

# Review of: "The Universal Accessibility Provisions in Hospitals of New Delhi, India"

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Potential competing interests: No potential competing interests to declare.

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The reviewer declares no potential conflict of interests

## I. STRUCTURE

The research article under review is divided into sections, such as introduction, review of literature, need for the study, material and methods, results, discussion, conclusion, and references. Additional sections cover details on conflict of interests, ethical clearance, tables, and acknowledgments.

This article is not any disability access audit report-though it comes closer to being so. The structure of an audit report, if it was one, will typically contain an introductory section, the scope of the audit, and a summary opinion statement of the auditor with recommendations for time-bound action and suggested dates for re-review. Note that this paper is meant to serve as a statement of fact or expression of opinion about the truth and fairness of the fact, figures, and statements and not an audit certificate (which ratifies the truth and correctness of a fact, figure, or statement). These distinctions are important in the absence of auditor reporting standards, as well as an official certifying body to issue disability audit testimonials for agencies or organizations in the country. Towards the end, there can be conclusions such as (a) a clean report; (b) a qualified report with few riders; (c) an adverse report; or (d) a disclaimer report where one is unable to express any opinion. The missing sub-sections in the main article are details on operational definitions of key variables, a statement on the research design adopted for this study, a mention of what theoretical framework was espoused or how sampling estimation was undertaken,

## II. CONTENT

If the key variables in this study are identified as UNIVERSAL ACCESSIBILITY, and the targeted population is PUBLIC HOSPITALS in Delhi, these phrases should have been operationally defined in observable-measurable terms. Does it not include hospitals run by the Railways, Employee State Insurance, AYUSH Departments, and Military Hospitals? Clear statements on sample inclusion and exclusion criteria would have clarified the ambiguity of their inclusion or non-inclusion. Presumably, Primary Health Centers, nursing homes, private clinics, sub-centers, community health centers, sub-district hospitals, district hospitals, first referral units, dispensaries, medical laboratories, and diagnostic centers are all excluded. The inclusion/ exclusion criteria and delimitation of the study could be given.

## III. TIMELINES

As per section 45 of the Rights of Persons with Disabilities Act, 2016, the time limit of five years from the date of notification imposed by the Central Government for making all existing infrastructure and premises to become accessible ended on June 15, 2022. The period of study when responses were received from 26 out of 32 participant hospitals in Delhi using the Right to Information (2005) is mentioned as falling between April 2022 and August 2022. Delhi reported the first case of COVID-19 in the 1<sup>st</sup> week of March 2020. Note that hospital infrastructure during the pre-COVID19 era was drastically transformed during the pandemic. Further, funding, the priority of services, accessibility, quality, and quantity of facilities also changed for better or worse, for PWDs during this period<sup>1-3</sup>. These factors have not been taken into account in this investigation.

1. Venkatesan, S. (2021). How does the pandemic impact society? *International Journal of Recent Scientific Research* 12(9): 42971-42975. DOI: <http://dx.doi.org/10.24327/ijrsr.2021.1209.6187>
2. Venkatesan, S. (2021). Book Review: *COVID-19: Epidemiological And Mental Health Challenges*. Authors: R. C. Jiloha & J. Kishore. New Delhi: Century Publications. 2021 Edition. *Indian Journal of Clinical Psychology*, 48(4): 112-115.
3. Venkatesan, S. (2021). Book Review: *COVID-19 In India: Problems, Challenges, And Strategies*. Editors: Swaran Lata, Shikha Verma & Shobana Joshi. New Delhi: Global Vision Publishing House. 2021 Edition. *Indian Journal of Clinical Psychology*, 48(4): 108-111.

## IV. ACCESS INDIA CAMPAIGN

There is an ongoing Access India Campaign (a.k.a. Sugamya Bharat Abhiyan) launched by the Department of Persons with Disabilities, Ministry of Social Justice & Empowerment, Government of India, on December 3, 2015, on the occasion of International Day of Disabilities. This program covers three parts. Part A: Built Environment Accessibility. Part B: Transportation System Accessibility. Part C: Information and Communication Eco-System Accessibility. The Accessibility

Audit Checklist used as part of ACCESS INDIA CAMPAIGN provides a 40-page inventory which, after evaluation of a facility can be graded on evaluation rank from 1: Highest (Hazardous, Inaccessible and Unsatisfactory); 2: High (Inaccessible and unsatisfactory); 3: Moderate (Unsatisfactory but acceptable); 4: Low (Accessible and Acceptable - Access Code Compliant); and 5: Lowest (Accepted as a Best Practice in Accessibility). In short, the audit evaluation covers the building, environment, and service parameters.

4. <http://www.iphnewdelhi.in/WriteReadData/Access%20Audit%20Checklist.pdf> Retrieved November 7, 2022

## V. REVIEW OF LITERATURE:

Talib et al<sup>5</sup> received reports of being "satisfactory" from 96 respondents (including staff and visitors) who rated on a survey questionnaire the extent of provision for PWDs in three hospitals in Perak, Malaysia.

5. Talib, Y. A., Ghani, N. I., Ismail, K., Salleh, N. A. (2016). The provision of disabled facilities in Public Hospitals. In: *Matec web of conferences* (Vol. 66, p. 00081). EDP Sciences.

Venkatesan et al<sup>6</sup> used a cross-sectional comparative case study design in 2012 to undertake a disability access audit of six representative public utility buildings in an institution working for persons affected by communication disorders run under the aegis of the Government of India. Results on the 117-item Disability Access Audit Checklist based on-round verification by expert raters showed 9.1 % and thereby leaving a vast scope for improvement. The tool was prepared based on the principles of universal accessibility, such as used by all, flexible use, accessible space and use, simple and intuitive use, use requiring little effort, safe use, and access to information. At that time, professional disability access audit bodies, apparatus, and activism in the field were still an emerging phenomenon in the country<sup>7</sup>.

6. Venkatesan, S., Jayakaran, G.T., Purusotham, P., & Rafi, M. (2012). Disability access audit of public service facilities. *Journal of All India Institute of Speech and Hearing* 31: 190-201.
7. Friedner, M., & Osborne, J. (2013). Audit bodies: embodied participation, disability universalism, and accessibility in India. *Antipode*, 45(1), 43-60.

Over the next few years, some more estimations of disability access to health care started to take shape in the country. In another early attempt, an on-site cross-sectional facility-based assessment for physical accessibility of 67 primary health care centers (PHCs) in the Dakshina Kannada (DK) district in Karnataka was undertaken by using a checklist. Data were analyzed for frequencies and percentages. Out of 67 PHCs, 57 (85%) PHCs had an accessible pathway and 60 (90%) PHCs had a ramp for wheelchairs. Only 25 (36%) PHCs had accessible doors. No PHCs had height-adjustable examination tables, disable friendly toilets and only two PHCs had accessible weighing scales<sup>8</sup>.

8. Nischith, K. R., Bhargava, M., & Akshaya, K. M. (2018). Physical accessibility audit of primary health centers for people with disabilities: An on-site assessment from Dakshina Kannada district in Southern India. *Journal of Family Medicine and Primary Care*, 7(6): 1300.

## VI. PROCEDURE:

Most of the studies on audit evaluation research typically involve a cross-sectional current measure of the parameters against predetermined standards (benchmarks). The parameters usually target a process, impact, outcome, or summative evaluation. The authors of the study under review have undertaken an innovative approach of collecting and corroborating access with RTI notes submitted by respective auditees or the agency being audited. Along with this approach, actual ground checks or direct observation against the chosen parameters-at least on sub-sample would have aided cross-verification, comparison, and agreement between the two pieces of information, and enhanced the validity of the audit. Further, nothing is mentioned about time and labor costs, post-audit monitoring and control, and repeat audits of the same agencies after a specified length of time would help strengthen the reliability of this report.

## VII. SCOPE OF STUDY

Accessible healthcare covers both hard and soft parameters. It requires availability of services, physical access and accessible physical design of healthcare infrastructure, access to required information, easy communication, trained staff with reasonable accommodation (sensitivity to individual differences, and disabilities), awareness of specific needs of PwD, and skills to take care of their needs, affordability, and acceptability of the services. Accessibility standards for medical care are more specific. Supported by legislative and policy measures.

Whether all the 21 disabilities listed under the official definition in the country were included? Whether all the types of barriers to accessibility, such as architectural barriers, communication barriers, attitudinal barriers, and social/economical barriers considered? Among the factors that limit the accessibility to healthcare, there are elements like distance to the healthcare facility, transportation problems, inaccessible physical structure of the facility, inaccessible environment in the facility, inaccessible services, lack of information, inaccessible physical and electronic information, and communication material, inability to access and operate information and communication technology products, and use multi-media contents and services, inaccessible equipment and furniture, lack of understanding of needs of PwDs, staff untrained in removing the barriers, inadequate staff, lack of coordination among health care providers, negative attitude of staff, denial of treatment by staff, harmful practices, particularly while dealing with persons with psychological disabilities. Are all these factors taken into account for the measurement of the targeted variable (accessibility) in this study?

Creating an accessible environment and services requires specific checks on the entrance/exits to the premises of the health facility, the path from the health facility entrance to parking, parking, front entrance of the building or accessible alternative entrance, doors, routes to move to the areas related to getting the required healthcare and other related services, reception counters and service windows, writing desk/table, seating/waiting area, phone for voice, data and video communication and for access to various apps and services, amenities like toilets, bathroom, changing rooms, etc. To add to this list, information, including electronic information, a room like examination rooms, laboratories, medical equipment, aids and appliances for an easy approach, and manpower training in accessibility are all necessary. To what specifics or micro level the present audit was undertaken is NOT specified.

## VIII. SAMPLING:

The investigators have chosen 32 public hospitals in Delhi out of which only 26 responded. According to one source, there are 107 public hospitals in urban Delhi as of 2019<sup>9-10</sup> (CEIC, 2019). How was the sampling estimation carried out not explained?

9. [https://ddc.delhi.gov.in/sites/default/files/2022-06/Health\\_Report\\_2015-2022.pdf](https://ddc.delhi.gov.in/sites/default/files/2022-06/Health_Report_2015-2022.pdf) Retrieved November 7, 2022

10. <https://www.ceicdata.com/en/india/health-infrastructure-government-hospitals/government-hospital-delhi-number-of-hospitals-urban> Retrieved November 7, 2022

## IX. CONCLUSIONS

Although not the main target of this study, the newly conceptualized or introduced *Aam Admi Mohalla Clinics* have been a design innovation to provide universal access to health care with one such facility for a 10000 population within a one-kilometer distance. This finds no mention either in the introduction, conclusion, or implications for the study. On the whole, and in sum, the article is commended as a needed area for study which is likely to serve as inviting as well as an opportunity to trigger more similar research in this country.