# TOR for a Hospital Survey on Quality of Health Care and RSBY/ SCHIS implementation

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# A Project description

## A.1 Brief description of the project

**Health and social security in India**

The Government of India is committed to the goal of universal health coverage (UHC). The new National Health Policy defines UHC as the "universal access to *good quality health care* services for all citizens without anyone having to face financial hardship as a consequence". However the reality is still far from what India strives to achieve. Public spending on health ranges at around 1.2% of Gross Domestic Product (GDP), one of the lowest figures worldwide. The resulting financial constraints are exacerbated by high inefficiencies due to a lack of regulation and coordination of both public and private health care providers. As a result, India's health system is characterized by large inequalities, huge gaps in the network of public health care providers, one of the highest shares globally in private out-of-pocket payments (OOP)[1], and ultimately poor quality of health services. The needs of the population are not adequately met.

While most countries in the world today have implemented a system of output based financing, where providers receive payments according to the delivered services and with stringent accountability mechanisms in place, India largely follows a system of paying for inputs with a provision that essential health care services in public facilities should be delivered for free. However in reality even in the public system the prevalence of OOP is very high in most states. Moreover poor people often use private health care providers, either because they believe to receive a better quality of care or because no public facility is within reach and willing to admit them.

The situation is particularly bad for workers in India's informal sector and their families that belong to the most socio-economically deprived groups in India. They usually have an unsatisfactory access to public mechanisms of social health protection and in case of illness run the risk of slipping further into poverty. Affected families often have to think of short-term survival strategies in times of crisis to lessen their financial burden: Taking expensive loans, selling productive assets, interrupting school education or engaging in child labour are some of the measures taken by affected families. Or they postpone urgent treatments thus aggravating the situation. Women, who on the whole have a lower social status than men in the Indian society, are more seriously affected by poor health outcomes.

In India, the majority of social security programmes like health insurance and pension schemes are restricted to workers in the formal sector. However, over 90% of workers either work in the informal sector, are self-employed small farmers or run small businesses. Most of them do not have access to comprehensive and reliable social security. In 2008, the Indian Government passed the Unorganised Workers' Social Security Act (UWSSA) to implement social security schemes across the country for the informal sector. Various ministries and other government agencies offer social security schemes for informal sector workers and their families, but these programmes remain limited in their scope and reach and are often uncoordinated.

[1] The high OOP for health services in India are a major contributor to poverty. According to the National Sample Survey Organisation (NSSO) data, around 63 million Indians are pushed below the national poverty line due to OOP every year. According to estimates by the World Economic Forum, India will lose USD 4.38 trillion before 2030 due to preventable illnesses and premature death from non-communicable diseases, which so far have limited affordable coverage in India. This is very counter-productive given the immense efforts that are undertaken in the country towards poverty alleviation.

**Rashtriya Swasthya Bima Yojana (RSBY)**
An important scheme under the UWSSA is Rashtriya Swasthya Bima Yojana (RSBY), a government sponsored national health insurance scheme for below poverty line families (BPL) and certain categories of informal workers. Launched in 2008, RSBY currently covers around 41 million households in 19 States and Union Territories.

The objective of RSBY is twofold:

a) To provide financial protection against catastrophic health cost through reducing OOP for hospitalization and
b) To provide access to *quality health care* for below the poverty line households and other vulnerable groups in the unorganized sector.

In order to improve access to public and private health care services and to reduce OOP the central government currently revamps and extends RSBY. The government has also announced the launch of a new National Health Protection Scheme (NHPS). It will build upon the processes, financing mechanisms and IT architecture of RSBY. The new scheme represents a major shift in the financing of health services, moving towards a system of output based financing instead of paying for the inputs. This shift, if properly implemented, will result in improved efficiency, transparency and accountability in the Indian health system. The new scheme will significantly expand the health financing model and systemic changes initiated by RSBY. It will comprise of a comprehensive benefits package with predefined package rates covering secondary, tertiary and partially preventive care, thus inter alia responding to the rising importance of non-communicable diseases in India. It will cover a much larger target population than the RSBY and receive a much increased budgetary allocation. Another objective of the new scheme is to improve the quality of medical care and ensuring that the empanelled service providers follow minimum quality standards. Over time a system of quality grading shall be established as well as an incentive based mechanism that rewards improvements in quality by service providers. A mechanism to improve the quality of health care services using the purchasing power of the RSBY is missing.

**Senior Citizens Health Insurance Scheme (SCHIS)**
A separate cover of Rs. 30,000 per senior citizen per year in the form of the Senior Citizens Health Insurance Scheme (SCHIS) is provided to RSBY-beneficiaries. The SCHIS has been implemented since April 2016 in 8 states in India. Gujarat, Kerala and Meghalaya are states where RSBY and SCHIS are both implemented and therefore both can be studied and evaluated together.

## A.2 The GIZ Indo-German Social Security Programme

GIZ has been advising the Indian Government on the design and implementation of RSBY since 2008. In 2011, GIZ's advisory role was expanded with the establishment of the Indo-German Social Security Programme (IGSSP).

IGSSP applies different methodological approaches. It combines technical and sector-specific advisory services along with process and organisational consultancy in order to harmonize social security programmes. It also provides training and skill development. The project works at various levels and implements measures in the two operational areas (1) health insurance and (2) coherence and convergence of social security programs.

IGSSP works on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ) and is currently commissioned until April 2020. The project is co-financed by the Bill and Melinda Gates Foundation (BMGF).

**Target groups and other stakeholders**
The target groups of IGSSP are workers in the informal sector or independent small farmers and owners of small businesses and their families, as defined in the social security legislation for the informal sector in India. These are mainly families which are very poor or threatened by poverty, as well as women without proper access to social security.

Other stakeholders are technical and executive staff of the governmental partner agencies in charge of the implementation of social security programmes, such as the Ministry of Finance (MoF), which is administrating a supplementary insurance scheme for the elderly and an accident insurance scheme. It also includes the Ministry of Information Technology and the National Informatics Centre (NIC), which is responsible for the development of the NHPS software. Furthermore, the governments of the states, in particular state health departments are also supported. Other parties are private (e.g. Apollo Munich) and state (e.g. National Insurance Company) insurers, trade unions and non-governmental organizations.

## A.3 Lead executing agency and implementing organisations

The political partner of IGSSP is the central Ministry of Health and Family Welfare (MoHFW). The MoHFW has the political responsibility to execute RSBY and its successor scheme.

At the state level, the project works with Health Departments and the State Health Authorities (SHA). In the federal states, the State Nodal Agencies (SNA), which are responsible for the implementation of RSBY, are being expanded to better equipped SHAs. Their main responsibility will be the administration and implementation of RSBY/ NHPS in the federal states.

## B. Terms of Reference

## I. General Terms of Reference for the Firm of Consultants

The poor regulation of the Indian health sector has tremendous implications for the supply and quality of services and care. Improving the supply and quality of care and ensuring minimum quality standards for empanelled hospitals are important objectives of RSBY and have to be long term objectives of India's health care system. In order to continuously improve the availability of health services and social security measures, the administration and implementation of a health insurance scheme, the delivery of health care services to beneficiaries and ultimately the improvement in quality of care, a continuous flow of data is required.

### Objective of the assignment

The objective of this assignment is to carry out a cross-sectional survey in hospitals which focuses on quality of health care. The results, conclusions and recommendations from the study shall ultimately be fed into and inform policy and decision making processes on quality of health care services of hospitals at central and state level in India, particularly of those empanelled under RSBY. Furthermore the results shall function as a baseline for a follow-up study that will be tendered at a later point in time. Moreover the results may also support the development of a quality grading system for hospitals and a mechanism to incentivise hospitals to move to a higher quality rank over time.

### Target group and other stakeholders

The primary target group of the results of this evaluation are leading/ senior government officials in the MoHFW as well as technical experts working in relevant departments of the ministry. Officials from State Health Officials/ SNAs/ SHAs, especially from the states in which this evaluation is carried out, are also an important target group.

## II. Detailed specifications

### Focus area:

The focus of this assignment is to collect cross-sectional data on the quality of health care (services) and RSBY/ SCHIS implementation experiences among public and private empanelled and non-empanelled hospitals to allow for an evaluation of quality of health care in 3 states with RSBY implementation experiences. The perspective of the hospital staff (e.g. medical, administrative) and hospital (process) data (e.g. number of beds, specialities available etc.) should be emphasized, as the perspective of the patients and RSBY/ SCHIS beneficiaries is part of another assignment.

The following two areas of investigation are part of this assignment (The research questions are indicative and serve as a guidance; they can be modified by the agency and elaborated more in detail as part of the technical bid):

1) <u>Quality of health care</u>

- Input based quality: availability of services, drugs and consumables, medical infrastructure and equipment, supply of doctors, specialists, nurses, pharmacy, etc;

- Process based quality: clinical evidence-based protocols/guidelines, quality standards and quality grading, quality management, monitoring and supervision, effective logistics and implementation of programmes, etc;
- Output based quality: needs-based and patient-centred services, mortality, inpatient complication rates (e.g. infections, pressure ulcers), effectiveness/efficiency of care (average length of stay, bed occupancy, re-admission etc.), equitableness of care, utilization of resources, improvement of health indicators, etc.

Research questions for area 1:

- What is the status of the quality of health care among empanelled and non-empanelled public and private hospitals? Are there differences in the quality of health care stratified by empanelment status, private/public hospitals and state/district-wise?
- What variables and factors influence quality of health care and why? What is the role of the empanelment status?
- What are barriers and facilitating factors for quality of health care (services) on different levels of the health care system?
- What is the most efficient and equitable way to improve quality of care?

2) <u>RSBY/ SCHIS implementation experiences</u>

- Motivation for a hospital to join/ not to join RSBY/ SCHIS;
- Experiences with RSBY/ SCHIS (i.e. IT system, claims settlement, smartcard).

Research questions for area 2:

- What are the reasons for hospitals to join/not to join RSBY/ SCHIS? If the hospital joined, what are its experiences?
- In which areas are hospitals satisfied/ not satisfied with the experience under the scheme? Additionally, how should RSBY/ SCHIS be improved in order to improve the scheme from the perspective of a hospital?

**Research methodology:**

The agency is requested to provide a detailed research methodology for the study in hospitals at the time of bidding (including rationalizations for selected methods). That methodology shall include - but is not limited to - the below listed aspects:

a) Study design
b) Data collection: research instruments, data collection methods
c) Sample: sample size (incl. representativeness of the data), sampling (incl. selection of districts and beneficiaries), sample recruitment strategy
d) Data management and analysis
e) Quality assurance mechanisms
f) Time and work plan: i.e. time and resource planning to conduct the research activities

These aspects including further information on what the agency shall submit as part of the bid is further specified below:

a) <u>Study design:</u>

The hospital evaluation is to be developed as an impact evaluation (counterfactual design) that will be conducted once (cross-sectional) in 3 states employing a mixed methods approach. The research design and methodological approach shall be developed by the agency and submitted at the time of bidding.

b) Data collection:

Quantitative as well as qualitative tools shall be used to perform the assignment and to answer the research questions. Data shall be collected in the following hospitals:

- Public hospitals not empanelled under RSBY/ SCHIS
- Private hospitals not empanelled under RSBY/ SCHIS
- Public hospitals empanelled under RSBY/ SCHIS
- Private hospitals empanelled under RSBY/ SCHIS

*Quantitative section of the study:* GIZ will develop a quantitative questionnaire and provide it to the agency. The agency may suggest certain modifications in the questionnaire. After finalisation, the agency has to pre-test and further refine the questionnaire in consultation with GIZ.

The quantitative questionnaires should preferably be conducted with the hospital administrator/ manager/ director or other appropriate interview partners. Further information could be collected through patient records. The feasibility of using patient records shall be explored by the agency in the bidding.

*Qualitative section of the study*: The quantitative part is to be complemented by qualitative research that could build on short semi-structured interviews and an observation memorandum. The interviews are to be conducted with 2-3 people per hospital. If the hospital has an RSBY desk, an interview should be strived for with a person from this desk. In addition, interviews with the following persons can be carried out:

- hospital administrator/ manager/ director
- financial administrator
- general physician (in a hospital that is enrolled in RSBY, the interview should be carried out with a physician that treats RSBY patients)

A semi-structured interview is to be developed by the agency in close consultation with GIZ during the design and preparatory phase. Nevertheless, a draft is to be submitted with the bid as well as a short concept for transcription conventions (i.e. level of detail and abstraction). That concept will be further developed in the design and preparatory phase into a transcription manual, in consultation with GIZ, and it will be binding for all transcriptions.

Furthermore, a hospital visit observation memorandum (in short: memo) shall be conducted by the agency. The memo should include – but is not limited to - general observations of the hospital setting, its ‘condition’, observations that are made in the context of the areas of investigation that contribute to the research questions and remarks on what went well and what went less well during the research field visit. A refined method is to be submitted by the agency by the time of bidding.

Patient records, if deemed necessary and appropriate, could be thought of as another source of qualitative information that can inform the research questions.

*Data collection methods:* The agency shall use reliable and valid methods to collect the data. If possible, the agency shall use non-paper-based –methods to collect data. The use of tablets to collect data (whenever possible) is encouraged.

c) Sample:

A sound sample plan, sample size calculation, sampling and recruitment strategy and rationale (incl. criteria) for the selection of study districts is to be submitted by the agency at the time of the bidding.

*State and district sample:* The evaluation shall be carried out in the following 3 states (the final decision on the states will be taken in consultation with GIZ):

- Bihar or Uttar Pradesh
- Chhattisgarh
- Kerala or Gujarat

*Sampling strategy:* A sample shall be drawn from 2 districts per state. For selecting the districts, some criteria could be the following (further criteria can be added by the agency):

- Conversion rate of enrolment of families in RSBY/ SCHIS
- Number of public hospitals empanelled in the district
- Number of private hospitals empanelled in the district
- Hospitalization rate in RSBY/ SCHIS
- Backward district, socio-economic status of beneficiaries

The sample should represent the distribution of different types of hospitals (e.g. size, public/ private, areas of speciality, target group, rural/urban setting) within the respective district. However, in order to improve the overall methodology, the agency shall strive for a randomized method of selection. The final decision on the selected districts shall be taken in consultation with GIZ and in agreement with the State Nodal Agency.

The agency shall furthermore submit a recruitment strategy for hospitals (i.e. how they plan to recruit hospitals for the participation in the study).

*Sample size* (i.e. the number of hospitals): can vary among the states depending on its population size, RSBY/ SCHIS enrolment ratio and hospitalization rate of RSBY/ SCHIS beneficiaries. About 8-10 hospitals are to be sampled from each study district in each state (i.e. about 60 hospitals in total).

d) Data management and analysis:

The agency shall submit a plan to manage the data (i.e. how and where it will be stored and processed) and how it plans to analyse the different types of data.

e) Quality assurance mechanisms:

The agency shall implement mechanisms on how the quality of data is guaranteed (i.e. reliability and validity) through monitoring and supervision activities for the whole study

process. Specifications on how the agency plans to implement this shall be submitted to GIZ as part of the bid.

For the data collection phase, the following mechanisms shall be implemented by the agency:

- A representative of the agency (team leader or investigator, see section VI for further details) is requested to supervise the collection of data in the first five hospitals of the study. After the collection of data in the first five hospitals is completed, the agency shall perform a preliminary analysis of the data and send the results to GIZ. The results will be discussed with GIZ.
- The agency shall send raw data as well as preliminary results, if any, to GIZ every two weeks (i.e. 6 times within the data collection phase of 3 month).

GIZ reserves the right to be present at the field training during the design and preparatory phase (see III. 1.) and to randomly visit the data collection in the field.

f) Time and work plan:

The agency shall submit a detailed time and work plan for the activities and deliverables of this assignment.

After the selection of the agency, the methodology for the survey will be finalized in close consultation with GIZ in a design and preparation phase. If deemed necessary and appropriate, the agency may propose other methods of data collection to GIZ. In addition to the above mentioned points, the agency shall elaborate on ethical considerations in their bid.

## III. Tasks and activities to be performed by the agency

The assignment described in these TOR consists of the following phases which are described in further detail below:

1. Design and preparatory phase: for 2 months after signing the contract;
2. Data collection phase: for 1-2 month
3. Analysis and reporting phase: 1-2 month

The contract has a total duration of 6 month.

### 1. Design and preparatory phase:

The assignment starts with a design and preparation phase that shall consist of the following tasks (additional tasks to be added by the agency if deemed necessary):

- Literature review and study of background (desk review)
- Consultation with GIZ, MoHFW and other stakeholders. A meeting in Delhi shall be organized in collaboration with GIZ during the design and preparatory phase.
- The agency prepares the data collection tools for the qualitative surveys in consultation with GIZ. These shall be shared with GIZ and approved by GIZ before the data collection starts.

- For the quantitative analysis, a data mask in Excel/SPSS with assigned variable labels and value labels is to be prepared by the agency. The files are to be shared and discussed with GIZ.
- Pre-testing of the quantitative and qualitative research tools according to scientific standards. The results of the pre-tests are to be discussed with the GIZ.
- Before the field work starts, the agency shall conduct a proper training of the field researchers and other personnel involved in the collection of data. The training has to be designed in way to guarantee that the field team is enabled to collect valid data autonomously. The training should include the following:
    - Recruitment strategies (e.g. asking persons to participate in the study)
    - Mock data collection interviews
    - Research instrument training to foster a basic understanding of what is being measured and why
    - Data storage (i.e. how and where is the collected data secured)
    - Communication/ behaviour/ research ethics (basic understanding of the do's and don'ts in research and the dealings with sensitive interview contents)

  If deemed necessary, the agency can add training-contents. An outline and time plan of the training of the field team is to be submitted by the agency with the bidding proposal.

**2. Data collection phase:**

The data collection phase shall be implemented and carried out by the agency as described in section II.

**3. Analysis and reporting phase:**

Analysis: The agency is responsible for conducting preliminary analyses of the data already during the data collection phase. The agency shall also ensure a proper preparation and quality check of the data before the data is analysed.

Any outputs and coding, respectively, from statistical as well as qualitative analysis software packages, is to be submitted to GIZ.

Reporting: The agency is requested to provide the draft deliverables to GIZ two weeks before the end of the contract, the final deliverables shall be provided at the end of the contract. A detailed description of the deliverables is listed under section V.

## IV. Additional tasks to be performed:

- Regular face-to-face meetings are to be held with GIZ (direct or video conference).
- Tablets shall be used for the collection of data (whenever possible).

## V. Deliverables

The following deliverables shall be provided to GIZ by the agency:

| No | Deliverables | To be delivered until: |
|---|---|---|
| 1 | **Design and preparatory phase**<br><br>Inception report containing the following:<br>- Detailed proposal (work plan) with planned methodology, desk review, timeline, etc.<br>- Report on the results of the pre-tests of the research instruments<br>- Research instruments for the hospital study | Signing of contract + 2 months |
| 2<br><br>3<br><br>4 | **Data collection phase**<br><br>Preliminary results after five hospitals: short descriptive results of the quantitative survey variables'<br><br>Raw data and preliminary results: the agency shall send the collected quantitative data (in excel or SPSS) as well as qualitative data (written transcripts in English) and – if available – any preliminary results to GIZ<br><br>Final data: Collected questionnaires from the field (photocopies or soft copies), an integrated raw data-file (Excel and SPSS) for the quantitative data for all study states and districts, transcripts of qualitative interviews in the regional language and translated into English in electronic format and all memos | As early as possible<br><br>Every two weeks of data collection phase (6 times)<br><br>End of data collection |
| 5<br><br>6<br><br>7 | **Data analysis and reporting phase**<br><br>Outputs from statistical and qualitative analysis: e.g. in SPSS .spv-files<br><br>Draft summary report: main findings and recommendations, with detailed outline<br><br>Draft detailed report: consisting of an overall analysis and state-wise analysis, with detailed outline | After analysis<br><br>Mid-month 6 of the contract |
| 8<br><br>9 | **Final deliverables**<br><br>Summary report: main findings and recommendations (10-15 pages without annex)<br><br>Detailed report: consisting of an overall analysis and state-wise analysis (35-50 pages without annex) | End of contract |

All documents shall be written in English and provided in an electronic format to GIZ (in both PDF-format and as a Word-file, exception: files that are a part of the analysis). For each report, the agency shall provide an outline to GIZ before the reports are drafted and finalised.

All draft reports shall be sent to GIZ. The final versions of each report shall be sent to GIZ one week (5 working days) after comments on the draft versions have been sent by GIZ to the agency. The agency shall consider this feedback loop while setting up the work plan.

## VI. Specification of inputs

### 1. Assignment of personnel

GIZ requests proposals from reputed national consulting agencies, research institutes, universities etc. (henceforth described as “agency”) with a strong track record in designing and implementing impact evaluations, data management and analysis in the areas of public health, health insurance and financing, social health protection and specifically quality of (inpatient) health care (services).

The following qualifications and experiences are mandatory:

- Previous experience in carrying out large-scale hospital surveys in rural and peri-urban areas;
- Excellent proficiency in both quantitative and qualitative research methods;
- Research experience and excellent understanding of the Indian health care sector, quality of care and impact evaluations;
- Prior experience in the accreditations of hospitals/ or for accreditation agencies;
- Good grasp and in-depth knowledge of scientific and non-scientific discussions and reform processes related to health insurance and financing as well as quality of care in India.

**Experts to be provided by the agency:**

The agency shall have the following full-time personnel available throughout the assignment period which shall serve as a core team until the completion of this assignment. Excellent proficiency in written and spoken English is required for all members of the core team.

The exact composition of the team and responsibilities assigned to each team member shall be provided by the agency as part of the bidding.

| Designation | Educational Qualification | Professional Experience | Main responsibilities |
|---|---|---|---|
| 1 Team Leader (75 working days) | PhD, Masters in health, social science, economics, statistics or related field. | - 10 years of work experience as team leader of large scale surveys and evaluations in the area of health in India;<br>- Expert in the design and implementation of primary data collection exercises in the area of health. | - Overall responsibility for all activities related to the successful completion of this assignment.<br>- Overall quality assurance of the data collection, analysis and deliverables. |
| 1 Investigator (75 working | PhD, Masters in health, social | - 8 years of work experience in large | - Coordinator of the hospital survey. |

| | | | |
|---|---|---|---|
| days) | science, economics, statistics or related field. | scale household surveys, data analysis (quanti and quali), report writing and research work in India.<br>- Expert in health financing, health systems development, quality of care. | - Data preparation and analysis.<br>- Assurance of the quality of data. |
| 1 Support investigator (30 working days) | Masters in health, social science, economics, statistics or related field. | - 5 years of work experience in large scale household/ hospital surveys.<br>- Profound knowledge in the areas of data preparation and analysis (quanti and quali) in India as well as reporting writing. | - Data entry, data checks.<br>- Data analysis.<br>- Report writing. |
| 1 Assistant (75 working days) | University graduate in appropriate field. | - 5 years of work experience in administration, support and logistics for large scale surveys. | - Administration, support and logistics. |

**Field team:**

The data collection in the field shall be carried out by separate data collection teams. For each state, a separate team – consisting of 1 senior and 1 junior data collector – shall be deployed. In addition, 1 support staff helping with logistics, mobility, and safety can be part of each team.

Ideally, the members of the data collection teams have previous experience in carrying out hospital surveys. They shall be trained by the agency to carry out the data collection exercise. All team members need to be familiar with data collection technology and need to be fluent in the respective local languages. A research degree (i.e. Bachelor's degree with (health) research training) is of added value for any personal that collects data.

It is desirable, that the agency has an existing in-house team which is already trained and has experience in collecting data of hospital surveys. However, the agency can outsource or hire additional workforce to carry out the field work.

In case the agency needs to hire data collection teams and in case the details of the teams are not yet available at the time of bidding, the agency must provide the following details to GIZ at least one week before the start of the field work: details of team members, source of hiring, qualification and experience of team members, tentative route plan, work plan, etc.

## 2. Items of equipment

No procurement of equipment or assets is foreseen for the successful completion of this assignment. The data should be collected electronically from the hospitals for the quantitative part of the study.

The agency may budget the costs of up to 2 software programmes (i.e. qualitative and quantitative data analysis) which need to be procured or programmed specifically for this assignment at the time of bidding.

In case tablets need to be rented for the rounds of data collection, the agency shall budget these costs as well.

## 3. Other items

Shortlisted agencies may be requested to meet GIZ before conclusion of the contract.

## List of abbreviations

| | |
|---|---|
| IGSSP | Indo-German Social Security Programme |
| MoHFW | Ministry of Health and Family Welfare |
| NHPS | National Health Protection Scheme |
| OOP | Out of pocket expenditure/payments |
| RSBY | Rashtriya Swasthya Bima Yojana |
| SCHIS | Senior Citizens Health Insurance Scheme |
| SHA | State Health Authority |
| SNA | State Nodal Agency |