AN ASSESSMENT

OF

PUBLIC–PRIVATE PARTNERSHIP OPPORTUNITIES

IN

INDIA

Vinod B. Annigeri
Lizann Prosser
Jack Reynolds
Raghu Roy

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ACRONYMS

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

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APPENDICES

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 heath authority and that rarely have the flexibility to meet the needs of a specific community, partner, or intervention.

I. BACKGROUND

The United States Agency for International Development in India (USAID/India) has been active in supporting the government of India on population and reproductive health issues since 1980. Since 1992, USAID/India has provided significant funding for the Innovations in Family Planning Services (IFPS) project, which has focused exclusively on interventions in Uttar Pradesh (and since 2001, in the newly formed states of Uttranchal and Jharkhand). IFPS is implemented by the parastatal agency, State Innovations in Family Planning Services Project Agency (SIFPSA).

Through longstanding experience, donors and the government of India have recognized that unmet reproductive and child health (RCH) needs outstrip their capacity and financial resources. Although India has an active private health sector, its role in the provision of preventive RCH services has been primarily the delivery of contraceptive supplies through social marketing programs. Data indicate that more than 75 percent of current users obtain oral contraceptives and condoms from the private sector. More than 70 percent of the population obtains curative health care from the private sector. Of the women who seek treatment for any reproductive health problem, 71 percent seek care from the private sector.[1] However, the private sector tends to concentrate on curative care for middle and upper income families in urban areas. If it were possible to expand private sector involvement to include preventive care for low-income people in rural and urban slum areas, then significant improvements could be made in public health. Strategic public–private partnerships (PPPs) could be the mechanism to do this.

Various examples of a PPP exist in India, a number of which have been replicated and expanded. Examples include social marketing of condoms, oral contraceptives, and oral rehydration salts (ORS); community-based distribution of contraceptives through nongovernmental organizations (NGOs); development of workplace projects; and contracting of primary health care services. USAID is interested in identifying, testing, and documenting effective mechanisms that encourage the private and public sectors to work together to expand access to quality RCH services, especially among the urban and rural poor. Toward this end, USAID commissioned an assessment team to identify potential public–private partnership models that could be designed, developed, and tested in Uttar Pradesh under the IFPS II project.

[1] Chakraborty, S., "Private Health Provision in Uttar Pradesh, India," Health Policy Research in South Asia, World Bank, 2003.

II. METHODOLOGY

A four-person team made up of two Indian and two international consultants conducted the assessment. A minimal amount of background material was provided in advance of the assignment. The majority of the team's work was conducted in India over a 4–week period during October and November 2004. The findings are based on interviews and background materials.

The team met with USAID/India officials as well as the primary implementing partner, SIFPSA, to finalize the scope of work and to identify areas of emphasis. This was followed by team trips to Kanpur in Uttar Pradesh and Patna in Bihar to investigate PPPs in the field. In the third week, the team divided into two teams for further field investigation. One team went to Raipur in Chhattisgarh and Ahmedabad, Bharuch, and Vadodara in Gujarat, while the other team traveled to Hyderabad, Medak in Andhra Pradesh, Bangalore in Karnataka, and Chennai, Dharmapuri in Tamil Nadu. Interviews were also conducted with various donor organizations and individuals familiar with PPPs in India.

III. PARTNERSHIPS

THE NATURE OF PUBLIC–PRIVATE PARTNERSHIPS

USAID has a broad view of what constitutes a public–private partnership. USAID believes that partnerships can take many forms, including formal, written agreements between a public entity (the government) and a private entity (a vendor, NGO, or commercial firm) to carry out certain activities. Partnerships can also be less formal agreements that spell out the responsibilities of each party but are not legally binding agreements.[2] To USAID/India, the structure of partnerships is less important than the outcomes achieved, which for the current USAID PPP program are increased use of reproductive and family planning services and increased use of key child survival interventions.[3] Thus, the Mission expects that IFPS II will "develop, test and document appropriate working models of public–private partnerships (PPP) to increase access to and use of essential and integrated RCH services."[4]

The team adopted a classification of PPPs from the literature with the understanding that it was only a starting point and that these mechanisms were not mutually exclusive. The basic mechanisms are social marketing, social franchising, and contracting. A brief description of each, including basic strengths and weaknesses, follows.

Social Marketing

Although numerous definitions for social marketing exist, they share the same general principles. Social marketing, at its simplest, is the application of commercial marketing techniques to achieve a social objective. Most social marketing programs include

- an objective that is beneficial to the consumer and/or society;
- implementation that is not driven by profit;
- a goal focused on changing behavior, not simply increasing awareness;
- an approach that is tailored to the specific needs of the target audience;
- the creation of conditions that are conducive to the targeted behavior change; and
- reliance on commercial marketing concepts.

Social marketing has been applied to expanding the use of and access to contraceptives for nearly 30 years. Approaches to social marketing vary, and different philosophies are held by different implementers. Traditionally, there have been two broad models for the social marketing of contraceptives: the distribution model and the manufacturers' model. The distribution model focuses on maximizing access and usually relies on donated or subsidized products. The manufacturers' model usually includes an agreement with the contraceptive manufacturer to provide products at a reduced price in return for demand

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[2] Rosen, James E., "Contracting for Reproductive Health Care: A Guide," HNP Discussion Paper, World Bank, December 2000, p. 4.

[3] Increased safe behavior for HIV prevention is also desirable.

[4] Draft Statement of Work, "Technical Assistance for IFPS II: Phase Two of the Innovations in Family Planning Services Project," p. 12.

creation that is achieved through an information, education, and communication (IEC) or behavior change communication (BCC) program. Currently, there are many variations on these two models.

RCH products that have been socially marketed include male and female condoms, oral contraceptives, intrauterine devices (IUDs), injectable contraceptives, emergency contraception, oral rehydration salts (ORS), micronutrients, mosquito nets, and safe delivery kits.

Social Franchising[5]

Franchising is an established business model designed to allow growth and replication while retaining certain controls and quality standards. Social franchising applies the principles and structure of franchising to initiatives that are designed to bring about social change.

Three key components need to be in place for social franchising to function:

- a business format,
- a brand, and
- quality assurance.

The franchising format defines the services that are being franchised and how they must be delivered by franchisees. The brand links a particular service delivery point with the franchise in the minds of consumers. The brand is advertised to consumers as an indication of high-quality, affordable services. If marketed properly over time, the brand will build up a great deal of equity. For the franchisees, the primary benefit of association with a high-equity brand is increased business. Thus, two mechanisms—quality assurance and monitoring and evaluation—need to be in place to ensure that the franchisees deliver products and services that are consistent with the brand image.

- Quality assurance mechanisms include training and support provided by the franchiser to enable franchisees to deliver goods and services in accordance with specified quality standards.

- Monitoring and evaluation mechanisms ensure that franchisees are, in fact, operating in accordance with the protocols of the franchise.

Two primary models have evolved in social franchising: stand-alone or full franchises, and fractional or partial franchises. In a stand-alone social franchise, the franchiser controls all of the goods and services. An example would be Apollo Family Health clinics. Apollo provides the blueprints for facilities, the equipment, and protocols for services; screens all staff; sets prices; and handles quality assurance and related issues. In a fractional franchise, the franchiser only controls one or a few of the goods and services. The Vanitha clinics,

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[5] McBride, Julie and Rehana Ahmed, "Social Franchising as a Strategy for Expanding Access to Reproductive Health Services," Commercial Market Strategies Project, September 2001, and World Bank, "Franchising for Primary Health Care: Draft Discussion Document," March 2004.

which are limited to IUDs, condoms, and oral contraceptives, illustrate this type of franchise. Another entity controls all other services (such as antenatal care, immunizations, and surgery).

Each model of social franchising has advantages and disadvantages. The principal advantage of stand-alone franchises is that the franchiser has done all the development work. For a fee, the franchisee acquires the business blueprint containing all the information and systems needed to operate a business. The franchiser often provides advertising, discounted products, and training, among other services. A fractional franchise is usually smaller, less expensive, and involves less risk than a full franchise.

Contracting

A contract is a legally binding written agreement between two or more parties that specifies something provided (such as products or services) and something received in return (usually payment for the products or services). In most RCH cases, the government contracts with an individual or an organization to provide certain products (e.g., contraceptives, posters, test kits) or services (e.g., training, HIV testing, x rays) in return for money.

A World Bank report lists five contracting mechanisms; the assessment team focused on the first three: [6]

- contracting in,
- contracting out (outsourcing),
- subsidies,
- leasing or rentals, and
- privatization.

Contracting In

The government hires one or more individuals on a temporary basis to provide services. A typical example is a health center hiring a medical specialist (e.g., an obstetrician or a pediatrician) to work at the clinic once a week.

Contracting Out

The government pays an outside individual or organization to manage a specific function. Examples include contracting an NGO to train reproductive health (RH) providers, contracting a university to conduct needed research, and contracting a hospital to operate a primary health center.

[6] Rosen, op. cit., p. 4.

Subsidies

The government gives funds or commodities to private groups to provide specific services. For example, the government might contribute vaccines or a per capita stipend to a private hospital to provide immunization services to the poor.

Leasing or Rental

The government offers the use of its facilities to a private organization. For example, the government might rent its primary health center to an NGO to provide services to people in the area.

Privatization

The government gives or sells public health facilities to a private group. For example, the government might give a primary health center to a private hospital on the understanding that the hospital would provide RCH services to the local population.

The most common of these options is contracting out. A recent World Bank article summarized the advantages and risks of this mechanism.[7] The advantages are increased competition, focus on outputs rather than inputs, increased responsiveness, increased emphasis on performance, improved coverage of the poor, and improved public sector efficiency. The risks listed are cost overruns, reduced equity, reduced quality, fragmentation of health services, and monopolistic prices.

QUALITY ASSURANCE AND THE ENABLING ENVIRONMENT

The literature shows that these partnership mechanisms may not work without quality assurance and a positive enabling environment. That is, separate activities may need to be undertaken to ensure that providers are adequately trained and supervised, political commitment has been secured, and government agencies have the capacity to ensure that the private providers are regulated and monitored.

On the quality side, there is a need to ensure that providers are accredited, standards are set and followed, guidelines and protocols for diagnosis and treatment are developed and used, providers are kept up-to-date through continuing medical education, and systems are in place to monitor and correct such important aspects of quality as infection prevention, client satisfaction, and access to services.

On the enabling side, there is a need for the government, including the district and block levels, to understand the advantages, disadvantages, and requirements of partnerships. They need to understand that partnerships are based on common objectives, shared risk, shared investments, and participatory decision-making. They also need to understand the characteristics of different partnership mechanisms (i.e., social marketing, social franchising, contracting); the different payment options (e.g., block grants, capitation, fee

[7] World Bank South Asia Region, *Contracting for Primary Health Care,* November 2003, pp. 3–5.

for service, third-party insurance); the advantages and disadvantages of bidding (e.g., open bidding, short lists, sole source bids); the size, scope, and duration of partnerships; and the negotiation, management, sanctions, and termination of partnerships.

One World Bank paper noted that "what is required…is a gradual change in the mindset of government officials… Government will have to focus on its stewardship of the sector, on policy setting and regulation, and will have to avoid micromanaging the provider's business."[8]

[8] Ibid., p. 13.

IV. FINDINGS

This section describes 23 models, components of models, and suggestions for models. They are divided into three categories:

- 7 models that were of particular interest to SIFPSA and/or USAID/India and that were examined in depth,
- 10 models that appear to have potential but that might need to be revised to fit SIFPSA's and USAID's requirements, and
- 6 other ideas and suggestions for public–private partnerships.

SUMMARY MATRICES OF MAJOR PPP MODELS

The following matrices (tables 1 and 2) summarize seven models that were of great interest to SIFPSA and USAID. All were designed to have a significant and direct effect on coverage and health status. The first matrix (table 1) describes each model, and the second (table 2) assesses each. The criteria for the description and assessment of the models are presented first. The models are described and assessed in detail after the matrices.

Criteria for Description of PPP Models

- **RCH/Service Delivery Problems**: health and service delivery problems this model addresses (e.g., contraceptive prevalence, immunization, child nutrition)
- **Public Entity**/purchaser/donor: public partner in this model (e.g., MHFW, DHFW, SIFPSA)
- **Private Entity**/contractor: private partner in this model (e.g., Janani, missionary hospital, private nursing home)
- **Target Group(s)**: main target populations of this model (e.g., poor women 15–44, infants over 2 years, adolescents)
- **Transaction**/service/function: services the private entity provides (e.g., family planning services, primary health care services, social marketing of contraceptives) and services the public sector provides (e.g., training, funding, monitoring)
- **Implementation Procedures**: key components or activities to be undertaken
- **Coverage**/impact: improvements this model has achieved (or will achieve) in terms of health outcomes or impacts (e.g., coverage of target groups, reduction in fertility)
- **Type of Partnership**: true partnership, social franchise, social marketing, contracting, other

Criteria for Assessment of PPP Models

- **Strengths**: advantages/strengths of model (e.g., well designed, inexpensive, easy to replicate, tested)

- **Weaknesses**: disadvantages/weaknesses of model (e.g., not acceptable to government, limited reach, effectiveness unknown)

- **Costs**: cost of the model; need for subsidization; affordability

- **Equity Element**: reaches the poor and the poorest of the poor, those in rural and remote areas; affordability by the poor

- **Quality Element**: quality assurance component; monitoring of quality; level of priority of quality

- **Sustainability**: sustainable now; self-sustaining or requires donor assistance; if not sustainable, whether it will become sustainable

- **Scalability:** model being scaled up; model can be scaled up; date when it will be scaled up; barriers to scaling up[9]

- **Coverage**: valid and reliable coverage data (e.g., contraceptive prevalence, fully immunized children); if no, why not; level of priority of evaluation; if not a priority, why not

- **Health Outcomes**: availability of data (currently or in the future) on the impact of the model on morbidity, mortality, and fertility; if not available, why not

- **Constraints and Issues**: significant constraints to implementation (e.g., government support, funding, human resources)

- **Recommended**: team recommends this model for consideration by SIFPSA and USAID

[9] Scalability is a term used by USAID that refers to replication and expansion of a project, often to the national level.

Table 1
PPP Description Matrix

Criteria	Clinical Model	USHC Model	PHC Model	Kurji Model	Janani Model	CBD Model	Social Marketing
RCH Problem	Low voluntary sterilization and IUD use	Poor RCH status among urban poor	Poor RCH status among rural poor	RCH status among poor	High RCH morbidity and mortality	High fertility rates in rural areas	Low use of spacing methods in rural areas
Service Delivery Problem	Low private sector services	Limited access to RCH services	Limited access to RCH services	Weak government services	Low coverage of rural and poor	Lack of access to spacing methods	Lack of access to spacing methods
Public Entity	UP DHFW, district societies	AP Commissioner of Family Welfare	Karnataka DHFW	Bihar DHFW	MHFW	SIFPSA, UP DHFW	SIFPSA
Private Entity	Private hospitals, nursing homes	NGOs	Karuna Trust	Kurji Hospital	Janani	CBD volunteers, village health committee	HLFPPT, PSI, DKT International, HLL
Target Group(s)	Rural poor	Poor in urban slums	Rural poor	Very poor in area	Low and middle segments	Low income in rural areas	Low income in rural areas
Public Transaction	Reimburse private hospital/nursing home for voluntary sterilization and IUD services	Commissioner of Family Welfare built 192 urban health centers, pays NGOs	DHFW turns over primary health care center, pays 75% of salaries, medications	Provision of some commodities	MHFW provides condoms, oral contraceptives	SIFPSA provides stipend, referral fees	SIFPSA provides distribution and communications support for social marketing
Private Transaction	Provide voluntary sterilization, IUD services, transportation	NGOs manage urban health centers and outreach	NGOs manage primary health care centers, pay 25% plus	Provision of comprehensive RCH services	Provision of affordable RCH services	Community-based distributors/village health committees provide products and information	Partners distribute contraceptives in assigned areas
Implementation Procedures	MOU, training of providers, services, follow up	Services, community participation, BCC	Services, outreach, ambulance, on call 24 hours/7 days a week	Two community health centers: urban and rural, all RCH except family planning	Shops, Titli Centres, Surya Clinics, quality assurance	Community-based distributors selected, trained, expand over five years	Distribution only; IEC component not implemented
Coverage Plan	Negotiated geographic areas	All households in slum area	All households in area	All of catchment areas	Parts of Bihar and Jharkhand	15% of population in UP	All of UP
Type of Partnership	Reimbursement	Contract out, contract in	Contract out	Discounted commodities	Partial and stand-alone franchise, social marketing, contract in and out, discounted commodities	Contract in community-based distribution workers	Contract out distribution

Key

AP: Andhra Pradesh BCC: Behavior change communication CBD: Community-based distribution DHFW: Department of Health and Family Welfare	HLFPPT: Hindustan Latex Family Planning Promotion Trust HLL: Hindustan Latex, Limited MHFW: Ministry of Health and Family Welfare MOU: Memorandum of understanding	PHC: Primary health center PSI: Population Services International UP: Uttar Pradesh USHC: Urban slum health center

Table 2
PPP Assessment Matrix

Criteria	Clinical Model	USHC Model	PHC Model	Kurji Model	Janani Model	CBD Model	Social Marketing
Strengths	Statewide coverage, simple, decentralized	Strong support, high demand, good services	Strong support, good services, trust has funds	RCH services at low prices; accessible	Well designed; implementation outsourced	Universal coverage, village health committee oversight	Statewide coverage
Weaknesses	Inadequate reimbursement, capacity of DS	Low salaries, late payments, shortages, no user fees	Depends on strong NGO with resources	No contraception; unreliable government supplies	Abortion a key service; takes years to set up	Design untested, outcomes unrealistic	Insufficient demand creation
Costs	Low but private hospitals/nursing homes not fully reimbursed	Moderate; CFW covers 67%, NGO covers 33%	Moderate; DHFW pays 75%, NGO pays 25%	Low	Expensive	Likely much higher than estimated	Expensive; about 140 million Indian rupees/year
Equity Element	Limited to young, low parity poor	Focus on very poor	All in area are poor	Poor in area	Focus is low and middle income	Designed to reach all of the rural poor	Designed to reach all of the rural poor
Quality Element	Uncertain	Very good	Very good	Some problems	Built in but inadequate	Not built in	N/A except for testing of condoms
Sustainability	Unlikely	Easily	Yes	As is, yes	Maybe 60%	Unlikely	No
Scalability	Depends on private hospitals/nursing homes	Easily	Yes	Need funding	Yes, slowly	Probably not	Depends on subsidy
Coverage	100% target very ambitious	100%	100%	100% immunization and antenatal care	CYP data only; no contraceptive prevalence data	Unrealistic	All of Uttar Pradesh until March 2006
Health Outcomes	Potential is high	Very good	Appear good	No data	No outcome data	No targets	No data
Constraints and Issues	Low incentives, district societies capacity, rural coverage	Low salaries, no user fees, government commitment	Scarcity of physicians and ANMs, mistrust, need NGO with funds	Government unreliable, no family planning, expensive for any other NGO to implement	Abortion, cost, slow expansion, no evaluation	Village health committee capacity, management burden, costs	Government policies, lack of demand creation, costs
Recommended	Yes, pilot first	Yes	Yes	No	No	No	Yes, but not in current form

Key

ANM: Auxiliary nurse–midwife	CYP: Couple year of protection	MHFW: Ministry of Health and Family Welfare
CBD: Community-based distribution	DHFW: Department of Health and Family Welfare	PHC: Primary health center
CFW: Commissioner of Family Welfare	DS: District societies	USHC: Urban slum health center

DESCRIPTION AND ANALYSIS OF MAJOR PPP MODELS

This section elaborates on the descriptions and analyses of major PPP models summarized in the matrices. These models are described as major because they are the most likely to have significant outcomes on coverage and health status if enacted effectively. However, only three of the six seem worth pursuing at this time. The models are listed in approximate order of feasibility.

UTTAR PRADESH, SIFPSA PROPOSAL: CLINICAL CONTRACEPTION THROUGH PRIVATE PROVIDERS[10]

Description

RCH problem: Need for increases in voluntary sterilizations and IUDs to achieve population stabilization

Service delivery problem: Inadequate involvement of the private sector in providing sterilization and IUD services

Public entities: District societies, Uttar Pradesh State Department of Health and Family Welfare

Private entities: Private hospitals and nursing homes

Target groups: Rural poor in Uttar Pradesh

Transactions (public and private): The government will reimburse private hospitals and nursing homes that provide sterilization and IUD services. District societies will implement the program with funds allocated through the decentralized district action plans.

Implementation: Interested private institutions will sign a memorandum of understanding with the appropriate district societies to cover service protocols, quality standards, roles, and responsibilities. The private hospitals and nursing homes will be selected by the project manager and chief medical officer. The latter will authorize the private hospitals and nursing homes to provide sterilization services. The district societies will assess the need for no-scalpel vasectomy training. The private hospitals and nursing homes will provide free sterilization and IUD services, including preoperative investigations, postoperative medicines, follow-up visits, transportation, management of complications, and reporting to the district society. The district society will set up and pay for verification. Upon verification and within 45 days, the district society will reimburse the private hospitals and nursing homes 1,000 Indian rupees (Rs) per sterilization and Rs100 per IUD insertion as well as an additional Rs100 for each year the patient does not get pregnant for up to five years.

[10] SIFPSA, *Discussions on Public–Private Partnerships and Proposed Strategies.*

Coverage: Each private hospital or nursing home will be given a geographic catchment area based on capacity and unmet need.

Assessment

Strengths: The program is straightforward, would cover the entire state, and would increase sterilizations significantly. Management and monitoring are decentralized to the districts.

Weaknesses: Private hospitals and nursing homes would have to subsidize the program as costs are likely to exceed government subsidies and the services have to be free. They need to have enough working capital to finance delays of government payments. The district societies may not have the capacity to monitor quality of care. Older women and those who have more than three children are not eligible.

Costs: The government will only reimburse costs on specific line items up to Rs1,000 per sterilization and Rs100 per IUD insertion. The actual cost to the private hospital or nursing home is likely to be greater than that, given the services required (especially transportation, community mobilization, follow up, and management of complications). However, state officials in Karnataka believe that if laparoscopy was the standard procedure and the state paid a flat fee of Rs1,000 per sterilization, then this would be attractive to private hospitals and nursing homes.

Equity: The program is specifically designed to reach the poor. Reimbursements are limited to women of "low age and parity, up to a maximum of three children."

Quality: The district societies will be responsible for monitoring adherence to standards and grievances. Whether they will have the time, resources, and capacity to do this is uncertain.

Sustainability: The program is not self-sustaining. It requires continued contributions from the government and the participating private hospitals and nursing homes.

Scalability: SIFPSA notes that this strategy "has been tried out with success in 2003–04 in Allahabad district (and)…hence the practice can be up-scaled for the entire state wherever the accredited private nursing homes/private hospitals are willing." Whether they are willing and able is a key question.

Coverage: Theoretically, the program would cover the entire state, including the poor in both urban and rural areas. Whether this would really occur, especially in rural areas, is uncertain.

Health impact: Theoretically, the program would have a significant impact on health and fertility, if it were implemented as planned.

Constraints and issues: There are no obvious incentives for private providers to join the program. It would have to be sold on the basis of social responsibility. The reimbursement is unlikely to cover costs, much less make a profit for participating private hospitals and

nursing homes, which would make it unattractive to many institutions and providers. However, if the government paid a flat fee of Rs1,000, it would be attractive to those who do laparoscopies. The district societies may not have the management or monitoring capacity to fulfill the roles assigned to them. Required approval from the chief medical officers could dissuade some private hospitals and nursing homes from joining the program. It may be difficult to find private hospitals and nursing homes that reach rural areas.

Experience from other states: In Tamil Nadu, the government has partnerships with accredited private nursing homes that are paid Rs200 for each case. The client pays the remainder directly to the nursing home (about Rs2,800). A pilot project in Bommidi and Dharmapuri does not charge the patient anything, but pays the nursing home (Rs800 for a visit in Bommidi and Rs1,800 per case in Dharmapuri). The Chhattisgarh government has identified 27 not-for-profit hospitals (with good coverage in tribal areas) and 131 commercial hospitals with which to form partnerships. Under this plan, the government would reimburse its partners for all RCH services offered to clients living below poverty level, and for family planning, sterilizations, and IUDs provided to all clients. The fee schedule for these services would be fixed, but the facilities would be free to provide other services at their own prices. A monitoring program of facility visits, client interviews, and annual rate reviews has been designed.

Conclusions and recommendations: The SIFPSA strategy looks attractive from a service perspective but not from an economic one. However, if the Rs1,000 payment was a flat fee instead of a reimbursement, then it would probably be more attractive to the providers. In addition, it would probably work if it adopted the Bommidi or Dharmapuri financing mechanisms. It will also be important to examine the experience in Allahabad district to identify the advantages and weaknesses of this strategy, especially in rural areas. Finally, it would probably be prudent to try the model out in two or three districts before expanding it statewide.

Reference

SIFPSA. *Discussions on Public–Private Partnerships and Proposed Strategies.*

ANDHRA PRADESH: URBAN SLUM HEALTH CENTERS

Description

RCH problem: Poor health outcomes among urban poor

Service delivery problem: About 6 million urban slum dwellers had little access to primary health care services and could not afford private care. The governments of India and Andhra Pradesh received assistance from the World Bank to establish the Andhra Pradesh Urban Slum Health Care Project (2000–02). Afterwards, the state government continued the project with its own funds.

Public entity: Andhra Pradesh Commissioner of Family Welfare (CFW)

Private entity: NGOs (e.g., Lions, Rotary, Vasavi Clubs, women's organization)

Target groups: Poor in urban slums

Transactions (public and private): The Commissioner of Family Welfare, with World Bank support, built 192 urban health centers in 74 municipalities. The urban health centers are similar to a primary health center outpatient clinic in structure, staffing, and services. The CFW contracts with NGOs and provides an annual budget of Rs310,000 that covers salaries, operational expenses, equipment, furniture, and pharmaceuticals in addition to NGO training. The NGO hires five providers and three support staff. It provides basic RCH preventive care (antenatal care, immunization, vitamin A, birthspacing, reproductive tract infections, and sexually transmitted infections); services for childhood diseases (e.g., acute respiratory infection, diarrhea, measles); referrals (for high-risk pregnancies, newborns, emergencies); and outreach. It does not provide such inpatient care as deliveries, sterilizations, or abortions. The urban health centers are open 6 days a week, from 9 a.m. to 12 p.m. and from 4 p.m. to 6 p.m. The schedules are determined by a local urban health center advisory committee to fit the needs of local residents.

Implementation: The project has three components: service delivery, community mobilization, and behavior change communication (BCC). There are no fees or registration charges. The local urban health center advisory committee oversees the project. Two auxiliary nurse–midwives alternate between providing services at the urban health center and community outreach.

Coverage: Services are limited to the poor in the geographic area (population of 15,000–20,000). The objective is to cover all households in the area (about 3,000–4,000). The NGOs claim that the two auxiliary nurse–midwives cover all households every 1–3 months.

Assessment

Strengths: There was no significant opposition to contracting NGOs to operate these clinics, apparently because they were new facilities and the NGOs are nonprofit. Demand has been high and most of the urban health centers have performed well. The structure, service package, staffing pattern, and schedules all seem to be well designed and implemented. Community involvement is strong. The local advisory committee involves local stakeholders in selecting NGOs and oversees management. There is a heavy emphasis on performance and achievement of results. The government provides a rigorous training program for NGOs.

Weaknesses: Staffs complain of low salaries, especially for physicians and auxiliary nurse–midwives, compared with similar government positions. Payments from the government are often late. There is a lack of basic laboratory equipment (e.g., microscopes) and supplies as well as a shortage of medicines. User fees have been prohibited because of political opposition.

Costs: The funds provided by the CFW cover about two thirds of the costs. The NGO has to raise the remainder, about Rs5,000–20,000 per month. Three of the NGOs visited raise these funds from their memberships; another solicits contributions from commercial firms.

Equity: Equity is very high. The urban health centers only service the poor; however, some who can afford to pay have tried to obtain free services, at least in some areas. Some urban health centers have eligibility criteria and others do not.

Quality: Quality appears to be very good but there does not seem to be a quality assurance mechanism, except for client complaints. Everyone seems to equate performance assessment with quality assurance.

Sustainability: As long as NGOs can raise adequate funds to complement the government contribution, the centers will be easy to sustain.

Scalability: The fact that there are urban health centers at 74 sites indicates that the model is scalable.

Coverage: The advisory committee oversees performance, which is assessed along 17 service statistic indicators (e.g., number of antenatal care cases registered, number of children fully immunized). Over time, the urban health centers seem to reach all of the target population, either through clinic services or outreach.

Health impact: NGOs have seen significant reductions in childhood illnesses, 100 percent immunization rates, 100 percent institutional deliveries, improvements in child nutrition, and similar improvements in all other indicators.

Constraints and issues: Physicians are difficult to find because of low salaries. Most physicians who take the jobs are retired government officials. It is difficult to institute user fees for political reasons. However, there is no objection from clients. Government commitment to the scheme has been good so far but permanent support is not certain as yet. New facilities have to be constructed because of the political opposition to handing over existing facilities to private entities.

Experiences from other states: The Mitra Chikitsak Yojana in Chhattisgarh is intended to identify a pool of specialists that would be available and willing to provide services at specific health centers on either a scheduled or as-needed basis. Although this program is yet to be implemented, interest in participating is reported to be high among specialists.

Conclusions and recommendations: The urban health center project appears to be a resounding success from most perspectives, including the service package, outreach, costs, staffing patterns, and most importantly, results. This is a legitimate public–private partnership that is both replicable and scalable. As such, it deserves serious consideration. However, the enabling environment needs to be assured beforehand to ensure that there is no community or political opposition to the scheme.

References

World Bank South Asia Region. *Andhra Pradesh: A Rapid Private Health Sector Assessment: A Discussion Document.* March 2004, pp. 23–27.

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KARNATAKA: CONTRACTING OUT PRIMARY HEALTH CARE CENTERS

Description

RCH problem: Poor RCH status among rural poor

Service delivery problem: Lack of reliable and affordable primary health care services, especially RCH.

Public entity: The State Department of Health and Family Welfare

Private entity: The Karuna Trust is a charitable trust that provides health, education, and other services to the poor. There are other NGOs that have taken over primary health centers in other sites.

Target groups: Primary health care catchment areas

Transactions (public and private): The basic transaction is turning over the management and operation of some of the worst primary health centers to the trust. The Karuna Trust currently operates seven primary health centers (and their subcenters), two public health units, and three health centers. In return for operating the primary health centers, the government provides the building and all of its equipment, furniture, and supplies. It also pays 75 percent of staff salaries (the trust is responsible for the remaining 25 percent) and provides Rs75,000 annually for medications. The trust receives the facilities and uses its own funds for whatever is needed, including renovation, equipment, furniture, and beds.

Implementation: The Karuna Trust hires all staff, provides training as needed, and handles procurement. The staff consists of one physician, one laboratory technician, one nurse, two auxiliary nurse–midwives, two clerks, and an administrator, all of whom are on one-year contracts. The center also supervises about 20 community workers. The primary health center is open 7 days a week from 9:00 a.m. to 1:00 p.m., and from 2:00 p.m. to 5 p.m. All staff members live nearby and are on call 24 hours a day. The center offers the same primary health care services as government-operated centers, specializing in RCH and outreach. It handles normal deliveries and sterilizations. The trust has added a few new services, including pregnancy, hemoglobin, and HIV tests as well as cataract examinations and treatment.

Coverage: The population in the target area is 14,000. The community workers and auxiliary nurse–midwives reach all of the households. In addition, they carry out an annual household survey to update health status and to set targets for the next year.

Assessment

Strengths: There has been no significant opposition to the government contracting primary health care services out to a nonprofit NGO. The Karuna Trust has enough resources to complement those of the government. Management appears to be supportive but businesslike. The primary health center is able to provide a full range of primary health care services, in particular RCH. Performance is good and constantly monitored.

Weaknesses: The model may not work where there is mistrust of the private sector on the part of the government and/or the community. The model is highly dependent on the reputation of the NGO and the recruiting of physicians and paramedics, who are willing to live in the community, accept lower wages, and be on call 24 hours a day. NGOs that do not have management capability and adequate resources to provide partial subsidies would have difficulty implementing this model.

Costs: The government originally provided 90 percent of the costs, but the trust requested that the amount be reduced to 75 percent to avoid attracting unstable NGOs. The government is considering raising its contribution to 90 percent again to encourage expansion of the model. The trust has made significant investments in the facility, including an ambulance and renovation. Currently, it provides approximately Rs200,000 (2 lakh[11]) annually to keep the center operational.

Equity: Almost all the people in the target area are poor. The center does not require proof; it accepts all who come for services. All basic primary health care services are free except for pregnancy, hemoglobin, and HIV tests; these are provided at cost. The center makes no profit on any of its services.

Quality: An important element of quality is reliable access to services. This is assured by the center's policies and the proximity of the staff. They live close by and are on call 24 hours a day. The center assesses service quality by examining its performance indicators to determine, for example, if a pregnant woman received antenatal care and tetanus toxoid shots. There is no mechanism for assessing the quality of service delivery (e.g., client–doctor interaction, adherence to clinical standards, and infection prevention practices), except for client complaints.

Sustainability: The fact that the trust has been doing this kind of work for nine years without any significant problems indicates that this model is sustainable. However, an interested NGO will have to cover part of the costs with its own funds. If the government adopts a 90 percent contribution policy again, that will make sustainability much more certain.

Scalability: The fact that the trust operates 12 centers and expects to have 27 eventually (one in every district) is a good indicator of the scalability of this model. However, scalability is dependent on a large enough pool of capable NGOs that have independent

[11] One lakh (a unit of measure) equals 100,000.

sources of funding. One expert noted that of approximately 1,600 primary health centers in his state, only about 50 could be contracted out to NGOs.

Coverage: Service statistics and the annual household survey show that coverage on all basic indicators (antenatal care, fully immunized children, and contraceptive usage) is very good.

Health impact: Although there are no population-based surveys to assess coverage and improvements in health status, the annual household survey could be used to make such an assessment in some areas. Qualitative data indicate that health status is, indeed, improving.

Constraints and issues: This model has to overcome a number of constraints. One of the most important is the scarcity of physicians. The trust now employs retired government and newly graduated doctors. It is very difficult to attract other physicians as well as auxiliary nurse–midwives. The trust is now hiring general nurse–midwives and training them in outreach and other auxiliary nurse–midwife skills. The model requires an NGO that has the financial resources to complement the government's contributions. Government officials at state, district, and block levels as well as local leaders have to be educated about PPP. Many are distrustful of private organizations being involved in the delivery of primary health care services. It is also essential that the NGO have full hiring and firing authority over staff. User fees are generally prohibited, but some charges can be made for extra services and donations are acceptable. The government does not advertise for contracting out primary health centers; NGOs have to submit proposals. Profit-making organizations are not considered.

Experiences from other states: This very popular model has great appeal but also generates great resistance. In Uttar Pradesh, SIFPSA spent almost two years trying to find an appropriate NGO to take over a primary health center only to be asked by the district to find another site. Apparently, the district thought it would be embarrassing to admit that it could not provide basic health services. SIFPSA came up with a less ambitious plan but the district has not responded to it. The issue is now "in cold storage," according to SIFPSA. In Bihar, the government has no plans to introduce this scheme because it is concerned about the quality of care and its ability to monitor the NGOs. In Andhra Pradesh, the government believes that it is not at all possible to implement this scheme for several reasons: the primary health center is the only facility that can provide a broad range of services—NGOs would not be able to do that; private hospitals would be suspect unless they were nonprofit; and the Communist Party would see this as the first step in privatizing health care in India. In most states, the scheme may not be economically viable because primary health care services are supposed to be free. The private entity would not be allowed to charge user fees, even to cover costs, and the government is not willing to provide a large enough subsidy to make up the shortfall in income. Where this idea has been proposed, the trade unions have been upset, seeing it as a way to reduce government jobs. Tamil Nadu is strengthening its primary health centers rather than contracting them out to the private sector. The head of the Karuna Trust in Karnataka believes that only 50 of 1,600 primary health centers in the state can realistically be contracted out to NGOs because of the lack of qualified NGOs. He believes that the NGOs should work at the taluka (a governmental local district) level to build the capacity of district and taluka staff

to improve primary health care services, with an NGO–managed primary health center as a demonstration model in each taluka.

The Society for Education, Welfare, and Action (SEWA) Rural project in Gujarat was initially funded by the state government at 100 percent for 10 years. It was very successful; introduced a number of changes (new management information and accounting systems, team meetings, quality control, and evaluation); and increased contraceptive prevalence (from 37 percent in 1983 to 71 percent in 2000). The government made a number of concessions early on that contributed to the project's improvements, but as time went on the relationship deteriorated and SEWA Rural returned the primary health center to the government. The official reason was that SEWA Rural wanted to set up a first referral unit but did not have enough human resources to manage both it and the primary health center. Other respondents reported that SEWA Rural had become too frustrated with the government to continue.[12]

Providing 24–hour access to primary health care services is becoming a popular primary health center feature. In Karnataka, the medical staff members (doctor and paramedics) live close to the center and are on call 24 hours a day, largely to handle deliveries and emergencies after regular hours. This option is only possible if staff members are willing to live in the village. In Tamil Nadu, there is a pilot project to provide the same 24–hour service by hiring three staff nurses (one for each 8–hour shift) at the primary health center. The government believes that it is so successful that it will train 1,000 additional staff nurses to expand the service.

Contracting in specialists is now routine in Tamil Nadu and common in other states. The government pays these specialists (obstetricians, anesthesiologists, surgeons, dentists, and ophthalmologists) to fill gaps in services and to meet local demand. Some of these are hired full time, while others have contracts to provide services 2 or 3 times a week.

Conclusions and recommendations: Assuming that the constraints mentioned above can be overcome, this model appears to be a viable PPP. It is a legitimate public–private partnership that is both replicable and scalable. USAID and SIFPSA should examine it closely and seriously consider testing it in Uttar Pradesh, perhaps starting with defunct centers or subcenters. USAID and SIFPSA should also consider the suggestion to set up model primary health centers and use them to train district and block-level officials in how to operate a primary health center.

[12] SEWA Rural, *Making a Primary Health Centre—The SEWA Rural Experience,* 2003.

BIHAR: THE KURJI HOLY FAMILY HOSPITAL AND COMMUNITY HEALTH CENTERS

Description

RCH problem: Unacceptably high infant and maternal morbidity and mortality

Service delivery problem: Unmet need for RCH services among the poor in the hospital's catchment areas

Public entity: State and district governments

Private entity: Kurji Hospital

Target groups: Poor women in the hospital's catchment areas

Transaction (public and private): The hospital has established partnerships with the government to provide immunizations and to host and manage an HIV/AIDS voluntary counseling and testing (VCT) center; a tuberculosis directly observed treatment, short-course (DOTS) center; and a leprosy detection and treatment center. In each case, the government has provided drugs and laboratory reagents. The hospital receives no subsidies from the government for the operation of the community health center or for its services to the poor. This is a very limited partnership (80 percent private, 20 percent public).

Implementation: This 300–bed hospital is a missionary-managed facility that has been operating in Patna since 1939. It is part of a larger, international organization with headquarters in London. It does not have a presence in Uttar Pradesh. As a secondary hospital, it provides a broad range of general and specialty services, including RCH. It also has an extensive nurse training program. Its fees for both outpatient and inpatient care are approximately 30 percent less than other private, profit-making hospitals. As part of its mission to help provide equal access to quality health care for all, it has set up two community health centers to serve the poor living in surrounding communities. One community health center is in the hospital compound, and the other is in a nearby rural area. Immunization, antenatal care, growth monitoring, family planning counseling (but no contraceptives), and health education classes are available for an initial registration fee of Rs10. Subsequent visits cost Rs5. The hospital has also helped poor women set up 88 self-help groups that have created all-purpose savings funds.

Coverage: The program covers virtually all of the poor in its two catchment areas.

Assessment

Strengths: The major strength of this program is the ability of the hospital to provide comprehensive RCH and other care for a large number of the poor at very low prices. Another strength is the commodities partnership with the government, which makes the provision of key services possible. The hospital's self-help groups are also impressive.

Weaknesses: As a Catholic organization, the hospital does not provide contraceptives to its clientele. The program is dependent on a reliable supply of commodities from the

government. The supply chain often breaks down and immunizations, for example, sometimes cannot be given because of the lack of vaccines. Government-assisted programs are also at the whim of the government, which recently told the hospital to close its VCT center. No explanation has been given. Bureaucratic procedures and arbitrary policies (e.g., do not test pregnant women for HIV) are also frustrating.

Costs: A World Bank report shows that the annual budgets for the two community health centers are Rs871,362 and Rs731,264. This compares with Rs2,657,185 for the government's primary health care center.

Equity: The community health centers cater to the poor; fees are extremely low.

Quality: The hospital staff interviewed acknowledged that there have been some quality problems, for example, the disposal of needles and syringes. There was not time to assess the quality of services.

Sustainability: The current program and its two community health centers are sustainable.

Scalability: The hospital would be willing to consider this but does not have the funds to set up additional community health centers; outside funds would be needed. The model itself is replicable, however.

Coverage: The hospital claims to have reached 100 percent immunization and antenatal care coverage.

Health outcomes: There are no evaluation data to confirm the impression of the staff that the program has had an impact on health.

Constraints and issues: The unreliability of government commodities and the unpredictability of government policies are major concerns. The hospital would prefer not to work with the government for these reasons. The hospital's unwillingness to provide family planning services is a serious constraint.

Conclusions and recommendations: The Kurji program is very impressive. Coverage is very high and costs are very low. The government's (unreliable) provision of vaccines, drugs, and reagents is very important, but that is its only contribution. It provides no subsidy or per capita contribution for serving its primary target group—the poor. It relies on the generosity of the hospital to subsidize those services. The unwillingness of the hospital to provide contraception is a significant limitation. The arbitrary closure of the VCT center by the government is another significant limitation. In general, it does not seem that this model fits USAID requirements.

Reference

World Bank South Asia Region. *Bihar: A Rapid Private Sector Assessment: A Discussion Document.* March 2004.

BIHAR: JANANI SOCIAL FRANCHISING MODEL

Description

RCH problem: One third of the deaths in Bihar are due to poor RCH and communicable diseases.

Service delivery problem: Poor RCH coverage of the low and middle-income segments of the population is a major reason for these deaths. Janani is working with state and district government agencies to address this problem.

Public entity: State and district government agencies

Private entity: Janani, an affiliate of DKT International

Target groups: Low and middle-income segments of the population throughout the state

Transactions (public and private): This is not a true example of a public–private partnership. The public sector role is limited to providing condoms and oral contraceptives to Janani for a discounted price. However, the value of that transaction is significant—approximately US$ 1 million annually. Nevertheless, there is no formal or informal agreement between Janani and the state government and no coordinated planning or services. The entire operation is planned, implemented, and monitored by Janani.

Implementation: Janani uses economies of scale and subsidies to lower the costs of RCH and other services, so that those who cannot afford to pay full private sector prices can receive high-quality RCH services. Janani relies on three delivery mechanisms: shops that sell products to clients; Titli Centres, which also sell products and provide basic services and referrals; and Surya Clinics, which provide the entire range of RCH services. Janani helps private providers set up and operate these services through a franchise mechanism. In return for a small fee and adherence to quality standards, Janani provides training, advertising, commodities at bulk prices, referrals, and support services. As a result, prices are 30–40 percent lower than commercial prices, which attracts the target groups. Providers make money as long as they adhere to Janani's quality standards and prices, and clients are assured of reasonably priced quality services. Janani relies heavily on outsourcing in implementation, which lowers its management burden and costs.

Coverage: Couple year of protection (CYP) data show that the program accounts for 15 percent of couples protected in Bihar and Jharkhand, or 1.1 million couples. An estimated 640,000 births were averted last year. The cost to protect a couple per year is Rs115; the cost to avert one birth is Rs200. These figures are based on sales, not on population-based surveys, and are unverified.

Assessment

Strengths: Janani combines social marketing, social franchising, much contracting out, and even some contracting in. Although complex, the model is clearly defined and easy to understand. The project was originally designed to expand contraceptive use, but it has evolved into an RCH and then a general health services program. By broadening the range of services, the program is more successful in attracting both providers and clients. In general, the program is well designed. The three-channel delivery system (shops, Titli Centres, and Surya Clinics) provides an effective referral chain that seems to work very well. Janani has found ways to outsource much of the implementation of the system, which lowers Janani's overhead costs and management burden. The information, education, and communication (IEC) strategy relies on local media, interpersonal communication, and mass media (especially radio, wall paintings, and billboards), which seem to be effective in attracting clients. Television is limited in the area. The scale of the program is impressive: there are now 32,000 shops, over 25,000 Titli Centres, and 550 Surya Clinics. Janani plans to establish one Super Titli Centre for every 20 villages, and one Super Surya Clinic in each district to take over basic training, supervision, and distribution functions. The creation of Super Surya Clinics will allow for a reduction in the number of Surya Clinics. When fully operational, there will be 40,000 shops, 57,000 Titli Centres, and 360 Surya Clinics. The program plans to cover the entire states of Bihar and Jharkhand, including all villages.

Weaknesses: The program takes years to establish. It began in 1996; in 2000, training physicians and setting up clinics began. Probably half the planned shops, Titli Centres, and Surya Clinics will not be completely operational for another two years. Abortion is a key service that is provided by the Surya Clinics. Janani contends that it could still operate effectively without offering that service (and is willing to do so in Uttar Pradesh) but that seems debatable, given that the program earns so much from this service. The public sector role is limited to the provision of condoms and oral contraceptives to Janani for a discounted price. However, this source is unreliable.

Costs: The program is very expensive. DKT International estimates that a three-year budget for Uttar Pradesh would be US$ 19 million. In fiscal year (FY) 2001–02, total expenditures were $3.7 million (42 percent for IEC and advertising, 24 percent for Titli Centres, and 15 percent for commodities).[13]

Equity: The market has been segmented into affluent (those who can pay full price), low and middle-income, and those below poverty level. Janani targets the low and middle-income segment that cannot afford to pay full private sector prices but that can afford partial payment. This is one of the weaknesses of the program—that the poorest population is not a target group. This group has to be covered by subsidies or discounted prices, neither of which is built into the model.

[13] World Bank, *Franchising for Primary Health Care: Draft Discussion Document*, March 2004, p. 18.

Quality: Built-in training, supervision, and infection prevention are keys to maintaining quality, most of which has been contracted out. Although quality appears to be much better than in the public sector, a number of deficiencies were found in the Surya Clinics visited.

Sustainability: To date, the program is highly subsidized by donors. Although Janani management believes that the program will be self-sustaining, that is years away at best.

Scalability: The program is already being scaled up and plans call for it to be operating statewide in the next several years.

Coverage: A deficiency is the lack of evaluation. Janani relies exclusively on CYP data. There is no evaluation of the effect of the program on contraceptive prevalence or other RCH coverage indicators. Janani states that it would be too expensive. The coverage estimates described above are based on CYP calculations and cannot be verified without population-based data.

Health impact: No data were collected or are available; management believes that this would be too expensive.

Constraints and issues: Infrastructure is often worn down and could require extensive renovation. The principal income-generating service is abortion. Whether the model would work without abortion is uncertain. Costs are very high, perhaps too high for Uttar Pradesh. The time required to set up the various shops, Titli Centres, and Surya Clinics is at least several years. The lack of evaluation means that there is no way to determine whether the program has any effect on coverage or an impact on health. The program is not designed to reach the poor.

Experiences in other states: Chhattisgarh has developed a franchise model called Mitan Kendra. It is fashioned after the Janani franchise model except that a project management unit under the State Health Society or the State Health Research Committee (SHRC) would serve as the franchiser. The proposed components of the network are medical clinics providing comprehensive RCH services, including emergency obstetric care; medical clinics providing some RCH care, but not all; and paramedical (largely nurse and midwife) clinics providing some RCH services, but not all. In return for paying a franchise fee, the franchisees will receive a logo/brand name, active promotion of the clinic, paid referral arrangements, management assistance with franchiser staff at each clinic, and training to close skill gaps. The project management unit has developed detailed budgets, proposed fee schedules, and project management protocols.

Conclusions and recommendations: The Janani model is attractive in many ways. Given the experience gained to date in Bihar, management believes that it would be relatively easy to replicate it in Uttar Pradesh, even without the abortion component. That may or may not be true. However, the program is very expensive, would take too long to cover the state, does not reach the poorest of the poor, and has not yet been evaluated. If it were tried, it should be limited to one or two districts, then fully evaluated in terms of its RCH coverage and effects on contraceptive prevalence and other RCH indicators. It might be worthwhile for SIFPSA to visit Chhattisgarh to examine its franchising plan.

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UTTAR PRADESH, SIFPSA PROPOSAL: VOLUNTEER COMMUNITY–BASED DISTRIBUTION

This analysis combines two SIFPSA proposals because both concern community-based distribution (CBD) volunteers. [14]

Description

RCH problem: High fertility rates in rural areas

Service delivery problem: Lack of reliable access to spacing methods and qualified NGOs in rural areas

Public entities: SIFPSA, State Department of Health and Family Welfare

Private entities: CBD volunteers and village health committees

Target groups: Rural poor in the state

Transactions (public and private): CBD volunteers will be recruited, given one-year contracts, and paid by local village health committees to distribute free and branded (i.e., socially marketed) contraceptives and other RCH products door-to-door in their communities. They will also provide family planning counseling, enroll pregnant women in antenatal care, enroll children for immunization, organize community activities, work with the auxiliary nurse–midwife, conduct group health education discussions, attend to certain child illnesses (e.g., diarrhea), and refer clients for IUDs and sterilization. The CBD volunteers will travel to nearby towns to pick up contraceptives and other supplies. In return, the CBD volunteers will receive a monthly stipend of Rs400, plus Rs50 for each sterilization and Rs20 for each IUD referral. Their transportation costs to pick up contraceptives will be reimbursed. Seed money (Rs200) will be provided to purchase

[14] SIFPSA, *Discussions on Public–Private Partnership and Proposed Strategies.*

initial RCH products. Funds will be deposited by SIFPSA into a village health committee bank account every 6 months, and checks will be written monthly to the CBD volunteer by the committee.

Implementation: One CBD volunteer per village will be selected and appointed by the village health committee. The state government will provide training and technical, logistic, and other support. Training will be provided for the CBD volunteers, Panchayati Raj Institution members (community workers), service providers, and block health supervisors. The CBD workers, under the guidance of block supervisors, will conduct baseline surveys and go door-to-door to provide counseling, information, and products to eligible couples. The block supervisor will hold meetings with the CBD volunteers every 2 months. Free supplies will be picked up during these meetings. The CBD volunteers will maintain records and prepare monthly reports. A midterm evaluation will be conducted by an external agency. Partnerships will be set up with commercial marketing organizations to ensure that their contraceptives and other products are distributed to the CBD volunteers.

Coverage: SIFPSA expects this intervention to be implemented in stages over a five-year period. At the end of five years, "the targets set would have been achieved and it is expected that many villages would have reached saturation level…"[15] For those villages that are not yet saturated, SIFPSA expects the government of India to continue to support the program through its family welfare budget.

Assessment

Strengths: The program is designed to achieve statewide coverage with basic RCH products and services within five years. Planned outcomes, if achieved, would be very significant. Community involvement is built in through the village health committees and annual community assessments of the CBD volunteers. The payment mechanism appears to be simple and relatively direct. Baseline and annual household censuses will provide important coverage and performance data.

Weaknesses: Many key assumptions are likely to be challenged. This version of the model (based on village health committees rather than NGOs) has not yet been tested. There is no quality assurance element. The logistical requirements are likely to be formidable and are not addressed specifically in the proposal. The expected outcomes are unrealistic and the projected contraceptive prevalence gains of 5 percent per year seem very ambitious. These gains seem to be based on a study whose methodology has been challenged. Five days of training for the CBD volunteers seems to be inadequate, given the scope of what must be learned. There is no provision for follow up, refresher training, or continuing education. The bimonthly meetings with the block supervisor could be a vehicle for continuing education. There is no transportation allowance for the CBD volunteers to attend these meetings, although transportation to pick up branded contraceptives and other RCH products would be reimbursed. If these happen at the same time, this would not be a problem. It is not clear how the CBD volunteers would receive referral fees. The monthly stipend may not be seen as an incentive, but as a right.

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[15] Ibid.

Costs: There are no cost estimates, but given the large scope of the project and the layers of staff required (SIFPSA managers, district managers, block supervisors, block trainers, auxiliary nurse–midwives, village health committees, CBD volunteers) and transportation requirements, the costs are likely to be high. In addition, turnover will likely be high, requiring continual expenditures on recruitment and training of replacements at all levels. The SIFPSA management costs are not included.

Equity: The program is designed to reach the rural poor.

Quality: There is no specific quality assurance mechanism built into the proposal. The bimonthly meetings with the block supervisors do not by themselves ensure quality.

Sustainability: The expectation is that the program will help many villages reach saturation level coverage and, presumably, will no longer be needed. "Wherever it has not reached saturation level, it is expected that the government of India will continue to support the program from its family welfare budget…"[16] Both of these assumptions seem unrealistic.

Scalability: SIFPSA believes that the model has already been shown to be successful.[17] It is now proposing to bring it to scale statewide. This will likely be more difficult to achieve than expected.

Coverage: A baseline household census is planned for each village. Assuming that this is conducted each year, the program should generate good data on coverage. The program expects to achieve statewide coverage at the end of five years. Expected coverage outcomes are an annual increase in contraceptive prevalence of 5 percent (60 percent limiting and 40 percent spacing, with emphasis on low parity), 40 percent of clients provided socially marketed contraceptives, 80 percent of pregnant women receiving two doses of tetanus toxoid and 60 percent receiving 100 iron/folic acid tablets, and 85 percent of infants immunized and 60 percent of children aged 1 to 5 immunized. All of these expected outcomes seem very ambitious.

Health impact: No specific targets are set for morbidity, mortality, or fertility, but if the expected coverage targets are met, the impact should be large and significant. Again, that seems optimistic.

Constraints and issues: The program will be managed by village health committees because of the scarcity of credible NGOs in Uttar Pradesh. This assumes that the village health committees will have the needed capacity, which seems optimistic. There will be a significant management burden on SIFPSA itself, which will need to be addressed. Costs have not been estimated and may be much higher than expected. There is no infrastructure as yet to support this program at the district, block, and village levels; they will need to be developed. There is a built-in assumption that the CBD volunteers will be ready, willing,

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[16] Ibid.

[17] Ibid. The strategy has been "…implemented by over 150 NGOs…covering a 25 million population in 29 SIFPSA districts in the state of Uttar Pradesh."

and able to undertake a large number of tasks for very little cost. That assumption needs to be validated.

Experience from other states and countries: The Janani project uses rural shops and Titli Centres instead of community-based distributors and does not pay stipends. It does pay commissions on sales and fees for referrals. Projects in Andhra Pradesh, Karnataka, and Tamil Nadu seem to rely more on auxiliary nurse–midwives, but they do not sell commodities. It was learned that community midwives are being used as service providers and depot holders for RCH products, including contraceptives. This may be similar to a village midwife program in Indonesia that has been very successful.

Conclusions and recommendations: This appears to be a very ambitious and potentially costly intervention that is based on a number of questionable assumptions. It does not seem to take into account prior worldwide experience with CBD schemes, which have generally shown that CBD is expensive, labor intensive, and unsustainable without government subsidies. Since the model has not yet been tested, it would be prudent to do so on a small scale before trying to implement it statewide. SIFPSA might also consider experimenting with community midwives instead of CBD volunteers. They would be private and able to provide a wide range of RCH services, including deliveries and IUD insertions. They would also be able to handle all of the tasks expected of the CBDs.

Reference

SIFPSA. *Discussions on Public–Private Partnerships and Proposed Strategies.*

UTTAR PRADESH: SOCIAL MARKETING

Description

RCH problem: Low adoption of contraceptives in rural areas

Service delivery problem: Lack of availability of good contraceptives at affordable prices

Public entity: SIFPSA

Private entities: Hindustan Latex Limited, Population Services International (PSI), DKT International, and Hindustan Latex Family Planning Promotion Trust (HLFPPT)

Transactions: SIFPSA has awarded performance-based contracts to several social marketing organizations for distribution and communications support throughout the state of Uttar Pradesh. The government of India provides the contraceptives at a subsidized rate to SIFPSA's partners for distribution and sales.

Target groups: Low income and poor in rural areas

Implementation: All of the private partners have created standard sales distribution systems for supplying the contraceptives to their assigned areas. A distributor–retailer

chain has been established and each social marketing agency employs field personnel to maintain this chain.

Coverage

- Statewide marketing being implemented by Hindustan Latex Limited for the duration (April 2003 to March 2006)

- Integrated rural marketing being implemented by HLFPPT in Western Uttar Pradesh (excluding Moradabad Division) for the duration (April 2003 to March 2006)

- Integrated rural marketing being implemented by DKT International in the Central and Bundelkhand regions of Uttar Pradesh for the duration (April 2003 to March 2006)

- Integrated rural marketing being implemented by PSI in the Moradabad Division for the duration (April 2002 to March 2006)

Assessment

Strengths: This program has improved the penetration and visibility of contraceptive and RCH products in the state and has resulted in a significant increase in the sale of condoms throughout the target area. In the 2000–03 timeframe, condom sales achieved 110 percent of the performance targets.

Weaknesses: Weaknesses include the following: the sales of oral contraceptives in the 2000–03 time period only reached 79 percent of performance targets; as currently implemented, the social marketing organizations have been engaged solely for distribution and sales, not for a fully integrated social marketing program that involves demand generation and impact analysis, which may have hampered the effectiveness of the social marketing program; and this program is perceived to be excessively expensive by SIFPSA.

Costs: Project costs between 1997 and March 2004 have totaled Rs364 million. Commitments for April 2004 to March 2006 are Rs275 million.

Equity: Although statewide coverage was provided, the focus was on rural areas, with a special focus on villages in the C and D category villages. These villages have populations ranging from 1,000 to 5,000.

Quality: No quality issues with this program were identified.

Sustainability: No sustainability analysis of the social marketing program has been implemented. As currently designed, the program relies on subsidized products and is, therefore, not financially sustainable. All of the social marketing partners, however, are established organizations. Thus, if SIFPSA is willing to continue subsidizing the program, it will be sustainable.

Scalability: All of the social marketing partners should have the institutional capacity for expansion, should the subsidy component remain unchanged.

Coverage: The number of villages with outlets providing condoms has increased from 19 to 44 percent during the social marketing program; however, a similar increase in condom contraceptive prevalence has not occurred.

Health outcomes: No impact analysis appears to be available. Monitoring data consist of sales and the number of outlets that stock contraceptives.

Constraints and issues: SIFPSA believes that this program is excessively expensive and is planning to shift its emphasis to CBD workers. This is apparently based on an internal SIFPSA study that calculates the cost of a CYP delivered by a CBD program to be Rs14, and the cost of a CYP delivered by social marketing to be Rs40. Both of these numbers appear to be extremely low; based on other studies comparing CBD with social marketing, they are likely to be inaccurate.

Experience from other states and countries: The Andhra Pradesh Social Marketing Programme (APSMP) is intended to market contraceptives and child health products. In reality it is largely focused on condoms, oral contraceptives, and referrals for IUDs. The program began in October 2003 and continues through September 2006. It is expected to cover 17,588 villages (populations between 1,000–10,000) through rural medical practitioners. The objective is to enroll 130,000 (1.3 lakh) new users of condoms and oral contraceptives. Referrals will also be made to Vanitha clinics for IUDs. The critical elements are the rural medical practitioners, of whom 5,000 have been trained already. Upon completion of training, the rural medical practitioner is given a kit containing identification, a signboard, the rural medical practitioner oath, a flip chart, IEC materials, and reporting forms. The attraction for the rural medical practitioners is profits from sales (after two to three years) and recognition as trained providers. Fifty clients a week visit each rural medical practitioner for family planning. A practitioner receives Rs100 for referring a maternity case and Rs15 for IUD insertion. This is a variation of a standard CBD strategy; experience from other countries has shown this to be expensive and of limited effectiveness. This strategy may be similar to that proposed by SIFPSA for Uttar Pradesh.

Conclusions and recommendations: Although social marketing is perceived by SIFPSA as expensive, it is generally known worldwide to be the least expensive way to reach a large number of people. The problem with the current situation is that the social marketing firms are limited to distribution; social marketing usually includes demand creation as well as distribution. Before dropping social marketing, it would be prudent to examine the potential reach of the current social marketing programs, and to compare this with the cost-effectiveness of CBD interventions that are not complemented with social marketing demand creation.

OTHER MODELS, PROPOSALS, AND SUGGESTIONS

A number of other partnership opportunities have been identified, particularly by SIFPSA.[18] There are also a number of suggestions from other states. The information gathered in this assessment is not as complete for these models as for those just examined. In many cases, the model is just an element, intervention, or suggestion. Most of these would require further analysis and testing before being implemented. Several are suggestions that could be incorporated into one or more of the models described above.

Promising Models and Proposals

The following models are both feasible and likely to have an impact on health, although not as much as those described above.

UTTAR PRADESH, SIFPSA PROPOSAL: OBSTETRIC AND PEDIATRIC EMERGENCY SERVICES

The team merged this idea with ambulance services, which is a central element of the model. There are a number of ambulance service models under development or being tested. Some of these, such as the one in Bommidi (Tamil Nadu), were set up to provide quick access to emergency Caesarian sections for poor women in remote areas. The women are transported and undergo surgery free of charge. A local RCH project (managed by the Department for International Development [DFID] in four northern provinces) paid Rs1,800 to the doctor or nursing home for each procedure. From June 2003 through October 2004, there have only been four Caesarean emergency cases, which raises the question about the cost-effectiveness of this model.

Another model involves an agreement between the district health office and a local NGO (in this case, SEARCH in Tamil Nadu). The government loans an ambulance to the NGO, which is responsible for operational costs (fuel, maintenance, and driver), and which can charge Rs5 per km to use the ambulance (the poor do not have to pay). The ambulance can be used for any emergency to transfer the patient to the nearest hospital. There is an average of 35 cases a month, including obstetric emergencies.

A third model involves the government stationing an ambulance at a tribal hospital in the Sitliny Valley to transport emergency cases to the hospital from distant villages. The system has the same features as the SEARCH example above. On average, 25 emergency cases are transported each month, including emergency obstetric care.

This is an attractive model that seems well suited to rural and remote areas. However, use solely for emergency obstetric care does not seem warranted. It would be better to use the ambulance for all emergencies. An NGO in Karnataka uses its ambulance for outreach when it is not needed for emergency work.

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[18] SIFPSA, *Discussions on Public–Private Partnerships and Proposed Strategies*.

This would seem to be a good PPP to use as a first attempt. It is simple, fills an important gap, and can save lives.

Models and Proposals With Potential

UTTAR PRADESH: MADHURAJ NURSING HOME, KANPUR

This is one of the Commercial Market Strategies' (CMS) injectable contraceptive pilot project sites. Two others are in Agra and Varanasi. The objective is to demonstrate the possibility of providing Depo-Provera through private medical facilities. This is a fractional franchising model that has no link to SIFPSA or the government; it is a private–private arrangement. Pfizer provides Depo-Provera at a reduced price. The price to the client at this facility is Rs100 for a 3–month injection. Madhuraj does not charge for counseling, but it appears that at least one of the other two sites does charge for counseling. In addition to Depo-Provera, the physicians and paramedics are trained; advertising, signage, and method information are provided; and CMS provides ongoing supervision. This model might be worth incorporating into other family planning programs if the government were willing to do so and if it were willing to provide Depo-Provera at a reduced price. An important incentive for the owner is that the program helps bring in new clients who purchase other services. In marketing terms, it is an effective loss leader.

ANDHRA PRADESH: VANITHA FRANCHISE CLINICS, HYDERABAD

This model is similar to the one described above although it provides IUD rather than injectable contraceptive services. The clinic also provides condoms and oral contraceptives. HLFPPT is implementing this pilot in 34 sites in five Andhra Pradesh districts. The European Commission is providing financial assistance. The franchise is with the physician, who pays Rs500 for a one-year membership. In return, he/she receives such support as commodities and advertising. The state DHFW provides free space in maternity hospitals for these clinics. HLFPPT provides a trained physician, a counselor, a nurse, and a receptionist/secretary. The clinic charges Rs120 for an IUD insertion (including counseling, follow-up visits, and removal, if desired). Family planning counseling costs Rs20. The clinic averages 25–30 insertions per month, compared with 5 in the hospital's program. Another Vanitha franchise in a maternity and nursing home averages 15–20 insertions per month. The staff believes that the reason for this is the counseling provided by the Vanitha clinic staff. The units are clean and comfortable, and quality seems quite good. The biggest problem is that the clinics are not financially viable. Total income is less than Rs4,000 per month, while costs are Rs30,000 for the clinic in the maternity hospital. The doctor in the other clinic states that she makes nothing from IUD insertions. However, it does bring in new customers. The clinic would have to add a number of income-generating services (such as pregnancy testing and cytology examinations) in addition to streamlining staffing to break even, which is the case in the second clinic. The HLFPPT's long-term plan is to fold this service into a larger franchise package that is now being developed.

ANDHRA PRADESH: PROPOSED HLFPPT FRANCHISE MODEL

After seeing the positive results of the Vanitha partial franchise, HLFPPT commissioned KPMG India to prepare a feasibility study to determine the financial viability of a full franchise model. KPMG India concluded that such a model would be feasible. HLFPPT then developed a design and business plan that is now being considered by the planning commission. The proposal is to set up 200 new nursing homes or hospitals in Andhra Pradesh and Uttar Pradesh that provide a full range of clinical services, emphasizing RCH. The target groups are low and middle-income eligible couples who can pay part of the fee but not the full commercial price for such services. HLFPPT would franchise these facilities to young physicians, providing them with standardized, high-quality, well-equipped hospitals or nursing homes in return for a Rs3 million (30 lakh) franchise fee, plus a 5 percent royalty per service. KPMG India estimates that the facilities will break even within three to four years and will start turning a profit within five to six years. These facilities will be linked to the Vanitha clinics and hundreds of rural medical practitioners, who are expected to make referrals to the hospitals and nursing homes. There is a strong quality component and the model should be both sustainable (in three to four years) and scalable. Equity, however, is a concern. It is not clear if and how this model will serve the poor. This partnership with the public sector has not yet been articulated, but it could easily include reimbursement for sterilizations and IUDs as well as the distribution of free condoms and oral contraceptives through rural medical practitioners, shops (as in Janani), and/or CBD volunteers or community midwives. No evaluation component is envisioned, and the impact that this model will have on health is not certain. Unfortunately, the full description of this model is not yet public. Thus, this is a model that should probably be examined more closely when more information becomes available.

UTTAR PRADESH, SIFPSA PROPOSAL: ACCREDITATION SYSTEM FOR PRIVATE CLINICS

Accreditation is an important area, but this proposal calls for accreditation by SIFPSA, which does not seem appropriate. In other countries, professional associations (e.g., hospital associations, nursing home associations) with a government endorsement usually carry out accreditation. Although some accreditation programs are developing in India (through ICRA Limited and CRISIL), they focus on large hospitals. Apollo has taken a significant step in applying for Joint Commission on Accreditation of Healthcare Organizations (JCAHO) international accreditation. However, it may be a long time before there is any attempt to develop procedures to accredit health centers.

In addition, the SIFPSA proposal goes beyond accreditation to encompass the development of standards of care, protocols, certification of providers, and social franchising (similar to Pakistan's Green Star, Egypt's Gold Star, and Indonesia's Blue Circle). All of these are important areas for development. However, accreditation models for RCH were not found.[19] Some states have developed standards and protocols but much more needs to be done. It is uncertain whether SIFPSA wants to become involved in this area. If it does,

[19] Tamil Nadu contracts with accredited private nursing homes for sterilization services, but the team did not pursue how accreditation is undertaken.

then it may want to begin with a small, discrete area, such as the certification and branding of RCH services in primary health centers operated by NGOs.

UTTAR PRADESH, SIFPSA PROPOSAL: TECHNICAL TRAINING TO PRIVATE PROVIDERS

A SIFPSA report[20] calls for continuing medical education for private practitioners "to create a cadre of as many trained providers as possible in the private sector…" This idea needs further elaboration and evaluation. The experience in Indonesia was excellent for midwives, but dismal for physicians and pharmacists. SIFPSA may want to combine this proposal with the accreditation proposal and provide continuing education for providers in primary health centers managed by NGOs.

Somewhat related is a fellowship program for rural doctors in Gujarat. Recognizing the shortage of rural physicians, Shree Krishna/Patel Medical School developed a fellowship program for recent graduates willing to serve for five years in a rural area. The program lends money to the recent graduate to build a small clinic, buy a scooter, and cover similar expenses; deposits Rs200,000 (2 lakh) in an account to be turned over to the fellow, with interest, at the end of five years; and provides free tuition for diploma studies. In return, the physician must cover 8–10 villages and provide a fixed set of services at set fees, which he/she can then retain. The physician is also allowed to provide other income-producing services.

To date, no one has shown an interest. The chief executive officer attributes this to the desire of most medical students in Gujarat to go overseas or to pursue a specialty. However, such an approach might be attractive in a state (such as Uttar Pradesh) where career expectations and aspirations are more modest.

UTTAR PRADESH, SIFPSA PROPOSAL: INVOLVEMENT OF THE CORPORATE SECTOR

This proposal calls for the corporate sector to make significant investments in a variety of activities because of its corporate social responsibility. There is no incentive proposed for such involvement. Expectations that corporate involvement will increase by 25 percent seem unrealistic. This idea would need much greater development as well as discussion with potential corporate sponsors.

A popular model that is used in many states is the adoption of a primary health center. Adoption means that a corporation (or an individual, group, or trade union) would donate a certain amount of money (e.g., Rs25,000) to a center with no conditions to be met. The company might be allowed to display its logo or other material, but it would have no voice in the management of the center. This is more of a charitable contribution than a partnership but is worth considering nonetheless.

[20] SIFPSA, *Discussions on Public–Private Partnerships and Proposed Strategies.*

UTTAR PRADESH, SIFPSA PROPOSAL: UTTAR PRADESH HEALTH FOUNDATION

Apparently, the foundation has already been established. SIFPSA's role, if any, is unclear. This seems to be more a fundraising mechanism than a partnership.

GUJARAT: DEEPAK CHARITABLE TRUST

The trust was established in the early 1980s as a corporate-supported NGO focused on improving access to basic health care in the district of Baroda, Gujarat. As it implemented its various initiatives to improve the training of traditional birth attendants, increase spousal involvement in prenatal and postnatal care, and provide prenatal care and checkups, it realized that it shared an objective of improving maternal and child health with the government of Gujarat. With this in mind, it approached the government with a proposal for a partnership that would combine enhanced support by the Deepak Charitable Trust operating through the public health system, a partnership that eventually evolved. This partnership currently covers the entire Baroda District, which includes a primarily rural population of 2.2 million (22 lakh) in 1,600 villages and 12 blocks. The Deepak Charitable Trust has divided the blocks into clusters that are organized around the primary health center and focus on the following four initiatives:

- social mobilization,
- emergency obstetric and neonatal care,
- training for traditional birth attendants, and
- management information and tracking systems.

The Deepak Charitable Trust provides a variety of training and support services that were previously lacking. This includes additional training for the auxiliary nurse–midwives on basic health care, such as blood pressure measurement and antenatal care, as well as training for medical officers on both technical and procedural/reporting issues. As a priority, the Deepak Charitable Trust has focused on making the public subcenters functional. After convincing the government that many of the subcenters were dysfunctional, the trust was given the authority to manage all of the subcenters in the Baroda District. The Deepak Charitable Trust has significantly improved the use of the subcenters by providing a support network for auxiliary nurse–midwives that assists in the solution of problems and provides a community for discussion and sharing of information and techniques. Additionally, the Deepak Charitable Trust has established a network of outreach workers who oversee 25–30 villages each. Recently, the trust has proposed to the state of Gujarat that it expand its involvement in the public health system by assuming responsibility for the management of local social and health workers (anganwadis) and to use them as village health workers. Overseeing them would be a project administrator, who in turn would be supervised by a project director. This proposal would cost Rs250 million for all 12 blocks for five to six years. Fifty percent already has been pledged by the trust; it has also committed to raising the other 50 percent either internally or externally.

This partnership between the Deepak Charitable Trust and the government of Gujarat has improved the functionality and effectiveness of the public health facilities in the district of Baroda. Although the government continues to supply vaccines and compensate the auxiliary nurse–midwives, the bulk of the financial burden for this partnership is borne by

the Deepak Charitable Trust and its donors. Although this partnership has dramatically improved the health outcomes in the district, its replicability relies on the identification of an organization with the same social objective and financial resources.

GUJARAT: TRIBHUVANDUS FOUNDATION

The Tribhuvandus Foundation began working with dairy cooperatives in the late 1970s to improve access to health services in rural areas of Gujarat. Since that time, it has established a health care network that uses village health workers, reference subcenters and access to a hospital for curative care, and an insurance plan that provides financial coverage. The plan currently covers 530 villages. It uses a village health worker who is employed by the village and is paid approximately Rs200–300 per month. The village health worker's primary job is to take care of pregnant women and to identify at-risk pregnancies. They can refer such pregnancies to four subcenters, which are owned by the Tribhuvandus Foundation and operated by Shree Krishna Hospital. Supervising the village health workers is a field worker who is an employee of the foundation who is responsible for 8–10 villages, which are visited fortnightly on an established schedule. Group leaders oversee four or five field workers, or approximately 50 villages, and make unscheduled village visits to track quality. Both report to the subcenter once a week to compare findings. Although these health services were originally available only to the cooperative members, membership has since been made available to the general population. These services are paid for through an insurance program. Approximately one third of the insurance revenues are collected from members (about Rs25 per family per year), one third is contributed by the cooperative, and one third is paid by Amul, the dairy product company to which the cooperative sells its milk. However, despite the perceived and actual value of the plan to the participant, it is difficult to collect the annual fee. As a result, the cooperative automatically deducts it from the annual production bonus that it pays its members. This plan influences the cooperative structure and provides a significant community for risk pooling. However, the need to effectively garnish the wages of the participants to ensure payment may have implications for its replicability. Although this is primarily a private venture, it does use government vaccines for immunizations.

Other Suggestions

UTTAR PRADESH, SIFPSA PROPOSAL: NGOS TO PROVIDE FAMILY PLANNING AND IMMUNIZATION SERVICES

Regarding family planning and immunization, these services are already covered in one or more of the major models described previously. However, this proposal also calls for selected NGOs to carry out a number of ancillary functions, including training of service providers, resource mapping, establishment of groups to involve fathers and husbands in reproductive health, and outreach in poor performing areas. In addition to being too general, it was learned from SIFPSA that the government does not support this idea.

UTTAR PRADESH, SIFPSA PROPOSAL: PROMOTING COMMUNITY INVOLVEMENT AND OWNERSHIP BY FULLY FUNCTIONAL VILLAGE HEALTH COMMITTEES

This is a very short proposal that seems to call for a major role for village health committees without any regard to their capabilities or willingness to assume such responsibilities. It is not clear how this intervention would be funded. State officials in Karnataka stated that their village health committee model did not work. If SIFPSA is serious about pursuing this idea, it should first conduct a thorough analysis of prior experiences.

UTTAR PRADESH, SIFPSA PROPOSAL: CAPACITY BUILDING AND TECHNICAL ASSISTANCE TO COMMUNITY-BASED NGOS

This proposal calls for adding RCH/family planning to the functions of community-based NGOs, but there is no mention of incentives or paying for it. Experience in other countries demonstrates that the most effective NGOs are those already specializing in community health. It is very difficult and costly to introduce RCH service provision into nonhealth NGOs. Although SIFPSA has made progress on this effort in the past 10 years, continued success would require an investment and resources that might be better used elsewhere.

UTTAR PRADESH, SIFPSA PROPOSAL: PROMOTING ALL-MALE REPRODUCTIVE HEALTH CLINICS

This is another very short proposal that does not indicate what the public–private partnership would be nor the funding source(s). This model has been attempted in other countries with mixed success. The clinic in Chennai would be worth examining, but an exploratory study should be undertaken before committing to the idea.

UTTAR PRADESH, SIFPSA PROPOSAL: SUPPORTING CORPORATE HOSPITALS TO SET UP RURAL UNITS

This is a very brief, vague proposal that has already been incorporated in previous models. However, it may be difficult to find profit-making hospitals that are willing to undertake this activity.

BIHAR: RUBEN SINGH MEMORIAL HOSPITAL, PATNA

Many of the large, profit-making hospitals have been established by returning nonresident Indians. These hospitals provide services to some of the very poor at no charge. The Ruben Singh Memorial Hospital falls in that category. The owner, a urology specialist, has also mobilized several community workers (arm and body ladies) and quacks (a nonpejorative term for traditional, local homeopathic healers) to work with him in six villages. He is doing this on his own without government support. When asked if he would be willing to take over a primary health center or community health center, he responded that he definitely would, but not if the government were to intervene because it would be too problematic.

This may or may not be a common view, but it reflects the degree of mistrust that exists among some private sector entities. The public sector needs to take the lead, as in Tamil Nadu, to meet and interact with the private sector to find mutual ground where collaboration and partnership can flourish. By beginning with small partnerships (such as outsourcing cleaning and maintenance), both sides can learn to trust each other.

Another example is the Shree Krishna Hospital in Gujarat. This is a private teaching hospital that is affiliated with the Patel Medical School. The chief executive officer of both is a professional manager, and the quality of both organizations appears to be extremely high. Shree Krishna is the type of institution that would make an excellent partner in any type of collaboration. It is delivering quality health care, is committed to serving the poor, and is innovative. It would be willing to take over a primary health center, but is not willing to be subjected to government management and oversight. Despite its views on the government, Shree Krishna has initiated several programs on its own with the intent of improving access to health care for the poor, including providing obstetric/gynecologic specialists to primary health centers, regularly visiting villages, establishing partnerships with the Tribhuvandus Foundation cooperative programs, and similar services.

V. CONCLUSIONS AND SUGGESTIONS FOR FUTURE ACTIVITY

GENERAL CONCLUSIONS

Public–private partnership is a popular term for engaging the private sector in the delivery of health services. However, partnerships in their true sense are quite different from the interventions observed in India. A true partnership requires shared objectives, shared risks, shared investments, and shared rewards. Much of what are being called partnerships in India are merely transactions or contractual arrangements between a public and a private entity. For example, the contracting out of cleaning and maintenance is not a true partnership. The government pays a vendor to do what it (the government) wants done. However, contracting out the management of a primary health care center to the Karuna Trust is a true partnership. Both the government and the trust share the same objectives, share in the risks of providing services, share in the investments, and share in the achievements.

To develop true partnerships, much work needs to be done on

- developing an enabling environment for partnerships,
- facilitating improved attitudes and trust between the public and private sectors,
- designing transparent and accountable management and financial systems,
- establishing an accreditation and oversight structure that ensures quality,
- developing management capacity for both the government and implementing partners, and
- instilling an atmosphere of shared responsibility, investment, and accountability.

Additionally, USAID and SIFPSA need to examine the purpose of their PPPs. It is not enough to develop partnerships simply to show that they exist. The ultimate purpose of a PPP, either directly or indirectly, must be to improve the provision of, access to, or quality of RCH services. However, there are many ways to do this, such as improving the government's primary health care services, contracting the provision of such services to qualified NGOs, subsidizing some of these services at private hospitals and nursing homes, and developing social franchises to provide primary health care services. PPPs should be viewed as one of several mechanisms available to expand coverage and improve health. The best mix of these mechanisms is likely to be location specific. USAID and SIFPSA should be examining the best ways to expand coverage rather than the best PPP models to support.

The concept of added value should be applied to each alternative. For example, what is the value in contracting out a service to an NGO rather than having the government provide the service? What is the advantage to franchising a service versus contracting it out? Table

3 summarizes some preliminary guidelines that might help policymakers decide which partnership mechanism to choose for a given situation. For example, franchising may be a better choice than contracting out if the need is to have a standardized service package in a large number of clinics. Contracting out may be more appropriate if the clinics are very different from each other.

Table 3
Type of Partnerships for Specific Situations

Type of Partnership	Applicable Situations
Contracting In	Need for a specific service (e.g., a pediatrician) in a clinic on a regular basis Need to replace missing staff until position is filled
Contracting Out	Need for an organization to manage a specific primary health center Need for an organization to manage several different primary health centers
Social Franchising	Need for a standardized service (e.g., IUD insertions) in many clinics Need for a standardized package of services (e.g., maternal and child health) in many clinics
Social Marketing	Need for broad promotion and provision of products (e.g., contraceptives)

Another question is whether there is an optimum distribution of the public and private shares in the partnership (e.g., 25–75, or 50–50). Based on its limited field experience, the team hypothesizes that the closer the share is to 50–50, the better the distribution. It was observed that when one entity had a limited investment in the partnership (e.g., 10 percent), it had much less interest and stake in the partnership than when both parties had significant investments, both in terms of the amount and the proportion.

PROFILE OF THE PUBLIC–PRIVATE PARTNERSHIPS EXAMINED

A variety of PPPs were reviewed in several states. This section provides a general description and assessment of them.

Description of the PPP Models

Most of the PPP models reviewed were initiated due to the lack of adequate RCH or primary health services in a target area. In all cases, the public partner was the state or district Department of Health and Family Welfare. The private partners, however, were more diverse. They included NGOs, both local and international; private hospitals; nursing homes; and charitable trusts. The target groups for these interventions were those populations with low access to RCH service, both rural and urban.

The majority of models reviewed were variations on contracting out, although examples of contracting in, social marketing, and social franchising were also examined. The scope of contracting-out arrangements ranged from contracting for a specific service (i.e. sterilization or IUD insertion) to contracting out the management of a network of primary health centers. Generally, the private partner (or contractor) is then reimbursed by the public sector on a prearranged payment schedule. The public sector might also provide commodities, information materials, or other resources as part of the arrangement. The specifics of the implementation are varied and appear to be model specific. In the case of contracting out, full implementation responsibility lies with the private sector, while financial accounting and performance are monitored by the public sector. In the case of

social franchising, implementation is by the franchisee, with quality monitored by the franchiser. Social marketing generally provides for full implementation by the social marketing agency, with performance monitoring by the public sector based on such preestablished criteria as sales and outlets reached.

All of the PPP models recommended have demonstrated good coverage of their target populations.

Assessment of the PPP Models

As expected from any partnership, there are strengths and weaknesses in each implementation intervention reviewed. These strengths and weaknesses vary from intervention to intervention based on the unique design of each. In general, though, the PPPs have resulted in expanded RCH coverage, improved management systems, a high level of quality and accountability, and the investment of additional resources. The charitable orientation of many of the private sector partners has also resulted in a variety of ancillary efforts in education, women's empowerment, and sanitation that have improved the well-being of the target community. The most consistent weakness observed was related to finances. Government payments were often inadequate, delayed, inflexible, and subject to burdensome scrutiny and oversight. Many NGOs have supplemented operations with their own funding to ensure quality service delivery. The government entities interviewed were comfortable working with mission hospitals and charitably oriented NGOs. There was, however, a distinct distrust of the for-profit private sector, fueled by the belief that a profit motive would undermine quality.

The contracting out models were generally low to medium in cost, while the social franchising and social marketing models required larger investments. Reimbursement arrangements vary. In one case, the government provided an NGO with 100 percent of the budget to manage a primary health center; in another case, the payment was 75 percent. Additionally, the private partner might receive commodities, essential drugs, or other resources from the government.

Equity was quite high across the models as they generally targeted the poor, both rural and urban. When user fees were incorporated into the model, an accommodation was made for clients below the poverty level. A possible exception would be the Janani franchise, which is focused on low and middle-income clients. Quality was generally high in models that are operational, although there were exceptions. Most partners recognize the importance of quality and have established systems to ensure that it is delivered.

The sustainability of any of these models is dependent on several factors, including adequate financing, good management, organizational stability, and qualified staff. Although the focus is often on financial sustainability, the absence of any of these factors will threaten sustainability. If the success of an intervention is overly dependent on a key individual or substantial external financing, long-term sustainability is in question. Similarly, scalability is dependent on several factors, including the organizational capacity of the partners and available resources. Both sustainability and scalability need to be analyzed on a case-by-case basis.

Several models have demonstrated excellent coverage with measurable health impact. Others appear to be providing good coverage and impact, but do not have the data to support this. Some of the proposed models have set high targets for themselves, but it is unclear whether they will be able to be met.

The challenges and constraints for any of these models are varied. Models that use trained medical professionals often have difficulty recruiting due to pay and location. Models dependent on community-based distributors or village health workers need to provide training and incentives to ensure quality and to overcome little or no pay. In all cases, the interface with the government is difficult. A centralized government system lacks the flexibility and delegation of authority that is ideal for PPPs.

PRIORITY MODELS

Of the models examined, the following five should be considered by SIFPSA and USAID: 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 among the Uttar Pradesh DHFW and private hospitals and nursing homes. The private hospitals and nursing homes would provide sterilization and 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. First, the private hospitals and nursing homes should either be reimbursed for their total costs or paid a flat fee for service (Rs1,000 for voluntary sterilization and Rs100 for IUD). Second, there should be no restrictions regarding age or parity. Third, 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 among the Uttar Pradesh DHFW and qualified NGOs, built on the successful model in Andhra Pradesh. The government would build urban health centers in slum areas to serve the urban poor. The urban health centers would be fully equipped by the government, which would also pay at least two thirds of all costs. The NGOs would raise the rest. The NGOs would hire their own staff 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 center should contract in specialists 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 Out Rural Primary Health Care Centers

Such a model would also involve a contracting partnership among the DHFW and qualified NGOs. It is recognized that SIFPSA has tried to set up a similar partnership without success. It seems worth trying again, perhaps in another district where there are defunct primary health centers. The following modifications are recommended: payment of 100 percent of the costs, an advisory board, and full primary health care services, including outreach; development of the center as a model for the area, including 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 among 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 (fuel, maintenance, and driver) and which could charge Rs5 per km to use the ambulance (persons below 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 out in several rural and remote areas.

MANAGEMENT CONSIDERATIONS

Many of the challenges in the implementation of PPPs revolve around management structures and conventions that were designed for a large, centralized public health authority. They do not necessarily have the flexibility to meet the needs of a specific community, partner, or intervention.

These challenges include the lack of needs assessments, inadequate stakeholder analysis and participation, rigid financial systems, centralized personnel and decision-making, insufficient monitoring and evaluation systems, and a general lack of flexibility. A paradigm shift in thinking by the government is required. The government will no longer be dictating, with others implementing. Rather, partnerships require shared analyses of problems, mutual discussion of solutions, and interventions in which all parties have shared ownership. Some states visited, most notably Tamil Nadu and Chhattisgarh, seem to be moving in this direction. It is recommended that SIFPSA or the government of Uttar Pradesh meet with the officials in those states to examine their reasoning and approach.

Some specific challenges were observed:

- **Financing PPPs**: Financing is a challenge both in quantity and management. Where the government does provide funding or reimbursement to an implementing partner, those funds are often inadequate, delayed by 6–12 months, restricted by line items, and subject to audits that invite corruption. Most of the more interesting interventions reviewed relied on funding that was additive to the resources provided by the government, such as flat fees, donations, donor funding, and corporate sponsorship.

- **Needs Assessments**: One note of caution heard was that India is a very heterogeneous country and that what works in one state, or even one district, may not work in another. Yet there is a similarity of services provided by the government that belies this cautious note. Health facilities throughout the country are designed to provide exactly the same services with the same type of personnel, regardless of the situation. There is no assessment of actual needs or how those needs might best be met. Additionally, there is little community involvement in the design and location of health care services and facilities, which inhibits ownership and a stake in ultimate success.

- **Strategic Planning**: As the public sector pursues PPPs, it is important to remember that PPPs alone will not close the gap between the supply of and demand for health services. For example, one of the most promising models visited was the management of primary health centers in Karnataka by the Karuna Trust. However, Karuna estimates that at most, 50 of the 1,600 primary health centers in Karnataka could be managed by NGOs. This shows that PPPs can clearly be part of the solution but not the entire solution. It also demonstrates the need for a district or statewide strategic plan for providing health services. The World Bank's follow-on initiative, Reproductive and Child Health Care Project II, appears to provide the framework for such planning.

- **Monitoring and Evaluation**: Although there are extensive processes for collecting data, there is little monitoring of data collection and almost no assessment of accuracy or analysis of meaning. As a result, there are an abundance of health statistics, but no confidence that they are accurate. If PPPs are pursued and additional implementing partners are introduced, it is essential that monitoring and evaluation systems be strengthened and implemented.

ALTERNATIVE PAYMENT MECHANISMS

Although insurance or third-party payments were not a focus of the assessment, several payment processes were observed that are worthy of note and that might be useful in future interventions.

- **Insurance**: Although commercial insurance plans are generally out of reach for the target population (and usually focused on curative rather than preventive care), some plans have been developed through cooperatives or communities. An example is the plan and health network developed by the Tribhuvandus

Foundation through the milk cooperative in Gujarat. The SEWA Rural health insurance program is another model.

- **Vouchers**: Specific voucher programs were not observed, but vouchers as a payment mechanism were discussed with both government officials and implementing partners. Both agreed on the useful potential for vouchers, particularly when they are designed for specific services, such as transportation or obstetrics.

- **Government Bypass**: A number of respondents, including some from the government, noted that it is better to channel private sector funds, including user fees for RCH services, through societies and such reputable organizations as the Red Cross. Some respondents noted that if the money were given to the government, it would be lost. Other respondents suggested sending funds directly to the primary health centers.

ENABLING ENVIRONMENT CONSIDERATIONS

To ensure that PPPs are as successful as possible, it is important to provide an environment that is both encouraging and enabling. First and foremost, it is essential that the public and private sector participants learn to view each other as colleagues and partners and not as adversaries. This requires education about the attributes, qualifications, and contributions of both parties as well as an honest and sincere discussion of concerns, with mutual agreement on their resolution. It is also important to enhance the implementation capacity at all levels. Asking a health officer to be a manager of a portfolio of PPPs is unreasonable unless he/she has received the proper training and support. Public officials, in particular, need to learn the advantages and risks of contracting, the bidding process, the different payment mechanisms available, how to negotiate contracts, and how to manage them, how to employ sanctions for nonperformance, and how to terminate contracts.

The legal and regulatory environment needs to be understood and, in many cases, reformed. Regulatory issues can also impede the success of a PPP. Regulations and reporting requirements should be reviewed with consideration toward eliminating redundant and outdated requirements. Certification and accreditation programs that expand the use of paramedics, where appropriate, should be encouraged. Logistics and procurement systems should be overhauled with a focus on transparency and efficiency.

QUALITY ASSURANCE CONSIDERATIONS

Quality assurance is often confused with performance monitoring in the models reviewed. When staff and managers were asked how they measured quality, they would often bring out a form with 11 or 17 performance criteria (such as the number of antenatal care visits made and the number of women receiving two doses of tetanus toxoid). Although these can be seen as quality assurance indicators, what was sought were procedures for ensuring that providers adhered to minimal standards of care (e.g., infection prevention procedures, client–patient interaction, waiting time, informed consent). These latter quality assurance indicators were not used often. The closest indicator was client complaints. Some models

assign quality assurance to district committees, but there is no assurance that these committees have the training or experience to assess quality.

In the absence of accreditation and regulation mechanisms at the primary health care level, it will be important to build quality assurance into all the partnership models to be tested. This can be done, in part, through the training of managers, providers, and oversight committees. However, it will also require the development of standards and protocols for each RCH service, if they do not already exist.

SIFPSA may also want to follow up on its accreditation proposal (see Uttar Pradesh, SIFPSA Proposal: Accreditation System for Private Clinics, in the previous section), which could be combined with the training of private providers and tested in primary health centers operated by NGOs.

APPENDICES

A. SCOPE OF WORK

B. PERSONS CONTACTED

C. REFERENCES

APPENDIX A

SCOPE OF WORK
(from USAID)

Scope of Work

Assessment of Opportunities for Enhanced Partnership with the Private Sector to Improve Reproductive Health Outcomes in North India

(Finalized by USAID on October 11th in India)

I. Summary

USAID/India requires a consulting team to conduct an assessment of the potential for increased partnership between the public and private sectors aimed at improving reproductive health outcomes. This assessment will respond to keen government of India (GOI) interest in introducing and going to scale with public–private partnerships (PPPs), and support planning for the second phase of the government of India's reproductive and child health program (RCH-2) in Uttar Pradesh. Results will also be used to help steer USAID/India assistance as it transitions into the second phase of the Innovations in Family Planning Services Project (IFPS II), in which PPPs will be an important component. It is anticipated that this assessment will include a review of current PPPs in India, identification of those that might have application in Uttar Pradesh and recommendations for future activity.

For the purposes of this assessment, the private sector is defined broadly to include all non-governmental entities involved in the delivery of health care services: private providers (physicians, paramedics), drug sellers, traditional healers (ayurvedics and homeopaths), NGOs, distributors/manufacturers of health products, and the corporate for-profit sector.

II. Background

USAID/India has been active in supporting the government of India (GOI) on population and reproductive health issues since 1980. Since 1992, USAID/India has provided significant funding for the Innovations in Family Planning Services (IFPS) project, which has focused exclusively on interventions in Uttar Pradesh (with the addition of the newly formed States of Uttaranchal and Jharkand in 2001). IFPS is implemented by the parastatal agency—State Innovations in Family Planning Services Agency (SIFPSA).

Through longstanding experience, donors and the government of India have recognized that unmet reproductive and child health needs outstrip their capacity and financial resources. And although India has an active private health sector, its role in the provision of RCH services has been primarily the delivery of contraceptive supplies through social marketing programs. Data indicate that more than 75 percent of current users obtain oral contraceptives and condoms from the private sector. Over 70 percent of the population obtains curative health care from the private sector. Of the women who seek treatment for any reproductive health issues, 71% seek care from the private sector.[21] Thus, there is great potential to tap the private sector to expand the provision of quality RCH services through interventions designed to strengthen strategic partnerships with the public sector,

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[21] Chakraborty, S. "Private Health Provision in Uttar Pradesh, India", Health Policy Research in south Asia, World Bank, 2003.

improve quality and sustainability of private providers, and design incentives to increase private sector participation in public health objectives.

Various examples of public–private partnership exist in north India; a number of which have been used at scale. Examples include social marketing of condoms, pills and oral rehydration salts; community-based distribution of contraceptives through NGOs, factory-linked projects, dairy cooperatives and urban development agencies; contracting-in individual service providers; contracting-out services and even facility management; and providing public sector training to private sector. USAID is interested in the exploring the expansion of clinical and RCH services through these and other mechanisms that engage the private sector.

With this in mind, USAID has included the "Delivery of integrated RCH services increased through PPPs" as a Sub-Result for the pending IFPS II Project. To support that SR, USAID has commissioned this Assessment to review the state of PPPs in India and offer recommendations for implementation under IFPS II.

III. Deliverables

This assignment will produce the following deliverables:

1. Draft Assessment Report: The draft assessment report will be submitted to USAID/India during the week of November 8th, 2004 for review and comment. The draft assessment report will follow the Report preparation guidelines; contain clear findings, conclusions and recommendations. The draft will be submitted in pdf format via email and, if so requested, in hard copy.

2. Final Assessment Report: The Final Assessment Report should be approximately 30 pages in length, excluding appendices (Times New Roman font 12 point). The assessment will review, analyze and document experiences in PPPs for reproductive health in North India, with an emphasis on Uttar Pradesh. It may also include examples of PPPs that are not currently engaged in health activities or are not present in India, but which might have applicability. The strengths, weaknesses, applicability and scalability of the identified models will be discussed, resulting in recommendations for future activity.

3. Formal Briefing and Debriefing: The POPTECH assessment team will formally brief and present a draft report and findings to USAID/India, GOI and SIFSPA, during the week of November 8th.

IV. Scope of Assignment

Background reading will be recommended/ provided by USAID/India and should include a thorough review of USAID/India's health portfolio and the IFPS project. The assessment team will also conduct interviews, meetings, and site visits in Uttar Pradesh, and 2-3 other states. The scope of the assessment will encompass the following areas:

a) Brief Overview of Private Sector Participation: A background understanding of private sector participation in the healthcare provision in India will be gained through

background reading that might include NFHS data, USAID funded RH surveys, Health Financing Surveys, World Bank Studies, RCH-2 studies (e.g. demand side financing, comprehensive sector approach, etc.) and other secondary sources

b) Review PPP models in India: The assessment team will review, analyze, evaluate and document existing models for public private partnership in India. A range of models will be explored. Potential suggestions for site visits and further exploration include: USAID-funded Commercial Markets Strategies Project, USAID-funded PACT-CRH project, Janani Reproductive Health Clinic Franchises, PSI health provider network/Saadhan network, PSS clinics, etc.

c) In-depth Understanding of Social Franchising and Provider Networks: The assessment team will identify existing models of social franchises, private provider associations and provider networks operating in India. The team will assess potential opportunities to strengthen, scale up, and leverage existing and create new models

d) Enabling Environment and Public Policy: The assessment team will recommend potential interventions for developing an enabling environment that encourages public–private partnerships and increased private sector participation in public health goals

e) Quality of Care: Inadequate regulation and standards for quality of care and limited enforcement are key issues. The assessment team will explore different methodologies and models for improving quality of care in the private sector

f) Reaching the Poor: The issue of equity and targeting the poor is a critical issue in India. The assessment team will describe approaches to ensure that private sector partnerships pay attention to the needs of the poor (Below-poverty line)

V. Methodology

The assessment team will apply the following methodology to conduct the assessment and provide recommendations for future activity:

1. 1. Team planning meeting: The final SOW will be developed during an in-country team planning meeting at the beginning of the consultancy. It is anticipated that USAID/India and GOI officials will participate in this meeting, as appropriate.

2. 2. Literature review: USAID/India will recommend/provide the literature to be reviewed. Examples of review documents might include: IFPS-2 project documents, selected RCH-2 design studies including demand-side financing, comprehensive sector approach, Janani's review report, DIMPA and Goli Ke Hamjoli program documents, and Uttaranchal policy health & population issues reports.

3. Key informant interviews: All interviews are to organized by USAID/India Mission staff and may include: cooperative agency staff (IFPS, PACT-CRH and EHP); SIFSPA staff; government of India; ICICI Bank staff; private providers; Janani; PSS, PSIRCH staff; and development partners.

4. Field visits and observations: Uttar Pradesh, Uttaranchal (PSI provider network; urban health activities), Bihar (Janani), Gujarat (urban health posts managed by NGOs).

VI. Proposed Level of Effort and Timeframe

The assessment is estimated to require approximately 6 weeks (at least 4 weeks in country) for each consultant to allow gaining familiarity with key stakeholders and allow sufficient time for field visits throughout Northern India, with an additional 2 weeks for the team leader. The assessment will begin on/around October 2004.

VII. Team Composition

The assessment team should consist of the following:

A) Team Leader: The team leader should have familiarity with USAID and at least 10 years of experience in international health and specific expertise in public-private partnerships, social franchising, and financing. The team leader should have proven ability in conducting assessments, leadership, writing, facilitation and interpersonal team skills.

B) One International Consultant: The international consultants should have experience working with the private sector on international health issues, including quality of care issues.

C) Two National Consultants: The Indian national consultants should have extensive experience and knowledge of health programs in Uttar Pradesh, health systems at the national and district level, SIFSPA and the IFPS project. USAID/India will be involved in the selection process for the national consultants.

The team should have the following skill mix - sound understanding of public health issues, experience and knowledge of health sectors in India (both public and private sectors), expertise in public–private partnerships including social franchising, health financing, quality assurance, behavior change communication and marketing, analytic skills and thorough understanding of policy and regulatory issues in India.

VIII. Funding and Logistics

All funding and logistical support will be provided through POPTECH. POPTECH activities will include recruiting and supporting the assessment team (including travel, per diem and related team expenses), and producing and distributing the final report. USAID/India will assist POPTECH in the facilitation of all meetings/interviews to be conducted in India, including those with GOI, SIFPSA, other donors, and securing country clearances.

The final SOW will be developed with input from the team during an in-country team planning meeting at the beginning of the consultancy.

Attachment 1

Outline for Final Assessment Report

I. Table of Contents
II. Executive Summary
III. Background
IV. Methodology
V. Summary Findings – The structure of this section will be determined by team based on findings, but it should represent the bulk of the report and will likely include:

i. Summary of models identified including:

1. social franchises
2. provider networks
3. voucher schemes
4. contracting out of services and/or facilities management
5. social marketing
6. public training of private providers

ii. Review of models that are applicable w/

1. advantages
2. disadvantages
3. sustainability
4. scalability
5. quality of care issues
6. policy concerns
7. equity
8. market segmentation implications
9. IEC concerns

iii. Key lessons learned to date

VI. **Conclusions and Recommendations for Future Activity –** The specific organization of this section will depend on findings, but is likely to include recommendations for the following.

i. Establishing an enabling environment
ii. Services and products most receptive to PPPs
iii. Insuring demand for PPP products and services
iv. Scalability and replicability

Annexes
A. Scope of Work
B. List of Contacts
C. References

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

U.S. Agency for International Development/India
Robert M. Clay, Office Director, Population, Health, and Nutrition
P. Randy Kolstad, Senior Population Advisor
Sheena Chhabra, Division Chief, PRIME Project
Anjana Singh, Reproductive Health and Child Survival Advisor
Dr. Meenakshi, Reproductive Health and Child Survival Advisor
Jyoti Shankar Tewari, Senior Analyst
Sameer Wadhwa, Senior Project Management Assistant
Lissy Mathew, Secretary

U.S. Agency for International Development/Washington
Shyami De Silva, Senior Technical Officer

State Innovations in Family Planning Services Project Agency (SIFPSA)
Kalpana Awasthi, Executive Director
S. Krishnaswamy, General Manager, Private Sector
Baijendra Singh, General Manager, Public Sector
Savita Chavhan, Deputy General Manager, Private Sector
Sulbha Swaroof, Deputy General Manager, Public Sector
M. K. Sinha, Deputy General Manager, Public Sector

SIFPSA/Kanpur District Innovations in Family Planning Services Agency (DIFPSA), Project Management Unit
Daman Ahuja, Executive Secretary

Madhuraj Nursing Home
Ruchi Tomdon, Medical Doctor
Akanksha Loomba, Medical Doctor

Commercial Market Strategies (CMS) Project
Smita Mazumdor, Depo-Provera Marketing Advisor
Anand Sinha, Former Research Director

Government of Bihar, Department of Health and Family Welfare
C.I. Anil, Additional Secretary, Health
S.N. Singh, Director in Chief
Gita Sorasau, Director, Health
Shiwanand Sinha, Deputy Director, Health and Family Welfare
Manoranjan Jha, Medical Officer, Regional Office for Health and Family Welfare
Rakesh C. Jha, National Expert (funded by the European Commission)

Indira Gandhi Institute of Medical Services, Patna
D.K. Yadava, Director
S.K. Shami, Medical Officer

Janani, Patna
K. Gopalaksishnan, Program Director
Ms. Sangita, Executive Assistant
Dr. Nilasha, Deputy General Manager
Pankaj Kumar Singh, Manager, Sales and Operations
Prachi Shukla, Administrator, Surya Clinic
Aochana Jha, Assistant, Quality Control
K.C. John, Deputy Manager, Inventory Control
Tafsir-ul-Mazahir, Assistant Manager, Quality Control
Latika Lawanyamayee, Deputy Manager, Franchise Clinics
Sashank Shelehab Jha, Senior Assistant, Sales and Operations
Sanjur Nayan Ko, Assistant Manager, Finance
Sunil Kumar Sah, Manager, Franchise Clinics
Sandhya Ahuja, Consultant, Management Information Systems
Priyadarshini Roy, General Manager, Planning, Training, and Implementation
Reetima Das, Assistant Manager, Training
Sandeep Srivastava, Manager, Finance
Nagesh Kumar Chaudhary, Assistant Manager, Finance
Noah Spaofkin

Janani, Titli Centres
Sukech Kumar, Owner
Ravindra Kumar, Owner
Nageshwar Prasad, Owner

Janani, Surya Clinic (Rural)
D.C. Mishura, Owner, Medical Officer

Janani, Surya Clinic (Patna)
Prachi Shukla, Administrator

Kurji Holy Family Hospital
Sr. Juliana, Administrator
Jose Nampch, Assistant Administrator

Ruben Singh Memorial Hospital
Ruben Singh, Owner, Medical Officer

State Health Resource Centre, Chhattisgarh
T. Sundararaman, Director
Kamlesh K. Jain, Programme Coordinator

State of Chhattisgarh
B.A. Agrawal, Secretary, Department of Health and Family Welfare
Alok Shukla, Secretary, Department of School Education (former Secretary of Health)

Panth Shree Grindhmuninam Memorial Hospital
Chetan Verma, Chairman

Government of Gujarat
Amarjit Singh, Health Commissioner
Dhananjay Bhatt, Additional Director (Family Welfare)
K.N. Patel, Additional Director (Health Services)
Manorama Shah, Additional Director (Medical Services)

European Union Technical Assistance Office, Gujarat
Kiran Mukerji, Gujarat Team Leader
Uma Vyas, Programme Advisor

Indian Institute of Management
Ramesh Bhat, Professor and Chairperson, Management Development Programmes
K.V. Ramani, Chairman, Public Systems Group and Chairman, Centre for Management of Health Services
Dileep V. Mavalankar, Associate Professor, Public Systems Group

Shree Krishna Hospital
Sandeep Desai, Chief Executive Officer
Pragnesh Gor, Deputy Manager (Extension Programme)

Tribhuvandus Foundation
J.I. Khristmukti

Society for Education, Welfare, and Action (SEWA) Rural Project
Pankaj Shah, Senior Manager

Deepak Charitable Trust
Anupa Mehta, Deputy Director

Low Cost Standard Therapeutics (LOCOST)
S. Srinivasan, Founder and Manager

Department for International Development (DFID), United Kingdom
Joanna Reid, Senior Health Advisor
Ranjana Kumar, Health Advisor

World Bank
Peter Berman, Lead Economist, Health, Nutrition and Population
G.N.V. Ramana, Senior Public Health Specialist

European Commission
Davendra Verma, Programme Advisor
Urbashi Chandra, Programme Consultant
J.P. Misra, Programme Advisor
Paula Quigley, Programme Consultant

Acumen Fund
Denise MacKay, Consultant

Apollo Health and Lifestyle Limited
Rohit Das, Vice President, North
Javed Alam, Assistant General Manager, Business Development

Indraprastha Apollo Hospitals
Anne Marie Moncure, Managing Director

Population Services International (PSI)
Tim McClellan
Wilda Campbell

Government of Andhra Pradesh
C.B.S. Venkata Ramana, Commissioner, Family Welfare and Ex-officio Secretary to the Government of Andhra Pradesh
P. Ramaih, Joint Director, Urban Projects, Department of Health and Family Welfare
V. Sarala, Additional District Medical Health Officer, Sangareddy District
K. Ravi Prasad, Medical Officer, Mulugu Primary Health Center

Vanitha Clinics, Andhra Pradesh
T. Sunita, Government Maternity Clinic, Hyderabad
Gayatri Devi, Doctor/Proprietor, Gayatri Nursing Home
Dr. Balraj, Rural Medical Practitioner, Padma Clinic

Urban Health Centers, Andhra Pradesh
Mr. Shekhar, Community Organizer
M. Shaden, Community Organizer
A. Shankar
G. Ramesh, Lion Club Member; Coordinator, Urban Health Center II
Mr. Shekhar, Project Coordinator
C.H. Madhusudan, Community Organizer
V.L. Narayana, Lion Club Member
A. Raghava Reddy, Lion Club Member
G. Rama Devi, Social Worker

Administrative Staff College of India (ASCI), Hyderabad
Kinnera Murthy, Chairperson, Strategic Management

Hindustan Latex Family Planning Promotion Trust (HLFPPT)
Kallol Mukherji, Project Manager
Anant Kumar, Team Leader
K. Suresh, Project Manager

Karuna Trust, Bangalore
T.K. Deb, Project Director, Health

Government of Karnataka, Department of Health and Family Welfare
G.Y. Nagaraj, District Reproductive and Child Health Officer
Jayachandra T., Medical Officer, Sugganahalli Primary Health Center
V.S. Patil Kulkarni, Health Management Consultant
P.K. Srinivas, District Health and Family Officer
Sushma Godbole, Under Secretary, KHSDP
Dr. Sanaullah, Commissioner of Health Services

Government of Tamil Nadu, Department of Health and Family Welfare
M.V. Ashokbabu, Programme Manager, Private Sector Intervention
K. Mohanraj, Project Director/Member, Tamil Nadu Blindness Control
M. Mutia Kalaivanan, Commissioner for Maternal, Child Health and Welfare
Supriya Sahu, Joint Secretary
P. Padmanabhan, Reproductive and Child Health Project
T.P. Jayanthi, Reproductive and Child Health Project
B.T. Desikachari, Reproductive and Child Health Project
P.C. Devadass, Joint Director, Public Health
Dr. Kalyanasundaram, Director
Mr. Krishnamurthy, Statistical Officer

AIDS Prevention and Control Project, Voluntary Health Services (APAC–VHS)
M.V. Ashokbabu, Programme Manager
P. Krishnamurthy, Project Director

APPENDIX C

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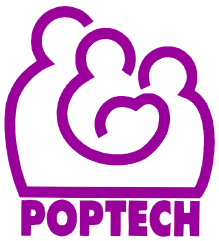

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1101 Vermont Ave., NW Suite 900 Washington, DC 20005 Phone: (202) 898-9040 Fax: (202) 898-9057 www.poptechproject.com