Scope of Work

Formative research for assessing comprehensive primary health care in Mysore city

**Background**

## Primary health care

Primary health care (PHC) is defined as “A whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multi-sectoral policy and action; (c) empowered people and communities.”[1]. In this definition of PHC, there are four elements:

* Personal care (curative, promotive, preventive, palliative) which is comprehensive, continuous, patient-centred, coordinated, integrated, accessible, available, acceptable, affordable and of quality.
* Population care
* Addressing the determinants of health
* Empowering the community

Evidence shows that with a robust primary healthcare system, better health outcomes could be achieved [2]. A strong primary healthcare system is crucial to achieving health-related sustainable development goals (SDG) and attaining universal health coverage (UHC) [3] including financial risk protection, access to quality essential health-care services and access to safe, effective, quality, affordable essential medicines. However, in lower-and-middle-income countries (LMIC) such as India, critical primary healthcare gaps pose a significant challenge to achieving SDGs and UHC.

## Primary health care in India

Recent national reports such as the Task Force report on Comprehensive Primary Health Care[4] suggest primary health care is the only affordable and effective path to achieve UHC. A series of transformative initiatives including increased investments on primary health care had seen India make improvements in health promotion, disease prevention and service outreach. Despite such reports and efforts, PHC remains inadequate and fragmented and is associated with high out-of-pocket health expenditures. A substantial proportion of people (~70%) are still accessing ambulatory care from the private health sector, where the cost of care remains high, and standards of treatment remain questionable [5]. Currently, even a well-functioning primary health centre (PHC) caters to less than 15% of all morbidities for which people seek health care[4]. Studies show that 11.5% households in rural areas and about only 4% in urban areas, reported seeking any form of outpatient care at Government primary care facilities, indicating low utilization of the public health systems[6]. Situation analysis of primary health care in India further shows that demographic health indicators are highly skewed across and within states, and between population subgroups, reflecting inequities in service access and coverage.

One fundamental problem with current PHC services in India is the focus on RMNCHA, neglecting the epidemiological and demographic transitions that have occurred in our country. Data from the Sample Registration System shows the top three causes of mortality in young & middle-aged adults to be cardiovascular diseases, including diabetes & hypertension; respiratory diseases; and cancers [7]. Self-reported morbidity proportions are about 26 per 1000 for infections and 24 per 1000 for NCDs, as per the recent National Sample Survey (2017) [7]. Prevalence of hypertension and diabetes among adults >30 years of age were found to be 30% and 15% respectively in an urban slum in Bangalore (2018). Prevalence of hypertension and diabetes among adults >30 years of age was found to be 20% and 12% in urban Mysore (2018) [8].

The Government has recently introduced the “Health & Wellness Centres” (HWC) under the umbrella of Ayushman Bharat[9]. The HWC has decentralised PHC to 5,000 population and has expanded the package of services to include NCD services.

## Urban *vs* Rural health differentials

Compared to rural areas, urban areas allegedly have an ‘urban health advantage’ [10] made possible through better access to healthcare, education, better sanitary conditions, more extensive social networks, infrastructure that support transport and other amenities all of which can contribute to city dwellers enjoying a healthier life. These potential urban health advantages can only be achieved if they are actively created, planned and maintained through policy interventions.

While both rural and urban areas of India have its share of challenges in organising health care, the urban health system has been posing new challenges and complexities in the recent past. Patient health seeking behaviour as well as the organisation of urban health care system is quite complex. India is rapidly becoming urbanised, and large-scale migration poses challenges to the organisation of adequate health service delivery in urban settings.

Urban vs rural comparisons unfortunately however also ‘hide’ as much as they ‘reveal’. While the urban averages for health and other indicators may appear better than rural averages, the urban averages tend to hide the enormous disparities within urban populations. The urban poor suffers almost as much as the rural communities in terms of risk factors and health services. This is the ‘urban health disadvantage’.

## The national urban health mission

Given the neglect of urban health care, the Government of India introduced the National Urban Health Mission (NUHM) in 2013 to provide quality and health care to its urban citizens, especially for those living in the slums[11]. Broadly the focus has been on:

* Health care through Urban Primary Health Centres (UPHCs) but targeted in outreach to the urban poor in listed and unlisted slums as well as vulnerable populations
* Public health thrust in other sectors (solid waste management, water supply, sanitation, etc.)
* Public health capacity-building in ULBs
* Community strengthening
* Convergence with National Disease Control Programmes

## Mysuru

Mysore, officially Mysuru, is one of the major districts in the southern part of the state of Karnataka, India and home to the world heritage Mysore city in south Karnataka. It served as the capital city of the Kingdom of Mysore for nearly six centuries from 1399 until 1956. The cultural ambience and achievements of Mysore earned it the title Cultural Capital of Karnataka.

Mysore city is a city corporation with a population of 9.2 lakh (2011 census) in 2,15,061 households. Of this, 11.6% and 5% belong to the SC and ST community, respectively. Using a conservative decadal growth rate of 20%, we estimate that the population of Mysuru city will be about 11 lakhs in 2020 (). This population is spread over 65 wards at a median population of 12,600 per ward (7000 to 31,600 people). Around 18% of the city population lives in slums and slum-like areas. The literacy rate of Mysuru is 86.84%, and 38% of the total population is employed in some form or the other.

The primary drainage system is a closed system and water is supplied by the corporation through taps from treated sources. Nearly 96% of homes were electrified, and 86.5% of houses had toilets. There were 4,622 industries and 43,122 commercial entities in the city in 2011. The city is a consistent top performer in the cleanliness rankings by the Government of India for urban areas.

## Health status in Mysuru city

**Inputs**

The DoHFW has a network of 21 Urban Primary Health Centres (UPHC) spread over Mysuru city which is staffed by a total of 37 MOs, 21 staff nurses, 90 ANMs, 21 lab technicians and 20 pharmacists. The average population covered by a UPHC is 57,250 (± 9,152) with a range of 42,326 to 74,816. The average slum population is 17.5% (2,11,482) with a range of 2% to 40% per ward. Nineteen of the 21 UPHCs have several Mahila Arogya Samitis (MAS), with an average of 13 MAS per UPHC (range 2 to 35). The average population covered by a MAS is 5,000 (870 for slum population). Other than the UPHCs, there are two urban CHCs, two medical colleges, private clinics& hospitals, Ayurvedic colleges, Homeopathic colleges, Unani colleges, Nursing colleges.

*Figure 1: Population growth in Mysuru*

The data from the NFHS 4 shows that undernutrition among children and overnutrition among adult females is quite prevalent () [12]. The proportion of adults with diabetes and hypertension is relatively low because the denominator is only up to 49 years of age. Using the burden of disease data of Karnataka as a proxy, we can hypothesise that the causes of premature mortality are ischemic heart diseases, suicide, stroke, and COPD ().

**Services provided**

The Government health facilities offer a mix of primary, secondary and tertiary care. This is also provided by the private health facilities, especially the formal ones. Unfortunately, data from the private sector is lacking.

**Outputs**

Despite an educated urban population and a relatively generous distribution of PHCs in Mysore, we note that only 34% of pregnant women received full ANC and only 39% of children received full immunisation (Table 1). Performance of other preventive services like screening for cancer is also very low. The prevalence of under-nutrition is widespread among children, while women appear to be over nourished.

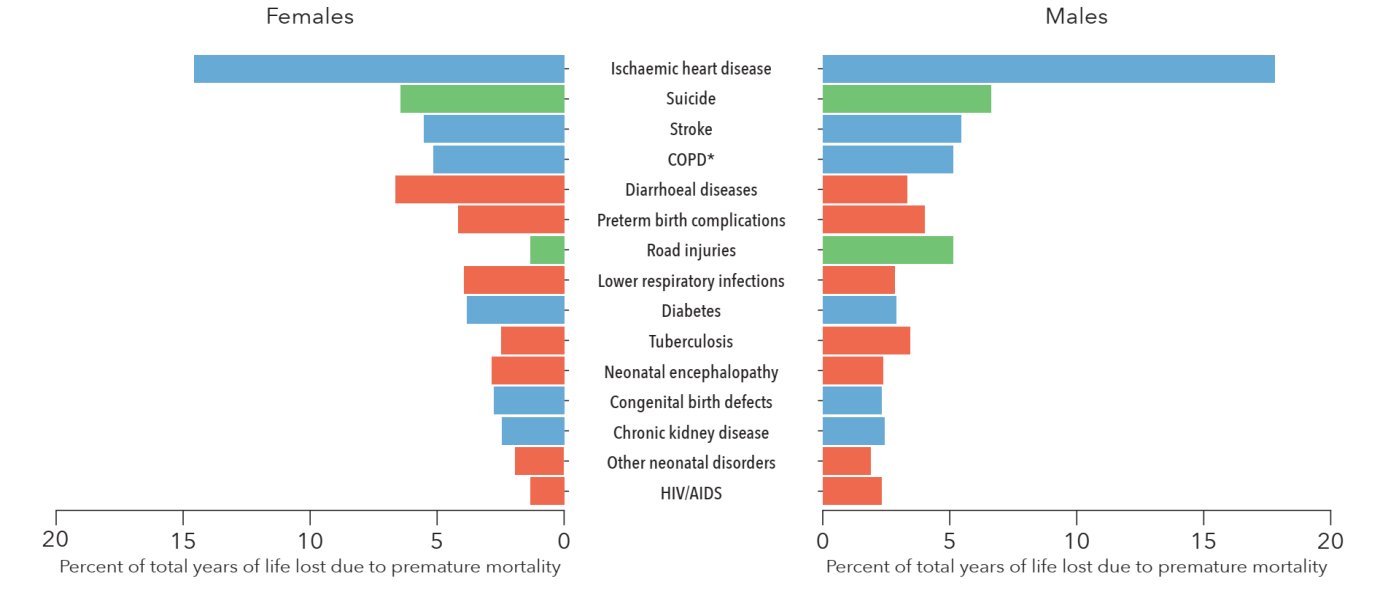


Figure 2: Percent of total years of life lost due to premature mortality – Karnataka

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| --- | --- |
| **Indicator** | **Value** |
| Children (<60 months) who are severely wasted | 3% |
| Children (<60 months) who are stunted (height for age) | 21% |
| Children (<60 months) who are underweight (weight for age) | 18% |
| Women whose BMI < 18.5 kg/m2 | 12% |
| Men whose BMI < 18.5 kg/m2 | 10% |
| Women whose BMI > 25 kg/m2 | 43% |
| Men whose BMI > 25 kg/m2 | 23% |
| Children (5 – 59 months) who are anaemic | 55% |
| All women who are anaemic | 46% |
| Women with blood sugar > 140 mg/dl | 7% |
| Men with blood sugar > 140 mg/dl | 5% |
| Women with high BP (SBP > 140 and / or DBP > 90) | 11% |
| Men with high BP (SBP > 140 and / or DBP > 90) | 10% |

*Table 1: Health output and outcome indicators for Mysuru*

## 

## Implementation Gaps and Need for an Assessment

The above indicators in 2 show that there may be a deficiency in providing health care services in Mysuru. Preventive care indicators are low, indicating weak primary health care services. Given the caveat that this data is nearly four years old, it would be useful to assess the status of primary health care in Mysuru using similar indicators but maintaining a PHC lens. Also, it is essential to understand the underlying reasons for the poor performance of the health services and come up with recommendations on strengthening primary health care, in Mysuru and also in Karnataka. We propose to conduct assessment of the primary health care services in Mysuru city to document the status of primary health care services in Mysuru city, understand the reasons for the status and also identify possible pathways to strengthen primary health care in Mysuru city. This assessment is part of a larger implementation project.

|  |  |
| --- | --- |
| **Indicator** | **Value** |
| Institutional delivery | 100% |
| Institutional delivery @ govt facility | 56.2% |
| Caesarean section rate | 43.7% |
| Mothers who received PNC within 48 hours | 93.5% |
| Average OOPE for delivery | Rs 4,143 |
| Unmet FP needs | 5.6% |
| Children (12 – 23 months) who received full immunisation | 97.2% |
| Children (< 36 months) breast fed within one hour of birth | 49.9% |
| Children (<60 months) who are wasted (weight for height) | 15.6% |
| Women who have been screened for CA Cervix | 0.9% |
| Women who have been screened for CA Breast | 1% |
| Women who have been screened for CA Oral cavity | 0.3% |

*Source: NFHS-5,2019-20 – Factsheet Mysore*

*Table2: Health outputs in Mysore city*

# **Framework for Primary Health Care**

To assess primary health care in Mysuru, we have developed a framework () that looks at all the elements required to ensure that primary health care is provided.

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Figure 3: Framework for Primary Health Care

Any primary health care service is expected to provide personal care services, population care services and address the determinants of health.

## Personal care services

Personal care services are focussed on providing comprehensive care (curative, preventive, promotive and palliative care) as per the local community’s needs and requirements. This care should ideally be continuous, coordinated, integrated, accessible, available, acceptable, affordable and of quality.

## Population care services

The primary health care team should also be responsible for the health of the population in the catchment area and take proactive measures to reach out to this population, stratify the population at risk and provide them with the required services.

## Determinants of health

The primary health care team is expected to connect with other sectors who have an effect on health, e.g. the water and sanitation sector, the food sector, the education sector and the pollution control board.

For all this to function, primary health care requires good governance, adequate health care finances, competent human resources, enough medicines, consumables and equipment. The entire primary health care should have a robust information system that can help supervisors, as well as the community, make the appropriate decisions based on evidence. If all these functions well, then we would achieve the necessary outcomes of reduction in premature mortality, and an increases financial protection as well as a responsive health system.

# **Objectives of the assessment of primary health care services in Mysuru city**

Overall objective of formative research is to describe the current status of urban comprehensive primary health care system in Mysore city, identify and analyse barriers and facilitators to comprehensive primary health care, and identify design options to strengthen urban primary health care

## Specific Objectives

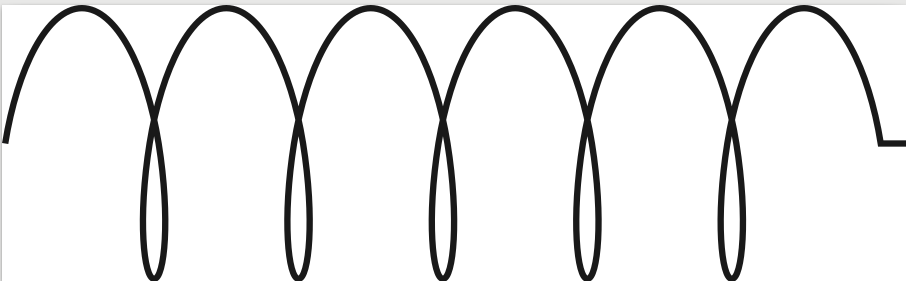
1. To identify and explore the role of key stakeholders in the provision of urban primary health care;
2. To describe the current status of urban comprehensive primary health care in Mysore city at three different levels – health systems, facility and community
   1. at health system level for capacity for designing, developing, implementing and monitoring urban primary health care in Mysore city
   2. public and private health facility readiness for delivering preventive and non-domiciliary curative primary health care in urban Mysore
   3. profile the community morbidity status, health care-seeking and costs incurred for selected acute and chronic conditions in urban wards of Mysore city
3. To identify and explain barriers and facilitators to comprehensive Primary Health Care and
4. To identify design options for strengthening urban primary health care.

Further to deepen our understanding of status of urban primary health care in Mysore at both the supply and demand levels, to understand the reasons for the status of primary health care in Mysuru and to identify possible options for strengthening primary health care in Mysuru city, we have proposed set of activities. This is attached as Appendix-A.

# **Methods**

This situational assessment is part of a larger implementation research study, wherein the research team (consisting of external researchers as well as Government implementers) together assess the situation of primary health care, identify the gaps, design reform packages, implement these packages and then review the outcomes of the implementation. If the results are less than satisfactory, then once again assess the situation, design the reform package, implement it and evaluate the situation (Figure 4). This iterative process of research will finally provide the final satisfactory product of comprehensive primary health care that takes care of all the health needs of the community in an affordable, efficient and equitable manner [13].

The situational assessment is a mixed-methods study, with a quantitative first design. This will be conducted during the first year of implementation of this larger implementation research study. The initial quantitative study will capture the status of primary health care in Mysuru, and the following qualitative study will explore the reasons for this status and the possible options for improving primary health care. Data from secondary sources will supplement this. While St. John’s Research Institute (SJRI) will lead the quantitative study, Karnataka Health Promotion Trust (KHPT) will lead the qualitative study as part of this situational assessment phase. Study population is attached in Appendix-B.





*A = Assessment; D = Design the intervention; I = Implement the intervention*

Figure 4: The overall implementation research design

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| --- | --- |
| Objective | Method |
| Why is this status and how to improve this status? | Stakeholder consultations followed by  Interviews with   * Patients * Providers (Government and Private) * District health officials * Policy makers |

## *Table 3: Research Methods*

## **Qualitative Research**

The qualitative study will mainly focus on ‘why’ and ‘how’ questions. Key Informant (KI) Interviews, Public Engagement (PE) Programs, In-depth Interviews (IDI), Focus Group Discussions (FGD), Participant Observation, will be the key techniques [15] [16] [17] used to elicit information from different stakeholders at different levels of health care. Based on the socio-demographic and population characteristics, five wards in the Mysore city will be purposively selected for the qualitative study. A specific study tool/interview guide for each of the above-stated interview techniques will be developed. This will mostly be based on the findings from the quantitative survey, supplemented with secondary data.

Tools will be pilot tested in the field and refined further before the actual data collection*.* Different methodologies used for data collection are depicted in .

Policy makers & program officer @ state level

Policy makers & program officers @ Mysuru

stakeholders @ Mysuru

IDI with selected participants from PE @ Mysore

stakeholders @ Mysuru

Observations in 5 UPHCs area @ Mysuru

*Figure 6: Methods for qualitative data collection*

1. *Key Informant (KI) Interviews*

The KI interviews are semi-structured, relying on a list of issues to be discussed. This resembles a conversation among acquaintances, allowing a free flow of ideas and information. Interviewers frame questions spontaneously, probe for information and take notes/record conversation, which will be elaborated or transcribed later. The respondents for KI interviews will include policymakers at the state level and at Mysore city. Few of the senior officials previously working in the health department will also be interviewed. The semi-structured interview guide will include specific questions on priority for urban health, current gaps and scope for CPHC, rural health v/s urban health, urban health response to NCD, the feasibility of implementing CPHC in the urban health setting. A semi-structured interview guide will be carefully designed and field-tested prior to fieldwork. Prior approval will be sought by the research team to brief the participants about the objective of the interview and also to seek consent.

1. *Public Engagement programs*

Public engagement is a participatory exercise where a group of people are engaged through different activities to conceptualize a problem, share thoughts, concerns and provide recommendations to solve the problem. It can also help maximize knowledge flows, learning between the stakeholders and the research team. This is specifically helpful in eliciting information from more numbers of respondents in a shorter duration.

The PE programs will be conducted in Mysore city, and the respondents will be purposively selected from the different sectors. Each PE program will consist of 15-20 participants representing both health and non-health sectors, and both academic & non-academic institutions in Mysore city. A specific venue and the dates for each PE program will be decided, and an invitation from KHPT will be ensured well in advance. The activity for each PE program will be planned for half a day. Specific questions on CPHC in Mysore

city will be framed in advance; different participatory activities such as ‘Fishbone diagram’, ‘Spider Diagram’, ‘Desired Changes’, ‘Service or intervention web’, ‘Low hanging fruit’, etc.[18]will be used to encourage the discussion and elicit in-depth information. A total of four PE programs will be conducted, and details of participants representing each group are depicted in .

Figure 7: Public engagements with different stakeholders

1. *Focus group discussions (FGDs):*

In the study, we are proposing FGDs with a homogeneous group of respondents representing different sectors within Mysore city. FGD will be conducted with a group of nurses, general physicians both Government and private, private retail pharmacists, laboratory technicians, counsellors, kiosk, mobile health unit workers, community members and frontline workers. FGDs are slightly different from PE programs, and it allows us to go into an in-depth discussion with participants on their views and opinion on specific issues. Each FGD will be led by a moderator and assisted by a note-taker. All FGDs will be audio-recorded and a seating chart along with a debriefing form will beused to contextualize the process of data collection. Respondents representing the five wards in Mysore city will be purposively selected.

A close up of a map

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*Figure 8: Potential stakeholders for focus group discussions*

1. *In-depth Interviews (IDIs)*

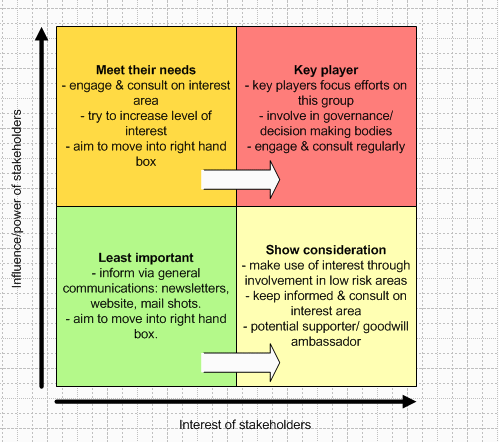
IDIs are face-to-face interviews, and these are useful in eliciting the in-depth understanding of specific issues from key stakeholders to elicit their perspectives on an issue of interest. For this study, IDIs are proposed with specific individuals who will participate in the PE program. This is to get a deeper understanding of the specific topic discussed during the PE program, and three respondents from each PE program (total 9) will be purposively selected for the IDI. An in-depth interview guide will be developed based on the key findings from the PE program and IDIs with selected respondents on the next day or within a week of the respective PE programs.

1. *Participant Observation*

This technique will be used to gather data informally through both; by observation alone or by both observing and participating with different stakeholders (by asking questions or getting clarifications). In this methodology, the researcher approaches the participants in their own environment. Using participant observation techniques, the research team will spend extensive time in all five selected UPHCs and few private hospitals preferred by a majority of the population. Our observation techniques will aim to understand services available at the hospital, people’s behaviour towards the healthcare services, inter-personal communication between patients and the healthcare provider, physical, social and cultural context of the UPHC environment. This process will also enable us to develop a familiarity with cultural milieu and the information collected from this method will be triangulated with the information that comes from other methods in this study. As part of this study, a total of 15 observation notes will be written.

1. *Stakeholder mapping*

A preliminary listing of stakeholders will be undertaken as a desk-based exercise. This list will be expanded based on discussions with Government officials at the state level and at the district/city level. In addition, key partners from the private sector will also be included. Experts from curative and preventive health sector domains representing medical, nursing, allied health, housing, waste management, sanitation, public parks, etc. will be included. Community organizations will be represented, and patient interest groups will also be included. Subsequently, analysis and mapping of these stakeholders according to the level of interest and level of influence will be carried out for subsequent commensurate roles and actions (Figure 9).



*Figure 9: Stakeholder mapping*

*(vii)Willingness to pay* study

We will undertake ‘willingness to pay’ study. This will be part of the qualitative method wherein we will interact with community members and understand the extent to which they are willing to pay for their primary health care services. HSTP will bring in specialists who will do this exercise. KHPT field staff will be required to organise the logistics for data collection.

*(viii) Sampling for qualitative assessment*The CPHC study team will develop a master list of respondents who can potentially participate in this study. This will be a comprehensive list of individuals representing different departments, institutions both at the state and district levels. The master list will include the name of the concerned person, designation, representing department/institutions, and the contact number. Respondents for each of the proposed methods will be purposively selected. The overall sample includes 58 interviews (15 KI interviews, 4 PE programs, 15 FGD, 9 IDI, 15 Observation field notes) covering about 213 participants. Other respondents, especially in the policy maker category, may be included based on their availability, readiness to participate in the study and need for further information to fulfil the study objectives. The principle of data saturation will purely guide sampling. The details of the proposed sample are mentioned as appendix E.

**Team composition for qualitative assessment**

The qualitative study team will consist of fivemember team: Study coordinator (1), Research Officers (2) and two field investigators (1 male & 1 female). The qualitative researcher will be overall in-charge of study and will be conducting KI interviews at the state level, developing the study tools, data analysis, and writing the reports. The research officers will assist the qualitative researcher in data collection and analysis, along with overseeing the quality of data. The two research investigators will be based at Mysore and will be responsible for mobilizing the respondents, conducting FGDs, IDIs at the district level. The study team will undergo intensive training on ethical procedures, objectives of the study, qualitative research techniques, field notes writing, broad orientation on the CPHC and overall study. The study team will closely work with the CPHC program team and will be supported by the qualitative research unit lead at KHPT.

**Data collection**

Tools for each of the methods will be developed according to study objectives, subject and participant group. Each of the tools will be translated into the local language and will be field-tested before finalizing (Appendix C). Ethical approval will be taken prior to the study. A study coordinator will lead a research team of three, both at the state and district level, supported by the central KHPT qualitative research team. All the team members will be given extensive training on the study objectives, qualitative research, tools, protocols and timelines. A systematic workflow and reporting system will be developed by the central research team prior to the data collection, which will ensure quality and timely delivery of the data. A research diary will also be maintained by the study coordinator, documenting each and every step, decisions, field experiences, meeting minutes undertook during the whole process of the data collection. Standards and systems for note taking, audio recording, transcribing and storing visual data from participatory techniques such as drawings, graphs, use of metadata, systems storing will also be defined. Data quality will be assured through routine monitoring by the study coordinator, field coordinator, and periodic cross-checks against the protocols by the central research lead.

**Data analysis of qualitative assessment**

Centrally a directory will be maintained with details of each respondent, activities conducted, and timelines. The file names and the directory will have a pre-determined naming pattern, so as to avoid any kind of confusion during the documenting process. As per the study needs, at each stage of data collection, a quick analysis will be done. It will involve documenting the initial findings based on the audio files without undertaking a detailed process. An iterative process will be undertaken to refine the tools based on the qualitative and quantitative study findings. This is to feed information to the program and field team as well. Since most of the data collected will be in the vernacular, a separate team will simultaneously continue to transcribe and translate. All the recordings will be transcribed using agreed formats and standards for handling the issues like multiple voices, interruptions, labelling of participatory and other activities. Where translations are undertaken, the quality will be assured by one other researcher fluent in local language checking against the original recording or notes.

Transcripts will be imported to NVivo [19] [20], a software to organize, manage and analyze qualitative data.After completion of the fieldwork, in-depth analysis will be carried out, and then a coding dictionary will be developed based on the interview guide, responses, field notes, and available literature. The new codes/categories that emerged during the analysis will be included in the subsequent coding process. The research team will check through each transcript for consistency with agreed standards. Thematic saturation will be observed, and extensive memos will be written while coding, which provides space to compare the data and to draw inferences, interpretations, based on those comparisons. Themes emerging from the data will be narrowed down by careful reading and re-reading of transcripts against the research questions. Validation will be ensured by comparing the findings of the quantitative data as well as from findings emerging from different groups of qualitative data.The study coordinator and the KHPT research team will be responsible for writing the report. The report will comprise of the detailed process of the qualitative research and will include key findings emerging from the qualitative data will be presented in the forms of excerpts and narratives.

## **Permissions/approvals**

GoK and Mysore city corporation permissions have been obtained via direct interactions with the MD-NHM, Health Secretary-GoK and the Nodal Officer for Urban Health-GoK. A preliminary workshop was held in Bangalore (Appendix D) and another one in Mysore to get buy-in from state and district level stakeholders. Ethics approval will be obtained from the St John’s Medical College-Institutional Ethics Committee (SJMC-IEC). Informed consent will be obtained from study participants.

# **Roles of the consortium members**

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| --- | --- | --- | --- | --- |
| **Teams**  **Roles** | **KHPT** | **SJRI** | **HSTP** | **GoK** |
| Principal Investigator/ Lead | ++ | + | ++ |  |
| Admin & Finance | ++ |  | + |  |
| Government clearance | ++ |  |  | + |
| Ethics approval |  | ++ |  |  |
| Data - Quantitative | + | ++ | + | + |
| Data - Qualitative | ++ | + | + | + |
| Project Report\*\* | ++ | + | ++ | + |
| Dissemination of findings | + | + | ++ | ++ |
| Publication | + | + | ++ | + |

++ lead partner; + additional partner

\*\*Quantitative study report will be led by SJRI, Qualitative study report by KHPT and overall compilation and submission by HSTP

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# **Gantt chart**

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| **Activity** | **0** | | | | **1** | | | | **2** | | | | **3** | | | | **4** | | | | **5** | | | | **6** | | | | **7** | | | | **8** | | | | **9** | | | |  |
|  | **Sep-21** | | | | **Oct-21** | | | | **Nov-21** | | | | **Dec-21** | | | | **Jan-22** | | | | **Feb-22** | | | | **Mar-22** | | | | **Apr-22** | | | | **May-22** | | | | **Jun-22** | | | | **Jul-22** |
| MoU drafting & signing |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Qualitative study** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Refinement of qualitative tools |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Qualitative tool review workshop |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Starting and completion of qualitative data collection |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Starting and completion of qualitative data analysis |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Others** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Stakeholder mapping |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Secondary research |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Submission of cleaned and analysed data to HSTP |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Submission of 1st draft of report to HSTP |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Submission of final report to HSTP |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dissemination of results |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

# **Risks and mitigation**

Chief risks are technical, schedule-related or political.

Technical risks are related to scientific aspects such as those related to research design, assumptions taken while undertaking sample size calculation, and assumption of uniform participation rates in different subgroups within an urban area. To mitigate these risks, we have resorted to the use of standard research designs, been very conservative in sample size calculation assumptions and used a trade-off between reasonable risk versus increasing complexity of study procedures for assuming attrition rates.

Schedule-related risks usually may arise from inherent risks while working with the state and local Governments wherein routine Government programmes or emergency work will take precedence over research study. In addition, assumptions in the time taken for fieldwork may get delayed or complicated while working with certain subpopulations in urban areas, especially if there are gated communities or apartment complexes with security systems. For both, we have reasonable built-in buffers in terms of person-time (about 5-10%) and a contingency line item to be able to finish the work as per schedule. We have also considered risk-sharing by cross-utilization of resources between the consortium partners.

Political risks include foreseeable and unforeseeable scenarios. For the foreseeable scenario, we anticipate that there may be some resistance from some sections of the study population against the background of concerns related to “citizenship”. To overcome this, we have considered dropping sensitive questions or segments of questionnaires from the study tools to be able to at least collect a reasonable amount of relevant information or delay the survey in some areas or replace geographic sub-regions with other sub-regions during the sampling procedure, though some aspect of representativeness of the study area may be distorted in the last procedure.

# **Study to understand primary care linkages**

A mixed-methods research study will be conducted in T,Narasipura Block, Mysore District to understand the primary care linkages under the Ayushman Bharat program and recommend reforms to strengthen it. This is a separate study in addition to the formative research for assessing comprehensive primary health care in Mysore city.

**Grant Value**

The total budget approved is INR 9,616,888 (Rupees Ninety Six Lakh Sixteen Thousand Eight Hundred Eighty Eight Only) inclusive of all applicable taxes and this will be reimbursing against expenses incurred as per the timelines mentioned in the milestone schedule.

**Budget**

|  |  |  |
| --- | --- | --- |
| **S. No** | **Budget Line Items** | **in INR** |
| **Gross Total** |
|
| 1 | Personnel | **1,656,000** |
| 2 | Consultancy & Technical Support | **4,114,125** |
| 3 | Travel & Communication | **731,250** |
| 4 | Field work and data processing charges | **1,827,250** |
| 5 | Equipment's | **180,550** |
| 6 | Training & Capacity Building | **175,950** |
| 7 | Knowledge Translation | **57,500** |
| 8 | Office Overheads | **874,263** |
| 11 | Sub-Grants | **-** |
|  |  |  |
|  | **Gross Totals** | **9,616,888** |

**Bank Account Details**

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| Name of the Beneficiary | Karnataka Health Promotion Trust |
| Bank Name | State Bank of India |
| Bank Address | New Delhi Main Branch, N D Main Branch 11, Parliament Street, New Delhi, NCT of Delhi 110001 |
| Account Number | 40081378773 |
| IFSC Code | SBIN0000691 |
| Swift Code | SBININBB104 |

**Payment Terms**

This is a cost reimbursable grant. An initial advance will be made to initiate the activities and subsequent tranches will be paid against the milestones mentioned below along with audited utilization report. Please refer to the Format for Utilization Certificate.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Grant Instalment no.** | **Milestone** | **Percentage of grant amount disbursed** | **Payment Due** | **Amount in INR** |
| 1 | Signing of contract and submission of the inception report with field plan for qualitative Research | 30% | September 2021 | 2,885,066.40 |
| 2 | Completion of data collection (qualitative) and submission of cleaned data (qualitative) | 30% | April 2022 | 2,885,066.40 |
| 3 | Submission of draft report | 20% | June 2022 | 1,923,377.60 |
| 4 | Submission of the final report | 20% | July 2022 | 1,923,377.60 |
| **Total** | | | | **9,616,888.00** |