Department of Health and Family Welfare Documents

Govt. of India

CONVERGENCE BETWEEN THE NATIONAL AIDS CONTROL PROGRAMME (NACP) AND THE DEPARTMENT OF HEALTH AND FAMILY WELFARE (DOHFW)

1. INTRODUCTION

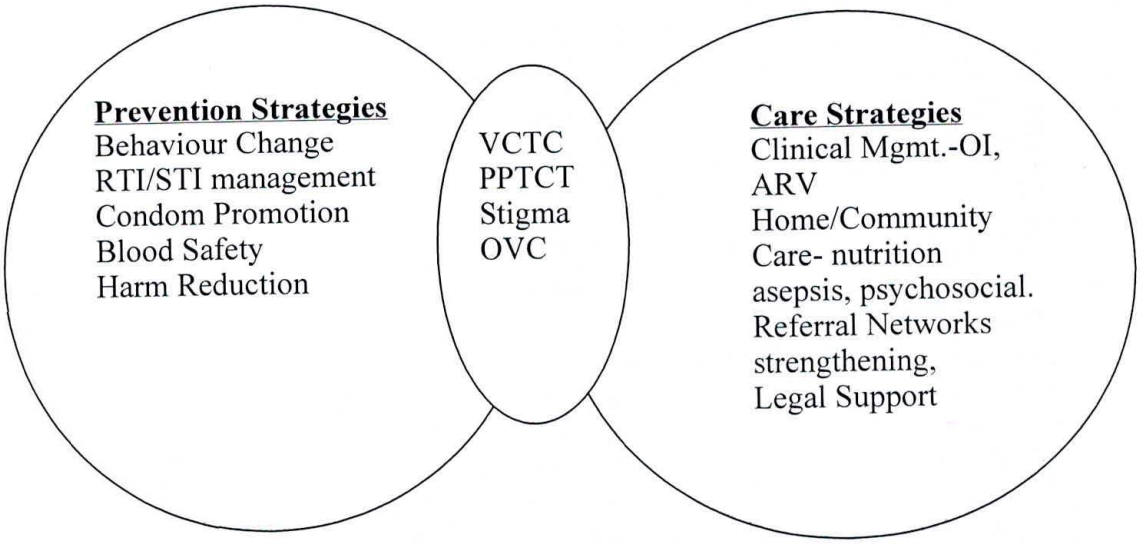
1.1 The HIV/AIDS epidemic in India is complex, with intense focal epidemics among sub groups (IDUs, Sex workers, Truckers, Men who have sex with Men) in some states, situations where prevalence is over 1% in the general population, and low prevalence in some others states. In states like Andhra Pradesh, Karnataka, Tamil Nadu, Maharashtra, Manipur, and Nagaland, prevalence among antenatal women (based on sentinel surveillance data (2003) located in ANC clinics), considered representative of the general population, is around 1.25%. Annexure 1 provides state wise HIV prevalence levels from 455 sentinel surveillance sites, for the year 2003. NACO has classified states as high prevalent, medium prevalent, highly vulnerable and vulnerable states (Annexure 2). The index of vulnerability is based on extent of migration, size of population, and poor health infrastructure. Among highly vulnerable states are: Bihar, Rajasthan, MP, UP, Uttaranchal, Chhatisgarh, Jharkhand, Orissa, and Assam. This includes all the EAG states of the DHFW.

1.2 There is a pressing need to scale up prevention strategies based on factors of risk, vulnerability, and impact, expand delivery of interventions and ensure that populations at risk and vulnerable groups are reached. India is at a stage in the epidemic where all sexually active individuals must be offered information and services on preventive interventions. Sexually active youth, particularly girls are at high risk given the paucity of needs specific information and services. HIV/AIDS infection prevalence is increasingly acquiring gender connotations. Sentinel surveillance data also show that women account for more than half of all infections in rural areas (nearly 60%) and about two fifths of all infections in urban areas. Sentinel surveillance sites are located mainly in either Antenatal clinics or in STD clinics. Given the evidence that most STD clinic attendees are men, it can be assumed that most women who are positive are also pregnant, a rather ominous portent for risk of transmission to newborns, and a substantial justification to expand the number of sites offering PPTCT.

1.3 **Convergence between the National AIDS Control Programme (NACP)** with over a decade of experience and technical competence in HIV/AIDS prevention and care interventions and the **Health and Family Welfare programmes (HFW)** with its infrastructure, human resources and capacity reach to every village and community is critical to ensure scaling up and effective service delivery.

1.4 Behavior Change, prevention/management of RTI/STI and condom promotion are the cornerstones of HIV/AIDS prevention. All three areas have a significant degree of overlap with interventions in the Reproductive and Child Health programme, since target groups and services fall in the same arena. Other areas of prevention linked to HIV/AIDS interventions and which have implications for services in the HFW are Voluntary Counseling and Testing, (VCTC), Prevention of Parent to Child Transmission (PPTCT), and ensuring safety of blood and blood products. Comprehensive HIV/AIDS Programmes include components of both prevention and care. VCTC and PPTCT are two areas of overlap between prevention and care strategies. Areas of cross cutting importance that need to be addressed in prevention and care strategies include: gender, private sector involvement, and reduction of stigma and discrimination among health care providers and communities.

(Figure1)



2. CONVERGENT TECHNICAL STRATEGIES AND PROGRAMMATIC INTERVENTIONS OF NACO AND HFW

2.1 The National AIDS Control Organization (NACO) is the implementing agency for the NACP. At the state level, State AIDS Control Societies (SACS) implement HIV/AIDS interventions. Currently NACO and the SACS support about 900 NGOs for targeted interventions aimed at reaching the so-called high-risk groups. (those with high numbers of sexual encounters increasing possibility of transmission, such as Sex Workers, Truckers, Men who have sex with Men, Intravenous Drug Users, Adolescents, Migrant men and women,). They also support behaviour change communication aimed at the general population through variety of mechanisms. The reach of the NACP to men and in urban areas is significant.

2.2 In the public sector, NACO and the SACS support RTI/STI management, VCTC, PPTCT, Blood Safety, and several other interventions. However the reach of these interventions through the health system is primarily through teaching hospitals and medical colleges, district hospitals and in the case of the six high prevalence states, taluk hospitals as well. The SACS in the high prevalence states (most of which are the ones with better health infrastructure and moderate to high care seeking) are also active in implementing HIV/AIDS interventions.

2.3 The Department of Health and Family Welfare at National and State levels (with state specific variations) supports a range of services for improving primary (including reproductive) health care at community, primary, secondary and tertiary levels. Community based interventions are primarily provided by the Auxiliary Nurse Midwife located at the sub center. The coverage of the sub centre is about 5000 (3000 in tribal areas) and covers about the area of three to four gram panchayats. Service delivery is through the sub center on fixed days, supplemented by outreach visits to the coverage area. At the village level, the Anganwadi Worker (AWW) and/or the Traditional Birth Attendant (TBA) often assist the ANM. With the advent of the National Rural Health Mission it is

expected that the ANM will soon be supported by a female community health volunteer (ASHA), and assisted by the AWW and TBA. Thus the potential reach of the system will be to every community and habitation. In addition to the public sector health system, the DHFW supports NGOs (through the Mother NGO scheme) to implement a range of RH interventions (Safe motherhood, family planning, adolescent health, RTI/STI management, child health, and male involvement) in areas underserved or not served by the public sector system. While the DHFW through its flagship RCH project does include enhancing male responsibility as a key intervention, the emphasis is on women and children. Urban health is a component of the RCH 2 programme.

2.4 The following areas of convergence have been identified[1] for scaling up HIV/AIDS prevention responses: RTI/STI management, Condom Promotion, Voluntary Counseling and Testing, Prevention of Parent to Child Transmission, Behaviour Change Communication, Blood Safety, Training, and Management Information Systems. In addition *male involvement* and ensuring convergence of NACP and DHFW through *strengthening urban health infrastructure and reach* are two additional strategies, which are common to the major areas identified above.

2.5 This paper provides a broad framework for action to address the major convergence areas. The effectiveness of convergence of key interventions is dependent on several factors, but critical is the operationalization of convergence within *well functioning health systems and programme management structures at all levels*. RCH II has been designed to address reproductive and child health interventions through a framework of health sector reforms at various levels. It is opportune that NACO and DHFW *jointly look for ways to improve reach, enhance access and coverage, provide quality services, address synergistic intervention elements, and prioritize interventions based on prevalence, infrastructure, current programme efficacy, and resources.* It must be emphasized that this framework is proposed at the National level and state level consultations with key stakeholders are necessary to operationalize the plan in the context of state realities.

2.6 Section 3 provides substantive details on each convergence area, with a brief technical background for each area, highlights current interventions of NACO and DHFW, identifies points of convergence in order to reach groups and communities that are at risk and vulnerable, and defines broad areas for operationalizing these strategies. Section 4 includes operationalization of convergence and details institutional mechanisms to facilitate convergence. Section 4 is supplemented by a matrix, which summarizes key convergence areas, primary responsibility, and convergence aspects. Section 5 briefly discusses next steps.

3. OPPORTUNITIES AND ISSUES FOR CONVERGENCE

3.1 *RTI/STI prevention and management*

3.1.1 *Background:* RTI/STI has a severe impact on the reproductive health of individuals as well as significantly enhances the risk of transmitting or acquiring HIV/AIDS. Women are biologically more vulnerable to acquiring RTI/STI and consequences of STI in women are more serious (ectopic pregnancy, pelvic inflammatory disease, still births). Unequal gender relations resulting in sexual coercion is more pronounced among women, and women often have limited access to care. There is evidence that RTI/STI care is more often sought in the private sector than in the public sector and in several places from untrained practitioners as well as chemists. There is little published comparable and reliable data on RTI/STI in the country. Efforts at programme planning have been based on micro studies conducted with different methodologies, using varying criteria and for clinical and laboratory diagnosis.

3.1.2 *DHFW strategies:* The National STD control programme has been in place since 1946. However, it was only in the RCH 1 programme, that RTI/STI management was included on a national scale. Many donor-funded programmes in states have also supported RTI/STI services through state health and family welfare programmes. While there are no formal evaluations to assess the performance effectiveness of these efforts, anecdotal evidence suggests that several lacuna hampered these efforts and they remained largely out of the reach of women and men in need of services. Current policy guidelines stipulate that only medical officers are allowed to prescribe RTI/STI drugs, thus limiting the reach of effective RTI/STI services.

3.1.3 *NACP strategies*: RTI/STI management has been attempted through several approaches:

a. NGOs working with High Risk Groups on targeted interventions are provided with support for medical personnel, clinics, and Drugs for RTI/STI. In some instances NGOs collaborate with the public health system or private providers to provide STI diagnostic and treatment services.
b. Annual Family Health Awareness Campaigns are held across the country. These are two week campaigns which are period of heightened activity at the district level and below when the machinery of the HFW system is expected to conducts house to house and group education, media and advocacy events and promote care seeking for RTI/STI. Patients are referred to PHC and above, where RTI/STI are treated using the syndromic approach. Annexure 3 provides details of the achievements of FHAC from 1999 to 2003. Coverage increased from 100 districts to 572 districts.
c. NACO has provided support to establishing STD clinics at hospitals upto and including district hospitals. By the end of fiscal 2004, NACO had supported 735 STD clinics in all medical colleges and in most district hospitals. Each STD clinic includes a qualified STD specialist and laboratory support for diagnosis and treatment of STI. NACO also ensures a continuous supply of STI drugs. (Annexure 4 provides details of number of STD clinics in each state)
d. NACO supported training of a range of HFW providers (MO, ANM, LHV, Laboratory technicians) in areas such as RTI/STI, universal precautions, nature and content of HIV/AIDS programming, stigma and discrimination. Annexure 5 provides details of personnel trained.

3.1.4 Core Convergence Recommendations for RTI/STI:

From the above data it is clear that NACP interventions in the public sector system reach only the district hospitals and are not programmed to be gender sensitive. Although Medical officers have been trained in syndromic diagnosis, they are located in primary health centers and above. Current utilization of PHCs is low. Thus the benefit of the knowledge and skills of the medical officers does not reach communities in many parts of the country. The FHAC could do a good job of spreading awareness but services are still provided at the district level, reducing reach. DFW interventions are also primarily through medical officers. Grass roots workers such as the ANM in most areas are not empowered to provide information and services for RTI/STI. There is little by way of health education at the community level on RTI/STI, which highlights issues of risk and vulnerability, male responsibility, and the use of condoms for dual protection. This varies from state to state and in high prevalence states, awareness levels are high, but access to services remains low. One of the challenges that needs to be taken into account while converging the programme into the DHFW programme is that the reach to important core and bridge groups such as: "sex workers, men who have sex with men, men in the general population, and youth. RCH II does include interventions to address youth, enhance male responsibility, and health in urban areas and care must be taken to ensure that convergence mechanisms address the inclusion of such groups.

a. Public Sector interventions from district to peripheral level for RTI/STI to be implemented through DHFW, in line with the RCH II design document. RTI/STI prevention, management of

the client, partner notification, treatment, and follow-up are the key components of an RTI/STI programme. Comprehensive RT/STI treatment will be provided at CHC and 24 hour PHC (clinical and etiologic) and first line drugs at the PHCs.

b. RTI/STI control among High Risk Groups through NGOs with funding support for RTI/STI diagnosis and treatment, to continue through NACO and SACS, but reporting also to HFW.

c. It is expected that ASHA will be provided with enough information/supplies to support health education, prevention advice and treatment facilitation (through referral) at the village level. Presently the closest possible site for services by trained personnel is the sub center level. The ANM/Male MPW will be the frontline service providers for RTI/STI management, MO/SN/LHV at the PHC level, and MO/Ob-Gyn. at the CHC/FRU level. It is expected that over time, with strengthened Primary Health Care, laboratory based management of RTI/STI will be the norm rather than the syndromic approach. At the CHC level, basic screening tests for RTI/STI will be made available. At the district level, RTI/STI will be managed by STD specialists supported by or linked through referral to high quality laboratory services supporting the full complement of laboratory tests for RTI/STI.

d. At the community health centers and district hospitals, RTI/STI management has to be included in protocols in Ob/Gyn and Medicine departments. Medical and paramedical professionals to be oriented to risk identification and referral to VCTC.

e. NGOs under HFW to include RTI/STI in their package of interventions, with referral or services as appropriate.

f. Private providers (reached through Indian Medial Association (IMA) and Federation of Obstetrics and Gynaecology-FOGSI) to be part of RTI/STI management strategy for training and to ensure appropriate reporting and notification, particularly in the case of sexually transmitted infections and drug resistance surveillance. This will also need to be implemented through DHFW.

3.1 *Voluntary Counseling and Testing Centers (VCTC)*

3.2.1 *Background:* Voluntary Counseling and Testing is now acknowledged as an efficacious and pivotal strategy for prevention and care for HIV/AIDS. Counseling is an important skill and is a necessary part of interventions for several areas within Family Welfare, family planning, safe motherhood, RTI/STI, and in dealing with youth. It is also more cost effective to integrate VCT into sexual and reproductive health services, rather than support them as freestanding sites. Counseling requires specialized skills and attitudes, space to assure confidentiality, laboratory services for testing, adequate reporting systems.

3.2.2 *DHFW strategies:* While counseling is an important element of several reproductive health services, counselors are not part of the health provider cadre. ANM, LHV and other providers have been trained in basic motivation, interpersonal skills, but these are not dealt with in any depth, nor are they geared toward attitudinal change. It has thus far formed part of an integrated training package. In some states donors have supported separate training to improve counseling and motivation skills of ANM and LHV (UNFPA through IPD projects, USAID in SIFPSA), but only in selected districts.

3.2.3 *NACP strategies:* NACO and the SACS have established 650 VCTCs across the country with about half of them located in high and medium prevalence states. They are primarily located in medical colleges and district hospitals. Annexure 6 provides state wise details of numbers of VCTC. Each VCT includes one male and one female counselor, and one laboratory technician. NACO and SACS supply testing kits for these VCTCs. In the medical colleges, the VCTC are located within the microbiology departments (with counselors reporting to the HOD, Microbiology) and in charge of the Pathologist in a district hospital. Currently the view of the

State AIDS Control Societies is that VCTC utilization is low, particularly in the low prevalence states.

3.2.4 *Core Convergence Recommendations for VCTC*

a. The NACP will manage the VCTC in collaboration with the key staff of the facility in which the VCTC is located. Youth information centers to be established with the VCTC to increase access of young people to information and referral for services for a range of reproductive and sexual health issues.
b. NACP will support the staff of VCTC and supplies required with DHFW will provide the physical infrastructure.
c. It is proposed that the district VCTC function as a satellite center to coordinate, support and supervise operations of the VCTC's located in the CHC and 24 hour PHC. This internal coordination is important for several reasons- to maintain quality of services at all sites, to ensure uninterrupted supplies, link with PPTCT at district and CHC levels, and to enable referral linkages of clients that test positive to appropriate centers.
d. VCTC' s will not function as sites for counseling of HIVAIDS alone. Counselors in VCTC, particularly at secondary and primary health care levels should be able to counsel for family planning, RTI/STI prevention, safe delivery, and male responsibility. A cadre of counselors could be established who would serve the RH needs of women and men, including HIV/AIDS, and the RH information and service for young people. It is hoped that this measure will increase utilization of VCTC.
e. Expand the number of VCTC sites. The expansion should be informed by a rapid assessment of VCTCs in low and high prevalence areas, and identify systems issues, human resource training gaps, and logistics. **The expansion is proposed in a phased manner, and will be governed by the following: prevalence, physical infrastructure, human resources, and community use of facilities.** Fortunately the high prevalence states also have better infrastructure and increased utilization (higher rates of antenatal coverage, institutional deliveries, and overall increased care seeking behaviour). As a long-term plan, (by 2012) it is expected that all PHCs will have VCTC facilities that will cover a range of services beyond just HIV/AIDS counseling. The expansion process is proposed as follows:
   Phase 1: (2005-2008) In the high prevalence states, district hospitals, all CHCs and all 24 hour PHCs will have Voluntary Counseling and Testing Centers, staffed by a full complement of male and female counselors; separate space and laboratory back up. In the low prevalence centers, VCTC could be located at the district level and at all CHCs. In high prevalence districts within low prevalence states, the choice of whether 24 hour PHCs could offer VCTC could be left to the state.
   Phase 2: (2008-2010) All PHCs in high prevalence states and 24 hour PHCs in other states will have VCTC.
   Phase 3: (by 2012): PHCs, all CHCs and district hospitals, will offer VCTC services.
   Expansion will be based on review of past experience, utilization and need.
f. Basics of Counseling for all cadres of staff (sub center to CHC) to be included in training package, so that at the very minimum all staff have the skills to enable clients to understand risk perception, motivate them to seek services, and finally be able to facilitate informed referral.
g. Involvement of private providers and private laboratories, through IMA, FOGSI, and pathologists Association, where testing takes place to ensure that their clients also are counseled and their data is reported at district and state levels.
h. NGOs under HFW programme and NGOs working with High Risk Groups to include information on VCTC functions and sites so that they can carry the message to the community, and increase utilization as appropriate.

3.3 *Prevention of Parent to Child Transmission (PPTCT)*

3.3.1 *Background:* Core PPTCT interventions need action in the community, and depending on the package of services offered, at the levels of the sub center, Primary Health Center and at the Community Health Center. PPTCT interventions for HIV positive women relate to a range of services provided in the HFW system: antenatal, delivery, and postpartum care, abortion services, VCTC, Management of STIs in pregnancy, Antiretroviral therapy based on current policies- (currently Nevirapine), Family planning counseling and easy access to services, Expansion of well baby clinics, high quality education and information provision on nutrition, breastfeeding, RTI/STI, and HIV/AIDS, male involvement in MCH care, and linkages to community based care and support programs for HIV/AIDS.

3.3.2 *DHFW Strategies:* DHFW per se does not implement PPTCT interventions. Currently PPTCT interventions are being provided in selected locations through the health facilities of HFW. However, training, supplies and logistics, and drugs are primarily supplied through NACO.

3.3.3 *NACP strategies:* Currently NACO is providing PPTCT services in 273 units across the country of which 234 are located in high prevalence states. Annexure 7 provides details of PPTCT in the country presently. They are primarily located at the medical colleges of high and low prevalence states and at district hospitals only in the high prevalence states. They are located in the Ob/Gyn department. A counselor, mostly female and one laboratory technician staff each PPTCT. Staff of PPTCT sites (PPTCT team- Ob/Gyn, Microbiologist, Paediatrican, Staff nurse, and one health educator) are trained for five days. Counselors of PPTCT are trained for a ten-day period. Sensitization training of other staff in the facility where the PPTCT site is located is also conducted.

3.3.4 Core Convergence Recommendations for PPTCT

a. The management of PPTCT sites should continue to be with the NACP, since all clients of the PPTCT will need to be followed up for care and support. At the institution level, the PPTCT staff will continue to report to the Head of Ob/Gyn. PPTCT at the district level will function as the hub or satellite center to coordinate quality, supplies, reporting and facilitation of referral.
b. NACP will fund the counselor and laboratory technician in the PTCT and the supplies required for the PPTCT programme. The PPTCT will be located in the Ob/Gyn department of the CHC and will function through existing staff.
c. PPTCT sites should be expanded in a phased manner. Since PPTCT is a function of the obstetric department, and since RCH II is focusing on improving/strengthening access and quality of institutional deliveries, PPTCT can be implemented within the framework proposed for RCH II.

   Phase 1 (2005-2008): All district hospitals and CHCs to offer PPTCT, regardless of prevalence.
   Phase 2 (2008-2010) In high prevalence states, 24 hour PHCs, should also offer PPTCT.
   Phase 3(by 2012 years): 24 hour PHCs in all states to offer PPTCT services, based on prevalence, utilization, and need.

d. At the community level, ASHA/ANM will be trained through health education and motivation among women and men for risk perception, risk identification, facilitation in accessing VCTC, and thus identifying positive women in need of PPTCT. Para medical and medial providers at the PHC level will also be trained in similar areas to facilitate referral to PPTCT and enable follow up.
e. Positive women will be followed up through pregnancy by ANM/ASHA and encouraged to opt for institutional delivery in district or CHC/FRU.

f. PPTCT programmes should establish linkages with the Integrated Management of Neonatal and Childhood Illnesses (IMNCI) component of RCH II, to address issues of infant feeding, nutrition, and infections.
g. All providers would need sensitization on issues of stigma and discrimination, so that positive women do not fear institutional deliveries. PPTCT teams should be specially trained in areas of infection prevention, and stigma and discrimination attitudes, as well as the specific technical aspects of PPTCT
h. Institutions to be strengthened to adopt universal precaution measures and waste management. Delivery kits to be made freely available under the PPTCT programme.
i. Orientation and sensitization of private providers (through IMA, FOGSI, Indian Health Care federation, Hospital forums and associations) and involvement of private hospitals in VCTC and PPTCT as appropriate.
j. NGOs supported by DHW and NGOs working with high-risk groups to be provided with information on location of PPTCT sites and encouraged to facilitate referral and follow up.

3.4 Behavior Change Communication

3.4.1 *Background:* Changing individual and community behaviour is critical to HIV prevention In order to impact the epidemic it is necessary to target behaviour change interventions at the individual level to increase knowledge, enhance risk perception, and develop safe sex skills. These are primarily through interpersonal communication and small group discussions and peer education. Such efforts at the individual level need to be reinforced by community level interventions to increase understanding of a supportive environment to reduce risk and vulnerability, and influence societal norms. Messages that are targeted to sexually active individuals include: postponing age of sexual activity, using condoms correctly and consistently, decreasing number of sexual partners, increasing STI and TB treatment seeking and prevention behaviors.

3.4.2 *DHFW strategies:* HFW has not integrated HIV/AIDS messages in BCC material till date. However, in the past few months, efforts are on to integrate HIV/AIDS prevention messages in some initiatives of the HFW department- wall calendar and diary for 2005 of the MOHFW includes HIV/AIDS messages. Adolescent health education and life skills programmes have included HIV/AIDS content quite substantially, especially in the adolescent friendly health clinics, piloted by MOHFW.

3.4.3 *NACP strategies:* At the National level, NACO frames guidelines for IEC activities countrywide and undertakes multimedia campaigns along with political and media advocacy. NGOs working with high-risk groups for targeted interventions develop their own BCC strategies. SACS in each state have mass media campaigns and other activities for general population- varied across states and school AIDS Education programmes.

3.4.4 *Core Convergence Recommendations for BCC*

- Create a mechanism to ensure that the leadership for developing BCC strategies and programmes for DHFW and NACP is vested with one authority.
- Joint (NACO, DFW) behaviour change communication strategy to be developed based on commonality of target groups, and tailored for reach of general as well as high-risk populations. This needs to take place at state level as well between State AIDS Control Societies and State IEC bureaus.

3.5 Condom promotion

3.5.1 *Background:* Currently the male condom is the most widely available effective protection

method against HIV and other STI. Condom distribution can be through free or social marketing channels. They could be through community based distribution systems, depot holders, health facilities, pharmacies, and village stores. For any scaled up prevention response it is important to improve access and availability of condoms to all communities (rural and urban) and groups.

3.5.2 *DHFW Strategies:* In the family welfare programme, male condoms are promoted as a method of contraception. In order to improve the use of condoms as a contraceptive, several initiatives at social marketing and distribution through government and NGOs are being undertaken. Thus DFW is the repository of substantial experience in promoting condom use as well as condom procumbent and distribution. However the use of condoms as a method of dual protection has not been promoted so far. About 25% of the overall condoms procured are distributed as free supplies with 75% being programmed though social marketing agencies. Of these 25 %, over three quarters are channeled to NACO for distribution to HRG through NGOs.

3.5.3 *NACO strategies:* Currently NACO procures and supplies condoms to the NGOs working with HRG. Primarily NACO and the SACS obtain their supplies through the DHFW. NGOs also directly access social marketing agencies. NACO and SACS ensure hat there is adequate supply of condoms in STD clinics, VCTC, and Ob/Gyn clinics. SM condoms are made available at outlets situated near state highways and in areas where TI projects are underway. NGOs are encouraged to use a mix of free and SM approaches.

3.5.4 *Core Convergence Recommendations for Condom promotion*

- Create a mechanism to ensure that condom programming for NACP and DHFW is managed within a single entity to provide leadership and direction. This integration will greatly facilitate streamlining the condom promotion strategy between the FW and HIV/AIDS programmes.
- Joint development of a strategy on condom procurement and distribution to meet the needs of sexually active women and men as a contraceptive method, as a method of dual protection and to meet the needs of high-risk groups.
- Condom supplies for NGO s involved in TI to be through NACO and SACS.
- HFW to promote condoms as dual protection method through improved distribution channels.
- Pilots to promote female condom use among general population as well sex workers both as a contraceptive and barrier method.

3.6 *Safety of blood and blood products*

3.6.1 *Background:* In addition to ensuring blood safety, other strategies to reduce transmission include: reducing the need for transfusions, educating and motivating low risk individuals to donate blood.

3.6.2 *DHFW strategy:* Currently blood banks are located at state and at district levels. Stringent guidelines for blood banks are in place. In the RCH II programme, DHFW has planned blood storage centers at FRU level. However the procurement of blood will be primarily from the blood banks certified by NACO, so quality control appears to be taken care of.

3.6.3 *NACP Strategy:* NACO has been involved in developing a blood safety policy and guidelines for blood banks. Annexures 8 and 9 provide state wise details of blood banks supported and strengthened by NACO respectively.

3.6.4 *Core Convergence Recommendations fro Blood Safety*

It is recommended that this policy be continued so that stringent quality controls are maintained at the district levels, and high quality blood is available at secondary levels of care.

3.7 Training

3.7.1 DHFW strategies: In RCH 1, Medical Officers, Staff Nurses, Lady Health Visitors and ANMs were trained for periods of between 4 to 6 hours (depending on job profiles) in the area of HIV/AIDS and RTI/STI. In RCH II, four core committees are currently reviewing the content of training for each level of provider.

3.7.2 NACP strategies: NACO, SACS (and partner agencies- NGOs) have developed modules for training in a range of areas- prevention, universal precautions care and support, PPTCT for all providers. These have been implemented separately from the HFW trainings.

3.7.3 Core Convergence Recommendations for training

- NACP to designate an officer to coordinate with the groups responsible for ongoing module development for RCH II and ensure that HIV/AIDS training inputs cover all areas of concern adequately.
- Joint finalization of areas of training with respect to content, duration, mix of knowledge and skills, for all cadres of health and community workers.
- NACO and DHFW to jointly develop a specific plan to train staff of PPTCT and VCTC to ensure that these functions include other HFW elements as well.
- Finalized modules to be shared with private sector and NGO partners supported by HFW and NACP.

3.8 Management Information Systems

3.8.1 *DHFW strategies:* As part of the RCH II programme a Management Information System is being designed. An Integrated Disease Surveillance Project is also underway. Both these systems will essentially capture data on an ongoing basis at all levels for programme implementation and ongoing monitoring. Small and large scale surveys such as the NFHS and District level HH surveys are also conducted periodically.

3.8.2 *NACP strategies:* The nationwide sentinel surveillance system captures data on an annual basis from about 455 sites across the country. In addition, VCTC, blood banks and PPTC serve as a reporting base. Programme supported NGOs also report on STI treated, condoms distributed and coverage of high-risk groups.

3.8.3 Core Convergence Recommendations for Management Information Systems

- Joint working group to review data needs, assess ongoing sources, and finalize requirements to fit into RCH II MIS, so that all facilities report service performance on RTI/STI, VCTC and PPTCT as part of routine reporting, while maintaining confidentiality.
- State and national level surveys (NFHS III, DLHS) designed to provide information on KAP related to RTI/STI/HIV/AIDS
- Research and prevalence studies to assess nature of STIs to develop suitable management protocols and assess antibiotic resistance patterns. Need to explore linkages with integrated disease surveillance programme.
- Mechanisms to ensure periodic reporting on STI/HIV/AIDS by private providers
- Include NGO reports as part of district level reporting.

3.9 Male involvement: The case to promote male participation in improving reproductive and sexual health for women has been articulated in several documents and is being implemented

through several community-based initiatives. However, the reach of programmes of the DHFW to men is low. NACP on the other hand, (given that men are the predominant target group in the general population) has significant experience in approaches to reach men, through condom promotion, STI clinics, and mass media. In RCH II, it is proposed to provide gender sensitization training for all providers. Specific BCC interventions will implemented to increase demand for male contraceptive methods, male RH services, and to heighten awareness about men's responsibility in support of women's sexual and reproductive health.

Core Convergence Recommendations to improve male involvement

- Ensure that NACP and DHFW training include male responsibility as a key area
- BCC strategies for both NACP and DHFW to address the area of male responsibility and shared action for improved women's RH as a major issue- includes partner notification, drug compliance, safe sexual practices and condom promotion.

3.10 *Strengthening urban health services to improve convergence:* Urban health particularly among the poor presents a special challenge to the DHFW. While overall health indicators in rural areas may be better than in rural areas, they mask significant disparities. The reach of the poor to good health care is limited, and they are often served by the private sector, poorly regulated and offering care of questionable quality. Given the increase of slum populations, migrants, and street children, and that these groups are identified as high risk groups for HIV/AIDS, it is essential that their access to the services such as RTI/STI, VCTC, PPTCT, condom promotion and BCC interventions be improved.

The NACP supports several targeted interventions in urban areas, primarily through NGOs, and targeted at marginalized, high-risk groups, and not often general population based. NACP also support STI clinics, VCTC and PPTCT in large medical colleges/teaching hospitals. However primary and secondary health care facilities in urban areas are not as clearly structured or organized as in rural areas. RCH II proposes a two-tier facility – an urban health center for a population of 50,000- to address primary health care needs of the population, particularly the vulnerable, and a second tier (mix of private and public sector) to serve as referral sites.

Core convergence Recommendations to improve reach of urban health

- Strengthening urban health infrastructure, including training of urban providers will have benefits for urban RCH and NACP.
- Involvement of urban private sector practitioners in training programmes, through involvement of IMA and FOGSI. .
- Referral information on sites where RTI/STI, VCTC, and PPTCT are available to be widely disseminated to both general and high risk populations through NGOs, private sector, and IEC efforts.
- UHC and Referral sites to offer a range of RCH services without discrimination and in an equitable manner to general populations and populations at risk.

4. OPERATIONALIZATION OF CONVERGENCE

4.1 Of the key areas identified for convergence, RTI/STI management for the general population could be integrated within the DHFW. VCTCs and PPTC still need to be managed by NACO and the SACS to retain focus and ensure referral linkages to care and support. In the area of blood safety, it is recommended that NACO continue to ensure safe blood supplies at

district levels, and that blood storage units at secondary levels of care procure supplies from the district. In the areas of behaviour change and condom procurement/distribution, it is recommended that the leadership for the programmes be entrusted to one entity to ensure overall guidance of both areas for Health, Family Welfare and the National AIDS Control Programme. Male involvement needs to be woven into all components. Strategies to improve services in rural areas must be replicated/adapted for urban areas. Joint working groups are recommended at national and state level to ensure that the training plans and monitoring and reporting systems of the DHFW and NACO (and corresponding groups at the state levels) are well coordinated, reflect shared concerns and are synchronized at the delivery levels.

4.2 *Recommended Institutional Mechanisms*

4.2.1 At the National level a *NACP-HFW convergence committee* is to be set up at DHFW to provide policy inputs and oversight to the convergence between NACP and DHFW. The Convergence Committee will be chaired by Secy, HFW and co-chaired by Project Director NACO.

4.2.2 At the National level, two joint working groups are visualized comprised of technical and programme mangers from NACO and DHFW. They include:

1. Joint working group on convergence of RTI/STI, VCTC and PPTCT into DHFW infrastructure and services. (NACO/DDG/MH)
2. Joint working Group on Training and MIS. (NACO/DC Training, and CD, Statistics)

Broadly the roles of the JWG are to review quarterly performance from each state and jointly review and prepare a report on performance coverage and quality. Reporting formats would be developed in conjunction with existing formats or those proposed for larger programmes so that programme managers at state and district levels are not burdened. It is expected that the NACP-HFW Convergence Committee, which meets every quarter, will obtain reports from each of the National JWG, provide feedback and serve as a problem solving mechanism.

4.2.3 It is recommended that at the state level, a similar mechanism be set up, so that the state and central level review and monitoring, and information needs and flow are co-ordinated.

4.2.4 At the district level, NACO is considering the appointment of a convergence facilitator who could ensure coordinated inputs between those programmes directly implemented by NACO/SACS, between various NGO managed programmes, and finally between those interventions that depend upon the DHFW resources for effective operationalization. In addition this individual would follow up on the training plan for the district as well as the MIS to ensure that there is convergence. This individual would report to the SACS and to the CMO at the district level. At the district level, the District Health Mission (where all other programmes of HFW are integrated), will include a sub- group to review HIV/AIDS and HFW convergence in the major service areas (RTI/STI, VCTC, PPTCT) and NGO functioning.

5.NEXT STEPS

As pointed out initially, this paper is only a broad framework for actions on convergence. The framework needs to be validated at state level to ensure that there is ownership of the issues between the State AIDS Control Societies and the Departments of Health ad Family Welfare. While RCH II is the focus of convergence since it is due to be launched fairly soon, and there has been significant

decentralized planning and design, it is emphasized in this document. However there are several other programmes and partners that also need to be viewed through the lens of convergence to ensure appropriate and effective local responses to HIV/AIDS.

	Role and Functions of DHFW	**Role and Functions of NACP**	**Convergence mechanisms/aspects**

Area of Convergence			
RTI/STI	-**Primary Responsibility**-integrate RTI/STI management at all levels in public sector system -Increase private sector involvement in high quality RT/STI treatment- IMA and FOGSI -Broadly RCH II strategies should be followed-At PHC level, first line drugs to be offered, -District, CHC and FRU to offer comprehensive etiological and lab based treatment. At district level, linkages with STD referral labs to be strengthened.	-Support to HRG-NGOs to continue. Service delivery whether directly through NGOs or referral to public or private sector. -Ensure that all STI service data and special studies are provided to JCWG to enable reporting at the Convergence committee level.	-At National level, NACP and DHFW to set up a JCWG group to monitor access of RTI/STI services for general population and for HRG. Report to HIV/AIDS Convergence Committee. -Training of providers (public, private and NGO) and lab techs within purview of DHFW. -DDG-MH/NACO
VCTC	-Infrastructure (space) to be provided in facilities where VCTC are located. -Support to ensure referral from other departments -Overall supervision by head of facility, in collaboration with Ob/Gyn, STD, Paed, and other depts. -Frontline providers to motivate community at risk for VCTC	**Primary responsibility—** - increase VCTC sites-expansion in phased manner -NACP support for staff and supplies, -Include Youth Friendly Information Centers at CHC and PHC -VCTC to serve other counseling needs. -Cadre/of counselors to staff the sites.	-JCWG to review functioning of VCTC through periodic state reports. Report to HIV/AIDS Convergence Committee -Training of providers of DHFW at all levels to include elements of risk protection, motivation for testing-through DHFW -NGO training facilitated by NACP, but modules jointly developed. NACO/DDG-MH
PPTCT	-Overall supervision by head of facility -Located in Ob/Gyn department, managed by HOD -Ensure non discriminatory practices -Ensure universal precautions -At the community level, ANM/ASHA follow up of VCTC clients testing positive for ANC, and motivate for PPTCT -	**Primary Responsibility** to ensure functioning PPTCT -Expand PPTCT sites in a phased manner -NACP to support once counselor and lab. Tech. And supplies for PPTCT.	-JCWG to obtain data on functioning of PPTCT and review performance -Training for all providers to include attitudinal as well technical skills, and universal precautions.-DHFW -Private sector through IMA and FOGSI-DHFW NACO/DDG-MH
BCC	-All messages for HFW to include HIV/AIDS prevention and care and support as	-Messages for HIV/AIDS highlight appropriate service provision through public and	-BCC strategy/division for NACP and DHFW under single

	appropriate -Ensure that NGO programmes also use message content as defined	private health system -Ensure that NGOs highlight service access in addition to prevention messages.	management.
Condom Promotion	-Enhance condom use for dual protection -Female condoms to be promoted as a contraceptive/barrier method	-Condom promotion key to prevention -Female condoms to be promoted as a contraceptive/barrier method	Condom procurement and distribution for FW and NACO under single entity.
Training	**Primary Responsibility** for training of all service interventions (except VCTC/PPTCT) to be within DHFW -Support training content and technical support for VCTC and PPTCT training	-Support training in terms of content and technical support **-Primary responsibility** for training VCTC counselors in a range of issues including HIV/AIDS, which include safe motherhood, family planning and childcare. PPTCT staff training also to be conducted by NACO/SACS.	-NACP to coordinate with groups working on RCH II modules to ensure HIV/AIDS content for all workers. -Joint Working Group to be instituted to review and ensure that HIV/AIDS messages and content for training are tailored to each level of provider -Ensure that training modules are shared with NGO partners of DHFW and NACP. -Develop protocols and guidelines for key services- -Ensure dissemination of protocols and guidelines to NGOs and private sector.
Reporting	DHFW MIS to capture service data- RTI/STI, VCTC, and PPTCT -MIS to include HIV/AIDS indicators -Support sentinel surveillance data collection	-Ensure that VCTC, PPTCT, and sentinel surveillance data is reflected in district MIS.	-NACP to coordinate with RCH II MIS convener (CD, Statistics to ensure that HIV/AIDS indicators are included in MIS for RCH II. -Joint Working Group to review RCH II MIS and ensure that reporting of RTI/STI, VCTC, and PPTC is also included. -Surveys (NFHS III and DLHS)to include information on HIV/AIDS as well.
Blood Safety	Maintain quality of blood taken from blood banks to blood storage centers at secondary levels of facilities.	**-Primary Responsibility** to assure safety of blood at banks at district level and above	

[1] NACO and the DFW jointly constituted a six member Task Force in late December, 2004 to identify areas of convergence and develop an operational plan by January 31, 2005.

DRAFT REPORT ON RECOMMENDATION OF TASK FORCE ON PUBLIC PRIVATE PARTNERSHIP FOR THE 11TH PLAN

The Planning Commission constituted a Working Group on Public Private Partnership to improve health care delivery for the Eleventh Five-Year Plan (2007-2012) under the Chairmanship of Secretary, Department of Health & Family Welfare, Government of India with the following members:

1.	Secretary, Department of Health & Family Welfare, New Delhi	Chairman
2.	Secretary (Health), Government of West Bengal	Member
3.	Secretary (Health), Government of Bihar	Member
4.	Secretary (Health), Government of Jharkhand	Member
5.	Secretary (Health), Government of Karnataka	Member
6.	Secretary (Health), Government of Gujarat	Member
7.	Director General Health Services, Directorate General of Health Services, New Delhi	Member
8.	President, Indian Medical Association, New Delhi	Member
9.	Medical Commissioner, employees State Insurance Corporation, New Delhi	Member
10.	Dr. H. Sudarshan, President /Chairman, Task Force on Health & Family Welfare, Government of Karnataka, Bangalore	Member
11.	Dr. Sharad Iyengar, Action Research & Training in Health, Udaipur, Rajasthan	Member
12.	Executive Director, Population Foundation of India, New Delhi	Member
13.	Dr. S.D. Gupta, Director, Indian Institute of Health Management Research, Jaipur	Member
14.	Ms. Vidya Das, Agragamee, Kashipur, District Rayagada, Orissa	Member

15.	Dr. C.S. Pandav, Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi	Member
16.	Dr. V.K. Tiwari, Acting Head, Department of Planning & Evaluation, National Institute of Health & Family Welfare, New Delhi.	Member
17.	Dr. A Venkat Raman, Faculty of Management Sciences, University of Delhi	Member
18.	Dr. K.B. Singh, Technical Adviser, European Commission, New Delhi	Member
19.	Shri K.M. Gupta, Director, Ministry of Finance, New Delhi	Member
20.	Shri Rajeev Lochan, Director (Health), Planning Commission, New Delhi	Member
21.	Joint Secretary, Ministry of Health & Family Welfare, New Delhi	Member Secretary

The Terms of reference of the Working Group were as under:

(i) To review existing scenario of Public Private Partnership in health care (Public, Private, NGO) in urban and rural areas with a view to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stablization and also achieve goals set under the National Health Policy and the Millennium Development Goals.

(ii) To identify the potential areas in the health care delivery system where an effective, viable, outcome oriented public private partnership is possible.

(iii) To suggest a practical and cost effective system of public private partnership to improve health care delivery system so as to achieve the goals set in National Rural Health Mission, National Health Policy and the Millennium Development Goals and makes quantitative and qualitative difference in implementation of major health & family welfare programmes, functioning of health & family welfare infrastructure and manpower in rural and urban areas.

(iv) To deliberate and give recommendations on any other matter relevant to the topic.

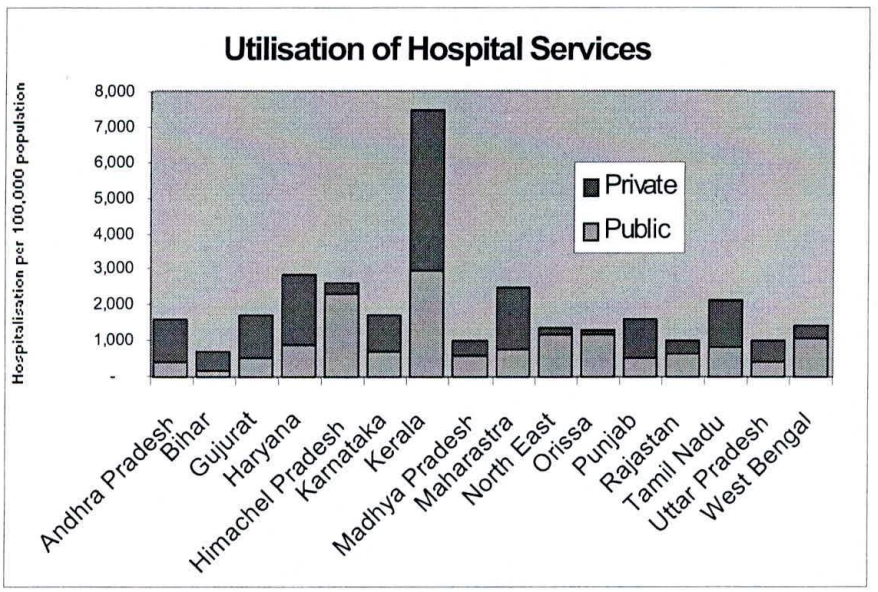
DEFINING PUBLIC PRIVATE PARTNERSHIP IN HEALTH

Public-Private Partnership or PPP in the context of the health sector is an instrument for improving the health of the population. PPP is to be seen in the context of viewing the whole medical sector as a national asset with health promotion as goal of all health providers, private or public. The Private and Non-profit sectors are also very much accountable to overall health systems and services of the country. Therefore, synergies where all the stakeholders feel they are part of the system and do everything possible to strengthen national policies and programmes needs to be emphasized with a proactive role from the Government.

However for definitional purpose, "Public" would define Government or organizations functioning under State budgets, "Private" would be the Profit/Non-profit/Voluntary sector and "Partnership" would mean a collaborative effort and reciprocal relationship between two parties with clear terms and conditions to achieve mutually understood and agreed upon objectives following certain mechanisms.

PPP however would not mean privatization of the health sector. Partnership is not meant to be a substitution for lesser provisioning of government resources nor an abdication of Government responsibility but as a tool for augmenting the public health system.

THE ROLE OF THE PRIVATE SECTOR IN HEALTH CARE



Source Pearson M, Impact and Expenditure Review, Part II Policy issues. DFID, 2002

Over the years the private health sector in India has grown markedly. Today the private sector provides 58% of the hospitals, 29% of the beds in the hospitals and 81% of the doctors. *(The Report of the Task Force on Medical Education, MoHFW)*

The private providers in treatment of illness are 78% in the rural areas and 81% in the urban areas. The use of public health care is lowest in the states of Bihar and Uttar Pradesh. The reliance on the private sector is highest in Bihar. 77% of OPD cases in rural areas and 80% in urban areas are being serviced by the private sector in the country. *(60th round of the National Sample Survey Organisation (NSSO) Report.*

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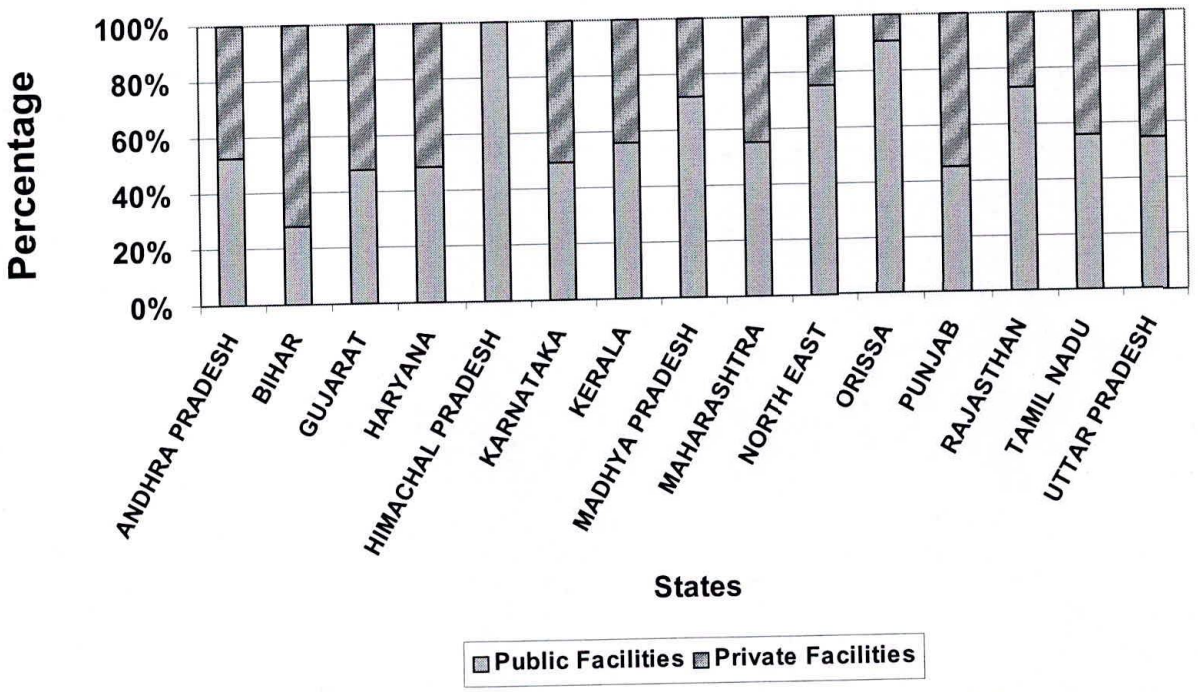
The success of health care in Tamil Nadu and Kerala is not only on account of the Public Health System. The private sector has also provided useful contribution in improving health care provision.

Studies of the operations of successful field NGOs have shown that they have produced dramatic results through primary sector health care services at costs ranging from Rs. 21 to Rs. 91 per capita per year. Though such pilot projects are not directly upscalable, they demonstrate promising possibilities of meeting the health needs of the citizens by focused thrust on primary healthcare services. (NSSO 60th Round)

India: Percentage of Hospitalizations In The Public and Private Sector Among Those Below The Poverty Line, According To State



Source Pearson M, Impact and Expenditure Review, Part II Policy issues. DFID,2002

While data and information is still being collated, the private health sector seems to be the most unregulated sector in India. The quantum of health services the private sector provides is large but is of poor and uneven quality. Services, particularly in the private sector have shown a trend towards high cost, high tech procedures and regimens. Another relevant aspect borne out by several field studies is that private health services are significantly more expensive than public health services – in a series of studies, outpatient services have been found to be 20-54% higher and inpatient services 107-740% higher. ***(Report of the Task Force on Medical Education, MoHFW.***

Widely perceived to be inequitable, expensive, over indulgent in clinical procedures, and without standards of quality, the private sector is also seen to be easily accessible, better managed and more efficient than its public counterpart.

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Given the overwhelming presence of private sector in health, there is a need to regulate and involve the private sector in an appropriate public-private mix for providing comprehensive and universal primary health care to all. However there is an overwhelming need for action on privatization of health services, so that the health care does not become a commodity for buying and selling in the market but remains a public good, which is so very important for India where 1/3 of the population can hardly access amenities of life, leave alone health care.

In view of the non-availability of quality care at a reasonable cost from the private sector , the upscaling of non-profit sector in health care both Primary, Secondary and Tertiary care, particularly with the growing problems of chronic diseases and diseases like HIV/AIDS, needs long term care and support.

OBJECTIVES OF PUBLIC PRIVATE PARTNERSHIPS

Universal coverage and equity for primary health care should be the main objective of any PPP mechanism besides:

- Improving quality, accessibility, availability, acceptability and efficiency
- Exchange of skills and expertise between the public and private sector
- Mobilization of additional resources.
- Improve the efficiency in allocation of resources and additional resource generation
- Strengthening the existing health system by improving the management of health within the government infrastructure
- Widening the range of services and number of services providers.
- Clearly defined sharing of risks
- Community ownership

REVIEW OF EXISTING SCENARIO OF PPP

POLICY PRESCRIPTION

Public-Private Partnership has emerged as one of the options to influence the growth of private sector with public goals in mind. Under the Tenth Five Year Plan (2002-2007), initiatives have been taken to define the role of the government, private and voluntary organizations in meeting the growing needs for health care services including RCH and other national health programmes. The Mid Term Appraisal of the Tenth Five Year Plan also advocates for partnerships subject to suitability at the primary, secondary and tertiary levels. National Health Policy-2002 also envisaged the participation of the private sector in primary, secondary and tertiary care and recommended suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments/medical institutions. The policy also wanted the participation of the non-governmental sector in the national disease control programmes so as to ensure that standard treatment protocols are followed. The Ministry of Health and Family Welfare, Government of India, has also evolved guidelines for public-private partnership in different National Health Programmes like RNTCP, NBCP, NLEP, RCH, etc. However, States have varied experiences of implementation and success of these initiatives. Under the Reproductive and Child Health Programme Phase II (2005-2009), several initiatives have been proposed to strengthen social-franchising initiatives. National Rural Health Mission (NRHM 2005-2012) recently launched by the Hon'ble Prime Minister of India also proposes to support the development and effective implementation of regulating mechanism for the private health sector to ensure equity, transparency and accountability in achieving the public health goals. In order to tap the resources available in the private sector and to conceptualize the strategies, Government of India has constituted a Technical Advisory Group for this purpose, consisting of officials of GOI, development partners and other stakeholders. The Task Group is in the process of finalizing its recommendation.

REVIEW OF PPP IN THE HEALTH SECTOR

During the last few years, the Centre as well as the State Governments have initiated a wide variety of public-private partnership arrangements to meet the growing health care needs of the population under five basic mechanisms in the health sector:

- **Contracting in-**government hires individual on a temporary basis to provide services
- **Contracting out-** government pays outside individual to mange a specific function
- **Subsidies-**government gives funds to private groups to provide specific services
- **Leasing or rentals-**government offers the use of its facilities to a private organization
- **Privatization-**government gives or sells a public health facility to a private group

An attempt has been made here to encapsulate some of the on-going initiatives in public private partnerships in selected states.

A. Partnership between the Government and the for profit sector

1. Contracting in Sawai Man Singh Hospital, Jaipur

- The SMS hospital has established a Life Line Fluid Drug Store to contract out low cost high quality medicine and surgical items on a 24-hour basis inside the hospital. The agency to operate the drug store is selected through bidding. The successful bidder is a proprietary agency, and the medical superintendent is the overall supervisor in charge of monitoring the store and it's functioning. The contractor appoints and manages the remuneration of the staff from the sales receipts. The SMS hospital shares resources with the drug store such as electricity; water; computers for daily operations; physical space; stationery and medicines. The contractor provides all staff salaries; daily operations and distribution of medicine; maintenance of records and monthly reports to SMS Hospital. The SMS Hospital provides all medicines to the drug store, and the contractor has no power to purchase or sell medicines himself. The contractor gains substantial profits, could expand his contacts and gain popularity through LLFS. However, the contractor has to abide by all the rules and regulations as given in the contract document.
- The SMS Hospital has also contracted out the installation, operation and maintenance of CT-scan and MRI services to a private agency. The agency is paid a monthly rent by the hospital and the agency has to render free services to 20% of the patients belonging to the poor socio-economic categories

2. The Uttaranchal Mobile Hospital and Research Center (UMHRC) is three-way partnership among the Technology Information, Forecasting and Assessment Council (TIFAC), the Government of Uttaranchal and the Birla Institute of Scientific Research (BISR). The motive behind the partnership was to provide health care and diagnostic facilities to poor and rural people at their doorstep in the difficult hilly terrains. TIFAC and the State Govt. shares the funds sanctioned to BISR on an equal basis.

3. Contracting out of IEC services to the private sector by the State Malaria Control Society in Gujarat is underway in order to control malaria in the state. The IEC budget from various pharmaceutical companies is pooled together on a common basis and the agencies hired by the private sector are allocated the money for development of IEC material through a special sanction.

4. Contracting in of services like cleaning and maintenance of buildings, security, waste management, scavenging, laundry, diet, etc. to the private sector has been tried in states like Himachal Pradesh; Karnataka; Orissa (cleaning work of Capital Hospital by Sulabh International); Punjab; Tripura (contracting Sulabh International for upkeep, cleaning and maintenance of the G.B. Hospital and the surrounding area); Uttaranchal, etc.

5. The Government of Andhra Pradesh has initiated the Arogya Raksha Scheme in collaboration with the New India Assurance Company and with private clinics. It is an insurance scheme fully

funded by the government. It provides hospitalization benefits and personal accident benefits to citizens below the poverty line who undergo sterilization for family planning from government health institutions. The government paid an insurance premium of Rs. 75 per family to the insurance company, with the expected enrollment of 200,000 acceptors in the first year.

The medical officer in the clinics issues a Arogya Raksha Certificate to the person who undergoes sterilization. The person and two of her/his children below the age of five years are covered under the hospitalization benefit and personal accident benefit schemes. The person and/oor her/his children could get in-patient treatment in the hospital upto a maximum of Rs. 2000 per hospitalization, and subject to a limit of Rs. 4000 for all treatments taken under one Arogya Raksha Certificate in any one year. She/he gets free treatment from the hospital, which in turn claims the charges from the New India Insurance Company. In case of death due to any accident, the maximum benefit payable under one certificate is Rs. 10,000.

B. Partnership between the Government and the non-profit sector

1. Involvement of NGOs in the Family Welfare Programme

- The MNGO (Mother NGO) and SNGO (Service NGO) Schemes are being implemented by NGOs for population stabilization and RCH. 102 MNGOs in 439 districts, 800 FNGOs, 4 regional Resource Centers (RRC) and 1 Apex Resource Cell (ARC) are already in place. The MNGOs involve smaller NGOs called FNGOs (Field NGOs) in the allocated districts.

  The functions of the MNGO include identification and selection of FNGOs; their capacity building; development of baseline data for CAN; provision of technical support; liaison, networking and coordination with State and District health services, PRIs and other NGOs; monitoring the performance and progress of FNGOs and documentation of best practices. The FNGOs are involved in conducting Community Needs Assessment; RCH service delivery and orientation of RCH to PRI members; advocacy and awareness generation.

  The SNGOs provide an integrated package of clinical and non-clinical services directly to the community

- The Govt. of Gujarat has provided grants to SEWA-Rural in Gujarat for managing one PHC and three CHCs. The NGO provides rural health, medical services and manages the public health institutions in the same pattern as the Government. SEWA can accept employees from the District Panchayat on deputation. It can also employ its own personnel by following the recruitment resolution of either the Government or the District Panchayat. However, the District Health Officer or the District Development Officer is a member of the selection committee and the appointment is given in her/his presence. In case SEWA does not wish to continue its services, the District Panchayat, Bharuch would take over the management of the same.

2. The Municipal Corporation of Delhi and the Arpana Trust (a charitable organization registered in India and in the United Kingdom have developed a partnership to provide comprehensive health services to the urban poor in Delhi's Molarbund resettlement colony. Arpana Trust runs a health center primarily for women and children, in Molarbund through its health center 'Arpana Swasthya Kendra'. As contractual partners, Arpana Trust and MCD each has fixed responsibilities and provides a share of resources as agreed in the partnership contract. The Arpana Trust is responsible for organizing and implementing services in the project area, while the MCD is responsible for monitoring the project. The MCD provides building, furniture, medicines and equipment, while the Arpana Trust provides maintenance of the building, water and electricity charges, management of staff and medicine.

3. Management of Primary Health Centers in Gumballi and Sugganahalli was contracted out by the Government of Karnataka to Karuna Trust in 1996 to serve the tribal community in the hill y areas. 90% of the cost is borne by the Govt. and 10% by the trust. Karuna Trust has full responsibility for providing all personnel at the PHC and the Health Sub-centers within its jurisdiction; maintenance of all the assets at the PHC and addition of any assets if required at the PHC. There has been redeployment of the Govt. staff in the PHCs, however some do remain in deputation on mutual consent. The agency ensures adequate stocks of essential drugs at all times and supplies them free of cost to the patients. No patient is charged for diagnosis, drugs, treatment or anything else except in accordance with the Government policy. The staff salaries are shared between the Govt. and the Trust.

Gumballi district is considered a model PHC covering the entire gamut of primary health care – preventive, promotive, curative and rehabilitative

Similarly in Orissa, PPPs are being implemented for safe abortion services and social marketing of disposable delivery kits. Parivar Sewa Sanstha and Population Services International are implementing the Sector Investment Plan in the state.

4. The Government of Tamil Nadu has initiated an Emergency Ambulance Services scheme in Theni district of Tamil Nadu in order to reduce the maternal mortality rate in its rural area. The major cause for the high MMR is anon-medical cause - the lack of adequate transport facilities to carry pregnant women to health institutions for childbirth, especially in the tribal areas. This scheme is part of the World Bank aided health system development project in Tamil Nadu. Seva Nilayam has been selected as the potential non-governmental partner in the scheme. This scheme is self-supporting through the collection of user charges. The Government supports the scheme only by supplying the vehicles. Seva Nilayam recruits the drivers, train the staff, maintain the vehicles, operate the program and report to the government. It bears the entire operating cost of the project including communications, equipment and medicine, and publicizing the service in the villages, particularly the telephone number of the ambulance service. However, the project is not self-sustaining as the revenue collection is lesser than anticipated.

Seva Nilayam also operates another program in the Theni district called the Emergency Accident Relief Center for which the government has also provided a vehicle.

5. The Urban Slum Health Care Project the Andhra Pradesh Ministry of Health and Family Welfare contracts NGOs to manage health centers in the slums of Adilabad. The basic objectives of the project are to increase the availability and utilization of health and family welfare services, to build an effective referral system, to implement national health programs, and to increase health awareness and better health-seeking behaviour among slum dwellers, thus reducing morbidity and mortality among women and children. To serve 3 million people, the project has established 192 Urban Health Centers. Five 'Mahila Aarogya Sanghams' (Women's Wee-Being Associations) were formed under each UHC, and along with the self-help groups and ICDS workers mobilize the community and adopt Behaviour Change Communication strategies.
The NGOs are contracted to manage and maintain the UHCs, and based on their performance, they are awarded with a UHC, or eliminated from the program. Additional District Magistrates and Health Officers supervise the UHCs at district level and the Medical Officer is the nodal officer at the municipality level. The District Committee approves all appointments made by the NGOs for the UHC staff. The Govt. of Andhra Pradesh constructs buildings for the UHCs; provide honoraria to the Project Coordinators of the UHCs, medical officers and other staff; train staff members; and supply drugs, equipment and medical registers.
6. In recent examples, collaboration that has developed between Government of Arunachal Pradesh, VHAI and Karuna Trust in managing significant number of PHCs may be seen at Annexure IV.

C. Partnership between the Government and a private service provider

Several examples for the above partnership could be quoted from the Indian experience:

1. Partnership between the Department of Family Welfare and Private Service Providers:

- The DoFW has appointed one additional ANM on contractual basis in the remote sub-centers (which constitute 30% of all sub centers in C category districts in 8 states) to ensure better emergency obstetric care under the RCH programme. Similarly 140 ANMs could be appointed in Delhi for extending their services in the slum areas. The scheme has been extended to the North Eastern states with effect from 1999-2000
- Public Health/Staff nurses have been appointed on a contractual basis at PHCs/ CHCs having adequate infrastructure for conducting deliveries.
- In order to plug deficiencies in providing emergency obstetric care at FRU due to non-availability of anesthetist for surgical interventions, states have been permitted to engage the anesthetist from the private sector on a payment of Rs.1000 per case at the sub-district and CHC level.
- With a view to supplement the regular arrangement, provision has been made for engaging doctors trained in MTP as Safe Motherhood Consultant who will visit the PHC (including CHCs in NE states) once a week or at least once in a fortnight on a fixed day for performing MTP and other Maternal Health care services. These doctors will be paid @Rs.500 per day visit.
- A scheme for reservation of sterilization beds in hospitals run by government, local bodies and voluntary organizations was introduced in 1964 with view to provide immediate facilities for tubectomy operations in hospitals. At present too, beds are sanctioned to hospitals run by local bodies and voluntary organizations and grant-in-aid is provided as per approved pattern of assistance.
- The Haryana Urban RCH Model is being implemented in 19 urban slums and benefits 15 lakh beneficiaries. In this model, a private health practitioner (PHP) has been identified to provide comprehensive primary health care service to a group of 1000-1500 targeted beneficiaries. S/he provides services related to National Disease Control Programme, contraception, immunization, ambulatory care. The PHP gets an incentive of Rs. 100 p.a. per beneficiary by the Government. The model is envisioned to be self-sustaining by the 5^{th} year.
- A proposal has been submitted by PSS, Rajasthan to the GOI for establishing a comprehensive RCH clinic in 3 districts, wherein PSS would provide services like sterilization, MTP, spacing, ante/post natal care, immunization, RTI/STI. The cost to be borne by the Govt. is Rs. 18 to 20 lakhs p.a. per clinic. With a view to ensure project sustainability, the user fees is sought to be deposited in a bank account.
- The Samaydan Scheme in Gujarat aims to ease the problem of vacancies of specialists in health and medical services. About 125 honorary and part-time specialists have been appointed in rural hospitals under the scheme and the removal of age-eligibility criteria for appointment of doctors in government services is also being considered.
- Under the Urban Health Care Project, the community base health volunteers in the urban areas would roped in to provide primary health care in the urban slums of Gujarat. Their activities would be monitored by CHC/PHC/PPU/Urban Family Welfare Center/Trust Hospital and they would be paid a fixed monthly honorarium.

2. The Department of AYUSH envisages accreditation of organizations with the MoHFW for research and development in order to be eligible for financial assistance under the scheme of Extra Mural Research on ISM&H. The eligible organizations include R&D organizations recognized by the Ministry of Science and Technology, Govt. of India; one Government or semi-Government or autonomous R & D Institution under the GoI/State Government/Union Territory; and one private R&D institutions registered under any State/Central Act as Research Organization.

D. Partnership between the Government and a private sector and/or the non-profit sector and/or a private service provider and/or multilateral agencies

1. The National Malaria Control Programme has involved the NGOs and private practitioners at the district level for the distribution of medicated mosquito nets. (LOGISTICS)

2. Under the National Blindness Control Programme, District Blindness Control Societies have been formulated, which are represented by the Government, non-government and private sectors. The NGOs have been involved for providing a package of services

3. The National AIDS Control Programme has involved both the voluntary and private sector for outreaching the target population through Targeted Interventions (WIDER COVERAGE)

4. The Revised National Tuberculosis Control Programme has involved the private practitioners and the NGOs for the rapid expansion of the DOTS strategy. The non-inclusion of the private providers had been one of the main reasons for the failure of the earlier programme. The private medical practitioners serve as the first point of contact for more than two-thirds of TB symptomatics.

The GOI has initiated a Public Private Mix (PPM) pilot project with technical assistance from WHO in 14 sites across the country viz. Ahmedabad, Bangalore, Bhopal, Chandigarh, Chennai, Delhi, Jaipur, Kolkata, Lucknow, Patna, Pune, Bhubaneshwar, Ranchi and Thiruvananthapuram. The areas of collaboration with the NGOs include: community outreach; health education and promotion; provision of DOTS and in-hospital care for TB disease; TB Unit Model; programme planning, implementation, training and evaluation.

Presently, there are 550 NGOs and 200 Private Practitioners involved in RNTCP. Attempts are also underway to involve the medical colleges in the programme.

5. The Rajiv Gandhi Super-specialty Hospital in Raichur Karnataka is a joint venture of the Government of Karnataka and the Apollo hospitals Group, with financial support from OPEC (Organization of Petroleum Exporting Countries). The basic reason for establishing the partnership was to give super-specialty health care at low cost to the people Below Poverty Line. The Govt. of Karnataka has provided the land, hospital building and staff quarters as well as roads, power, water and infrastructure. Apollo provided fully qualified, experienced and competent medical facilities for operating the hospital. The losses anticipated during the first three years of operation were reimbursed by the Govt. to the Apollo hospital. From the fourth year, the hospital could get a 30% of the net profit generated. When no net profit occurred, the Govt paid a service charge (of no more than 3% of gross billing) to the Apollo Hospital.

Apollo is responsible for all medical, legal and statutory requirements. It pays all charges (water, telephone, electricity, power, sewage, sanitation) to the concerned authorities and is liable for penal recovery charges in case of default in payment within the prescribed periods. Apollo is also responsible for maintenance of the hospital premises and buildings, and maintains a separate account for funds generated by the hospital from fees for registration, tests and medical charges. This account is audited by a Chartered Accountant engaged by Apollo with approval of the Governing Council. Likewise, Apollo maintains separate monthly accounts for all materials used by patients below the poverty line (including diagnostic services), which are submitted to the Deputy Commissioner of Raichur for reimbursement. Accountability and responsibility for outsourcing the support services remain with the Apollo.

The controlling authority of the Govt. of Karnataka is vested in its District Commissioner. A Governing Council is established to review the performance of the hospital periodically (twice a year), make recommendations to improve the administration and management and also resolve any disputes that might arise. The ten-member council is chaired by the Karnataka Health

Minister and includes the Raichur District Collector, the Apollo CEO, the Principal Secretary, the Health Secretary, the Finance Manager, the Hospital Operations Manager, Medical Directors and local Members of the Legislative Assembly (as special invitees).

6. The Karuna Trust in collaboration with the National Health Insurance Company and the Government of Karnataka has launched a community health insurance scheme in 2001. It covers the Yelundur and Narasipuram Taluks. Underwritten by the UNDP, the Karuna Trust undertook the project to improve access to and utilization of health services, to prevent impoverishment of the rural poor due to hospitalization and health related issues, and to establish insurance coverage for out-patient care by the people themselves. The scheme is fully subsidized for Scheduled Castes and Scheduled Tribes who are below the poverty line and partially subsidized for non-SC/ST BPL. Poor patients are identified by field workers and health workers who visit door-to-door to make people aware of the scheme. ANMs and health workers visiting a village collect its insurance premiums and deposit them in the bank.

The annual premium is Rs. 22, less than Rs.2 a month. If admitted to any government hospital for treatment, an insured member gets Rs. 100 per day during hospitalization – Rs. 50 for bed-charges and medicine and Rs. 50 as compensation for loss of wages – up to a maximum of Rs.2500 within a 25-day limit. Extra payment is possible for surgery. The insurance is valid for one year. If members want to continue the coverage, they must renew their membership and pay the full premium.

7. The Government of Karnataka, the Narayana Hrudalaya hospital in Bangalore and the Indian Space Research Organization initiated an experimental tele-medicine project called 'Karnataka Integrated Tele-medicine and Tele-health Project' (KITTH), which is an on-line health-care initiatives in Karnataka. With connections by satellite, this project functions in the Coronary Care Units of selected district hospitals that are linked with Narayana Hrudalaya hospital. Each CCU is connected to the main hospital to facilitate investigation by specialists after ordinary doctors have examined patients. If a patient requires an operation, s/he is referred to the main hospital in Bangalore; otherwise s/e is admitted to a CCU for consultation and treatment.

Tele-medicine provides access to areas that are underserved or un-served. It improves access to specialty care and reduces both time and cost for rural and semi-urban patients. Tele-medicine improves the quality of health care through timely diagnosis and treatment of patients. The most important aspect of tele-medicine is the digital convergence of medical records, charts, x-rays, histopathology slides and medical procedures (including laboratory tests) conducted on patients.

8. The Yeshasvini Co-operative Farmer's Healthcare Scheme is a health insurance scheme targeted to benefit the poor. It was initiated by Narayana Hrudayalaya, super-specialty heart hospital in Bangalore, and by the Department of Co-operatives of the Government of Karnataka. The Government provides a quarter (Rs. 2.50) of the monthly premium paid by the members of the Cooperative Societies, which is Rs.10 per month. The incentive of getting treatment in a private hospital with the Government paying half of the premium attracts more members to the scheme. The cardholders could access free treatment in 160 hospitals located in all districts of the state for any medical procedure costing upto Rs. 2 lakhs.

The premium is deposited in the account of a charitable trust, the regulatory body for implementing the scheme. A Third Party Administrator – Family Health Plan Limited that is licensed by Karnataka's Insurance Regulatory and Development Authority. The FHPL has the responsibility for administering and managing the scheme on a day-to-day basis. Recognized hospitals have been admitted to the network throughout Karnataka, which are called as network hospitals (NWH). These hospitals offer comprehensive packages for operations that are paid by Yeshasvini. A Yeshasvini Farmers Health Care Trust is formed to ensure sustainability to the scheme, which comprises of members of the State Government and the network hospitals. The Trust monitors and controls the whole scheme, formulates policies, appointed the TPA and addresses the grievances of the insured members or doctors.

Only the members of an agricultural cooperative society could join this scheme, and also all members of a given cooperative society must become members of Yeashsvini. This ensures increase in the enrollment rates. The Government, apart from the premium subsidy has provided key access to the cooperatives. The Department of Cooperatives has provided an administrative vehicle to popularize the scheme.

The major drawback of this scheme is that the poor farmers are not covered for all health related issues but only for out-patient care and all expenses connected with surgery.

9. A Rogi Kalyan Samiti (RKS) was formed in Bhopal's Jai Prakash Governement Hospital to manage and maintain it with public cooperation. The RKS or Patient Welfare Committee or Hospital Management Society is a registered society and the committee acts as trustees for the hospitals responsible for proper functioning and management of the hospital. Its members are from local PRIs, NGOs, local elected representatives and government officials. Participation of the local staff with representatives of the locl population has been made essential to ensure accountability. It functions as an NGO and not a government agency. It may utilize all government assets and services to impose user charges. It may also raise funds additionally through donations, loans from financial institutions, grants from government as well as other donor agencies. The funds received are not deposited in the State exchequer, but are available to be spent by the Executive Committee constituted by the RKS/HMS. Private organizations could be contracted out for provision of the super specialty care at a rate fixed by the RKS/HMS.

At JP Hospital, RKS was formed due to lack of resources and other functional problems, which acted as an impediment to timely, and quality health service delivery. Due to delay or no disbursement of funds, creation of a hospital management society capable of generating revenues became imperative. After the formation of RKS, the quality of services increased in terms of 24-hour availability of doctors and medicine, diagnostic facilities, better infrastructure, cleanliness, maintenance and timeliness of services. Through RKS, the hospital has also been able to provide free services to patients below the poverty line.

10. A public/private DOTS model was established on a pilot basis in Hyderabad at Mahavir Trust Hospital, which is a private non-profit hospital. This partnership also involves private service providers like doctors and nursing homes. This new approach is known as PPM DOTS (Public Private Mix DOTS). As there are virtually no government services in the area, the private sector is a full substitute for the public sector. Individual private practitioners were involved in the DOTS programme as they form the first point of contact for most of the TB patients both for quality health care as well as convenience to refer to the private practitioners rather than the hospitals at frequent intervals.

The Mahavir Trust Hospital acts as a coordinator and intermediary between the government and private medical practitioners (PMPs). It also acts as a supervisor. The PMPs refer patients suspected of having TB to the hospital or to any of the 30 specified neighborhood DOTS centers operated by PMPs. The patients pay the fees to the PMPs. In addition to providing a referral center for an hour every morning at their own expense, the doctor gains professional and commercial benefits to their practice that far outweigh the loss of several patients who could never afford proper treatment in any case. In turn the Mahavir TB clinic informs the private practitioners about the progress of their patients throughout their treatment. The Mahavir Hospital and the PMPs keep the records for the government. The government provides TB control policy, training, drugs and laboratory supplies. Five outreach workers trace late or delinquent patients and provide community mobilization.

All stakeholders gain an advantage through this partnership. The Mahavir Trust Hospital benefits because the money spent on the DOTS service cures patients. The government benefits because the DOTS medicine are properly used instead of being wasted or even contributing to the development of drug resistant TB. The medicines are curing the patients and the spread of the

disease is being arrested. From tan economic point of view, the PMPs and nursing homes are able to provide an effective treatment, which enhance their goodwill and affects their business as a whole too.

The pilot project is aimed at attaining uniformity in the diagnosis, treatment and monitoring, wider programme coverage; saving the patient's time and expenditure by a good referral network.

11. Multilateral organizations like the World Bank and the European Commission have supported the Sector Investment Programme in India and the Department of International Development (DFID) in the area of health sector reforms in India.

12. In recent examples, the Chiranjeevi experiment of Govt of Gujarat may be seen at Annexure IV.

CHALLENGES FACED IN THE OPERATIONALISATION: KEY CONCERNS

The existing evidence for PPP do not allow for easy generalizations. However it appears that despite additional efficiencies, the objective of additional resources is not met, as State revenue remains the bedrock of all services. The evidence also reveals great disparity in services and in remuneration. As is evident the objectives of the initiatives have been to overcome some of the deficiencies of the public sector health systems.

Donations, introduction of user fees, insurance schemes are methods to augment resources. Contracting out is resorted to when health facilities are either underutilized or non functional while contracting in is used to improve quality of services or improve accessibility to high technology service or to improve efficiency. Contractual appointment of staff aims to reduce the negative impact of vacant positions. Voucher schemes and community based health insurance etc are invoked to reduce the adverse effects of health care costs on poor patients and improve equity in health system. Mobile health schemes, involvement of CBOs, health cooperatives etc are models in improving accessibility, both physical and to the health system. Some of the partnerships are for a short duration while the other is longer. The thrusts of the partnerships also vary. Some focus on service delivery, some to augment resources and infrastructure, some towards organizational and systemic improvements while others are simply advocacy oriented.

Contracting is the predominant model for public private partnerships in India. Some partnerships are simple contracts (like laundry, diet, cleaning etc) others are more complex involving many stakeholders with their respective responsibilities. For example the Yeshaswani scheme in Karnataka includes the State Department of Cooperatives, the Yeshaswani Trust with its almost 200 private hospitals, a corporate Third Party Administrator and the beneficiaries with the eligibility conditions.

It is seen that in most partnerships, the State Health Department is the principal partner with rare stakeholder consultation. In most cases it signs contracts with very few cases of Hospital Management Societies signing the contracts in a decentralized manner.

In terms of monetary value the contracts at Kolkottta's Bagha Jatin General Hospital provided inexpensive dietary services at the rate of Rs 27 per meal for about 30 patients a day and cleaning service at Rs 24000/- per month. The most expensive partnership was the Rajiv Gandhi Super Speciality Hospital in Raichur where the Government of Karnattaka has paid several hundred million rupees to the partner as start up cost plus an assurance to cover future losses.

The above initiatives also show that more than 75% of the projects have been located in backward areas of the states.

However true partnerships in sense of equality amongst partners, mutual commitment to goals, shared decision making and risk taking are rare.

The case studies also bring to fore genuine concerns summarized in terms of absence of representation of the beneficiary in the process, lack of effective governance mechanisms for accountability, non transparent mechanisms, lack of appropriate monitoring and governance systems and institutionalized management structures to handle the task

It is seen that the success or failures of the initiatives are as much dependant upon the above issues as on the political environment, legal framework of the negotiation, the capabilities of the partners, the risks and incentive each party incurs, funding and the payment mechanisms, cost and price analysis prior to negotiation, standardization of norms, performance measurement and monitoring and evaluations systems.

POTENTIAL AREAS FOR PARTNERSHIP

Different models of PPP are useful under different circumstances. The PPP lists have a wide-ranging set of PPP options ranging from options for improved service delivery, augmentation of resources and infrastructure, organizational and systemic improvement, to advocacy.

However any mechanism of PPP must be based on an assessment of local needs and a situation analysis. For example strengthening the public health structure would be a more viable option in many of the remote corners of the North Eastern states where the presence of private sector is negligible.

On a conceptual level, it is quite clear that the private sector is as much responsible for the health of the nation, therefore all health establishments, must provide some critical services, i.e. family welfare, accidents and trauma and emergencies within their geographical areas and manage infectious diseases of epidemic proportions.

However no health system can work through only a network of tertiary care hospitals. The remedies for most of the deficiencies of the health system largely fall within the ambit of Primary Health Care – whether they are promoting, preventive or curative. Therefore at least in the next five years the focus should be on augmentation of the primary health care services in terms of focus on better service delivery options, including ancillary services like ambulance services and radiology services.

However to fulfill the requirement of additional manpower in terms of requirement of 3 lakh nurses and 12,000 Specialist doctors under NRHM, it is essential to explore a range of partnership options in terms of private sector support to nursing institutions and medical schools and colleges to make available the human resources required for NRHM. There would also be massive requirement of managerial capacities under NRHM, which may be obtained through partnerships.

The potential areas may be as follows:

- Services, disease control and surveillance, diagnostics and medicines.
- Infrastructure
- Health manpower
- Behaviour change communication
- Capacity building including training and systems development.
- Managerial service and auxiliary activities of the health sector

In the initial phase caution should be exercised against expanding into too many sectors. Government funding should not exceed an overall cap of 15% of the budget allocation.

Super specialty care is not the goal. The intention is to provide basic health care to all citizens of this country so that they do not face distress and duress in meeting health care needs.

RECOMMMENDATIONS FOR A PRACTICAL AND COST EFFECTIVE MECHANISM

Framework For Regulation

As is evident Partnership mechanisms do not work without quality assurance and an enabling environment. Government must ensure that providers are accredited, at least essential standards are set and followed, guidelines and protocols for diagnosis and treatment are developed and used, and providers are kept updated through continuing medical education. System must monitor and correct such important aspects of quality as infection prevention, client satisfaction and access to services. For enablement the government must understand the

advantages, disadvantages and requirements of partnership. They need to understand that partnerships are based on common objectives, shared risks, shared investments and participatory decision-making.

Since there is an element of contradiction in the objective of strengthening of the public health system by the private sector in which the private sector apparently is the ultimate looser, therefore it is essential that the framework for the whole process of partnership is not ad- hoc. **Equity, Quality and Regulation** should underline the entire deliberation and apply not only to the Private Sector but also to the Public Sector.

Primary goal of any health system should be assurance of health care professional competence to the public. For a minimalist regulation system that may be feasible in the current socio-political environment it is suggested that:

1. Any Health Care Professional, practicing in any area / institution, should register with the Primary Health Officer of the Area or the Institution as the case may be. For this purpose an appropriate officer in the Primary Health Centres / Urban Health Centres may be identified as the Primary Health Officer. Every Health Care Institution may be required to designate an officer as the Institution's Primary Health Officer. The Registers maintained by Primary Health Officers should be accessible to public. The Register will also help Primary Health Centres and Public Health Officials to manage public health emergencies and for epidemiological surveillance.
2. Clinical Establishment Act, requiring registration of Health Care Institutions and Hospitals with appropriate Health Authority. Clinics, Nursing Homes and Small Hospitals of less than 100 beds may register with Local Health Authority, to be designated for about 5 lakh population (Revenue Division / Sub Division), larger hospitals may register with District Health Authorities and Tertiary Referral Hospitals may register with concerned State Health Authority. The Act should also provide for registration at the district level with the Zilla Parishad or the DHA wherever capacities of PRIs are wanting and include redressal mechanism for health institutions (Example diagnostic Centres) owned by a non-medical person.

The registers of professionals practicing in an area or within an institution should in the public domain available for public use and scrutiny. This would eventually lead to setting up of a national database on professionals practicing in different areas and institutions in different parts of the country and will also help in the judicial process. Therefore it is important that Registration should be in the Government domain and not with an autonomous body

The need for regulation should not only be for providers but also for training educators and training facilities. There is also a need for a regulatory framework for the proposed Rural Medical Practitioners as they would be key players in the primary health delivery systems.

Since managerial issues and governance capacities within the public health system are key issues in determining the effectiveness of registration therefore, in the initial phase, self registration should be encouraged followed by an interim accreditation mechanism developed with the help of FOGSI/IMA before a fully e-governed registration system could be institutionalized.

"Accreditation" as a voluntary process with set standards, provision for external review etc. must also be supported and incentives for accreditation must be encouraged. The accreditation initiatives in India at the National level (QCI, NABL) and at the State Level (AP, Karnataka, Tamil Nadu, Kerela and Maharashtra) are progressive steps.

A range of Accreditation Systems ranging from compulsory accreditation, accreditation by independent agencies, and facilitation of establishment of State Accreditation Councils to a blue print developed by the Ministry of Health & Family Welfare may be explored. It is however important to involve the stakeholders, build capacity, have different bodies at different levels, and collect evidence base for the whole process. Accreditation should have synergy with Regulation.

The process of accreditation of Mother and Child Hospital specifying certain minimum standards had already begun in Tamilnadu for the Janani Suraksha Yojana (JSY) Scheme.

However, in the process of accreditation there should be no fallback to the License Raj. There should be a single window for registration/accreditation of health institutions.

Framework Of Partnership

It is a prerequisite to make the partnership a publicly driven process in order to improve its legitimacy in the eyes of the common citizen. It is also important that there is clear articulation of responsibility, an open process and meticulous detailing to avoid suspicions and apprehensions in the minds of all. Therefore the power relations in the partnership also needed to be understood.

There is a need for defining the specific elements of the partnership from both sides as many a time the private provider feels that the Government itself does not undertake any guarantee in the Partnership.

All PPPs should meet at least two basic criteria, namely (a) Value for Money and (b) Clearly defined sharing of risks. There is need to develop skills within the government for assessment of the Value for Money and Risk sharing characteristics of PPPs. One common requirement for assessment of Value for Money proposition is existence of good comparators. For example; NGO Management of PHCs uses current budgetary allocations of PHCs as a comparator to make financial allocation. Similarly average out patient consultations or such other therapeutic procedures, and public health activities in other PHCs can be used to assess the performance of PHC under PPPs. CAG should be requested to develop specialised skills for assessment of Value for Money and risk sharing characteristics of PPP projects. Auditing of government expenditure through PPPs requirement would be different from traditional audit of expenditure directly made by government departments. Unless the CAG develops capacity for auditing of public expenditures through private partnerships, large scale expansion of PPPs would be difficult.

Transparency, Accountability, Trust, measurable efficiency parameters and Pricing remain vexatious issues in the partnership process.

The framework of partnership should also provide for the costing of services to ensure that common citizens can get/buy cost effective services.

The governmental system of fixing rate is fraught with difficulties and it is better to adopt public costing with moderation and states need to work out the cost effectiveness very meticulously. It may be noted that no serious effort at costing of services and standard treatment protocol has been attempted in the government domain. The National Commission on Macro-economics and health (NCMH) is the first attempt to document the cost of services in the public sector. Attempts at costing under various PPP schemes like the Yeshaswani scheme of Karnattaka and the Chiranjeevi scheme in Gujrat have been attempted. However more work is required to be done in this area and the initiative should be taken by the Ministry and the States. (Examples of a few cost effective options are at Annexure 1)

Decentralization should be the key in dealing with partnerships as centralized models suffer from failings enumerated in the aforesaid sections. The challenge under the NRHM is to operationalise partnerships at the District level. Therefore there is also a requirement for district level skills and managerial capacity for making the process accountable, affordable and accessible to common citizens.

The resource support and technical assistance for the PPP mechanism may come from the National Health Systems Resource Centre (NHSRC), State Health Systems Resource Centre

(SHSRC) and the District Health Systems Resource Centre (DHSRC) being set up under NRHM at the National , State and the District level respectively.

The National Institute of Health & Family Welfare (NIHFW) can be the nodal agency for guiding PPP Policy at the National level. A PPP Cell at the NIHFW can also function as the Documentation and dissemination Centre for PPP initiatives in the States. Resource support may be provided under NRHM to fund this Cell. These Cells may be replicated in the States and the Districts within the overall umbrella of the State Health Society and District Health Society under NRHM.

District level Health Resource Centres, can help in developing transparency in PPP and provide the much needed managerial capacity to manage processes like Accreditation and Standards.

Public Private Partnership needs to be mutually beneficial to both the parties so that there is encouragement of enterprises and element of pragmatism. It is important that the health professionals also earn in the process to sustain the partnership. However, the earning should be commensurate to the health services provided specially to the poor. This is possible through the volumes of patients, which the private sector would be getting from the public sector.

There is a need for further documentation of the ongoing experiments in PPP and evaluation of their impact. The evaluation mechanism should highlight the issues of access, utilization, sustainability, cost effectiveness and pricing, equity, transparency, audit etc.

Models For Partnership

It is essential to appreciate the diversity in terms of regional variations in the health status across the country. Therefore, generic models of existing PPP practices like contracting in, contracting out, social marketing, and social franchising may be modified to suit local variations. The assumption here is that a homogeneous prescription would not work and therefore the challenge is to develop the nitty-gritty of a framework allowing for diversity of models esp. at the District Level.

Public-Private-Partnership Models (Details at Annexure 2)

- Contracting :
  - Contracting out
  - Contracting-in
- Franchising :
  - Partial franchising
  - Full franchising
  - Branded clinics
- Social marketing
- Joint ventures
- Voucher schemes
- Hospital autonomy
- Partnership with corporate sector/ industrial houses
- Involving professional associations
- Build, operate and transfer
- Donation & philanthropic contributions
- Involvement of social groups
- Partnership with co-operative societies
- Partnership for capacity building
- Partnership with non-profit community-based organizations
- Running mobile health units
- Community based health insurance

PRINCIPLES 0F PPP

Although the approaches are different for each typology to resolve the health crisis currently in hand, there are certain common underlying principles guiding each of such partnerships, which are enumerated below:

1. Setting up of common goals and objectives, which are committed by all the partners.
2. Outcome based planning
3. Joint decision-making process
4. Creation of a social good by improving the health situation of the poor and underserved as well as standardization and uniformity of quality health service delivery
5. Accountability and responsibility set out vividly for each partner
6. Sharing of costs and resources are done on the basis of equity. The same principle is followed for sharing risk and rewards. Central to any successful public-private partnership initiative is the identification of risk associated with each component of the project and the allocation of that risk factor to the public sector, the private sector or perhaps a sharing by both. Thus, the desired balance to ensure best value (for money) is based on an allocation of risk factors to the participants who are best able to manage those risks and thus minimize costs while improving performance.
7. Regular meetings among the partners to discuss issues at hand and planning and coordinating for the future
8. A clear understanding of the strengths and weaknesses of the partners among themselves is essential to understand their roles and responsibilities clearly
9. The monitoring mechanisms are made sound in order to address the diversity of the partnerships
10. Financial sustainability is an all-pervading factor, which forms the backbone of all partnerships. There has to a regular flow of funds in order to meet the personnel and operating costs. Some programs have become self-sustainable only by involvement of the people. Such schemes do not require regular funds from the Government
11. Partnerships could be full substitution of the provision of health services, or managing the operations or monitoring or provision of infrastructure (equipments, manpower, etc.)
12. Any vested interest in such structures could destroy the base, and lead to the failure of the whole institution. Thus, a high level of trust and confidence is required in all the PPP initiatives.
13. Effective communications are key to the public's understanding of public-private partnerships. Communications are required to be planned and carried out as an integral part of the management process for any project. It involves timely sharing of information, accurate and consistent messages conveyed to key audiences, realistic messages from trusted sources that set realistic expectations.

14. PPP involves a long term relationship between the public sector and the private sector. While the collaboration between the two may take various forms like buyer seller relationship, donor recipient relationship, the most stable partnership is in the form of "contract" binding on both the parties. The contract mirrors the basic objective of the programme/project, the tenure of agreement, the funding pattern and of sharing of risk and responsibilities. The need to define the contract very precisely, therefore, becomes paramount under PPP.

Project/Programmes under PPP may, however, broadly be classified under three heads namely (i) service contract (ii) operations & maintenance (management) contract and (iii) capital project, with operations & maintenance contract.

Selection of Service Provider

Transparency in 'selection' is an essential feature of PPP. Selection of the developer or the service provider may be done in any of the following three ways.

(i) Competitive Bidding

This involves it well publicized and a well designed bid process to ascertain financial, technical and managerial capabilities of the service provider or the developer. Either of the two

formats for bidding, namely single round sealed bid auction or multiple round open entry (ascending) bid auction could be adopted. The appropriate biding process depends on the nature of the valuation that the bidders place on the concession, that is, on the right to do the job.

In some cases the valuation of the project depends on factors that are within the bidder's control, such as construction and maintenance cost of a building or a road. These are also known as 'private value items'. In other cases, the valuation does not depend just on the bidders own assessment, but also on certain unknown factors that need to be anticipated. These unknown factors are common to all bidders and each bidder may update his/her own assessment based on the assessment of other bidders. These are know as 'common value items' and include factors such as the size of market, willingness to pay of consumers and future behaviour of regulatory etc.

For private value items, a single round auction is appropriate since bidders do not need to learn from the revelation of information of other bidders and a sealed bid auction is preferable since that has the least potential for collusion. Concessions with common value characteristics on the other hand, are best awarded through multiple round bids since this facilitates the process of value discovery by bidders, allowing bidders to observe and respond to quotations/prices as they emerge. Multiple round bid can also be sealed bid but there is opportunity to rebid after the bids are opened. Moreover, wherever the bid process is characterized by a two stage process involving for instance, mega infrastructure projects, the bidders are required to obtain from their prospective lenders the financial terms, expectations regarding state support as well as their comments on the concession agreement etc.

The final selection of the developer/service provider depends upon one or a combination of the following (a) lowest capital cost of the pr0oject (b) lowest operation and maintenance cost (d) lowest bid in terms of the present value of user fees (c) lowest present value of payment from government (d) highest equity premium (c) highest upfront fee (f) highest revenue share to the Government and or 9g) shortest concession period.

Under situations of only a sole bid being received, the authorities have the choice of either accepting or rejecting the sole bid. In the case of rejecting the sole bid, or when no bid is received, the project/programme proposal its3elf may be modified and the bid process restarted. Alternatively the selection of the developer/service provider is done through competitive negotiation with the private sector participants.

(ii) Swiss Challenge Approach

The Swiss Challenge approach refers to suo-moto proposals being received from the private participant by the government. The private sector thus provides (a) all details regarding its technical financial and managerial capabilities (b) all details regarding technical, financial and commercial viability of the project/programme (c) all details regarding expectation of government support/concessions.

The government may examine the proposal and if the proposal belongs to the declared policy of priorities, then it may invite competing counter proposals from others (in the spirit of 'Swiss Challenge' approach) giving adequate notice. In the event of a better proposal being received, the original proponent is given the opportunity to modify the original proposal. Finally the better of the two is awarded the project/programme for execution.

(iii) Competitive Negotiation

Competitive negotiation (direct or indirect) is considered a variant of competitive bidding. The Government thus specifies the service objective and invites proposals through advertisement. The government then negotiates/finalise the contract with the selected bidders.

The government agency (or the local authority) may select the service provider/developer through competitive negotiation in the following cases:

a) Social sector projects and programmes involving VOs/NGOs/Local Community.
b) Project involving proprietary technology or a franchise;
c) Linkage project related to a mega project or a major activity.
d) Projects and programmes which failed to solicit any response to a bidding process.
e) Su-moto proposal from private participants.

Negotiation may, however, be 'simple' (direct) or 'complex' (indirect). In the second case, the government negotiates through a master contractor/mother, NGO. In other words, contracts for (public) services are contracted out and the master contractor handles all dealings with sub-contractors/franchises. While the government reviews the works of the master contractor through its monitoring (officials) who may visit the site of programme implementation and meet the beneficiaries, the master contractor may monitor the programme (run by sub-contractors) through collecting information from the beneficiaries selected randomly, based on questionnaires/interviews.

Advantage of Master Contractor

Some of the advantages mentioned about master contracting are: (a) government has administrative convenience, and better control in dealing with less number of service providers (b) funds can be raised from other public and private sources, other than the government (c) decision can be taken more quickly despite political pressures and (d) training programmes can be organised for the sub-contractors/service provider/vendors by the master contractor more innovatively.

However, master contract is not always relevant and negotiation vis-à-vis the contract ought to be done directly with the community/beneficiaries as for instance, in the case of wild life protection with the residents living in the vicinity of the forest. Competitive negotiations are, however, less transparent than competitive bidding. With a view to ensure fairness nonetheless, it is recommended that the government auditor may audit such contracts.

16. Payment mechanism: Payment to the private sector could take the form of (a) contractual payments (b) grants-in-aid and 9c) right to levy user charges for the asset created/leased in. Contractual payment may be in the form of advance payment, progress payment, final payment annuities and guarantees for receivable etc. Annuities, in turn could be with respect to recovering the fixed cost or for recovering both variable cost and the fixed cost of the project. In the form case, both the government and the private partner share the risk of running the project.

Grant-in-aid in turn can take different forms such as a block grant, capital grant matching grant, institutional support etc. Lease agreement license similarly may allow the concessionaire to recover the cost of construction/operation & maintenance through levying user charges. Moreover, in the case of lease agreement, the asset reverts to the government after the expiry of the contract. The agreement ought to also provide for the condition of asset that would be returned at the end of the contract.

17. Monitoring & Evaluation: It is quite often, thought that the job is over with the signing/finalizing the contract. Payments have to be, however, linked to performance, which in term requires monitoring. Performance measurement can be done with respect to measuring efficiency or measuring effectiveness. While measurement of efficiency entails comparing the unit cost of providing the service from amongst the various alternatives, measurement of effectiven3ess involves comparing the desired outcomes from amongst the various alternatives.

Monitoring may be done in either of the following ways (i) by government departments authorized to do so, based on a standardized scale (ii) by independent agencies/regulators based on a standardized scale (iii) by the department or independent agencies, based on the simple criteria of pass and fail by the department or independent agencies, based on the feed back received from the beneficiaries.

Involvement of third party/independent agencies for monitoring appears to be preferable as they leave the government hassle free over the project and minimize government control. A certain percentage of the cost of the project needs to be, therefore, earmarked for contract management. The government and the developer/service provider could mutually decide the third party. The third party involvement could be further supplemented with provisions for adjudication by the highest judiciary.

The following would be useful parameters in monitoring and evaluation of the initiatives:

- Profile of implementing agency: history, organizational structure, management board, business, service provided
- Procedures followed in signing the partnership- decision making process, competitiveness and transparency in selection process, criteria for selection and time taken
- Cope and coverage of services under agreement
- Eligibility conditions for the private agency-minimum investment, proper experience
- Specific clauses in the **MOU**-maximum duration of the contract, pricing and service specification, billing and payment mechanism, managerial flexibility, supervision and monitoring, quality control, employment service conditions of the staff, physical infrastructure support, subsidies and incentives, penalties and fines, exit clause, grievance redressal system
- Performance evaluation, renewal of contract
- Public health objective clause- specific services and subsidies to poor, women and children
- Feedback of stakeholders-state and central bureaucrats, public health facility managers, private agency managers, beneficiaries, staff in both public agency and private agency, community leaders

Conclusion

The Government plays a predominant role in any PPP. Hence it has to follow certain successful strategies in order to become a better partner. The key elements of a successful PPP are as follows:

1. The Government should look at the long-term value in a partnership
2. Selection of the right partner becomes imperative for the government to achieve tangible outputs and create the 'best value'. A partner's experience in the specific area of partnership being considered is an important factor in identifying the right partner.
3. By aligning the stakeholders' interests, the Government could endeavor better value creation
4. The Government could a adopt a more strategic approach by stepping back from the day to day management of public enterprises, and instead focusing on the drivers of long term value, setting targets and encouraging alliances and partnerships with the private sector.
5. The Government should introduce greater transparency. Greater openness about the financial performance and service delivery of public enterprises will be a useful discipline on managers within those organizations. Focusing on a few strategic targets will be a start.
6. The Government could introduce greater shareholder expertise by ensuring an appropriate mix of skills and experience among the partners to help carry out the health objectives more efficiently.
7. However, if PPPs are genuinely going to deliver better quality services, it is vital that they are designed with the focus on outputs and performance. The private sector partner or partners need to be clear about what is expected from them and the implications if they fail to deliver.
8. The Government must recognize that it has a continuing role in the public service element of essential services. In some cases, this may mean retaining some elements of service delivery in

the public sector. Therefore it becomes critical to decide on retaining the control over certain services, rather than contracting them.
9. The Government could adopt the following approaches to deliver partnerships:
(a) Undertaking appropriate partnerships by understanding what works best in a given situation, the circumstances in which they are to be implemented and the objectives which they are intended to serve
(b) Creating innovative and imaginative partnerships and creating new ways of working - learning by doing - is key, particularly where there is no existing best practice
(c) Designing a holistic approach PPPs by joined-up thinking, reflecting the needs of customers, potential partners and providers, as well as joined-up Government initiatives rather than the narrowing the objectives to the departmental territory.

The performance of any PPP in the health sector could be evaluated based on the following building blocks:
1. Beneficence or public health gains
2. Non-malfeasance or not leading to ill health
3. Autonomy enjoyed by each partner
4. Shared decision-making
5. Equity or distribution of benefits to those most in need

However it may be reiterated that the private partnerships are not sufficient to resolve the dilemma of inadequate health care for the people. The focus of Public policy in the context of the11th Five Year Plan should be the flagship march for strengthening the public health sector.

Annexure-1

MOST PRACTICAL & COST EFFECTIVE MODE OF PPP FOR IMPROVEMENT IN HEALTH SERVICES DELIVERY

PROBLEM AREAS AT VARIOUS LEVELS IN HEALTH SERVICES DELIVERY	TYPE OF SUGGESTED PARTNERSHIP	WORKING MODELS	COST EFFECTIVITY	REMARKS
		HOSPITAL SET-UP		
SHORTAGE/ ABSENCE OF SPECIALISTS	APPOINTING SPECIALISTS ON CONTRACT BASIS ON WEEK ENDS OR SO.	GOVT OF GUJARAT IMPLEMENTED THE PARTNERSHIP IN SEP 2002 IN NARMADA DISTT. AND LATER EXTENDED TO RAJKOT DISTRICT	FUND POOLING FROM UNUSED BUDGET DUE TO VACANT SPECIALISTS POSITION TO USE FOR CONTRACTING PRIVATE PRACTITIONERS	PARTNERSHIP IS ON CONTRACT BASIS AND RS 500(LATER EXTENDED TO RS. 1000 PER VISIT) PER VISIT TWICE A WEEK IS PAID. EVALUATION SHOWED THAT ARRANGEMENTS ENSURED ACCESS TO SPECIALIST SERVICES AT HOSPITALS. HOWEVER, PER DAY HONORARIUM SHOULD BE KEPT EQUIVALENT TO ONE DAY SALARY OF SPECIALIST WITH CONVEYANCE CHARGES OF RS 500/-
ABSENCE/ POOR QUALITY OF RADIO DIAGNOSTIC MACHINERY	INSTALLATION OF RADIO DIAGNOSTIC MACHINERY (CT,USG,X-RAY) BY PRIVATE SECTOR ON CONTRACT IN BASIS IN THE PREMISES OF THE HOSPITAL	CT MACHINES HAVE BEEN INSTALLED AND ARE BEING RUN BY PRIVATE AGENCIES IN 7 GOVT HOSPITALS IN WEST BENGAL .	SERVICES ROUND THE CLOCK AT REDUCED PRICES, FREE SERVICE FOR BPL PATIENTS & SENIOR CITIZENS, A FIXED NO. OF INVESTIGATIONS/MONTH /HOSPITAL AFTER WHICH THEY CAN CARRY AS MUCH AS THEY WISH BUT THEY WILL HAVE TO PAY COMMISSION PER PATIENT	TERMS & CONDITIONS STATE THAT FREE SERVICES SHOULD BE GIVEN TO AT LEAST 35 PATIENTS/ HOSPITAL AND TO NOT MORE THAN 615 CASES/ HOSPITAL/ MONTH AT APPROVED GOVT RATES. 25% COMMISSION AFTER THE SPECIFIED CASES TO BE PAID TO STATE GOVT. MODEL RESULTED IN OVERALL COST REDUCTION ACROSS THE CITY. PATIENTS FEEDBACK IS MUST FOR COMPLIANCE OF CONDITIONS

				IN CASE OF SMALLER UNITS, GOOD AND BAD LOCATIONS SHOULD BE AWARDED TOGETHER TO COMPENSATE FOR POSSIBLE LOSSES
ABSENCE OF 24×7 LAB SERVICES	ON THE BASIS OF CONTRACTING IN PARTNERSHIP WITH THE PRIVATE SECTOR	PARTNERSHIP BETWEEN M/S THUKRAL DIAGNOSTICS CENTRE LUCKNOW & BMC AND PG ALIGUNJ IMPLEMENTED IN MARCH 2003 IN 1994 IN SWEDEN A FOR PROFIT LABORATORY CALLED MEDANALYZE WAS AWARDED A CONTRACT TO HANDLE LAB TESTS FOR PRIMARY CARE PHYSICIAN IN A DISTRICT OF STOCKHOLM COUNTY.	NO EXTRA COST ON STRETCHING THE LAB SERVICES TO ROUND THE CLOCK, FREE SERVICES FOR BPL PATIENTS WHOSE FEES CAN BE REIMBURSED FROM THE HOSPITAL WELFARE COMMITTEE	SELECTED DIAGNOSTIC CENTRE PROVIDES 3 DIFFERENT PACKAGES AT REASONABLE COST FOR EMERGENCY INVESTIGATIONS. THE ARRANGEMENT ENSURES THE PREGNANT WOMEN AND CHILDREN HAVE THE ROUND THE CLOCK ACCESS TO LAB INVESTIGATIONS AT AN AFFORDABLE COST THE STOCKHOLM MODEL FAILED AS THE COMPANY WAS UNABLE TO HANDLE THE LARGE VOLUME OF SAMPLES AND BEGAN MISHANDLING SPECIMENS AND EVEN FABRICATING RESULTS AS A MEAN OF COPING. EXIT POLICY MAY BE CONSIDERED. ONLY ACCREDITED AND TRUSTED LABS IN HEALTH SECTOR SHOULD BE CONSIDERED. GOVT MAY EXEMPT RENT, WATER CHARGES ETC FOR REMOTE AREAS
DIFFICULTY IN ACCESS TO SUPER-SPECIALIST HEALTH SERVICES IN REMOTE AND HILLY AREAS	SETTING THE TELE-MEDICINE & TELE-HEALTH SYSTEM ON CONTRACTING OUT BASIS WITH THE PRIVATE SECTOR	KARNATAKA INTEGRATED TELE-MEDICINE AND TELE HEALTH PROJECT, IN KARNATAKA DISTT HOSPITAL, NARAYANA HRUDAYALYA BANGALORE IN COLLABORATION WITH	REDUCED TRAVEL AND ELIMINATION OF UNNECESSARY PATIENT TRANSFER, LOW CAPITAL INVESTMENT FOR ESTABLISHING A CARE PRESENCE, TRAINING AND RE- TRAINING AT THE LEAST COST POSSIBLE	THE 27 TELEMEDICINE CENTERS IN INDIA ARE THE LARGEST E-HEALTH CENTERS IN THE WORLD. SO FAR 16000 HEART PATIENTS HAVE BEEN TREATED VIA AN

		INDIAN SPACE RESEARCH ORGANIZATION. OPERATIONAL SINCE 2002.		'E-WAY'. GOVT MAY OFFER TAX INCENTIVE OR SOME OTHER RELIEF IN LIEU OF WORKING IN REMOTE AREAS. PENALTY CLAUSE FOR NON FUNCTIONING OF FACILITY. FACILITY CREATED MAY ALSO BE OPEN TO OTHER PYT PRACTITIONERS IN SURPLUS TIME.
LOW AVAILABILITY OF DOCTORS AND MEDICAL SERVICES	PARTNERSHIP WITH THE CORPORATE/ BOT FOR MEDICAL/ DENTAL EDUCATION & SERVICES	VARIOUS PRIVATE MEDICAL/ DENTAL COLLEGES ACROSS THE INDIA.	NO EXTRA BURDEN IN CORPORATE AND NO RUNNING COST IN BOT	POLICY FOR PRIVATE SECTOR PARTICIPATION IN MEDICAL/ DENTAL EDUCATION SEEKS TO ATTRACT PRIVATE SECTOR TO SET UP COLLEGES IN THE STATE. CRITERIA IS LAID DOWN BY THE STATE GOVT, MCI & DCI. FINAL DECISION IS BASED ON THE AVAILABILITY OF LAND WITH THE ORGANIZATION, AVAILABILITY OF HOSPITAL HAVING MINIMUM 300 BEDS FOR MEDICAL COLLEGE EXISTING EXPERIENCE FAILED IN DELHI. GOVT MAY PURCHASE SERVICE FOR POOR/NHPS ON PREDETERMINED RATES. HOWEVER, GOVT MAY DECIDE THAT NEW PHCS/CHCS WILL BE OPENED BY PYT PLAYERS AND GOVT WILL BY SERVICES ON YESHASVINI MODEL
NON/LOW AVAILABILITY OF MEDICINES & SURGICAL ITEMS	PARTNERSHIP OF SOCIAL MARKETING TYPE CAN PROVIDE CHEAPER MEDICINES & SURGICALS IN HOSPITAL PREMISES	LIFE LINE FLUID DRUG STORE IN SAWAI MAN SINGH(SMS) HOSPITAL, JAIPUR, RAJASTHAN STARTED IN 1996	WITH NO EXTRA COST STATE GOVERNMENT CAN PROVIDE STANDARD STUFF TO THE PATIENTS AT REASONABLE PRICE ROUND THE CLOCK	THROUGH OPEN TENDER , RMRS INVITE BIDS FROM SUPPLIERS TO PROCURE MEDICINES THAT LLFS SELLS TO

				SMS PATIENTS AT THE PROCUREMENT PRICES. RMRS DECIDES THE PERIOD OF THE CONTRACT, WHICH IS RENEWABLE ON THE BASIS OF GOOD PERFORMANCE. WITH FIXED SALARY AND A ONE – PERCENT COMMISSION ON ALL SALES, THE CONTRACTOR APPOINTS AND MANAGES STAFF FROM THE RECEIPTS. WILL BE SUCCESSFUL WHERE HIGHER VOLUME OF SALE EXIST. SMALLER HEALTH UNITS MAY ALSO BE TAGGED WITH BIGGER ONE IN CONTRACT
LACK OF AMBULANCE/ TRANSPORT SERVICES	PARTNERSHIP WITH NGOS/CBO,USER CHARGES/KM SCHEME	EMERGENCY AMBULANCE SERVICES, THENI DISTRICT, TAMIL NADU, PARTNERSHIP IS OPERATIONAL SINCE 2002.	AMBULANCE/TRANSPORT SERVICES CAN BE PROVIDED WITH NO EXTRA EXPENDITURE ON PURCHASING/ MAINTENANCE OF THE VANS	TOTAL COST OF THE PROJECT IS 6,50,000. RS. 5 PER KM AS USER FEE. FREE SERVICES TO 10% CASES,(BPL PATIENTS). MEMBERS OF WOMEN'S SELF HELP GROUP GET 10% CONCESSION. THIS TYPE OF INITIATIVES WILL BE SUCCESSFUL IF LARGE NUMBER OF AMBULANCES ARE CONTRACTED WITH LEAST IDLE TIME AND RATE IS SUBJECT TO REVISION WHEN HIKED BY GOVT
LOW SANITATION AND LAUNDRY STANDARDS	CONTRACTING OUT/NGO PARTNERSHIP	GOVERNMENT OF UTTARANCHAL HAS HANDED OVER LAUNDRY SERVICES IN 9 BIG HOSPITALS TO PRIVATE AGENCIES IN DECEMBER 2001 WHILE THOSE IN DOON HOSPITAL WERE HANDED OVER IN FEB 2003	IMPROVED SANITATION AND LAUNDRY	THESE AGENCIES HAVE BEEN SELECTED ON THE BASIS OF THE COMPETITIVE BIDDING. MANPOWER, CONSUMABLES, EQUIPMENT AND SALARY TO EMPLOYEE

				SHOULD BE CAREFULLY DRAFTED IN AGREEMENT OTHERWISE SITUATION WILL GET WORST
DIETARY SERVICES	CONTACTING IN WITH PRIVATE CATERERS ON COMPETITIVE BIDDING BASIS	ALONG WITH THE LAUNDRY/ SANITATION SERVICES THE GOVT. OF UTTRANCHAL HANDED OVER THE DIETARY SERVICES AS WELL IN THE FOR MENTIONED HOSPITALS	HYGIENIC AND NUTRITIOUS FOOD WITHOUT EXTRA BURDEN ON INFRASTRUCTURE	THE SELECTION OF THE PRIVATE PARTNER WAS ON THE BASIS OF THE COMPETITIVE BIDDING BY THE HOSPITAL AUTHORITY. POOLING OF ANCILLARY SERVICES WILL RESULT INTO BETTER PROFIT TO CONTRACTOR. STRICT CONDITIONS ABOUT COMPETENCE OF CONTRACTOR AND JOB TO BE DONE IS NEEDED
HEALTH INSURANCE COVERAGE TO THE STATE POPULATION	COMMUNITY BASED HEALTH INSURANCE ALSO CALLED SELF FUNDED HEALTH INSURANCE SCHEME. HOWEVER THE SCHEME IS NOT FULLY SELF FUNDED BECAUSE IT REQUIRES GOVERNMENT CONTRIBUTION	YESHASVINI-CO-OPERATIVE FARMER'S HEALTH CARE, KARNATAKA. PARTNERSHIP BETWEEN NARAYAN HRUDAYLAYA BANGALORE & APOLLO HOSPITALS HYDERABAD, TRUST WAS LAUNCHED IN 2002	PROVIDE SURGICAL CARE THROUGH LOW PREMIUM HEALTH INSURANCE. COVER NEARLY 1600 TYPES OF SURGERIES. FREE OUT-PATIENT CONSULTATION. MEDICAL AND DIAGNOSTIC INVESTIGATIONS AT NOMINAL RATES. SCHEME COVERS EVEN PREEXISTING ILLNESSES.	1,600 DIFFERENT SURGERIES COSTING UP TO A MAXIMUM OF RS. 200,000.MEDICAL TREATMENT NOT LEADING TO SURGERY IS NOT COVERED. GOVT. OF KARNATAKA ORIGINALLY CONTRIBUTED 50% OF MONTHLY PREMIUM FOR EACH MEMBER NOW ONLY A CONSOLIDATED AMOUNT (OF RS. 3.5 MILLION IN THE SECOND YEAR AND 1.5 MILLION IN THE THIRD YEAR) . FHPL IS PAID 4% OR AROUND RS. 5.9 MILLION AS THEIR FEE. COMMITTED GOVT CONTRIBUTION ON LONG TERM BASIS AND TIMELY COLLECTION OF CONTRIBUTION IS MUST. RATHER CREATING NEW HOSPITALS, GOVT MAY ENCOURAGE SUCH SCHEMES ON LONG TERM BASIS
AT CHC/ PHC LEVEL				

IMPROPER MANAGEMENT	CONTRACTING OUT WITH THE PRIVATE SECTOR	MANAGEMENT OF PRIMARY HEALTH CENTERS, KARUNA TRUST, KARNATKA A NON PROFIT NGO, FROM 1996 ON TRIAL BASIS , BUT BASED ON FORMAL POLICY DECISION, SINCE 2002	IMPROVED MANAGEMENT WITH THE SAME/LOW BUDGET	GOVT. PROVIDES PHC PREMISES, INITIAL EQUIPMENTS AND SUPPLIES, AND 75% TO 90% SALARIES. STAFFING BY THE NGO. RS. 25000 PER ANNUM AS CONTINGENCY. RS. 75000 PER ANNUM FOR DRUGS/ SUPPLIES. FREE HEALTH CARE TO ALL PATIENTS. SELECTION OF WORKERS SHOULD BE THE PREROGATIVE OF NGO., GOOD WORKING AND POOR WORKING FACILITIES SHOULD BE JOINTLY HANDED OVER. INCREASE IN SALARY OVER TIME MAY BE KEPT IN MIND. APPRAISAL BY THIRD PART IS MUST. GOOD FINANCIAL MGT IS KEY TO SUCCESS
POOR OUTREACH AND REFERRAL SERVICES FOR SLUM POPULATION.	CONTRACTING OUT TO PRIVATE ORGANIZATIONS	ARPANA SWASTHYA KENDRA MOLARBUND, DELHI, IN PARTNERSHIP WITH MCD. PERFORMANCE MEASURES ARE SET FOR THE TRUST, INITIAL CONTRACT IS FOR 5 YEARS.	DISTRIBUTING THE BASIC HEALTH PRODUCTS SUCH AS CONTRACEPTIVES, ORS, CLEAN DELIVERY KITS TO THE SLUM DWELLERS THRU EXISTING COMMERCIAL NETWORK FUNDS POOLED FROM RS. 10 FOR OPD CARDS INCLUDING MEDICINES FOR 3 DAYS, RS. 50 TO 100 FOR EMERGENCY AMBULANCE SERVICES.	PERSONALITY DRIVEN PROJECT. LACK OF CLARITY ON USER-FEE, SHORTAGES OF RESOURCES COMMON. LONG PROCEDURES, OVERCROWDING, LACK OF FOLLOW UP ACCEPTABLE QUALITY OF SERVICES ; COMMITTED STAFF. EXISTING PVT PRACTITIONERS MAY BE TRAINED AND INVOLVED WITH INCENTIVE OF PER UNIT OF SERVICE. EXISTING PPM APPROACH OF RNTCP CAN BE HELPFUL INITIALLY, SOME SEED MONEY MAY BE GIVEN TO START THE

				PROJECT COOPERATIVE SOCIETIES MAY BE ROPED- IN
UNDER STAFFING OF THE MEDICAL OFFICERS/ ANMS	APPOINTING MEDICAL OFFICERS & ANMS ON CONTRACTING IN BASIS	UTTRANCHAL GOVT. HAS MADE EFFORTS IN APPOINTING MEDICAL OFFICERS & ANMS. THIS HAS BEEN DONE IN VIEW TO IMPROVE HEALTH SERVICES IN REMOTE AREAS AND GIVEN THE DIFFICULTY IN RETAINING SERVICES OF PROVIDERS DUE TO LACK OF ACCOMMODATION AND LOW SALARY.	NO EXTRA BURDEN ON INFRASTRUCTURE AS FUNDS CAN BE POOLED FROM THE FUNDS UNSPENT DUE TO VACANT POSITIONS	TO RETAIN THE SERVICES GOVT. HAS INCREASED THE HONORARIUM OF CONTRACTUAL MEDICAL OFFICERS FROM 11,000 PER MONTH TO RS. 13000 PER MONTH W.E.F. FEB 2004.IN ORDER TO PROMOTE INSTITUTIONAL DELIVERIES, 24 HOURS DELIVERY SERVICES ARE BEING PROVIDED IN 85 HEALTH CENTERS AND CERTAIN INCENTIVES ARE PROPOSED FOR SERVICE PROVIDERS WHO CONDUCT DELIVERIES BETWEEN 8.00 PM TO 7.00 AM. LOCALLY PRACTICING DOCTORS AND STAFF MAY BE GIVEN PRIORITY AS THEY MAY FIND THE AMOUNT ACCEPTABLE. REGULAR REVIEW OF SCHEME IS NEEDED
NATIONAL HEALTH PROGRAMMES				
FAMILY WELFARE PROGRAMME	CONTACTING WITH THE NGOS	1459 PRIVATE HOSPITALS ARE APPROVED FOR PERFORMING VASECTOMY, TUBECTOMY, MTP AND OTHER CONTRACEPTIVES.	GOVT. PROVIDES BASIC SERVICES WHERE NGO CAN PROVIDE BEDS, SURGICAL ITEMS TO PERFORM STERILIZATION SERVICES	DRUGS CHARGES AND OPERATING SURGEONS FEES ARE PAID BY THE GOVT. PAYING COMPENSATION TO STERILIZATION ACCEPTOR. OPERATIONAL COST IN GOVT SET-UP MAY BE CONSIDERED AS SERVICE CHARGE TO PVT PROVIDERS. ADVANCE PAYMENT WILL IMPROVE PERFORMANCE
CATARACT	CONTRACTING	CERTAIN NGOS LIKE	NGOS CAN PERFORM	SOME 100 PRIVATE

BLINDNESS CONTROL PROGRAMME	WITH PRIVATE SECTOR (NGOS)	VHS, CHRISTIAN MISSION HOSPITAL, ANDHRA MAHILA SABHA, F.P.A.I. ETC. ARE GIVEN ANNUAL GRANTS BY GOVERNMENT FOR THEIR RECURRING EXPENDITURE. THIS IS APPLICABLE TO CERTAIN DISPENSARIES RUN BY NGOS IN TRIBAL AREAS ALSO.	CATARACT SURGERIES, ARRANGE EYE CAMPS WHERE GOVT PROVIDES FINANCE.	HOSPITALS ARE APPROVED FOR UNDERTAKING MAJOR SURGERIES UNDER THE ABOVE SCHEME. ONLY ACCREDITED NGOS HAVING SKILLED MANPOWER SHOULD BE CONSIDERED.
TB CONTROL PROGRAM	PARTNERSHIP WITH PRIVATE PRACTITIONER TO GIVE IEC ON THE DOTS SCHEME AND FOR IDENTIFICATION AND TREATMENT OF THE PATIENTS, GOVT. LABS ARE OPEN FOR THE USE BY THE PRIVATE PRACTITIONER FOR TB DIAGNOSIS	MAHAVIR TRUST HOSPITAL, HYDERABAD , SEWA AT AHMEDABAD AND, MANAV SARTHAK KUSTHASHRAM, JAIPUR ARE SOME OF THE SUCCESS STORIES	SPREADING AWARENESS THROUGH PRIVATE DOCTORS IS COST FREE, OPENING THE LABS FOR USE BY THE PRIVATE DOCTORS CAN DIAGNOSE MORE TB PATIENTS AND TREATMENT OF THE SAME	HOSPITAL CREATES A REFERRAL CARD , INITIAL DIAGNOSIS , COUNSELING , AND TREATMENT PROTOCOL AND REFERS THE PATIENT TO DESIGNATED DOTS CENTER FOR DRUGS. GOVT PROVIDES FREE DRUGS AND MEDICINES TO THE DOTS CENTERS ALSO TRAIN MEDICAL STAFF, PROVIDES LAB SUPPLIES, PRIVATE MEDICAL PRACTITIONERS REFER PATIENTS MODEL OF RNTCP HAS STRONG POTENTIAL FOR ADOPTION IN ALL NHPS
AIDS CONTROL PROGRAMME	PARTNERSHIP WITH NGOS TO SPREAD AWARENESS ABOUT THE HIV/ AIDS , MAKING FREE CONDOMS AVAILABLE TO THE PEOPLE BY NGOS		WITH NO EXTRA COST GOVT CAN SPREAD HIV/ AIDS AWARENESS AND PROVIDE CONDOMS TO THE PEOPLE	MONITORING IS MUST
PULSE POLIO PROGRAMME	PARTNERSHIP WITH PRIVATE DOCTORS / NGOS. NGOS CAN CONDUCTS PULSE POLO CAMPS, PRIVATE DOCTORS CAN GIVE POLIO DROPS TO THE UNDER FIVE CHILDREN THOSE WHO VISITS THEM AS PATIENTS OR WITH PATIENTS		WITH INVOLVEMENT OF PRIVATE PEOPLE PROGRAMME CAN BE IMPLEMENTED MORE EFFECTIVELY WITHOUT ANY BURDEN ON EXISTING INFRASTRUCTURE	VACCINE PREVENTABLE DISEASES ARE ALSO ISSUED FREE OF CHARGE TO PRIVATE NURSING HOMES FOR THEIR USE
RCH PROJECT	CONTRACTING WITH THE PRIVATE HOSPITAL	UNDER RCH PROJECT	EFFECTIVE AND ECONOMIC RCH & FAMILY WELFARE	FUNDS FOR THE SCHEME WILL BE

	UNDERTAKE LSCS SURGERIES WHERE GOVT SERVICES ARE NOT AVAILABLE, FEES ARE MET BY GOVT. HOSPITAL, OBSTETRICIANS , ANESTHETIST CAN BE HIRED FOR LSCS SURGERIES IN GOVT HOSPITAL WHERE THEY ARE NOT AVAILABLE. MTP SERVICES ARE ALSO PROVIDED IN THE PRIVATE HOSPITALS AGAINST THE VOUCHERS WHICH REIMBURSED AFTER EVERY MONTH FROM THE STATE GOVT.	INNOVATIVE MODEL LIKE VIKALP ARE GOING ON. DELIVERY HUTS MAY BE HANDED OVER TO NGOS ALREADY INVOLVED IN RCH	SERVICES CAN BE PROVIDED TO THE PEOPLE	PROVIDED FROM THE DEPARTMENT OF HEALTH, HARYANA TO THE MOTHER NGO FOR FURTHER PAYMENT. THE PAYMENT WILL BE MADE OUT OF THE FUNDS AVAILABLE VOUCHER SCHEMES UNDER THE RCH Π PROGRAMME. AN AMOUNT OF RS 1.5 CRORES IS AVAILABLE FOR IMPLEMENTING VOUCHER SCHEMES IN THE YEAR 2005-07. THE NORMS FOR PAYMENTS WILL BE FINALIZED AFTER NEGOTIATION BETWEEN MNGOS AND PRIVATE PROVIDERS. ADVANCE PAYMENT IN FIRST QUARTER MAY BE EXPERIMENTED

Annexure-2

MODELS OF PUBLIC PRIVATE PARTNERSHIPS

Various models can be utilized for putting these partnerships into action; some of the possible mechanisms for implementation of PPP are given below:

1. Franchising

Franchise is a type of business model whereby a manufacturer or marketer of a product or service (the franchiser) grants exclusive rights to local independent entrepreneurs (franchisees) to conduct business in a prescribed manner in a certain place over a specified period. Typically the franchiser has developed specialized skills, knowledge, and strategies and thus able to share its blueprint for a successful product line with franchisees. The franchisees contribute resources of their own to set up a clinic and pay membership to franchiser.

Partial Franchising: Most of the social franchising models followed in India are partial franchising models. Franchiser identifies private hospitals and enters into an agreement with franchisee to provide certain services in lieu of payment of fee or commissions from sale of services and goods. These contracts largely confine to a basket of RCH services. However franchisee provides many other services that are not part of the contract. There is no control over quality of services provided by franchisee outside the contract.

Usually one-year subscription fee is given by franchisee to franchiser. In this arrangement, increased performance of franchisee does not lead to increased revenues to franchiser. There is no incentive to franchiser to improve performance through promotional activities. One way to overcome this problem is to have a revenue sharing arrangement between franchiser and franchisee. However many of the hospitals are not transparent about their financial transactions or do they maintain complete record of services provided. One of the innovative aspects of these social franchising efforts is to link rural medical practitioners and/or community based organizations such as SHG to franchisee that has helped to increase the client load for RCH services. The partial franchising efforts in India do not represent public-private partnerships but offer a model and experiences that are highly relevant. Government can have its own model of social franchising with franchiser-franchisee-RMP-CBO linkages. Concentration of private hospitals/ nursing homes in urban areas has to be taken into consideration. In many rural and inaccessible areas where the need for improved access to services is the highest, there are not private hospitals/nursing homes.

Full Franchising: Franchisee provides services defined by the franchiser and expansion of range of services depends on mutual agreement. For existing nursing homes and hospitals, this can mean a considerable revenue loss and this has to be filled in by subsidies till the client load improves and the hospitals start making operating profits. Time required for transition of loss making unit to profit making unit depends on a variety of factors such as location of hospitals, demand for services, perceived quality of services and competition. Not many hospitals may opt for this given the uncertainties in financial returns, unless guarantees are given to sustain the model for a long period of time.

2. Branded Clinics:

A few organizations have started a chain of branded clinics that offer a wide range of reproductive and child health services. There is scope to expand the range of services provided by these clinics and add social mobilization efforts to their functions. These branded clinics can be opened in areas where there is a need with minimum effort. Branded clinics are more sustainable because of their ability to generate more income than social franchising units.

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3. Contracting Out

Contracting out refers to a situation in which private providers receive a budget to provide certain services and manage a government health unit. The two parties usually agree on some or all of the following: the quantity and the quality and the duration of the contract.

Common criteria for identifying those government health clinics that need to be contracted out are the first step in this direction. Large number of vacancies for a long period, high absenteeism, and consistent low performance on all RCH indicators could be the critical criteria.

Some states are more prepared for contracting out services compared to others. Fear of losing jobs and perceived shrinking role of government in health sector are the main reasons for resistance. Advocacy efforts are required in those states where resistance levels are high for contracting out services.

There are several levels at which the contracting out can be done depending on the degrees of freedom given to the contractor. Higher the freedom, higher should be the performance levels of key RCH indicators.

Option 1: Government hands over the physical infrastructure, equipment, budget and personnel of a health unit to the selected agency.

Option 2: Government hands over the physical infrastructure, equipment, budget but gives freedom to the selected agency to recruit personnel as per their terms and conditions but following the government norms such as one ANM per 5,000/3,000 population.

Option 3: Government hands over the physical infrastructure, equipment, and budget but gives freedom the select agency to have their own service delivery models without following the fixed prescribed pattern.

Option 4: Government hands over the physical infrastructure, equipment, budget and gives freedom to the select agency to have their own personnel, service delivery models, freedom to expand types of services provided and freedom to introduce user fee and recover some proportion of costs.

4. Contracting In

Contracting in is done for a variety of services particularly in major hospitals. These include: maintenance of buildings, utilities, housekeeping, meals, medicine stores, diagnostic facilities, transport, security, communications etc. Hospitals are given freedom to choose the services to be given to contractors. In many cases they lack comprehensive plans and sound financial analysis. Nevertheless, contracting in many hospitals has resulted in conservation of resources, improved efficiency and better quality of services. Contracting in services leads to surplus human resources and they need to be transferred to other health units to fill in vacant positions, if any. Resentment of employees and interference of trade unions are some of the major obstacles to this process.

Contracting in does not work in some places for particular types of services. For instance some state governments could not attract private sector participation for diagnostic services in remote area hospitals with low client load. One option is to subsidize the equipment purchased by private agencies and the other is to make services located in government hospitals open to all. Even a person with prescription from private clinic should be allowed to use privately run diagnostic facilities in government hospitals. This increases the volume of transactions and makes the unit financially viable.

Recruiting doctors, technicians and other staff on contractual basis for a stipulated period of time is widely practiced in several states. In some cases the contracted staff performs all duties of regular staff and in other instances, their services are contracted for a few days in a month and to provide services in a particular clinic. In many states, a large proportion of vacant positions were filled in following this process.

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BANGALORE-34

5. Social Marketing

One of the earliest efforts at building public-private partnerships is in the area of social marketing of contraceptives. For more than a decade, HLL, ITC, Indian Oil and other large FMCG companies helped the government with social marketing of contraceptives by piggy backing Nirodh to their products. Later private social marketing companies have emerged as a force to reckon with and gained considerable experience in marketing contraceptive products both social and commercial. The increasing trend now is to enlarge the basket of products by including ORS, IFA tablets, and other health products to make the marketing efforts more self-sustaining. Government provides the subsidized contraceptives, and finances brand and point of purchase promotion schemes of selected marketing agencies.

6. Build, Operate and Transfer

Build, operate and transfer (BOT) models are highly successful in infrastructure development sector in India. BOT requires part financing of projects by the government, financial guarantees when needed, subsidized land at prime locations and assurance of reasonable returns on investment. These models could be useful to establish large hospitals and ensure quality services at reasonable rates to poor people. However these hospitals should be able to withstand market competition to survive and sustain themselves.

7. Joint Venture Companies

Joint venture companies are companies launched with equity participation of government and private sector. Proportion of equity of each partner may vary from one venture to another. Joint venture companies, in most cases in commercial sector, have not succeeded in India due to lack of understanding and trust between partners, inordinate delays in decision-making and dominance of government even with low equity. There is even less chance of their succeeding in health sector.

8. Voucher System

A voucher is a document that can be exchanged for defined goods or services as a token of payment (tied-cash"). This consists of designing, developing and valuing health packages for various common ailments / conditions (like ANC package / STI package / Teen pregnancy package / family planning package etc) which can be bought by the people at specific intervals of time. These vouchers can then be redeemed for receiving a set of services (like 1-2 consultations, lab tests, procedures, counselling and drugs for the condition) from certified / accredited hospitals or clinics and are to be used within 2-3 months of buying the voucher. This means that the package can be bought, used as and when required and ensures privacy for the client.

Regular monitoring is required for ensuring quality standards, training of providers and networking with the people to ensure that the proper use of vouchers. The vouchers are redeemed to the clinics for the number utilised depending on the price for each package of service provided. Clinics that fail the quality standards of service and do not do well on patient satisfaction can be removed from the certified services.

9. Donations from individuals

Within a large country like India and with a creditable high income and middle income groups there are many examples of private donors willing to partner with the public sector. Rich philanthropists, individual donations may be the crucial requirement in areas to make the PPP initiative effective in delivering health care. Though in some states mechanisms and provisions are present for utilizing these private donations for improving local health situation, many other states lack these systems. Efforts have to be made to create simple and transparent institutional mechanisms to encourage donations to contribute to the growth and improvement in reproductive and child health services in their area.

10. Partnerships with Social Clubs and Groups (e.g. Rotary Club)
Clubs like Rotary and Lion's played a significant role in immunization campaigns, Pulse Polio campaign and other health care services. Since these clubs have a nation wide network, their involvement ensures better coverage. They also bring in their expertise and resources to the health care services.

11. Involvement of Corporate sector:
The corporate sector has a rich history of being supportive of the health and family welfare interventions for people that work in and live around its premises. Under Corporate Social Responsibility, the corporate sector through the Confederation of Indian Industries (CII) and the Federation of Indian Chamber of Commerce and Industries (FICCI) and several other sector wise business and industry associations have played a significant role in advocacy efforts, funding non-government organizations for innovative interventions, introducing new schemes to encourage service utilization and expending their own resources for promotion of reproductive and child health services particularly family planning services..

12. Partnership with Professional Associations
There are several professional associations such as Indian Medical Association, Gynaecologists federation, nurses associations etc. These association from time to tome extended help in launching new programmes such as Vande Mataram Scheme, Gaon Chalo project and immunization programme particularly pulse polio. They have technical skills and expertise to provide advice on various other matters such as setting standard protocols, quality assurance systems and accreditation. However the managerial capacities of these professional associations have to be strengthened.

Moreover, with widespread chapters/ branches all over the country and huge membership they can play a very important on ethical issues.

13. Capacity building of private providers, pharmacists and informal providers (RMPs)
Several initiatives taken by the government in the past to improve the technical and counselling skills of private medical practitioners particularly rural medical practitioners by providing them training improved quality of services offered by them. Since they have a huge presence in rural areas and urban slums and a significant proportion of population depend on them for services, there is a need to involve them in a significant way to create demand for services and in making referral system effective. Similarly government medical officers and administrator benefited by participating in training programmes conducted by private institutions. Consultancy services offered by private institutions in the areas of communications, systems development etc is another example of public-private partnership. Another area of partnership is contracting out management of training institutions such as ANM Training Centres, Regional Training Centres to NGOs and private agencies.

14. Special "Category Campaigns" with the private sector to improve health
The WHO-ORS campaign and the Goli- ke- Hamjoli campaigns are examples of the use of the commercial sector to advance national health goals. The category campaigns expand use of a health/family-planning product, increases the volume and the users for the product. In India, the Goli ke Hamjoli and WHO-ORS campaigns succeeded in increasing product awareness, availability, sales, and use. At the same time, this entails using a generic promotional strategy, increased private-sector investment and the value of the market, policy change; coordination with partner pharmaceutical firms; affiliation with professional associations; expansion of market channels; and consumer outreach. Initially, the program should use mass media vehicles to improve product awareness and contemplation. But, as the program develops, its emphasis should shift to encouraging product trial, and use interpersonal approaches to reach out to potential consumers.

These special campaigns in partnership with the private sector can focus on demand generation for refurbished and revitalised public sector, generic promotion of health products (life saving ORS, Menstrual Hygiene with Sanitary Napkins etc).

15. Autonomous Institutions

Giving autonomy to public institutions within the system can lead to improvement in quality, accountability and efficiency. It also ensures greater involvement and ownership at the level of the institution, ensuring greater morale and encouragement to the work-force. Many such projects have been implemented and have shown to yield excellent results, as the need for the change in management systems is self-driven. This is also sustainable and easy to replicate.

16. Partnering with CBOs / NGOs

For designing and implementing innovative approaches to RCH services, partnerships with community based organizations and non-government organizations are a significant step. Government for long encouraged participation these grass roots organizations in demand creation and delivery of services. These organizations often worked in remote rural areas where access to RCH services is difficult. Recent NGO Policy of the MOHFW envisages a scheme where each district would have a mother NGO and linked to several field NGOs within the district with greater degree of autonomy and decentralization. Community mobilization efforts yield effective results and community ownership of the programme is sustainable.

17. Mobile Health Vans

In geographical areas with difficult terrain with no transport facilities and poor road connectivity usually the outreach and institutional services of PHCs are not to the expected standards. This has resulted in gross under utilization of services. To overcome this problem, in some states private sector agencies have taken a lead in launching mobile vans. These vans go to clearly identified central points on fixed days and provide comprehensive health services including RCH services to a cluster of villages. While private sector resources were put to use to purchase vans, the government contributed to these services by deputing medical officers and medicines. This approach has significantly helped to improve access to quality services.

18. Insurance and Public-Private Partnerships

In one of the recently planned schemes, the government insures and pays health insurance premium for families below poverty line. These families in turn are insured against expenses on health and hospitalization, up to a certain amount. On similar principle, it is possible to develop sustainable health insurance schemes that are community based. In such schemes, the community members pay a minimum insurance premium per month and get insured against certain level of health expenditure. This protects them from sudden and unexpected expenditure on health. Such community based schemes also ensure that the local needs and expectations of the people are met, by preferentially reimbursing local trained healthcare providers.

CLASSIFYING PPPs

Since public-private partnerships vary significantly, it is necessary to categorize them in order to understand their nature and thrust areas of partnerships. Some of the partnerships are for short duration or one time activity and others are for long term. These partnerships also work in specific thrust areas. Some of the partnerships may cover all thrust areas and others one or more.

Nature of PPP	Examples
One time /Short term Partnership	Donation of land, money, equipment etc Participation in campaigns
Continuous / Long term partnership	Social franchising of service Contracting In and Out Social marketing Capacity building

Thrust areas of partnership	Examples
Service oriented	Social Marketing Social Franchising Contracting healthcare providers Mobile vans
Information oriented/Advocacy oriented	Contracting out IEC activities to NGOs Category Campaigns with Private Partners
Infrastructure oriented	Construction of buildings Repairs to buildings Equipment, Vehicles
Capacity building oriented	Training for skill development and counselling Systems development Managerial capacity

CRITERIA FOR INITIATING PPPs

Types of public-private partnerships relevant for a particular state depend on prevailing conditions, needs and functional requirements. Some criteria by which the public-private partnerships should be selected are given below, as follows:

Form of Partnership	Criteria for initiation
1. Franchising	• The effort to revitalize the complete govt. infrastructure is time consuming and a slow process • Resources required to expand public health infrastructure is enormous. • Need for services is enormous and the government health institutions are not in a position to cater to needs • Availability of vast network of private hospitals in places needed • When objective is to improve access to services on immediate basis. • Improve quality standards of private sector and provide high quality care at affordable prices.
2. Branded Clinics	• Need to expand services rapidly • Provide high visibility to clinics • Offer a package of services selected for the purpose • High quality services at affordable prices
3. Contracting Out	• Difficult to manage government health units in remote and inaccessible areas • Utilization of services and performance levels are consistently low due to non-availability of staff • Aim is to put government health facilities to optimum use • Increase responsiveness of government health facilities to local needs through community involvement

4. Contracting In	• Improve efficiency levels of services provided • Make management of services more effective • Conserve scarce resources by cutting costs • Try out innovative approaches to improve efficiency and effectiveness
5. Social Marketing	• Combine service delivery with demand creation • Availability of products in a vast network of easily accessible retail outlets • Encourage brand choices and competition to improve penetration levels • Perceived value attached to priced products than products distributed free of cost
6. Build Operate Transfer (BOT)/ Joint Ventures	• An enormous number of service delivery points whether hospitals, labs or diagnostic centres have to be constructed within a short span of time. • When the cost of building and maintaining a unit is prohibitive for the govt. to bear alone • When returns on investment are guaranteed. • Government treats health as infrastructure industry.
Voucher System	• Improve access to services and provide choice • Costs act as a major barrier to services • Existing service delivery points do not have provision to all types of services • Inadequate knowledge about the value of service (eg importance of antenatal care) • Generate demand for services particularly among poor and disadvantaged sections
8. Donations from individuals	• Presence of affluent families, philanthropic organizations • Identified needs to improve quality of services • Clear procedures and guidelines to accept donations • Transparent and accountable systems that enhance image of institutions
9. Partnerships with Social Clubs and Groups (eg. Rotary Club)	• Partnerships to popularise revitalized service points, communication campaigns and logistics management • Organization of camps on a large scale • Need for additional resources and also management and technical expertise • Need to step up advocacy efforts
10. Involvement of Corporate sector	• Resources to outreach services through NGOs in remote areas • Effective services to employees in organized sector • Policy advocacy efforts • Adoption of villages or CHCs/PHCs by corporate health sector to improve services.

11. Partnership with Professional Associations	• Presence of active professional associations with clear guidelines • Internal committees to promote ethical practices • Management expertise to implement projects • Need to prepare standard protocols, quality assurance system by building consensus • Improvement of technical skills of professionals in both private and public sectors • Improve professional response to programme needs
12. Capacity Building of Private providers, pharmacists and Informal providers (RMPs	• High dependence of people on private sector for services • Technical knowledge and skill levels are not to a desirable standard • Improve quality standards of providers and increase access to quality services • Put in place an effective referral system • Involve services providers in social marketing efforts
13.Special "Category "Campaigns with the Private Sector to improve health	• When the need to promote a service or health care product is established • Multiple partner involvement is required to promote a product • Advocacy efforts to make product acceptable at all levels
14.Autonomous Institutions	• Need to upgrade quality of services and initiate use of state-of-the-art technology in health care delivery • Provide enough flexibility to health units • Improve efficiency and effective levels of management • Reduce costs and facilitate quicker decision-making • Allow institutions to generate alternate sources of funding
15 Partnering with NGOs/CBOs	• Encourage community involvement • Improve community ownership of programme • Test innovative and cost-effective approaches to service delivery • Cover inaccessible and remote areas
16. Mobile Clinics	• Provide access to services people living in inaccessible terrain • Make services available at central location to reduce travel time and costs of clients • Improve utilization of services in remote areas
17. Insurance Schemes	• Focus on poor and disadvantaged • Provide services at affordable costs • Long term solution to health problems • Improved choice of health units • Reduce indebtedness among poor due to health costs

Annexure 3

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CHIRANJEEVI-THE CONCEPT

- For reduction in maternal and child deaths / access and equity
- In five backward districts
- For EmOC and Em transport services
- With weak Public Health Facilities in Obstetric care
- In Partnership with FOGSI
- For making available private specialists to BPL pregnant woman
- Unit cost Rs 1795/- based on package of services includes:

CHIRANJEEVI-THE CONCEPT-II

- Rs200/- for transport to pregnant mother
- Rs 50/- for midwife or attendant
- Pvt gynaecologist pays above and avails reimbursement
- ANC Registration in a Govt facility a must
- Advance of Rs 15000/- to the pvt gynaecologist
- CDMHO empanels and monitors

DISTRICT-WISE PERFORMANCE OF DELIVERIES UNDER CHIRANJIVI YOJANA, GUJARAT

Progress Dec 05- March06

District	Total number of Private specialists	Number of Private specialists enrolled	Deliveries under Chiranjivi Yojana till	Average performance per Doctors
Panchmahal	29	27	2313	86
Sabarkhanta	73	46	1897	41
Banaskhanta	50	52	1436	28
Kutch	47	20	726	36
Dahod	16	18	1421	79
Total	215	73.6%	7793	48

CHIRANJEEVI-OUTCOMES

- 163 MoUs signed. 76% enrollment
- 87% Normal and 5% Caesarian delivery
- Avg Delivery per specialist is 48
- 31% (2415)of 7793 BPL pregnant mothers have delivered
- No maternal death reported. As per MMR 30 mothers would have died
- 9 infant deaths reported. As per IMR 350-450 infants would have died
- Access of BPL pregnant mothers to institutional delivery

ARUNACHAL PRADESH EXPERIMENT : THE CONCEPT

- Pilot Project: 90% Govt 10% NGO
- State hand over infrastructure of PHC/SC to Agency
- State to provide cost towards personnel, drugs and consumables

THE CONCEPT(2)

- **Agency to engage its own staff and ensure availability 24X7**
- **Staffing Pattern**
  - ⇨ **MO - 2**
  - ⇨ **Pharmacist - 1**
  - ⇨ **Staff Nurse – 2**
  - ⇨ **ANM – 2 (PHC)/ 6 (SC)**
  - ⇨ **LHV – 1**
  - ⇨ **lab tech – 1**
  - ⇨ **Driver – 1**
  - ⇨ **HA (Jr.) – 1**
  - ⇨ **Group D - 4**

THE CONCEPT (3)

- **Agency to provide all services expected of a PHC**
- **PHC Management Committee-RKS**
- **State Steering Committee**
- **National level NGOs**
- **Exit policy for Agency and Govt**
- **Audit and Accounting**
- **Output based performance indicators**
- **Outreach Activity**
- **Implementation of National Programmes**
- **External Evaluation/Concurrent evaluation**

PARTNERS IN AP

- Karuna Trust : 9 Districts
- VHAI :5 Districts
- JAC(Prayas) : 1 District
- FGA, Itanagar : 1 District

Chapter 3
Findings of the Study Team

Status of Infrastructure, Coverage, Supplementary Nutrition Programme, Health and Education

"I was searching for the Anganwadi of Mongolpuri in the middle of August, 2006, but no one could give any clue from the address I had in my hand. After a long time I could identify a group of women sitting outside.
"Can you please tell me where the Anganwadi is?" I asked.
"What is that?"
"Anganwadi is where dali, chana etc are distributed to children."
"OK, two houses to the left"
"Don't your children go to the Anganwadi?"
"No, but my sister in law's sons go. There!" she pointed out to a lady washing clothes in one of the municipality taps.
I approached her and said, "Does your child go to Anganwadi?"
"No, but I bring the khichdi or dalia for him," she answered.
"How does it taste? Does your child enjoy it?"
"Not at all! Its so watery, the dalia swims in the water."

I reached the anganwadi centre and could find only the landlady at around 11 am. It certainly did not look like one. It was just a room with no children, no charts and no toys. Only two big empty drums were lying there...

Sheetal, Field Investigator

2.1 Infrastructure – Adequate infrastructure is necessary for delivery of services of SNP, Pre School Education, Growth Monitoring etc. Regarding infrastructure, the **experience** in Delhi was varied.

Swarn Park: A Model Anganwadi Centre

During our visit to Swaran Park AWC we were received warmly, in a neat and decorated Aanganwadi Centre where there was ample space for the children's activities and play. A group of happy, chirpy children welcomed us. There was clean drinking water and toilet and the Aanganwadi Worker, the Supervisor and the CDPO were actively involved in making it into a model AWC. Later we found out there is only one AWC, which needs quality improvement in the whole project area.
The AWC was decorated with colourful chains made out of waste material, we sat on multi coloured "darhi"s made by the women from the community with waste pieces of clothes and jute bags. There were colourful teaching aids made out of jute bags in which SNPs are supplied. Everything in the centre was neat, clean and vibrant. The CDPO, the

Supervisors, the AWW and the mothers have joined hands to run the centre in the best possible manner.

Khanpur: A Centre with no space

In Khanpur, the place used as the premises of the AWC centre, is a 4 ft x 7 ft garage where the landlord keeps his motorcycle. There is no toilet, no drinking water facilities. During summer and monsoon it is difficult to have activities outside. Generally the activities are carried out in the open space which actually meant only for distribution of SNP, whose quality was questioned by everyone present in the meeting, including functionaries and beneficiaries.

Issues:

- **Space** - Most of the centres in Delhi suffer from a severe inadequacy of space both for storage and for carrying out activities. 58% AWWs complained of space constraint. In most centres, due to the inadequacy of space, the number of children registered is only 20-25 whereas, according to the norms, the number should be 40 for children between 3 to 6 years.
  10% of the AWCs have either kutcha infrastructure or they operate from *jhopris.* These centres have serious lack of space and cleanliness

- **Location and access** – There were no complaints regarding location and accessibility of the AWCs other than those in Govindpuri, Khyala and Jahangirpuri areas where AWCs were located on 3rd or 4th floor making the access difficult and unsafe.

- **Rent: a)** Low allocation for rent **:** As per our survey, 96% centres are on rent. The allocation for rent is a meager Rs. 500/- per month (the revised provision of rent since June 1, 2006). 90% Aanganwadi Workers during their interviews, and 8 out of 10 group discussions, pointed out that meager allocation for rent is a serious concern. Within this amount, it is not possible to get an exclusive place in Delhi for the AWCs, where there is space for equipment, for activities, a kitchen and a clean toilet. All the functionaries have expressed that "the rent should be raised to Rs.1000/- at least".
  b)Irregular payment of rent – 96% AWWs functioning from rented centres. said they all said rent is irregular. It is generally allotted once a year. As the rent is irregular, the landlords prefer not to give out premises exclusively for use of the AW. So the centre cannot be locked. In these circumstances, the worker and supervisor do not feel it is safe to keep equipment inside. If the landlord has guests, or if someone in the house is not well, the centre cannot be opened. This poses a challenge for the regular functioning of the centre. There have also been instances of Supervisors and Anganwadi workers being harassed by the landlord

on the ground of irregular payment of rent. Irregular rent is thus an issue of concern.

- **Drinking water and sanitation**: Only 57% of the centres have toilets and 58% have access to clean drinking water. Most of the toilets are common toilets. Sometimes the neighbours provide drinking water to the centre.
  The AWWs have complained of scarcity of resources to buy essentials like jugs for water storage. At times they have provided it by spending their own money.

- **Scarcity of equipment:** 82.23% of AWWs said there was scarcity of equipment like weighing machines, education kits, toys etc., and it interferes with the functioning and compromises the quality of the program.

Table 4:Comparison between Neeve Study, Delhi and FOCUS Report* (Data on Active and Dormant States) **Data on Infrastructure**

	Active States (FOCUS)	Delhi Neenv Study	Dormant States (FOCUS)
Own building	44%	0%	22%
Kitchen	48%	-	29%
Storage facilities	57%	42%	55%
Drinking water	65%	57%	70%
Toilets	20%	58%	20%

Note: * FOCUS Report
Table 3 shows that Delhi lags behind even the dormant States studied in the FOCUS Report as regards infrastructure

2.2 Outreach:

While sharing our findings on outreach we would like to comment that coverage is a common issue for all components. The children not reached through SNP, Preschool and Health all throw up concerns related to coverage. In this section we have dealt with coverage from the aspect of attendance recorded in AWC on the day of the survey. The sub-section on exclusion is the record of the facts that emerged from focused group discussions.

The following table records the average number boys and girls available in the AWW's area and derived from the surveys done by the AWWs in Column 3. Column 4 and 5 captures the average number of boys and girls registered and the attendance on the day of the survey. The average has been arrived by dividing the total number of boys/girls by the number of centres covered. The source of Columns 3 and 4 are AWWs' registers and Column 5 is the finding of the research team. Minimum and maximum number of children found in a centre ranges from 0 to 15.

Table 6: Attendance

Beneficiary		Average no. per centre as per survey done by AWWs	Registered as per AWW's register (average no. per centre)	Attendance (average no. per centre) as observed on the day of survey
Children between 7 months to 3 years	Boys	35	27	9
	Girls	31	25	9
Children between 3-6 years	Boys	25	16	7
	Girls	23	15	6
Pregnant ladies		10	9	3
Lactating mothers		11	8	3
Adolescent girls		3	Not even 1	Not even 1

The above Table highlights the discrepancy between the official data and the reality on the ground. There is also a glaring contrast between the enrolment recorded in the registers of AWCs and their number actually found attending.

The surveys made by AWWs are also irregular in Delhi. There are centres where no survey has occurred for more than three years in a row.

Exclusion - as observed during the survey:

- **Leaving out the poorest of the poor** – The AWC at Selampur is accessed by economically backward communities. The service delivery other than SNP was observed to be poor. In Nizamuddin area, one meeting took place inside the Valmiki Mandir. We found a group of rag pickers (they are considered to be Bangladeshis as they spoke Bengali and were Muslim in religion) who are not given access to the centre though they lived in the same compound. Within a few months they were forcibly evicted. Communities in slums who suffer demolitions, are resettled and then uprooted - are left out of ICDS.
  The best AWC we have come across in Kanjhawala was mainly accessed by children who are from families that are economically comfortable. During discussions and community meetings, we have seen the poorest of the poor is often left out. The MLA in Karol Bagh area also hinted that the programme is not reaching the needy. The Supervisors felt that the performance of the programme will improve if it really reaches the poorest strata of Delhi.

Exclusion of poverty groups like street children or children from the construction sites: The presence of the poor migrants, rag pickers, street children has not been felt during data collection through questionnaires or Focussed Group Discussions. Most of the AWCs are located in resettlement colonies and slums. This leaves the child of the migrant labourers in construction sites and the street children out.

- **Exclusion due to poor service delivery** – The poor quality of service delivery is responsible for denying the children their rights and entitlements. There is poor attendance due to low quality of service.

2.3 Supplementary Nutrition Programme

The objective of distributing supplementary nutrition (norms in Annexure -A) through AWC is to supplement deficient nutrition among children below six years and pregnant and lactating mother.
According to Secondary data:[1]

- 63% of Delhi's children below 3 years suffer from anaemia
- 33% suffer from malnutrition
- 30% children are born underweight

Findings from the study on SNP

Food Quality: Cooked food was started from July 2006. The comments from the beneficiaries and AWWs are as follows :

- During the summer a number of our beneficiaries have reported that the food has become rotten food as it was cooked early in the morning.
- The beneficiaries look forward to dry ration as that can be stored as well as shared within the family for a long period of time.
- The new system requires their presence during daily food distribution and therefore, being resented as "it adds to the demand to their time". Even **caste issues** came up during discussions. Mothers expressed concerns over the caste of the cook.

The complaints about irregularity have lessened after cooked food was started. Complaints of poor quality came from 39% of the centres. One major problem was that there was no fixed time of supply. There have been days when food has come after 1 pm. During summer the food has become rotten. Najafgarh area has specifically complained of insects and dirt found in the food material

[1] NFHS III, 2003 (Annexure – IV)

Quantity of SNP distribution - The children followed over six months in case studies have been receiving food from the centre regularly. Some described the quantity as "one katori" some as "two karchi". Only one mother specifically mentioned 200 grams.
The AWWs and helpers during the discussions revealed that the quantity distributed is variable. Days when the numbers of beneficiaries are more, they distribute less quantities of food.

Regularity/irregularity in distributing SNP - 26% of the centres who had complained about irregular supply was mainly surveyed before cooked food was initiated. However, during the days of polio vaccination, irregularity was observed. The workers either stop distributing food on those days or they distribute dry foods like biscuits.

Coverage of pregnant women and lactating mothers: On an average only 17 women under this category are found to be registered in an AWC. On an average 3 to 4 pregnant women and lactating mothers are attending the centre.

Sharing of SNP: 76% of our beneficiaries were found to be sharing SNP with family members, hence the targeted nutrition is not reaching the beneficiaries. **O**nly 82 beneficiaries out of 2861 beneficiaries interviewed are taking food in the centre.

The following Table gives a comparison on the status of SNP in Delhi with active and dormant FOCUS states:

Table 7:Status of SNP: Comparison between Neenv Study and the FOCUS[2] States

	Active States (FOCUS)	Neenv Study	Dormant States (FOCUS)
% of AWCs where SNP is provided	94	100	93
% of AWW who feel food distribution is regular	95	74	54
% of AWW who feel food is of poor quality	2	39	35

There is 100% coverage by SNP in Delhi, but there are a large number of concerns about regularity and quality. Complaints about quality of food are higher than those from the dormant states in the FOCUS Report.

[2] FOCUS(Focus on Children under Six) Report is a report on a study on ICDS in nine states of India. The states where ICDS is functioning efficiently are referred to as Active States and states where the programme is not runnin efficiently are termed Dormant States

2.4 Health and Nutrition Monitoring[3]

2.4.1 Immunisation

Our survey finds immunization status encouraging. Beneficiaries who are accessing the PHCs show high rate of immunization than the data represented in MWCD's Website. The AWW's interviews confirm that in 97% projects, immunisation is happening in Primary Health Centres and Dispensaries.

Table 8: A Comparison between Secondary Data from the Ministry's Website and Neenv Findings on Immunisation Status in Delhi.

Immunization	Secondary data from WCD Ministry(in per centages)	% of 0-3 years (Neenv Study) old children	% of 3-6 years (Neenv Study) old children	% of Pregnant ladies (Neenv Study)
BCG	87	98	98	
Polio	79	88	88	
DPT I	71.7	98	98	
DPTII		98	98	
DPT III		96	97	
Measles	78	86	94	
MMR	-	49	68	
TT to PL	-			88
Vitamin A	17.1	25%		

Comment: NFHS data shows that the percentage of fully immunized children in Delhi has declined in NFHS III from NFHS II whereas the above Table indicates that coverage of immunization is good.

- **AWC-PHC Linkage**
  Immunisation mostly done by ANMs - 85% of the immunizations are done by the ANMs. in Primary Health Centres and Dispensaries. This is good news for campaigns involved in universalisation. It also underlines the role played by AWC-PHC linkage in this matter.
- **Discrepancy between data** provided by AWWs and that by beneficiaries: The ten children whom we have followed all had their immunization done and the parents had immunization cards. 87% AWCs had data on immunization for the children below 3 years and 67% for the 3-6 year old children. 46% reported TT immunization of pregnant women where as the beneficiaries' data shows 88% pregnant women are immunized. 88% of beneficiaries said that they have received iron tablets from PHCs. The AWWs records, however, have no data on

[3] Secondary data and literature survey on this in Annexure - V

iron tablet distribution which indicates that the *AWWs records are not updated or there is a gap in linkage.*

- **Coverage of Vitamin A distribution** - Data on Vitamin A distribution is available in 9% of the centres but the survey on beneficiaries reveals that 25% of the children below 6 have received Vitamin A. This shows that though immunization is good, *Vitamin A distribution has remained low.*

2.4.2 Weighing and Growth Monitoring

Most of the centres shared the weighing machines, as they either did not have the weighing machine or the place to keep it. The data on weighing was not encouraging.
The table below compares the information given by AWWs and beneficiaries' on weighing

Table 9: Weighing of the Beneficiaries as per Information Provided by the AWWs and the Beneficiaries

Item	As per AWW's survey	As per beneficiary's survey	Active Focus states	Dormant Focus states
% of 0-3 years children weighed	81%	25%	82%	47%
% of 3-6 year old children weighed	68%	25%		
% of Pregnant women weighed	1.2%	0.9%		

The Table reveals neglect of growth monitoring and interventions for malnutrition and support to pregnant women. Our survey finds an average attendance of 3 pregnant and 3 lactating women per centre. Only 9% pregnant women are weighed.

Among the ten children followed for five to six months for the case studies, 5 of them had not been weighed during these six months. The sixth child (who migrated to UPas a result of his father losing his job due to sealing drive in Delhi) also was not weighed. The reason given was non-availability of weighing machine or the weighing machine was not in working condition. Out of these10 children, one nineteen-month old child suffered from calcium deficiency. He had received intervention at the PHC. Another 5-year old girl, who is weighed every three months is only *14 kgs at the age of 5 years*, whereas the average weight of an Indian girl at the *age of 5 years should be 17.7 kgs*. The child is yet to receive any intervention on malnutrition. Another four-year old child who is weighed regularly is only 11 kg. She is in Grade II of malnutrition and is treated at the MCD Centre. She is also identified as an anaemic child and has been given blood at the MCD hospital.

Issues of Data Discrepancy: There is a serious question about the accuracy of the records on weighing kept by AWWs and also about the figures quoted by the government on malnutrition.

Another issue very closely connected to this is the issue of maternal health. Anaemic, underweight mothers give birth to low birth-weight babies who carry the inheritance of undernutrition forward. Only 38% mothers as per NFHS III [4] have consumed IFA for 90 days during their pregnancy. Around 30% pregnant women suffer from anaemia. These are alarming figures. From our findings too, it is clear that the SNP and health components of Delhi AWCc are not supporting the pregnant women in breaking this vicious cycle of malnutrition. This indicates that the probability of giving birth to a low birth weight baby also goes unaddressed. The saga of intergenerational legacy of malnutrition continues...

2.4.3 Malnutrition

- **Data on malnutrition:** When we come to the primary data on malnutrition it seems to endorse our inference that weighing has actually not occurred. One of the best AWCs surveyed in Kanjhawala project had data on III rd and IV th grade malnutrition, while among all other centres surveyed, only 4 centres had data on grade III and IV malnutrition. 17% of the centres had data on Grade I and 17% on Grade II malnutrition and only one centre has offered medical intervention and around 9% offered double SNP to the malnourished children. 55% of the projects of the 27 projects covered could not provide us with **any** data on malnutrition at all. This raises doubts about the accuracy of the number of malnourished children quoted by Delhi Government.

- **Coverage of the issue in AWW's training programmes** - Out of the 242 AWWs interviewed, 27% had special training on AIDS but only 18% on nutrition

- **Monitoring and supervision mechanism:** The monitoring and supervision mechanism of the scheme demands data on malnutrition from both the AWW's report as well as the CDPO's report. However, that the absence of data for so many projects goes unnoticed is a proof of negligence in the monitoring mechanism of malnutrition for the children of the capital.

- **Awareness of beneficiaries on nutrition needs of the children**: The focused group discussions, large number of beneficiaries sharing SNP with other family members and indifference about the quantity of SNP served shows the lack of awareness on nutrition needs of children.

  The sessions on Nutrition and Health Education also have not been able to generate much informed participation within the community. The mothers who participated in Focus Group discussions are largely unaware of the issue of

[4] The status of children under six as per NFHS III data is given in Annexure 4

malnutrition. They are irregular participants in the NHE meetings and their lack of awareness has never been consistently addressed.

2.4.4 Children with Disability and ICDS

In our survey we have not come across even one AWC with a child with disability. Only 2.89% AWWs had special training on Disability. Inclusion of children with disabilities is national mandate. The system in ICDS does not stress importance of fulfilling this mandate.

2.4.5 Support of Senior Functionaries such as MO and ANM

- 84% of AWWs have said that the MO had not visited the centre for more than six months.
- ANMs are more regular visitors. 51% of them visit centres once a month. But as per the AWW's experience only 28.5% have been supportive.

2.5 Pre School [5]

- **Attendance of AWWs and children:** We were unable to interview 11% of Anganwadi Workers despite making three visits to each of these centres. Out of the rest 89% anganwadis, 43.38% centres had no children for pre-school on the day of the survey (the entire survey lasted 8 months). **There were no children in 105 out of 242 centres on the day of survey**

Table 10:Attendance in Pre-School

	Registered as per AWW's record	Average no of children registered per centre	Attending as per the attendance recorded by the surveyor on the day of the survey	Average no of children attending per centre
Boys	4234	16	1746	7
Girls	3930	15	1618	6
Total	8164	31	3364	13

[5] Secondary data available in Annexure - VI

- **Discrepancy between recorded attendance and attendance observed:** An average of 14 children was observed attending the centres for pre school education. There was a dismal average of 14 children attending per centre The attendance register in more than 70% cases show attendance varying from 5 to 20 children on the previous day but 43.38% centres recorded no attendance on the day of the survey.

- **Availability of space to carry out Pre School activities** -57.83% Anganwadis reported space constraint for activities. Most of the AWC did not even have the place where 40 children can be made to sit. Focus group discussions have even brought out that some days classes are carried out in open spaces as there is no place within the centre. It has come out very strongly during our meetings with all functionaries and beneficiaries that the major sufferer for inadequate space, infrastructure and aids has been preschool education.

- **Learning needs of 0-3:** None of the Anganwadi gives any ECCE inputs to children below 3 years of age. The mothers are also not given any inputs on stimulating exercises for children below three years of age.

Chapter 4
Role of Functionaries and Issues Pertaining to their Role

3.1 The Anganwadi Worker[6]

The Anganwadi is the place through which services reach the beneficiary families of the community and the AWW is primarily responsible for service delivery. She is the link between the community and ICDS, the health functionaries and ICDS and also between primary education and pre school education. The AWW has perhaps the most important role in service delivery of this largest government programme for children below six years. She is largely responsible for service delivery of the components, which are directly linked to protecting the survival, protection, development and participation rights of children below six years. Her roles and responsibilities are defined[7] on the website of Women and Child Development Ministry

Background and Training – Of the 242 workers interviewed, 33% are in the age group of 30-40 years and, 46% in the age group of 40-50 years. 32% of the 242 AWWs are X th pass, 40% XII th pass and 28% are graduates. 93% have received job training and 82% have received the week-long refresher course. Apart from that 10% are trained on RCH, 27% on AIDS and 18% on nutrition.

[6] Role of AWW in Annexure VII

Ad hoc Status -This functionary has a long list of responsibilities but she does not enjoy an employee status. She is hired on an ad hoc basis and receives a fixed honorarium of Rs. 1500 per month. One of the AWWs we met during our FGDs said, "The scheme is "sarkari"(government), all functionaries except us are "sarkari". We are the only ones in this scheme which is "gair-sarkari"(private)"

Late payment of honorarium -There is no security of job. The payments do not come regularly. Although she is accountable for her regular attendance 96% of the AWWs interviewed said they are not receiving payment in time. This is a serious issue as the Worker does not feel motivated to come to the centre everyday. We have come across workers who feel that since the government is not serious about paying their honororium every month, they also do not feel the commitment towards coming to the centre everyday. The Anganwadi Workers de-motivation contributes significantly towards low quality and irregular (other than SNP) service delivery of the AWCs.

Lack of support - During discussions, the anganwadi workers said that they have to buy registers with their own money; some have to buy earthen pots and Mayur Jugs for storing water for the children. Sometimes the AWWs have paid rent to get rid of the landlord's harassment. Due to non-permanent status, low wage and irregular payment the AWWs are not a motivated lot, although they feel that they are respected within the community.

Extra Responsibilities: All of them during the survey and during the discussions complained that they have extra responsibilities. These responsibilities include giving polio drops (a small payment is given for this task), carrying out surveys for widows pension, poverty survey and all information related to schemes concerning women and children. As the priority has always been on these surveys, the activities of AWC apart from SNP distribution take a back seat during these days.

Level of support the AWWs have received from other functionaries and community.

- 14% have expressed that they have received support from CDPOs
- 40% from beneficiary families
- 12% have received support from mahila mandals
- 6% from local MLAs.
- All the AWWs have expressed that they have received support from the Supervisors and ANMs.

Irregularity in attendance of AWWs: Our survey started in March 2006, before that, our research investigators visited centres and found mainly only helpers. She is there to distribute the weekly ration. However, the AWW is more regular in attendance (though only for a short time) after cooked food has been introduced in the centre.

Hopelessness and demotivation: We observed a tone of hopelessness about the system in the functionaries. Some even felt Delhi does not need AWCs as there is hardly any poverty. We would however like to end this chapter in a positive note by quoting one CDPO who felt our initiative of this study to improve status of ICDS was worthwhile as

the Scheme is very good but it is not reaching the people in its fullest capacity. She said," *Hum log ummid kar sakte hain aur aplog kaushish kar sakte hain*"

3.2 The Helper

The helpers are playing a very major role in AWCs. In most of the days the surveyors find only the helper at the AWC distributing SNPs. As pre-school activities are highly neglected due to multiple reasons, the helpers are present most of the time during the day to keep the AWC functional. As per their role definition they are supposed to cook the food. However, as NGOs are mainly distributing cooked food in Delhi, their role has become distribution of food. They also make home visits.

3.3 Monitoring and Supervision by CDPOs and Supervisors

The mechanism of monitoring and supervision and the forms devised for monthly reporting of CDPOs (*refer to Annexure* B), Supervisors and AWWs as per the scheme is comprehensive enough. Yet we observed gaps in the status of monitoring.

Lacuna in the chain of supervision: The first lacuna we observed is that the chain between CDPO, Supervisor and Anganwadi Workers is not functioning properly.

- 66% of AWWs said the CDPOs have not visited the centre for more than 6 months
- 14% have said that they have received support from the CDPO.

Too many centres to supervise: The Supervisors is the functionary who is giving support to the AWW on a regular basis. From our Focus Group discussions, we found out that there are many CDPOs who are willing to provide the support to the Scheme but as they have too many centres (the norms is 100 centres, but in more than 80% cases the average number of centres supervised by the CDPO was more than 120) to supervise they are not able to do justice to their responsibilities (some were supervising more than one projects). The chain of supervision breaks down here.

There are supervisors who are monitoring more than 50 centres (20-25 is the number specified by the ICDS norm). We have met supervisors who were monitoring 80 centres, which means they are monitoring almost the same number of centres (100) specified for CDPOs. Hence the centres remain unvisited and records unchecked. During group discussions we also heard that Supervisors are given election duties and other office duties for a long period of time. Hence they are forced to ignore their roles as ICDS Supervisors and give their ad hoc roles a priority.

The Anganwadi worker hence remain largely unsupervised. We were unable to meet AWWs in 28 centres **in spite of making three visits.**

Lacunae in monitoring record keeping: Absence of malnutrition data in all 10 centres surveyed in 15 out of 27 projects shows that record keeping has gone unsupervised. With

a 63% prevalence of anaemia among Delhi's children, this negligence cannot be justified in any way.

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Chapter 5
Role of the Community and their Participation

Community participation is an important component in the design of the ICDS Programme. All through the data collection and focus group discussions the study team examined the status of community participation.

Community Participation

During our survey we have found community participation is confined to the parents of the child beneficiaries. They at times help in food distribution and in providing drinking water to the centre. But this group of people has remained mainly non-participatory. The community mainly looks at AWCs as a food-distributing centre.

Awareness of the Community: The mothers do not participate regularly in the Mahila Mandal meetings. The Nutrition and Health Education (NHE) meetings have sensitized the community on some aspects of nutrition but the mothers are largely unaware about malnutrition, anaemia, growth monitoring and the role of nutrition in improving health conditions. To be precise, the community is largely unaware about the objectives of the scheme and the rights of their children attached to it.

One of the major gaps we noticed is that the community is not aware about the basket of services offered through AWWs and the objective of the scheme. The lack of information on the scheme and sensitization on issues of children have has led to lack of constructive interest and demand for quality services. Lack of knowledge on a scheme which has been in existence for 32 years can only be explained by lack of interest from both the community's and the functionary's side.

Involvement of community members: The 242 AWWs interviewed said that 40% centres have received support from the beneficiary families. Only 6% centres said the local MLA has visited the centre and 10% have received support from the local Pradhan. Absence of interest of local leaders and non-empowered beneficiaries together are responsible for low demand and participation from the community.
The focus group discussions endorse this finding. The lack of interest of the community leaders like MLAs, Ward Councillors and Pradhans indicate that the negligence happening in service delivery of ICDS is actually not a factor in the voters mind and plays no part election campaigns. Prevalence of anaemia (63% among Delhi's below 3 children), malnutrition (30% of Delhi's children are born underweight), low participation of children in "informal" preschool education, has not become part of the political agenda.
The MLA we interviewed felt that his area (Karol Bagh) did not require anganwadi centres. He felt that AWCs are more relevant for villages. Delhi requires proper a survey and relocation of centres according to need. He had not spent any amount of his development fund on AWCs.

Howerver, in the entire study one project stood out as an exception. The community in Khajhawala Block took an active interest in AWC and is an example of the difference community participation and interest can make to the functioning of the ICDS programme. However, it may be noted that the economic status of this communitry was better than in most of the other areas studied

Role of Community in making the Anganwadi function in Khanjhawala Block.

The community in Khanjhawala has shown great initiative and come forward on their own to help the Anganwadi worker. This was the first AWC that the Study Team found running well. Despite the problems of low budget, irregular supplies etc., the community were able to assist the Anganwadi worker to run a lively Anganwadi with good activities, clean environment, personal hygiene of children, up-to-date records, mother's meetings etc.

The above reveals the potential ICDS has of fulfilling Child Rights when local communities come forward and take an interest.

New Resettlement Colony: Status of AWC

Bawana was chosen as part of the study initially to examine the difference between ICDS and non- ICDS areas. However, it was found that the newly relocated families had succeeded in having AWCs opened after a tough struggle. The study team was therefore able to look at the functioning of newly opened AWCs.

The Bawana AWC was found to have been handed over by the government to NGOs. This provided the team an opportunity to look at the advantages and disadvantages of NGO-run ICDS centres which was introduced by the state in 2006.

Our survey findings are not very encouraging regarding the status of implementation, monitoring and supervision of AWCs run by NGOs. NGOs involvement may not actually result in quality improvement.

The AWC in Bawana are all functioning under NGOs since November 2006 and they are providing SNP and pre school facilities to 20-25 children between 3 to 6 years. There are no health services provided by ICDS and no linkage with health departments. The beneficiaries access nearby hospitals independently for health check ups and immunization. The nearby two centres we visited did not have any teaching aids and did not wear a neat and tidy look. Moreover the only group of beneficiaries is the twenty children in the age group of 3 to 6 years.

From the above it is evident that the system of NGO run AWCs as observed from the Focussed Group Discussions conducted in NGO run AWCs have problems and needs to be looked at very carefully as once an NGO takes over the running of the AWC, the government brushes off a major part of its accountability. Moreover, the community does not appear to express its dissatisfaction as NGOs are considered a private domain. Not much had been done to sensitise the community on the programme. The NGOs role as implementers of the programme has actually eliminated the role of the community as a partner and advocate.