharlal Nehru University, New Delhi.

Bhandari's study[32] of diarrhoea management in Delhi slums showed that households sought treatment in nearly 60 per cent of the cases by resorting to private practitioners. These private practitioners have varied backgrounds and training and their practices are irrational in the management of diarrhoea in children. The study suggests that since people utilise their services for primary level healthcare, it is extremely important to register and train them in rational therapeutics

P. Nanda, and R. Baru[33] expressed concern at the low rate of registration by the private nursing homes in Delhi as this could be regarded as the first step towards any effort at future regulations in their study on 'Private Nursing Homes and Their Utilisation: A Case Study of Delhi'. The trends in utilisation pattern among inhabitants of resettlement colonies were initial preference for the private practitioners with 60 percent of the inhabitants opting for it. However, for major complaints 80 percent sought treatment in government hospitals. This study also highlights 'the utilisation of Ayurveda and Homeopathy along with Allopathic services by the communities'.

The doctoral work of Kalpana N Desai[34], discusses the satisfaction of the community residing in three areas – unauthorized slum, resettlement colony and an urban village with different providers. The study first graded all the three areas on physical and socio economic conditions and found that the people living in the unauthorised slum were the poorest, followed by those residing in the resettlement colony and the urban village respectively. The study showed that the people in the unauthorised slum showed maximum satisfaction with the private clinics and alternative system of medicine. The study also brought forth that for a number of acute conditions like fevers and diarrhoea and skin infections majority of the households went to the private practitioner. For chronic ailments like tuberculosis, and STDs there was less reliance on the private practitioner; around 40-60 percent of the households relied on the public hospital.

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[32] Bhandari, Nita (1992): *The Household Management of Diarrhoea in the Social Context: A Study of a Delhi Slum*, Unpublished Ph.D. Thesis, Jawaharlal Nehru University, New Delhi.

[33] Nanda, P and Baru, R.(1997): *Private Nursing Homes and their Utilisation: A Case Study of Delhi*, Voluntary Health Association of India, New Delhi.

[34] Desai, Kalpana N (1997) : *A Psychosocial Study of Selected Health Problems in Low Income Urban Colonies of South Delhi*, Unpublished Ph.D. Thesis, Jawaharlal Nehru University, New Delhi.

Another study by Chirmule Deepti and Anuradha Gupte[35] conducted in states Gujarat, Maharashtra, Karnataka, Uttar Pradesh, Rajasthan and published by Bharatiya Agro Industries Foundation, Pune concluded that the utilisation pattern of the health services is determined by factors like cost, quality of services, their availability, etc. The research showed that due to the inefficiency of the Public Health Centres people preferred seeking treatment from private practitioners. For example, in Laila (Rajasthan), people went to the private practitioners or used home remedies as the health infrastructure was not well developed.

De Zoysa I .et al[36] suggested that maternal recognition of illness was not a limiting factor in the use of healthcare services for sick infants and are usually prompt in seeking care outside home. They are not however able to discriminate among the many source of health care available and give preference to local unqualified private practitioners.

D. K. Taneja et al.[37], in his study concludes that urban slums comprise of heterogeneous population most of who have migrated from different states and this results in low collective responsibility and voluntary efforts. The presence of multiple agencies providing healthcare makes coordination difficult and this combined with poor image of the public sector result in people going to the unqualified but affordable health practitioners. This results in delay and inappropriate care for the sick newborn. This can further be seen in the following datas- in most episodes of diarrhoea affecting young children, they were taken to private doctors (76.9 percent). Home management was low (15.3 percent). In most cases (71.6 percent) fluids are either decreased or even withheld. Decrease or withholding of food was reported in 51.6 percent. ORT use rate was just 28.4 percent which is much below the national average (38.0 percent).

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[35] Deepti, Chirmule and Gupte, Anuradha (1997): *Study on Factors Affecting Health Seeking And Utilisation of Curative Health Care,* Bharatiya Agro Industries Foundation, Pune. http://www.cehat.org/

[36] I,. Zoysa et al (1998): 'Care seeking for illness in young infants in an urban slum in India', *Journal of Social science and medicine*, vol47, n 12, pp 2101-2111.

[37] Taneja, D. K. et al (2000): 'Status of Reproductive and Child Health in Delhi' *in the Indian Journal Of Community Medicine,* Vol. 25, No. 4 (2000-10 - 2000-12).

The view put forward by Dr. Rajendra Kumar and Dr. P.L. Trakroo[38] was that in order to improve the health status of slum dwellers, a mechanism may be developed to involve private practitioners along with government health care providers. It showed that the slum dwellers take medical care only when they are really sick and allopathic care is the preferred form of medical care used by the slum dwellers irrespective of their age, sex and socio-economical status. However, non-allopathic care was found to be common among the slum dwellers of higher socio-economic class. The slum dwellers mainly consulted the private practitioners even though they preferred government facilities.

The current understanding on dynamics and structure of private healthcare has been enhanced by a study[39] in Madhya Pradesh on Unqualified practitioners. It gives an insight into the social and demographic profile of the unqualified practitioners practicing in M.P as well as the key position they occupy in the public and private primary health services referral chain.

A study[40] on Revised National Tuberculosis Control Programme (RNTCP) and the role of private practitioners concluded that the need of the hour is to include the private sector in the National Tuberculosis Programme since India has the largest private health sector in the world. However, one should be aware of the fact that the Private Practitioner's use non-recommended drug regimens with an inclination towards over-treating in terms of number of drugs as well as duration of the therapy. To regulate this it is important that reporting of all cases is made mandatory for TB diagnosis and treatment by private practitioners to the health authorities which will help build a system of accountability.

Nupur Barua[41] while studying the health seeking behaviour of households in poor areas found an overwhelming preference for the private sector. Inspite of the presence of free government institutions in urban areas, a startling majority of the poorest of the poor

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[38] Kumar, Rajendra and Trakroo, P. L.(2001): Medical Care Seeking Behaviour Among Selected Slum Dwellers of Delhi, Thesis , published by NIHFW, New Delhi.

[39] Taru Leading Edge (2002): *Study on the dynamics and structure of private healthcare in Madhya Pradesh*, Department for International Development (DFID), India.

[40] Garg, Kumar Vinay and Garg, Das . J. K. (2004): Role of Private Practitioners in Implementation of Revised National Tuberculosis Control Programme (RNTCP) in East Delhi Area, Thesis, published by NIHFW, New Delhi.

[41] Barua Nupur(2005): *How to develop a pro-poor private health sector in urban India?* Presented at Global Forum for Health Research, Forum 9, Mumbai, India.

go to the private practitioners as a first resort. Reasons for this preference were quoted as issues of access, perceived quality of treatment, affordability and convenient timings. Narratives of treatment seeking strategies are replete with mistrust of the public delivery of health care.

K.V. Narayana's (2006) study[42] on unqualified medical practitioners in Andhra Pradesh has brought to the fore the nexus of the unqualified practitioners with the qualified Doctors who use them to mobilize patients for surgeries and diagnostic tests by offering commissions.

Conceptualisation of the Study

The encouragement given to the private initiative in healthcare delivery in the National Health Policy of India has paved the way for the fast growth of the private sector in this field in India. At the time of independence, less than 8 percent of all medical institutions in the country were maintained by wholly the private health sector in the world.

Private health expenditure in India has grown at the rate of 12.5 percent per anum since 1960-61 and the utilisation studies have shown that 81 percent of out patients use private health care facilities. Studies have been undertaken to increase the understanding about the nature, spread, functioning and quality of care provided by the private sector. These studies have brought out the diverse nature of the private health services available which is in the form of corporate, trusts, non-profit, specialist services, sole proprietor, diagnostic facility, pharmacy and unqualified practitioners. Since greater resources are spent on out patient care as immense expenditure is incurred by households on it.

Studies have shown that for out patient care, especially for acute illness, majority of the urban poor prefer going to the private practitioner, most of whom are unqualified. This is despite the fact that different types of primary healthcare providers are available

[42] Narayana,V,K (2006): *The Unqualified Medical Practitioners, Methods of Practice and Nexus with the Qualified Doctors*, Working Paper No. 70, Centre for Economic and Social Studies, Hyderabad.

to the urban poor including qualified private doctors, public dispensaries, health outpost, charitable hospitals etc.

The number of unqualified practitioners is growing along with the surge of the organised private sector in the field of medical care[43]. However, the literature available on the urban health sector is sparse, especially those looking at the urban poor. It is important that a comprehensive research involving unqualified practitioners is undertaken as little is known about their number, age training, education methods of practice etc.

A review of available studies shows the dependence of the urban poor on the private sector (Bhandari Nita 1992, P.Nanda, and R. Baru 1993, Nupur Barua 2005). Moreover, factors like cost, quality of services, their availability in the context of approachability and sympathetic attitude of the practitioners towards their patients affect the health seeking and utilisation pattern of the urban poor, who mainly avail the services of the unqualified practitioners (Kalpana N Desai 1997, Chirmule Deepti and Anuradha Gupte 1997, Dr. Rajendra Kumar and Dr. P.L. Trakroo 2001). These studies also bring out the immense "popularity" and the dependence of the urban poor on the unqualified practitioners, with the most vulnerable population accessing their services. There are also studies concentrating on the unethical medical practice of the unqualified private practitioners and how these practitioners only exacerbated the health problems of their patients. These practitioners due to lack of skill could not recognize the early signs and their diagnostic and treatment regimen defeated the efforts of bringing epidemics in cities under control and hence it was felt that they cannot be relied upon for disease surveillance (Ritu Priya et al 1988, Vinay Kamat 2001).

However, very few studies have exclusively studied the unqualified practitioners and their method of practice. Hence, little is known about the social and knowledge network of unqualified practitioners, how they operate, their linkages with both the formal as well as the private sector, especially in Delhi.

Therefore, there is a need to look at the various aspects of unqualified practitioners in a holistic manner and explore as to 'who they are' and 'what is their social background, knowledge networks', especially process of skill acquisition and linkages with the formal and private sector. Since the outreach of the public health sector

[43] Ibid : 42

among the most vulnerable is limited as studies show, hence, it is important to understand the approach of the government on the issue of unqualified practitioners who are a reality in urban slums and are the first point of contact for medical care for the urban poor. They exist, in spite of the fact that their practice has been termed as illegal by the government.

This dissertation builds on the methodology and findings of the TARU study and Narayana's study as they have worked on the unqualified medical practitioners in Madhya Pradesh and Andhra Pradesh respectively. The Taru and the Naryana study were primary in-depth studies aimed at identifying the socio-economic characteristics of RMPs[44] and their number. It explored the type of medical system practiced, income profile, training, patient load and nature of medical practice. Linkages with qualified medical practitioners were examined to understand their referral behaviour. While the Narayanan Study was confined to unqualified practitioners in allopathic medicine the Taru study included both informally trained ISM practitioners as well as Allopathic practitioners. Both the studies were conducted on rural health practitioners.

Objective of the Research

The overall objective of the study "Practices of Unqualified Practitioners in Selected Urban Slums of Southwest Delhi: An Exploratory Study", would be to improve the current understanding of the structure and dynamics of unqualified private practitioners operating at the primary level of healthcare provisioning, in the urban slums of southwest Delhi and understand their linkages with the formal health sector.

The study would seek to explore the following research questions-

- What is the Social Background of the unqualified private practitioners?
- What is their distribution and what is their number?
- What is the social characteristic of these unqualified practitioners?
- What is the nature of their medical practice?

[44] The unqualified medical practitioners are popularly known as RMPs which stands for Registered Medical Practitioners . It refers to a medical practitioner with no specific reference to legal or statutory status. In practice, most of these RMPs are either unqualified medical practitioners or Indian System of Medicine and Homeopathy licences or Diplomas.

- What is their interaction with the formal system of health services as well as the private sector?

The specific objectives would include-

- Mapping the plurality of unqualified practitioners and their practice.
- To explore the social background of these practitioners in terms of age, educational background, caste, religion and gender.
- To gain insight into the social profile of the patients treated.
- Discern pathways of knowledge and skill acquisition and its upgradation for their practice.
- To explore the factors that motivate them to get into practice in terms of income, respect, trust etc
- To explore patterns and pathways of referral with the public and private health service institutions.

Research Design

Methodology- Study Design

Selection of the Area

The area of my study includes ward no 171 of Mahipalpur and ward no 172 of Nazafgarh in South West Delhi. Both the areas are near to the Masoodpur Market, which is adjacent to Vasant Kunj. The selection of the area was done because of my familiarity with the place and due to the fact that it has a large slum population, public dispensary and also has adequate number of private nursing homes and unqualified practitioners. Since the study aims at exploring not only the socio and educational background of unqualified practitioners but also their linkages with the formal as well as private sector, this can be undertaken easily in this area. Also, the area is inhabited with varied population - the very rich, those settled in authorised colony and also migratory population residing in unauthorised colonies.

A study of unqualified practitioners operating in these areas will bring out the heterogeneity in their practice. The method of sampling was purposive. The areas

selected include :--- i) Settled authorized colony -- Harijan Basti ii) Unauthorized area with a migratory population -- Jai Hind Camp and iii) Unqualified practitioner from Masoodpur Market.

I have done a physical mapping of the unqualified practitioners of the area using the snowballing sampling method, which has provided a snapshot view of the

- Location of the clinics
- Distance from Masoodpur Market

Tools Employed

For the purpose of the study, intensive in-depth case study of 5 unqualified health practitioners was undertaken using a mix of semi structured interview and observation schedule. Five practitioners were selected on the basis of those open to being studied and effort was made to pick those who were most frequented. Two practitioners from each area were chosen for the study and as already stated one was selected from the Masoodpur Market.

Here participant observation is very difficult as practitioners are very skeptic and averse to anyone documenting their interactions. However, during my pilot study I found that a few of them were slightly more open than others, though they were very cautious.

- The semi-structured interview technique broadly characterize the area of enquiry into 9 groups of thematic questions-
    1. Demographic profile- social background
    2. Training and affiliation
    3. System of medicine practiced and expertise
    4. Motivational factors
    5. Clinical Practice details
    6. Social profile of patients
    7. System of referrals
    8. System of Investigation
    9. System of Payment
    10. Problems faced

Quasi participant observation of 5 unqualified medical practitioners was done for a period of 5 days. Since the aim was to observe the most frequented practitioner, I have used key informant interview and observation to get information about the most frequented unqualified practitioner by the community. The observation timing coincided with the practice timings of the clinics. Though initially I had planned to make observations in the morning as well in the evening, majority of the observations were made in the evenings as few patients turned up at the clinics in the morning.

Interview of 30 patients was done to understand their perception of the usefulness of having these unqualified practitioners in the area. Use of National Sample survey (NSS) methodology of recall of not more than one month was used.

Observation Schedule

Six skill areas deemed essential in doctor patient interactions include-

1. Empathy → good eye contact
   → active listening
   → facilitative response
2. Being responsive to clients
3. Expressing positive emotions
4. Eliciting information
5. Giving information
6. Encouraging patient participation

Non verbal Behaviour

1. Eye contact
2. Courteous
3. Respectful
4. Sensitive

Check list for key information to be gathered (observation)-

Observation of the interactions between the practitioner and the patient will be interpreted in the following format-

No.	Communication patterns	Tick	Time devoted
	Clinical History		
	physical examination		
	use of laboratory aids		
	Therapy		
	preventive medicine		
	Length of visits in minutes		

Observation schedule of condition of clinics and equipment in practitioners clinics have been borrowed from Sunil Nandraj and Ravi Duggal's -- physical standards in the private health sector[45] and has been modified to suit the study.

Observations of Condition of Clinics

Positive Features

1. Location of the clinic (clean place)
2. Signboard (present)
3. Noise Level (quietness)
4. Condition of wall (good)
5. Height of Ceiling (above 8 ft.)
6. Ceiling Type (cemented)
7. Condition of Ceiling (good/clean)
8. Condition of Floor (good/clean)
9. Natural Light (sufficient)

[45] Nandraj, Sunil and Duggal. Ravi (1997) : *Physical Standards in the private health sector; A case study of rural Maharashtra*, accessed on Thursday, April 30, 2009, 9:19:33 PM,www.cehat.org.

10. Artificial Lighting (sufficient)
11. Ventilation (adequate)
12. Seating for Patients (available)
13. Water Availability (present)
14. Record of Patients (kept)
15. Environment (uncongested)
16. Dustbin (present)
17. Examination Table/ area (present)
18. Privacy (available)
19. Dispenses medicine (present)

Equipment in practitioner's clinics

1. Gauze swabs[46]
2. Sterile pads
3. Scissors
4. Adult weighing machine
5. Children's weighing machine
6. Kidney tray[47]
7. Antiseptic solution
8. Syringes (disposable)
9. Needles
10. Sterliser Bowls
11. Towels and napkins
12. Revolving stools
13. Ordinary stools
14. Examination table

[46] In medicine, a cotton swab is a small piece of material, such as gauze or cotton, which is used to clean wounds, apply medications, or retrieve samples of body fluids such as blood or mucus.
[47] A **kidney dish** is a bowl used in medical and surgical wards to receive soiled dressings and other medical waste. Reusable dishes are usually made from bright stainless steel, while disposable ones may be made from paper pulp or plastic. The shape of the dish allows it to be held against the patient's body to catch any falling fluids or debris.

15. Screen stands or curtains
16. Refrigerator
17. Wall clocks
18. Stethoscope[48]
19. BP Instrument [49]
20. Thermometer[50]
21. Tongue Depressor[51]
22. Scalpel [52]
23. Artery forceps[53]
24. Auriscope[54]
25. Dressing material
26. Sutures and ligatures[55]

Rapport Building

The rapport building exercise took some time as the unqualified practitioner's were not very open to outsiders. They are accessible as long as you are a patient. But they are not open to visits with the intention to study their practice. Since their clinics do not have any placard or signboard it becomes difficult to locate them. Though people from the community residing in the area are ready to help but approaching them is often very difficult. The Malaria Inspector of the Nazafgarh Malaria Circle, Lalchand Yadav, helped significantly in approaching the community. Yadav's staff accompanied me to the

[48]The **stethoscope** is an acoustic medical device for listening to the internal sounds of an animal body. It is often used to listen to heart sounds.
[49] **blood pressure meter** is a device used to measure blood pressure, comprising an inflatable cuff to restrict blood flow, and a mercury or mechanical manometer to measure the pressure.
[50] The **thermometer** is a device that measures temperature
[51] A **tongue depressor** is a device used in medical practice to depress the tongue to allow for examination of the mouth and throat.
[52] A **scalpel** is a small but extremely sharp knife used for surgery, anatomical dissection.
[53] They resemble a pair of scissors with the blade replaced by a blunted grip. They also feature a locking mechanism to allow them to act as clamps. A hemostat is commonly used in both surgery and emergency medicine to control bleeding, especially from a torn blood vessel, until the bleeding can be repaired by sutures or other surgical techniques.
[54] An **Otoscope** or **auriscope** is a medical device which is used to look into the ears. Health care providers use otoscopes to screen for illness during regular check-ups and also to investigate when a symptom involves the ears.
[55] Sutures (also known as stitches) are divided into two kinds – those which are *absorbable* and will break down harmlessly in the body over time without intervention, and those which are non-absorbable and must be manually removed if they are not left indefinitely.

practitioners, who seemed more friendly than on earlier occasion when I had approached them alone.

Perhaps my approaching them with a government staff gave me and my study a genuine status. Since both the Malaria Office and the unqualified practitioners have been operating in the area and have over the years developed a relationship of trust, it may have been a factor in their growing confidence to interact with me. Obviously, they were apprehensive because of their illegal status and were also suspicious of such studies as they are often used against them by the authorities.

Analysis

The notes of the field diary were used to develop the qualitative description of the method of practice of these unqualified practitioners. This was reinforced through analysis of the semi-structured interview schedule.

Limitation of the study

The sample size is small as obtaining access to these unqualified practitioners is difficult, especially with the limited time available for the study. Despite the rapport developed, the element of suspicion and indifference could not be completely overcome. The practitioners were quite skeptic of such studies as they feel insecure being probed and feel that such studies can harm their interest.

They were also not open to their interactions with the patients to be recorded with an audio device. Hence, most of the recordings have been done through noting done in the field as well as by recall.

The language used by the practitioners, most of whom were Bengali, was Hindi and Bengali. Though the practitioner translated these conversations in Hindi whenever required, many of the nuances were lost during translation first in Hindi and then in English, the language of the study.

Ethical issues

It is difficult to explain the objective and the relevance of the study for the unqualified practitioner in order to take their consent and win their trust. The time of the unqualified practitioners used for the study is another ethical issue.

CHAPTER II

SOCIAL CHARACTERISTICS, KNOWLEDGE NETWORKS AND PRACTICES OF UNQUALIFIED PRACTITIONERS

Profile of Delhi

Located in northern India, the national capital Delhi shares borders with the states of Uttar Pradesh and Haryana. It has an area of 1,483 sq. kms with a maximum length of 51.90 kms and greatest width of 48.48 kms.[56] Delhi is one of the fastest growing cities in the country with 47 percent[57] decadal growth. The annual growth rate of population of Delhi during 1999-2000 was 3.85 percent which was almost double the national average. The high-level of migration to the city is mainly responsible for the massive population increase experienced over the last decade. The metropolis has seen a surge in economic growth, with rapid expansion of industries and commerce. The large-scale migration from backward and stagnant regions, characterized by low degree of economic opportunities, is aimed to improve the economic conditions of the migrant population..

The Census data indicates that only 0.21 million persons were living in urban areas in Delhi in 1901 which increased to 12.82 million in 2001. In terms of percentage, urban population was 52.76 per cent in 1901 and it rose to 93.18 per cent in 2001. In effect, it has led to a massive urbanisation in the capital city, which according to the Population Census of 2001 had the highest percentage of urban population in India - Delhi (93.18%) and was closely followed by Chandigarh (89.78%) and Pondicheri (66.57%).

[56] NURM- *Delhi City Development Plan*, pg 38, http://www.ccsindia.org/delhicdp.asp accessed on Wednesday, May 06, 2009, 10:43:00 AM

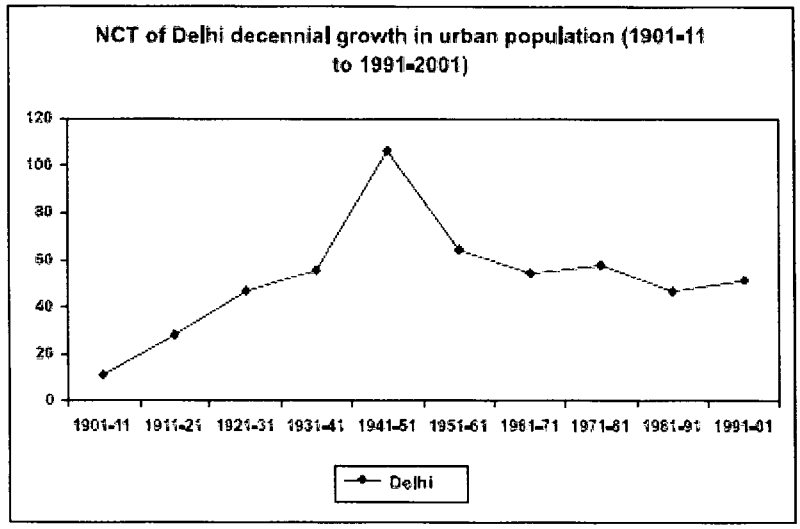
[57] Ibid: 1 pg 38

Table 2.1 : Trend of urbanisation in Delhi 1901-2001

Census Year	Total Population	Total urban Population	Percent urban Population	Annual exponential growth rate	Decennial growth percent
1901	405819	214115	52.76	...	...
1911	413851	237944	57.50	1.1	11.13
1921	488452	304420	62.32	2.5	27.94
1931	636246	447442	70.33	3.9	46.98
1941	917939	695686	75.79	4.4	55.48
1951	1744072	1437134	82.40	7.3	106.58
1961	2658612	2359408	88.75	5.0	64.17
1971	4065698	3647023	89.68	4.4	54.57
1981	6220406	5768200	92.73	4.6	58.16
1991	9420644	8471625	89.93	3.8	46.87
2001	13850507	12905780	93.18	4.2	52.34

Source: Economic Survey of Delhi 2005-200

Figure: 2.1 Trend of urbanisation in Delhi 1901-2001



Source: Economic Survey of Delhi 2005-2006

The census suggests a pattern of uneven urbanisation in Delhi, with high growth of population in concentrated pockets in the capital. Delhi was considered a single district for the Population Census of 1991. In 1996, the Government of NCT of Delhi created 9 districts and 27 sub-divisions through a Gazette Notification. Population Census 2001 was conducted in Delhi in each of the 9 districts and 27 Sub-divisions. The following table gives ranking of districts by population.

Table 2.2 : District-wise Population

District	2001		1991		Decadal Growth
	Population	% to total	Population	% to total	
North-West	2,860,869	20.65	1,777,968	18.87	60.91%
South	2,267,023	16.37	1,501,881	15.94	50.95%
West	2,128,908	15.37	1,433,038	15.21	48.56%
North-East	1,768,061	12.77	1,085,250	11.52	62.92%
South-West	1,755,041	12.67	1,087,573	11.55	61.37%
East	1,463,583	10.57	1,023,078	10.86	43.06%
North	781,525	5.64	686,654	7.29	13.82%
Central	646,385	4.67	656,533	6.97	- 1.55%
New Delhi	179,112	1.29	68,669	1.79	6.19%
Total	13,850,507	100	9,420,644	100	47.02%

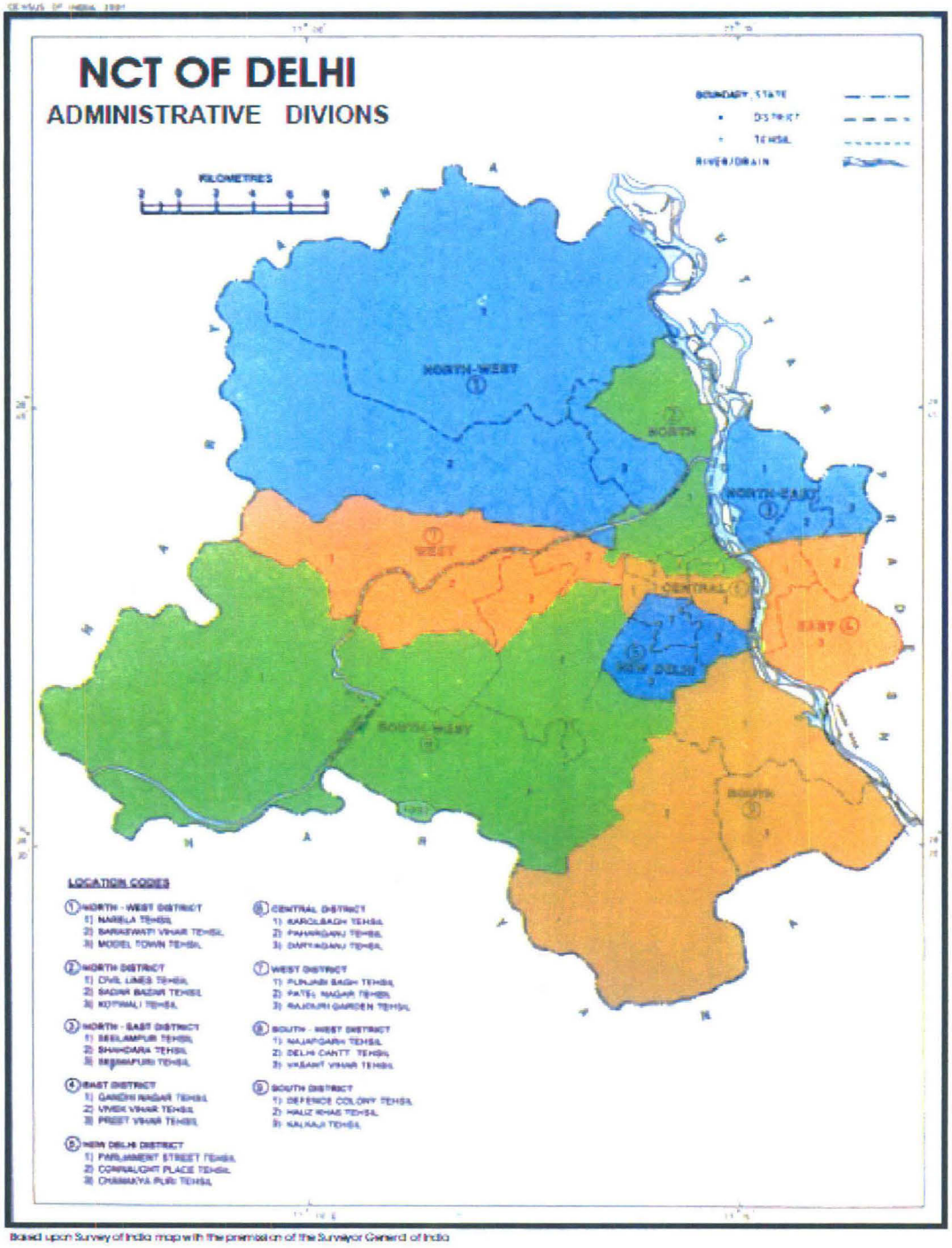
Source: Delhi Economic Survey 2005-6

Population Density

Rapid urbanisation of Delhi has resulted in a sharp increase in the density of population, which according to the Census 2001 averages 9,340 persons per sq. km. as against 6,352 persons in 1991. The density of population in Delhi is the highest among all states / UT's in the country which was far above the all India level of 324 persons per sq km in 2001. The spatial distribution of the population density in Delhi is given below-

Table 2.3 : Density of population (Per person Sq. kms)

District	Population Density	
	1991	2001
North-East	18,088	29,468
Central	26,261	25,855
East	15,986	22,868
West	11,116	16,503
North	11,471	13,025
South	6,012	9,068
North- West	4,042	6,502
New Delhi	4,791	5,117
South-West	2,583	4,179
All Delhi	6352	9340



Source : Delhi Economic Survey 2005-6

The rapid urbanisation process in Delhi has gone hand-in-hand with positive health indicators of decline in the birth and death rate (per'000 population) since the last decade of the 20th century. According to Civil Registration Records, the birth rate dropped to 21.25 in 2001 from 28.48 per 1000 recorded in 1991 while the death rate declined from 6.35 per 1000 in 1991 to .86 per 1000 in 2001. Infant mortality rate has also declined from 32.37 per thousand live births in 1991 to 24.49 in 2001. The following table clearly shows this-

Table 2.4: Population growth

Birth rate and Death rate (figures in lakhs)

Year	Population as on 1st July (in lakhs)	Growth	Total Birth	Total Death	Natural Increase	Migration
1991	95.5	3.89	2.72	0.61	2.11	1.78
1992	99.37	3.87	2.74	0.62	2.12	1.75
1993	103.38	4.01	2.7	0.64	2.06	1.95
1994	107.5	4.12	2.62	0.68	1.94	2.18
1995	111.74	4.24	2.75	0.69	2.06	2.18
1996	116.1	4.36	2.83	0.76	2.07	2.29
1997	120.57	4.47	2.89	0.71	2.18	2.29
1998	125.14	4.57	2.84	0.8	2.04	2.52
1999	129.82	4.68	2.88	0.79	2.09	2.59
2000	134.6	4.78	3.17	0.8	2.37	2.41
2001	139.5	4.9	2.96	0.81	2.15	2.75

Source: Delhi Economic Survey 2005-6

From the above table, it is clear that the large-scale migration is also responsible for major surge in Delhi's population apart from the high intrinsic growth rate of the city. A look at the migration pattern during 1981-1991, one notices a trend towards migration mainly from the poor states like U.P and Bihar. The following table shows the estimate of origin of migrants-

Table 2..5 : Origin of Migrants

State of Origin	% of total migration
Uttar Pradesh	49.61%
Haryana	10.26%
Bihar	13.87%
Rajasthan	5.16%
Punjab	4.72%
West Bengal	3.18%
Madhya Pradesh	1.85%
Other States	17.39%

Source: Delhi Economic Survey 2005-6

The major reasons for migration to Delhi are indicated below-

Table 2.6 : Migrants- Classified reasons for migration

Reasons	% Migrants	
	1981-91	1991-2001
Employment	31.29	37.6
Business	4.07	0.5
Education	2.28	2.7
Family moved	41.45	36.8
Marriage	15.62	13.8
Natural calamities	0.13	-
Others	5.16	8.6

Source: Delhi Economic Survey 2005-6

As per a survey done by The Institute of Economic Growth, Delhi, a vast majority of the migrant workers (around 80 per cent) were employed as petty traders or vendors in the service sector and manufacturing units. Most of the migrants from Bihar and U.P are poor as indicted by the economic status table below:

Table 2.7 : Economic Status of Migrant population

Place of Origin	Rich	Middle	Poor
Delhi	20	53	27
Bihar and Jharkhand	7	31	61
UP and Uttaranchal	10	46	45
Rajasthan	36	51	13
Other States	23	49	28

Source: NURM

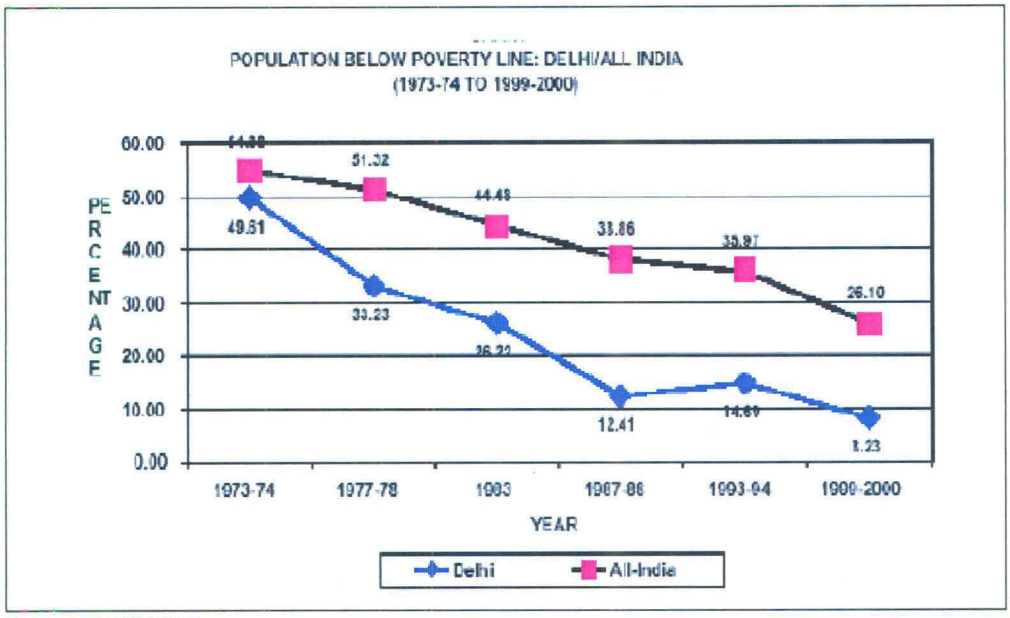
Poverty Line in Delhi

Large-scale urbanisation and migration has taken place in the backdrop of growing economic disparity between the various sections of the city's population. The Planning Commission of India has estimated the proportion and number of poor separately for rural and urban India at the national and state levels based on the recommendations of the Task Force on 'Projections of Minimum Needs and Effective Consumption Demands' (1979). The Task Force had defined the poverty line (BPL) as the cost of an all India average consumption basket at which calorie norms were met. The norms were 2,400 calories per capita per day for rural areas and 2,100 calories for urban areas. These calories were expressed in monetary terms.

However, an alternative method was suggested by the expert group under the Chairmanship of late Prof. D.T. Lakdawala. It recommended the use of consumer price index for agricultural labour to update the rural poverty line and a simple average of weighted commodity indices of the consumer price index for industrial workers and for urban non-manual employees to update the urban poverty line.

The estimates show that in the last two decades the percentage of population below the poverty line in Delhi declined significantly from 49.61% in 1973-74 to a meager 8.23% in 1999-2000.

Figure 2.2: Population below Poverty Line



Source: NURM

Urban Poverty and Slum in Delhi

Rapid urbanisation and growth due to industrialisation could not benefit all section of the society and hence urban poverty and slums have become problems for urban development. The surge in urbanisation and population has become a very serious problem and has led to housing shortages, unemployment, congestion, growth of slums, pollution, increase in crime rates, inadequate urban services like water supply, sanitation, drainage, sewerage, transport and deficient health, education and welfare facilities.

Table 2.8 : Below Poverty Line Population (2005)

Year	Urban BPL population	%age to Total
1973	21.78	52.23
1983	17.95	27.89
1987	10.15	13.56
1993	15.32	16.03
2000	11.42	9.42

Source: NURM

A large 85 per cent of the poor are squatters and live in constant fear of being evicted from their site as the authorities can decide to reclaim the land at any time, giving little notice. Those who stay on rented accommodation have to part with a substantial proportion of their income as rent. These rented accommodation lack basic infrastructure facilities. One third of the poor are employed in the service sector and 41 per cent of the unskilled poor work as casual labourers, with little access to dependable income. The average monthly income of the poor range from Rs 1,500-2,500 and they are increasingly dependent on the local moneylenders, who exploit them with high interest rates. And once they get into their clutches it becomes difficult for them to get out of it.

Housing is one of the most basic needs of the poor and most of them do not have access to any secure tenure. The migrant population, who come in search of livelihoods, settle themselves in vacant sites belonging to the government or the private landlords, mostly near the place of their work. These vacant sites grow into slums where people live in unhygienic and unsanitary conditions due to lack of basic infrastructure and civic amenities.

The unplanned or semi-planned areas inhabited by these people in Delhi can be classified as: (a) Legally Notified Slum Areas; (b) Resettlement Colonies; (c) Unauthorised Colonies and Harijan Bastis and (d) Pavement Dwellers (e) Urban Villa (f) *jhuggi jhopris* (JJ) Clusters or Squatter settlements.

Table 2.9: Estimated breakdown on Population of Delhi settled in slums and urban village[58].

Settlement Type	App. Pop. (lakhs)	Percentage (approx)
Regularised Unauthorised colonies	18	13
Resettlement/relocated Colonies	18	13
Urban Villages	8	6
Unauthorised Colonies	7	5
Notified Slums	27	19
JJ cluster	21	15

[58] Batra, Jeet Bikram (2005): *Entitlement to Services and Amenities in JJclusters, JJ Relocation Colonies and Other Non-Planned settlements in Delhi: An Overview*, Ensuring Public Accountability through Public Action 2005, Institute Of Social Studies Trust , New Delhi. http://www.isst-india.org/PDF/Entitlement%20to%20Services.pdf accessed on Saturday, May 09, 2009, 9:55:45 PM

(a) Legally Notified Slum Areas

The notified areas are those which have declared/ notified as slum areas under Section-3A of the Slum Areas (Improvement and Clearance) Act 1956. Such slum areas are scattered all over Delhi. An estimated 20 lakh population is believed to be living in the areas which are legally notified as slums.

(b) Resettlement Colonies and Relocated JJ Clusters

Under the schemes for resettlement of JJ clusters 47 resettlement colonies were developed during 1961-77. Around 2.0 lakh plots were developed to accommodate about 2.4 lakh households. These resettlement colonies, however, have degenerated due to intense population pressures and unorganized development and there is urgent need to invest towards up gradation of physical infrastructure here to improve civic life.

The spatial distribution of these colonies indicate that they are located mainly in the south-east, north east, north-west, south-west and central parts of the NCT of Delhi. There are five colonies in South-East, eight in North-East, 15 in North West, seven in South West and 12 in central Delhi. The most recent relocation has been made to three sites like Dwarka (known also as Papan Kalan), Rohini, Narela and Savdar Ghevada. The main pockets from where JJ Clusters have been relocated are Central, South and East Delhi areas.

Thus, during 1999- 2000, 3,741 squatter households from the JJ clusters at CGO complex, Chanakyapuri, Kotla Mubarakpur, Andrews Ganj, Sadiq Nagar, Mahki Sarai, Shahdara were shifted to Narela and Rohini. Allotment of 27.4 acres of land has been made at Molar Bund for shifting of the JJ cluster at Gautam Nagar behind AIIMS. In 1997-98, DDA allocated 32 acres of land in Tehkhand village for relocation of squatter families. However, these relocation / resettlement sites offer no security of tenure to habitants who are expected to begin a new life without security, basic services, schools and other basic amenities. One of the main problems faced in relocation is that the original allottees transfer the plots for payments and squatter elsewhere.

(c) Unauthorised Colonies and Harijan Bastis: The emergence of the unauthorized colonies is the result of shortage of houses and house plots in planned and approved

residential colonies. There are about 1000 unauthorised colonies in Delhi at present. However, there are113 harijan bastis in Delhi i.e. slums meant for the lower-caste people.

(d) Pavement Dwellers: There are those squatters who do not have even a roof over their head and they resort to living on the pavements of Delhi especially at night to sleep. According to the DDA, Slum Wing, about 70,000 population of Delhi live on pavements.

(e) Urban Villages: The urban villages in Delhi have been de-notified vide Notification No. LB 2106/2 dated 28-08-1985. These villages experienced slums like environment due to fast growth of population. At present there are about 135 urban villages in Delhi.

(f) JJ Clusters or Squatter settlements

The squatter settlements are encroachments on mainly public land. As such these are illegal clusters (JJCs) and are devoid of any legal entitlements. The poor rural migrants coming to Delhi generally accept whatever accommodation which can be quickly erected with waste materials or with those which can be procured at low costs on open spaces or unused vacant land. The people inhabiting these areas include domestic help, hawkers, vendors, low paid workers in the industrial, commercial and business sectors etc. However, efforts are made by the government to extend basic social and environmental services to these squatter settlements.

According to a 1983 survey by the City Planning Wing, DDA (Delhi Development Authority), there were 534 JJ Clusters comprising of 1,13,386 households in the NCT (National Capital Territory) of Delhi. With the continuous flow of migrants post-1970, there was a massive increase in JJ Clusters in Delhi. These clusters are scattered all over the city and are situated on vacant lands along railway lines, roads, drains and river embankments and also vacant spaces near residential, industrial and commercial complexes.

Table 2.10 : Location of JJ Clusters in Delhi

Areas with Encroachment	Number of Squatters	%age of Total
Residential Areas	34100	55.86
Road Berms	24184	39.62
Park and Open Spaces	966	1.58
Schools	500	0.82
Market	1093	1.79
Railway station	200	0.33
Total	61043	100.00

Source: NURM

In 1951, Delhi had 12,749 JJs scattered over 199 clusters and had reached 98,483 JJs by 1973 . However, around 2.4 JJs were resettled in different parts of Delhi. due to the resettlement scheme pursued vigorously in 1962-77. In 1977 only 20,000 JJ households remained to be located but this number grew to 1.13 lakhs. However, in 2001 the JJ clusters had further declined due to relocation of around 300 clusters from Gautampuri, Kingsway Camp, Ashok Vihar, AIIMS and Hauz Khas etc.

Table 2.11 : Status of JJ Clusters in Delhi

Year	JJ Clusters	Jhuggi HHs	Area in HA	Population
1951	199	12749	21.1	63745
1973	1373	98483	164.1	492415
1983	534	113000	188.3	565000
1990	929	259000	431.7	1295000
1997	1100	600000	902.1	3000000
2001	728	429662	650.2	2148310

Source: NURM

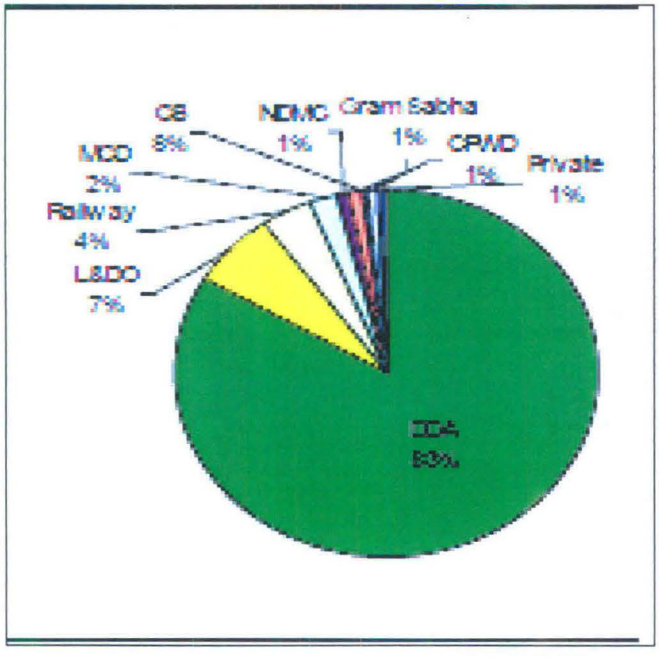
However, there is an argument that most of these tracts of land are intended for residential use in the master Plan and can therefore be 'regularized' by the land owning agencies, if a political and administrative decision is made.

Table 2.12 : The land on which these JJ clusters come up belong to various agencies-

Land Owning Agency	Number of Jhuggies	Population 1994	Areas in Acres
	1994		
DDA	349705	1856683	1865.93
L&DO	29415	132327	149.86
Railway	17346	78929	84.34
MCD	11052	52045	47.29
NDMC	4487	20182	22.52
Gram Sabha	4360	19619	21.31
Cantonment Board	1700	7064	7.86
CPWD	4316	19421	16.84
Private	2885	12980	14.45
Total	425266	2199250	2230.4

Source: NURM

Figure 2.3: The land on which these JJ clusters come up belong to various agencies



Source: NURM

Access to Infrastructure in Slums/JJ Clusters

Water and sanitation facilities in these unorganized colonies, particularly in the JJ clusters, are very poor. Only 21 per cent of colonies are covered with piped water supply and 10 per cent are covered by sanitation.

The following table presents a satisfactory level of infrastructure availability in the unplanned settlements especially in the regularized unauthorized colonies and the resettlement colonies, but these facilities are non- functional in around 75-80 per cent of the clusters. Around 85-90 per cent of JJ clusters did not have even community toilets, with the result that the habitants of the area were forced to defecate in the open near the water bodies or drainage channels.

Table 2.13 : Service Provision in Unplanned Settlement

Service Provision in Unplanned Settlement	Piped Water Supply		Sewer Facility	
	Number	% of Colonies	Number	% of Colonies
Regularised Unauthorised colonies	557	98.2	458	80.7
Resettlement Colonies	44	100.0	44	100.0
JJ Clusters	158	21.7	72	9.8

Source: NURM

Slum Development Polices & Strategies

The government has adopted a three pronged approach towards areas notified as Slums under the Slum areas Act 1956: (i) Clearance/Relocation; (ii) In situ up gradation; and (iii) Environmental Improvement Schemes. Towards the JJ clusters and squatter settlements the main policy has been slum clearance and relocation. However, the programme of squatter clearance was discontinued at the end of the sixth plan (1980-85), to be initiated again in 2005. Further, the general policy adopted by the government has been that removal of past encroachments, which were in existence up to 1990, was to be done only after providing alternatives and that no new encroachments on public land were to be permitted.

For the JJ clusters and Squatter settlements, the strategies adopted by the Government of Delhi include: (i) Relocation of Jhuggie Households; (ii) In-situ Up gradation of JJ Clusters; and (iii) Extension of minimum basic civic amenities for community use under Environment improvement of Urban Poor (EIUS) schemes in JJ clusters.

Apart from these other schemes have also been initiated by the government that seeks to provide better living conditions to people living in the slums. For instance, as per Economic Survey of Delhi (2002), the government made provisions for the following schemes in JJ clusters:

- Construction of Basti Vikas Kendra
- In situ up gradation of JJ clusters
- Environmental Improvement in JJ clusters
- Construction of Pay use Jan Suvidha Complex
- Shishu Vatika/ Common Space in JJ clusters
- National Slum Development Programmes
- Sanitation in JJ clusters
- Urban Basic Services
- Swarn Jayanti Shahri Rojgar Yojna
- Water Supply in JJ Clusters
- Electricity Connection in JJ Households
- Mobile Van Dispensaries in JJ Clusters
- Health Centres in JJ Clusters
- Integrated Child Development Scheme

Health Services

The health system in India consists of the public and private sectors. Majority of the private sector consists of an informal network of providers who operate within an unregulated environment. There are no controls on the services provided, by whom they are provided and the cost. In addition, there are no standards against which the quality of services by this segment of the private sector can be measured.

The per capita expenditure on health is much higher in Delhi as compared to the national level as indicated from the per capita expenditure on health in Delhi which stood at Rs.436.40 and is more than double the per capita expenditure on health at the all-India level (Rs.179.65) in 2001-2002. Compared to state expenditure on health the private household expenditure is nearly four to five times more than that of the state (Duggal and Amin, 1989).[59]

Though the spending on healthcare is 6 percent of gross domestic product (GDP), the state expenditure is only 0.9 percent of total spending. Thus only 17 percent of all health expenditure in the country is borne by the state, and 82 percent comes as 'Out of pocket payment' by the people. A substantial financial burden of households is for meeting health care needs. This gains significance when we realize that nearly half of the country's population does not have enough resources to meet its food requirements.

In Delhi, healthcare facilities are being provided by (a) Hospitals, Govt. Dispensaries, Mobile Health Clinics, primary healthcare centers and subcenters, and paramedics; (b) the private not-for-profit sector, including voluntary health programmes, charitable institutions, missions, churches, and trusts; (c) the organized private for-profit sector, including general practitioners (having at least a bachelor's degree or equivalent in medicine), private hospitals and dispensaries (popularly known as nursing homes), registered medical practitioners, and other licensed practitioners; and, (4) the private informal sector, including unqualified practitioners not having any formal qualifications.

According to the Delhi Medical Council (DMC) there are 31,124 registered Medical Practitioners. The distribution of these practitioners is highly skewed, with areas with slum population having small numbers of qualified practitioners. In effect, people living in the slum areas face a choice between traveling and queuing for hours at public hospitals, or paying prohibitive prices at private clinics for qualified doctors. Most of the time, as a result, the unqualified practitioners who flourish in these slums become the first choice of treatment for these poor people who never choose to visit a government dispensary.

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[59] Ibid: 6

Profile of the Area Selected

1. **Harijan Basti in Masoodpur village**

The Harijan Basti is situated opposite sector B Pocket 8 a middle/upper middle class area in Vasant Kunj in South Delhi.The land known as Harijan Basti was part of the Masoodpur village which was allotted to the Scheduled Castes (SC) under the 20-Point Programme, of the late Prime Minister Indira Gandhi that was initiated in 1974. This was undertaken with the intention to provide succour and relief to the landless and poor belonging to the weaker sections of society. Under this programme, land and residential plots were allotted to the weaker section of the society throughout the country. The residents of Delhi also benefited from this scheme and thousands of people belonging to the weaker sections (SC) were allotted agricultural land and residential plots out of the Gaon Sabha land in various villages of the capital. It was one of the most "revolutionary programmes" executed by the Delhi government. In Masoodpur village only 20 plots were transferred, with the owners having no right to register these plots to others but could transfer the right of attorney to use the land to someone else.

Apart from the authorized land, many unauthorized encroachments have also come up on the DDA land in the area. The unauthorized plots and buildings constructed in the area have been given plot number and house number by the Residents Welfare Association (RWA). Nevertheless, this is more or less an authorized colony, with people having authorized electricity and water facility. People who reside here also have ration card, voter I-D, Pan Card etc. The residents are employed in government service, private service as well as business class. The owners of the buildings are quite well off but those staying in the rented rooms and accommodation are poor and are mostly engaged as workers in farmhouses, security guards or as workers in nearby petrol pumps. Some of the houses have their own boring to extract groundwater which they provide to their tenants. It is common to come across long queue for filling water containers for their daily use. The road inside the Basti is narrow, barely enough for a car to pass and full of potholes. The road has been encroached upon by the residents, some even using it to relax during power cuts, particularly in the evening.

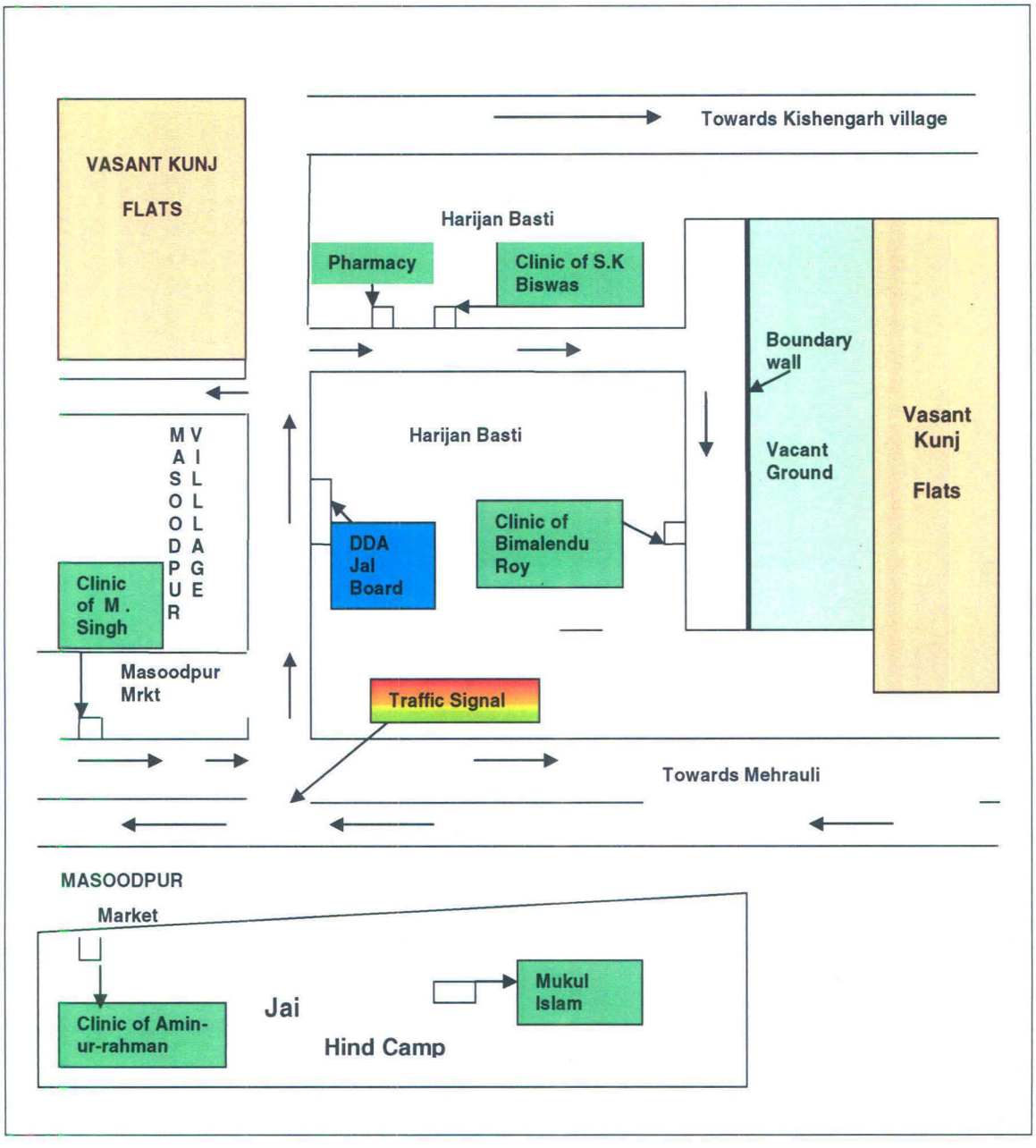
A glimpse inside the buildings facing the street shows cramped rooms, which are poorly lighted. Many of the houses are also used for small businesses by vendors to sell

utilities of daily use, such as vegetables, grocery items and fish or often used as tailoring houses. Behind the Harijan basti there is a boundary wall that seperates it from the main Vasant Kunj colony. Adjacent to the boundary wall is a few yards of vacant land, which is full of garbage and filth. The garbage mound has become so huge that it almost touches the top part of the boundary wall. One can catch glimpses of pigs roaming around and scavenging on the garbage. This is the place were the people of Harijan Basti dispose their garbage. The Basti has 60 houses but the average family size is large so they live in congested condition

Unqualified practitioners in Harijan Basti

Amidst this, there are two unqualified medical practitioners for the residents of the Harijan Basti. Both of them are placed at different locations with one having his clinic at the entrance of the Basti while the other practices at the far end. There is one pharmacy shop in the Basti located at the entrance.

Figure 2.4: Map of the Area Studied



2. Jai Hind Camp

Jai Hind Camp is an unauthorized JJ slum of around 400 Jhuggies on land that belongs to the DDA. However, the previous landowners, who have refused to accept the compensation distributed by the government, continue to collect rent from the "Dadas", in charge of renting out the jhuggis. The "landowners" have gone to court and lost the case, but are not ready to relinquish their rights. These contractors have constructed small rooms built with waste material like plastic sheets, packaging material etc and have rented them out. There are around 15-20 acres of land occupied by these clusters.

The people living here are migrants mainly from West Bengal's Cooch Behar while some also belong to Assam, Bihar and U.P. Around 95 per cent of the people residing here are Bengali Muslims. The officers of the Malaria circle, however, believe that majority of the population residing here are illegal migrants from Bangladesh. They have no proof of their identity. Some of them have procured voter I-card with the help of touts and local politicians, for whom they form a "vote bank" during elections.

The pradhan of the area complain of police harassment and intimidation. "The police keep harassing us as they think that we belong to Bangladesh which is untrue as we belong to Cooch Behar, which is in West Bengal though on the border of Bangladesh. Most of us have voter I-card but the police is not ready to accept this," the pradhan said.

Recent studies on transnational migration bring out the fact that "Established patterns of migration have transformed and intensified more recently. Bangladeshis are moving away from the border into relatively prosperous parts of north and northwestern India. Specifically, a steady stream of migrants are moving into affluent urban areas like New Delhi and Mumbai (formerly Bombay) where there is a constant demand for cheap labour. Here too they occupy the lowest social echelons, joining the vast ranks of the urban poor living in slums and shanties in these cities. Many Bangladeshi women work as maids or domestic servants in middle-class Indian households in these cities, while male migrants seek employment as laborers, rickshaw pullers or rag pickers who salvage re-saleable material out of garbage."[60]

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[60]Ramchandran Sujata (2005): " Indifference, impotence and intolerance: transnational Bangladeshis in India" *Global Migration Perspectives No 42, September 2005,* Global Commission on International

The people residing in Jai Hind Camp are mainly working as maids in the nearby flats of Vasant Kunj while the men are engaged in collecting garbage and work as hawkers. Since the Camp is an unauthorized slum, the people inhabiting this cluster have no access to piped water, sewerage, sanitation and electricity. People pay a fixed monthly amount for water that is made available to them by the contractors. DDA water tankers are pressed into service in different locations, with only a section of the population benefiting everyday. The slum dwellers have no facility of community toilet and hence defecate in the open.

In effect, the whole area gives the impression of being situated on garbage with mounds of garbage being dumped after being collected from nearby areas to be physically filtered. They engage children in this work, convenient as a form of cheap labour. Handling of garbage everyday exposes the men and children to a host of oro-fecal infections, with most suffering from some or the other skin diseases. Moreover, staying amidst so much filth often expose the people to chemical toxins and make them prone to injuries from broken glasses, scrap and rusted iron pieces etc. Almost 70 per cent of the minors are engaged in child labour. The population here has no access to electricity, forcing them to access power through illegal means. The tenants, however, pay twenty five rupees per household for the illegal electricity connection to the contractors, who use it to pay the local police, MCD and DDA officials.

Most of the families who stay here are known to each other as they originally belong to the same place (Cooch Behar in West Bengal). Almost every household has three to four children and in most cases they are staying in the ancestral villages with their grand parents, uncles and aunt. According to the residents, it is difficult for them to look after their children, especially grown up girls. As a result these girls are sent home where they are looked after by their families and also get some education. The lack of educational facility here is cited as a reason for sending the children to their villages.

The only school in this area is run by the local Masjid from a single room. The dwellers feel that the schools back in their ancestral villages are better and more affordable since they are run by the government. Moreover, since both husband and wife

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Migration, pg 7, http://www.gcim.org/attachements/GMP%20No%2042.pdf, Wednesday, May 06, 2009, 9:53:38 AM

are engaged in work for most part of the day, they have little time to take care of their children. Mamta, a resident working in the nearby flats, argues against keeping her children with the family here. "If we enroll our children in nearby school than who will take them for classes and who will bring them back from school as both I and my husband are busy in our work. My son keeps playing around, with no one to look after him as I have already sent my daughters, three of them, to their grand parents in the village to study. Now, I will send my five-year-old son to my village since he should go to school. Hence, I will send him to my ancestral village," she reasoned.

The slum is also on the Delhi Health Services (DHS) list of Mobile Health Clinics. The area is covered by 'Mobile Health Scheme 5', with mobile health clinic scheduled to visit the Camp every Wednesday and Saturday. However, the people complained that Mobile Health Clinics were not available at most times, with regular visits only during times of government-sponsored programmes for pulse polio drops. Two Auxiliary Nurse Midwife (ANM) of the Indian Population Project center at Rangpuri Pahari, another close by cluster camp, also visit the area.

However, unqualified medical practitioners[61] cater to the bulk of the health needs of the community in the Camp. There are a total of six unqualified practitioners here, each one of them conveniently located in the front, middle and at the back of the slum so as to cover the entire population in the Camp, indicating the heavy dependence of the community on these practitioners.

Unqualified Medical Practitioners

There are three unqualified medical practitioner in the Harijan Basti, though only two of them practice in the area while one caters to the need of the slum dwellers in Jai Hind Camp, a Jhuggi Jhopri cluster situated around a kilometer away from the Harijan Basti. Jai Hind Camp has six unqualified medical practitioners operating in the cluster. Five of the practitioners stay in the area while one has his clinic in the area but resides in Harijan Basti.

[61] The unqualified medical practitioners have no professional qualification and no license to practice in Delhi. Quack is a derogatory term often used for them.

Between Harijan Basti and the Jai Hind Camp is situated Masoodpur Market, which has a number of clinics of both qualified as well as unqualified medical practitioners. A well-known unqualified practitioner of the area has a clinic based in the Masoodpur Market, which caters to the need of the people living in Vasant Kunj. He has been included in the study in a bid to bring in the plurality of practice of unqualified medical practitioners.

Characteristics of Unqualified Medical Practitioners in Harijan Basti:

In this section we examine the social background, training and affiliation, system of medicine practiced and motivational factors of these practitioners.

S. K Biswas and Bimalendu Roy, the two unqualified practitioners, are based in the Harijan Basti. The clinic of Biswas is situated at the entrance of the Basti, with a pharmacy shop adjacent to it. B. Roy has his clinic at the far end of the slum. Amin-ur Rahman, another unqualified practitioner, who previously had his clinic in the area, has now shifted to the neighbouring Jai Hind Camp due to escalating rent cost.

"The rent has gone up in the area. I have been practicing for the past five years in this area but the landlord has raised the rent to Rs 5,000 so I had to find an alternative as I could not afford such an expensive place. The room is very small, with insufficient place for a clinic. Hence, I have shifted to the neighbouring Jai Hind Camp," A. Rahman said.

S. K Biswas

A newcomer to Harijan Basti, one can easily pass by without noticing the clinic of S. K Biswas. It is difficult to identify the clinic of Biswas as it is has no signboards or name plate. Located at the entrance of the Basti, the clinic is adjacent to a pharmacy shop. Only on careful observation, one can see the green coloured curtains hanging from the door to indicate the presence of a clinic, with bottles of medicine syrups displayed on racks inside the room.

From the outside, one can get glimpses of Biswas sitting on a chair, either reading a newspaper or watching the 16 inch black and white television, which is fixed inside the wall. The room is quite spacious, about 20x20 sq ft, with a bench kept on one side for

patients. At one end of the room is a small area which is covered by a green curtain meant for examination of the patient.

Biswas is frequently found sitting with his wife. In his absence, Mrs Biswas occupies the chair of her husband. Inside the clinic, there are three telephone sets at one end of table. Another room at the backside of the clinic is used by Biswas' family as their residence, where his wife and two sons stay with him. Though he was not ready to reveal the rent for the clinic, my enquiry suggested that "the big clinic" with "good location" must be costing the doctor not less than Rs 3,000. The area around the clinic is unexpectedly less noisy, with the clinic in a better condition than those of other practitioners. Though the ventilation is insufficient, with no windows in the room, the walls and ceilings are in good condition, painted in white. The floor is cemented and polished, and kept clean. The room has adequate lighting arrangements.

39-year-old Biswas is a Hindu Bengali, who belongs to the Schedule Caste. He is a native of West Bengal, with education till 10+2 (Table 8). However, a careful observation of his grammar and his handwriting reveals that difficult to believe his educational background. Biswas, who also claimed to have been registered in West Bengal, began his practice in 1996 in Gorakhpur, where he was staying with his sister's family. He shifted his base to the capital, where he arrived after practicing for 2 years from 1996-1998 in the eastern town of Uttar Pradesh. Since the last decade, Biswas has been practicing in Delhi after settling down in his profession in the Harijan Basti.

According to Biswas, his clinic at D -16/2 in Harijan Basti was open from to patients from 8:00 am to 1:00 pm and from 5:00 pm to 9:30 pm. However, during the period of my observation, I found the clinic mostly closed, particularly in the morning. At times when I found it open, it was Mrs Biswas who was in the practitioner's chair and was watching T.V. Though the clinic wears a very deserted look, it was kept clean, with a bucket of water in the corner used for washing hands by the practitioner while examining patients.

Biswas has a rural background, with his father coming from the farming community. He was introduced into the profession while working for 2 years under MBBS doctor R.K Sarkar, who was associated with Kalayl hospital in Calcutta. Dr Sarkar was from the same area as Biswas and shared the common schedule caste

background. According to Biswas, his brother-in-law who had a clinic in Gorakhpur influenced him to shift to the eastern city of Uttar Pradish as it would be more lucrative than in Kolkata.

Biswas was, however, vague about his reason for shifting from Gorakhpur to Delhi. He justified it on professional grounds, arguing that: "In Gorakhpur the earning was not enough to run the family. Some of my relatives, who stay in the capital, encouraged me to move to Delhi"[62].

He claimed that he used to specialise for the treatment of Piles, STD and similar diseases, but has now stopped treating such patients as it is too risky. "I don't even have a proper clinic to keep the patients after surgery and that for such diseases you need a proper nursing home, which can cater to emergencies. I don't want to take the risk of keeping patients at my home. I have had very bad experience in the past so now I have stopped this," he argued.

Often, I found that he went into complete silence while explaining about his past, as if trying to make an extra effort not to reveal his background. One can only guess that perhaps it may be one of the reasons why he shifted his base from Gorakhpur to Delhi. The clinic has both types of medicines, Ayurvedic syrups as well as Allopathy medicines, which are displayed in the cupboards. However, Biswas mainly practices the Allopathic system of medicine. He reasons that "this is what people demand here". He only gives Ayurvedic medicines "while prescribing tonics",

Biswas took up the practice because of the initial opportunity to work under the Qualified Medical Practitioner and the ease with which he learnt the skill. The only other alternative he had was to take up farming. He had concluded that life was more difficult in the villages, and with his elder brothers already involved in agriculture on the ancestral land, he had little options but seek another profession elsewhere. "I am happy with my decision as I am able to live a decent life with my family and is in a position to educate my sons in proper school and also sends them for tuition classes" he underline, though agreeing that "life in a metropolitan town like Delhi is tough"

Biswas, however, was disappointed by the declining growth in the profession as people are increasingly approaching qualified doctor in hospitals and private clinics in the

[62] Interview conducted on 21st January 2009 at 10:00 a.m

market than coming to them for treatment. Biswas said he was forced to supplement his earning, for example with running a phone booth. "Ab Is kaam mein zyada faida nahi raha isliye maine Idea ke telephone connection liye hain jise mein thode bahut paise kama leta hoon. Yahan ka kiraya bhi bahut zyada ho gaya hai to koi khaas phaida nazar nahin ata hai ab is kaam mein", he said. (There is not much profit in this work so I have procured Idea phone connections and earn some money from this. The rent of the room has gone up so it is difficult to survive only on this profession).

However, it was difficult to comprehend his professional worry since most of the time he was found absent. His wife, who was found present in the clinic most of the time, justified his absence as "he was busy in some other personal work". It was revealed to me from other practitioners of the area that Biswas' main profession was money lending and that the clinic was only a side profession, mainly to attract clients. He was also considered to have little education by other practitioners of the area.

Bimalendu Roy

Bimalendu Roy is another unqualified medical practitioner in Harijan Basti, with his clinic located at the far end of the cluster. Roy's clinic has no signboard or name plate (Table 9.2) making it difficult to locate it. I had to enquire from the people to locate Roy's one-room clinic, which was much smaller than that of Biswas (about 10x 20 sq ft). The entrance to the clinic was very small; the room was in a very dilapidated condition, with cemented floors and cracked walls that are chipped at several places. The clinic has a very shabby look with a large worn out wooden table and chair in the centre which fills up the whole room with barely enough space to move around. On the left side of the table is a wide wooden stool used for examining patients.

Obviously, there is no privacy for patients, who are examined in the presence of other people, relatives and acquaintances of the Roy. Behind the chair of Roy, there is a wooden cupboard with Ayurvedic syrups, allopathic medicines and IV fluid bottles displayed. The clinic has a phone set with a call meter near the entrance, indicating it be a part of a side business of Roy. The clinic has an opening into another room, which is used by Roy as his residence where he lives with his family.(A map of the layout??)

One can get a glimpse of his house especially if the curtain on the door to his living room is not properly drawn.

44-year-old Roy has a very pleasing personality and seems to be very popular in the area. He seemed confident about his practice and did not make an effort to hide the fact that he was an unqualified practitioner and introduced himself as a "quack" (a derogatory term generally used for "fraudulent or ignorant pretender to medical skill"). He is a native of West Bengal and a Hindu belonging to the Schedule Caste.

Roy, who claimed to be registered in West Bengal, has been practicing in Harijan Basti since 2002. Before shifting to Delhi, he was involved in assisting his father, an unqualified practitioner in his native village Cooch Behar in West Bengal. He made the decision to move to the national capital as the family business (clinic) in the village was inherited by his elder brother. "My father was a very popular practitioner of the area and now with my elder brother having taken over the family clinic, people would approach my elder brother first because of the level of confidence built by my father over the years. It would take me years to build that same level of trust among the people of the area, hence, I shifted out," Roy said. Roy, who has a 10+2 certificate (Table 8), moved to the national capital along with some acquaintance who live in South Delhi.

On his decision to opt for this trade, he said: "This was the vocation I had been trained in by my father, an unqualified practitioner himself." "I could not think of anything else to do and hence decided to remain in the same profession," he argued. A garlanded photograph of his father has a pride of place in the clinic as a mark of respect.

The clinic timings of Roy are from 8:00 am to 1:00 pm and 5:30 pm to 9:30 pm. Roy, however, is mainly present in his clinic in the evening. The clinic attached to his residence is an advantage for Roy as can attend to his patient even at untimely hours. In the evening, Roy has good number of patients as most of the poor in the slums find it convenient to go to the clinic after returning back from work.

Apart from patients, number of people hover around the clinic to make phone calls, particularly to their native villages, and even seek his assistance for filling up documents, forms and applications. It is an indication of Roy's multiple utility for the people in the neighbourhood, where people consider him "helpful". On observation, it is clear that he is popular in the area and has the maximum number of patients coming to

his clinic. It is also obvious that the "medical profession" is the main source of his livelihood.

Roy mainly practices Allopathic form of medicine, but also gives Ayurvedic medicines as tonics. According Roy, most of his patients are casual labourers or part-time workers, who are seeking "quick relief" so as to return back to work soon. Hence, he uses allopathic form of treatment.

He is not very optimistic about his trade in Delhi and "the practice has stagnated" as people prefer going to qualified doctors in the main market. Even the slum dwellers feel that the unqualified practitioners "are not good enough" as they lack medical knowledge.

In the early stages of my observation, Roy accepted that he was an unqualified practitioner and introduced himself as a "Quack", but was very cautious in revealing his treatment procedures. He said he "only provides first aid" to his patients. However, as Roy's comfort level grew, he disclosed that he could not ignore patients with different ailments like viral, stomach ache, diarrhea etc as they would then go to other unqualified practitioner for treatment which will lead to shrinking of his "customer base".

He pointed to the "sky rocketing" rent of Rs 4,500 for the clinic and his residence. He is forced to accept the landlord's discretionary hikes as moving to new area would consume valuable time, energy and resources in establishing himself. To meet his growing expense, Roy said he was running "the STD phone booth as a side business".

Characteristics of Unqualified Medical Practitioners in Jai Hind Basti

Jai Hind Camp is an unauthorized JJ slum of around 400 Jhuggies on land that belongs to the DDA. It has six unqualified practitioners, located in different parts of the cluster, mainly occupied by people who are the natives of West Bengal's Cooch Behar.

40-year-old Aitwar Hussein, who claimed to be educated up to higher secondary, was initially brought into the profession after receiving training from his father based in Cooch Behar. Hussein, a Bengali Muslim unqualified practitioner, shifted to the Jai Hind Camp after a short apprenticeship with Subhash Rai based in the JJ cluster near Vasant Kunj. Hussein said Rai handed over his Jhuggi used as his clinic after he returned to his native village due to personal reasons,

Hussein's primary mode of occupation is working in a gas repair shop, but was available at his home-cum-clinic from 6 pm to 9pm. He claimed to have around 40 permanent patients, mostly those originating from his native village.

Accordingly, his clinic has a deserted look, with just few bottles of medicine displayed and a few strips of medicine in the cupboard behind his seat. During my initial observations during the first week, I only saw a minor girl coming to his clinic to buy some medicines.

Similar was the case of Jalal Mandal, Jamal Mia and Amir Hossain, all unqualified practitioner who were also natives of of Cooch Behar in West Bengal. Hossain claimed to have studied upto the secondary level, while Mandal and Mia said they had passed class 10. They were Bengali Muslims from the Schedule Caste community.

27-year-old Hossain, Mandal, 29, Mia, 32, had side businesses, including vegetable shop and phone booths, apart from their medical practice. Except for Mandal, who had trained under a qualified practitioner, the other two had had only worked with unqualified practitioner in their village. Now all of them practiced Allopathy system of medicine.

Though their clinic size varied from 10x10 to 10x15 sq ft in size, it gave the same appearance, with walls and ceiling made of waste material. Mia had placed a bed in the clinic, which was used by him for sleeping at night. The three clinics had some arrangement for patient waiting area, but had no privacy for examination of patients.

None of them had their family staying with them in Delhi and had left them in their native village.

After a week-long observation of their clinics and interaction with their patients, it was reveled that the most frequented practitioners of the area were Amin-ur-Rahman and Mukul Islam.

Amin-Ur-Rahman

Amin-Ur-Rahman, who has his clinic at the one end of the Jai Hind Camp, was among the most educated unqualified practitioners in the area. He claims to have finished his graduation in Political Science, Bengali and History. He also claimed to be registered in West Bengal to practice though he had no proofs to show for it.

He considered himself to be well-equipped to treat his patients as he "was better educated than the other unqualified practitioners operating in the area". He claimed to have received training for 3 years under "a well-known qualified medical practitioner Dr. Mohammad Fazala Haq" in West Bengal's Dinhata district. Dr. Mohammad Fazala Haq also was the health minister of the state in 1972 and belonged to the same caste as Rahman.

39-year-old Rahman, a Bengali Muslim from the Schedule Caste community, looks much older that his age due to his obese frame. After three years of apprenship under Dr. Haq, Rahman returned to his native village in Cooch Behar and began his practice in 1998.

He shifted to Delhi following 5 years of practice to explore new possibilities after many of his acquaintance shifted to the national capital, where he set up his practice in Harijan Basti in 2003. In March 2009, he shifted his clinic to the neighbouring Jai Hind Camp as he "could not meet the ever rising rent demand of his landlord". Rahman was unable to find "an appropriate house", which "was big enough" when his landlord hiked the rent of his room, which he used as clinic-cum-residence, from 4,000 pm to Rs 6000 per month.

It forced him to stay in a room, which was just small enough to cater to his family's need for shelter. Thereafter, he decided to set up his practice in Jai Hind Camp where some of his relatives and number of people from his native village stayed. Rahman said he had been invited by his acquaintances staying at the Camp to come and practice in the JJ cluster.

Rahman's clinic, which is based in a temporary hut made of waste material with 10 x 12 sq ft in size, is open from 9:30 am to 12:30 pm and 5:00 pm to 9:00 pm at Jai Hind Camp.

Based in the far end of the Camp the area around the clinic is unhygienic. There is a huge garbage mound just about 10 yards from his clinic. Though the children of the cluster are found playing on the garbage dump, it is full of dangerous items like broken bottles, scrap material and metal items here and there.

The clinic is poorly lit. Light from the three electric bulbs in the clinic was very dim due to high fluctuation in voltage. Most of the electric connection in the area was illegal, with wires directly attached to the electric poles.

Even when patients were being attended, the clinic was in an unhygienic condition, with houseflies and mosquitoes swarming inside the hut. During one of my observations, Rahman was so embarrassed due to the poor hygienic condition that he sent me outside to interview the patients while he burnt some incense to drive away flies from the clinic. Rats were swarming around, often entering the open cartons containing medicines.

The clinic had temporary shelves displayed with syrups, Ayurvedic tonics and IV fluid bottles. It also had five cartons with allopathic medicine strips. Though there were two chairs and a bench, which were used by the practitioner and the patients, there was lack of privacy during the examination of the patients.

Among the unqualified practitioners of the area, Rahman appeared to be quite serious about his profession. It was apparent from his regular presence during clinic hours and from his effort to stockpile allopathic medicines in his clinic. Moreover, he did not have any explicit side businesses like the other practitioners and had only an extra mobile phone which residents of the area used to make STD calls. Occasionally, he also went on call to households in the cluster as and when required. At their residence in the Harijan Basti, his wife often attended to patients and took instructions from him on phone when he was not present.

Though Rahman set up his clinic in Jai Hind Camp only in March 2009, he seemed to be doing quite well. Apart from the residents of the JJ cluster, labourers who were employed in the shops of Masoodpur market and in the nearby Malls also visited him for treatment even though they did not reside in the area.

Rahman was hopeful that his practice here would soon be well established as the poor people of the area, who could not afford the expensive treatment in private nursing homes or far-off government hospitals, required a medical practitioner like him to look after their needs.

Mukul Islam

Unqualified practitioner Mukul Islam has been staying and practicing in the Jai Hind Camp for the past five years. 28-year-old Islam, a Bengali Muslim of the Schedule Caste community, is a native of Cooch Behar in West Bengal.

Islam, who claimed to be educated up to the higher secondary level (10+2), said he had been trained while doing apprenticeship for one-and-a-half-years with a qualified medical practitioner Dr. Robin in his native village. He shifted to New Delhi with his friends and relatives from Cooch Behar, who were based in the camp and elsewhere in the national capital in search of better livelihood.

His clinic, a small jhuggi of around 10 x 15 sq ft in size, is located in a very congested lane in the heart of the Jai Hind Camp. It is adjacent to a huge open space used by the people in the JJ cluster for public meetings or whiling away the time in the evenings. Often, it is used by Muslim clerics for religious preaching organized by the local mosque in the Jai Hind Camp. As such, the noise level here is very high.

There are three clinics separated by a small distance of few yards that belong to Islam and two other unqualified practitioners, Jamal Mia and Jalal Mandal. The clinic of Islam is slightly bigger than the other two for which he pays a monthly rent of Rs 1,200. The jhuggi, which is constructed from waste materials like plastic sheets and packaging material, has a slightly lower ceiling that would make it difficult for even a person with average height to stand fully erect with his hands above. However, it had adequate ventilation as the jhuggi was fully open from the front.

The jhuggi had one chair, table and a bench for patients to sit. A jug full of water was kept in one corner. On one side of the clinic was a bed, which was often used by Islam for examining patients or to relax while waiting for patients. It had an old steel cupboard and a shelf, which displayed Ayurvedic syrups, tonics, IV fluid bottles etc. The table behind which Islam sat had a drawer full of strips of medicines.

Islam like other practitioners in the area practices Allopathic system of medicine as he told me that "he has been trained in this skill and knows no other way of treatment". Islam, who also works as a driver of retired army officer in the near by Vasant Kunj's sector D-6, told me that the timing of his clinic was from 7:00 am to 10:00 pm and 4:00 pm to 10 pm. However, during my observation period I noticed that Islam left the clinic

by 9:30 am so that he was on time for duty and often came late from work at least not before six.

Islam is unsure whether the clinic will provide him with enough money for his survival in times of declining profit. He said the patients in the camp are now going to private nursing homes in the main market, hitting at his profit.

He said "Yahain pe log pehle hamare paas hi atey thei par ab pehle jitna phayda nahin hai. Ab log bade doctor ke paas bhi jatey hain". (When I came here in the beginning people residing here used to come to us but now they often go to big doctors),

"Aura ab meri shaadi ho gayi hai to jyada paison ki jaroorat hai. Main apni biwi ko padha rahaa hoon. Voh mujse bhi jyada padhi hai aur ab Calcutta University se correspondence se MCA kar rahi hai. Isiliya ab mein naukri bhi karta hoon," Islam underlined. (Now since I have also got married my expenses have increased. I am also providing for my wife's education. She is more educated than me and is doing her MCA through correspondence from Calcutta University. Hence now I am also working as a driver).

Islam lives in another jhuggi nearby with his family that makes it convenient for his wife to look after the clinic in his absence. Often, it is Islam's wife who is found in the clinic in the evening in his absence, particularly when he is expected to arrive late from work. She does not examine patients, but gives painkillers and standard medicines to check fever etc. During my observation period, most of the patients arrived after 7:30 pm, well aware that Islam would not be present earlier than that.

During my interview with the patients, it came out that Islam was well trusted in the locality and is considered to be good in his profession. The people, who are linked to his native village, felt that Islam was well trained under Dr Robin, a well-known doctor in native village Cooch Behar.

Mahendra Singh

Mahendra Singh has a clinic in Masoodpur market near the Vasant Kunj DDA flats about one kilometre from Harijan Basti and Jai Hind Camp. Located in a prime location in the heart of the market, this unqualified practitioner has a wide customer base, which ranges from labourers, maids, IVth grade employees to even residents living in

Vasant Kunj. A former resident of nearby Mahipalpur village, Singh's patients are mainly from the Jai Hind Camp, Harijan Basti, Mahipalpur, Masoodpur, Kishangarh villages, Masoodpur dairy farm and residents of Vasant Kunj.

It is reflected in the upkeep of his clinic. 46-year-old Singh, who is a native of Haryana belonging to the prosperous high caste Jat community, was the only unqualified practitioner in the area who has signboard outside his clinic, with his name and his various degrees and qualification prominently mentioned.

Singh's 10x10 sq ft size clinic costs him a monthly rent of Rs 3,000. The ventilation is poor, with the main entrance as the only means for fresh air and natural light. It has a small area separated by a glass door where patients wait for consultation. There was a small table and a chair for the doctor to sit and two chairs for patients during consultation. Behind Singh's chair, there is a narrow bench with cushions for patients to lie down and be examined. Clearly, there is no privacy for the patients.

Wooden shelves on the wall are displayed with Ayurvedic and Allopathic medicines. There is availability of drinking water for the waiting patients and attendants. Compared to other unqualified practitioners of the area, Singh's clinic exhibited both better cleanliness and greater stock of medicines. He also maintained a register with records of patients and drugs prescribed and sold.

Though Singh claimed to be an "Ayurvedic doctor" there were no certificates displayed in the clinic. Singh said he began his training in Ayurvedic system of medicine but could not continue as he was expelled from his college on allegations of "cheating". Singh claimed that he not only completed his course later from U.P, but also got himself registered in the state. However, he did not show any documentary proof for it.

Singh, who has been in practice in Delhi since 1985, began with Ayurvedic system of treatment but gradually shifted to Allopathic. He said the shift to Allopathic treatment was mainly because most of the patients showed leanings towards it as they sought immediate relief, particularly those from the working class and the labourers.
He also said "business considerations" were involved in the "cross practice".

Though he was practicing from the same clinic for over 10 years, there was little profit while he strictly practiced Ayurvedic form of treatment. Singh said that even today

he practiced both Ayurvedic and Allopathic system "as and when needed and demanded by the patients".

Singh said he had no formal training in Allopathic treatment. He learnt the treatments from "studying medical journals" and from observing qualified practitioners in the vicinity of his clinic about "the latest forms of treatment". He also "adequately equipped" himself about different forms of medicines by interacting and learning from the neighbouring pharmacists.

Singh's clinic is open from 9:00 am to 9:00 pm, making "his service available throughout the day". Often, Singh's wife sits in the clinic when he is away "for some urgent work". However, she does not examine patients or sell medicines. She is mainly present to ensure that patients "do not turn away" by giving them information about the "doctor's whereabouts"

Singh takes his work seriously as it is the main source of income. An ardent follower of Baba Ramdev, he has been closely associated with Patanjali, the ashram from where the Yoga guru runs his various programmes. Baba Ramdev, who has a massive worldwide enterprise of well-known alternative system of medicine, has already caught the imagination of the public. Singh's clinic has become a centre for the distribution of medicines prescribed by Baba Ramdev, another source of profit for the unqualified practitioner.

Clearly, the clinic in the heart of the market has brought him prosperity. He has shifted his residence from the Mahipalpur village to the nearby Mahipalpur highway. His children are well educated, studying in IT and other science courses. Singh is hopeful that his children would soon be launched on lucrative careers.

The above descriptive analysis has been presented in tabular form below:

Table 2.14 : Social Characteristics of Unqualified Practitioners

Name of Practitioner	Age	Qualification	Caste	Religion	Family Background	Native of
S. K Biswas	39	10+2	SC	Hindu Bengali	Agriculture Base	Cooch Behar, West Bengal
Bimalendu Roy	44	10+2	SC	Hindu Bengali	Father was an unqualified practitioner	Cooch Behar, West Bengal
Amin- Ur-Rahman	38	B.A	SC	Muslim Bengali	Agriculture Base	Cooch Behar, West Bengal
Mukul Islam	28	10+2	SC	Muslim Bengali	Agriculture Base	Cooch Behar, West Bengal
Mahendra Singh	46	B.A	High Caste	Hindu	Agriculture Base	Haryana

Note: Questions have been raised about the authenticity of the place of migration of the practitioners especially those linked with Cooch Behar.

From the above data it is clear that majority of the practitioners were above 38 years old. Only one out of the total practitioners included in the study was from the high caste while the rest belonged to the schedule caste. Three of the practitioners were educated up to 10+2 while the rest were graduates. Only one of the practitioners had chosen the profession of his father while the rest all had agricultural base and had shifted to this profession. Most of the unqualified practitioners in the area were from Cooch Behar from West Bengal. However, it is suspected that the people residing in the Jai Hind Camp who claim to have come from Cooch Behar are actually migrants from Bangladesh who fake to be Indians.

Table 2.15 : Training and affiliation and practice details

Name of 5P5ractitioner	Apprenticeship under	Years of Training	Years of Practice	Number of places practiced
S. K Biswas	Qualified Medical Practitioner	2 years	12 years	2 - in Gorakhpur and Delhi in Harijan Basti
Bimalendu Roy	Hereditary	-----	6 years	1 - in Delhi in Harijan Basti
Amin- Ur-Rahman	Qualified Medical Practitioner	3 years	10 years	2 - In Delhi in Harijan Basti and Jai Hind Camp
Mukul Islam	Unqualified Medical Practitioner	11/2 years	5 years	1 - in Delhi in Jai Hind Camp
Mahendra Singh	None	-----	23 years	1 - in Delhi in Masoodpur Market.

Two of the practitioners got trained under a Qualified Medical practitioner while the other two got trained under unqualified practitioners like themselves. It is interesting to note that one of the practitioner who had the maximum years of practice and who is also the most frequented unqualified practitioner claims that he did not get training from any other practitioner but learnt the art while studying in an Ayurvedic College from where he got rusticated for using illegal means in exam. This is also the practitioner who has his clinic in the Market and has a wider consumer base.

Table 2.16 : Ownership of the Clinic and system of medicine practiced

Name of Practitioner	Ownership of the clinic	System of medicine practiced	
		Primary	Secondary
S. K Biswas	Rented	Allopathic	Ayurvedic
Bimalendu Roy	Rented	Allopathic	Ayurvedic
Amin- Ur- Rahman	Rented	Allopathic	Ayurvedic
Mukul Islam	Rented	Allopathic	Ayurvedic
Mahendra Singh	Rented	Allopathic	Ayurvedic

All of the practitioners ran their clinic from rented place. The practitioners did cross practice with Allopathy being the primary system of medicine practiced. They also prescribed Ayurvedic medicines.

Table 2.17 : Condition of the Clinic

Location of the clinic (clean place)	S. K Biswas	Bimalendu Roy	Amin- Ur-Rahman	Mukul Islam	Mahendra Singh
Signboard (present)	Not present	Not present	Not present	Not present	present
Noise Level (quietness)	less	less	more	More	more
Condition of wall (good)	good	bad	Made of waste material	Made of waste material	good
Height of Ceiling (above 8 ft.)	Above 8 ft	Above 8 ft	Very low ceiling	Very low ceiling	Above 8 ft
Ceiling Type (cemented)	Cemented	Cemented	Made of waste material	Made of waste material	cemented

Location of the clinic (clean place)	**S. K Biswas**	**Bimalendu Roy**	**Amin- Ur-Rahman**	**Mukul Islam**	**Mahendra Singh**
Condition of Ceiling (good/clean)	Good and clean	Not good	Very shabby	Very shabby	Good and clean
Condition of Floor (good/clean)	Moderately clean and good	Not good and also not very clean	Floor made of mud	Floor made of mud	Moderately clean and good
Natural Light (sufficient)	Not sufficient	Not sufficient	sufficient	Sufficient	Not sufficient
Artificial Lighting (sufficient)	sufficient	sufficient	Sufficient but available through illegal means	Sufficient but available through illegal means	sufficient
Ventilation (adequate)	Not adequate	Not adequate	Not adequate	Not adequate	Not adequate
Seating for Patients (available)	available	available	available	Available	available
Water Availability (present)	Present but how clean questionable	present but how clean questionable	present but how clean questionable	present but how clean questionable	present
Record of Patients (kept	Not kept	Not kept	Kept	Not kept	Kept
Environment (uncongested)	Congested	Congested	Congested	Congested	Congested

Location of the clinic (clean place)	**S. K Biswas**	**Bimalendu Roy**	**Amin- Ur-Rahman**	**Mukul Islam**	**Mahendra Singh**
Dustbin (present)	present	present	present	Present	present
Examination Table/ area (present)	present	present	Not present	Not present	present
Privacy (available)	available	Not available	Not available	Not available	Not available
Dispenses medicine (present)	present	present	present	Present	present

The unqualified medical practitioners in Jai Hind Camp had a very poor environmental condition in which they were practicing with their clinic situated on garbage dumps. The clinic was constructed of plastic sheets and packaging material. The condition of the clinic of two practitioners one in Harijan Basti and the other in Masoodpur market was in good condition compared to others. Another clinic in Harijan Basti though had cemented wall and floor but was in quite a dilapidated condition. There was hardly any ventilation, in any of the clinics. There was no privacy for examining patients in any of the clinic except one. Level of hygiene and cleanliness was good in only two of the clinics. Further except two of the practitioners none kept a record of patients and medicines prescribed.

Table 2.18 : Motivational factors for adopting this profession

Name of Practitioner	Motivation factors in order of rank		
S. K Biswas	Influenced by a relative	Better career option	No other option
Bimalendu Roy	Hereditary	Social Recognition	Social service
Amin- Ur- Rahman	Better career option	Personal Interest	No other option
Mukul Islam	Personal Interest	Better career option	No other option
Mahendra Singh	Better career option	Personal Interest	No other option

Only one of the practitioners had taken up this profession from his father while the rest had come to this in the hope of better option and personal interest. Only one had been influenced by a relative to take up this profession.

CHAPTER III

UNQUALIFIED MEDICAL PRACTITIONERS : CHARACTERISTICS AND PRACTICES

The predominant providers of healthcare in urban slums are the unqualified private practitioners who have no formal training in either allopathy or non allopathic systems of medicine. They are sought after mainly by those who cannot afford to go to a qualified doctor mostly for a variety of common medical conditions. However, the medical services provided by these practitioners, who largely practice in a discipline in which they have little or no training can prove to be highly damaging. For example, indiscriminate and injudicious use of antibiotics in the 'cocktail' treatment provided by these unqualified medical practitioners has been viewed to give rise to multi drug resistance. Taru study as well other studies have shown that the irrational drug prescription can have harmful affects. "Amidopyrine, dipyrone, phenylbutazone and oxyphenbutazone can all poison the bone marrow and are now virtually unobtainable in many countries in the West. One or more of these drugs was given to over half the patients requesting a painkiller from a general practitioner or a pharmacist, although for most types of pain none of the drugs are superior to aspirin or paracetamol"[63].

The Delhi Medical Association (DMA) has been pushing vehemently for the passing of the anti-Quackery bill which it feels would give more teeth to agencies trying to penalise those practicing without proper qualification and registration. RMP[64] associations, which are considered by many "to be much stronger than even the DMA due to its large numbers", were lobbying against the legislation.

However, since these practitioners are the first point of contact for people residing in the slums seeking treatment for their health needs, it would be sensible to accept that they are providing an important service. Hence, it is important to understand the method in which these practitioners conduct their practices and the nature of services provided by them so as to be able to understand and plan how best to use their services and also identify methods and areas where they need to be regulated.

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[63] Greenhalg Trisha (1986) : "Three times daily-habits in India? *New Internationalist issue 165, Nov 1986* . file:///C:/Documents%20and%20Settings/Admin/My%20Documents/A%20PILL%20FOR%20EVERY%20ILL%20Cashing%20in%20on%20World%20Health%20-%20NI%20165%20-%20Three%20times%20daily%20presciption%20habits%20in%20India.htm accessed on May 10, 2009, 11:07:02 PM

[64] ibid: 44

Average Income of the Practitioners

Medical practice is the primary source of livelihood for almost all the unqualified practitioners, though most of them also have other sources of income. The areas where they practice, especially catchments of practice, determine the income of the practitioner. Among the unqualified practitioners, the one based in Masoodpur market had a wider catchment area as it was more centrally located and could be accessed by inhabitants of Harijan Basti, Jai Hind Camp, Kishangarh Village, Masoodpur Village, Vasant Kunj residents and workers of Masoodpur market. A glance at the monthly earnings of the practitioners in the study makes it clear that those based in Masoodpur Market had more income than others.

Table 3.1: Monthly Income (also includes expenditure on medicines, rent etc)

Name of the Practitioner	Location of the clinic	Monthly Income (also includes expenditure on medicines, rent etc) The quoted amount is approximate amount.		Other Occupation
		Off season (Rs)	Peak season (Rs)	
S. K Biswas	Harijan Basti	5,000-6,000 Rent –3000 Medicine-1500-2000	8,000	Money-lending, STD booth
Bimalendu Roy	Harijan Basti	8,000-10,000 Rent- 2225 Medicine- 2000-3000	12,000	Money lending, STD booth
Amin-Ur-Rahman	Jai Hind Camp	9,000 Rent- 1200 Medicine- 5000-6000	-----	STD facility, Money lending
Mukul Islam	Jai Hind Camp	5,000-6,000 Rent- 1200 Medicine- 1500	9, 000-10,000	Driver
Mahendra Singh	Masoodpur Market	15,000-16,000 Rent- 3000 Medicine- 3000-4000	20,000	--------

It is clear from the above table that the unqualified practitioners in Jai Hind Camp had the lowest income while those practicing in Harijan Basti were slightly better off. To compensate for the low income most of these practitioners resorted to adopting a side profession, including opening up an STD booth in the clinic itself and money lending was carried out from the clinic. Only once in a while the practitioners went out to collect money from creditors when they did not give the interest on time. Though the practitioners never accepted that they were involved in money lending such practices were evident during my observation from the terminology used by the people. 'Shoodh', a Bengali word used for interest on loan, was commonly used term while depositing money with the practitioner even though they did not come for any medical consultation.

The practitioner maintained what seemed "a well documented register" with scores of names and amounts. When inquired about the unusual exchange of money, the practitioners clarified that these people were clearing their dues accumulated over months on phone bills. In most cases, it was a fellow practitioner who revealed the money lending part of the side business of the other, often explaining in detail the modus operendi. The business of money lending was more common among practitioners based in Harijan Basti. Among the practitioners observed, only one was involved in full time side profession i.e that of a driver. He was also the practitioner with the lowest income from the clinic among the five.

Money lending by Practitioners

B. R and **S.K B**, the two practitioners based in Harijan Basti, seemed very disturbed and were absent from their clinics for three days. Though their clinics remained open, it was conveyed that they were away for some urgent work. Patients waited for hours and returned. My interaction with the patients suggested that Roy and Biswas were troubled because some people, who owed them money, had left the slum cluster and were not to be traced. Obviously, it was a great set back to the two practitioners, whose earnings were heavily dependent on the money lending business.

Average Patient Load and Seasonality

Patient load per day varies from season to season. In the summers (from May to October) the patient load is more than in the months November to April. This information is based on the answers given by the Practitioners especially for peak season during in depth interview and was also based on the observation made.

Table 3.2: Average Patient Load and Seasonality

Name of the Practitioner	**Location of the clinic**	**Years of Practice in the area**	**Patient load per day May-Oct (Peak-season)**	**Patient load Per day Nov-Apr (Off season)**
S. K Biswas	Harijan Basti	10 years	10-15 patients	5-8 patients
Bimalendu Roy	Harijan Basti	7 years	20-25 patients	10-15 patients
Amin-Ur-Rahman	Jai Hind Camp	6 years in Harijan Basti and 3 months in Jai Hind Camp	25-30 patients	10-15 patients
Mukul Islam	Jai Hind Camp	5 years	15-20 patients	8-10 patients
Mahendra Singh	Masoodpur Market	23 years	20-25 patients	10-15 patients

It is evident that the patient load of the three practitioners, who have their clinics in Masoodpur Market, Jai Hind Camp and Harijan Basti is almost similar. These clinics are also the most frequented by the slum dwellers of their respective areas. The number of years put in by the practitioners is not the predominant factor taken into account by the patients. Other factors such as regularity of his presence at his clinic, greater sensitiveness shown towards the patients and more effective treatment were quoted by the patients as reasons for approaching a particular practitioner. Not surprisingly, Amin-ur-Rahman, who had shifted his clinic to the Jai Hind Camp just few months back, had a better patient load than Mukul Islam, who was practicing in area for the past five years.

Major Diseases Treated

Among the common illnesses being treated by the practitioners include fever, cough and cold, headache and body ache, loose motion, diarrhea, gastric problems, anemia, cut and sprain etc.

Table 3.3: Main Diseases Treated

S.N	Illness for which treatment was sought	Harijan Basti	Jai Hind Camp	Masoodpur Market
1.	Fever, Cough and Cold	25%	30%	20%
2.	Gastric	10%	5%	5%
3.	Accidents, cut and Sprain	12.5%	15.5%	15%
4.	Loose motion	5%	7.5%	0%
5.	Diarrhea	0%	2%	0%
6.	Low B.P	5%	7.5%	5%
7.	Body ache	20%	10%	25%
8.	Eye problem	5%	5%	0%
9.	Weakness	5%	10%	15%
10.	Others – abortion, tooth problems, anemic patients, pain in neck, high B. P, getting false medical certificates etc.	12.5	7.5	15

The data above shows that common trend in the three areas, with large number of cases of fever being reported mainly because of the winter season when people tend to run fever accompanied with cough and cold.

Since most of the people residing here were involved in manual labour of some sort or the other, they often suffered from muscular and body pain due to excessive physical strain.

High incidence of cut, sprain and accident cases were also observed. This was most visible in the Jai Hind Camp where majority of the male adults were engaged in the work of garbage collection and salvaging the garbage to separate wastes that could be

sent for recycling. This is a highly risky profession as it exposes them to injuries from broken glass, toxins and scrap etc.

Patients coming for treatment to Jai Hind Camp and Harijan Basti often complained of weakness and took medication from the practitioners in the form of vitamin injections, tonics, vitamin tablets and substitutes. Prevalence of Low B. P cases was also noticeable in both Jai Hind Camp and Harijan Basti, with the condition being widespread among the females.

Redness and allergy in eye was frequent among the people staying in Jai Hind Camp and Harijan Basti. These were people working on farmhouses near Vasant Kunj as gardeners or as garbage collectors, who were infected while spraying insecticide on plants or while filtering the garbage.

Incidence of diarrhea was not much observable in any of the places except in the Jai Hind Camp. The practitioners, however, revealed that diarrhea cases were most reported during the rainy season.

Apparatus Used and Treatment Methods

The unqualified practitioners use various types of medical equipments for treating their patients. As acknowledged in the Taru Study[65] "the use of medical equipment and dispensing of drugs and other medicines enable the RMPs[66] to project an image of medical competence." The practitioners, especially those active in the Jai Hind Camp, made an active display of medical apparatus available with them probably with an aim to portray that they were proficient in using these to carry out effective diagnosis and treatment.

More or less, most of the practitioners used thermometer (electronic), stethoscope and B.P measuring device while examining the patients. They also made use of scissors, scalpel, gauze swabs, sterile pads and antiseptic lotions while cleaning wounds and cuts.

All of them used disposable syringe while giving injections. Though IV fluid set could be seen displayed in most of the clinics there were hardly any patient suffering from acute diarrhea during the winter season and therefore these were almost never used.

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[65] Ibid: 39
[66] Ibid: 44

Table 3.4: Apparatus Available in Practitioners Clinics

S.N	Equipment	S.K Biswas	Bimalendu Roy	Amin-ur-rahman	Mukul Islam	Mahendra Singh
1.	Gauze swabs[67]	√	√	√	√	√
2.	Sterile pads	√	√	√	√	√
3.	Scissors	√	√	√	√	√
4.	Kidney tray[68]	x	X	x	x	√
5.	Antiseptic solution	√	√	√	√	√
6.	Syringes (disposable)	√	√	√	√	√
7.	Needles	x	X	x	x	x
8.	Sterliser Bowls	x	X	x	x	x
9.	Towels and napkins	x	X	x	x	x
10.	Revolving stools	√	√	x	x	√
11.	Ordinary stools	√	√	√	√	√

[67] In medicine, a cotton swab is a small piece of material, such as gauze or cotton, which is used to clean wounds, apply medications, or retrieve samples of body fluids such as blood or mucus.

[68] A **kidney dish** is a bowl used in medical and surgical wards to receive soiled dressings and other medical waste. Reusable dishes are usually made from bright stainless steel, while disposable ones may be made from paper pulp or plastic. The shape of the dish allows it to be held against the patient's body to catch any falling fluids or debris.

12.	Examination table	√	√	x	√	√
13.	Screen stands or curtains	√	X	x	x	x
14.	Wall clocks	√	√	x	x	√
15.	Stethoscope[69]	√	√	√	√	√
16.	BP Instrument	√	√	√	√	√
17.	Thermometer	√	√	√	√	√
18.	Scalpel	√	√	√	√	√
19.	Dressing material	√	√	√	√	√

It is clear from the above observation that a similar pattern existed for apparatus used among most of the practitioners, with few deviations in the availability of screen stands or curtains, examination table, wall clock, towels and napkins etc. These give an indication of the competitive environment existing among the practitioners of the area and the compulsion that each one had to procure and keep medical equipments so as to be able to give the impression of being professional enough so as to attract more and more patients

[69]The **stethoscope** is an acoustic medical device for listening to the internal sounds of an animal body. It is often used to listen to heart sounds.

Table 3.5: Common Medicines Prescribed & Dispensed

S.N	Disease	Common Medicines Prescribed & Dispensed
1.	Fever, Cough and Cold	Paracetamol, Analgesic, Antialergic, Vitamin B complex, Medicine for acidity (Ranitidine, Femotidine), Antibiotics (Ampicilin, Citrazine, Tetracycline, Amoxycilin, Cephalexi, Oflax), tablet and syrup for cough and cold (Sinarest, Biodryl, Nimucelet)
2.	Gastric	Digene, Zyme, liver tonic
3.	Accidents, Cuts and Sprains	Used tincture iodine and providine to clean the wound, bandaged the wound, antibiotic (Ceprofloxacin, Ciprovit, Phenac plus, Flexon, Gentamycin injection, Taxim-O injection) Painkillers (Voveran injection), Paracetomol, TT injection, Vitamin B complex Methyl Cobalimil.
4.	Loose motion	ORS, Norflox, Zyme, Femotidine, Metrogyl, Nortiz, Alaloc, Endroquium
5.	Diarrhea	Metrogel, Norbit, Nomofane
6.	Low B.P	Tonics, Calcium tablet, Iron tablets, Saitobion
7.	Body ache	Paracetomol And Analgesic (Diclo, Flexon)
8.	Eye problem	Eye Drop, Galifloxacin, Ceflox-D, Citcip
9.	Weakness	Vitamin Injections, Calcium Tab, Iron Tab And Vit B-Complex
10.	Abortion	Mesoprost, M. T pill, Amicacin, Methargine, Doxycyclin, Iron Tablets.
S.N	**Disease**	**Common Medicines Prescribed & Dispensed**
11.	Deworming	Deworming tablets (Albendazole)
12.	Teeth	Althrasin, Ceprovit, Tooth gum paint
13.	Family Planning methods	Mala-D, Saheli, Ovral-L, Condoms

The practitioners of the areas under observation prescribed as well as dispensed medicines. The unqualified practitioners followed a 'cocktail' treatment method, which included prescribing paracetamol, antibiotics tablets or injections, anti allergic tablets,

medicine for acidity and multivitamin tablets and tonics. This line of treatment was followed with the intention that at least one of the medicines would work. However, the main aim of the 'cocktail' treatment was to bring quick and immediate relief to patients, who was seeking to recover fast and return back to work as soon as possible so that they do not loose their daily wages. As the interest of the practitioners lay in bringing quick relief, they were not bothered about the doses and strength of the medicine and cared little about multi drug resistance.

Most of the time the practitioners seemed quite vigilant and in cases, where the fever did not come down within three days, sent the blood and urine samples for diagnostic tests. Even in cases where there were complains of fever and urinary complications they sent patients for further tests to ascertain the problem.

Patients often came with the demand for "Hari patti wali goli", "the green coloured strip of medicine", which the practitioners explained was a terminology used by the illiterate slum dwellers for a combination of medicine used during fever and body pain. In most cases, it was a combination of a paracetamol and an analgesic like paracetamol and Diclofenic or Crocin and Vovran.

In the initial stages of the observation, the practitioners presented a very cautious attitude and claimed that they only administered first aid. However, after interaction with them over a longer period and after further probing and observations, it was clear that they entertained all kinds of patients to the extent that they even administered medication for teeth and eye problems. Moreover, they even took up abortion cases and gave pills for aborting the fetus. In fact, they even dealt with such cases when it went out of control rather than referring them to qualified practitioners.

Due to the winter season cases of diarrhea were recorded but whatever cases came to the practitioners were dealt through anti-diarrheal drug. The practitioners had arrangements for putting patients on IV drip whenever required. One practitioner was seen administering ORS while dispensing medicines for treatment for diarrhea.

Some patients suffering from weakness and low B. P also visited the practitioners, though they disclosed that cases of high B.P was almost nonexistent among the slum dweller. High B.P cases were observed among patients coming from the nearby Masoodpur village and Vasant Kunj flats.

The practitioners, especially in the Jai Hind Camp, kept oral contraceptives and condoms, which were made available to these practitioners by the ANMs of the Indian Population Project who frequently visited the area. Among the oral contraceptives 'Saheli' was popular even though 'Mala-D' was much cheaper, as women who used it often complained of vomiting and dizziness. Condom was the least preferred form of contraceptive used.

Allopathy system of medicine was the most preferred form of treatment and Ayurvedic drugs were only dispensed in cases where tonics were prescribed. This was basically done so as to reduce cost as these tonics and syrups were cheaper than most of the allopathic tonics. The packaging and name of these Ayurvedic tonics were also very attractive and had names like "Braintop", "Calm-lo", "Liv 52", "Hemidex", "Honitus", "Wilcold", "Hepaliv", "Becopen" etc.

All the practitioners used disposable syringes "to avoid any kind of hygiene issue". It was also done in a bid to give an impression that they were as proficient in their work as any of the qualified medical practitioners and avoid doubts in the mind of the patients who have increasingly become more conscious about these matters now.

The slum dwellers also bought tonics, medicines, de-worming tablets etc from the practitioners for the purpose of sending it to their native villages, where most of their children and family members lived. Most of the workers in the Jai Hind Camp lived alone as they kept their children in their native place with their grandparents or uncles so that they could get a more secure environment and some education, which was cheaper in the countryside than in a metro like New Delhi. As such, whenever someone from the camp went to visit their families in the native village the residents sent tonics, medicines, de-worming tablets for their families.

Modes of payment

The patients paid in cash most of the time. Once in a while they even took treatment on credit, which was availed mainly by those who were well known to the practitioner, lived in close proximity and was a regular visitor.

At times, practitioners accepted fees much below their official charges, provided it covered his basic costs, when the patient did not have the required amount at the time, In such cases, the patient agreed to pay the remaining amount as quickly as possible. Most of the practitioners maintained a register in which records of such patients and money due from them were recorded. It was revealed that in most cases the patients would pay the due amount, but sometimes they would just disappear. No payment was made in kind. The urban setting was probably responsible for this as the people availing the medical facility were mostly daily wage earners.

Table 3.6: System of Payment

System of Payment	Proportion of patients (in Harijan Basti and Jai Hind camp)	Proportion of patients (in Masoodpur Market)
Cash	80%	95%
Credit	20%	5%

Method of Charging for Treatment

There was no standard method of charging for treatment. The consultation fee not only varied with the kind of treatment specified and medicines dispensed, but also dependent on the social profile of the patient visiting the unqualified practitioner. Broadly, the practitioner's consultancy charges were similar in the JJ cluster and Harijan Basti. The charges were higher in the clinics more centrally located in the market and boasted of cliental coming from a slightly higher social and economic order than the rest.

Handling of Accident Case and Method of Charging

S thirty-five-year old labourer working on a construction site in Masoodpur, had severe injury on his head and leg when the ceiling caved in. His head had several cuts and was bleeding while his legs seemed crushed and cuts all over his left hand. Obviously, it was an emergency situation. He was brought to the clinic of **MS** by the contractor along with two labourers.

MS immediately attended to the patient and cleaned his wounds using tincture iodine and providine and bandaged his wounds. He gave him Tetanus injection, analgesic, vitamin B-complex as well as antibiotic injections. The practitioner asked the contractor to get an X-ray done on the laborer's leg as he feared fracture.

He then gave antibiotics, vitamin B-complex and analgesic tablets to the patient in separate doses wrapped in pieces of paper and explained when and how to take each dose. He even gave methylcobalimil for head injury as well as for good sleep. The whole procedure took one-and-a-half hour, for which **MS** charged Rs 900. He said "if you had taken him to a hospital they would have charged you somewhere around five thousand for the same treatment".

The practitioners dispensed medicine along with consultation. The practitioners were clear that they did not believe in taking money only for "Baat cheet" (talking with the patient) as they were catering to the needs of the very poor. In most cases, they dispensed medicines and took money for it, with only a meager amount as consultation fees. The charge for accident cases were in proportion to the gravity of the situation and could go up to as high as nine hundred rupees. However, the practitioners only gave first aid in such cases and if the case was more severe than they could handle, they were advised to see a qualified medical practitioner.

In most cases, the practitioner did not charge extra money for home visits as they only visited nearby houses in emergency cases of people, who also happened to be their regular patients. Home visits were also available for the disabled and the elderly patients, who found it difficulty to visit the clinics. The practitioner in the Massodpur Market rarely ever went on home visits in the area of his practice. For him, home visits were limited in cases of emergency, that too from his neighbours at nights,

Table 3.7: Method of charging for treatment

S.N	Charge type	Consultation fee(in Harijan Basti and Jai Hind camp)	Consultation fee (in Masoodpur Market)
1.	Only Consultation	Consultation was always with medicine	Never done without dispensing medicine
2.	Only Medicine (includes tonics)	Rs 5 - 80	Rs 20 - 120
3.	Only injection	Rs 10 – Rs 35	Rs 30 - 50
4.	Consultation & Medicine and at times injection	Rs 10 - 200	Rs 50 - 200
5.	Cleaning wounds, Bandage, Medicines and injections where necessary	Rs 30 - 100	Rs 100 - 900
6.	Follow up visit (charge taken after 3 days and if medicine changed)	Rs 10 - 30	Rs 20 - 50
7.	IV fluid per bottle	Rs 125-150	Rs 150-200
8.	Home visit	No extra charge	Not applicable as the practitioner never did home visits

Social profile of patients

The patients coming to the practitioners in the Harijan Basti, Jai Hind Camp and the Masoodpur Market belonged to different socio economic groups. People residing in the Harijan Basti JJ cluster and Jai Hind Camp were alleged to be illegal migrants from Bangladesh. Hence, they not only belonged to the economically weakest group, but were also socially the most isolated. Most of the patients approaching the unqualified practitioners in Jai Hind Camp came from this section while relatively a more mixed group like daily wage workers, workers employed on farmhouses, with RWA as well as fourth grade government employees and small businessmen were seen in the clinics of

Harijan Basti. The variation in the socio economic profile of the patients visiting the clinic in the Masoodpur Market was the maximum. It was evident that even people who belonged to the middle class visited the clinic in the market.

The social profile of the patients in the Jai Hind Camp was lowest, with the group also being the most vulnerable. Their alleged illegal status exposed them to continuous harassment at the hands of the police. They were also reluctant to visit any government run hospitals not only because of high waiting time, leading to loss in wages, and language barrier but also due to the deferential treatment meted out to them by the "inconsiderate" government doctors. Moreover, they did not have the resources to go to qualified doctors because of the high fee structure which they only shelled out in emergency cases.

The patients seeking medication In the clinics of Harijan Basti were from both the lowest social strata -- like the daily wage earners -- as well as the slightly better off -- for example those working in the resident welfare associations of the flats in Vasant Kunj, farm houses, those who were self-employed as well as fourth grade employees in government services.

Social profile of patients visiting the clinic of the unqualified practitioner in the Masoodpur Market had the maximum variation, with casual labourers in the nearby mall to workers in shops, shopkeepers and residents of Vasant Kunj flats approaching for treatment.

Table: 3.8 Social Profiles of the Patients

S.N	Social Profiles Of Patients	Jai Hind Camp (Total 40 patients)	Harijan Basti (Total 40 patients)	Masoodpur Market (Total 20 patients)
1.	Daily Wage earners (Labourers, garbage collectors, maids)	80%	40%	30%
2.	Workers of RWA, Workers in farm houses	12.5%	32.5%	15%
3.	Small businessmen	7.5%	15%	10%
4.	Fourth grade employees in government jobs	_	7.5%	_
5.	Landowners in Masoodpur village	_	5%	35%
6.	Residents of Vasant Kunj Flats.	_	_	10%

Social Profile of Patient, Patterns of Communication and Method of Payment

One evening, a fine-looking man of 70 year plus and dressed affluently entered the clinic of Mahendra Singh in Masoodpur Market. His interaction with Singh gave the impression that he was a frequent visitor and enjoyed a friendly relationship. **A**, a B.tech and a resident of Vasant Kunj flat in sector B-4, had come to the clinic to take medication for sore throat and injection of B-complex for weakness. It was a follow up treatment which he was taking for the past three days.

However, what was conspicuous was that the patients did not pay for the injection and instead requested the practitioner to note it down in his register and said will clear the total amount at the end of the month. Subsequently, he was informed that an amount of Rs. 1500 remained due in his name.

Since there was no other patient in the clinic, they sat down for a cup of tea and started discussing personal issues linked to their families after the consultation was completed. They discussed various issues for about one hour, after which he left saying that his family would get worried due to his long absence from home. After the man left, Singh explained that he was like a family doctor to **A** and his wife and they consulted him regularly and even made payments on a monthly basis.

Sources of Information about Drugs

Most of the unqualified practitioners claimed that they updated their knowledge about latest medicines and treatment through brochures on new drugs available in the market. However, during my observation no such pamphlets were found in the clinics on Allopathic medicines. Few leaflets were available only for new Ayurvedic tonics and medicines available in the market.

The practitioners claimed that they were wary of prescribing new medicines to the patients till they were convinced it had no side effects. They also got information about new drugs from the prescriptions of patients who visited qualified practitioner either through them or with them. They often shared information about new drugs with their peer groups in the profession.

The unqualified practitioners disclosed that they also received information about latest drugs available in the market through pharmacies in the area. However, when these pharmacies were contacted, they denied any such interactions with the unqualified practitioners.

The practitioners explained that that while procuring medicines they were updated by the pharmacists, who enlighten them with latest popular and alternative drugs, especially when the medicines sought by them were not immediately available with the pharmacy.

Medical Representatives (MRs) do not visit any of the practitioners practicing in Jai hind Camp and the Harijan Basti. However, the clinic of the unqualified practitioner in in Masoodpur market was frequented by the MRs in an effort to disseminate information about new drugs endorsed by their company and also to sell the physician's samples.

These samples of medicines are less in quantity than the standard drugs available in the market and are sold to the practitioner at one fourth price than the actual value of the medicine. These are the medicines which are mostly dispensed by the unqualified practitioners.

System of Referral

The unqualified practitioners at times referred their patients to other qualified medical practitioners (QMPs) and government hospitals. Most often this was done only when they felt that they could not handle the case any more. They would give medication for three days and if the situation did not improve they generally sent the patients for medical diagnostic tests and would in the meantime change their medicines. Only after their failure to figure out the exact cause of the disease from the reports do they refer the patients to medical practitioners. By this time six to seven days of precious time is lost and the situation of the patient invariably deteriorates.

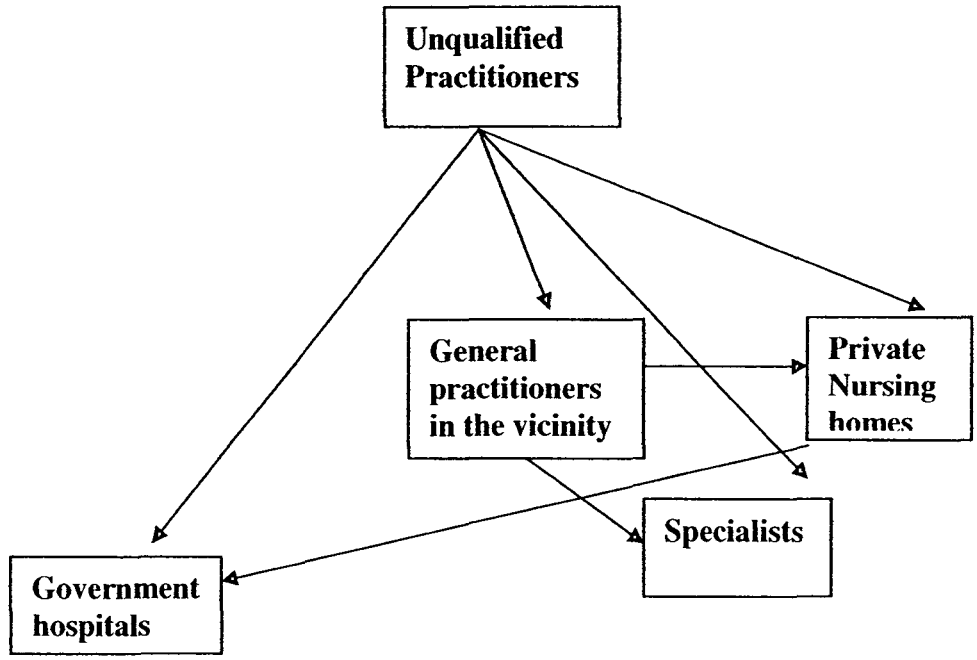
More often, unqualified practitioner helped the patients, who lived within their proximity and who were close to them, seek medical care from a qualified practitioner or nursing home as and when required or requested by the patients. This was mostly done in emergencies especially in pregnancy and infant illness. They referred or at times even accompanied them to gynecologists, general practitioners and pediatrics in the neighbourhood.

Since the practitioners have been practicing in the area for quite some time they had built a rapport with few qualified practitioners in the vicinity. Those medical practitioners or private nursing homes that projected a more sensitive attitude towards the poor patients coming to them for consultation and often lowered their fees were preferred.

There was no payment of commission involved as was inferred in the Narayana Study on unqualified practitioners in Andhra Pradesh. However, qualified doctors do accept that they were approached by these unqualified practitioners who ask them for percentage in fees for referring patients to them.

At times when the unqualified practitioners realized that the patient had some disease they could not comprehend they would refer them to Safdarjung Hospital. Though they said that getting treated here was cheap but it was time taking effort and would hence involve precious loss of labour time for the patients. However, in times of emergency this was the only option for the unqualified practitioners.

Figure3.1: Schematic representation of referrals of unqualified practitioners included in the study



They almost never referred their patients to any Government dispensary in the area as they felt that they had as much skill as any doctor sitting in these dispensaries which were not sensitive to the needs of the poor patients and also involved loss of valuable time both in travel as well as waiting in the hospitals. Moreover, they found it to be more expensive as medicines were mostly not available in the dispensary and they had to purchase it from the market.

All the unqualified practitioners except Mahendra Singh in the Masoodpur Market sent their patients to a particular diagnostic centre named **P D C** in the neighbourhood. They revealed that they preferred this diagnostic centre because of its prompt service and also it offered them good commissions on time.

Singh, however, did not send his patients to **PDC** even though he was also offered commission as "the diagnostic centre did not give accurate reports and had provided incorrect information in the past which made it difficult for him to infer the exact cause of ill health of his patients". He preferred another diagnostic centre which was situated slightly far away. It provided him commissions, though not very promptly, but more importantly, its reports were more accurate.

The Factors Behind the Popularity of the Unqualified Practitioners in the Area

The presence of 40,000 unqualified practitioners in Delhi according to DMC estimates is an indication of the popularity of these unqualified practitioners and their survival in spite of being illegal. It clearly indicates that they are serving an important need of the people where they exist.

The most important factor responsible for the flourishing practice of the unqualified practitioners is the fact that they fill a gap left wide open by the health service sector. In effect, the unqualified practitioners are providing low-cost, timely, accessible and appropriate treatment to the class of people whose health needs they cater to.

The most significant factor which gave these practitioners space to flourish in the areas they carry out their practices was that they enjoyed the trust of the community. They were considered by the people to be one among them and belonged to the same class as most of them and hence shared a greater comfort level with them. In effect, people felt they could share medical as well as personal problems with them.

Moreover, the practitioners were available for their patients most of the time. Since they were open to making home visits, it was widely felt that their presence in the community was indispensable as they could cater to emergencies, tends to the needs of the disabled and the elderly and could be approached even at odd hours.

In case of medical emergencies, these practitioners not only provided first aid but also accompanied the patients to hospital and even helped in supervising the follow-up treatment. The good rapport built by these practitioners with qualified doctors to whom they referred their patients also led to reduction in consultation fees.

Patients preferred their treatment not only because of convenience in availability of their service but also because of being low-priced and availability of some variance of credit facility. The short-term treatment by the practitioners and the possibility of ad hoc payments on "small installments" basis were major attractions for the patients who were mainly daily wage earners and could not afford heavy one time payments.

The fact that these practitioners shared a very good rapport with the community gave legality to their status in the area and they were not shy to accept that they were "Quacks". Since most of the patients visiting them were also their acquaintance as either they were neighbours or came from the same native place, they were ready to help them in times of need. Also the practitioners were considered to be "educated" by the slum

dwellers and hence people thronged their clinics for advice, completing paperwork linked to identify and ration cards or starting self help groups.

Glancing at the interaction between the practitioners and patients from the following table it can be observed as to why these practitioners enjoy the confidence and trust of the people where they practice. Though the table does not include the rapport building that is continuously taking place when the practitioner is sitting idle and acquaintances swarm their clinic.

Table 3.9: Communication Patterns

S.N	Communication patterns	Average time devoted while interacting with patients*				
		S.K Biswas	Bimalendu Roy	Amin-ur-rahman	Mukul Islam	Mahendra Singh
1.	Clinical History	60sec	75sec	70sec	60sec	2 min
2.	physical examination					
3.	use of laboratory aids					
4.	Therapy[70]	50 sec	50 sec	45 sec	40 sec	1min
5.	preventive[71] medicine	20 sec	25 sec	25 sec	25 sec	45 sec
6.	Socio-emotional[72] talks	20sec	55 sec	50 sec	40sec	2min
7.	Length of visits in minutes	<3min	<4min	<4min	<3min	< 6min

Note:

1. The value given is approximate as during observation it was not possible to pen down the exact seconds as at times there were more patients and the practitioner went through the routine of examining patients quite fast.
2. This does not include cases of accident, cut and sprains as these took more time of the practitioner and patient and hence there was more interaction along with therapy, most of which were socio-emotional talks.

[70] It mainly includes dispensing medicines, giving injections etc.
[71] This includes advice related to safety measures, eating and drinking instructions etc
[72] High levels of rapport building

From the table above, it is clear that the maximum time spent on socio- emotional talks was by Mahendra Singh who had his clinic in Masoodpur Market. Since most of his patients were well acquainted to him, his enquiries also revolved around their families. Apart from providing medicines, he also offered lots of advice on health issues. Probably it was one of the reasons for his popularity in the locality.

Similar, is the case of Bimalendu Roy of Harijan Basti and Amin-ur Rahman of Jai Hind Camp who were also more forthcoming in giving advice and explaining the pros and cons of eating habits, precautions to be taken etc. These information along with their good rapport building skills made them among the most frequented unqualified practitioners of their respective areas.

Some patients, nevertheless, showed their dissatisfaction with the method of treatment used by the unqualified practitioners. Many of the dissatisfied patients said they consulted "big doctors" and approached the unqualified practitioners only for "small and minor problems". Many of the patients, who visited these clinics only to find the practitioner absent, complained that these practitioners have turned into money lenders and were only interested in collecting interest from their clients.

Interaction and Communication Patterns

F approached Amin-ur Rahman for treatment of loose motion and stomach ache. Unqualified practitioner Rahman started examining the patient with his stethoscope and put forward questions like- what did you eat? **F** answered "Chapati and vegetables". Rahman inquired "How many times have you had loose motions? Fazal responded "five times and also have pain in stomach". Rahman further probed "Any vomiting"? **F** replied "No". After being satisfied with his investigation he gave him tablets – Metrogel, Norflox and Ranitidine and pointed out that generally loose motions do not occur in the winters but be careful and do not eat stale food.

Problems Faced by the Practitioners

According to the estimates of the Delhi Medical Association (DMA), there were around 40,000 unqualified practitioners in the national capital while the number of medical practitioners registered with the Delhi Medical Council was 38,852. Though the practitioners under study claimed to be registered in places other than Delhi, mainly West Bengal, they could not furnish any evidence. The Delhi Government has stalled the registration of such practitioners, making their practice in the capital illegal. The government only recognises B.A.M.S, B.H.M.S, and BUMS as the alternative medical practices other than M.B.B.S.

The fact that their profession has been termed illegal poses many hardships and challenges for the unqualified practitioners in the form of police harassment, demand for bribe and fear of imprisonment or fine by DMA. It makes them an insecure lot and therefore wary of even putting up sign boards at their clinics. There is no way to know the where about of such practitioners unless you enter their clinics, with word of mouth being their only source of publicity.

The fact that their practice is termed illegal by the government was an obstacle in the growth of their practice as they felt that the people, whose needs they cater to, believe that they are not capable enough, pushing them to approach qualified practitioners. It has cut into their profits, forcing them to adopt other means to increasing their earnings. At the same time, they also accepted that they were not "as knowledgeable" as qualified practitioner and lacked the skill to diagnose and cure diseases of very serious nature, However, the unqualified practitioner considered their role important as they were filling an critical gap in the health services structure and providing an essential service to the needy and downtrodden who were neglected by the government.

The unqualified practitioner took credit for providing medical services on credit basis, though they found the system against their interest as it was often difficult to recover the money from the patients, apart from wasting precious time running after them.

They underlined the need for further training of the unqualified practitioner in order to equip themselves with better diagnostic and prescriptive skills. The practitioners

were confident that given the opportunity for proper training, they could act as a crucial support of various National Health Programmes. These practitioners also wanted recognition from the government as professional health care providers so as to contribute in improving the delivery of health care services, especially among the urban poor.

RMP Association

RMPs associations exist in Delhi for the welfare of such unqualified practitioners, but these practitioners think becoming a part of such associations a waste of time as no tangible benefit has come to even those affiliated to them. These associations are highly politicised and are controlled by a handful of powerful players. One of the unqualified practitioners, who previously had been associated with these associations, raised doubts about the working of these associations, which raised money for its meetings by collecting fees as high as Rs 500 from the unqualified practitioners. In their view, the association lacked transparency as they never disclosed the accounts to the members or how the money was utilized. In fact, they were fed up of contributing and participating in such meetings with no concrete benefits accruing to them.

Further, they also feared that in case some scheme by the government is initiated to provide training to some selected unqualified practitioners, it would be these associations who would get the job of identifying such practitioners. The reputation of these associations were so dubious that the practitioners were certain that only candidates who would pay huge sum of money would be selected. As such, they had little hope of being included in any such programme in the future.

Delhi Medical Association

DMA has taken a very clear stand that unqualified practitioners should not be allowed to practice in Delhi, supporting stringent action in the form of fines and imprisonment against those found guilty of carrying out such an activity. The DMA has established an 'anti-quackery cell' with an aim to curb the activities of unqualified practitioner. In this mission, it has coordinated with the Directorate of Health Services to bring them to book. They have issued show cause notice to some unqualified

practitioners and initiated prosecution proceedings against some of them in the courts. They have also tried to sensitise the judiciary, which has evolved procedures to simplify the executive and judicial process to book these offenders. It has resulted in the arrest of many unqualified practitioners who have also been denied bail.

The DMA has mobilized doctors to step up pressure on the Delhi Government to the pass an 'Anti Quackery Bill' and conduct regular raids on the clinics being run by unqualified practitioners, on institutions that award fake medical degrees and on drug stores that sell Schedule H/X drugs without proper prescription. The draft of the 'Anti-Quackery Bill' states that only qualified doctors would be allowed to practice. It recommended a minimum fine of Rs three lakh and three years imprisonment to any person found practicing without a proper degree.

Under the **Medical Council of India (MCI) Act 1956**, only persons with basic MBBS degree are allowed to practice allopathic medicine. Similarly, under the Drugs and Cosmetics Act 1940, only persons with MBBS degree are eligible to prescribe allopathic drugs.

However, the task of banning the unqualified practitioners and preventing them from functioning are two separate and difficult tasks. Even doctors on the board of DMA admitted that there has been evidence of some nexus between such unqualified practitioners and qualified medical practitioners. Dr. Walia, a government doctor in a health centre in Delhi and editor of DMA bulletin in 2008, accepted that such nexus was widespread. Dr. Walia, who also runs a private clinic in South West Delhi's Munirka market, alleged that he had been approached by more than one such unqualified practitioners who tried to strike a deal to share earnings from patients sent by them for treatment. At the same time, he also accepted that "there are black sheep in every profession and there are qualified doctors who fix commissions for these unqualified practitioners and use them as touts to bring in patients." According to Dr Walia, there were just few doctors who were involved in such activities, mainly to increase their earning as they were unable to attract patients in normal course of events.

Case Studies

Case 1

G D, wife of a daily wage earner **M** who worked with a building contractor as a painter, had shifted to Delhi a year back in an effort to increase the earning of her husband. Mother of four children -- two boys aged eleven and eight and two girls aged nine and six years – **G D** had left them with her mother-in-law in Bihar's Sitamarhi district, which is one of the most backward districts of the country.

She was forced to leave Sitamarhi as her land did not provide her enough to fulfill the basic needs of the family, with the district regularly affected by floods every monsoon which made cultivation of two crops a year difficult.

Though her husband **M** had moved to New Delhi in search of better opportunities six years back, things at home had not improved. **M**, who used to send some money back home initially for two year, stopped aiding his family on a regular basis. **G D** had heated arguments with her husband whenever Mahesh came to the village and suspected that he was wasting money on alcohol and other women. **G D**i was particularly concerned that they had to save enough for the marriage of her elder daughter. Her repeated plea that she should accompany him to his work place so that she could add to the family income finally bore fruits after three years.

G D, who was based in Harijan Basti, has been working as household maid for over a year in the nearby Vasant Kunj flats in South West Delhi. They have been struggling to manage their expense after sending some money back home every month for their children.

G D has been consulting S.K Biswas, an unqualified practitioner, for she believes that "Biswas Chota Dactor hai par achaa dawai deta hai, phaida karta hai" (He is a small doctor but gives effective medicines). She consulted Biswas for fever and urinary problems.

During consultation Biswas wanted to know since when was she suffering from the problem? He checked her temperature using an electronic thermometer, which he washed with water and wiped with spirit. The practitioner took care to wash his hands before he examined her eyes.

Biswas gave her medicines for three days - Alkasal, tetracycline, phenac plus, ranitidine. He asked her to drink a lot of water and be prepared for urine test if the medicine did not have the desired effect and did not bring the fever down. He instructed her how to consume the medicines and asked her to come again for check up. Biswas charged **G D** Rs 52. However, she paid him only Rs 30 and promised to pay the rest of the amount when she visited him next time. Subsequently, the practitioner noted the amount against her name in a register. During her follow up check up two days later, **G D**said she felt better but complained of weakness.

Biswas gave her medicines for three more days along with a bottle of Ayurvedic tonic. **G D** paid the practitioner Rs 100, which included the earlier dues and got her name deleted from the register.

Case 2

S, a 35-year-old woman came to the clinic of Bimalendu Roy with her husband and a relative amid fears that she may pregnant after she had missed her menstrual period. Roy, an unqualified practitioner, asked her: "when was your last period"? **S**, an illiterate woman, failed to recollect the exact date but vaguely answered that though she "can't remember the exact date, it was some two months ago". When further probed on other symptoms, she mainly answered "No". As such, Roy asked her to collect her first urine next morning in a clean bottle and bring it to his clinic for examination.

Accompanied by her husband and another neighbour, **S** returned at 10:15 am with her urine. The practitioner took the urine bottle inside his living room, where he did a quick examination and told her that she was pregnant.

Roy asked her about her next move. "What do you want to do now?" **S** and her husband, who looked uncomfortable, kept silent while the accompanying woman informed Roy that they planned to abort the pregnancy. She also enquired "whether it can be done by medicine?" Roy gave her an M.T pill Mesopride and adviced her to take adequate rest for the next one week and avoid any stressful activity, such as lifting of heavy objects.

S, who returned to the clinic after three days, looked weak and had high fever and complained of heavy bleeding. The practitioner, who had a number of patients waiting at the peak hour of 7:30 pm, quickly checked her temperature and pulse. When Roy inquired whether she had lifted any heavy objects, the woman told the practitioner: "Yes I had picked up a bucket of water". Roy told S not to repeat "the big mistake" and even scolded her husband for bringing her to the clinic "in such a bad shape" as he "could have visited their house to examine the patient". Advising the woman to sleep with her legs slightly elevated with pillows, he told her husband to allow her "adequate rest" for the next fifteen days. The practitioner gave her an injection Amicacin 500 mg. using disposable syringe Dispovan, and tablets Methargine, Doxycyclin and Iron capsules to be taken orally.

He charged her husband Rs 198, justifying the amount on the ground that "It's very late, you should have come earlier". "If you had come earlier so much money would not have been spent," Roy said, as he asked her husband to "keep him informed about her condition".

Case 3

P, a resident of Kishangarh Village adjacent to Vasant Kunj, came to the clinic of Mahendra Singh for a fake medical certificate for his daughter **S**, who had missed her school for one week due to some family engagement.

Fifteen- year-old **S**, who was studying in class IX, had been asked by the school to produce a medical certificate as she had told the school that she was unwell. Singh, an unqualified medical practitioner, had a printed form (medical certificate) where he cited viral fever as the reason for the girl's absence from school. He charged Rs 50 for preparing the false medical certificate.

Case 4

P, a 4-year-old-girl, was brought to the clinic of Bimalendu Roy by her mother as the child was suffering from tooth ache, with swelling in the gums near the lower molar teeth on the right side. Roy, an unqualified practitioner, examined the area and inquired whether the girl had pierced her gum with some sharp object or if a tooth had broken.

When the mother replied in the negative, Roy prescribed Althracin and an analgesic tablet. He charged Rs 10 for the treatment.

After three days **P** again came to the clinic with her mother and complained of severe pain in the gum. After examination, Roy told the mother that there was a pus formation in the area. The worried mother asked the practitioner "whether the matter was serious enough to approach a dentist?"

Roy told her that approaching a dentist would only be a waste of at least Rs 200 as he would treat her for much less. The practitioner changed her medicine from Althracin to Ceprovit and asked her to buy candid tooth gum paint. He advised the mother to give **P** the medicine and regularly wash her mouth with warm water mixed with Dettol and fill the tooth gum paint in the wounded area using a cotton pad and wooden stick. He charged Rs 14 as his fee and assured them that it help in healing the wound.

Thus it is clear from the above observations that the unqualified practitioners practicing in the urban slums are the most preferred form of treatment for minor ailments and form the first point of contact. The most significant factor which gave these practitioners space to flourish in the areas they carry out their practices was that they were accessible, affordable and enjoyed the trust of the community. They were considered by the people to be one among them who shared a greater comfort level with them and could share medical as well as personal problems with them. However, Due to lack of choice and information the urban poor also become target of exploitative charging practices and face the largest out of pocket expenditure on health which cripple them financially.

The fact remains that in spite of the best efforts of the IMA and other authorities to ban the unqualified practitioners, they continue to exist and their presence and role has been widely acknowledged but there has been little effort on the part of the government to integrate them into the health services delivery. In fact the government in view of shortage of manpower in the health sector could make use of their services which would also enable them to regulate the unqualified practitioners and their irrational practices.

CHAPTER IV

HEALTH SEEKING BEHAVIOUR AND ROLE OF PRIVATE SECTOR AMONG THE URBAN POOR

This dissertation examines the health seeking behaviour of the urban poor and the role of unqualified practitioners in the Harijan Basti and Jai Hind Camp in Southwest Delhi. The study has tried to build an understanding on the social characteristics of the unqualified practitioners in the area in terms of age, education, caste, religion and gender. The existing knowledge networks, plurality and prescribing practices of the practitioners and has also tried to discern pathways of referral with both private and public health service institution.

Urbanisation, Migration and Urban Poverty,

Decades of rapid urbanisation in India has resulted in 31.2 percent decadal growth in urban areas in 1991-2001 as compared to 17.9 percent in rural areas. India's urban population, which was 285 million in 2001, is estimated to reach 534 million by 2026[73]. In 2001, there were 35 cities with million plus population and it is estimated that the number of million plus cities in India will grow to 51 by 2011[74]. Urbanisation in India is marked by increasing concentration of population in larger cities. In 2001, Class I cities comprised of 68.7% of the total urban population.The national capital Delhi is considered one of the fastest growing cities in the country, with an annual population growth rate of 3.85 percent which was almost double the national average. According to the Population Census of 2001, Delhi had the highest percentage of urban population in India which was 93.18 percent.

Excessive migration to the city has been largely responsible for the enormous increase in population over the years. The exponential growth in population is driven mainly by huge influx of migrants to the city, put at about 2 lakh per year during the decade 1991-2001. A look at the migration pattern during 1981-1991, one notices a trend towards migration mainly from the poor and neglected states like U.P and Bihar which have been left out due to the lopsided development patterns of the governments.

An important aspect in rural urban migration is the "push factor". Poverty in the backward states has forced the people to throng the city in search of better livelihood opportunities. The number of people below poverty line is only slightly higher in rural areas when compared to the urban regions. The slow growth of modern industry and

[73] Reort (2007): *State of Urban Health in Delhi*, Ministry of Health and Family Welfare.
[74] Ibid: 1

tertiary activities in Delhi as compared to the high population growth makes it difficult to provide jobs for the migrants who end up finding work in the informal sector requiring low skill with poor wages. This is evident from the fact that informal sector in urban areas has grown exponentially. In 1991-2001 workers classified as "marginal workers" registered an increase of 360 percent while the workers classified as "main workers" grew only by 23 percent. This shows that the benefits of massive urbanisation have eluded this class and most of them end up living in slums.

There has been surge in the number of unregulated slums, with the result that over one-fourth of the urban population in the country today live in urban slums. An analysis of India's population growth trends between 1991 and 2001 makes it clear that it grew at an average annual growth rate of 2 percent, with growth in urban areas at 3 percent, mega cities at 4 percent and slum population by 5 percent[75].The census estimated that 18.7 percent of the population of Delhi resides in slums. Further, about half (52 percent) of Delhi's population resides in urban poor habitations like resettlement and unauthorised colonies including slums[76].

This unplanned and unregulated urbanisation along with simultaneous growth of urban poverty have had noticeable impact on the quality of life of the slum dwellers as the existing infrastructure and services has been overstretched to cater to this growing population in the cities, where the poor are left out and have to cope with housing shortages, unemployment, congestion, pollution, inadequate urban services like water supply, sanitation, drainage, sewerage, transport and scarce health, education and welfare facilities and live under inhumane conditions with increased susceptibility to disease and ill health. Current trends in urban poverty suggest that the number of poor in the cities is set to increase considerably in future in the absence of a well-planned, regulated and long-term intervention strategy.

Slums are considered illegal and are ignored and neglected despite the economic contribution of the large informal force residing in them. All slums are, however, not

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[75] Chatterjee, G (2002). *Consensus versus Confrontation: Local Authorities and State Agencies Form Partnerships with Urban Poor Communities in Mumbai.* Urban Secretariate, United Nations Human Settlements Programme. UNHABITAT.

[76] Ibid:1

equal and the most vulnerable pockets are often missing on the official slum list and hence, do not benefit from any government effort aimed at their welfare.

As a significant proportion of the urban poor are migrants who have come in search of better standard of living but end up being downgraded to a very low social class and lower socio-economic status with poorly paid jobs that have few career prospects and little or no access to social services, particularly those of healthcare.. Furthermore, their standard of living is precariously low with a large portion of their earnings being sent home to support families left behind. The situation of illegal migrants from other countries is worse as they have to face social exclusion and marginalisation. Migrants lacking "official status" are unable to benefit from state welfare activities and become extremely vulnerable. It also leads to underutilisation of healthcare services because the migrants are unfamiliar to the urban system of healthcare provision which is further worsened because of little social support. Planners and service providers often embrace the perspective that providing service to 'illegal slums' necessitated giving them legal sanctity. In effect, most of them end up accessing the services of unqualified medical practitioners.

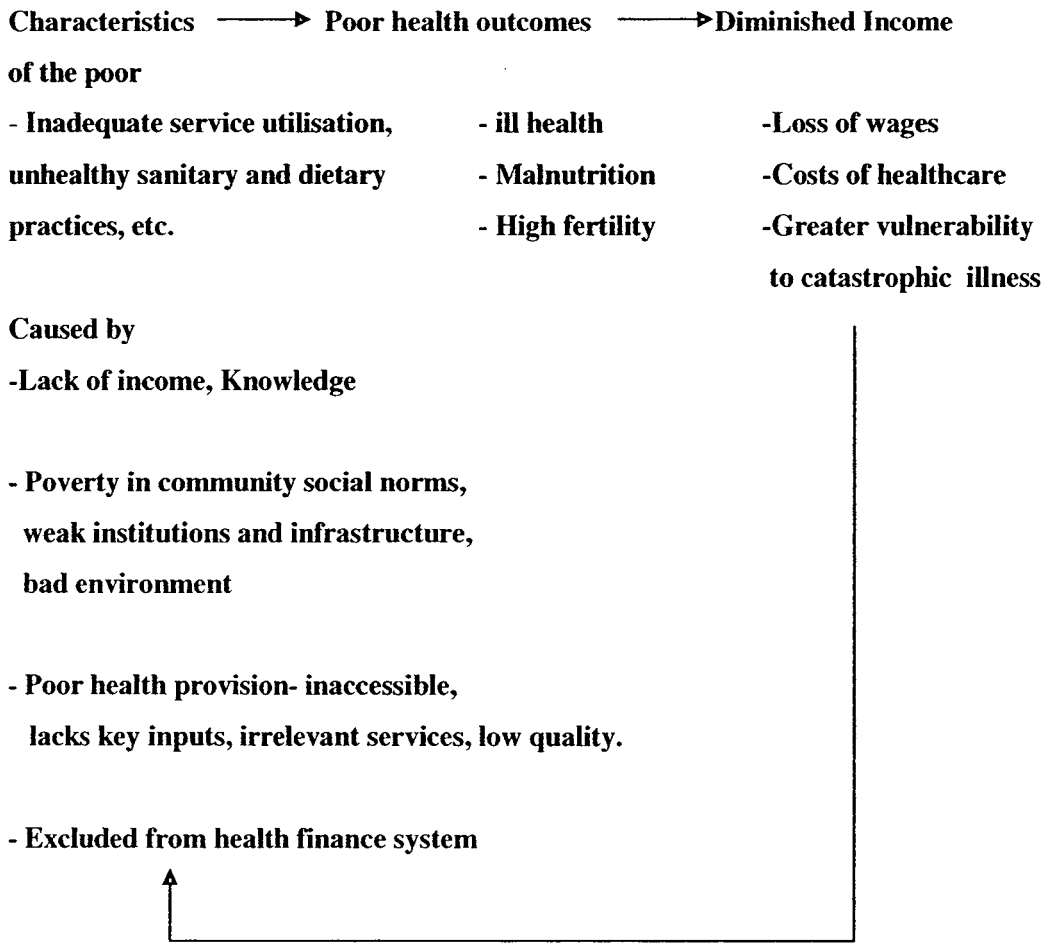
Further, the migrant population have to regularly deal with pressing issues like threat of eviction, struggle to access basic services such as water and sanitation, police interference in day to day life and also have to cope with employment problems, which threaten their basic existence. In such circumstances, they tend to ignore their health problems as they have little time to seek healthcare. Moreover, the lack of education and low health awareness make them vulnerable to being exploited by the private health providers, especially the unqualified practitioners who are easily available in these slums. These practitioners take advantage of the ignorance and the circumstances of the slum dwellers and project themselves as qualified to treat patients. Due to lack of choice and information the urban poor also become target of exploitative charging practices and face the largest out of pocket expenditure on health which cripple them financially in the absence of any form health insurance.

Poverty and Health

The urban poor suffer from poor health outcomes, which are often not reflected in commonly available health statistics. Most sources of health information, which provide for rural and urban average figures, mask the disparities that exist within the various economic groups in urban areas. For instance, the under five mortality rates (U5MR) among the urban poor (72.7) was higher than the overall urban average (51.9). As per the NFHS-3 and NFHS-2 data, only 40 percent of the urban poor children are fully immunised by completion of one year of age. The percentage of children under 3 years who are underweight among the urban poor is 47.1 which is more than the urban average 32.7.

A well-established relationship exists between poverty and ill health and one causes the other and runs in both directions. Due to ill health the productivity of this section of the population gets severely restrained and leads to diminished income, poor health outcomes and increases their vulnerability to catastrophes. The poor people once caught in this vicious cycle are unable to come out of this: poverty breeds ill health and vice versa.

Figure 4.1: Cycle of Health and Poverty



Source: Wagstaff A (2002): "Poverty and Health Sector Inequalities" *Bulletin of WHO 2002, 80:97-105*, Pg 98

Poor Reach and Usage of Public Sector Services and High Dependence on Private Health Sector

The Delhi Government has devised various policies and programmes with an aim to improve the conditions of the urban poor. It includes policies aimed at improving housing, basic services of water, sanitation, toilets, health, education, environmental improvement in urban slums, generation of employment and community empowerment, particularly focused on women etc. However, these policies have not been translated into

effective programmes which could have a significant impact and enhance the quality of life and health of the urban poor.

The government has recognised the non-availability of primary health care services to the urban poor in important policy statements such as the National Population Policy (NPP) 2000, RCH II and Tenth Five Year Plan. The sub-mission on basic services under the Jawaharlal Nehru National Urban Renewal Mission (JNNURM) envisaged to improve basic services in slums in 63 identified cities including Delhi. The Ministry of Health and Family Welfare, Government of India, had announced its intention to launch the National Urban Health Mission by the end of 2007 to strengthen health services in urban areas particularly aimed at improving the condition of the poor living in the cities. However, the mission has not yet been launched as it is still in its draft stage.

The National Health Policy of 2002 accepts that while the public health investment in the country has been very low even in the past, it has further declined from 1.3 percent in 1990 to 0.9 percent of gross domestic product (GDP) in 1999. Out of this, only 17 percent of aggregate expenditure is public health spending, and most of the rest balance comes as 'Out of pocket payment' by the people which is more than 80 percent.

Health services to the urban poor in Delhi are provided by various departments such as Health, Social Welfare, and Slum Development under different authorities such as MCD and GoNCTD. However, there is weak coordination between these agencies.

Primary health care facilities have not grown in comparison to the population of Delhi and as a result the urban poor remain underserved. The proximity of the poor to urban public health facilities has not improved their accessibility to the service, which remains severely restricted due to socio-economic, language and ethnic barriers. Most importantly, prejudices and insensitive attitude of the health providers have played a primary role in limiting the accessibility of the service to the urban poor. Moreover, the lack of accountability, poor staff quality, inconvenient timings at the health centers, absence of medical personnel and poor referral system in the public health sector have seriously restricted the poor from accessing the services.

Other issues include cost of treatment, loss of income as well as people's perception of quality of care. The migrant population is vulnerable in terms of negligence and isolation to the main culture. It leads to lesser control over available resources meant

for the population as a whole, including the migrants, and the way in which these are geographically distributed within a large urban area. Thus, there is an uneven distribution of services, including health services. Since the migrant population is considered to be an "outsider" and because of their illegitimate status with more or less no power, they end up with limited choices and very little negotiating power to voice their discontent and improve their circumstances for the better.

As a result of these major deficiencies in the public sector health systems, the urban poor in the national capital as much as the rest of the country are forced to seek services from the private sector, also the most unregulated sector, which has gained a dominant presence with three-quarters of the human resources and advanced medical technology, Sixty-eight percent of a total of over 15,097 hospitals and 37 percent of over 623,819 beds in the country are in the private sector (Directory of Health Services, GOI 1996). According to the 52nd round of the National Sample Survey (NSS), private sector accounted for 81 percent of all outpatient care.

There is also enough evidence to show that the private sector has been providing an increasing share of primary healthcare and that large segments of the poor are also using the private sector, especially the services of those providers who are not registered, qualified or regulated. The quality of care provided by these unqualified practitioners is extremely low and at times harmful to the health of the patients. The Supreme Court has ruled the operations of the unqualified practitioners as illegal and labeled them "quacks" but the fact is that they are often the only ones available to the urban poor.

The Characteristics And Role Of Unqualified Practitioners In Urban Slums Of Southwest Delhi: Summary Of Findings

According to the estimates of the DMA, there are 30,000 unqualified private practitioners in the national capital. Most of the unqualified private practitioners are located in the slums and a few in markets of centrally located areas. Being the front line primary healthcare provider to a large proportion of the population, the unqualified practitioners can be considered one of the most utilised resources in this sector. People residing in the urban slums show preference for these unqualified practitioners, especially for minor ailments, even though there are qualified doctors in the vicinity. The urban

poor tend to consult the qualified medical practitioners only in case of serious health problems and emergencies.

Since the unqualified practitioners were the first point of contact and the main source of out patient care in the urban slums and are also unregistered and their practice being termed illegal by the authorities, little is known as to who they are and what is their social characteristics? Where are they from? What is the nature of their practice? The dissertation examines these and tries to gain more information on these aspects.

Social Caracteristics, Knowlegde Base and Training

The unqualified medical practitioners, who are mainly based in the slums under research, operate on a profit basis, offering mainly curative services. Majority of them are male solo practitioners in outpatient settings.

A high percentage of unqualified practitioners in the area of research belonged to the deprived section of the society, with very few from the upper caste. Majority of the practitioners were Muslims especially those practicing in the area inhabited by Bangladeshi Muslims.

Generally, the unqualified practitioners were above the age group of thirty five, with minimum education up to Class 10+2 while few were graduates. Poor employment opportunities had pushed the educated poor into this profession. Though the practitioners moved into the national capital from their native village in search of better prospects, often some relatives or acquaintance was responsible for motivating them to shift to Delhi.

Almost all the unqualified practitioners were trained on the job while undergoing apprenticeship with either a qualified medical practitioner or with another unqualified practitioner. Only one had inherited the profession from his family. Most of them claimed to have been registered in West Bengal, though were unable to furnish any proof for the same.

Nature of Practice

The practitioners indulged in cross practice between Allopathy and Ayurvedic, with Allopathic form of treatment being the most preferred and was practiced without the requisite skills and qualification. The most common reason quoted for this being the demand of the patients who sought quick relief. For most ailments, the practitioners dispensed Allopathic medicines. However, for weakness, liver problems and cough and cold they dispensed Ayurvedic drugs and tonics which were often cheaper than Allopathic syrups and tonics. They gave injections to their patients frequently, with the most common injection being vitamin B12 complex that was little more than a placebo which was mainly given to satisfy the demand for injections by the patients.

The unqualified practitioners had dispensing practice whereby drugs were obtained in bulk and repackaged into little packets and distributed. Dietary prescriptions were offered with most of the medicines dispensed. Two of the unqualified practitioners maintained records of medicines dispensed to patients, but all of them strictly avoided giving any prescription to the patients. Indiscriminate and injudicious use of antibiotics in a 'cocktail' treatment provided by these unqualified medical practitioners has been viewed to be highly damaging. The evidence gathered during the study on the irrational prescribing practices can also be corroborated with observations made in the other studies. Kamat's study on the role of private practitioners in the resurgence of malaria in Mumbai found that "Driven primarily by the need to retain the patronage of patients and maintain one's popularity in a highly competitive health arena, many providers practiced medicine that was unethical and dangerous"[77].

One would agree with Abhay Shukla's observation about the culture of irrational medical practices. "One consequence of the unregulated proliferation of the private medical sector has been the phenomenal growth of various forms of irrational medical practices. These improve the "financial health" of certain doctors, but fail to improve, and may even damage the health of the patient. These measures have now even been internalized by large sections of the population. Three well-known practices which drain people's pockets of hundreds of crores every year are unnecessary injections,

[77] Ibid: 30

unnecessary intravenous infusions and "tonics". It has been estimated in a well-known district level study that nearly two-thirds of expenditure on medications prescribed by doctors was unnecessary. This irrationality extends to prescribing of unnecessary antibiotics and steroids." [78]

Apart from the earnings from their practice, most of the practitioners also had other sources of income, which included money lending, running STD booths or working as a part time worker or driver. The practitioners claimed they had no option but to resort to dual earnings as "there was no growth in practice", with "escalating expenses due to astronomical rise in prices". Some of the practitioners, though, accepted that their income had increased from the practice which has grown over the years.

In general, the unqualified practitioners operated from a single rented room, often living in a room adjacent to the clinic. The use of medical equipments like electronic thermometer, stethoscope, Blood Pressure instrument and use of disposable syringe by the practitioners was done with the intention to convey the impression of being professional in a bid to attract patients.

These practitioners attend to 10-25 patients per day for which they received between Rs10-50 per consultation, depending on the type of ailments. There was no standard method for charging for treatment and the consultation fees not only varied with the kind of treatment specified and medicines dispensed, but also with the social profile of the patients. Higher consultation fees were charged in areas where the practitioner was more centrally located and had catchment area of well to do patients.

Often, the poor patients with little information about the diagnostic and treatment options frequently demanded symptomatic relief that seemingly would solve their immediate problems, even when this was medically ill-advised. The urban poor also found it very convenient to get consultation and medicines under a single roof, "saving them the problem of having to go elsewhere to get medicines".

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[78] Shukla Abhay (2007): 'Key Public Health Challenges in India: A Social Medicine perspective', *Journal of Social Medicine, Vol 2. No. 1,, March 2007,* Pg-5

System of Referral

Despite their lack of knowledge and skill to diagnose and dispense medicines and frequent involvement in potentially harmful practices, they managed to hold the trust of the people and earned a living from consultation fees and commissions from diagnostic centers, where they referred their patients for various tests.

There was no clear evidence of commissions being paid by the qualified practitioners to the unqualified practitioners, who referred the patients in case of their inability to treat the patients, However, claims were made by the private qualified medical practitioners that they had been approached by unqualified practitioners who wanted to strike a deal for commissions for referrals.

Social Profile of Patients and reasons for the popularity of these practitioners

In most cases, the people who used the services of these practitioners belonged to the very poor sections and lower income group. However, at times where the clinic was located more centrally away from the slums even upper middle class and middle class people approached them for treatment.

These practitioners have also adapted flexibly to the demands of the community in the slums, particularly when it comes to their availability at odd hours in times of emergency. Consequently, they are available for consultation "twenty-four hours" and keep their clinics open at convenient times (usually from 8am – 1pm and from 6pm – 10pm). They also readily make house calls on the aged and in emergency cases and often charged no extra fees for it. In most cases, it was seen that they uniformly "treated patients with kindness and respect". In case of medical emergencies, these practitioners not only provided first aid but also accompanied the patients to hospital and even helped in supervising the follow-up treatment. The good rapport built by these practitioners with qualified doctors to whom they referred their patients also led to reduction in consultation fees.

Another striking feature which makes the services provided by these practitioners attractive to the urban poor is that the treatment is provided on credit to those who cannot afford to pay immediately. The percentage of patients seeking treatment on credit was

around twenty percent. Often, however, the practitioners found it difficult to recover the credited amount from the patients.

Also the practitioners were considered to be "educated" by the slum dwellers and hence people thronged their clinics for advice, completing paperwork for ration cards or starting self help groups.

Latest Information About Drugs and Training Needs of the Unqualified Practitioners

The practitioners tried to update their knowledge on latest drugs from the pharmacies and leaflets, especially from Ayurvedic drug making companies. They also got information about new drugs from the prescriptions of patients who visited qualified practitioner either through them or with them. They often shared information about new drugs with their peer groups in the profession.

The practitioners explained that while procuring medicines they were updated by the pharmacists, who enlightened them with latest popular and alternative drugs. Only one unqualified practitioner was visited by Medical Representatives (MR) who showed more interest in selling physician's samples rather than disseminating information about new drugs endorsed by their company.

The unqualified practitioners accepted the need for formal training in order to equip themselves with better diagnostic and prescriptive skills. The practitioners were confident that given the opportunity for proper training, they could act as a crucial support of various National Health Programmes. These practitioners also wanted recognition from the government as professional health care providers so as to contribute in improving the delivery of health care services, especially among the urban poor.

The Supreme Court has ruled the operations of the unqualified practitioners as illegal and labeled them "quacks". The fact that their profession has been termed illegal poses many hardships and challenges for the unqualified practitioners in the form of police harassment, demand for bribe and fear of imprisonment or fine by DMA. However, they continue to practice and flourish though they try to be less conspicuous in order to avoid the attention of the government authorities. Accordingly, most of their clinics are located in the interiors of the slum with no signboards or placards revealing their existence.

There is resistance from the Indian Medical Association against these practitioners. The IMA has raised the demand and lobbied for a ban on these practitioners. It is vigorously pushing for the passing of the 'Anti-quackery Bill' by the government. However, the associations of the unqualified practitioner have also lobbied against any act to clamp down on their practice.

The fact remains that in spite of the best efforts of the IMA and other authorities to ban the unqualified practitioners, they continue to exist and their presence and role has been widely acknowledged. Even as these practitioners provide a critical service and are the first point of contact for treatment, there has been little effort on the part of the government to integrate them into the health services delivery.

The Way Forward

The private health sector has grown without direction or planning and also without any standards of quality and provides more than 80 percent of curative services for the rich and poor and both to rural and urban population. The heterogeneity of institutions in the private sector, the lack of standardised costs, variability in infrastructure, manpower etc substantiates the need to regulate the private sector. Regulation is necessary to check irrational practices, mandate transparency of fees, appropriateness of care and improve the quality of health services so that the interests of the patient remain paramount. To achieve this it is important to recognise the various actors and their function in the health services and here it is important to understand that both trained and untrained providers are a part of this and they are also linked to each other.

The unqualified practitioners represent the informal sector in the medical care and they have no professional qualifications and license to practice any form of medicine. They along with drug shop owners have grown into the dominant type of provider of outpatient medical care and are collectively known as unqualified practitioner. The growth of these unqualified practitioner is a result of the largely under funded public health sector with shortage of trained manpower and non- availability of primary health care services to the urban poor. These untrained providers have been ignored by the

central and state Ministries of Health. Even the Supreme Court has ruled out their operations to be illegal and labeled them "quacks".

According to the Indian Medical Council (IMC) Act 1956, only persons having an MBBS degree are allowed to practice allopathic medicine. Similarly, under the Drugs and Cosmetics Act 1940, only persons with MBBS degree are eligible to prescribe allopathic drugs. Under the IMC Act, the state government, the district magistrate and the chief medical officer were responsible for identifying and ending the practice of the unqualified and unregistered practitioners. Quackery is a non-cognizable offence and the quacks are punishable under the IPC420 for unethical practice of cheating the public. In the absence of any single law to exclusively deal with the so called quacks there have been efforts by the IMA to get the anti-quackery bill passed.

The health professionals have been powerful enough to prevent the unqualified practitioners from getting legitimatized through its civil society organizations or licensing arrangements. Medical associations have shown interest and concentrated more on preventing any kind of competition to their profession rather than promoting quality of care.

However, the growth of the practices of these unqualified practitioners in an unregulated manner has led to a growth of various forms of irrational medical practices. These have led to an increase in the income of the practitioners but at the same time have at times proved harmful and damaging for the health of the patient. Since they are the first point of contact for majority of the urban poor the government needs to think seriously about them.

Even though the concerns regarding their lack of skill and malpractices are genuine, it is important to accept that in spite of various laws to check their practice they continue to exist and flourish. Previous experience with Indian law and enforcement agencies have clearly shown that it has been futile to check their practice and hence further tightening of laws by the State to prevent the unqualified practitioners from practicing would bear no fruit. Hence it is essential to think of some other way to tackle this issue.

In the wake of the fact that the state expenditure is only 0.9 percent of total spending which in the near future is unlikely to increase much there is unlikely that there

will be much improvement in the public health infrastructure and whatever will be done will only be a stop gap arrangement. For example the starting of the programme of Mobile Health Clinics in Delhi to cater to the needs of the urban poor has not proved to be that successful simply because it could not visualise that attending to patients in an urban slum two days in a week is not sufficient and where would the patient go for follow up if things did not improve the next day. In the absence of Mobile Health Clinic from the slum four days in a week, patients are forced to consult the unqualified practitioners available in the area.

Here it is important to note that the unqualified practitioners are not only the first point of contact for the urban poor but the very fact that they enjoy their trust and goodwill, are locally available, accessible and affordable clearly shows that they have become indispensable for the community which they serve. Under the circumstances it becomes imperative to train and educate the available unqualified practitioners in the basic curative care and safeguard the interests of people in the urban areas as denying their existence would not help. More evidence needs to be gathered about the treatment practices of the unqualified practitioners which would contribute significantly into understanding the degree of irrational prescriptions so as to be able to plan training input for upgrading their knowledge and skill.

The training of these unqualified practitioners will also be beneficial from the point of view of Public health as presence of uninformed and untrained medical practitioners would prove be detrimental for the health of the people. It should be sufficient to give them short course training in skills which would enable them to treat common conditions included in primary level of healthcare so that they understand the dangers of giving unnecessary injections, wrong and incomplete doses of antibiotics etc and at the same time would be able to identify severe cases which needs to be referred to the PHCs and other public hospitals. They can also be used in providing follow up treatment of TB, Leprosy and other such diseases under the guidance of doctors. Here it would be necessary to establish a good supervision mechanism.

Achieving this would not only ensure a better quality of services on the part of the unqualified practitioners but at the same time would enable the public health system to overcome shortages of staff which is seriously hindering its provision of services and

successfully use a huge pool of resources (unqualified practitioners) which is available and the people are anyway using. Including the unqualified practitioners in the health care delivery by providing training would ensure better utilisation of available resources in the given circumstances. It is important to devise an incentive structure both monetary as well as well as providing other form of opportunities to grow for the unqualified practitioners. Similar programmes like that in Nepal to provide training and promotion opportunities for medical auxiliaries which have met with huge success, can also be started in India by providing a certain percentage of seats in Medical colleges to the unqualified practitioners as an incentive to enable them to become qualified doctors.

India should learn from the experience of China where barefoot doctors have been immensely successful in achieving basic health care for the population. This is evident from its better health indicators in spite of being more populated than India. Here they have very successfully utilised local people in village clinics and primary health centers by providing them training in preventive and curative medicine of both traditional Chinese and Allopathic schools, for periods ranging from one to three years. The skills of these barefoot doctors are continuously upgraded by apprenticeship and in-service courses. An active referral system ensures that only complicated cases reach the country hospitals.

One of the constraints in giving legitimacy to the unqualified practitioners would be the medico-legal issues which can be dealt with by bringing the necessary changes in the legal system and also devising proper methods of supervision. Another stumbling block would be resistance on the part of the established associations of professional doctors like IMA, MCI etc. There should be dialogue with these bodies to build consensus in support of inclusion of the unqualified practitioners in the delivery of health care with adequate supervision. They should be made to understand that this inclusive method would be the best way to regulate them.

The existence of the unqualified practitioners is because they are serving a crucial need of the people and that is, catering to their health need. Once the government is able to provide an alternative source, the unqualified practitioners would disappear gradually on their own.

This alternative could be in the form of a public policy aimed at providing trained paramedic to provide curative care in areas where the unqualified practitioners are flourishing. Introduction of medical courses, below the level of MBBS instead of creating a vast number of graduates in basic sciences would enable the youth to get enhanced employment opportunities.

The recently launched National Rural Health Mission (NRHM), an outcome of government's commitment towards bringing about reforms in the health services, aims to raise public spending on health to 2-3 percent of the GDP and bring about improvement in the health services with particular focus on primary care and targeting the poorer sections among the population. The NRHM also recognizes the important role played by the private practitioners and hence the need to legitimise their position in health care delivery. To achieve this, it proposed to provide training to the Rural Medical Practitioners (RMPs) and the Traditional Birth Attendants (TBAs). Some degree of simple laboratory skills like testing for anemia and some curative skills to assist the ANM can also be provided. It proposed identification of RMPs having basic functional literacy and whose skills can be improved through orientation. This would enable accreditation of the RMPs and the promotion of common treatment protocols and current practices and priorities would be a way forward to ensure quality of services and at the same time would also provide a regulatory framework. This is an important policy initiative which would go a long way in actually reforming the primary level of private provisioning. The Indian government is in the process of preparing a draft proposal to launch a National Urban Health Mission on the same lines and it is essential that this initiative should be replicated here also which would help in improving the quality and accountability of the primary private health services.

National Health Policy of 2002 endorsed the objective of increasing public health expenditure from 0.9 percent of GDP to 2 percent GDP by 2010. It also proposed to increase the state sector health spending from 5.5 percent (of total budget) to 7 percent by 2005, and 8 percent by 2010. To achieve this, enormous political will and significant reordering of resources needs to be mobilized. This would enable addressing issues like increased establishment of health centers for the unreached areas, make up for the deficiency of essential supplies, concentrate on shortage of trained manpower and other such maladies strife in the health system which severely restricted its services and utilisation.

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Draft

Non formal Medical Practitioner

A. Area Identification

Schedule Code..... Date.....

Locality.....

B. Background Information of Medical Practitioners

1. Name of Medical Practitioner:.....
2. Address:.....
   .....
   Telephone:.....
3. Clinic:.....
4. a. Sex: Male/Female b. Age.....years
   c. Caste..... D. Religion
5. Qualifications and Training

Sl. No.	Qualification	Specialization/ Training	Year	Where/ by whom

b. Why did you choose this profession.....
.....

c. System of medicine practiced.(Allopathic, Ayurvedic, Homeo, Unani, Others)
.....
Reason for practicing more than one system of medicine:
.....

d. Affiliation with other doctors, hospitals, nursing homes, associations etc.:
.....
e. Other services practiced other than RMP and Why?.....
.....

C. Details of Clinical Practice and Infrastructure.

6. Details of Practice
   a. Years of experience.....Practicing in the area since.....
   b. Reason for selection of the area.....
   c. Details of Practice/ Service Provision.

Location	Years of practice	Frequency/Schedule (day / week)	Catchment (distance in km)

d. Nature of Practice

Nature of Practice	Average fees of each services	Payment in Cash	Credit	Both
Home				
OPD				
IP				
Minor surgery				
Major surgery				
Others (specify)				

7. Clinic details:

a) Owned / Rented

b) Size of clinic.....sqft

c) Patient waiting area □ Available □ Not-available

If available, then, for no of patients:.....

d) Bed for patient's checkup □ Available □ Not-available

e) Toilet □ Available □ Not-available

f) Arrangements for privacy during examination □ Yes □ No

g) Arrangement to Dispense drugs □ Yes □ No

h) Others (specify).....

B. Staff if any.....

a) If yes then □ Full Time □ Part Time

b) Qualification, Specialisation and Training.....

c) Monthly wage/ Fee .....

D. Financing

a) Location □ Own □ Rented □Other (specify).....

b) Total Cost and Financing

Sl. No	Type of Expenditure	Total Cost	Loan if any	Total Earnings
1.	Capital Cost			
2.	Running Expenses			
3.	Other Expenses			
4.	Rate of Interest on borrowings			

c) Key financing Issues.....

8. A. Profile of Patients

Sl.No	Profile of Patients	Area they come from	Occupation	Age and Sex

B. Average Patient load per day

Season	Months	Patient Load (Per Day)			Remarks
		Average	Min	Max	
Summer					
Winter					
Rainy					

C. Major Diseases Treated (rank according to the patient load)

i) .....
ii) .....
iii) .....
iv) .....
v) .....

D. Is your practice growing? □ Yes □ No

If Yes, then why do you think so.....
.....
.....

9. System of Referral followed

a.) Total no of cases referred to in the last one month.....

b) Proportion of cases referred to:

i. Public hospital..... Where.....
ii. Private hospital Nursing Home.....Where.....
iii. Private Doctor / Clinic (GP/Specialist).....
iv. Other system of Medicine (specify).....

c) What other services / help provided in addition
i. inform the referral doctor.....
ii. Go with the patient.....
iii. Others (specify)

d) Factors influencing referral arrangements
i. Commission from the referral agencies.....
ii. Consideration of emergency/ professional help.....
iii. Competence of referral doctor.....
iv. Issues of accessibility and affordability.....
v. Other factors.....

e) do other doctors refer patients to you?
□Never □Occasionally □Frequently □Most often
What proportion of patient load referred by others(%).....

10. System of Investigation/ Diagnostics

A. How often do you recommend for routine or special investigation?
□Never □Occasionally □Frequently □Most often □In all cases

B. Do you refer patients to a particular diagnostic center? □Yes □No
If No then, how often do patients ask for information regarding which diagnostic centre they should approach?
□Never □ Occasionally □ Frequently □ Most often □ In all cases

If yes then where and what is the bases of your recommendation (Distance, quality, affordability and others).
.....
.....

C. Do you dispense your own medicines? □Yes □No
a) Drugs prescribed in case of major diseases treated.
i. .....
ii. .....
iii. .....
iv. .....
v. .....

D. Do you refer patients to a particular chemist shop? □Yes □No
If No then, how often do patients ask for information regarding which chemist shop they should approach?
□Never □ Occasionally □ Frequently □ Most often □ In all cases

If yes then where and what is the bases of your recommendation (Quality/ Genuineness, Availability of medicines, reasonable price, Other).

.....

.....

11. Cost of Service Provision

A. Fee Structure:

i. Fee at clinic/ home.....
ii. Fee for home visit.....
iii. Charges for inpatient care.....
iv. Other charges (specify).....

B. System of payment followed:

□Cash □ Kind □ Credit □ Cash and Kind

Patient Interview Schedule

1. How often have you visited the unqualified practitioner in the past and what was the purpose?
2. How often did the unqualified practitioner listen carefully to you?
3. How often did unqualified practitioner explain things in a way you could understand?
4. How often did unqualified practitioner show respect for what you had to say?
5. Were you satisfied with the treatment?
6. What do you do if the treatment is not effective?