LifeSpring™ Maternity Hospital
Safe ✲ Clean ✲ Affordable

Analyzing the Local Healthcare Demand to Design a Sustainable Primary Healthcare Model for

LifeSpring Hospitals

USAID FROM THE AMERICAN PEOPLE | Pahal Partnerships for Affordable Healthcare Access and Longevity | IPE GLOBAL Expanding Horizons. Enriching Lives.

Contents

Executive Summary

Historically, the delivery of health services in urban areas has been sub-optimal and fragmented. As a policy response, in May 2013, the GOI launched the National Urban Health Mission (NUHM) to reach an estimated 22.5 million urban poor spread out in over 1,000 cities. NUHM in its current stage and pace would take few more years to address the health needs of the entire population in urban India. Meanwhile, the private sector, which already has a strong presence in urban areas with a stake of nearly 70% health care coverage, has the potential to plug in service gaps for the urban population including marginalized and urban poor. In this context, with the goal of playing the role of a catalyst and convener of a market based healthcare delivery systems, USAID and IPE Global have partnered to leverage the financial and technical resources to ensure greater participation of the private sector towards delivering public health through it program 'Partnership for Affordable Health and Longevity' (PAHAL). To fulfill its objectives, PAHAL has entered into a technical partnership with LifeSpring Hospitals (LSH) in order to develop a sustainable healthcare model with an objective to provide affordable maternal and child health care services to the unreached population and thereby an increase utilization of services that are currently being offered at the hospital level.

In order to develop a comprehensive Primary Healthcare Model for LifeSpring, Hospitals, the assessment was undertaken to capture the current health care needs and practice, available options, community's preference. Efforts were also directed to examine the scope of the proposed Community Extension Centre (CEC). Separate attention was also given to understand the level of efforts and possible role of the staff that would be required to reach out to the community with information and services so that the community would be informed about the health needs, options and cost associated with it.

A qualitative assessment was done in the last week of March 2017 in three identified areas of Hyderabad using Focus Group Discussions(FGD), In depth Interview (IDI) covering community (both male and female), visit to health facilities and interacting with the health care givers and also the program management staff of the LSH.

Low awareness about health and preventive behaviors was found common across the sites with high demand for services

The findings of the assessment suggest that for routine maternal and child health care services, it is the Anganwadi Center and the Asha (in some areas) that are the providers which are largely confined to nutritional supplementation and routine immunization (RI). Low awareness about health and preventive behaviors was found common across the sites with high demand for services, especially quality care for pediatric, obstetric and gynecological care as well as for non-communicable diseases. For pregnancy related services, community is depend on the private qualified health care providers, especially females including delivery while people with lowered socio-economic strata, resort to public facilities. Community

representing both the categories are well concerned with the quality of the health care services. Unqualified health care providers are not consulted for pregnancy related care since they are mostly male. Factors influencing utilization of care in the private sector include socio-economic, access, entitlements and perceived quality of care. There is low-demand but high-need for spacing methods since permanent sterilization at very young age are practiced frequently without considering future consequence and option of choice. The outreach staff members need capacity building to engage communities effectively including targeting and follow up with clients, organizing awareness events with local existing community groups and front line staff of public health system to enhance synergy with government system.

The findings clearly suggest that there is a demand for health care services, particularly maternal and child health. The community has also expressed willingness to pay against the accepted quality of service. The proposed model has three important components a) Community b) CEC and d) LH Hospital. The CEC, which is the central piece of the primary health care model would play a critical role in this model by providing immediate health care needs of the community and also ensure forward linkage with the LifeSpring Hospitals for tertiary care services. The success of the model would therefore depend on easy availability of health care services which includes counseling, diagnosis, drugs and referral support, in case of emergency. There is a need to ensure focus attention at the community level by the Out Reach Workers who would be engaged to increase the demand for service.

The outreach staff members need capacity building to engage communities effectively including targeting and follow up with clients

Background

URBANIZATION IN ASIA

South Asia's urban population grew by 130 million people between 2001 and 2011, and it is forecast to rise by almost 250 million in the next 15 years[1]. South Asia is currently home to more than 23 percent of the world's population and at least 14 percent of its urban population. It is also home to the largest concentration of people in the world living on less than $1.25 per day as per the World Bank's poverty estimates. By 2030, Asia would account for more than 50 percent of the urban population. Estimates suggest that by 2015, 18 of the world's 27 'mega cities' (cities with over ten million people) will be in Asia (including Delhi, Mumbai, Kolkata in India)[2,3].

By 2050, India is projected to add 404 million urban dwellers, China 292 million and Nigeria 212 million. To add to this, over half of the world's slum dwellers would be living in Asian cities by 2020.

URBANIZATION IN INDIA

Over the last two decades, India's urban population increased from 217 million to 377 million. This is expected to reach 600 million, or 40 percent of the population by 2031[4].

Nearly one-fifth of India's urban population lives in slums. Slums are overcrowded, often polluted and lack basic civic amenities such as clean drinking water, sanitation and health facilities. Not all urban poor live in slums and slum dwellers in urban areas are not necessarily poor. However, slums do present a marginalized living condition. A study on living conditions in eight cities found that poverty was more prevalent in slum areas than in non-slum areas[5]. Urban growth is a result of a natural increase in population, net migration from rural to urban areas or even the reclassification of towns.

1 Ellis, Peter, and Mark Roberts. 2016. Leveraging Urbanization in South Asia: Managing Spatial Transformation for Prosperity and Livability. South Asia Development Matters Washington, DC: World Bank. doi: 10.1596/978-1-4648-0662-9. License: Creative Commons Attribution CC BY 3.0 IGO
2 The State of the World's Cities Report 2006/7
3 World Urbanization Prospects, 2003 Revision, (The Department of Economic and Social Affairs. of the UN)
4 New Climate Economy Report by the The Global Commission on the Economy and Climate
5 Kamla Gupta, Fred Arnold, H. Lhungdim; Health and Living Conditions in Eight Indian Cities; National Family Health Survey (NFHS-3) India, 2005-06, Ministry of Health and Family Welfare Government of India

STATE OF HEALTHCARE IN URBAN INDIA

The private healthcare sector is responsible for the majority of healthcare in India. Most healthcare expenses are paid out-of-pocket by patients and their families, rather than through insurance. This has led many households to incur Catastrophic Health Expenditure (CHE) which can be defined as health expenditure that threatens a household's capacity to maintain a basic standard of living[6]. With government expenditure on health as a percentage of GDP falling over the years and the rise of private health care sector, the poor are left with fewer options than before to access health care services. Private insurance is available in India, as are various government-sponsored health insurance schemes. According to the World Bank, about 25% of India's population had some form of health insurance in 2010. A 2014 Indian government study found this to be an over-estimate, and claimed that only about 17% of India's population was insured. About 78.8% (i.e. close to 80%) of the urban population is accessing services from private healthcare providers (Table 1). More than half of the populations from the low economic categories are going to private healthcare providers in case of hospitalization[7]. A substantial part of the poorer section of urban population is going to private facilities for child birth (Table 2).

Quality healthcare services in the private sector are often expensive and beyond the means of the urban poor. The Government hospitals are stretched thus creating a major healthcare services supply gap. Due to high catastrophic health expenditures and limited availability of affordable quality services, the health of the urban poor is compromised.

Urban Population (% of total) in India

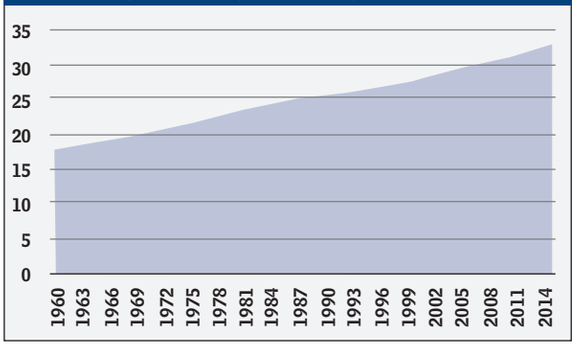


Table 1: Percentage distribution of spells of ailment treated during last 15 days by level of care, 2014

Level of Care	Rural	Urban
HSC, PHC & others*	11.5	3.9
Public hospital	16.8	17.3
Private doctor/clinic	50.7	50.0
Private hospital	21.0	28.8
All	100.0	100.0

** includes ANM, ASHA, AWW, dispensary, CHC, MMU.*
Source: Health in India, NSS 71st, Round (January – June 2014), GoI

Table 2: Percentage distribution of women aged 15-49 who gave birth of child during last year by place of childbirth for each quintile class of MPCE – Urban

Quintile	Public	Private	Home	All
Q1 (Poorest)	53.5	31.7	14.8	100
2	47.7	40.7	11.3	100
3	42.1	47.0	10.8	100
4	31.8	59.8	8.2	100
5 (Richest)	18.9	77.0	3.1	100
All	41.7	47.5	10.5	100

* MPCE - Monthly per capita consumption expenditure (INR)
Source: Health in India, NSS 71st, Round (January – June 2014), GoI

URBAN HEALTHCARE DELIVERY IN INDIA

Historically, the delivery of health services in urban areas has been sub-optimal and fragmented. Past interventions have tended to be in the form of vertical programs focusing on particular diseases, rather than investments made to strengthen broader urban health systems. The facilities established under GOI's urban Reproductive and Child Health (RCH) Program along with the limited urban health facilities established by urban local bodies have been the mechanism for delivering health in the urban context. These facilities suffered from weak referral linkages, are underutilized, vary in norms and quality, and have limited scope of services, such as in community outreach and health promotion.

6 "Catastrophic Health Expenditure and Poor in India: Health Insurance is the Answer?"
7 MPCE - Monthly per capita consumption expenditure (INR) Source: Health in India, NSS 71st, Round (January – June 2014), Government of India

NUHM proposed Population Coverage

429
Cities

220
million people

"The National Urban Health Mission would aim to improve the health status of the urban population in general, but particularly of the poor and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system, partnerships, community based mechanism with the active involvement of the urban local bodies."
– NUHM Framework, 2013

As a policy response, in May 2013, the GOI launched the **National Urban Health Mission (NUHM)** to strengthen health service delivery in urban areas. However the NUHM is currently in its nascent stages with a focus on rationalizing and creating urban health infrastructure and recruitment of human resources.

Health Condition of India's Urban Poor

- U5MR 72.7% against urban average of 51.9%
- 46% under-weight children among urban poor; urban average 32.8%
- 46.8% women with no education; urban average 19.3%
- 44.4% institutional deliveries; urban average 67.5%
- 71.4% anaemic among urban poor; urban average 62.9%
- 18.5% urban poor have access to piped water supply; urban average 50%
- 60% miss total immunization before completing one year
- Poor environmental condition with high population density
- Poor access to safe water and sanitation
- High incidence of vector borne diseases among urban poor

Core strategies of the NUHM Framework

- Improving the efficiency of public health system in the cities by strengthening,revamping and rationalizing existing government primary urban health structure and designated referral facilities
- Promotion of access to improved health care at household level through community based groups – Mahila Arogya Samitis
- Strengthening public health through innovative preventive and promotive action
- Increased access to health care through creation of revolving fund
- IT enabled services (ITES) and e-governance for improving access improved surveillance and monitoring
- Capacity building of stakeholders
- Prioritizing the most vulnerable amongst the poor
- Ensuring quality health care services

Despite the current efforts of the GOI through NUHM, there is a clear opportunity for the private sector to help bridge the healthcare service gap.

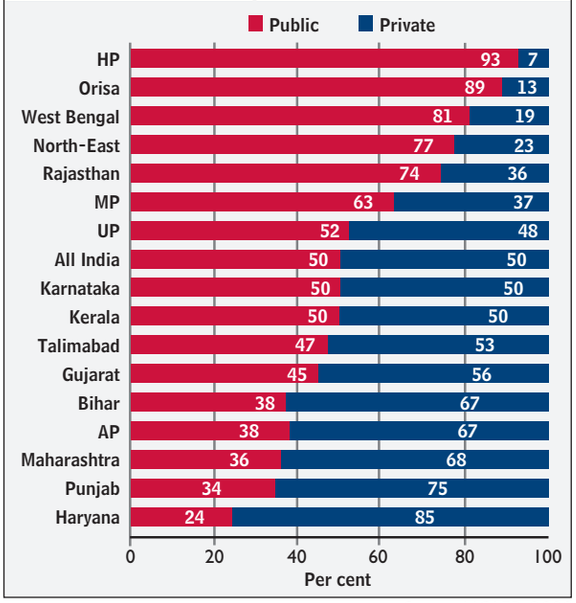
EMERGENCE OF THE PRIVATE SECTOR IN URBAN HEALTHCARE DELIVERY

The private sector in India plays a key role especially in primary curative services and an important role in the delivery of hospital services. However the private sector providers are highly unregulated and disaggregated. The private sector consists of a wide range of providers from private medical practitioners of many different systems of medicine, paramedics and even traditional practitioners who possess no formal training. Surveys further indicate that the private sector is an important source of care even where public services are available. The distribution of patients between private and public sector hospitals provides us some insight about the availability of private sector across the Indian states. The draft report[8] on Urban Health Task Force under the Ministry of health & Family Welfare, Government of India recognizes that contracting the delivery of health services to the private sector is a viable option to consider as government health facilities do not have adequate reach in urban slums leading to low demand and poor utilization. With the new CSR policy of 2013, CSR

8 Draft Final Report of the Task Force to Advise the National Rural Health Mission on "Strategies for Urban Healthcare". May 2006. Source: http://www.mohfw.nic.in/NRHM/Task_grp/Report_of_UHTF_5May2006.pdf.

has rapidly evolved in India with some companies focusing on strategic CSR initiatives to contribute toward nation building. Gradually, the companies in India have started focusing on need-based initiatives aligned with the national priorities such as public health, education, livelihoods, water conservation.

Figure 9.9: Distribution of inpatients between Public and Private by State



Source: NCAER, 2000

EXPERIMENTS IN PRIVATE SECTOR LED URBAN HEALTHCARE MODELS

'Saathiya' Initiative, Abt Associates'

Objective: Addressing the reproductive health needs of young married couples belonging to lower socio-economic groups.

'Saathiya' was a PPP program associated with the Merrygold Health Network Hospitals in Uttar Pradesh and Uttarakhand. Implemented by Abt Associates since 2007, Saathiya was designed to address family planning and reproductive health needs of young married couples belonging to lower socio-economic groups by delivering quality reproductive health, family planning services, with a focus on PPIUCD services. Saathiya had a large network of private sector pharmacies, family doctors, Indian Systems of Medicine and Homeopathy (ISMH) and specialist obstetrician-gynecologists that had undergone training to strengthen their family planning knowledge and counseling skills. The project successfully established five nodal clinical training sites and developed a pool of master trainers within the network. As a result, these institutions saw an increase in client footfall as well as newer opportunities to develop the hospital as a training site for other services and also an increased credibility among its peers.

Mohalla Clinics in Delhi, 2016

Objective: Use of technology innovations to better engage communities.

About 1,000 Mohalla clinics are proposed to come up in Delhi in the coming years. These clinics offer screening, treatment, diagnostics and ambulance services for referral, all free of cost. The diagnostics are carried out by Swasthya Slate. This $600 device, the size of a cake tin, performs 33 common medical tests including blood pressure, blood sugar, heart rate, blood hemoglobin, urine protein and glucose. Each test only takes a minute and the device uploads its data to a cloud-based medical-record management system that can be accessed by the patient.

Community Based Health Insurance (CBHI), Sure Start – Path Nanded

Objective: Social protection for maternal care.

This model introduced a CBHI scheme for MNH care within a target slum population of Nanded city. The intervention consisted of a Needs Assessment for design, formation of a service providers' network and implementation of the community based health insurance scheme known as *Apni Sehat*. The outcomes included reaching out to 30,000 people and benefitting 664 families and 161 mothers and newborns. Institutional deliveries increased to 90% in 2011, compared to 60-70% in 2008.

Private Sector created over

70%

of the new beds, increasing its share of beds between 2002 -2010*

**India Healthcare: Inspiring possibilities, challenging journey; McKinsey & Company; December 2012*

The PAHAL Project

The urban poor or the Base of Pyramid (BOP) population spending less than $8 per day, are chronically underserved when it comes to basic necessities, especially healthcare. Despite challenges of access, the BOP population represents a significant unfulfilled demand. While there has been growing policy and project focus on addressing the health needs of the urban poor through the public health systems, there are gaps and challenges in the service delivery, which makes this group vulnerable and dependent on the private sector which exceeds public health spending but is also highly fragmented. The private sector provides more than 75% of healthcare services to this segment and it is largely financed through out-of-pocket payments.

This has led to the growth of private-sector led Inclusive Business Models (IBMs) and growing recognition that poor are "clients" rather than just "beneficiaries" creating a potential market for affordable and quality healthcare. Several IBMs today exist in healthcare delivery, outreach and medical technologies with significant potential to improve the landscape and health outcomes for the poor. There is improving level of support for IBMs from government, donors and the private sector (impact investors, angel investors, PE funding, etc.). However, while the environment is improving for IBMs, they still face a number of challenges especially when it comes to those focusing on urban primary health care because of the nature of services and type of cliental.

Towards the same, **USAID** and **IPE Global**, have partnered to leverage financial and technical resources via project **PAHAL – Partnerships for Affordable Healthcare Access and Longevity**.

Reach 10 Million Urban Poor in India

By 2020 Pahal will

Reduce Out-of-Pocket (OOP) expenditure by 30%

PAHAL aims to provide catalytic support to growth stage scalable social enterprises in developing affordable & quality healthcare solutions for the urban poor. PAHAL is a **collaborative platform** which seeks to connect, capacitate and catalyze innovative social enterprises focused on improving health outcomes.

PAHAL, was created with a vision to build an inclusive and self-sustainable health ecosystem that will strengthen private healthcare networks to expand and scale-up their services and coverage for the urban poor.

The project identifies that the private sector, with its strong entrepreneurial culture, exemplary skill sets and access to capital, has the potential to solve some of the biggest healthcare challenges faced by the urban poor with a special focus on maternal, neonatal, child health, family planning & TB services for underserved urban communities.

The **Program Goal** is to reduce preventable morbidity and mortality among women and children in urban areas through improved access to affordable, quality RMNCH+A services and better health seeking behavior.

The intended PROJECT outcomes are:

- Increased access to affordable & quality health care ensured for 10 million urban poor
- Out-of-Pocket (OOP) Expenditure for urban poor for health care reduced by 30%

PROJECT STRATEGIC FRAMEWORK

PAHAL follows an ecosystem approach leveraging partnerships & innovations to promote inclusive and sustainable healthcare solutions. The strategic focus of the Project will hinge on providing **technical and financial advisory** to Inclusive Business Models catering to the urban poor, which will in turn help to improve access to quality affordable healthcare solutions.

In its first year, the Program established partnerships with a key healthcare provider Merrygold Health Network aligned with the goal of improving access to affordable primary care for India's underserved.

Merrygold Health Network is India's largest social franchising model of Hindustan Latex Family Planning Promotion Trust with scale up potential to reach over 20,000,000 and scale up to 1,000 network hospitals and 700 MGHN facilities. The network offers quality affordable maternal care, childcare, family planning services.

LifeSpring Hospitals

A joint venture of HLL Lifecare Ltd. and Acumen Fund focused on delivering quality, affordable maternity care for low income women & children. LifeSpring Hospitals (LSH) currently operate a 12-hospital network based on a standardized, no-frills services model with a strong focus on clinical and operational protocols. The first low cost, high quality hospital for maternal health called LifeSpring Hospitals at Hyderabad in 2005. The focus on a standardized, no-frills services model with emphasis on clinical and operational protocols allows LifeSpring to:

- Service higher volumes of deliveries and out-patients per bed per month
- Charge prices that are 20-30% lower than those in private hospitals
- Maintain high levels of quality control

The LifeSpring facilities currently cover a population of one million in Hyderabad

The LifeSpring facilities currently cover a population of one million in Hyderabad (11 facilities) and Vishakhapatnam (1 facility) and plan to scale up activities to the states of Odisha, Jharkhand, Gujarat and Madhya Pradesh (35-40 facilities), thereby increasing its reach to 8 million. The service mix includes pre-n atal care, deliveries, post-natal care, family planning, pharmacy, pediatric care, immunization and diagnostics. With an average 500 deliveries and 93,000 OPDs per annum, the LSH facilities are currently operating at 30-40% capacity signifying need for rapid demand generation.

Community Engagement

LSH hospitals is committed to providing quality, affordable and dignified care to the lower and middle income groups families in urban areas. With the team of 28 OBGYNs, 30 Anesthetists, 20 Pediatricians and 4 General Surgeons their chain of 12 hospitals provide OPD services to more than 10,000 clients per year and have delivered nearly 50,000 babies till date. Although services are predominantly related to maternal care, the hospitals provide pediatric and gynecological care as well.

LSH plans to operationalize ten community extension centers (CEC) in 2017. They have initiated operations through the first CEC in Annojiguda which is affiliated to the Boduppal hospital. The CEC is a brick and mortar clinic located within the community and currently offering the following services:

- Weekly OPD services by a MBBS doctor
- Monthly OBGYN services through a specialist
- Lab/diagnostics are provided once a week
- Monthly Health Camps/Special Outreach Days
- Availability of an ambulance on call

The community extension activities implemented at each CEC are managed by LSH's team consisting of one Business Executive and one Outreach Workers (ORW) per hospital. The Business Executive or Marketing Executive is responsible for organizing community based events; liaising with important members of the community; supervising the work of the ORW and supporting the linkage of the client with the facility. The ORW is responsible for conducting house to house visits to identify and motivate the pregnant woman; liaising with the community level care providers and community structures; and supporting organization of community events.

The community extension activities implemented at each CEC are managed by LSH's team

LSH organizes a range of community-based events which include – health camps for mothers, free BP checkups at bus stops and temples; counselling through ambulance workers at government hospital and other sites; counselling through Business Executives on two wheelers; awareness rallies with school children; and felicitation of and competitions for pregnant women and delivered clients. In addition to the events, as discussed, the ORW conducts house to house visit to orient women; meets with AWWs and attends SHG meetings.

IPE Global and LifeSpring Hospitals entered into a technical assistance MoU in April 2017 to help strengthen LSH's community engagement activities and support the development of a self-sustainable CEC model for further scale-up. As a first step towards this, IPE Global's PAHAL team conducted an assessment of the CEC and current community engagement activities undertaken by LSH.

Understanding & Assessing Communities

OBJECTIVES OF THE ASSESSMENT

The assessment of levels and avenues of community engagement was carried out with the following objectives:

1. Review & understand the existing LSH community engagement model
2. Access existing mechanisms of community mobilization in LSH catchment area
3. Suggest models of community Engagement
4. Design Implementation framework for roll-out

METHODOLOGY/ASSESSMENT SAMPLE

LifeSpring has 12 hospitals in Hyderabad with plans to operationalize 10 extension centers in the coming year. The analysis of current utilization statistics[9] revealed that six hospitals had very low utilization rates (5-12%) while the rest exhibited moderate utilization rates (25-45%). Applying a 30% sampling rate three hospital areas were identified as the required sample size. The sample was stratified by utilization rates and one community catered by hospital with moderate utilization rates and two hospitals with low utilization rates were selected through convenient sampling. Hospitals where extension centers have not been planned were excluded from the sampling unit. The selected areas were:

Community Extension Centre	Affiliated LifeSpring Hospital	Utilization Rate
Rasoolpura CEC	Bowenpally Hospital	33%
Annojiguda CEC	Boduppal Hospital	13%
Attapur CEC	Puranapul Hospital	12%

The field activities planned included:

- Meetings with LifeSpring leadership/management
- Visits to three LifeSpring Hospitals
- Visit to one operational Community Extension Centre
- Visit to three communities/catchment areas
- Meetings with Ward/Municipal Official/Opinion leaders

9 Proportion of deliveries being conducted vis a vis the capacity of the facility, calculated annually

The analysis of current utilization statistics revealed that six hospitals had very low utilization rates

Table 1: Assessment methods with sample size*

Method	Target Participants	No. of Participants
Focus Group Discussion with Women (3)	Women of reproductive age group – mix of pregnant women, women with young infants, women with under 5 children	45 women
Focus Group Discussion with Men (3)	Men – FP users with children under 5 years of age	36 men
Small group discussion (3)	Hospital/Community Extension Centre staff	12
In-depth Interviews (4)	Community health workers. – AWWs, ASHAs and ANM	9
	Ward/Municipal Official	3
	Clients of LifeSpring at the facility	9
	LifeSpring leadership/management	1-2

**A detailed list of assessment tools and list of people met are provided in Annexure 1 and 2 of this report*

LIMITATIONS

Community Extension centers have not been established or currently not operational in Rasoolpura and Annojiguda and the Attapur extension Centre has recently started services in December 2016. Therefore findings on extension centers are restricted to the limited services being provided at the Attapur Centre.

Assessment Findings

DEMOGRAPHIC AND POPULATION PROFILE

According to a 2012 report submitted by GHMC to the World Bank, Hyderabad has 1,476 slums with a total population of 1.7 million, of which 66% live in 985 slums in the "core" of the city (the part that formed Hyderabad before the April 2007 expansion) and the remaining 34% live in 491 suburban tenements[10]. About 22% of the slum-dwelling households have migrated from different parts of India in the last decade of the 20th century, and 63% claim to have lived in the slums for more than 10 years[11]. Overall literacy in the slums is 60–80% and female literacy is 52–73%. A third of the slums have basic service connections, and the remaining tenements depend on general public services provided by the government. According to a 2008 survey by the Centre for Good Governance, 87.6% of the slum-dwelling households are nuclear families, 18% are very poor, with an income up to ₹20,000 ($300) per annum, 73% live below the poverty line, 27% of the chief wage earners are laborers and 38% are illiterate.

The LifeSpring Hospital and/or CEC catchment areas are not slums in the traditional sense. They are better described as low-income pockets of the city. The areas visited by the Project Team were resettlement colonies with pucca tenements. A list of LifeSpring Hospitals, CEC's and estimated population coverage is provided in Table 2.

10 "World bank team visits Hyderabad slums". The Times of India. 12 June 2012.
11 "Exploring urban growth management in three developing country cities" (PDF). World Bank.

Table 2: Coverage area of LifeSpring Hospitals				
LifeSpring Hospital Name	**Name of Ward/ Municipality**	**Est. Population Coverage**	**Extension Center**	**Est. Population Coverage**
MoulaAli	Kapra	266,000	Malkajgiri	200,000
Mallapur	Kapra	114,000		
Boduppal	Uppal Kalan	117,000	Annojiguda	75,000
Vanasthalipuram	LB Nagar	133,000	Anand Nagar	100,000
Champapet	LB Nagar	187,000	Meerpet	100,000
Puranapul	Karwan	186,000	Attapur	200,000
Mehdipatnam	Mehdipatnam	149,000		
Kukatpally	Kukatpally	212,000	Jagadgirigutta	200,000
Alwal	Alwal	137,000	Balaji Nagar	100,000
Bowenpally	Contonment	270,000	Rasoolpura	200,000
Chilakalguda	Secunderabad	250,000	Bholakpur	200,000
Amberpet	Amberpet	190,000		
Visakhapatnam	Vishakaptnam	170,000	Atchyutapuram	75,000

The list of localities covered by the three facilities visited under this assessment and their distance from the hospital is presented in Annexure 4.

Rasoolpura is a registered slum next to the Begumpet airport, with concrete lanes and water supply from the Municipality once in four days for a period of 45 minutes. It has a population of 2.5 lakhs with proportionate representation from Muslim and Hindu communities. All households have individual toilets and open defecation was not reported, even among children. Most households are employed in domestic work or daily wage activities. The environmental surroundings were not clean, solid waste dumps, stagnation of water and open sewage were visible across the locality.

Annojiguda area was developed under the Rajiv Awas Yojana in the year 2008 and has 88 building with 33 apartments in each block. It has a total population of 12,000. The one room tenements have regular water supply from Hyderabad Metropolitan Water Supply & Sewerage Board and solid waste management system through Greater Hyderabad Municipal Corporation. Male members of the community are engaged in various jobs such as peon in the bank, office security, driver and auto driver, while women are employed as domestic help in the suburban IT hub 'Singapore township'. The community is predominantly Hindu (SC/OBC) with a small population of Christians and Muslims. The locality was the cleanest of the three areas visited, had vast open areas.

Attapur area which was a village (Chintalmate) is now urban agglomeration since 30-35 years. It is a part of ward number 24. The locality has a population of 15,000 and is the designated place for the LSH extension Centre. The tenements are at par with middle class localities with a mix of independent bungalows and smaller one room pucca households. The community is composed of Muslims (50%),

Most households are employed in domestic work or daily wage activities

Hindus belonging to Reddy and OBC castes (40%) and Christians (10%). The male community members are engaged as daily wagers, car cleaners, plumbers, washer men, taxi drivers and vegetable vendors; and females as maids, daily wagers construction workers, sweeper at school or other institutions. The area has a big migrant population as well which migrates seasonally in search of daily wage activities. There appears to be a pocket of middle class Muslims in the area managing tourism businesses as well. The locality receives municipal water every alternative day. The environmental surroundings were moderately clean and solid waste dumps or any other hazards were not identified.

DISEASE PROFILE

Focus groups and interviews revealed that the communities suffer from **respiratory ailments** such as common cold, pneumonia, bronchitis and asthma attributed to the pollution. Water stagnation also results in increased density of mosquitoes and consequent diseases such as **malaria, chickungunya and dengue**. Women complained of weakness due to low levels of hemoglobin. Common ailments among children include common **fevers, acute respiratory illnesses and diarrhea**. A few women reported gynecological ailments and infertility. Men and women reported the prevalence of non-communicable diseases such as **hypertension** and **diabetes**. Rampant alcoholism and use of tobacco was reported.

Each community has an Anganwadi Centre through which they access pre-school, nutrition and immunization services

AVAILABILITY OF HEALTH PROVIDERS AT THE COMMUNITY LEVEL

Each community has an *Anganwadi* Centre through which they access pre-school, nutrition and immunization services. The **ANM** visits these centers once a month to provide vaccination and ante-natal care. The **ASHA workers** have not been designated in Rasoolpura and Attapur. Annojiguda has an ASHA worker. All communities have private providers and pharmacies. Most of them are either informal providers (**RMPs**) or ISM (Indian System of Medicine) doctors providing allopathic care. None of the areas had a female practitioner. A transact of approximately 500 meters across the localities revealed the presence of 5-6 health care providers.

AVAILABILITY OF CURATIVE CARE SERVICES

Several private and public facilities are available to the three communities visited that provide primary, secondary and tertiary curative services. As discussed in the previous section, the provision of services related to health promotion is limited to the AWW/ASHA and the ANMs in the community. The various options for curative care available in the localities are listed in Table 3.

Table 3: Options for Healthcare Services

Area	Primary Care		Secondary Care		Tertiary Care	
	Public	Private	Public	Private	Public	Private
Rasoolpura	ANM Services Electronic UPHC	Several RMP doctors	Paldas Hospital	Mahindra Hospital LifeSpring Hospital	Gandhi Hospital	Mahindra Hospital
Annojiguda	ANM and ASHA Services PHC at Narapalli	Several RMPs	Ghatkesar Area hospital	Madhav Nursing Home Janapada LifeSpring Hospital	Koti hospital	Madhav Nursing Home, Janapada
Attapur	ANM/ASHA PHC Rajender Nagar 104 mobile clinic	RMPs Taj Clinic (BUMS)	Dudhbodi Area Hospital	Janani Hospital Soumya Hospital Rama Hospital Ushodaya hospital LifeSpring Hospital	Nilofer Hospital Nammapalli Hospital Jajgikhana Maternity Hospital	Vijay Mary Hospital

PREFERENCE FOR CURATIVE PROVIDERS

The communities had differing preference for providers based on multiple factors.

Day to day health problems: All three communities preferred to either visit the local RMP or use over the counter medication from the pharmacies for common fevers, cough and injuries. Some residents however expressed a demand for qualified medical practitioner and indicated visiting nearby nursing homes for even minor problems.

Major or long term problems: The communities overwhelmingly preferred a tertiary government facility for major problems. However, this preference was equal for government and private facilities in Attapur.

Maternity services: Women sought antenatal care mostly from the private sector. However, they visited the government facility at least once to register their names. Alternatively they sought care from the ANM at the community level in order to be registered for government services. Based on social and economic consideration, described in the next section, women sough delivery services both from public and private facilities.

Postnatal care: Was largely missing for the mother and the child and women visited the delivery facility after a month to seek follow up services.

Family Planning: Little awareness and hence demand for spacing methods, women sought terminal methods of FP from the public facilities.

Little awareness and hence demand for spacing methods, women sought terminal methods of FP from the public facilities

Gynecological services: Women preferred to either defer care or sought care from private providers for gynecological issues. Infertility care was mostly sought from the private providers.

Pediatric ailments: Private providers are the preferred choice pediatric ailments. Women were not aware of the availability of Oral Rehydration Solution with the AWW/ASHA and did not seek their services. There is a huge demand for quality pediatric and gynecological care closer to the communities.

FACTORS INFLUENCING THE PREFERENCE OF CARE PROVIDER

Factors influencing the preference for the provider are:

Economic: Families which can afford prefer to seek it from the private sector owing to the perception of quality and access. However, the choice to incur out-of-pocket expenditure goes beyond affordability owing to social factors as well.

The cost of the first child birth is borne by the maternal family of the woman and therefore there is a social pressure to seek 'quality care'

Social: The cost of the first child birth is borne by the maternal family of the woman and therefore there is a social pressure to seek 'quality care' resulting in a preference for the private sector. Families reported taking a loan to fulfill this social obligation. The cost of delivering the second child is borne by the in-laws and the decision to choose a public facility over a private one is generally related to affordability. However, some women reported delivering their second child in a private facility as well owing to a growing demand for 'quality care'

Access: The availability of several nursing homes and small hospitals in these areas influence the preference as well except in Annojiguda which does not have access to these facilities within the 5 km radius. The RMPs are sought for ailments which are considered minor; however there is a growing demand for services from a qualified provider for minor ailments as well.

Quality of care: The assessment explored the definition of quality among the respondents. Quality is perceived as

- Clean and hygienic facility
- Responsive and kind facility staff who treat patients with dignity

- Wait time for receiving services
- Flexibility in the number of care takers allowed with each patient –termed as a safety factor
- Paid service is better service
- Exposure to other infections and dead patients in public facilities
- Outcome of the event – healthy mother and child, disease managed and cesarean avoided

Based on this perception of quality most residents prefer the private sector, every time when economics permit, and for major short term events, even when they cannot afford the services. The perception of a good outcome is also a reason for families seeking care in a public facility, as they believe that government hospitals have qualified doctors and do not overmedicate, prescribe unnecessary diagnostics or perform unwarranted surgeries.

Entitlements: The assessment found that entitlements are a factor for only the economically weaker families as even though the care in the public facilities is free of cost the entitlements do not cover the cost of seeking such care. The family incurs ₹2000 to ₹3000 per delivery on transport (mother's and daily transport costs of family members. to and fro from the facility) and lost wages.

Economically weaker families factor in entitlements while selecting providers as the cost of seeking care is not included in the free public facilities offered

OUT OF POCKET (OOP) EXPENDITURE AND DEMAND FOR HEALTH INSURANCE

The monthly income of the families ranges from ₹5,000 in Rasoolpura to ₹40,000 in Annojiguda to ₹10,000 in Attapur on an average. All three communities reported incurring ₹300-₹800 per month on health expenditure. Averaging for an annum (as communities said 'major events do not occur every month'), the families spend about 20% of their income on health related issues. The cost of managing major illnesses and deliveries range from ₹10,000 to ₹35,000 and for pediatric illnesses this ranges from ₹4,000 to ₹5,000. Respondents reported taking loans from family members, friends and chit funds to pay for these expenses. This results in substantial mental stress, social costs and compromising on other household expenses. The cost of seeking care is as follows:

- Minor illnesses (cough, cold fever): The families spend between ₹300-₹500 while seeking care from the local practitioner (RMP).
- Moderate event (food poisoning, pediatric cases requiring admission): The families spend between ₹4,000–₹5,000 while seeking care from the local nursing homes.
- Major events (surgery, delivery, and chronic illnesses requiring admission): The families spend between ₹10,000 and ₹35,000 while seeking care from the private sector.

Many respondents hold Aarogyasri (state government's insurance program for tertiary care) cards in Rasoolpura; however this does not cover maternal care or other issues that currently result in OOPs for the residents. While women were not aware, men in Rasoolpura reported paying into an insurance (could not indicate the name) with a premium of ₹3,500. One informed man in the FGD group reminded the others of the payment. Residents in the other two locations are neither covered by Aarogyasri nor by any private health insurance. None from all three communities were registered with RSBY.

The concept of health insurance was alien to all three communities and therefore this was explored further by describing the social protection tool to the respondents. All respondents unequivocally expressed a demand for health insurance and indicated that they are willing to pay a monthly premium ranging from ₹100 to ₹200 for such coverage.

The concept of health insurance was alien to all three communities and therefore this was explored further by describing the social protection tool to the respondents

KNOWLEDGE AND PRACTICE RELATED TO HEALTH

With the exception of antenatal care, institutional delivery and need for hygiene, the FGD respondents were hugely unaware of preventive measures for maintaining health among mothers and children. Areas of concern include lack of knowledge about:

- Diet for pregnant and lactating mothers
- Care during pregnancy
- Maternal emergencies
- Need for post-natal care for neonates and mothers
- Home based neonatal care
- Prevention of dehydration
- Preventive products available with the AWW/ASHAs – chlorine tablets, ORS, condom
- Spacing methods
- Point of use' care for water

Focus groups did not reveal any specific practices of concern however, most respondent sought care for minor and major ailments from providers while residents of Rasoolpura had heard of LifeSpring hospitals. The respondents in Attapur and Annojiguda were not familiar with its services. Even the private providers in these two localities were unfamiliar with the facility.

DECISION-MAKING PROCESS

The decisions pertaining to care seeking, especially for maternal services, are taken by the husband of the woman in consultation with his wife. In Rasoolpura (more economically weak than the other two areas) respondents said that it was the head of the household who makes the decision. The decision is mostly economic and relies on the ability of the family to take and repay a loan.

GENDER PERSPECTIVE

Substantial proportion of respondents in Annojiguda and Attapur said that women are involved in the decision making process with respect to place of delivery. In Rasoolpura however, both men and women responded that the decision is left to the head of the household indicating that lower status accorded to women in this community. Domestic violence was reported from both Rasoolpura and Annojiguda and not explicitly in Attapur. Women were articulate in all three communities, literate to the level of at least 10th standard and exhibited awareness about the social issues. The preference for son was indicated in all three communities however, including among women.

FINDINGS AT THE COMMUNITY LEVEL

Two of the three areas visited by the team had special outreach activities being implemented on the day of the visit. These are the areas from where LifeSpring gets the largest proportion of its clients and also organizes maximum number of outreach camps. However, a substantial proportion of the men and women were not aware of LifeSpring Hospitals and their services. The clients interviewed revealed that they heard about LifeSpring from ex-clients and not from the Business/Marketing Executives or the Extension workers or the outreach camps.

Women in 2 out of 3 communities reported physical violence- which is an astonishing revelation

The community teams of LSH were reaching out to the CHWs, ORW, AWW, ANM, the ASHAs (if present), private providers and opinion leaders. However, the presence of a large network of Self Help groups (both men and women) has not been identified and considered as of yet by the LSH team in Attapur and Annoujiguda. The community team could not provide an estimate of the number of groups in Rasoolpura, although they reported having contacted one such group.

The Outreach Workers (ORWs) interviewed revealed that they cover a population ranging from 1.8 lakhs in Boduppal and Puranapul to 2.7 lakhs in Bowenpally. ORWs visit each household to check if a pregnant woman resides there.

Once the ORW meets the woman she asks her about the state of her pregnancy and informs her about the services available at LSH. Specifically she shares information about the camp; location of the hospital; cost of care; availability of a first free antenatal checkup; emphasizing the commitment to avoiding unnecessary cesarean sections. Once the woman is enrolled and attends the camp, the same message is provided and the woman invited for a free diagnostics weekly event.

(i) When asked, one ORW mentioned that she identifies 18-20 pregnant women each day. The assessment finds this number to be an over-estimation based on population statistics for the given area and unless the

ORW is making only two visits per month to the area (which was not the case) she is not likely to find 18-20 women during each visit. Data pertaining to number of women converted as LSH clients through this approach will have to be analyzed to understand the efficiency of this approach.

(ii) ORWs seemed to lack an understanding of the catchment area, the number of households and generally dependent on their supervisors, the Business Executives to plan their field activities. The ORWs reported receiving orientation upon induction and on the job training to perform their duties. This includes a basic understanding of maternal and child health. However, the interviewed ORWs were observed to be not very knowledgeable about the issues and were not sharing this information with the clients. The 'counselling' is limited to sharing information about the LSH services. Furthermore they lack the capacity to identify community needs and demands from health care services.

(iii) The Business Executive similarly covers 30-35 localities under the LSH coverage area. He or she prioritizes the areas which have chosen to utilize LSH services for conducting camps. Areas from where women have not sought LSH services are visited once in three months (rough calculation on an average).

(iv) The mapping of distance from each of the locality provides the areas that could be prioritized for the camps, as interviews with clients reveal that the

Once the woman is enrolled and attends the camp, the same message is provided and the woman invited for a free diagnostics weekly event

decision to utilize LSH services was due to the recommendation of a happy client in the immediate community and not from the outreach camps. The Business Executives have been encouraging local providers and AWWs to refer clients to the LSH on a commission basis. This has resulted in a few referrals, however the providers who are mostly male do not receive female clients and the AWWs caters to a lower socio-economic group that does not perhaps have the economic bandwidth to access private services.

FINDINGS AT THE COMMUNITY EXTENSION CENTRE (CEC) LEVEL

The CEC in Annojiguda coverage area has been operational for the past four months. Current CEC services include:

- Weekly OPD services by a MBBS doctor
- Monthly OBGYN services through a specialist

Areas from where women have not sought LSH services are visited once in three months

While the consultations and some medication are free of charge, the lab diagnostics are billed to the patient. Till date the Centre has registered 10 ANC clients and referred two for delivery at the LSH. The Centre currently lacks any health awareness material and has not been organizing any specific behavior change communication activities aimed at maternal and child health. Very few women or men met during focus group discussions were aware of the CEC.

FINDINGS AT THE LIFESPRING HOSPITAL LEVEL

All current clients (including postpartum and antenatal women) interviewed at the facility level said that they had heard about LSH through a former satisfied client i.e. through positive word of mouth. Even upon encouraging several times

clients did not offer any suggestions for improvement, expressing that they were extremely satisfied with the care.

Some areas of concern or improvement were observed and they are:

- The first interface between the client and the facility is through the Nurse Administrator who counsels the client. This counseling is however limited to the services available and the costs. The **counseling could be expanded** to incorporate several MCH behavior change communication topics and birth planning.

- All mothers met had been advised to buy a feeding bottle by the Pediatrician and asked to give formula feed as the first feed. This is against the tenets of **GoI's Skilled Birth Attendance policy** which promotes exclusive breast feeding till six months of age.

- There are missed opportunities for generating a **demand for spacing methods of FP** at the facility level. The client is counseled by the doctor following the delivery and there is a provider bias may be at play as well. Primi-paras are often not counseled about spacing methods as doctors assume that they may be unwilling to adopt methods before they complete the desired family size. Most conversations of FP therefore are targeted at the multi-gravidas for limiting methods. While there is a general lack of demand in the communities for spacing methods, there is an opportunity for creating the demand.

- The **USP of LSH** which is the effort that is put into ensuring a normal delivery – this communication to the client needs further amplification. In addition, clients who have undergone a CS need to be informed of the cause for the operation – most women did not know why they had to undergo a CS.

Till date the Centre has registered 10 ANC clients and referred two for delivery at the LSH

'Doctors, nurses and ayas, all respond promptly upon seeking help'.

'I had a cesarean but they really tried hard to ensure a normal delivery'.

'Safety is the best quality of this hospital, two caretakers were allowed by the side of the patient, ensuring she is never left alone'.

'We were examined comprehensively, attention was paid and we were asked several questions to understand our problem'; are some of the comments of the satisfied clients.

Summary of Community Assessment

Based on the assessment the existing gaps and barriers to community engagement and the available opportunities have been summarized below:

PROGRAMMATIC AREA: HEALTH AWARENESS AND PREVENTIVE KNOWLEDGE

Existing Gaps

- Current sources of information are community health workers and mass media
- Limited contribution of LSH teams towards generating awareness
- Awareness areas include maternal nutrition, early pregnancies, spacing of pregnancies, neonatal care and child nutrition and care

Opportunities

- Establishment of more CECs to disseminate health awareness material
- Behaviour Change Communication (BCC)
- Innovative mHealth application for household visits and outreach camps
- Training of nurse administrator on client communication

PROGRAMMATIC AREA: DEMAND FOR SERVICES

Existing Gaps

- Current demand for pediatric care, gynecological issues and NCDs
- Create demand for spacing methods in community

Opportunities

- Introduction of these elements through CECs
- Demand for spacing can be created through BCC at community and facility level
- Opportunity for delaying first pregnancy can be created by specially targeting newly married couples

PROGRAMMATIC AREA: UTILIZATION OF SERVICES

Existing Gaps

- Women seek antenatal care but visit public facilities for delivery due to benefits under JSY
- Substantial out-of-pocket expense
- Maternal services available through other private hospitals as well; one costing less than LSH (3,000 for normal delivery) was reported at Annoujiguda
- Current CEC services free of cost, need to introduce a user fee

Opportunities

- Demand for insurance and willingness to pay the premium.
- Community based insurance schemes and privately provided insurance schemes
- Amplification of LSH USP in every communication; expanded basket of services through the CEC to increase footfalls of decision makers

PROGRAMMATIC AREA: TARGETING APPROACHES

Existing Gaps

- Lack of understanding of the coverage area and customer profile among the ORWs
- Not all localities covered at the same frequency with outreach camps
- Despite BP camps, most people met did not know about LSH
- Efficiency of house to house visits is low, data not separately captured for footfalls emanating from such visits
- Self Help Groups have not been adequately targeted
- One ORW per LSH coverage area limits the quality of support she can provide in increasing utilization of services

Opportunities

- Mapping of the localities to identify important stakeholders; expected number of pregnancies, under five children, eligible couples and adolescent girls by each locality
- Phasing approach to covering fewer localities, saturating and moving to newer localities
- Leveraging self-help groups creating awareness, introduction of commission and identifying potential clients
- Redefinition of CE team to incorporate incentivized community workers and groups under the IPE partnership

Phasing approach to covering fewer localities, saturating and moving to newer localities

PROGRAMMATIC AREA: CAPACITIES FOR COMMUNITY ENGAGEMENT

Existing Gaps

- ORWs and Business Executives and nurse administrators, lack skills in counselling
- Facility nurses may also require additional capacities to counsel mothers on breastfeeding, family planning and neonatal care to amplify the message – currently being done by the Doctor

Opportunities

- Revised job descriptions and capacity building inputs to the staff who interface with the client
- Reference material to support ongoing capacity needs in counseling and community engagement

PROGRAMMATIC AREA: MCNH SERVICE COMPONENTS

Existing Gaps

- Gynecological care, infertility, sexually transmitted diseases, post-natal and neonatal care currently not available at the CEC level
- Post-natal and neonatal follow up is limited to first five days in the hospital

Opportunities

- Introduction of additional services at the CEC level.
- Capacity building of ORWs and CEC Centre functionaries to provide postnatal follow up and HBNC (home based neonatal care) counselling

Community Engagement Strategy

LifeSpring Hospitals (LSH) currently operate a 12-hospital network based on a **standardized, no-frills services model** with a strong focus on **clinical and operational protocols**. The focus on a standardized, no-frills services model with emphasis on clinical and operational protocols allows LifeSpring to service **higher volumes** of deliveries and out-patients per bed per month, charge prices that are **20-30% lower** than those in private hospitals and maintain high levels of **quality control**.

LSH offers Prenatal Care, Family Planning, Normal & C-sec Deliveries, Postnatal Care, Immunization, Pediatric Consultation and Diagnostic services. The current utilization statistics indicate that the LSH hospital performs at approximately 26% of its total capacity. With a clear need to strengthen demand for its services and to improve linkages with the community, LifeSpring decided to setup a network of Community Extension Centres in around its Hospitals in Hyderabad and Vizag. Each LSH is to be supported by 2 CECs in its operational area. The estimated population covered by each CECs ranges from 1-2 lakhs. Given the first CEC was functional only in December 2016, the current community engagement model is not leading to expected levels of hospital utilization and not generating the desired result.

Existing Community Engagement Model

Outreach Worker

- Catchment – 75,000 population
- Demand-generation and BCC
- Door-to-door visits
- Counsel on health behavior
- Inform community about LSH

Community Extension Centre

SERVICES PROVIDED
- Weekly OPD-MBBS doctor fee of cost
- Monthly OBGYN services
- Lab/diagnostics – once a week
- Ambulance – on call
- Monthly Special Outreach Days

LifeSpring Hospital

30 BEDDED HOSPITAL
AFFORDABLE MATERNITY CARE
SERVICES OFFERED –
- Prenatal Care
- Family Planning
- Diagnostics
- Normal & C-sec Deliveries
- Postnatal Care
- Immunization
- Pediatric Consultation
- Pharmacy

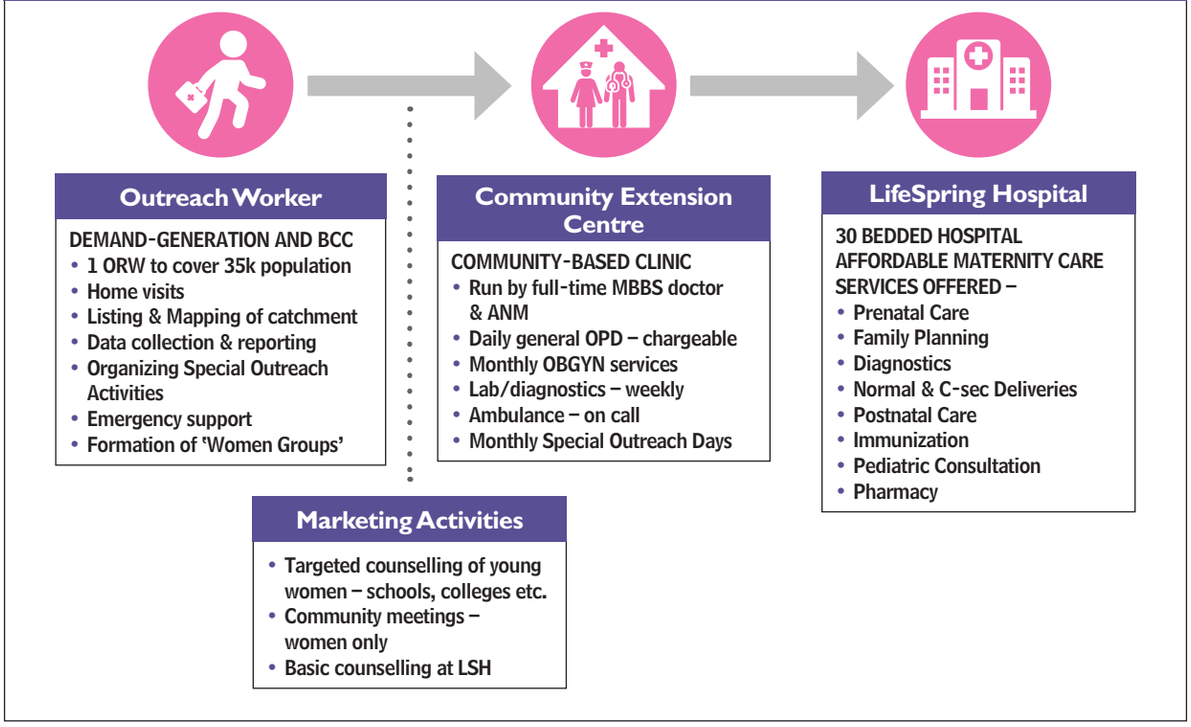
Marketing Activities

- B.P. Checks at Bus stops/Govt. hospitals/temples
- Awareness rallies
- Counselling
- Competitions for young mothers

Additional resources required for implementation of the Proposed Model.

Manpower: The new structure would require a pool of full-time MBBS doctors and ANM's to run the CEC on a daily basis. Each CEC would require one full-time MBBS doctor and one ANM. In addition to this, we have proposed the addition of one ORW per CEC. There should be 2 ORWs supporting each CEC.

Proposed Community Engagement Model



Training of ORWs: As the proposed model has widened the role of an ORW, regular training and mentoring will be required.

Job-aids for ORWs: Technology based tools to help the ORWs and CEC function more efficiently.

Standard Guidelines for all outreach activities: Develop SOPs for all community-based marketing activities

Data reporting formats and tools: Devise standard paper-based or electronic data collection formats for data monitoring and reporting.

Defined roles and responsibilities of Marketing team: Clearly outline the roles and responsibilities of a Business Executive/Marketing Executive.

Collaboration with existing SHGs in the area:
Tap into existing SHG's or other 'Women's Groups' in the area so as to use this as an additional platform for LSH's activities.

Move towards charging for services provided at CEC
The existing CEC format offers all consultation services free of cost. While this may be an effective short-term marketing strategy, we propose all services at the CEC should be provided at a nominal fee. Interactions with the community revealed that most people are open to paying for medical services.

The existing CEC format offers all consultation services free of cost

Annexure 1
Assessment Tools

TOOL 1
FGD Guide for Women

For each community observe the following:

- Locations of slums or other low income pockets/catchment and the distance from the health facility of IBM.
- Area and catchment size of the location (no of slums, registered vs unregistered)
- Health and other facilities distance and access, education institution, AWC, community center, PDS
- Education – institutional access and utilization including AWC
- Technology penetration : Mobile, Cable, FM etc. (% women have access to mobile and type)
- Legal status of the slums and legal entitlement of the residence
- Caste, religion composition
- Occupation profile male/female; occupational hazards;
- Key health player's private and public
- Level of service primary, secondary and tertiary (locations and functional status)
- Diagnostic facilities and service provision
- Any prominent environmental concern – dumping yard, low land, railway line, stagnation of water

General Questions

- Since how long have you been a resident of this community? Legal status of the area.
- What are some of the major health problems (seasonality dengue, Malaria, endemic TB, skin disease any disease associated with profession and or occupation) of this community? Explore Drug abuse, smoking alcoholism gambling , domestic violence ?
- Where does this community seek curative care from? How far are these facilities?
- Where does the community seek preventive care from? How far are these facilities?
- Are there any other facilities nearby? Why they are not utilized?
- Who are the public providers visiting this community? (Probe for ANMs, health visitors, TB workers, other NGO workers)? Do any providers visit your homes? If yes which?

Topic	Discussion/Transitions
Introduction and Greeting	*Namaste*, I am Facilitator's and this is Observer's namste
Purpose of FGD	The name of the 'implementing agency' has been working on a project for the urban poor to improve maternal, neonatal and child health. Because you are women from this community we would like to learn from you about your opinions about maternal, neonatal and child health issues. Your ideas can help us understand how our project performed and inform us about any changes that we can incorporate in our future projects to improve maternal and child care. May we begin the discussion? (Allow for those who do not want to participate in the discussion leave).
No right or wrong answers	We would just like to know your frank opinion. There is no right or wrong answers to any of the questions. This is not a test. We just want to learn from you. The idea is for everyone to share their honest opinions and experiences so that we can learn from you and your experiences to strengthen projects in the future. Although you are members of the same group, your experience may differ. The group members will allow for all differing views to be presented.
Length of time	The discussion would take about an hour and a half. During that time we will be asking some questions about different topics related to the project. We are interested in hearing what you think and feel.
Talking to one another	As we will be discussing about each of your opinions, it will be important that we do not talk at once because we will want to hear each other so we should not talk together. Everybody should try and participate and everybody will be given a chance to put forth their views. If you have any queries we will try to address them at the end of the discussion.
Explain note taking Confidentiality	We want to inform you that this discussion is voluntary. You may not answer a question that makes you uncomfortable. Your name will not be associated with your comments. You may leave in the middle of the discussion if you wish. (Name of Observer/reporter) will be writing down some of the things that we will be talking so we can remember later. Does anyone object? We are the only ones who will know your names; we will not use any names in our reports. In case you have any questions or concerns about our discussion you can contact the person, phone number is being provided to you. Do you agree to participate?
Checking understanding	Does everyone understand what I have said? Does anyone have any questions?
Participants introductions (Warm up)	Please introduce yourselves

- What are the health inputs being provided by the Aanganwadi centers, ASHAs, ANMs and UPHCs in the community?

- Which private provider is frequently visited by your community for MCHN related issues? The reason for preference?

- Have you heard of LifeSpring Hospital? Do families in this community utilize their services? If yes what are the three things you like most and anything you did not like?

- What is the role of men in ensuring health in your community?

Questions Specific to Maternal and Reproductive health

- Can you name some complications associated with
  - Pregnancy
  - Delivery – at home/facility
  - Post-partum period?

- Can you name a few things a woman can do to prevent these complications?

- Where do women in your community seek care and why?
  - ANC
  - Delivery
  - Post-partum
  - Emergency during pregnancy
  - For each provider mentioned

- How far is the provider?

- What is your opinion of the quality of service provided?

- Is there a cost implication – how much is spent per visit?

- Can the family afford/willing to pay the amount?

- What is the maximum amount that the family is willing to pay for quality maternal services?
  - ANC
  - PNC
  - Delivery
  - Diagnostics

- How do you prepare for the delivery when you are pregnant (birth planning)?

Questions Specific to Family Planning

- What are the preferred methods of contraception and why?

- Why are other methods not used?

- Where do you seek each kind of method? Which is the preferred provider for FP and why?

- Are you willing to spend on FP, how much?

Questions Specific to Newborn and Child

- Can you name some complications associated with
  - Neonates
  - Infants
  - Under 5 children

- What can be done to prevent these complications?

- What are the methods of household management of
  - Diarrhea
  - ARI
  - Neonates

- In which kind of illness do you rake the child to a health provider?

- For each illness kind of provider and why
  - Where do women in your community seek care and why?
  - Immunization
  - Malnutrition
  - Diarrhea
  - ARI
  - Neonatal emergencies

- For each provider mentioned:
  - How far is the provider?
  - What is your opinion of the quality of service provided?
  - How will you define quality? What constitutes quality in your perception?
  - What is the range of services provided by the provider? Probe for types of services?
  - Is there a cost implication – how much is spent per visit?
  - Can the family afford/willing to pay the amount?

- What is the maximum amount that the family is willing to pay for quality child care services (Preferred service providers and cost)

- OPD services

- Immunization

- Hospitalization

- Diagnostics

- WASH related questions

- Availability of water – Drinking and household use
- Quality of water
- Availability of sanitation facilities type (septic)
- Utilization of sanitation facilities
- Habit of disposal of child fecal matter

OOPs Related Questions

- What is the monthly household expense?
- Current level of expenditure towards healthcare
- What is the monthly household Income of the client?
- Do you have health insurance coverage? Govt. or private
- Willingness to adopt new insurance package and paying capacity
- RSBY – if yes have you received the reimbursement for your last hospitalization?
- Would you be willing to pay for health insurance?

Other Services

- What are some of the critical health services that are required and are currently not easily available or accessible at low-cost?

Gender and Decision-Making

- Does this community experience any alcoholism, substance abuse or gender based violence? What influence does that have on maternal and child health?
- Who is involved in making the decision about delivery in the institution and facility based care that has a financial implication?
  - For a woman
  - For a child
  - For FP

Thank you indeed for your time. Is there any question you have for us? Respond to best of knowledge or inform implementing partner to find the answer and respond.

Topic	Discussion/Transitions
Introduction and Greeting	*Namaste*, I am Facilitator's and this is Observer's name
Purpose of FGD	The name of the 'implementing agency' has been working on a project for the urban poor to improve health. Because you are men from this community we would like to learn from you about your opinions about health issues impacting children, women and men. Your ideas can help us understand how our project performed and inform us about any changes that we can incorporate in our future projects to improve health care. May we begin the discussion? (Allow for those who do not want to participate in the discussion leave).
No right or wrong answers	We would just like to know your frank opinion. There is no right or wrong answers to any of the questions. This is not a test. We just want to learn from you. The idea is for everyone to share their honest opinions and experiences so that we can learn from you and your experiences to strengthen projects in the future. Although you are members of the same group, your experience may differ. The group members will allow for all differing views to be presented.
Length of time	The discussion would take about an hour and a half. During that time we will be asking some questions about different topics related to the project. We are interested in hearing what you think and feel.
Talking to one another	As we will be discussing about each of your opinions, it will be important that we do not talk at once because we will want to hear each other so we should not talk together. Everybody should try and participate and everybody will be given a chance to put forth their views. If you have any queries we will try to address them at the end of the discussion.
Explain note taking Confidentiality	(Name of Observer/reporter) will be writing down some of the things that we will be talking so we can remember later. Does anyone object? We are the only ones who will know your names, we will not use any names in our reports.
Checking understanding	Does everyone understand what I have said? Does anyone have any questions?
Participants introductions (Warm up)	Please introduce yourselves

TOOL 2
FGD Guide for Men
General Questions

- Since how long have you been a resident of this community?
- What are some of the major health problems of this community?
- Where does this community seek curative care from? How far are these facilities?
- Where does the community seek preventive care from? How far are these facilities?
- Are there any other facilities nearby? Why they are not utilized?

- Who are the public providers visiting this community? (Probe for ANMs, health visitors, TB workers, other NGO workers.)

- What are the health inputs being provided by the Aanganwadi centers, ASHAs, ANMs and UPHCs in the community?

- Which private provider is frequently visited by your community for MCHN related issues?

- Have you heard of LifeSpring Hospital? Do families in this community utilize their services?

- What is the role of men in ensuring health in your community?

Gender and Decision Making

- Knowledge about the care during pregnancy, delivery and after that ?

- Role of husband and other family members?

- Does the role and responsibility of the male members in the family particularly husband change when it comes to maternal health issues? How?

- Does this community experience any alcoholism, substance abuse or gender based violence? What influence does that have on maternal and child health?

- Who is involved in making the decision about delivery in the institution and facility based care that has a financial implication?
  - For a woman
  - For a child
  - For FP

Questions Specific to Maternal Health

- Can you name some complications associated with
  - Pregnancy
  - Delivery
  - Post-partum period?

- Can you name a few things a woman can do to prevent these complications?

- Where do families in your community seek care and why?
  - ANC
  - Delivery
  - Post-partum
  - Emergency during pregnancy

- For each provider mentioned
  - How far is the provider?
  - What is your opinion of the quality of service provided?

- Is there a cost implication – how much is spent per visit?
- Can the family afford/willing to pay the amount?

- What is the maximum amount that the family is willing to pay for quality maternal services
  - ANC
  - PNC
  - Delivery
  - Diagnostics

Questions Specific to Family Planning

- What are the preferred methods of contraception and why?

- Why are other methods not used?

- Where do you seek each kind of method? Which is the preferred provider for FP and why?

- Are you willing to spend on FP, how much?

Questions Specific to Newborn and Child health

- Can you name some complications associated with
  - Neonates
  - Infants
  - Under 5 children

- What can be done to prevent these complications?

- What are the methods of household management of
  - Diarrhea
  - ARI
  - Neonates

- Where do families in your community seek care, associated price and why
  - Immunization
  - Malnutrition
  - Diarrhea
  - ARI
  - Neonatal emergencies

- For each provider mentioned
  - How far is the provider?
  - What is your opinion of the quality of service provided?
  - What are the range of services provided by the provider?
    - ANC
    - Delivery
    - PNC
    - Child care
    - Others.

- Is there a cost implication – how much is spent per visit
- Can the family afford/willing to pay the amount
- What is the maximum amount that the family is willing to pay for quality child care services
  - OPD services
  - Immunization
  - Hospitalization
  - Diagnostics

WASH Related Questions

- Availability of water-Drinking and household use
- Quality of water
- Availability of sanitation facilities type (septic)
- Utilization of sanitation facilities
- Habit of disposal of child fecal matter

OOPs Related Questions

- What is the monthly household expense?
- Current level of expenditure towards healthcare
- What is the monthly household Income of the client?
- Do you have health insurance coverage? Govt. or private
- Shared premium?
- Willingness to adopt new insurance package and paying capacity
- RSBY – if yes have you received the reimbursement for your last hospitalization?
- Would you be willing to pay for health insurance?

Other Services

- What are some of the critical health services that are required and are currently not easily available or accessible at low-cost?

Thank you indeed for your time. Is there any question you have for us? Respond to best of knowledge or inform IP to find the answer and respond.

TOOL 3
Small Group Discussion/IDI with Facility Staff

As you are aware, under the PAHAL program, IPE Global and LifeSpring Hospitals have partnered to promote MCHN behaviors and service utilization. We would like to seek your perceptions about the services being provided as well as your understanding of your client profile. This will help us develop a responsive model of community engagement.

- Since when have you been associated with this facility?
- What is your role?
- How many patients do you see in a day?
- How do you provide counseling
- What is the profile of these patients?
- Why are your patients seeking care from your facility?
- Is there a follow up mechanism in place to trace your patients?
- Do they return as advised for further care?
- What are some of the other services that your patients seek from your facility?
- According to you what is the most important element for the client which influences the “quality”
- In your opinion, do your patients find it difficult to pay for the services? If so which services in particular?
- What are some of the BCC methods used in this facility to inform patients? Who provides these inputs?
- For what conditions do you refer your patients to other or higher facilities?
- Any other issues that you would like to discuss?

Thank you

TOOL 4
IDIs with AWW/ASHAs/ANM

- Name of the Interviewer_____
- Date_____
- Greet
- Introduce Self
- Preamble: You would be aware that the Government has been implementing NUHM in these communities. We are here as to understand your role in the program and the status of the health in these communities. This will enable us to disseminate good practices and also improve upon the strategies that did not work, in our future projects. This will be a confidential discussion and your name will not be attached to your quotes. We anticipate the discussion to take about half an hour. Do we have your permission to proceed?
- Location _____
- Type of worker and facility _____
- Name of the Interviewee _____
- Total months in the current position: _____
- What have been the main activities of NUHM in the communities of your district?
- What are your activities in these communities? Could you please answer a few technical questions for us?
- What are the Health challenges faced by these communities?
- Where do women seek care from and why
  - ANC
  - PNC
  - Delivery
  - Immunization
  - FP
  - Neonatal emergencies
  - Diagnostics
  - Childhood illnesses
  - Severe malnutrition
- What are some of the prevailing health behaviours practiced by the community which are not considered “ideal behavior “? Why impact it has on our health?
- How are you addressing them?

- What more can be done to promote healthy behaviours?
- What services are available in your UPHC?
- Is there a nutritional rehabilitation Centre near your community?
- What are the existing govt.schemes and services related to health?
- Where are severely malnourished children referred?
- What are some of the WASH related problems, how are they being addressed currently?
- Are families willing to spend on health care? In your opinion how much money do families spend on health care?
- In your opinion what proportion of your population access private care?
- For which reasons?
- From where?
- Why do you think they prefer the private facility?
- Are families willing to spend on health insurance? What amount?
- What are the other services that families are willing to pay for?
- Are there any MAS in your area, what are their activities, how do they support you?
- Are there any NGOs in your area, what are their activities, how do they support you?
- For ASHAs – how much incentive money do you receive per month?
- Have you heard of LifeSpring Hospital? Have you been contacted by them, or offered an incentive for referring patients?
- Would you be willing to refer patients that can afford to pay for low cost quality services?

Thank you indeed for your insightful remarks.

TOOL 5
IDIs with Ward/Municipal Staff

- What is the role of the ULB in ensuring health for the marginalized population of urban areas?
- Please describe the systems in place within this department to effectively converge for promoting urban health and WASH.

- Is there a separate designated Nodal Officer for NUHM?
- Is there a separate Public Health Department/Cadre?
- What are the separate public health functions performed by the corporation?
- What is the current budget allocation for Health?
- What are some of the challenges you face in promoting health care and WASH (probe for funds, human resources, information for monitoring and capacities)?
- We understand that the NUHM works closely with your organization. What is the role of ULB in the approved activities under NUHM?
- Mapping of vulnerability completed? How is it being utilized?
- City health plan how was it developed? Was it approved? Gaps in requested and received funds?
- HR in CPMU/U-CHC/U-PHC and other Urban Health facilities
- Training of ULB staff (trained vs. untrained/planned)
- Infrastructure for PHC
- Medicines in PHC
- Coordination meetings: numbers, frequency, decisions taken
- Expenditure of allocations under NUHM
- How do you support PPP initiatives for health and WASH? Please describe any such partnerships you may have?
- How do you coordinate with private providers? What services could be provided by the PPs to strengthen public delivery of services? How is the quality of services regulated?
- Any other suggestions?

TOOL 6
LifeSpring Client

Preamble, greeting and confidentiality

- Why did you visit the facility today?
- Have you visited this facility before, for what reasons?

- How did you come to know about this facility?
- What are some of the problems you face to visit this facility?
- Who in your family made the decision to visit this facility and why?
- What services did you avail today and what did it cost you?
- How much time did you spend on this visit
  - Travel
  - Wait time to meet doctor
  - Diagnostics
- What are some of the things you liked about this facility?
- What are some of the things that can be improved about this facility?
- Do you avail services from the public sector facility as well – for which conditions an why?
- Do you avail services of any other private provider – for which conditions and why?
- Would you recommend this facility to your neighbors and friends – why/why not?
- What additional services should be made available to you to continue seeking services from this facility?

TOOL 7
Private Provider

Greet; we are from an organization called IPE and are studying the use of private providers by the communities. We have been informed that you are one of the popular providers of this area. We would like to understand a little more about your practice.

- What kind of services do you provide?
- How many patients do you see?
- Which are the most common diseases that you encounter?
- What according to you are some of the common health problems in this community?
- Do you manage pregnant mothers – services provided, cost
- Do you treat under five children – services provided, cost
- Do you provide FP services – methods offered, cost

- What are your patients willing to spend on health care? Do you encounter patients who cannot afford your fees – what do you do under such circumstances?

- How do you follow up your patients?

- Do you also refer your patients? To which facilities?

- Are you aware of LifeSpring Hospitals?

TOOL 8
LifeSpring Management & Community Extension Program

- What is your vision with regard to community extension program?

- With regard to CEP:
  - Capex
  - Opex
  - Service & referral protocol
  - Staff and their role
  - Community engagement program
  - Monitoring and follow up
  - Reporting mechanism

- What are your current capacities to engage the communities?

- What additional support will be required?

- What are the branding exercises currently employed?

- How do potential clients become aware of LifeSpring hospitals?

- What is the referral mechanism for addressing issues which cannot be solved at your facility – are there any identified referral facilities?

- Is there a mechanism to follow up referred clients?

- What will be the cost of running small clinics/extension centers/mobile clinics in the target communities?
  - Rent
  - Electricity
  - Salary of paramedics

- What is the current mechanism to identify and target potential clients at the community level?

- How would the community models be scaled up – resource mobilization strategies

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Partnerships for Affordable Healthcare Access and Longevity

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