AN ASSESSMENT

OF

PUBLIC–PRIVATE PARTNERSHIP OPPORTUNITIES

IN

INDIA

EXECUTIVE SUMMARY

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## ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANM</td>
<td>Auxiliary nurse–midwife</td>
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<tr>
<td>AP</td>
<td>Andhra Pradesh</td>
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<td>APSMP</td>
<td>Andhra Pradesh Social Marketing Programme</td>
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<tr>
<td>BCC</td>
<td>Behavior change communication</td>
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<tr>
<td>CBD</td>
<td>Community-based distribution</td>
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<td>CFW</td>
<td>Commissioner of Family Welfare</td>
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<td>CMS</td>
<td>Commercial Market Strategies Project</td>
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<td>CYP</td>
<td>Couple year of protection</td>
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<td>DFID</td>
<td>Department for International Development (United Kingdom)</td>
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<tr>
<td>DHFW</td>
<td>Department of Health and Family Welfare</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human immunodeficiency virus/acquired immune deficiency syndrome</td>
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<td>HLFPPT</td>
<td>Hindustan Latex Family Planning Promotion Trust</td>
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<tr>
<td>HLL</td>
<td>Hindustan Latex, Limited</td>
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<tr>
<td>IEC</td>
<td>Information, education, and communication</td>
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<td>IFPS</td>
<td>Innovations in Family Planning Services project</td>
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<td>IUD</td>
<td>Intrauterine device</td>
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<td>JCAHO</td>
<td>Joint Commission on Accreditation of Healthcare Organizations</td>
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<td>MHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MOU</td>
<td>Memorandum of understanding</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<td>ORS</td>
<td>Oral rehydration salts</td>
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<td>PHC</td>
<td>Primary health center</td>
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<td>PPP</td>
<td>Public–private partnerships</td>
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<td>PSI</td>
<td>Population Services International</td>
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<td>RCH</td>
<td>Reproductive and child health</td>
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<tr>
<td>RH</td>
<td>Reproductive health</td>
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<tr>
<td>SEWA Rural</td>
<td>Society for Education, Welfare, and Action Rural Project (Gujarat)</td>
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<td>SHRC</td>
<td>State Health Research Committee</td>
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<td>SIFPSA</td>
<td>State Innovations in Family Planning Services Project Agency</td>
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<tr>
<td>UP</td>
<td>Uttar Pradesh</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>USHC</td>
<td>Urban slum health center</td>
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<tr>
<td>VCT</td>
<td>Voluntary counseling and testing</td>
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EXECUTIVE SUMMARY

In the fall of 2004, the United States Agency for International Development in India (USAID/India) commissioned a four-person team to review public–private partnerships (PPPs) focused on health in India and to provide suggestions for future activity. The Mission was specifically interested in partnership structures that might be appropriate for implementation under the pending task order for the private sector program.

The team met with USAID/India and its primary implementing partner, the State Innovations in Family Planning Services Project Agency (SIFPSA). The team then divided and conducted field visits throughout India, including Uttar Pradesh, Bihar, Chhattisgarh, Gujarat, Andhra Pradesh, Karnataka, and Tamil Nadu. Interviews were also conducted with various donor organizations and individuals familiar with PPPs in India. In all, the team examined and assessed nearly two dozen PPP models.

Of the seven major PPP models reviewed, five are suggested for further consideration by USAID and SIFPSA:

- clinical contraception through private providers,
- urban slum health centers,
- contracting out rural primary health care centers,
- social marketing, and
- obstetric and pediatric emergency services.

CLINICAL CONTRACEPTION THROUGH PRIVATE PROVIDERS

Such a model would involve a contracting out partnership between the Uttar Pradesh Department of Health and Family Welfare (DHFW) and private hospitals and nursing homes. The private hospitals and nursing homes would provide sterilization and intrauterine device (IUD) services to the rural poor, including transportation to and from the hospital, and would be reimbursed for the costs by the DHFW. Three changes are suggested.

- The private hospitals and nursing homes should either be reimbursed for their total costs or paid a flat fee for services (1,000 rupees [Rs] for voluntary sterilization and Rs100 for IUD).
- There should be no restrictions regarding age or parity.
- The model should be tested in two or three districts before being replicated throughout the state.

URBAN SLUM HEALTH CENTERS

Such a model would involve a contracting out partnership between the Uttar Pradesh DHFW and qualified nongovernmental organizations (NGOs), built on the successful model in Andhra Pradesh. The government would build urban health centers in slum areas
to serve the poor. The centers would be fully equipped by the government. The NGOs would pay no more than one third of the costs; the government would pay the rest. The NGOs would hire their own staffs and provide all needed primary health services, including outreach. A local advisory board would represent the communities in the catchment area. Two modifications are recommended:

- the government should pay 100 percent of the costs (or a large enough fixed payment to cover all costs), and
- the urban health centers should hire specialists under contract on an as-needed basis (user fees would cover these costs).

This model should also be tested before being fully expanded throughout the state.

**CONTRACTING OF RURAL PRIMARY HEALTH CARE CENTERS**

Such a model would also involve a contracting out partnership between the DHFW and qualified NGOs, as above. SIFPSA has tried to set up a similar type of partnership without success. It seems worth trying again, perhaps in another district where there are defunct primary health centers. The following three modifications are suggested:

- payment of 100 percent of the costs, establishment of an advisory board, and full primary health care services, including outreach, as above;
- development of the center as a model for the area, including the training of government primary health care personnel in how to operate a successful primary health center; and
- addition of an emergency ambulance service.

**SOCIAL MARKETING**

Such a model would involve a contractual relationship between SIFPSA or the DHFW and one or more social marketing organizations. The characteristics of the final social marketing model would be determined after a comprehensive review of current social marketing experience, both within India and throughout the world. The review would consider program costs, alternative mechanisms for achieving similar objectives, consumer characteristics, the current programming environment, and other relevant factors.

**OBSTETRIC AND PEDIATRIC EMERGENCY SERVICES**

Such a model would involve a contracting out partnership between the DHFW and qualified NGOs, similar to the SEARCH model in Tamil Nadu. The government would loan an ambulance to the NGO, which would be responsible for all operating costs (such as fuel, maintenance, and driver), and which could charge Rs5 per km for its use (persons below the poverty level would be exempt). The ambulance could be used for any emergency to transfer patients to the nearest hospital. This partnership should be tried in several rural and remote areas.
In addition to the above models, there are several models that have potential but may be more difficult to replicate and expand. (These are outlined in section IV, Other Models, Proposals, and Suggestions.)

Comments are also provided on management and policy issues that have an impact on the models reviewed. The PPPs that are achieving success in India are doing so despite numerous challenges and obstacles. Principal among these are management structures and conventions that have been designed for a large, centralized public health authority and that rarely have the flexibility to meet the needs of a specific community, partner, or intervention.