

Community Engagement Strategy for **LifeSpring Hospitals**

LifeSpring TM Maternity Hospital
Safe • Clean • Affordable





Contributors

Sabiha Mahboob

Medha Verma

Kaveri Haldar

Sujata Rao

Drishya Pathak

Shivangee Malik

Ajay Kumar Singh

Aditi Attrey

Vijaybhasker Srinivas

Subba Rao

L.M. Singh

Amit Bhanot

Contents

Executive Summary	4
Background	5
LifeSpring	5
PAHAL	5
PAHAL Platform	5
LifeSpring – PAHAL Partnership	6
LifeSpring: Community Engagement	6
Operationalizing the Community Extension Centers (CEC)	7
Evaluation of Community Extension Centers	8
Respondent Profile	9
Performance of CECs	9
Awareness Levels in the Community	12
Health Awareness of Existing Patients	13
Health Seeking Behaviour	14
Operations	16
Learnings	17
Recommendations	18
Way Forward	20



Executive Summary

India's national health priorities are increasing focus on community centric healthcare along with emphasis on wellness and prevention. A community-centric approach to healthcare can bring a shift in focus to the patients themselves, involving them in their own care processes and empowering patients to play a larger role in making health related decisions for themselves. Engaging with the community can have several benefits eventually leading to the promotion of preventive, promotive and curative care.

Especially for hospitals and clinics in tier II & tier III cities, deploying community-centric models for the purpose of outreach and health awareness, can fulfill their larger goal of demand generation in the healthcare facilities, in addition to making quality, affordable healthcare more accessible. Together, they have the potential to strengthen primary healthcare in underserved communities.

Community-Centric Care



**Prioritization of
Community Needs**



**Risk Screening and Early
Detection of Illness**



**Health Education for Better
Health Seeking Behavior**

PAHAL, along with LifeSpring Hospitals (LSH) is piloting a community engagement model in Hyderabad. We have supported the operationalization of ten community extension centers (CEC), in the catchment areas of each of the 10 LifeSpring Hospitals in Hyderabad. The first community extension center was set up in March 2017, and the tenth CEC was operationalized in December 2017.

The report outlines LifeSpring's need for a community-centric approach to healthcare, and provides an explanation of the model of community engagement proposed to LifeSpring after an in-depth assessment of their target communities. PAHAL also carried out an evaluation of the community extension centers to assess if the objectives with which they were set up were being met. Key findings from which have been presented.

We have concluded by **providing recommendations for the creation of a successful model of community engagement based on our understanding and experience** of working with LifeSpring Hospitals.



Background

LifeSpring

LifeSpring Hospitals is a 50-50 joint venture between HLL Lifecare Ltd. and Acumen Fund. It is committed to bringing dignity to the lives of women by creating an alternative to the low quality public healthcare system in the form of an affordable healthcare provider. Typically, LifeSpring caters to urban poor communities and focuses on providing quality pre-natal care to women in order to reduce the instances of high-risk pregnancy and morbidity amongst mothers and children.

Features of LifeSpring Model

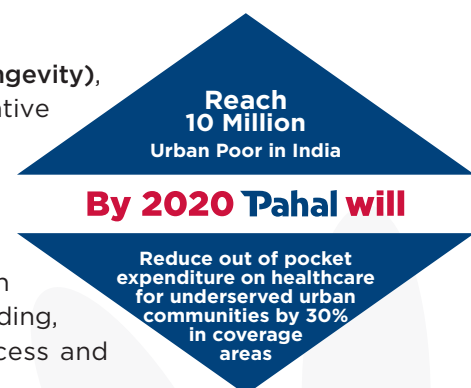


It currently operates an 11 hospital cluster (10 hospitals in Hyderabad and 2 in Visakhapatnam) on a **standardized, no-frills services model** with a strong focus on **clinical and operational protocols**. This allows LifeSpring to service higher volumes in terms of deliveries and out-patients per bed per month and charge prices that are 20%-30% lower than those in private hospitals. LifeSpring's low-cost & high-quality service architecture can potentially serve 70% of India's households as compared to 25% by typical private hospitals.

PAHAL

PAHAL (Partnerships for Affordable Healthcare Access and Longevity),

a joint initiative of USAID and IPE Global, aims to bring innovative financing solutions in healthcare and provide catalytic support to growth stage scalable social enterprises in developing affordable & quality healthcare solutions for the urban poor and vulnerable sections of the community. Over the past three years, PAHAL has built strategic partnerships with several social enterprises in healthcare delivery, innovation, medical technology, skill building, financing, insurance to develop solutions for improving access and reducing cost of quality healthcare.



PAHAL Platform

The project has collaborated with healthcare provider networks consisting of 700+ hospitals, 3,000+ doctors and over 15,000 community workers and owning an exclusive health care delivery model, with the objective of reaching out to 10 million urban poor and reducing out of pocket expenditure by 30%.



LifeSpring – PAHAL Partnership

PAHAL's interactions with the LifeSpring management and assessment of LifeSpring's target communities yielded that LifeSpring Hospitals had:

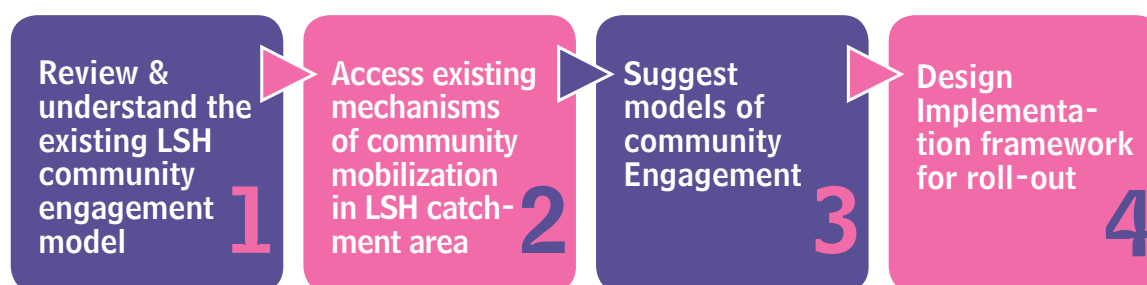
- ❖ Low capacity utilization levels
- ❖ Low brand recognition in the target community
- ❖ Narrow value proposition for patients

In order to assist LifeSpring in the above aspects, PAHAL entered into a partnership with LifeSpring Hospitals in March 2017.

PAHAL identified LifeSpring as a core Healthcare Inclusive Business Model (IBM) to provide Technical, Financial and Self-Learning Assistance aimed to strengthen and scale up LifeSpring Hospitals and improve linkages with the communities by building, operating and scaling up of a sustainable community engagement model. The larger goal was to reduce preventable morbidity and mortality among women and children, improve access to quality RMNCH+A services, promote better health seeking behavior and reduce out of pocket expenditure on health.

LifeSpring: Community Engagement¹

PAHAL carried out an assessment of LifeSpring's existing community engagement model. The objectives of the assessment were as below.



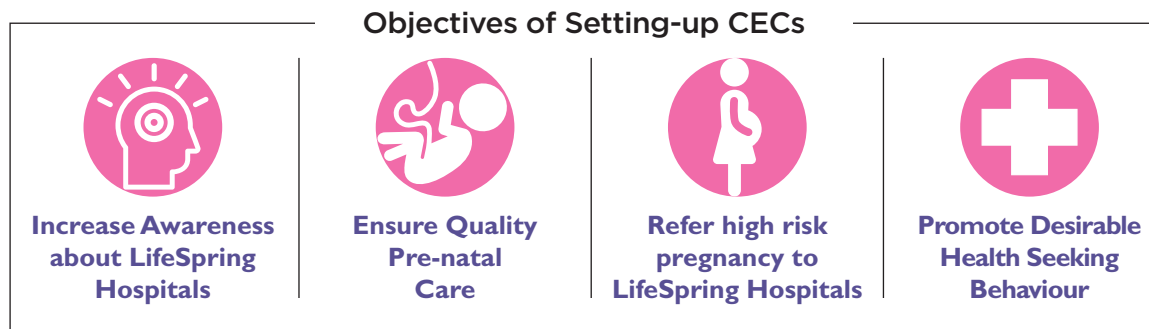
The assessment brought to light that LifeSpring was operating at a **capacity utilization of around 30%-50%**, indicating towards a pressing need for demand generation activities to enhance revenues and also bring quality healthcare to more people in the need for it. The awareness about LifeSpring Hospitals was also low in the community and the role of community health workers in providing key health information on nutrition, early pregnancy, spacing methods and neonatal care was limited. There was a lack of understanding of the coverage area and customer profile among the ORWs.

In order to enhance capacity utilization, there was a clear need to strengthen demand for services offered by LifeSpring by improving linkages with the community and positioning LifeSpring as a community-centric quality & affordable hospital.

¹ http://www.ipeglobal.com/pahal/resources/media/2018/LifeSpring%20Community%20Assessment%20Report_Print%20Ready%20File_Revised_27th%20Feb.pdf

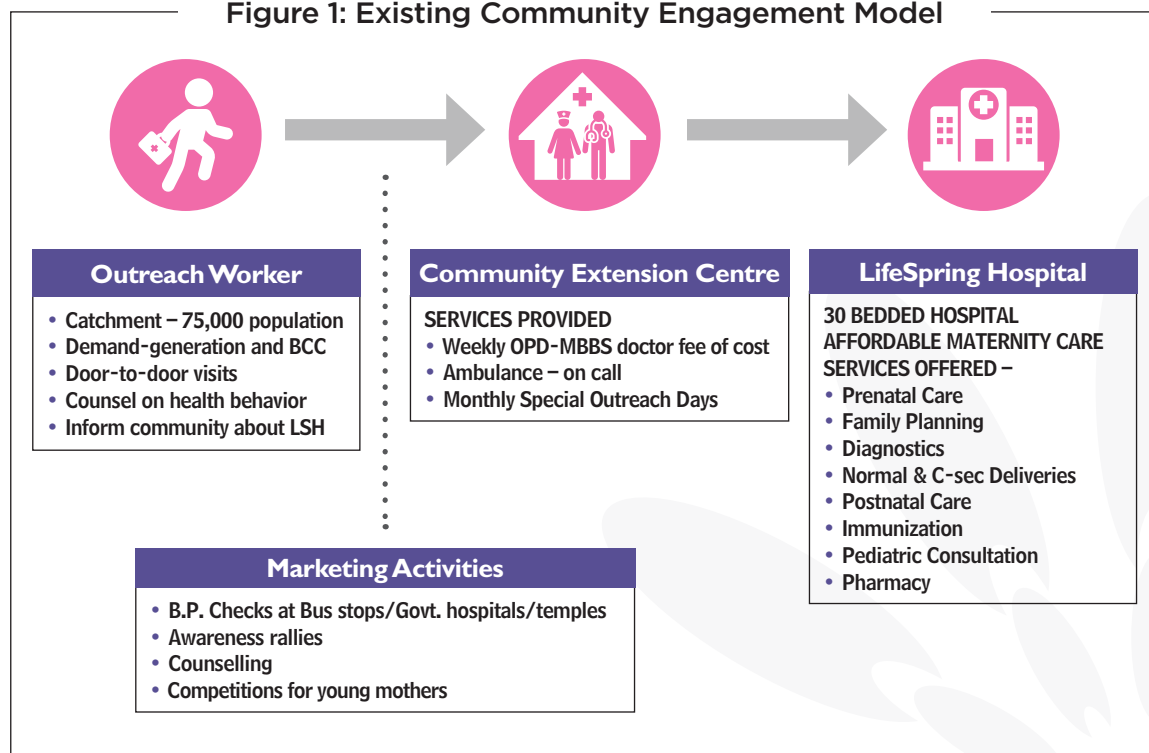
Operationalizing the Community Extension Centers (CEC)

PAHAL decided to assist LifeSpring in setting up 'Community Extension Centers' in the catchment areas of the hospitals with the below objectives:

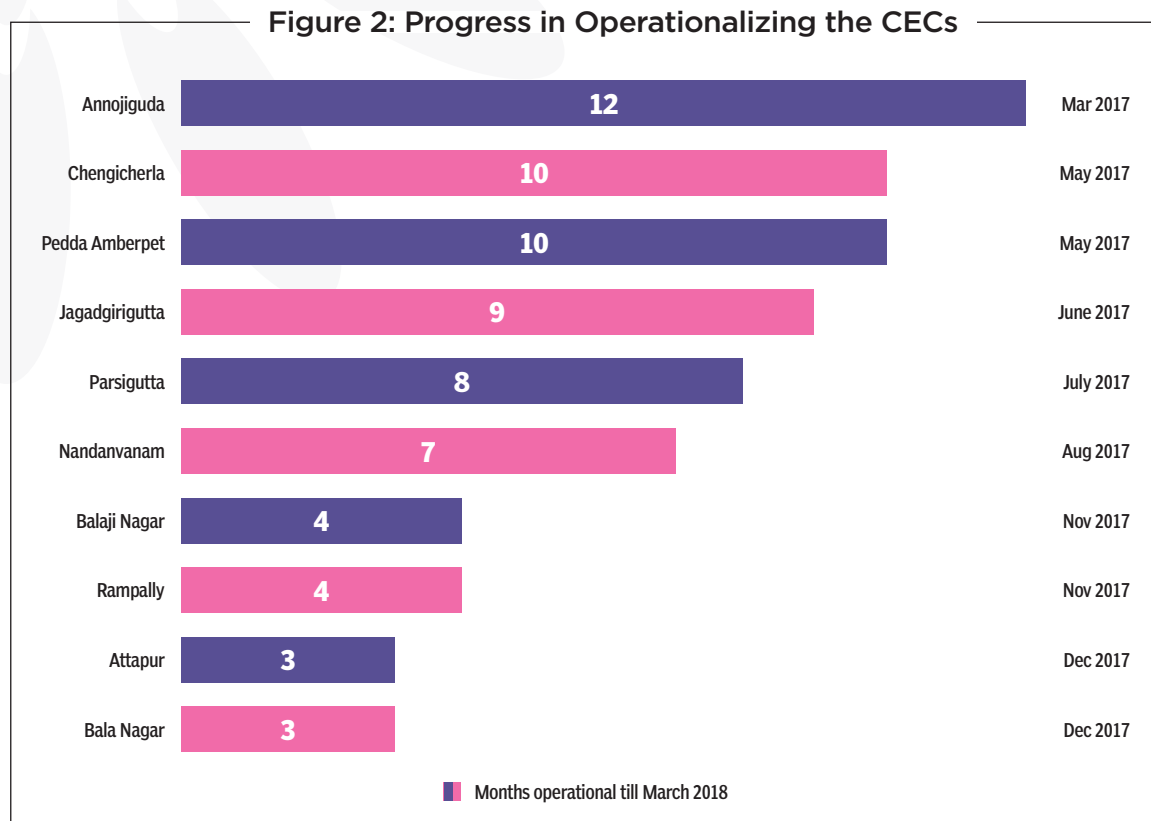


- ❖ Community Extension Centers ("CECs") are brick and mortar, 1-2 room clinics, bringing health care to the doorstep of the communities.
- ❖ They provide ante-natal services and general OPD services free of cost to the visiting patients.
- ❖ They serve as the maternity referral network for LifeSpring Hospitals.
- ❖ Each CEC is assigned to one Outreach Worker (ORW) to mobilise pregnant women to visit the CEC and regularly follow-up with them and counsel them on the requisite care and nutrition required during pregnancy.
- ❖ Care is delivered at the CEC by an MBBS doctor and nurse from the LifeSpring Hospital.

Figure 1: Existing Community Engagement Model



The progress in operationalizing the CECs is presented as below:



Evaluation of Community Extension Centers

PAHAL carried out an evaluation to understand whether the proposed model of community engagement was yielding the expected results. A mix method approach was used for the evaluation. The project MIS data was also used to assess the progress of CEC on key indicators. LifeSpring Hospital management, doctors and outreach workers were the supply side stakeholders who were evaluated using qualitative in-depth interviews. The beneficiaries accessing services from the CECs and the community at large were the target respondents for demand-side evaluations.

PAHAL's intervention included conveniently selected samples from

- i. Community members dipstick survey (n=200)
- ii. Exit Interviews with beneficiaries (n=100)
- iii. In-depth interviews with Outreach Workers (n=10)
- iv. In-depth interviews with Doctors (n=4)
- v. Interviews with Senior management (n=2)

The objectives of the evaluation were:

- i. To ascertain the performance of the CECs and their impact on LifeSpring Hospitals
- ii. To assess the awareness level about the CECs in the community
- iii. To assess the health awareness of the beneficiaries and their families
- iv. To understand the health seeking behavior of the patients
- v. To understand the challenges and opportunities inherent in operating the CECs

The results of the evaluation have been presented below keeping these objectives in mind.



Key Results

Respondent Profile

The age profiles of respondents from community dipstick and exit interview are as below:

Figure 3: Age of Respondents (Community Dipstick)

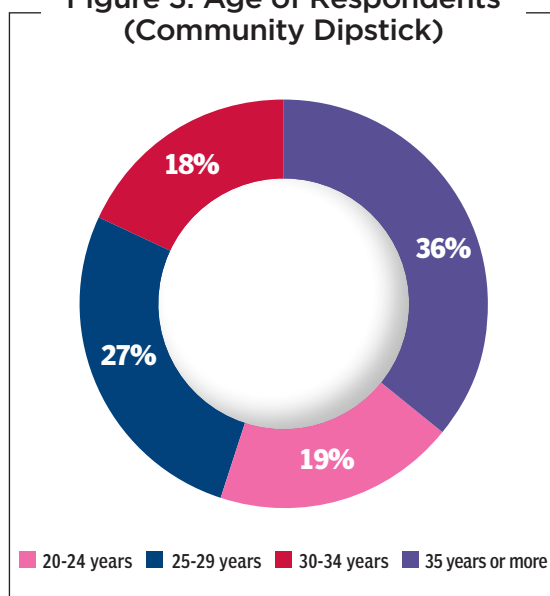
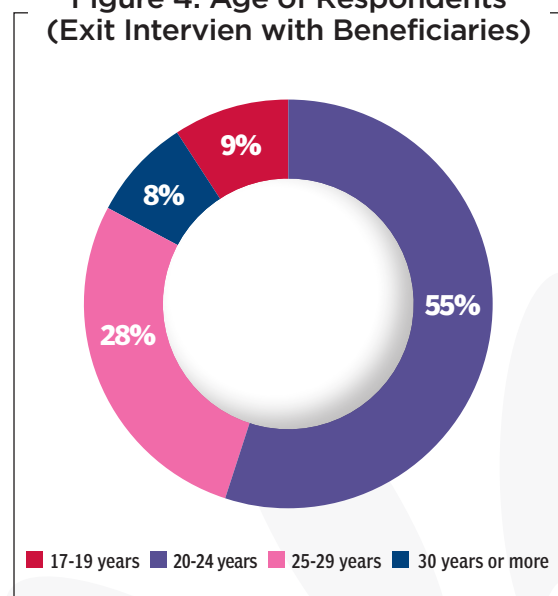


Figure 4: Age of Respondents (Exit Interview with Beneficiaries)



Performance of CECs & Impact on LSH

The key findings over the period of April 2017–March 2018 are below:



232

OPD Clinics Held



22+

Deliveries Converted to LifSpring Hospitals from CECs

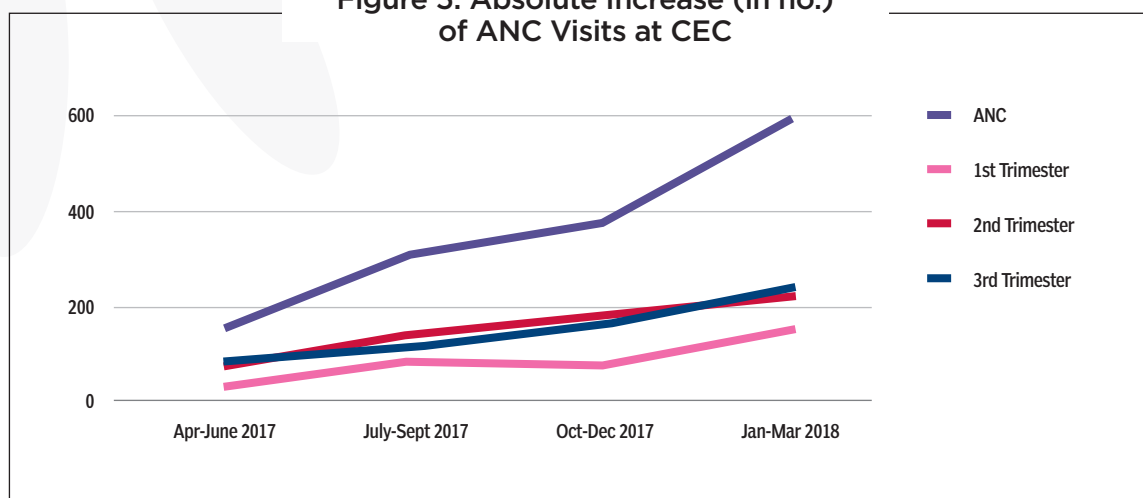


1,800

Direct Beneficiaries

The most significant change was in the early pregnancy registration and ANC at the CECs during the first trimester. According to 3 months moving average, the early registration of ANC increased by more than **251.28%** from June 2017 to March 2018 (Figure 5).

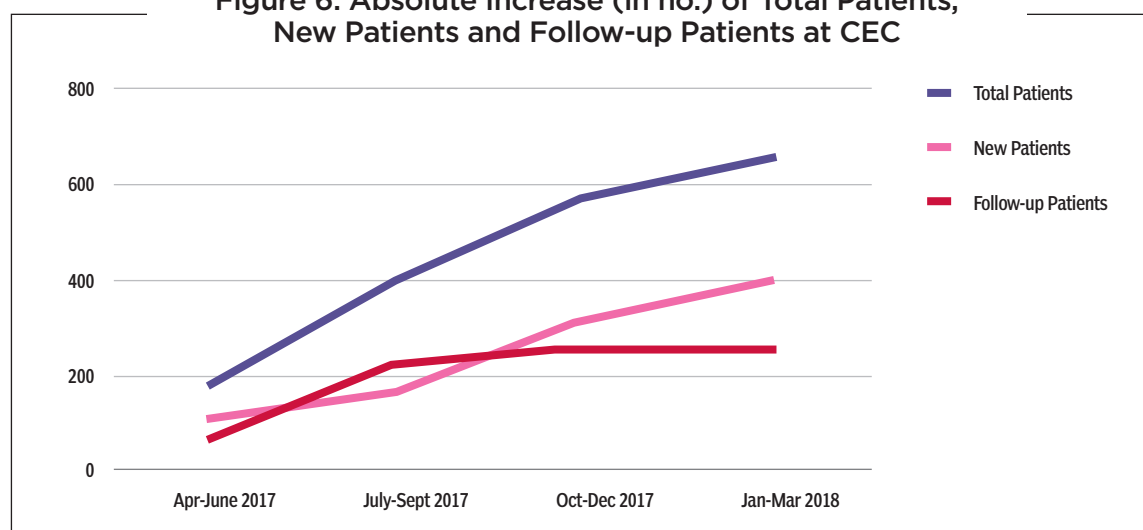
Figure 5: Absolute Increase (in no.) of ANC Visits at CEC



This is a very significant achievement for CECs' role as catalysts for improving community's health seeking behaviour. An increase in early registration of pregnancy has the potential to reduce pregnancy related maternal and child complications significantly.

According to the data collected from each CEC, the percentage increase in footfall was more than **50%** in three of the CECs. The figures indicate that these centres have the capacity to attract patients in high numbers and further strategic planning should be done in order to tap the potential (Figure 6).

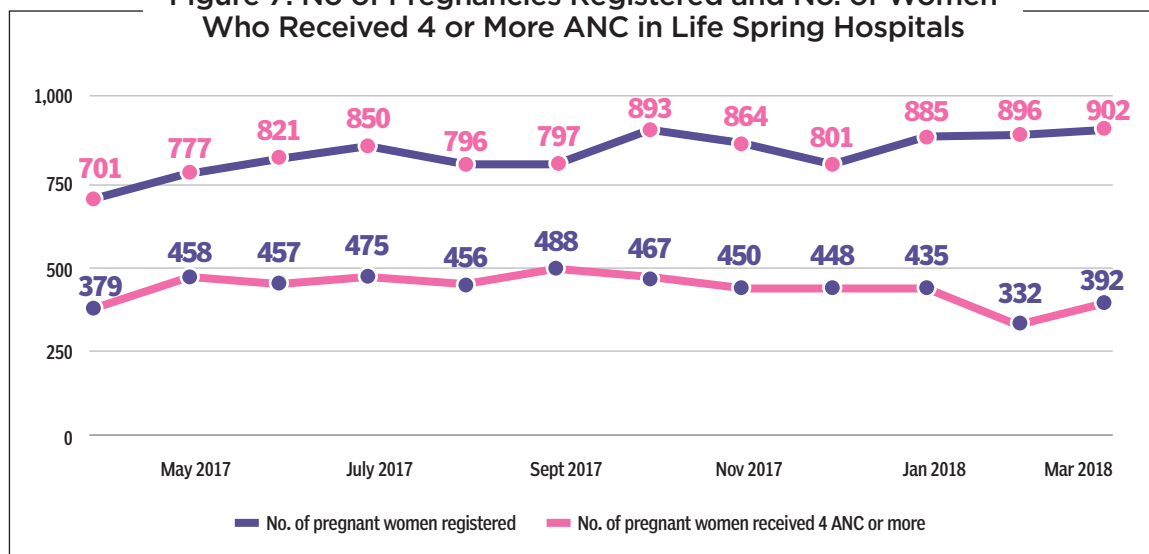
Figure 6: Absolute Increase (in no.) of Total Patients, New Patients and Follow-up Patients at CEC



Apart from serving the community at its doorsteps to improve maternal and child health indicators in the intervention areas, CECs were also set up with the purpose to increase the visibility of LifeSpring Hospitals.

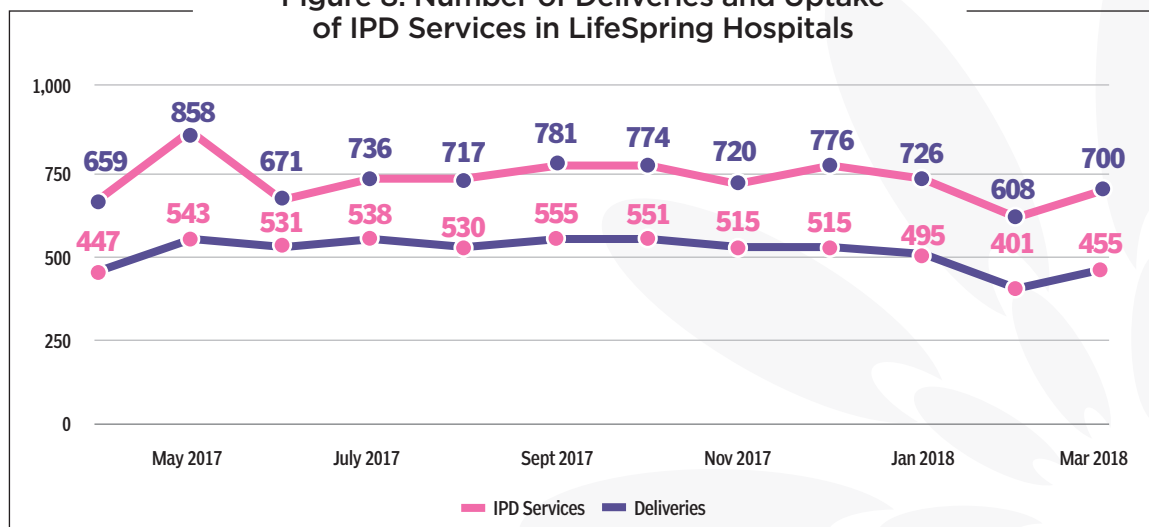
The data suggests that across all LifeSpring Hospitals there has been a 28% increase in the early registration of pregnancies (Figure 7). The trend in the number of registered women receiving four or more than four ANC in LSH post the setting of CECs is encouraging.

Figure 7: No of Pregnancies Registered and No. of Women Who Received 4 or More ANC in Life Spring Hospitals

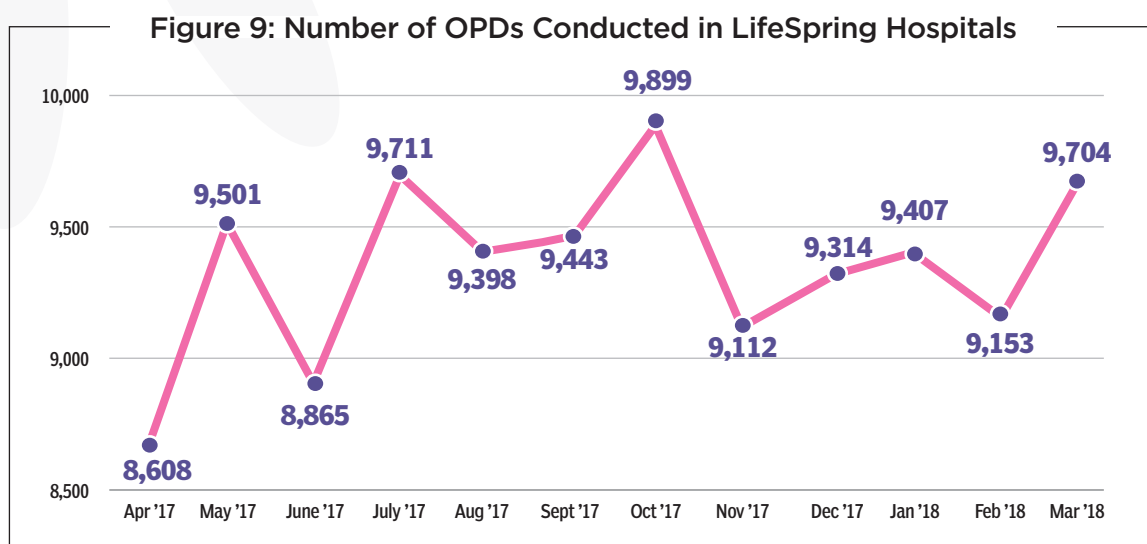


It was found that an average of 60% of women out of the total registered pregnant women in LSH went for institutional delivery in the LSH only. The finding also suggests that there was an increase of around 6% in uptake of IPD services in LSH after the CECs began functioning in a period of 12 months (Figure 8).

Figure 8: Number of Deliveries and Uptake of IPD Services in LifeSpring Hospitals



Based on the data collected there was a 13% increase in the total number of OPDs conducted in all the LSH after operationalisation of the CECs, indicating their positive impact on LSH visibility, with an increasing trend of female patients visiting LSH (Figure 9). On an average 8,557 female patients visited the LSH OPD per month with an overall 16% increase from April 2017 to March 2018.

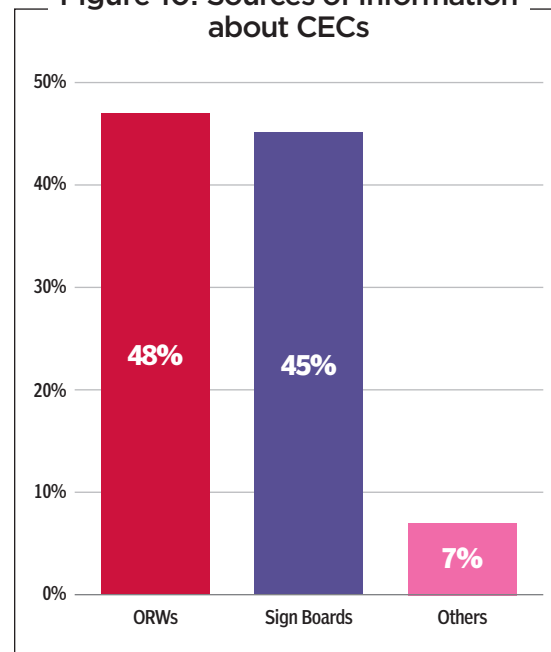


The trend for all these indicators had been increasing or consistent throughout the studied period with a slight dip in between. Overall the impact of CECs on LSH service uptake was positive.

Awareness Levels in the Community

- ❖ More than two-thirds of the people in the community were aware of the CECs.
- ❖ Out of these approximately 48% had heard about it through the ORWs (Figure 10).

Figure 10: Sources of Information about CECs

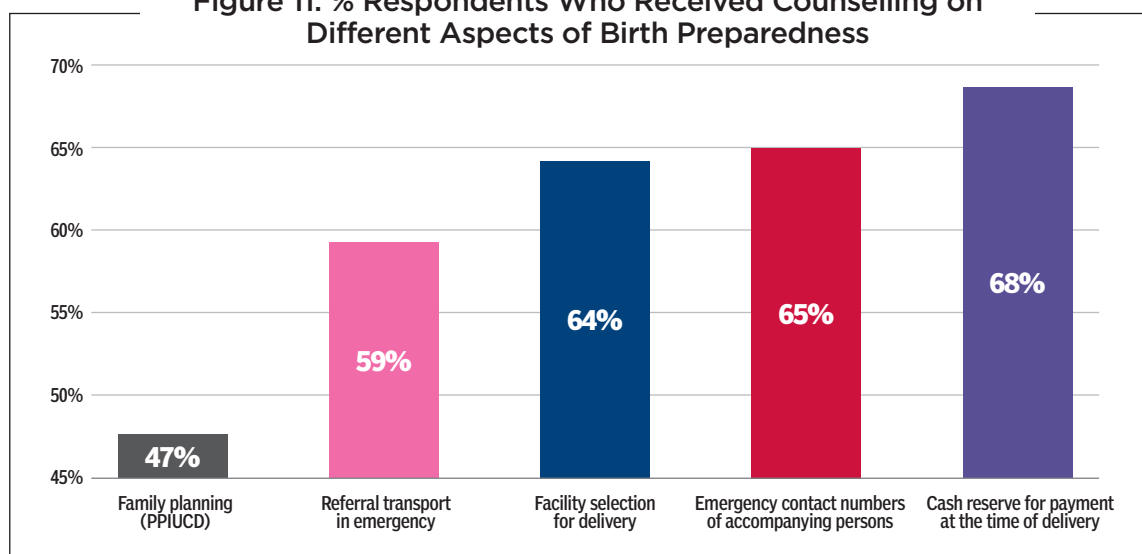


Health Awareness of Existing Patients

On being questioned about their awareness levels related to birth preparedness and nutrition and care during pregnancy, most women had been counselled by the ORW on the above mentioned topics.

More than 50% of the respondents mentioned that they were given information about birth preparedness either by the ORW or by the doctor at the CEC. The respondents were adept at identifying the symptoms of high-risk pregnancy with only 23% of them not being aware of it. This indicates that the information disseminated by the ORWs for the benefit of pregnant women is not only reaching them, they are practicing it in their day-to-day lives as well. They were also aware about the importance of ANC with 91% responding in favour of four ANCs

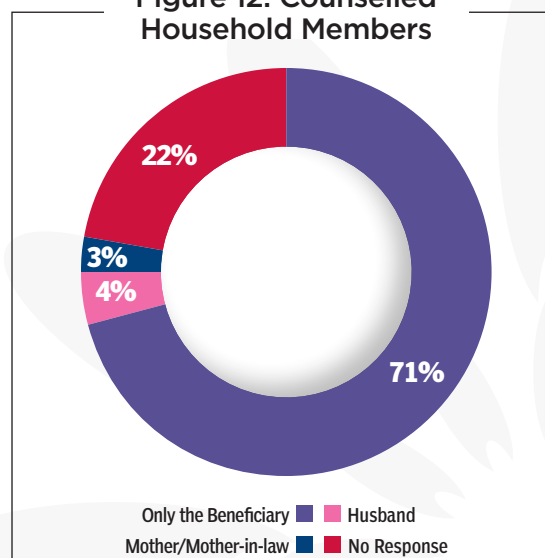
Figure 11: % Respondents Who Received Counselling on Different Aspects of Birth Preparedness



or more & 9% responding in favour of three or less ANCs. The patients were fully aware of the merits of institutional deliveries and were all planning for delivering in either the government or private hospital nearby.

The respondents were also tested on their knowledge of sanitation and hygiene practices especially during pregnancy. There was universal knowledge among the respondents about the importance of washing hands after using the toilet, before feeding or preparing food, disposing faeces in the latrine and after changing/disposing sanitary napkins. Moreover, counseling was not limited to the patients. There was an attempt made to counsel the household members of the beneficiaries as well.

Figure 12: Counselling Household Members



Health Seeking Behaviour

Patients were inquired about their paying capacity, types of services availed and whether they had access to any form of health insurance coverage.

- ❖ Of the patients interviewed, the maximum number of respondents were in their third trimester of pregnancy (Figure 13).
- ❖ Majority of the people had come to avail ANC, followed by general OPD services and PNC (Figure 14).
- ❖ 48.4% had been escorted by an ORW to the CEC and 47.3% came voluntarily (Figure 15).
- ❖ 20.9% mentioned that they were contacted once by an ORW in the last 30 days.
- ❖ 64.8% responded that they would avail the CEC's services if a small fee were charged.
- ❖ 41% responded that they could spend ₹100 per OPD visit (Figure 16).
- ❖ Only 36.3% respondents had some awareness about health insurance schemes of these, around 61% had some type of health insurance (Figure 17).
- ❖ The decision about which facility to approach for care during pregnancy was mostly taken by the woman herself, with little input from her husband and other family members.

Figure 13: % Respondents Across Different Trimesters of Pregnancy Seeking ANC Services

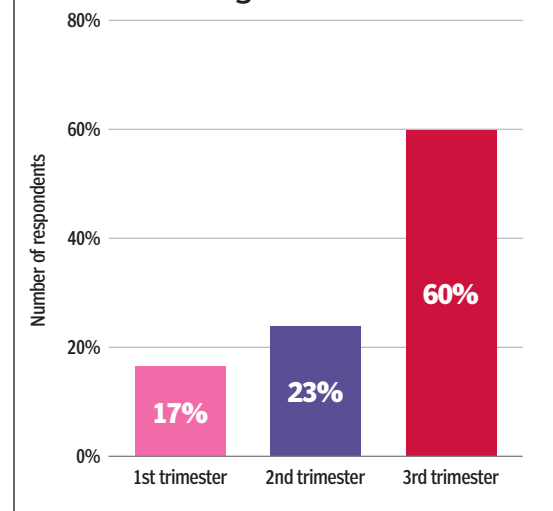


Figure 14: Types of Services Availed from CECs

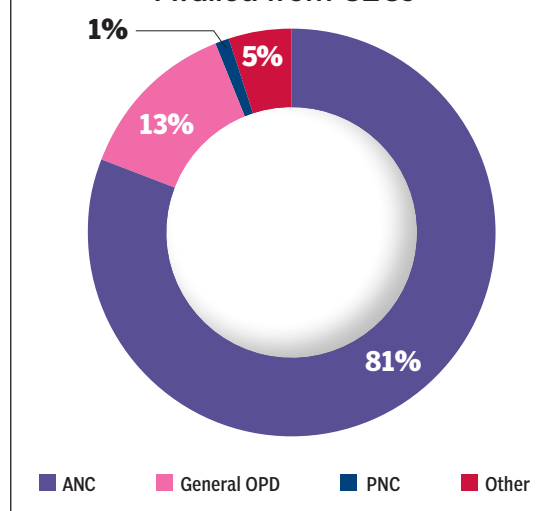


Figure 15: Number of Contacts by an ORW in the Last 30 Days

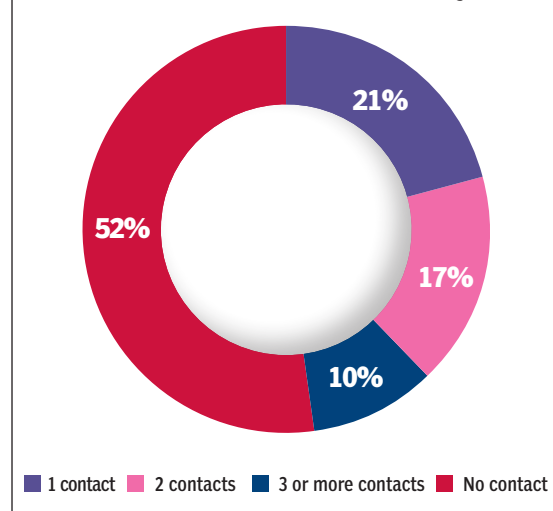


Figure 16: Paying Capacity per OPD Visit

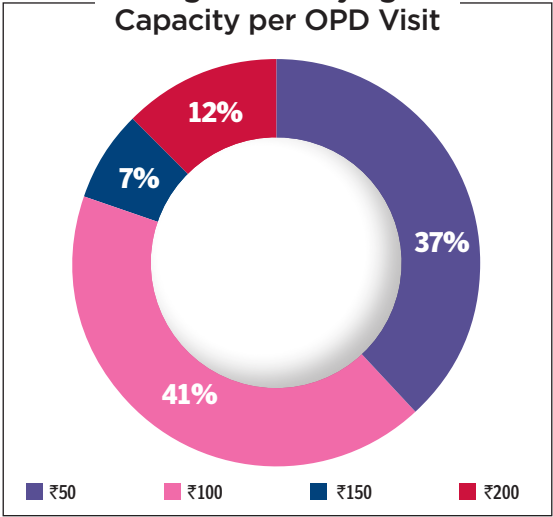


Figure 17: Health Insurance Coverage

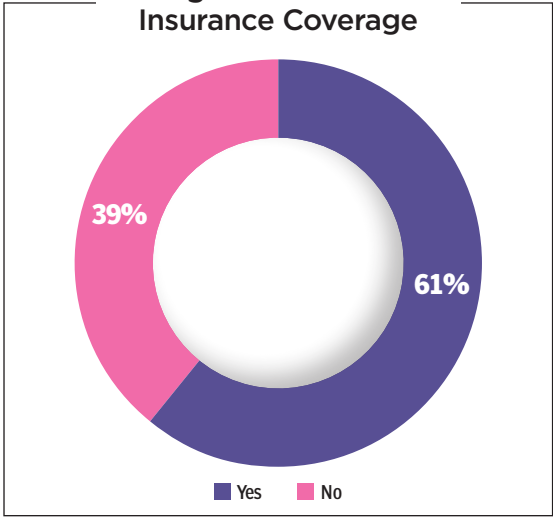


Figure 18: Types of Health Insurance

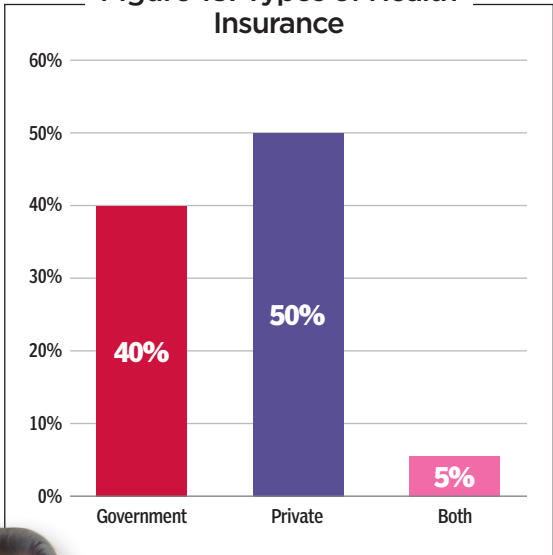
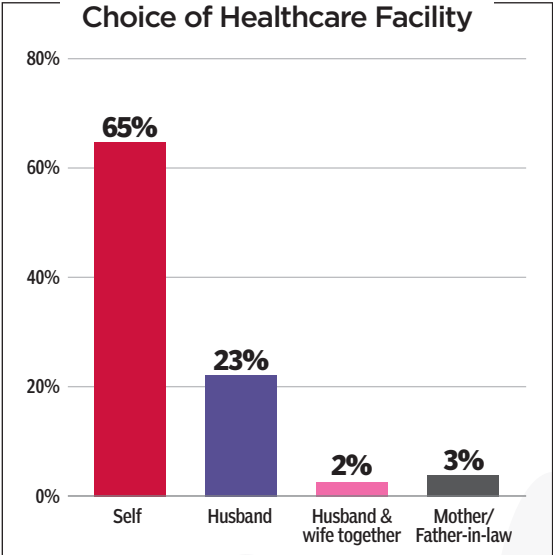


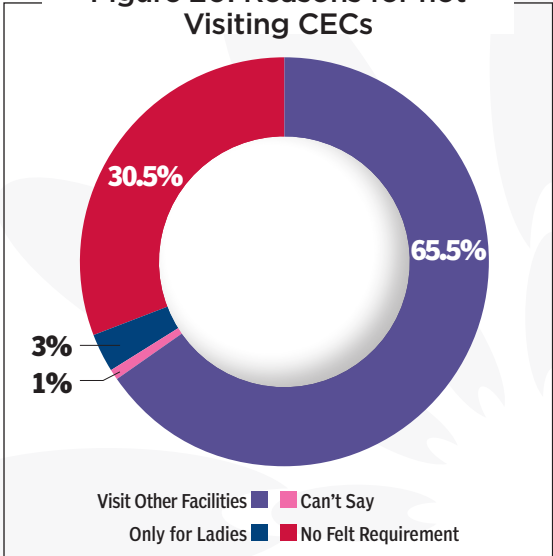
Figure 19: Decision Maker for Choice of Healthcare Facility



Reasons for Not Visiting CECs

The major reason in the community for not visiting the CECs was a preference for other healthcare facilities (Figure 20).

Figure 20: Reasons for not Visiting CECs



Overall, most people wanted the CECs to be functional at least five to six days in a week as they have to wait for an average of eight minutes for their turn on the day when the clinic opens with the waiting time varying from zero minutes to thirty minutes. The respondents unanimously agreed that availability of medicines and ambulance services for pregnant women would help attract more patients

Operations

The team responsible for the day-to-day running and operations of the CEC includes an outreach worker, MBBS doctor once a week in each CEC, as well as the LifeSpring management. PAHAL's evaluation included interactions with members of the catchment area, existing patients, outreach workers, the doctors as well as the LifeSpring management. These conversations threw light on the operational challenges, motivating factors and learnings to be incorporated in the functioning of the CECs as provided below:

STAKEHOLDER FEEDBACK				
	Patients	ORWs	Doctors	Management
Motivating Factors	<ul style="list-style-type: none"> • Good quality of care • Approachable doctor • Mobilisation by ORW • Private services free of cost 	<ul style="list-style-type: none"> • Social recognition • Financial independence • Working for a noble cause • Flexible work timings 	<ul style="list-style-type: none"> • Using their skill to help the underserved 	<ul style="list-style-type: none"> • Fairly good awareness levels in community about LifeSpring • Most patients satisfied with quality of care provided • Improved pre-natal care in community
Demotivating Factors	<ul style="list-style-type: none"> • Clinic operational once in a week • Preference for other/ government facility 	<ul style="list-style-type: none"> • Field work gets tiring • Pay incommensurate with effort • Social criticism at times • Competition from government hospitals makes it difficult to mobilise 	<ul style="list-style-type: none"> • Low footfall • Limited hygiene standardisation across CECs due to absence of exclusive washroom 	<ul style="list-style-type: none"> • Referrals to LifeSpring Hospitals low • Irregular performance of CECs - dependent on ORW activities • Not all CECs are promising • Retention of ORWs and doctors
Learnings	<ul style="list-style-type: none"> • Clinic should be held regularly • Ambulance, pharmacy added to the offerings 	<ul style="list-style-type: none"> • Capacity building of ORWs • 2 ORWs per CEC • Introduction of technology to make operations easy 	<ul style="list-style-type: none"> • Need for developing quality assurance and standard operating procedures for the CECs • Better maintenance of privacy 	<ul style="list-style-type: none"> • People willing to pay for services - can create a revenue generating model • Select CEC locations more scientifically • Expand services - could also have OPD for men

Learnings

Selection of CECs

- ❖ It was found that the catchment area of different CECs varied immensely.
- ❖ This affected the performance of CECs with those having low catchment population proving to be inviable in terms of deployment of resources.

ORWs are the Most Important Link in the Continuum of Healthcare Delivery

- ❖ It has been observed that the performance of the CECs have largely depended on the efforts of the ORWs in the catchment areas.
- ❖ However, there is very high attrition among ORWs due to incommensurate pay and resistance they may face from within the community.

There is Scope to Expand Service Offering at CEC

- ❖ The clinics have been branded as maternity clinics and men hesitate to approach the clinic for general OPD services, thus limiting the scope of the CECs.
- ❖ The services available to women are also restricted to ANC as of now. Gynaecological, infertility and sexually transmitted diseases care is currently not available at the CEC level.
- ❖ Post-natal and neonatal follow up is limited to only first five days in the hospital.

Branding and Marketing

- ❖ Three clinics were running in buildings where some other RMP used to provide services. In this situation there are higher chances of the LifeSpring brand being diluted.
- ❖ There is no robust communications and branding strategy for LifeSpring Hospitals, and minimal external branding was observed at the CECs.
- ❖ Given the above, the burden of marketing & awareness generation about the CECs thus falls on ORWs alone.

Technology

- ❖ The technology tool provided to ease data collection on the field was yet to be rolled out in all CECs but it is expected to be a significant intervention that will make the work of ORWs paperless and ensure better management of ORWs by their supervisors.

Standard Operating Procedures

- ❖ There was no standardization of operating procedures that was being followed across the CECs.
- ❖ The infrastructure and availability of equipment at each CEC hasn't been standardised. Some CECs lack an exclusive washroom and inadequate measures for privacy and safety of pregnant women (ramp, wheelchairs).

Health Seeking Behaviour in Communities

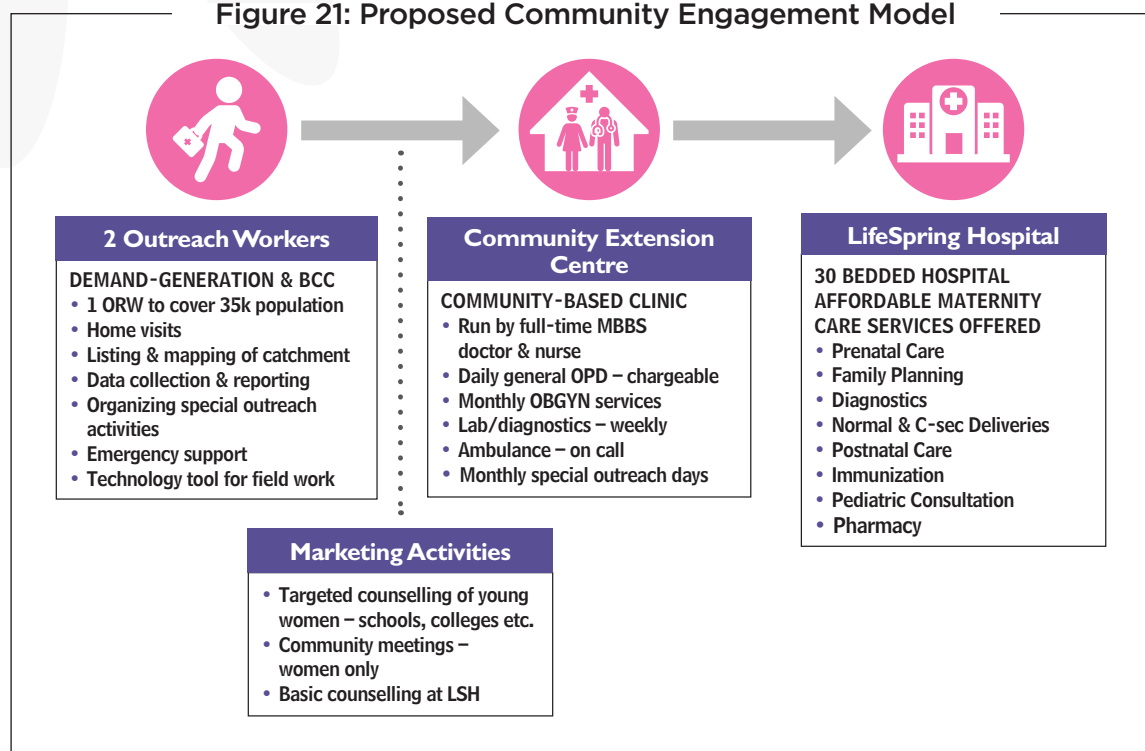
- ❖ There is a perception among patients that unpaid services are sub-standard.
- ❖ The evaluation has apprised us on their willingness to shell out small amounts for services availed at the CEC if they demonstrate quality.
- ❖ People are aware of the importance of care during pregnancy and are increasingly relying on institutional health facilities for care.

Recommendations

PAHAL's learnings from operationalizing a model of community engagement for LifeSpring Hospitals form the basis of the recommendations provided below for establishing a community engagement model for providing primary care that is

- ❖ Financially Viable;
- ❖ Demand Generating;
- ❖ Committed to Improving Care in Underserved Communities.

Figure 21: Proposed Community Engagement Model



Pay-per-Use

A pay-per-use model will ensure that the centers are financially viable. The costs should be on the lower end as compared to the private sector competitors. This will lend credibility to the services provided especially as more and more people perceive free services to be of sub-standard quality. The pricing should be finalized based on an assessment of the willingness to pay of the customers. A revenue generating model will not only help to ease the financial burden on the hospitals to provide for CEC operations; but will also translate in lower referral requirements from CEC to hospital in order to break-even.

According to PAHAL's experience, a typical community extension centre established in peri-urban or urban slums will cost close to ₹90-₹1 lac for one month, including rent, salaries of doctors, nursing staff, outreach worker as well as maintenance. The potential revenues from ANCs, general OPD services and basic diagnostics were estimated to be close of ₹35,000-₹40,000 per month. In order to recover the costs of setting up the extension centre, the CEC team together will need to mobilize at-least 6-7 women per month to deliver in the LifeSpring Hospital. This is in context of a community size of roughly 70,000-80,000 patients with a

very active government hospital network providing services free of cost. The specifications of the model will change according to the

- ❖ Level of competition from government and private facilities in the vicinity;
- ❖ The catchment area of the CEC;
- ❖ The bundle of services offered at the CEC and the type of cases referred to the main hospital;
- ❖ The prevailing prices for all cost items and;
- ❖ The health seeking behaviour in the community of operation.

Brand Recall & Trust to Increase Demand Generation

A number of interventions can be put in place to increase brand retention of hospitals among communities. Hoardings, wall-paintings and audio-visual communication material used by outreach workers is one of the techniques. The second way to increase retention is to operate at-least five days a week. This will also demonstrate reliability. Care should not be offered in instalments but should be a continuum which needs to be maintained by being accessible to the patient at all times. The community will only think of visiting the clinic once it sees the clinic in action in addition to being told about the clinic by outreach workers or word of mouth. A third intervention to generate demand is to offer a bundle of services to the patients. This could mean offering more care services at the clinic like expanding to adolescent care, gynaecological and infertility consultations, and counselling on STDs in the case of LifeSpring's CEC or by providing integration with other services like diagnostics, sample collection, pharmacy and ambulance for emergency.

The most important link to facilitate demand generation are the outreach workers. They form the backbone of any large-scale health intervention at the community level and are an indispensable force when it comes to establishing linkages with the communities. ORWs must be recruited exclusively for the CECs and must be provided with the requisite training in communication skills, persuasion skills, and better patient targeting. They should serve as the repository for all relevant health-related knowledge and best practices. They must be equipped with suitable technology that is easy to operate and makes their field work of listing households, following-up with patients and counselling community members standardized.

Operational Requirements

The success of any extension centre in the communities depends on the location. Thus, it becomes imperative to select the location scientifically, keeping in mind the size, the community's willingness to spend on quality healthcare and the prevailing competition in the locality. An in-depth assessment must be done to ascertain these parameters before selecting the location. All extension centres must have standard operating procedures and quality control mechanisms in place. Basic minimum patient-friendly and standardized infrastructure must also be put in place to attract patients.



Way Forward



The model of community engagement supported by PAHAL has seen considerable progress and favorable outcomes in terms of improvement in pre-natal care amongst urban poor communities, referrals to LifeSpring Hospitals and an overall increase in health awareness and improvement in health seeking behavior.

The model needs to fulfill the dual objective of improving health outcomes in the community and also increasing uptake of quality healthcare facilities available to the community. According to PAHAL, the key recommendations that need to be adapted to build a successful model of community engagement are:

- ❖ The community extension center should be operational atleast 5-6 days in a week
- ❖ Pay-for use model.
- ❖ Consistent Branding of the CECs.
- ❖ Communication strategy for generating awareness.
- ❖ Standard operating procedures and quality assurance mechanisms.
- ❖ Expand service offering, set pricing and client footfall targets.
- ❖ Operationalize a suitable technology solution across all CECs.
- ❖ Skilling and training of ORWs and nursing staff.

PAHAL believes that a community-centric model of healthcare requires a deeper understanding on the part of the hospital and its practitioners of how involving the consumer can support broader organizational and public health missions. As of today, the healthcare field is still lagging behind in strategically engaging consumers. In order to achieve success in engaging with the target patients, facilities should attempt to delegate more authority to the people on the front line, like outreach workers and community health workers, whose basic role is to drive community outreach. Offering a comprehensive package of care and ensuring quality control at the grassroots level, accompanied by a targeted marketing strategy can further contribute towards making the model of community engagement a success.

Notes

Notes



Pahal

Partnerships for Affordable
Healthcare Access and Longevity

Urban Health (USAID) Project

For more information contact:

L. M. SINGH

Project Director, PAHAL and Head-Impact Investment, IPE Global Limited

IPE Global House

B-84, Defence Colony, New Delhi-110024, India

Ph: +91 1140755900; Email: pahal@ipeglobal.com;

<http://www.ipeglobal.com/pahal/>

Disclaimer: This publication is made possible by the support of the American People through the United States Agency for International Development (USAID), under the terms of Cooperative Agreement No. AID-386-A-15-00014. The contents of this report are the sole responsibility of IPE Global and do not necessarily reflect the views of USAID or the United States Government.

Design: PealDezine, peal.duttagupta@gmail.com

