Whose Public Action?
Analysing Inter-sectoral Collaboration for Service Delivery

KARUNA TRUST AND DEPARTMENT OF HEALTH AND FAMILY WELFARE GOVERNMENT OF KARNATAKA: MANAGEMENT OF PRIMARY HEALTH CARE CENTRES

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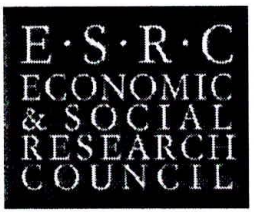
Lucknow, India

Published: July 2008

ISBN: 0704426730
9780704426733



UNIVERSITY OF BIRMINGHAM

This research is funded by the Economic and Social Research Council under the ESRC Non-Governmental Public Action Programme. The ESRC is the UK's leading research and training agency addressing economic and social concerns. ESRC aims to provide high-quality research on issues of importance to business, the public sector and Government.

CONTENTS

ACRONYMS

ANM	AUXILARY NURSING MID-WIVES
BHO	BLOCK HEALTH OFFICER
CHC	COMMUNITY HEALTH CARE CENTRES
DH&FW	DIRECTORATE OF HEALTH & FAMILY WELFARE
DHO	DISTRICT HEALTH OFFICER
FCRA	FOREIGN CURRENCY REGULATION ACT
GP	GRAM PANCHAYAT
GoK	GOVERNMENT OF KARNATAKA
IPP IX	INDIA POPULATION PROGRAMME IX
ISRO	INDIAN SPACE RESEARCH ORGANSIATION
MCI	MEDICAL COUNCIL OF INDIA
MO	MEDICAL OFFICER
NGO	NON GOVERNMENT ORGANSIATION
NSP	NON- STATE PROVIDERS
OT	OPERATION THEATER
PHC	PRIMARY HEALTH CARE
PHU	PRIMARY HEALTH UNIT
PPP	PUBLIC- PRIVATE PARTICIPATION
RCH	REPRODUCTIVE & CHILD HEALTH
THO	TALUKA HEALTH OFFICER
VGKK	VIVEKANADA GIRIJAN KALYAN KENDRA
VVNL	VISWESWARAYYA VIDYUT NIGAM LIMITED
WHO	WORLD HEALTH ORGANISATION
ZP	ZILLA PANCHAYAT

KARUNA TRUST AND DEPARTMENT OF HEALTH AND FAMILY WELFARE GOVERNMENT OF KARNATAKA: MANAGEMENT OF PRIMARY HEALTH CARE CENTRES

SUMMARY

This case study focuses on the relationship between Karuna Trust, a Bangalore based NGO, and the Department of Health and Family Welfare, Government of Karnataka. Karuna Trust has been almost exclusively working in the health care sector for the past two decades, with primary heath care as its core function. Over the years other related programmes like education and community development were integrated into the portfolio of Karuna Trust, although health continues to be the centre of focus. This report looks at the relationship between Karuna Trust and the Department of Health and Family Welfare through a partnership programme, wherein the former manages a selected list of government Primary Health-Care Centres (PHCs) in the State. A pioneer in the area, especially on a relatively wide scale, the model is attracting interest in some other States in the country.

1. BACKGROUND AND METHODOLOGY

1.1 Research Agenda

This case study is part of a larger study on non-government public action and the relationship between the state and non-state providers (NSPs). The core argument of the research is that the government and NSPs involved in the delivery of specific services are conditioned by their respective organizational and institutional structure and policies. This in turn may lead to tensions over the very purpose and process of 'public action.' Further, the research hypothesizes that they manner in which the relationship is formally and informally organized also affects the capacity of partners to influence and control the service delivery agenda and process. Three service delivery sectors were identified for the research: sanitation, education and health sectors.

1.2 Methodology

The whole research project was undertaken in stages over a period of two and a half years and included (i) a scoping study to trace the evolution of the sector and identify the key policies and programmes; (ii) selection of a specific programme within each sector through which the core research issues were to be studied; and (iii) finally identifying cases to analyse relationships in more depth. In the health sector, Primary Health Care was identified as the programme which offered most scope to examine the dynamics of the state-NGO relationship. Karuna Trust in turn was identified for the case study because this was the only case of an NGO managing several PHCs over a period.

Like, the other case studies in the project, field work and data collection stretched over a 10 months and involved three rounds of visits to the project sites and interactions with a range of stakeholders at the state, district and *gram panchayat* (rural local council) (GP) level as well as the three tiers of the Primary Health Care structure in the state. Apart from interviews with the director and staff of Karuna Trust, the limited documents available were reviewed to construct the evolution of the

NGO, especially in relation to its involvement with the state. Interviews were also held with senior officials from DH&FW to understand the state perspective and policy on health care at large and on partnership in particular. The researcher thereafter visited a number of PHCs and Sub-Centres managed in partnership with Karuna Trust and interviewed the staff employed by Karuna Trust as well as the concerned government staff at block and district level who are directly responsible for monitoring and managing the performance of Karuna Trust as well as providing necessary support. This included the Block Health Officer (BHO) and the District Health Officer (DHO) and their respective teams. An in depth understanding of the functioning of the elaborate three- tier health care structure in the state was obtained. The researcher also interacted with some members of the community and community representatives at the GP and block levels.

2. ORGANISATIONS IN THE RELATIONSHIP

This section attempts to build a profile of the two partner organizations in terms of their vision and consequent approach to health care delivery. In the process it describes their separate goals and missions as well as their activities, organizational structure and functions. The profile itself is drawn with the purpose of locating the two partners in relations to the partnership and understanding the synergies generated.

2.2 Karuna Trust

2.2.1 Origin and features of public action

Karuna Trust (henceforth referred to us the Trust), was established as a public charitable Trust in 1986 and an affiliate organisation of the Vivekanada Girijan Kalyan Kendra (VGKK) in B.R. Hills, a sub region in the State of Karnataka. VGKK itself was founded earlier in 1981 by a medical practitioner, Dr. H Sudarshan, who, concerned about the plight of the predominantly tribal (Soliga) population of this very backward area, had initiated basic health care programmes here. Although, initially Sudarshan managed the activities on his own, he was soon joined by a small team of dedicated and like minded people, some of whom were natives of the region.

While working in the regions, the founder discovered that leprosy was prevalent amongst the tribals, who in reality contracted it from the non- tribals in the area. As the disease was 'hyper endemic' in the region and the situation was alarming, calling for urgent and focused action, a separate (Karuna)Trust was set up by Sudarshan to address the problem and to bring the non tribals within the scope of the interventions. Sudarshan (henceforth referred to as 'director of the Trust') decided that a separate organization was necessary because VGKK itself was committed to working exclusively with the tribals. By 1990 the Trust had covered substantial ground under the Leprosy programme and hence turned its attention to other health issues. Over the next few years it expanded both in terms of geographical coverage as well as health issues to include, control of TB, eye care, dental health, mental health, RCH, etc. Subsequently, towards the later half of the 1990s (1996) the Trust developed its signature approach to primary health care through the structure of the PHCs. The health and community-based rehabilitation programmes subsequently became part of a broad set of socio-economic activities.

By 1996 the Trust, spread rapidly to cover 59 villages in Yallandur Taluk[1] (Chamrajnagar District) and 119 villages in T Narasipur Taluk (Mysore district) in the

1 A *Taluka* is a sub- region in a district

state of Karnataka with a package of health, education and livelihood projects. Thereafter, it entered into a partnership with the state government to manage a string of PHCs (28 PHCs / PHUs and 138 sub-centres) covering 23 out of the 28 districts of Karnataka. Thus, while most of the integrated activities are now centreed on villages in Yelandur Taluk (Chamrajnagar District) and T Narasipur Taluk (Mysore district), the Trust now has a state wide presence, through its PHC management programme. It has also initiated similar work in 9 districts of the state of Arunachal Pradesh in the north eastern part of the country, covering 9 PHCs and 36 sub-centres. In terms of interventions, subsequently, the Trust has expanded its sphere of operations to include, education, livelihood and community development, besides a range of health care activities, including epilepsy, mental health and dental care, amongst others. Public–Private Partnership initiatives and development of innovative and replicable health care models is the key approach being adopted. Thus, begun as a response to a single disease, and initially as an independent programme, the Trust has now grown to become a full fledged organization with a vision and mandate of its own, working in close collaboration with the state at several levels, although ideologically following the same philosophy as VGKK.[2]

2.2.2 Vision and purpose

VGKK, and subsequently the Trust, appears to owe its origin to the personal experience of its founder at a very young and impressionable age, when he lost a parent due to the lack of adequate medical facility in the village. This, coupled with his exposure to the teachings of Swami Vivekananda, a Hindu philosopher of the 19th century, led him to opt for working with the poor after he obtained formal training in medicine. Although not a Faith Based Organisation in the true sense of the word, the basic philosophy of Swami Vivekananda of an equitable society and service to mankind permeates the vision and mission of the Trust. This philosophy has also led to the founder's involvement in other rights based activities like the Rejuvenate India Movement, of which he is currently the President.

Self reliance of marginalised communities: It is obvious that VGKK and the Trust operate as separate organizations with separate mandates, with the principal difference being that while the former supports the tribals in the region, the later provides health care services to the non tribals. While VGKK has a vision for a '...self-reliant, united and progressive Soliga tribal community' (Das Gupta and Ghanshyam, 2006), the Trust specifically focuses on health, and to some extent, on education of both the tribal as well as the non- tribals in the rural and urban areas with empowerment as an overarching issue. A subtle difference between the two organisations perhaps is explained by one of the senior staff of the Trust as 'VGKK is surreal while the Trust is professional and replicable'. This definition indicates the greater influence of specific philosophical ideologies of equality and service on the former and the programme oriented approach of the later primarily aiming to improve existing systems. Then again while VGKK appears to be a way of life, the Trust translates some of its principles into functional services.

The approach of the Trust to rural development is '...holistic, democratic, decentralised and participatory...' and takes into account the '...cultural and regional differences...' while aiming to empower every individual. It therefore seeks to provide the necessary information, knowledge and skills to lead a healthy life. Hence, the

2 VGKK has grown into an integrated development programme for the tribals and focuses on the broad areas of health, education, community development, community organization, sustainable livelihood and conservation of bio- diversity. It has also expanded its area of operation to other regions of Karnataka State (Yelandur and Chamrajanagara) as well as other States like Tamil Nadu, Andaman and Nicobar and Arunachal Pradesh

PHCs attempt to focus on '...community-oriented preventive medicine, instead of a top-down approach.' (Rademachers et al, 2005)

Thus, while the vision statement of the Trust declares that the organisation aims for a '...society in which we strive to provide an equitable and integrated model of health care, education and livelihoods by empowering marginalized people to become self reliant,' the mission in turn is to '...develop a dedicated service- minded team that enables holistic development of marginalized people, through innovative replicable models, with a passion for excellence' (Karuna Trust leaflet). Equity, integrated development around the issue of better health services and empowerment and self reliance of the community are central to the mission. And interestingly, the director of the Trust states that '...It is not enough to create excellence, creating impact is necessary...My basic agenda is to provide quality health care to the people of Karnataka...' (Vijay 2003) The Trust has consciously opted to work among the marginalised tribal and backward communities, who are both socially and economically backward. Largely located in remote and inaccessible areas these communities are also often deprived of development resources. This backwardness has also compelled the Trust to work very closely with the communities through community based groups. The focus is on empowering the communities to prevent diseases and promote good health rather than only provide curative medicines.

Good governance is central to effective service delivery: The Trust does not intend to work like a 'contractor'. According to Sudarshan, 'contractors' in the Indian system are synonymous with corruption. He concluded that for the Trust, partnership is '...an integration of ideas and activities...' and that it '...works on the basis of a humanistic philosophy.' Within such a philosophy there is no place for corruption and the issue of corruption has received considerable attention from the Trust in general and the director in particular. 'Good governance is one of the most important factors in improving the health services. Merely adding new technological packages are not enough and they may improve the out come marginally.' (Director, Trust) While the Trust attempts to make the functioning of the PHCs as transparent and accountable as possible, by involving community institutions, the director, himself has been crusading against corruption in the health sector since several years. He has also been the Vigilance Director in the Karnataka Lok Ayukt, the principal corruption fighting body in the state, and is widely recognised as a professional out to clean the system. This is reflected in the value system of the Trust which does not accept any bribe and orients every staff to this philosophy of the organization. An example of this commitment to transparency and accountability was the removal of a medical officer from a Trust- managed PHC on charges of corruption. The post remained vacant for a long time affecting the work, but the Trust convinced the community that a vacant post was better than a doctor who was corrupt.

The influence of the overall service and 'humanistic' philosophy is somewhat reflected in the overall functioning of the organization in terms of the dedication of the staff, the low cost and functional infrastructure and also the long tenure of some of the staff members. Within this framework, the Trust defines its core objectives as (Karuna Trust, 2006):

- Provide integrated development of the focus group – tribal and urban and rural poor - through health, education and training for livelihood;
- Empower and organise the rural poor to become self reliant;
- Enter into public–private partnership for innovative, replicable and sustainable model of integrated development of the marginalised community;
- Integrate mental health with primary health care and establish facilities for care and rehabilitation for both men and women;

- Support the government to improve the quality of education through improved teaching, resource material and community participation;
- Promote vocational training and develop profitable business models for manufacturing and distribution of in- house products; and
- Advocate in order to influence government policy and reforms and to enable other NGOs to adopt models in their respective areas.

2.1.3 Activities

The Trust, in order to realize its objectives has over the years initiated activities that can be grouped into Health Care, Education, Livelihood and Community Development, although health remains as the core function:

a. Health

Integrated services in Gumballi and T Narsipura: The first project of the Trust was its own funded leprosy programme in Yellandur in 1986, which was subsequently supported by the state on a district wide scale under its Leprosy Control Programme. Subsequently, Epilepsy (1990), Tuberculosis (1992) and mental illness (1995) gradually became part of its service portfolio. In fact, the Trust claims to have introduced the method of administering drugs to TB patients under the supervision of para medical workers, long before WHO launched its DOT programme in the country. Mental health included setting up help lines, providing transit care and rehabilitation. By the turn of the century, comprehensive eye care, community dental health a mobile dental units, cancer detection, promotion of safe drinking water and sanitation had been added to the list of services. Each service was born out of a felt need and as way of addressing existing service delivery gaps. Significantly, it was also built around the existing national health care progammes. The services were not limited to curative care but also included prevention through awareness generation and health education. Research, setting up of testing facilities, provision of required drugs as well as establishing a cadre of trained para professionals was part of the strategy. Thus, over the years the Trust not only diversified into other health care services but evolved a holistic health care programme and reports that it has progressed from curative health through community health and community development to sustainable development (Annual Report, 2006-07).

> 'We look at health in a holistic manner, rather than as one that needs isolated curative services. We have attempted to address either directly, or indirectly, every health need that people have. Indirect needs could mean safe drinking water, or sanitation, which ultimately lead to better health among the people.' (Sudarshan, quoted in Das Gupta and Ghanshyam, 2006)

In both these project areas the Trust also began to address non- health related issues like livelihood, micro-finance and primary education, which obviously had an effect on health and the overall quality of life. Thus, the range of activities in these two project areas includes:

- Primary Health Care – PHC at Gumballi
- National Health Programs – Leprosy, Tuberculosis, Mental Health & Epilepsy, Chronic/Non-communicable Diseases (Diabetes, Hypertension & Cancer)
- Comprehensive Eye Care – Vivekananda Eye Hospital and community-based eye care (Yellandur)
- Mobile Dental and health unit
- Rural Livelihoods - Vocational training programs at Gumballi, Food Processing Unit & Herbal Medicine Processing
- Community Micro-finance and Health Insurance
- Integrated Education Program

- Referral Support – Ambulance (T. Narsipura)
- Diet service in District Hospital (T. Narsipura)
- Sanitation program (T. Narsipura)
- Village Resource Centre (T. Narsipura)

Public-private partnership in the management of PHCs:
While the health services evolved as separately funded programmes and were initially delivered through the Trust's integrated projects in Yalandur and Narasipur and catering to a cluster of villages in the area, they subsequently also became an integral part of the services provided by the PHCs under the management of the Trust. Since then 25 PHCs and PHUs have been handed over to the Trust across the state. The PHCs have apparently evolved into innovative models of public- private partnership.

In 1996 the state Government of Karnataka handed over the PHC at Gumballi, together with 5 sub-centres under it (covering Yelandur Taluk and the tribal population living in the hamlets scattered across BR Hills) to the Trust as an experiment in public- private partnership. This model has been adopted under the Tenth Five Year Plan and currently the Trust while running 25 PHC across 22 districts in Karnataka is also managing 9 PHC in the State of Arunachal Pradesh and supporting other state governments to launch similar experiments.

Over the years the innovations have been packaged into well defined components that include:

- Mainstreaming of HIV-AIDS in primary health care services
- Epilepsy control programme
- Integration of mental health care
- Mainstreaming traditional medicines in primary health care
- Community Health Insurance

Other unique features of the PHCs are:

- Community participation through village health committees
- 24 hour service with the staff living on the premises of the PHC.
- Gender sensitive care
- Development of an improved system of management of the PHC including, a Health Monitoring and Information System (HMIS) and generation of gender disaggregated data.

Other health related activities:
Community Health Insurance: The Trust implemented a community health insurance programme in Karnataka between 2002 and 2005. The project was undertaken on a pilot basis in partnership with UNDP, National Insurance Corporation and the Government of India. Implemented in phases it eventually covered 332 villages in Naraipura taluk (Mysore) and Bailhongal taluk (Belgaum) in the first phase and 173 villages of Yallandur Taluk (Chamrajnagar) and Belgaum taluk (Balguam) and 57 tribal hamlets of BR Hills (Chamrajnagar). A community based model of health insurance evolved with the following features: low premium, no disease exclusion, immediate settlement of claims, provision for security against wage loss and out- of-pocket expenses, and cover for surgery and drugs. The project was funded by UNDP and came to an end in 2005. The State government apparently intends to scale it up and the Trust plans to introduce a pilot project together with UNDP and National Insurance Corporation, for antiretroviral drugs for people who are HIV positive.
Mansa and community health programme: The 'Mansa' project focuses on health and care of the mentally ill through the Community Mental Health component

integrated into the services of the PHCs managed by the Trust, a Home for treatment and care of destitute mentally ill women in Mysore, and the psychiatric services at Nirashrithara Parihara Kendra (Beggars' Home) in Mysore, run by the State Social Welfare Department.

Tele medicine The Trust has in recent years (2005) introduced telemedicine services, initially under a pilot project called the Integrated Tele-cardiology and Telemedicine Project, in collaboration with a renowned private super-specialty heart hospital(Narayana Hrudayalaya, Bangalore). The tele- conferencing itself is facilitated by the Indian Space Research Organisation, Department of Space, GoI, (ISRO) as part of its space application technology activities, under which ISRO has provided facilities for the Trust to set up Village Resource Centres to focus on education, agriculture, health and watershed. The Trust is now using the facility to monitor the PHCs through tele- conferencing and to implement the tele- medicine programme in the PHCs at Chamrajnagar and MM Hills.

Shivasamudra and Shimshapura Hospitals: In 2001 the Trust took over the management of the two clinics at Sivanasamudram and Shimsapura under an agreement with Visweswarayya Vidyut Nigam Limited (VVNL). The clinics cater to the employees of VVNL and state government undertaking for the generation of electricity, the villages nearby and the migrant labor working at new hydroelectric projects being setup in the area. The Trust is attempting to provide similar services as that provided at the PHCs through these clinics, apart from capacity building of staff and overall improvements in management.

Promotion of low cost generic drug and Rational Drug use: For this purpose the Trust has entered into a partnership with LOCOST, a Baroda based pharmaceutical company for distribution of low- cost and quality essential drugs to NGOs and hospitals.[3] It also stocks Biocare Pharmacies for generic drugs in collaboration with Arogya Raksha Yojana Trust.

Mobile Dental Units: The Trust has started a mobile dental care unit functioning under the Gumballi PHC to provide dental care to remote villages in Yelandur, T. N. Pura and Chamrajnagar blocks and covering a range of 800 Kms. The clinic provide prophylactic care, restorative and corrective interventions as also follow up and awareness regarding dental hygiene and care. The unit visits around 13 PHCs every month.

Vivekanad Eye Hospitals: The Trust has set up the Vivekananda Eye Hospital at the Gumballi PHC for ophthalmic care and functions as an independent unit in coordination with the ANMs and health workers and under the guidance of a renowned ophthalmologist from the Vittala International Institute of Ophthalmology, Bangalore and his team. It provides both preventive and curative hospital based care and follows up and covers 4 sub-regions of Chamrajnagar district and two in the Mysore District.

Homeopath Clinic: The clinic, started about 3 years back, currently operates only on the weekends and treatment and medicines are free except for a one time nominal registration fee

ANM School: Niveditha Female Junior Health Assistant School was launched in BR Hills in October 2006. Approved by the Government of Karnataka it caters to the training of auxiliary nurses, most of whom belong to the tribal or socially backward

[3] In the year 2006-06 the Trust reports a total sale of drugs worth Rs. 2.6 million under this programme.

communities. The first batch of 30 students is currently under training (18 months course). For practical trainings the students are placed at the local district hospital.

Internship programme: The Trust has a unique arrangement with State level medical colleges to provide internship facilities for students in the various PHCs. While, this provides an opportunity for students to be exposed to rural community based health care, it provides the Trust with much needed trained manpower.

Promotion of traditional medicines: The Trust is attempting to revive the use of traditional medicines by documenting traditional knowledge and assessing and validating the practices for effectiveness and replicablity. Effective practices are then distributed through PHCs managed by the Trust and Government Ayurvedic Dispensaries. An integral component is support for the propagation of herbal medicine plants through SHGs and PHCs. The Trust has set up an Herbal Medicine Processing Unit in BR Hills with a drug license for production of more than 40 traditional Ayurvedic drugs.

Hospital service at T Narsipur: The Trust also provides non- clinical services like ambulance and free diet at the hospital in Narsipur, since the year 2000.

b. Integrated Education Project

An integrated project called Samagran Shikshan Project was initiated in 2003 in partnership with the State Resource Centre, and US based India Literacy Project. Initially launched in 40 villages of Yalandur taluk, in 2005 it was extended to Narasipura, Kolar and Gowribidanur taluks. The project focuses on pre- school, school and adult education and addresses the needs of three groups within the community: 0-6 age group and 6-14 age group of children enrolled in anganwadis and schools as well as those who are out of school in these age groups; and illiterates in the productive age group of 15-35. The project seeks to completely eliminate illiteracy, increase enrollment, decrease dropouts and develop an integrated education cum literacy model. The inputs, true to the Trust aim to empower communities and improve the quality of services, include:

- Strengthening of the Balvikas Samitis (Child Development Committees) at the Anganwadi level;
- Building the capacities of the School Development Committees;
- Capacity building and monitoring of teachers for quality education;
- Establishing a cadre of village volunteers for adult education and mobilizing dropouts to re-enter mainstream education; and
- Strengthening continuing education centres.

c. Livelihood and Community Development

The Trust believes that strengthening of livelihoods, community development and empowerment are overarching conditions for sustaining any development programmes. Therefore the Trust has initiated several activities in Yelandur and T Narsipura Taluks. These include:

- Setting up of a network of women's SHGs who are also involved in income generating activities, community health insurance, herbal medicine processing and community micro- finance (primarily savings and credit groups);
- Setting up Village Resource Centres in collaboration with the Indian Space research Organisations to provide tele-education, tele-medicine and both technical and market related information for agriculture;

- Collaboration with the GREEN Foundation to promote multi- cropping and sustainable agriculture through use of traditional seed conservation and organic farming targeting the small and marginal farers;
- Initiating several vocational training and livelihood activities; and
- Community development, including Community Convergent Action, formation of Village Development Councils and convergence of services a village level by leveraging existing government programmes.
- Spiritual empowerment of the rural poor through self reliant and participatory community work is being implemented on a pilot basis. Voluntary work for the development of the village is a key approach.

This case study focuses on the management of PHCs under a public–private partnership framework.

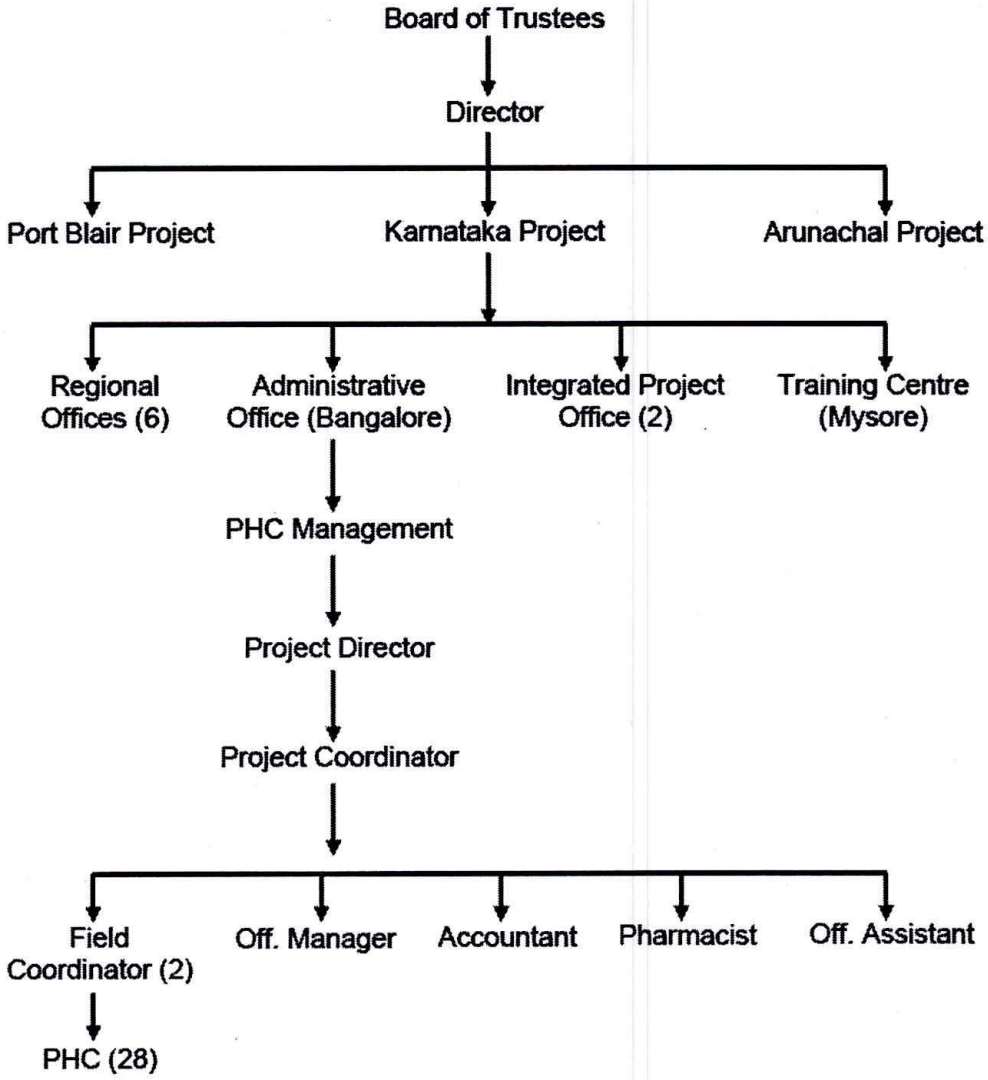
2.1.4 Organisational structure and management

The Trust is registered as a charitable trust under the Indian Trust Act of 1851 and as such is eligible for tax exemption. It has also acquired clearance from the Home Ministry for accessing external donor funds (FCRA). It is governed by a Board of Directors, headed by a President of tribal origin and hailing from the area where the Trust began its activities.

For administrative purposes the Trust is divided into six regional offices with the head office located in BR Hills, Chamrajnagar and the administrative office at Bangalore, the capital of the State of Karnataka. Besides, there are two separate offices at Yelandur Taluk, Chamrajnagar and T. Narsipura for the integrated projects being run here. There is also a Training Centre at Mysore located within the Technology Resource Centre, which manages the Manasa Project at Mysore and coordinates the training programs. Outside the State of Karnataka the Trust has regional offices at Itanagar and Roing in Arunachal Pradesh and another one in Port Blair, Andaman Islands. While the Bangalore office has an oversight of the PHC public- private partnership programme in both Karnataka and Arunachal Pradesh and is also responsible for all the PHC related innovations, stocking and distributing the drugs and advocacy, the Port Blair initiatives, launched 4 years back, have now been brought together under a separate unit of the Trust registered in the Andamans.

The Bangalore office functions out of a small but well equipped and functional building which has been recently constructed on land donated by the State (in recognition of the services rendered by the director) and through donations from individual donors. The core team located in Bangalore consists of the Director(Dr. Sudarshan), a Project Director, a Project Co-ordinator, two Field Co-ordinators each responsible for a group of PHCs, an Office Manager, Accountant, Pharmacist and an Office Assistant. While the day to day activities of the PHCs in Arunachal Pradesh are taken care of by a Co-ordinator located in the State, close support is provided by the Project Director and Coordinator from Bangalore, both of whom are also doctors by training and experience. The two Field Coordinators are each responsible for the two integrated projects at Yelandur and Narsipur. Each PHC has a team of Doctors, nursing staff, technicians and management and administrative staff.

Fig 1:Karuna Trust - Structure for PHC Management



The leadership of the Trust is an 'inspired' one: inspired by the founders philosophy of equity and enhanced quality of life for the poor and marginalized, much of which is more evident in the manner in which the integrated projects at Yelandur and T Narsipura have evolved and the various attempts to provide quality services at the lowest of costs. A process of collective management and voluntarism is visible in the way that the flagship project at BR Hills (Yallendur) is managed, albeit under the banner of VGKK. While, much of the responsibility for operational management of the Trust itself has been devolved down to the Programme Director and his team as also the running of the Training and Resource Centre at Mysore, it is clear that the Chief Functionary has a large role to play in terms of vision and directional goals. While the chief functionary allocates a substantial amount of his time for his larger roles at the State and national level, he remains connected to the ground activities through the project in the BR Hills, where he tends to spend a considerable amount of time and takes weekly meetings. This is perhaps in a way a weekly spiritual pilgrimage to the

place and people that inspired him to initiate work.[4] However, as the programme has spread over the years, his visits to the other project areas have considerably reduced and are limited to events of critical importance.

It was interesting to note that while programme and financial records are meticulously maintained, decisions ranging from activities to be undertaken to positioning of staff are taken with quickly and verbally communicated, to ensure that activities flow without much interruptions. While regular weekly meetings are held between the core team in Bangalore and the chief functionary, updates and monitoring of activities are carried out through exhaustive site visits and increasingly also through tele-conferencing. However, it was also observed that while the staffs at the PHCs interact to some extent with the District and Taluka Health Offices, the senior mangers visits are limited.

Although the individuals of the core team have clocked anything between 3 to 8 years with the Trust, difficulties are being encountered in sustaining the staff in the PHCs for longer durations. It is also obvious that for a large number of the medical professionals in the team, the Trust is a learning centre and gives them valuable experience in community based health delivery services and an opportunity to sharpen their skills. In fact, the credibility of the Trust has led it to be seen as a stepping stone to better employment. Thus, while many of the staff is motivated to continue with the Trust because of the nature of work, others remain till they find alternative and better paying employment in the government or private sector. For money others, it is an alternative employment after retirement and closer to their roots or place of origin.

Recruitment across the board is often made on informal basis, with potential candidates often approaching the Trust for long term or temporary work or internship and being quickly absorbed into the organisation. Decisions to employ are also taken by the Programme Coordinator. The senior staff indicated that quick turnovers and a constant shortage of staff in the PHCs forced them to recruit either professionals with little experience or often those who had retired from government services and were looking for alternative employment.

Over the last three years, out of a total of over Rs. 65 million received as grants and donations from various sources, the largest contribution accounting for 57 percentage of the total funds has been received from the state (GoI, GoK and its various departments), while donations from individuals and private institutions accounted for 15 percent and other institutional grants (UNNDP, FPI, Helpage India) and user fees together accounted for the remaining 28 percent. Apart from PFI and UNDP the Trust does not have any other large institutional funders. The Trust manages to generate funds from individual donors, most of who are natives of the state of Karnataka but now settled out of the country and are keen on contributing towards its development. The Trust effectively plays on their 'guilt feelings'. Most of these funds are used to develop additional and upgraded facilities for the various PHCs under its management as also the integrated project in BR Hills where the NGO also runs residential boarding schools for the tribal children.

4 This zeal and commitment has won him the Right Livelihood Award in 1994 for contributing towards preserving tribal culture and showing how this could be addressed in such a way that it helps indigenous tribes to secure their basic rights and fundamental needs.

2.2 Department of Health and Family Welfare

2.2.1. Health care and systems in Karnataka: the context

Karnataka is one of the fastest growing states in India in terms of per capita income and is also rated as being above the national average in terms of the overall health status and the health care delivery system. Apparently a wide network of primary, secondary and tertiary institutions have been established in the state providing comprehensive health care services while state policies have led to the establishment of medical, nursing and professional health education institutions ensuring reasonably good supply of health professionals. In fact, the overall health status of the population has also shown improvement in terms of higher life expectancy, decline in birth and death rates and substantial control over infectious disease Moreover, over the last few years the state government has also developed policies and undertaken initiatives that have led to improved infrastructure as well as dialogues and participation with the voluntary organisations (Government of Karnataka, 2001; Government of Karnataka, 2005).

However, there are regional differences as well as disparities amongst different socio- economic groups, which have apparently widened over the decade and effectiveness, access and inclusion of the most vulnerable communities have been of concern. Neglect of public health and distortions in primary health care in the State in recent years, as also have other issues like a lack of focus on equity, gaps in implementation, cultural gap and medical pluralism, corruption, a decline in the ethical values and growing apathy in the system have been attracting increasing criticism. In fact poor institutional capacities, inadequate attention to essential services, inadequate health financing strategies and widespread growth of the private sector without a balancing mechanism to upgrade standards and ensure quality and cost of services have been found to be other gaps in the system. Besides, while it is believed that the political economy of health has been always neglected, poor status of human resource in the health sector and the exclusivity of the government for health service provisions at the cost of ignoring the potentials of the community, private sector and the civil society organisations have not helped in improving the sector (Government of Karnataka, 2001).

> 'The relatively low level of public confidence in public sector health services, particularly at primary health centres, is recognized. Lack of credibility of services adversely affects the functioning of all programmes. Underlying reasons for implementation gaps need to be understood and addressed.' (GoK, 2004)

This has led the state to take various corrective policy measures and effect institutional changes in recent years, the most important being the development of the State Integrated Health Policy.

2.2.2. Public action

Purpose and agenda

The Karnataka State Integrated Health Policy of 2004 clearly defines the present vision and mission of the health sector based on beliefs and values of comprehensive and integrated services. The state has adopted the principles developed by WHO in 1978, which defines health as " 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', creating the ability to lead a 'socially and economically productive life' (GoK, 2004).

Comprehensive and integrated care is thus the basis of the state's primary health service policy and its' mission is to provide 'improved access to good quality health care and promote an enabling environment for development of the health sector.'

Equity, responsiveness to the needs of the people, and '...transparency, accountability and community participation' are some of the key principles it aims to follow. This implies health care service with a focus on promotive, preventive, curative and rehabilitative care at the primary, secondary and tertiary levels and an effective link to a good referral system (GoK, 2004) Accordingly, the State has adopted the following goals and the provision of:

- An integrated and comprehensive primary health care.
- A credible and sustainable referral system.
- Equitable delivery system.
- Public private partnership in provision of quality health care in order to better serve the underserved areas.
- Improved health infrastructure.
- Enhanced human resources.
- Safe and quality drugs at affordable prices.
- Systems of alternative medicine.

Further, the State recognizes the value of both public health and primary health care and attempts to bring about a synergy between the two through inter-sectoral coordination, community participation and equitable distribution of services. It also gives due recognition to the socio- cultural, demographic and economic diversities of the State. Moreover, it recognizes the critical role played by the private sector, including the NGOs in health care delivery and is committed ' ... to play a facilitating role in harnessing resources, energies and ideas from private and voluntary sector.' (GoK, 2004)

Activities

Within this policy framework the Department of Health and Family Welfare provides public health services and comprehensive health care which includes promotive, preventive and curative care cutting across cutting across various health issues. The services are largely provided through national and State funded programmes including the rural health component of the erstwhile Minimum Needs Programme, Medical Development Programme and Hospital Pharmacy Programme, a number of vertical national programmes like Reproductive and Child Health (RCH), TB, Blindness Control, Malaria, AIDS control, etc., Prevention and Control of Communicable Diseases, Nutrition Education and Demonstration Programme, Health Education and Training, Laboratory Services and Vaccine Production Unit, Education and Environmental Sanitation and Curative Services, etc. Some of these programmes have been in existence since over a decade and have gone through several phases of implementation. For instance RCH is being implemented from 1997 as a 100% Centrally Sponsored Scheme, with the objective of not only stabilization of the population but also to improve the health of the mother and child and has now entered into a second phase; TB has metamorphised from routine control and clinical treatment to DOT or Direct Observation Therapy method; similarly, a School Health Service is being implemented since the early 1990s and includes comprehensive care of health and well being of children throughout the academic year. HIV-AIDS is of relatively more recent origin but has grown in importance to merit a separate institutional set up within the sector and a large amount of dedicated funds focusing on awareness and education, counselling and care.

Since the early 1970s, the state has also been implementing several externally supported programmes focusing largely on strengthening primary health care services, and to some extent also the secondary services in the state (although in terms of budget, secondary and tertiary have a larger share, perhaps because of

their infrastructure focus). While some of the primary health care projects are comprehensive in design (IPP IX and UNICEF) others have a vertical focus on single diseases like AIDS, TB, etc. The externally funded projects include the Word Bank funded IPPVIII and IX (India Population Project), KfW funded focusing on improved services at district and sub-district levels, UNICEF supported projects, etc. A major programme of the Department since 1996 has been the implementation of the Karnataka Health Systems Development and Reforms Project, funded by the World Bank. The Project is currently in the second phase of implementation. While the first phase focused on the revitalisation of 200 secondary level hospitals the second and current phase has a wider remit. It aims at improving delivery of services in the secondary hospitals, through increased utilization of essential curative and public health services of adequate quality, particularly in underserved areas and among vulnerable groups. The essential services include all those services that can improve maternal and child health outcomes and reduce communicable diseases. While some of these are implemented as state components of the Government of India supported programmes, others are state level projects (Narayan, 2001).

Besides, the Department runs district hospitals which provide a range of specialist services from medicine, surgery and pathology to obstetrics, gynaecology, orthopaedic, ENT, ophthalmology and psychiatry; it manages several public health institutes, like diagnostic labs, water testing labs, food testing labs, etc.; and also runs medical educational institutions for ensuring continuous availability of trained professionals and para-professionals.

2.2.3 Organisational structure and management

The DH&FW delivers these services through an elaborate health structure and a range of medical institutions. In fact the health care delivery system in the state has been developed based on the guidelines issued by the Government of India and the recommendations of various national committees like the Bhore Committee, the Mudaliar Committee, etc.

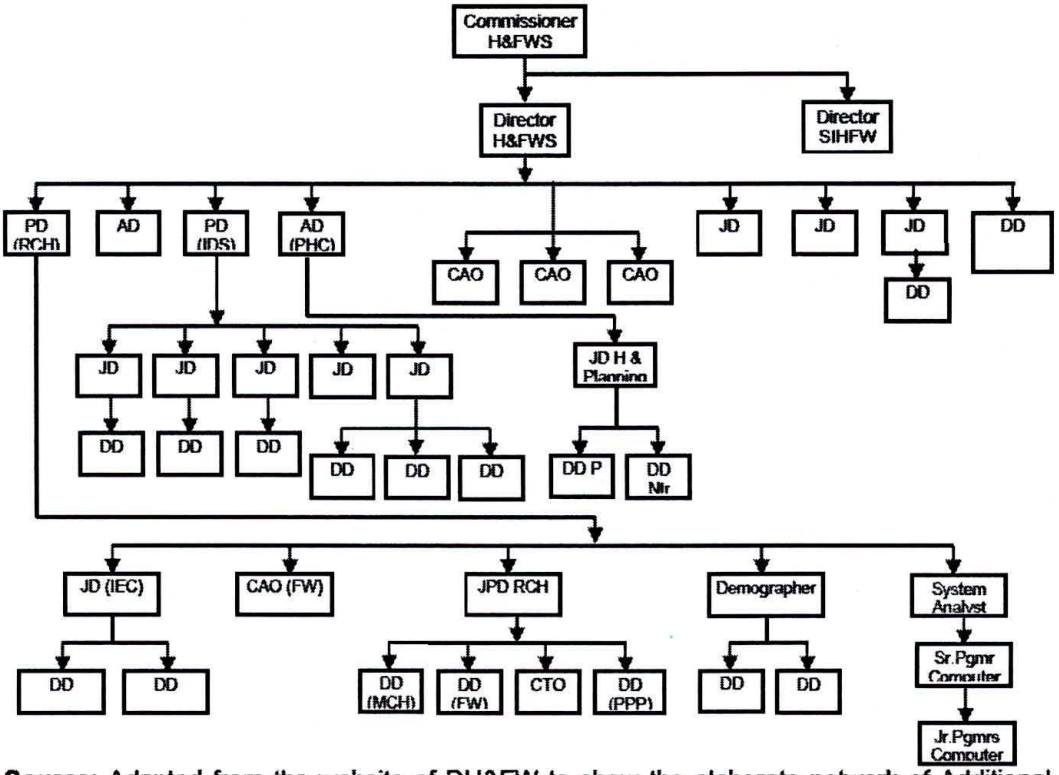
The state thus set up a specific delivery system and created the Department of H&FW under the Minister of H&FW. A Directorate for Health and Family Welfare (DH&FW) was subsequently set up to take care of all the health related services, apart from the establishment of separate Directorates to oversee the activities under the Medical Education and Indian System of Medicines and Homeopathy components, together with a Drugs Control Department, all under the Department of Health and Family Welfare. This case study primarily refers to the Directorate of Health and Family Welfare responsible for the primary health care system and structure.

The rural health service is provided through a three tier structure that includes, sub-centres at the lowest level, PHCs at the next level and Community Health Centres at the highest level. This three tier network is the standard format across the country for health care delivery in the rural areas and it is through this structure that all the national programmes and the comprehensive health care services are delivered. In fact, the PHCs with its backward and forward linkages perform two sets of activities: the first is the preventive and promotional functions under which the national programmes are implemented and monitored; and the second the curative functions.

At the lowest level and closest to the community is the Sub Centre. One Sub Centre with a female health worker is established for every 5000 population in plain areas and for every 3000 population in hilly and tribal areas. It is the closest point between Primary health Care System and the Community. Currently there are over 8140 Sub-

Centres in the state. At the next level is the PHC, wherein one unit caters to a population of 30,000 in the plain areas and to 20,000 in the hilly and tribal areas.

Figure 2: Organisational Structure of Directorate of Health and Family Welfare, Karnataka



Source: Adapted from the website of DH&FW to show the elaborate network of Additional Directors(AD), Joint Directors(JD), Project Directors(PD) and Deputy Directors for programme management and Chief Accounts Officers(CAO) for administration.

The PHC is the first contact point between the rural community and the Medical Officers and consists of a team (technically 14 in number) of paraprofessionals and other staff headed by the medical officer. It is also the referral unit for 6 Sub- Centres and has facilities to take care of a small number of in-patients. The PHC provides the entire range of activities from curative to preventive, promotory as well as family welfare services. There are 2195 PHCs and 17 urban centres in the state. At the third and the highest level is the Community Health Centre, established for a rural population of 100, 000. The CHCs consist of a team of specialists including a Surgeon, Physician, Gynaecologist and Pediatrician supported by paramedical and other staff. It has facilities for in- door patients OT, X-ray, Labour room and Laboratories. There are 249 Community Health Centres in the State (GoK website).

In order to manage this three tier system the DH&FW has established a District Health Office headed by a District Health Officer (DHO) in each of the 28 districts District and a Taluka Health Office, headed by a Taluka Health Officer (THO) in each of the 175 Talukas. While the THO provides is responsible for support and day to day monitoring of the PHCs and the sub- centres attached to it, the DHO provides the

oversight. The DHO also has a team of specialists who manage the various programmes.

The state has a budget of over Rs.1243 crores (124.3 million) in the current year (2007-08) for RCH and public health programmes, a tremendous raise from Rs. 377 crores (37 million) in 2004-05. This includes funds from the centre as well as the state. In terms of external funds while UNICEF and DANIDA have initially been major supporters and while the former still continues to be a key player, currently the largest source of external funding is the World Bank. Besides over the years there has also been an apparent shift from a grant to a loan component.

2.3 Positioning of the Trust and DH&FW within the sector

While both the Trust and the DH&FW are committed to equity in delivery of health services as well as have seemingly adopted a comprehensive service delivery package there is obviously some difference in the way the organisations are not only structured but also in the definition of the value systems and its practice. The Trust has grown out of the specific needs of the community, specially the tribals that it serves. Hence, it attempts to tailor its services accordingly.

In terms of its organisational structure, although it is now spread across the state and has several categories of employees the decision making is simple and quick unlike the hierarchal structure of DH&FW. It also has the additional advantage to innovate and raise its own funds for the purpose, all of which makes for a more efficient system of service delivery.

3. CONDITIONING FACTORS

A number of factors have influenced the agenda and the structure of both the DH&FW and the Trust. While the DH&FW has been largely governed by Central and state programmes and policies, the Trust has been effected by these same policies as well as its own ideological commitments to preserving the traditions and cultures of the community. It has also been influenced by the global approach to holistic and comprehensive primary health care. The fact that the director of the Trust has held key positions in several policy forming committees at both the state and National level is significant and has admittedly influenced the policies of the state and perhaps to some extent even at the national level.

3.1 Policies of the Central Government shape programmes and structure

Health care, as mandated by the Indian Constitution, is a state subject, implying that all decisions regarding the structure and services to be delivered as well as their management are the responsibility of the respective state governments. However, the Central government plays a critical role by holding the States to account in terms of national and international commitments to improve the health status and also by channelling some critical targeted resources, although the health expenditure is largely met by the state, with 82% (public sector expenditure) being accounted for by the Government of Karnataka and 18% from the Central Government. This is perhaps what allows the state to have a steer on the quality of services and evolve its own policies to some extent.

In Karnataka, like in other states the health care system and services have been based on guidelines enshrined within successive national Five Year Plans, decisions of the Central Council of Health and Family Welfare, central health legislation and

national health programmes, including the Central Government's goal of Health For all by 2000 in line with the National Health Policy. Thus, while over a period of time separate policies at the National level have been developed for Health (1983 revised in 2002), Nutrition (1993), Drug Policy (1986 revised in 1994), Pharmaceutical Policy (2002) and Medical Council of India (MCI) guidelines (1998,1999 and 2000), Karnataka has attempted to translate these into state level goals and operational plans. The vertical national programmes currently being implemented in Karnataka are the result of these policies and guidelines.

Commensurate with these programmes, over the years the Central Government set up several Commissions to recommend a suitable structure for the delivery of primary health care services, and the three tier structure of primary health care followed across the country, including Karnataka, is an outcome of these recommendations (Bhore Committee, Mudaliar Committee).

The National Rural Health Mission, lunched across the country in 2005 is the most recent in the line of central policies. Although Karnataka, because of its rating as one of the better performers in health, is not listed amongst the 18 focus states, still comes under the scope of the Mission. As such it needs to comply with the vision of greatly improving the health system and promote policies that would strengthen public health management and health care delivery in the state. Some of the key components of the Mission are the provision of a female health activist or ASHA, in each village; a village health plan prepared under the supervision of a Village Health and Sanitation Committee (Panchayat); strengthening the delivery of primary healthcare; revitalizing the local health traditions and mainstreaming AYUSH into the public health system; effective integration of health concerns with determinants of health like hygiene, sanitation, safe drinking water and nutrition; decentralisation of programmes for district management of health; and improving access, especially of marginalized rural communities, including women and children, to 'equitable, affordable, accountable and effective primary healthcare.' In order to realize the mission, NRHM has outlined specific core and supplementary strategies which encompass a range of activities and interventions from capacity building to improved structures and facilities, all of which are slated to be achieved by the year 2012.

The other significant move on the part of the Central government, reflecting its serious intent to facilitate a partnership approach was the setting up of a high level Task Force at the national level to recommend strategies for public- private partnership in the forthcoming Eleventh Plan. The Task Force was to identify potential areas in the health care delivery system where an 'effective viable, outcome oriented public private partnership' was possible and to suggest 'practical and cost effective system' of public private partnership. (Planning Commission,) It is significant that the director of the Trust was member of this Task Force.

The draft Task Force report defines some of the objectives of PPP as improving the 'quality, accessibility, availability, acceptability and efficiency, of health care through exchange of skills and expertise, mobilization of additional resources, improving management, expanding the range of services as well as the number of services providers. It emphasizes the need to define the sharing of risks as well as community ownership. The (Draft) Report identifies the following as potential areas for PPP:

- 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

The report however cautions against expanding into too many areas in the initial phase of PPP and recommends that the government funding should not exceed 15 percent of the budget allocation. It suggests a framework where (a) value for money and (b) clearly defined sharing of risks are the base. It recommends that the framework should also provide for costing of services and decentralization should be the approach for management, while a network of resource centres at various levels should provide technical and management support and ensure transparency. Generic models of PPP should be adapted keeping in mind the regional variations. The report concludes by providing certain principles for PPP but clearly cautioning that PPP cannot be a substitute to '...resolve the dilemma of inadequate health care for the people.'

However, Karnataka, much before the National Rural Health Mission was launched, had initiated steps to correct existing anomalies and gaps in its health care services, primarily relating to regional as well as urban and rural inequalities, poor nutritional status of U-5 children and anaemia amongst women. Besides, the state was also concerned about the overall poor health care status of women, relative neglect of mental health and disability care. The outcome was the setting up of a state level Task Force to look into these issues and not only recommend solutions but also monitor the implementation of the recommendations. One of the critical recommendations was also the development of a comprehensive health policy for the state.

In the case of the Trust, the concept of managing a PHC, launched with the Gumballi PHC was in itself derived from the opportunities offered by IPP IX. Gumballi was a difficult and backward area and had no health services and whereas IPP IX (India Population Project funded by the World Bank) had the autonomy to initiate innovative projects. Therefore, the Trust negotiated with the state and got two projects, including Gumballi, approved on an experimental basis under IPP IX. Subsequently, the states decision to expand the experiment led the Trust to expand its own scope of work.

3.2 Task Force on Health and Family Welfare and Integrated Health Policy

A Task Force on Health and Family Welfare was hence constituted by the Government of Karnataka in 1999 to specifically look into bringing about improvements in the public health system in the state, propose ways of stabilizing the population and recommend improvements in management and administration of the DH&FW. The Task Force was also to recommend changes in the health education system, including clinical and public health. An added remit was to monitor the impact of the recommendations especially in the initial days. In the course of its activities, the Task Force also recognised the need to address another critical issue- that of widespread corruption in the health sector and the lack of integrity. What is significant to this study is that the Task Force was chaired by the director of the Trust.

The Task Force made a series of short and long term recommendations focusing on reforming the DH&FW and to improve the equity and quality of service delivery. While addressing a range of issues from primary, tertiary and secondary health care to multi-sectoral and inter-sectoral coordination, partnerships and decentralization, it empahsised that state policies related to health were to be governed by the '...principle of equitable access to effective care to meet the needs of the people', and that minimum 'acceptable standards' need to be developed for health care institutions, with the concept of 'comprehensive primary health care' being propagated and accepted by both the people and the service delivery mechanism.

Therefore, PHCs need to be upgraded in terms of better infrastructure and adequate manpower and a synergy should be brought about between primary health care public health, including water and sanitation, solid waste management, hazardous and bio- medical waste. Besides, a Health Monitoring Information System for infrastructure, human resource and disease surveillance needs to be established for overall management.

The Task Force also proposed, and in fact went ahead and developed, an integrated health policy which was adopted by the state in early 2004. The policy is comprehensive and includes sub- policies on health, population, drugs, nutrition, control of nutritional anemia, blood banking, education for health sciences, pharmaceutical, ISM&H and policy for communicable and infectious diseases. The role of voluntary and private sector in improving health care is specially emphasized: 'Participation of voluntary and private sector will be enhanced through outsourcing certain services, in infrastructure maintenance and investments in health services.' (GoK, 2004). The policy also recognizes the need to involve the community and to institutionalise this process through the PRIs.

3.3 Externally aided programmes

The state health sector has also been influenced by the large number of externally aided projects that have been present in the state since the early 1970s. These have included international agencies like the World Bank and UNICEF and bilateral agencies like DANIDA and KfW. Each of the external funded projects have had their own focus and have included support to control of specific diseases like TB, HIV-AIDS and blindness control, while others have been more compressive and supported the wider issue of RCH (Reproductive and Child Health) and population stabilization and primary health care. Some of them were state components of GoI projects while others were state specific projects.

A study undertaken in 2001(Narayan, Ravi 2001) indicates that the World Bank has been the biggest donor and over the years has become one of the only donor. And not surprisingly therefore there has been a gradual shift from grant component to loans over the years. The study adds that most of these projects, till the early part of this decade have been stand alone projects and hence whatever synergies were affected was unintentional, although this gave the project a certain amount of autonomy to innovate. The Study is critical about the lack of capacity and ownership of the DH&FW in most cases as also the effect of omnipresent corruption and the lack of transparency and accountability in these projects like in the case of the others. It also interestingly pointed out that a perception that most of these projects were donor driven was because the state officials themselves tended to accept the conditions and strategies, without contributing their own ideas.

3.4 Influence of the tribal culture on the Trust

The founders of the Trust had begun their work with tribals communities located in scattered remote forest areas and not only have the Soliga tribes remained a core focus of their activity, but the existence of VGKK, the parent organisation of the Trust, is closely linked to the tribals themselves. This ideological relationship with the tribals ensured that the founders of the VGKK and the Trust protected their 'inherent culture' and developed all interventions around it. This was because director and his team believed that the tribals are an integral part of the forest and as such their future depended on ensuring that they did not get alienated from nature. This led VGKK to integrated traditional health practices and cures with modern medicines and also subsequently led them to promote traditional medicines through the activities of the

Trust. More importantly it was this need to preserve the traditional culture and ethos of the Soliga tribes that let the director to create a separate unit to take care of the health needs of the non-tribals.

4. SHAPING OF THE REALTIONSHIP

4.1 Growth of the relationship between the Trust and DH&FW

4.1.1 A beginning is made with the Leprosy Control Programme

As mentioned earlier, the Trust was launched with an independent leprosy control programme targeting the tribals and non- tribals in Yellandur Taluka of Chamrajnagar district. Within a year of its existence the Trust had brought the problem of leprosy in the area under control and the Karnataka government, impressed with the early results, entrusted the responsibility of implementing its Leprosy Control Programme in the entire district to the Trust. Thus, the first formal collaboration between the NGO and the state came into being in 1987 soon after the establishment of the organization. The results have been impressive and the incidence of the diseases is reported to have reduced drastically from a little over 21 percent in 1987 to less than 1 percent in 2002.

For the control and treatment of Leprosy the Trust adopted, what was known as the SET method of treatment which involved elements of detection, education and treatment and required a close interaction with the community as well as effected households. During the process, the NGO discovered the presence of other diseases like Epilepsy, various types of mental illness and TB in the community and gradually began to take steps to control and treat these ailments too. As part of the interventions it also interacted with the local PHCs and supported the doctors and health workers through trainings and development of manuals and audio visual tools. In a pioneering effort, the Trust trained the doctors at the PHC to identify, treat and thereafter follow up on the progress of mentally ill patients. Thus, apparently for the first time a PHC in the state addressed mental illness. The Trust was innovative in utilizing all effective government resources to improve conditions of service in the community. Hence, it also established contact with the National Institute of Mental Health and Neuro-Sciences (NIMHANS) who provided both training for a group of local health workers as well as regular treatment.

Thus, within a few years of its establishment by early 1990s the Trust had clearly evolved a process of responding to local health needs through its own professionals and para professionals as well as supporting the state run PHCs to perform better. These were however, small projects, ad hoc and localized in nature, covering a cluster of about 50 villages in Yallendur Taluka and implemented with the support of various individual and small institutional donors and technical support from private as well as government specialists located in the capital city of Bangalore.

4.1.2 Move to Narsipur Taluk, Mysore District: widening scope of relationship

In 1996 the Trust expanded its area of operations to cover T Narsipur Taluk in Mysore district, North West of Chamrajnagar. The Trust's decision to expand to this taluka, was primarily based on the fact that even though the taluka received adequate government funds they were not being utilised properly and hence remained under developed. The benefits of the programme were not reaching the poor so the Trust adopted a strategy to bring the community and the government departments together. Community organisations and capacity building became the key focus and not only was the scope of activities widened to include education,

livelihood, etc., but the Trust also began to interact with other government departments. Again, funds for the Trust's activities were initially largely generated from an NRI (Non- Resident Indians), with roots in one of the project villages. Over the years the projects at Yallendur and Narsipur developed into separate integrated projects where although health was at the core of the Trusts interventions, livelihood and education also were addressed.

4.1.3 Takeover of the Gumballi PHC

In the same year (1996) the Trust also took the next significant step in its evolution as well as its partnership with the State: it began to manage the Gumballi PHC and its' 5 sub centres catering to a population of 20,000 living in 15 villages, where the Trust has been active for some years. The population includes both tribals and non - tribals. The fact that Gumballi was a backward area with no health services was the reason why the Trust chose to work here. Besides, although a PHC had been proposed here by the government for some time, it had not as yet been established and the community had to depend on the poorly equipped sub- centres or travel a distance to the nearest government hospital. The Trust, which had been running a clinic in this area since the last few years offered to manage a full fledged PHC.

Although the then existing national programmes had scope for contracting NGOs for various activities related to programme development, implementation and management under a Grant in Aid system, there was no provision for allowing an NGO to manage a PHC in its entirety. However, the Trust realized that the World Bank supported India Population Project (IPP IX) had scope for innovation and submitted two[5] proposal for Honnur and Thithimathi in March 1995 to the DH&FW for undertaking the management of a PHC on an experimental basis. Both the proposals were finally approved in March 1996 in a meeting chaired b the Secretary, DH&FW and the Trust was allowed to establish a PHC at Honnur. The PHC was being run out of a rented building at that time but a decision was taken at the meeting to construct a new building using the IPP IX funds and hand it over to the Trust for a an initial period of ten years. It was also decided that grant in aid would be provided to the Trust, with the government meeting 90 percent of expenses out of the ZP budget, while the Trust would manage the remaining 10 percent. However, whenever drugs would be supplied the budget provisions will be accordingly reduced. The existing government staff in the PHC was to be withdrawn and relocated in other areas while the Trust would employ its own staff, however with no liabilities on the Government.

As the proposed arrangement was a deviation from normal practice, the approval of the sate Cabinet was obtained before handing over the charge of the new PHC to the Trust. The project was titled as the' PHC Handing-over Project' and this was one of the 50 PHCs which the government proposed to hand over to NGOs at that time. (Proceedings, dated 08.06.95)

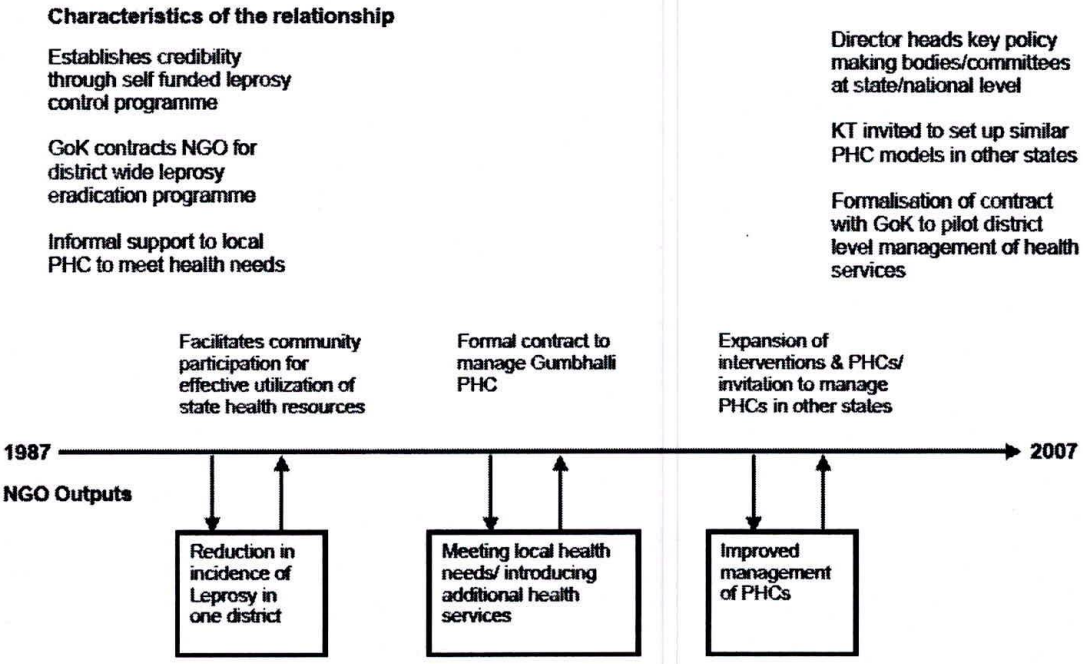
However, subsequently the Trust apparently changed its decision and opted to set up and manage a PHC at Gumballi, as Honnur would not have benefited the tribal population who the Trust's primary target. (IDPAD, 2006). This decision was also facilitated by the fact that when the concerned ZP (Mysore district, under which Yellandur Taluk was located before bifurcation) was consulted regarding the proposal, while it gave its concurrence, it suggested that a new PHC may be opened in Gumballi for the scheduled tribes and handed over to the Trust. The government therefore agreed to the change and launched its first collaborative management of a

5 The second PHC at Tithimathi in Virajpet Taluk of Coorg district is being managed by the Vivekanada Foundation, a federation of 12 voluntary organisations, including VGKK and headed by Dr. Baslasubramaniyam

government PHC in Gumballi in 1996. Incidentally, as the Trust was at time in the middle of constructing its own building for its activities, it offered to use this to run the PHC and the offer was readily accepted by the Government [6]. Moreover, since this was a new PHC additional grant was provided under IPPIX to equip it with furniture. (Proceedings, dated 11.03.96)

Over the next few years several health programmes, community dental care and care of epilepsy, diabetes, hypertension and mental health were integrated into the primary health care activities of the Gumballi PHC as by then the Trust had adopted the concept of comprehensive care recommended at the Alma- Ata conference in 1978. By 2001 the Gumballi PHC had evolved into a relatively mature integrated model of promotive, preventive, curative and rehabilitative care wherein equitable distribution of health care through free services and medicines, community participation, appropriate health technology through integration of traditional and Indian system of medicines and a multi- sectoral approach was the key strategy. The PHC in Thithimathi, although not technically under the Trust, also developed along similar lines and benefited from the support provided by Sudarshan and both continue to work under the partnership format till today.

Fig 3: Karuna Trust : Evaluation of relationship with Government of Karnataka in Management of PHC



4.1.4 Expansion of partnership

For the next few years there was no expansion of the Trust's PHC management portfolio. However, in 2001 the Trust was handed over the management of two clinics being run by the Visweswarayya Vidyut Nigam Limited (VVNL), a subsidiary of Karnataka Power Transmission Corporation Limited, located in the south east of Karnataka in the district of Mandya. These clinics, catering to the staff as well as the

6 This is apparently the only PHC which is at a distance of only 3 KM from the Taluka (Block) headquarters as against the norms of distance and coverage laid down by the government.

local, largely migrant population, were not running efficiently and the Trust took it over under an agreement with the VVNL. Subsequently, the Trust also agreed to manage two adjacent government sub- centres which were not running efficiently. Permission for this was granted by the DHO who had the authority to do so.

It was not until June 2003 that the Trust reached another milestone when two more PHCs were handed over to it. Subsequently more PHCs were added every year and today the Trust is managing 23 PHCs, 2 PHUs and 2 clinics across Karnataka. In 2005 the Trust went across to length of the country to the North Eastern State of Arunachal Pradesh where it entered into a contract with the State Government to manage 9 PHCs and 36 sub- centres falling under it covering 9 districts, as part of a pilot programme involving a total of 16 PHCs and 4 NGOs.

The expansion in 2003 and thereafter was made possible by a policy decision of the Government of Karnataka to hand over 100 PHCs to NGOs and private medical colleges in the first phase under the 'Scheme for involving private medical colleges and other agencies in the management of PHCs' launched in 2000. The scheme had provision for NGOs, reputed Trusts or private agencies to either manage a PHC fully or just to contribute to the improvement of facilities- the Trust has opted for full management. Discussions with Project Coordinator of the Trust however, indicated that there has been some debate within the NGO regarding the model to be adopted. The Project Director had reservations about the 'Adoption System' where any agency could monitor a PHC on payment of Rs. 25, 000, because it was difficult to manage the government staff that had to be retained. The director of the Trust however was of the opinion that NGOs should work with the Government staff. However, since there were great difficulties in working with the government staff, the Trust continues to largely depend on staff appointed by it.

In the initial days the DH&FW apparently handed over 50 PHCs to various NGOs, Trusts and private medical colleges. Subsequently however, many of these either dropped out of the project or their contracts were terminated because they failed to meet the requirements. Thus so far the DH&FW has not managed to meet its target of a 100 organisations primarily because most NGOs do not have the capacity or additional resources to manage a PHC or are weary of engaging with the government because of allegations of corruption, red tapism and delays. (Director in interview). The Trust thus remains as the NGO with the largest number of PHCs under it.

However, since 2006 it has deliberately not expanded the list of PHCs in Karnataka as the purpose was to establish one in each district as a model and not to be co-opted into the system or expand the management of PHCs. In fact, at the time of the interviews the Trust was on the verge of successfully concluding negotiations to take over the management of the primary health care system in 4 districts on a pilot basis. The Trust would be initially funded by two institutional donors (Deshpande Institute and the Ashoka Innovators) in this venture and thereafter intends to negotiate for the use of NRHM funds, a strategy that it consciously follows.

Looking at all the factors that went into setting up the relationship, it is evident that the Trust itself, and more specifically the director, have played a critical role. In fact it was the Trust that initiated the process of partnership and negotiated with the Government of Karnataka. The first formal call for such a partnership was apparently made at a meeting of SCOVA or the Society for Coordination of Voluntary Agencies in Karnataka, of which the Trust was also a member. The issue was taken up from there by the Trust and various levels of officials as well as the community- including the members of the district and taluka panchayats were consulted. What however,

appeared to have facilitated the process is also the interest of the Government itself, who found it difficult to manage remote PHCs with poor infrastructure and a shortage of qualified staff. At the same time, the Trust was able to meet the additional funding requirements of the partnership and sustain interventions because it was able to raise funds from individual and other donors who are mostly settled out of the country but have their roots in the Trust's area of operations. In fact the Non Resident Indians have been instrumental in funding improvements in infrastructure, money for which is generally difficult to come by.[7]

4.2 PERCEPTIONS ABOUT THE PURPOSE OF THE RELATIONSHIP

4.2.1 NGO's perception: support and effectively utilise government resources

There were two reasons that compelled the Trust to take a decision to enter into a partnership with the state to manage the PHC: The first, as indicated by the director, was the realization that by running parallel schemes to the government, '...we were only duplicating resources when the government actually had resources and infrastructure available with them...'; and the second was the difficulties that the Trust itself faced in continuously raising funds from private individuals and donors: 'We had to beg to get money from donors...'(director, Trust). Besides, even though there were several programmes and provisions for redressing the problems of the poor in all the districts, they were ineffective in many districts.

The Trust realized that managing 'micro- level interventions' and establishing parallel facilities would only solve the problem of poor services to some extent and scaling up to larger levels itself was restricted due to resource limitations. The Trust therefore felt that it was more prudent to utilize the vast but inefficiently used government infrastructure to upscale and improve services and also bring the state and the community together on to a common platform and thus started work with the state in the PHC in Gumballi .

There is no ambiguity in the Trust's statement that it is not running the PHC's for its own survival but for improving the system and hence would not like to compromise on issues of 'equity, integrity and quality'. Besides, as the Trust does '... not want to take more money and do more and perhaps better work if it is not replicable...' it has opted to work within the given working conditions and constraints faced by the PHCs in the State '...including less money but focusing on better outcomes.' [8] (Sudarshan, interview). This implies that the models that it develops are adaptable to the given environment and not designed to work only in a simulated framework.

At the same time however, the Trust does not want to be co-opted into the government system and prefers to remain autonomous. The Trust would rather be a partner to trigger change and improve policies, systems and institutionalize the processes than collaborator only in implementation. The director of the Trust himself believes in a partnership between the state and the private sector, and observes that his own role as a key member of various Commissions and Committees at the state and National level is also a form of PPP that contributes to policy changes.[9] Although he acknowledges that the for- profit private sector does have a major role to play in

7 During field visit to the Suganhalli PHC, in Bangalore (rural) district, it was observed that apart from contributing to substantial upgradation of the PHC building, a number of other community facilities had been provided by a local family, now based in USA, and all these facilities (PHC, school, library, etc.) were named after the family created Foundation-KRS Foundation

8 However, there appears to be some contradiction here and that is the fact that as an approach the Trust replaces the existing government staff with its own contacted staff, instead of improving the performance and accountability of the former.

9 At present Sudarshan is also trying to propagate the concept of PPP at the district level through his position as a member of PPP Task Force constituted by the Planning Commission, GoI

the delivery of health services and that in Karnataka 90 percent of the ambulatory care was being managed by the for- profit private sector, the not- for profit sector or the NGOs were more critical to ensure equity, integrity and quality of service. However, the reality was that at the moment they only accounted for 3 percent of the services.[10]

The director believes that the government and NGO have ;...two extreme perceptions about each others value '... while the government thinks that it works best and all NGOs are bad the NGOs think that everything that is 'government' is corrupt...But the truth lies in between.' In fact many NGOs do not want to work with the Government because of corruption, red tapism, delays in decision making and fund flows and general loss of business. But this is again a situation which needs to be addressed and resolved for while '...technical package can give only a small percentage of benefits, good governance will do better'. He also adds that the general opinion in India is that basic services like primary health care should be the responsibility of the public sector. The Trust on the other hand believes that '...partnership is an integration of ideas and activities and that total privatization is not possible.' On the other hand they believe that over the years they have been able to facilitate bringing about a paradigm shift from a '...medical model to a social model...a model that is multi sector and integrated...' (director, interviews with the author).

4.2.2. For DH&FW partnership is a matter of convenience...

Within DH&FW the understanding of the purpose of partnership is mixed. Most of the officials at the state level view the partnership as a matter of convenience and a policy imperative which will be sustained in the future. In fact the Commissioner, DH&FW stated that Karnataka was a progressive state and that they were keen on community involvement and would go forward with a PPP strategy in management of PHCs. He added that NGOs would be involved in the training of ASHA for which the Trust and another reputed private hospital would take the lead. Besides, under the 12th Finance Commission a trauma care would be provided in each taluka with 2 drivers and 2 nurses outsourced as a mobile unit. On the other hand at the district and block level, while some see an advantage in terms of availability of staff and innovations, others are of the view that the partnership does not add any value to the performance of the PHC.

The Director, of DH&FW while stating the official position on the partnership indicated that the PHCs were being handed over to 'reputed' NGOs because the government itself had great difficulties in managing remote PHCs and recruiting adequate staff. This was a reason also echoed by some of the officials in the districts, who observed that there was a shortage of staff in the Government as recruitments were made only once in 5 or 6 years. The Trust, they observed, was on the other hand able to recruit doctors at a lower salary and fill up most of the vacant posts, especially in the PHCs located in remote areas, thus benefiting the local community. However, they also observed that management of PHCs was not a profit making and viable option for NGOs, and therefore most of them did not venture into this field, unlike the Trust, which was more focused. Besides, even in the Trust, because of the low remunerations and the difficult working conditions, the attrition rates were high and it was generally able to recruit only retired doctors (Interviews with THO, Yemallur, EX-Administrative Officer, Jagallur).

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10 In fact Sudarshan is also not averse to a system of general practitioner as established under the NHS service in UK and is of the view that they should also work under a PPP framework

Some of the officials at the district and taluka (block) levels believed that there were other advantages in entering into a partnership with the Trust. They conceded that the doctors recruited by the Trust were generally more committed and the work in the field also tended to be better managed because of the availability of ANMs as well as better monitoring. The presence of the Trust also lightened the burden of supervision on the government staff at the block and district level. Besides, NGOs like the Trust facilitated innovations and new strategies, while '...creating an atmosphere of healthy competition.'(DHO Timkur, THO, Chamrajnagar)

However, there were others who were convinced that the partnership with the Trust was the result of 'political pressures' and the influence of the director of the Trust and the outcomes were not impressive (DHO Devengari). They observed that the stated purpose of PPP is to improve the quality of services, but this had not happened in the case of the Trust, except for the introduction of tele- medicines and the setting up of village resource centres. In fact the performance of the OPD had also not apparently improved. Interestingly, a key reason for this alleged poor performance, they stated, was the lack of capacity and management of the medical staff employed by the Trust. Not only was the staff not approved by the government, but often they were not appropriate. They not only lacked knowledge but were also not suited for the specific responsibilities assigned to them.[11] Although they conceded that the fact that the staff stayed on the premises of the PHCs managed by the Trust was encouraging, it had not led to much improvements in services (THO, Jagalur). Besides, most of the NGO managed PHCs focused largely on the curative aspects and did not adequately plan and implement the National Programme. The fact that the NGOs were trained by the Government as part of the partnership was interpreted to imply that the Government was more qualified and hence there was no relevance in handing over PHCs to NGOs. Besides, one of the THO's also opinioned that '...NGOs do not have as much of commitment as the government. They are also not so bound by requirements...' (THO, Jagalur). They concluded that although the Trust was operating relatively better, there was nothing' extraordinary' in their performance. (DHO Timkur).

4.3 Formal rules and contracts

The partnership between the Trust and the DH&FW for the management of the PHC has been formalized through a simple government order in the case of Gumballi and a contract, backed by elaborate terms of reference, in the subsequent PHCs.

4.3.1 PHC Handing Over Project: Based on Government Order

The process of formalizing the agreement between the Trust and DH&FW for the handing over of the Gumballi (and Thithimathi) PHC took exactly a year from the time the former submitted an application for the same. During this period, as mentioned earlier, there was a major change and the original proposal to manage the PHC at Honnur was dropped in favour of setting up and managing a new one at Gumballi. Accordingly, an order to this effect, duly endorsed by the State Finance Department, was passed by the GoK (executed in the name of the Governor of Karnataka and signed on his behalf by the Under Secretary, Health and Family Welfare Department) on the 11th of March 1996 and communicated to the Trust. This then was the formal basis of the partnership.

11Two cases were cited by the THO of Jagalur: that of a Staff Nurse discharging the duties of an ANM and a retired Medical Officer managing the PHC. While the Staff Nurse is not expected to have any knowledge about the national programmes or experience in field work, the MO would not have an understanding of the reporting processes.

The order had the following primary clauses:

- A new PHC at Gumballi along with the sub- centres attached to it was to be handed over to the Trust
- The building under construction by the Trust will be used as the PHC building.
- 50 percent of the management cost will be borne by the State together with an additional grant for furniture (from IPP IX budget) as this is a new building.
- While the government will sanction the required staff; however, the Trust will be responsible for appointing its own staff subject to the approval of the DH&FW.
- The CEO, ZP will sanction the grant to the Trust in the form of 90 percent grant-in-aid.
- The arrangements were to hold for a period of 5 years.

Besides, in an annex, the order also laid out some conditions for financial control. These primarily included the authority to '...inspect the style of working and accounts of the organisation,' and the proviso that the state would not sanction pay scales that exceed the pay scales given by the state government. Besides, the Trust was also to 'strictly' follow the minimum educational qualifications prescribed by the state for specific posts. Interestingly, however, at the request of the Trust, the required qualification for ANMs was relaxed to a minimum of grade 7, as it was impossible to find more qualified women at that time amongst the tribal population. Other then this no specific guidelines were issued for implementing the project but a high powered committee was set up to monitor it, as it was a pilot initiative with potential for expansion.

4.3.2 Scheme for involving private medical colleges and other agencies in the management of PHCs: Scheme document and contract

In the second phase, when the partnership was formalized on a larger scale with more NGOs and private medical colleges, besides the Trust, a relatively elaborate document was prepared indicating the eligibility criteria for agencies and the procedures for submission of proposal as well as the evaluation and selection process. The document also included guidelines for management as well as 'adoption' of the PHC by the agencies, the responsibilities of the agencies, stipulations regarding the assets of the PHC, funding and fund flow for the government, co-ordination and monitoring as well as provisions for financial control and audit.

The contract itself is a one page document to be executed by the Director H&FWS on behalf or the Governor of Karnataka and the concerned agency, although the funds are released by the district The contract specifies the name, place and location of the PHC and SCs and commits the agency to abide by the clauses as laid down in the Scheme document 'in consideration...' of the financial commitment made by the government. Besides, the contract also indicates that the government will 'reimburse' the amounts to the agency for the services specified in the Scheme document on a quarterly basis. However, the services have not been defined in detail and only broadly refers to the implementation of the National and State health and family welfare programmes and the primary health care services that are delivered through the PHC and its sub-centres. It also instructs the agency not to charge any patients any amount for '... diagnosis, treatment and drugs or for any other purpose except in accordance with the government policy.'

Thus, as per the document, the Scheme allows NGOs, Trusts and charitable institutions as well private medical colleges to either fully manage or contribute towards the management of PHCs (infrastructure and services). The PHCs are

grouped into two categories according to their level of performance with the first category being that of the top 50 percent of the better performing PHCs and the second category that of the bottom 50 percent of the poor or non-performing ones. According to the document 100 PHC in the second category were to be handed over to selected NGOs etc., for management on a first come-first-served basis. The Scheme was to be reviewed after two years and the guidelines revised accordingly. Only those NGOs or Trusts working in the rural areas and are legally registered for a minimum of three years under Societies Registration Act or similar State Acts, or Indian Trust Act (1982), or Religious Trusts Act(1920) are eligible to participate in the scheme. Besides the NGO should be reputed, should have been working in the same district for a minimum if two years, should be financially sound and should not have been a defaulter in the use of government funds. Similarly conditions were also laid down for medical colleges and Trust run by corporate bodies.

The document indicates that the NGOs are to submit the proposal to the Commissioner H&FWS[12] through the Chief Executive Officer of the concerned ZP. However, each agency, excepting for those backed by corporate organisations, could apply for only one PHC in the first Phase, perhaps to ensure that they have the financial capacity to sustain. Although the Scheme was launched in 2000, the Trust itself entered into a contract under it only in 2003 with two PHCs and thereafter added an average of 6 PHCs in the next three years. A selection committee headed by the Commissioner H&FW, and also including a member from SOSVA, has been constituted to ensure a fair selection. The selected agency is accordingly informed by the Director H&FWS and thereafter enters into a contract with the later. The agency is 'entrusted' with the management of the PHC for a period of 5 years, but is to be '...reviewed and confirmed...' after two years. The agency is evaluated in the fifth year and renewal of contract thereafter is based on performance.

The document also lays down some modalities for the management of the PHCs, and states that the agency has to take full responsibility for adequate staffing of the PHC and its sub-centres in accordance with the staffing pattern, norms and qualifications laid down by the government. Besides, the staff would be employees of the agency with no liability on the government. The government itself will withdraw all its' staff, although some of them could be retained on deputation, based on mutual consent. The agency is also required to provide inform the DH&FW the details of remuneration to the staff. If any of the staff appointed by the agency proceeds on leave of over 15 days, a stand in arrangement ahs to be ensured. The services of the staff employed by the agency will be terminated automatically once the contract with the agency comes to an end.

While the existing assets of the PHC are to be handed over to the agency at the time of entering into the contract, the agency is also allowed to add to the assets but at no cost to the DH&FW. The agency will also have to provide the details about the assets added to the Directorate. These assets, together with the government assets will have to be handed back to the Government on the termination or closure of the contract. The agency also has to ensure that adequate stock of essential drugs are maintained and dispensed to the patients at no cost.

The DH&FW on its part will reimburse the costs as per specified norms that include[13]:

- Staff cost at 75 percent of the salary paid to government staff at the minimum scale.

12 At that time the Directorate of Health and Family Welfare was known as the Directorate of Health and Family Welfare Services

13 The annual government budget for a PHC in Karnataka is Rs. 12 Lakhs whereas in AP it is Rs.27 lakhs. However, unlike in Karnataka the government AP is particular that the Trust stands by its commitment to contributing towards 10 percent of the salary.

- Leave salary for up to a maximum of 30 days per year
- Maternity leave salary for up to a maximum of 90 days per delivery and restricted to two deliveries in the service period. POL charges to a maximum of 100 litres a month if the agency has an exclusive vehicle for the PHC
- Full reimbursement of water and electricity charges to a maximum of 1500 per month
- Rs. 25,000 annually for maintenance of the building
- Funds (at present Rs. 75, 000) for drugs as per the scale fixed by DH&FW
- Funds will be released on a quarterly basis by the District Health and Family Welfare Officer (DHO) from the district sector on approval of the ZP.

Another reason for the government to include a 75%-25% funding clause, besides ensuring cost sharing, was to initially put of all and sundry NGOs clamouring to manage a PHC and also to stop politicians forming NGOs and then lobbying to hand over PHCs to them. Apparently, the State has recently agreed to give 90% percent costs but the order is yet to be executed.

According to the Scheme document, the District Health and Family Welfare Officer(now known as the DHO) is to monitor the working of the PHC in terms of the services that it is required to provide within the framework of the various National and State Health and Family Welfare programmes and the '...provisions of the general Health care services in the PHC as per the general directions of the Government.' (GoK Scheme document, 2000) .

In order to ensure effective coordination between the agency, the DHO and the ZP, a coordination committee consisting of the Commissioner H&FWS, CEO of the ZP, Chief Accounts Officer & Financial Advisor and the Additional Director (PHC) was set up. The government has also given itself the right to issue directions to the PHC in specific circumstances. The authority for issuing directions however has been vested with the Director of H&FW or officials of a higher rank.

Finally while the Scheme document audits it also allows the Government to terminate the contract for violations of the conditions of contract, after due enquiry. The agency also has the right to terminate the contract after a 60 day notice period. Sudden termination without notice by the agency is likely to attract penalties equal to the budget amount for the period.

Thus although the contract document gives some directions for control and the agreement describes the relationship as a contract, holding the Trust to perform the tasks as laid down under national and state programme mandates, some of the clauses indicate that there are elements of horizontal collaborations as it gives freedom to recruit own staff and expand activities and facilities with just intimation to the government. Besides, it also implies that the NGO will bring in additional resources to improve both facilities and services.

5. THE RELATIONSHIP IN PRACTICE

In practice the dynamics of the relationship between the Trust and DH&FW is reflected at two levels: At the state level there is general willingness of decision makers to continue with the experiment as a potential strategy for managing remote PHCs; and on the other hand at the district and taulaka levels, there is a range of reactions from perceptible reluctance to placid acceptance or active support. While, some see it as an unnecessary intrusion by an agency that is allegedly unable to perform better than the government, others are informed enough to appreciate the

advantages that the NGO offers. There are also a few who simply accept it as one of the many projects of the government which need to be implemented according to the rules. Obviously then there are operational dynamics, which impact on the partnership and it various from district to district. What also becomes obvious is the fact that the influence of Sudarshan at the state and national level appears to have infused strength into the relationship.

5.1 Operation of the relationship

5.1.1 At the State level

Although the intensity of interactions between the state and the NGO is significantly greater at the Taluka and district levels, it is at the level of the Directorate and the Department of H&FW that policy decisions to launch, sustain and change the relationship are taken. And here, interviews with various senior officials indicate that although operational problems, and at times even issues related to performance do exist, the concept of partnership as well as the Trust's commitment, integrity and better performance is well recognized and acknowledged. The director of the Trust states that the Trust '....has *alliances* within the government with people who understand the process and we know that they will support us.' (director, interview) While this 'understanding' has emerged from an informed and extensive debates, discussions and research at various levels and forums, the Trust's confidence it self has emerged from having demonstrated viable models while not compromising on its commitments and integrity.

In fact, it is evident that the Trust had a role to play in initiating the partnership process for the management of PHCs as far back as in 1996. While, Sudarshan was a key person in not only the negotiations with the DH&FW, but was also instrumental in identifying a way forward to locate the initiative within an on going project (IPPIX). The Trust consulted all the stakeholders, primarily the communities and although most of the communities were agreeable to the proposed arrangement, one of the gram panchayat (Yeragamballi), encouraged by local private doctors and others with vested interests, tried to block the proposal on the pretext of it being a stepping stone privatization. The issue was eventually resolved after prolonged meetings and dialogues with the members and the community in which the director of the Trust himself participated. Eventually, it was the community that sent a written request to the Government to allow the Trust to run a PHC at Gumballi.

The Trust also supported the DH&FW to obtain approval from the Finance Department which was reluctant to hand over government PHCs to NGOs.[14] The Finance Department was eventually convinced, when DH&FW, backed by the Trust, mooted a cost sharing arrangement with NGOs, in which the Department would be able to save money. In fact, the director of the Trust himself was invited to participate in a high powered meeting in June 1995 chaired by the Secretary of the DH&FW to finalise the handing over of two PHCs and also apparently contributed to the drafting of the modalities for the subsequent scheme that was launched in 2000. The Trust could also convince the State to subsequently hand over the Gumballi PHC instead of Honnur. It is interesting to note that here the Trust strategically mobilized support of local leaders including the local MP, and ZP, Taluka and GP members for effecting a transfer. Besides, the fact that at that time only the Trust and the Vivekanada Foundation, which was again an NGO with which Dr. Sudarshan was associated, were the only two in the programme, indicates the extent of credibility and influence that he carried.

14 The State was also apprehensive that politicians may open NGOs with no commitment, when they saw an opportunity.

But this is not to say that the Trust does not have to face a fair share of scrutiny and criticism from the state officials. The Director, H&FW, explained that there were two aspects to PHCs - i.e. the promotional and preventive functions monitored under the National Programmes and the curative function. He observed that, while NGOs have discharged their curative responsibilities effectively, many of them have failed to deliver the former responsibilities, and the Trust was also facing the same gap in implementation, although it performed well on other scores. According to him a major reason for this could be the shortage of staff, especially ANMs, with adequate capacity. In fact about 6-7 NGOs had to withdraw from the project because of poor quality of staff and lack of performance. NGOs were unable to attract adequately trained and experienced staff because of the low remunerations. The Trust, like other NGOs and medical colleges participating in the programme is subject to periodic reviews and evaluations by the DHO and third parties and has also been had also been advised about the lack of training of its staff and perhaps this and the shortage of ANMs was the reason that it has set up an ANM training institute with license from the state.

5.1.2 At the operational level

Handing over the PHC: Vested interests and lack of information were initial hurdles

The Trust is aware that while 'The top level is happy with (its) performance...the district is at times not happy.' However, the Trust is convinced that given time and inputs, the government run PHCs, with its backward and forward linkages at the District level, can also improve its performance '... But ...vested interests at the district level ...are acting as hurdles.' (director, interview).

There are several functional areas where the Trust and the THO and the DHO offices interact. For instance at the time of taking over the PHC; for specific support like training for its staff, organising health camps, support in the case of a disease outbreak, etc.; in review and monitoring; and in the release of the agreed drug supply and budget. And how smoothly these functions flow depends to a large extent on attitude of the concerned THO and DHO and the relationship between them and the Trust run PHC.

The first point of interface is the process of taking over of the management of a PHC. The process is long drawn and requires sanctions and feedbacks from several layers, including the elected local body or the ZP.

The process of obtaining approval for taking over the management of a PHC is long:

- The Trust submits an application to a central committee at the State level;
- The application is forwarded to the Zilla Parishad (ZP) in whose territory potential PHCs are located;
- The ZP sends it's comments to the District Health Officer (DHO), who will then shortlist 2-3 PHCs to be adopted
- The ZP then gives its final comments which are thereafter forwarded to the State government.
- Once they get an order from the state government the Trust takes the order to the Taluka Officer (who is often surprised but complies). Together with the Taluka Officer an inventory of equipment, stock, etc. are made and books of account signed off. The Government staff may choose to stay or be replaced- which is what happens in most cases.

The whole process takes anything from 2-3 months and even longer if any of the concerned stakeholders oppose the move. Often there is initial resistance from two quarters: the community and its representatives as well as the government staff at

the PHC, THO or DHO level. At times it was a case of the government staff instigating the community because of vested interest and sometimes it was the community itself reacting to the unknown and unfamiliar. Their fear is centreed round the belief that the advent of the NGO would lead to 'privatization' of the PHC, consequently making it inaccessible to the poor, a 'left wing' concept, as the director of the Trust puts it. Some of the ZPs also fear a loss of control when the PHC management is handed over in its entirety, although they are not averse to NGO involvement in the implementation of individual national programmes like immunization, AIDS-HIV control, etc. Some of the ZP members also had a more narrower interest regarding the authority of the Medical Officer of a NGO run PHC to issue medical certificates, especially for medico-legal cases (only a government officer designated as 'Class I Gazetted Officer has the authority to issue such certificates). A few of the takeovers, like the ones in Thithimathi, Coorg and Kadugu have been really difficult with community leaders in some cases even taking out agitating against the move in public. In fact, some of the senior managers indicated that initial resistance from the community was the rule rather than an exception.

In the case of the DH&FW officials in some of the talukas and districts the resistance was due to vested interests or lack of the right information. Corruption, as indicated by state commissioned reports, is rampant in 'epidemic' proportions in the health sector in Karnataka: in delivery of services by staff from ward boys to doctors and specialists,[15] in various services -from the time of birth to death- offered by the PHCs and government hospitals termed as the 'life cycle approach to corruption', corruption in civil works related to the health sector, in health administration and finally corruption in medical education (Sudarshan, 2006). Against this background, it is not surprising that doctors, para- medics and administrators posted in these PHC for long years feel threatened and deprived of their 'under the table income' when the Trust takes over the management and the existing staff is either relocated to other PHCs or has to opt to work with the NGO at reduced remunerations. Often, the staff who feel threatened, instigate the community with notions of 'privatisation' and takeover.

The Trust however, dismisses these as 'teething problems' and adds that they continued to stand by their values and '...do not compromise.' (meeting with senior management of Trust). It feels that this situation arises because of a tremendous lack of understanding at the PHC and district level in turn due to lack of effective and informed communication from the State. It is also partially because of the fact that the PHCs handed over to the Trust are also the most difficult ones.

Almost always the Trust eventually manages to come out of seemingly impasse situations with the community. Such issues have so far been addressed through intense dialogues between the community and its leaders and the Trust- with at times, even the chief functionary of the Trust participating in the dialogues. There have also been instances when the DHO (Chamrajnagar) has intervened to assure the community and ZP that the government was only temporarily 'renting' out the PHC to the NGO to ensure service delivery. What is significant is that once the Trust has established a rapport and credibility with the community, the later often become an ally in furthering the agenda by donating land for additional facilities for the PHC, contributing or raising funds for buildings, staff quarters and other facilities, using their influence to negotiate with higher levels of the government- even up to the level of the State- for additional resources and facilities for the PHC. The Trust therefore,

15 'For instance the Medical Officer gives money to the Taluk officer as a regular feature All this gets affected with our kind of approach' (Sudarshan, Interview)

routinely informs the GP/ ZP members about activities so that they do not create problems. The two factors that encourage the GP/ZP them to do so are the commitment of the staff, the almost complete absence of corruption in the PHC, the on campus presence of medical professional 24 hours in the day and also the relatively more humane response to their needs.

In the case of the government staff from the PHCs, THO and DHO, the impact is reduced or dies away once the community is agreeable to the new arrangement. In fact, the community then takes up cudgels on behalf of the Trust when required or then the director himself has to request the State to intervene and to allow the Trust to takeover the PHC. However, often the hostility from the taluka/ district level officials continues in different ways, even after the Trust has formally taken over the management of the PHC. Sometimes, the resistance is also due to lack of information or wrong notions. But this is cleared soon after the partnership actually begins to function. In fact one of the THO (In-charge, Kalam), observed that before the partnership was initiated in one of the PHCs under jurisdiction, he and his colleagues believed that it was not good move as the Trust would hire its own staff over whom the THO would have no control. But now they think otherwise.

There are other staff related issues that also arise at this stage. One is the problem of managing excess government staff from the Sub Centres who are handed over to the Trust together with the SCs. In many cases the Trust negotiates with the DHO, and sometimes also mobilizes the DH&FW, to redeploy them to SCs under some other PHC. However, such relocated staff from the SCs still continue to draw salaries from the Trust managed PHC, with consequent administrative implications. In the initial days the Trust also realised that there were some unwanted posts in the PHCs, like that of a First Division Clerk, with little work. The Trust negotiated with the State and converted the FDC's post to that of an Administrator, who worked was employed for the full time . Thus, the Medical Officer in charge of the PHC was relieved of much of the burden of administration, freeing time for community work.

Such flexibility was also visible in other aspects of manpower planning and management within the partnership. For instance, the DH&FW also recruited and positioned staff on behalf of the Trust in the PHCs. This involved transferring additional posts from other PHCs and recruiting staff that were then paid by the Trust. In some cases the State recruited as well as paid for the staff.[16] The government also passed orders allowing the post of the Medical Officer to be filled by CAMS or Ayurvedic doctors. But such arrangements, whereby doctors work with the Trust but are paid by the government, at times causes problems, as the doctors report to the DHO and hence their allegiance is often divided.[17] Another hurdle is that some of the State appointed doctors find it difficult to relate and interact with the THO and the DHO in the same manner that an NGO appointed doctor would do, indicating the obvious play of hierarchy and subordination. Even in the case of ANMs appointed and paid by the State, management at times becomes difficult, especially if the ANM is powerful or is a political appointee.

16 In the PHC at PatnayakHalli, one of the lady doctors (Laxmi) is on a transferred government post but paid by the Trust, while the second lady doctor (Somya), has been recruited by DH&FW and posted here on an 'Additional Doctor' post. She is also paid by DH&FW

17 The Programme Director of the Trust reported a case of an Additional Doctor posted in one of the PHCs who was constantly causing problems and reporting late for duty. The Trust has warned him that he would have to leave if his performance did not improve.

Conducting business

Once the PHC has been handed over and the initial hurdles resolved the Trust has to ensure that services, i.e. the national programmes and regular primary services, as stipulated by the State are delivered effectively. It was obvious that the Trust has considerable freedom to organize and run the activities within the PHC and also add to the services and facilities, however at its own cost. In the process of conducting its business however, it has to interact with the offices of both the THO and the DHO for procuring drugs on a periodic basis and for release of funds from the State, channelled through the ZP and the DHO. From time to time the Trust also seeks help for specific purposes like organising health camps and at times of medical emergency. Further, the Trust's activities are also monitored by the THO and the DHO.

Ensuring quality of services: In reality, to a large extent the Trust relies on its own staff and on various types of collaborations with other private institutions for improving the quality of services and providing additional services. For instance, it has tie ups with a renowned hospital located in Bangalore for heart related treatments and, as indicated earlier, has established a system of regular consultations through its telemedicine facilities or acquires the services of specialists for short term and on voluntary basis. Occasionally the Trust has to seek the help of the THO/DHO and reportedly such help has been usually forthcoming. For instance, in the case of the PHC at Patnayakhalli, in Tumkur, while the Tubectomy cases are referred to the Taluka Hospital, Cataract camps are organised in collaboration with either the district hospital or a private hospital. Similarly, the THO, Yemallur stated that his office and team provides support whenever help is requested. The THO also involves the Trust in the health camps that his office organizes and provides training in health education.

Procurement of drugs: The more regular interactions between the Trust and the THO/DHO are primarily for the release of funds and procurement of drugs. Rs.75, 000 worth of drugs is delivered annually to each PHC by the state, out of which 60 percent is purchased on the basis of a general indent and decentralised procurement and 40 percent through the State Drugs and Logistic Society. The reason for this arrangement apparently is to ensure that the essential drugs are available in the PHCs because, as often some MOs do not indent for these. While some of the Trust managed PHCs complained that there were delays in procuring the supply of drugs as well as gaps in the quantity supplied one of the PHC also reported that the concerned staff in the DHO's had tried to extract bribe from the Trust. While one of the DHO's admitted that there were delays and shortfall in the drug distribution system and that this was largely due to bureaucratic failure, he also observed that the NGOs needed to understand that the government was very hierarchical in decision making and hence often the DHO may have genuine reasons for delays in responding to the request of NGOs (DHO, Chamrajnagar).

Thus it is obvious that the Trust does not have any say in procurement as apparently the government rules are rigid on these issues. However, it has tried to respond to these problems by evolving its own system of additional procurement on one hand and trying to influence the state to improve elements of the system. Thus, a significant percentage of the drugs are procured by the Trust - through LOCOST - and distributed at its own cost to all Trust managed PHCs. For instance one of the PHCs (PatnayakHalli, Tumkur) reported that in the year 2006-07, the Trust had supplied almost Rs. 300,000 worth of drugs. The Trust, therefore often ends up spending its own money. Besides, the Trust has also facilitated the state to prepare a list of essential drugs for mandatory distribution to the PHCs. It is also advocating for indent based supply of drugs and although the order to this effect has been passed

by the government it is being complied only by some districts. Apparently, localized procurement of drugs has helped to some extent and the lag time has been reduced. But problems still exist: for instance drugs go missing, wrong kind of drugs are supplied at times and of course there is corruption.

Release of funds: The release of funds is also a cause of some tension between the Trust and the DHO at times. The budget itself is agreed with the state and funds are released by the DHO but on the approval of the ZP. Under these conditions delays occur from a minimum of one month to a maximum of even 10 months if the Trust's relationship with either the ZP or the THO/DHO is not very conducive to collaboration. In the early days of the partnership there were apparently occasions when the Trust was also asked to pay a percentage of the funds as bribe for releasing the money. But the Trust has managed to resolve this by firmly refusing to comply and at times formally using its influence at the State level. Delays however continue and the Trust is able to cover the expenses without disrupting the activities of the PHC, only because it is able to raise additional private funds.[18] The Trust attributes these delays '...to the process adopted by the system and the still prevailing corruption. Bad management is another reason.' (director in interview).

Earlier the reimbursements from the DHO used to be routed through the Bangalore office of the Trust. However, because of complaints from the PHC about late payment of salaries, etc., an account has been opened in the name of the MO and the Administrator of the PHC and the funds are deposited into this account. The Trust has provided a rotating fund to start of the process and while some DHOs have already initiated the process others have agreed to start it in the new financial year.

The Trust has managed to recently negotiate with the state and correct this to some extent by instituting a process of monthly reimbursements. The Project Director indicated that there was also great rigidity in the way the budget lines were defined. For instance although the contract allowed for some amount of funds for POL, some of the PHCs could not access this amount because either the PHC did not have an ambulance and a driver or in some cases had the post of a driver but no vehicle! Again the Trust, through its own resources has been able to procure a vehicle for some PHCs. Then again, although there is a budget for administrative costs, there is no provision for training the staff. Therefore the Trust has to rely on training offered by the DHO or on its own funds. It generally chooses to do the later.

At times, the Trust also has difficulties in accessing specific programme funds. For instance it reported that the Janani Surakhsah Yojana (an amount given by the State to every expectant mother to encourage institutional delivery) could not be accessed till the director of the Trust approached the officials in the DH&FW. The Trust was denied the use of these untied funds because they were a "private entity'. The fact the Project Director of the Trust is familiar with the functioning of the State because of his previous experience as an employ of the state, also helps.

Monitoring and review: The THO by virtue of its position is responsible for the direct monitoring the PHCs run by the Trust. The planning and reporting system according to the Trust is cumbersome because there are almost 20 formats to be generated from the PHC to the DHO level. Besides, the ANMs are required to maintain 13 books of records and 18 formats.

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18 Apparently, the Trust has already spend over Rs. 4000,000 on drugs and other expenses in the current year, which was yet to be reimbursed at the time of the interviews.

The Trust is required to report on a monthly basis to the DHO through the THO, who requires programme-wise information to be submitted on prescribed formats, common to both the NGO as also the state run PHCs.[19] There are also regular monthly review meetings conducted by the THO at the taluka level and in which the Trust run PHCs are also required to attend. The MO attends some of these meetings while all the ANMs and their Supervisors are expected to attend all the monthly meetings. At times separate meetings are also held for specific programmes. While some Trust managed PHCs reported cordial and supportive relationship with the THO during the monthly review meetings, some like the PHC, Mallapura complained of either being ignored, as it was an NGO run PHC and hence not perceived to be the responsibility of the THO or were actually given 'step- motherly treatment' and humiliated. The THO or his team only visited the PHC once in a month instead of more often as required. They were also apparently not provided with the requisite training and this was the reason why the ANMs could not perform better vis a vis the national programmes. Those who were supportive were generally the THOs who realized that as the PHC was their responsibility any good or bad performance would reflect on their own ability to deliver (MO, Yemallur PHU).

In most of the districts the MOs are not required to attend the monthly meetings organised by the DHO (these meetings are primarily held with the THOs of the district). Therefore, the MOs of the Trust managed PHCs interact only at special meeting a few times a year or when the DHO or his team visits the PHC. In the case of Gumballi PHC under the Chamrajnagar DHO, the ANM/Health Supervisors also meet with the DHO once a month. However, this is a district specific case instituted on the initiative of the DHO for several reasons: apparently it helps in keeping up the moral of the Supervisors; it enables the DHO to communicate what is important and urgent; it facilitates the DHO to become aware and understand the grassroots problems; and it allows the DHO to monitor cash flow and ensure necessary checks and balances in case any MO in the PHC (both State and Trust managed) is not performing according to requirements (DHO, Chamrajnagar). The DHO also ensures that at least one Programme Officer participates in the monthly meetings at the THO- in fact this seems to be a practice followed by other DHOs also as indicated by the RCH Officer of Devangari District. He stated that the DHO also has adequate interactions with the NGO. The Programme Officers from the DHO thus maintain their contact through the monthly visits to the PHCs, review meetings at the DHO as well as THOs, district level ICDS meting with the THO, quarterly meetings with the MOs, as well as workshops from time to time.

The PHCs are evaluated at the end of the stipulated period by a third party commissioned for this purpose. Currently, the evaluations are carried out every year by a joint team consisting of the DHO, District Surgeon and the Women and Child Welfare Officer of the district.

Levels of satisfaction: While many of the THOs and DHOs were satisfied with the overall performance of the Trust managed PHCs, some of them were unhappy about the concept itself. For instance the DHO in Chamrajnagar has a good rapport with the PHC and appreciates the work done;[20] on the other hand although the THO perceives the PHC to be an NGO one does not create any problem. The director's influence in this area is very strong because of the long years of presence as well as

19 The Trust run PHCs however generate additional formats (7 in number) which is then submitted to Trust office in Bangalore giving management and structure related information. Besides, the Trust has also constituted a supervisory team consisting of the MO, AO and the Senior Health Worker to provide and overview of the critical CNA survey undertaken by the ANMs based on which a number of activities are planned

20 In fact Sudarshan was influential in posting the current DHO here and both appear to have a mutual respect for each other.

the work done here. It was also reported however, (DHO, Chamrajnagar) that although the ZP did not object to NGOs implementing specific projects, it only had confidence in the Trust and would not allow any other NGOs to manage the PHC. Others, like the Director IPP, who monitors the Yemallur PHU was happy with the innovations in the PHU and carried out only minimal supervision, as she thought that the Trust was capable of running it without much supervision. This was also corroborated by the concerned THO. However, he was of the opinion that in order to make the partnership work better, there should be a better understanding between the community and the NGO.

Those who were strong in their criticism of the Trust (THO Jagalur and DHO Devengar) apparently were unhappy with both the concept of PPP as well as the Trust itself. According to them poor performance was observed in several areas including in the Patient Department, the number of in- patients who were treated, the low numbers of deliveries conducted in the PHC, poor performance in immunization services and lack of knowledge about immunization schedules. 'I do not think that KT has made any difference. The fact that the staff stays on the premises of the PHC is good but this has not led to much improvements in services. ' (THO, Jagalur).

They attribute this condition to several factors including a lack of knowledge about various national programmes, not having the right people on the right job, high rates of attrition – perhaps because of low levels of remuneration, etc. The THO, they complained, was left to just function as a 'post office' within the partnership because the staff from the Trust went to the THO/ DHO only for reimbursements and not advice. 'They do not come to the THO to enquire about programme and discuss the difficulties they face... The PHC does not refer to the Taluka Office, we do not know what drugs they have received...referrals are in fact very poor (Official of the THO, Jagalur). Stating that they were not satisfied with the overall work, one of the officials also alleged that the NGO managed to get funds from the government because they were influential and 'powerful'. In fact the THO did not have any control over them and instead the Trust put 'pressure ...from all sides'.

However, the Trust pointed out that often the DHO itself was not willing to take decisions that were within its authority, and the Trust had to resort to the State, perhaps giving the impression that it had overstepped the authority of a lower level official. For instance some PHCs have a large number of SCs spread over a vast area and become difficult to manage(In Bijapur and Tumkur there are 11 SCs each spread over 80 KMs). This requires some amount of reorganization of the SCs and connecting it to other PHCs- a task that is within the jurisdiction of the DHO. But the DHOs wants the decision to come from the state and therefore the Trust took up the issue with the Director- H&FW, who has in turn asked the Trust to submit an application together with a map showing the current and proposed locations and attachments of SCs.

The DH&FW as well as the DHOs were aware of these tensions between some the Trust run PHCs and the DHO/THO, and attribute it to bureaucratic systems, lack of information and a belief amongst some of the officials that these PHCs are not their responsibility because they are run by a private entity. However, they also clarified that at no time do they excluded the NGO run PHC because PPP does not mean excluding such PHCs. They also do not give it a step motherly treatment and '...review the NGO PHC with equal responsibility because anything good or bad about that PHC reflects on the DHO' (DHO, Tumkur). However, they observed that they had no systematic control over these PHCs like they did in the case of the government managed ones. It was also stated that the decision to continue with the partnership arrangement with any of the PHCs was taken at the state level and that

the DHO could only recommend about continuation. On the other hand the DHO and the THO were accountable for the health status of the community across all PHCs and in case of any health related emergency then the health department is blamed.

6. EFFECTS OF THE RELATIONSHIP

6.1 Effect on the partner organisations

The Trust and the DH&FW entered into the partnership with similar goals- of ensuring equity in the delivery of primary health care services. For the Trust this was translated into empowerment of the rural and urban poor, especially the tribal communities, through integrated development with better health care services as a core strategy. Besides, the Trust's aim of effectively using the state resources instead of running parallel systems has been achieved because it is able to access a large percentage of the cost of running the PHC. For DH&FW on the other hand, the goal of health care with equity, like all government agencies with a larger mandate to service all the communities but with a provision to ensure that the poor and the marginalised are not excluded, implied improving the services of the poor performing PHCs. As such the relationship conforms to the individual goals of both the partners, without in any way effecting the overall ideologies and identities.

Having said that, in terms of functional relationship at the implementation level, the bureaucratic system, and more so the pervasive corruption within the institutions of the THO and DHO, poses a challenge to both efficient operations as well as institutional internalization of innovations and lessons. While the Trust does not feel that it has to compromise on its values, ideas and identity, a sense of imposition of the relationship exists amongst some of the THOs and DHOs. While this is due to a variety of reasons- partially vested interests and partially lack of information- it does make the process of the relationship that much more difficult, especially for the Trust. Hence, for the difficult THO and DHO the Trust is more a thorn in the flesh or an irritant that cramps its style and authority in the area, whereas for the more accommodating district or taluka level agency the Trust takes off some of its burden of work.

Considering that the Trust's relationship itself varies from active participation to resistance or passive engagement, the overall impression is that the Trust has considerable freedom to take forward its own agenda. The factors that make this possible are the influence and credibility of the organisation and more so its leader. It is also because of the autonomy that it gets through the additional resources it is able to generate to not only to upgrade facilities but also to provide a back up when funds from the government are delayed or is inadequate. Besides, the fact that most of the PHCs handed over to the Trust are in any case the difficult and remote ones limits interference on a day to day basis to some extent.

6.2 Effect on the agenda

Over the years the Trust has been able to bring about some policy level changes having an impact on the operations. For instance, it assisted the state to prepare the list of essential drugs and also influenced them to become flexible and change the norms of allocating a fixed annual amount of Rs. 75, 000 per PHC for drugs, irrespective of the patient load. At the time of the study the Trust was also negotiating with the state to hire contract doctors and depute them to the PHCs managed by it in order to meet the shortage of doctors. Overall, the chief executive of the Trust (Sudarshan) has played a key role in shaping the health sector in the State, primarily

through his contributions as a Task Force Member and the Chair of the Committee appointed to draft and oversee the implementation of the health Policy. The fact that a number the recommendations of the Task Force and the integrated Policy reflects elements of the Trust's learnings is an indication of the extent of the formers ability to influence. The director of the Trust observes that he considers his role as a member of the state Task Force, and a Vigilance Officer in the Lok Ayukta and the chair of the PPP at the national level to be forms of public private partnership: 'I consider all these roles as another form of public- private partnership and that partnership is being affected at various levels.' He also is of the opinion that issues like influencing the state to change the norms for allocation of funds to the PHC are also the impact of PPP.

As far as a model of NGPA in partnership with the state is concerned, the Trust has been able to demonstrate a model which is a shift from a medical to a social model and where community is central to the strategy. It now does not therefore feel it necessary to expand to more PHCs and instead intends to move up to the higher level of the district.

What seems to be missing here, however, is a concerted and visible effort and process either on the part of the state or most of the districts to imbibe lessons from the experience of the Trust. What is also disconcerting is the fact that though the Trust itself has been able to advance its activities across Karnataka and even other states, in Karnataka itself there are very few NGOs who have opted to enter into similar relationship with the state. In fact, the state has been unable to achieve its original goal of handing over 100 PHCs in the first Phase. The director of the Trust attributes this to the reluctance of many NGOs to engage with the Government for fear of red tapism and corruption. However, the DH&FW is of the opinion that most of them either lack the capacity - both in terms of skills and resources - or are themselves too corrupt to sustain the relationship. Therefore, while the Trust itself has been effective in taking its agenda forward both in terms of coverage, depth of activities and influence on policy, there is a gap in terms of confidence and acceptance of the approach amongst the various stakeholders.

7. CONCLUSIONS

The relationship between the Trust and the DH&FW is informed and cordial at the level of the state but generates a mixed response at the implementation level. It is a relationship that has been clearly pushed by the Trust in the initial stages and well accepted at the policy making level. However, the tensions at the operational level as well as the hitherto, almost single focus on the PHC, has perhaps limited its impact, although it has been successful as a model of an efficient PHC responding to community needs. Perhaps, its forthcoming experiment with partnership focusing at the district level health care services may address these problems.

The role of the leader in not only initiating the relationship, but also in taking it forward and integrating it into the health policy of the state as well as at the national level comes out clearly. It is one of those classic cases where the NGO has strategically moved from demonstration models to impacting at the state and national level.

The relationship reflects a horizontal collaborative model, although based on a loosely structured contract. It gives relative freedom to the NGO to contribute both in terms of resources and ideas.

LIST OF INTERVIEWEES

1. Dr. H.S. Sudarshan, Director Karuna Trust
2. Dr. Deb, Project Director, Karuna Trust
3. Dr.Prashanth, Field Coordinator, Karuna Trust
4. Manjunath, Manager, Head Office/ Administrator, PN Hulli PHC, Karuna Trust
5. Staff of PatnayakHalli PHC, (Karuna Trust managed)
    - i.Dr. K. Sheshagiri Nayak, Dr. In- charge
    - ii.LMO,
    - iii.Administrator,
    - iv. Lady Doctor,
    - v. ANM
6. Staff at Gumbahlli PHC (Karuna Trust managed)
    - i.R.N. Sharma, Manager
    - ii.Dr. K. S. Sharat, Medical Officer
    - iii.Jeshri, MHW/ Supervisor
7. Taluk Panchayat Member, BR Hills
8. Hindi Teacher, of the school run by VGSK in BR Hills
9. Yamallur PHU (Bangalore Urban District)(Karuna Trust Managed)
    - i.Dr. Rema Marar, MO,
10. PHC Mallapura (Karuna Trust Managed)
    - i.M.V. Hosur, M.O
    - ii.Venkatesh, Administrator
    - iii. Usha, Staff Nurse
    - iv.Anand Kumar, Pharmacist
    - v.Surya Prabha, Female Health Worker, Anapur SubCentre.
11. Mr. Basvraja, Commissioner, Health and Family Welfare, GoK
12. Dr. M.B. Rudrappa, Director, Health and Family Welfare, GoK
13. Dr. Vishwanath Kumar, DD MCH, GoK
14. Dr. Buwaneswari, Varathur PHC, Bangalore, GoK
15. Nanja Reddy, Health Inspector, Varathur PHC, GoK
16. Dr. Shapatti, DHO, Chamrajnagar, GoK
17. Dr. K.S. Mamata, Director IPP Hospital, GoK
18. THO, YemallurGoK
19. Dr. Shivparakash , Ex Administartor, THO, Jagalur, Devengare district
20. Bharat Bhushan, THO, Jagalur, GoK
21. Dr. Shakarappa, Jagalur, GoK
22. DR, Arvidam, DHO, Tumkur; GoK
23. Dr. Gandhi, Malaria Officer, Tumkur, GoK
24. Dr. Ranganath, In charge THO and Medical Officer of Kalam, GoK
25. DHO, Devengari, GoK
26. Dr. Muawar, RCH Officer Devengare , GoK
27. Pawan Kumar, an MBA graduate recently appointed as Manager under NRHM (District Programme Manager), GoK
28. Thema Reddy, Community Leader
29. M.R. Shobha, husband of one of the GP members
30. K.R. Hanumant Rai, G.P Member
31. PatNayakHalli, GP meeting
32. GP members
33. S.K Ramma Reddy ZP member, Mallapura (Hiremallenkote Panchayat)

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ORIGINAL ARTICLE

Year : 2009 | Volume : 2 | Issue : 2 | Page : 46-52

Primary health care and public-private partnership: An indian perspective

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Date of Web Publication 10-Jun-2010

Abstract

Background: In the new millennium, the progress and success of primary health care (PHC) in India has been delegated to and nurtured in the hands of growing number of 'for-profit' and 'not-for-profit' public-private partnerships along with secondary and tertiary care. This article tries to analyze the adequacy and quality of the ever increasing public-private partnership (PPP) in PHC in India. **Objective:** To assess time trends and overall patterns of public-private partnership in PHC in India. **Materials and Methods:** We conducted a literature search for data sources through an extensive search in indexed literature and website-based population survey reports; 13 states with public-private partnerships working on PHC were identified. A broad criterion to define both 'for-profit' and 'not-for-profit' PPPs was taken. Outcome variables were success of PPPs in PHC implementation. **Results:** The study critically reviewed PPPs in the light of their services in the PHC segment and significant policy perspectives by an in depth analysis with operational issues in the management and functioning of the schemes. In the health sector PPPs in India, as social entities, pool the best features of the two merging authorities of Government and private sector. They have already shown their potential. **Conclusions:** In India, PHC, PPP have shown accountability to the people in India. The time has come to explore this to the fullest extent.

Keywords: Public private partnership, primary health care

How to cite this article:
Pal R, Pal S. Primary health care and public-private partnership: An indian perspective. Ann Trop Med Public Health 2009;2:46-52

How to cite this URL:
Pal R, Pal S. Primary health care and public-private partnership: An indian perspective. Ann Trop Med Public Health [serial online] 2009 [cited 2016 Mar 23];2:46-52. Available from: http://www.atmph.org/text.asp?2009/2/2/46/64269

Introduction

In 1978, the World Health Organization (WHO) and the United Nations Children Education Fund (UNICEF) studied a history of global health rights in Alma Ata, USSR. In the Alma Ata Declaration, 134 countries subscribed to the goal of "Health for All by Year 2000". They affirmed WHO's broad definition of health as "a state of complete physical, mental, and social well being". To approach health for all, the world's nations, together with WHO, UNICEF, and major funding organizations, pledged to work towards meeting people's basic health needs through a comprehensive, remarkably progressive approach called "primary health care" (PHC). PHC includes promotion of proper nutrition and an adequate supply of safe water; basic sanitation; maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and the methods of preventing and controlling them; and appropriate treatment for common diseases and injuries. The declaration stresses the need for a comprehensive strategy that not only provides basic health services for all, but also addresses the pervasive underlying social, economic and political causes of poor health that links health to a strongly participatory strategy known as people-centered development . India's commitment to provide PHC to the masses dates back to the recommendations of the Bhore Committee in 1946. India's rededication to the PHC approach in 1978, implicit in the signing of the Alma Ata declaration of HFA 2000 AD redefined this approach for provision of health care to the masses. Considering the predominance of the rural population, great emphasis was placed on the development of infrastructure techniques and manpower for service delivery mainly in rural areas - rightly so!

The transition from agrarian to urban based economics necessitates a reorientation of the national polices and priorities. Urban slums are deprived human settlements, which are demographically, economically and environmentally vulnerable. It must be realized that the average figures of urban areas hide the stark reality of the urban deprived slums. No clear cut data on slum population was available. The health problems of the urban poor are related to a complex web of causation. The provision of PHC, therefore, cannot be compartmentalized, but has to be provided as a part of overall comprehensive urban slum development. [1]

The concept of Public-Private Partnership (PPP) has been popular in the last decade of the last millennium and has now become an increasingly popular option in health care delivery system in India. Historically many such projects have been implemented in the PHC segment in different states of India with different levels of perspectives. The National Rural Health Mission (NRHM: 2005-2012) from the Government of India planned to set up PPPs at different levels of health care as key partners to success in implementation. NRHM has contemplated that involving the private sector as part of the RCH initiative will provide more effective health care delivery system. [2] The number of private sector institutions and dependence on them has been increasing over the years; the private sector now provides more than 70% of curative care. In Uttar Pradesh, of the women who seek care for reproductive health problem, 71 % seek

levels of health care as key partners to success in implementation. NRHM has contemplated that involving the private sector as part of the RCH initiative will provide more effective health care delivery system. [2] The number of private sector institutions and dependence on them has been increasing over the years; the private sector now provides more than 70% of curative care. In Uttar Pradesh, of the women who seek care for reproductive health problem, 71 % seek care from the private sector. [3]

India has, since independence, developed a huge health care infrastructure in both public and private sector (including voluntary organizations).

Apart from the for-profit private sector for health care, the non-governmental organization (NGO) and voluntary sector have also been providing health care to the community. More recently, PPPs have been attempted to involve the private sector in delivery of national health programs and in drug development. Some of the initiatives in India include improving access to PHC services. [4] There are a few important issues in PPP, like choice of model for shared investments and operating expenses and time frame for contract, defining a formula for shared revenues for a fair contract; estimating volume growth is tricky. There are many sources of revenue,; we can charge the client (utility, service provider or citizens) or generate from advertisements-building, transaction slips. Legal and policy frameworks which encourage PPP are authentication and security of private partner transactions, design of service level contract (obligations on all partners) and ability to enforce as PPP model can create another type of monopoly. Conditions that foster reform are strong political driver and seasoned civil servant executor- In high risk projects (innovations) presence of both is ideal, political support is required to end monopoly provision of services by departments and tackle vested interests and civic pressure plays a limited role in initiating the project.

However, civic pressure is critical in preventing a rollback of reform. Media plays an important role in minimizing resistance from vested interests and in motivating the staff enabling policy framework and legal environment that encourages civil servants to be entrepreneurial. [5]

This article tries to analyze the progress and success of PHC in the new millennium when, due to different reasons, not only secondary and tertiary care but also PHC is delegated to and nurtured in the hands of growing number of 'for-profit' and 'not-for-profit' PPPs.

Materials and Methods

Study design

Retrospective study design based on systematic review of primary health care was appraised on an extensive collection of studies, including meeting presentations and personal communications, from different sources in which PPPs were reported.

Literature search for data sources was done through an extensive search in indexed literatures and website- based population survey reports. Thirteen states were identified where public-private partnerships are working on primary health care found in thirty potentially relevant articles.

All published articles in indexed journals available from various institutional libraries of India and websites on PPPs were included in this study. Studies have also been identified by searching Pubmed-entrez and abstracts from scientific meetings. Reviews of citations and reference lists helped identify additional eligible studies. The search terms included PPPs and PHC. Sources were contacted (wherever possible) for further information on survey data not readily available in the public domain. Manual searches were conducted from review articles and previous meta-analyses. We also contacted authors for additional information or translations from languages other than English.

Selection criteria

We developed a broad criterion to define both 'for-profit' and 'not-for-profit' PPPs.

Study design

Retrospective study design based on systematic review of PPP on PHC was done by an extensive array of data. We attempted the comprehensive, annotated assembly of survey results from different sources; published surveys and field studies in which PPP on PHC were reported, meeting presentations, personal communication on recent surveys not included in previous analyses. Sources were contacted for further information on survey data not readily available in the public domain.

Review criteria

Standard nomenclatures based on information provided in the publications by the global experts have been used.

Outcome variables

Success of PPPs in implementation of PHC

Results

In an ideal PPP, in the health sector, the newly created entity pools the best features of the two merging authorities. Various state governments in India have been experimenting partnerships with the private sector to reach the poor and underserved sections of the population. PPPs are increasingly seen as an important mechanism for improving PHC. Located in rural and urban areas, the health services studied included mobile services, general curative care, maternal and child health services, community health financing activities, health promotion activities. We examined how the roles of a common shared vision, strong governance, and effective management influence a partnership's ability to achieve its objectives.

and child health services, community health financing activities, health promotion activities. We examined how the roles of a common shared vision, strong governance, and effective management influence a partnership's ability to achieve its objectives.

The findings, based on both qualitative and quantitative analyses, underscore the importance of membership organizations' perceived benefits and cost of participation and management capabilities to the partnership's progress toward a vision. In India, several private partnership initiatives are currently under implementation in the Manipal Group of Health Care enterprises including Sikkim-Manipal University of Health, Medical and Technological Sciences, Gangtok, Sikkim.

In the array of these forms of partnerships, there is little evidence to indicate the relative merits of one form of private partnership over the others. There are four types of operational issues in the management and policy perspectives on PPP. A brief overview of them is needed before any specific analysis. 'Contracting' (contracting 'out' and 'in') was the predominant model of private partnership. Other two forms of partnerships i.e. social franchising and social marketing, were also studied in the research. [6] The private sector was represented in the form of individual physicians, commercial contractors, large private and corporate super-specialty hospitals and NGOs.

Some of the partnerships deal with simple contracts (diet, laundry, cleaning, etc) while others are more complex involving many stakeholders (Yeshasvini, a community based self financed health insurance scheme). In almost all partnerships, the principal public partner is the department of health and family welfare, either state or central, directly or through health facility level committees. In terms of the monetary value, the least valued contract was in providing dietary services at a rate of Rs. 27 per meal for about 30 meals a day (Bhagajatin hospital, Kolkata). The oldest partnership (since 1996) is the adoption and management of primary health centers in Karnataka by Karuna Trust. The Chiranjeevi scheme (engaging private doctors for deliveries) in Gujarat is the newest of the initiatives (since Dec. 2005). Most of the projects are specific to a geographical region while some benefit an entire state (Yeshasvini scheme). [7]

The role of individuals in the initiation and success of PPP is very crucial. For example, in the case of Arpana Swasthya Kendra, the project director of Arpana Swasthya Kendra worked hard to convince the political leaders and administrative heads of the Municipal Corporation of Delhi, for approval for a proposal to hand over the Corporation health centre to the NGO under an agreement. In the case of Yeshasvini scheme, founder and director of Narayana Hrudayalaya, Dr. Devi Shetty played a critical role in setting up the Karnataka Integrated Telemedicine and Tele-health project. There are of course other personalities involved in the project too. In the case of adoption and management of the primary health centers in Karnataka, role of Dr. Sudharshan from Karuna Trust was crucial. Similarly initiatives of people like Col. Pant (Uttaranchal mobile health clinic), Dr. KJR Murthy (Mahavir Trust Hospital), Mr. M.A. Wohab (Boat based mobile health services in Sunderbans), and Dr. Haren Joshi (Shamlaji Hospital, Gujarat) have inspired partnership initiatives. Chamrajanagar, a predominantly tribal inhabited district, had only primary care facilities in the district hospital. [7]

In the case of Karnataka and West Bengal, the state level policy on public-private partnership was framed after launching few pilot projects. In the case of Tamil Nadu, Rajasthan, and Gujarat, the state policy towards the private sector partnership seem to have been introduced without any prior experimentation. Tamil Nadu is one such state where private sector involvement in health services was encouraged for a long time, especially encouraging the industrial houses. It would be fair to say that as of now the policy is virtually ineffective. The state of Andhra Pradesh, had a positive engagement in health sector reforms, does not have any private sector partnership initiatives of significance in the state currently. Government pays 75% of the running cost and the rest is to be mobilized by the NGO. Karnataka is one of the first states to begin this scheme for involving NGOs and private medical colleges in running primary health centers. Karuna Trust was the first NGO to be handed over a primary health center when in 1996 the Gumballi PHC in Chamarajanagar district was handed over to us after 10 years of work in that area on Leprosy, Tuberculosis and Epilepsy [Table 1] [8]

Discussion

From the analysis of the cases, it is clear that the government grants under PPPs are invariably directed towards primary care services. This repudiates the claim in some quarters that partnership with private sector would divert government resources towards tertiary care services. The argument that private partnership is a route towards privatization does not hold much truth even in the primary care services as the private sector cannot sustain operations at these locations without government grants. Therefore government role is indispensable. The critical issue in PPP all over the world, is the timely release of grant/reimbursement to the private partner. Core to this issue is the procedural requirement in getting the funds released.

Across the world, partnership with the private sector has emerged as a new avenue of reforms, in part resulting from resource constraints for the public sector by various governments. [9] However, there is a growing realization that given their respective strengths and weaknesses, neither the public sector nor the private sector alone would be at the best interest of the health system. [10] Involvement of the private sector is, in part, linked to a wider belief that public sector bureaucracies are inefficient and unresponsive and that market mechanisms will promote efficiency and ensure cost effective, good quality services The World Bank and the National Commission on Macroeconomics in Health strongly advocate harnessing the private sector's energy and counter its failures, and to make both public and private sectors more accountable. [11],[12]

Governments in India presuppose that partnerships could help in ameliorating the problem of poor health services delivery at two levels: a) to improve delivery mechanisms and, b) to increase mobilization of resources for healthcare. Other presumed benefits of partnerships include improvement in quality of services, reduced cost of care either due to competition or through economies of scale, re directing the public resources to other areas, reduction in duplication of services, adoption of best practices, targeted services to the poor, and improve self regulation and accountability. [13] The government is ultimately responsible for the delivery of services. If there are any deficiencies from the private sector the responsibility for dereliction of services fall on the government health functionaries. Inadequacy in the PPP in the PHC delivery system is a product of failures in a range of quality measures -- structural (lack of equipment and essential drugs), process failings (non-use of the national case management algorithm and lack of a protocol of systematic supervision of health workers). Efforts to improve the quality in the study setting and similar locales in less developed countries (LDC) should focus not only on resource-intensive structural improvements, but also on cheap, cost-effective measures that address actual delivery of services (process), especially the proper use of national

essential drugs), process failings (non-use of the national case management algorithm and lack of a protocol of systematic supervision of health workers). Efforts to improve the quality in the study setting and similar locales in less developed countries (LDC) should focus not only on resource-intensive structural improvements, but also on cheap, cost-effective measures that address actual delivery of services (process), especially the proper use of national guidelines for case management, and meaningful supervision. Since a majority of the partnership projects has to do with primary care services, it is presumed that quality issues in specific terms may not have been envisaged. Opportunities exist for PPP in a competitive environment. Private institutions may deliver their services at a profit but at reduced prices, subsidized or even fully paid for by the government. Similarly, the government may make available products, such as drugs, for free or at significantly low costs to private providers who serve the poor. There is no shortage of ideas to improve the quality of health care delivery, while ensuring access for everyone regardless of income. However, only with a global commitment to improving PHC can the present health crisis faced by developing countries be effectively addressed. Primary health care is a new approach to health care, which integrates at the community level all the factors required for improving the health status of the population available to all people at the first level of health care. In a radical departure from the traditional health care system, it is conceived as an integral part of the country's plan for socio-economic development. [14]

The National Health Policy 2002 states: "In principle, this policy welcomes the participation of the private sector in all areas of health activities - primary, secondary or tertiary." The policy includes not just private sector companies but also NGOs, community-based organizations (CBOs), Panchayati Raj institutions (PRIs) and other forms of civil society. [15]

Conclusion

Private partnership is an administrative decision. An obvious but important point is that it must enjoy political and community support. It is important to understand not only what services are to be provided under private partnership, but also the basis on which such decisions are made. We explored the implications of this research for future evaluations of public-private primary health partnerships. One of the core components of PPP is mutual responsibility/ commitment. All the partnership projects are expected to provide services under national programs, including immunization, family planning, etc. All the partnership agreements should have clear operational guidelines and specific performance indicators for the private partners.

In India, deficiencies of the public health system could be overcome by reforms in the health sector. One of the important reform strategies is collaborating with the private sector in the form of PPP. Partnership with the private sector is particularly critical in the Indian context. Due to the deficiencies in the public sector health systems, the poor in India are forced to seek services from the private sector, under immense economic duress. In the health sector, the PPP as a social entity pools the best features of the two merging authorities of government and private sectors which have already shown their potential of accountability the people of India. The time has come to explore this to the fullest extent to promote health of the common mass in our country.

However, there are not many reports on PPP in PHC. Inter observer bias is possible and hence critical comments on data presented here are welcome. [19]

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