OP-33 EQUITY IN HEALTH CARE: LESSONS FROM PUBLIC-PRIVATE PARTNERSHIP INITIATIVES IN TRIBAL HEALTH FROM ODISHA, INDIA

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Background In the current age, when health is expected to be equitable and sustainable, Odisha seems lost in time with health care still remaining a distant dream for the tribal population in the state. Implementation of health policies in tribal areas remains a challenge as the community suffers from malnutrition, lack of clean drinking water, poor sanitation, poverty, and geographic inaccessibility. In last seven years, public-private partnerships (PPPs) were used as a medium to remove social taboo and improve access to health care among the tribal population. The objective of this study is to evaluate the effectiveness of various PPPs in tribal health and the lessons learnt.

Methods We analysed primary and secondary data to evaluate the PPP projects in tribal health in the state of Odisha. The PPP projects considered for evaluation included primary health centres (PHCs) run by non-government organisations (NGOs), *Maa Gruha* (maternity waiting homes) schemes, *Janani Express* and *Arogya Plus* (mobile health units) run by NGOs. We collected primary data from various stakeholders including NGOs, health officials and beneficiaries. Our secondary data included a baseline survey, monthly reports, annual reports and data from the health management and information system. Quantitative data on infrastructure, manpower availability, outpatient and in-patient services, institutional deliveries and outreach services were collected over the last three years. Qualitative data collection included interviews with patients availing services, field health workers (Accredited Social Health Activists and Auxiliary Nurse Midwives), NGO officials and district officials.

Findings We documented considerable improvements through PPP initiatives in health care in tribal areas of Odisha. The *Janani Express* and *Maa Gruha* schemes have been important factors for rise in the number of institutional deliveries in the state. Pregnant tribal women availed free of cost referral transport along with a free stay at the maternity centres. With respect to *Janani Express*, the vehicles took considerable time in reaching beneficiaries and back to health facilities especially where road connectivity is still an issue. The vehicles were not fully equipped to deal with emergencies during the travel. The incentives for drivers and other staff were supposedly not in practice. *Maa Gruha* centres were a boon to tribal women but a major obstacle was that many such centres were away from the health facilities. The average number of pregnant women who stayed in the *Maa Gruha* centre was about 25. They stayed for an average of 10 days in this facility before they moved to the health facility for delivery. Due to this scheme, the overall institutional delivery rates in the tribal area increased.

The *Arogya Plus* project greatly improved the accessibility of the tribal population to health services but the major issues were the irregular and infrequent visits by the units which disturbed the continuum of services, and the lack of proper diagnostic equipment, drugs and supplies. The scheme struggled to retain staff and maintain records. The PHCs managed by NGOs have also shown mixed results. Many have shown considerable improvements, but a few were not able to perform any better than in the time they were run by the state government. A significant improvement was found in terms of the average outpatient visits that was about 30 patients per day and in-patient admissions of about 10 per month due to availability of better manpower. It was noted that in one remotest PHC in Malkangiri, the average of outpatient visits per day was around 120, which was remarkable. Institutional deliveries were around 10 per month in the good performing PHCs. Earlier, when the PHCs were run by government, institutional deliveries were not happening. In a few PHCs, the main obstacles included lack of medical officer, lack of outreach activities from NGO and, in few places, misuse of funds. All in all, the NGOs through these PPP models, improved the accessibility to health services in difficult to reach populations in the tribal areas of Odisha and brought forth the inadequacy of the public health delivery system.

Discussion Our study indicates that the PPP model for tribal health in Odisha led to a considerable improvement in the healthcare utilisation by the tribal populations, though there is still a lot to be achieved. Overall maternal death rates have come down in the tribal districts where these PPP programmes have been introduced. State and district administration need to carefully select capable NGOs who would genuinely indulge in innovations and outreach activities. It is not just the private partners that need to be responsible and accountable for a successful PPP. The public partners also need to fulfil their duties in a time bound fashion. Government should cut short the bureaucratic delays in funding and address the issues of the private partner as and when required. Government shall undertake monitoring and evaluation of these initiatives using better performance indicators. Such symbiotic partnerships, which bank upon the assets and mask the deficiencies of the other partner, have the potential to revolutionise public healthcare delivery system in India.

No competing interest.