Public-Private Partnerships in Maternal Health Services

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In recent years public-private partnerships have been offered as the miracle-cure that would help fix all the challenges to the health sector. Over the last decade, a number of PPPs providing maternal health services have come into existence but few have been evaluated. This paper examines whether PPPs with the for-profit private sector which provide maternal health services have contributed or are likely to contribute to making quality maternal health services accessible at affordable prices to the poor and marginalised sections of the population, as envisaged by policymakers. The limited evidence indicates that they have not increased either availability or physical access to services for a vast majority of women living in rural areas. The investment of substantial government and donor resources in PPPs without robust evidence on their contribution to reduction of maternal mortality does not appear justified.

1 Introduction

Public-private partnerships (PPPs) have in recent years been offered as the miracle-cure that would help fix all the problems affecting the health sector. The National Rural Health Mission (NRHM), launched in 2005, mentions the promotion of PPPs in health as being among its supplementary strategies. A Task Force on PPPs set up to advise the government recommended that this is a useful strategy for meeting the massive requirement for resources, manpower and management capacity under the NRHM. The report emphasised that the purpose of PPPs should be to contribute to the goal of providing basic healthcare to all citizens of India, and that super-speciality services were therefore not to be considered under PPPs. Regulation of the private sector and putting in place quality-control and accountability mechanisms were also highlighted by the report (NRHM 2009).

Despite these policy pronouncements, some state governments have proceeded to enter into partnerships for tertiary and specialised care. For example the Andhra Pradesh government has entered into agreements with B Braun, a private health company from Germany to set up 11 dialysis centres in teaching hospitals and tertiary care centres across the state (CHMI 2011). Similarly the Gujarat government has entered into partnerships with international healthcare companies such as Wockhardt and Fortis and local private hospitals for the provision of super-specialty services (Singh nd). Further, actors other than the government who have been active in the promotion of PPPs in health do not necessarily share the government’s perspective on the role of PPPs in health services. This is true of PPPs promoted as an explicit objective under the Health Systems Development Projects supported by the World Bank and numerous private provider networks and social franchises in reproductive health promoted with United States Agency for International Development (USAID) funding (Ravindran 2011).

The past decade has witnessed the emergence and proliferation of PPPs in maternal health and family planning services in a number of states. A recent exercise at mapping these showed that state governments are public-partners in PPPs for maternal health services with for-profit private sector providers in seven states: Assam, Delhi, Gujarat, Haryana, Madhya Pradesh, Uttar Pradesh and West Bengal. In most states, the state government is involved in contracting-out to private for-profit providers but in Haryana, the government has initiated a voucher scheme which women from low-income groups can use in private facilities for accessing a package of maternal health services. There are 10 public-private...
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interactions (PPPs) that do not involve the federal or state governments located in 16 sites in India, spread over five states: Uttar Pradesh (7), Uttarakhand (3), Jharkhand (3), Bihar (2) and Assam (1) (Ravindran 2011).

This paper attempts to examine whether PPPs providing maternal health services have contributed/are likely to contribute to making quality maternal health services accessible at affordable prices to the poor and marginalised sections of the population, as envisaged by policymakers. For this, I have used the limited number of evaluations and assessments available for a subset of PPPs engaged in maternal health service provision in India.

This introductory section defines the concepts used and presents information on policy positions on PPPs in India. Sections 2 to 4 present examples of different modes of PPPs in maternal health in India, and evidence on their performance. The concluding section discusses the implications of PPPs for equitable access to quality maternal health and family planning services.

Concepts and Definitions

There are numerous definitions of “public-private partnerships” because of the many different ways in which each of its component terms: “public”; “private” and “partnership” is used by different authors.

“Public” is usually defined as all sectors of the government at different levels, but other definitions include inter-governmental agencies such as the World Health Organisation (WHO) and the United Nations Children’s Fund (UNICEF) and bilateral donors as well as private foundations who provide major funding support to countries to develop public services. Some protagonists of “public-public” partnerships have argued for including within the “public” category community organisations, other non-governmental organisations (NGOs) and trade unions that function in the interest of public Welfare and do not have a profit motive (Kitchen 2003; Hall et al 2005).

The private sector in health has been defined by Mills et al (2002) to include all providers who exist outside the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat or prevent disease. According to this definition, the private sector includes large and small commercial companies, groups of professionals, such as doctors, national and international NGOs, and individual providers and shopkeepers.

PPP appears to stand for “a continuum of loose to tight arrangements” (Njau et al 2009) between actors in the public and private sectors towards achieving a specific objective. PPPs maybe arrangements between multiple partners or between just two; they maybe global, national, sub-national or local in scope; maybe traditional arrangements between the public and private sector such as contracting-in or contracting-out, or new entities that includes representatives from the public and private sectors, however each of these sectors maybe defined.

Some authors, for example WHO and Richter (2003) have chosen to use the term “public-private interactions” rather than PPPS (WHO 2001; Richter 2003). The choice of the term “interaction” is deliberate, and is meant to emphasise that most of the public-private arrangements are not in fact partnerships at all, in that there is neither equality in relationship nor reciprocity in obligations.

Although in agreement with WHO and Richter’s critique of the term “partnership” I use the term PPP in this paper because of its widespread use in the field. The paper focuses on the for-profit private sector whose aims are commercial, and non-profit and philanthropic organisations are excluded from the discussion. Henceforth, private sector in this paper would mean the for-profit private sector. The following are some common forms of PPPs (or interactions) involved in maternal health services in India:

- Contracts
- Voucher-Schemes
- Private-provider networks and social franchises

Governments often enter into “contracts” with private parties for acquiring a specific product or service of a defined quantity and quality at an agreed-upon price. Contracting implies an ongoing (as opposed to a one-off) relationship between two parties based on a legally binding agreement or contract (Harding and Preker 2003).

Voucher schemes involve the distribution of vouchers to a specific group of beneficiaries for availing a specific package of health services free or at subsidised costs from a panel of accredited health facilities. Providers collect the vouchers and provide the intended services, and claim reimbursement from a voucher management agency who in turn receives funding from the government, a bilateral or multilateral donor, a private foundation or a combination of these.

Voucher schemes are a form of “demand – side-financing”. They provide low-income groups with purchasing power to choose from among a panel of service providers. There is scope for quality assurance by contracting with facilities which meet minimum standards. Impanelled providers have to compete with each other to attract voucher-holding clientele and this is also expected to encourage providers to ensure acceptable quality standards. The strategy is meant to be efficient because it allows for targeting a specific population before services are sought rather than at the point of service delivery (Meyer et al 2011).

A social franchise in health is a network of private health providers who own and operate their own health facilities; provide a set of standardised “franchised” health services (and may also provide other non-franchised services and products); offer clinical services with or without franchise-brand commodities; and receive payments on the basis of services provided, although the mechanism of payment may vary and include client out-of-pocket, voucher, third party insurance or other systems (UCSF Global Health Sciences 2011).

Subsequent sections examine different types of PPPs currently engaged in the provision of maternal health and family planning services in India.

2 Contracting

In India, the most common form of contracting in the area of maternal health is contracting out to for-profit providers and facilities.

Chiranjeevi Yojana – Gujarat

One of the best known and widely acclaimed examples of contracting-out to for-profit private sector providers in health is the Chiranjeevi Yojana in Gujarat. The scheme was initiated in December 2005 with five under-served tribal districts with the
aim of reducing maternal and infant mortality and increasing institutional deliveries. The scheme was subsequently extended throughout the state.

Chiranjeevi Yojana is an arrangement between the department of health and family welfare, Government of Gujarat and obstetrician/gynaecologists based in private clinics, nursing homes and/or private hospitals (Venkataraman and Bjorkman 2009). Payment to providers was fixed at Rs 1,79,500 for 100 deliveries, factoring in a certain proportion of normal and c-section deliveries and other related costs. Providers are given an advance payment of Rs 1,50,000 and reimbursed the additional expenses incurred (Barai-Jaitley 2010).

The scheme provides free pregnancy and delivery related care to women from households living below the poverty line (BPL). To be eligible, a woman should produce her BPL card or a certificate from a village official stating that she is from a BPL household. She is also required to register for antenatal care in a government hospital (ibid).

Private providers in the scheme conduct normal as well as complicated deliveries, and are provided medication for a pre-determined fee. Pregnant women are reimbursed for conveyance costs incurred and the accompanying health worker is given an honorarium (ibid).

One of the earliest evaluations of the scheme was carried out in 2007, and covered one of the five pilot districts. This study focused on the socio-economic profile of beneficiaries and the extent to which the Chiranjeevi Scheme had provided financial protection to the poor. The study found that the vast majority (94%) of beneficiaries belonged to households with an annual income of less than Rs 12,000, or a daily income of less than Rs 32.90, and the scheme achieved its objective of targeting the poor. The costs incurred by each beneficiary was Rs 727 as against Rs 4,000 incurred by non-beneficiaries of the scheme, thereby saving Rs 3,273, a major amount for families with BPL income. There were also limitations. A significant proportion – about 20% – of deliveries to women from BPL households were not covered by the scheme and they spent on an average Rs 4,000. Beneficiaries had to pay out-of-pocket for additional drugs and for some part of the transportation. Moreover, only 30% of beneficiaries received post-partum care (Bhat et al 2009).

A subsequent article based on interviews with a small number of providers in Surat district reported that impanelled private providers were situated in urban areas, implying that access to delivery care for rural women may not have improved significantly because of the scheme. Further, most private providers under the scheme took only “safe” cases and sent those in need of emergency obstetric care (EMOC) to public hospitals. The article seriously questioned the claim that the scheme could, under these circumstances, have made any substantial impact on maternal mortality ratios given that obstetric emergencies contribute most to maternal deaths (Acharya and McNamie 2009).

A qualitative study from the predominantly tribal Sabarkantha district found that 75% of the 32 women interviewed did not know about the Chiranjeevi Scheme. Those of them who knew about it said that the scheme’s private providers were located very faraway and that they could not afford to pay for the transportation. The providers interviewed said that they referred obstetric patients to the government facility when blood transfusion was required including in instances of severe anaemia in women (Kastia and Bish 2009).

The 2010-11 annual report of the Comptroller and Auditor General (CAG) of India stated that the five-year-old Chiranjeevi Scheme, launched by the Government of Gujarat had failed to reduce maternal mortality ratio from 389 per 1,00,000 live births to 100 per 1,00,000 live births as set out in its objectives. According to the CAG report, in 40% of the talukas (93 out of 231), no private doctors had opted for the scheme. In six tribal-dominated districts Dahod, Banaskantha, Panchamals, Vadodara, Sabarkantha and Kutch, a fund of Rs 27,93 crores for the scheme remained unutilised, probably because of the non-availability of eligible providers and/or facilities (Indian Express, 31 March 2011).

Mamta Friendly Hospital Initiative – Delhi

Delhi’s equivalent of the Chiranjeevi Yojana is the Mamta Friendly Hospital Initiative. This is a scheme meant to provide free delivery and EMOC for pregnant women from urban slums in Delhi. Nursing homes registered under the Delhi Nursing Home Registration Act were eligible to apply for the scheme. By 2008, memoranda of understanding (MOUs) had been entered into with 36 Mamta Friendly Hospitals (NIFPH 2010).

An evaluation was carried out in 2009 covering 35 Mamta Friendly Hospitals, and also interviewing beneficiaries and non-beneficiaries. The evaluation found that private providers registered with the scheme found it unattractive and two-thirds of them were planning to discontinue. The main reason stated by private providers was that the remuneration was lower than the prevailing market prices, and in some instances – e.g., for c-section, lower than the actual costs incurred. They also found the reimbursement process cumbersome and paperwork heavy (ibid).

Beneficiaries reported having to pay extra for many services. For example, they had to pay for the ultrasonography carried out during pregnancy. About seven of 10 beneficiaries had incurred an average expense of Rs 750 per delivery. Complications in delivery and post-partum and neonatal complications were referred from the Mamta Friendly Hospitals to government health facilities, and patients had to pay out-of-pocket for referral transport. No postnatal care was provided by the Mamta Friendly Hospitals (ibid).

Of the non-beneficiaries interviewed, 59% were unaware of the scheme. The others had been unable to use the scheme because they could not produce evidence of their BPL status or provide documented proof of residence in Delhi; yet others were located too far from a Mamta Friendly Hospital to be able to access it (ibid).

Janani Sahyogi Yojana – Madhya Pradesh

The Janani Sahyogi Yojana in Madhya Pradesh contracted out services to private for-profit and also to not-for-profit health facilities. The aim was to provide maternal and child healthcare including delivery services and EMOC for BPL households. The scheme was implemented in 2006. The intention was to cover the underserved rural populations (NIFPH 2008).

However, an evaluation carried out in six districts of the state in 2007-08 found that 91% of the 83 providers registered under the scheme were located in urban areas, and only 9% were located in rural areas. Half of all private health institutions under the scheme did not have blood availability, critical for saving the lives of women in an obstetric emergency. In 15% of the facilities
there were not enough reagents to carry out pathological tests during pregnancy and 28% of facilities did not routinely provide immunisation for pregnant women or infants. Forty-six per cent of the facilities charged patients for some of the services. A large proportion (60%) of heads of health facilities were not satisfied with the remuneration package offered by the government and wished for substantial increases; e.g., an increase from Rs 1,200 to Rs 2,000 for normal deliveries and from Rs 5,500 to Rs 8,000 for c-sections. More than half (59%) of the beneficiaries were from non-BPL households. High c-section rates were found: 24% among BPL and 46% among non-BPL women (ibid).

3 Voucher Schemes

Voucher schemes for maternal health have been implemented in partnership with the for-profit private sector in three states: Haryana, Uttarakhand and Uttar Pradesh.

A voucher scheme for maternal healthcare funded by USAID and the World Bank was implemented in Uttarakhand and Uttar Pradesh since 2007. USAID supported voucher schemes in seven rural blocks of Agra, 35 urban slums of Kanpur and two rural blocks of Haridwar while the World Bank supported the voucher scheme in two rural blocks of Bahraich (SIFPSA 2011).

The voucher schemes in both states had a number of common features. The recipient of a voucher was eligible to have three antenatal visits (check-up, tetanus toxoid immunisation, iron and folic acid tablets and nutritional counselling) with an accredited health facility; institutional deliveries (normal and c-section); two post-natal visits and family planning services including sterilisation; child immunisation; reproductive tract infection (rtti)/sexually transmitted infection (stt) check-up and treatment, partner counselling and diagnostics. However, EMOC is not included and women are referred to the district hospital (ibid).

The schemes have as front line workers the Accredited Social Health Activists (ASHAs) of the government in rural areas, and community health volunteers of NGOs in urban areas. Their responsibilities include dissemination of information on vouchers, distribution of vouchers to eligible women, accompanying women to private hospitals, arranging for transportation for doing so, etc. NGOs were appointed to be the interface with the community. They train ASHAs and community health volunteers, verify the receipt and use of vouchers by women and are also responsible for monitoring and evaluating the scheme (ibid).

Private hospitals are accredited by a voucher management committee (VMC) headed by the district magistrate or the chief medical officer (CMO). In Agra, the government medical college hospital does the accreditation of private hospitals. Other players involved in the scheme are State Innovations in Family Planning Service Agency (SIFPSA) and the Futures Constella (USA) group – the latter plays a major technical support role to VMCs. The VMCs have to train the private sector providers, devise a system of financial disbursement, set up a management information system (MIS) and carry out project audit and beneficiary feedback (ibid).

The Agra-Voucher Scheme: Started in 2007, it lasted for 24 months. In the first year, 10 nursing homes were accredited in Agra. From 15 March-31 July 2007, 2,857 women used vouchers for antenatal services but only 351 institutional deliveries were recorded. Of 3,51,154 deliveries 44% were c-sections. An early assessment in 2007 (USAID 2007) found that emergency care, post-partum care and neonatal care were not being covered by private hospitals and that quality assurance varied considerably across different hospitals (NRHM 2005; USAID 2007).

Another assessment (2009) reported that only 15 of 100 private clinics had accredited themselves under the scheme by the end of the project period. There had been an increase of 0.5% in contraceptive prevalence among "eligible couples" within the first 15 months of implementation. Three major problems that impeded successful implementation were:

- The number of accredited providers was small and almost all were located in Agra city. This limited the increase in access for rural women.
- Private providers did not find remuneration adequate for some of the procedures and they routinely referred the women to government health facilities.
- The ASHA was not given any incentive for family planning services and she therefore de-prioritised family planning services and focused exclusively on promoting pregnancy and delivery care (URHI 2009).

The Kanpur Voucher Scheme: It was started a year after the Agra Scheme, in November 2008 and lasted for 24 months. Only 13 of 75 private nursing homes were accredited under the voucher scheme. The programme targeted the urban poor. Taking lessons from the Agra Scheme, the remuneration for complicated deliveries was increased and a corpus fund was created to pay for some services. However, this scheme also showed poor performance. At the end of the project period, contraceptive prevalence among eligible couples had increased marginally by 0.4% and better access to delivery care was reported (ibid).

Janani Suvridha Yojana: This is a state-initiated voucher scheme by the Haryana government started in 2006. Under this scheme, vouchers are distributed to pregnant women and mothers with children and infants who can use it to seek services from private providers impanelled in the scheme. Private providers then redeem the vouchers from the government who compensate them. The Department of Health Services also provided drugs and vaccines free of cost to private health providers (NRHM).

Rather than a straightforward contract between the Government of Haryana and the private providers, this was a more complex partnership which involved also the mother NGOs (MNGOs) and field NGOs (FNGOs) under the reproductive child health (RCH) scheme. The scheme was to cover urban slums in eight districts. The MNGOs and FNGOs were to do community sensitisation, voucher distribution and ensuring redemption of vouchers to the private providers. The FNGOs were to engage sakhis who would escort women and children to the private health facility. An early report up to March 2007 showed that the scheme covered only about 13% of all deliveries and that the performance was particularly poor in the districts of Sonipat, Gurgaon and Narnaul (http://www.esocialsciences.com/data/.../Document12072007230.7838556.pdf). As of January 2008, 666
sakhis had been recruited, 28,507 pregnancies registered, and 118 private providers were empanelled (nrhm). No further report of performance could be found.

4 Private Provider Networks and Social Franchises

Private provider networks and social franchises offering maternal and family planning services are found predominantly in Bihar, Jharkhand, Uttar Pradesh and Uttarakhand. Uttar Pradesh seems to have the highest concentration of social franchises in health.

Janani

One of the earliest social franchises in India is the Janani, set up by the US based ngo, DKT, in 1995 with financial support from USAID. The franchise is now operational in Bihar and Jharkhand. 

According to an early report (2002), Janani consisted of a two-tiered system with Surya clinics in towns linked to rural medical practitioners (rmps) at the village level. The rmps were selected by the organisation, and were required to have literate wives. The rmps and their wives received training in primary care for reproductive and sexual health. The women were trained to diagnose reproductive tract infections using the WHO protocol for syndromic management. This network of rmps provided basic primary care and rti diagnosis and treatment using the protocol for syndromic management, and distributed condoms and oral contraceptive pills. They referred patients to the Surya clinics for intrauterine device (iud) insertion, abortion and voluntary sterilisation, for which they received a referral fee (Gopalakrishnan et al 2002).

Recent reports state that each Surya clinic has at least one doctor with a minimum qualification of mbbs, one Auxiliary Nurse and Midwife and an anaesthetist on call. It provides oral contraceptives, condoms, injectables, T Copper, emergency contraceptive pills, sterilisation and abortion, both medical and surgical (Montagu et al 2009).

The Janani franchise also markets its own brand of contraceptives through the Surya clinics and Titli centres. Their products include Mithun and Style condoms, Apsara oral contraceptive pills, Urvashi multi-load iu ds, Pari three-monthly injectable contraceptive, Postpil, emergency contraceptive pill and safe-t-kit medical abortion pills (Janani 2011a).

Reports published in 2003 indicate that the franchise was facing a number of problems. The volume of clients for family planning and abortion services was not large enough to retain the interest of franchisees. The franchise began to explore the possibility of adding on new services in order to make franchise membership worthwhile for private providers (Janani 2003).

Several changes seem to have been made to the Surya clinics network after 2005. Newsletters of Janani published during 2009-10 mention that after the launch of nrhm and the Janani Suraksha Yojana, the Surya clinics stopped providing institutional deliveries and began to focus on family planning and safe abortion services. They now receive government support of Rs 1,500 per sterilisation operation performed, and provide the procedure free of cost to the client. Although clients would get a cash incentive if they underwent sterilisation in a government facility, many clients were happy to get free services in a Surya clinic and were willing to forego the cash incentive (Manthan 2010). Health providers who ran Titli centres were renamed “Surya Health Promoters”, who carried out family planning education and referred clients for services to the Surya clinics. As before, they are paid according to each case that is referred to them (Manthan 2009a). A new category of women service providers were introduced since 2007 in about 4,000 villages of Bihar. Known as “Women Health Outreach Workers” or “wow”, these women were trained by Janani and provided the following services: messages on prenatal, natal and postnatal care; provision of family planning and reproductive health products; prevention of sexually transmitted diseases and HIV/AIDS; pregnancy testing; measurement of blood pressure and body weight; breast examination and examination for reproductive tract infections and stds (Manthan 2009b). According to its website, the network currently consists of 36 of its own clinics, 21 private sector doctors who are fractional franchisees and about 9,000 Surya Health Promoters (Janani 2011b).

Data on performance of Surya clinics is available from a study conducted sometime in 2001-02 by Janani. We were unable to locate more recent studies. The 2001-02 study was a cluster evaluation which compared the Surya clinics with public facilities and other private facilities. The study found that these clinics catered to relatively better-off and literate clients and to women from the “higher” castes. The proportion of sc/st clients in Surya clinics was 12.6%, as compared to 17.7% in non-franchised private provider clinics and 25.2% in public facilities. The average monthly family income of a Surya clinic client was Rs 3,156 as compared to Rs 3,046 of those attending non-franchised private clinics and Rs 2,380 of those attending public health facilities. According to the same study, the waiting time in Surya clinics (43.2 minutes) compared poorly with that in non-franchised private clinics (25.8 minutes) and government facilities (15.1 minutes). The quality of contraceptive counselling in Surya clinics – in terms of discussion of side effects and offering space for the client to ask questions – was no better than that in non-franchised private clinics or government health facilities (ibid).

The Merrygold Network

In Uttar Pradesh, the Hindustan Latex Family Planning Promotion Trust (hlfppt) together with sifpsa launched a social franchising network in 2007 called the Merrygold. This network consists of four tiers.

At the village level are the “Tarang” partners who are rmps and the Merry Tarang partners who are practitioners of Indian systems of medicine, chemists and the ashas. They provide counselling for family planning, and are mainly engaged in social marketing of a range of products: condoms, oral contraceptives pills, sanitary napkins, test kits for pregnancy and malaria (urhi).

At the next level are the Merrysilver clinics which have one or two beds and offer immunisation, antenatal and postnatal care, conduct normal deliveries and antiretroviral therapy (arv). All those who require emoc are referred to the next level of Merrygold hospitals (ibid).

The third-tier – Merrygold hospitals have 20 beds, and offer diagnostics and laboratory tests, a round-the-clock pharmacy,
conduct normal and complicated deliveries and run well-baby clinics. They also have ambulances to transport referral patients from Merrysilver clinics to their facility.

The fourth tier consists of two tertiary care hospitals one in Agra and one in Kanpur, called Life Spring hospitals. All the facilities in this franchise charge fees but these are 50-60% below the market prices (ibid).

According to 2011 reports, the network covers 35 out of 70 districts in up, has 64 Merrygold hospitals, 367 Merrysilver clinics and 10,880 Tarang and Merry Tarang members in 36 districts of up. Since its launch, this network is reported to have provided safe delivery services to 84,489 women, antenatal care to 4,63,714, IUCD services to 23,370 women and sterilisation to more than 5,993 women (Press Trust News 2011).

A Masters’ dissertation published in 2010 provides some information on the performance of the Merrygold network. This research report states that almost all the clinics in Lucknow block, where the study was conducted, were located in urban or semi-urban areas. Franchisees of Merrysilver clinics from Lucknow were dissatisfied with the franchising arrangements. Franchise membership had not brought them new patients; the advertising of the brand was not adequate. Community health promoters who were supposed to refer clients/patients to them were hardly referring any client, and demanded incentives for each and every task. Quantitative data collected on clients indicated that 70% of the sc/st clients and clients from low-income households in the sample used public sector facilities and only 30% used Merrysilver clinics. In contrast, 60% of non-sc/st women and 75% of women from higher income groups in the sample used the franchised clinics. In other words, the franchise catered predominantly to better-off sections of the population. According to the manager of one of the franchised clinics, the poor could simply not afford their services. At the same time, users of public sector facilities were more likely to report that they were not satisfied with the quality of services (Blanco 2010).

**Drishtee Maternal Healthcare**

Drishtee Maternal Healthcare is a social franchise of informal providers operational in Assam, Bihar and Uttar Pradesh. Women are trained to be “health entreprenuers” called Drishtee Health Franchisees (DHF) who run Drishtee Health Kiosks. They provide maternal health services for a nominal fee. The network is reported to be operational in areas where government health facilities do not exist, in order to avoid duplication of efforts. DHFs are trained in basic maternal care, and to provide non-invasive diagnostic and pathological tests such as determining blood pressure; estimating glucose levels and reading body temperature (Changemakers 2011).

The Drishtee Health Kiosk is equipped with a digital thermometer, blood pressure monitor, digital blood glucose monitor, weighing scales, pregnancy test strips, etc. The amount to set-up such a kiosk is financed by Drishtee and is repaid by the DHF in the form of easy monthly instalments. Ten DHFs are linked to one ANM and also to an obstetrician/gynaecologist. The ANM visits a Drishtee Health Kiosk once a week, and the gynaecologist visits once a month. At other times they are available to the DHFs for consultations over the phone. The pregnant women are charged a small user fee for the registration. The ANM, the gynaecologist, Drishtee and the franchisees share the revenue generated by the registration of the pregnant women (ibid).

The DHF registers all pregnant women in her target area. She holds community meetings advocating for greater priority to maternal healthcare and educated pregnant women about self-care, and birth preparedness and complication-readiness. She holds once a week antenatal clinics in her DHK with the support of the ANM, and once a month check-ups with the specialist to screen for complications. The DHF also ensures that the pregnant woman is prepared for institutional delivery and makes post-natal visits (ibid).

This project is highly acclaimed as an innovation in maternal healthcare and received the Asoka Prize for social innovations. It was started in the state of Assam and has now expanded to Bihar and Uttar Pradesh. No reports assessing the performance of Drishtee were available to us.

**The Saadhan Network**

The Saadhan Network of the Population Services International launched in 2004, works in the urban slums of Uttarakhand. The network consists of 1,000 clinics run by obstetrician/gynaecologists and general physicians and offers condoms, T Copper, Injectables and medical abortion services. A team of community health workers make house-to-house visits, counsel and refer women to network doctors. Most of the doctors are also members of the Federation of Obstetric and Gynaecological Societies of India (fogsi). The partnership with fogsi is reported to be enhancing the visibility of the programme, thus encouraging doctors to join the network and has helped to increase the standards of quality related to IUD and medical abortion services (psi 2005; Saadhan 2010).

An evaluation carried out in 2005, 16 months into the programme, reported an increase in the use of Saadhan’s branded oral contraceptive pills from 38% to 41%, and its clean delivery kits from 18% to 28%. Tetanus toxoid coverage among pregnant women increased from 84% to 89% and coverage of pregnant women with Saadhan’s brand of iron and folic acid tablets increased from 61% to 72% (psi 2005).

From the outcome indicators measured in the evaluation, it appears that the Saadhan network is a mechanism for promoting and marketing psp-One’s contraceptive brands, clean delivery kits, iron and folic acid tablets and other health products. There is no mention of any health outcomes, and success has been evaluated in terms of successful marketing and sales.

**Sky Care Network**

Yet another social franchise in Uttar Pradesh is the Sky Care Project operating in Meerut, Muzaffarnagar and Bijnore districts of up. The project was launched by World Health Partners (whp) in late 2008.

This is a complex, many layered network consisting of rural health providers or rmps, telemedicine centres, franchised clinics, pharmacies, diagnostic laboratories and a central medical facility.
unit. Figure 1 summarises the structure of this network (World Health Partners 2010).

The local informal providers or RMPs who already live in each village are the first tier in the network. They receive training in delivering basic diagnostic services and also serve as social marketing agents for non-clinical contraceptives and over-the-counter products. They also act as agents of WHP and refer patients to for advanced treatment to other tiers in the network (ibid).

The second tier consists of Sky health centres which are telemedicine centres. Its field staff approach families to run these telemedicine centres. The centres are usually run by a woman entrepreneur in close partnership with a male member of the family. The women are high school educated with good standing in the community. They provide space, attend trainings, maintain and promote the telemedicine centres and invest about Rs 1.5 lakh. WHP provides computer, satellite equipment, generator, furniture, promotional materials, technical support and training (ibid).

The entrepreneur records patient-information, operates diagnostic equipment and this is communicated to the physicians in the central medical facility. The physician in the central medical facility reviews electronic medical history, “examines” patients, electronically records notes and prescribes medication. The software incorporates diagnosis/treatment algorithms. When necessary, the physician refers the patient to a franchisee clinic for follow-up (ibid; Lo 2008).

The central medical facility houses a panel of experienced, accredited physicians who consult with clients in Sky Health Centres located in the villages of the WHP network. These doctors, many of them specialists, provide long-distance medical consultations to patients via the internet (ibid).

Clients who require surgical or inpatient care involving specialised procedures and healthcare services that cannot be delivered via telemedicine are referred to the nearest franchisee clinic. Clinic doctors receive ongoing professional training and delivered electronically to doctors at the central medical facility. Sky Care is also linked to rural shops, most of them pharmacies, to ensure patients’ access to medicines and products. Sky Care Providers, Sky Health Centres, and franchisee clinics also have stocks of medicines and contraceptives, including condoms and birth control pills (ibid).

The fee for each consultation in the telemedicine centre is Rs 50. Of this, Rs 10 goes to the RMP who refers the patient to the telemedicine clinic, while Rs 20 is shared between WHP and the entrepreneur (1:0).

Many would consider the Sky network a welcome intervention that brings consultation with qualified doctors within reach of rural women and men. This may be the case, and an evaluation of the proportion of cases successfully treated/problems resolved would be important to understand the scope and potential of such interventions.

A student intern who visited this project reports that villagers wanted the telemedicine centres to also provide drugs and diagnostic services. He also raises some important concerns. One is about the pricing of services. The RMP in the village charges only Rs 20 per consultation and also gives medicines. Why then would a patient be willing to pay Rs 50 only to be given a prescription for drugs or diagnostic tests? The other concerns relate to the ethics of providing care through a standardised syndromic diagnosis and treatment procedures (ibid). We share the same concerns. The first point of contact at the telemedicine centre is an entrepreneur with no training in health, and she will therefore not be able to provide any immediate relief to the patient. Worse still, she may miss signs of distress and danger and contribute to delays in care-seeking,
worsening the prognosis. The use of hi-tech equipment like, for example, the neurosympathetic diagnostic attachments – thermometer, electrocardiography (EKG), stethoscope – may give the illusion of high quality care without actually being so.

5 Conclusions

With one or two exceptions (e.g., the Chiranjeevi Yojana in Gujarat) there are very few independent assessments of the contribution of PPPs to the promotion of maternal health, and health overall. This is especially true of PPPs that do not involve the Government of India or state governments. Further investments in PPPs however, continue unabated, despite the lack of evidence that they work well. This raises some key concerns, based on the evidence presented in this paper.

Private Sector Providers

• Government contracting of private sector providers for providing maternal health services does not have scope for improving access to care for the poor except in instances where affordability alone is the major barrier constraining access. Since most qualified private health providers are located in urban and semi-urban areas, low-income women from such settings may possibly benefit from such arrangements, although we do not have concrete evidence that this has been the case.

For a majority of rural women the major problem is non-availability of services of a qualified professional – public or private – within a reasonable distance, and they are far less likely to benefit from contracting arrangements between the government and urban private sector providers.

• Despite major investments by government to ensure maternal healthcare free of cost to low-income (mostly urban) women through private providers and facilities, users are often required to pay out-of-pocket for many services. This would discourage the very poor from using the services. There are other barriers. Some – most probably from the most marginalised groups – find it difficult to produce documentary evidence of their BPL status or proof of residence. Further, many of those eligible to benefit from the schemes are not aware of their existence.

• A significant proportion of private facilities does not have blood storage or blood banking facilities and refer patients with obstetric emergencies to government hospitals. This leads us to question the claim that contracting with private providers would help reduce maternal mortality.

• The government does not seem to be in a position to monitor quality of care. The report of the high number of c-sections under some schemes causes serious concern about the quality of maternal healthcare provided by contracted partners.

• In a scenario where there are few regulations governing private sector health facilities, the government is often in a weak bargaining position vis-à-vis the private sector. Private providers demand payment at market rates and threaten to withdraw from the schemes if the arrangement is not lucrative enough.

Voucher Schemes

• Voucher schemes are a form of demand-side financing, suitable for contexts where there are a variety of providers that users can choose from, and where affordability is the main barrier to access. For those who have no maternal health service facilities available within easy access, vouchers make no difference.

• Some of the voucher schemes examined in this paper did not include EmOC in its services package, and therefore, are likely to contribute little to the reduction of maternal mortality. The impact on contraceptive prevalence was observed to be marginal. On the other hand, in one of the schemes the c-section rate was as high as 44%, indicative of unnecessary medical procedures.

• Voucher schemes are difficult to administer. Users are often told that some components of services are not covered by the voucher and have no recourse to help to ascertain if this is true.

• In the voucher schemes implemented thus far, willingness of private providers to seek accreditation has been a major challenge. Private providers are usually located in urban or semi-urban areas where government services are also available, and it does not make business sense to them to be competing with the government’s heavily subsidised or free services, and especially when users receive incentives as in the case of the Janani Suraksha Yojana.

Private Provider Networks and Social Franchises

• These pose some of the same problems as the other two types of PPPs: these are also concentrated mainly in urban areas, and do not increase availability for those located in rural and far-to-reach areas.

• Unlike the other two forms of PPPs, social franchises charge for services provided. Evidence thus far clearly shows that they cater mainly to the economically better-off and non-SC/ST caste groups, and that low-income women find socially franchised facilities unaffordable.

• There are no mechanisms in place to ensure the technical quality of care in socially franchised clinics. There is reason to be concerned especially about outlets run and services provided by unqualified providers who are an integral part of many social franchises described above. Experiences from other countries indicate that the quality of services in some franchised facilities could be far from satisfactory (Ravindran 2010).

In addition, there are three overarching concerns. One is that there appears to be considerable duplication of efforts in many places. This is especially so in terms of deploying community health volunteers and “women entrepreneurs” as part of social franchises to render the same services that public-sector employed ASHAs currently provide. In some instances (e.g., Merrysilver clinics, Sky clinics) a new cadre of volunteers is not employed but government employed personnel are also employed by the private social franchises. For example ASHAs are expected to refer women for antenatal care and delivery to Merrysilver clinics and to government institutions; ANMs are counted as service providers in the Drishtee network and Sky clinics. Under the circumstances, it becomes unclear whether the performance indicators quoted by social franchises indeed represent their own contribution or include the work done by government health personnel.
The second important concern relates to the wisdom of heavy investment by government and donors in strengthening already existing private for-profit providers and facilities as compared to creating more service-delivery points closer to where the majority of women reside. Given that most private facilities refer women requiring EMOC to government facilities, would not the money invested in private providers be better spent in equipping government facilities to provide better quality and timely EMOC? Also, it is important to question whether the government can afford to invest increasing amounts in payments to private providers without any guarantees that this would contribute to improving access to care for the poorest.

The third concern relates to the accountability of private-provider network and social franchises which are completely private initiatives funded by international donors. They appear to be proliferating in a few states even before there is any evidence to show that they are a good investment. It is not clear who the projects are accountable to and there is nothing to inform the concerned citizen about their impact except what the organisations themselves choose to report. The need for a comprehensive assessment of these initiatives cannot be overemphasised.

NOTES
1 RMPs are a group of unqualified private health providers, almost all male, used widely by rural low-income groups in many states of India.
2 For example, the World Health Partners were reported to be launching in 2011 in Bihar a large scale replication of their SKY health care network model that has been operational in UP for the past few years.

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