A dissertation report on Accessibility & Utilization of Rajbhra ARV's (Arogaya Rath Vahan) a Public Private Partnership venture in delivering of healthcare services

A dissertation submitted in partial fulfillment of the requirements for the award of

Post-Graduate Diploma in Health and Hospital Management

by

Richa Tyagi
PG/11/079

International Institute of Health Management Research
New Delhi -110075

May, 2013
(PG/11/079)

FEEDBACK FORM

Name of the Student: Richa Tyagi

Dissertation Organization: Rajbhra Medicare Pvt. Ltd.

Area of Dissertation: Project planning, Monitoring, Administration, Implementation

Attendance: 100%

Objectives Achieved: All the tasks were achieved

Deliverables: All were accomplished

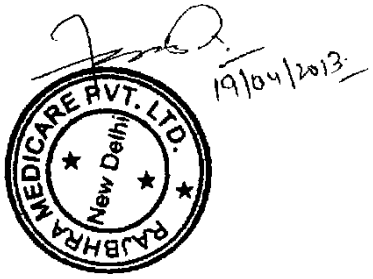
Strengths: Team player, Hard working, Creative, Good communication skills

Suggestions for Improvement: -

Signature of the Officer-in-Charge/ Organization Mentor (Dissertation) Anil Kumar Singh

Senior Project Manager

Rajbhra Medicare Pvt. Ltd.



Certificate of `Approval

The following dissertation titled "A REPORT ON ACCESSIBILITY & UTILIZATION **OF RAJTIHRA's ARV (AROGAYA RATH VAHAN) A PUBLIC PRIVATE PARTNERSHIP VENTURE IN DELIVERING OF HEALTHCARE SERVICES"** is hereby approved as a certified study in management carded out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post-Graduate Diploma** in **Health and Hospital Management for** which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Disertation Examination Committee for evaluation of dissertation

Name	Signature
DR. SHER SINGH KASHYOTIA	
DR. NITISH DOGRA	

Certificate from Dissertation Advisory Committee

This is to certify that Ms. **Richa Tyagi ,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management,** has worked under our guidance and supervision. She is submitting

this dissertation titled " A RPORT ON ACCESSSIBILITY & UTILIZATION OF RAJMIRA ARV'S (AROGYA RATH VAHAN)A PUBLIC-PRIVATE PARTNERSHIP VENTURE IN DELIVERING OF HEALTHCARE SERVICES) in partial

fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Faculty Mentor

Kumar Singh

Designation

IIHMR

Medicare Pvt. Ltd.

New Delhi

Organizational Advisor **Anil**

Designation Sr. Project Manager

Organization Rajbhra

Address N-18 A, Green Park Extension

19th April -13

RAJBHRA MEDICARE PVT. LTD. New Delhi

19/04

TO WHOM IT MAY CONCERN

This is to certify that Dr. Richa Tyagi has successfully completed his 3 months internship in our organization from January 01, 2013 to April 01, 2013. During this intern she has worked as an Assistant Project Manager on ARV (Arogaya Rath Vahan) and MSSC (Multi Speciality Surgical Camps) Project under the guidance of me and my team at Rajbhra Medicare Pvt. Ltd.

She has worked on all the aspects of Project planning and implementation with uttermost dedication and responsibility.

We wish her good luck for her future assignments

(Signature)

19/04/2013

N *roject Manager*

RAJBHRA MEDICARE PVT. LTD. New Delhi

Rajbhra Medicare Pvt. Lt .
N-18A, 2nd Floor, Green Park Extension New Delhi-1100 6
+ 91-11-46024961, + 91-11-460249 2
Fax:+ 91-11-460249 3
E-mail: admin@rajbhra.com Website: www.rajbhra.co n

ABSTARCT

Deficiencies in the Indian Public Health system results in a high out of pocket expenditure on the poor and the under-privileged section of the society. Delivering affordable healthcare is one of the most intractable challenges faced by the government specially in a developing country like India the challenge rises even more because there is a need to build in the infrastructure and apart from that to provide healthcare facilities to the masses. There have been various initiatives like the RSBY and the NRHM, which are an example of Public Private Partnership (PPP) and have been introduced by the centre for the benefit of the masses. The public sector model in healthcare has not been able to accomplish it's objectives of providing better health facilities for the masses. This dissertation report highlights the work of Rajbhra ARV (ArogayaRathbVahan) in providing primary healthcare services to the people of Uttrakhand where the geographical make up of the state act as an hindrance .This report highlights the work of Rajbhra ARV and its accessibility and utilization in providing primary healthcare services to the masses.

ACKNOWLEDGEMENT

I owe a great many thanks to a great many people who have helped and supported me during the completion of my report.

My deepest thanks goes to **Mr. Anil Sing (Program Manager Rural)Rajbhra Medicare Private Limited, New Delhi, India**, for their guidance and constant supervision as well as for providing necessary information regarding the project and also for their support in helping me to complete the project.

My deep sense of gratitude goes to **Dr. Dharmesh Lal (Associate Dean IIHMR, DELHI)** for guiding and mentoring me during the report, and for correcting various documents of mine with attention and care. He has taken a pain to go through the project and had made necessary corrections when needed.

I thank **Mr. Rajnish Casshyap (Managing Director, Rajbhra Medicare Pvt. Ltd.,New Delhi India), Ms.Sukhmani Pantal (General Manager Projects, Rajbhra Medicare Pvt. Ltd.,New Delhi)** and **Er.Abhinav Jain** and all the staff and members of **Rajbhra Medicare Pvt. Ltd.**, for their support, guidance and for their encouragement in completing this project.

I would also thank my parents **(Mr. Satish Chand Tyagi and Mrs.UrvashiTyagi**) and my family members without whom this project would have been a distant reality.

INDEX

LIST OF FIGURES

LIST OF TABLES

LIST OF APPENDIX

ABBREVIATION

PPP	Public Private Partnership
ZPs	Zila Panchayat
MoU	Memorandum of Understanding
RCH	Reproductive Child Health
CHC	Community Health Centres
ANM	Auxiliary Nurse Midwives
MO	Medical Officer
BPL	Below Poverty Line
APL	Above Poverty Line
NHP	National Health Policy
GoUK	Government of Uttrakhand
MOHF&W	Ministry of Health & Family Welfare
TB	Tuberculosis
ANC	Antenatal Care
PNC	Postnatal Care
ARV	Anti-Retroviral Treatment
DOTS	Directly Observed Treatment Service

1.0 ABOUT RAJBHRA

"Health at the Door-Step of All"

Rajbhra is a private limited company which is registered under the **Companies Act of 1956**, and runs on the name of **Rajbhra Medicare Private Limited**. The Registered Office of the company is situated in the National Capital Territory of Delhi. The main objectives for which the company is established are:-

- To carry on the business of providing Mobile Medical Health, Mobile Hospitals and ambulances and to promote Medical equipment, Specialized Medical products, modern medical equipment, inventions and medical accessories on the basis of its technical superiority and utility with reference to cost benefit.
- To provide Mobile Medical Health services to the clients like State Governments, Central Governments, Cooperates within India and also outside the Indian continent.
- To provide and outsource Medical professional manpower to various State Governments, Central Governments and also outside the Indian sub-continent as part of Human Resource management to Hospitals, agencies and organizations.

MISSION

To improve the health seeking behavior and make it for all section of the society including the poor and the under-privileged. The health objective is to ensure equal access to all community member irrespective of location and socio-economic standards of living.

VISION

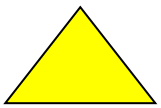
- Hanging focus.
- Improving standards.
- Advancing quality.
- Defining performance parameters.
- Identifying desired outcomes.
- Reassess performance

2.0 OVERVIEW OF THE PROJECT

In rural India and its disadvantaged sections of society, the government, today, remains the almost only provider of health services. Other private operators, which are also barely adequate for large rural populations, are either encasing on the ignorance of the poor and needy or holding them to ransom in case of an medical emergencies. **Rajbhra has pioneered the concept of providing medical aid through its mobile clinics and services in underserved areas in the country today.**

GOALS OF THE PROJECT

Preventive health care



Information **Diagnosis and treatment**

To provide holistic healthcare by preventive measures, information and diagnosis and treatment in underserved region in **Uttrakhand** through an alternate model of healthcare to improve the quality of life

- Based on deployment of mobile multi- tasking clinics equipped with medical and testing equipment to assist in primary health screening by professionals in a sustained manner
- Multi – tasking units to include other services like veterinary service, agricultural services, and education for children and adults, water testing services and may other as devised with the community to increase outreach and services in minimum infrastructure.
- Train personnel from the community to operate such systems and earn a livelihood.
- To involve the government health functionaries in the day to day operations of the clinics and create new partnerships.

3.0 INTRODUCTION

The healthcare in India consists of public sector, private sector, and an informal network of care providers. The size, scale, and spread of the country hampered complete adherence to the number of well-intended guidelines and regulations. Although there are norms and guidelines, compliances is minimal. In reality, the sector operates in a largely unregulated environment, with minimal controls on what services can be provided, by whom, in what matter and what cost. Thus, wide disparities occur in access, cost, levels and quality of health services provided across the country. The health sector already has a large vibrant private sector presence- both in formal and informal markets. In some states of India, private sector provision of healthcare is as high as 70%. The health services markets (to a great extent) have evolved into two distinct streams: private sector provisions for those who can afford to pay for health services, and public sector provision for those who have limited means. The private sector provision that caters to the upper end of the market is already based on a self-sustaining revenue mode and is highly commercialized. The public sector provision that caters to the lower end of the market or to the poor has limited scope of revenue generation. This may limit the scope for model is based on cross-subsidy. Provision of public services and infrastructure has traditionally been the exclusive domain of the government. However, with increasing population pressures, urbanization and other developmental trends, government ability to adequately address the public needs through traditional means has been severely constrained. This has lead the Government's across the world to increasingly look at the private sector to supplement public investments and provide public services through Public Private Partnership. There is no single definition of Public Private Partnership (PPP). PPP broadly refers to long-term contractual partnerships between public and private sector agencies, specially targeted towards financing, designing, implementation and operating infrastructure facilities to provide services that were traditionally provided by the public sector.

As per the Guidelines of IIPDF scheme of, Department of Economics Affairs, Ministry of Finance, Government of India has defined Public Private Partnership (PPP) as:

"Partnership between a public sector entity (Sponsoring authority) and a private sector entity (a legal entity which 51% or more of the equity is with the private partners) for the creation and/ or management of infrastructure for public purposes for a specified period of time,

(concession period) on commercial terms and in which the private partners has been procured through a transparent and open procurement system."

Public Private Partnership (PPP)in the healthsector is seen as an instrument by governments to improve efficiency,reliability and availability of services in health system.PPP is undertaken to improve access of services to the poor and socially vulnerable sections of the population especially in the remote and underserved areas. For the study,"Public"was defined as Government or organizations functioning under State budgets, "Private" was the Profit/Non-profit/Voluntary sector and "Partnership"meant a collaborative eeffort and reciprocal relationship between two parties with clear terms and conditions to achieve mutually understood and agreed upon objectives following certain mechanisms. One such initiative in India which has been prominent in the eighties is the management of Primary Health Centers (PHCs) through PPP. Numerous states in India like Orissa, Arunachal Pradesh, Gujarat, Karnataka, Himachal Pradesh etc have such initiatives in their states.OneofthePrimaryfunctionsoftheStateistoprovideaffordable,accessibleand qualityhealthservicestothepopulation.PresentlytheRuralHealthservicesprovided by Government Hospitals are under-utilized due to the non-availability of regular doctors, absence of motivated and unavailability of specialist services to serve the rural population.

STATE PROFILE UTTRAKHAND

The state of Uttrakhand previously (Uttaranchal) was created in 2000 from portion of Uttar Pradesh state in the year 2001 as per the census of India. Uttrakhand is distinguished by its hilly and mountainous Himalayan terrain. Owing to a hilly terrain the state has virtually no railway network. Only five major towns in four districts are connected by railway namely-Dehradun, Rishitesh, Haridwar, Haldwani and Kathgodam are connected by railway.

The remaining nine districts are completely dependent on the road network. Access to even primary healthcare services is nearly impossible for many people. In addition to the challenges of physical access to facilities, the quality of services is limited by a scarcity of

basic amenities and an insufficient number of healthcare providers, as an insufficient number of healthcare providers, as a large number of positions of doctors, laboratory technicians, pharmacists, nurses and mid-wives remain vacant. In 2005 with the launch of National Rural Health Mission (NRHM), the GoUK set specific goals for itself to improve the health indicators of the state. In 2005-06, the total fertility rate was 2.5 children per woman as against the 2010 NRHM goal of 2.1, leaving the room for improvement. The infant mortality rate (IMR), at 41 deaths per 1,000 live births, was significantly higher than the projected goal of less than 30 deaths per 1,000 live births. Regarding maternal health indicators, maternal mortality rate (MMR) was 440 deaths per 1,00000 live births, whereas the 2010 goal projected to be below 100 deaths per 100,000 live births. Further, the institutional delivery rate in Uttrakhand in 2006 was 32.6 as compared to the 2010 goal set at 80 percent. According to NFHS-3 , for most households in Uttrakhand, the private health sector is the main source of healthcare (52% of urban households and 55% of rural households). Among households that do not use government health facilities, the main reasons given are poor quality care (64%) and lack of nearby facility (49%). An important reason for low health indicators has been limited access to fixed healthcare facilities due to poor transportation infrastructure in the more remote and interior regions of Uttrakhand. Faced with the challenges of getting to a facility, many people either refrain from seeking medical help or use the services of untrained medical service providers living in the vicinity. Those who are most in need, such a the below poverty line (BPL) population, find it especially difficult to access these fixed point facilities, as their health seeking behaviors are impacted by the costs of travel and lost wages. Growing inequalities are visible in accessing healthcare services between the rural and urban populations, the poor and the rich, and the scheduled caste/ scheduled tribes versus others. For example, only 36 percent of rural women had access to three antenatal checkups visits versus 71 percent of urban women who had access to them and only 20 percent of rural women had institutional deliveries versus 59 percent of urban woman.

Uttrakhand , the 27th state of the Republic of India and was carved out of Uttar Pradesh on 9th Nov 2000. There are 13 districts in Uttrakhand which are grouped into two divisions Kumaun and Garwhal

Kumaun division includes six districts.

- Almora

- Bageshwar
- Champawat
- Nainital
- Pithoragarh
- Uddham Singh Nagar

The Garhwal division includes seven districts.

- Dehradun
- Haridwar
- TehriGarhwal
- Uttarkashi
- Chamoli
- PauriGarwal (Garhwal)
- Rudraprayag

4.0 REVIEW OF LITTERATURE

One of the Primary functions of the State is to provide affordable, accessible and quality health services to the population. Presently the Rural Health services provided by Government Hospitals are underutilized due to the non-availability of regular doctors, absence of motivated and health staff and unavailability of specialist services to serve the rural population. Almost 79% of the Indian population use out of pocket expenses for availing of health facilities from private sectors. Public Private Partnership are collaborative efforts between private and public sectors, with clearly defined/identified partnership structures, shared objectives and specified performance indicators for delivery of asset of health services in a stipulated time period. Partnership, Integration and Convergence are the need of hour for imparting best quality healthcare based on values of efficiency, effectiveness and equity. The main aims and objectives of the PPP is to provide services of medical officers at each PHC, improving quality, accessibility, availability, acceptability and efficiency of existing health infrastructure. mobilization of additional resources, to achieve regular Aganwadi visits, Comprehensive School Health program me and regular MCP sessions. To Provide Specialist health services that is Surgery, Obstetrics and Gynecology, Pediatrics, ENT etc. on weekly basis at PHCs and Gynae, Pediatrician visits at sub center level on monthly basis. To increase the No. of institutional deliveries through availability of specialist services. To decrease the MMR and IMR through quality health services. Providing emergency services and developing proper referral plans. To develop model PHC and as per IPHS standards. To monitor quality of healthservicesandtoobtainregularfeedbackforappropriatetransformation/ redressalaction.[1]

It was felt that convergence of private sector interests and public sector goals would be be brought about by seeking partnership .Hence, initiatives in public- private partnership were under taken, with a view to enable optimization of resources such as human power, hospital buildings, and medical equipment amongst others. The nature of public private partnerships include contracting out of non-clinical services, management of bio-medical waste, supply of diet to hospitals, out sourcing of clinical services to private institutions.

PPP involves a contract between a public sector authority and a private party ,in which the private party provides a public service or project and assumes substantial financial, technical and operational risk in the project. In some types of PPP, the cost of using the service is borne exclusively by the users of the service and not by the tax payer. In other types (notably the private finance initiative),capital investment is made by the private sector on the strength of a contract with government to provide agreed services and the cost of providing the service is borne wholly or in part by the government. Government contributions to a PPP may also be in kind (notably the transfer of existing assets). In projects that are a immediate creating public goods like in the infrastructure sector, the government may provide a capital subsidy in the form of a one-time grant, so as to make it more attractive to the private investors. In some other cases, the government may support the project by providing revenue subsidies,
Including tax breaks or by providing guaranteed annual revenues for a fixed period.[2]

Agreement between government and the private sector regarding the provision of public services or infrastructure . Purportedly a means of bringing together social priorities with the managerial skills of the private sector, relieving government of the burden of large capital expenditure, and transferring the risk of cost overruns to the private sector. Rather than completely transferring public assets to the private sector, as with privatization, government and business work together to provide services. The British Government has used PPPs to finance the building of schools, hospitals, for

Defense contracts and specific capital projects such as the Channel Tunnel Rail Link, the National Air Traffic Services , and improvements to the London Underground. The system has been criticized for blurring the lines between public and private provision, leading to a lack of accountability with regard to funding, risk exposure, and performance.[3] Recognizing and acknowledge in that the private sector provides a large component of curative care and therefore its involvement in healthcare delivery is in evitable ,the 11th five year plan(2007-2012)and the National Rural Health Mission(2005-2012) constituted a working group and task force, respectively, on public private partnership (PPP).The terms of reference of these groups was to suggest ways to improve health care delivery so as to ensure universal access that is equitable, affordable and responsive to people's needs and help reduce maternal and infant mortality. Some individuals or officials were members of both the groups. They viewed the public- private partnership as contributing to improving the accountability of the publicsector.[4]

Public hospitals around the world are facing a growing financial crisis, squeezed by rising health care costs and public budget constraints. Public-Private Partnerships (PPP) in the public hospitals can provide innovative ways to control costs, improving the viability of public hospitals and the quality of their services. In India “corporatization" has led to the expansion of urban secondary care hospitals at the expense of rural, primary health care facilities. State government shave restructured hospitals with World Bank loans. Equipment and pharmaceutical companies have developed partnerships with specialist hospitals. The private sector has grown unevenly in India. Individual private practitioners made up part of the private sector. There has also been an expansion of hospitals and nursing homes ,so expanding the number of private sector beds but the size of many of the establishments is relatively small. Larger hospitals, run under business principles,areoftenpartneredbyIndiandoctorsandnon-Indiandoctorsandarebased in urban areas. [5] Starting from the Bhore Committee report in 1946 there has been an increasing emphasis on the state providing health care services through a three-tiered approach in India. However, despite these efforts and despite many healthcare and family welfare plans and program me made since then, health out comes in India have remained closer to those in sub-Saharan Africa than in industrialized nations among which India wouldliketobecounted.Public-privatepartnershipsaimtoharnessthelargepoolof private sector healthcare resources and draw them into the process of nation building.[6] 12

According to the GOI‘s Planning Commission‘s Task Force on Public Private Partnerships (2007), this network is currently insufficient to provide adequate healthcareservicestotheIndianpopulation.Keepinginmindthehealthgoalsofthe equityarrangements.However,thechallengesinthehealthcaresector,liketheneed for an appropriate policy framework backed by an appropriate institutional mechanism. Another setback in PPP was use of generic contracts without any reference to specific indicators like number of free treatments offered by the Government and cost of serving the Below Poverty Line (BPL) policies.[7]

HealthCare is delivered in India through Public and Private Health Institutions. Recent surveys indicated that people mostly avail curative healthcare from Private Health Institutions by paying fee-for-service where as preventive healthcare such as Immunization and Contraception is availed free of cost from Government Health Services which has established a network of health center in the rural are as where Qualified Private Health Care Practitioners are generally not available. The public healthcare professionals oppose the provision of services through the private practitioners where as private medical practitioners have endorsed the scheme and have agreed to refer patients for admission to government hospitals where bed occupancy rages from 60-70%. However, government health care professional perceive the scheme as a means of gradual privatization of the government health system and thus in the long run decimating the public health system. Health administratorsfavortheschemeasitavoidshugeinvestmentintheinfrastructureand theconsequentdelayinprovisionofservicesandalsobecauseitmakesuseoftheidle bedavailableinthegovernmenthealthsystem.[8]

However utilization of services can be influenced by several factors, such as availability, accommodation and acceptability, where acceptability in turn influences utilization as much as it influences satisfaction.[9] Hong Kong provides a PHC service for a fixed number of patients on a daily basis and is often clogged up with patients with chronic illnesses who need a refill of their medication. Most of these clinics are closed during public holidays and none are open 24 hours a day. Only a few of those clinics are staffed with a qualified family physician.[10] In 2002, the Namibian government reported disparities between the patterns of utilization of the services and allocation of staff where the poorer localities were relatively underprovided. Utilization of services in Windhoek was said to be satisfactory as people travelled shorter distances to the clinic and the poor were exempted from user fees. Lack of staff and long waiting periods were found to be deterrents in using the nearest clinics. [11]

Implementation of PHC in sub-Saharan countries, indicated that child immunization coverage has increased remarkably in most countries, with almost two-thirds of all children less than 1 year being immunized. [12]

It has been reported that geographical accessibility of health services has a direct bearing on utilization of services. Distance to a facility has been associated with increasing maternal and infant mortality, decreased vaccination coverage and decreased contraceptive use. Improving geographical access to PHC can help to improve these adverse health outcomes

Transportation and distance were the biggest hindrances) to utilization of services, particularly in rural areas. A lack of financial resources for transport was the barrier most often cited by women who did not attend antenatal care. These factors include limited financial resources, influence of family members, family responsibilities, women not realizing they are pregnant and difficulty in obtaining time off from work. With regard to barriers to utilization of child health services, the following factors were stated: socioeconomic constraints (no money for transport to a facility) , beliefs about causes of illness (witchcraft), lack of awareness of danger signs (several mothers stated that they did not realize the seriousness of the child's condition and therefore delayed seeking care), poor quality of care (improper diagnosis and treatment) and the role of traditional healers (several caregivers reported consulting a traditional healer if their infant's condition did not improve following care at a clinic or hospital or if clinic was out of stock of relevant drugs).

5.0 RESEARCH OBJECTIVE

To study how Rajbhra ARV's a PPP initiative of the government has helped to achieve its development goals of access to Primary healthcare.

SPECIFIC OBJECTIVES

- To investigate whether the ARV's services are accessible to the communities of Almora Region.
- To determine primary health care service utilization in the three blocks of Almora Region.

6.0 RESEARCH METHODOLOGY

6.1 Study Design

A cross-sectional study was carried on where self-administered questioner was used to assess the accessibility and utilization of the services being provided at ARV (Arogaya Rath Vahan)

6.2 Study Area

ARV runs in seven district of Uttrakhand namely (Pauri, Tehri, Chamoli, Uttarkashi, U.S. Nagar, Rudraprayag and Almora),because of time constraint lottery method was adopted in order to select the district for study. Out of 7 districts Almora was selected as the study area.

6.3 Almora District

Almora is located at 29.62N and 79.67E latitude, having an elevation of 1,651 meters. The entire district is divided into 13 blocks out of these blocks 9 blocks are being covered by Rajbhra ARV's namely (Hawalbagh, Tadikhet, Lamghra, Dhauladevi, Takula, Dwarahat,Chaukutiya,Deghat,Bhikyasain).Out of these 9

6.4 Sample Size

Almora has a rural population of 559,595 as per the Census 2011, out of which 302,916 are males and 256,679 are females.

Sample size was calculated using EpiInfo.,taking 95% confidence interval and 10% error the sample size obtained was 96, however 100 samples were interviewed from 3 blocks of Almora.

6.5 Sampling Method

Multi staged random sampling has been done. On the basis of the population selected in selected blocks within Almora district, the proportionate number of samples have been drawn to form a cumulative sample size of 100.OPD Registers of the ARV were seen and it was analyzed that a minimum of 50 patients were registered in a day on that basis to derive a sample size of 33, every second patient was interviewed to derive a sample size of 33 from the respective block so hat every person had equl chance of being included in the study.

6.6 Data Analysis

Data was analyzed using SPSS 16.0 version and Microsoft excel

Table:1 Number of blocks covered by ARV (Arogaya Rath Vahan) Almora

S. No.	Name of block covered by Arogya Rath Vahan (Almora)
1	Lamghara
2	Dhauladevi
3	Takula
4	Dwarahat
5	Chaukhutiya
6	Deghat
7	Bhikyasain
8	Hawalbagh
9	Tadikhet

Table: 2 Details of staff in ARV (Arogaya Rath Vahan) Almora

Position	Number of staff
Assistant Project Coordinator (APC)	1
Medicalofficer (MO)	1
Pharmacist	1
Laboratorytechnician	1
X-Ray technician	1
ANM	1
Driver	1

Table: 3 Details of servicing being provided by ARV (Arogaya Rath Vahan) Almora

S. No.	Services being provided
1	Curative services
2	RCH services
3	Family planning services
4	Diagnostic services
5	Emergency services
6	IEC & BCC activities
7	Testing for HIV/AIDS
8	Counseling

Table: 4 Route Plan of ARV (Arogaya Rath Vahan) Almora for the month of March
RMPL/500/ARV/AL/1/corss./5

Route Plan

ARV N. R. H. M.

Rajbhra Medicare Pvt. Ltd. Delhi

S.No	Date	Camp Site	Block
1	03-Mar-13	Jalana	Lamgada
2	04-Mar-13	Motiyapathar	Lamgada
3	05-Mar-13	Bhanoli	Dhauladevi
4	06-Mar-13	Gudaditya	Dhauladevi
5	07-Mar-13	Dhyadi	Dhauladevi
6	08-Mar-13	Naini	Dhauladevi
7	09-Mar-13	Panuvanaula	Dhauladevi
8	10-Mar-13	Jamaradi Band	Bhaisiyachana
9	11-Mar-13	Dhanyan	Lamgada
10	12-Mar-13	Basauli	Takula
11	13-Mar-13	GwalakotManan	Takula
12	14-Mar-13	Bhaisadhgao	Takula
13	15-Mar-13	Jhupulchaura	Takula
14	16-Mar-13	Binta	Dwarahath
15	17-Mar-13	Badi	Dwarahath
16	18-Mar-13	Pokhri	Dwarahath
17	19-Mar-13	Bairtipan	Chaukhutiya
18	20-Mar-13	Patalgao	Chaukhutiya
19	21-Mar-13	Jainal	Bhikiyasaid
20	22-Mar-13	Nail	Syailde
21	23-Mar-13	Chanagolu	Dwarahath
22	24-Mar-13	Govindpur	Hawalbagh

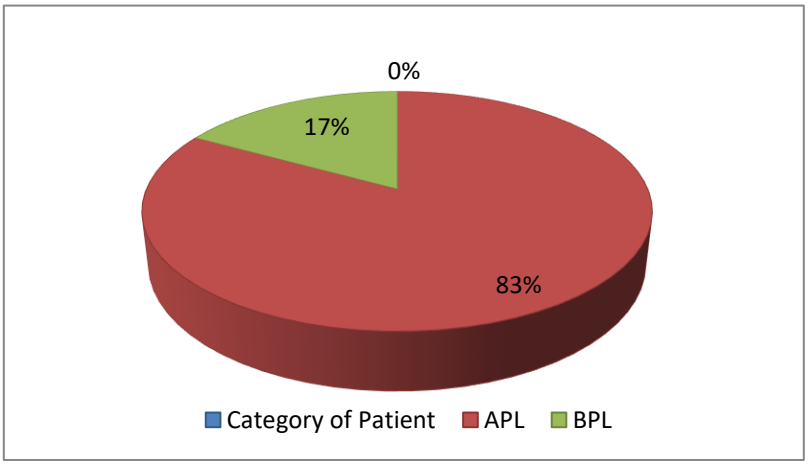
7.0 FINDINGS

Table: 5 Distribution pattern of respondents as per age

Distribution patter of respondents as per age			
Accompanied By		**Female**	**Male**
Parents/ Guardians	< 5 years	12	8
Self	16-25 year	14	6
	26-35 year	18	7
	36-45 year	6	13
	>45 year	3	13
	Total	53	47

Table:5 shows the age distribution pattern of the respondents that were interviewed, larger number of the respondents that were interviewed lie in the age group of (26- 35 year), which was followed on by (16 - 25) year and (< 5) year respectively. However the least number of respondents fall between the age group of (>45) year.

Figure: 1 Distribution of the respondents on the basis of APL and BPL category



Of the total respondents that were interviewed 83% of the total respondents fall in the APL (Above Poverty Line) category and the remaining 17% fall in the category of BPL (Below Poverty Line).

Table: 6 Distance travelled by respondents to reach ARV (Arogya Rath Vahan)

Distance travelled by respondents to reach ARV	
Distance	**Response**
Less than 1Km.	53%
2-5 Km.	27%
5-10 Km.	16%
Above 10 Km.	4%

As distance travelled by the respondents was taken as a means to assess the accessibility so it showed that 53% of the respondents travelled less than a kilometer to reach the ARV, 27% travelled 2-5 km., 16% travelled a distance of 5-10 km., and the remaining 4% travelled a distance of more than 10 km. to reach ARV.

Table: 7 Travelling time taken by respondent to reach ARV (Arogya Rath Vahan)

Travelling time taken by respondents	
Time	**Response**
Less than 30 mins.	81%
30 min. - 1 hr.	16%
> 1 hr.	3%

Travelling time that was another parameter to assess accessibility showed that 81% of the respondents had to spend less than 30 mins. To reach ARV, 16% respondents took 30 min. – 1 hr. to reach ARV and the remaining 3% had to spend more than an hour to reach ARV.

Table: 8 Reason for coming to the ARV (Arogya Rath Vahan)

Name of disease	**No.of patients**	**Name of disease**	**No. of patients**
Nervous System	1	Malnutrition	0
Infectious Disease	1	Tuberculosis	4
Wound	7	Skin infection	4
ENT	1	Leukoderma	0
Ophthalmic	2	Rabies	2
Respiratory	0	Fungal disease	3
Cardio Vascular	0	Gynecological	6
Gastrointestinal	4	ANC	14
Acid peptic disease	3	PNC	1
Anemia	1	Immunization	14
Orthopedics	12	Leprosy	0

Family planning services	4	Voluntary counseling and testing	11
Water born disease	1	Miscellaneous	2

The reason that was given by the respondents to reach ARV were as represented in the table, however the most common reason was Immunization, ANC check-up and Orthopedic disorder as shown in the table.

Figure:2 Number of Children < 5 years of age who came for immunization

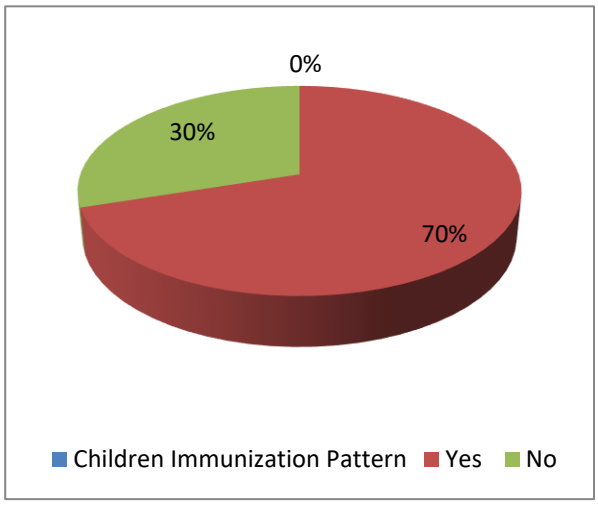


Fig. 2 shows that out of the total number of children under 5 years of age who were interviewed70% of the total respondents came for Immunization and the remaining other came for other check-up at the ARV.

Figure: 3 Percentage of females within reproductive age group who reported for family planning services at ARV (Arogya Rath Vahan)

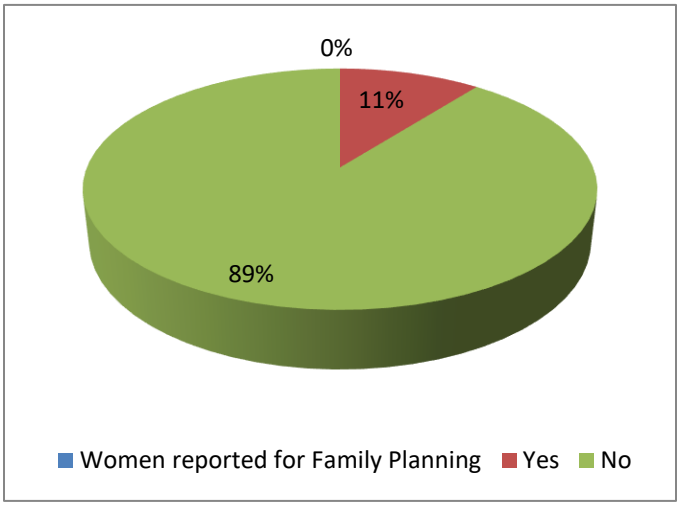


Fig. 3 shows that out of the total women respondents of the reproductive age group that were interviewed, only 11% of the total respondents reported for family planning services.

Figure: 4 Percentage of women within reproductive age group who reported for ANC at ARV (Arogaya Rath Vahan)

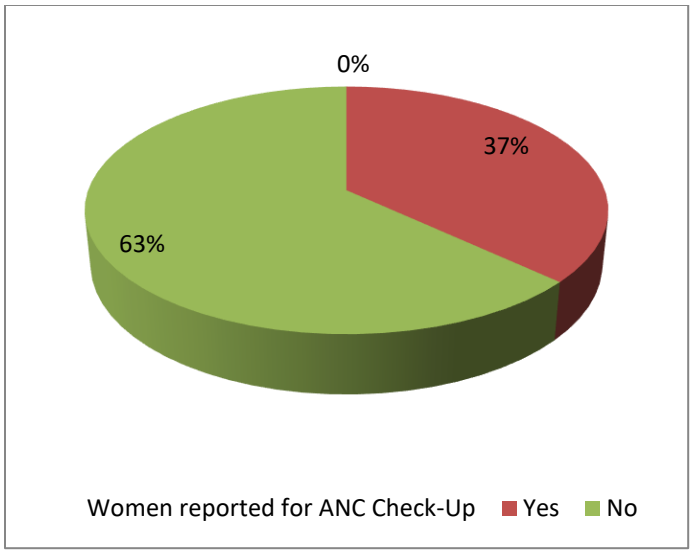


Fig. 4 shows that out of the total respondents within reproductive age group 37% of the females reported for family planning services at the ARV.

Table: 9 Number of people who came to ARV (Arogaya Rath Vahan) for Voluntary Counseling and Testing

Age (Years)	VCT	
	Male	Female
16-25 yrs.	1	2
26-35 yrs.	2	2
36-45 yrs.	1	1
> 45 yrs.	1	1
Sub-total	5	6
Total	11	

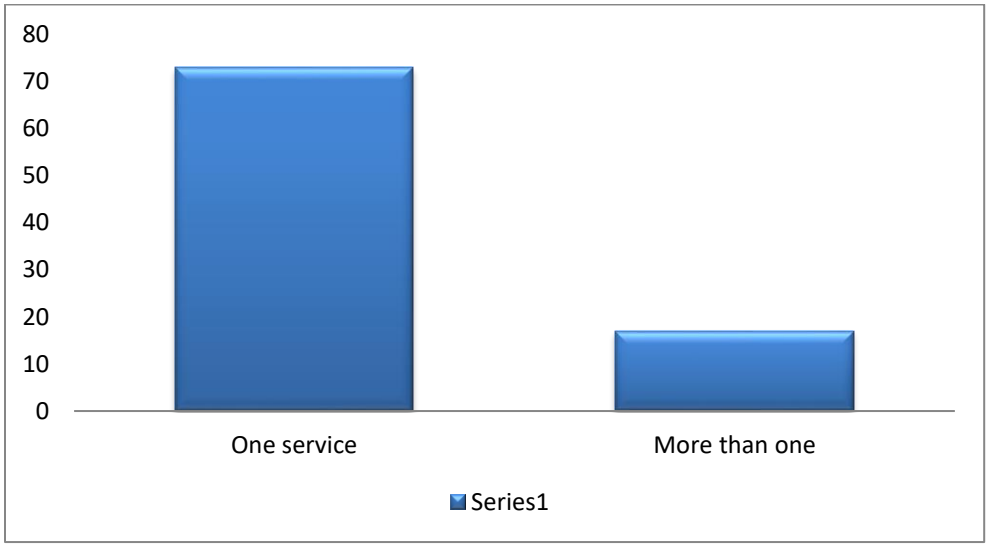
Table 9 represents that respondent of various age group that came to ARV for voluntary counseling and testing, however maximum number was observed between the age group of 26-35 years which was followed on by 16-25 years and so on.

Table: 10 Number of people who came to ARV (Arogaya Rath Vahan) for Tuberculosis Treatment

Age (Years)	Tuberculosis Treatment	
	Male	Female
16-25 yrs.	1	0
26-35 yrs.	1	0
36-45 yrs.	1	0
> 45 yrs.	0	1
Sub-total	3	1
Total	4	

Table 10 shows the number of respondents of various age group that came to ARV for Anti-Retroviral treatment (ARV)

Figure: 5 shows that respondents who utilized one or more service when they visited the ARV (Arogaya Rath Vahan)



The above graph shows ARV utilization by the respondents as 70% of the total respondents visited ARV for utilizing one service and 17% of the remaining respondents came to ARV for utilizing more than one service.

Figure: 6 Represents the percentage of respondents who wereSeen by Doctor or Support Staff when they first visited the ARV (Arogaya Rath Vahan)

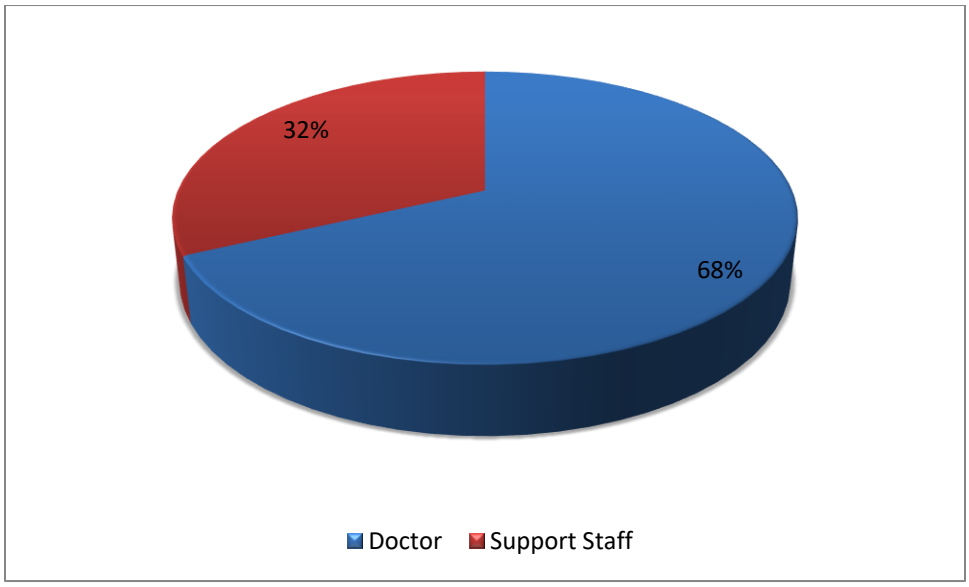


Fig. 6 represents that 68% of the respondents were seen by the Doctor when they visited ARV and the remaing 32% of the respondents were seen by support staff when they visited ARV.

Figure: 7 Represents the response of respondents against the medicines that were issued on time or not

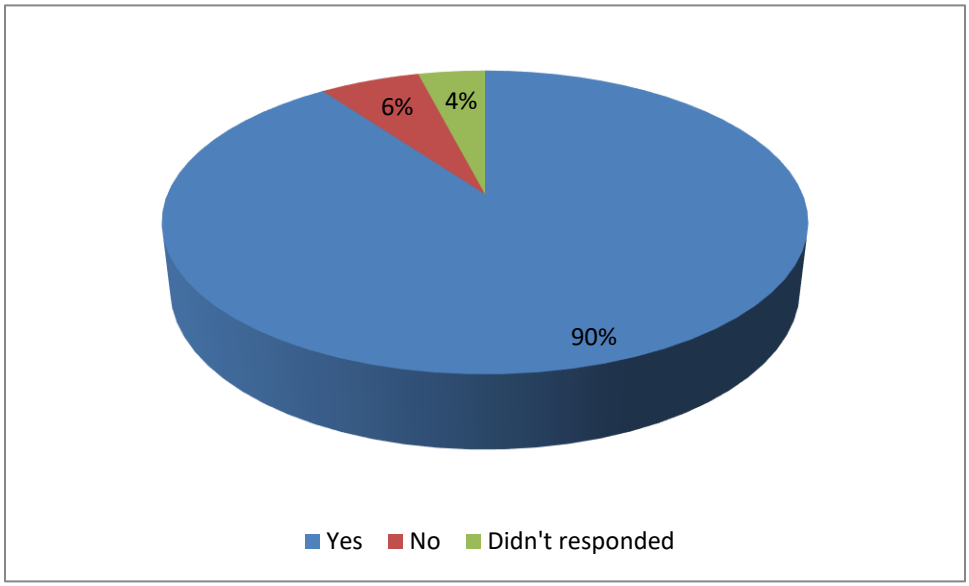


Fig.7 shows that 90% of the respondents said that medicines were issued to them on time, however 6% of the total respondents reported that medicines were not issued to them on time and the remaining 4% of the respondents didn't responded for the same question.

Figure: 8 Represents the response of the respondents regarding their health needs were catered on time or not

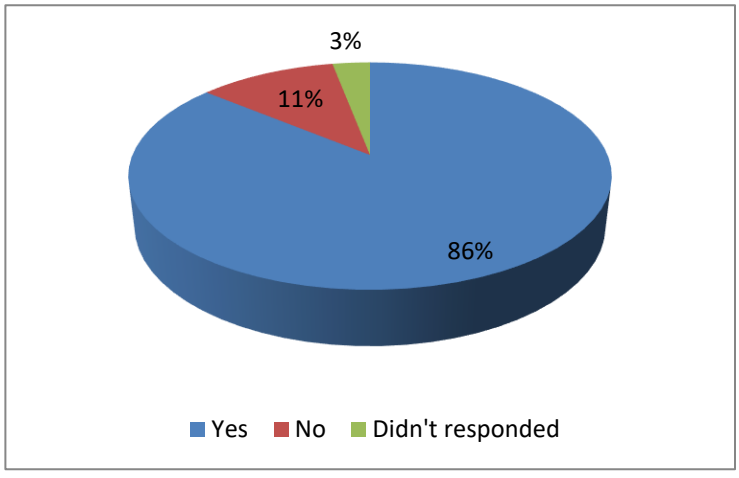


Fig.8 shows that 86% of the respondents said that their health needs were catered at ARV, however 11% of the respondents said that their health needs were not catered at ARV and the remaining 3% of the remaining respondents didn't responded for the same question.

Figure: 9 Represents the response of the respondents regarding the services were available at the time they visited ARV (Arogaya Rath Vahan)

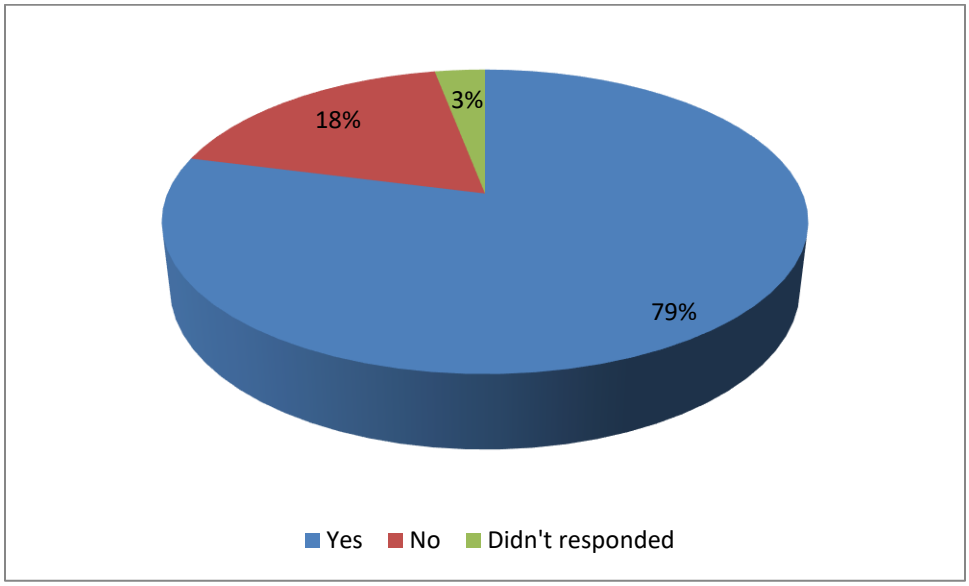


Fig. 9 shows that 79% of the respondents said that the services were available on time at the ARV, 18% of the respondents said that services were not available on time and the remaining 3% didn't responded for the same.

Figure: 10 Represents the response of the respondents against the satisfaction they had with the services provided by the ARV (Arogaya Rath Vahan)

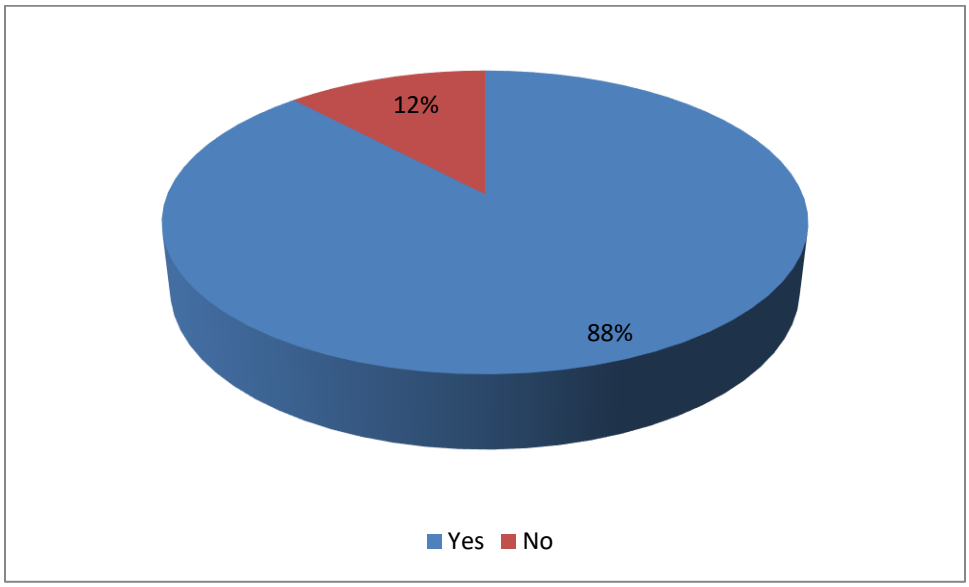


Fig. 10 shows that 88% of the respondents were satisfied by the services they received from ARV and the remaining 12% of the respondents were not satisfied by the services they received from ARV.

Figure: 11 Represents the behavior of the staff of ARV (Arogaya Rath Vahan)

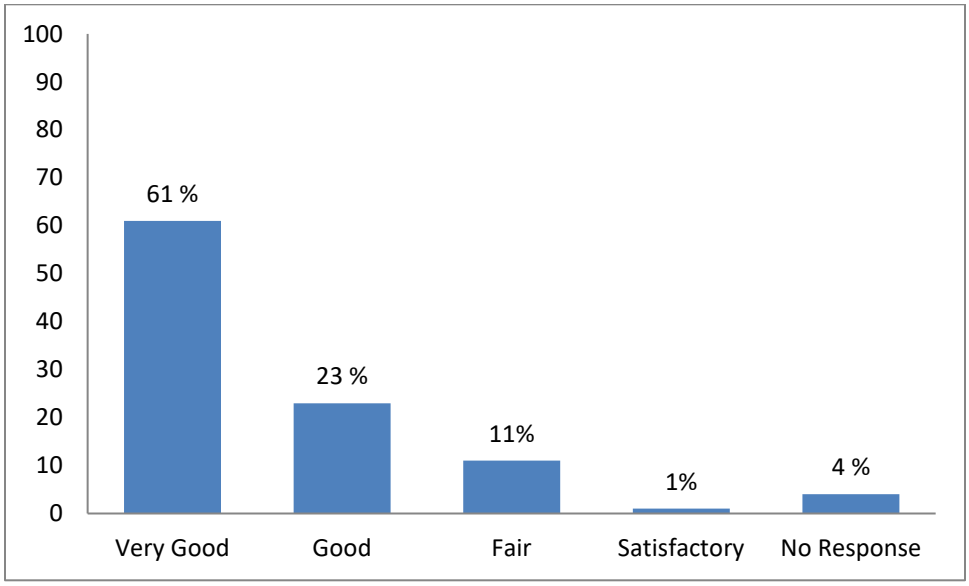


Fig.11 in the above graph shows the response of the respondents they made on the behavior of staff when they visited ARV as 61% of the respondents says that the behavior of the ARV staff was very good, 23% said that it was good, 11% said that it was fair, and 1% said that it was satisfactory however the remaining 4% didn't responded for the same.

Figure: 12 Represent the awareness the respondents had about ARV(Arogaya Rath Vahan) visits and work

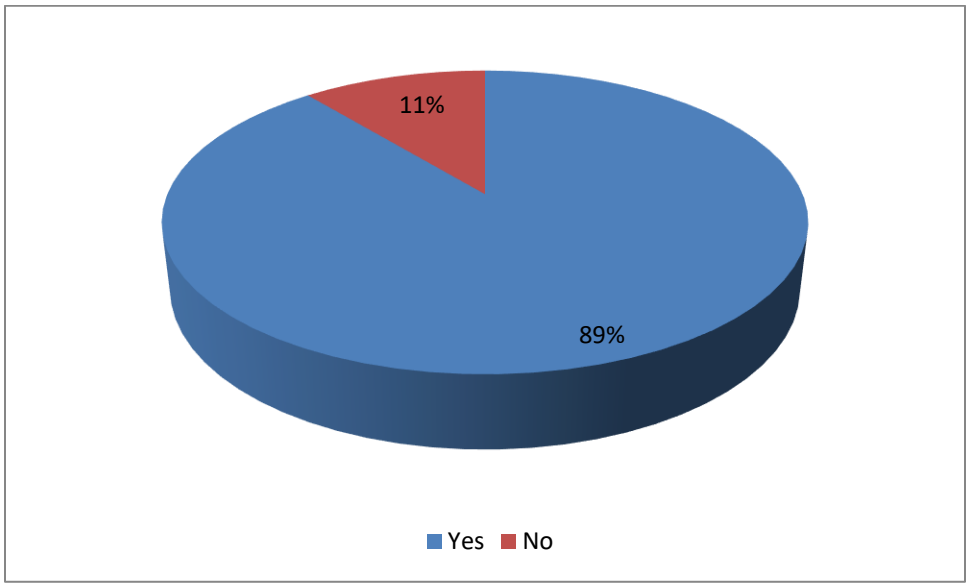


Fig. 12 represent that 89% of the people had awareness about ARV and the remaing 11% didn't had awareness about ARV.

8.0DISCUSSION

The majority of the respondents were females at the time of the study (table:). The services attracted females most probably because of the kind of services offered, antenatal care, family planning, post-natal care and immunization that are more female oriented, however there was no specialized service for the males such as urology. It was also seen that majority of the respondents were APL (Fig.:) and the BPL category were less in number. The study showed that in terms of distance, ARV (Arogaya Rath Vahan), was accessible to most of the respondents as most of the respondents lived within less than one km. (table:)of the location of ARV (Arogaya Rath Vahan), according to IPHS standards and a study conducted in Khulna city of Bangladesh also support the fact that distance and the time taken to travel the health facility are a measure of accessibility to the health facility.[13,16]The study revealed that all the services provided by the ARV (Arogaya Rath Vahan) were utilized i.e. family planning, curative, diagnostic and immunization. However immunization and antenatal services were maximally used, which shows a change in the thinking of people regarding RCH (Reproductive and Child Health) services, however previous studies shows that in the past decades there were certain barriers related to immunization coverage in India [14] and one of them was accessibility and behavior which is catered by Rajbhra ARV (Arogaya Rath Vahan).

Study shows that only 11% of the total women of the reproductive age group reported for family planning services. And total of 11 respondents reported for Voluntary Counseling and Testing, and 4 respondents came to ARV for tuberculosis treatment. 70% of the total respondents utilized one service at a time From ARV and the remaining respondents utilized more than one service at a time from ARV. 88% of the respondents said that they did received all the services that they wanted, when they visited the ARV, 61% of the respondents reported that the nature of the staff was very good and 89% of the respondents had awareness about ARV that ARV runs in the blocks of Almora districts.

9.0 CONCLUSION& RECOMMENDATIONS

Current study found that the health needs of the people were met, people were also satisfied with the services being provided, nature of the staff and the availability of services and medicines at the ARV Almora. However, minority of the people were not satisfied because of the long queues. Rajbhra ARV has acted as a model that has made primary healthcare available to the masses at their doorstep, especially in a state like Uttrakhand where Geographical constraints act as an hindrance in providing basic primary healthcare services to the people.

- ARV should also work on providing diagnostic and emergency support to the people.
- More support staff should be employed in order to enhance functioning of the ARV.
- One of the main problem that was observed was the frequency of visits of ARV, i.e. ARV should visit more frequently on the designated stoppage, so that follow up with the patients can be made.
- Government should increase the number of ARV running in the district.
- There should be strict monitoring of the project.

10.0 REFRENCES

1) David Hall.Public-Private Partnerships (PPPs).PSIRU, Bussiness School, University of Greenwich, Park Row, London. U.K;EPSU;Oct. 2008. 26
2) PPP: the Gujrat Experience 2009 Dec. [cited 2013. Feb. 25] Avialable from :http://www.india-seminar.com/2009/604/604_leela_visaria.htm
3) James Warner Bjorkman, A. Venkat Raman. Public-Private Partnership in Healthcare Delivery: Context, Outcomes and Lessons in India. 13 thWinelands Conference on Public Administratio; 2-4 April. 2012; University of Stelenbosh, Republic of South Africa.
4) Irina A. Nikolic and HaraldMaikisch. Public-Private Partnerships and Collaboration in the Health Sector An Overview with Case Studies from Recent European Experience. HNP Discussion Paper. Oct. 2006; Vol. 1: 25
5) Study Backs in PPP in Healthcare. Express Healthcare:2008 October
6) Nirvikar Singh. Public Private Partnership for Healthcare in Punjab. CASI Working Paper Series – Sept. 2011; Vol. 11 (02): 81
7) Penchasky R. Access: Defination and Measurement of Medical Care. 2001; Vol. (19): 127-140
8) Donald K.T.Li. Primary Care in Hong Kong.Asia Pacific Family Medicine.2003;March,28; Vol. (2), Issue (1); 2-4
9) Bell, R., Ithindi, T. & Low. Improving equity in the provision of primary health care: lessons from decentralized planning and management in Namibia.Bulletin of the World Health Organization.2002; Vol. (80): 675-681
10) Chatora RR, Tumusime P. Primary Healthcare Research and Development. Cambridge Journal. 2006; Oct.,31; Vol. (5), Issue (4):296-306
11) Mohammad Sariful Islam &Shamimumima Akhtar. Measuring physical accessibility to health facilities-case study of Khulna City. World Health and Population Journal.2011; Vol. (12), Issue (3)
12) Suresh Sharma. Immunization Coverage in India. Population Research Centre, Institute

of Economic Growth. 2007; Vol. 283

13) Kathleen Sebelius, Thomas R. Frieden, Edward J Sondik.Health United States, with Special Features on Death and Dying.Wahington DC: U.S Department of Health and Human Services, Centre for Disease Control and Prevention, National Centre for Health Statistics; Feb.-2011. Report no. 76-641496

14) Janet Currie, Patricia Reagon. Distance to Hospital and Children's Access to Care: is being closer better and for whom. Ohio State University.1999;September

11.0 QUEISTIONNAIRE FOR RAJBHRA ALMORA ARV

INSTRUCTIONS

- Please read the questions carefully. Tick the appropriate answer with an X in the space provided. Provide information/ explanation where needed.
- In case of minors, the parent/ guardian may complete the questionnaire.
- Please answer the questions as honestly as possible.
- The information obtained will be used for research purposes only, not for personal gains.
- The responses to the questions will be taken as presented by the respondents.
- Taking part into this study will remain anonymous.

QUESTIONS

Name of the Block:

Date:

DEMOGRAPHIC DATA

1. Participant:

Self		Parent/guardian	

2. Age:

Under 5 years		6-15 years		16-25 years		26-35 years		36-45 years		Above 45 years	

3. Gender:

Male		Female	

4. Do you belong to APL category?

Yes		No	

5. Address: …….

…….

…….

6. What distance do you travel to reach ARV (Arogaya Rath Vahan)?

Less than 1 km		2 – 5 km		5 - 10 km		Above 10 km

7. How long does it take you to reach ARV (Arogaya Rath Vahan)?

Less than 30 min		30min – 1hr		More than 1hr

ARV INFORMATION

1. Reason(s) for coming to the ARV (Arogaya Rath Vahan)

Name of disease	**Response**	**Name of disease**	**Response**
Nervous System		Malnutrition	
Infectious Disease		Tuberculosis	

Wound		Skin infection	
ENT		Leukoderma	
Ophthalmic		Rabies	
Respiratory		Fungal disease	
Cardio Vascular		Gynecological	
Gastrointestinal		ANC	
Acid peptic disease		PNC	
Anemia		Immunization	
Orthopedics		Leprosy	
Family planning services		Voluntary counseling and testing	
Water born disease		Miscellaneous	

10. How many check-ups did you get today?

1		2-3		4-5		Above 5	

11. When you reached ARV whom were you seen first by:

Doctor		Nurse	

12. Did they refer you to?

Doctor		Hospital		Specialized services		none	

13. Prescription (medicine) chart issued

Yes		No	

13.1 If yes all prescribed medicine were issued?

Yes		No	

13.2 If no, why? .....

14. Were all your health needs (what you came for) attended to?

Yes		No	

14.1 If no, give reason(s): …….

…….

15. The service(s) that you use or need, are they available every time you visit the ARV (Arogaya Rath Vahan)?

Yes		No	

15.1 If no, give reason(s): …….

16. Are you satisfied with the services that are available at ARV (Arogaya Rath Vahan)?

Yes		No	

16.1 If no, give reason(s): ……..

……..

17. Would you recommend someone (friend / family) to come to the ARV (Arogaya Rath Vahan) when they are sick?

Yes		No	

17.1 If no, give reason(s): ……..

……..

18. In your opinion is there anything that you feel need attention or to be changed?

Yes		No	

18.1 If yes, give details: ……

……...

……

Thank You