Case Study

e-Health Point
Transforming Healthcare Delivery in Rural Punjab

June 2012
Table of Contents

Executive Summary .................................................................................................................. 2
Methodology ............................................................................................................................ 3
Background ............................................................................................................................... 3
Objective .................................................................................................................................. 6
Programme Design .................................................................................................................. 6
  Key Stakeholders .................................................................................................................. 7
  Process Flow ......................................................................................................................... 7
  Financial Funding ............................................................................................................... 10
Achievements .......................................................................................................................... 11
Challenges In Implementation ................................................................................................. 12
Potential for Replication ......................................................................................................... 13
Sustainability of the Project .................................................................................................... 13
Conclusion ................................................................................................................................ 14
References ............................................................................................................................... 16
Appendix A – Interview Questionnaire .................................................................................... 17
Executive Summary

Health facilities in India are in a deplorable condition. Sources of drinking water are non-existent for approximately 200,000 rural communities and the situation gets worsened since an even larger number have no effective access to qualified doctors, modern diagnostic tests, or a licensed pharmacy within their locality. Statistics show that there are about 2.5 million informal health providers in rural India as opposed to 60,000 doctors on whom the rural community relies for variety of their medical treatment. Also, the informal pharmacies engage in selling fake and low potency medicines that community members are often unaware of.

Designed explicitly to address these unmet needs, the E–Health Point (EHP) model is a unique initiative to bring together preventive care, that is, access to safe drinking water and curative care, that is, access to diagnostics, doctors and modern health services by bringing to rural areas medical facilities hitherto limited to urban areas.

The E-Health Point model has proven to be a pioneering and exclusive model as it relies on use of a combination of various existing and emerging technologies (like broadband and telemedicine, electronic health records, point of care and mobile diagnostics, and reverse osmosis based water purification) and de-skilling of many aspects of primary care through standardised procedures and thorough training of local staff. Along with these, the initiative has been able to bring cost of medical treatment affordable for most rural households. For the below poverty line (BPL) population, EHP provides further discounts. These units provide clean drinking water, generic medicines, comprehensive diagnostic services, and advanced tele-medical services to the poor at subsidized rates.

In order to understand their customers and patients better, EHP has included a feedback facility where in people can drop in their suggestions in a designated box; suggestions are duly followed up. Patients can also give their feedback by calling the helpline number of the EHP grievance cell, which also helps in addressing their concerns and queries. Follow up is done on the health of the patients through random calls made by customer care executives. EHP maintains health records confidentially Electronic Medical Records (EMR) software developed by leading companies in the United States.

Thus, EHP has developed and implemented an innovative, effective, culturally acceptable, replicable, participative, scalable and sustainable model to reduce health inequities and enhance human productivity. Being a new contribution to the field, EHP has had direct social impact resulting in other states expressing interest in replicating the initiative.
Methodology

Health care services in India are blemished by class inequalities, inadequate healthcare opportunities for disadvantaged groups, poor accessibility to healthcare in rural areas and rampant corruption. The same trend is perceptible in Punjab (Government of Punjab, 2004). This necessitates government’s active role either in the form of direct provision of health care services or regulation of supply of health care facilities by the private sector for ensuring equitable access, particularly to the poor (Walsh, 1997).

Taking into account the lack of safe drinking water and proper health care facilities, Healthpoint Services India set up E-Health Point (EHP) units in 5 districts of Punjab with the support of the state government. The EHP employs multipronged strategies aiming not only at preventive care (access to safe drinking water) but also curative care (access to doctors, diagnostics, and medicines) in modern, purpose-built clinics in rural areas for improving wellness, productivity, and quality of life.

The Governance Knowledge Centre (GKC) research team identified EHP as a best practice since it is a unique initiative in India that seeks to work towards improving the health care system along with providing safe drinking water in rural areas. This document was prepared making use of both primary and secondary research methods. Desk-based research was conducted to gather most of the information on the background and the operations of the project. Further, a telephonic interview was conducted with Dr. Sumeet Ahluwalia (AVP and Head, Health Operations, EHP) as part of the primary research to elaborate upon the findings of the secondary research. Efforts have been made to present this information as objectively as possible.

Background

Health care outcomes in India represent a continuously degenerating scenario. Providing accessible and qualitative healthcare to a vast population still remains an uphill task for medical service providers. One of the primary healthcare challenges that the country faces is the availability of safe drinking water, a vital human need that is largely unmet. Polluted drinking water causes water borne diseases, exacting a toll on human health. Trapping millions in cycles of poverty and poor health, it also renders a loss in economic opportunities by making people unable to earn their livelihood. This necessitates government’s active role either in directly providing health care services or regulating health care supply by the private sector to ensure equitable access, particularly to the poor (Walsh, 1997).
During the late 1990s, policy makers increased spending on health to counter India’s failure in achieving effective health outcomes but issues pertaining to quality of spending along with lack of proper incentives for delivery of public health services persisted. Realising this, the Indian government identified the need for public policy action and, therefore, implemented the National Rural Health Mission (NRHM) to improve public sector delivery of health care services, especially in poorer states. However, NRHM has constantly suffered from issues pertaining to corruption and inefficiency in procurement and delivery of medicines. Long standing problems with the delivery of appropriate medicines and equipment were not fixed or even ameliorated by greater spending. Sub-centers and rural dispensaries seldom received the appropriate of supplies appropriate for the specific needs of patients. Long-standing quality issues were not challenged by increased spending in the sector.

In the developing world, the cumulative effect of water-related diseases has throttled economic growth and pressurised the already overburdened healthcare systems. Absence of local expertise in the construction and maintenance of water systems, a lack of necessary financial resources for their construction, wars and conflicts, and natural disasters have often obstructed provision of safe and secure drinking water supply. Further constrictions blemishing health care services in India include the perceived corrupt and ineffective state governments, political turmoil and its aftermath, class and caste inequalities, denial of opportunities to disadvantaged groups, and poor accessibility to water sources and health care centres. Lack of effective funding due to inadequate assignments to local bodies and lack of local institutional capacity are some of the other bottlenecks in delivering public services down to the local level, particularly rural governments.

The health care scenario is Punjab was not different from the national scenario. In spite of being one of the richest states in terms of economic development, Punjab lagged behind on account of social development, particularly in the area of health. In 1995, a World Bank-supported Secondary State Health System Development Project was launched in Punjab to renovate existing health care facilities, improve the delivery and quality of health care services in secondary health care hospitals, broaden access to health care facilities and improve efficiency in the allocation and use of health resources. The performance of the Punjab Health Systems Corporation (PHSC) was viewed as mixed. It was criticised for its inefficiency and for instituting user charges that worked against the interests of the poorer sections of population. According to the Punjab Human Development Report 2004, public investment in health was very low. The state budget allocated meagre resources to both primary and secondary health care sectors. Primary health care suffered majorly due to lack of investment and, thus, the poorer sections of population were pushed towards procuring health care from the expensive
and unregulated private sector (Government of Punjab, 2004). Lack of accessibility and availability of clean drinking water and proper health care services led to increase in number of water borne diseases and aggravated the problem.

Against this backdrop, Healthpoint Services India (HSI) came into existence to counter the problems pertaining to health care in Punjab. The seeds of the partnership between the co-founders, Amit Jain, an Indian clean water pioneer, and Al Hammond, a global base-of-the-pyramid expert, were planted during the Santa Clara Social Benefit Incubator in 2008, where they realised significant synergies between their ideas about delivering healthcare and associated health services to rural communities in India through a well-designed social enterprise. This was an amalgamation of ideas on telemedicine-pharmaceuticals-diagnostics that needed demand generation and the delivery of clean water in order to attract customers to clinics and produce both demand and revenue. Resources, skills, and capabilities of both these pioneers were complementary and together they brought perspective on models for business at the base-of-the-pyramid and knowledge about willingness-to-pay and the much needed social marketing expertise, operational know-how, and experience with implementation. Al and Amit, along with the social enterprise incubation services of Ashoka, the global association of leading social entrepreneurs, started the Healthpoint Services India, a for-profit organisation.

E-Health Points (EHP) are units owned and operated by Healthpoint Services India with the prime concern to provide families in rural villages with clean drinking water, medicines, comprehensive diagnostic tools, and advanced telemedical services by connecting qualified doctors and modern, evidence-based healthcare with the rural community. EHP overcame problems of accessibility by providing quality services at affordable prices and implementing a technology-based social enterprise for low income groups. The organisation has worked towards altering the perspective of the public regarding private health sector.

EHP identifies its area of operation based on primary and secondary data collection along with inputs from the stakeholders. It, then, effectively combines prevailing and evolving technologies in the domains of health and water services provision to achieve unique synergies with an aim of enhancing affordability and quality in its services. Functioning since the last 5 years, the organisation has its branches spread over 5 districts in the Malwa region of southern Punjab with a total of 550 units currently in operation.
**Objective**

Healthpoint Services India, a for-profit social enterprise, has launched the initiative of setting up innovative clinics termed ‘E-Health Points’ in remote villages and towns where doctors are scarce and potable water is scarce. The chief objective of this initiative is to catalytically transform rural and peri-urban healthcare and subsequently contribute to the Millennium Development Goals and India’s National Rural Health Mission via a service delivery model that uniquely leverages technology in healthcare and water sectors.

**Programme Design**

The organisational structure of EHP is such that it has a head office in Delhi, a regional office which is currently in Bhatinda, Punjab and field units that are the health points and water points. The head office is mainly accountable for handling top management and finances whereas the regional office handles regional operations and the IT sector. Among the delivery units, each water point has one water operator and one water promoter and the health point has clinical assistants who are Auxiliary Nurse Midwives (ANM), health coordinators, pharmacists, and lab technicians. Health points also have water points attached to them.

**Salient Features**

- Use of clean water to decrease rates of water-borne diseases and increase footfalls in the clinics to raise awareness about health issues
- Innovative idea of positioning preventive care (access to safe drinking water) together with curative care (access to doctors, diagnostics, and medicines) in a modern, purpose-built clinic in rural villages.
Key Stakeholders

- E HealthPoint partnered with mHealth Alliance and Ashoka Innovators for the Public Health Foundation of India for implementing newer pilot approaches for improving maternal and child health.

- On October 28, 2009, the Naandi Foundation, Ashoka and Healthpoint Services started a new model to confront the challenges and transmute the rural health sector in India.

- There has been a recent collaboration of EHP with Procter &Gamble Futureworks for learning and investing partnership.

- Public sector stakeholders: State governments and local level panchayats and public institutions such as National Rural Health Mission, Public Health Foundation of India, Jansankhya Stiththa Kosh, etc.

- Health care providers and customers: licensed doctors, pharmacists, lab technicians, and village health workers who are taking part in the EHP initiative.

- Agent investors and impact investors: who look at various criteria to validate the organisation’s work and justify their investments.

- Community stakeholders: the communities that benefit from EHP initiative.

Process Flow

DETERMINE TARGET AREA OF OPERATION AND CUSTOMER BASE

With the dual aim of providing good quality preventive care along with curative care that is not only affordable but also easily accessible by rural poor, EHP units are currently operational in 5 districts in the Malwa region of Punjab. Healthpoint identifies its target areas based on the information available, field visits, primary and secondary data collection and feasibility of setting up the units.

The enterprise selected Southern Punjab as its launch pad since it is a poor region with low per capita income. Since Healthpoint Services was able to acquire local support in this area (through an introduction to the ex-finance minister), it became easier for them to lay the foundation. Rural Punjab is classified into 3 income groups:

- Topmost 5 percent: Wealthy population that can readily afford health services.
- Dominant middle 60-65 percent: Successful farmers, merchants, and such like with an income of about $2 per day per family member. This section can afford medical services at costs similar to that of Healthpoint Services.

- Lowermost 30 percent: Landless immigrants and migrants who typically cannot procure medical services if they are not free of cost.

The core market for Healthpoint Services India is the middle 60-65 percent population though efforts are being made to capture the bottom 30 percent of the population via public-private partnerships and offering subsidies.

**WATER TREATMENT**

Advanced Reverse Osmosis (R.O.) units provide safe drinking water on a monthly subscription basis as a preventative measure against water-borne diseases. EHP water points have a water source building and an R.O. plant to purify water. Various steps of filtration take place and purified water is distributed thereafter. A subscription fee of INR 75 ($1.50) is charged per month for a household and is often equivalent to about half-day wage in the rural settings in India, and provision of 20 litres of clean drinking water on a daily basis is assured. Water point has a catchment area of about 1000 households on an average catering to approximately 6000-7000 of population in that area. The staff members at EHP units raises awareness about health issues and encourage early treatment of medical conditions as villagers come to these units for their daily water supplies. Frequent visits to EHPs also provide social cover for patients with socially taboo conditions, such as tuberculosis or HIV. Facilities, staff, and technical support is utilised by EHP unit more efficiently than separately operating water treatment units, clinics, and pharmacies, enabling lower costs for patients.

![Figure 2: An EHP with water point attached to it](image_url)  
**Source:** E-Health Point
TELE-MEDICAL CONSULTATION

As there is a dearth of doctors practising in remote villages, licensed medical doctors and trained health workers become the need of the hour. EHP, through its unique idea to bring the doctors to the patients through the use of wireless broadband to conduct tele-medical consultation via video-conferencing, proved to be a really successful initiative. EHP health points have a catchment area of 3000 households on an average. The consultation fee charged at Healthpoint Services India’s urban tele-medical centres is a meagre fee of about INR 20 ($ 0.40) per consultation. Consultation rooms are equipped with the tele-medicine system that is a screen to view the doctor and diagnostic tools. Clinical assistants (ANMs) set up the video conference between the patient and the doctor. To make villagers more comfortable, the doctors are sourced from local areas for linguistic and cultural familiarities and are specially trained in providing tele-medical consultations and identifying such cases that may require referral for advance treatment. In order to overcome the distance barrier and boost association with the villagers, these doctors periodically meet the community in EHP villages. Pilots are conducted for procuring the services of specialist doctors from reputed medical colleges and hospitals to provide affordable consultancy services to EHP beneficiaries. Situations that are beyond the primary care treatment scope of the EHP unit are referred to district hospitals or specialist doctors. These situations include childbirth, acute trauma, heart attacks, cancer, accident related emergencies and others.

EHP has both full time and part time doctors working in its units. They also have women doctors in their team in order to make female patients more comfortable. In cases of emergency, there is a government facility of an ambulance service (that can be accessed by dialling 108) whereas in situations where the treatment is beyond the scope of EHP, the patients are referred to government hospitals.
through the network of EHP. Provisions are also made in case a patient is willing to go to private hospitals.

ADVANCED DIAGNOSTIC TOOLS

Advanced diagnostic tools such as digital stethoscope, non-invasive blood pressure monitor and electrocardiogram (ECG) are housed in the EHP units and more than 70 additional diagnostic tests are facilitated. Electronic health records are used to share the results with the doctors and a real-time Disease Surveillance Capability is used to alert the local and state health officials about the outbreak of new diseases. Diagnostics related material from reputed sources is further sourced by the EHP and an admirable quality audit system is instituted to provide quality assurance to the customer. Most of the diagnostics tests are provided at high discounts as compared to those in the nearest towns or cities. Recently introduced mobile diagnostics provide patients with a higher degree of convenience and helps enhance health-seeking behaviour amongst the communities.

MEDICINES

Each EHP has a robust generic pharmacy where licensed pharmacists distribute medicines to the patients at subsidised rates. The pharmacy provides primarily generic medicines as well as a range of over-the-counter drugs at low costs to the patients. Around 50 percent discount is given on the list prices along with the guarantee of genuine medicines sourced directly from authorised channel members of leading pharmaceutical companies.

Financial Funding

ESI is a for-profit social enterprise. It works on a revenue generating model in order to ensure financial sustainability of the initiative. The initial set up cost is $20000 for a health point and $12000 for a water point. Owners plan to spend $50,000 per village and probably $30 million of investment capital per country for which the need to upscale their project and need to do more than 100 units which is the current scenario. They need to get enough units on a large scale so that capital markets and the global health market start viewing this as an alternative method to solve problems relating to healthcare provision in rural areas.

The doctors are paid around INR 30,000 per month. The village health workers are paid by them, the unit staff is hired by them and train is imparted from the village, all of these covered using patient fees. The health consultation fee is INR 20 per consultation with discounts being provided for below poverty line population. In case of surgeries, patients are referred to a network of doctors either in the government hospitals or in the private ones wherever they are
more comfortable. Potable water costs around INR 75 per month for 20 litres of supply on a daily basis.

Achievements

Since its inauguration in November 2009, the initial three EHP units (and subsequently opened additional units) have provided more than 33,500 tele-medical consultations, performed 19,500 diagnostic investigations, given Hepatitis B Vaccination to 3,000 rural inhabitants and filled 39,000 prescriptions, and are providing safe drinking water to 5,00,000 users daily. At present, there are 100 water points and 8 health points in operation in the selected 5 districts of Punjab. It has a direct social impact by providing the underserved rural and peri-urban communities with greater access to high quality healthcare and safe drinking water services resulting in better health and well being, enhanced productivity and improved standard of living. It also provides employment opportunities to the villagers.


Success story – EHP units in Punjab

A villager from Punjab consulted the doctors virtually about his shoulder and neck pain. He had previously visited a government doctor who advised him to take vitamins and aspirins. The pain still persisted, and even got worse. During the video consultation, the doctor discovered that the villager has a history of seizures and suspected epilepsy. The villager was referred to a specialist and epilepsy was confirmed. He now buys the necessary medicine from EHP clinic and is back to work. Such tele-medicine consultation allows for efficient use of a doctor’s time and also brings high quality patient care to remote villages.

Source: E Health Point

Researched and documented by

OneWorld.net
OneWorld Foundation India
Challenges in Implementation

During the initial stages of project implementation, Healthpoint Services faced certain challenges. There existed a high rate of attrition of talented middle level and field staff, low attractiveness of this model for the conventional venture capitalists, deep-rooted consumer preference for reaching out to urban facilities coupled with shortage of electricity and poor internet connectivity in the rural areas. However, steps were taken to mitigate these issues through the tie up of EHP with Reliance and other leading companies along with support and cooperation from the government.

**Prevalence of a culturally sensitive context**
Villagers are often hesitant in discussing their medical conditions with doctors. This is largely because villagers are not habituated to consult formal health care services for their ailments. Most of their medical requirements were hitherto attended to by a local, often untrained, medical practitioner.

Healthpoint Services India realized this and undertook a variety of steps to counter prevalent cultural bottlenecks. Local doctors were sourced to enable cultural and linguistic familiarity with the context of operation. Separate rooms were built in EHP units for medical examination of men and women. Female patients are attended to by women doctors. Water facilities in EHPs allow villagers to visit these centres frequently and this offers social cover for patients with socially-taboo conditions, such as tuberculosis or HIV.

**Lack of awareness regarding modern forms of medicine**
Some of the village people were initially apprehensive towards the usage of modern medicines; ayurvedic treatment was still considered more effective by them. The vast majority of rural individuals were looking for solutions using traditional medicine and EHP was able to provide them. The villagers have gradually come to take pride in availing formal health care facilities provided by well-built clinics with an on-site licensed generic pharmacy and licensed doctors in the rural setting.

**Doctors’ unwillingness to serve in remote villages**
Lack of availability of licensed doctors in remote villages has been a persistent problem. EHP came up with a unique idea to bring doctors to the patients in these rural areas instead of bringing patients to doctors in the cities. It has set up video consultation using wireless and broadband internet services as well as tele-medicine services to help mitigate the distance barrier.
Potential for Replication

EHP is a social business enterprise model having high potential for being replicated in a variety of rural settings. It qualifies to be of substantial value and interest to public sector organisations, corporate social responsibility agencies, social investors and mainstream venture investors and financial institutions.

Healthpoint Services India plans to upscale their operations across Punjab and the rest of the country. Various Indian states have expressed an interest in replicating the practice in their specific contexts. Further, Healthpoint Services is partnering with the local government and with Ashoka to scale its operations in India as well as pilot the model in additional countries. A mutually advantageous partnership has been fostered with P&G wherein P&G will deliver investment and technical support and, in turn, learn about the rural services market by participating in it with Healthpoint. Healthpoint plans to undertake a momentous public-private partnership with the Rajasthan Government. By partnering with the government, it would receive support for setting-up EHPs in areas where the representation of the formal Public sector service delivery mechanism is low but the necessity of it and demand is high.

Sustainability of the Project

EHP is a sustainable social business enterprise with great degree of economic returns for the beneficiary rural communities. This model has the potential to alter the way in which governments and private sector view and address health care. Furthermore, it can help millions of people lead a productive and healthy life.

The initiative is financially sustainable. The major heads of expenditure include doctors’ salaries of about INR 30,000 per month, payments made to village health workers, unit staff members hired and trained from the village. EHP covers these costs with the consultation fee of INR 20 charged from every patient. The turnover of patients at EHP units is collectively sufficient to make this practice economically sustainable.

EHP provides clean and safe drinking water in remote villages and thereby ensures that its operations are environmentally sustainable.

People in remote villages have enthusiastically accepted this service. Women in particular appreciate telemedicine because it gives them access to women doctors. Since the doctor is not located in the same area, women are convinced of the confidentiality of information they share with the doctors. Post-service surveys report that people feel they are getting a higher quality
service than they could find elsewhere and they think the pricing is fair. People who visit the EHP clinics in Punjab are impressed with the range and quality of the services provided (70 different diagnostic tests and about 400 medicines with doctors dealing with or detecting and referring to specialists several health problems, including cancer, epilepsy and brain tumours). Paying for securing medical services instils a sense of pride in consumers who, until recently, had limited access to formal health care facilities. The model also provides multiple employment opportunities to villagers. Owing to these factors, the EHP units provide a socially sustainable model of rural healthcare provision.

HSI has received substantial governmental support for its sustained existence. It has recently entered into a partnership with the Rajasthan government. Several leading companies in e-health, pharmaceuticals, water technology, and consumer goods as well as government representatives from various countries visit the EHP sites regularly.

**Conclusion**

Healthpoint Services India brought four technologies to the rural community that either did not exist or were not affordable few years ago - advanced and cheap water treatment, broadband internet services, efficient telemedical software, advanced point-of-care diagnostics.

The organization’s key innovation was to put preventive care (access to safe drinking water) together with curative care (access to doctors, diagnostics, and medicines) in a modern, purpose-built clinic in rural settings. Though a successful initiative, it needs to standardise procedures and improve efficiency in order to continue with its streak of innovations and match the expansion in scale of operations.

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References


Appendix A – Interview Questionnaire

Background

1. What was the motivation behind the EHP initiative?
2. How did you come up with this innovative idea to put preventive care (access to safe drinking water) together with curative care (access to doctors, diagnostics, and medicines)?
3. What kind of drinking water facilities and medical services existed in Punjab and other areas of your operation prior to the initiation of EHP?
   i. How is EHP an improved delivery model over the existing ones?
   ii. In how many states/districts/blocks is the project currently operational?
   iii. How many EHP units are currently in operation?
   iv. How were the target areas identified?
4. Who are the key stakeholders in the project and what are their roles and responsibilities?

Programme Design

Process components – curative care

5. What is the organisational structure of an EHP? Please provide details on the human resources involved and their exact roles.
   i. Do these doctors work elsewhere also? If yes, then how much time does they devote towards this initiative?
   ii. Do you have female doctors as well on the team of doctors to make women more comfortable?
6. What are the medical equipment’s that all EHPs are equipped with? Which facilities are provided by the EHP units?
7. Where are the patients referred to in case of cases beyond the scope of primary care treatment?
   i. Where is the centre and how is it operated?
   ii. How are the doctors sourced for these centres?
   iii. Considering that patients with conditions beyond the scope of primary health care are sent to other centres, what arrangements are made for their transportation?
8. How are the health records of patients maintained? Are they updated regularly?
9. Do you have a toll free number/service helpline to help villagers in case of emergency?
10. Do you offer transportation/ambulance services to villagers in case there is any emergency?
11. Do you have any grievance cell/customer feedback centre? If yes, how is it run?
12. How does mobile consultation function?
i. What are the charges that accrue to the user for calling on this number?

ii. How is follow up on the patient’s condition done?

*Process components – preventive care*

13. Where is water sourced from for the reverse osmosis process?
14. What kind of infrastructure is involved in the treatment of water?
15. What process is followed in the treatment of water?
16. Can you explain how this purified water is then distributed?
17. How do villagers collect this water? How many centres cater to the need for the distribution of water?

*Awareness generation*

18. How was the support of local doctors secured? Were they apprehensive about working for this initiative?
19. When villagers come for their daily supply of water, do you supply to them other useful information regarding healthcare as well?
20. How else do you spread awareness in the village community?
21. How did you manage to convince women in the community to use your services?

*Capacity building*

22. How do you train the villagers to be adept at using EHP?
23. Was there any sort of training process for the doctors hired under this project?
24. How do you train the nurses /helpers working at the EHP units?

*Technology*

25. Were the villagers initially averse to the use of technology? How were they made comfortable on this front?
26. What technology is involved in video consultation? (Wireless broadband, screen, etc.)
27. Can you throw some light on the softwares used for front end and back end development?

*Financial model*

28. Can you explain in detail the funding model (major heads of expenditure, daily operational costs, and costs of development) of the project?
29. How much are the villagers charged in return for different services? Is it a uniform fee for all or does it depend on the different groups of users and services?
30. Do medical services offered include operations/surgeries as well? If yes, what percentage of the total costs is borne by the patients?

31. Can you shed some light on the financial sustainability of the project? How do you offer these services at subsidised rates and still make profits?

32. Who handles the financial accounts/collections at the EHP centres?

**Monitoring and evaluation**

33. Do you share the results and health status of the villagers with the government?
   i. If yes, how do you follow up the use of this data?
   ii. If no, how is the data utilised by you?

34. What metrics are used to assess the performance of the project?

35. How do you monitor the performance of EHP units as to whether they are running smoothly or not?

**Impact**

**Achievements**

36. What has been the overall impact of this initiative? How do you assess the betterment in health status of the beneficiaries?

37. Please provide latest data on the following:
   i. Total number of EHPs
   ii. Percentage decrease in the rate of water-borne diseases
   iii. Number of prescriptions
   iv. Tele-medicine consultations
   v. Diagnostic investigations
   vi. Number of users of these services

**Challenges**

38. What were/are the major challenges faced in the implementation of this program and steps taken to mitigate them?

39. Did you face any friction from the government? If yes, how were you able to counter it?

40. What kind of infrastructural bottlenecks were faced in the remote villages? How were these overcome?

**Enhancements**

41. Have any enhancements been planned for inclusion in the project?
   i. How many more districts does EHP plan to cover?
ii. Has there been any effort to advocate the up scaling of EHP at the state level?

iii. Are there any other services planned for inclusion in the project?

42. What do you think are the necessary preconditions for the success of such an initiative? Have any other states showed interest in replicating EHP?

43. In case of withdrawal of EHP units from the current areas of operation, how do you think improved medical and drinking water facilities will be sustained in these areas?