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 toless 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’**Invalid source specified.** 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 [10]. 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 under nutrition among children and overnutrition among adult females is quite prevalent () **Invalid source specified.**. 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.

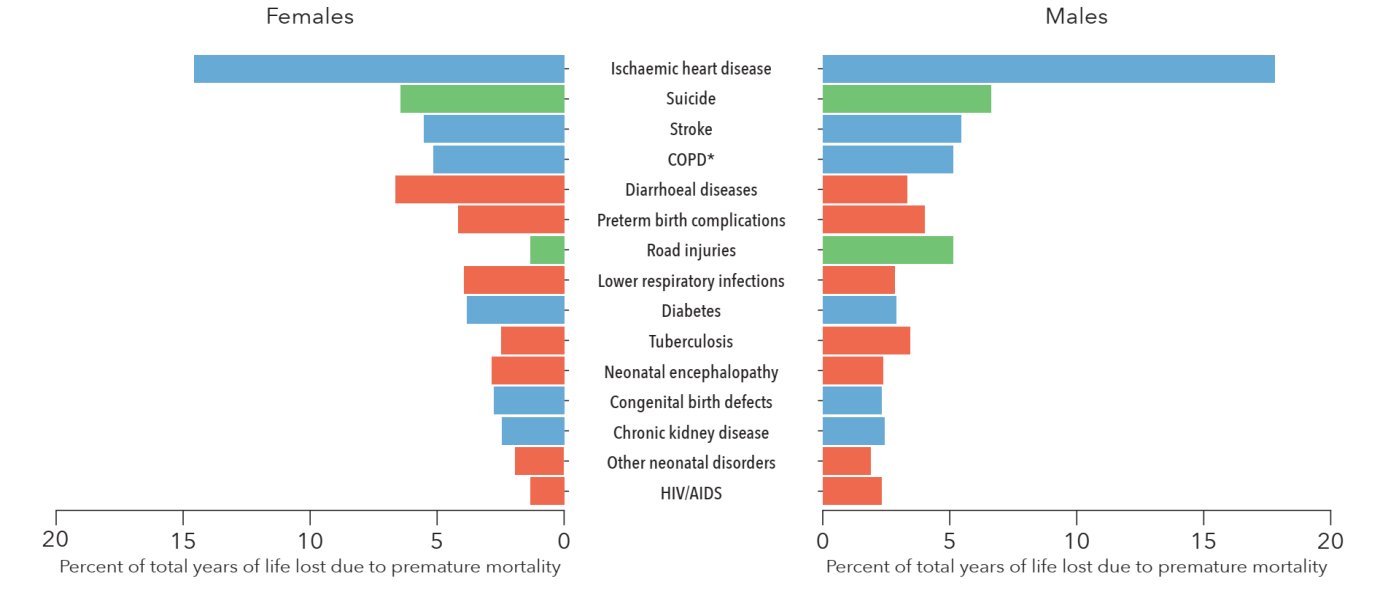


Figure 2: Percent of total years of life lost due to premature mortality – Karnataka

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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.

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| **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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Description automatically generated

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

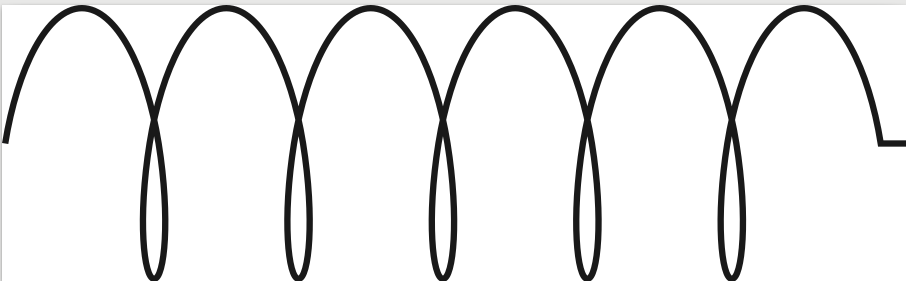
1. To identify and explore the role of key stakeholders in the provision of urban primary health care;
2. To describe the current status of urban comprehensive primary health care in Mysore city at three different levels – health systems, facility and community
   1. at health system level for capacity 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 [11].

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

## *Table 3: Research Methods*

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| --- | --- |
| Objective | Method |
| What is the status of Primary health care? | Household survey   * What is the morbidity pattern among the population? * Where do they get care? * How much do they spend on this care? * What is the satisfaction level?   *All this disaggregated by socio-demographic and economic status* |
| What is the status of Primary health care? | Facility survey   * What are the facilities in Mysore? * What are the services that they are providing?   + Which conditions?   + What lab tests?   + What medicines?   + Counselling?   + Palliative care?   + Promotive care?   + Preventive care? |

## Quantitative study – General Household Survey

We will use a multi-stage stratified random sampling to identify the sample households.

**Sampling method**

The universe is the citizens residing in the 65 wards of the Mysuru City Corporation. Each ward will be further subdivided into Census Enrolment Blocks (CEB). Those wards with less than 5 CEBs per ward will be excluded from the study sample. The rest of the wards will be divided into two strata, the first strata consists of wards with 5 to 20 CEBs each and the second strata contains wards with more than 20 CEBs each. Ten wards will be randomly sampled from the first strata, and 15 wards will be randomly sampled from the second strata. Ten CEBs will be randomly sampled from the wards in the first strata while 20 CEBs will be randomly sampled from the wards in the second strata. At this stage, there will be 100 CEBs in the first strata and 300 CEBs in the second strata. From each CEB, 15 households will be randomly selected giving a total of 6,000 households (). These households will be listed, and those with a patient with acute illness or a diabetic/hypertensive will be chosen for the study.

*\* In this stratum, there are wards with 5 to 20 CEBs. So, we may not get 10 CEBs in some of the wards*

Figure 5: Multistage, stratified random sampling for the household survey.

**Sample size calculation**

The sample size for the General Household Survey is calculated as follows:

* Expected prevalence of general morbidity in the past 15 days = 3%
* Confidence interval = 95%
* Precision = 25%
* Design effect = 1.5
* Attrition rate = 20%

This gives a sample size of 3,724 individuals. (Table-4).

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Study parameter | Expected prevalence | Confidence interval | precision | | design effect | attrition | Required sample size | |
|  |  |  | 20% | 25% |  |  | 20% | 25% |
| **Person with ailment** | 2% | 95% | 4704 | 3010 | 1.5 | 0.1 | 7840 | 5016 |
| 3% | 3106 | 1988 | 0.2 | 5173 | 3724 |

*Table 4: Sample size calculation for the general population community survey*

**The tools**

The questionnaire for this survey is in Appendix - C.

## Quantitative study - Special Household Survey for Diabetes & Hypertension

This will build on the above general HH survey. It will capture more details about the health seeking behaviour and treatment experiences of patients with diabetes and hypertension.

**Sampling method**

Those households that have patients with diabetes and/or hypertension and identified in the General Household Survey will be the sample for this element of the study.

If the proportion of PHC coverage for diabetes/hypertension will be at least 25% among adults aged 30 years and above, with 20% relative precision and 95% confidence interval, the number of households required will be 288. Accounting for the clustering of households in wards, using design effect of 1.5 [12] and drop-out rate of 20%, total numbers adults with common NCDs – DM/HT) required will be 518.

**Sample size calculation**

Fig. Sample size calculations NCD community survey

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Calculations  Study  parameter | Proportion with C-PHC\* coverage | C.I. | computed sample size  Relative precision | | Design effect | Attrition | Sample size required after accounting for clustering and attrition | |
|  |  | 15% | 20% |  |  | 15% | 20% |
| Adults with NCD | 0.25 | 95% | 512 | 288 | 1.5 | 20% | 922 | 518 |

\* C-PHC: Comprehensive Primary Health Care -

Proportion of C-PHC coverage - Considering 25% of the adults with NCD would be utilizing C-PHC

**Assumptions**

The number of households that need to be visited in order to obtain these required numbers for the three different groups are shown below. Assuming that the prevalence of diabetes/hypertension will be at least 20% among adults aged 30 years and above, 2700 households will yield the required number of adults.

Hence overall, 6000 households will need to be included in the survey to obtain required sample size.

**The tools**

The questionnaire for this survey is in Appendix C – Section 6.

## Quantitative study – Facility survey

Unlike the household survey, the facility survey will look at primary health care from the supply side and try and understand the extent to which the facilities are equipped to provide primary health care in Mysuru city.

**Sample size calculation**

In the Government sector, all the primary health care facilities in Mysore city (numbering approximately two dozen) will be studied. In the private sector, an equivalent number of smaller clinics serving as first point of contact will be studied. These clinics will be selected depending on the results of the household survey, with purposive sampling of those clinics that are commonly used by the community.

In addition, we will also purposively select a handful of secondary and tertiary care hospitals to study morbidity profile of patients attending select general OPDs (outpatient departments) to estimate proportions that could possibly have been seen in primary care clinics in the neighborhood.

**The tools**

The questionnaire for this survey is in Appendix D.

## Quantitative study – Secondary data

Considerable data will also be collected from existing secondary data. This would be in the form of existing registers and reports. Specifically, data about the general context of Mysuru, of the health status of Mysuru, of the performance of the Primary health care facilities and of the details of the private health care facilities will be collected from various relevant sources.

## Data collection methods

All quantitative data will be collected using tablets. Questionnaires will be loaded on to laptops and data being saved onto a server on a real-time basis if network connectivity is available (or) stored in the laptop temporarily with later synchronization once network connectivity is re-established. All data will be downloaded and stored as .csv files and used for analysis by statistical software.

## Quality Control

* Standardization training of research assistants (field investigators and supervisors), pre-testing of questionnaires and pilot studies
* In-built range checks and hard/soft error checks in the electronic questionnaires
* Internal quality control – by supervisors for oversight of data collectors
* External quality control – about 5-10% re-sampling of data that is collected by the research team will be validated by an experienced external quality control team.

## **Permissions/approvals**

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**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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

# **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.

**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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| **Quantitative study** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Database development |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Advt & hiring of Mysore field staff |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Pre-test tools and database |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Field worker training |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Pilot study in Blr/Mys |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Starting and completion of quantitative data collection |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Starting and completion of quantitative data analysis |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Quantitative feed in to the qualitative team |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| External QC |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Others** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| IEC approval |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Grant Value**

The total budget approved is INR 7,302,900 (Rupees Seventy Three Lakh Two Thousand Nine Hundred 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 | **2,588,000** |
| 2 | Consultancy & Technical Support | **1,760,000** |
| 3 | Travel & Communication | **935,000** |
| 4 | Field work and data processing charges | **188,000** |
| 5 | Equipment's | **928,000** |
| 6 | Training & Capacity Building | **240,000** |
| 7 | Knowledge Translation | **-** |
| 8 | Office Overheads | **663,900** |
| 11 | Sub-Awards | **-** |
|  |  |  |
|  | **Gross Totals** | **7,302,900** |

**Bank Account Details**

|  |  |
| --- | --- |
| Name of the Beneficiary | CBCI Society for Medical Education |
| Bank Name | State Bank of India |
| Bank Address | 40091883332 |
| Account Number | FCRA Cell, 4th Floor, New Delhi Main Branch,11, Sansad Marg, New Delhi-110001 |
| 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 milestone 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 | 2,190,870.00 |
| 2 | Completion of data collection (qualitative) and submission of cleaned data (qualitative) | 30% | April 2022 | 2,190,870.00 |
| 3 | Submission of draft report | 20% | June 2022 | 1,460,580.00 |
| 4 | Submission of the final report | 20% | July 2022 | 1,460,580.00 |
| **Total** | | | | **7,302,900.00** |