Case Study

‘CHIRANJEEVI YOJANA’ FOR IMPROVING MATERNAL HEALTH - GUJARAT

Rural Health

CASE OVERVIEW

Country: India

***State*:** All 25 districts in Gujarat

Sector: Health ***Sub-Sector:*** Rural Health

Award Date: Programme launched in December 2005 in 5 pilot districts

Type of concession: Capitation based payment – Voucher scheme (Memorandum of Understanding)

Stakeholders:

Contracting Authority	District Health Authorities and the Department of Health and Family Welfare, State Government of Gujarat
Concessionaire	Private Practitioners (Obstetricians and Gynaecologists – henceforth ObGyns) empanelled on the basis of pre-determined criteria
Oversight Arrangement	Monitoring at District level through the District Project Management Unit (DPMU) appointed under the Reproductive and Child Health Programme (RCH).

Present Status of Project: Started as a one-year pilot scheme in 5 low performing (in terms of Infant and Maternal health statistics) districts. The scheme is now being implemented in all 25 districts in Gujarat

PROJECT TIMELINE:

1992-2004	*Implementation of initiatives for improving Emergency Obstetric Care (EmOC) facilities through funding from World Bank and UNICEF* *Consultative Policy Dialogue between Gujarat Government and academic institutions, NGOs and Private agencies for harnessing private participation in health care*
2005	*Launch of the National Rural Health Mission (prime source of funds for project)* *Launch of the Chiranjeevi Yojana*
2005-06	*Successful pilot in 5 districts*
2006 onwards	*Extension of the scheme to all 25 districts in Gujarat*

1. PPP CONTEXT

1.1 ENABLING ENVIRONMENT

1. Commitment of the State Government (Gujarat Vision 2020 document) to reduce Maternal Mortality Ratio (MMR) from 389 per 1 lakh live births in 1998 to 100 and Infant Mortality Rate (IMR) from 60 to 30.
2. Recognition in the early 1990s of Emergency Obstetric Care (EmOC) as one of the most effective strategies for reducing MMR. Improvements in EmOC facilities in the form of First Referral Units were initiated throughout the country through schemes such as the Child Survival and Safe

Motherhood (CSSM, 1992) and Reproductive and Child Health (RCH, 1997-2004) schemes through funding support from the World Bank and UNICEF. However these initiatives failed to achieve desired outcomes due to unavailability of Government employed ObGyns in the rural areas.

3. Initiation of a Consultative Policy Dialogue by the Government of Gujarat with academic institutions such as IIM-Ahmedabad, NGOs such as Sewa Rural and private agencies such as GTZ in order to overcome such constraints and explore possible options for providing EmOC through the private sector,.

4. Launch of the National Rural Health Mission (NRHM) in 2005 by the Government of India, which laid down the framework for public-private partnerships in public health delivery systems and which formed a major funding source for the Chiranjeevi Scheme.

1.2 SECTORAL CONTEXT

1. In 2003 the MMR in the State was about 172 per 1 lakh live births; high as compared to comparable states such as Kerala (110) and Tamil Nadu (134). A majority of the vulnerable group belonged to Below Poverty Line (BPL) households due to low financial capability for accessing healthcare systems.

2. A major reason identified for the high MMR was the low incidence of institutional delivery, with a majority of deliveries being conducted by untrained persons in unhygienic conditions. While this was in part due to lack of awareness and unaffordability, the situation was compounded by the unavailability of public practitioners in rural areas. Only 8 ObGyns were available to serve a population of 32 million as against a requirement of around 272 professionals. The shortfall in Gujarat was the highest amongst various States as seen in the following table:

Availability of Public Practitioners (Obgyns) – Top 5 states with highest shortfall – September 2005

State	Required	Sanctioned	In Position	Shortfall	% Shortfall
Gujarat	272	34	8	264	97%
Uttar Pradesh	386	370	123	263	68%
Rajasthan	326	152	105	221	67%
Madhya Pradesh	229	63	13	216	94%
Chhattisgarh	116	116	15	101	87%

3. In contrast, Gujarat had more than 700 private ObGyns practicing in rural areas.

2. PROJECT DEVELOPMENT

2.1 PROJECT CONCEPTUALIZATION

In order to bridge the gap in availability of ObGyns for providing EmOC and institutional delivery in rural areas of Gujarat, the State Government formulated the 'Chiranjeevi Yojana'. The scheme sought to use the potential resource available in the form of large number of private providers, to provide free and quality services to poor pregnant women in return for predetermined capitation based payment from the Government. Beneficiaries could avail of the scheme through vouchers (distributed under the scheme) or through BPL cards. The project was initially planned as a pilot in 5 priority districts: Banaskantha, Dahod,

Kutch, Panchmahal and Sabarkantha, and was to be scaled up to all districts in the State based on the results.

2.2 PROJECT DEVELOPMENT

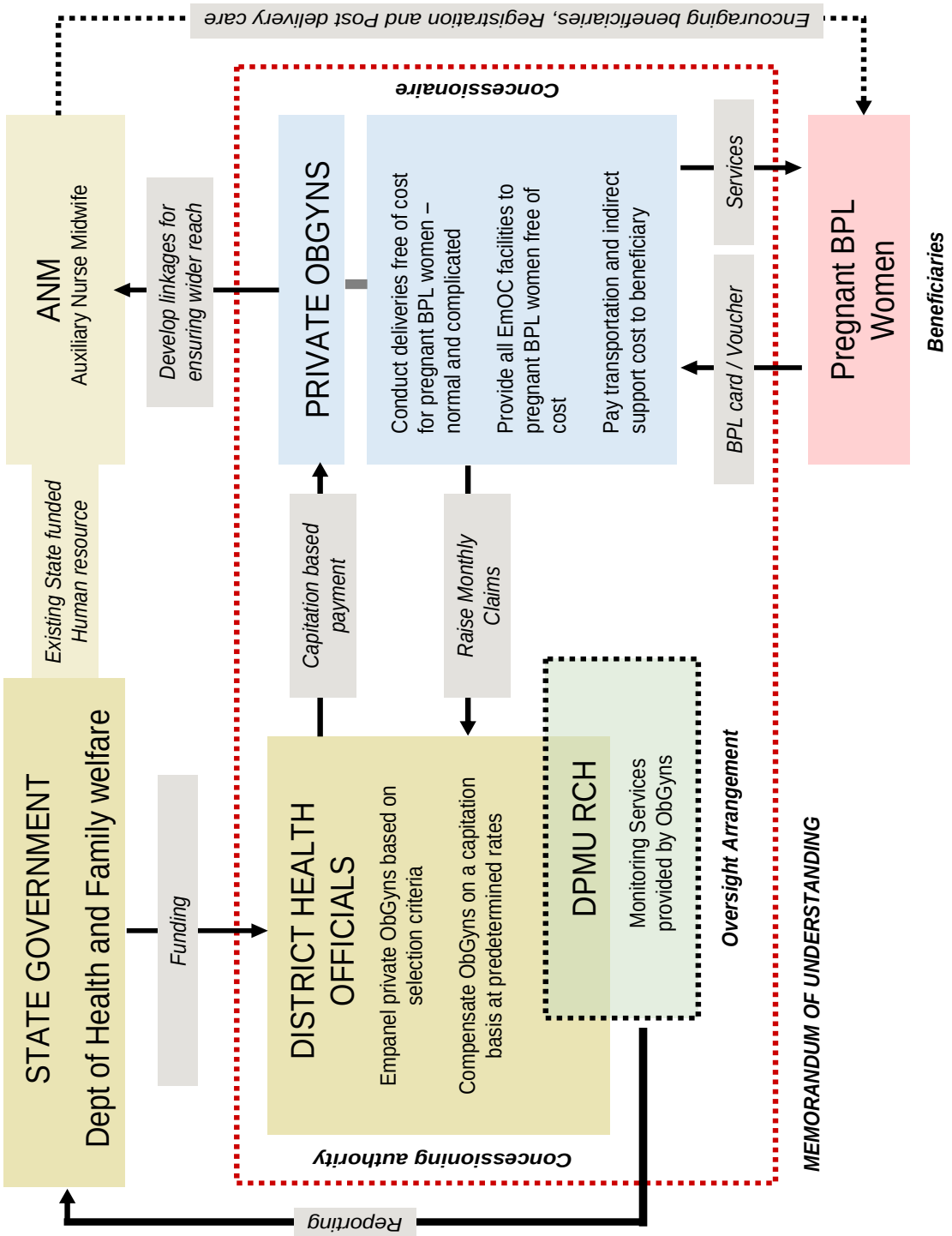
1. The project envisioned that district level health officials would anchor and implement the project. For this purpose training was provided to officials in aspects of negotiation, consultation and networking skills.
2. Detailed selection criteria were developed for choosing private ObGyns such as educational qualifications, availability of own hospital with labour room, operation theatre and blood store, and ability to arrange for anesthetists and perform emergency surgeries.
3. Based on the selection criteria an inventory of Private ObGyns in the district was prepared by respective District Health Officials in the 5 districts where the programme was to be piloted.
4. Details of remuneration to the Private practitioners were established through consultations with existing providers and professional bodies such as the Federation of Obstetricians and Gynecology Society of India (FOGSI) and the Society for Welfare and Action.
5. Vouchers were distributed through District Health Officials to pregnant women belonging to BPL families

2.3 PROCUREMENT PROCEDURE

The District Health Officials identified and empanelled private practitioners, based on the selection criteria and on the basis of interest expressed by practitioners. This was followed by a Memorandum of Understanding (MoU) between the practitioner and the District Health Authorities. The District Project Management Unit (DPMU) instituted under the RCH programme was in charge of the documentation.

3. CONTRACTUAL ARRANGEMENTS

3.1 PROPOSED CONTRACTUAL STRUCTURE



3.2 OPERATOR OUTPUT OBLIGATIONS

Following were the obligations of the private practitioner under the MoU:

1. Conduct institutional deliveries for women from BPL households – both normal and Caesarean Section.
2. Provide antenatal, delivery and post natal care for both the mother and infant.
3. Provide good infrastructure facilities, and prompt high quality services to the beneficiaries.
4. Reimburse the beneficiary for direct and indirect costs such as travel costs and loss of wages to the accompanying person at predetermined rates.

Though not binding as part of the MoU, the practitioner was also expected to develop strategic linkages with health workers and other State-funded human resource such as Auxiliary Nurse Midwives (ANMs), for generating awareness, registering prospective patients and providing post natal care.

3.3 REGULATORY AND MONITORING ARRANGEMENTS

DPMU appointed under RCH for each of the districts, reviewed the performance of the providers periodically and reported the progress of the scheme to the State Health Directorate. On a daily basis the ANMs and Health Officials linked with the project monitored and ensured optimum utilization of services under the scheme and adequate targeting of beneficiaries.

3.4 PROJECT FINANCIALS

1. Public investment required for the project was made through State Government funds and grants provided by the Central Government under the NRHM.
2. The private practitioner was to be paid on a capitation basis. A fixed reimbursement package was developed of Rs.1.79.500 for every 100 deliveries (or Rs.1795 per delivery). The reimbursement package was based on an assumed proportion of 85% normal and 15% complicated cases (including Caesarean section deliveries) and included the amount of Rs.200 to be paid to the beneficiary for travel and Rs.50 to cover the loss of wage of an accompanying person (*dais* for instance). The private practitioners were expected to claim their reimbursement on a monthly basis from the DPMU RCH.
3. The practitioners were paid an advance sum of Rs.25,000 in order to initiate services.

4. PARTNERSHIP IN PRACTICE

The Chiranjeevi Scheme has helped improve the coverage of EmOC services in the State, by reducing multiple barriers such as lack of awareness, unaffordability and inaccessibility for families living below the poverty line.

4.1 PROJECT OUTCOMES

1. In the pilot phase, around 175 doctors were enlisted in the 5 pilot districts, improving the available specialists from the prevalent 8 nos of filled Government posts. A total of 853 doctors have enrolled within the scheme across all 25 districts in the State up till February 2008.
2. Use of awareness mechanisms such as the integration with ANMs and removal of barriers such as affordability have improved the health seeking behaviour positively amongst women resulting in increased proportions of institutional deliveries and reduced MMR.
3. During the pilot phase itself, institutional deliveries in the five districts increased from 38 to 59%. Up till 2008, 1,65,278 number of deliveries had been conducted resulting in reduction of maternal deaths from an estimated 642 to 32, and reduction in deaths of newborns from an estimated 6561 to 559.
4. Though the overall procedure was not entirely cashless for the beneficiaries (expenditure was incurred in case of transportation costs exceeding predetermined remuneration and on post delivery use of medicines); the project reduced the average cost incurred for institutional delivery substantially - from Rs.3070 to Rs.727 under the scheme.
5. The reimbursement package assumed a specific proportion of normal and complicated deliveries. This acted as a deterrent for avoiding unnecessary use of Caesarean Section Procedures.

4.2 PROJECT SHORTCOMINGS

1. The monitoring framework does not capture the quality of services provided to beneficiaries.
2. Mechanisms for post-delivery care of mother and infant have not been established adequately.
3. While the standardized remuneration package did act as a deterrent for unnecessary Caesarean Sections, it also acted as a disincentive in the handling of high risk cases. Providers have often tended to refer complicated cases to public facilities to avoid excess costs and care.

5. LESSONS LEARNT

1. Importance of proper project identification and structuring. The Chiranjeevi case is noteworthy for the use of existing private medical resources in rural areas in order to fill existing gaps in public service delivery and creating a ‘win-win’ structure so as to encourage both providers and beneficiaries
2. Importance of developing effective and stimulating compensation/ remuneration systems, in order to harness quality services from private providers, while building in requisite disincentives for misuse.
3. Importance of proper Information, Education and Communication (IEC) for ensuring success of a PPP initiative. In the Chiranjeevi case the strategic linkage established with ANMs and other Health Workers for providing information and generating awareness contributed largely to the success of the endeavour (82% of beneficiaries were tied up through such efforts).
4. One of the most important success factors of the project is the relatively simple procedure for obtaining benefits under the project – encouraging beneficiaries and removing possible procedural hurdles for availing benefits.

5. Need for establishing robust monitoring frameworks so as to capture not only the reach of such projects but also the quality of services being provided