PUBLIC PRIVATE PARTNERSHIPS IN HEALTHCARE

OUTSOURCING OF MOBILE MEDICAL UNITS IN CHHATTISGARH

A CASE STUDY

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SUPPORTED BY: OXFAM INDIA

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PHOTO CREDIT

Cover page photo taken in Durgkondal, Kanker by Sulakshana Nandi

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I. INTRODUCTION

The Mobile Medical Unit (MMU) has often been seen as an effective strategy for providing health services in remote and rural areas. The first MMUs or 'Mobile Health Units' were introduced in 1951 in tribal areas in order to provide health services to 'underserved and inaccessible' areas (Dash et al, 2008). Subsequently, the concept was adopted by various states. They are designed as "portable and self-contained vehicles managed by teams that provide medical services" and are ideally administered by the Primary Health Centre (PHC) and its Medical Officer(Dash et al, 2008).The National Rural Health Mission (NRHM), renamed the National Health Mission (NHM),too promoted the concept of MMUs. The NRHM mission document under the component of "Strengthening Disease Control Programmes" mentions that the provision of a Mobile Medical Unit at district level for improved Outreach services has been made. The NHM Operational Guidelines for MMU, 2015 states that MMUs were envisaged under NRHM "to provide a range of health care services for populations living in remote, inaccessible, un-served and underserved areas mainly with the objective of taking healthcare service delivery to the doorsteps of these populations". It suggests three broad models of operationalizing MMUs (NHM, 2015):

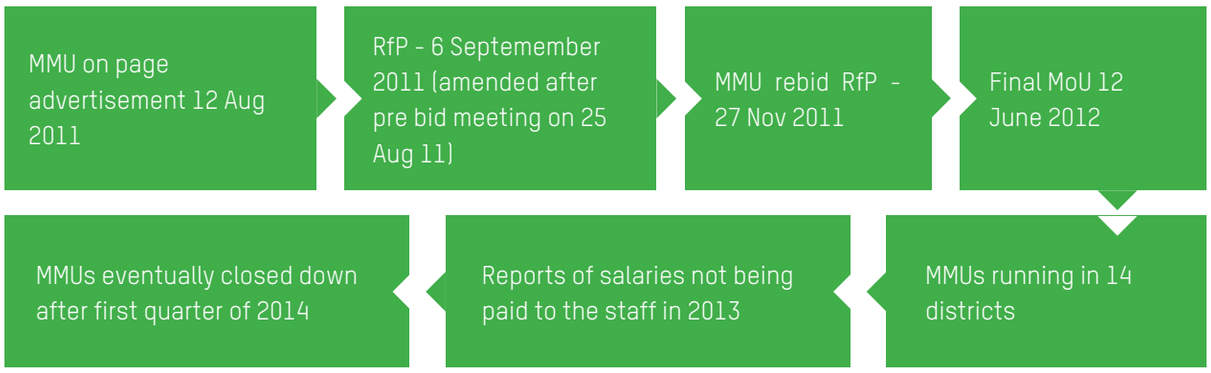
a. Government operated MMU

b. Operation of MMU on Outsourcing basis- Capital expenditure & drugs and supplies provided by Government

c. Outsourcing of MMU services with government providing Capital expenditure, operating expenditure and drugs and supplies.

In Chhattisgarh the MMUs that were introduced in 2012 through PPP mode, did not come under any of the above categories as the government provided operating costs and part drugs and supplies but did not provide any capital expenditure. MMUs were started both in rural and urban areas. However in this study only the rural MMUs have been studied. After inviting tenders and the bidding process through the State Health Resource Centre (SHRC) in August 2011, the operation of a fleet of 30 Mobile Medical Units was rolled out in a phased manner starting from August 2012 in 10 districts. Most of these districts were those affected by 'Left wing extremist' (LWE) conflict. The scheme was finally rolled out in 14 districts. The aim was to provide primary health care services in the remote and difficult-to-access areas through mobile units. However, after almost a year the private entity halted its service and eventually the government terminated the contract.

Figure 1: Timeline of operationalisation and closure of the outsourced MMUs



This study was undertaken in order to understand the reasons for introducing outsourcing of MMU, analyse its performance, evaluate its impact on the community for which the initiative was started and understand the reasons for it closing down.

II. METHODOLOGY

This study was a qualitative case study that involved data collection through individual and group interviews and review of documents.

Sampling

Out of the 14 districts in which MMUs were operational, two districts were selected for the study, based on geographical considerations. These districts were Kanker district in Bastar zone (South Chhattisgarh) and Surguja district in Surguja zone (North Chhattisgarh). Two blocks were selected from each district for the primary study.

In Surguja, two blocks of Udaipur and Lakhanpur were chosen while Koylibeda and Durgkondal were selected in Kanker on the basis of remoteness, with some means of access.

Data collection

The methodology involved collection of primary data through interviews with Health officials and community members and review of documents. Discussions were held with the community and community health workers (Mitanins) in five locations (three in Kanker and two in Surguja) where the MMU used to provide services.

For primary data collection checklists were prepared separately for different stakeholders. Existing reports and documents related to the contractual and operational aspects of MMUs were reviewed. The findings from these documents constitute a large part of the findings on these dimensions, asless information was available from the administration. Due to limited involvement of the BMOs in running of the MMUs not much information could be sourced from them. Hence, other health facility staff and Mitanins were interviewed. CMHOs could not be interviewed as in one district, the CMHO refused to be interviewed without an official letter from the government while in the other district, the CMHO remained unavailable for interview despite repeated visits to his office. Informed consent was taken verbally from all respondents.

Table 1: List of interviews and group discussions

State Level Officials	Interview with the then State Nodal Officer for the initiative			
	Durgkondal	**Koylibeda**	**Lakhanpur**	**Udaypur**
District Level officials and health staff	i. BMO ii. MO CHC iii. Group Interview with PHC staff and a Mitanin (4 participants)	i.BMO	i. RMA-PHC ii.BMO Not able to give any information on MMU as block office did not have any contact with running of MMUs.	i. BMO not able to give any information on MMU.
Interviews with the community and community health workers	i. Individual interview with Mitanin ii. 1 Group Interview with 6 Mitanins	One group interview (20 Mitanins in cluster meeting)	Two Group Interviews i. 5 Community members ii. Mitanins & anganwadi worker (5 nos.)	One group Interview with 6 community

Table 2: List of documents/reports reviewed

S No	Documents reviewed
1	Chhattisgarh state PIPs and ROPs from 2006 to 2016
2	MMU RfP, MMU Advertisement, MMU Route Plan and Route Chart, MMU MoU
3	MMU performance reports for five quarters from Quarter 1st 2013- Quarter 1st 2014 submitted by the agency to the government.
4	Monitoring Reports by SHRC (PPP monitoring Cell)
i	Inspection by monitoring team in June 2013 in Surguja zone of 10 MMUs locations
ii	Report prepared through company office visit in Raipur in July 2013
iii	Analysis of work done by MMUs as per information provided by Jain VoW main office to State Health Resource Center for January- March 2014

III. FINDINGS

1. Reasons for introducing Mobile Medical Units in Chhattisgarh

A review of the state NRHM Programme Implementation Plans (PIPs) since 2006 helps to trace the history of introduction of MMUs in the state, their rationale and their outsourcing.

Table 3: MMUs through the NRHM PIPs (2006 to 2015)

Year of PIP	Status of MMU	Proposal
2006-07	74 MMUs already functioning in tribal areas, with funding from state budget	One MMU per district, start with MMUs in eight districts. Jeevan Deep Samiti (The Hospital Management committee) to be responsible for operationalising MMUs
2007-08	74 MMUs are operational in the tribal and conflict affected districts. 10 by NGOs	2006-07 funds to purchase vehicles still under process
2008-09		Same as 2007-08
2009-10	52 MMUs (out of 74) functional (32 in Bastar and 20 in Surguja divisions)	Previous funds to be utilised, along with additional operational costs
2010-11	Budget for purchasing MMUs not been utilized since 2007-08	One prototype MMU has been supplied to the state and procurement is underway
2011-12	Carry over activity from 2010-11	Same as 2010-11
2012-13	MMUs not implemented previously due to procurement issues	MMUs will be outsourced to private agency
2013-14	30 MMUs outsourced to private agency	16 new MMUs proposed in addition to previously outsourced 30 MMUs
2014-15	Outsourcing of MMUs has been stopped	Government itself would run the MMUs. Number of MMUs increased from 30 to 37

The review of the PIPs shows that prior to NRHM being launched, the state government was operating MMUs in tribal districts. After NRHM, the opportunity for availing funds for MMUs opened up, with the objective to "take health care to the doorstep of the public in the rural areas, especially in under-served area" (2006-07). In consecutive years, the state government budgeted for it in the NHRM PIPs. However, the MMUs could not be made operational due to procurement issues and the funds kept getting carried over. Finally, in 2011-12, the government decided to outsource it and signed a contract with a private agency in the financial year 2012-13. In 2014-15 the PIP stated that the outsourcing has been stopped and it was decided that the government itself would run the MMUs.

2. Selection of the agency and roll out of the initiative

The selection of the agency was done at the state level. On 12th August 2011, the government put up an advertisement on its website, inviting agencies to apply for operating MMUs.

The advertisement,which was posted on behalf of MD, NRHM, invited agencies/companies to run Mobile Medical units in underserved areas of Chhattisgarh. The agency was to be contracted by the State Health Society and "will be required to organise delivery of an agreed package of services through pre selected points". Proposals were to be submitted to the State Health Resource Center(SHRC).

A pre bid meeting took place on 25 August after which an amended Request for Proposal (RfP) was put up on the website by the State Health Resource Center (SHRC). SHRC was the third party involved by the state government to engage in the contracting process and for the purpose of monitoring. This revised RfP had slight changes in conditions. In this RfP, Director Health Services, Government of Chhattisgarh and not MD NRHM, as in the original RfP, invited proposals.A comparison between the two RfPs and the MOU can be found in Annexure 1.

Thereafter the agency was selected and the MoU signed on 12th June 2012. Delhi based agency, 'Jain Video on wheels' was selected after the entire process. Around the same period,Jain Video on Wheels was named as one of the agencies in a high profile 'scam' over purchase of mobile medical units in NRHM Uttar Pradesh[1]. It was subsequently also involved in a legal issue with the state of Bihar over delayed payment to staff of ambulances that it was running in 2014[2].

The project was to be rolled out in 10 districts as per the RfP. This was changed in the MOU to allow expanding it to additional districts as may be required (Annexure 1). In the final operation of the scheme, 14 districts were being covered. Four districts of Balrampur, Sukma, Kondagaon, Surajpur were added as they had been newly formed.

3. Salient features of the MoU in terms of services to be provided by the MMUs

The MMUs, as per the MoU, were assigned the tasks in terms of delivery of minimum services for primary healthcare in remote villages. This was charted out in the list "Minimum Services to be Delivered" and included Curative, reproductive and Child health services, Family Planning Services, Diagnostic Services. Each MMU was to have atleast five staff- doctor, ANM, Lab technician, Pharmacist cum data entry operator and driver. Each MMU was expected to hold 20 village health camps in a month preferable at weekly/haat bazaar sites, the duration of campsite to be atleast 7 hours. There were incentives for holding more than 20 camps. The vehicle cum medical unit was to be arranged by company on its own. The medicines, vaccines, contraceptives and IEC materials were to be provided by the CMHO while the private agency was required to arrange equipment and supportive supplies like weighing machine, BP apparatus, surgical instruments, disinfectant, delivery kits, microscope, semi auto-analyser, reagents for diagnostic tests, lancet and slides for microscope, pregnancy detection kits, rapid diagnostic kits, test tubes and other necessary lab supplies.

4. Functioning of the MMUs

Number and location of the MMUs

The 30 MMUs were distributed across 14 districts and stationed at base locations(Annexure 2). Base locations are the sites usually at the block level facility (CHCs) where MMUs would be parked and from where it would operate. From the base locations, the MMUs would travel to the assigned venues for camps as per the monthly route chart/plan.

In Kanker there were two bases for MMU, one at Antagarh, which served the Koylibeda area and the other at Durgkondal that served the Pakhjanjur area (BMO, District Kanker) (refer to Annexure 3). As per the route plan available in public domain, the MMU at Antagarh block as base served the Antagarh and Koylibeda area. The MMU in Durgkondal block as base served in Pakhanjur and Durgkondal. For Surguja, there were three base locations; Lakhanpur (MMU 1), Sitapur (MMU 2) and Ambikapur (MMU3) (Annexure 3). MMU 1 that was based in Lakhanpur served the blocks of Lakhanpur and Udaypur, MMU 2 based in Sitapur served Batauli, Sitapur and Mainpat blocks and MMU 3 based in Ambikapur served Ambikapur and Dhaurpur blocks.

The monthly schedule for the MMUs was planned from the CMHO office mostly according to the weekly markets that were held in villages. This was confirmed during the discussions with community members at the camp

[1] http://www.firstpost.com/india/ias-topper-is-prime-suspect-in-nrhm-scam-in-up-265962.html
http://www.firstpost.com/india/former-up-health-seccy-arrested-in-nrhm-probe-304700.html
[2]http://www.downtoearth.org.in/news/bihars-ambulance-service-staff-go-on-strike-43487

locations. Therefore most of these camp locations were less remote village, with some road infrastructure and often with a PHC nearby. Of the five camp locations where discussions were held with community members and CHWs, one was in the block town (Durgkondal) itself, with the CHC only half a kilometre away. In two camp locations, the PHC was also co-located, while in one place a PHC was subsequently sanctioned and set up.

Discussions with community members and Mitanins revealed that for locations that did not have a health facility nearby, it was convenient for the community to receive services in their village itself. For instance, in Patkurra village, there was a sub center but it was non-functional due to non-availability of ANM and therefore people had to travel more than 18 kms to reach the nearest PHC. Once the MMU started, people got medicines in their village itself. Similarly, people in Konde had to travel nearly seven kms to the nearest PHC and found it convenient that the MMU would come to their village. Later a PHC was established in this village. In Kapse, though there was a PHC, there was no permanent posting and the RMA would visit only thrice a week therefore they were happy about being able to consult a doctor in the MMU. In Durgkondal where the MMU set up camp near to the CHC, respondents said that this just made it convenient for the people coming to the Durgkondal weekly market. They could get treatment for minor ailments from the MMU instead of going to the CHC, which was usually very crowded on market day.

A RMA in Surguja said that earlier the PHC would organised health camps and checkups in the remote villages. But after the mobile medical units were introduced, this was discontinued and as a result, the remote villages could not be covered anymore. He contended that only people who were living near the haat bazaar area had benefitted from the MMUs while the remote villages still remained without services.

Frequency and regularity of the MMU camps

In terms of frequency and regularity of MMUs, the experience was mixed for community members. In some locations, community members said that in the locations with the weekly market, the MMU would usually come on the day of the weekly market and stay for five-six hours. But in Konde and Kedma, people said that it would not come every week.

In villages that did not have a weekly market, there were more issues with regards to the MMU following the weekly schedule. For example, people in Patkurra (Surguja) said that there was no specified day of the week for the MMU visit. It would suddenly arrive one day, with no prior information to the *Mitanins* or the community. Once in the village they would announce their arrival through loudspeaker and take the help of the *Mitanins* to call people for treatment and often make the *Mitanins* stay with the MMU for the whole period.

An RMA who was in charge of a PHC said that there was no pre- information about the MMU visits as the PHC would not be kept in the loop about it. He expressed his dissatisfaction at the quality of services being provided by the MMUs and is happy that the MMUs closed down (RMA, Surguja).

Third party monitoring by SHRC also reveals that the MMUs were often not regular. In June 2013, the inspection team from State Health Resource Center visited the Surguja zone where it inspected 10 MMU sites. Seven of these MMUs were found to be operational (Ambikapur, Lakhanpur, Surguja, Bagicha, Jashpur, Baikunthpur, Manendragarh) while three of the MMUs (1 in Sitapur, 2 in Balrampur) were not in use due to unavailability of doctors.

They found that there was no pattern in the campsites of the MMUs (SHRC, 2013a). They suggested that every month two days should be fixed for each MMU camp so that the community is also aware of the days. Moreover, they stressed that, as mentioned in the MoU, seven hours of service for every camp has to been ensured, as it was not happening (SHRC, 2013a).

Further, the SHRC analysed information provided by Jain VoW main office to State Health Resource Center for the months of January-March 2014[3] and concluded that in 'Left wing Extremist' (LWE) affected area camps are not being held, the main reason being the unavailability of doctors (SHRC, 2014). For instance, in January and February 2014, four of the 30 MMUs did not organize any camps. Of the remaining 26, eight MMUs in January and 12 in February organised less than the stipulated 20 camps in a month. In March 2014, 14 out of the 17 operational MMUs organised less than 20 camps in the month. In three LWE affected blocks (Kondagaon, Bhairamgad, Bijapur), the MMUs were not functional throughout this period. This means that the MMUs were not functioning in the more remote areas.

5. Human Resource for the MMUs

The HR for the MMUs were recruited by the private agency, with the CMHO office verifying the documents of the MMU staff in all the districts where MMUs were operational (State Nodal Officer).

The main issues related with HR that emerged during the study were that ofhigh attrition rate of the doctors and irregular salaries. A BMO in Kanker said that the salary to the MMU staff would not be given on time, resulting in low morale and de-motivation for the MMU staff. Moreover, there was a difference in the salary promised in the contract and actual salary received. He said that retention was an issue and doctors would change frequently (BMO, Kanker). Another issue that emerged was related to the quality of HR that was posted in the MMU. A CHC MO in Kanker said that according to him the staff recruited in the MMU did not have the requisite qualifications and that proper verification of documents had not been done. Community members said that in most of the MMUs, there seemed to be around 4-5 staff members, including one doctor.

The monitoring report by SHRC also states that the MMU staff in Surguja region had not been paid salaries for many months, which resulted in high attrition rates and posts lying vacant (SHRC, 2013a). They found that in four blocks, the post of doctor was lying vacant and that Lab technicians in two blocks had gone on leave, without any alternative arrangement being made by the agency (Table 4).

Table 4: Availability of staff in the MMU (SHRC, 2013a)

S. No.	Sample blocks	Availability of all 5 staff members*	Remark
1	Ambikapur	N	Staff had not been paid for a month
2	Lakhanpur	N	Lab technician was absent
3	Surajpur	N	Post of doctor was lying vacant
4	Manendragarh	Y	
5	Baikunthpur	Y	
6	Bagicha	Y	
7	Jashpur	N	Post of doctor was lying vacant. Staff had not been paid for a month. Lab technicians were absent.
8	Sitapur	N	Post of doctor was lying vacant.
9	Balrampur - 1	N	Post of doctor was lying vacant.
10	Balrampur - 2	N	Post of doctor was lying vacant.

Source: Tabulated on the basis of SHRC 2013a report

*The five designated staff -Doctor, ANM, Lab Technician, Pharmacist and driver.

Moreover, the SHRC Report of the visit to the company office in Raipur in July 2013 states that only five MMUs (Bhaiyathan, Surajpur, Rajpur, Koriya, Jagdalpur) out of the planned 30 MMUs were fully functional. Nearly23 MMUs were non-functional due to unavailability and non-recruitment of doctors, while the doctors of other two MMUs were on leave. Raipur office officials said that there were delays in appointment from the head office of

[3] SHRC Monitoring reports. Available at: http://www.shsrc.org/PPPCellReports.htm

Jain Video on wheels head office in Delhi, which could be avoided if the recruitments took place in the state office in Raipur (SHRC, 2013b).

6. Services provided by the MMU

The information on services that were provided by the MMUs was elicited from three sources- a) Discussions with community members and Mitanins CHWs b) Agency's self reported mandatory disclosure and performance reports c) Monitoring reports by SHRC (third party). Community members and CHWs mainly talked about convenience and availability of staff as a positive feature in MMUs.

However, a number of community members stated problems like the MMUs not being regular, not having a fixed day for visit, providing very basic treatment and not providing ANC services.

Quantum of service provided

As per the MOU, the agency had to submit regular performance reports. On the Chhattisgarh Government Health website, five Performance Reports are available, from quarter 1 in 2013 to quarter 1 in 2014 (Q1 2013 to Q1 2014, March Data Performance Report, MMU data sheet Sept- Nov, mandatory disclosures).

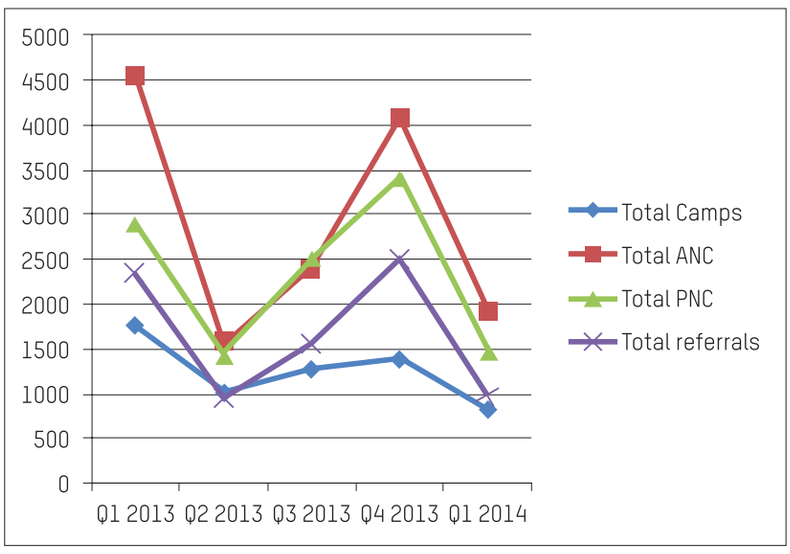
In comparing the MMU's performance for five quarters, between 2013 and 2014, we find a decrease in services provided, from quarter 1st in 2013 to quarter 2nd in 2013 then an increase and then again a sharp decline in the first quarter of 2014. The Table and Graph below illustrate this trend:

Table 5: MMU Performance Reports for whole of the state (Q1, 2013 to Q1, 2014)

Indicators	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014
Total Camps	1757	1013	1278	1391	800
Total OPD	89260	54169	69991	87002	39776
Total ANC	4550	1573	2376	4065	1924
Total PNC	2898	1443	2516	3414	1465
Total Diagnostics done	14703	7704	10148	12906	5869
Total referrals	2344	939	1548	2526	944

Source: MMU Performance Reports Available at: http://cghealth.nic.in/ehealth/conditionalities/conditionalities.html

Figure 2: Quarter wise Trend for selected MMU Performance Indicators for the whole State (14 districts)



Similar trends are observed in the performance of Kanker and Surguja districts through the five quarters.

Table 6: MMU Performance Reports for Kanker and Surguja (Q1, 2013 to Q1, 2014)

Indicators	Kanker					Surguja				
	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014
Total Camps	112	57	90	91	37	170	75	136	180	66
Total OPD	6423	3447	5224	5377	2260	8459	3358	6434	10426	3426
Total ANC	115	27	109	171	113	794	168	200	484	175
Total PNC	89	9	33	78	83	478	129	775	295	111
Total Diagnostics done	1057	613	990	1439	605	2259	572	921	1529	473
Total referrals	19	1	59	56	21	550	128	253	397	49

Source: MMU Performance Reports

Nature of services provided

The monthly mandatory disclosure report[4] for Quarter 1, 2014, enumerates the services being provided by the MMUs. They include OPD, Ante-natal Care, diagnostics and referrals. However, contrary to the report, the community members who were interviewed emphasised that no ANC services were being provided by the MMU. They said that the MMU staff would treat minor illnesses, some mentioned illnesses like cough, cold, fever, and body ache. For any other illness, people would have to visit the nearest government health centre.

The following services, though included in the MOU, were not being provided by the MMUs (MMU Monthly Report):

(i) Immunization of children

(ii) Family Planning Services (OCP/ECP, Condom, IUCD)

(iii) Surgical operations

(iv) Screening Children under RBSK

(v) Blood smear collection/RDT tests

(vi) Sputum collection

(vii) X-Ray

According to the community members, there seemed to be sufficient availability of basic medicines in the MMU. According to them, the MMU staff would do blood tests and urine test. In Surguja, they mainly did malaria tests. In Kanker district, while in Konde, people said that they would get the test reports by evening, in Kapse, they would get the reports the next time the MMU came to their village. In none of the locations were there any incidents of demands for money.

The block officials were quite critical of the MMUs. One BMO in Kanker said that their performance was not satisfactory and the MMUs would not do their jobs properly (BMO, Kanker1). He said that he had visited these camp-sites and was not satisfied with the work of the MMUs. He said that the conditions that were to be fulfilled and services that were to be provided by MMUs like test for pregnant women, medicine dispensation etc were not being fulfilled.

[4] MMU Monthly Report. Available at: http://cghealth.nic.in/ehealth/conditionalities/conditionalities.html

Monitoring visits reports of the Third Party states that primary treatment for diseases such as TB, Leprosy, local endemic contagious diseases, high blood pressure, diabetes, cataract, mental illness, tobacco related diseases, and treatment to minor surgical cases are not being provided by the MMUs (Table 7)(SHRC, 2013a). Further, with regards to family planning, other than counselling services, and distribution of consumables like condoms, no other services were being provided (Table 7), the reason for which was reported to be the lack of training to the staff and supply of family planning related consumables like IUCDs.

Table 7: Availability of services and diagnostics in the MMUs

S. No.	Sample Blocks	Services/diagnostics provided							
		Urine Test	Malaria test		Vidal test	Pregnancy test	Blood test	Family planning services	Primary treatment for diseases*
			PF	PV					
1	Ambikapur	Yes	Yes	No	Yes	Yes	No	Yes	No
2	Lakhanpur	Yes	Yes	Yes	No	Yes	No	Yes	No
3	Surajpur	Yes	Yes	Yes	No	Yes	No	Yes	No
4	Manendragarh	Yes	Yes	No	No	No	Yes	Yes	No
5	Baikunthpur	Yes	Yes	No	No	Yes	No	Yes	No
6	Bagicha	Data not available							
7	Jashpur	Data not available							
8	Sitapur	MMU not functional due to unavailability of doctor							
9	Balrampur- 1	MMU not functional due to unavailability of doctor							
10	Balrampur- 2	MMU not functional due to unavailability of doctor							

Source: Tabulated on the basis of SHRC 2013a report

*Such as TB, Leprosy, local endemic contagious diseases, high blood pressure, diabetes, cataract, mental illness, tobacco related diseases, and treatment to minor surgical cases

As per norms, all MMUs are supposed to have supplies like reagents for examination, like slides, lancets, Pregnancy Detection Kit, Rapid Diagnostic Kit for Malaria, test tube and other important lab supplies however, the team found that reagents, stains and other consummables were not being supplied by the private agency. For instance, there was no cover slip for microscope available and hence Urine Microscopic Test could not be done. However, as the monitoring reports show, thatwith respect to diagnostics, comprehensive services were not being provided (Table 7).

Moreover, there was a lack of sufficient supply of child drugs as a result of which diseases related to children were not treated in the MMUs. Due to unavailability of buffer solution, spirit lamp, distilled water supply, sickle tests cannot be done at MMUs. In some cases Haemoglobin test could not be done, as the haemoglobinometer wasnot available (Table 8). Similarly, the team found that in some places there was no Semi auto analyser and infant weighing machine and BP machine were not working (Table 8).

Table 8: Availability of Instruments & equipment in the MMU

S. No	Sample Blocks	Availability of Instruments & equipment				
		Microscope	Semi autoanalyser	Infant weighing machine	BP machine	Three sets of surgical equipments
1	Ambikapur	Y	Y	NWC*	Y	Y
2	Lakhanpur	N	N	Y	Y	Y
3	Surajpur	N	N	N	Y	N
4	Manendragarh	Y	Y	Y	NWC*	N
5	Baikunthpur	Y	Y	Y	Y	Y
6	Bagicha	Y	Y	Y	Y	N
7	Jashpur	Y	Y	NWC*	Y	Y
8	Sitapur	MMU not functional due to unavailability of doctor				
9	Balrampur- 1	MMU not functional due to unavailability of doctor				
10	Balrampur- 2	MMU not functional due to unavailability of doctor				

Source: Tabulated on the basis of SHRC 2013a report

* NWC- Not in working condition

7. Monitoring

For monitoring at the state level, one nodal was appointed from the company and one from within the health department (State Nodal Officer). The SHRC was designated as the third party agency to monitor this PPP (State Nodal officer). Further, as per the MOU, the agency had to submit regular performance reports. On the Chhattisgarh Government Health website, five Performance Reports are available, from quarter 1 in 2013 to quarter 1 in 2014 (Q1 2013 to Q1 2014, March Data Performance Report, MMU data sheet Sept- Nov, mandatory disclosures).

As per design, monitoring was to be done mainly from the district level, through the CMHO office. Therefore, at the block level, there does not seem to have been any monitoring. One BMO (Kanker1) in Kanker of a block where the MMU used to visit said that he was not involved officially in monitoring. He said that the BMO of the block, which is the base location, might be more involved. However, the BMO2 (Kanker2) of the block, which was a base for the MMU, said that there was no significant monitoring of the MMUs by the block office. At the most the block level staff would visit the MMU camp-site, however there did not seem to be any formal mechanism for feedback to the CMHO office.

He also said that the MMU doctor would be called to the block level meetings and coordination would be done with other health staff. The block office would inform the ANMs in advance whenever there had to be health camp by the MMU (BMO, Kanker2). However, he also said that there was no power or control given to the block health office in terms of monitoring and reporting and therefore the agency was lax in their performance. He added that monitoring through the CMHO office for health camps being run in distant remote areas is not very useful (BMO, Kanker2).

The RMA of a PHC in Surguja in whose area the MMU was functional was not aware of the exact frequency of the visits as he said that the PHC staff had nothing to do with MMUs.

"We only gave attendance and paydata of the Staff Nurses to BMO at the CHC" (RMA, Surguja).

As per the MOU, the MMU staff had to get their camp verified each time either by a member of the panchayat or by the Secretary of the Village Health Sanitation and Nutrition Committee who is a *Mitanin* (ASHA). In the discussions with the community, it emerged that in most of the places, the MMU staff got the slip signed by the *Mitanin*.

8. Finances

The Mobile Medical Units were funded under the National Rural Health Mission. The MMU payments were fixed differently for different years of running, adjusted as per escalation rates in the MoU. For second year of their running (2013-14), the MMUs were paid as per the fixed amount of 1,71,600 per vehicle per month for 20 trips made (8580 per day per trip for every vehicle). For every extra or less trips made, bonus/incentives would be paid or penalty levied as per the rules in the MoU.

85% of the bills based on this criterion were to be paid by the government after deducting one third of the mobilization advance (an amount that was paid by the government to the agency within 30 days of execution of agreement) within one month of agency submitting the bill. The remaining 15 % were to be paid after approval from CMHO and Nodal Officer.

During the period of outsourcing, the Government spent more than Rs. 5.9 crore for the MMUs for the period September 2012 to May 2014, in quarterly disbursements, in proportions of 85% and 15% (Annexure 4).

The amount of funds spent by the state on the outsourced MMUs needs to be seen in the context of the funds that were subsequently budgeted by the government for the in-house MMUs. The government budgeted Rs. 2 lakh per month per outsourced MMU in 2013-14, while the amount budgeted for the MMU to be operationalised by the government itself in 2015-16 was Rs. 33100 per month per MMU. This means that the outsourced MMU was six times more expensive than the government MMU as the government MMU could 'piggyback' on existing staff and programmes.

9. Closure of MMUs and current situation

The MMU outsourcing was closed down in 2014. According to the State Nodal officer, the contract of the private agency was cancelled due to their poor performance. After the termination of the contract with the private player, the government is now running its own MMUs in the same areas (State Nodal officer). The non-payment of salaries to the staff was the final straw leading to closure of the service as per most newspaper reports[5].

The 2015-16 PIP annexure on 'Proposal for Primary Health Care Services Through Mobile Medical Units (MMUs)' states that the "Rural MMU service was terminated due to inconsistent and irregular services provided by the private party" and therefore from this year onwards, the government will itself operate the MMUs.

The government currently is running its own MMUs, though it is being run only in some areas (BMO, Kanker 1&2). Since it is a government run program it is monitored from the block office (BMO, Kanker2). They conduct health camps in haats in remote areas. Also instead of MBBS doctors, RMAs have been recruited for the MMUs. In current model two RMAs, two ANMs and a driver go with the vehicle, sometimes along with the pharmacist from one of the PHCs. When there were issues about the pharmacist post lying vacant then one of the two pharmacist from the CHC were recruited for MMU (BMO, Kanker2).

In Surguja too, the government is running mobile ambulance, which is supported from CHC Lakhanpur. The staff is designated to do four health camps in a month. The ambulance stays at weekly market place and gives care and treatment to the community (RMA, Surguja).

The community also spoke of the government MMUs that have started operating in recent years. In Durgkondal, a Mitanin said that after the MMUs closed down, now the government is running the MMUs and they visit both the weekly markets and the interior villages. The community in Konde also reiterated this. However, they said that these MMUs do not have lab facilities, unlike the earlier MMUs. Moreover, the current vehicles are smaller as they are not specifically designed for the purpose of operating an MMU. In Patkurra, the government run medical units come once in a month, with staff from CHC Lakhanpur and the nearby PHC. The staff is supposed to do four health camps in a month. The ambulance stays at weekly market place and gives care and treatment to people there.

[5] http://www.thehindu.com/news/national/other-states/another-ppp-project-halted-in-chattisgarh/article4988863.ece

IV. DISCUSSION

Chhattisgarh as a state faces a number of challenges in ensuring equitable access of people to health services, especially for people living in areas considered 'remote' or 'inaccessible'. Conflict between the state and LWEs in some districts exacerbates the situation. Mobile Medical Units have been identified as a viable strategy for addressing such issues (NHM, 2015). The Mobile medical units in Chhattisgarh were also started with the aim of increasing access of people living in remote areas, to health services and this was enumerated in consecutive PIPs developed by Chhattisgarh. However, when the Government finally decided to roll it out, decision was taken for it to be outsourced to a private agency instead of running it itself. As the study finds, the MMUs were outsourced to an agency with dubious precedents & antecedents. The study finds that to an extent, the MMUs were able to provide services where previously health services were not being provided whether due to lack of human resource or of a health facility. In situations where no health services existed, the community members welcomed it, especially when they were being provided nearer to home.

However, mostly the location for the MMU camps was the village where weekly market was held rather than remote villages. Such villages are usually bigger villages that are not very remote with some road infrastructure and often with a health centre (PHC or sub centre) nearby. In one sample block, the camp was located very near to the block CHC. This means that there was a duplication of services being provided in such area, with the MMU and the health facility covering the same area. Moreover, more remote villages where no government health infrastructure existed seem to have been left out from the MMU services. In the more remote blocks, the MMUs became non-functional very soon mainly due to attrition of doctors.

The interviews and the monitoring reports show that there were serious lapses in regularity and quality of services being provided by the MMUs. This was more the case in the more remote and underserved area. In terms of regularity, the study finds that often the MMUs did not have a fixed schedule and would not operate the camp for the mandated time period. It is clear that they were not providing all the mandated services. Moreover, only selected primary illnesses were treated and no ANC services were provided though they were part of the MoU. As a result, one of the most vulnerable groups with the most in need, the pregnant women, were not able to utilise the services. The agency failed to ensure availability of basic equipment and supportive supplies as per the MOU, along with certain lapses in provision of supplies from the government.

A major reason for lapses in quality and quantity of services was that the private agency too was unable to get health workers to work in remote rural areas and the attrition rate was very high. This was exacerbated by the fact that salaries were delayed, though the study was unable to explore reasons for this delay. Therefore HR shortages continued and many of the MMUs became non-functional due to non-availability of doctors or they functioned without doctors, in violation of the terms of the MOU. It was also found that often the Mitanins (ASHAs) would be called on to serve with the MMUs, without any compensation for their time.

Monitoring was undertaken only in terms of 3rd party monitoring by SHRC and the self-reported performance reports. The power to monitor was centralized at the district level and the BMO who could have actually monitored the MMUs was not given any powers by the district health administration. The district neither established a decentralized monitoring system nor an effective day-to-day monitoring system.

The MMUs seemed to be functioning in parallel to the public healthcare system rather than filling a critical gap where services were not available. There did not seem to be any out of pocket expenditure incurred by the community while getting services from the MMUs. However, the services being provided seem to be very limited and still people had to visit the PHCs or CHC for treatment of illnesses that should have been taken care of by the MMUs. The availability of basic lab facilities was very useful to the community and this highlights the need for providing basic diagnostic services at the PHCs, where often they are not provided. However, the monitoring reports also show that limited diagnostics were being provided and there were shortages in supplies of lab supplies and consumables by the agency. As mentioned above, these lapses and "inconsistent and irregular services" led to termination of contract with the private agency.

The expenditure on the outsourced MMUs was six times higher than expenditure on government run MMUs.

In a situation where health budgets are decreasing, it is pertinent to scrutinise the cost effectiveness of these initiatives.

V. CONCLUSION

The study throws up critical lessons in planning for underserved areas and private sector partnerships. Firstly, study shows that the outsourcing of MMUs did not adequately address the gap that it was supposed to and it was fraught with the same problems of unavailability of HR and medicines and supplies as with the larger public healthcare system. Moreover, it was much more expensive than the government system. Therefore, filling the HR and other gaps in the sub centers and the PHCs could yield better and more sustainable results.

It is pertinent to note that though the rationale given for outsourcing was toserve under- served areas, the more remote areas remained underserved as the MMUs chose to operate in the not so remote areas. Moreover, the MMUs for the more remote blocks became non-functional after some time. With no scope for monitoring at the block level, the block health administration felt very powerless, and was not in a position to intervene in improving the functioning of the MMUs. The partnership with the private agency was finally terminated by the government due to lax implementation. Though the government spent huge amount of funds on them, the MMUs did not give commensurate health services and moreover, currently, there is nothing to show for the MMUs that were functioning. Now that the government has taken over the responsibility of operating MMUs, it seems that they are better able to provide services to the more remote areas though, a proper assessment needs to be done. The study underlies the importance of improving the government's own delivery system in these areas, instead of implementing temporary solutions that also do not adequately address the health needs of people living in these areas.

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VI. ANNEXURES

ANNEXURE 1

Comparison between the amended RfP (6 Sept '11) and the rebid RfP (27 Nov '11) and the final MoU

S. No.	Heads under tender	Amended RfP(6 Sept '11)	Rebid RfP (27 Nov '11)	MoU
1.		Circular released by NRHM CG	Circular released by Govt of CG, DHS	
		The project will be rolled out in 10 districts.	The project will be rolled out in 10 districts.	The directorate may offer the agency to take up additional districts.
2		4 wheel driven Tata 407 chassis	MODIFICATION - 4 wheel driven Tata 407 LPT / 709 or equivalent chassis.	
3	Payment terms	"No escalation cost will be allowed; the bidder has to quote a monthly rate per vehicle that will be valid for thr entire duration of the project, i.e. 5 years. In other words, the bidder has to make an assessment of all costs involved including escalation (e.g. on account of salary increase) or inflation."	MODIFICATION – "Annual Escalation:: The base rate (say, X) determined through bidding will be allowed to increase at the following rates: · Year-2: X * 1.10, rounded to nearest multiple of 10 paise · Year-3: X * 1.20, rounded to nearest multiple of 10 paise · Year-4: X * 1.30, rounded to nearest multiple of 10 paise · Year-5: X * 1.40, rounded to nearest multiple of 10 paise"	
			ADDITION- "Performance Guarantee: The successful bidder will have to provide a separate bank guarantee equivalent to amount that would be payable to the bidder for operating all 30 vehicles for one quarter. In other words, the bank guarantee amount will be 'quoted monthly rate' multiplied by 90. The bank guarantee will be released one quarter before the end of the contract period."	

S. No.	Heads under tender	Amended RfP(6 Sept '11)	Rebid RfP (27 Nov '11)	MoU
4	Procedure for submitting proposals		ADDITION NOTE TO TECHNICAL PROPOSAL- "Note: Certificates issued by the clients in support of ongoing and completed projects is mandatory. The template for obtaining the certificate is given at attachment titled 'Form- C'."	
			*ADDITION- "Financial proposal as per attached format (Form-F):"	
		"The SHRC shall not be responsible for misplacement, losing or premature opening if the outer envelope is not sealed and/or marked as stipulated."	*MODIFICATION – "The State Government, or the agency appointed by it to manage the bidding process on its behalf, shall not be responsible for misplacement, losing or premature opening if the outer envelope is not sealed and/or marked as stipulated".	
5	Templates to be used for submitting proposals		*ADDITION- "Letter of certificate in support of past experience and number of MMUs in operation on the date of submission of tenders should be as per the format given at attached Form C. The letter must be on official stationery of the client(s) giving contact details of the person signing the letter of certificate".	

S. No.	Heads under tender	Amended RfP(6 Sept '11)	Rebid RfP (27 Nov '11)	MoU
6	Evaluation procedure		DELETION- Experience of less than 2 years removed DEL_ less than 10 MMUs deleted MOD- Decrease in weightage to no. of MMUs being operated. MOD- Decrease in weighatge to content of services. ADD- Weightage to geographical spread of the MMUs already being operated by the agency. Client/ state ADD- OR bids not accompanied by bid fee / bid security will be disqualified.	
7	Other terms and conditions	"In case of deficiency in service delivery or required human resources, penalty will be imposed, which will be decided on a mutual agreement basis at the time of agreement."	*ADD- "No interest payable on bid security amount of 1 lakh. " ADD- "In addition to Bid Security, a **bid fee** of Rs 10,000 (Rupees Ten Thousand only) in the form of Demand Draft from any commercial bank in favour of "State Health Resource Centre, Chhattisgarh" should also accompany the Proposal. Bid fee is not refundable." **DEL**- "In case of deficiency in service delivery or required human resources, penalty will be imposed, which will be decided on a mutual agreement basis at the time of agreement." ADD- "state gov can re-evaluate some or all proposals, should any evaluated bid may be found to be non-responsive at a later stage." *ADD- Format for Letter of certificate from previous employer	DEL FROM MoU- The vehicles will be assigned to the districts and will not be shifted from one district to another without the written permission from the State Government. The vehicles allotted to a district may operate from any central location in that district. The tentative distribution of the vehicles, to be finalized after selection of the agency, is as follows:

ANNEXURE 2: BASE LOCATIONS OF 30 MMUs IN 14 DISTRICTS

S. No.	District	Block/Base Location
1	Rajnandgaon	Dongargarh
2		Ambagarh Chowki
3	Kawardha	Borla
4		Pandariya
5	Kanker	Antagarh
6		Durgkondal
7	Kondagaon	Keshkal
8		Kondagaon
9	Jashpur	Jashpur
10		Farsabahar
11		Sana/Bagicha
12	Surguja	Sitapur
13		Ambikapur
14		Lakhanpur
15	Surajpur	Bhaiyathan
16		Surajpur
17	Balrampur	Rajpur
18		Ramanujganj
19	Koriya	Baikunthpur
20		Manendragarh
21	Bastar	Tokapal
22		Bakawand/Jagdalpur
23		Bhanpuri
24	Bijapur	Bairamgarh
25		Bijapur
26	Sukma	Sukma
27		Konta
28	Dantewada	Dantewada
29		Geedam
30	Narayanpur	Narayanpur

Source: (April-June 2014 quarterly performance report available on www.cghealth.nic.in)

ANNEXURE 3: BLOCKS COVERED BY THE MMUs

MMU	Blocks/Areas served		
KANKER (2 MMUs)			
Antagarh	Antagarh	Koylibeda	-
Durgkondal	Durgkondal	Pakhanjur	-
SURGUJA (3 MMUs)			
Lakhanpur	Lakhanpur Block	Udaypur Block	-
Sitapur	Batauli Block	Sitapur Block	Mainpath Block
Ambikapur	Ambikapur Block	Dhaurpur Block	-

Source: MMU Performance reports available on www.cghealth.nic.in)

ANNEXURE 4: QUARTERLY STATUS OF MOBILE MEDICAL UNIT PAYMENT

S. No.	Quarter	Payment of 85 % bills	Payment of 15 % of bills
1.	First Quarter (Sep 2012-Nov 2012)	1,77,547.00	5,81,865.00
2.	Second Quarter (Dec 2012-Feb 2013)	61,36,607.00	20,46,405.00
3.	Third Quarter (Mar 2013 - May 2013)	86,02,866.00	20,17,980.00
4.	Fourth Quarter (June 2013 –Aug 2013)	62,45,630.00	11,02,170.00
5.	Fifth Quarter (Sep 2013-Nov 2013)	97,78,774.00	17,25,666.00
6.	Sixth Quarter (Dec 2013-Feb 2014)	99,22,874.50	17,51,096.00
7.	Seventh Quarter (March 2014-May 2014)	77,86,212.00	13,47,038.00
Total		4,86,50,511.00	1,05,72,220.00

Source: State Nodal Office for MMU. Health Department Chhattisgarh

PUBLIC HEALTH RESOURCE NETWORK

Public Health Resource Network (PHRN) is a network of individuals and organizations with the perspective of strengthening technical and management capacities to take action towards the common goal of 'Health for All'. Its main objective is to contribute and strengthen all efforts directed towards the goal of 'Health for All' through promotion of public health, social justice and human rights related to the provision and distribution of health services, especially for those who are generally left underserved.

JAN SWASTHYA ABHIYAN

Jan Swasthya Abhiyan is the Indian circle of the People's Health Movement, a worldwide movement to establish health and equitable development as top priorities through comprehensive primary health care and action on the social determinants of health. The Jan Swasthya Abhiyan coalition consists of over 20 networks and 1000 organisations as well as a large number of individuals that endorse the Indian People's Health Charter.

OXFAM INDIA

Oxfam is marking its 67th year in India this year. In 1951, Oxfam Great Britain came to India during the Bihar famine to launch its first full-scale humanitarian response in a developing country. Over the past 66 years, Oxfam has supported civil society organisations across the length and breadth of the country. In 2008, all Oxfams working in India came together to form Oxfam India, a fully independent Indian organisation (with Indian staff and an Indian Board), which is a member of the global confederation of 18 Oxfams.

PHRN

Jan Swasthya Abhiyan
People's Health Movement-India

ऑक्सफैम इंडिया
OXFAM
India