

PROVIDING CEmONC SERVICES IN TRIBAL AREA AN INNOVATIVE PPP MODEL

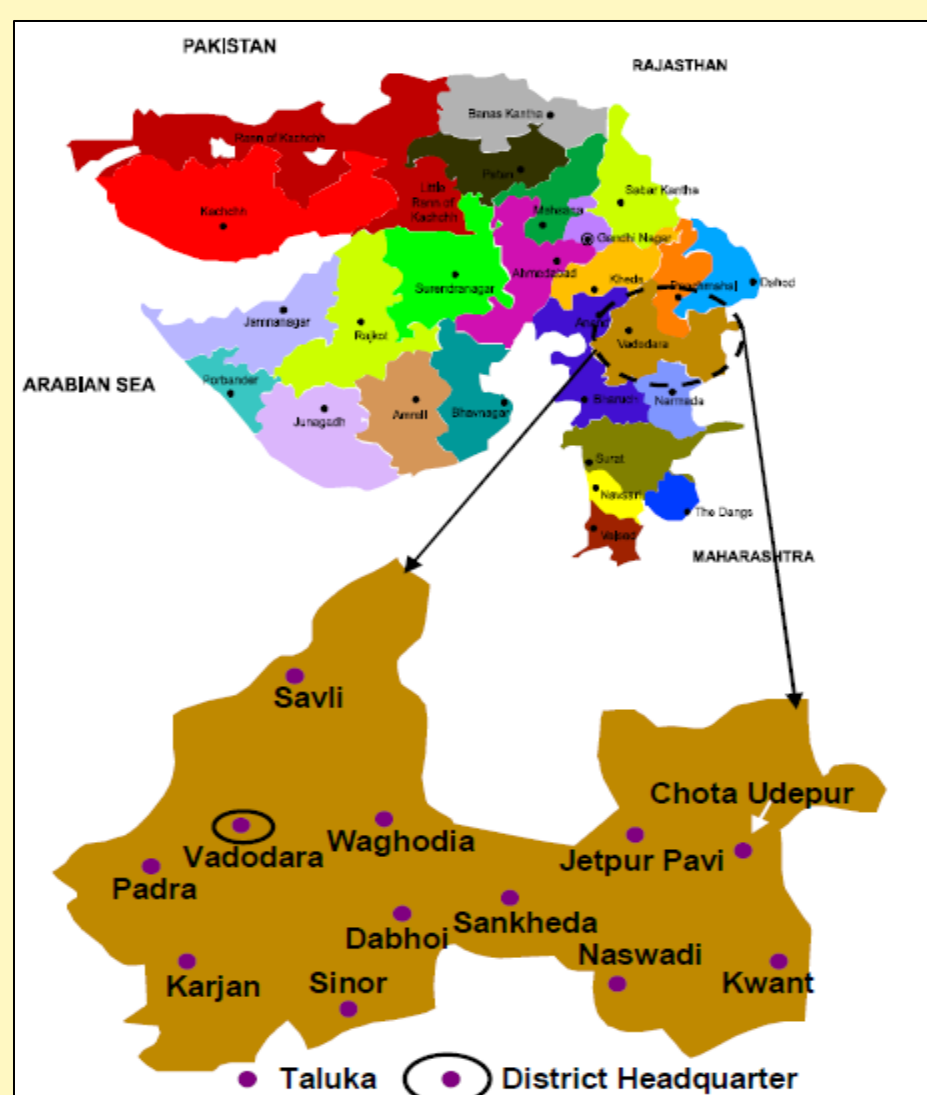
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Introduction & Problem Statement

Socio-economical and geographical inequalities remain major hurdle in achieving Millennium Development Goal 5 (Maternal Health).

Gujarat has 12 tribal districts on eastern side of the state. Again there are huge intra district variation in availability of health services. For example, Vadodara district has district capital in Vadodara, which is 3rd biggest populated city in Gujarat with all medical facilities including medical college hospital.

At the same time, there are neighboring taluks within same district where health system is not very strong. In Pavi-Jetpur Taluk, there are no specialist doctors are available and CHCs are manned by medical officers only. Hence majority of complicated cases were referred to the nearby taluks.



PUBLIC PRIVATE PARTNERSHIP

To provide CEmONC services (comprehensive emergency obstetric and newborn care) in this area, Government of Gujarat developed a Public Private Partnership with DEEPAK FOUNDATION, VADODARA in 2006. This foundation is working in this area since many years. It was decided that foundation will have 10 bedded facility within CHC Jabugam. Government shares 80% of the cost while rest is shared by the partner organization.

management of facility including human resources is done by the partner organization.

RESULTS

CEmONC services are improving in Jabugam PPP. Over the years increase is observed in to OPD clinic (Figure 1), number of deliveries conducted (Figure 2) in hospital.

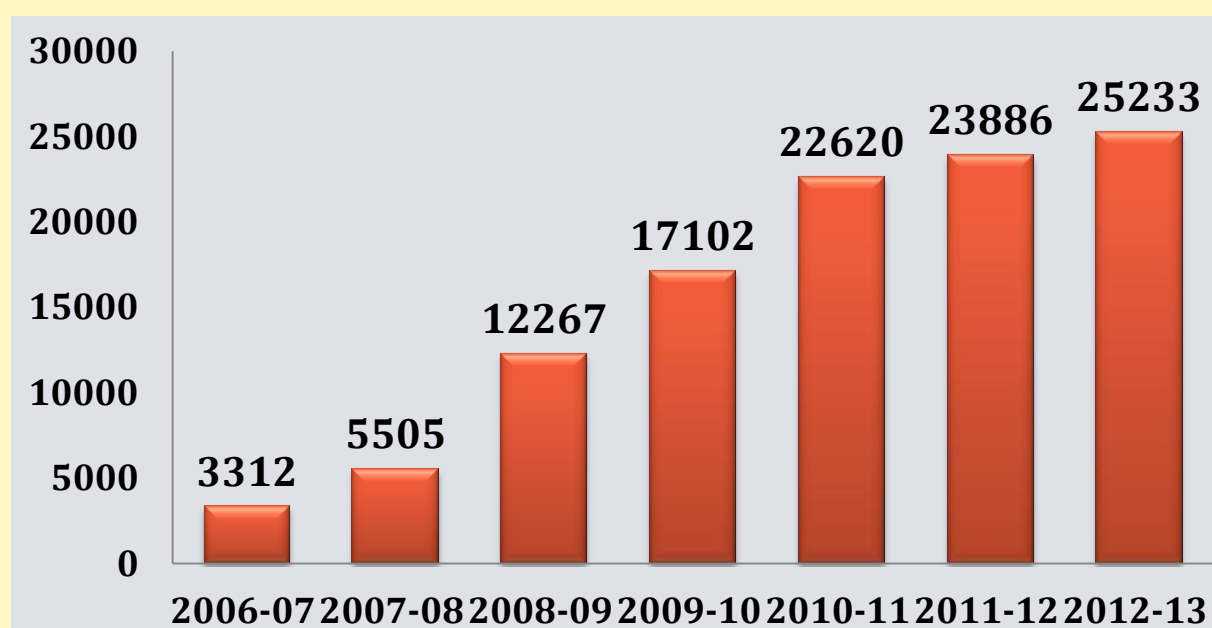


Figure 1: No. of OPD cases

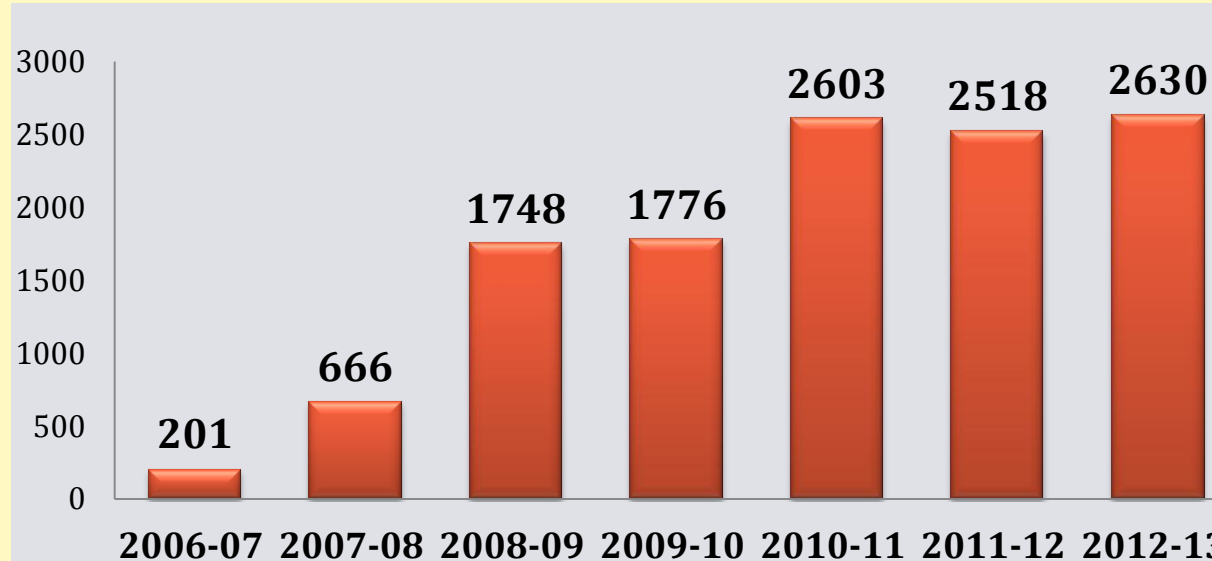


Figure 2: No. of deliveries conducted

At the same time, it is important to note that Caesarian section rate has steadily increased over the years and reached 8.6% which is almost equal to Maximum cut off point (10%) prescribed by WHO (Figure 3).

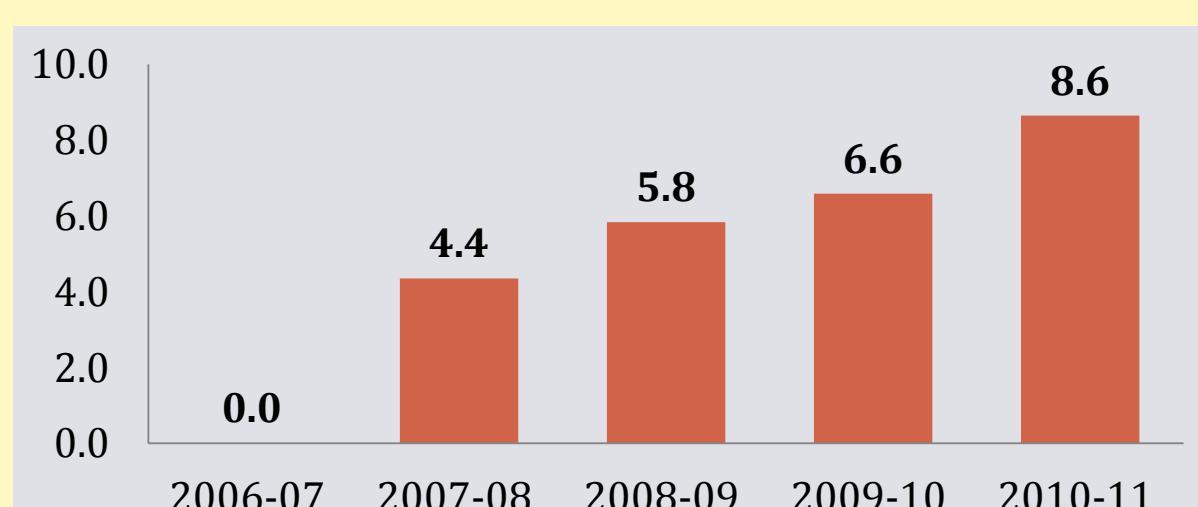


Figure 3: Caesarian Section rate

POST NATAL STAY

Post partum stay of 48 hours is very important for the delivered women as more than half of women die on the first post partum day.

Majority of women (76%) delivered at Jabugam stayed for at least 48 hours and more (figure 4).

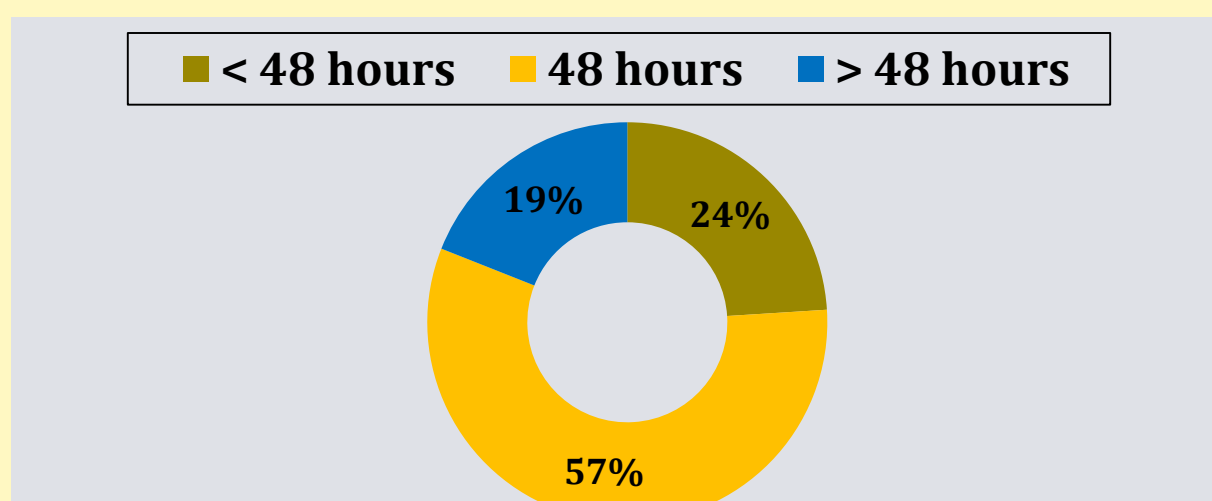


Figure 3: Post Natal stay

COST ANALYSIS

Scalability of any successful model depends on financial viability of that model. We have calculated two models to understand the cost effectiveness. First of all we have calculated average cost per delivery (Figure 5). Higher cost during year 2006-07 is due to establishment expenses incurred. Cost of the delivery has declined over the years.

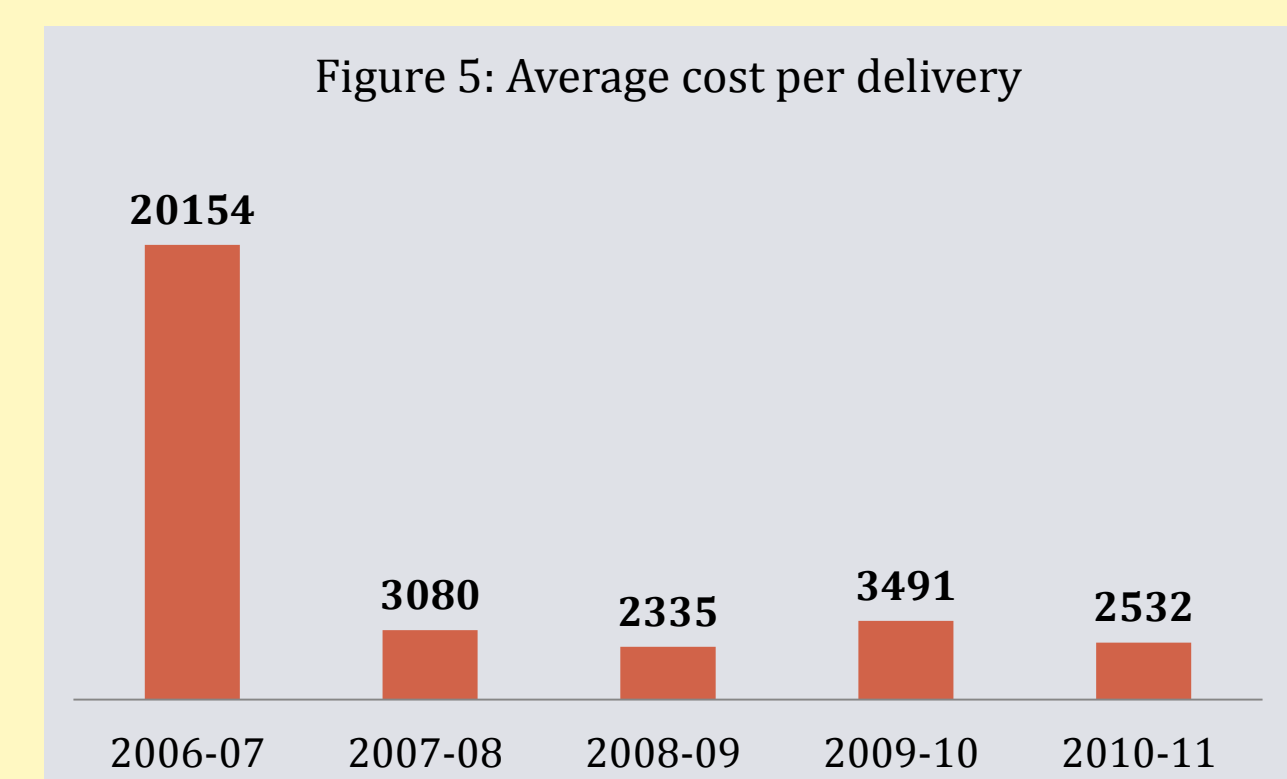


Figure 5: Average cost per delivery

CONCLUSIONS

Jabugam has been successful model of Public Private Partnership to improve maternal health.

Quality of services is also good and evident by increasing number of OPD load and Deliveries conducted at Jabugam.

At the same time, lower Caesarian rate indicates towards ethical clinical practice of performing CS only for required cases.

This model has provided quality services in tribal hard to reach area reducing inequality in maternal health service provision.

More such models should be tried out to see overall impact of these partnerships on maternal mortality ratio and overall maternal health.



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