DRAFT

GUIDELINES

VOLUNTARY CONTRIBUTIONS - GOODS AND SERVICES TO PUBLIC HEALTH FACILITIES

"The simplest acts of kindness are by far more powerful than a thousand heads bowing in prayer."

— Mahatma Gandhi

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SECTION I

1. INTRODUCTION

1.1 Contributions to healthcare facilities are made in many situations and ways. They generally come to the forefront as humanitarian aid during emergencies/ disaster like situations. Contributions are also common as part of development aid in non-emergency situations. They may be corporate donations or individual donations aimed directly at single health facilities. Such contributions may be either in cash or in kind. In kind contributions could take the shape of goods or services.

1.2 Besides the above, very often philanthropic, charitable and public spirited individuals/organizations wish to be part of efforts for betterment of health of poor and under-privileged. However, they are not aware of how to go about it, and there are concerns about the donations made by them regarding their usage. Many public health facility in-charge also wish to raise support from the community but are not clear about due process. The revised Guidelines of Rogi Kalyan Samities now facilitate public contribution to public health facilities and also public involvement.

In the recent years, there has been large scale investment in strengthening the Public Health System. Consequently, availability of health human resources, equipment and drugs has improved. However, significant gaps still remain. It is this context, tapping of the voluntary contributions, both in terms of goods and services especially to public health facilities and involvement of the community needs to be encouraged and facilitated.

1.3 Such contributions to public health facilities would also bring about greater awareness and involvement between the services providers, public spirited individuals/ organisations and the service recipients as partners.

1.4 These guidelines have been developed to facilitate ease of contributions to public health facilities across States in the country both from the standpoint of the contributor and the recipient.

2. CORE PRINCIPLES OF CONTRIBUTIONS

2.1 Each state may create a portal that facilitates interaction between philanthropic and public service oriented individuals/ organizations and the health facilities that require support in cash or kind

Contributions should benefit community availing services at public health facilities to the maximum extent possible. Each facility should therefore put up its list of requirements in public domain with some level of prioritization. Contributions in kind (equipment, support for civil work, consumables etc) outside the list are to be discouraged.

2.2 Contributions made should be supportive of the health policies, guidelines and treatment protocols as current.

2.3 Quality of an item unacceptable in the contributorôs organization/ work place is normally unacceptable as a donation to the public health facilities. As a general rule, Standards of quality should not be compromised. There should be effective communication between the contributor and the recipient authority. Contributions in kind should not be sent without prior consent and approval of the competent authority representing the recipients.

Section II - GOODS

3. ROLES AND RESPONSIBILITIES OF RECIPIENTS

Standardized equipment

3.1 Equipping a medical unit is more than simply obtaining the equipment. Maintenance is vital, and maintaining a vast array of different equipment can be problematic. Each state should have a compiled facility level-wise ó*State Standard Essential Equipment List'* to keep the number of equipment to the desirable level. The list of equipment provided in IPHS (Indian Public Health Standards) may be used as reference point. This should then be elaborated with comprehensive details and specifications of the equipment. Such a list is useful for the following reasons:

a) Equipment included on the list can be fully supported in terms of consumables, spare parts, maintenance and operating instructions.
b) Installation and operation arrangements for users and maintenance procedures for technical personnel are simplified.
c) Lower prices due to bulk purchase of consumables (Reagents and controls in laboratories, films in radiology) are possible, and planning for storage space is easier.

Before making a request, it needs to be *checked whether the equipment requested is on the State Standard Essential equipment/ IPHS list.*

3.2 Parameters to be considered for accepting equipment donations:

a) *Staff* experience and training required for installation, operation, and maintenance. Consider both the clinical staff and the technical service staff required to operate the equipment.
b) *Location* for the equipment including site accessibility and the space available.
c) *Climatic and environmental conditions*, such as heat (temperature), humidity, dust, ventilation, etc.
d) *Utilities:* power supply, reliability of supply (fluctuating power, interruptions, rationing, etc.), type of power (voltage, frequency, phase, AC/DC);type of water (softness of water, etc.) and its delivery system (piped, stored, well, river, rain, etc.).
e) *Support services* required for operation, procedures, and clinical use of the equipment.
f) Sophisticated modes offered by the equipment are often not utilized.
g) *Maintenance costs:* in terms of spare parts, downtime during normal servicing and level of expertise of technical staff required.
h) *Availability of consumables*: Some equipment may require consumables which are not available locally, for example, special papers, films, filters, etc. These are recurrent cost items and their availability must be assured.
i) *Other specific requirements* related to the equipment. For example, whether additional equipment has synergy will conform to existing equipment, whether air-conditioning is required for computerized equipment, or solid walls/lead coated for x-ray machines, or a boiler for autoclaves, or power stabilizers for electronic equipment etc.
j) *Duplication* of already available equipment should be taken into consideration.

Involve end users, clinicians and technical personnel & department.

3.3 In preparing the Standard Essential Equipment List and before accepting donations, technical personnel users like clinicians and technicians should be involved to advise upon:

a) All aspects of the requirements for installation, operation, and maintenance
b) Essential spare parts and other special requirements, their availability, and costs
c) Availability of technical personnel and level of training required
d) Estimated lifespan of the equipment based on the model, year of manufacture - Appropriateness of equipment in terms of running costs and design.

Specify clearly items to accompany the equipment

3.4 All equipment must be provided with a full set of technical documents. That is, documentation for installation, for user operation, for repair and maintenance (manuals), a list of spare parts and diagrams and technical data in a language that is understood by the users. All equipment should be accompanied by a reasonable quantity of spare parts and consumable items. This should take into account the ñlead periodò (i.e. period between placing an order and receipt of spare parts). All new equipment must be accompanied by documents of warranty (guarantee) etc.

Communicate preferences and constraints.

3.5 If a financial contribution to allow local or regional purchase would be more appropriate, cheaper or easier, this information needs to be stated clearly. Issues on which the donor is unable to comply needs to be discussed. The solution should be understood and agreed upon by both parties. As a result, the donors will not substitute items believing that such alternatives would be equally suitable. If minimum requirements of both parties are not met, the donations should be politely but firmly turned down.

Maintenance:

3.6 It needs to be ensured that donated equipment are maintained regularly and are included in the equipment maintenance plan of the facility or the state. For the maintenance and supply of consumables, the stateôs budgetary support would be essential. RKS funds may also be used for this purpose

Role of Rogi Kalyan Samitis(RKS)/Hospital Management Society/Patient Welfare Committees

3.7 RKS (Rogi Kalyan Samitis)/Hospital Management Society/Patient Welfare Committees are registered societies created under NHM to encourage community participation in management of public health institutions and maintain transparency. They must play a pivotal role in generation and utilization of donations from corporate, industry and individuals. Any donation made to health facility preferably should be through RKS, which is also responsible to maintain the expense and utilization records. Before utilization of any donation, the same shall be documented and report on utilization should be shared with the donor.

Accounts and Audits

- It is desirable to make the RKS or equivalent as the competent authority for accepting, rejecting, utilizing, maintaining and disposing equipments.
- Any monetary donations exceeding Rs. 5000 (Five thousands) should be received by cheque only.
- The RKS should obtain necessary approval from the income tax authorities for tax benefits to the donors (under section 80G)
- All donations received by the Society in any form shall be acknowledged by a receipt.
- The name of donor/s may be displayed at the facility, if so desired by the donor/s. Any such display shall be consistent with the existing color scheme and signage system maintaining the aesthetics and decorum of the facility. RKS could make the rules regarding this.
- Separate account head for ódonationsô shall be maintained.
- Details of expenses made shall be maintained.
- The accounts of the Society shall be audited annually by a Chartered Accountant firm included in the panel of Chartered Accountants drawn by the designated authority of the State Government.
- The report of such audit shall be communicated by the auditor to the Society, which shall submit a copy of the Audit Report along with its observation to the District Collector.
- Public service oriented persons/ philanthropist individuals or organizations should also be made a member of the RKS, as per the RKS Guidelines/ Articles of Assciation.

4. ROLES AND RESPONSIBILITIES OF CONTRIBUTERS (Individuals, corporate, Institutions, foreign countries and other donor partners):

Donated equipment would only be useful if it is properly installed, operated, maintained and used appropriately.

4.1. *Communicate with the recipient*

Before supplying any equipment, donor shall request for a comprehensive description of the equipment required by the recipient. Ensure that the conditions that cannot be fulfilled are communicated to intended recipient. An agreement on all conditions should be reached before installing the equipment. This ensures that the equipment supplied is clinically, economically, and technologically appropriate.

4.2. *Supply fully functional equipment*

Equipment should be pre-tested before dispatch, and all essential parts, accessories and working materials should be included before shipment. A basic list of all components must be provided to the recipient. It should be ensured that the manufacturer continues to produce

spare parts, spare parts are available in the country / state and the ñlife expectancyò of the equipment is indicated.
Old, broken, outmoded, and redundant equipment for which spare parts and consumables are no longer available, or equipment which is no longer supported by the manufacturer, are useless. If it is difficult for the donor to service the equipment, it will be impossible for the recipient. Supply of such items should not be accepted.

4.3. ***Supply all technical documents.***
These include all installation, operation, maintenance, and repair manuals. It is particularly important to include technical diagrams as the symbols used have uniformity in understanding internationally. The technical documents should be supplied in the language of the permanent employees of the recipient enterprise.

4.4. ***Supply an initial requirement of consumables and spare parts***
Recipients often face lengthy and complicated procurement procedures. Equipment should therefore be supplied with initial consignment of consumables and spare parts expected to last at least two years (or as requested), and a full list of spare parts. The list must clearly indicate the part name and number, and full name and address (including phone, telex and fax numbers, if possible) of the manufacturer or authorized dealer. Vagueness over the description and source of spare parts can cause months of delay in an already long process.

4.5. ***Ensure proper packaging***
The consignment is likely to endure long periods in ships, airplanes, trains, motor vehicles, bicycles and even on animal backs or by hand. The packaging must therefore be strong and sturdy to withstand rough handling and to minimize damage during transportation. It should also include a clear packing list identifying all component.

4.6. ***Supply shipping documents promptly***
Consignments have been known to remain at ports for months, facing possible damage and accumulating demurrage charges (penalty for delayed action) due to late submission of shipping documents. Prompt submission of documents is essential and should be sent by express insured mail. If possible, arrangement should be made to send advance copies by fax.

4.7. ***Offer technical assistance.***
Where possible, promote, recommend and provide training for the use and maintenance of the equipment. Onsite training is usually very useful.

4.8. ***Approved Medicine and medical supply:***

Donated medicines and medical supplies should be only those, which are approved for their usage in the country. It is reiterated that drugs, vaccines, sera & equipment for clinical trial should not be donated as medicines & supplies. Drug samples are also not allowed for donation. Large bulk of liquid containers should not be used, they are not suitable for dispensing purposes and they increase the risk of further contamination of the products,

because of need for repacking. The strength and formulation of donated medicine and medical supplies should, as much as possible be similar to those commonly in India. Generally the drugs donated should be within the States EDL unless certain new services have been added which require specific drugs but are not part of EDL. The competent authority should ensure that the donated drugs have undergone quality checking before being finally used in the health facility.

5. CONTRIBUTION FOR CONSTRUCTIONS

5.1 It needs to be ensured that buildings donated are not designated as heritage category.

5.2 While supporting new construction in the hospital (e.g. construction of additional ward/ addition of night shelter for patientsô relatives, seminar room, conference hall etc.), the land available within the hospital could be used with prior approval of Rogi Kalyan Samiti (RKS) or other competent authority in writing. While according approvals, it needs to be ensured that developed new infrastructure is not óstand-aloneô structure. It is in congruity with existing building. The construction plan would essentially include water connection, drain, sewer line, approach road/ pathway, electricity connection catering to anticipated load of the building. The facility administration should facilitate provisioning of such support, so that the newly constructed building is put to functional use, immediately after its construction.

5.3 Construction of new building should be on the actual need of the facility, not merely on the ówishô of the donor. An ideal situation would be that each facility has a comprehensive development plan for the civil work and donor is strongly urged to identify a portion (either in part or in totality) to support such work. However due consideration would be given by RKS/ competent authority, while approving the new construction.

5.4 Agency responsible for the maintenance of the building should be consulted while approving such donation. Their representative should periodically visit and render the advice on the support services (water, sewer, electricity, etc), so that after newly constructed building is taken over by the hospital and put to use, the agency undertakes maintenance work seamlessly.

5.5 Very often, recipients of contributions at State, District and Healthcare facilities are skeptical about accepting the donations e.g. Drugs, Equipment, Construction, Cash, sponsorship etc. generally on account of the following concerns:

- Where (in which account) to deposit the donated money?
- Where and how to keep the records of expenses?
- Should higher authorities be informed?
- How to operate, maintain, and condemn the donated equipment?
- How to manage their consumables?

However, the RKS have been authorized to receive contributions in cash and kind.

5.6 Donated equipment though given with the best of intentions may sometimes be inappropriate for the recipient health facility for a number of reasons such as - it may be unserviceable, or at the end of its life cycle, or not supported by the manufacturer, spare parts may not be readily available and accessories and attachments may have not been provided in sufficient quantity, the equipment has the unsuitable voltage and frequency in term of Indian Electricity Supply System, or supplied without service/ user manual. Similarly, there are examples of drugs donations which cause problems instead of being helpful. Donated drugs are not relevant for the disease pattern or level of healthcare facility. Unsorted drugs and drugs labeled in language other than recipientsô language, drugs with short expiry, donated in wrong quantities. Hence, it is important for Donors as well as recipient to be aware of particular need and the utility of the donation.

5.7 These *Guidelines* aim to describe this common core of ñGood Donation Practiceò for as a philanthropic activity including corporate social responsibility, mandated under the companies law.

5.8 These guidelines are for non-emergency situations only. For Emergency situations, õWHO Guidelines for Healthcare Equipment Donationô March 2000, and õWHO Guidelines for Drug Donationsô revised 1999 may be referred.

5.9 Indicative models for support with costing for Labour rooms and Ambulances is attached as Annexure A and B.

Section III – SERVICES

6. Tapping services of medical professionals - medical officers and specialists

6.1 India has an acute shortage of medical professionals ï medical officers and specialists in the public sector. While Government is taking efforts to augment the number of medical officers and specialists through various measures, this is likely to take time. In the meanwhile, particularly in areas where there are shortages, the MoHFW intends to tap on the strength and services of medical professionals, retired/ in -service within the country and overseas resident medical professional purely on voluntary basis. This initiative is not intended to substitute the regular staff but to supplement and fill critical gaps.

6.2 This initiative welcomes medical professionals from within India and overseas to volunteer their services at district and sub-divisional facilities in urban and rural areas. Services can be volunteered for a specified duration of few days/week/months. It could also be for few hours a day on week days or on holidays or after office hours. For instance, services on a weekend- where elective surgeries could be scheduled, or where patients can be given prefixed appointments for a particular condition: for example, neurology, cardiology, urology, gastroenterology; a week/fortnight long camp type set up in a district for scheduled surgeries and medical consultations or services on holidays and between six pm to nine pm at urban PHCs. The gynaecologists services should particularly be welcomed particularly on the 9^{th} of every month.

6.3 The health professional would indicate the place or location he/she would like to volunteer and for what services. Where the volunteered services are for surgical procedures, the facility in which the volunteers would be offering their practice should have all the necessary support infrastructure, diagnostic equipment and drugs.

6.4 The details of the initiative would be placed in the website of the Union Health Ministry with link to states. Interested applicants would need to complete the application form online/offline. *Model Application form is provided at Annexure C.* In each state, a dedicated nodal officer would download/acknowledge the applications, match with needs and inform applicants of the decisions within a specified timeframe, as decided by the State.

6.5 While it is envisaged that the volunteers would bear the cost of travel to and from the residence, but once the site is reached, the state could take care of all local hospitality - boarding and lodging and make arrangements for local travel as required.

6.6 This would be a purely voluntary effort and no honorarium would be provided. A certificate of appreciation/ commendation should be provided. If any referrals for diagnostics or to a higher level facility, it would be in the public sector. If for any reason the private sector is chosen, the hospital committee /or facility in charge would certify the need to do so. An undertaking would need to be provided.

6.7 Through wide publicity of this initiative, expression of interest would be encouraged through a range of networks - IMA, local state Medical associations, medical school alumni

associations, India ï abroad, Medical professional networks of Indian doctors in US, Europe, UK, etc

Annexure A

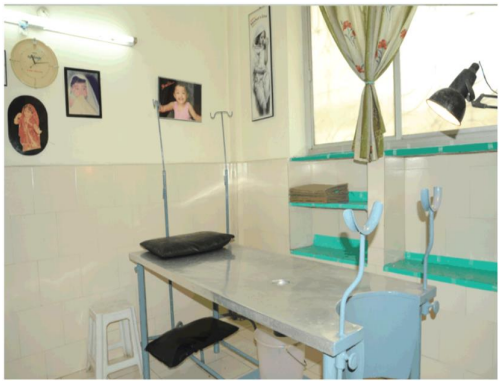
Labour Room

India contributes to 20% of global maternal deaths. Around 47,000 women die every year in the country due to pregnancy or pregnancy related causes. To reduce maternal mortality strategies and interventions have to be tailored to specific needs and situations and implemented as a continuum of care. The Labour room is seen as the nucleus, where such interventions would yield remarkable results.

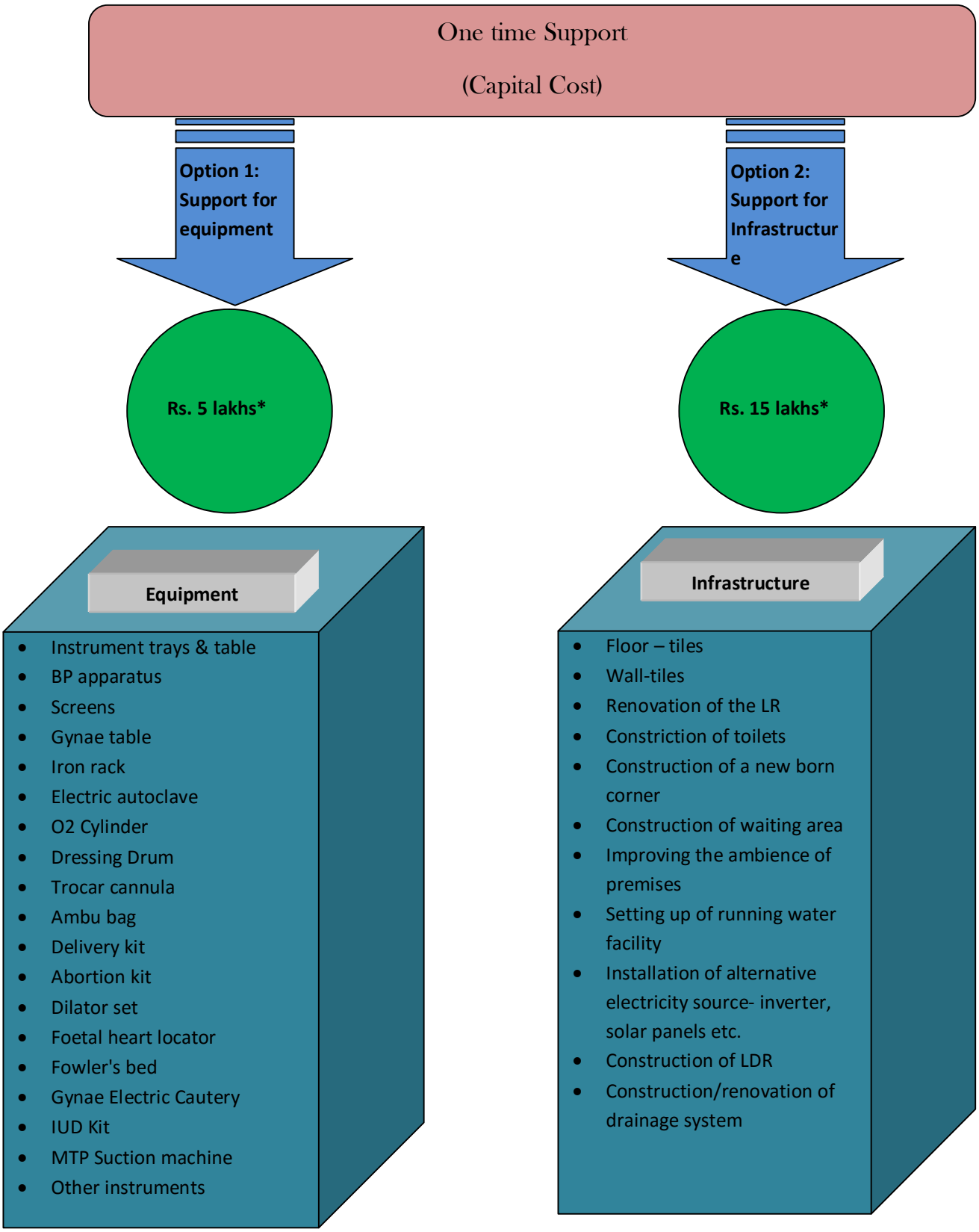
Labour Room-Obstetric examination & Normal delivery services are provided in a labour room.

In a primary care setting it has the following areas:

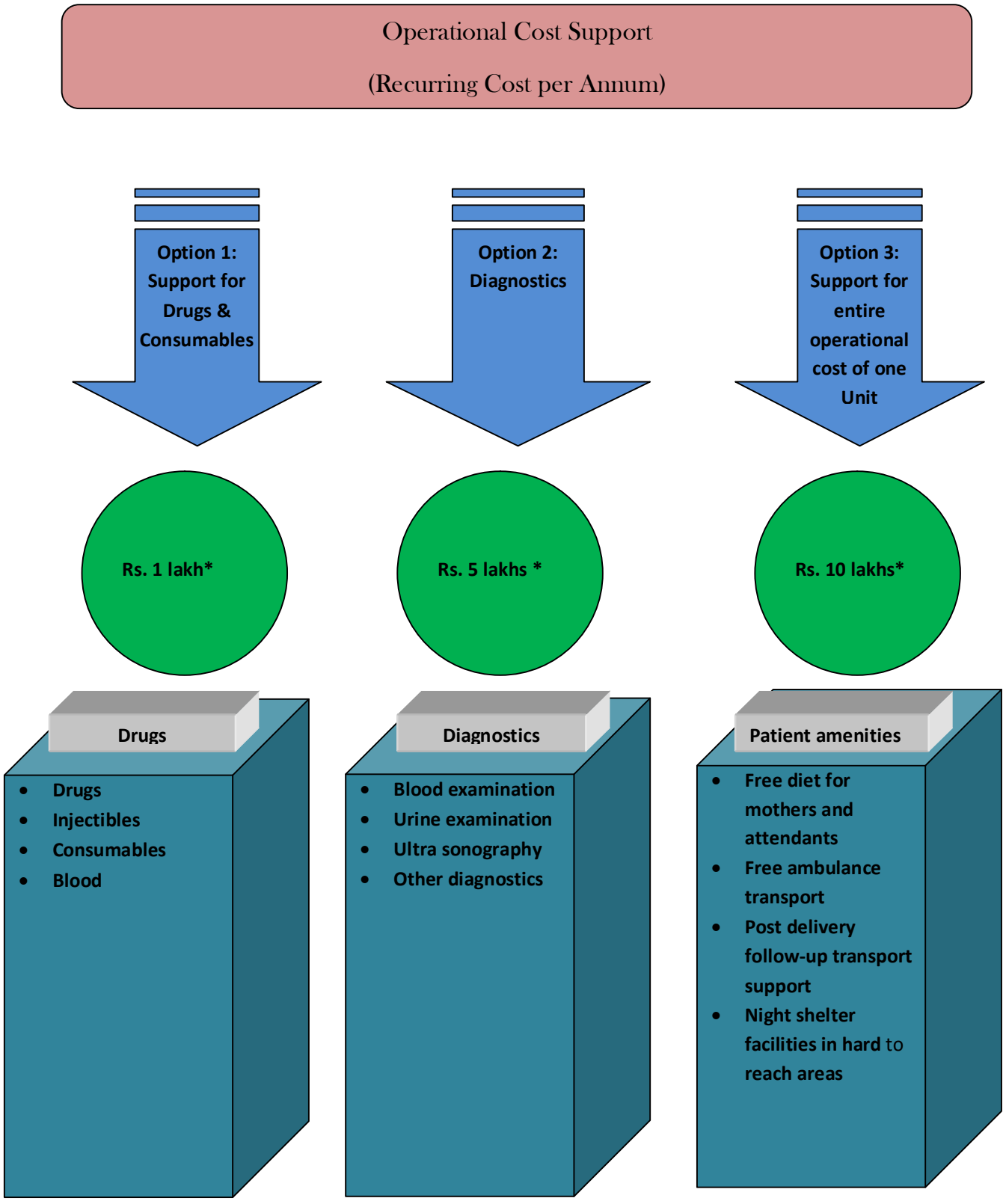
- Receiving area
- Examination room
- Pre-delivery observation room (1st stage area)
- Delivery (Labour) room
- Post-delivery observation room (4th stage area)
- Newborn care corner/LDR



Philanthropic support from Private/ Public /Non-Governmental Agencies can be for strengthening the services rendered through Labour room. This support can save many mothers and their children. It can be provided through following options.



**Costs are Indicative only*



**Costs are Indicative only*

Annexure B

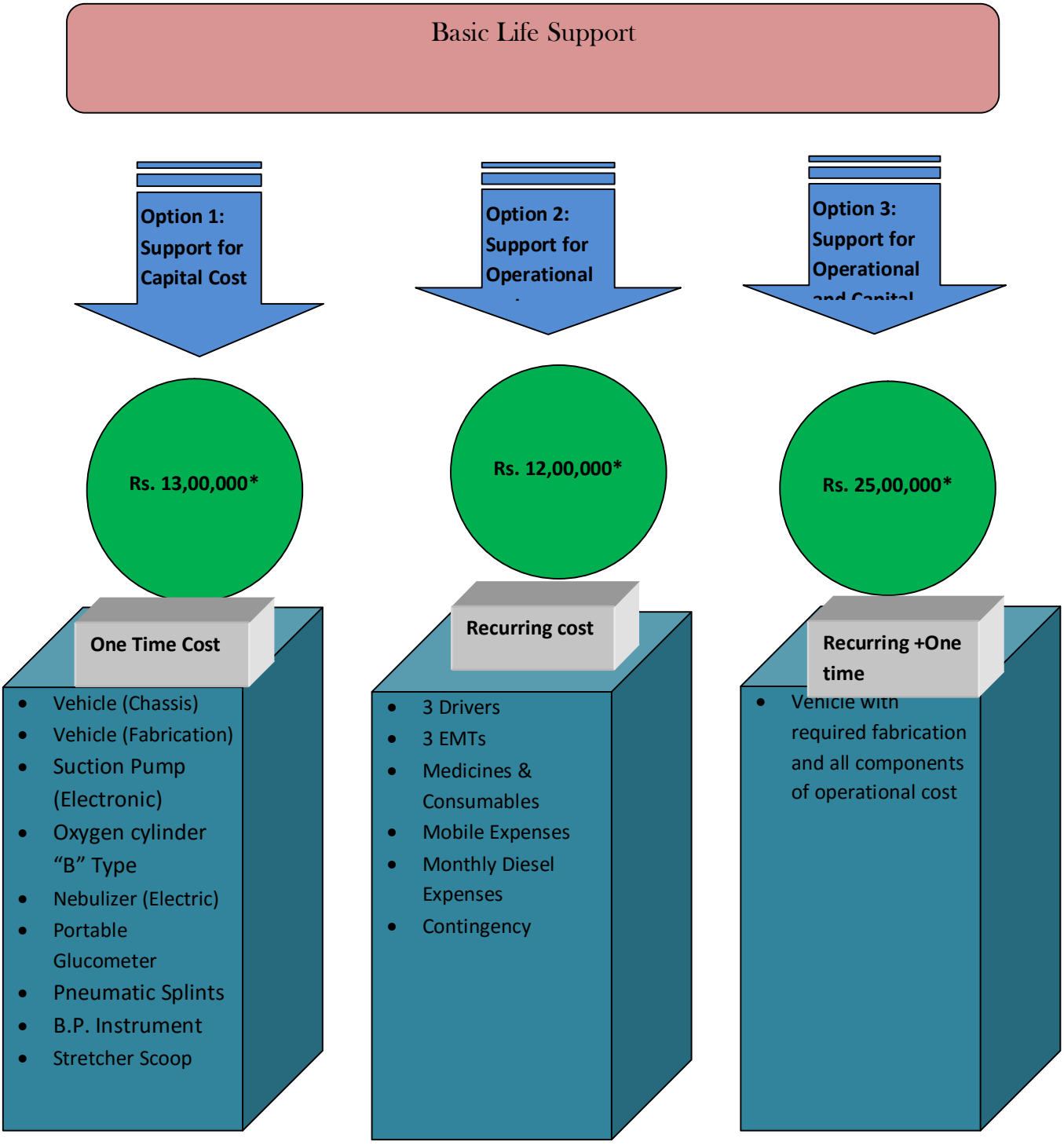
Ambulances

- Few events are more distressing than an unexpected loss of life or permanent disability caused by physical violence or accidental injury. As per the latest data published by the National Crime Record Bureau, ôRoad Accidentsô in India have increased by 2.9 % during 2014 compared to 2013.

- Under National Health Mission, Ministry of Health & Family Welfare has taken various initiatives towards establishing robust emergency response services system in the States. Ambulance network with state-of-the-art ambulances is an essential part of this system. At present, 28 States/UTs have the facility where people can dial 108 or 102 telephone number for calling an ambulance. 108 is predominantly an emergency response system, primarily designed to attend to patients of critical care, trauma and accident victims etc. 102 services essentially consist of basic patient transport aimed to cater the needs of pregnant women and children though other categories are also taking benefit and are not excluded.

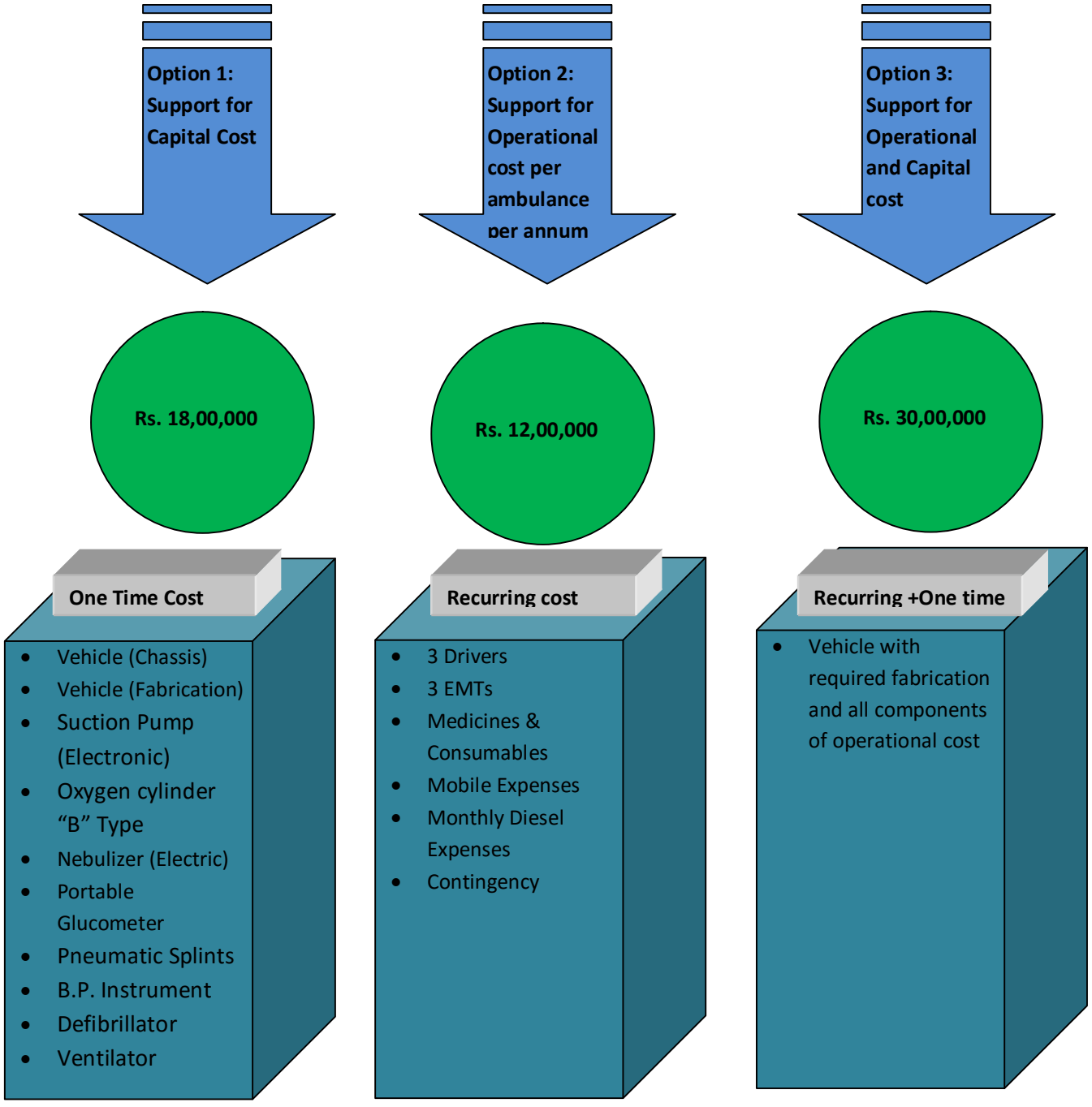
- **Two Types of Ambulances are required for emergency response services**
  - ✓ The Basic Life Support (BLS) ôambulance is the basic model for all emergency rescue services. BLS is equipped with state-of- the-art equipment including blood pressure monitoring equipment, pulse oximetry and oxygen delivery devices.
  - ✓ Advanced Life Support provided high level of emergency care and is equipped with state-of-the-art heart and blood pressure monitoring equipment, pulse oximetry, IV pumps, oxygen delivery devices including a an automatic external defibrillator and ventilator.

- Philanthropic support from Private/ Public /Non-Governmental Agencies for strengthening the services rendered under the Referral transport System. This support can make difference in many ways.
- Support can be provided through following options:



**Costs are Indicative only*

Advanced Life Support



Annexure C

Volunteer Application for Doctors

Please return to:
(Name, address, phone, email) of coordinating body

Personal Information

Name _____ Gender_____
DOB/Age: _____
Address: _____
_____
Home Phone: _____
Mobile Phone: _____
E-mail Address: _____

Availability

Number of hours per week of availability _____
Please specify days and preferred hours

All Day 8:00am - 8:00pm
First Shift 8:00am - 2:30pm
Second Shift 1:30pm - 8:00pm

_____
Expected length of availability(weeks, months)_____
Date available to begin : _____

Other comments

Education – please attach copy of relevant degree certificates

Academic Qualifications :
Year of passing:

Institution: _____

Area of specialization: _____

Relevant work and volunteer history
Attach CV

Employment: _____
_____
_____
_____

Volunteer experience: _____
_____

(Use back of this form if you need more room)

Job skills
Please check as many as applicable

General Duty Medical officer
Surgeon
Paediatrician
Obstetrician