International Journal of Research in Social Sciences
Vol. 9, Issue 3, March - 2019,
ISSN: 2249-2496 Impact Factor: 7.081
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

PUBLIC PRIVATE PARTNERSHIIP IN HEALTH CARE SERVICES IN RAJASTHAN

Dr. Laxmi Parewa, Assistant Professor

Department of Public Administration, University of Rajasthan, Jaipur

Background:

The concept of Public Private Partnerships (PPPs) has emerged as a viable option for infrastructure development especially in the context of developing countries. PPPs are emerging as an innovative policy tool for remedying the lack of enthusiasm in traditional public service delivery. They represent a claim on public resources that needs to be understood and assessed. They are often complex transactions, needing a clear specification of the services to be provided and an understanding of the way risks are allocated between the public and private sector. In the context of developing countries, the recent increase in PPPs has been attributed to several reasons such as the desire to improve the performance of the public sector by employing innovative operation and maintenance methods; reducing and stabilizing costs of providing services; reinforcing competition; and reducing government budgetary constraints by accessing private capital for infrastructure investments. Private sector involvement in the delivery of public services is not a new concept; PPPs have been used for over three decades, predating the contracting out initiatives of 1970s in the USA. Initially focussing on economic infrastructure, PPPs have evolved to include the procurement of social infrastructure assets and associated non-core services. In Asia, countries like China, Malaysia and Thailand started some projects with private participation in mid 1980s in one sector or so, but later on in the 1990s most of the countries in the region involved private sector in the provision of one or more of the infrastructure facilities. This chapter sheds light on the PPP concept and the rationale for increasing use of PPP projects in developing countries. It also discusses the evolution of PPP at the international level as well as in Asia and India. Finally, this chapter discusses the current status of PPP projects in India at the central and state level as well as in various sectors.

International Journal of Research in Social Sciences
Vol. 9, Issue 3, March - 2019,
ISSN: 2249-2496 Impact Factor: 7.081
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

Definition: According to the Department of Economic Affairs, Ministry of Finance, Government of India, 2007, PPP is defined as „A partnership between a public sector entity (sponsoring authority) and a private sector entity (a legal entity in which 51% or more of equity is with the private partner/s) for the creation and/or management of infrastructure for public purpose for a specified period of time (concession period) on commercial terms and in which the private partner has been procured through a transparent and open procurement system". Thus, in Indian context we can say that "Public Private Partnership (PPP) Project means a project based on a contract or concession agreement, between a Government or statutory entity on the one side and a private sector company on the other side, for delivering an infrastructure service on payment of user charges".

PPPs do not mean reduced responsibility and accountability of the government. They still remain public infrastructure projects committed to meeting the critical service needs of citizens. The government remains accountable for service quality, price certainty, and cost-effectiveness (value for money) of the partnership. Government remains actively involved throughout the project"s life cycle.

Healthcare: The Situation On Ground

We shall try and sketch a premise of the healthcare scenario, for we need to understand the ground reality before we use case studies to dissect Public Private Partnerships. Basic Financial Facts

• Healthcare in India is a State subject with the Centre confining itself to vertical national health programmes. Funding is predominantly at the state level. In 1990-91 the Central share of healthcare was just 9% of the total. This share has been steadily increasing over the years.

• Through the 1990's, the share of public spending on healthcare as a percentage GDP kept declining; the gains of liberalization were not allocated to trickle into health.

• By 2004-05, public spending on healthcare was about 0.9 % of the GDP, ranking India 171 among 175 nations on healthcare spend. In May 2004, a Common Minimum Programme (CMP) was announced, in which the newly elected government decided to raise this public spend to a broad

range of 2-3% of GDP over the next five years. • By 2009-10, five years after the announcement of the CMP, proportion of public spends on healthcare to GDP had increased to 1.4%.

• From 2004-05, while the economy grew by nearly 13.5% year on year nominally, public healthcare spend increased by about 5% points more (18.7%). Most of this rise was due to increasing share of funds from the Centre. Central spending increased by almost 30% (29.76%) year on year from 2004-05, though it grew from a low base. More than 95% of the increased central spend was Revenue Expenditure, on account of NRHM which employed about eight lakh social health activists, ASHAs.

• The State spend on healthcare grew by about 16% in the same period, more than 27% of the health spend in states was on capital expenditure (even after including the spend on Family Welfare; Family Welfare has minimal capital expenditure.) In 2008 however the State Finances deteriorated due to the economic crisis and implementation of the Sixth Pay Commission. The revenue surplus which had been maintained since 2006-07 declined, and became a deficit in 2009-10. 28 of the 30 Indian states have enacted the Financial Responsibility Legislation which sets an upper limit on their Gross Fiscal Deficit/Gross State Domestic Product and hence limits their spending.

• With the fiscal position worsening, and a cap on the deficit, States cut down on healthcare spend in 2009- 10. Total state health expenditure grew by 9.9% which was lower than the rate at which the state nominal GDP grew. Capital Investment stalled (growth of 0.3% nominally and hence negative growth in real terms) and though the Centre tried to compensate, the total Centre plus States' Capital Expenditure grew by 4%, which is again negative in real terms.

International Journal of Research in Social Sciences
Vol. 9, Issue 3, March - 2019,
ISSN: 2249-2496 Impact Factor: 7.081
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

Schemes and Modalities of PPP

Schemes	Modalities
Build-own-operate (BOO) Build-develop-operate (BDO) Design-construct-manage-finance (DCMF) Buy-build-operate (BBO) Lease-develop-operate (LDO) Wrap-around addition (WAA) Build-operate-transfer (BOT) Build-own-operate-transfer (BOOT) Build-rent-own-transfer (BROT) Build-lease-operate-transfer (BLOT) Build-transfer-operate (BTO	The private sector designs, builds, owns, develops, operates and manages an asset with no obligation to transfer ownership to the government. These are variants of design-build-finance-operate (DBFO) schemes. The private sector buys or leases an existing asset from the Government, renovates, modernises, and/ or expands it, and then operates the asset, again with no obligation to transfer ownership back to the Government. Build-operate-transfer The private sector designs and builds an asset, operates it, and then transfers it to the Government when the operating contract ends, or at some other pre-specified time. The private partner may subsequently rent or lease the asset from the Government.

Source: Public Private Partnership, Fiscal Affairs Department of the IMF.

1. **Operations and Management:**

The O&M model indicates a contractual arrangement for the management of the whole or part of a public facility by a private player. Such contracts allow private sector skills to be brought into service design and delivery, operations, labour management and equipment procurement. The ownership of facility and equipment is retained by the public sector and the private player is given certain specific responsibilities. Usually the contract period is short: typically 1 to 5 years;

however the contract period may be longer depending upon the complexity of services. The private player is paid a fee to manage and operate services; by and large, the fee is performance-based. Management contracts are quite common in the healthcare sector for providing services such as laboratory and imaging services, and also pharmacy and non-core elements of healthcare operations such as laundry, food and beverage services.

2. **Build – Operate – Transfer (BOT)**

In this type of arrangement, the private sector builds an infrastructure project, operates it, and eventually transfers ownership of the project, or a major component of it, to the government. In many instances, the government becomes the firm's only customer and promises to purchase atleast a predetermined amount of the project's output. This ensures that the private player recovers its initial investment in a reasonable time span. At the end of the contract, the public sector assumes ownership but can opt to assume operating responsibility, contract the operation responsibility to the developer, or award a new contract to a new partner. There are many variations to the basic BOT structure, like:

Build–Transfer–Operate (BTO): The public sector contracts with the private player to design, construct and operate the proposed facility. Once completed, the private player transfers ownership of the facility back to the public sector. The public sector then leases the facility back to the private partner under a long term contract to operate the facility.

Build–Own–Operate (BOO): The public sector either transfers ownership and responsibility for an existing facility or contracts with a private partner to build, own and operate a new facility in perpetuity. The private partner generally provides the financing.

Design–Build–Operate (DBO): The public sector contracts with the private player to design, construct and operate. Ownership of the facility remains with the government. Design–Build–Finance–Operate

(DBFO): The private player is responsible for designing, building, financing, and operating the facility. DBFO arrangements vary greatly in terms of the degree of financial responsibility that is transferred to the private partner.

International Journal of Research in Social Sciences
Vol. 9, Issue 3, March - 2019,
ISSN: 2249-2496 Impact Factor: 7.081
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

Private Finance Initiative (PFI): PFI is a type of PPP where the private sector consortium finances, builds and maintains the project in return for an annual fee from the government for a period of 25-30 years, throughout the life of the project. A Special Purpose Vehicle (SPV) is responsible for the financing the project. The creation of a 'Special Purposes Vehicle' company for the delivery of a particular project allows for private financing of the project. The SPV is formed by a consortium made up of a building firm, a facilities management company and equity finance providers. The SPV designs and builds a facility and then manages it for a number of years under a number of sub-contracts. The government pays the SPV a risk premium over and above the cost of the project

Objectives of Public-Private Partnerships

It is necessary that Public-private partnerships display that the following objectives are met in a balanced way to reflect the best interests of all stakeholders:

1. To ensure government services are delivered in an economical, effective and efficient manner;

2. To create opportunities for private sector growth and to contribute to the overall economic development of the District/State/Country through the stimulation of competitiveness and initiative; and

3. To ensure the best interests of the public, the private sector and the community are served through an appropriate allocation of risks and returns between partners.

PPPs differ from traditional contracts in several key respects

1. Complexity: A PPP is an inherently more complex operation than traditional contracts, as many players with competing interests are involved in the same. A great amount of assistance from qualified legal, financial or technical experts to undertake the requisite due diligence is required.

2. Financing: Traditional government contracts are government-funded. PPPs typically entail financing wholly or predominantly from the private sector.

International Journal of Research in Social Sciences
Vol. 9, Issue 3, March - 2019,
ISSN: 2249-2496 Impact Factor: 7.081
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

3. Risk Allocation: There must be some sharing of risk in a PPP, e.g. project completion risk (costs/time/specification), operating risk (demand/operating/performance/continuing quality), etc., and the provider has to be paid a premium to accept these risks.

4. Duration: PPP contracts may extend for 30 years or longer. This greatly complicates the difficulty of projecting service demand, and quantifying other risks such as technological and regulatory change, and currency fluctuation.

5. Coordination: PPPs require a much greater amount of communication and coordination among the players involved so as to ensure effective implementation of the project.

Principles

All public-private partnerships are typically based on the following guiding principles:

1. Project definition: The project is of sufficient size and/or complexity to provide an opportunity to the private sector to demonstrate its initiative, innovation and expertise.

2. Competitive private sector market: Sufficient qualified private sector proponents exist to ensure a competitive process.

3. Shared rewards: The public receives 'value for money' from the initiative, while the private sector can reasonably expect to receive a fair return on its investment.

4. Premise of risk transfer: Risks are allocated to the partner best suited to assume the risk.

5. Signed contract: The acceptance of a usually long-term relationship established through signed contractual arrangements.

6. Communications: A proactive, ongoing and transparent communications plan designed to keep people informed is implemented

International Journal of Research in Social Sciences
Vol. 9, Issue 3, March - 2019,
ISSN: 2249-2496 Impact Factor: 7.081
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

Potential Advantages of PPP:

A PPP that bundles out several service-pieces together has certain advantages over a traditional sequential model. For instance in a sequential model, the government first bids out for the project design, approves it, and then again sends tenders for construction, and later contracts separately for the maintenance. Whereas in a design, build, maintain (DBM) PPP, a single consortium is responsible for all the three tasks. Hence in a DBM, since the same provider now performs the whole task, the provider has an incentive to design the project in such a way that the construction is smooth and construct in such a way that maintenance is efficient. Hence a PPP can encourage:

• Innovations in service delivery;

• Better institutional integration throughout the life-cycle of the facility; and

• The potential for increased value for money relative to traditional approaches, as possible increase in project cost at inception is offset by better efficiency during the lifecycle. Other potential advantages are:

• Access to new private capital including taxable equity and either taxable or tax-free debt to supplement scarce public funds.

• Higher quality and customer satisfaction due to focus on performance-based standards, enhanced quality control and assurance, and contractual accountability.

• Public agencies are able to focus on their strengths, including long-term service planning and management, environmental clearance, permitting, right-of-way acquisition, standards setting, and performance measurement and reporting – having turned over part or all of financing and/or day-to-day operating responsibility to their private partners.

PPP in Rajasthan Health care sector:-

The programme started in December 2015, when the Rajasthan government opened bids to private parties, both non-profit and for-profit organisations, to run 213 of the state's PHCs. The

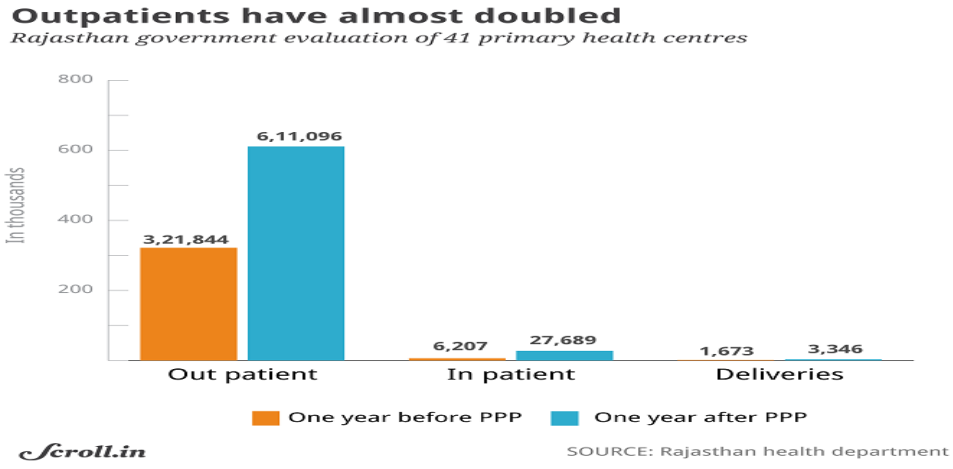
International Journal of Research in Social Sciences
Vol. 9, Issue 3, March - 2019,
ISSN: 2249-2496 Impact Factor: 7.081
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

terms of the public private partnership agreement state that the government would pay the private party between Rs 22 lakh and 35 lakh, depending on the bids received, to run a PHC for five years. After evaluating the private organisation's performance, the contract could be extended beyond five years. The private organisation is expected to employ at least 11 staff members including a doctor, a pharmacist, laboratory technicians and cleaners. Even Auxiliary Nurse Midwives who manage health sub-centres and have so far been employed by the government are transferred to or hired by the private organisation. The government's contribution to the partnership is infrastructure – the building, medicines, and equipment like surgical supplies and laboratory reagents.

Evaluation of PPP in health Care Scheme of Rajasthan

To assess the government's claims about the success of the programme,*Scroll.in* visited five PHCs run by the private providers and found mixed reports of their performances from residents using the facilities. While in some villages, the people were satisfied with services provided, in others people were distrustful of the privately-run PHCs.

The Rajasthan government's evaluation report of the 41 PHCs details the footfall in outpatient departments and in-patient departments as well as the number of deliveries both one year before and one year after the change in management. The report states that there has been almost double the number of outpatients, almost four times as many in-patients and twice as many women delivering babies across the PHCs.



International Journal of Research in Social Sciences
Vol. 9, Issue 3, March - 2019,
ISSN: 2249-2496 Impact Factor: 7.081
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

Review of the Scheme in Rajashtan

The report does not contain evaluations of vaccination rates, use of contraception, antenatal check-ups or screening of malnourished children. The public private partnership contracts list 16 evaluation parameters:

- Out patient numbers
- In patient numbers
- Registration of pregnant women
- Number of pregnant women who get all four antenatal check-ups
- Normal child deliveries
- Referrals of high risk pregnancies
- Whether infants at higher risk of dying are identified and referred
- Whether malnourished children identified and referred
- Number of children fully immunised
- Sterilisation rates
- Temporary sterilisation methods recommended
- Laboratory tests performed
- On-time submission of medical records
- Death audit reports
- Attendance in monthly monitoring meetings
- School health check-ups

Moreover, there is uneven progress even in the three parameters evaluated. For example, no children have been delivered in five of the 41 PHCs. Only four PHCs conducted more than 200 institutional deliveries in the past year – a target that has been set in the public private partnership agreement.

A PHC is the first point of contact with a public sector doctor, especially in villages across India, and typically serves about 30,000 people. The bulk of the healthcare work that a PHC conducts is preventive – vaccination drives, conducting antenatal check ups, screening for diseases like malaria and tuberculosis, and implementing other government health programmes.

International Journal of Research in Social Sciences
Vol. 9, Issue 3, March - 2019,
ISSN: 2249-2496 Impact Factor: 7.081
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

Public health specialists in Rajasthan say that the PHCs now managed by private organisations may work well on curative healthcare, but do not implement preventive and promotive health measures. This means that these centres are little more than clinics.

Scroll.in visited five villages with privately-managed PHCs in October – Achnera and Ambirama in Pratapgarh district, and Loondta, Kun and Savina in Udaipur district – where vaccination rates fell short of the government-mandated target of having 90% of all children fully immunised.

Scroll.in could not verify what the vaccination rates in these areas were since the state has not provided details.

Little accountability

A big problem Rajasthan's public private partnership model of running PHCs is the lack of a grievance redressal system built into the contract.

Sub-district health officers are not clear on what kind of action they can take against private managements in case they fail to deliver requisite health services.

Who is running PHCs?

Among the private parties running the 41 PHCs are WISH Foundation, a non-government organisation that works on innovation in healthcare technology, and Vani Sansthan, a non-governmental organisation that works on health rights. Others include medical or nursing colleges such as Geetanjali Medical College and Hospital, Udaipur and private hospitals. Some organisations like Chitransh Education and Welfare Society have no experience running a healthcare facility. Chitransh has runs a small school in Jaipur and claims to have conducted training programmes for health workers.

Health experts in Rajasthan are also concerned that the programme is being implemented on a large scale without a test run.

In 2015, when the Rajasthan government had drawn up the public private partnership plan and before it started the bidding process, the union health ministry recommended that the state would need to run a pilot in five or 10 PHCs and get an independent evaluation before scaling up the model. This was not done.

In 2016, the Jan Swasthya Abhiyan filed a public interest litigation at the Rajasthan High Court alleging that the public private partnership model would destroy the public health system as it would break the established chain of referral – from primary health centre to district hospitals at the secondary level to medical colleges at the tertiary level.

International Journal of Research in Social Sciences
Vol. 9, Issue 3, March - 2019,
ISSN: 2249-2496 Impact Factor: 7.081
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

The petition states that the money offered to run these PHCs was "ridiculously minuscule" and that the conditions of the public private partnership agreement would only be acceptable only to private bodies who "have the motive of earning profits" from the arrangement.

But all the private organisations partnering with the Rajasthan health department that *Scroll.in* spoke to claimed that their motive to enter this scheme was social service.

The Jan Swasthya Abhiyan petition also asked for independent evaluation and monitoring of the programme.

The Rajasthan government has still not commissioned an independent evaluation. Instead, in addition to the 41 PHCs already being privately managed, the state handed 57 more urban and rural PHCs over to private organisations in 2017.

The non profit organisation Prayas, which is not a partner in the scheme, conducted a fact finding exercise at 25 privately-run PHCs to get a sense of how they function. "While some health facilities were found to be in a relatively better state in comparison to others, some were much below the standard," said Chhaya Pachauli from Prayas. "None of the health facilities was found to be doing outstandingly well in comparison to those being directly operated by the government."

She added that PHCs that are still being run by the government but have been upgraded and categorised as Adarsh (meaning ideal) PHCs function much better than the privately-run PHCs.

What PHC users say

Loondta village got a primary health centre five years ago. However, the facility began admitting women for childbirth only four months ago. This is because the PHC, which has been handed over to Geetanjali Medical College and Hospital, now has a a full-time doctor and public health worker called a Lady Health Visitor who delivers babies. But residents of Loondta still say services at the PHC should be better.

Residents of Kun village have been vehemently against the privatisation of their PHC. Their main complaint is that the doctor is hard of hearing and they do not trust him. They feel forced to go to larger health facilities even for small ailments. But these larger hospitals are much further away.

Preventive healthcare takes a back seat

Before the Rajasthan government decided to implement the public private partnership model, they had been warned about possible pitfalls.In August 2015, CK Mishra who was then the union health secretary expressed concerns about the model. Mishra said that the union government's policy is to help states strengthen primary health care and that health services should be contracted out only as temporary measures.

International Journal of Research in Social Sciences
Vol. 9, Issue 3, March - 2019,
ISSN: 2249-2496 Impact Factor: 7.081
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

The National Health Systems Resource Centre, a technical body attached to the National Health Mission, also evaluated the Request of Proposal prepared by the state to invite bids for managing PHCs. They said that the package of services envisaged in the proposal are limited to reproductive and child health and there is no clear articulation of the other services in the state and national health programmes such as management of communicable and noncommunicable diseases. The body recommended that the model should be piloted in five to 10 PHCs before it is scaled up.

India's biggest public private partnership healthcare experiment has been Karnataka's Arogya Bandhu Scheme launched in 2008. The scheme allows non-government organisations, medical colleges, and philanthropic organisations to help run PHCs. An evaluation in 2016 showed that there was not much difference between the PHCs run by the government, and those run by private parties. Karnataka's privately-run PHCs also did not properly implement immunisation and antenatal services.

Dr T Sundararaman, dean of the School of Health Systems at the Tata Institute of Social Sciences in Mumbai, said that the public private partnership model aims to fulfill the function of a dispensary, which only takes care of curative aspects of medicine. The model does not even account for some very important functions of primary health care such as basic vector control activities or disease surveillance.

NEW POSSIBILITIES PUBLIC-PRIVATE PARTNERSHIP

Suggestions for areas of partnership and for effective governance are as follows:

• There are many backward districts in rajasthan where socio-economic and infrastructure development is required. Industrial Houses could partner with district administration in adopting one district each. Excepting mine-townships, very few PHCs have been taken up by private sector. Incentives should be provided to the industrial houses partnering in such development initiatives (concessional water, electricity, import and export of products/raw materials).

• Pharmaceutical Industry should manufacture cheaper drugs for the masses, donate drugs for HIV-AIDS, viral Hepatitis, Malaria, TB and other chronic diseases. Firms like LoCost should be encouraged.

• Rajasthan has largest number of teachers of primary, middle, high school and college teachers from village to state level. These teachers should be given responsibilities, territorial jurisdictions and the groups to educate, and monitor the implementation of the programmes.

International Journal of Research in Social Sciences
Vol. 9, Issue 3, March - 2019,
ISSN: 2249-2496 Impact Factor: 7.081
Journal Homepage: http://www.ijmra.us, Email: editorijmie@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal - Included in the International Serial Directories Indexed & Listed at: Ulrich's Periodicals Directory ©, U.S.A., Open J-Gate as well as in Cabell's Directories of Publishing Opportunities, U.S.A

• Non-formal leaders in rural and urban areas could be trained – carpenters, barbers, blacksmiths, preachers of all religions, shop keepers, and women leaders could be trained for health education programmes. Successful initiatives have been made in Punjab and Himachal Pradesh. Give details here too.

• Medical Colleges, Nursing and Para-Medical schools, public health training institutions could be extensively involved in organizing camps, early diagnosis, referral, and health education and awareness programmes.

• Large number of training institutions, chapters of Indian Medical Association, Nursing Associations, and manage ment schools could be involved in training programmes. The Indian Society of Health Administrators (ISHA) has trained over three lakhs personnel in various fields, particularly representatives of voluntary organizations, medical colleges, nurses, doctors working in the Central Government Health Scheme, and senior executives working in the Central Government Public Sector Enterprises. PPPs in preventive healthcare are minimum; corporates should sponsor preventive healthcare campaigns promoting ideas like breast feeding and other health promotion activities.