Implementing a Public Private Partnership Model for Managing Urban Health in Ahmedabad

Amit Patel
K.V. Ramani
Dileep V. Mavalankar
Anurag Agarwal
Shilpa Maiya
Beena Nayak

W.P. No.2007-09-03
September 2007

INDIAN INSTITUTE OF MANAGEMENT
AHMEDABAD-380 015
INDIA

Implementing a Public Private Partnership Model for Managing Urban Health in Ahmedabad

Amit Patel
K.V. Ramani
Dileep V. Mavalankar
Anurag Agarwal
Shilpa Maiya
Beena Nayak

Acknowledgements: We are thankful to UNFPA, New Delhi for funding this research study. We also acknowledge the excellent cooperation from Ahmedabad Municipal Corporation, Gujarat Cancer Society, Gujarat Cancer Research Institute, SAATH, and Akhand Jyot Foundation for carrying out this study.

Implementing a Public Private Partnership Model for Managing Urban Health in Ahmedabad

Abstract

Governments in many developing countries acknowledge they are facing difficulties in their attempt to meet the basic health needs of their populations. They rely on contracting out to private (for-profit and not-for-profit) organizations as a strategy to meet the needs of underserved populations. For the most part, the public sector chooses to contract out primary healthcare services to the private sector to expand access, increase the availability of medicines and medical supplies, and improve the quality of care. In both urban and rural settings, private for-profit and non-profit health service providers serve both the rich and the poor. Communities often recognize private sector healthcare providers to be more responsive to their healthcare needs and preferences in terms of services available, suitable timings and geographical access etc. Private sector has always played a significant role in the delivery of health services in developing countries. Public-private-partnership (PPP) is an approach under which services are delivered by the private sector, while the responsibility for providing the resources rests with the government. Establishing a PPP requires a legal framework acceptable to all the partners, clarity on the commitment of resources, roles and responsibilities of each partner, as well as accountability to provide a given set of services at a desired level of quality and affordable user charges. Formalizing such an arrangement between partners requires conceptualising a framework for Public Private Partnership (PPP) to manage the delivery of health services.

In this paper, we describe the design, development and implementation of a PPP for managing urban health services in Ahmedabad city, Gujarat. Our model has succeeded in bringing together compatible public and private partners to plan and deliver quality healthcare services to meet the community needs of Vasna ward, in Ahmedabad. The new Vasna Urban Health centre was inaugurated on July 23, by the Chief Minister of Guajarat. This new centre now serves about 120 outpatients everyday as against an average of 10 outpatients daily earlier.

Implementing a Public Private Partnership Model for Managing Urban Health in Ahmedabad

Contents

List of Figures

List of Tables

List of Exhibits

Implementing a Public Private Partnership Model for Managing Urban Health in Ahmedabad

1. Public Private Partnerships in Health

1.1 What is Public Private Partnership?

Governments in many developing countries acknowledge they are facing difficulties in their attempt to meet the basic health needs of their populations. They rely on contracting out to non-governmental organizations (NGOs) and to for-profit organizations as a strategy to meet the needs of underserved populations (GOI, 2004). For the most part, the public sector chooses to contract out primary healthcare services to the private sector to expand access, increase the availability of medicines and medical supplies, and improve the quality of care. In both urban and rural settings, private for-profit and non-profit health service providers serve both the rich and the poor (Bennet, 2005). Communities often recognize private sector healthcare providers to be more responsive to their healthcare needs and preferences in terms of services available, suitable timings and geographical access etc. Private sector has always played a significant role in the delivery of health services in developing countries.

Public-private-partnership (PPP) is an approach under which services are delivered by the private sector, both non-profit and for-profit organizations, while the responsibility for providing the resources rests with the government. This kind of a partnership refers to the sharing of resources needed to work together towards a common goal while respecting one another's identity. Negotiations among all the partners would give rise to a clear understanding of each other's roles and responsibilities (Marcou, 1997). PPP involves sharing of risk and reward between the partners. It is essential that all the generic risks be identified before finalizing the contract. The assurance of the government to share the risks with the private partner is a significant confidence building measure. Quite similarly, if the actual output/returns exceed those contemplated at the start of the project, the windfall is to be shared equally between the public and private sectors.

Studies reveal that it takes several years of preparation and institutional strengthening to establish a working PPP that can be sustained and replicated successfully.

1.2 Forms of PPP

All forms of PPP, ranging from simple service and management contracts to increasingly complex performance-based management contracts, asset leases, articles of association, concessions and asset divestitures, involve a partnership between the government and the private sector. However, they differ in their allocation of risks and responsibilities, in their duration, and in where they assign asset ownership.

Service and fee-based management contracts may be implemented without adequate baseline information, cost-reflective tariffs, or performance monitoring systems in place.

However, regulatory frameworks and reliable databases are essential for leases, concessions and divestitures. Benefits accruing from PPP grow as increasing responsibility and risk is placed on the private partner. Performance based management contracts can be cost-effective if used to leverage deeper forms of PPP. Until qualified and reputable private providers emerge in India, such contracts are likely to be costly. Management contractors should have the right and responsibility to use resources optimally, improve service quality, and prepare the ground for more effective forms of PPP. In practice, hybrids are becoming more the norm than the exception, with the private sector taking some commercial risk under management contracts and being responsible for some investments under leases.

It is important to consider the degree of enforceability of PPP agreements. A contract is a binding commitment — "enforceable" in the legal sense. It means that non-fulfillment of the clauses by one of the parties can lead to penalties, and ultimately the parties can invoke the commitments before the courts. The contract usually contains provisions for these penalties and for the means of enforcing them (Walsh, 1995).

1.3 Challenges in Establishing PPP

Though PPP is widely acknowledged as a possible solution to achieve health goals, there are significant challenges to establish public and private sector partnerships. Underlying these challenges, there are several causes that relate less directly to the achievement of health goals but need to be addressed for effective partnerships. Root causes reflect the lack of information on private sector in developing countries, lack of trust between public and private sector and lack of skills in the public sector to deal with the private sector. Certain challenges that need to be addressed include:

- Tailored contracting so as to take account of the heterogeneity of private sector
- Overcoming mistrust between public and private sector (Laing, 2001).
- Improving information availability and reliability about the private sector service providers, the range and quality of services they offer and treatment outcomes
- Developing management capacity of the public sector to deal with the private sector
- Promoting a more organized private sector, so as to reduce the transaction costs of working with a large number of small, disparate groups. At the same time, strengthening government's ability to manage the vested interests of private sector organizations

The complexity of engaging private sector depends substantially on the nature of the task they are involved. Public Private Partnerships in health sector are extremely diverse in terms of the types of actors that use it, the type of contractual relationships that are established and the purposes thereof. However, one must consider the fact that PPP is a tool that should be evaluated on the basis of the performance of health system and

ultimately on people's health. PPP should not be reduced to a mere management tool to cut health costs of the public sector.

Continuous monitoring and periodical evaluations are the cornerstones of a successful PPP. Payments have to be, however, linked to performance, which in turn requires monitoring. Performance measurement can be done with respect to measuring 'efficiency' or measuring 'effectiveness'. While measurement of efficiency entails comparing the unit cost of providing the service from amongst the various alternatives, measurement of effectiveness involves comparing the desired outcomes from amongst the various alternatives. Involvement of third party/independent agencies for monitoring appears to be preferable as they leave the government hassle free over the project and minimize government control. The government and the service providers could mutually decide the third party. The third party involvement could be further supplemented with provision for adjudication by the judiciary.

Conceptually there are three major ways of establishing partnerships (Elizabeth, 1998)

- Swiss Challenge Approach
- Competitive bidding
- Competitive negotiations

Swiss Challenge Approach: The Swiss Challenge approach refers to *suo-motu* proposals being received from the private participant by the government. The private sector thus provides all details regarding its technical, financial and managerial capabilities and its expectations of government support/concessions. The government may examine the proposal and if the proposal belongs to the declared policy of priorities, then it may invite competing counter proposals from others with adequate notice. In the event of a better proposal being received, the original proponent is given the opportunity to modify the original proposal. Finally, the better of the two is awarded the project/program for execution.

Competitive Bidding: This involves a well publicized and a well-designed bid process to ascertain financial, technical and managerial capabilities of the service provider or the developer. The selection of provider depends upon one or the combination of the lowest capital cost, lowest operation and maintenance cost, lowest user fees, lowest support from government and so on.

Competitive Negotiation: Competitive negotiation is considered a variant of competitive bidding. The government specifies the service objectives and invites proposals through advertisements. The government then negotiates and finalizes the contract with the selected bidders. Negotiations may, however, be 'simple' (direct) or 'complex' (indirect). In the second case, the government negotiates through a 'master contractor'/mother NGO, who in turn handles all dealings with sub-contractors/franchisees, and monitors the program by collecting information from the beneficiaries. Some of the advantages about master contracting are administrative convenience, and better control in dealing with less number of service providers. 'Master contract' is not always relevant and negotiation vis-

à-vis the contract ought to be done directly with the community/beneficiaries. Competitive negotiations are less transparent than competitive bidding.

However, the decision to use one or the other of these methods should be based on an in-depth study to determine which strategy is the most suitable. This is where the importance of context comes into play in establishing PPPs.

1.4 Local Self Government and PPP

PPP is a suitable method of delivering services commonly provided by local governments and is generally applicable to most components of service delivery. The types of services that could be provided through PPP will vary from one local government to the other based on their needs and priorities. Local governments may consider partnerships with the private sector when any of the following circumstances exist:

- If the involvement of a private partner would allow the services or project to be implemented sooner than if only the local government were involved
- If a private partner would enhance the quality or level of service from that which the local government could provide on its own
- If the user communities would support the involvement of a private partner
- If there is a track record of partnerships between the local government and the private sector
- If the services or project cannot be provided with the available financial resources or expertise of the local government

1.5 Role of Government in PPP

Government has a fundamental responsibility to set the rules of engagement. Government should provide private sectors with overall policy direction, define clear roles for government and private sectors, and help develop a predictable and transparent environment within which private sector actors can operate. Separating operational and management responsibility from policymaking and regulation is important for better accountability. Private sector participation will in itself help consolidate this separation by reducing the influence of government in day-to-day operations. A clearly articulated institutional and policy framework for PPP in Health sector in general and Urban Health in particular, underpinned by enabling laws and a realistic implementation plan, would permit a systematic reform and help insulate reforms from political process (GOI, 2004).

A crucial element of success in urban health reform involving the private sector is an appropriate legal framework. Ideally encapsulated within a single Urban Health Law and supported by the State Municipal Act, the legal framework should underpin the state sector policy and the envisaged institutional framework. The regulatory framework

should clearly delineate state and local-level regulatory roles, and remain sensitive to authorities vested in the local government bodies under the 74th Constitutional Amendment Act.

Governance and public sector management must be improved in parallel to facilitate healthy public-private partnerships. In most cities, existing legal, regulatory and governance frameworks and industry structures would need to be amended to implement the new policies and create an enabling environment to encourage private sector participation.

2. Sample PPP Case Studies under NRHM

2.1 About our case studies

In this section, we share with you our observations based on an analysis of a wide range PPP arrangements in social services through case studies located in rural and urban areas. They include diagnostic services, curative care, maternal health services, child development services, health promotion activities and food catering services.

We have compiled thirteen cases in various parts of India to reflect and assess different models of PPP after careful review of various 'PPP Models' in the social sector. We critically reviewed the cases through contract documents, government resolutions, memoranda of understanding and other available documents. We also compiled the feedback from public and private partners as well as operational issues in the management and functioning of partnerships in some cases. Table 2.1 provides a brief overview of the thirteen case studies.

Though we do not present a detailed analysis of these partnerships here, we highlight and debate some key issues involved in PPP in the social sector in India. The case studies are analyzed under two main frameworks: operational issues in PPP and policy related issues in PPP.

Contracting is the predominant model of PPP. The private sector is represented in the form of individual service providers, large hospitals and NGOs. Some partnerships dealt with simple agreements (catering services for Mid Day Meal Scheme) whereas other more complex agreements involved many stakeholders (NGO council represents several civil society organizations and it seeks involvement of community at large). Of the ten PPP case studies, most are specific to a geographical region, some partnerships benefit people in the entire state (Radiology services in the state of Bihar).

While the forms of partnerships vary, there is little evidence to indicate the relative merits of any one form of PPP over the others. Little is known about the scope and coverage of the services under partnership with the private sector in India. There is a dearth of research indicating the institutional capacity of government agencies to design, negotiate, implement and monitor such partnerships. The current knowledge base is silent on subsidies, performance and quality of services under PPP, operational constraints, overall effect on the health system and the stakeholders' perception on PPP. There is no clear consensus on the appropriate private sector involvement in healthcare or an appropriate policy towards the private sector.

2.2 Lessons learnt from case studies

We present below, our analysis of the case studies to understand the underlying factors that influences success (or failure) of PPP in the health sector in India. The learning from this analysis has given us valuable insights for designing the PPP for urban health services.

2.2.1 Selection of Private Partners: This is a critical component for a successful PPP, but often neglected. Upgrading the existing urban family welfare services into urban health centres through a Government Resolution (GR) is an example.

Most partnership projects we studied, point to the importance of prior negotiations with the potential partners. In some cases, prior experience of the agency was used as a basis for choosing the private partner.

We suggest an invited or negotiated partnership in the health sector for selecting private partners, instead of a competitive process, since health projects are not commercially viable. The selection process adopted by the National AIDS Control Organization (NACO) is worth following for urban UHC (See Figure 2.1). The NACO guidelines highlight the assessment of previous experience of the private partner and a pilot test component before entering into long-term contract. We may not insist on pilot test/demonstration if a private party has a good record of providing health services.

2.2.2 Enabling Circumstances: Clear vision and leadership of key people, relationships based on trust or compelling circumstances have triggered partnership initiative as against enabling circumstances created through policy pronouncements.

Except in two partnerships, where the government chose to go through bidding, most partnerships reveal that the government and the private partner chose to consult each other before venturing into partnership agreements.

There were also compelling circumstances and relationships based on trust that were critical in triggering partnership initiatives. For example, Ahmedabad Municipal Corporation (AMC) has been managing a Maternity Home and was facing several operational problems. An NGO called Karuna Trust, working for Polio in this area since long, came forward and volunteered to manage the Maternity Home. The trustees of this NGO worked hard to convince the political leaders and administrative heads of AMC and eventually obtained their approval to manage the Maternity Home.

In case of policy pronouncements, partnerships with the private sector tend to be more successful if the policy is built around the lessons from previous experiments. For example, in Gujarat, state level policy on public private partnership for Chiranjeevi Yojana was framed after launching a pilot project in five districts of Gujarat. Pilot project was studied before it was up-scaled and several important policy level improvements were suggested.

2.2.3 Serving the Poor and vulnerable: In the absence of any formal Monitoring & Evaluation system, it is not possible to verify the extent of benefits to the poor and vulnerable sections of the society under PPP even if the partnership gives special privileges to the poor under various clauses of agreement.

Difficulty also arises in identifying the real BPL families. There are no uniform procedures adopted for the identification and verification of authentic BPL beneficiaries. Decisions about who qualifies as BPL patients are often left to the interpretation of the service providers. There are exceptions like the Chiranjeevi Yojana in Gujarat designed for BPL women, which authorizes the local government officers to verify the BPL status.

2.2.4 Roles and Responsibilities of Partners: All partnerships we studied give us a general impression what responsibilities each actor, public and private, typically assumes in PPP. We found that in most partnerships, public sector is committed to providing physical infrastructure in the form of building, equipment, supplies, access to electricity, water and drainage. In most cases, private sector commit service provision to the target population, selection and recruitment of appropriate staff, maintaining the physical infrastructure provided by the public sector, and provides information to the public sector in the form of reports and account details.

There is a lack of clarity about the roles and responsibilities of all partners. Inability of the government to provide committed resources (finance, staff, medicines, equipment purchases and repairs) in time, and recurrent funding shortfalls severely constrain the service delivery by the private sector. There are indications which suggest that the public sector tends to treat 'for-profit' organizations better than 'not-for-profit' organizations for grant or budgetary support.

2.2.5 Performance Monitoring: Monitoring and Evaluation, which is central to performance monitoring, remain neglected by the public and private sectors. Periodical statutory reporting is mandatory, but not continuous monitoring of the performance.

Most partnerships we studied mention the monitoring mechanisms but do not actually provide specific details of performance monitoring. Performance indicators are not mentioned in most agreements. This a serious concern, since outcomes of the partnership may severely get affected in the absence of performance monitoring. Therefore we suggest performance monitoring to be an integral part of any PPP agreement in social sector.

2.2.6 Managerial Capacity: While it is known that the public sector lacks management capacity, the same is true for the private partners as well. Managerial capacity of the private sector is important especially when they have to manage the resources given by the government to deliver services, efficiently and effectively.

We recommend an assessment of the managerial capacity of NGOs as a part of the selection process and if needed to add a managerial training component in the agreement.

Certain initiatives taken by the Gujarat Government are worth mentioning. The Gujarat

State Department of Health and Family Welfare has formulated detailed agenda for Health Sector Reforms. The Gujarat Infrastructure Development Board (GIDB) has the overarching role of enabling PPP in the state through the Gujarat Infrastructure Development Act. GIDB's technical and managerial capacity helps Department of Health & Family Welfare to enter into meaningful partnerships which is evident from the breadth and depth of Model Contract GIDB has prepared for involving private sector in managing District Hospitals in Gujarat.

2.2.7 Quality of Services: Poor M & E leads to neglect of service quality. Most partnerships do not specify minimum service standards as a part of partnership agreement. Nor do they specify any mechanism to monitor the quality standards. In exceptional cases, some preliminary parameters of service quality are included such as maximum allowed time to resume services in case of break-down of equipment (case of radiology services in Bihar).

2.2.8 Degree of Autonomy: Private partners enjoy a certain degree of freedom to take day-to-day operational decisions without cumbersome bureaucratic processes. They also enjoy some autonomy due to poor supervision by the public sector.

We suggest providing autonomy to the private sector for additional services which they might be willing to provide if they are not conflicting with the core activities. Or adding value to the original set of services. For example, Karuna Trust was permitted to provide other medical services from the maternity home which helped gaining popularity amongst the population.

2.2.9 Term length of Agreements: Partnership arrangements vary from 2 to 10 years, though most partnerships are on a short-term contract. We suggest a medium-term of say 5 years, so as to provide reasonable time for the private partner to perform and demonstrate a sustainable PPP. As against long term contracts, short term contracts also enable the partners to re-negotiate the contract for service quality improvements based on past experience.

2.2.10 Dispute Resolution Mechanism: Most partnerships are legal contracts and disputes can be resolved in court, which would be very lengthy and unpleasant situation for all partners. We therefore suggest a mechanism, such as a Management Committee of all stakeholders, to resolve disputes.

2.2.11 Exit Mechanism: Notice period for withdrawal from PPP is an important component. It is necessary to provide enough time for the public sector to select a new partner, and not to disrupt the service delivery.

2.3 Our recommendations

There are several issues both at policy level and operation level that need careful examination to establish relative efficiency of one mode of partnership over others. Some of the questions to be answered are:

- How partnerships could be designed to target and benefit the poor?
- What is the institutional capacity of both public and private sector to manage a partnership?
- What are the conditions for successful partnership?
- How to ensure that the poor actually benefit?
- Who should do what? Responsibilities and commitments of each partner.
- Level of incentives and disincentives.
- What performance indicators should be used?
- How to monitor the functioning of partnership?

The National AIDS Control Organization (NACO) of the Government of India has outlined a detailed process for bidding, selecting appropriate partner NGOs, and monitoring their performance for service delivery. We strongly recommend the NACO guidelines for establishing PPPs for urban health services.

Figure 2.1
Bidding Process & Selection of NGOs for Service Delivery
(NACO Guidelines)

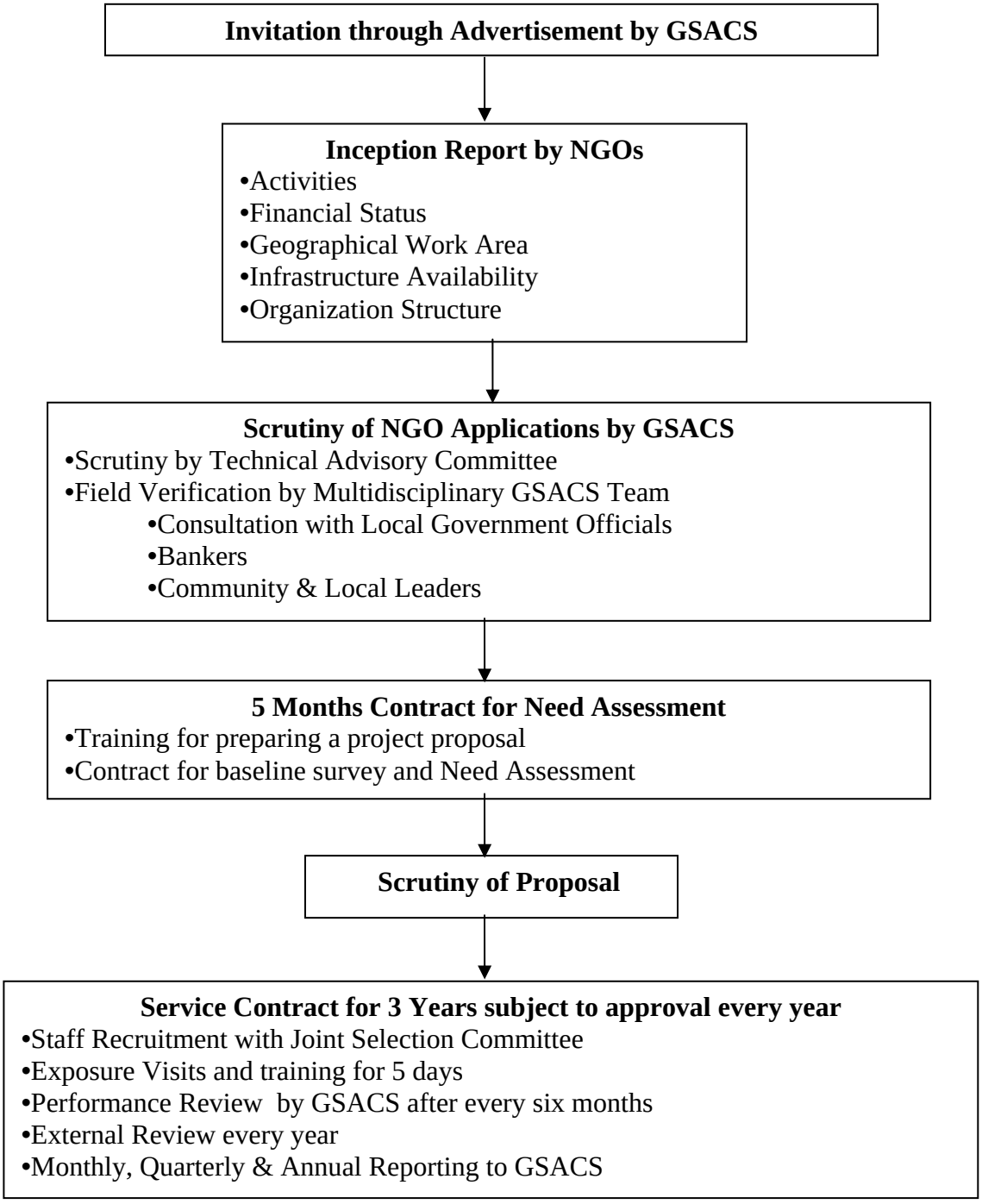


Table 2.1 Case Studies: Public Private Partnerships in Social Sector in India

Document Title	Objectives	Nature of Partnership	Selection Process	Payment Mechanism	Monitoring Mechanism	Penalty/ Incentives	Benefits/ Remarks
Agreement between Government of Bihar and IGE Medical Systems	To ensure timely and cost effective radiology services at government hospitals of Bihar	Lease Agreement (on Build Own Operate Basis)	Competitive negotiation	Government of Bihar doesn't provide any grant but provides right to levy fixed user charges. IGE Medical Systems pays rent for each facility to Government of Bihar on monthly basis.	Monitoring is done by the Rogi Kalyan Samiti of each facility	An incentive to provide services from government hospitals to private patients at market rates. Penalty on per hour basis for breakdown of services.	Private Financing of Infrastructure for radiology services at each government facility with demand risk and maintenance of facilities retained with private sector
Agreement between Government of Bihar and Rajbhra Consultants Pvt. Ltd.	To provide and develop mobile medical services to the poor population in Bihar	Lease Agreement (on Build Own Operate Basis)	Competitive negotiation	Government of Bihar provide grant through District Health Societies on monthly basis on production of claims and vouchers	By Medical Officer In Charge, Civil Surgeon on daily basis and District Magistrate, head of District Health Society would monitor activities on daily, weekly and monthly basis. State Health Society of Bihar would monitor the overall contract especially the financial commitment of Rajbhra Consultants Pvt. Ltd. time to time and evaluate the performance at the end of the year.	Government would not pay in case of failure to fulfill the contract terms. No payments in case of break down for more than 4 hours.	Introduction of mobile medical services in the remotest villages of all districts of Bihar with private financing of physical infrastructure as well as recurring expenditure at fixed cost to government.
Agreement between Government of Assam and Marwari Hospital, Guwahati.	To provide maternal and child health services to slum population in selected wards of Guwahati city	Purchase of services on contractual basis	Direct negotiation/ Voluntary offer	Government of Assam provides grant for capital support as decided in action plan and allows levying fixed user charges	Monitoring is done by the official of Health & Family Welfare Department of the State Government	None	Saving of government resources to provide maternal and child health services to urban poor in Guwahati.

Agreement between Government of Gujarat and SAATH, Ahmedabad	To provide tuberculosis control services to slum population in Vasna ward of Ahmedabad city	Purchase of services on contractual basis	Direct negotiation/ Voluntary offer	District TB Control Society of Ahmedabad provides grant to SAATH.	Monitoring is done by the District TB Control Society of Ahmedabad	None	To increase the outreach of TB treatment with higher cure rate
Agreement between Ahmedabad Municipal Corporation and SAATH, Ahmedabad	To provide AIDS control services to slum population in Ahmedabad city	Purchase of services on contractual basis	Direct negotiation/ Voluntary offer	Ahmedabad Municipal Corporation AIDS Control Society provides matching grant to SAATH in the proportion of 90-10.	Monitoring is done by the Ahmedabad Municipal Corporation AIDS Control Society	None	To increase the outreach of AIDS Control Services
Agreement between Municipal Corporation of Greater Mumbai and NGO Council	To increase citizen's participation in formulation, implementation, monitoring and evaluation of various policies, programmes and schemes for the efficient delivery of civic services	Partnership with civil society	Voluntary offer by active citizens	Municipal Corporation of Greater Mumbai funds the activities, events, meetings etc. to enable the citizens to participate in planning and policy making.	Not applicable	None	Partnership increases the accountability of government, generates the demand for civic services amongst the citizens, promotes the participatory development
Model Agreement between Government of Gujarat and Private Sector Entity	To improve the health facilities, infrastructure, clinical and operation facilities and treatment at all government hospitals in Gujarat	Lease Agreement (on Rehabilitate Operate Transfer Basis)	Competitive bidding	Government of Gujarat will pay grants annually in two installments which is decided at the time of entering into contract subject to fixed percentage increase year over year.	Performance review will be done by Performance Review Committee. Hospital Accreditation after one year of entering into contract is mandatory.	Performance Review Committee is empowered to penalize if the performance is not improved in the given timeframe.	Improvement of health facilities and quality of healthcare in government hospitals of Gujarat. (Intended – no PPP exists till date)

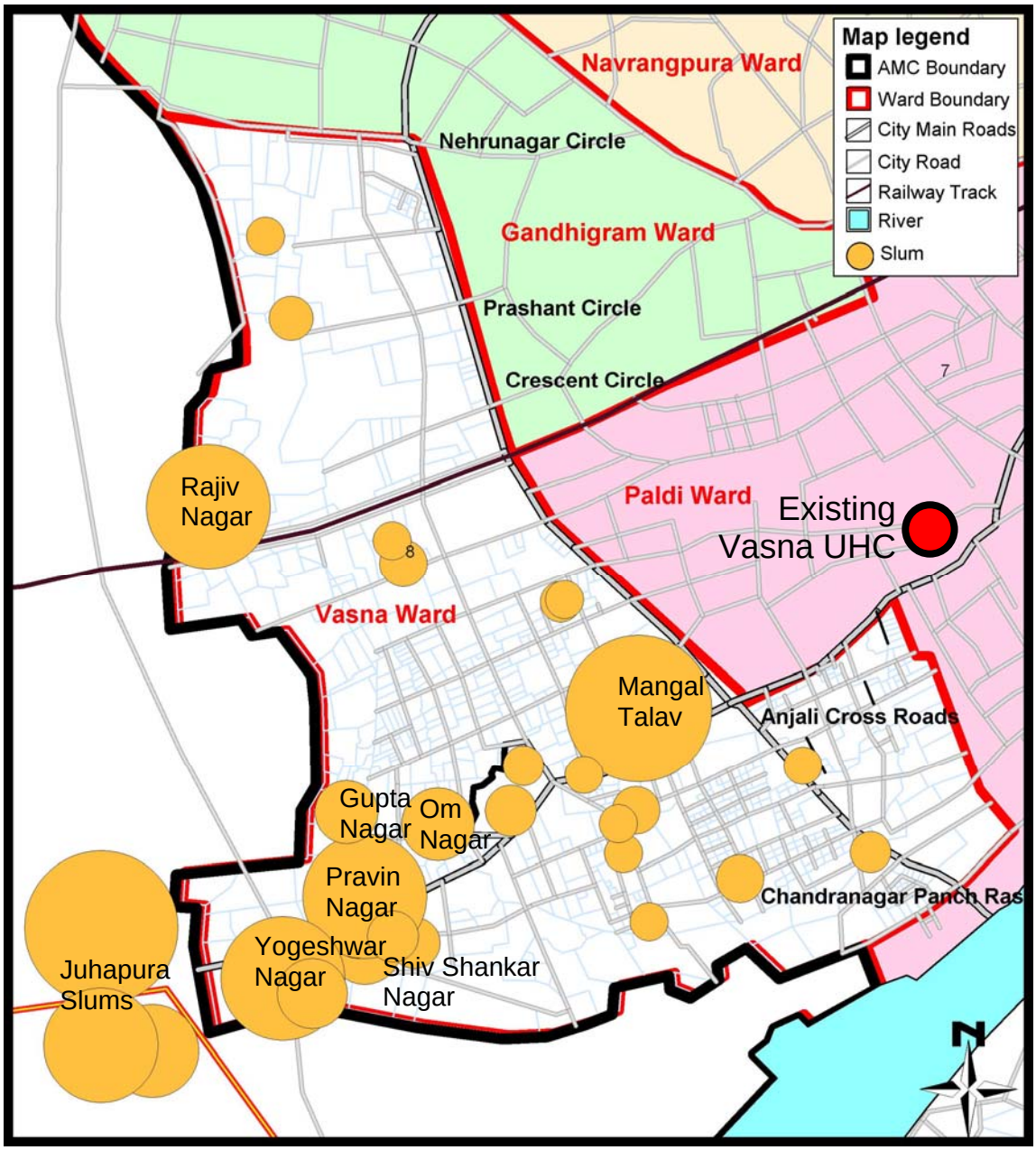
Contract between NGO and Gujarat State AIDS Control Society	Engaging NGOs for field interventions for AIDS Control	Purchase of services on contractual basis	Negotiated contracts	GSACS provides amount based on annual budget required for specific tasks	Mother NGO selected as Project Support Unit would monitor on behalf of GSACS through MIS reports	None	Increased community outreach of interventions for AIDS Control
Chiranjeevi Yojana	Engaging private obstetricians and gynecologists for conducting deliveries	Purchase of services on contractual basis (Voucher type)	Direct Negotiations/ Voluntary offer	Government of Gujarat provides fixed amount per 100 deliveries	District Health Authorities monitors the scheme through weekly reports	None	Increased institutional deliveries and reduced maternal and infant mortality
Partnership between Government of Gujarat and SEWA Rural, Jhagadia	Managing a PHC and provide healthcare services	Lease Agreement (on Rehabilitate Operate Transfer basis)	Direct Negotiations/ Voluntary Offer	Government of Gujarat provides all resources available to a PHC	Monitoring through state health machinery on the same pattern for public sector PHCs	None	Better service quality and higher utilization of the government facility

3. Urban Health Services: Analysis of Existing PPP Arrangements

3.1 The existing scenario

The existing Vasna UHC is situated on the second floor of the Akhand Jyot Foundation Building in the neighboring ward Paldi (see Figure 3.1).

Figure 3.1
GIS Map: Location of Slums in Vasna Ward and the Vasna UHC in Paldi Ward



The current Vasna UHC managed by Akhand Jyot Foundation in its Paldi building provides the following services, as mandated by AMC (see Exhibit 1).

1. Birth and Death Registration
2. Registration for the eligible couple and Family Welfare Services –temporary and permanent
3. Registration of the Pregnant women, antenatal care, and postnatal care and find the high risk pregnant women and provide them referral services
4. Primary health care for all the diseases through general OPD
5. Distribution of the vitamin-A and iron folic acid pills
6. National Health Programs: Revised National T. B. Control Program
   School health, Leprosy
   Malaria – Dengue Control
   Sexually Transmitted Disease Control
7. Notification and control of infectious diseases
8. Health Education
9. Laboratory Services: Blood test, Urine test, Hepatitis, infectious diseases
10. Immunization: Every Monday, Wednesday, Friday at the facility
    Every Tuesday, Thursday, and Saturday in the community
11. Surveillance: Neonatal Tetanus, Polio, TB, Measles, Diphtheria, Leprosy, Cataract, Blindness control and mortality

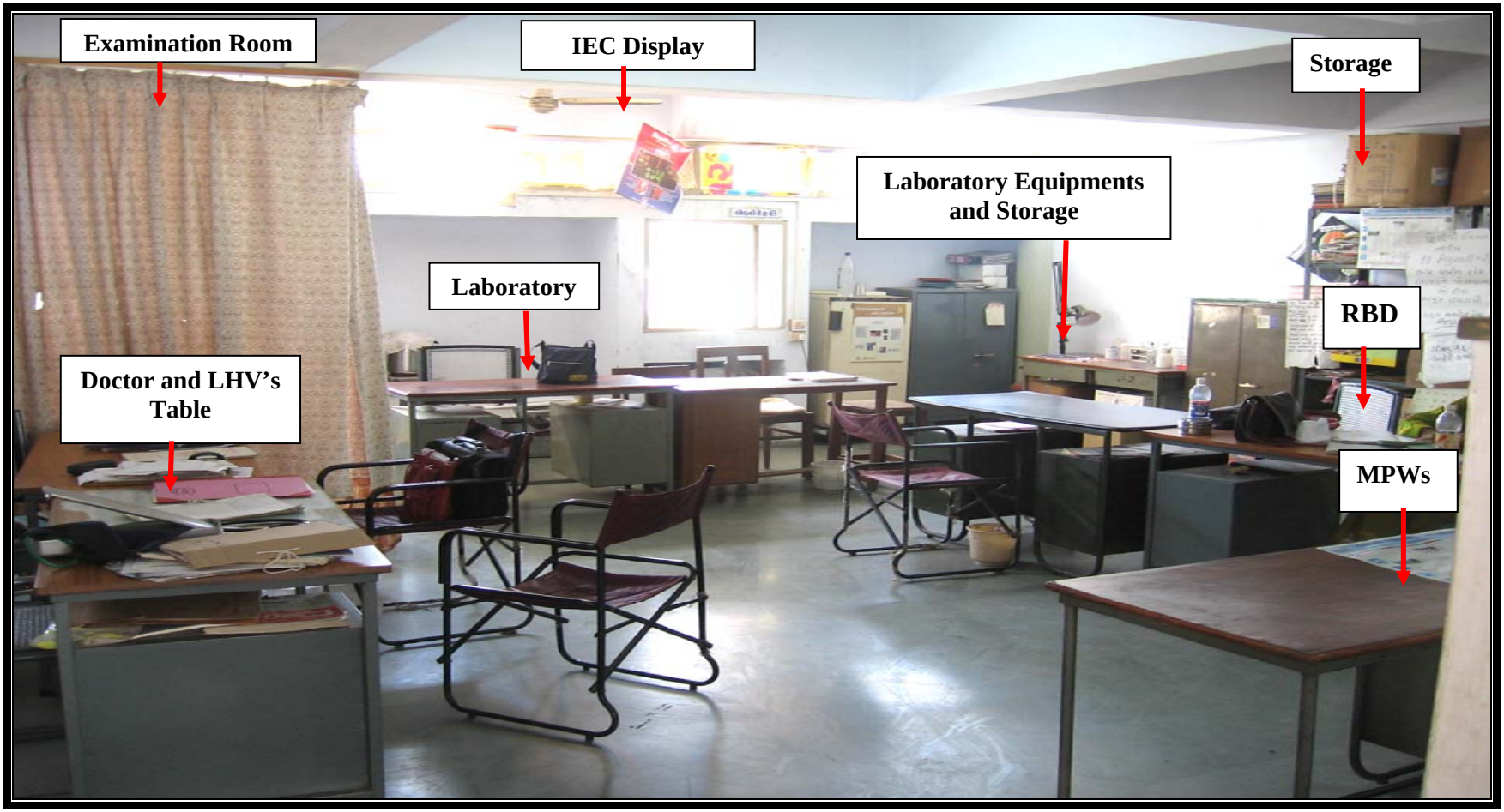
3.2 Infrastructure

A large room 20 ft by 20 ft with 6 workstations provides the above services. The Medical Officer and the Lady Health Visitor sit on adjacent tables to see patients for medical and RCH services. Adjacent to the LHV's table is a curtained area of about 8 ft x 8 ft examination room. Next to this is the laboratory section with one table and one chair. There are two tables for the MPWs and one for the clerk cum accountant.

The limited infrastructure hampers a smooth functioning of the UHC (see Figure 3.2) and adversely affects the service delivery.

- Location in the 3rd floor makes access difficult for pregnant women
- No privacy in the examination room
- Aseptic techniques cannot be practiced in the space allocated for the laboratory
- Most of the records are bundled in an unorganized manner making it inaccessible when needed. Such poor management of information system leads to delayed delivery and irregular follow-up of therapy protocols
- In terms of amenities for patients and staff, the center has shared amenities such as drinking water, toilets etc. with other users of the building

Figure 3.2
The Urban Health Center



The UHC is a single (20ft X 20ft) room. This room accommodates the Doctor, the examination room, the laboratory, storage (including medicines, and paperwork), registration of birth and death, and staffs all the MWPs.

3.3 Utilization of UHC Vasna

Average number of patients attending the OPD is around 15-20 /day in peak periods like monsoon. Percentage of women using RCH services in proportion to the population is below 10% of the target age group[1]. Only 40 % of the pregnant women register for ANC services, and 75 % receive all 3 ANC checkups. While 75 % of he registered women received the TT1 and TT2 doses, only 10 % received the Booster dose. About 15 % of ANC registered women receive treatment for anemia, and 50 % of the registered women are given prophylactic treatment

3.4 Human Resources at UHC

Staff for the current Vasna UHC at Paldi is drawn from three different organizations: (i) AMC, (ii) Reproductive and Child Health (RCH) Society, and (iii) the Department of H & FW, Government of Gujarat.

In Table 3.1, we present the staff position under each of these organizations. Many posts of MPWs under the RCH Society are lying vacant, while no post of MPW is vacant under the Dept of H&FW, GoG. Lack of job clarity for the MPWs lead to delays in service delivery and preparation of statutory reports. There is an urgent need to develop a coherent HR policy for UHCs.

The Akhand Jyot Foundation (service NGO) has been providing FW services under the Central Government FW program since 1967. Akhand Jyot Foundation and other similar NGOs were brought under the Central Government's Urban Health Project[2], a few years ago.

SAATH, a local active NGO in the Vasna Area provides community link services. The GoI letter mentioned above authorizes the RCH society to fund MPW sans Link workers, since the original FW program has no provision for MPWs or Link workers.

The presence of two NGOs (one for managing the UHC and the other for link workers) does not seem to be working well. The coordination between the two NGOs needs considerable strengthening in order to provide community need based services.

[1] In the year 2005-06, the number of Eligible Couples in Vasna is estimated at 17, 600. The Birth Rate of Ahmedabad is 2.26. The target set by the AMC for ANC Registration was 2,546. However, only 1,231 ANC cases were registered. Thus, only 48.35% of the target set by the AMC is met.

[2] Letter and Guidelines from Government of India to all State Health Secretaries for formulating Urban Health Project Proposal, February 2004.

Table: 3.1

Staff Strength in Vasna UHC: 2005-06

Organization	Dept. of H & FW, GoG								Ahmedabad Municipal Corporation								The RCH Society			
	Medical Officer		Lady Health Visitor		Account-cum-Clerk		Multipurpose Workers		Gynecologist*		Pediatrician*		Vaccinator/Clerk (RBD)**		Class IV**		Lab Technician		Multi Purpose Workers	
Month	Sanctioned Post	Vacant Post	Sanctioned Post	Vacant Post	Sanctioned Post	Vacant Post	Sanctioned Post	Vacant Post	Sanctioned Post	Vacant Post	Sanctioned Post	Vacant Post	Sanctioned Post	Vacant Post	Sanctioned Post	Vacant Post	Sanctioned Post	Vacant Post	Sanctioned Post	Vacant Post
April	1	0	1	0	1	0	2	0	0	0	0	0	1	1	1	1	1	0	7	3
May	1	0	1	0	1	0	2	0	1	0	1	1	1	1	1	1	1	1	7	3
June	1	0	1	0	1	0	2	0	1	0	1	1	1	1	1	1	1	0	7	3
July	1	0	1	0	1	0	2	0	1	0	1	0	1	1	1	1	1	0	7	4
August	1	0	1	0	1	0	2	0	1	0	1	0	1	1	1	1	1	0	7	4
September	1	0	1	0	1	0	2	0	1	0	1	0	1	1	1	1	1	0	7	4
October	1	0	1	0	1	0	2	0	1	0	1	0	1	1	1	1	1	0	7	5
November	1	0	1	0	1	0	2	0	1	0	1	0	1	1	1	1	1	0	7	4
December	1	0	1	0	1	0	2	0	1	0	1	0	1	1	1	1	1	0	7	4
January	1	0	1	0	1	0	2	0	1	0	1	0	1	1	1	1	1	0	7	4
February	1	0	1	0	1	0	2	0	1	0	1	0	1	1	1	1	1	0	7	6
March	1	0	1	0	1	0	2	0	1	0	1	0	1	1	1	1	1	0	7	3
Vacancy (Man-Days)	0		0		0		0		0		60		0		0		30		1410	

* Post Created Effective from May 2005

** Shared resources with other wards and AMC

3.5 Drugs and Equipments

The clinic drug supply is based on the minimum use/minimum supply principles. Though the CMSO list for an Urban Health Center includes 70-80% of all Essential Medicines List recommended by WHO for countries with limited resources in the tropics, many of the basic drugs necessary for primary health care are not available at all times. It is necessary to strengthen the coordination between CMSO and UHCs in order to ensure availability of drugs at all times.

Laboratory equipments are used in an office setting as there is no special provision for laboratory (See Figure 3.2). The sterilizer is obsolete and under repair. A new autoclave with a new dressing set has been requested. Maintenance coverage of equipment is not satisfactory.

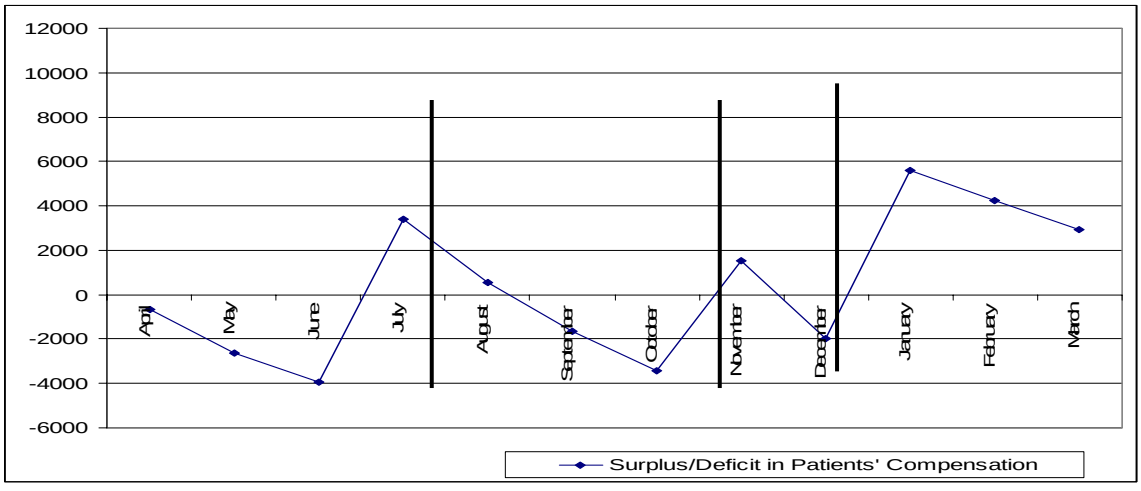
Supply of Biomedical waste bags required for disposing biomedical wastes is very irregular, raising social concerns on the management of biomedical waste.

3.6 Financial Resources for UHC

The pattern of giving grant to the Vasna UHC was studied in detail through the account registers that are maintained by the service NGO (the Akhand Jyot Foundation). Two types of Grants are received from the Government of Gujarat; one for the staff salaries while the other is received for patient compensation. Recurrent funding shortfalls have led to delays in the disbursement of salaries and patient benefits. We display below the impact of delayed receipt of grant on patient benefits.

Patient Compensation: A sum pf Rs. 195 is paid to each patient adopting family planning techniques and a sum of Rs. 25 is paid to the surgeon providing these services. It can be seen from Figure 3.3 that no patient compensation was given for a few months owing to delays in the receipt of grants for patient compensation.

Figure 3.3
Grant Received for Patients' Compensation: 05-06

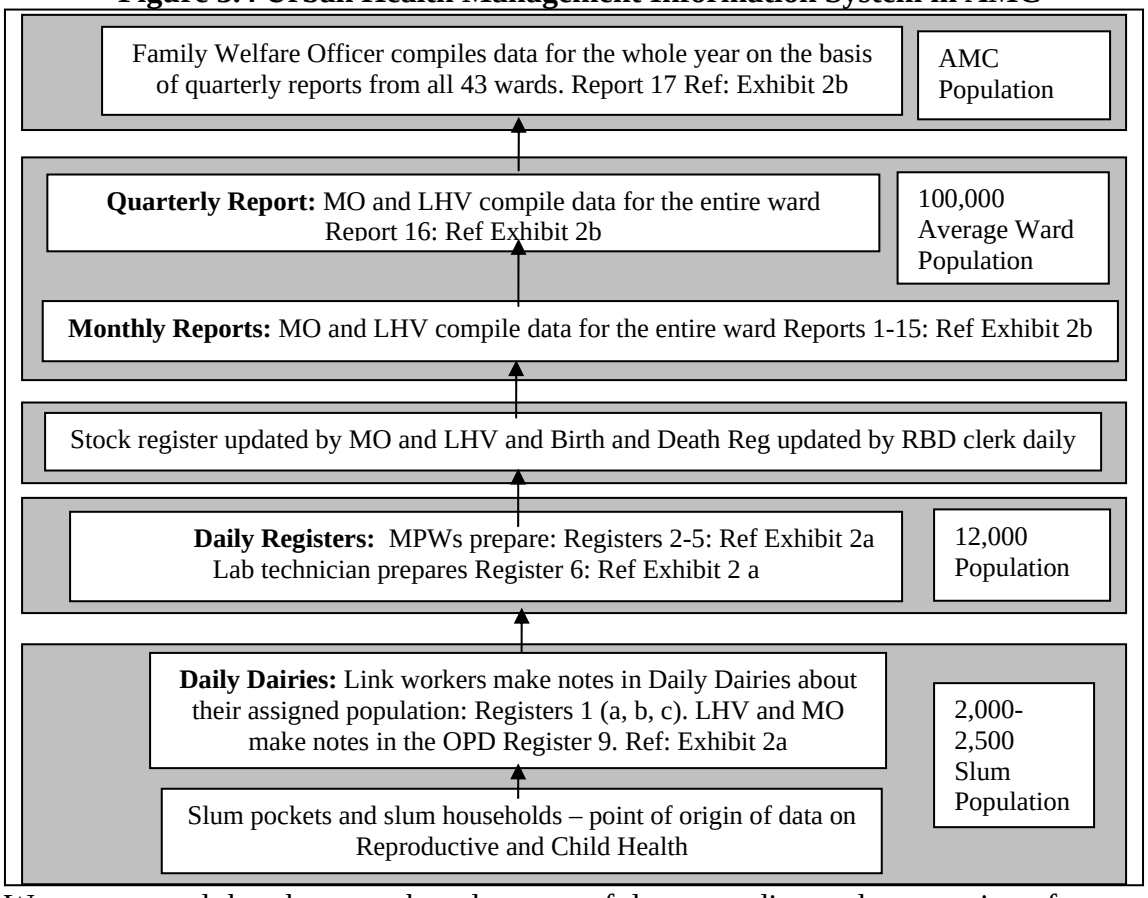


3.7 Monitoring and Evaluation System

Current information system within a UHC is based on collection of information at facility as well as in the field. Entire UHC staff maintains various types of registers. Health reports are prepared by AMC based on such registers generated monthly, quarterly and annually by the UHCs in all wards of AMC. Data is collected on a monthly basis from each ward and is compiled by the Family Welfare Officer for the entire city of Ahmedabad, which is then sent to the Gujarat State Family Welfare Department, and the State RCH Society. These reports primarily provide information on service delivery statistics and have data on various reproductive and child health indicators.

Health Management Information System (HMIS) in AMC is based on the National Information System suggested by the Ministry of Health & Family Welfare. The Urban Health System primarily focuses on Reproductive and Child Health Program (RCH II). In the existing Urban Health MIS, input documents are maintained as daily diaries and various other registers. Process Documents are maintained as separate registers for each service under RCH. Output Documents are in the form of Reports generated at various levels. The current Information flow in Urban Health System of AMC is shown in Figure 3.4.

Figure 3.4 Urban Health Management Information System in AMC



We recommend that the paper based system of data recording and preparation of reports be replaced by a computer bases MIS.

4. Design, Development and Implementation of a PPP for Effective Urban Health Services: The case of Vasna UHC

4.1 Design and Development of a model PPP

Given the poor availability of government health facilities, and the presence of a large number of private health facilities in urban areas, we have brought together compatible public and private partners to plan and deliver quality healthcare services to meet the community needs. Formalizing this requires conceptualising a framework for Public Private Partnership (PPP) to manage the UHC. Establishing a PPP requires a legal framework acceptable to all the partners, clarity on the commitment of resources, roles and responsibilities of each partner, as well as accountability to provide a given set of services at a desired level of quality and affordable user charges.

We discuss below our PPP Model for Vasna UHC. Based on our analysis of we have developed after a detailed study of urban health in Vasna ward (Ramani, 2006).

GCS will construct a UHC in Vasna, next to its Community Oncology Centre (COC) as per the government norms and hand it over to AMC.

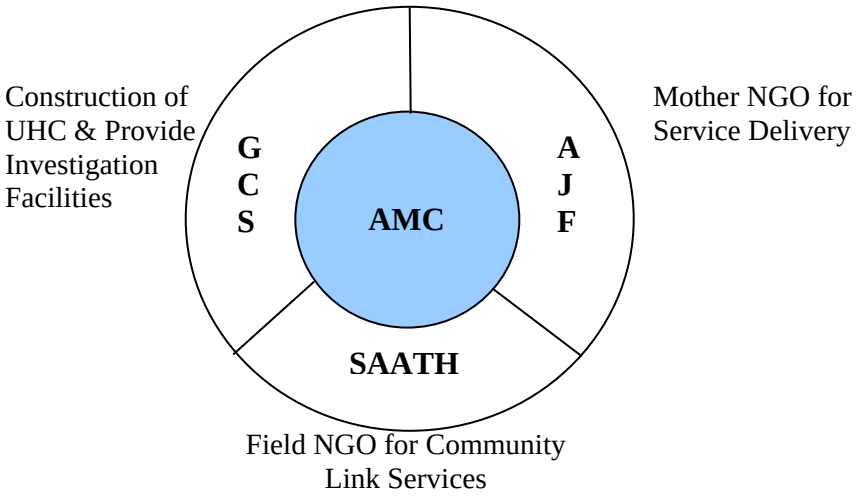
GCRI will offer its investigation services to UHC patients at GCRI rates, which are lower than AMC hospital rates

AMC will provide all the necessary resources as per government circular for UHCs

The current Service NGO, namely AJF, will shift its UHC operations from Paldi to the new location of Vasna UHC in GCS compound

The current, field NGO, namely SAATH, will continue to provide community link services to Vasna UHC

Figure 4.1
Public Private Partnerships to establish Model UHC



4.2 Implementation of the PPP for Vasna UHC

4.2.1 MoU between AMC and GCS: The Gujarat Cancer Society in the Meeting of its Governing Council held on January 7th, 2006 approved our proposal and assured its support in the proposed PPP. (See Exhibit 3) This meeting was chaired by His Excellency, the Governor of Gujarat, in his capacity as the President of the Gujarat Cancer Society.

The Standing Committee of AMC, in its meeting on April 27th, 2006 approved the construction of Vasna UHC by GCS in its Vasna compound and hand it over to AMC. (See Exhibit 4) AMC will be responsible for providing UHC services for Vasna community through a mother NGO and a field NGO. A Management Committee will be set up consisting of representatives from AMC, GCS, Indian Institute of Management Ahmedabad, mother and field NGOs, as well as local representatives to plan and monitor the service delivery from the Vasna UHC.

Subsequently, the AMC Board, in its meeting held on June 23rd, 2006 endorsed the recommendations of the AMC Standing Committee. A Memorandum of Association (MoA) has been signed to the above effect between AMC and GCS (See Exhibit 5). GCS will, in turn request GCRI to provide investigation services, while AMC will oversee the health service delivery through mother and field NGOs.

4.2.2 Contract between AMC and Service provider NGO: Establishing a Public Private Partnership for service delivery from UHC is a two step process: Selection of a suitable partner NGO and then a legal agreement for service delivery.

Step 1: Selection of Service NGO: The first step in this process is the selection of NGOs, while establishing a PPP for UHC. Such a selection should be through a bidding process. The selection criteria would include an assessment of the technical capacity of the NGOs, past experience with similar activities, relative standing of NGOs in the wards, and so on. We suggest that AMC follows the National AIDS Control Organization (NACO) guidelines for the selection process of NGOs. We have modified the selection process so as to meet the AMC needs for selecting suitable NGOs for PPP. (See Exhibit 6)

This step may be waived by AMC if an NGO which is already providing UHC services satisfactorily in Ahmedabad is willing to serve the new UHC. Accordingly, AJF was selected as Service NGO for the new Vasna UHC.

Step 2: Contracting with Service NGO: The second step is to enter into a contract for service delivery between AMC and the NGO. Based on our learning from the several case studies, we formulated a model contract between AMC and Akhand Jyot Foundation (AJF) for managing the new Vasna UHC. Note that AJF is currently a UHC service provider. We held several meetings with AMC and AJF before and during the preparation

of the draft agreement. We discussed several aspects of ensuring service quality for urban poor in the ward and proposed mechanisms to address the concerns of both parties, taking into account the community needs. The role, responsibility, and accountability of AMC and AJF in the provision of good quality primary healthcare services were clearly spelt out. Subsequently, IIMA facilitated a meeting between both the parties to negotiate the formal contract. IIMA played the role of a facilitator in discussing the contract to ensure the sustainability of PPP and taking an unbiased view from the perspective of patients and communities' welfare (See Exhibit 7). AMC has since entered into formal contract with AJF for managing the Vasna UHC. (See Exhibit 8).

4.2.3 Contract between AMC and Filed NGO: At present, there is a formal agreement between AMC and Filed NGO (see Exhibit 9). We found it satisfactory for providing community link services to Vasna UHC. However, there are certain observations in order to make it more sustainable:

The link worker scheme currently covers expenses for community link workers but there is no provision for a position for managing these link workers. There is need for one position at managerial level for supervision, performance monitoring and generating reports. It is therefore worthwhile to introduce such a position in the current agreement. AMC is also aware of this requirement and our proposal is under consideration.

4.2.4 Capacity Building: IIMA held a training program for all UHC staff in Ahmedabad including the staff at all levels for the new Vasna UHC. This program was aimed at capacity building to manage the UHC under the new PPP arrangement, which offers comprehensive primary health services, including investigations (lab and radiology services) for the first time in India.

4.2.5 Management Committee Meetings: The Management committee has met twice to discuss the details of managing the UHC under the new PPP (Exhibit 10 and Exhibit 11).

4.3 Recommendations:

HR Management: As mentioned in the earlier section, the Staff for the UHCs is drawn from three different organizations: (i) AMC, (ii) Reproductive and Child Health (RCH) Society, and (iii) the Department of H & FW, Government of Gujarat. Some MPWs are appointed by the RCH Society and some by the Department of H & FW, Government of Gujarat. It may be better if staffs with the same designations are not appointed by several departments.

The role of RCH Society (Mother NGO) as articulated in the NACO guidelines should be followed in UHCs as well.

After several discussions with all the stakeholders, we realize that it would be better to have only one NGO for service provision as well as community link. It would reduce the

burden of managing partnerships for the public sector (AMC) and also reduce the lack of coordination between two NGOs for essentially interlinked activities in the field and facility (See our comments earlier section). We have proposed to incorporate this concern in new partnerships that AMC may enter in future.

We recommend having only one NGO for both community link services and managing the UHC so as to facilitate a well coordinated effort to improve the urban health service delivery as per community needs.

5. Conclusions

The new Vasna UHC in the GCS compound, Vasna was inaugurated by the Chief Minister of Gujarat Shri Narendra Modi on July 23, 2007 (Figure 5.1). The inauguration by the CM has helped galvanize the political will to improve the urban health services. As a result, the State Department of Health and Family Welfare has requested IIM Ahmedabad to extend the Vasna Model throughout Gujarat state.

Figure 5.1
The Chief Minister Shri Narendra Modi inaugurating the UHC at Vasna

Prof. K V Ramani with Mr. Amit Shah (Mayor AMC), Mr. Narendra Modi (Chief Minister of Gujarat), Mr. Ashok Bhat (Health Minister of Gujarat) and Dr. Pankaj Shah (Director, GCRI) at the Inauguration Ceremony of the Vasna UHC.

For any successful PPP, it is essential that each partner respects the contributions from all other partners, as each partner offers complementary skills. No single partner should ever assume higher importance over others. It is also necessary to frequently monitor the performance of the UHC service delivery. The role of IIM Ahmedabad in the Vasna UHC Management Committee is therefore very crucial in sustaining the PPP arrangements between the partners in ensuring improved services to meet the community needs for healthcare.

This UHC is now serving about 100 OPD patients cases every day, which used to be an average monthly load in its earlier location at Paldi (Figure 5.2).

Figure 5.2
Patient queue at the new Vasna Urban Health Centre

Unfinished Tasks: It is necessary for the ward officers in charge of sanitation, malaria control etc to co-ordinate their work with the UHC. The disease profile of the ward and epidemic mapping has not yet started. Many para medical services such as physiotherapy, dental care, eye care etc. are not part of the UHC so far. Provision for such additional services has to be developed so as to offer comprehensive primary healthcare services in UHCs.

Discussion are underway with AMC to extend the Vasna UHC (Tier I model of OPD clinic) to a Tier II model of Maternity Home in Naroda Road

Exhibit 1a
AMC Circular on UHCs (Original in Gujarati)

RCH

THE URBAN RCH SOCIETY

CHARITY TRUST R. NO. 9825 DT. : 30-12-03

Office Add. : City Family Welfare Bureau, Dinbai Tower, Mirzapur Road, Ahmedabad-380 001.

CHAIRMAN
Shree R. K. Tripathi I.A.S.
Municipal Commissioner
Ahmedabad Muni. Corp.

Ref. No.

SECRATERY
Dr. P. K. Makwana
Medical Officer of Health
Ahmedabad Muni. Corp.

Date : 2-૪-૦૬

પ્રતિ
(૧) પરિવાર કલ્યાણ અધિકારીશ્રી - ઝોન ઝોનલ
(૨) RBD
(૩) DTO- RNTCP
(૪) PM- AIDS- Control Society.
(૫) DYHO Malaria.

અર્બન RCH પોગ્રામ હેઠળ ૪૩ વોર્ડમાં અર્બન હેલ્થ સેન્ટર તા.૧-૩-૦૪ થી શરૂ કરવામાં આવેલા છે. અર્બન હેલ્થ સેન્ટર ધ્વારા નીચે મુજબની આરોગ્ય સેવાઓ નાગરિકોને આપવાની છે. જેમાંથી અમુક સેવાઓ તમારા વિભાગનેલગતી છે.

(૧) જન્મ અને મરણ રજીસ્ટ્રેશન - (RBD)
(૨) લાયક દંપતિનું રજીસ્ટ્રેશન અને પરિવાર કલ્યાણ સેવાઓ - કાયમી અને હંગામી - (FW)
(૩) સગર્ભા બહેનોનું રજીસ્ટ્રેશન એન્ટીનેટલ કેર, નેટલ, પોસ્ટનેટલ સારવાર અને જોખમી માતાઓ શોધી જરૂરી રેફરલ સેવાઓ આપવા. - (FW) ICDS
(૪) તબીબી સારવાર - ન્યુમોનીયા, ઝાડા, ઝાડા-ઉલ્ટી, તાવ STD- RNTCP
(૫) વિટામીન-એ અને આયર્ન અને ફોલીકેસીડની ગોળીઓનું વિતરણ - (FW) ICDS
(૬) રાષ્ટ્રીય આરોગ્ય કાર્યક્રમોનો અમલ:-
:અ: રિવાઇઝડ્ નેશનલ ટી.બી. કન્ટ્રોલ કાર્યક્રમ -(DTO- RNTCP)
:બ: રક્તપિત્ત, સ્કૂલ હેલ્થ - (FW)
:ક: મેલેરીયા -ડેન્ગ્યુ નિયંત્રણ- તાવના કેસોમાં લોહીના નમૂના, લઈ લેબોરેટરીમાં તરત જ તપાસ કરી સારવાર આપવી. (MALARIA)
:ડ: જાતિય રોગો નિયંત્રણ- (AIDS Control Society)
(૭) ચેપીરોગોનું નોટિફીકેશન અને નિયંત્રણ
(૮) આરોગ્ય શિક્ષણ
(૯) ઈમ્યુનાઇઝેશન -
(૧૦) સર્વેલન્સ-નીઓનેટલ ટીટનેસ, બાળલકવો, ઓરી, ડિપ્થેરીયા, ટી.બી., રક્તપિત્ત, આંખના મોતિયાના કેસો અંધાપો નિવારણ- STD
૦-૧ ના બાળકોના મૃત્યુ અને કારણો

RCH-1 ૨૦

- સગર્ભા માતાઓનાં મૃત્યુ અને કારણો
(૧૧) ઘર સુવાવડ બંધ કરવા જરૂરી વાતાંવરણ ઉભું કરવું.

નાગરિકોને આરોગ્ય શિક્ષણ આપી જન-જાગૃતિ કેળવવા અને લાભાર્થી બાળકો, સગર્ભા માતાઓ, લક્ષિત દંપતિ, શંકાસ્પદ ટી.બી.ના દર્દી, શંકાસ્પદ જાતિય રોગોના દર્દીઓ, મેલેરીઆ-ગ્રેન્ચ્યુ, રક્તપિત્ત, આંખના મોતિયાના કેસો વિગેરે ને સમજાવી હેલ્થ સેન્ટર ઉપર જરૂરી RCH અને તબીબી સેવાઓ માટે લાવવાના રહેશે. એકપણ લાભાર્થી બાકી ન રહે તે પ્રકારનું વાતાવરણ ઉભું કરવા લાભાર્થીઓ અને શંકાસ્પદ દર્દીઓનો સર્વે રજીસ્ટ્રેશન, આરોગ્ય શિક્ષણ આપી જન-જાગૃતિ કેળવવા અને લાભાર્થીઓને RCH અને તબીબી સેવાઓ સમયસર આપવા સંકલનથી કામ કરવા સુચના આપવામાં આવે છે.

FW, Malaria, RBD, IMMUNISATION, RNTCP, AIDS Control Society, ICDS વિગેરેએ તેમનો સ્ટાફ અને NGO ની પૂરી મદદ આપવી અને તમામ ૪૩ UBC ની વિઝીટ કરી મેડિકલ- પેરામેડિકલ સ્ટાફને જરૂરી માર્ગદર્શન આપી કાર્યક્રમનું મોનીટરીંગ કરવું.

RCH, આઈ.સી.ડી.એસ, રિવાઈઝડ નેશનલ ટી.બી.કન્ટોલ કાર્યક્રમ અને એઈડસ કંટોલ કાર્યક્રમ હેઠળ સેવાઓ આપતી NGO અને સ્ટાફ દ્વારા RCH સેવાઓ હેઠળ આવરી લીધેલ તમામ કાર્યો અને કામગીરી માટે તેમને ફાળવેલ વસ્તી અને વિસ્તારમાં આરોગ્ય શિક્ષણ, જન-જાગૃતિ કેળવી શંકાસ્પદ દર્દીઓ અને લાભાર્થીઓને અર્બન હેલ્થ સેન્ટર ઉપર RCH અને તબીબી સેવાઓ માટે લાવવા યોગ્ય વાતાવરણ ઉભુ કરવામાં અર્બન હેલ્થ સેન્ટરના મેડિકલ ઓફિસર અને પેરામેડિકલ સ્ટાફ સાથે સંકલનમાં રહી નાગરિક સેવાઓ આપવા સૂચના આપવામાં આવે છે.

(ડો.પી.કે.મકવાણા)
આરોગ્ય અધિકારી
અને સેક્રેટરી RCH સોસાયટી

નકલરવાના:
(૧) Addl. MOH (East Zone)
(૨) Addl. MOH (Central Zone)
(૩) Dy.H.O. (North Zone)
(૪) Dy.H.O. (south Zone)
(૫) Dy.H.O. (West Zone)
(૬) M.O.- ૪૩ અર્બન હેલ્થ સેન્ટર
(૭) CDPO ICDS I & II

Exhibit 1b
AMC Circular on UHCs (Translated into English)

The URBAN RCH SOCIETY
CHARITY TRUST NO. 9825 DT. : 30-12-03.

OFFICE ADD. : City Family Welfare Bureau, Dinbai Tower; Mirzapur Road, Ahmedabad.

CHAIRMAN
Shree R. K. Tripathi I.A.S.
Municipal Commissioner,
Ahmedabad Municipal Corporation
Corporation

SECREATARY
Dr. P. K. Makwana
Medical Officer of Health,
Ahmedabad Municipal

Ref. No Date: 02-04-04

To,
1. Family Welfare Officer
2. RBD
3. DTO – RNTCP
4. PM – AIDS – Control Society.
5. DYHO Malaria.

Under the Urban RCH project Urban Health Centers are started in 43 wards from dt.1-03-04. The services mentioned below will be provided through urban Health Center to the citizens out of which certain services are relevant to your department.

1. Registration for Birth and Death (RBD)
2. Registration of eligible couple and Family planning Services—Permanent and Temporary (FW)
3. Registration of Pregnant women, Antenatal Care, Natal and Post natal Care, and to identify the complicated cases and to provide referral services. (FW) ICDS.
4. Medical Treatment for Pneumonia, Diarrhea, Diarrhea- Vomiting, fever, and STD – RNTCP.
5. Distribution of Vitamin A & Iron and Folic Acid Tablets- (FW) ICDS.
6. Implementation of National Health Programs:
    a) Revised national T. B. Control Program—(DTO- RNTCP)
    b) Leprosy, School Health—(FW)
    c) Malaria- Dengue prevention, to collect blood samples in case of fever, and send to laboratory for investigation immediately and to provide treatment.
    d) Sexually Transmitted diseases (AIDS CONTROL SOCIETY)
7. Notification and control of contagious diseases.
8. Health Education
9. Immunization
10. Surveillance—Neonatal Tetanus, AFP, Measles, Diphtheria, T.B., Leprosy, Cataract, Blindness, STD

Reasons for death of Infant between 0-1 yrs.
Reasons for death of pregnant women.

11) To create environment to stop home deliveries

Impart Health education and bring public awareness and to convince and bring beneficiaries as children, pregnant mother, eligible couples, suspected T.B. cases, Suspected STD, Malaria Dengue, Leprosy, Cataract cases to the health center for RCH and medical services. It is strongly recommended to work in coordination to create such an environment that no single beneficiary is left out from the RCH and medical services. In order to achieve this, the survey for beneficiaries and suspected cases should be conducted and they should be registered. Health education should be provided to them for public awareness.

FW, Malaria, RBD, IMMUNISATION, RNTCP, AIDS Control Society, ICDS staff should give support to NGOs and to visit 43 UHC and provide guidance and monitoring of medical and paramedical staff.

It is informed to RCH, ICDS, RNTCP AND AIDS Control Program under which services are provided by the NGO's and there staff should work in coordination with Urban Health Center Medical Officer and paramedical staff to create the environment for bringing the suspected patients and beneficiaries to Urban Health Center for RCH and medical services from their allotted population and area through Health education and public awareness.

-Sd-
(Dr P. K. Makwana)
Health Officer,
& Secretary RCH society.

C.C to

1) Addnl . MOH (East Zone)
2) Addnl. MOH (Central Zone),
3) Dy H.O. (North Zone)
4) Dy H.O. (South Zone),
5) Dy H.O. (West Zone)
6) M.O. 43 Urban Health Center,
7) CDPO ICDS I & II.

Exhibit 2a
Input Documents of HMIS

Register No		**Register Name**	**Prepared by**
1	Register 1 (a)	Daily Dairy	L. W.
	Register 1 (b)	Daily Dairy	M. P. W.
	Register 1 (c)	AMC : Malaria Dept (SF-2)	LW / MPW
2	Register 2 (a) & Register 2 (b)	Eligible Couples Survey Register	LW / MPW
3 Family Welfare Services Registers	Register 3 (a)	Male / Female Operation Register.	MPW
	Register 3 (b)	Copper T Register	MPW
	Register 3 (c)	Oral Pills Register	MPW
	Register 3 (d)	Nirodh Register	MPW
	Register 3 (e)	MTP Register	MPW
4	Register 4	Maternal Care Reregister	MPW
5	Register 5	Child Care and Immunization	MPW
6	Register 6	Malaria Register	Lab Technician
7	Register 7	Stock Register	LHV and MO
8	Register 8	Birth and Death Register	RBD Clerk
9	Register 9	OPD Register	LHV and MO
10	Register 10	Vaccine Camp	LHV and MO
11	Register 11	IEC Register	LHV and MO
12	Register 12	Green Card Register	LHV

Exhibit 2b
Output Documents of HMIS

Report No	Report Name	Prepared By
Report 1	Green Card Report	L.H.V
Report 2	Monthly Report of MPWs	L.H.V
Report 3	Family Planning Technique Report	L.H.V
Report 4	Form -8	L.H.V and M.O
Report 5	Categorization of Sterilization and Copper –T (according to G-form)	L.H.V
Report 6	Monthly Report on Oral Contraceptive Program	L.H.V
Report 7	P2- Nirodh Information of Stock	L.H.V
Report 8	CSSM & FW Services Report	L.H.V
Report 9	Universal Immunization Program. Monthly Urban Center Performance Report	L.H.V
Report 10	Malaria Report	L.H.V
Report 11	Infant Mortality Report	L.H.V
Report 12	Monthly Report of Link Worker	L.W.
Report 13	Monthly Report On RCH Involvement Activities.	L.H.V
Report 14	OPD Case Report	L.H.V and MO
Report 15	Public Awareness Report	L.H.V and MO
Report 16	Quarterly Report On Performance of Urban Family Welfare Centers submitted to State Unit.	L.H.V and MO
Report 17	Report of Urban RCH Centres for the Year	F.W.O

Exhibit 2c
Input Output Relationships of HMIS

Inputs	Process	Outputs
Green Card Register	13	R1 Green Card Report
Daily Diary 1b	2b, 3a, 3b, 3c,3d, 3e, 4, 5	R2 MPWs Monthly Report
Daily Diary 1a, Daily Diary 1b	2a, 2b, 3a, 3b, 3c, 3d	R3 Family Planning Techniques Report
Daily Diary 1a, Daily Diary 1b	3a, 3b, 3c, 3d, 3e, 4, 5, 7, 8	R4 Form 8
Daily Diary 1a, Daily Diary 1b	3a, 3b	R5 Categorization as per G form
Daily Diary 1a, Daily Diary 1b	3c, 7	R6 Oral contraceptive report
Daily Diary 1a, Daily Diary 1b	3d, 7	R7 Condoms Report
Daily Diary 1a, Daily Diary 1b, OPD Register 9	4, 5, 9	R8 Child Survival and Safe Motherhood Report
Daily Diary 1a, Daily Diary 1b, OPD Register 9, Vaccine Camp Register 10	4, 5, 9, 10	R9 Immunization Report
Malaria Register	6	R10 Malaria Report
Daily Diary 1a, Daily Diary 1b	5	R11 Infant Mortality Report
Daily Diary 1a, Eligible Couples Register 2a	1, 2a	R12 Link Workers' Monthly Report
OPD Register 9	9	R13 RCH Involvement Activities Report
Form 8	Form 8	R14 Quarterly Report
OPD Register 9	9	R15 OPD Report
IEC Register 11	12	R16 IEC Activities Report

Exhibit 3
Minutes of the meeting held on January 7th, 2006

Venue: Community Oncology Centre, Vasna

Members Present:

Pandit Shri Nawal Kishore Sharma H.E. the Governor of Gujarat & President, GCS
Shri Arvind Narottam Vice President, GCS & Executive Chairman
Shri Amarjit Singh, IAS Commissioner of Health Services
Shri Deepak Navnitlal, Vice President, GCS
Shri Anil R. Bakeri, Vice President, GCS
Shri Prashant Kinnarivala, General Secretary, GCS
Dr. Pankaj M. Shah Hon. Director, GCRI
Shri Kshitish Madanmohan, Secretary, GCS
Smt. Bhartiben Parikh, Treasurer, GCS
Shri Kaushik D. Patel, Treasurer, GCS
Dr. Shilin N. Shulkla, Joint Secretary GCS
Dr. Kirti M. Patel, Joint Secretary, GCS
Dr. N L Patel, X-Director GCRI
Shri. Amrish H. Parikh, Member GCS
Prof. K. V. Ramani, IIM Special Invitee
Shri. BharatBhai Kshatriya, Member GCS
Smt. Padmaben JayKrishna, Member GCS
Shri. Sudhirbhai Nanavati, Legal Advisor
Shri, Chandra Vardhan R. Patel, Member GCS
Shri Dilipbahi Sarkar, Member GCS
Shri N.T Chavda, Hospital Administrator GCRI & Member GCS
Smt. Zarine Naushir Cambatta, Member GCS
Shri. V. J. Shah, Statutory Auditor, CC Chokshi and Co.
Shri. Yogesh Shah, Income Tax Consultant, CC Chokshi and Co.
Shri. Bipin M. Shah, Internal Auditor, Shah Brothers
Shri Malav J. Shah, Member GCS
Smt. Madakini P. Bhagwati, Member GCS

Relevant Excerpts on UHC for Vasna:

Dr. Pankaj Shah Hon. Director, informed about the "Urban Health Project" and requested Prof. Ramani to dive details. Prof. Ramani explained the importance of the project and the role played by GCS, GCRI, Ahmedabad Municipal Corporation and other non-government organizations. He also explained the benefit received from this project by poor and needy people of surrounding areas of Vasna and gave reasons of selecting Community Oncology Center Vasna for this project.

Exhibit 4a

Relevant Excerpts from Standing Committee Meeting held on January 7th 2006

શરતોઃ-

૧. સદરહુ જમીનમાં ગુજરાત કેન્સર સોસાયટી અર્બન હેલ્થ સેન્ટર માટે જરુરીયાત મુજબનું ક્ષેત્રફળ ધરાવતા લેબોરેટરી, પાણી, લાઈટફીટીંગ, ડોકટર રુમ, દર્દીઓનો વેઈટીંગ રુમ, વીઝીટીંગ રુમ, દવાનો સ્ટોર રુમ વગેરે જેવી ઉપલબ્ધ તમામ સગવડ સાથે ઓછોમાં ઓછા ૬ રુમ ધરાવતુ મકાન પોતાના ખર્ચે બનાવી અમદાવાદ મ્યુનિ. કોર્પોરેશનને અર્બન હેલ્થ સેન્ટર ચલાવવા માટે મકાનનો કબજો આપવાનો રહેશે.

૨. અર્બન હેલ્થ સેન્ટર નું નામ : વાસણા અર્બન હેલ્થ સેન્ટર
અમદાવાદ મ્યુનિ. કોર્પો. તથા ગુજરાત કેન્સર સોસા. સંચાલિત (દાતાના નામ) રાખવાનું રહેશે.

૩. આ અર્બન હેલ્થ સેન્ટર માં કેન્દ્ર સરકાર, રાજય સરકાર અને અમદાવાદ મ્યુનિ. કોર્પોરેશનના માર્ગદર્શન મુજબ લાભાર્થીઓને માતૃબાળ કલ્યાણ સેવાઓ , આર.સી.એચ, ફેમીલી પ્લાનિંગ, તબીબી સેવાઓ સહીત રાષ્ટ્રીય આરોગ્યના વખતોવખતના ફેરફાર મુજબના કાર્યક્રમનો અમલ કરવાનો રહેશે.

૪. અમદાવાદ મ્યુનિ. કોર્પોરેશન પોતે અથવા એન.જી.ઓ. મારફતે આ મકાનનો ઉપયોગ અર્બન હેલ્થ સેન્ટર ચલાવવા માટે કરી શકશે.

૫. અર્બન હેલ્થ સેન્ટરની લેબોરેટરીમાં થતાં લેબોરેટરીના ઈન્વેસ્ટીગેશન અમદાવાદ મ્યુનિસિપલ કોર્પોરેશનના વખતોવખત ના નિયમો તથા પ્રવર્તમાન ચાર્જીસ મુજબ તથા આ ઉપરાંતના લેબોરેટરી ઈન્વેસ્ટીગેશન, એકસ રે અને અન્ય તબીબી સવલતો દર્દીઓને કેન્સર હોસ્પીટલ વાસણા દ્વારા તેમના વખતોવખતના પ્રવર્તમાન ચાર્જીસ મુજબ નાગરીકોને ઉપલબ્ધ રહેશે.

૬. આ કોન્ટ્રાકટ નો અમલ ૧૦ વર્ષ માટેનો રહેશે. ત્યારબાદ બન્ને તરફવાળાઓની સહમતીથી કોન્ટ્રાકટની મુદત વધારી શકાશે.

૭. સદરહુ મકાન અર્બન હેલ્થ સેન્ટર ના હેતુ માટે હોઈ તે સિવાયના અન્ય કોઈ હેતુ માટે ઉપયોગ કરવાનો નથી. જેથી બન્ને તરફવાળા વચ્ચે મકાન માલીક કે ભાડુઆત વચ્ચેનો સબંધ કોઈ રીતે ઉભો થતો નથી અને ભવિષ્યમાં પણ તેવો સબંધ ઉભો થશે નહિં.

૮. મજકૂર મિલ્કતનો ઉપયોગ હળીમળીને સંયુકતપણે પ્રત્યક્ષ કબજામાં રાખી કરવાનો છે અને તે રીતે બન્ને તરફવાળાના સુલેહ અને સંપર્કથી મિલ્કતનો ઉપયોગ કરવાનો છે.

૯. બન્ને તરફવાળાએ જયારે કોઈ સંજોગોમાં જગ્યા ખાલી કરવાની રહે કે થાય તો જગ્યા ખાલી કરવાના ત્રણ મહીના પહેલાં નોટીસ આપી તેમ કરી શકાશે.

૧૦. ગુજરાત કેન્સર સોસાયટીને પ્રતિ માસ રુ.૫,૦૦૦/- ગ્રાન્ટ તરીકે આપવાના રહેશે. ઈલેકટ્રીસીટી, ટેલીફોન, પ્રોપર્ટીટેક્ષ તથા અન્ય આનુસાંગિક નિભાવ ખર્ચ આરસીએચ સોસાયટી અથવા અમદાવાદ મ્યુનિ. કોર્પોરેશને ભોગવવાના રહેશે.

૧૧. અર્બન હેલ્થ સેન્ટર માટે મંજૂર થયેલ પ્લાન સિવાય વધારાનું કોઈ બાંધકામ કે ફેરફાર કરવાનો હોય તો બન્ને પક્ષની સંમતીથી મ્યુ. કોર્પો. નગર વિકાસ વિભાગની મંજૂરીથી કરી શકાશે.

૧૨. વાસણા વોર્ડના અર્બન હેલ્થ સેન્ટરના સંચાલન માટે એક કમિટીની રચના કરવામાં આવશે જેમાં મેયરશ્રી, મ્યુનિ. કમિશ્નરશ્રી, ડે.મ્યુ.કમિ.શ્રી (હેલ્થ) તથા વાસણા વોર્ડના ચુંટાયેલા એક મ્યુ.કાઉ.શ્રી તેમજ ગુજરાત કેન્સર સોસા.ના બે સભ્યો, આઈ.આઈ.એમ. અમદાવાદના બે સભ્યો તથા સ્વૈચ્છિક સંસ્થા જેને આર.સી.એચ. અર્બન હેલ્થ સેન્ટરની કામગીરી સોપવામાં આવેલ હોય તેના એક પ્રતિનિધિ રહેશે. તેઓ વખતોવખત અર્બન હેલ્થ સેન્ટરના કામકાજ અંગે મીટીંગ કરી જરુરી સૂચના તથા કામગીરીનું માર્ગદર્શન આપશે.

૧૩. આ મકાન માટે પાણી અને ડ્રેનેજની સગવડ મ્યુનિ. કોર્પો. દ્વારા વિના મૂલ્યે આપવામાં આવશે.

Exhibit 4b

Translation of Relevant Excerpts from Standing Committee Meeting held on January 7th 2006

Conditions:

1. Building for Urban Health Centre should be built by Gujarat Cancer Society at its own cost on specified land which should have minimum six rooms including laboratory, water, doctor's room, patient's waiting room, visiting room and medicine store etc. all facilities available and should be handed over to AMC to run the UHC.
2. Name of the Urban Health Center: Vasna Urban Health Center,
   Run by AMC and Gujarat Cancer Society (donor's name)
3. In this UHC, beneficiaries should be provided Mother and Child welfare services, RCH services, Family planning, medical services as per Central Govt., State Govt. and AMC guidelines as well as National Health Programmes should be carried out as per the changes made time to time.
4. AMC can use this building on its own or through NGO to run the Urban Health Center.
5. All laboratory investigations provided in Urban Health Centers should be made available to citizens as per the AMC rules and prevailing charges and apart from this, other laboratory investigations, X-Ray and other medical facilities will be made available to citizens by Cancer Hospital Vasna as per their prevailing charges.
6. This contract is valid for ten years. After that period of contract can be increased by both the parties' consensus.
7. Building is for Urban Health Centre purpose and should not be used for any other purpose. Hence there is no relationship of landlord and tenant between both parties and no such relationship would exist in future.
8. This property should be utilized in direct possession with cooperation nand both parties should use the property with mutual understanding and cooperation.
9. In any circumstances of evacuating the property by either of the parties, they can do it with the three months prior notice.
10. Gujarat Cancer Society should be given grant of Rs.5000/- per month. Electricity, telephone, property tax and related maintenance expenses should be bourn by RCH Society or AMC.
11. If there is any need to modify or construct the building other than the plan which has been approved for UHC, it can be done with both the parties consensus after getting approval of Department of Town Development.
12. To run the Vasna Urban Health Center one committee should be formed in which Mayor, Municipal Commissioner, Deputy Municipal Commissioner (Health), one elected municipal Councilor of Vasna ward, two persons from Gujarat Cancer Society, two persons from IIM Ahmedabad and one member of NGO to whom activities of RCH urban health center is given. They will meet regularly and will give necessary instructions and guidelines for the activities.

For this building, water and drainage facilities will be given by Municipal Corporation free of cost.

Exhibit 5
MoU between AMC and GCS

The Ahmedabad Mercantile Co-op. Bank Ltd., Maninagar Branch. GUJ/SOS/AUTH/AV/ 45/2006

भारत 07269 SPECIAL ADHESIVE गुजरात
186584 NOV 10 2006
14:03
Rs.0000100/- PB5631
INDIA STAMP DUTY GUJARAT

NOTARIAL NOTARIAL
NOTARIAL NOTARIAL

SERIAL NO. 322/2006
NOTARY
NOV 2006

MEMORAMDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING arrived at Ahmedabad on this 18th day of November, Christian year Two thousand six, between the **Municipal Corporation for the City of Ahmedabad,** a Corporation established under the provisions of the Bombay Provincial Municipal Corporations Act, 1949, having its office at Sardar Patel Bhavan, Danapith, Ahmedabad (hereinafter referred to as "the Corporation" (which expression shall unless it is repugnant to the meaning and context thereof shall mean and include the said Corporation and its successors and assigns) of the **ONE PART** and the **Gujarat Cancer Society**, a Society registered under the Societies Registration Act, 1860, and also registered under the Bombay Public Trust Act, having its office at New Civil Hospital Complex, Ahmedabad - 380016 hereinafter referred to as "the Society" (which

expression shall unless it is repugnant to the meaning and context thereof shall mean and include the said Society, its Trustees for the time being and their respective heirs, executors, successors and assigns) of the **OTHER PART,**

WHEREAS the Corporation was seized and possessed of or otherwise well sufficient entitled to a vacant piece and parcel of land bearing Final Plot No. 317 of Mouje Vasna in the Registration District Ahmedabad, Sub District Ahmedabad 4 (Paldi) and more particularly described in the schedule hereunder written (which land is hereinafter referred to as the "said land"). Plot Assoc

AND WHEREAS the Corporation leased the said land to the Society for a period of 99 years on the terms and conditions contained in its Resolution No. 2026 dated 12-1-1989 and General Meeting Resolution No. 917 dated 27.11.1989 on yearly token rent of Rs.101/- per annum;

AND WHEREAS at the request of the Corporation Indian Institute of Management, Ahmedabad (IIM for short) undertook a study to find out a suitable place for relocating for shifting the Urban Health Centre at Vasana and after making necessary enquiries and physical visits, IIM was of the opinion that the aforesaid land, especially in view of its vicinity of Oncology Centre run by the Society would be a suitable place for establishing such Urban Health Centre on yearly token rent of Rs. 101/- per annum.

AND WHEREAS the Corporation requested the Society to build up a building on the said land at the cost of the Society for the user of the said land and building for 'Urban Health Centre' and hand over the possession thereof to the Corporation by its letter dated 29th September, 2005, a copy whereof is annexed hereto and marked **ANNEXURE "A";**

AND WHEREAS the Society acceded to the request of the Corporation for construction of a building and to hand over the same to the Corporation, to run such Urban Health Centre on the terms and conditions mutually agreed between the parties which are recorded herein.

NOW THIS MEMORANDUM OF UNDERSTANDING WITNESSETH THAT:-

1) This contract shall remain in force for 10 years and the period shall be extended by consent of both the parties.

2) For the purpose of rendering health and medical services to the residents of Vasna, Ahmedabad, the Society shall on the above land construct a building for the Health Centre as per the required area containing minimum six rooms having other facilities like Laboratory, water, light fittings, Doctors Room, Waiting Room for patients, visitors room, medicine store room and such other necessary fixtures at its own cost and shall hand over the possession thereof to the Corporation for

restricted purpose of running an "Urban Health Centre" (the said building and the said land are hereinafter referred to as "the premises").

3) Name of the Urban Centre shall be Ahmedabad Municipal Corporation & GCS run MADAN MOHAN RAMANLAL Vasna Urban Health Centre.

4) The said Health Centre shall be run by the Corporation through its own competent and qualified staff or with prior written permission of the Society by a non-government organization through the competent and qualified staff.

5) The Urban Health Centre shall implement National Health programmes from time to time including child mother services, R.C.H. family planning and other medical services as per the guidelines of Central Government, State Government and Corporation.

6) There shall be Committee constituted for the working and administration of the Urban Health Centre consisting of Mayor, Municipal Commissioner, Deputy Municipal Commissioner (Health), an elected Municipal Corporator of Vasna ward, two representatives of the Society, two representative of the non-government organization permitted to run the Health Centre. The Committee shall call for the meeting from time to time and will guide in the

administration and will give necessary instructions to run Urban Health Centre.

7) The Society shall provide necessary assistance for Laboratory investigation, X-Ray and other medical facilities at the usual rate charged by the society to other patients at its Community Oncology Centre run by it in the adjoining premises.

8) It is expressly agreed by and between the parties hereto that the Corporation is permitted to use the said premises only for running Urban Health Centre and not for any other purpose of any nature whatsoever.

9) It is expressly agreed by and between the parties hereto that the right to use the land and the building constructed thereon by the Society given by the Society to the Corporation shall be only as a Licensee and it will not create any relations of landlord and tenant or landlord and occupant of any nature whatsoever and it shall only be a permitted use by the Corporation for running the Urban Health Centre only and the Society shall have a right to enter the premises and use for its own purpose without disturbing the Corporation for carrying on its activities of Urban Health Centre.

10) The Corporation has agreed to pay Rs. 5000/- per month as grant for the use of the premises to the Society and the Corporation shall pay and bear all the necessary electricity

charges, property taxes, other rates, taxes and cesses in respect of the said premises and normal renovation, repairing and maintenance expenses.

11) The Corporation shall make the arrangement for water and sewerage for Centre, free of cost.

12) The Corporation shall not make any structural or major alterations in the said building. However if any further construction is required or alteration is required, the same shall be carried out with the consent of both the parties and with permission from Urban Development Department of Corporation.

THE SCHEDULE ABOVE REFERRED TO

All that piece or parcel of land lying, bearing and situate at Mouje Vasna, Taluka City, Registration District Ahmedabad and Sub District Ahmedabad-4 (Paldi) bearing Final Plot No.317 of Ahmedabad Town Planning scheme No.21 admeasuring about 4640 Sq.Mts. or thereabouts and bounded as follows :-

On or towards North : — Vasna- Sarkhej Road.
On or towards South: — F.P No. 318.
On or towards East : — F.P No. 315.
On or towards West: — F.P. No. 316.

And delineated by red colour boundary line on the plan annexed hereto.

IN WITNESS WHEREOF THE PARTIES HERETO HAVE SET THEIR RESPECTIVE HANDS AND SEALED AND SIGNED ON THE DAY AND YEAR HEREINABOVE WRITTEN

Signed, sealed and delivered)
by the Municipal Corporation)
for the City of Ahmedabad by)
the hand of Shri D.B. Makwana)
an officer of the Corporation)
duly authorized by the Municipal)
Commissioner by its order No.)
_____ dated 18th Nov 2006.

In the presence of:

1. _____

2. _____

Signed, sealed and delivered)
by the hand of Shri Prashantbhai)
Jivanlal Kinariwala, General)
Secretary of the Gujarat Cancer)
Society, duly authorized by the)
Resolution passed by the)
Executive Committee of the)
said Society at its meeting held)
on 18th Nov 2006.

In the presence of:

1. _____
(Navendrasinh T. Chavda)

2. _____

HOSPITAL ADMINISTRATOR
The Gujarat Cancer & Research Institute
(M. P. Shah Cancer Hospital)
AHMEDABAD-16.

SIGNED/SOLEMNLY AFFIRMED
BEFORE ME

N. K. SISODIA
NOTARY
GOVT. OF GUJARAT

18 NOV 2006

N. K. SISODIA AHMEDABAD GUJARAT STATE R. NO. [illegible] OF GUJARAT (INDIA)

Administrative Officer,
The Gujarat Cancer & Research Institute
(M. P. Shah Cancer Hospital)
Civil Hospital Campus,
Asarwa, AHMEDABAD-380016.

Exhibit 6
Selection process for UHC: adaptation of NACO guidelines to AMC

With the help of the NACO Guidelines, GSACS entered into a contract agreement with CASP to act as mother NGO. In accordance to the NACO Guidelines, CASP is responsible for selecting, monitoring and evaluating NGO's.
We suggest a similar model for AMC. The AMC has engaged the Urban RCH Society as the mother NGO.

Stepwise Selection Process: Proposed guidelines for AMC based on NACO Model

Particulars	NACO Guidelines	Proposed Guidelines for AMC
Invitation	CASP runs the Project Support Unit for the state of Gujarat and invites NGO's to provide services.	Currently the AMC invites the NGO's to provide services. We suggest the RCH Society to take over the responsibility of advertising and selecting NGO's that would provide services in each ward.
Expression of Interest	NGOs express their interest in providing particular services in particular area through letter of interest.	NGOs express their interest in providing particular services in particular area through letter of interest.
Submission of Inception Report	NGOs interested in providing services submit an inception report to CASP that includes details of NGO: their past activities, financial status, geographical work area, infrastructure available, organization structure etc.	Interested NGO's should be submit inception report to Urban RCH Society which should include details of NGO including their past activities, financial status, geographical work area, infrastructure available, organization structure etc.
Verification of information provided in inception report	CASP in collaboration with GSACS visit the NGO's and the community (including the local government authorities like district level health officers, banks) to verify the facts in the inception report. After this assessment an	RCH in collaboration with AMC should visit the NGO and the community (including local leaders, bank officials) to verify the facts provided in the inception report. After this assessment one NGO should be chosen per ward.

	NGO is chosen per area.	
Initial Contract for Need Assessment	Restricted to need assessment GSACS enters into an initial contract of 5 months with the NGO. GSACS provides training to NGO staff for baseline survey, data analysis, data presentation, preparing proposals etc. NGO will then carry out the baseline survey and prepare a proposal based on their need assessment for services.	Not Required
Scrutiny of proposal	NGO's submit proposal's after 5 months of need assessment and baseline survey. GSACS scrutinize the proposals based on their experience and ascertain the authenticity of the proposal. At this stage, if found inadequate they may deny the actual service provision contract.	Not Required
Service Contract	GSACS enters into a service contract with NGO's for the duration of 3 years and approve the one year's proposal and sanctions the budget for a year. The NGO appoints the required staff with having a member of GSACS in the selection committee. GSACS facilitates the exposure visits of new staff to field for 5 days. NGO starts providing services and submits monthly, quarterly and annual reports to GSACS. Other than this,	AMC would enter into the service contract with NGO for the duration of 3 years. In consultation with the Urban RCH Society, AMC would approve the one year's proposal and sanction the budget for a year. Other than this, every three months, their performance would be reviewed by Urban RCH Society in collaboration with AMC.

	every six months their performance is reviewed by GSACS. There is also an external review near the end of the year.	
Extension for continuing services for second and third year	Near the end of the first year, NGO's prepare the proposal for next year based on their first year's experience in the field and their modified need assessment. In order to continuing services in second year, GSACS sends a letter of extension of services based on their new proposal for second year. The same procedure will be repeated for third year also and work will continue after issue of letter of extension at the start of third year.	Near the end of the first year, NGO would prepare the proposal for next year based on their first year's experience in the field and their modified need assessment. In order to continue the services in second year, AMC would send a letter of extension of services based on their new proposal for second year.
Renewal of contract after end of the term	After initial three years, GSACS renews the contract with NGO's for another three years following steps 7 and 8. This cycle continues unless the NGO is not performing satisfactorily or NGO withdraws from the contract on its own.	After initial three years, AMC would renew the contract with the NGO for another three years with the approval of the Management Committee and the Urban RCH Society's verification team and. This cycle will continue unless, the NGO is not performing satisfactorily or NGO voluntarily withdraws from the contract.

Exhibit 7
Minutes of the Meeting for discussing the contract between AMC and AJF

Date: 22nd January 2007

Venue: KLMDC, IIM Ahmedabad

Members Present:

Dr. S.P. Kulkarni, Medical Officer of Health, Ahmedabad Municipal Corporation
Dr. Kinnari Mehta, Family Welfare Officer, Ahmedabad Municipal Corporation
Smt. Nirmala Patel, Trustee, Akhand Jyot Foundation
Shree Utpal Patel, Akhand Jyot Foundation
Shree Rakeshbhai, Project Co-ordinator, Akhand Jyot Foundation
Prof. K V Ramani, Indian Institute of Management Ahmedabad
Prof. Dileep Mavalankar, Indian Institute of Management Ahmedabad
Mr. Amit Patel, Project Associate, Indian Institute of Management Ahmedabad
Ms. Shilpa Maiya, Project Associate, Indian Institute of Management Ahmedabad

Minutes of the Meeting:

The meeting was arranged to facilitate the process of dialogue and discussion between the members of the two parties (AMC and AJF) regarding the contract agreement that is to be signed between the two organizations for running Model Urban Health Center.

Prof. Ramani began by discussing the importance of a model contract that the AMC could use so as to replicate in the other wards. He also explained that the contract between the AMC and AJF is one such model contract and is very important since there is no contractual agreement exists between AMC and AJF and other NGOs for managing the UHC.

Prof. Ramani discussed the previous arrangements of UHC and how the existing partnerships evolved. Dr. Mehta explained that AJF has the agreement with Government of Gujarat to function as Urban Family Welfare Center since 1966 which is based on a Government Resolution. In 2004, Ahmedabad got the Urban Health Project and converted all UFWC into UHC since GoI insisted in the formulation of the project that existing facilities should be considered for the development of Urban Health System to avoid duplication of infrastructure. Based on GoI sanction, AMC sent the orders to all UFWC to function as UHC but there was no agreement done between AMC and AJF (and other NGOs) to manage the UHC. However, Dr. Mehta suggested that AMC has requested Government of Gujarat to handover all UFWC to AMC so as to manage them as UHC. Dr. Mehta informed that two such letters have been sent to GoG in this regard but consensus is yet to be achieved. The serious concern was that until and unless there is a clear ownership of UHC in AMC area, it is difficult for AMC to make commitments since a lot of resources are still received from GoG to run these new UHCs. GoG has a

direct control over these resources and they monitor the performance and give targets.

Prof. Ramani requested Nirmalaben to read the draft contract so as to enable them to understand each clause properly.

There seemed to be a problem with the second clause regarding the consultation time. Nirmalaben was of the opinion that 30 minutes is a very rigid time for the consultation. Prof. Ramani answered to her query keeping patients' perspective in mind. He argued that 30 minutes is an ideal waiting time. Moreover AMC will also provide resources required for enabling this and AJF should also be allowed to recruit more staff if that is a constraint. Prof. Ramani was of the opinion that we should not have a fixed staffing pattern irrespective of patient load. If there are more patients, there should be more doctors to treat them. He suggested that this clause would link the patient load with the resource requirement.

There was a debate and discussion regarding the revised timings of the UHC. Dr. Kinnariben was skeptical whether the MPW's and link workers or the doctors would work from 4-9 in the evening. Prof. Ramani was of the view that the proposed timings are very important based on the community needs assessment that was carried out. There is a clear need to provide services in the evening hours to serve the poor in the area. AMC and AJF pointed out the service rules that GoG has set for the staff which doesn't allow breaking service and provides no flexibility in timings. Though Prof. Ramani considered the practical concerns of AMC and AJF, he suggested that this was an important point in Urban Health Project and GoI suggested keeping the timings based on community needs. He suggested that we may explore newer ways to ensure this. Prof. Ramani and Amit suggested a few alternatives to extend the UHC timings in evening hours. One of the suggestions was that one MO, one Lab Technician and one MPW is required during the evening hours to run the OPD and rest of the staff can perform during normal duty hours. For Medical Officer, it was suggested to recruit one more doctor on honorary basis for evening hours and expenses can be met through resources generated from patient fees. It was suggested that the evening service could be looked at as an optional service provided by the AJF in collaboration with AMC. Since this is an optional service provided, the AJF could charge more than the usual fees and retain the additional money with them to recruit the doctor on honorary basis. Dr. Kulkarni suggested that The MPW who works in evening hours can start later in the day and that can be mentioned in the recruitment letter. It was also suggested that two MPW's could be recruited especially for the evening hours and the other MPW's can work in the morning. For investigation, one suggestion was to train one MPW for sample collection and the test can be performed by Lab Technician next day and those patients may need to come again next day to collect the results.

AJF was expected to come out with the list of optional services that they are willing to provide from new UHC. The part of that contract (Annexure C) would only be formed after AJF's input. AJF informed that they would work out the feasible optional services that they could provide soon. AJF initially come out with the idea to have a de-addiction

center, yoga classes, physiotherapy, dental clinic etc. at the new UHC as a part of the optional services.

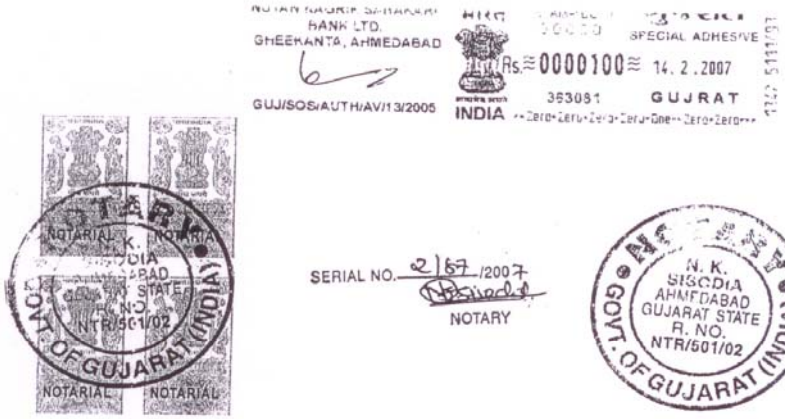
For recruiting staff, AJF was concerned about not getting the committed resources from RCH Society and GoG. For example, they have many positions vacant and it takes a very long time to recruit and fill the positions. It was discussed to take care of this in contractual agreement.

Regarding making resources available to AJF, AMC pointed out that there are several resources committed by GoG and AMC can not take responsibility. The crucial resources like Medical Officer and Lady Health Visitor are the people recruited under agreement between AJF and GoG and hence the success of this PPP depends on GoG committing the timely resources. Dr. Kulkarni pointed out the importance of handing over all UFWC located within the city limits to AMC for better management of the partnership.

Both partners appreciated the idea of retaining funds generated from service delivery for improvement of the services in UHC.

There was a concern for AJF regarding the contract period. Though AMC ensured that if service delivery is satisfactory, this contract can be extended for longer period.

Exhibit 8
Contract Agreement between AMC and AJF



SERIAL NO. 2/67/2007

NOTARY

AGREEMENT BETWEEN AHMEDABAD MUNICIPAL CORPOATION AND AKHAND JYOT FOUNDATION

This Agreement is between AMC (Ahmedabad Municipal Corporation) and AJF (Akhand Jyot Foundation) for the purpose of involving NGOs in delivery of healthcare services as suggested by Government of India guidelines for urban health project to encourage public private partnership in general and for Vasna ward and surrounding areas particular.

AKHAND JYOT FOUNDATION

Service Specification :

1. AJF shall provide quality healthcare services at a reasonable price. AJF shall coordinate with the field NGO for community service.
2. AJF shall ensure that services are provided in a reasonable time to the patients. No patients should be required to wait for more than 30 minutes for consultation.
3. AJF shall provide the UHC services from 9 am to 5 pm in accordance with GoI norms on Family Welfare Services. In addition to this timing, AJF shall explore possibilities of extending UHC services till 9 pm from the same facility so as to meet the community needs. AMC will have no objection to use of UHC beyond 5 pm and will try to provide MPWs if possible.
4. AJF shal provide the healthcare services as mentioned in Annexure "A" and patient amenities as mentioned in Annexure "B" to the patients visiting Vasna UHC.
5. AJF may provide optional services as mentioned in Annexure "C" from the same facility.
6. AJF shall refer its patients to GCRI for investigation services and to other AMC approved facilities for further care.

Administrative Specifications:

1. AJF shall use all resources provided by AMC exclusively for the intended purpose as per AMC norms.

1-1

NOTARY GOVT. OF GUJARAT (INDIA) N. K. SISODIA AHMEDABAD GUJARAT STATE R. NO. NTR/501/02

2. AJF may recruit staff to provide optional services as mentioned in Annexure "..." at its own cost or with donors' contribution duly acknowledged.

3. AJF shall maintain a dead stock register for all capital items received or purchased for this project under this contract.

4. AJF shall indent the required drugs and consumable to AMC as per AMC approved Drug Schedule well in advance.

5. In case of break down of any equipment, AJF shall immediately inform AMC. In case AMC fails to repair it within 2 days, AJF shall have the right to get it repaired and AMC shall reimburse the same.

6. In case AMC fails to supply the drugs and medicines within one month of indenting by AJF, AJF shall have the right to purchase and AMC shall reimburse the same.

7. AJF shall maintain the database and records of all the parameters of service provision in the prescribed format provided in Schedule I. AJF shall submit all the reports to AMC as provided in schedule II.

8. In case of termination of non-renewal of contract, Management Committee's approval shall be sought and Management Committee shall provide its recommendations to Ahmedabad Municipal Corporation. In case of termination or non-renewal of contract, AJF shall return to AMC all items received or purchased by AJF for this project under this contract.

9. AJF shall have the right and the duty to manage the UHC on day-to-day basis. Serious issues need to be referred to the Management Committee for approval.

10. AJF shall have the right to fill up 'leave vacancies' by ad hoc appointment for a maximum of period of three months.

AHMEDABAD MUNICIPAL CORPORATION

1. AMC shall have a right to monitor the functioning of UHC from time to time. AJF shall cooperate in such monitoring. AMC may ask the patients to contact them directly for feedback and any complaints.

2. AMC shall make available resources (financial, personnel, material, equipment, medicines and drugs, information systems etc.) to AJF as per government norms as illustrated in the Annexure "D", "E", "F", "G", "H" and "I".

3. In case AMC fails to make available all resources within stipulated time depending on the resources, AJF shall have the right to acquire the same as per AMC norms and AMC shall reimburse the same.

4. AMC shall provide adequate number of personnel to AJF. In case of 'leave vacancy', AJF shall have the right to fill it with suitable personnel and AMC shall reimburse the same.

5. AMC shall supply medicines and drugs within one week of the indenting if the medicines and drugs are stock. AMC shall supply medicines & drugs within maximum one month of indenting by AJF if they are not in stock.

1-2

6. AMC shall be responsible for maintenance and repairs of equipment, which shall be carried out in two days after being informed of equipment failure by AJF.

7. AMC shall provide necessary computer equipment (along with software) as per government norms. AMC shall provide the building with necessary infrastructure for the functioning of Urban Health Centre.

8. AMC shall be responsible for the maintenance and repair of the building. AMC shall bear all the charges of utilities including electricity, telephone, water and any tax etc.

9. AMC shall determine the user charges for the essential services provided by AJF and shall authorize AJF to collect these charges from the patients/consultant for improving service quality.

10. AMC shall be responsible for all coordination with the Central and State governments for making resources available to AJF.

N. K. SISODIA AHMEDABAD GUJARAT STATE R. NO. NTR/501/02 NOTARY GOVT. OF GUJARAT (INDIA)

GENERAL

1. A 'Management Committee' as constituted under the MOU between AMC and GCS shall be constituted for this contract also. It comprises Mayor, Municipal Commissioner, Deputy Municipal Commissioner (Health), and elected Municipal Corporator of Vasna ward, two representatives of the Gujarat Cancer Society, two representatives of Indian Institute of Management Ahmedabad and two representative of the non-government organization permitted to run the Urban Health Centre.

2. AJF shall seek the approval of the Management Committee in case of any major deviation from the AMC norms.

3. Any dispute arising out of this contract between AMC and AJF shall be resolved first by negotiation failing which by mediation of 'Management Committee' and ultimately by arbitration as per the law in India.

4. The agreement commences from the date of signing and shall be valid for a period of three years from commencement.

5. The agreement can be terminated by either party with a three months prior notice.

Date: '0 2 MAR 2007'
Ahmedabad.

Nirmala A. Patel
Managing Trustee
AKHAND JYOT FOUNDATION
Fatehpura Gam, B/h. Police Chowky,
Paldi, AHMEDABAD-380007.

1-3

Draft

Annexure "A"
Mandatory Services to be provided by AJF from Vasna UHC

To be provided by AMC. This annexure can be augmented in future as per the need and government directions time to time.

Illustrative Annexure is provided below:

1. Birth and Death Registration
2. Registration for the eligible couple and Family Welfare Services –temporary and permanent
3. Registration of the Pregnant women, antenatal care, natal, postnatal care and find the high risk pregnant women and provide them referral services
4. Primary health care for all the diseases through general OPD
5. Distribution of the vitamin-A and iron folic acid pills
6. National Health Programs
   - A: Revised National T. B. Control Program
   - B: School health, Leprosy
   - C: Malaria – Dengue Control – for the fever cases blood samples should be taken and investigate in laboratory for the immediate treatment.
   - D: Sexually Transmitted Disease Control
7. Notification and control of infectious diseases
8. Health Education
9. Laboratory Services
   Blood test of the Pregnant Women, Urine test, Hepatitis, infectious diseases
10. Immunization
    Every Monday, Wednesday, Friday at the facility
    Every Tuesday, Thursday, and Saturday in the community – from where all the slum area and Anganwadi beneficiaries can be covered.
11. Surveillance: Neonatal Tetanus, AFP, T.B, Measles, Diphtheria, Leprosy, Cataract, Blindness control
    - death of 0 to 1 year children and reasons
    - death of Pregnant women and reasons
12. To create the environment against the compulsory home deliveries.

Health education and explanation should be given to the people, children, pregnant women's, patients for sexually transmitted diseases, malaria, Dengue, eye cataract problems. RCH and other medical services to be provided at UHC.

Source: Family Welfare Office, Ahmedabad Municipal Corporation as on July 2006

Annexure "B"
Patients' Amenities to be provided at Vasna UHC

AJF shall be responsible to maintain following patient's amenities in working condition on day-to-day basis:

1. Waiting facilities
2. Citizen's charter: important information and notice
3. Drinking water facilities
4. Toilets
5. Signage and information of the facilities available

1-4

Annexure "C"
Optional Services to be provided by AJF from Vasna UHC

AJF will provide following optional services at its own cost from Vasna Urban Health Center. AJF may charge to the patients as they may clime fit for providing optional services. AJF may provide there services at their convenient timing provided it does not hamper the regular functioning of UHC. AJF may start or discontinue these services as per their consentience and availability of resources. AJF may seek donor's contributions for providing such services on their own.

The optional services are as follows :

1. Physiotherapy services.
2. Eye check-up.
3. Training for traditional Birth Attendent.
4. Ayurveda/Homeopathy/Naturopathy Services.
5. Dental Care Services.
6. De-addiction Services.
7. Yoga Classes

NOTARY
N. K. SISODIA
AHMEDABAD
GUJARAT STATE
R. NO.
NTR/501/02
GOVT OF GUJARAT (INDIA)

Annexure "D"
Information Systems

To be developed by AMC.
Illustrated list is provided below:

1. Computer with necessary software.
2. Network connectivity to central database of AMC.
3. Necessary training to the staff for maintaining database.

Annexure "E"
Personnel Resources

Following personnel resources shall be provided by AMC to AJF for Vasna UHC.

1.	Gynecologist:	1 position	Visiting (3 hours a day)
2.	Pediatrician:	1 position	Visiting (3 hours a day)
3.	Multi Purpose Workers:	7 positions	Full time
4.	Laboratory Technician:	1 position	Full time
5.	Vaccinator-cum-clerk (RBD)	1 position	Full time
6.	Class IV Servant	1 position	Full time

Annexure "F"
Materials to be provided by AMC to AJF

Provide list of materials that each UHC is entitled to receive.

Illustrative list is provided below:
AMC shall provide following materials to AJF for Vasna UHC:

Furniture:

1.	Medical Officers' Chair	1
2.	Medical Officers' Consultation Table	1
3.	Tables for MPWs	9 (Varies equals to no. of MPWs)
4.	Lab Technician's Chair	1
5.	MPWs Chairs	9 (Varies equals to no. of MPWs)
6.	Almirah	3

1-5

Draft

7. Racks	4
8. Stools	4
9 Benches	2
10. Examination Table	1
11. Locker	1

Stationary:

AMC shall provide following stationary to AJF for Vasna UHC as per indents by AJF:

1. Quire Book
2. Indent Book
3. Expense book
4. Dead stock register forms pad
5. Simple case paper pad
6. Outdoor statement of patient register
7. Tickets pads for clinical cases

Annexure "G"
Equipment to be provide by AMC to AJF

Provide list of equipment each UHC is entitled to receive.

Illustrative list is provided below:
AMC shall provide following medical equipment (capital items) to AJF for Vasna UHC:

1. Stethoscope complete (Duo sonic Chest)	1
2. B.P. Apparatus	1
3. Binocular Microscope	1
4. Haemoglobinemeter	1
5. Weighing Machine (Adult)	1
6. Weighing Machine (Baby)	1
7. Refrigerator ILR (Vaccines)	1
8. Deep Freeze	1

Provide List of equipment each UHC is entitled to receive on recurring basis.

Illustrative List is provided below:
AMC shall provide following equipment (recurring items) as per the indent by AJF for Vasna UHC:

1. A.B. Cotton Wool
2. AB. Surgical Suture Catgut usp
3. Angle poise lamp with Castor bulb
4. Arti Forceps
5. Autoclave single drum portable
6. B. P. knife handle No3-6
7. B.B. Silk reel (non sterile)
8. Beaker cap,150 ml,
9. Beaker cap,250 ml,
10. Beaker cap,50 ml,

6

1-G

Draft

11. Blotting Paper sheet
12. Clinical Thermometer
13. Counting Chamber glass
14. Covered Arti Swab
15. Disposable B.P. Knife Blade
16. Dressing drum SS Seamless
17. Freser's artery forceps
18. Funnel plain
19. Glass Marking Pencils
20. Glass test tubes without rim
21. Graduated pipette,10cc
22. Graduated pipette,1cc
23. Graduated pipette,5cc
24. Hemoglobin pipette
25. Hemoglobin square tube
26. Kocher artery forceps
27. Mayo's Scissor
28. Mayo's Scissor
29. Micro cover glasses square
30. Micro slides Grnd polished edge 3"X1"x1.3MM
31. Micro slides Grnd polished edge 3"X1"x1.5MM
32. Microscope Bulb
33. Mosquito Scissors 55
34. Mosquito Scissors 6 ¾
35. Newbaur Chamber
36. Plastic dropper bottle cylindrical type
37. Pregnancy test kit
38. Saline stand (fix stand with Castor)
39. Slide box plastic
40. Slide caring tray
41. Slide Stand
42. Slides
43. Spirit lamp , Aluminum,
44. Sputum cup (plastic small tin)
45. St Cutting Tri. Suture Needle No. 28 & 38
46. Staining jar plastic cylindrical
47. Sulfur Powder
48. Surgical rubber gloves
49. Surgical kidney tray
50. Surgical tray with cover
51. Swab Holder
52. Syringe needle Destroyer
53. Teepol 5 ltr jar
54. Test tube holder,
55. Test tube stand metal
56. Tongue Depressor
57. Uterine Seems Sound
58. Vaginal Wall Retractor
59. W.B.C. pipette
60. Waste receptacle
61. Whatman's Filter Paper

GCTARA
N. K. SISODIA
AHMEDABAD
GUJARAT STATE
R. NO.
NTR/501/02
GOVT. OF GUJARAT (INDIA)

1-7

7

Draft

Annexure "H"
Medicines & Drugs

To be prepared by AMC.

Illustrative annexure is suggested below:
AMC shall provide following drugs & medical supplies to Vasna UHC:

Drugs & Medical supplies as per the indents made by AJF from the AMC approved Drug Schedule. The Drug Schedule can be changed time to time as per AMC norms.

1. Adhesive Plaster Roll
2. Blood Group antisera "A",
3. Blood Group antisera "B"
4. Blood Group antisera "D"
5. Blood Lancet Needle
6. Gram's Iodine solution
7. Methanol (Methyl Alcohol)
8. Miconazole Cream
9. Rehydration electro oral powder
10. Bandages Rolls Ready
11. Tab. B-Complex
12. Tab. Chloroquin
13. Tab. Ciprofloxacin 500
14. Tab. Deriphylline
15. Tab. Dictofenac Sodium
16. Tab. Iluprifer 400 mg
17. Tab. Metoclopromide
18. Tab. Metronidazile 200mg
19. Tab. Paracetamol 500
20. Tab. Primaquin 2.5/7.5 mg
21. Tab. Ramitifine 150
22. Urine Test Strips
23. Syp. Metronidazole
24. Tab. Albendazole 400 mg
25. Tab. Amoxicillin 250 mg
26. Tab. Amoxicillin 500
27. Tab. Calcium 500
28. Tab. Chlorphenirame Melate
29. Tab. Dicyclomine HCL
30. Tab. Erythromycin 250 mg
31. Tab. Ferros Sulphate (200 mg)
32. Tab. Norfloxacin + Tinifozate
33. Tab. Paracetamol Kid
34. Dextrose Monohydrate IP 200 gm PKT
35. Acetic Acid I. P Glacial .1X 500 M.L Bottle (gynaec test)
36. Antiseptic Liquid (Chloroxynol 3%.DCMX 1.25%,Trepinol 9%
37. Liq. Antiseptic Hosp. Conc,CHL.HXY.GLU.5%,Cetrimide 15%IP
38. Parafin Liquid Heavy(for oral Use)
39. Cap Doxycycline HCL
40. Tab. Amoxicillin 150 mg (kids)

N. K. SISODIA AHMEDABAD GUJARAT STATE R. NO. NTR/501/02 GOVT. OF GUJARAT (INDIA)

1-8

8

Draft

41. Tab. Metronidazile 400 mg
42. Tab. Hydroxyethylene + Theophylin
43. Tab. Antacid
44. Tab. Ibuprofen 400mg
45. Tab.Diclophenic Sodium
46. Tab. Albendazole 400 mg
47. Tab. B-Complex
48. Tab Dictofenac Sodium.
49. Syp. Metronidazole
50. Cream Miconazole
51. Tab. Clotrimazolew Vaginal (Anti fungal)
52. INJ. Dexametha Sod Phod
53. INJ.Anti Histamine
54. Ciprafloxin eye drops 0.5%
55. Povidone Iodine Usp 5%
56. A.B.Cotton Wool
57. Benedict's Solution
58. W.B.C Diluting Fluid
59. Benedict's solution Qualitative
60. Barium chloride solution
61. Sulfur Powder
62. N-10 HCL Solution
63. Field stain 'A'
64. Field stain 'B'
65. Fouchet's Reagent

Drugs & Medical supplies available under various national & state health programmes routed through AMC:

a. Family Welfare Programme
b. Leprosy Programme
c. Revised National TB Control Programme
d. Malaria Programme
e. School Health Programme

The list of programme may change time to time as per government directions.

Schedule 1
Registers to be maintained by AJF for Information System

Provide the format of each registers to be maintained by AJF. Please indicate who should maintain which register from UHC staff e.g. Medical Officer, Multi Purpose Worker etc. These formats are subject to change time to time as per government directions.

Schedule 2
Registers to be maintained by AJF for Information System

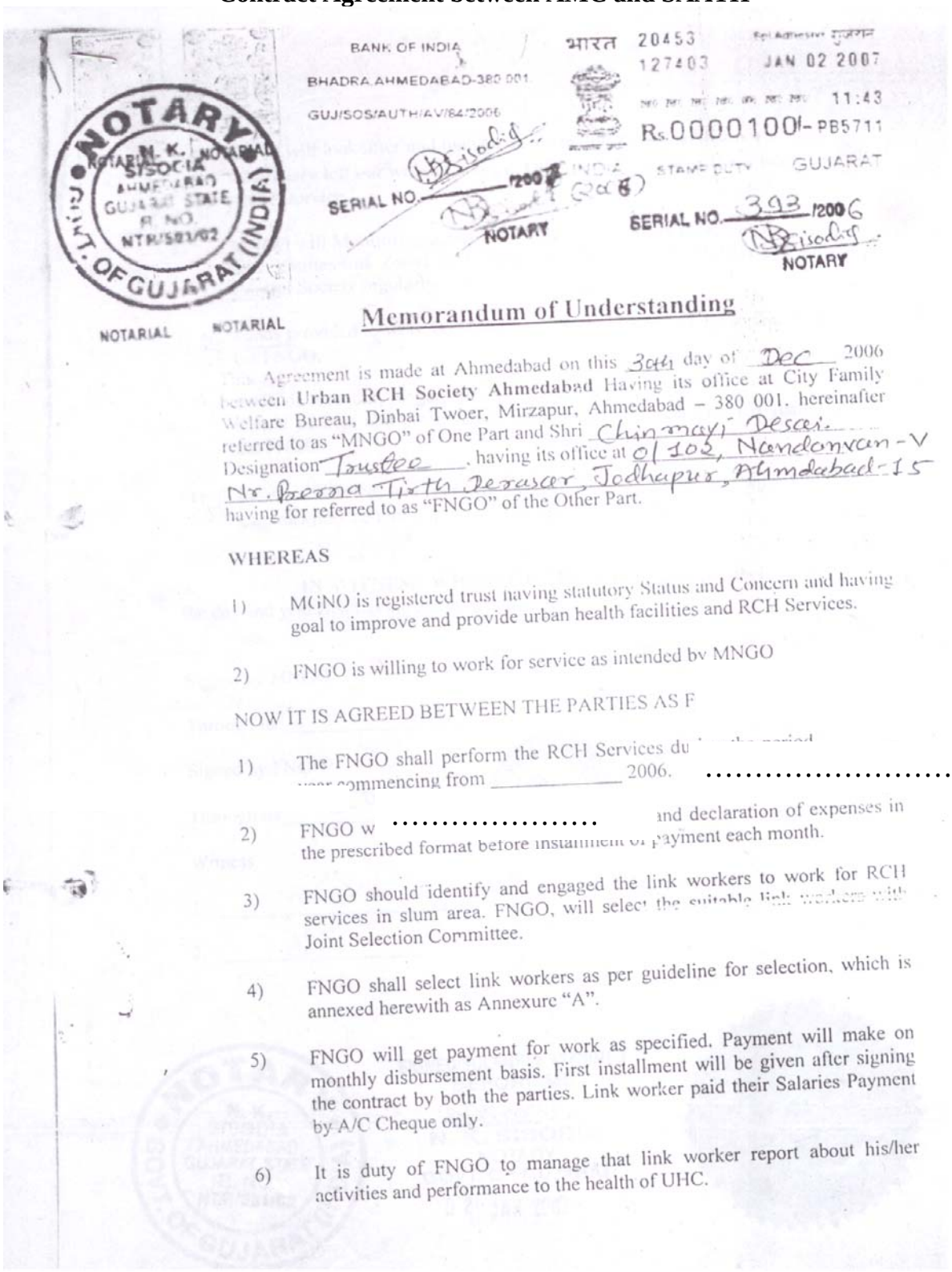
Provide the format of each report to be sent by AJF. Please indicate who should report to whom along with the frequency of reporting.
These formats along with frequency and reporting structure are subject to change time to time as per government directions.

1-9

9


NOTARY
N. K.
SISODIA
AHMEDABAD
GUJARAT STATE
R. NO.
NTR/501/02
GOVT. OF GUJARAT (INDIA)
AKHAND JYOT FOUNDATION
Nirmala A. Patel
Managing Trustee
AKHAND JYOT FOUNDATION
Fatehpura Gam, B/h. Police Chowky,
Paldi, AHMEDABAD-380007.
Dy. Muni. Commissioner(W. Z.)
Ahmedabad Muni. Corp.
Ahmedabad.
MEDICAL OFFICER OF HEALTH
AHMEDABAD MUNICIPAL CORPORATION
AHMEDABAD
SIGNED/SOLEMNLY AFFIRMED
BEFORE ME
N. K. SISODIA
NOTARY
GOVT. OF GUJARAT
02 FEB 2007
02 MAR 2007
1-10

Exhibit 9
Contract Agreement between AMC and SAATH



BANK OF INDIA
BHADRA AHMEDABAD-380 001
GUJ/SOS/AUTH/AV/84/2006
भारत 20453 127403 JAN 02 2007 11:43
Rs.0000100/- PB5711
INDIA STAMP DUTY GUJARAT
SERIAL NO. 1200 NOTARY
SERIAL NO. 393 /2006 NOTARY

NOTARY M. K. SISODIA AHMEDABAD GUJARAT STATE R. NO. NTR/583/02 GOVT. OF GUJARAT (INDIA)
NOTARIAL NOTARIAL

Memorandum of Understanding

This Agreement is made at Ahmedabad on this 30th day of Dec 2006 between **Urban RCH Society Ahmedabad** Having its office at City Family Welfare Bureau, Dinbai Twoer, Mirzapur, Ahmedabad – 380 001. hereinafter referred to as "MNGO" of One Part and Shri Chinmayi Desai Designation Trustee, having its office at 01/102, Nandanvan-V Nr. Reena Tirth Derasar, Jodhapur, Ahmedabad-15 having for referred to as "FNGO" of the Other Part.

WHEREAS

1) MGNO is registered trust having statutory Status and Concern and having goal to improve and provide urban health facilities and RCH Services.

2) FNGO is willing to work for service as intended by MNGO

NOW IT IS AGREED BETWEEN THE PARTIES AS F

1) The FNGO shall perform the RCH Services du ... year commencing from _____ 2006. .....

2) FNGO w ..... and declaration of expenses in the prescribed format before instalment of payment each month.

3) FNGO should identify and engaged the link workers to work for RCH services in slum area. FNGO, will select the suitable link workers with Joint Selection Committee.

4) FNGO shall select link workers as per guideline for selection, which is annexed herewith as Annexure "A".

5) FNGO will get payment for work as specified. Payment will make on monthly disbursement basis. First installment will be given after signing the contract by both the parties. Link worker paid their Salaries Payment by A/C Cheque only.

6) It is duty of FNGO to manage that link worker report about his/her activities and performance to the health of UHC.

7) FNGO will look after and manage in a way for service so that not a Simple beneficiary left out without service. Otherwise Payment will not made for (RCH) service.

8) MNGO will Monitoring activities of link worker by its representatives and other entities link Zonal H.O., M.O. of UHC, RNTCP, Malaria and Aids Control Society regularly.

9) Funds provided to work by MNGO to FNGO should be kept separately by the FNGO.

10) Book of Account, ledger, bills and Vouchers for the service and project should be kept and preserved separately for minimum Five (5) years by the FNGO.

11) In case, service and performance of FNGO found not satisfactory, Contract may be terminated on prior One-month notice.

IN WITNESS WHEREOF THE Parties have put their hand on the day and year first having above writer.

Signed by MNGO _____

Through its _____

Signed by FNGO

Through its _____

Witness

1. _____

2. _____

SATH CHHAVITAVE TRUST • AHMEDABAD • E-7257

NOTARY
N. K. SISODIA
AHMEDABAD
GUJARAT STATE
R. NO.
NTR/501/02
GOVT. OF GUJARAT (INDIA)

SIGNED/SOLEMNLY AFFIRMED
BEFORE ME
N. K. SISODIA
NOTARY
GOVT. OF GUJARAT
02 JAN 2007

Exhibit 10
Minutes of the First Management Committee Meeting

Date: 07 March 2007, 09:20 am

Venue: Mayor's House, S-11, Bhavna Apartment, Vasna

Members Present:

Shree Amit Shah, Mayor, Ahmedabad Municipal Corporation
Shree D.B. Makwana, Dy. Municipal Commissioner (Health), Ahmedabad Municipal Corporation
Dr. S.P. Kulkarni, Medical Officer of Health, Ahmedabad Municipal Corporation
Dr. Kinnari Mehta, Family Welfare Officer, Ahmedabad Municipal Corporation
Dr. AK Kharadi, Dy. Health Officer In-charge (West Zone), AMC
Shree Anil Bakeri, Vice President , Gujarat Cancer Society
Shree Prashant Kinariwala, General Secretary, Gujarat Cancer Society
Shree Kshitish Madan Mohan, Secretary, Gujarat Cancer Society
Shree Narendra Chawda, Hospital Administrator, Gujarat Cancer Research Institute
Smt. Nirmala Patel, Trustee, Akhand Jyot Foundation
Shree Siraj Mansuri, Co-ordinator, Akhand Jyot Foundation
Prof. K V Ramani, Indian Institute of Management Ahmedabad
Prof. Dileep Mavalankar, Indian Institute of Management Ahmedabad
Dr. Beena Nayak, Project Associate, Indian Institute of Management Ahmedabad
Ms. Shilpa Maiya, Project Associate, Indian Institute of Management Ahmedabad
Mr. Amit Patel, Project Associate, Indian Institute of Management Ahmedabad

Note: The Municipal Commissioner of AMC could not attend the meeting due to prior commitments.

Prof. Mavalankar gave a project brief and the progress made for establishing a Model Urban Health Center in Vasna ward, in the Community Oncology Centre campus of Gujarat Cancer Society (GCS), Vasna. He mentioned some of the new services to be provided from the new Vasna Urban Health Center (UHC) such as physiotherapy, ophthalmology, dental care, yoga etc in addition to the mandatory healthcare services for primary care. He also discussed the arrangements already finalized between AMC and Akhand Jyot Foundation (healthcare service provider in Vasna UHC) and suggested that the same arrangements for service provision can be replicated in all other wards of AMC also.

The Mayor, Shree Amit Shah appreciated the sincere and dedicated efforts of IIM Ahmedabad and GCS in the development of the new UHC in Vasna. In his opinion, the new Vasna UHC is the he best contribution to the society for all times. He recollected the time when this land was given to GCS and how GCS has responded to its social

obligations by setting up the Vasna UHC, which would become a model UHC for all wards of Ahmedabad. Shree Amit Shah extended complete support from AMC for this project including financial support from the Mayor's fund for this project. He also mentioned other public facilities in Vasna ward such as its municipal gardens, which win the Best Garden Award every year.

Shree Anil Bakeri briefed the Mayor about the progress of the UHC construction activities under his leadership. He mentioned that the actual expenditure has risen to almost Rs 26 lakhs, far exceeding the estimate of Rs 18 lakhs, and that the Gujarat Cancer Society has somehow managed to meet the additional cost. He then briefed the Mayor about the need to provide new and modern furniture to the Vasna UHC, instead of shifting the old furniture from the current location in Akhand Jyot Foundation. The Mayor offered financial support to the tune of Rs 15 lakhs for furnishing the UHC so as to provide excellent healthcare facilities.

Prof. K.V. Ramani suggested the need to provide technical and management training to all the UHC staff in AMC so as to improve the quality of services, and thereby establish Ahmedabad city as a model for excellent UHC services. The Mayor Sri Amit Shah readily agreed with the suggestion and asked the Dr. Kulkarni (MOH) to look into the training needs in detail.

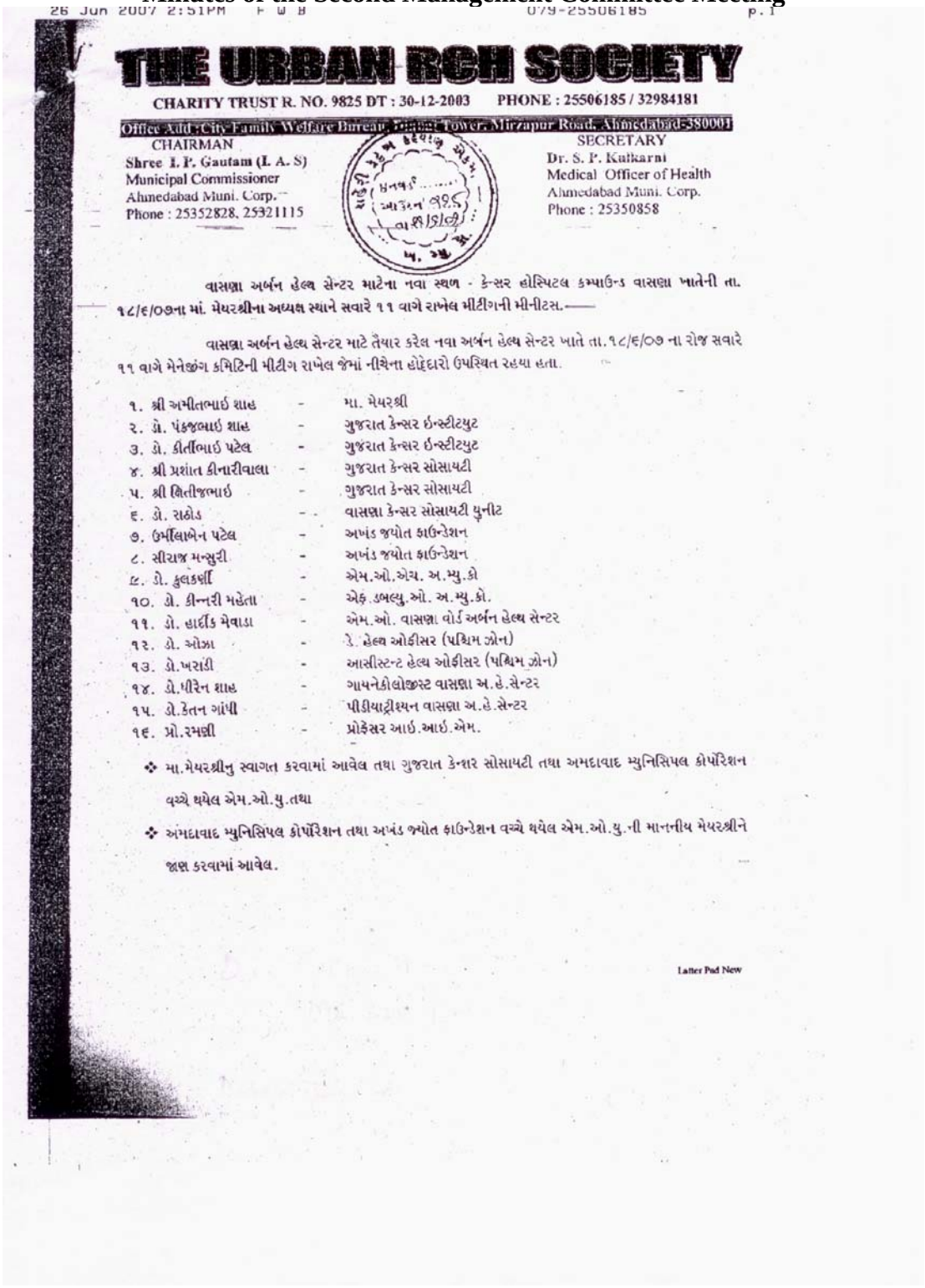
Smt. Nirmalaben thanked the mayor for his interest in the Vasna project and expressed the pressing need for offering physiotherapy services from the new Vasna UHC. The Mayor acknowledged the need and assured Nirmalaben of all possible help

Prof. Mavalankar then mentioned about the Vasna UHC model being extended to Naroda Road ward. Following our GIS based analysis, Kalapi Nagar would be the ideal location for the proposed new UHC in Naroda Ward, which would serve a larger number of slum population than the existing location in the Aravind Mills Compound across the railway track. Shree Amit Shah agreed to help us in getting the land for Naroda Road UHC, immediately talked to Shree Dinesh Makwana, Dy. Mayor of AMC, briefed him about our work for the Vasna Ward, and fixed a meeting of the IIMA team with the Dy Mayor for further discussions on Naroda Ward UHC.

Prof. Mavalankar suggested the idea to explore the involvement of municipal medical college interns in Urban Health Centers, especially the interns from Preventive and Social Medicine Department. Dr. Mavalankar also expressed the need to build partnerships in Naroda Road similar to the partnership that we have for Vasna Ward.

The meeting ended with the Mayor thanking the GCS and IIMA team for their excellent service to the society in establishing a model UHC in Vasna with Public Private Partnership.
The members thanked the Mayor for his leadership and support for improvement of urban health in Ahmedabad city.

Exhibit 11a
Minutes of the Second Management Committee Meeting



26 Jun 2007 2:51PM F W B 079-25506185 p.1

THE URBAN RCH SOCIETY

CHARITY TRUST R. NO. 9825 DT : 30-12-2003 PHONE : 25506185 / 32984181

Office Add : City Family Welfare Bureau, Council Tower, Mirzapur Road, Ahmedabad-380001

CHAIRMAN
Shree I. P. Gautam (I. A. S)
Municipal Commissioner
Ahmedabad Muni. Corp.
Phone : 25352828, 25321115

SECRETARY
Dr. S. P. Kulkarni
Medical Officer of Health
Ahmedabad Muni. Corp.
Phone : 25350858

વાસણા અર્બન હેલ્થ સેન્ટર માટેના નવા સ્થળ - કેન્સર હોસ્પિટલ કમ્પાઉન્ડ વાસણા ખાતેની તા. ૧૮/૬/૦૭ના માં. મેયરશ્રીના અધ્યક્ષ સ્થાને સવારે ૧૧ વાગે રાખેલ મીટીંગની મી-નીટસ.

વાસણા અર્બન હેલ્થ સેન્ટર માટે તૈયાર કરેલ નવા અર્બન હેલ્થ સેન્ટર ખાતે તા.૧૮/૬/૦૭ ના રોજ સવારે ૧૧ વાગે મેનેજીંગ કમિટિની મીટીંગ રાખેલ જેમાં નીચેના હોદ્દેદારો ઉપસ્થિત રહયા હતા.

૧. શ્રી અમીતભાઇ શાહ	-	મા. મેયરશ્રી
૨. ડો. પંકજભાઇ શાહ	-	ગુજરાત કેન્સર ઇન્સ્ટીટયુટ
૩. ડો. કીર્તીભાઇ પટેલ	-	ગુજરાત કેન્સર ઇન્સ્ટીટયુટ
૪. શ્રી પ્રશાંત કીનારીવાલા	-	ગુજરાત કેન્સર સોસાયટી
૫. શ્રી ક્ષિતીજભાઇ	-	ગુજરાત કેન્સર સોસાયટી
૬. ડો. રાઠોડ	-	વાસણા કેન્સર સોસાયટી યુનીટ
૭. ઉર્મીલાબેન પટેલ	-	અખંડ જયોત ફાઉન્ડેશન
૮. સીરાજ મન્સુરી	-	અખંડ જયોત ફાઉન્ડેશન
૯. ડો. કુલકર્ણી	-	એમ.ઓ.એચ. અ.મ્યુ.કો
૧૦. ડો. કીન્નરી મહેતા	-	એફ.ડબલ્યુ.ઓ. અ.મ્યુ.કો.
૧૧. ડો. હાર્દીક મેવાડા	-	એમ.ઓ. વાસણા વોર્ડ અર્બન હેલ્થ સેન્ટર
૧૨. ડો. ઓઝા	-	ડે. હેલ્થ ઓફીસર (પશ્ચિમ ઝોન)
૧૩. ડો.ખરાડી	-	આસીસ્ટન્ટ હેલ્થ ઓફીસર (પશ્ચિમ ઝોન)
૧૪. ડો.પીરેન શાહ	-	ગાયનેકોલોજીસ્ટ વાસણા અ.હે.સેન્ટર
૧૫. ડો.કેતન ગાંધી	-	પીડીયાટ્રીશ્યન વાસણા અ.હે.સેન્ટર
૧૬. પ્રો.રમણી	-	પ્રોફેસર આઇ.આઇ.એમ.

- મા.મેયરશ્રીનુ સ્વાગત કરવામાં આવેલ તથા ગુજરાત કેન્સર સોસાયટી તથા અમદાવાદ મ્યુનિસિપલ કોર્પોરેશન વચ્ચે થયેલ એમ.ઓ.યુ.તથા
- અમદાવાદ મ્યુનિસિપલ કોર્પોરેશન તથા અખંડ જ્યોત ફાઉન્ડેશન વચ્ચે થયેલ એમ.ઓ.યુ.ની માનનીય મેયરશ્રીને જાણ કરવામાં આવેલ.

Latter Pad New

079-25506185 P.2

❖ માનનીય મેયરશ્રીએ આઇ.આઇ.એમ.ના પ્રોફેસર રમણીની સુચના મુજબ ચાલુ વર્ષમા અખંડ જ્યોત સંસ્થાએ વિસ્તારની કામગીરીમા કરેલ યોગદાનની નોંધ રાખવા જણાવેલ કે જેનુ એક વર્ષ બાદ મુલ્યાંકન કરી શકાય જેને સર્વ સભ્યો દ્વારા બહાલી આપવામાં આવી.

❖ અમદાવાદ મ્યુનિસિપલ કોર્પોરેશન તથા ગુજરાત કેન્સર સોસાયટી વચ્ચેના એમ.ઓ.યુ.બાબત ડો.પંકજ શાહે જણાવેલ કે ગુજરાત કેન્સર ઇન્સ્ટીટ્યુટ તરફથી ડો.શીલીન શુકલ કાર્યવાહીમા હાજર રહેશે તથા જરૂર પડે ડો.પંકજ શાહ પણ ઉપસ્થીત રહેશે. જેને પણ સર્વે સભ્યો દ્વારા બહાલી આપવમાં આવેલ.

❖ કમીટીના સભ્યો બાબત માનનીય મેયરશ્રીએ અમદાવાદ મ્યુનિસિપલ કોર્પોરેશનનાં આંઠ સભ્યો રાખવાનુ જણાવેલ.

૧) માનનીય મેયરશ્રી
૨) માનનીય ડે.મેયરશ્રી
૩) મા.સ્ટેન્ડીંગ કમીટી ચેરમેનશ્રી
૪) ચેરમેનશ્રી હેલ્થ કમીટી
૫) ચેરમેનશ્રી હોસ્પિટલ કમીટી
૬) મા.કમિશ્નરશ્રી
૭) મા.ડે.કમિશ્નરશ્રી (હેલ્થ)
૮) આરોગ્ય અધિકારીશ્રી
૯) વાસણા વોર્ડના કોર્પોરેટર (હોદ્દાની રૂએ)
૧૦) એફ.ડબલ્યુ.ઓ.(અ.મ્યુ.કોર્પો)

તે સીવાય

- ક્ષિતીજભાઇ મદનમોહન - નવા અર્બન હેલ્થ સેન્ટર(મુખ્ય દાતા) ગુજરાત કેન્સર સોસાયટી
- પ્રશાંત કીનારીવાલા જનરલ સેક્રેટરી - ગુજરાત કેન્સર સોસાયટી
- ડો.પંકજ શાહ - ગુજરાત કેન્સર રીસર્ચ ઇન્સ્ટીટ્યુટ
- ડો.શિલીન શુકલ - ગુજરાત કેન્સર રીસર્ચ ઇન્સ્ટીટ્યુટ
- ઉર્મિલાબેન પટેલ - અખંડ જ્યોત ફાઉંડેશન ,એન.જી.ઓ.
- રાજેન ભાવસાર - સાથ ચેરીટેબલ ટ્રસ્ટ, એન.જી.ઓ.
- પ્રોફેસર રમણી - પ્રોફેસર (આઇ.આઇ.એમ.)

ઉપરના મેમ્બરોને મેનેજીંગ કમીટીમાં રાખવાની સુચનાને બહાલી આપવામાં આવેલ.

❖ સેન્ટરનાં ઉદઘાટન માટે માનનીય મુખ્યમંત્રીશ્રીને પત્ર લખેલ હોઇ હજુ બે દિવસ માટે તેઓ તરફથી જવાબની રાહ જોયા બાદ જો માનનીય મુખ્યમંત્રીશ્રી તરફથી સમયના ફલવાયતો માનનીય ગર્વનરશ્રી તથા માનનીય આરોગ્ય મંત્રીશ્રીને આમંત્રણ આપી તેમના અનુકુળ દિવસ તથા સમયે ઉદઘાટન કરવાની દરખાસ્તને સર્વે સભ્યો દ્વારા બહાલી આપવામાં આવી.

Latter Pad New

079-25506185 P.3

❖ વાસણા અર્બન હેલ્થ સેન્ટરના મકાનમાં પાણી તથા ડ્રેનેજના કનેકશન માટે આસી.એન્જીન્યર (વાસણા વોર્ડ) ને માનનીય મેયરશ્રીદ્વારા તાત્કાલીક કામકાજ એક અઠવાડીયામાં પુરૂ કરી આપવાની સુચના આપવામાં આવી.

❖ વાસણા અર્બન હેલ્થ સેન્ટર માટે બાંધવામાં આપેલ મકાનમાં સંપુર્ણ કબજો અમદાવા મ્યુનિસિપલ કોર્પોરેશન ને સુપ્રત કરવા ગુજરાત કેન્સર સોસાયટી જ્ઞણ કરવામાં આવી છે. કોર્પોરેશનના એસ્ટેટ ખાતા દ્વારા આ મકાનનો કબજો મળવાનો પત્ર તથા સેન્ટર ચલુ રાખવાનો સંમતિપત્ર તૈયાર કરી આપવામાં આવશે. જેની સર્વે સભ્યોએ નોંધ લીધી છે.

કુટુંબ કલ્યાણ અધિકારી
શહેરી કુટુંબ કલ્યાણ એકમ

આરોગ્ય અધિકારી
અ.મ્યુ.કોર્પો.

Letter Pad New

Exhibit 11b
Minutes of the Second Management Committee Meeting

THE URBAN RCH SOCIETY
CHARITY TRUST NO. 9825 DT. : 30-12-03.

OFFICE ADD. : City Family Welfare Bureau, Dinbai Tower; Mirzapur Road, Ahmedabad.

CHAIRMAN
Shree I P Gautam (I.A.S).
Municipal Commissioner,
Ahmedabad Municipal Corporation
Corporation

SECREATARY
Dr. S. P. Kulkarni
Medical Officer of Health,
Ahmedabad Municipal

New Places for Vasana Urban Health Centre – Minutes of meeting held on 18/06/07with Respected Mayor presiding, at 11 am, at Cancer Hospital Compound, Vasna.

For the UHC at Vasna, the managing committee meeting was held at the new Vasna UHC on the 18/06/2007. The Participants present were:

1	Shri Amitbhai Shah	-	Respected Mayor
2	Dr. Pankajbhai Shah	-	Gujarat Cancer Institute
3	Dr. Kirtibhai Patel	-	Gujarat Cancer Institute
4	Shri Prashant Kinariwala	-	Gujarat Cancer Institute
5	Shri Kshitijbhai	-	Gujarat Cancer Institute
6	Dr. Rathod	-	Vasna Cancer Society Unit
7	Urmilaben Patel	-	Akhand Jyot Foundation
8	Siraj Munsuri	-	Akhand Jyot Foundation
9	Dr. Kulkarni	-	M.O.H.A.M.C
10	Dr. Kinnari Mehta	-	F.W.O.A.M.C.
11	Dr. Hardik Mevada	-	M.O.Vasana ward Urban Health Centre
12	Dr. Oza	-	Deputy Health Officer (West zone)
13	Dr. Kharadi	-	Assistant Health Officer (West zone)
14	Dr. Dhiran Shah	-	Gynecologist Vasna Urban Health Centre
15	Dr. Ketan Gandhi	-	Pediatrician Vasna Urban Health Centre
16	Prof. Ramani	-	Indian Institute of Management, Ahmedabad

- Respected Mayor was welcomed. The Mayor was informed about the M.O.U. between Gujarat Cancer Society & A.M.C.
- The Mayor was also informed of the MoU between AMC and AJF.
- As per Prof. Ramani's suggestion, the Mayor told that AJFs activities should be recorded so that it can be evaluated after a year. All the members agreed to this.
- Dr Pankaj Shah informed that Dr Shileen Shukla will be available on behalf of Gujarat Cancer Institute for all the actions concerning the MoU between the AMC

and GCS. He also informed that he would also be present if need be. This was sanctioned by all.

- Respected Mayor asked eight members from AMC to be present in the Management Committee.

1 Respected Mayor
2 Respected Deputy Mayor
3 Respected Standing Committee Chairman
4 Chairman Health committee
5 Chairman Hospital committee
6 Respected Commissioner
7 Respected Deputy Commissioner (Health)
8 Health Officers
9 Corporator of Vasna ward (at Post)
10 F.W.O. (A.M.C.)

Also,

* Kshitijbhai Madanmohan	-	New Urban Health Centre (Main donor)
* Prashant Kinariwala, General Secretary	-	Gujarat Cancer Society
* Dr. Pankaj Shah	-	Gujarat Cancer Research Institute
* Dr. Sheelin Shukla	-	Gujarat Cancer Research Institute
* Nirmalaben Patel	-	Akhand Jyot Foundation, N.G.O.
* Rajen Bhavshar	-	Saath Charitable Trust, N.G.O.
* Prof. Ramani	-	IIM, Ahmedabad

The members mentioned above also sanctioned to be a part of the Management Committee.

- Respected Chief Minister has been invited to inaugurate the new Urban Health Centre. They would wait for two days for his reply. In case there is no reply after two days from the Chief Ministers Office, the Governor/Health minister would be invited to inaugurate the new UHC according to their convenience. This was agreed by all the members.
- The Mayor asked the Assistant Engineer (Vasna Ward) to complete the water and sewage connection within a week at the new Vasna UHC.
- GCS was asked to handover the custody of the new UHC at Vasna to AMC.
- The Corporation Estate Department will prepare a letter of having received the custody letter from GCS. The sanction to run the centre will also be prepared by the same. All participants are to keep this in mind.

Family Welfare Officer
Urban Family Welfare Unit

Health Officer
AMC

References

Bennett S. et al. (2005); Working with the non-state sector to achieve public health goals. Making Health Systems Work: Working Paper No. 2. World Health Organization.

Elizabeth B. (1998); Contract Procurement Solutions for Public-Private Partnerships, Research Paper, UNDP/Yale Collaborative Programme, 1998 Research Clinic, New Haven.

Government of India (2004); Report of the PPP subgroup on Social Sector: Public Private Partnership, Planning Commission, Government of India, New Delhi

Laing R et al. (2005); Ten recommendations to improve use of medicines in developing countries. Health Policy & Planning, 16(1):31-46

Marcou G, Rangeon F, Thiébault J.L (1997); Contractual cooperation and municipal management. Paris: L'Harmattan.

Ramani K V et al. (2006); "A Public Private Partnership Model for Managing Urban Health: A Study of Ahmedabad City" WP No. 2006-03-05, IIMA Working Paper Series, Indian Institute of Management, Ahmedabad.

Walsh K. (1995); Public services and market mechanisms. Competition, contracting and the new public management. Basingstoke: Macmillan.

List of Abbreviations:

AJF	Akhand Jyot Foundation
AMC	Ahmedabad Municipal Corporation
BPL	Below Poverty Line
COC	Community Oncology Center
FW	Family Welfare
GCRI	Gujarat Cancer Research Institute
GCS	Gujarat Cancer Society
GIDB	Gujarat Infrastructure Development Board
GIS	Geographic Information System
GOG	Governmental of Gujarat
GOI	Government of India
GR	Government Regulation
GSACS	Gujarat State AIDS Control Society
HMIS	Health Management Information System
IEC	Information, Education, Communication
M & E	Monitoring and Evaluation
MIS	Management Information System
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MPW	Multi-Purpose Worker
NACO	National AIDS Control Organisation
NGO	Non-Governmental Organisation
PHC	Primary Health Center
PPP	Public-Private Partnership
RCH	Reproductive Child Health
SEWA	Self Employed Women's Association
TB	Tuberculosis
UFWC	Urban Family Welfare Center
UHC	Urban Health Center
VO	Voluntary Organisation