Mohalla Clinics as an Affirmative Action: An Empirical Study in Delhi

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Introduction

1. Concern towards Public Health

The first and foremost responsibility of state is to provide the social, economic and political security to their citizens to give them the opportunity of better future and eradicate the social evils. One of the most imperative social evils raised in the society is deprived health status which directly targets the marginalized and undeserved clusters.

Despite the commitment and large investment in public Health Sector for accomplishing the goal of Universal Health Coverage, in reality, PHCs are unable to meet the health care needs of most poor people living in Delhi and other urban areas of India. As per the report submitted by Bhatia (2015), in PHCs on average,

Two medical officers responsible for providing care to as many as 400 patients a day.

In India, about 80% of outpatient and 60% of inpatient care is provided by the private sector. This large private primary care sector, accounting for as much as 40% of services, is made up of registered physicians in private practice and a range of unregistered health care providers, that the government considers 'unqualified'. Patients pay out-of-pocket for the services in the private sector, and there is no regulation of fees.

This severely limits access to care for the poor and puts those marginalized people at risk of financial distress. Public financing of health amounts to only 1% of gross domestic product (GDP) and out-of-pocket health spending represents 59% of health care expenditures of which 70% is spent on medicines alone, leading to indebtedness and poverty. Moreover, the challenge extends beyond leveraging additional resources to improving policy capacity, governance, and implementation of government programs. Some consequences of India's distribution of health care expenditure are well illustrated in Delhi where the private sector maintains a dominant position in the delivery of outpatient as well as inpatient health care services, including medico-technical facilities, diagnostic procedures, pharmaceuticals, and hospital construction.

2. Health System in Delhi

Delhi's health system reflects the contradictions of what *Dreze* and *Sen* have called the 'uncertain glory' of India with a population of 1.68 Crores (or 16.8 million) in 2011 with 97.5 % of population living in urban area, 1483 km^2 geographical area, and the population density 11,297 (range 3800-37346/ km^2). It is nearly 18 lakh (1.8 million) or 11% population living in slums and a large proportion of this population is migrants from various parts of country. The number of health facilities available in Delhi varies depending on sources.

The Delhi health authorities have made considerable efforts to respond to their population health and health care system challenges, but the multiple levels of government that are involved makes the whole regulatory policies exceedingly complicated. The Federal government's ministries and departments, the Delhi NCT, and local government authorities (Municipal Corporation of Delhi, the New Delhi Municipal Corporation, and the Delhi Cantonment Board) share responsibility for

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different aspects of the system. As a result, governance and health care are fragmented and complex.
There are some 39 Delhi Government hospitals charged with inpatient care as well as outpatient services, including preventive care and health worker training. The Family Welfare Directorate is also involved along with other agencies of Delhi Government, as well as non-governmental organizations (NGOs) in primary health care activities, schemes to provide financial assistance as well as free services to pregnant women, and adolescent health clinics. In addition, the Delhi NCT has strengthened partnerships with community groups.

3. Mohalla Clinics: An Overview

The Mohalla or community clinics initiative was launched by the government of Delhi under the *Aam Admi Party* (under the supervision of Chief Minister Mr. Arvind Kejriwal) in July 2015, with one clinic in a slum locality. The idea had origin in the success of mobile vans or mobile medical units (MMU). Behind this concept, main aim is to provide free healthcare services through a health facility within a walking distance (around 2-3 km radius or 10-15 min walking), open for at least 4-6 hours of every working day, assured availability of identified basic health services, a medicines, and diagnostic tests to underserved clusters, un-authorized colonies and cluster of migrant population colonies. Some of the key points are mentioned below:

a. An assured package of health services include outpatient consultations, basic first aid services, maternal and child health services including immunization, antenatal and postnatal services, family planning, counseling, and referral to next level of facilities for specialized treatment.
b. Specialists proposed to be available on weekly basis (pediatrician, gynecologist, and ophthalmologist). A system of referral through a tiered approach to health facilities been proposed (though yet to be made fully functional).
c. Sufficient supplies of medicines and diagnostics, free of cost to the people availing these facilities, from an approved list of 108 medicines and provision of less than 200 diagnostic tests.
d. The locations of Mohalla Clinics are decided with inputs from local community/Resident Welfare Associations (RWA)/survey by planning branch/verification of sites by team of health personnel.
e. The private doctors have been recruited to run these clinics at “fee for service” basis at the rate of Rs. 30 per patient as consultation charges. If a helper is positioned, an additional Rs. 10 per patient is paid. The fully ready chamber is made available to these doctors who are empanelled to manage them in 4-6 hours shifts as an outpatient clinic.

Above all, the success of the initiative in Delhi could focus attention on restructuring and revamping primary health care across states. That would be the real contribution of *Mohalla* clinics to India’s health care system.
According to Wadhawan Nikita (2017), in the last two years, as per government data, 110 such Mohalla clinics have been opened that have treated around 8 lakh patients. She also mention the benefits and drawbacks of these Mohalla clinics as mentioned below

Table 1: Drawbacks and Benefits of Mohalla Clinics

Benefits	Drawbacks
Delhi Budget 2016-17, government allotted 16% of outlay, 5259 crores to health.	There are too few clinics to gauge at the full potential.
All consultations, diagnostics and medicines are free.	The initiative is great but the implementation is not uniform.
Received praises across the globe.	Not able to provide all promise services.
Reduced health care cost for lower middle class people.	Control and management of the clinics continues to be a primary problem.

4. Methodology

With an aim of examine the utility and acceptability of the Mohalla Clinics among the marginalized urban population of Delhi. The nature of the study is descriptive in which deductive approach was used. The proposed study seeks the information about the beneficiaries belonging to marginalized group of community in Delhi who are getting benefitted from the very concept of Mohalla clinics in different parts of Delhi. The study is designed in a way that it collects quantitative data for the broader picture and qualitative data to understand the implementation part with an inclusion of three important objectives as mentioned below

I. **To understand the level of satisfaction among the beneficiaries.**
   Under this objective, this study comprises the detailed information about the level of satisfaction of the beneficiaries through understanding the quality, availability and accessibility of services delivery in the Mohalla Clinics.

II. **To analyze the disease burden among the beneficiaries, cost incurred in the Treatment**.
   Under this objective, this study comprises the detailed information about the social cost of the beneficiaries and the incurred cost pay by the patients during the treatment in private hospitals. This study highlight the medical cost (cost per patient for doctors) through secondary data (i.e. analyze the reports and literature reviews present on this issue).

III. **To determine the community participation in Mohalla Clinics**.
   Under this objective, the study was explored the detailed information about the level of participation and their acceptance in the functioning pattern of the Mohalla Clinic through decentralization of resources in the working pattern of the Clinics and also investigate the changes in health status among the beneficiaries.

Operationally, in this present study "Beneficiaries" is defined as the person who are availing the services or can avail the services belongs to poor and marginalized section (including slum dwellers) of the society and this study, geographically cover the areas of South East Delhi included *Sangam Vihar*, *Okhla* and *Badarpur* that covers 4 Mohalla Clinics.

The purpose of selecting these four areas for collecting the sample for the research study is that through literature review it analyses that the majority of population lived in these areas are underserved and migrants with low income due to which number of communicable diseases are more easily spread in these areas which affect the large number of population so as comparison to other areas, so it is important to understand the curability structure of the Mohalla clinics in these areas. For this present study the sample unit was the Beneficiaries (between 15 to 50 year's ages irrespective of the gender) with and inclusion of target Group between 15 to 50 year's ages

irrespective of the gender and beneficiaries who are availing the services of Mohalla Clinic. As a sample for the present study; 100 beneficiaries were selected for data collection in which 50 were men and 50 were women under non-probability conditions.

4.2. Data Collection:

For the study primary sources of data was used. Tools for data collection which was used are:
Demographic schedule: A demographic schedule was prepared to have demographic understanding about the beneficiaries. It included personal information like age, gender, educational attainment, family information which includes number of family members, number of children and number of earning member in the family.
Interview Schedule was prepared which access the two objectives of the study that include the questions to assess the level of satisfaction and cost benefits.

4.3. Data Analysis:

The data was collected and analyzed through Content Analysis (i.e. qualitative data) and Statistical Package for Social Science (SPSS) software (i.e. quantitative data).

5. Results and Discussions

In present study, results and discussions are divided into four sub-sections. As per the objectives and findings of the study, sub-sections are:

a) Background of the beneficiaries,
b) Information about level of satisfaction among beneficiaries,
c) Cost incurred for treatment,
d) Community participation by the beneficiaries.

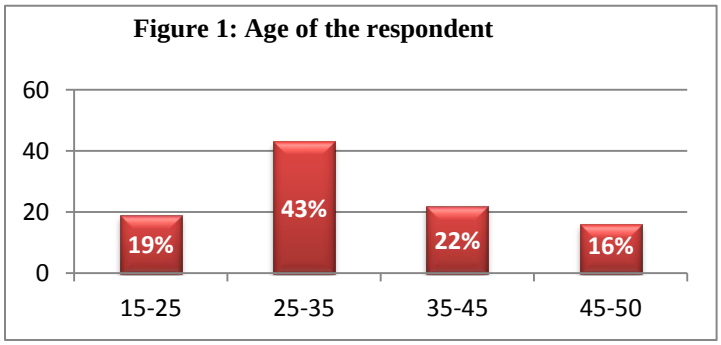
a) Background of the Beneficiaries

Figure No.1: Distribution of Respondent According to Age Group

The figure no. 1 focused on the age of the respondent which is the main criteria to understand the problem related to the health. As per the figure 1 the 19% of the respondents belong to the age group of 15-25, 43% of the respondents belong to the age group of 25-35, 22% of the respondents belong to the age group of 35-45 and 16% of the respondents belong to the age group of 45-50. This implies that communicable diseases have affected more to those people who are more in interaction with the outside environment. According to the study done by Gusmano M.K. *et al.* (2016), most of the community people who are affected by the communicable diseases are working laborers or daily wagers that have a direct contact with the environment. Mostly working labour age group belongs to the 20-40 years of age.

Figure No.2: Distribution of Place of Origin of the Respondent

According to the figure 2 majority (34%) of the beneficiaries were from Uttar Pradesh (UP), 33% of the respondents were from other states like Delhi, Assam and West Bengal, 19% of the respondents were from Bihar and the remaining 14% of respondents were from Rajasthan. A key question in this study was whether the beneficiaries were from Delhi itself or whether they had come to the city from other states. Only 3% of beneficiaries were from Delhi itself. This finding indicates that the migration to the city areas causes a huge influx of socio-economically poor population. The most common reason may be that after marriage beneficiaries may have shifted to Delhi or they must have come to Delhi for employment since Delhi is a metropolitan city. Working in the informal sector and daily wage employment becomes an important option for these beneficiaries.



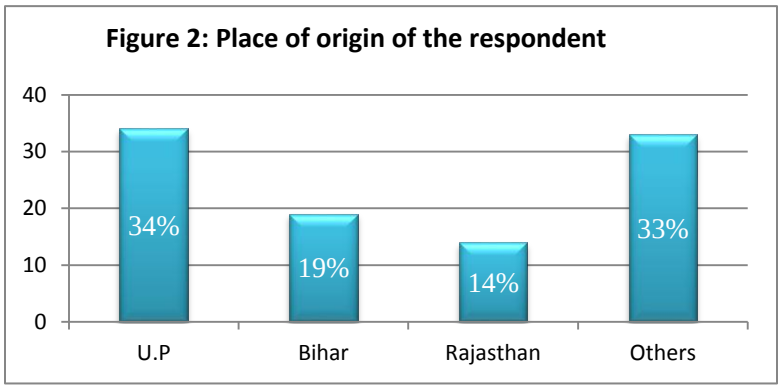


Table No. 2: Respondent's distribution–Marital Status and Type of Family

Demographic variables	Category	No. of respondent	Percent (%)
Marital Status	Married	79	79
	Unmarried	4	4
	Widow	17	17
Type of family	Nuclear family	72	72
	Joint family	28	28
Total		100	100

The above represented the marital status and type of family among the respondents depicts that 79 percent of the beneficiaries were married while 17 percent of the respondents were widow and only 4 percent of the respondents were unmarried. This may be attributed to the fact that the beneficiaries were the only earning person in the family and they did not want to marry due to reasons like inability of their parents to give dowry for their marriage.

The table no. 2 also projected that vast majority (72%) of the respondents were living in nuclear family and remaining (28%) of the respondents were living in a joint family. Now-a-days people do not want to stay with their parents or as a joint family due to urbanization and paucity of resources, living space etc. Even though Nuclear family system is dominant in urban life, Joint family system is good for social bonding and dealing with social problem or other crisis during emergency. The beneficiaries who lived in joint family had an ultimate aim to sustain or expand their business.

Table No.3: Respondent's Family Demographic Schedule

Demographic variables	Group/ Number	No. of respondent	Percent (%)	Mean (Standard Deviation)
Total number of family member	2-5	53	53	
	6-10	38	38	
	11-15	09	09	
Total number of children	1-3	78	78	2.60 (1.181)
	4-6	22	22	
Living Area	Slum Urban	19	19	N.A.
	Sub Urban	81	81	
Earning member in the family	1	18	18	2.45 (1.095)
	2	41	41	
	3	25	25	
	4	11	11	
	5	04	04	
	6	01	01	
Total		100	100	

The previous table no. 3 represents other demographic information about the beneficiaries like number of family member, number of children, living area of the respondent and earning member in the family. The above mentioned data project that, 53% of the beneficiaries had less than 5 family members while 38% of the respondents had 6 to 10 family members and remaining 9% of the respondents had 11 to 15 members in the family.

Majority of the beneficiaries (78%) had 2 or 3 children and remaining of the respondents (22%) had 4 to 6 number of children. It was analyzed that the respondents with 4 to 6 children were not aware about any contraceptives or other family panning methods. Also the reason for having more children was most likely to enhance their business in the future through their children as it creates a labour force but it also reflects the major cause of over population. The mean number of children was 2.60 and standard deviation was 1.18. This shows that most of the Beneficiaries had big family.

More than half of the beneficiaries were living in sub-urban area that was 81% and rest 19 % of the respondents were living in urban slum area. The respondents explained that they were not

able to pay high amount of money for the rented house and their family size was large with less monthly income.

The table no 3 also depicts about the total number of earning member in family. Most (41%) of the respondents had two earning members in the family. One fourth (25%) of the respondents had three earning members, (18%) of the respondents had only one earning member in the family, (11%) of the respondents had four earning members in the family, (4%) of the respondents had five earning members in the family and remaining (1%) of the respondent had six earning members in the family. The mean of earning member was 2.45 and standard deviation was 1.095. It was reported that in this group (41%) both the spouses were working to improve their socio- economic status.

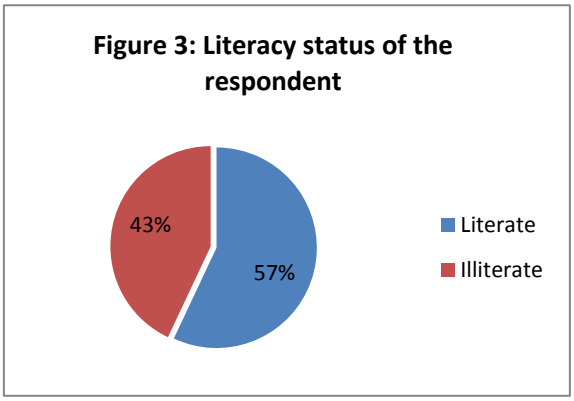


Figure No.3: Respondent's Literacy Status

The figure no.3 reflected the literacy status among the Beneficiaries. Most (57%) of the respondents were literate and the remaining (43%) of the respondents were illiterate. Illiteracy among the Beneficiaries it was found to be due to lack of opportunity to go to school or due to poverty or due to lack of interest in education.

According to Yaya Sanni et. al. (2017), that as per their findings suggested that policies enhancing improved education could benefit health awareness. Poverty elimination and income generation programs among women are also likely to improve awareness about community health clinics in the target population.

Figure No.4: Respondent's distribution–monthly Income

The figure no. 4 depicts about the monthly income of the Beneficiaries. Majority (40%) of the respondents earned between Rs.5001- 10000 per month, (28%) of the respondents earned between Rs.15001 & above per month, (19%) of the respondents earned between Rs.10001-15000 per month and the remaining (13%) of the Beneficiaries earned between Rs.1- 5000 per month. Monthly income of the respondents revealed that the crucial problem faced by these beneficiaries were that of economic one. Insufficient income made it difficult for them to survive and fulfill their basic necessities of life.

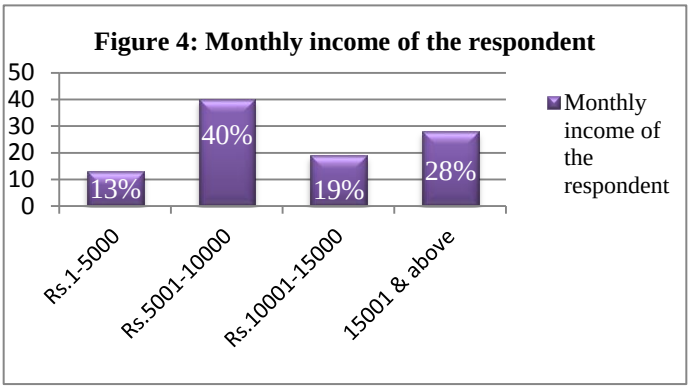
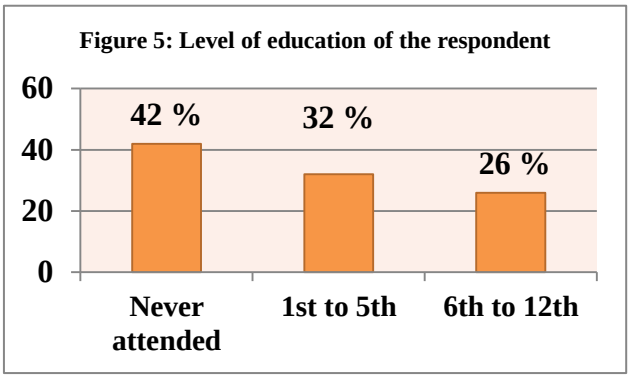


Figure No.5: Respondent's Educational Status

The figure no.5 reflected the very crucial aspect of the demographic profile i.e. education of the beneficiaries. It was reported that 42% of beneficiaries never attended school while 32% of the beneficiaries attained primary education (1st to 5th) and 26% of the respondents who have attained secondary education (6th to 12th). These findings suggested that beneficiaries is more pronounced a midst illiterate as majority of beneficiaries have no formal education.



B. Information about level of satisfaction among beneficiaries,

Figure No.6: Beneficiaries' Satisfaction Strata

The figure no.6 reflected the level of satisfaction among the beneficiaries. Most (55%) of the Beneficiaries are satisfied with the Mohalla clinic concept, while 33% of the respondent Beneficiaries are more satisfied with the Mohalla clinic concept and remaining 12% Beneficiaries are less satisfied with the Mohalla clinic concept. Less satisfied Beneficiaries stated that sometimes doctors are not available on time and due to which the patients suffered a lot in many perspectives.

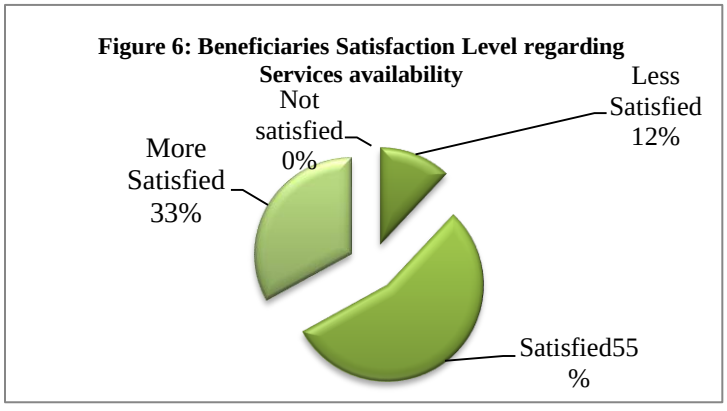


Figure No.7: Availability of Doctors, Treatment, Paramedical Staff and medicines

The figure no.7 reflected the availability of Doctors, Treatment, Paramedical Staff and medicines at Mohalla Clinics. Most (73%) of the respondents were in favour and the remaining (27%) of the respondents were against.

According to Wadhawan Nikita (2017), the doctors working with the project too have pointed to several glaring inconsistencies that include The doctors at Mohalla clinics are paid just Rs 30 per patients and work on commission basis whereas doctors in the hospitals earn more than Rs 50,000 per month. Many doctors are therefore demanding equal work and equal pay from the Government - however it is highly unlikely that the AAP Government will be able to fulfill their demand.

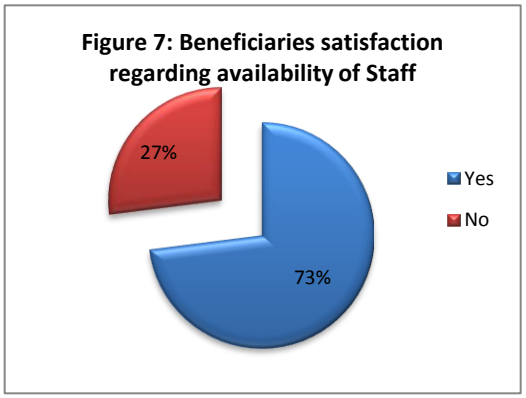
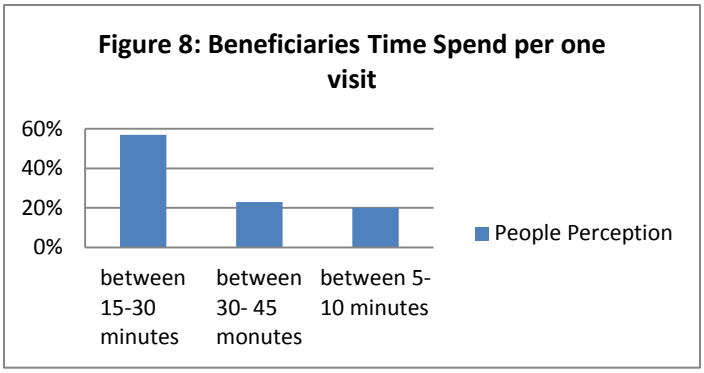


Figure No.8: Beneficiaries Time Spend per one visit



The figure no.8 reflected about Time spends during one visit in Mohalla Clinic. Here (57%) of beneficiaries were spent 15-30 minutes in one visit during their checkups, 23% of beneficiaries were spent 30-45 minutes in one visit during their checkups and 20% of beneficiaries were spent 5-10 minutes in one visit during their checkups. This variation of time depends upon the disease to disease treatment process.Also study find some reasons behind the delay in services like:

i. Crowd
ii. Spend long period of time on one patient
iii. Availability of one doctor at a time
iv. Expand in interval time (more than the time mentioned in the rules).

Figure No.9: Doctor's Time Spend per One Patient

The figure no.9 reflects the time spend on one patient by doctors of Mohalla Clinic. Here 45% of beneficiaries were in favour that doctors spend 15-30 minutes on one patient checkup, 15% of beneficiaries were in favour that doctors spend 30-45 minutes on one patient checkup and 40% were in favour that doctors spend 5-10 minutes on one patient checkup.

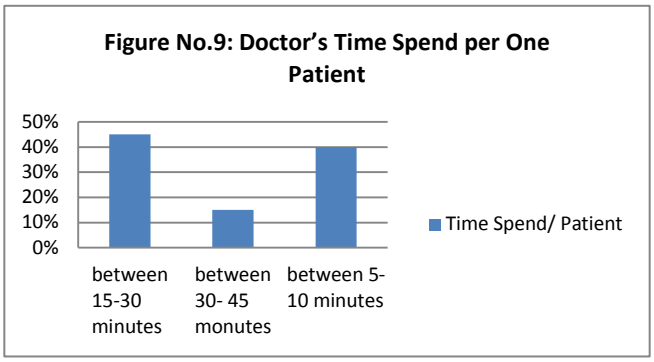


Figure No.10: Doctors Behaviour towards patient

The figure no.10 reflects about the doctor's behavior towards the patient. It shows that most of the patients says good for the doctor's behaviour that is 71%, 3% are not happy with the doctor's behaviour because they are not well treated or sometimes they may cause allergies because of the prescribed medicines given by the Mohalla clinic doctors and 26% of the patients are satisfied with the doctors behaviour. Many of the patients also find the difference in the behaviour in the private clinic doctors and Mohalla clinic Doctors like:

i. Private clinic doctors give more time to the patients for their psychological support but Mohalla clinic doctors give less time due to which patients are unhappy towards the diagnosis process of the Mohalla Clinic patients.
ii. Beneficiaries are more satisfied by the paramedical staff of private hospitals as compared to that of the Mohalla clinics because they are more polite in behaviour, they check the medicines properly before giving and also tell the schedule of taking medicine and they provide all the services in lesser time.
iii. There is no Government monitoring process for the service delaying of the Mohalla Clinics.

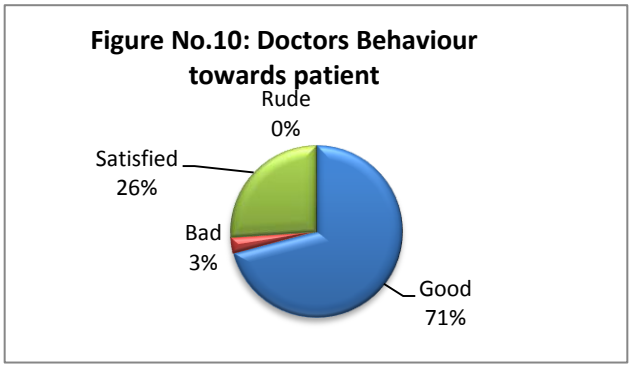
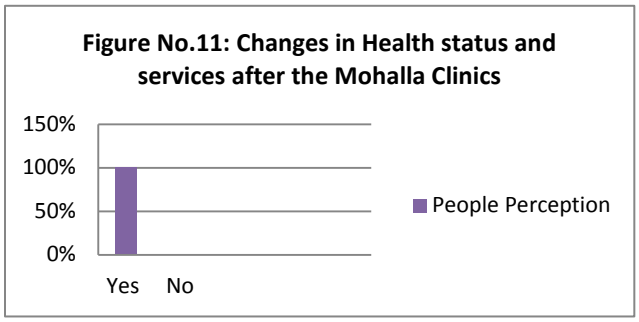


Figure No.11: Changes in Health status and services after the Mohalla Clinics

This figure no.11 reflected that 100% of the respondents have agreed that they have found certain changes in the Health status after the establishment of the Mohalla Clinic like:

i. Seasonal diseases are less spread in the community.
ii. Medicines are available at door step.
iii. Communicable diseases are less spread inside the community.

According to Wadhawan Nikita (2017), people flocked to the Mohalla clinics to avail free checkups and medication, the clinics seemingly have still effectiveness is fully felt.

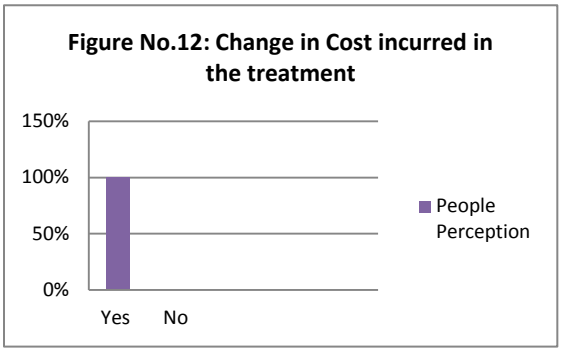


c. Cost incurred in the Treatment

Figure No.12: Change in Cost incurred in the treatment

The figure no.12 reflected that 100% of the respondents agree that they have found certain changes in the cost incurred in the treatment after the establishment of the Mohalla Clinic like clinics is positive with people saving money in consultation, medicines, diagnostic tests and transportation.

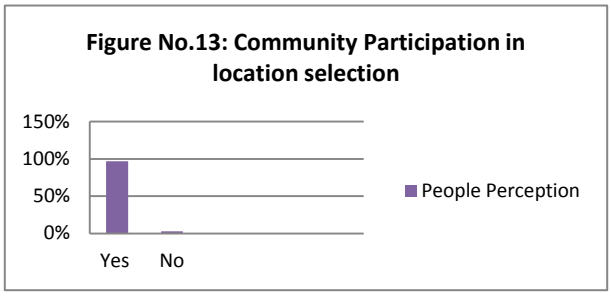
As per the analysis done by Komal, Rai Preeti (May 2017), the Mohalla clinics are positive with people saving money in consultation, medicines, diagnostic tests and transportation. The areas for improvement include better infrastructure, increase in number of medicines, physiotherapy facilities and forward linkages.



D. Community Participation by the Beneficiaries

Figure No.13: Community Participation in location selection

Figure no.13 also illustrates that 97% of the respondents are in favour that they have role in selecting the space for the Mohalla Clinic and 3% were not in favour that they have any role in selecting the space for the Mohalla Clinic. 97% of the respondent who played a role in selection of the Mohalla clinic establishment are selecting the area on two different perspectives:



a. Center of the community
b. Poor people locality
c. % of the respondents admitted that they did not have any role in selection of the space for the Mohalla Clinic because they remain busy outside the community for earning purpose.

Government had followed certain indicators for the IEC (Information Education Communication) to provide exposure to the Mohalla Clinics like:

i. Awareness announcement in the religious centers like Mosque and Temple

ii. Awareness announcement Rickshaws in the community.
iii. Providing pamphlets to the community people.
iv. Banners display at different bus stop and hoardings.
v. FM radios were used as a tool for educating and informing people about this health service availability for the masses.

According to Yaya Sanni et. al. (2017), about one-third (36.7%) of the women were aware of community clinics. Geographical location, level of education, household wealth status and frequency of reading newspaper were found to be significantly associated with awareness about community clinic services. Services reported to be obtained in the community clinics include family planning, immunization, tetanus, antenatal care, vitamin A, and health care for children and child growth monitoring.

Table 4: Community Participation at different level in Mohalla Clinics

S.no.	Service	Yes	No
1.	Role in Regulating the Services	-	1
2.	Beneficiary Monitoring Committee	-	1
3.	Participation in Report Submission	-	1

Table no. 4 shows that there is no participation of community in regulating the services and in report submission. Also there are fewer roles of the people in the services evaluation. The health services especially arrangements like Mohalla clinics also require people's perspective for the betterment of the services. But it was found that there is no mechanism established for the peoples' participation in the services monitoring.

6. Social work Implications and Recommendations

There have been studies which have been focused on the socio economic status and challenges faced by the vulnerable group to fulfill their health needs. This study focused on analyzing the level of satisfaction among the beneficiaries through understanding the quality, availability and accessibility of services delivery in the Mohalla Clinics. This study paid more emphasis to community participation in process of Mohalla Clinic. Various factors mentioned above and helped in designing strategies to deal with the same for long run. So, there is a need to develop a social support mechanism and Strong Community Monitoring process by engaging community people at prior and then government organizations and other NGOs.

The issue of vulnerable group also reflects the sad reality of the poor migrants in the urban for the search of job. These beneficiaries needs considerable support for micro-finance from an organized sector that they do get exploited at the time of need and also they can fulfill the health needs like taking proper nutrient diet for their family which directly creates a strong healthy surrounding for their body. Community participation at every level is very important for the success of the Mohalla Clinic in the community.

6.1. Implications

- Provide adequate education for beneficiaries to promote functional ability in case of emergency in the community during the absence of the doctors.
- Provide adequate training for enhancing their skills and capability for small injuries like cut and wounds through government skill development programs for the beneficiaries.
- Formulation of Beneficiary Monitoring Committee.
- Regular monitoring process done by the Government officials.

- Those who are not involved or don't know about the concept of Mohalla Clinic, encourage them to understand this concept for better implementation.
- Provisions of 24 hours emergency should be established in Mohalla Clinics.
- Improvement include better infrastructure, increase in number of medicines, physiotherapy facilities and forward linkages.

6.2. Future dimension for research

- The researcher for further study must take into consideration other Mohalla Clinics and compare it with the current study.
- The researcher should expand the respondent scale and include those also who wants to prefer the Private sectors for the comparison between the Mohalla Clinics and the Private Clinic (i.e. comparative study is needed).
- More research on community participation in Mohalla Clinics should be taken up.

6.3. Limitations of the study

- The study's sample size was small due to which a clear cut generalization cannot be made.
- Due to less duration of time in data collection, the study covers only four Mohalla Clinics.
- There was dialect problem because respondents were from different states.
- At time the respondents were hesitant to disclose the difficult incidences of their life like limitations of the Mohalla Clinic, doctors availability, Para-medical staff behaviour etc. in such situation convincing the beneficiaries and carrying out the interaction was challenging and time taking.

6.4. Major Findings

- The two most important issues related to healthcare in Delhi were the lack of access to primary healthcare and the lack of sufficient preventive health measures under public health.
- The minor ailments such as fever, headache, simple infections, skin rash etc. accounted for 90 - 95% of ailments, are easily treated in the Mohalla Clinics.
- The Mohalla clinics are open only between 9am to 1pm and most remain closed on Sunday thus creating considerable inconvenience for people in need of medical emergency. "The timing is such that we need to either take off from schools or take a half day from office," lamented a patient at one clinic.
- The doctors at Mohalla clinics are paid just Rs 30 per patients and work on commission basis whereas doctors in the hospitals earn more than Rs 50,000 per month.
- Specialists proposed to be available on weekly basic (like pediatrician, gynecologist, and ophthalmologist) but it is practice only few weeks in the starting time, right now there is no specialist visit in the Mohalla Clinics.
- The clinics were to provide 212 tests free of cost but till now only limited tests are been conducted.
- The existing dispensaries do not provide dental care, so people go to multi-specialty hospitals even for tooth fillings and simple extractions.

- The study also finds that there is no Beneficiary Committee for regulating the services of the Mohalla Clinics.

7. Conclusion

The study reported that beneficiaries who are below the poverty line faces a lot of problems to fulfill their health needs like financial problem to submit the bills of private Medical institutions. Almost every individual of this community poses a challenge to fulfill their health needs because they are unable to bear the economic setback emerge from the private medical sector's expenditure.

Regarding the suffering from any medical ailments like heart disease, diabetes and infections, most of the respondents were not suffering from any kind of major medical ailments. Therefore, they did not face any critical condition in which the Mohalla Clinic doctor's did not diagnose them or they need any special treatment where there is a use of high technical medical equipment.

In light of the above discussion and research findings it is undoubtedly true that migrants who lived in those areas where research was carried out are one of the most vulnerable groups among the unorganized sectors. They work in adverse situations that often put them in various critical situations like handling the goons, dealing with harsh climatic conditions, or comprising with personal hygiene and dignity. Most of these beneficiaries belong to poor families who needs care protection and support for fulfillment of their basic rights. The research highlighted these issues from Social Work perspective as social workers can play and active role in developing strength-based model for such beneficiaries and facilitates adequate policy guidelines at local and national levels.

The Mohalla clinics have brought health higher on the political discourse and agenda in Delhi states and there is high level of interest by Indian states.

It is proposed that in addition to establishing new facilities, a lot can be built upon existing health system infrastructure such as dispensaries, and convergence of functioning of these clinics with other existing/planned mechanisms such as U-PHC (Urban-Primary health Care Centers) under NUHM (National Urban Health Mission).

The Mohalla Clinics are a good start; however, the bigger success of this concept would be when it

- Brings attention on need for stronger primary health care across the country
- Health services acquire the ability to influence electoral outcomes and
- Catalyze efforts to strengthen health systems, amongst other.

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