**Understanding Urban Health**

**“A Guideline and Tool-Kit”**

**UNDERSTANDING URBAN HEALTH**

**A GUIDELINE AND TOOL-KIT**

**Chapter- 1**

**The Background, Objectives and Outcome**

The National Urban Health Mission (NUHM) seeks to improve access to primary health care in urban areas, with a focus on the urban poor and marginalized vulnerable populations. For designing sensitive, responsive, and relevant urban health policy and action, it is important for planners and programme managers to interact directly with the community and with vulnerable groups for whom the programme is intended. It is also important for them to establish a dialogue with programme implementers and providers at different levels, for they too have much knowledge, a considerable part of which is tacit knowledge and from which the planner must draw upon.

This publication is a tool-kit to assist state programme managers and technical support groups to conduct a rapid assessment and situation analysis that could be used to make the individual city or town health plans. This tool does not cover how these are integrated into the state NUHM programme implementation plan, nor touch upon the drafting of the NUHM PIP for which there are other guidelines.

The plans are being made in a context where public funds are limited and there are large gaps in both access to services and in ensuring financial protection from the growing costs of health care. Moreover there is a growing burden of disease and a rising costs of care that leads to a further worsening of the gaps.

Though the immediate context of the study and the planning is the NUHM, we remind ourselves that in some cities the NUHM contribution is only a small part of their total health budget. Further in all towns and cities there is the potential possibility of raising much larger revenues from the city’s own economy and from the state budget and even from philanthropic institutions. And thus once the plan is made the city’s leadership can choose how to mobilise resources to meet the health priorities.

We also note that planning is not for the purpose of resource mobilization alone. There are many areas where the main requirement is access to knowledge resources, or technical support and to institutional reform and improved governance. The plan must indicate and inform action in these fronts.

And finally we note, that this is not a study that we recommend for annual situational analysis. This is a base-line study that should inform a city planning effort over a plan period. It could be supplemented by structured sample surveys on access and cost of care in larger cities, but for most towns this would be adequate as a base-line for future evaluations.

**Objectives of the Study/Situation Analysis:**

Thus the purpose of study or situation analysis report must be able to answer the following questions and provide the information on the following themes

1. What are the health services currently available, to what extent are they being accessed and to what extent are these health services responsive to the needs and context for the poorest and most vulnerable sections of the population.
2. What is the urban poor doing to cope with their burden of disease and costs of care and their choices regarding both immediate and long-term arrangements required for their health care.
3. What services do public facilities and providers offer, and what are the limitations/ problems they face in expanding the range of services, the access to services, the quality of care and the financial protection of public sector provisioning.
4. How do we prioritize universal access to primary health care and within this prioritize preventive and promotive health care. What are the institutional structures and community processes that are present and how do we build on these.
5. What is the health related roles of the urban local body, and how do we enhance their performance. What is the level of contribution/ convergence of health related sectors and how do we improve on this.
6. How do we engage with different types on non-government agencies and private providers to supplement the capacity of the public health systems, and use their energy and investments to contribute to public health goals?
7. What is the distribution of roles, responsibilities and powers between the ULBs and state line departments for the governance and management of health and health related services and the institutional readiness and organizational capacity to deliver and expand on their roles. What is the fiscal space and financial resources made available for urban health?

**The Outcome or Deliverable:**

The immediate end point of situation analysis is a comprehensive urban health review report. The structure of this report is indicated below.

**THE FINAL CITY URBAN HEALTH REVIEW REPORT**

* + - 1. Profile and brief social history of city:
			2. City Map with locations
			3. Population of city - Demographics
			4. Slum Population (Notified/de-notified), SC/ST, Religion
			5. Growth of the city- by birth, migration and area inclusions.
			6. City health budget: Total sources and division between primary, secondary and tertiary
			7. Governance of Urban Health Care:
1. Roles and responsibilities of Department of Health
2. Roles and responsibilities of Urban Local Body
3. Roles and responsibilities of other departments of health.
	* + 1. The Organization of Primary Care – a descriptive note elaborating number and type of facilities and ownership. It would include secondary and tertiary care facilities and their linkage arrangements. The latter are sites of secondary or tertiary care- but also of primary care.
			2. Access; Costs of Primary Care: a feedback from the community and vulnerable groups. (This could be before/ after next section. Put in boxes- which at times could be more that a page)
			3. The Primary Health Care Centers-
4. Services available and the gaps vis a vis the mandate.
5. Financial barriers to access.
6. Other barriers to access-eg: timing, location.
7. Quality of care issues- in terms of effectiveness, safety, satisfaction.
8. Quality with reference to infrastructure, staffing, equipment
9. Quality with reference to support systems- procurement of drugs and supplies.
10. The mechanisms of monitoring and technical support.
	* + 1. The Urban Hospital (same sub-headings as for 10 above).
			2. The History and possibilities of Partnerships and insurance programmes.
			3. Health Related Public Services and their organisations
				1. Sanitation including toilets, sanitation.
				2. Drinking water provision
				3. ICDS and care for the pre-school child
				4. School education and school health.
				5. Food security- PDS, mid day meals, ICDS
				6. Food safety- hotel and slaughter house regulation
				7. Air Safety.
				8. Occupational Health.- special reference to sanitation workers- but also to industry.
				9. Registration of births and deaths,
				10. The management of death- cremation, burial, hearse vans.
			4. Perceptions of management, providers and the community on the way forward. The divergences and overlaps with current thinking on urban health care planning.
			5. Recommendations- but with reference to what NUHM PIPs are already suggesting.

***Note:*** *while writing each of the above 15 sections information is drawn upon secondary data, discussion with officers, facility visit, provider and user responses, and community interactions- as is relevant- making it clear what source one is drawing from and discussing the contradictions between perceptions if there are any.*

**Chapter -2**

**General Guidelines for the City Health Review:**

To write the city health review report, we need to collect different types of information from a number of sources. We have organized the tools required for collection of this information into three sections. Each of these sections has a number of sub-sections.

The three sections are:

**Tool- Kit Section 1** : **The Focus Group Discussions Guidance Tool :**

This assists a planner to conduct a focal group discussion with vulnerable populations and specific communities. This tool helps define the community group, understand their health needs, current levels of access and barriers to health care, their expectations and their efforts to secure their entitlements.

**Tool- Kit Section 2: State Healthcare Services Study Tool:**

To gather information on Organization of Health Care Services and health programmes and other functions of the state health and family welfare departments. This has four parts.

1. An interview schedule related to management and governance functions.
2. An interview schedule for information collection in urban hospital. This also has a section that interviews individual providers.
3. An interview schedule for information collection in an urban primary health care facility.
4. A semi-structured exit interview or community level interview for a set of 10 patients- which could be outpatient or inpatients.

**Tool- Kit Section 3: The Urban Local Body Study Tool:**

To gather information of the functions of the ULB as related to health, its financial contribution and potential to expand this and the services provided under its leadership. This too has two parts. The first part is to the leadership of the urban local body. This same tool could be used with the elected official, the senior generalist administrator and the municipal or city health officers.

The second tool explores the inter-sectoral areas and the respondents are the officers in charge of managing solid waste and sewage, drinking water and sanitation, ICDS and child welfare, and education.

Please note that to get a complete picture on any one area, multiple respondents would need to be interviewed, separately or together, and if in some areas the same question elicits different responses, this too must be recorded. One could use multiple copies of the same questionnaire if the interviews are conducted separately. Or , if multiple respondents are answering as a group, it is recorded in the same questionnaire with variations – usually on perceptions and recommendations- being recorded in.

**Secondary Data:**

Before setting out on the study, one begins with getting all the secondary information in place. The most common forms of this are reports on health put out by the state department or the city health office. There could also be studies done by local academic institutions- many of which may be un-published. Plans made under NUHM or to the state government for funds are also valuable sources of information. Basic city profile and demographics are also essential and acquired from reliable secondary sources.

**Selection of interview respondents and visit sites:**

Based upon available information one draws up a list of the key officers on the state department of health side and of the urban local body. They would help complete much of the state level interview schedules. We would find however that there are significant portions where a single respondent is unable to provide the answers- but almost always, they would be aware of who has to be contacted to provide the required information- and we just need to move from person to person till all the information we need is acquired.

The same principle holds even during the facility visit or community visit. No single respondent may be able to give the required information and we may need to identify more and more respondents till we get the information required.

Selection of facility requires a purposive sampling of each type or category of facility, keeping in mind that the purpose of the visit is not to judge/evaluate their functionality, but to understand what the institutional design is.

Selections of communities to visit are more complex and needs much background knowledge. One requirement is to visit both notified and non-notified or illegal slums. Other is to identify larger concentrations of vulnerable groups through dialogues with those NGOs who work on such issues, or in dialogue with the city health officer and then choose a sample of them to visit.

**Recording the Information:**

Each interaction would have to be recorded in writing: For purposes of latter collation and archiving and future referral it is important to preface each with a structured standard set of particulars. Such a suggested standard access format is given below:

1. City/Town: State/UT: District
2. Date of Visit- Day- Month- Year
3. Main Recording Researcher:
4. Category of Inquiry: 1. Focal Group Discussion or other dialogues with community 2. Information about a facility 3. Information about governance and management processes
5. For Focal group discussion- record group with which discussed, time of discussion, and name and contact of facilitator.
6. For Facility or Management Process: – Name: Current designation & Posting: mobile number, email. Brief line on earlier postings also.
	1. Main Respondent
	2. Supplementary respondents:
7. Have you given standard mandatory introduction before interview/dialogue process- explaining purpose of information collection and assurance of confidentiality, permission to take notes or tape record- where appropriate. Yes/No.

Note: It is important to store these notes properly for at least a year, so that these could be referred to.

**Reporting the Information:**

In addition to the instruments for collecting information, these guidelines recommend a final structure of presentation of the information gathered using these tools. The report would include a list of all the documents and notes that have provided inputs.

This tool-kit standardizes to some extent the minimum informational requirements for making a city health plan and a state NUHM plan. To a lesser extent it even standardizes the process of collecting this information. We hope this tool kit is useful to all town/ city health planners and programme-managers.

**Writing up the Report:**

The report is written using the broad outline provided in the first chapter, under the heading deliverables. It draws up information from each of the three primary sources above as well as from secondary data.

**Chapter – 3**

**Tool- Kit Section - 1**

**COMMUNITY DIALOGUE AND FOCAL GROUP DISCUSSIONS WITH VULNERABLE GROUPS**

* **Objectives of Community Dialogue/Focal group discussion**
1. To understand the community’s own perception about themselves and their identity especially, in relationship to marginalization and vulnerability;
2. To gather their experiences with respect to health and illnesses and their health seeking behavior and the response of health care system;
3. To understand their barriers related to access of all health and health related public services;
4. To understand the community’s expectations and preferences with regard to the organization and access to health care;
5. To learn the efforts made by the community through organization, or any form of mobilization to improve their health conditions and cope with their circumstances, so that the plan could build on these
6. To understand the processes of convergence between departments and thematic areas, between different levels of community institutions and governance.
* **Whom to dialogue with:**
* Plan for 3 to 5 focal group discussions at least.
* Each group should represent a vulnerability along one of the three axes-
	+ Occupational (rag-pickers, sanitation workers, sex workers, domestic workers, unorganized home based manufacture);
	+ Housing ( homeless, temporary shanties, railway line/canal/sewage line bordering houses, etc)
	+ Or Social disadvantage (dalit families, fisher-folk, street children, trans-gender, geriatric age group etc).
* Also, you may in addition, identify some areas by geography/habitation eg:inslum.There could be multiple vulnerabilities.
* Identification and mapping of all vulnerable groups in the city may already have been done. The possible sources for such information are:
	+ Municipal office’s list of “notified” and “unlisted” slums.
	+ Listing of infants/households for polio immunization:
	+ Non-Government organizations working with vulnerable populations.
* The choice of which groups to meet could also depend on access. An NGO with past experience in this work would not only help identify them, but also facilitate access to them. Such facilitation is essential for most groups. Facilitation could also be by some group/union/CBO which has contacts and trust in that community. If someone they trust introduces the study team, then it is far more likely that they would be open and forthcoming in the dialogue.
* At least some of the groups identified should have been organized previously as a CBO / association/ union or any other formal or informal collective, through whom we should approach the community.
* In most situations the FGD would be supplemented by a) observations and b) individual in-depth interviews may be done to get a deeper understanding of specific processes.
* The site of focal group discussion is important. Certain vulnerable groups are best brought to a closed room where privacy could be ensured and there are not others crowding around passing comment and sniggering. Also it allows for slow patient discussions. FGDs organized in the middle of slums are noisy and often become chaotic, but they could be much more productive of many types of information. An experienced facilitator or study team makes better choice of sites.
* Advisable to have no more than 8-15 people per FGD. Those organizing the FGD must be familiar with the methods of facilitating the dialogue, steering it into relevant issues, allowing space for the dialogue to evolve and then carefully documenting the discussions in text, and later subjecting it to analysis. In most such FGDs the group is homogenous in that they share the same vulnerability- but heterogeneous in that there are both men and women, both elderly persons and young people, both working population and those staying at home etc.
* It is envisaged that we would spend about 2 days for conducting 4 to 5FGDs.

**Organizing the Interaction:**

* The study team should have at least 3 persons- sharing the work. Ideally one person leads the dialogue, maintaining eye contact with the group at all times and not bothering too much on notes. Another is focused on documenting the entire conversation- both on tape and on notes. A third keeps an eye on the interview schedule and the tools, prompting and reminding on areas to be covered. Of course all three would do all these tasks, but one person has the main responsibility.
* Explaining ourselves. To both facilitating agency and the community we need to explain why we are undertaking this dialogue. Clarify that we cannot promise that the changes will all comeinto existence in the coming months or even years, but their views would be properly articulated and represented.
* Also assure the participants that we do not require names or personal histories and will exclude any information theyfeel at any point should not be finally included. Only with permission of all involved,would photos or recordings be made – and these would be used only to help us make our case and understand thesituation further. If they have anyquestions or concerns, they can be in touch with us.

**FGD TOOL**

**Vulnerable Groups and Community Processes**

* 1. **. About Vulnerable People as a Community:**
1. From when have you been staying here? Where do you all come from? Same place or distance places? So what brought you together here? How was the community formed? Are there shared roots, experiences, needs that helped create the community?
2. Do you identify yourself as being part of a specific community? If yes, please tell which community you belong to? (This question reveals the understanding of members about their community identity with respect to caste, religion, occupation, geography, or any other shared services).
3. What is the occupation or occupations that each of you are involved in? Are there any other occupational groups in your area? What do you do to earn a living? Are you employed throughout the year? If not, how many days on an average you work for an year?
4. How often do you get paid? (daily / monthly?). How many days per month do you get work/Do you get work?
5. What are the activities that you do as a community? (interactions, meetings etc)
6. Do you pay rent? How much and to whom? How secure and safe is the house? Ifthe house is owned by you, is the land also owned by you? What are the threats of being displaced from here? Of fire, or floods or physical dangers of any other sort.
7. How do you overcome the extreme weather conditions?
8. What are the other threats of vulnerability that as a community or as individuals you face?
9. Do you associate yourself with any other community organizations? How do these organizations identify themselves?
10. Do you have a cordial relationship with others in the neighbourhood and in the community with other groups?
	1. **. About Health Issues and Health Services:**
11. What are the health problems that you face? How frequently do you fall ill? Were you or anyone in your family ill in the last one month? Was anyone hospitalized in the last one year?
12. Where did you go to when you went ill the last time? (private or public health centre)Give reasons for why you choose the specific health facility?
13. What do you think, are the causes for your health problems?
14. Do you directly go to service provider in case of illness? Whom do you like to seek help from in case of illnesses? Why?
15. What are the services you get in the government health centres? Which is the nearest government center where you could go to
	1. For a pregnancy check up?
	2. For child-birth?
	3. For immunization?
	4. For a mild fever or cough?
	5. For a more serious fever or pain that is persisting?
	6. For a chronic condition- like diabetes or hypertension?
	7. For a hospitalization for accidents or any serious illness?
16. How far you have to travel to access these medical facilities? What are the problems in access to care in these facilities? How much does it cost you for a visit to the above health centre?
17. For which of the services as listed above is care sought for in a private sector? What were the costs? The reasons for preference- explore both negative reasons- why government was not preferred (no services available, long waiting time, rudeness, no time given to seeing patient, costs of care etc) and positive reasons ( my regular doctor, reliable and kind, convenient timings
18. Do you get the necessary drugs and diagnostics in the government facilities- or do you have to buy them outside with payments? How many days’ free drugs do you get? For a chronic patient like diabetes or hypertension- are you able to access free drugs throughout the month/year? How often are you able to go? Which would be a convenient site/process for access to such care?
19. For women, in case of recent pregnancy how do women confirm pregnancy? Where did the delivery occur?Who helps them reaching to a hospitalfordelivery? After delivery whether they get/where they get post pregnancy check- ups? What are the costs involved in each of these stages? Are there women who deliver at home? Why are they unable/unwilling to access a health care facility for delivery?
20. Are there tuberculosis patients in the group- or can they introduce us to some? What is their experience with access to care and drugs?
21. What are the problems for which you are unable to access any type of help/services? Can you give some example where this happened for you or anyone else you know in the community?
22. Is your family covered by any insurance scheme? Do you have a card for it? Which members of the family are covered and which are left out? Do you know what the sum assured is and in which hospitals you are eligible to free care? Have you made use of the card to get any free services so far? If so the details? If you or family members have been ill but despite this unable to access free services- what are the reasons?
	1. **. About Access to other Services and Relationships:**
23. Do you have an adequate and regular food supply? Do you have a ration card- and are all members of the family on it?
24. What food supplementation programmes does any family member access- eg: school midday meal, anganwadi meal, any others
25. What is the access to drinking water? Is it clean? Is it safe? How many hours of access? When? Where do you go to if there are problems in access and how responsive are the authorities on this?
26. What is the access to toilets? How clean and usable are these toilets? Are there user fees and if so how much? What is the extent of defecation in the open? What efforts have been made for more toilets- and why do you think these were not improved upon?
27. What is the arrangement for disposal of solid wastes/rubbish? Where are these disposed most?
28. Please describe about the vector control measures in place? What is done to reduce breeding sites? Problems of sewage and stagnant water- how are they being addressed.
29. What is current quality of housing? Are there any schemes or programmes they are aware of and/or have availed?
30. What is the current situation in access to Electricity and lighting? Are houses electrified? What are the payments? How often and long are the power-cuts?
31. Child care: do you have an ICDS Centre (Anganwadi) in the neighbourhood? Do you avail services from them? What are the services you avail through ICDS centre?What is the coverage of these services as against the total requirement for this service. Is supplemental food available in these centers?
32. Are there any crèche services? Do you need them?
33. Are you able to send your children in school? Approximately what percentage of children never go to school and what percentage of child are out of school at 5th class or at 8th class If they do not go, then what do they do during the day? Is the school mid day meal programme functional?
34. Are there school health programmes? How often does doctor or nurse come- are they aware of the school health programme at all?
35. Are you given a fair treatment when you approach the government authoritiesgaps in any of the above services?
	1. **. About Community’s Expectation on Services:**
36. Describe the hospital/ facility that you would like to go for your everyday health problems that require out-patient care? (If not government then ask next question- Should the government run this? Why?)
37. What services should be provided in this facility (both essential and optional).
38. If government were to provide a regular supply of free drugs to those with chronic illness like diabetes or asthma etc- where and how best to do this? What timings would be convenient?
39. What would you suggest be done to improve the current access and quality of in-patient care?
40. Do you need any service other than the hospitals to deal with illnesses? (Example- recovery shelters after hospital discharge for homeless, sickness compensations, social security for daily wage earners?)
41. Do you have a community health worker? If government appoints a community health worker to represent your interests what would you like them to do for you?
42. If government would constitute a committee to look after your interests who would represent you on such a committee?
43. At what level should the committee be formed? (basti, slum, ward etc)
44. What should be the role and responsibilities of the committee?
45. What kind of support is needed to sustain the committee? (for e.g. training etc.)
46. Can government take any steps to enable this committee to effectively represent your voice and bring necessary changes? If yes, what are they?
	1. **. About Organizations and Efforts made by themselves to get Better Health:**
47. Are you or members of your group organized as a community?
48. Did anybody or organization help you in organizing?
49. How often and where do the community members meet? (slum, worksite, any other place)
50. Were health issues one among the concerns to organize yourself into a community?
51. Do you address health related issues collectively at present?
52. What were the challenges faced by the community while mobilizing for health issues?
53. Did the community mobilization help in improving health of the community?
54. In case of any complaints who can the community members approach to?
55. How in your opinion can this community engagement be sustained?
	1. **. NGOs in Action:**
56. How did the organization facilitate community mobilization?
57. What are the terms of engagement of the NGO- government funded, based in its own funds etc and for what services/ activities? What are mechanisms to monitor their action?
58. What are the key lessons for its sustainability?

**Chapter-4**

**TOOL - KIT SECTION II**

**THE ORGANIZATION OF HEALTH CARE SERVICES AND RESPONSIBILITIES OF STATE DEPARTMENT OF HEALTH AND FAMILY WELFARE**

**Objectives**:

* To understand how the institutional structure of health care service delivery with reference to the population of the city/town. This would include:
	1. How the population of the city is divided into zones or other sub-units for the purpose of organization.
	2. Who are identified as vulnerable or marginalized sections, and as slums and where these are located within the city.
	3. What are the special efforts at reaching the health care to these sections.
* what are the different categories of public health care facilities and the numbers in each category and their distribution across zone- medical college, specialist hospitals, general hospitals, district hospitals, sub-district hospitals or community health centers, primary health centers, health posts , dispensaries, diagnostic facilities, cost controlled pharmacies
* What are the services available in each of these facilities?
	1. To what extent the official or perceived mandate of the facility, and its governance and financing limit the availability of services?
	2. To what extent does the availability or gaps in infrastructure, human resources, supply chain management and work ethic contribute to the availability or the lack of services with respect to the mandate of the facility?
* What are the institutional provisions for access to knowledge resources needed for governance, management and service delivery. This could be with respect to management information systems and analytics, learning from other cities or other experiences, and partnerships or networks with knowledge institutions.
* What is institutional capacity and mechanisms with respect to the following:
	1. Leadership roles/participation by/ coordination with elected members and officials of urban local bodies.
	2. Convergence of all health related services is taking place- whether they are under ULB or under different departments of state government or under the department of health.
	3. Ensuring health outcomes - each organization in the system has the necessary capacity and is delivering the expected outputs.
	4. Framework of rules especially in areas like financing,HR policies, procurement is adequate for the purpose.
	5. Partnerships with non-governmental agencies (commercial and not for profit) for reaching health goals are adequate in terms of task allocation and in terms of contracting and contract management.
	6. Stewardship function of the government with respect to private sector
	7. Regulatory functions of the government for the achievement of public health
	8. Institutional frameworks required for community processes and participation

**Process:**

1. Interview with state and district health officers. The numbers and choice of officers will depend on who all would be able to comment on and contribute to information on the above agenda. Though the questionnaire is constructed as if it would be asked to the chief medical officer of the district, or state- in practice- the same tool would be used with a number of state and district officers- each of whom may shed light on only some part of the questionnaire. Thus one of them who was most informative would be designated the main respondent and the others the supplementary respondents.
2. Once the above interviews are done, using the list of facilities a sample of each type of facility is drawn up and visits are organized to these. Broadly they could be categorized into hospitals with in-patient care and facilities providing only ambulatory care. For each of these we gather information from the officer in charge and from providers working in these facilities. Where possible this must be supplemented by exit interviews or interviews of a few inpatients to understand out of pocket expenditures, problems in access and overall satisfaction with care provided and the category of users the facility is attracting and catering to.
	1. **Interview Schedule for Collecting Information onOrganization of Health Services and Responsibilities of State Department of Health Responsibilities and Functions**

**Mapping the Urban Health Context:**

1. What is the urban population of this town/city? If it is part of which district and what is the population of district as a whole?
2. Is there a list of slums available? What percentages of the urban population are in slums? What are the other vulnerable sections?
3. What is the increase in city/town population in the last decade? What part of this expansion is due to expansion in city limits- by which a number of earlier semi-urban areas and even nearby villages is included? And what part could be attributed to in-migration?
4. **Types and numbers of primary healthcare institutions**: (all facilities with less than 4 beds providing non specialist care- health posts, sub-centers, PHCs, UHCs, dispensaries, AYUSH, mobile medical units others)
	1. Under Municipality/ Urban Local body:
	2. State government –
	3. any other public undertaking ( eg state medical college, labour department etc)
5. **Types and bed strength of government hospitals** – that is facilities with over 4 beds) – CHCs, municipal hospitals, district or sub-divisional hospitals, maternity homes, medical colleges etc)
	1. Under Municipality/ urban local body
	2. state government ;
	3. any other public undertaking- eg ESI, railways, etc)
6. **Morbidity and Mortality:** Is there any information on morbidity patterns and mortality. From demographic and health surveys, from local surveys, from registrar of births and deaths, from disease surveillance programme, from hospitals that are collecting and analyzing- whose data would act as sentinel sites. Any other sources.

Is there any data related to sub-groups especially of the vulnerable.

1. **Area Allocation and Coverage :** -
	1. Is there a clear allocation of every area with respect to primary care providers?
	2. Are there slums- “notified” and “unlisted”- where the population has no notified primary care provider? (Suppose there is a child without immunization, who would be responsible to identify and get the child immunized-? repeat same question for pregnant women, TB suspected case- to probe what they mean by coverage).
	3. If there are such areas- how big, how many and where are these areas- and what are the occupational and social features of these populations.
	4. Are there populations in each zone which have no household number? Which are these? These could be areas where only for pulse polio every household is covered? (Check with pulse polio register to understand this. Often listed as migrant in the pulse polio register!) How much such population/households exist outside the designated slum areas.
	5. Is the coverage/access effective in slums (There could be notional coverage- an ANM is assigned but for 20,000 population and she visits only a small part of this area. Probe whether such situation exists and again describe these areas and their populations).
	6. What is the difference in density of facilities/coverage between newly included areas and the earlier city/town limits?
2. **Human Resources of Municipal Health Care Facilities:** What is the staff strength sanctioned and present in municipal facilities what are the HR issues [vacancies and shortfalls in sanctions]: state separately for primary care facilities and for hospitals:
3. Specialists and doctors
4. Nursing staff
5. frontline health workers- ANMs, MPWs,
6. ASHAs
7. technical staff in health programs;
8. public health officers
9. **Drugs and Diagnostics and Equipment:**
10. Is there a separate budget for each of the above?
11. How is drugs and supplies procurement done- facility level, municipality level or taken from state government?
12. Are there Standard Treatment Guidelines, generic drug policy etc in place?
13. Are most drugs and diagnostics available within the health care facility? Or do they have to purchased outside
14. If available within facility - are drugs and diagnostics for free or charged? How are charges?
15. Is the logistics system responsive to needs? Is it able to avoid stock-outs of drugs?
16. What is level of equipment availability and gaps- which services cannot be delivered despite HR being present due to lack of equipment?
17. Is blood available? Are blood bank services available?
18. **Referral transport and referral linkages:**
19. Are there ambulances? Is it part of a call center based ambulance service?
20. What are usual sites of secondary and tertiary referral? When there is a referral made from primary level to secondary or tertiary care- Is there any advantage over patient having gone directly? Are there feedbacks received and a two way communication established between primary and secondary or tertiary levels of care?
21. **Bio-medical waste management**: What is the level of service provision?
22. **RKS and ancillary services :**
23. Are RogiKalyanSamitis [RKS] in place?
24. Are user fees present? How significant are the charges – main sources of earnings?
25. Does RKS look at patient amenities and ancillary services-
26. How is diet, laundry, security, sanitation and hygiene, infrastructure maintenance etc organized in these facilities– outsourced, by contract, by regular employees
27. How effective are these support services
28. **Financing mechanisms:**
29. What is extent of funds from state and central budgets?
30. What is the proportion of funds which are generated locally- and of these the contribution from user fees?
31. What is the income from other sources- e.g. RSBY and other insurance schemes
32. **Organization and delivery of RCH services**
	1. Immunization
	2. Family Planning
	3. School Health
	4. Ante-natal care
	5. Care at delivery including linkages and continuity for Emergency Obstetric Care
	6. Post natal care
	7. Abortion Services

On each of the above provide an estimate of the “proportion of population in need” who get effective coverage, the constraints, the areas with poor coverage, the participation of the private sector and NGOs. In large cities, this could be explored for a zone- or sub-region of the city.

1. **Organization and delivery of disease control programs**:
	1. TB and leprosy
	2. HIV/AIDS &RTI/STI/
	3. vector borne diseases;
	4. rabies control:
	5. NCDs;

On each of the above provide an estimate of the “proportion of population in need” who get effective coverage, the constraints especially with respect to vulnerable sections, the areas with poor coverage, the participation of the private sector and NGOs. In large cities, this could be explored for a zone- or sub-region of the city.

1. **Training and capacity building** activities for providers.
2. **What is the role of state government in**
	1. Collection of information on morbidity and service delivery
	2. Mechanism for disease reporting and notification [list of notifiable diseases];
	3. Epidemiologic services: surveillance networks; outbreak investigation and management; public health laboratory-
	4. IEC campaigns
3. **The Private Sector:**
4. Is there data on the number of private hospitals, clinics and beds?
5. Is there information on the nature and range or quantity of services provided?
6. Is there any systematic collection of information on morbidity or health care from them?
7. Is there any regulatory system in place- what aspects are brought under regulation? What are the issues?
8. Are there any partnerships for health care service delivery? What is the past history and experience of Public Private Partnerships [PPP] in urban health services.
9. What percentage and number of private hospitals are empanelled in pro-poor publicly financed insurance schemes.
10. What other forms of engagement with private sector- quality circles, training of private providers, microscopy centers, disease notification etc.

**19. Roles and coordination of state government and ULB:**

1. Coordination between ULB authorities and facilities and state government institutions for prevention and control of major health problems [e.g. water borne diseases; vector borne diseases; RTI/STI/HIV/AIDS; family planning; immunization; under nutrition; school health and midday meal.
2. Inter-sector coordination- in child care, ICDS, water and sanitation, education etc between state government and ULBs.
	* 1. **NUHM Progress:**
3. Components and services strengthened in urban areas under the National Rural Health Mission [NRHM] so far: frontline health workers [ASHA, ANM]; outreach services; clinical services
4. Urban health services under the National Urban Health Mission [NUHM]: current priorities
5. Planning process so far:
6. Interactions between state and ULB
7. Interactions with community groups, District Health Society, elected representatives
8. Plans in place for addressing urban inequities [vulnerable groups; spatial disadvantages]
	* 1. **Management Perceptions:**

Respond to the following three areas of decision making. These are a few key issues on which we have to take a call. With respect to your city what would be your recommendation/perception:

A. Statement: Urban Local Bodies do not have capacity and motivation to manage the public health and therefore

* + Option 1. We should place all such functions under the state mission and directorates directly.
	+ Option 2. We should take curative care at all levels and primary health care under the health department- but leave preventive and promotive and regulatory activities of public health with the urban local body.
	+ Option 3: in option 2, above, we should have a planned development of capacity and then or in parallel shift more responsibilities to the urban local bodies.
	+ Option 4: we should have a planned development of capacity and then in larger towns- shift both preventive and curative care into the urban local bodies.
	+ Option 5: capacity will develop only if there is a transfer- begin with a transfer.

In each of the above options discuss the pros and cons.

* + - 1. Poor and vulnerable groups [e.g. homeless people, sex workers, street children, elderly, have special needs, those in unauthorized settlements etc should be the major focus of urban primary health care. Therefore:
				1. Option 1. We need to first put in place a urban primary health care system and then when services for the poor are well established, then only would be able to build in affirmative action to reach the poorest.
				2. Option 2: we need to ensure that from the very outset there is affirmative action to build the most vulnerable that is built into the programme.
				3. Option 3: An excessive focus on the most marginalized would mean less attention to get the basics of health system in place. The responsibility of reaching these sections has to be shared with other agencies and not only our own.

In each of these options discuss the pros and cons.

* + - 1. For Urban Primary Health Care what would be the role and forms of engaging the private sector – not for profit, and commercial- through area contracts, through outsourcing facilities, through current insurance schemes, through new insurance design – others.
			2. Any other areas where there is a divergence expressed- examples on community processes, on the role of mahila arogya samitis, on the ASHA etc. Explore reasons and perceptions of the management- at different levels.
		1. **Management Recommendations :**
		- Suggestions for design and implementation of NUHM from the management staff interviewed:
			1. for the programme in the state as a whole
			2. for that specific town/city.

**2.2. Interview Schedule for Collecting Information onthe Urban Public Hospital**

**1. Mandate**

a. What is the population covered by this facility? By geography? By intent? In practice- where do the users come from?

b. Provide details of quantity of services provided by broad category:

|  |  |  |  |
| --- | --- | --- | --- |
| **S.No.** | **Service** | **Yes/No** | **Average no. in a day** |
| a. | Does the hospital provide 24 hour services? |  |  |
| b. | OPD Care? |  |  |
| c. | Indoor Beds available  |  |  |
|  | Male |  |  |
|  | Female |  |  |
| d. | Average bed occupancy rate |  |  |
| d. | Emergencies |  |  |

**2. Specialist Services available and provided:** (there is a judgement call required for some of these responses. Thus if a cardiologist is providing services- there is no problem, but if a general medicine person is running a special cardiac clinic or managing an ICU then also we would call it cardiology services provided by a general physician. However if he is handling cardiology cases as part of general OPD, then we would answer NO for cardiology services. And so on)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| S.No. | Service | Yes/No | Average No. in a month | Who provides them | Content of Service Provided |
| a. | General Medicine |  |  |  |  |
| b. | Cardiology |  |  |  |  |
| c. | General Surgery |  |  |  |  |
| d. | Obstetrics& Gynaecology |  |  |  |  |
| e. | Paediatrics |  |  |  |  |
| f. | Anaesthesia |  |  |  |  |
| g. | Orthopaedics |  |  |  |  |
| h. | ENT |  |  |  |  |
| i. | Ophthalmology |  |  |  |  |
| j. | Dermatology and Venerology |  |  |  |  |
| k. | Dental Care |  |  |  |  |
| l. | Mental health/Psychiatry |  |  |  |  |
| m. | Ayush |  |  |  |  |
| n. | Plastic Surgery |  |  |  |  |
| o. | Pathology  |  |  |  |  |
| p. | Blood Bank |  |  |  |  |
| q. | Physiotherapy  |  |  |  |  |
| r. | Minor Procedures |  |  |  |  |
| s. | Others (specify) |  |  |  |  |

**3. Diagnostic and other Para Clinical Services**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| S. No. | Service | Yes/No | Average No. in a month | Who provides them | Content of Service Provided ( give in brief the range of tests done) |
| a. | Laboratory |  |  |  |  |
| b. | X-Ray |  |  |  |  |
| c. | Ultrasound |  |  |  |  |
| d. | ECG |  |  |  |  |
| e. | Blood Transfusion and Storage |  |  |  |  |
| f. | Physiotherapy |  |  |  |  |

**4. Support Services**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| S. No. | Service | Yes/No | Average No. in a month | Who provides them | Content of Service Provided |
| a. | Medico legal / post-mortem |  |  |  |  |
| b. | Ambulance Services |  |  |  |  |
| c. | Dietary Services |  |  |  |  |
| d. | Laundry Services |  |  |  |  |
| e. | Security Services |  |  |  |  |
| f. | Housekeeping and Sanitation |  |  |  |  |
| g. | Inventory Management |  |  |  |  |
| h. | Waste Management |  |  |  |  |
| i. | Office Management (provision for computerized medical records) |  |  |  |  |
| j. | Counselling Services for Domestic Violence, Gender Violence, Adolescents, etc. |  |  |  |  |
| k. | Others (specify) |  |  |  |  |

**5. National Health / Disease Control Programs**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| S. No. | Service | Yes/No | Average No. in a month | Who provides them | Content of Service Provided |
| a. | TB/DOTS? |  |  |  |  |
| b. | HIV/ICTC |  |  |  |  |
| c. | Vector Borne Diseases |  |  |  |  |
| d. | Non-Communicable Diseases |  |  |  |  |
| e. | Mental health services |  |  |  |  |
| f. | Disease surveillance |  |  |  |  |
| g. | Others (specify)  |  |  |  |  |

**6. Linkages:**

1. What is the process of referral?
2. Are there guidelines on when to refer and when not to? What are the most common causes of referral?
3. Is there any measure or records of numbers referred?
4. When do we refer on hospital ambulance and who pays for it.
5. What is the number/proportion and type of cases referred up who are referred back for follow up?

**7. Governance and Management:**

|  |  |  |
| --- | --- | --- |
| a. | Who is head of hospital and what the second level managers is.  |  |
| b. | What is the mechanism of governance? To whom does hospital leadership report to – for administrative, salary purposes |  |
| c. | Who supervises/reviews clinical work of hospitals- to whom do they refer cases which they cannot handle |  |
| d. | What are the roles RKS is playing? What is the degree of public participation? What is the area of its supervision and its powers? |  |
| e. | Is there are quality management system in place? What are the efforts to address issues of quality |  |
| f.  | What part of the finances is raised from user fees and locally? What part from the state? what part from |  |
| e. | What are the efforts to make the hospital woman friendly, baby friendly, to address issues of social exclusion, to provide help-desks and support to patients. |  |
| g. | Mechanism of Grievance redressal in place. |  |

**8. Infrastructure**

|  |  |  |  |
| --- | --- | --- | --- |
| S.No. | Name | Yes/No | Remarks |
| a. | Hospital area |  |  |
| b. | O. T. |  |  |
| c. | ICU/high dependency ward |  |  |
| d. | Waiting Spaces adjacent to each consultation and treatment room |  |  |
| e. | General Wards |  |  |

**9. Public Health Engineering Services**

|  |  |  |  |
| --- | --- | --- | --- |
| S.No | Name | Yes/No | Remarks |
| a. | Electricity  |  |  |
| b. | Generator |  |  |
| c. | Piped water supply |  |  |
| d. | Drainage and Sanitation |  |  |
| e. | Cleanliness |  |  |
| f. | Fire Protection |  |  |
| g. | Residential Quarters for all medical and para medical staff |  |  |

**10. Equipment Gaps-** (Only note those equipment where there is an appropriately skilled provider available, and providing the services, but lack of equipment is a cause for referral away>)

|  |  |  |  |
| --- | --- | --- | --- |
| S. No. | Equipment | No available, Available but not working  | Remarks |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**11. Drugs ( need to check whether drugs appropriate to services are available – and if so how many days free supply will a patient get per visit).**

|  |  |  |  |
| --- | --- | --- | --- |
| S. No. | Name | Yes/No | Remarks |
| a. | Availability of drugs for RCH services |  |  |
| b. | For common acute medical illness –esp. antibiotics |  |  |
| c.  | For medical and surgical emergencies |  |  |
| d | For main chronic NCDs |  |  |
| e. | For TB, HIV leprosy |  |  |
| f. | Medical Store facility for indoor patients |  |  |
| g. | Are Standard Treatment Guidelines available? |  |  |

**12. Human Resource Issues**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| S. No. | Issue | Required | Sanctioned | In place | Vacant | Remarks |
| a. | Specialists |  |  |  |  |  |
| B | Doctors |  |  |  |  |  |
| C | Nurses |  |  |  |  |  |
| D | Paramedics |  |  |  |  |  |
| E | Technicians |  |  |  |  |  |
| F | Support staff  |  |  |  |  |  |

Are those present having necessary skills? Are there training programmes in place?

**Provider Interview: (could be used for doctor or nurse)**

1. Name of Respondent (optional) ………………………………………

2. Place of posting ………………………………………..

3. Post...................................................

4. Posted since ………………………………………..

6. Of services your institution provides? Which are the most utilized? Which are the least utilized?

7. Who are the most vulnerable groups in your area? How do you identify them and target service delivery?

8. What are their barriers to accessing and utilizing services?

9. What challenges do you face in rendering services to them?

10. What changes do you suggest in providing and improving services for them?

11. Where do you refer patients when required? What are the obstacles for accessing referral services? What are your suggestions to improve referral services?

12. What constraints do you face in delivering the program? [Infrastructure; staff shortages; supply logistics; diagnostics; ancillary services; travel]

13. What are your interactions and experience with private providers and NGOs?

14. What are your experiences regarding user fees/charges and RogiKalyanSamiti [RKS] in the specific context of vulnerable groups?

15. What are your suggestions for priorities for the NUHM, particularly for organization and delivery of primary health care services for the vulnerable sections of your town/city?

**2.3.** **Interview Schedule for Collecting Information on the Urban Public Primary Health Care facility (includes health posts, dispensaries, urban primary health centers)**

**1. Mandate**

1. What is the population covered? Is there a geographical area or a number of households allocated to the facility? Or do they provide care only to those who actively seek it?
2. Which services are provided in the facility;at an outreach point, and which are home based?
3. What are services provided by this facility and its staff? Which of these are restricted to its “service area” and which are open to anyone who walks in?
4. For services like ante-natal care and immunization, how do they ensure that no one is left out? Is there a comprehensive register of all families- or do they only treat those who seek their services.
5. What are the facility timings? When is it open? If it is open on a 24\*7 basis who stays during the night and what services are available then.
6. Other than preventive care- antenatal and immunization and safe delivery and contraceptive services – what is the quantity and range of out-patient services provided?
7. Are there any beds? What are they used for day-care? Delivery cases? Stabilization care or regular in-patient care?

**2. RCH services:**

Give a sense of quantity of RCH services in the table below

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **S. No.** | **Service** | **Yes/No** | **Average No. in a month** | **Who provides them** | **Content of Service Provided** |
| **Maternal and Child Health Care** (if applicable) |
| a. | Ante-natal care |  |  |  |  |
| b. | Delivery Services |  |  |  |  |
| c. | Post-natal care |  |  |  |  |
| d. | New born Care |  |  |  |  |
| e. | Child care including immunization |  |  |  |  |
| F | Family Planning |  |  |  |  |
| G | MTP |  |  |  |  |
| H | Management of RTI / STI |  |  |  |  |

1. Are there home deliveries taking place? Why is that? Is there an experience of being denied admission at higher facilities or at this facility for any reason?
2. Are home deliveries attended by a midwife from this facility? Who attends on them?
3. Are home visits made at least for past partum care?
4. Which is the site of ante-natal care and immunization- what proportion happens in this facility, and what happens at anganwadi or other outreach center, mobile medical unit and at home?
5. Is this facility declared a site of institutional delivery for purposes of JSY? What are the out of pocket expenses still present in the facility.
6. Are there any forms of adolescent health services?

**3. Disease Control Programmes.**

|  |  |  |
| --- | --- | --- |
|  | RNTCP | What RNTCP activities take place- referral for sputum testing, sputum collection, microscopy, DOTS provision, tuberculosis unit? If not happening here which is the nearest facility where these activities take place. How many TB patients in this facility’s area or taking drugs from here? Whatare the problems with follow up?  |
|  | HIV | Where is the nearest site for HIV testing? Where for ARV drugs? How much testing happens here? What is the number of HIV patients under care here?  |
|  | Leprosy | Same questions as for RNTCP- but in addition number of patients identified with disability and of these those received care and those waiting for surgery.  |
|  | Vector Borne Diseases | What are the main vectors borne diseases in this area? What activities happen at the facility (tests, treatment, referrals) and what in the area (testing blood in fever cases, insecticide spraying, source reduction etc)? What happens in referral sites? |
|  | Non-Communicable Diseases | Is there any specific NCD programme in place? Does this facility detect hypertension and diabetes, test for it, initiatetreatment; are drugs available- how many regulars depending on drugs from this facility? Which would be the site of referral for specialist opinion? Are there cases referred up that have come back and now under the facility’s follow up care?  |
|  | Mental health services | Same as above> |
|  | Disease surveillance | Does the facility report on S forms or P forms or L forms or a combination of these. Is there any feedback received on the reports. Any action triggered by these reports.  |
|  | Water-borne diseases | Are there outbreaks of jaundice or typhoid or diarrhoeas reported in this area? How frequently? What is the response to an outbreak?  |

**4. Other clinical services:**

a. What are other clinical services available in this facility?

b. What emergency care is available? Primary management of wounds, minor surgeries, burns?

c. Are there dental services available?

d. Are there AYUSH services available?

**5. Linkages:**

**With higher facilities:**

a. What is the process of referral?

1. Are there guidelines on when to refer and when not to? What are the most common causes of referral?
2. Is there any measure or records of numbers referred?
3. When do we refer on hospital ambulance and who pays for it.
4. What is the number/proportion and type of cases referred up who are referred back for follow up?

**With community level institutions:**

1. Are there facilities or service providers who work under this facility? Is there a reportingrelationshipto it- like ANMs reporting to the dispensary or to the PHC, or ASHAs reporting to the sub-center etc?
2. How many ASHAs or other community level workers are there under the leadership of this facility?
3. Is there outreach sessions conducted- in anganwadis or other sites on a regular basis?
4. Are there linkages with self help groups or other CBOs?
5. What if any are the efforts made to identify and interact with and give special attention to the marginalized and their community structures?

**With peer facilities:**

1. Are there institutional linkages with other government facilities- run by municipality, ESI, public sector undertakings etc?
2. Are there institutional linkages with private sector facilities?

**6. Governance and Management:**

a. Who supervises/reviews work of the facility? Who is in charge of facility? Who pays the salary?

b. Is there an RKS or equivalent structure in place? What is the degree of public participation? Whatis the area of its supervision and its powers?

c. Are fees of any sort- formally or informally collected by the facility staff?

d. Are there grievance redressal systems in place- for the service users and for the providers themselves?

**7. Human Resources at the facility:**

List the staff in the facility. If it has a clear service area assigned to that facility- also provide number of ASHAs, anganwadi centers, health posts etc under this facility.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S. No.** | **Facility Staff:**  | **Sanctioned** | **Posted** | **Remarks** |
| a. | Medical Officer |  |  |  |
| b. | Pharmacist |  |  |  |
| c. | Nurse-Midwife/Staff Nurse |  |  |  |
| d. | Health Worker (Female) |  |  |  |
| e. | Health Worker (Male) |  |  |  |
| f. | Health Educator |  |  |  |
| g. | Health Supervisor |  |  |  |
| h. | Clerks |  |  |  |
| i. | Laboratory Technician |  |  |  |
| j. | Driver |  |  |  |
| k. | Group D |  |  |  |
| l. | Others (specify) |  |  |  |
|  | **Total** |  |  |  |
|  | **Service Area below UPHC** |  |  |  |
| I | ASHA or other community volunteer or worker |  |  |  |
| Ii | ANM  |  |  |  |
| Iii | Nurse |  |  |  |
| Iv | Doctor- ayush or MBBS |  |  |  |
| V | Others – specify |  |  |  |

**8. Infrastructure**

|  |  |  |  |
| --- | --- | --- | --- |
| **S.No.** | **Physical Feature** | **Yes/No** | **Remarks/Observation** |
| a. | Location |  |  |
| b. | Travel time to reach the facility from the remotest place in the coverage area |  |  |
| c. | Building |  |  |
| d. | Is it a designated government building  |  |  |
| e. | If No: |  |  |
| Rented premises |  |  |
| Other government building |  |  |
| Any other specify |  |  |
| f. | Present condition of the building |  |  |
| g. | Cleanliness(Observe) |  |  |
| h. | Charter of services |  |  |
| i. | Separate toilets for males and females  |  |  |
| j. | Examination room/area with privacy  |  |  |
| k. | Reliable water supply  |  |  |
| l. | Process of Bio-medical Waste Disposal |  |  |
| m. | Reliable electricity supply  |  |  |
| n. | Reliable communication facilities |  |  |
| o. | Transport facility including referral transport |  |  |
| p. | Residential facility for the staff  |  |  |
| q. | Suggestions/Complaint Box/Register |  |  |

**9. Equipment Gaps: List those equipment where despite presence of providers, services are denied because of lack of equipment:**

|  |  |  |  |
| --- | --- | --- | --- |
| S. No. | Equipment | Not procured, or procured but not functional. | Remarks |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**10. Drugs- List drugs which are essential for mandated services – and their presence**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S. No.** | **Name** | **Part of facility’s essential list – Yes/No** | **If yes- is it present or stock out** | **Remarks** |
| a. | Antibiotics ( 2 to 3 at least is essential in most settings  |  |  |  |
| b. | Paracetamol, antihistamine, dicyclomine, and other basic symptomatic relief drugs.  |  |  |  |
| c. | Albendazole, Iron, Calcium, ORS |  |  |  |
| d. | Drugs relevant to RCH services |  |  |  |
| E | Drugs relevant to the main disease control programmes |  |  |  |
| f. |  Drugs needed for management of chronic diseases – taking diabetes and hypertension as trace indicators |  |  |  |

**Provider Interviews:**

1. Name of Respondent (optional) ………………………………………

2. Place of posting ………………………………………..

3. Post...................................................

4. Posted since ………………………………………..

6. What services do you/your institution provide? Which are the most utilized? Which are the least utilized?

7. Who are the most vulnerable groups in your area? How do you identify them and target service delivery?

8. What are their barriers to accessing and utilizing services?

9. What challenges do you face in rendering services to them?

10. What changes do you suggest in providing and improving services for them?

11. Where do you refer patients when required? What are the obstacles for accessing referral services? What are your suggestions to improve referral services?

12. What constraints do you face in delivering the program? [Infrastructure; staff shortages; supply logistics; diagnostics; ancillary services; travel]

13. What are your interactions and experience with private providers and NGOs?

14. What are your experiences regarding user fees/charges and RogiKalyanSamiti [RKS] in the specific context of vulnerable groups?

15. What are your suggestions for priorities for the NUHM, particularly for organization and delivery of primary health care services for the vulnerable sections of your town/city?

**2.4. Exit Interviews on Cost of Care**

Use separate form for OP patients and other for IP. For IP add a column number of days. In both instances a minimum of 10 patients per facility is recommended. Take 10 consecutive consenting patients.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | 1 | 2 | 3 | 4 | 5 |
| 1 | Diagnosis |  |  |  |  |  |
| 2 | Cost on drugs |  |  |  |  |  |
| 3 | Cost on diagnostics |  |  |  |  |  |
| 4 | Cost on fees of any type |  |  |  |  |  |
| 5 | Transport costs |  |  |  |  |  |
| 6 | Other costs- diet, attenders, |  |  |  |  |  |
| 7 | Cost for this episode |  |  |  |  |  |
| 8 | Source of funding |  |  |  |  |  |
| 9 | Livelihood loss costs |  |  |  |  |  |
| 10 | Episode outcome# |  |  |  |  |  |
| 11 | Monthly costs- if chronic patient |  |  |  |  |  |
| 12 | Is patient registered for insurance costs |  |  |  |  |  |
| 13 | Does he/she know what was cost of care bill signed- for insurance to reimburse? If yes mention the amount |  |  |  |  |  |
| 14. | Occupation of the patient- or main earning member in family.  |  |  |  |  |  |
| 15 | Satisfaction with care:  |  |  |  |  |  |
| a. | The quality of clinical advise |  |  |  |  |  |
| B | The quality of patient amenities for comfort  |  |  |  |  |  |
| C | The quality of provider- patient interaction and communication |  |  |  |  |  |

All costs mentioned in 2 to 7 above are only out of pocket expenditure at time of care.

Outcome for episode- is cured, relieved, no change, worsened.

Satisfaction is poor, fair, good and excellent.

**Chapter-4**

**TOOL-KIT SECTION III**

**THE ORGANIZATION OF HEALTH AND RELATED SERVICES BY THE URBAN LOCAL BODY**

**Objectives:**

* + - 1. To understand the roles and responsibilities that urban local bodies currently have in terms of the provision of health related services especially as regards maintenance of environmental health, nutrition and child care services, and the provision of safe drinking water and sanitation.
			2. To understand the roles and responsibilities of urban local bodies in provision of health care services.
			3. To understand how the above work is organized, what are the gaps in such service provision and the reasons for these gaps.
			4. To understand the issues of governance and financing of urban local bodies that have a bearing on health outcomes and health services
			5. To understand the organization of public services with reference to nutrition and food security, drinking water and sanitation, child care services, school education, health education- and the role of urban local bodies in provision, monitoring and coordination of these services.
			6. To understand the efforts made at convergence and coordination and the successes and gaps in this aspect.

**Process:**

* + To understand the overall governance issues and the issues of financing and the organization of all health related services under the urban local body, we have to identify three or four key officers. This would include in the least
		- 1. The generalist IAS cadre officer to whom the municipal health officer/city health officer reports to; this is usually a deputy commissioner health, but in smaller municipalities could be directly to the commissioner.
			2. The city health officer/municipal health officer
			3. Theprogramme officers in charge of ICDS, drinking water and sanitation programmes and school education.
	+ One may also need to take time with the officer in charge of the accounts and look at the income and expenditure statements of the ULB
	+ One would also need to discuss with elected leader of the ULB and the commissioner or whoever the leading administrator of the ULB is.
	+ With reference to the health care services and hospitals under the ULB control, most of the information would have been collected in section 2.1 to 2.3. Here only coordination functions need to be probed.

**3.1. Interview Schedule for Collecting Information on the roles and responsibilities of Urban Local Bodies towards ensuring Health Outcomes**

A. Funds:

1. What is the Municipal budget allocated? What proportion of Municipal budget is allocated to healthcare? What proportion to health related sectors- sanitation including waste disposal, drinking water, and education.

2. What are the priorities of allocations [activities/programs *within* the health sector?

3. What are the sources under which funds are mobilized for health care activities- municipality’s own revenues, central grants, state grants, user fees, others:

4. Under what circumstances could more funds be allocated/disbursed from existing budgets?

5. If you need more money from State, Centre, what would you want it for?

6. How could more funds be raised?

B. If there are Health Care Facilities UNDER the Municipality (use interview schedules 2.1 to 2.4).

C. What is municipality role in each of the following 11areas?

1. Provision of safe drinking water:
2. Provision of toilets and promotion of their use
3. Management of waste esp. solid waste management
4. Active linkage of above three activities with prevention of water borne disease.
5. Active linkage of above three plus additional activities undertaken for prevention of vector borne disease?
6. School health programmes and School midday meal programmes
7. ICDS programmes
8. Active linkage of above programmes with prevention, identification and management of malnutrition and anemia.
9. adolescent health programmes
10. Occupational health :the relevant occupations and related health issues : enforcement of standards, prevention, promotion and management
11. Programmes for diagnosis and prevention of TB, HIV, RTI/STIs.

In each of the above areas we seek to understand the following:

1. How is its implementation organized?
2. What is the staff strength working in each of this area? How adequate is this
3. How is it coordinated with health care delivery and outcomes?
4. Who are partners?
5. What does the ULB do for access to knowledge resources/technical guidance in this area- internal analytics, knowledge partners, its own resource organizations?

5. In each of the above areas of municipal roles, what is the situation with regard to vulnerable sections? What are the affirmative or additional measures in place to ensure that these sections are reached?

D. What does ULB do to respond to information of outbreaks? Who responds? Where do they get the information from- IDSP, journalists, word of mouth etc? What is the system of disease surveillance and of notifying diseases and how effective is this currently. How is information used for action?

E. What are non-clinical legal and regulatory services under municipality: To what extent and how does municipality manage these roles?

1. food safety including hotel hygiene
2. regulation of health trades;
3. Registration of vital events; especially births and deaths.
4. cremation and burial grounds;
5. hearse vans;
6. slaughter house hygiene
7. Monitoring air pollution and initiating action to safeguard health.
8. Any others:

In each of the above areas we seek to understand the following:

1. Whether the ULB has the mandate and is seized of it.
2. How is its governance and implementation organized?
3. What is the staff strength working in each of this area? How adequate is this?
4. How is it coordinated with health care delivery and outcomes?
5. Who are partners?
6. What does the ULB do for access to knowledge resources/technical guidance in this area- internal analytics, knowledge partners, its own resource organizations?

F. Partnerships:

1. Linkages with and role of NGOs- what is currently functional? Any major past efforts which are not sustained?
2. Describe the different forms of Linkages with and role of private [for-profit] sector
3. History and experience of Public Private Partnerships [PPP] in urban health care services so far: What has been tried? Is it still functional? What are its strengths and its weaknesses? If not functional, why did it fail to sustain?

G. Perceptions of Officers and elected members of ULB

1. Opinion about service provisioning by public health care facilities
2. Strengths and weaknesses in municipal bye-laws related to public health
3. Perceptions and issues on utilization of health services by:
	1. the urban poor and vulnerable groups [e.g. homeless people, sex workers, street children]
	2. those with special needs [e.g. adolescents, elderly]
4. Suggestions for strengthening public health services and primary health care in your town/city.

**VI. Governance Issues:**

1. What is the organizational structure for all the above functions (both of governance and of management)? An illustrative organogram would be useful and it could indicate the number of managers deployed for these functions? Also indicate the role of elected members of the ULB. How is their contribution?

2. Planning process – what is currently in place? What is proposed?

3. Interactions and coordination between state and ULB.How the Chairman is represented on the District Health Society? Do you have any say in the meetings, minutes, agenda etc.?

4. Is there any strategy for peri-urban locations; geographically distant, unauthorized settlements including non-notified slums?

5. Is there any Health Management Information Systems [HMIS]? What is the level of its completion and quality of reporting and use of information?

6 What are the other technical support agencies at work for this ULB? What areas of expertise and involvement do they have? These could be academic agencies or NGOs, or development partners or private consultancies?

**3.2. Interview Schedules for collecting information from the officers in charge of the following:**

**a. Solid waste management and sewage and the provision of toilets.**

1. What is the institutional arrangement for waste management in the city? Is there any public-private partnership in waste management?

2. Please tell us the role of public health department in waste management.

3. What is the quantity of waste produced in the city?

4. Does the corporation have a waste treatment facility like compost plant and incineration facility? How is the final disposal of waste carried out? Do you have a sanitary landfill for final disposal?

5. Do you provide waste collection service to both notified and non notified slums?

6. What is the total number of sanitary workers in the city? Please provide a break up of permanent and contract sanitary workers. Are they provided with equipment that protect from occupational hazards on a regular basis? Have you conducted a morbidity study of the sanitary workers?

7. Have the ULB been able to provide toilet facilities to all the notified and non-notified slums in the city? Is there are community involvement or PPP model followed in the provision of toilet facilities?

**b. Drinking water management.**

1. What is the institutional arrangement for water supply in the city?

2. Is the water connection in the city metered? What is the total amount of water supplied in the city? What is the average time of water supply in the city per day? Do you supply water for non domestic purposes?

3. Please provide a list of both notified and non notified slums having piped water connections and not.

4. What are the major challenges to adequate water supply in the city?

**c. School Health.**

1. What are the activities that are covered in the school health programme?

2. How often are the medical camps conducted in the schools?

3. How are the involvement of parents and teachers ensured in improving the child health?

4. What is the mechanism for monitoring of school health activities?

5. Are the children provided with mid day meal? What are the nutrient supplements given to children?

6. What are the challenges faced to effectively implement the school health programme?