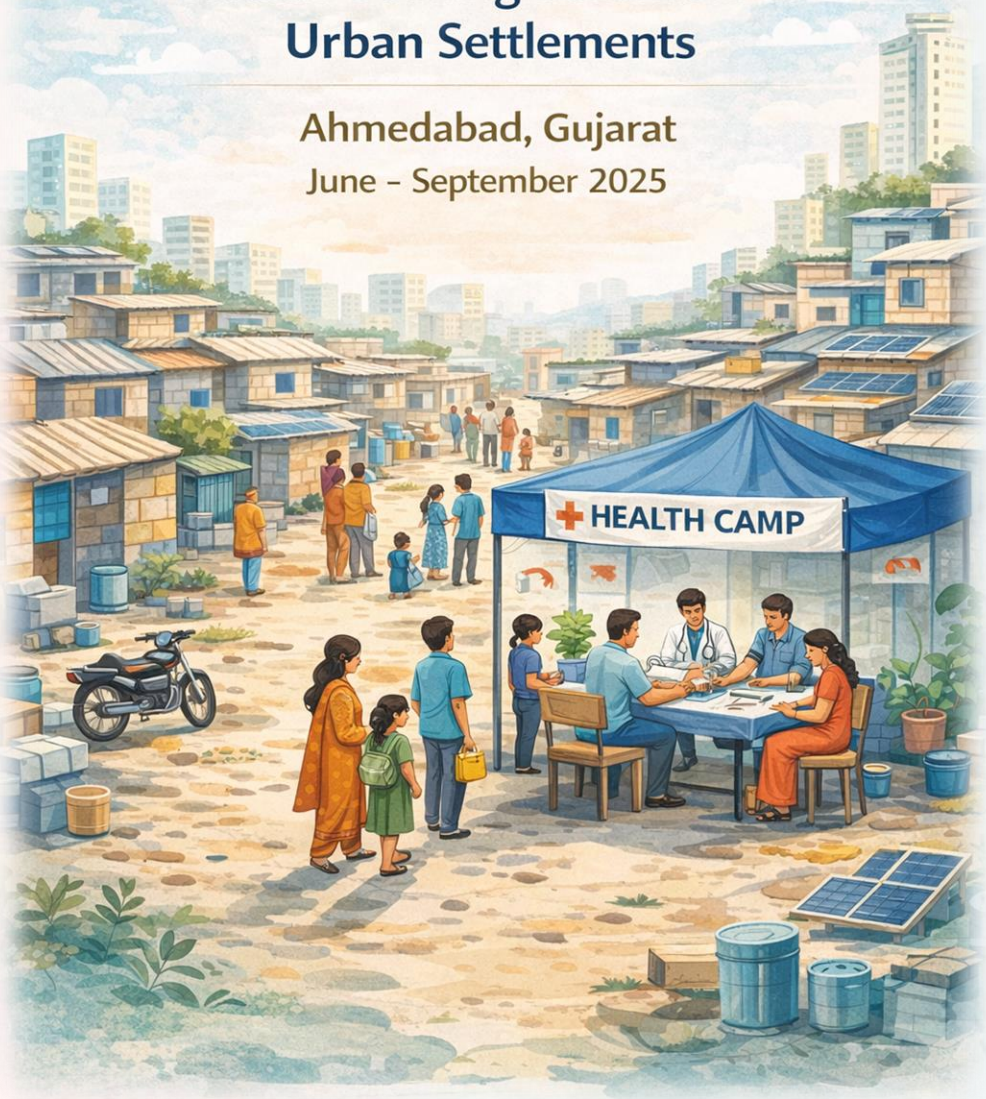
Saath Livelihoods

A Study on Access to Health and Health-Seeking Behaviour in Urban Settlements

Ahmedabad, Gujarat

June – September 2025



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Executive Summary

Access to Health and Health-Seeking Behavior in Urban Informal Settlements of Ahmedabad

Urban informal settlements in Ahmedabad are home to a large and diverse population that faces multiple vulnerabilities related to housing, livelihoods, and access to basic services. Overcrowding, poor sanitation, environmental pollution, and economic insecurity significantly influence health outcomes and the ability of households to seek timely and appropriate healthcare. Within this context, Saath Charitable Trust undertook a research study to understand patterns of health-seeking behavior, access to healthcare services, and the financial burden of health among urban poor communities.

The study was conducted between June and September 2025 across selected informal settlements in Ahmedabad, including Vatva, Behrampura, Ramol, Lambha, and adjoining clusters. These areas represent a mix of long-established settlements and newer peri-urban communities, with diverse religious, cultural, and occupational profiles, including a significant proportion of migrant households engaged in informal and industrial work.

A mixed-method research design was adopted. Quantitative data were collected through a household survey covering 402 households and 1,866 individuals. In addition, qualitative insights were gathered through five Focus Group Discussions (FGDs) and four In-Depth Interviews (IDIs) involving women, men, youth, elderly residents, and frontline health workers. As a follow-up component, health screening camps were organized for individuals aged 30 years and above to assess blood pressure and blood glucose levels. Quantitative data were analysed using descriptive methods, while qualitative data were thematically analysed to capture lived experiences, perceptions, and systemic barriers.

The findings indicate a high burden of both communicable and non-communicable diseases within the study communities. Hypertension and diabetes emerged as the most commonly reported chronic conditions, particularly among adults aged 40 years and above. Residents living near industrial areas, especially in Vatva, reported higher instances of respiratory and occupational health issues. Mental health concerns, including stress and anxiety, were reported across age groups, though these remain under-recognized and under-reported due to stigma and lack of accessible services.

Health-seeking behavior in the settlements follows a layered pattern. Households typically rely on home remedies and self-medication as the first response to illness. For minor ailments, nearby private clinics and pharmacies are preferred due to convenience, shorter waiting times, and perceived quality of care. Public health facilities such as Urban Health Centres (UHCs) and government hospitals are primarily accessed for maternal and child health services, chronic illnesses, and serious conditions. Despite relatively high awareness of public facilities, utilization

remains limited due to long waiting times, inconsistent availability of medicines, distance, and trust-related concerns.

The financial burden of healthcare on households is significant. The study found that out-of-pocket expenditure remains the dominant mode of health financing. Nearly half of the surveyed households reported borrowing money, selling assets, or relying on informal lenders to meet healthcare costs. Health insurance coverage was extremely low, and awareness and utilization of government health schemes such as Ayushman Bharat and ABHA IDs were limited, particularly among migrant families facing documentation barriers.

Gendered patterns of vulnerability were evident across the findings. Women frequently delayed seeking care for themselves, prioritizing the health needs of children and earning members of the household. Adolescent girls and youth reported limited access to reproductive health, mental health, and youth-friendly services. Frontline workers, particularly ASHA workers, were identified as critical links between communities and the public health system, especially for maternal and child health services.

Overall, the study highlights that access to healthcare in urban informal settlements is shaped not only by the availability of facilities but also by awareness, affordability, trust, gender norms, and systemic barriers. Strengthening community awareness, improving the responsiveness and accessibility of public health facilities, reducing out-of-pocket expenditure, and ensuring inclusion of migrant and informal-sector households are essential for improving health outcomes. The evidence generated through this study provides a strong foundation for community-centered interventions, system strengthening, and policy engagement aimed at advancing equitable urban health in Ahmedabad.

Background and Context

1.1 Urbanization and Health Vulnerabilities in Ahmedabad

Ahmedabad, Gujarat's largest metropolitan city, has experienced rapid urban expansion over the past two decades. Industrial growth, expanding service sectors, and infrastructure development have attracted large numbers of migrants from within Gujarat and other states such as Uttar Pradesh, Rajasthan, and Madhya Pradesh. While the city offers livelihood opportunities, urban growth has not been accompanied by equitable access to housing, sanitation, and healthcare services.

Nearly one-third of Ahmedabad's population resides in informal settlements characterized by insecure tenure, overcrowded housing, inadequate drainage systems, unsafe water supply, and limited access to public health facilities. These structural deficits create overlapping vulnerabilities that directly affect health outcomes. Environmental exposure, occupational hazards, and financial instability combine to shape patterns of disease and healthcare access among the urban poor.

Urban poverty in this context is multidimensional. It extends beyond income deprivation to include exclusion from social protection systems, lack of formal documentation, limited mobility, gender-based inequalities, and weak institutional trust. Families dependent on daily-wage labor, factory work, or informal employment lack financial buffers to manage health shocks. A single episode of hospitalization can push households into debt, forcing asset sales or high-interest borrowing.

Women, children, migrants, and informal workers remain disproportionately affected. Gender norms restrict women's autonomy in health decision-making, while migrants frequently face documentation barriers that limit their access to government entitlements. These structural conditions reinforce cycles of vulnerability.

1.2 Study Objectives

The study was undertaken by Saath Charitable Trust with the following objectives:

1. To document the socio-demographic and household profiles of urban poor families.
2. To identify prevalent health conditions and disease burdens within selected communities.
3. To examine patterns of health-seeking behavior, including the use of public and private providers.
4. To assess awareness and utilization of government health schemes and entitlements.
5. To estimate household-level out-of-pocket expenditure on healthcare and its financial implications.

6. To identify systemic, community, and household-level barriers to accessing healthcare services.

1.3 Scope and Limitations

The report focuses specifically on healthcare access and health-seeking behavior in selected informal settlements of Ahmedabad. By integrating quantitative survey findings with qualitative narratives, the study provides a comprehensive understanding of both measurable health patterns and lived experiences.

However, the scope of the study is geographically limited to five settlements and may not represent the entire urban poor population of Ahmedabad. The relatively short study duration may not fully capture seasonal variations in disease patterns. Additionally, sensitive issues such as mental health and reproductive health may be under-reported due to social stigma and cultural hesitations in discussing such topics openly.

1.4 Timeline of the Study

The study was conducted in multiple phases:

- Mid-June to Early July 2025: Household survey implementation.
- Mid-July to Early August 2025: Community health screenings, Focus Group Discussions (FGDs), and In-Depth Interviews (IDIs).
- August to Early September 2025: Data cleaning, analysis, interpretation, and report writing.

The phased approach allowed integration of survey findings with screening data and qualitative insights before finalizing the report.

1.5 Public Health Status and Urban Poverty in Ahmedabad

1.5.1 City Overview and Urban Structure

Ahmedabad's spatial growth has led to clusters of informal settlements, particularly near industrial zones and peripheral urban fringes. Many settlements lack proper drainage, waste management, and safe water systems. Proximity to industrial activities increases exposure to air and water pollution, contributing to respiratory illnesses and waterborne diseases.

Environmental health risks are compounded by overcrowded living conditions and poor housing quality, which facilitate the spread of communicable diseases.

1.5.2 Understanding Urban Poverty: A Multidimensional Perspective

Socio-Economic Profile

The majority of residents in the study areas are migrants from north and central India, employed in daily-wage labor, factory work, small-scale services, or home-based occupations. Income instability remains a defining feature of urban poverty.

Urban poverty reflects:

- Exclusion from basic services
- Limited social protection coverage
- Weak integration into formal healthcare systems
- Lack of financial resilience during emergencies

Multidimensional Vulnerabilities

Economic Insecurity:
Irregular employment and low wages often result in debt during health emergencies.

Environmental Risks:
Proximity to industrial zones increases exposure to pollutants, unsafe water, and vector-borne diseases.

Health Vulnerability:
High prevalence of disease is combined with limited preventive health awareness.
Documentation barriers restrict access to government schemes.

Gender and Age Inequality:
Women and adolescent girls face mobility restrictions and limited access to health information.
Decision-making power often rests with male household members**.**

Institutional Exclusion:
Lack of ration cards, Aadhaar linkage, or local identity proof prevents migrants from accessing subsidized services and health insurance schemes. Trust deficits toward public facilities further discourage utilization.

1.5.3 Disease Burden in Informal Settlements

Communicable Diseases

Tuberculosis, diarrheal diseases, malaria, and seasonal fevers remain prevalent. Limited sanitation infrastructure and unsafe drinking water contribute significantly to disease transmission.

Non-Communicable Diseases (NCDs)

Hypertension, diabetes, thyroid disorders, and musculoskeletal conditions are increasingly reported. Sedentary lifestyles, occupational stress, and dietary transitions contribute to NCD prevalence. Industrial workers are particularly vulnerable to respiratory, dermatological, and orthopedic issues, often without formal occupational health coverage.

Maternal, Child, and Mental Health

Maternal anaemia, child malnutrition, and incomplete immunization persist in several settlements. Emerging concerns include rising stress, anxiety, and substance use among youth and industrial workers, though mental health remains under-discussed due to stigma.

1.5.4 Healthcare System: Public and Private Dynamics

Ahmedabad has a network of Primary Health Centres (PHCs), Urban Health Centres (UHCs), and tertiary hospitals such as Civil Hospital, LG Hospital, and Sola Civil Hospital. Government schemes support maternal and child health services and subsidized treatment for certain conditions.

However, public healthcare facilities face challenges including:

- Overcrowding
- Long waiting times
- Staff shortages
- Medicine stock-outs
- Documentation barriers for migrants

As a result, many households turn to private healthcare providers. Private facilities are perceived as faster and more responsive but are often financially burdensome. High out-of-pocket expenditure forces families into debt or asset liquidation, deepening economic vulnerability.

1.5.5 Systemic Barriers and Health Inequities

The dual dependence on public and private healthcare reinforces structural inequities. Public facilities are theoretically affordable but operationally constrained. Private facilities offer accessibility and perceived quality but at catastrophic costs.

Migrants, women, informal workers, and undocumented households face compounded marginalization. Health shocks frequently translate into economic shocks, creating cycles of indebtedness and reduced future resilience.

1.5.6 Priority Areas for Intervention

To improve health equity among urban poor communities, the following priority areas emerge:

- Strengthening Public Health Infrastructure: Increased staffing, reliable medicine supply, improved diagnostics, and patient-centered service delivery.
- Inclusive Entitlement Systems: Alternative documentation pathways to ensure migrants' access to schemes.
- Preventive Health Promotion: Community-based awareness campaigns and routine screenings.
- Financial Protection Mechanisms: Expanded health insurance coverage and reduced out-of-pocket expenses.
- Gender and Social Equity Measures: Targeted reproductive health services and women's health awareness programs.
- Occupational Health Services: Workplace safety standards and regular screenings for informal and industrial workers.

Conclusion

Ahmedabad's healthcare landscape reflects a structural divide between availability and accessibility. Despite the presence of extensive health infrastructure, vulnerable populations—particularly migrants, women, children, and informal workers—remain disproportionately affected by systemic barriers.

Achieving equitable health outcomes requires not only strengthening service delivery but also addressing deeper structural inequities linked to urban poverty, documentation exclusion, occupational precarity, and gender disparities. Without systemic reforms, health risks will continue to reinforce cycles of social and economic vulnerability among the urban poor

2. Methodology and Research Design

2.1 Study Design

The study adopted a community-based mixed-methods design, integrating quantitative household surveys with qualitative tools including Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs). This design ensured both breadth and depth of analysis:

- The quantitative component captured measurable indicators such as disease prevalence, health-seeking behavior, scheme awareness, and out-of-pocket expenditure.
- The qualitative component explored lived experiences, perceptions, gender norms, decision-making dynamics, and systemic barriers shaping healthcare choices.

The research built upon the long-standing engagement of Saath Charitable Trust in informal settlements of southern Ahmedabad. Established community rapport contributed to high participation and low non-response rates.

2.2 Study Site Selection

To examine how healthcare access varies across different settlement contexts, the study focused on selected informal and peri-urban settlements located in the southern wards of Ahmedabad. These areas fall within the operational geography of **Saath**, which has been working for more than three years across six wards, reaching approximately 27,000 households in Vatva, Behrampura, Shahwadi, and Ramol. The broader geography was chosen to capture diversity in migration patterns, religious composition, occupational structure, and levels of integrtion with formal urban infrastructure.

Within this landscape, three field centres were purposively selected to enable comparative analysis across distinct socio-demographic settings.

Vatva represents predominantly Muslim migrant communities, many of whom are engaged in factory-based or daily-wage labour in nearby industrial estates.

Behrampura is a long-established settlement with a mixed Hindu–Muslim population and a wide range of livelihood activities, reflecting greater socio-economic heterogeneity.

Ramol is a peripheral settlement largely inhabited by Hindu migrant households from Uttar Pradesh, Rajasthan, and Madhya Pradesh, characterized by recent in-migration and limited access to formal services. In addition,

Lambha and adjoining peri-urban clusters were included to capture rapidly expanding settlements that remain only partially integrated into the city's infrastructure and service networks.

The purposive selection of these sites allows for systematic comparison across communities differentiated by religion, migration history, occupation, and settlement typology. Together, they represent varied segments of Ahmedabad's urban poor and provide a robust basis for analysing patterns of healthcare access and utilisation across different social and spatial contexts.

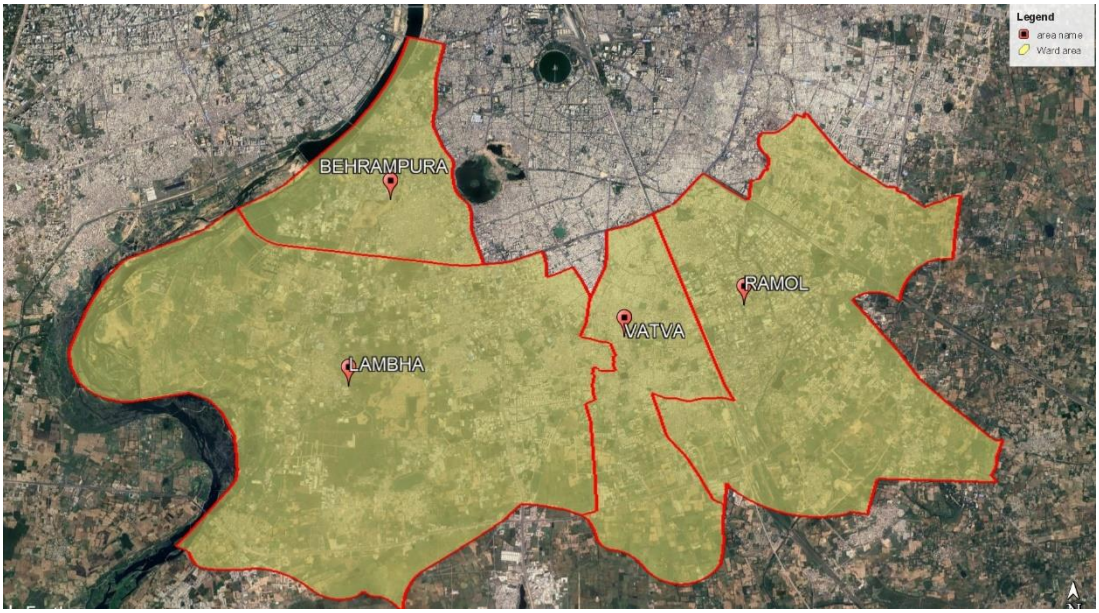

Figure 1 Study area map

2.3 Research Instruments

Quantitative Tool: Household Survey

The structured questionnaire was co-developed by APF and Saath teams and digitized using the Frappe mobile application to ensure systematic data entry and reduce manual errors.

The survey tool was translated into Gujarati and Hindi to enhance accessibility. It covered:

- Socio-demographic characteristics
- Disease prevalence and health conditions
- Health-seeking behavior and service utilization
- Awareness and use of government health schemes
- Out-of-pocket expenditure (OOPE)

The Frappe platform enabled real-time identification and mapping of respondents aged 30 years and above for targeted blood pressure and diabetes screening.

Qualitative Tools: FGDs and IDIs

Discussion guides were designed to explore beliefs, barriers, and practices related to healthcare access.

- Instruments were piloted and refined before field deployment.

- Discussions were conducted in local languages.
- Audio recording (with informed consent) ensured completeness and accuracy.
- Groups were segmented by gender, age, and role (women, men, youth, adolescents, ASHA workers).

Themes explored included health awareness, decision-making structures, gender barriers, affordability, migration challenges, and perceptions of service quality.

2.4 Sampling Design

The study targeted 400 households from a total universe of approximately 5,395 households across the selected areas.

- A systematic random sampling technique was applied.
- Starting from a randomly selected household, every 10th household was surveyed.
- In cases of unavailability, the immediate next household was selected.

This approach ensured spatial representation and minimized selection bias. A total of 400 respondents were successfully surveyed.

2.5 Research Team Composition

Survey Team:
Eight Field Officers (FOs) from Saath were selected based on:

- Residence within the community (facilitating trust and communication)
- Prior training in the Frappe application
- Familiarity with government health schemes

Qualitative Facilitation Team:
Three members from Saath's management team moderated FGDs and IDIs, ensuring neutrality, structured facilitation, and systematic documentation.

2.6 Training and Capacity Building

A multi-stage training process was conducted to ensure methodological rigor:

1. Centralized Training: Conducted at HDRC by APF, covering study objectives, research ethics, and tool orientation.

2. NGO-Level Training: Held at Saath's office, including piloting of the digital tool and refinements.
3. Qualitative Facilitation Training: Conducted at Sanchetna, focusing on moderation skills, note-taking, and group management.
4. Continuous Technical Support: Weekly virtual review meetings with APF and partner NGOs.
5. Field Supervision: On-site observations by APF in Behrampura to ensure adherence to sampling and quality standards.

2.7 Data Collection

Quantitative Survey

- Conducted in mid-June across Ramol, Behrampura, and Vatva.
- Fieldwork duration: Approximately 22 days.
- Surveys were primarily conducted in the evening to accommodate working respondents.
- Teams operated through Urban Resource Centers (URCs) to coordinate simultaneous fieldwork.

Field Challenges and Mitigation:

- Daytime unavailability required evening scheduling.
- Locked or reluctant households were revisited following rapport-building by local staff.

2.8 Health Screening Component

As a follow-up intervention and validation mechanism, health screening camps were organized in July for individuals aged 30 years and above.

Screening Services Included:

- Blood pressure testing
- Blood glucose testing
- Disability screening
- Health counseling and referrals

Partnership Model:

- Collaboration with Urban Health Centers (UHCs) in Behrampura and Vatva.
- Support from General Nursing and Midwifery (GNM) teams in Ramol.
- Supplementary support through Saath's Surgical Care Program where required.

Saath's Field Officers, trained and certified through the Red Cross, conducted BP and diabetes screenings.

Coverage:

- 97% of eligible individuals were successfully screened.
- 3% could not be covered due to refusal or unavailability.

2.9 Qualitative Data Collection

- Five FGDs (7–8 participants each)
- Four IDIs (male, female, ASHA worker, youth representative)

Qualitative data were analyzed under five thematic clusters:

1. Awareness and preventive practices
2. Barriers to healthcare access
3. Gender and decision-making dynamics
4. Economic constraints and OOPE
5. Perceptions of public versus private healthcare

2.10 Monitoring and Supervision

- Daily debrief sessions enabled real-time troubleshooting.
- Supervisors verified sampling adherence and data accuracy.
- APF conducted weekly review meetings and periodic on-site monitoring to maintain methodological consistency.

2.11 Data Analysis

Quantitative Analysis

- Data exported from Frappe were cleaned, validated, and coded.
- Descriptive statistics and cross-tabulations were conducted to analyze:
    - Disease prevalence
    - Health-seeking behavior
    - Expenditure patterns
    - Gender and age differences in utilization
- Inferential analysis examined associations between socio-demographic variables and healthcare utilization patterns.

Qualitative Analysis

- Audio recordings were transcribed verbatim and translated into English.

- Manual thematic coding was conducted using predefined categories.
- Triangulation of quantitative and qualitative findings ensured analytical depth and validity.

2.12 Reporting Process

Following analysis, a report-writing workshop was organized by APF for participating NGOs. The workshop focused on:

- Structuring analytical reports
- Integrating gender- and age-disaggregated findings
- Combining statistical evidence with narrative insights
- Presenting community voices alongside data

This structured reporting process ensured clarity, analytical rigor, and accurate representation of community perspectives.

3. Results and Findings: Quantitative Component

3.1 Socio-Demographic Profile

The quantitative survey covered 402 households across five informal settlements in southern Ahmedabad - KGN, Baghe Hasan, Baghe Kaushar, Ram Rahim no Tekro, and Gayatri Nagar - between mid-June and end-July 2025. Data were collected digitally using the Frappe survey platform.

A total of 1,866 individuals were enumerated, with an average household size of 4.6 persons, reflecting relatively dense living conditions typical of informal settlements.

The gender distribution was nearly equal:

- **Male:** 936 (50.1%)
- **Female:** 930 (49.9%)

			Target screening population			**Completed Screening Population**			
Area Name	**HH Covered**	**Population**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Pending**
KGN	75	337	68	68	136	68	67	135	1
Baghe Hasan	43	159	29	29	58	29	29	58	0
Baghe Kaushar	61	305	54	58	112	54	58	112	0
Ram Rahim no Tekro	100	480	89	112	201	87	112	199	2
Gayatri Nagar	123	585	121	113	234	120	112	232	2
Total	402	1866	361	380	741	358	378	736	5

Figure 2 Showing near-equal male–female distribution

Among the total population, **741 individuals aged 30 years and above** were identified as eligible for NCD screening (blood pressure and blood glucose testing), of whom **736 (99.3%) were successfully screened**, indicating strong community participation and effective field mobilization.

Religious Composition

The settlements reflect a socially mixed demographic profile:

Religion	Households	% of Total
Hindu	210	52%
Muslim	170	42%
Christian/Other	22	6%
Total	402	100%

This composition reflects the plural character of informal settlements in southern Ahmedabad, where communities often live in close proximity despite socio-economic vulnerabilities.

Housing Conditions

Nearly 47% of households reside in semi-pucca structures, while 22% continue to live in kutcha dwellings. The remaining households occupy pucca or mixed-structure housing. The persistence of kutcha housing indicates infrastructural fragility, exposure to environmental risks, and limited tenure security.

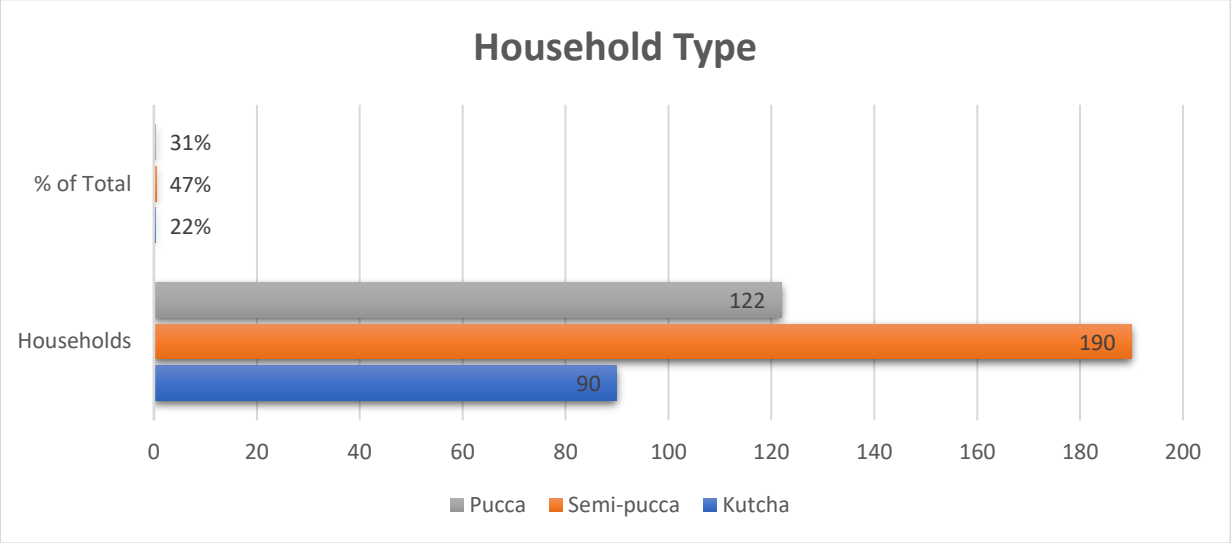

Figure 3 Housing quality distribution

Interpretation:

The socio-demographic profile highlights moderate household density, mixed religious composition, and significant housing vulnerability — factors that directly influence health risks, healthcare access, and financial resilience.

3.2 Awareness and Utilization of Health Facilities

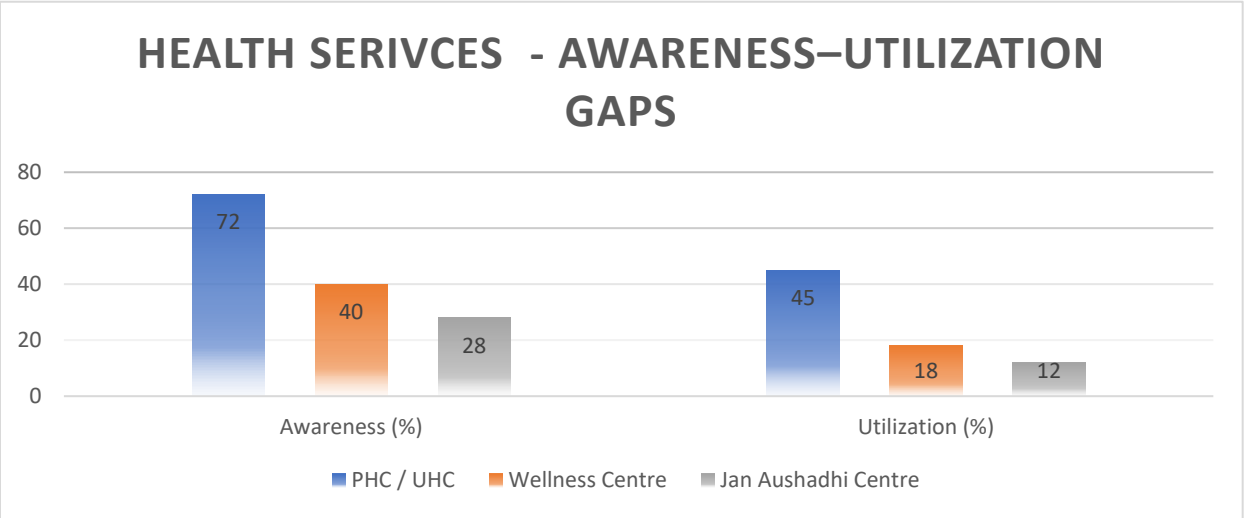

Figure 4 Showing awareness–utilization gaps

Access of public health infrastructure was relatively high compared to actual utilization.

A consistent gap emerges between knowledge of services and their use. Respondents cited long waiting times, perceived poor service quality, overcrowding, and distance from settlements as barriers.

Interpretation:
Physical presence of facilities does not automatically translate into effective access. Perception of service quality and convenience plays a decisive role in health-seeking decisions.

3.3 Reported Health Problems

Households reported the following health conditions:

Reported Health Issue	% of Households
Hypertension	26
Diabetes	18
TB / Respiratory Diseases	12
Skin / Orthopedic Problems	15
Mental Health Concerns	7
Others	22

Figure 5 Showing disease prevalence by type

Non-communicable diseases (NCDs) clearly dominate the health profile. Hypertension and diabetes together affect nearly half of all reporting households. Respiratory conditions are also

notable, particularly in industrially influenced areas such as Vatva, where environmental exposure may be a contributing factor.

Mental health concerns remain comparatively under-reported, suggesting stigma and limited recognition rather than low prevalence.

Interpretation:
The health burden in these settlements is shifting from acute infectious diseases toward chronic NCDs, requiring sustained screening, lifestyle counselling, and long-term management systems.

3.4 Financial Preparedness and Out-of-Pocket Expenditure (OOPE)

Financial protection against health shocks remains extremely limited:

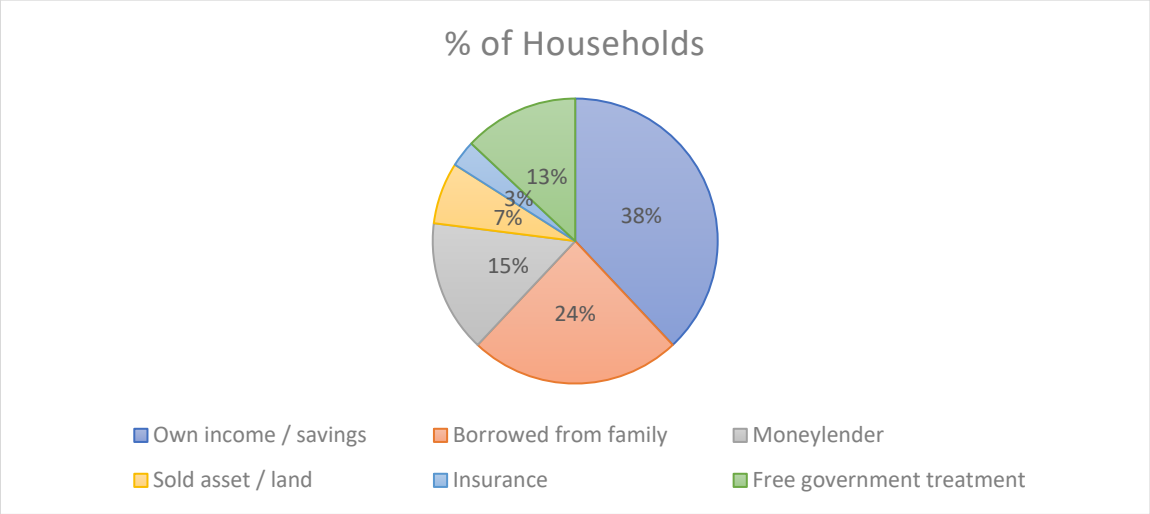

Figure 6 Showing major financing sources for hospitalization

- Only 3% of households reported using health insurance.
- 46% relied on borrowing money or selling assets to meet hospitalization expenses.

Despite the availability of government insurance schemes, coverage and utilization remain low due to documentation gaps, migration, procedural complexity, and limited awareness.

Interpretation:
Healthcare-related debt is a major vulnerability. Limited insurance uptake perpetuates cycles of poverty and financial instability.

3.5 Health Screening Outcomes

Screening Parameter	Screened Population	% with Elevated Levels
Blood Pressure (BP)	736	23% elevated
Blood Glucose (Diabetes)	736	17% elevated

Figure 7 Showing BP and Glucose screening outcomes

Of the 741 eligible individuals (30+ years), 736 were screened for blood pressure and blood glucose.

Findings:

- **23% showed elevated blood pressure levels**
- **17% showed elevated blood glucose levels**

Elevated BP was more common among individuals aged 40 and above. Elevated glucose levels showed higher incidence among women in certain settlements (notably Ram Rahim no Tekro and Gayatri Nagar).

Interpretation:
Screening data validates the survey-reported NCD burden. A significant proportion of adults are living with undiagnosed or poorly controlled hypertension and diabetes, underscoring the need for regular screening, follow-up, and referral linkages with UHCs and frontline health workers.

3.6 Awareness and Utilization of Health Schemes

- **Ration Cards:** ~85% coverage
- **Ayushman Bharat (PMJAY):** 9% enrolled/used
- **ABHA IDs:** 14% awareness
- **Mamta Card (maternal & child health):** 68% awareness among women

Food security entitlements are widely accessed, while health insurance and digital health services remain underutilized. Migrant households face additional barriers due to mobility and documentation challenges.

Interpretation:
Administrative complexity and limited digital literacy hinder effective uptake of health entitlements.

3.7 Health-Seeking Behaviour and Provider Preference

- 58% rely initially on home remedies or self-medication

- 49% prefer private clinics/pharmacies for minor illnesses
- 41% use government facilities primarily for serious or chronic conditions

The dominant pattern is "private first, government later." Households prioritize convenience and speed for minor ailments but turn to public facilities for cost-intensive treatments such as deliveries, TB care, or chronic disease management.

Interpretation:
Healthcare decisions reflect a balance between cost, perceived quality, and immediacy. Delayed engagement with formal systems may contribute to worsening conditions and higher long-term costs.

3.8 Maternal and Child Health

- **Pregnancy registration:** 82%
- **At least one ANC visit:** 76%
- **Full ANC (≥4 visits):** 52%
- **Institutional deliveries:** 88%
- **Complete child immunization:** 80%

Institutional deliveries and immunization coverage are encouraging, indicating effective outreach by frontline workers. However, completion of four ANC visits remains moderate, with respondents citing long waits and inconsistent follow-up as deterrents.

Interpretation:
While maternal and child health indicators show progress, continuity and quality of antenatal care require strengthening.

3.9 Field Implementation Challenges

Data collection encountered several operational challenges:

- Limited daytime availability of respondents (evening visits required)
- Seasonal migration leading to locked households
- Hesitation in responding to sensitive health and financial questions
- Initial technical issues with the Frappe application

These challenges were addressed through repeat visits, rapport-building, and refresher training sessions for field investigators with technical support.

Overall Synthesis of Quantitative Findings

The quantitative findings reveal a clear epidemiological and systemic pattern:

1. Rising NCD burden with significant undetected hypertension and diabetes.
2. Persistent awareness–utilization gaps in public health infrastructure.
3. High out-of-pocket expenditure and debt vulnerability.
4. Moderate maternal-child health performance with scope for improvement.
5. Low uptake of health insurance and digital health scheme.

4. Results and Findings: Qualitative Component

4.1 Overview

To complement the household survey, a qualitative inquiry was conducted across three urban settlements of Ahmedabad — Vatva, Ramol, and Behrampura. A total of five Focus Group Discussions (FGDs) and four In-Depth Interviews (IDIs) were held with diverse participants, including women, youth, elderly residents, community leaders, and ASHA workers.

The discussions explored lived experiences around:

- Illness response pathways
- Experiences with public and private health systems
- Maternal and child health practices
- Financial coping mechanisms
- Awareness and use of health schemes

The qualitative findings deepen the quantitative results by highlighting perceptions, behavioral patterns, and structural barriers that shape healthcare access in informal settlements.

4.2 Key Findings

1. Initial Response to Illness

Across all three locations, the first response to illness was commonly home remedies or over-the-counter medication purchased from nearby pharmacies.

Older women emphasized traditional or herbal remedies for routine ailments, while youth showed greater openness toward formal medical consultations, particularly for children's illnesses. A recurring gendered pattern emerged: women frequently delayed seeking treatment for themselves while prioritizing children and earning family members.

"If my husband or child falls sick, we go to the hospital. For myself, I wait—it's just weakness." – Female participant, Behrampura

Interpretation:
Self-medication and delayed care are normalized practices, shaped by financial constraints and gendered caregiving roles.

2. Government vs. Private Health Facilities

Participants described a clear distinction in their use of health providers:

- **Private clinics and pharmacies** were preferred for minor ailments due to proximity, shorter waiting times, and faster service.
- **Government hospitals** such as LG Hospital, Civil Hospital, and Kasiba General Hospital were utilized primarily for deliveries, surgeries, and major illnesses.

Common concerns about government facilities included overcrowding, long waiting times, limited availability of medicines, and perceived staff behavior.

"In government hospitals, you need patience. But if we go private, it's quick—just expensive." – Male participant, Vatva

Interpretation:
Healthcare decisions reflect a trade-off between affordability (government) and convenience (private). Perceived service quality significantly influences provider preference.

3. Common Health Issues by Group

The FGDs revealed age- and gender-specific health patterns:

- **Women:** Back pain, chronic weakness, reproductive health issues, hypertension, diabetes
- **Men:** Fatigue, joint pain, tobacco and alcohol-related health concerns
- **Youth:** Stress, thyroid disorders, poor diet, lifestyle-related conditions
- **Elderly:** Hypertension, diabetes, mobility-related issues
- **Children:** Recurrent cough, gastrointestinal infections, malnutrition

Participants frequently linked respiratory problems and fatigue to occupational exposure, particularly in industrial areas.

Interpretation:
The qualitative insights confirm the rising burden of NCDs while also highlighting occupational and lifestyle-related risks.

4. Maternal and Child Health

Most pregnant women reported accessing antenatal care (ANC) at government facilities such as Kasiba and LG Hospital. Some opted for private care due to perceptions of better attention and shorter waiting times.

Awareness of Mamta Cards and incentive schemes (e.g., Namo Shree) was present but inconsistent in terms of actual utilization. Information often spread informally among mothers rather than through systematic counselling.

"I didn't know delivery costs were covered under a government scheme until another mother told me."
– Female participant, Behrampura

Interpretation:
Peer networks play an important role in spreading information, but structured scheme awareness remains incomplete.

5. Unplanned Health Situations

In emergencies such as appendicitis, accidents, or delivery complications, families prioritized immediate proximity over cost considerations. Bills reported ranged from ₹3,000 to ₹50,000, depending on the facility and procedure.

Very few households reported using insurance coverage during such situations.

"We went to a private hospital because it was close. The bill was high, but there was no time to think."
– Female participant, Ramol

Interpretation:
Emergency decision-making is driven by urgency rather than financial planning, contributing to high out-of-pocket expenditure.

6. Financial Burden and Coping Mechanisms

Major illnesses often led to:

- Borrowing from relatives
- Mortgaging gold
- Informal loans
- Employer-linked emergency funds (in limited cases)

Even relatively small expenses were described as financially stressful.

"We borrow from relatives when someone is admitted. Even small costs are difficult." – Male participant, Behrampura

Interpretation:
Health shocks significantly strain already fragile household economies, reinforcing debt cycles.

7. Occupation-Related Health Risks

Factory workers in Vatva and Ramol reported chronic respiratory issues and musculoskeletal pain due to industrial work conditions. While some workers in Ramol mentioned access to limited employer-provided insurance schemes, most lacked formal health coverage.

"I have back pain daily from work. The company gives gloves, but no help if you're sick." – Male participant, Vatva

Interpretation:
Occupational hazards contribute substantially to chronic morbidity, yet workplace-linked health protection remains minimal.

8. Role of Frontline Health Workers

ASHAs and Anganwadi workers emerged as trusted health intermediaries, particularly for maternal and child health services. They reported conducting household visits before Mamta Days to encourage check-ups and immunization.

However, they also faced resistance linked to early marriage, addiction, superstition, and misinformation.

"I visit each household before Mamta Day to remind them for check-ups and vaccines. Some families still resist, but it's improving." – ASHA worker, Behrampura

Interpretation:
Frontline workers are critical connectors between communities and formal health systems, yet require continued institutional support.

4.3 Cross-Cutting Themes

Theme	Summary Insight
Trust and Access	Private clinics preferred for speed; government hospitals trusted for affordability in serious cases.
Youth Perspective	Younger respondents more open to formal healthcare and preventive services.
Gendered Burden	Women delay their own treatment while prioritizing family members.

Financial Vulnerability	High OOPE drives borrowing and asset liquidation.
Frontline Linkages	ASHAs play a vital role in maternal-child health and immunization outreach.

4.4 Summary Narrative

The qualitative findings reveal a structured pattern of health-seeking behavior:

1. **Home remedies and self-medication as the first response.**
2. **Private clinics for quick and accessible relief.**
3. **Government hospitals for chronic, serious, or high-cost treatment.**

Healthcare choices are shaped by community trust, financial capacity, proximity, and perceived service quality. While systemic challenges persist, frontline health workers and public health programs remain essential anchors for vulnerable families living in informal settlements of Ahmedabad.

5. Lessons for Organizations: Insights from Health-Seeking Behavior Study

The Ahmedabad Health-Seeking Behaviour Study has served as a strategic learning process for Saath Charitable Trust. While Saath has worked with urban poor communities for over three decades across housing, livelihoods, governance, and health, this focused research across Vatva, Behrampura, Ramol, and Lambha has deepened organizational understanding of healthcare decision-making, systemic bottlenecks, and socio-economic vulnerabilities shaping health outcomes.

5.1 Health-Seeking Patterns Are Diverse and Layered

The study confirms that healthcare pathways in informal settlements are neither linear nor uniform.

- Households adopt multiple, overlapping pathways, influenced by cost, proximity, perceived service quality, and prior experiences.
- Home remedies and informal care (chemists, traditional practices) are almost universally the first response to illness.
- Younger women and youth tend to access formal healthcare earlier, while older adults often delay treatment.
- Private clinics — such as small neighborhood providers in Vatva — are preferred for minor ailments due to trust and convenience, despite higher costs than public facilities.

Organizational Learning:

Interventions must recognize that households combine formal and informal care systems. Programs should work with existing behavioral patterns rather than assume exclusive reliance on public services.

5.2 Public Health Infrastructure: Present but Underutilized

Urban Health Centres (UHCs) and PHCs are physically available in most study areas. However, utilization remains selective.

- Long waiting times, medicine shortages, and perceived staff behavior affect trust.
- Public facilities are primarily used for maternal-child health and immunization.
- Private hospitals are preferred for emergencies and specialized care.

Organizational Learning:

Improving health outcomes requires rebuilding trust and confidence in public systems, not merely expanding infrastructure.

5.3 Financial Burden Remains a Core Vulnerability

Out-of-pocket expenditure (OOPE) continues to shape health decisions.

- Borrowing, mortgaging gold, and asset sales are common coping strategies.
- Enrollment and utilization of schemes such as Ayushman Bharat remain low due to documentation gaps and procedural barriers.
- Limited awareness of maternal schemes like Chiranjeevi Yojana further restricts financial protection.

Organizational Learning:

Health programming must integrate financial risk protection strategies, including entitlement facilitation and community-level financial literacy.

5.4 Gendered Dimensions of Health Vulnerability

The study reinforces that health-seeking is deeply gendered.

- Women frequently delay their own care while prioritizing family members.
- Adolescent girls show limited awareness of reproductive and mental health services.
- Older women rely more heavily on traditional remedies.

Organizational Learning:
Gender-responsive interventions including awareness campaigns, youth engagement, and safe spaces for women which are critical for equitable health outcomes.

5.5 Migration and Urban Exclusion

Migrant households from Uttar Pradesh, Bihar, Madhya Pradesh, and Rajasthan constitute a significant share of residents in Ramol and Vatva.

- Lack of local documentation restricts access to ration cards, insurance schemes, and other entitlements.
- Migrant families are therefore more dependent on informal and private care.

Organizational Learning: Urban health interventions must adopt a migrant-inclusive framework, simplify documentation processes and facilitating portability of entitlements.

5.6 Value of Community Rapport in Research

Saath's sustained presence (3–4 years) in these settlements enabled high participation and candid responses.

- Community-based Field Officers were essential in building trust.
- Local engagement enhanced data accuracy and participation in screenings.

Organizational Learning: Community-based organizations play a critical role in generating credible data and translating research into action.

5.7 Methodological Strengths

The mixed-method design (survey + FGDs + IDIs) enabled triangulation of findings.

- Quantitative data highlighted prevalence and patterns.
- Qualitative insights explained underlying behaviors and perceptions.
- Training and technical support strengthened internal research capacity.

Organizational Learning: Evidence-based programming requires combining numerical data with lived experiences to design responsive interventions.

6. Gaps in Awareness, Access, and Utilization

The findings reveal interconnected gaps that limit effective healthcare engagement among urban poor households in Ahmedabad.

6.1 Awareness Gaps

- Limited understanding of schemes such as Chiranjeevi Yojana and disability benefits.
- Incomplete knowledge of locations and services at UHCs and Jan Aushadhi Kendras.
- Low awareness of preventive health screening (BP, diabetes).
- Gender disparities in information access, particularly among women and adolescents.

6.2 Access Gaps

Geographical Barriers: Peripheral settlements like Ramol are distant from tertiary hospitals. Industrial zones such as Vatva expose residents to environmental risks without specialized nearby facilities.

Financial Barriers: Even “free” services entail transportation costs and wage loss. Private care often requires borrowing.

Documentation Barriers: Migrants lack required IDs for scheme enrollment.

Social Barriers: Mobility constraints for women and social divisions reduce timely care-seeking.

6.3 Utilization Gaps

- Trust deficits in public systems due to waiting times and medicine shortages.
- Preference for nearby private providers for minor illnesses.
- Preventive services (NCD screening, adolescent health) remain underused.
- Fragmented care pathways delay effective treatment.

Synthesis:
Awareness gaps limit knowledge, access barriers restrict entry, and utilization challenges reduce continuity of care, collectively reinforcing vulnerability.

7. Challenges Faced by Participants

The challenges operate across three interconnected levels:

7.1 Systemic Challenges

- Overburdened PHCs and UHCs.
- Shortages of medicines and diagnostic services.
- Trust deficits due to staff interactions.
- Fragmented preventive and curative care linkages.
- Documentation barriers for migrant families.

7.2 Community-Level Challenges

- Distance from tertiary hospitals.
- Industrial pollution exposure (Vatva).
- Poor sanitation and waterlogging.
- Cultural reliance on home remedies.
- Limited youth-friendly health spaces.

7.3 Household-Level Challenges

- High treatment and transport costs.
- Wage loss during illness.
- Borrowing at high interest rates.
- Gendered decision-making structures.
- Limited awareness of entitlements.

These interconnected barriers perpetuate delayed treatment, financial strain, and recurring vulnerability.

8. Recommendations for Moving Forward

Based on integrated findings, the following strategic recommendations are proposed:

8.1 Strengthen Awareness and Outreach

- Expand UHC outreach and mobile health services in peripheral settlements.
- Collaborate with ASHAs and community organizations to include migrants and women.
- Conduct targeted preventive health campaigns (NCD screening, maternal health).

8.2 Improve Quality and Accessibility of Public Services

- Ensure consistent medicine availability and diagnostic services at PHCs/UHCs.
- Train staff in respectful and culturally sensitive communication.
- Establish community monitoring committees to strengthen accountability.

8.3 Enhance Financial Protection

- Facilitate enrollment in Ayushman Bharat and maternal schemes.
- Promote Jan Aushadhi Kendras for affordable medicines.
- Explore community-based micro-health savings groups to reduce debt reliance.

8.4 Promote Gender-Responsive and Youth-Friendly Interventions

- Target maternal nutrition, anemia, and reproductive health.
- Create adolescent-friendly spaces for mental health and reproductive counselling.
- Support childcare solutions enabling women to access services.

8.5 Integrate Environmental and Migrant-Inclusive Planning

- Incorporate sanitation, drainage, and pollution mitigation into ward-level health planning.
- Simplify documentation processes for migrant households.
- Encourage public–private partnerships for subsidized urban health services.

Concluding Perspective

The study underscores that health outcomes in informal settlements are shaped by economic precarity, social norms, systemic barriers, and environmental exposures. A community-centered, evidence-driven approach — combining preventive awareness, strengthened public systems,

financial protection, and inclusive governance — is essential for improving health equity in Ahmedabad's urban settlements.

These findings provide Saath and its partners with a strategic foundation for program design, policy engagement, and collaborative action toward resilient urban health system

Annexures

Annexure 1: Household Survey Questionnaire

1. IDI guide to record sharing by respondents during IDIs (to be completed after each IDI)
2. Start time of discussion: Date:
3. Finish time of discussion:
4. Staff initials:
5. Gender and Age of respondent:
6. Site: (A, B, C etc. if site needs to be masked)

IDIs-

7. General and probe related points-
8. The space where the IDI is conducted has to be away from noise and disturbance & ensure
9. adequate privacy
10. Spend a few minutes in the beginning to establish a rapport with the subject.
11. Ensure that you have read out the oral consent to audio record the discussion. Specify that
12. in case the subject refuses to participate, there are no adverse consequences to any services
13. they might be receiving from your side.
14. In case the subject refuses to get the audio-recording done, please stop the IDI immediately.
15. Do not look at convincing the subject for audio recording
16. The IDI is a conversation where you are asking questions and respectfully listening without
17. judgement
18. You don't have to agree or disagree to anything that is shared. Any remedial measure you
19. want to take can to be done after the IDI is completed, not during the IDI
20. Do not jump into providing solutions during the IDI, do so after the IDI has been completed
21. While an IDI could last for up to 1.5-2 hours or longer, make sure that you end it when the
22. subject has shared all that they wanted to on the points you raised.
23. Do not push the subject to hurry up with the conversation
24. Ensure you have backup devices in case your recording device memory becomes full
25. After the IDI, convert the audio recording into English word document within a day.
26. It is important for the interviewer to be calm, respectful and focused throughout the IDI
27. especially when the subject might recount traumatic events from their experience
28. This guide is not a checklist. Use your field experience, judgement and wisdom suitably
29. Who will we speak with?
30. 1. One woman who has had some health issues for herself or in her family in the recent past
31. (such as the woman whose son had a bike accident from the Siddapura FGD done by MS)
32. 2. One older woman to cover similar issues as above but from an elderly lens
33. 3. One with a govt health worker (active ASHA / Anganwadi worker in the area)
34. 4. One adult man?

35. What aspects do we probe-
36. 1. A bit about their family members, who all is there in their family, who works for a living
37. 2. How was the comfort level of the respondents when the IDI was started? Please reassure
38. suitably if something was needed to encourage participation from respondents. For example
39. the respondent may have been quiet because someone came into the room.
40. 3. Their attitude towards health
41. 4. A bit of the health background of their parents and in-laws
42. 5. What type of work they do
43. 6. On a preventive basis, what do they or people in their community do for well-being
44. Typical dietary practices
45. i. What do they give to their child?
46. ii. What do they consume?
47. iii. What does their husband consume?
48. iv. What did they have for the most recent meal they had?
49. v. Are the govt-provided rations useful?
50. vi. What would they change about their family's dietary practices
51. 7. Incidence of addiction in the household or community (alcohol, tobacco, substance)
52. 8. How have they addressed the addiction?
53. 9. As individuals, when they get a bit of spare time from their work what do they do for
54. recreation?
55. 10. As a family, what do they do together? Going out to a park, mall, movie, restaurant, friends/
56. relative's places/ pilgrimages/ others? Also find out the approximate frequency of such visits
57. (for example, we go to the mall once a month)
58. 11. Who is their support system when there is an emergency?
59. 12. Whose support system are they for others in an emergency?
60. 13. Who forms their support system when they face stress?
61. 14. What services have they taken from govt health facilities? How was their experience? Ask
62. them to describe it in detail. Seek out any positive examples also.
63. 15. Describing the typical health-related trajectory of the subject-
64. When I was a child
65. When I was a teen
66. When I was a young married woman (pregnancy, delivery-related)
67. Where I am now
68. 16. Follow-up on points/ questions you had in case the subject was part of an FGD
69. 17. Rural health facilities in contrast to urban health facilities
70. 18. Accident at the work place
71. 19. Choice between very negative cases vis-à-vis cases where the subject has risen
72. 20. Were there questions/topics covered in the quantitative survey that the respondents
73. wanted to discuss further? Please detail.

21. During the course of IDIs there could be some personal or confidential sharing with you from
the respondents. A few examples are the following subjects. Please write down the sharing
in your own words.
- Violence experience
- Income related sharing
- Suicidal tendencies
- Neglect or indifference from family members
- Children
- Health seeking behaviour
- Older people and health needs
- Women and health needs
- Mobility
- Some community related issue
– Other
23. Any other relevant point you can think of
24. Were there suggestions that came up from respondent on future research topics or work we
can do in their community, that they consider useful? Please detail.

Annexures: 2 IDI And FGD Questioner

Format to record sharing by respondents during FGDs (to be completed after each FGD)

Start time of discussion: Date:

Finish time of discussion:

Number of respondents:

Number of men and their ages:

Number of women and their ages:

Staff initials:

Site: (A, B, C etc. if site needs to be masked)

How was the comfort level of the respondents when the FGD was started? Please explain if something was needed to encourage participation from respondents. For example 2-3 respondents may not have spoken or the women or younger people may have been quiet.

1. What are the common & recurring health issues in their household by gender and by age group. For each of the below ask them about what are the health issues, what do they do to get treated-

a. Women (18-45 years)

b. Men (18-45 years)

c. Children

d. Adolescent girls and boys

e. older women & men (45 & beyond)

2. How much approximately do they spend for their household in a month for common & recurring illnesses?

3. Understanding what they do for common & recurring illnesses-An example is given below-

a. Do they self-medicate

b. If their health doesn't become better, do they visit the medical store

c. After taking medicines from medical store, if they don't feel better, do they visit the local doctor clinic

d. Sometimes, does the doctor ask them for x-ray/ tests? How often does this happen & what are they suffering from when doctor asks them to get x-ray/ tests?

e. In the above process, understand from them about the type of doctors they visit (RMPs, Allopaths, Ayush doctors, others)

4. Do they visit doctor for follow-up check-ups for chronic ailments (say for hypertension/ diabetes)?

5. For planned events such as delivery-

a. Where do they go for checkups during pregnancy?

b. Do they go to their ASHA workers for help? What help do they get from their ASHA workers?

c. Where do they go for immunization of infants?

d. Discuss about delivery in govt vs private maternity hospitals -

i. Have they or their family members gone to a govt. maternity hospital for delivery? If yes, how many months ago?

ii. Have they or their family members gone to a private maternity hospital for delivery? If yes, how many months ago?

iii. Are there any differences in quality of care provided between govt & private maternity hospitals?

iv. Are there any differences in cost?

v. What do they have to spend for in a govt maternity hospital? And how much was spent?

vi. How much did they have to spend in a private maternity hospital?

vii. How is the behavior of govt maternity hospital staff towards patient and relatives?

e. A few questions about govt. maternity hospital-

i. Do they know where the nearest maternity hospital is located? Do they go there for any services?

ii. Why do they like going to there?

iii. What do they dislike about going there?

iv. If they don't go there, why don't they go there?

v. If they don't go there, where do they go for delivery?

6. For unplanned health situations that require hospitalization -ask questions to understand what did they do to get better – examples of a few health issues are given below-

i. Sudden acute stomach ache leading to appendix operation

ii. Heart attack

iii. You could ask them about anything else that happened to their health needing hospitalization

7. For unplanned health situations that require hospitalization-

i. How many months ago did they or their family member get admitted to hospital? Did they go to a govt or private hospital?

ii. What made them choose a particular hospital?

iii. What was the amount they had to spend for hospital expenses?

iv. What was the amount they had to spend for other expenses such as travel to hospital, food expenses and any other expenses?

v. Did they take leave from work for hospitalization? Was it paid leave or unpaid leave? Did their employer cut their salary due to their hospitalization?

vi. Did they use any health scheme that helped them to pay for the hospital expenses?

vii. If they paid for the hospitalization from their own pocket, what was

the source of the finances?

viii. Is there any change in how they live (standard of living) after hospitalization? (look for reduction of expenses on leisure outings, travel, films, visiting hotel etc)

8. Occupation-related health issues-What are the specific health issues they face due to their work? (for eg., a pourakarmika is likely to be suffering from backache)? Do they get any support from their employers to address their health issues that arise from the work they do? Get into details for this question.

Health-related schemes-

9. Understand if they have been enrolled in any schemes related to health. Examples are health insurance, maternity benefits

Healthcare facilities in the community-

10. Who are the healthcare practitioners in the community? Where do they go? Why do they like to go there (some common points are given below)

a. Convenient timings

b. Treatment quality

c. Doctor is known to family for many years, hence comfortable going there

d. Doctor fees is low

e. Less crowd

f. Doctor also gives medicines and conducts tests

11. Awareness of nearby public & private health facilities-

a. PHC/ Namma Clinic-

i. Do they know where the nearest PHC/ Namma Clinic is located? Do they go there for any services? What services do they avail from there?

ii. Do they like going there? Why do they like going to there?

iii. If they dislike going there, what do they dislike about going there?

iv. If they don't go there, why don't they go there?

b. Govt. Hospital-

i. Do they know where the nearest govt. hospital is located? Do they go there for any services?

ii. Why do they like going to there?

iii. What do they dislike about going there?

iv. If they don't go there, why don't they go there?

c. Private hospital-

i. Do they know where the nearest govt. hospital is located? Do they go there for any services?

ii. Why do they like going to there?

iii. What do they dislike about going there?

iv. If they don't go there, why don't they go there?

12. Think about the specific problems respondents shared during the discussion and list them, including your responses to them to manage the issue. Some examples of problems they share could be the following. Please include all that respondents share:

- Individual health issues
- health seeking behaviour
- neglect from family
- problem with specific health institution or health worker
- financial problems
- too much work/long hours
- access to services
- experience of violence
- older people and health needs
- women and health needs

- children

- Other (specify)

13. Were there topics for which there was internal disagreement? For example, did respondents have different views on a topic? If yes, please explain.

14. Were there suggestions that came up from respondents on future research topics or work we can do in their community, that they consider useful? Please detail.

15. Any feedback from the respondents for the FGD process.

16. And finally, at the household level, when it comes to health, what issues are they dealing with/ what do they wish for?

Annexure 3: Training Schedules for FGD And IDI

FGD Planning						
sr.no	Area	Group	Age	Number of person	Timing	Funder Criteria Category
						1. Women (18-45 years), 2 . Men (18-45 years) 3. Children 4. Adolescent girls and boys 5. Older women & men (45 & beyond)
1	Ramol	Older Female Group	40 to 60 year	10 person	03: 00 pm to 04:00 pm	
						1 . Modreated , 2. Obersrvaed - note keeper 3. Door Kepper.
2	Vatva	Youth Group	16 to 25 year	10 person	11:00 am to 12:00 am	2. Room Should be Noise free
3	Vatva	Male	18 to 45 year	10 person		
4	Ramol	Mix Group- female	16 to 25 year	10 person	03: 00 pm to 04:00 pm	
5	Behrampura	female	18 to 45 year	10 person	11:00 am to 12:00 am	
IDI Planning						
sr.no	Area	Group	Age	Number of person	Timing	
						1. One woman who has had some health issues for herself or in her family in the recent past (ex . such as the woman whose son had a bike accident from the Siddapura FGD done by MS)
1	Ramol	Female	18- 45 year	1 person	05:00 pm to 06:00 pm	2. One older woman to cover similar issues as above but from an elderly lens
						3. One with a govt health worker (active ASHA / Anganwadi worker in the area)
2	Vatva	Male	18- 45 year	1 person	02: 00 pm to 03:00 pm	4. One adult man?
3	Behrampura	Ashawork	18- 45 year	1 person	02: 00 pm to 03:00 pm	
4	Behrampura	older - Female	40 to 60 year	1 person	02: 00 pm to 03:00 pm	

Annexure 4: Detailed Screening Data Tables

Sr.no	Area Name	Total No. of Household Covered	Total Population			Health Screening Data						Screening pending
			No. of Screening Participants Target			No. of Screening Participants Target			No.of Participants complete Screening			
			Male	Female	Total	Male	Female	Total	Male	Female	Total	
1	KGN	75	163	174	337	68	68	136	68	67	135	1
2	Baghe Hasan	43	80	79	159	29	29	58	29	29	58	0
3	Baghe Kaushar	61	154	151	305	54	58	112	54	58	112	0
5	Ram rahim no tekro	100	231	249	480	89	112	201	87	112	199	2
5	Gayatri Nagar	123	308	277	585	121	113	234	120	112	232	2
Total		402	936	930	1866	361	380	741	358	378	736	5

1.1 Survey Photo in Vatva area settlement

Survey Photo in Behrampura area settlement

1.2 ID Photo

1.3 Screening Photo area

1.4 Filed visit Durning survey Photo area FGD Photo.