Provision of Reproductive Health Services to Urban Poor through Public-Private Partnerships: The Case of Andhra Pradesh Urban Health Care Project

Ramesh Bhat
Dileep Mavalankar
Sunil Maheshwari
Somen Saha

W.P. No.2007-01-07
January 2007

INDIAN INSTITUTE OF MANAGEMENT
AHMEDABAD-380 015
INDIA

Provision of Reproductive Health Services to Urban Poor through Public-Private Partnerships: The Case of Andhra Pradesh Urban Health Care Project[1]

Ramesh Bhat
Dileep Mavalankar
Sunil Maheshwari
Somen Saha

Abstract

Andhra Pradesh had initiated the Urban Slum Health Care Project to provide basic primary healthcare and family welfare services to urban poor living in slums in 2002. As of now, the project has established 192 Urban Health Centres (UHCs) in 74 municipalities of the state through contracting-out process to the NGOs. These UHCs cover population of about 3 million. State government has played pivotal role in creating capacities to monitor and supervise the functioning of these UHCs. This project was started with the World Bank support and the state has effectively managed the transition from a donor-funded project to government programme and at the same achieving demonstrable impact on health status among its target population. The scheme ensures people's participation in management of the UHCs and placing the power for identifying the health priority in the hand of the community. The case study identifies emerging challenges in the scheme implementation relating to (a) involvement of NGOs as partners in service delivery, (b) financing and financial management system, and (c) need to reposition the UHCs in view of changing epidemiological scenario. Some of the areas needing attention to address the challenge include: need to refine the service mix to better respond to the health needs of the population served; evolving a financial management practices to increase efficiency in disbursement; motivating NGOs to actively participate in the scheme; developing management capacity and competencies of both partners; and repositioning relationship between the state and non-state actors away from a contractual basis to an effective partnership.

[1] We gratefully acknowledge the financial support from World Health Organisation Geneva for this study. We are grateful to Dr. Dale Huntington, WHO for providing critical comments on the first draft of this study. Mr. C.B.S. Venkata Ramana, IAS, Commissioner of Family Welfare, Andhra Pradesh has kindly given the consent in carrying this study. Dr. Pattabhi Ramaiya from the Department of Health and Family Welfare, Government of Andhra Pradesh has shared his useful insight on the scheme design and implementation. Dr. V. Suryanarayana Regional Coordinator of Urban Slum Health Care Project, Dr. P. Jagannatham DMHO Visakhapatnam, Mr. P. Suryachandar Rao DEMO Visakhapatnam, Dr. K. Rama Rao Medical Officer - UHC Visakhapatnam, Dr. P. Rama Rao Medical Officer – UHC Vizianagaram, staffs and MAS members of the UHCs in Visakhapatnam and Vizianagaram have provided useful support and insight on the activities and challenges of the UHCs. Ms. Priya Mohan Das shared her views on conceptualisation of the scheme.

Provision of Reproductive Health Services to Urban Poor through Public-Private Partnerships: The Case of Andhra Pradesh Urban Slum Health Care Project

I. Introduction

The availability of basic primary health care services, particularly RSH services, is inadequate in most urban areas because of poor health infrastructure. This puts undue financial burden on poor because of dependence on private service and in situation where they cannot afford it puts burden on the tertiary healthcare facilities making it cost intensive. The needs of urban poor have been addressed through creation of Post Partum Units (PPUs) and Urban Family Welfare Centres (UFWCs). However, these centres have remained preoccupied with family planning and curative aspects of health having little focus on RSH services and little impact on key RSH parameters. Therefore, need to address the RSH services along with preventive and promotive aspect of health has been a long felt need.

The Government of Andhra Pradesh in 2000 initiated a scheme to provide basic primary healthcare and family welfare services to urban poor living in slums. The initial financial support for this project came from unspent funds of Indian Population Programme (IPP VIII). The scheme was implemented across the state in notified slums coming under 74 municipalities by establishing 192 Urban Health Centres (UHCs) each covering a population of 15,000 to 20,000. Basic primary healthcare and family welfare component under RCH programme formed as the basic package of service of UHCs.

The Department of Health and Family Welfare (DoHFW) provided support for building, infrastructure and equipments to run the UHCs. The basic infrastructure of each UHC includes rooms for doctor to provide consultation, counselling room, store room, waiting area cum hall for group counselling session, a store room, 2 beds for emergency and one labour table. The medicines and drugs required are indented from the district health office. The management of all the 192 UHCs was contracted out to the NGOs. For this purpose, a district level committee was constituted to make selection of NGOs. Mobilisation of communities was an important component of the programme. The scheme envisaged people's participation in management of the UHCs and placing the power for identifying the health priority in the hand of the community. State government played the role of supportive supervision in the scheme with scheme monitoring and implementation decentralised to the district level. In order to ensure proper implementation and role clarity in the scheme, the state government prepared a comprehensive reference manual defining the roles and responsibilities of the stakeholders in the scheme and expected outcome from the scheme. After the end of World Bank funding in 2002, the state government took over the role of funding the scheme from its planned budget expenditure and the scheme is now known as Andhra Pradesh Urban Slum Health Care Project (APUSHCP).

II. Study Objective and Methodology

APUSHCP is an initiative of public-private partnership through contracting-out management of the Urban Health Centres to NGOs in notified urban slums of Andhra Pradesh. The aim is to strengthen the managerial capacity of RSH programme implementation in urban setting. The present case study was carried out with three specific objectives. These are:

- Studying the structure and process in built up of partnership in the Urban Slum Health scheme in Andhra Pradesh;
- Understand the management capacity and competency in make-up of the UHC scheme;
- Identify pathways towards developing management capacity of stakeholders.

For this purpose, we identified key stakeholders of the scheme and carried out an in-depth interview with them. Apart from discussions at the Department of Family Welfare at the state capital, we visited Vishakapatnam and Vizianagaram districts and three field sites, which included one UHC with good performance record, one UHC with poor performance record and a municipality with no UHC.

This case study discusses various aspects. This includes: the origination and the conceptualisation of the scheme, process of assessing the training requirements, staffing pattern, financing pattern, reporting responsibilities and structure of the scheme, referral linkages, costing of packages, selection process of NGOs for managing the UHC, financial package for implementation of the scheme, interface with different stakeholders, monitoring of scheme performance, capacity and competency issues, challenges and lessons from the scheme implementation.

III. Background and conceptualisation of the scheme

Andhra Pradesh is the fifth largest state of India with a population of 75.7 million (2001 census). The urban population of Andhra Pradesh is 20.5 million. Of them, about 5.2 million are slum dwellers and are spread out in 109 municipalities and 7 municipal corporations. The state comprise of 23 districts with per capita income of Rs. 25,625[2] in 2006. Andhra Pradesh has a birth rate of 19 (2004), death rate 7 (2004), total fertility rate 2.2 (2003) and infant mortality rate 59 (2004)[3]. With the support from various development agencies the state had developed and initiated a comprehensive slum development and improvement programme. This included strengthening health facilities in Vishakapatnam and Vijayawada. This also included establishment of primary health centres and maternity and child health centres. With support from European Commission Sector Investment Programme, support of two additional ANMs was provided to existing Post-partum Units of several municipalities to address the need of urban slum population. After the end of IPP VIII project under World Bank assistance, the Government of Andhra Pradesh had unspent balance of Rs. 43 crore. Under an agreement with Government of India, the state decided to utilise the money for developing urban health and improving basic primary health infrastructure and family welfare services in urban areas, particularly for poor people living in slum areas. The scheme was to be

[2] Quoted from http://www.aponline.gov.in
[3] Quoted from http://indiastat.com

implemented in the entire state by involving the community in running the centre. The unspent funds of IPP VIII were required to be spent before 2000-01. There was a time constraint in implementation of the scheme. Table 1 demonstrates the milestones set for the scheme:

The DoHFW constituted the district level committees and delegated powers to them to implement the scheme. The district teams held meetings with the local municipality for identification of space for housing the UHC. Approximately 500 - 600 sq. yards of space was identified for this purpose. Most of the building and civil work was done by Andhra Pradesh Health, Medical Infrastructure Development Corporation.

The DoHFW played key role in providing guidance and supportive supervision in the scheme implementation. The Commissioner's Office of Family Welfare prepared and published a reference manual to ensure clarity of roles and uniformity of structures in implementation of the scheme. At the state level, Joint Director (Urban Slum Healthcare Project) coordinates the scheme implementation with the assistance of 6 Regional Coordinators whose key function is to ensure implementation of various components of the scheme and monitoring the performance of the scheme. At district level, district implementation committee comprises of District Collector as the chairperson and District Medical and Health Officer (DM&HO) as the member convenor. They look after implementation of the scheme, which includes selection of the NGOs for implementing the programme, fund release, review and monitoring of the scheme and addressing grievances. The broad structure of the project is given in Figure 1.

IV. Early implementation phase

The APUSHCP intends to provide comprehensive promotive, preventive and curative health care services to all urban poor for minor and common ailments and RSH services for women and children. The project has three components:

- Service Delivery
- Community Mobilisation
- Behaviour Change Communication

The scheme further has set 12 objectives to achieve RCH goals. Implementation of the scheme is discussed below:

NGO Selection: All the 192 Urban Health Centres were contracted-out to NGOs. Selections of NGOs were done by district implementation committee through a notification in newspaper seeking expression of interest from interested NGOs. District Implementation Committee can also select NGOs through sole source basis.

Staffing: UHCs are staffed by one Medical Officer, one community organiser, two ANMs and three support staffs. The staff for this project was hired on contract by the participating NGO and are expected to work for six hours a day. Monday is a holiday for the Medical Officer of the Urban Health Centre. The participating NGO also assign a senior representative to act as the Project Coordinator.

Community Participation: With an intention to ensure community participation and community mobilisation in the UHC scheme, Mahila Aarogya Sanghams (MAS) were

formed at the community level in all the 192 slum pockets of Andhra Pradesh. MAS consists of 10 to 15 members from the community and have the responsibility of monitoring the infant and maternal mortality rates within their communities. 5 MAS is formed per UHC and each MAS elect one representative to be part of UHC Advisory Committee.

UHC Workings: Each UHC were expected to perform a range of services, which include:

- Ante-natal care
- Immunisation and Vitamin 'A'
- Family Planning Services
- RTI & STI
- General OP
- Participating in all national programmes
- Health education and counselling
- Conducting regular field follow-ups
- Behaviour Change Communication
- Community Mobilisation

All UHCs in the state are operational for 6 hours a day, 8am to 2pm (Table 2). Monday is the weekly holiday for the UHCs.

Population catered by each UHC are divided between two ANMs. Each ANM divide the area under her jurisdiction into six pockets. She is supposed to visit three pockets in a week and the remaining three in the next week. This way she is expected to cover each pocket twice a month. Each UHC is also provided with 2 beds for emergency treatment and a labour table to attend emergency delivery. However, complicated cases are referred to the nearest First Referral Unit (FRU) for treatment. For referral of high risk cases to the first referral unit, a "Referral Transport Fund" was created and placed at disposal of each MAS and Medical Officer on replenishment basis for transport of emergency cases for maternal and infant care to FRU. The MAS/ Medical Officer have the authority to spend the money. "Emergency Funds" to a maximum of Rs. 10,000 per year is provided for handling emergency case, relating to pregnancy, childbirth and post-natal care, at the FRU to a maximum of Rs. 750 per beneficiary. Drugs for the UHCs are indented quarterly from the DMHO office by the UHC Medical Officer from an inventory of approved drugs. All UHCs have a specified drug budget for the purpose.

Management of UHC: Management of UHC is entrusted in the hands of UHC advisory committee. The UHC advisory committee consists of:

- Municipal Councillor – Chairperson
- Project Coordinator of concerned NGO – Vice Chairperson
- Medical Officer of UHC – Member Convenor
- Community Organiser of UHC – Member
- 5 elected MAS representative – Members
- One representative from the FRU
- District Extension Media Officer (DEMO) – Member
- Municipal Health Officer – Member

The UHC advisory committee meets on 26th of each month. The agenda for the meeting is set through an internal review meeting of the UHC staffs.

At the district level, every month a review meeting is convened at the DMHO office to review the performance of all the UHCs in the district. The meeting is attended by all the Medical Officers and Project Coordinators from the UHCs.

Funding Pattern: Funds for the UHC come from state Commissionerate to the district and thereafter funds are passed on to the contracted-out NGO to run the UHC

State Level: At the state level, the Commissioner of Health and Family Welfare draws money through the state treasury after approval of the budget at state cabinet.

District Level: Funds released by the state government are transferred into a bank account at the district level, maintained jointly by the District Collector and District Medical and Health Officer (DMHO). The DMHO is responsible for maintaining proper accounts and ensuring audit in respect of the funds received at district Level.

UHC Level: Funds are released to the UHC quarterly. Funds received by the UHC are deposited into a bank account, exclusively for the project, jointly operated by the Project Coordinator of the NGO and another senior representative of the NGO. The accounts of the UHC are audited half-yearly. The break-up of salary and other expenditures is given in Table 3.

Monitoring Mechanism: The Additional DMHO at the district level is responsible for monitoring the activities of the UHC. He is assisted by the District Extension Media Officer (DEMO). A dedicated Regional Coordinator for the scheme provides guidance to the UHCs. There are total of 6 regional coordinators in Andhra Pradesh, with each coordinator to supervise the project in about 10 to 12 municipalities in 3 to 4 districts. Monitoring of the UHC takes place at multiple levels:

Monthly Progress Report: Monthly progress report is prepared and submitted by the ANM and Medical Officer to the district level. From the progress report, the Commissioner of Family Welfare prepare monthly and annual progress report of the Urban Slum Healthcare Project on Family Welfare and Immunisation activities.

Registers maintained by ANM:

- Household Register
- Births, deaths and marriage information
- Clinic Register
- Stock and Issue Register

Register to maintained by Medical Officer

- Patient register
- Diagnostic monthly abstract
- Family planning acceptance register
- MTP register
- MCH register
- Mass media register
- CNAA format – Monthly progress report

UHC Advisory Committee Meeting: Monthly UHC advisory committee meeting are done with participation of all stakeholders. The purpose of the meeting is to conduct monthly planning and review of the UHC performance and consider steps for improving processes and outputs of the UHC. Review of the UHC performance is based on the monthly progress reports maintained by the UHC staffs and stakeholder analysis.

Review Committee: Quarterly releases of funds to UHCs are based on satisfactory performance of the UHC. To assess the performance of the UHC in the district and resolve problem areas, the District Medical & Health Officer with assistance of Regional Coordinators convenes a monthly meeting of the District Implementation Committee. The meeting is attended by the committee members, Medical Officers and Project Coordinator of all UHCs.

Annual validation exercise of the UHC: NGOs in the scheme are contracted out UHC for a period of one year. Renewal of the contract is preceded by a detailed performance appraisal of the NGOs. For this purpose the system has designed a grading system to evaluate the performance of the UHC. This format includes performance parameters based on which marks and grades are given to the NGOs. Each UHC is given a grade based on the performance score out of 200. Table 4 depicts the marking system for grading the UHCs.

Those NGOs securing 'A' grade is considered for renewal for next year. Those with grade 'B' are given time up to 3 months to improve their performance and if their show improvement their contact is renewed. Those with 'C' and 'D' grade are dropped and new NGOs with good record of accomplishment are appointed in their place. The validation is done by District Level Committee with the help of Regional Coordinator. Monitoring format for validation exercise is enclosed in Annexure 1. It has indicators to measure both performance and output of the UHC activities for which marks are assigned. There are provisions for negative marking for certain components relating to complaints of UHC activities and false reporting.

V. Stakeholder involvement

The involvement of various stakeholders determines the success of any scheme. The involvement of various stakeholders includes their level of participation and relationship, the attitudes and values that govern their interactions in the working of the UHC. This creates social capital for the scheme and this was encouraged not only in the form of community mobilisation of resources, but also through community participation and control in the day-to-day management of the UHC and its outreach activities. The project succeeded in mobilising and building social support of 3.6 million urban poor residing in urban slums. Mahila Aarogya Sanghams (MAS), a non-paid self-help group of women, also participated in the scheme and played the lead role at the community level in all the 192 slum pockets of Andhra Pradesh. They represent the clients in the service delivery mechanism. Although a non-paid position, MAS members have critical roles in governance of the UHC. Each MAS select one representative to take part in the UHC advisory committee and state level meetings. In the community, they have the responsibility on monitoring of critical RCH and health indicators. For attending to emergency cases MAS members have an emergency referral transport fund at their disposal.

VI. Performance of the Scheme

APUSHCP have succeeded in achieving some of the crucial public health goals of the state among its targeted population. The scheme covers around 3.05 million of the estimated 5.2 million slum population of the state. An analysis of the review reports of APUSHCP (Figure 2) shows that during March 2003 to 2005, the scheme achieved 42 per cent decline in IMR and 6 per cent increase in institutional deliveries among the target population.

Table 6 compares the performance of APUSHCP with the state data for the year 2003. The analysis shows that on key mortality indicators, UHCs scored around 4.5 times better than the state average, while on institutional delivery the difference is 1.44 times.

For operational and monitoring reason, 21 districts of Andhra Pradesh were divided into six regions and each region was assigned to a Regional Coordinator (see Table 7).

The percentages of institutional deliveries across districts in different regions do not vary except in Region 4 (see Figure 2). The mean institutional deliveries have, however, remained above 90 per cent in all regions.

An analysis of the annual validation exercise of UHCs for the year 2005 and 2006 (Figure 3) shows that over the year 17 per cent of the UHCs have got upgraded to “A” grade marking significant decline in “C” grade and no UHC falling under “D” grade.

To understand the effect of UHC performances on key family welfare indicators, we carried out a sample t-test among the UHC grades and performance report of 2005. Districts were ranked based on the composition of Grade A and B UHC combined. Table 8 ranked the districts based on combination of Grade “A” and “B”.

Based on the ranking of districts, districts having 90 per cent or more UHCs in Grade A and B are coded as Group 2 and all other districts were coded as Group 1. There are 9 districts in Group 1 and 12 districts in Group 2. These data were matched to find the influence of grading of UHC on reported institutional delivery, infant mortality rate and maternal mortality. The results are shown in Table 9.

The results (Table 9 and Figure 4) shows that better performing UHCs have lower IMR and MMR. However, there is no significant difference in institutional deliveries across the better and poor performing UHCs.

VII. Scheme Implementation

The scheme required involvement of three principal stakeholders in is management and key activities required to be performed by each stakeholder is as follows:

- **State:** Conceptualisation and development of the scheme, providing supportive supervision, financial support and developing detailed guidelines for implementing various components of the scheme and clarifying roles of various implementing partners.

- **District**: Responsible for programme execution including identification and contracting of NGOs, management and monitoring the performance of contracts.

- **NGO**: Responsible for service delivery through hiring staffs to make the UHC fully functional, maintaining records and complying with reporting requirements, acting as administrative head for the UHC, community mobilisation and motivating the MAS.

Several of the roles of the stakeholders, as discussed above, are inter-linked and require high coordination among the stakeholders. Managing such inter-linked role and role as facilitator of service delivery require health officials to assume several key competencies and skills.

Facilitative roles in health sector calls for coordination skills, communication skills and stakeholder sensitivity[4]. Competencies that are considered essential for staff with managerial or supervisory responsibility in any service or programme area are discussed in Table 10.

Table 11 draws a matrix to understand the roles and responsibilities required at each level of scheme implementation. The matrix depicts the nature of activities involved in different levels of scheme implementation along with the key competencies involved. The matrix was based on our field assessment and discussions with various stakeholders, both from state and non-state sector, involved in planning and implementation of the scheme.

Three researchers having significant experience and understanding of NGOs and India's Public Health system made an independent assessment of different competencies required in functioning of the scheme. Subsequently members shared their assessment on different component to other members. Through discussion consensus was arrived in reaching the final assessment of competencies. This method of assessment is in congruence with qualitative data analysis methods.

The matrix scales the different competency attribute in the programme on a scale of high involvement to low involvement. Though utmost care has been taken to ensure proper representation of the facts, interpretation of the matrix has to be done with a caution considering interviewer and judgement bias.

The findings suggest that NGOs participating in the programme score poor on several competencies considered essential for the implementation of the scheme. Issues identified as critical factors in functioning of the scheme are summarised below from the perspective of both state and non-state sector. These issues are discussed in the subsequent sections.

[4] Bhat, Ramesh and Maheshwari SK (2005). Human resource issues and its implications for health sector reforms. *Journal of Health Management*, 7, 1(2005), pp 1-39.

From NGO perspective	From Perspective of Health System
· Strategic Orientation	· Strategic Orientation at the District Level
· Creativity and Innovations	· Analytic Skills
· Analytic Skills	· Financial Management Skills
· Financial Management Skills	· Reporting Process
· Ownership	· Handholding support to partner organisations
· Involvement and Motivation	· Negotiation Skills
· Partner Orientation	· Ability to attract and motivate effective NGOs
· Commitment	
· Supervision and Monitoring	

Urban Health Centre in Andhra Pradesh initiative ensures provision of RCH services to the urban slum population. The Government of Andhra Pradesh is considering implementation of the second phase of the Urban Health Programme. The programme plans to set up 86 new Urban Health Centres and 11 new First Referral Unit in 43 municipalities and towns of Andhra Pradesh. However, implementation of the Urban Health Scheme in Andhra Pradesh, for around 6 years, has put forward several implementation issues needing attention:

Involvement of NGOs as partners in service delivery

The involvement of NGOs forms backbone of this scheme. The monitoring of the performance assumes critical significance in any pubic-private partnership. During the initial period of implementing, the scheme programme used to undertake a sample field survey to verify various performance indicators. However, the physical verification of certain performance indicators has been discontinued now. Instead, the district health team to assess the performance of NGOs and suggest renewal of contracts carries out annual validation exercises. The system of monitoring and validation is based on reports generated by the UHC. A close look at the validation format points that the exercise focuses only on some RCH programme indicators. The UHCs is expected to perform several other activities. In order to understand this in more details, we plot (Table 12) the different activities performed by the UHC against activities assessed through the current monitoring format. The analysis shows that the current validation format does not assess performance of general OPD cases, identification and referral of high-risk cases and utilisation of referral funds.

Incentive System

Financing the scheme leaves scope for reassessment. The total financial package of the scheme and support that NGOs receive was finalised during the conceptualisation phase. The staff salaries were fixed based on the prevailing market rates at that point of time. There has been no revision in the financial package over the years. During this time the demand for services has increased and increased the service load on NGOs. There has been no adjustment to cope with the inflation factor. Given the contractual appointments of the staffs and annual validation of NGOs there is a constant pressure on the UHCs to perform. The scope of work of UHCs has also increased because of requests from DMHO to UHC staffs to participate in national health programmes and emergency health situations. Low incentive for work, compared to government Medical Officers and ANMs, has been a major de-motivator for the UHC staffs. Over the period, Andhra Pradesh has emerged as IT hub with better incentive for professionals. Low incentive for

staffs is emerging as the major challenge to retain motivated and qualified medical professionals in the UHCs.

It was also observed that the current financial package and support received by the UHC does not provide for administrative expenses of the NGOs managing the particular UHC. The Project Coordinator who is supposed to act as the administrative head gets only an annual honorarium of Rs. 2,000. Such financial arrangement with NGOs makes them de-motivate to actively take part in scheme implementation. Participating NGOs were not seen to compliment the UHC activities in their routine work. For example, a health officer in Vishakapatnam district observed:

> "*NGOs were expecting more incentive from their UHC participation. Since we are not giving this, NGOs are less interested in the UHC activities. In certain instances, the participating NGOs are located 40 kms away from the UHCs. This also diminishes their role in the UHC activities. NGOs are taking the UHC as an entry point to partner with government programmes*." – DEMO Visakhapatnam

Delay in disbursement of funds

It was observed that several facilities have experienced the delays in disbursement of funds. The financial management issues and funds flow delays problems have been observed in other studies as well[5]. With an aim to prove the delay further, discussions were held with key district and state officials. Preliminary analysis shows that delays occur because of bureaucratic delays and because of inadequate reporting of information. These are discussed below:

Delay in Disbursement of Funds: Bureaucratic delays in disbursement of funds occur at two levels: state and district. At the state level, annual budget for the UHC project in Andhra Pradesh works out to Rs. 7 crore. Managing such fund requires approval from the state legislature and withdrawal from state treasury. This approval and withdrawal process takes its own time. At the district level, the fund is kept in a joint account of the project managed by the DMHO and the District Collector. There are instances of delay at the collectorate office due to their workload. De-linking the fund disbursement from the collectorate may result in removal of ownership from the district administration.

Delay in Submission of Fund Utilisation Certificate: There were instances of delayed submission of fund utilisation certificates by the respective UHCs. At one instance, finalisation of accounts at State level was held up for want of required reports for three consecutive years.

Increasing epidemiological challenges

Urban Health Centres were set up with the basic objective of primary health care. Apart from preventive and promotive aspect, curative health services are assuming significance in primary health care, especially for the slum population. The current UHC system is preoccupied with preventive and promotive aspect of family welfare programme with bare minimum facilities to tackle any health emergencies like dengue, malaria, tuberculosis, diarrhoea and other chronic and acute diseases. Diagnostic services at the

[5] World Bank (2005). Andhra Pradesh. A Rapid Private Health Sector Assessment. A Discussion Document. May 2005.

UHC cater to only pregnancy cases. Although each centre has 2 in-patient beds, they were virtually unutilised and in some places kept in store rooms. The UHCs face epidemiological challenge of meeting the expectations of communities in other health concerns. There is a need for upgrading the centres to cater to the greater need of general outpatient and in-patient services, diagnostic facilities and adequate stock of medicines.

Reference manual

The UHC Reference Manual was published in 2001 during conceptualisation of the programme. However, over time the manual has not undergone any revision. For example, family planning services have been changed into family welfare services, which do not get reflected in the manual. Similarly, the epidemiological profile of the state has been changing with newer disease burden. There is a need for annual or two yearly revision of the manual in tune with changed circumstances.

VIII. Learning and conclusion

The Urban Health Scheme in Andhra Pradesh has been implemented with an objective to provide RSH services by building primary healthcare infrastructure for the urban slum population through public-private partnership and contracting out. The scheme has focused on issues to improve performance of the primary healthcare infrastructure and ensure that poor in urban slums have good access to quality care and referral system. The scheme has developed an effective mechanism to evaluate and monitor the performance of the agencies implementing the scheme. Evaluation studies of the scheme[6] have shown the benefit of the scheme on both output and process indicators. Looking at the success of the scheme, the central government is actively exploring options to replicate the scheme to other states of India in the form of Urban Health Development Centres. Several key lessons emerge from a review of the scheme specifically in terms of the management capacity of the scheme partners and financial management in the scheme. This needs attention of policy makers for future up scaling and sustainability of the scheme.

Leadership in the Programme: Government leadership in the current programme has been significant to maintain the current level of activity. Over the years, however, the socio-economic and epidemiological scenario of the state has changed. There is a strong demand to transform the Urban Health Centres from a promotive centre for Family Welfare into a comprehensive basic health care service centre. Programme planners and managers of the scheme have to steer the change process in order to make the UHCs more relevant to the changing epidemiological scenario and demand of the community. There is a need for adopting different kind of management capacity for the scheme managers to steer the change process. Involvement of new generation NGO sector managers can bring in dynamism in the programme management capacity of the UHC project.

Financing the Programme: Per capita public expenditure on health in Andhra Pradesh during 2003-04 is Rs. 208[7]. Given that an estimated 52 lakhs slum dwellers are the target population of the scheme, their total health expenditure works out to Rs. 108 crore. Compared to this the annual budget for the Urban Health Centre scheme is only around 7 per cent. The budget for UHC projects works out to 0.56 per cent of total urban development budget and 0.40 per cent of the state budget on Medical and Health Sector

[6] Evaluation study conducted by TNS Mode in June 2003
[7] Source: http://indiastat.com

for the year 2005-06. Given this level of resource support, the implementing agencies face a major challenge to make a difference.

The success of the scheme lies in the sense of ownership and strong guidance and monitoring from the state and district-level health officials. Complexity in recruitment and managing human resources has been addressed through contracting the services to local NGOs. However, the current financial package and the delay in release of funds create may affect the performance of the NGOs involved in the scheme. There is a strong demand for revision in the financial incentive of the staffs and NGOs involved in the scheme to sustain their motivation. NGOs currently primarily look at the scheme to get involved in the government scheme with a view to gain credibility and attract funding from other agencies. Moreover, MAS members involved in the scheme have been a purely honorary position. Over time, this has reduced their motivation to get actively involved in the scheme implementation. There are even complaints of delay in release of Emergency Referral Transport Fund to the MAS members. The financial management capacity and funds flow systems needs to be looked into and synchronised for smooth implementation of the scheme.

Management capacity and competency: The programme implementation agencies have observed delay in disbursement of funds. De-linking of fund disbursement from the district collector office has been considered but this was not adopted for several reasons. This indicates that financial management systems are weak. The programme needs to involve various stakeholders including the staff from the Collector's office more intensely in policy formulation process and devise a system of ensuring time-bound release of funds and timelines for submitting financial reports. Similarly, all NGOs managing UHC have to submit their accounts in the stipulated time. This will require considerable strengthening of financial management systems. Management capacity of NGOs can be enhanced through in-house training and increasing interactions with other successful ventures. From a review of the scheme, implementation and discussion with key stakeholders in the scheme, following critical areas are identified which needs attention:

- Financial management skills of both the partners in the scheme
- Fostering creativity and innovation among the partners
- Developing analytical skills among the district health officials to analyse the reports and providing real time feedbacks to the UHCs
- Strengthening the supportive supervision skills of district officials
- Developing sense of ownership among the NGOs for the scheme
- Partner orientation among the NGOs
- Supervision skills of the NGOs to monitor the UHC staffs

However, competency and capacity development of NGOs cannot be sustained in absence of adequate motivation and incentive. Total funds allocated in the scheme are earmarked with little flexibility and discretion of NGOs to use the fund. While this is important in maintaining the financial discipline and control, it also makes the programme performance vulnerable. As discussed earlier, financial package for NGOs has is not very attractive to NGOs as compared to other programmes in health sector. The key motivation for NGOs to participate in the scheme is to ensure their presence in the UHC areas and activities and gain access to other health programme supported by the district health system. For example, calculation by the authors show that while in HIV/AIDS Targeted Interventions programme per capita budget works out to Rs. 1782, the same

works out to Rs. 15 in AP UHC scheme with no budget for their administrative cost. This has implications on the motivation of NGOs. The scheme has to develop innovative mechanisms, both monetary and non-monetary to motivate the NGOs participating in the scheme, which may include a combination of the following:

- Creating financing mechanism by providing monetary and other incentives to NGOs and UHC staffs managing the UHCs through an output driven incentive payment system. This includes rewarding effective innovation and efficient management in the delivery of quality services.

- Enhancing association among the NGOs by creation of best practice UHCs in each district and providing them with resources to upgrade the skills and competencies of not so well performing UHCs.

- Creating multi-stakeholders public health policy structure in the state by giving NGOs more direct access in framing UHC strategies and other health programmes.

Developing true partnership: Currently the programme has moved from a true partnership concept to a contract based system. True partnership is an involved affair with participation of all stakeholders in the process and dwells on a level playing field for both the parties. However, developing partnership in the programme is an involved task, which demands greater delegation of authority, financial autonomy, and faith in partners, accountability and capacity in the system. There are scopes for innovations from the NGOs provided they get the right environment and incentive to work. Besides, monetary incentives, the scheme should recognise well performing NGOs and NGO representatives should be actively involved in consultation in policymaking and implementation of the programme.

Last, but not the least the UHC scheme in Andhra Pradesh has demonstrated its potential to address the comprehensive health needs of Urban Slums. The time is appropriate to harness the benefit of the scheme through upgrading the centres to cater to the general outpatient needs, better diagnostic facilities and adequate stock of medicine to address acute and chronic health problems apart from MCH.

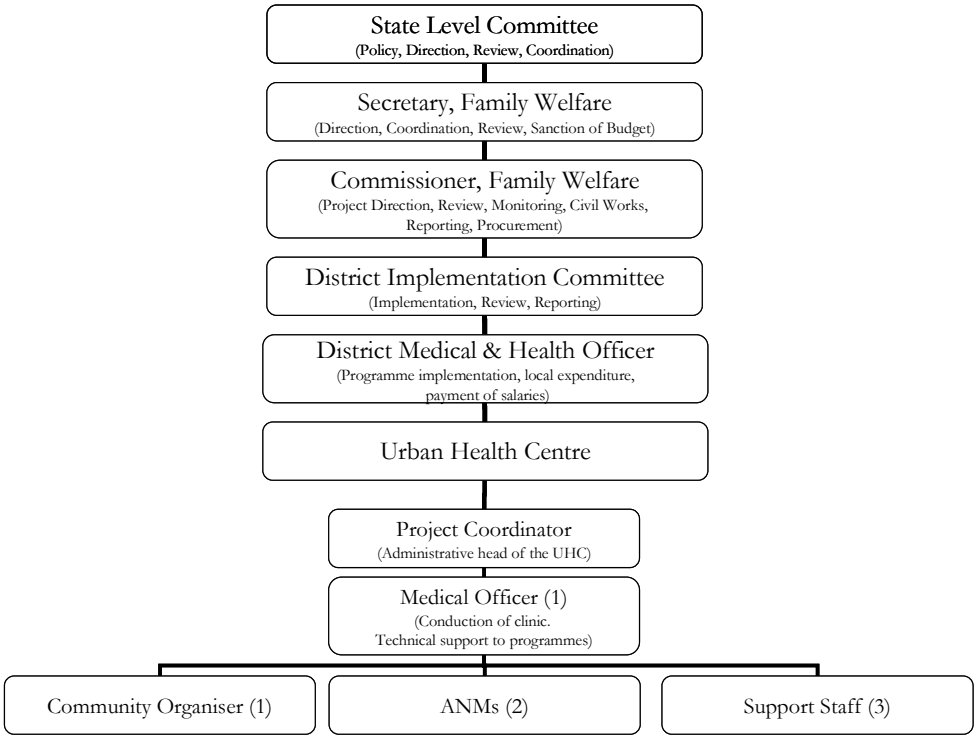
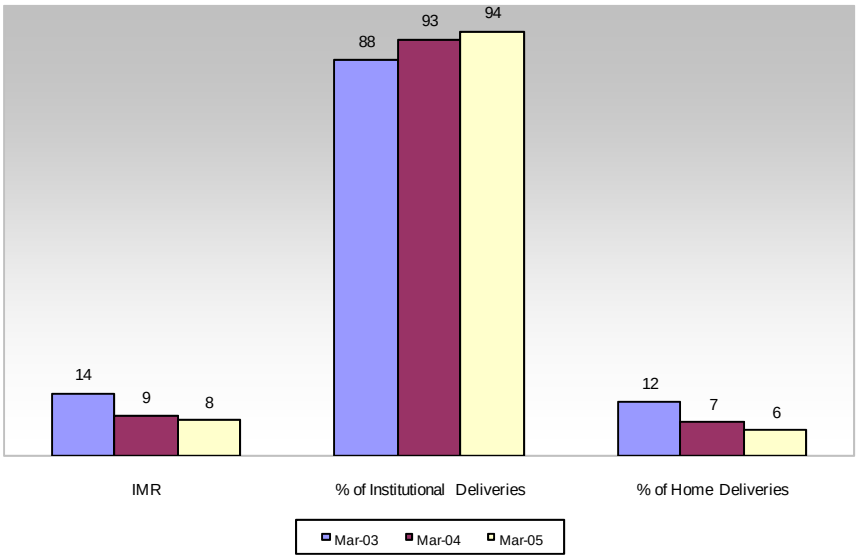
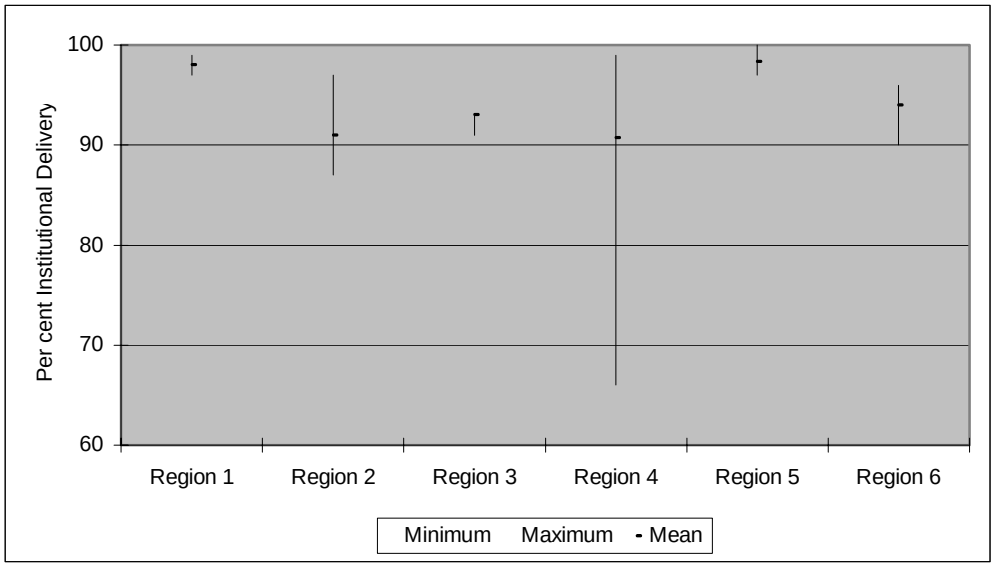


Figure 1: Project Structure



Source: Commissionerate of Family Welfare: Andhra Pradesh

Figure 1: Key Achievements of UHC Scheme (2003-05)



Source: AP Commissionerate Office 2005

Figure 2: Distribution of Institutional Deliveries across 6 Regions (2005)

Figure 3: Comparison of Grading of UHC (2005-06)

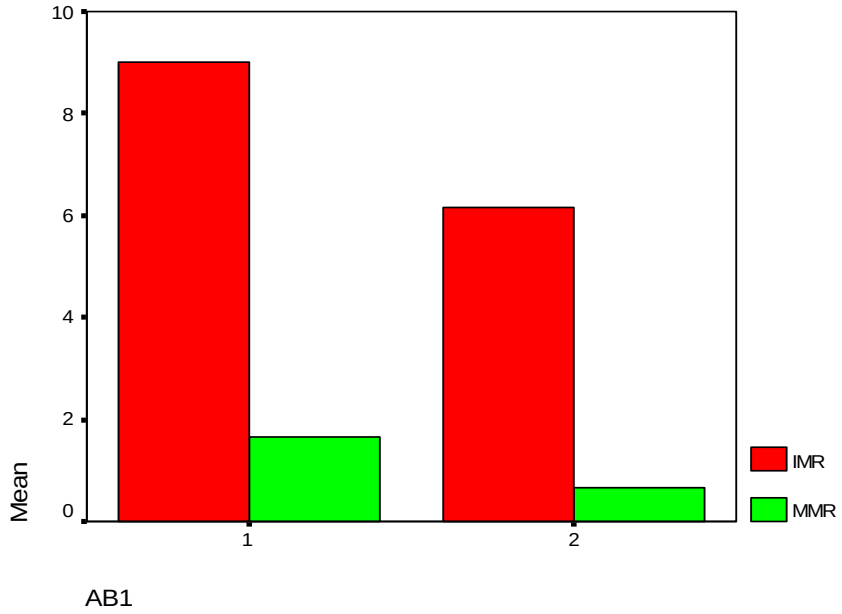


Figure 4: Comparison of two mortality indicators across better and poor performing districts with respect to IMR and MMR

Table 1: Milestone of the AP UHC Scheme

Milestone	Activities
February 2000	Scheme conceptualised
October 2000	Final draft of the scheme implementation was ready
March 2001	Financial support released. Initially UHCs were functional from rented premise. 30% of funds were for civil works
October 2001	50% of UHC operational.
Within next 18 months to 2 years, the UHCs were operational from own premises	

Table 2: Schedule of the UHC

Activities at UHC	Days	Timings
General OPD	All days in a week except on Mondays	8 AM to 10 AM
Antenatal Clinics	Sundays ANM – I Wednesday – ANM – II	10 AM to 2 PM
Immunisation Clinics	Thursday – ANM – I Saturday – ANM – II	10 AM to 2 PM
Counselling	Tuesday – MO, CO & ANMs	10 AM to 2 PM
Field Visit by MO	Friday – ANMs & CO	10 AM to 2 PM

Table 3: Expenditure Break-up	
Personnel	
Medical Officer (Part time) – One	Rs. 6,000 pm
ANM – Two	Rs. 3,000 pm
Community Organiser - One	Rs. 2,500 pm
Assisting Staff – Three	Rs. 1,500 pm
Project Coordinator – One	Rs. 2,000 pa
Establishment	
Water & Electricity Charges	Rs. 1,500 pm
Other Contingencies	Rs. 2,000 pm
Referral fund for Transport	Rs. 3,000 pm
Referral fund for Emergency	Rs. 10,000 pm
Contingencies to DM&HO to pay actual Bus/Train fare to the UHC Staff who attend the review meetings conducted by the DM&HO.	Rs. 100 pm @ one persons per UHC
Contingencies to DM&HO towards payment of audit fees and miscellaneous expenditure incurred by the DM&HO	Rs. 1,250 per quarter

Table 4: Points for Grading the UHC	
Grade	Percentage of Marks (Total Marks: 200)
A	=>100
B	Between 90 – 100
C	Between 75 – 90
D	<75

Table 5: Estimated Social Involvement in the UHC Scheme	
1 UHC	5 MAS
1 MAS	10 – 15 Females
No. of community members represented by 1 MAS member (50 household @ 5 per HH)	250
No. of community members represented by 15 members of 1 MAS @ 250	3750
No. of community members represented by each UHC (5 MAS@ 3750)	18750
No. of community members represented by the 192 UHC (192 UHC @ 18750 community members per UHC)	**3600000**
Note: The calculations are based on the UHC reference manual and authors' estimation of social capital generated in the scheme. Actual may vary.	

Table 6: Comparison of Andhra Pradesh State and Slum Healthcare Data (2003)			
Indicators	APUSHCP	AP State	Gap Ratio
IMR	14	62	1: 4.43
MMR	69	341	1: 4.94
Institutional Deliveries	88	61	1: 1.44

Source: APUSHCP data obtained from Monthly Progress report of the Commissionerate Office State data were obtained from EC Survey 2003 and MPR 2003

Table 7: Region-wise classification of districts and key statistics (2005)

Region and District	UHC	Total Population	No. of deliveries	Infant deaths	Maternal deaths	STI/RTI cases	Institutional Deliveries
Region 1	***28***	***422013***	***8290***	***31***	***0***	***3823***	***8176***
Srikakulam	2	28829	471	2	0	154	456
Vizianagaram	7	108903	2111	28	0	894	2048
Visakhapatnam	4	58137	1108	0	0	761	1100
East Godavari	15	226144	4600	1	0	2014	4572
Region 2	***32***	***503976***	***11250***	***65***	***3***	***5132***	***10291***
Adilabad	10	153701	3164	12	0	1948	2738
Nizamabad	10	158240	3845	31	1	77	3420
Karimnagar	12	192035	4241	22	2	3107	4133
Region 3	***33***	***534281***	***10004***	***67***	***1***	***3873***	***9233***
Prakasam	8	121022	2463	12	0	1235	2288
Kurnool	16	282932	4854	22	1	1703	4421
Mahabubnagar	5	74302	1602	30	0	704	1496
Medak	4	56025	1085	3	0	231	1028
Region 4	***54***	***860627***	***19873***	***227***	***12***	***8670***	***18873***
Warangal	9	150091	2537	6	1	217	1675
Guntur	21	322260	8087	101	2	1151	8040
West Godavari	14	219351	5056	101	5	6566	4994
Nellore	10	168925	4193	19	4	736	4164
Region 5	***17***	***265606***	***5199***	***61***	***4***	***2652***	***5092***
Krishna	4	66521	1998	18	0	1196	1939
Nalgonda	5	66353	1263	12	2	803	1262
Khammam	8	132732	1938	31	2	653	1891
Region 6	***28***	***464517***	***9726***	***47***	***3***	***4363***	***9075***
Anantapur	13	219716	4638	18	2	2341	4189
Cuddapah	5	80925	1695	5	0	519	1633
Chittoor	10	163876	3393	24	1	1503	3253
TOTAL	**192**	**3051020**	**64342**	**498**	**23**	**29213**	**60740**

Source: AP Commissionerate Office 2005

Table 8: Ranking Districts based on UHC Grading (Combining Grade A & B)

Rank	No. of Districts	Percent
0	2	9.5
60	1	4.8
63	1	4.8
79	1	4.8
80	2	9.5
86	2	9.5
90	1	4.8
92	1	4.8
93	1	4.8
100	9	42.9
Total	**21**	**100**

Table 9: Comparing UHC performance indicators across district ranking

Parameters	UHC Grouping	N	Mean	SD	Significance
% of Institutional Deliveries	Group 1	9	93.44	10.78	0.111
	Group 2	12	94.67	3.92	
Infant Mortality Rate	Group 1	9	9.00	6.26	0.422
	Group 2	12	6.17	5.39	
Maternal Mortality Ratio	Group 1	9	1.67	1.80	0.059
	Group 2	12	0.67	0.89	

Table 10: Competencies and their Attributes

Competencies	Attributes
Strategic orientation	Continuously able to develop appropriate business strategies and policies for the programme and translate programme strategies into clear objectives and action plans.
Creativity	Quality to benchmark best practices and encourage adoption of new practices.
Analytical skills	Quality to analyse and understand the programme dynamics, identify problem factors and problem solving skills.
Consultative Skills	Skills to discuss and learn from others in designing and implementation.
Partner orientation	Skills to understand partners view in implementation of the programme.
Financial management Skills	Ability to design and implement an adequate financial management mechanism so as to ensure minimum delay in authorisation, disbursement and accountability of funds.
Ownership	The state of assuming ownership of the programme by different stakeholders involved in implementation of the scheme.
Programme Execution	Capacity to carry out the tasks involved in implementation.
Analytical Skills	Ability to analyse and use the information gathered in the scheme for decision making.
Community Orientation	Ability to keep the perspective of larger stakeholders and end users in implementation of the scheme.
Supportive Supervision	Working with the health staffs to establish goals, monitor performance, identify and correct problems, and proactively improve the quality of services.
Handholding Support	Strong personal support and reassurance, especially to alleviate tension and anxiety.
Negotiation Skills	Ability to settle an argument or issue to benefit the programme objectives.
HR Planning and Management	Planning for adequate and motivated human resource to manage the scheme
Involvement and motivation	Attribute of different stakeholders in scheme implementation.

Table 11: Matrix of Competencies for Implementation of Urban Slum Health Care Scheme in Andhra Pradesh

Implementation Issues	Activities	Competencies Required	Adequacy	Initiative to enhance competencies
Conceptualisation	· Understanding the public health infrastructure and need of Urban areas · Learning from existing work on urban slum areas · Understanding the strengths and weakness of different alternative interventions · Developing strategies for implementation of the scheme · Consultation with stakeholders	State · Strategic Orientation · Creativity · Analytic Skills · Consultative Skills · Financial Management Skills · Ownership District · Strategic Orientation · Programme Execution · Creativity · Analytic Skills · Financial Management Skills · Ownership NGO · Strategic Orientation · Creativity · Analytic Skills · Financial Management Skills · Ownership	 High High Moderate High Low High Moderate Moderate Low Low Low High Low Low Low Low Low	Initial training programme for UHC staffs on UHC scheme implementation Training programme for NGOs on management capacity development Routine training of UHC staffs at District Training Unit.
Guidelines for Implementation	· Agreeing on the strategies of decentralisation · Developing a Reference Manual of AP Urban Slum Healthcare Project · Disseminating the information	State · Strategic Orientation · Creativity · Consultative Skills · Community Orientation	 High High High High	
NGO Selection	· Devolving power of NGO selection to the district level · Listing of eligible NGOs · Issuing notification for interested partners · Developing & discussing the terms and condition · MOU with NGOs for scheme implementation	State · Supportive Supervision District · Programme Execution · Negotiation Skills · HR Planning & Management · Ability to attract & motivate effective NGOs	 High High Moderate Moderate Moderate	Reference manual for all staffs to develop their capacity. Meeting and feedback to district officials from the commissionerate office
Early Implementation Phase	· Meeting with municipal commissioners for identification of space for housing the UHC building · Specification and plan for UHC building & infrastructure	State · Supportive Supervision · Sensitising different agencies for scheme implementation District · Involvement & Motivation · Programme Execution	 High High High High	Efforts towards developing ownership of the health officials in the scheme through creation of Regional Coordinators posts dedicated for scheme implementation and monitoring

Table 11: Matrix of Competencies for Implementation of Urban Slum Health Care Scheme in Andhra Pradesh

Implementation Issues	Activities	Competencies Required	Adequacy	Initiative to enhance competencies
	· Training of UHC staffs at different training institutions · Developing NGO management capacity · Developing monitoring capacity of district officials	· Supervision Skills · Hand holding support NGO · Commitment · Involvement & Motivation · Programme Execution	Moderate Low Moderate Low Moderate	
Scheme Management	· Dealing with NGOs involved in scheme implementation · Dealing with intersectoral partners like local municipalities, anganwadi workers & health authorities · Defining payment schedule & financial incentives for programme implementation · Ensuring participation of all stakeholders involved in scheme implementation · Ensuring proper functioning of referral linkages with FRU	State · Supportive Supervision · Fund Management District · Strategic Orientation · Involvement & Motivation · Supervision · Analytical Skills · Fund Management NGO · Programme Execution · Partner Orientation · Commitment · Fund Management	 High Moderate Moderate High Moderate Low Low Moderate Low Low Low	Efforts towards developing management capacity of NGOs through training & sensitisation programme. Constant supervision from the state level. Implementation of scheme delegated to district health officials. Routine meeting at district HQ with UHC and NGO officials. Monthly UHC Advisory Committee meeting to discuss progress and solve problems.
Scheme Monitoring	· Identifying crucial indicators · Reporting requirement from UHC · Cross verification of reports from UHC · Ensuring for proper use of referral funds · Checking for possible frauds and misappropriation of funds	State · Supportive Supervision District · Supervision and Monitoring · Analytic Skills · Reporting Process · Commitment NGO · Supervision and Monitoring	 Moderate High Low Moderate High Low	Creation of format for annual validation of NGOs Regional Coordinators dedicated for scheme monitoring and handholding. Additional District Medical and Health Officer assisted by District Extension Media Officer responsible for monitoring the scheme at the district level.
Participation of Stakeholders	· Ensuring participation of MAS in the scheme · Ensuring participation of local municipalities · Developing leadership skills among UHC doctors & NGO coordinator	District · Facilitative Skills · Involvement and Motivation NGO · Motivation	 Moderate Moderate Low	Creation of MAS to ensure community participation. Including local municipal councillor in UHC advisory committee.

Table 12: Monitoring Indicators for Activities of the UHC

Activities of the UHC	Monitoring Indicators
Antenatal Care	Yes
Immunisation	Yes
Family Welfare Services	Yes
RTI and STI	Yes
General OP	No
Childhood diseases	Yes
Identification & Referral of high risk new born	No
Counselling parents of low birth weight babies	No
Counselling of pregnant women & mothers on nutrition	No
Health Education and counselling	Yes
Conducting regular field visits	No
Behaviour change communication	No
Community mobilisation	Yes
Referral Transport Fund	No

Annexure 1

OFFICE OF THE COMMISSIONER OF FAMILY WELFARE
FORMAT FOR VALIDATATION OF NGOS

Name of the District:
Name of the UHC:
Name of the Municipality:
Name of the Voluntary Organisation:

Sl. No.	Item	Required numbers/submitted/done	Actual numbers/submitted/done	Maximum marks to be awarded	Marks given for the item
1.	Meeting of Urban Health Centres Advisory Committee			30 marks	
2.	Submission of CNAA reports			25 marks	
3.	Submission of SOEs			30 marks	
4.	Payments through Cheque			20 marks	
5.	Progress of work in the services provided (as judged from CNAA)			30 marks	
	i) AN Case: a) No. of cases registered b) No. of cases registered <12 weeks c) High-risk cases screened ii) Deliveries total institutional a) > 70 % 5 marks b) 50 – 70 % 3 marks iii) Infant cases a) No. of children fully immunised b) High-risk infants screened iv) Childhood illnesses a) ARI & Diarrhoea cases identified b) ARI identified & treated/ referred c) Diarrhoea cases treated d) Diarrhoea cases referred v) RTI/STI cases treated vi) FP methods Temporary: IUDs OPCs CCs Permanent: Sterilisation > 80% 3 mark Sterilisation 50 ≤ 80% 2 mark Sterilisation 20 ≤ 50% 1 mark			 2 marks 2 marks 1 mark 5 marks 3 marks 2 marks 2 marks 1 mark 2 marks 5 marks 2 marks 3 marks	
6.	Whether outreach services provided are satisfactory			20 marks	
7.	MAS monthly monitoring meetings held			20 marks	
8.	Conselling sessions held by Community Organiser			25 marks	
	Negative Indicators				
1.	Any complaints on the UHC/ NGO and diversion of funds			- 20 marks	
2.	Removal or replacement of staff without permission of District Committee			- 10 marks per unit	
3.	False Reporting			- 15 marks	
	Total			**200 marks**	