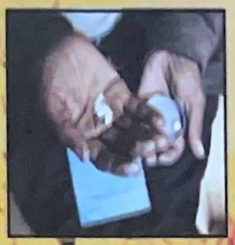
MEDICAL ANTHROPOLOGY

Tradition and Change



Edited by **B.V. SHARMA**

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The Role of State in Public Private Partnerships in Reproductive and Child Health Services

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This chapter focuses on understanding the role of Government in Public Private Partnerships (PPPs) in primary health services. It aims to understand PPPs in the most crucial part of health service delivery—reproductive and child health services which form crucial foundation pillars of a country's socio-economic development. The way actors in a partnership mainly the Government, private sector and NGOs interact with each other, has a bearing on the nature of services delivered and health outcomes for the population. The chapter uses case study method to understand three models or instruments of partnerships operational in primary health sector in Maharashtra. The study compares these PPP models of contracting, joint venture and a multi-stakeholder partnership on criteria like contractual design, leadership, financial management and monitoring all of which has a bearing on the success of the partnership. Findings point out to failures and success of PPPs, their reasons and implications for state to partner with non-state actors in health service delivery.

Introduction

In a striking contract to the Alma Ata Declaration of Health for All in 1978, where the role of state was central in providing healthcare, the idea of Universal Health Coverage (UHC) plan proposed by the

Government of India for the Twelfth Five Year Plan, is seen as retreating of the State's role to mere purchaser and manager of services while handing over the actual service delivery to the private sector (Dhar, 2012).

One of the strategies to achieve UHC is to "identify pathways for constructive participation of communities and the private-for-profit and not-for-profit sectors in the delivery of health care" as per the High Level Expert Group (HLEG) recommendations for the Twelfth Five Year Plan (The Planning Commission, 2011). PPPs in health forms an important recommendation of health systems development worldwide. In India too, PPPs in Health[1] are being considered as one of the key governance strategies for medical and health care delivery. Government of India and many State Governments have ventured out and experimented with various forms of PPPs over the last decade.

The idea of PPP is not new though. The non-state actors, mainly the NGOs have been collaborating with the State since 1950s mainly in malaria control and family planning programmes. In fact from the First Five Year Plan in 1951-56, the Government of India has entered into various collaborations and partnerships with both—for profit and with non-profit organizations. The question then arises on when, why and how a new terminology of PPPs emerged?

Baru and Nandy (2008) explains, "during the mid 1980s the idea of PPP was introduced into several disease control and reproductive and child health (RCH) programmes that received external funding, mainly from the World Bank which provided the rationale and guidelines for initiating and sustaining partnerships. The design of these partnerships was informed by the new public management (NPM) practices and techniques that emphasized a shift from the traditional administration to public management informed by notions of economic efficiency of markets. Gradually, WHO also endorsed the need for partnership between the state and market for financing, provisioning and research in health services."

Between the period of 2004 and 2006, Government's two apex policy-making agencies, the Planning Commission and the Ministry of Health and Family Welfare (MoHFW) prepared two documents to understand various policy implications of existing PPPs in social and development sector. Such a step was aimed at initiating a policy

framework on the role of private sector in health, something which has not been spelt out explicitly in the Five Year Plan documents. This marked a major shift in the public policy from direct provisioning to indirect provisioning, at least on paper. Both documents recommended re-orienting the role of Centre and State Governments from direct delivery of services to service management and coordination in the wake of Liberlisation, Privatisation and Globalisation (LPG) trends. The Planning Commission's 'Report on PPP Sub-group' included the broad 'social sector' encompassing education, women and child development, culture, health, environment, urban development with emphasis on 'contracting' as the main instrument to enter into PPPs (The Planning Commission, 2004). It did stock-taking and reviewed emerging partnerships across various players in the health sector in India in year 2004. The MoHFW report elaborated extensively on the theme of PPPs in context to its programmes RCH-I and II. Both these reports sourced from Government, especially from Ministry of Health and Family Welfare were more like theoretical review on the concept of PPPs, their strengths, prerequisites and also various typologies or models of PPPs, but these were not illustrated with examples from the field.

At the same time, there was a surge of partnerships for primary health services especially host of RCH programmes like contracting in private doctors for emergency obstetric care, social marketing of contraceptives, institutional services like contracting-out of PHCs and urban healthcare centres. Thus, PPPs were being mainstreamed increasingly so in the primary health, with little evidence in Indian context on which kinds of instruments and arrangements worked and in which settings they did not. Although a concept in itself, PPP is actually a web of intricate relationships and processes between state and other multiple stakeholders making it exigent to evaluate. Analytical studies on PPPs using primary data in the Indian context are very few and hence there are serious gaps both at policy and at programmes in designing and implementing PPPs in health. Not many empirical assessments exist to guide Governments on how to best partner with the private players to achieve public health goals with equity, quality and effectiveness. In is in this context it is crucial to systematically understand recent experiences of state's role in entering into PPPs.

Present Study

In 2008, the author under the aegis of a Mumbai-based think tank called Observer Research Foundation undertook a study to review the PPPs in reproductive and child health services in India. The objective of the study was to identify PPP in primary health services, understand their typology or model and analyze them on institutional assessment criteria as suggested by the existing literature on PPPs. The purpose was to understand role of various stakeholders in the partnerships, their contribution, the conducive environment that led to the partnerships and finally to assess their limitations and advantages. The idea was to understand the determinants of successful PPPs and also factors leading to failures of PPPs to learn lessons and inform public policy on health.

Three cases of PPPs in reproductive and child health were selected after ensuring that there was a written understanding like a contract or a memorandum of understanding (MoU) with clear roles and obligations between the Government actor and the private player. These were—Project Dilaasa of Centre for Enquiry into Health and Allied Themes (CEHAT), a crisis centre in a municipal hospital for women victims of domestic violence; Bhavishya Alliance, a multi-stakeholder partnership for combating child malnutrition, the Mother NGO scheme for child health services under NRHM. In few other cases, a contract was present between the private provider and the Government, but this information was either unavailable or denied sharing, like in case of Federation of Obstratians and Gynaecologists Association of India (FOGSI), Maharashtra State AIDS Control Society (MSACS) and SEARCH, Gadchiroli. Other collaborations did not qualify in the study criteria as they were either corporate social responsibility (CSR) initiatives like L&T Hospital and Hindustan Liver Family Planning Promotion Trust (HLFPPT) or were NGO involvement in Government programmes like Janani Suraksha Yojana and Institute of Health Management Pachod (IHMP). All the three selected PPPs were based in Maharashtra. Maharashtra was purposefully selected as every Indian state has one of the constant contexts for all the case studies. Different states have varying nature of socio-economic and political context which could have interfered while accessing the PPP cases on various institutional factors.

The methodology involved in-depth case study analysis of the partnership. An interview schedule was developed for evaluating the case studies, using the evaluation criteria generated from the review of secondary literature. It constituted questions mainly open-ended in nature, on various aspects of the partnership categorised into four major themes—nature of the PPP; management of partnership; services delivered as per the partnership; and beneficiaries' perspectives about the services. The interview schedule was administered to two or more senior officials of the partnership, the government representative and the private partner.

Case 1: Dilaasa (By CEHAT) at K.B. Bhabha Municipal Hospital, Mumbai

Dilaasa was established as a first hospital-based crisis centre in India for women facing domestic violence in 2001. It is a joint initiative between CEHAT, an NGO working on health related research and advocacy in Mumbai and the Public Health Department of the BMC (Brihanmumbai Municipal Corporation). Dilaasa runs as a department ward in K.G. Bhabha Hospital which is one of 16 peripheral general hospitals of the BMC (Deosthali, *et al.*, 2005).

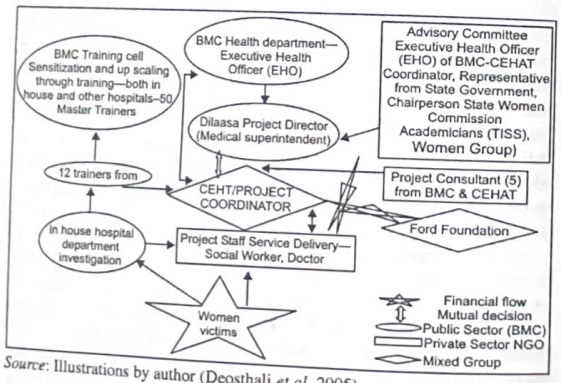
Before Dilaasa, women facing psycho-emotional abuse were completely ignored by the health system. On other hand, NGOs dealing with victims for psycho-social support had no linkages with the health system. Services to victims of domestic violence were hardly visible, *ad hoc*, unorganised and isolated from each other. Reason being that abuse like domestic violence takes place within the 'home' and considered a private matter and not a serious public health issue. There was complete absence of integrated services on physical and psychological post-violence trauma for victims of domestic violence in the public health domain.

Cases coming to Dilaasa are referrals from the outpatient or causality department of the hospital. Services at Dilaasa begin with rapport building session with the counsellor in a protective environment. Then a safety assessment of the women is ascertained whether she can return to her home with no risks of further violence. There is provision for temporary shelters like a 24 hour emergency shelter at the hospital in case of medical observations, injuries or one

Table 7.1: Roles and responsibilities of partners in Dilaasa

The Contract	*Roles*	*Responsibilities*
BMC (Bhabha Hospital, Bandra West)	Medical Superintendent of the Hospital provided leadership to Dilaasa and headed it.	Space—Rooms for counselling, legal aid and training.
	Dilaasa to be established as a department of the hospital—relational and functional space.	Temporary 24 hour Shelter for women victims.
	Dilaasa was completely owned by BMC, run in its name, all correspondence and liaison in its name.	Staff salaries—nurse, social worker, doctor, 12 trainers
	Joint decision making in consultation with CEHAT team.	Medical referral and support from other hospital departments. Provide trained full time staff for the project.
CEHAT	Assisting BMC in setting up and running a crisis centre for women victims of domestic violence.	Technical assistance in setting up the crisis centre.
	Create environment and conditions based on mutual respect and care for women victims aimed at inter-departmental and NGO collaboration.	Sensitization and training of the BMC hospital staff.
	To help BMC integrate the programme as a part of its service and replicate in other hospitals.	Secure funds for the project funds secured from Ford Foundation.

Source: Compiled from (Deosthali *et al.*, 2005).



Source: Illustrations by author (Deosthali *et al.* 2005).

Fig. 7.1: Dilaasa Organisational Structure

night separation on grounds of safety. Many women are encouraged to file non-cognizable complaint or an FIR and given legal counselling. Follow-ups sessions also including joint meetings with the abusive members, were also organised to negotiate the interests of the women (*ibid.*). Since, the centre is based in a peripheral hospital, it caters to the surrounding populations of a Mumbai suburb—Bandra West. Roles and responsibilities of the BMC and CEHAT were delineated in the Memorandum of Understanding (MoU). Table 7.1 describes these roles and contribution of each of the partners.

Dilassa was conceptualized and implemented as a joint project, between equal partners with equal contribution of human resources, leadership and management, both from CEHAT and the hospital. This was its biggest strength. Figure 7.1 shows the structure of Dilaasa project. The leadership to Dilaasa was provided by the medical superintendent of Bhabha Hospital in capacity of Project Director while project coordination and implementation was done by CEHAT. All the decisions regarding the project like policy, programme activities and future direction are taken jointly by representatives of both CEHAT and Bhabha Hospital.

Case 2: Mother NGO Scheme

MNGO scheme was one of the largest Government sponsored programme of contracting private, not-for-profit sector, i.e. NGOs of varying capacities, to deliver maternal and child health services in un-served and under-served areas in the country. Department of Family Welfare, Ministry of Health and Family Welfare had introduced MNGO scheme in the Ninth Five Year Plan (1997-2002) as a strategy to implement its RCH programme. The National Budget Estimate for MNGO scheme during 2006-07 was ₹ 329.10 million which was 0.36 per cent of the budget earmarked for National Rural Health Mission (NRHM) in India (NGO Division, Government of India 2005).

The scheme involved large number of contracts between Government (at Central, State and District levels) and the NGOs of varying sizes and capacities across India. In fact MoUs are also signed between the Central Government and State Governments indicating their commitment to increase contribution to public health budget,

preferably by 10 per cent each year; to increased devolution to Panchayati Raj Institutions and to develop performance benchmarks for release of funds (Ministry of Health and Family Welfare, 2005). The scheme follows almost a vertical structure involving NGOs, from advocacy, training right up to delivering services at PHC or sub-centre level.

Before MNGO scheme, most NGOs were working 'on' Government programmes independently rather than 'with' the Government. For instance, NGOs were contributing in RCH phase I programme limited to community mobilization or running of health centres. However, pinning accountability for the results was not possible and long term sustainability was weak. This had resulted in ineffectiveness of funds with no marked change in development outcomes. It was to address this challenge that GoI engaged NGOs through a formal and structured mechanism through the MNGO scheme.

The scheme innovatively took into account extreme diversification and variations in NGOs by classifying them in a hierarchy based on their size, capacity, nature of activities, credibility, past record etc. into—

- ***Regional Resource Centres***—These are large NGOs at state or national level involved in advocacy, capacity building and providing technical assistance.
- ***Mother NGOs***—They are large state level NGOs that have strong focus on health. Instead of implementing projects, they idenify projects, monitor, evaluate and build capacities of smaller regional NGOs. The role of MNGOs is to fund and mentor the FNGOs, look after their capacity building and training needs.
- ***Field NGOs***—These are smaller NGOs that directly work with the communities on the demand side, baseline surveys, RCH orientation, creation of conducive working environment for ANMs, documentation etc.
- ***Service NGOs***—These are moderate to big sized NGOs working directly with the communities with adequate infrastructure and personnel capacities to provide clinical services (supply side) directly. They are to provide an

integrated package of clinical and non-clinical services directly to the community like safe delivery, neo-natal care, prevention of RTI/STI, treatment of diarrhoea and ARI, adolescent reproductive health, abortion and IUD services.

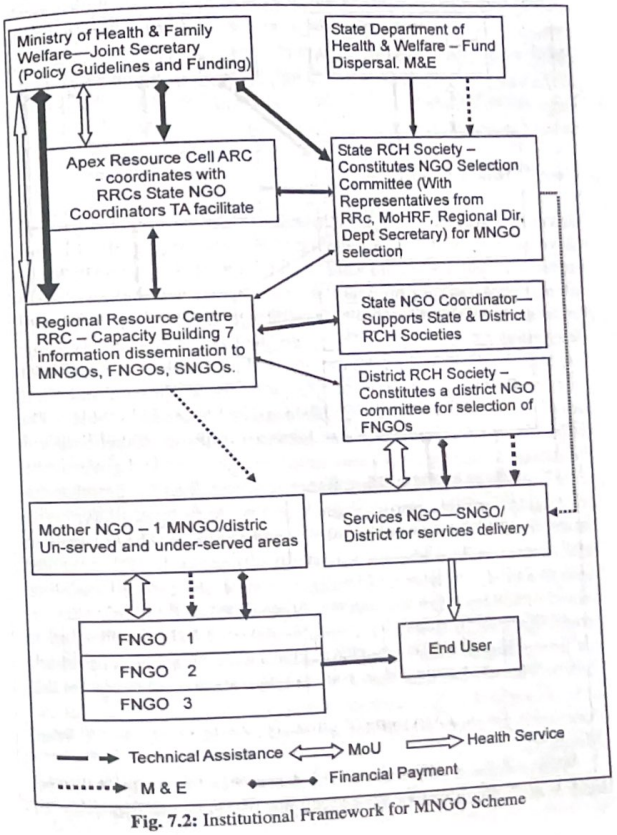


Fig. 7.2: Institutional Framework for MNGO Scheme

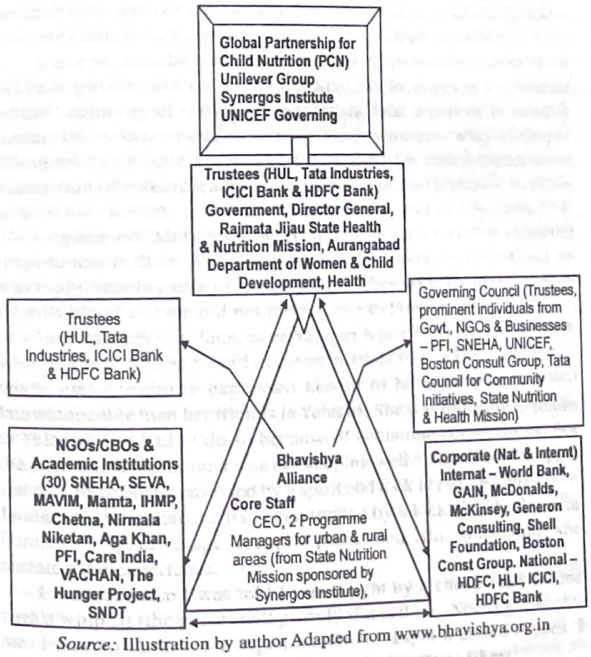
It was assumed that all kinds of NGOs would together complement the Government health delivery system for filling the gaps in RCH service delivery. Roles of participating NGOs are somewhat well defined but there is less clarity and diffusion of roles and responsibilities at various levels of Government from State RCH society, District RCH society, State NGO selection committees etc. (Bhat, *et al.,* 2007). In 2008, the MNGO programme was implemented in the country by 215 MNGOs in 324 districts with 800 FNGOs, 11 Regional Resource Centres (RRC) and 1 Apex Resource Cell (ARC) at the Central level (www.mohfw.nic.in).

Case 3: Bhavishya Alliance

Bhavishya Alliance was a multi-stakeholder partnership between Government, NGOs and corporates for combating child under-nutrition in India. Global Partnership for Child Nutrition (PCN), an international initiative brought together 3 international players to set-up Bhavishya Alliance as a registered non-profit trust in Mumbai (Bhavishya Alliance, 2007). They were the Unilever Group, Synergos Institute and UNICEF. At the first level, the partnership was formed between Bhavishya Alliance and Department of Women and Child Development, Government of Maharashtra through a MoU. The second level of partnerships was between multiple stakeholders in the Alliance, namely corporates, quasi-government and government organisations and NGOs. The alliance was based on the premise that under-nutrition is a complex issue requiring high level of synergies between significant sectors and major stakeholders. The focus of its intervention in Maharashtra was multi-dimensional including key areas like food and water, supporting infrastructure, capacity building, behaviour change and knowledge systems. The alliance began its programmes in 10 blocks of 5 rural districts of Maharashtra and in one urban slum in Mumbai in 2005. These were Thane and Mokhada blocks (Thane), Surgana and Peth blocks (Nashik), Dhargaon and Akkalkua blocks (Nandurbar), Dharni and Chikaldhara blocks (Amravati), Dhanora and Mulchera blocks (Gadchiroli) and L Ward (Mumbai).

With multiple stakeholders in a partnership in Bhavishya Alliance, there was a strong need to define the scope and intensity of

involvement of the various stakeholders. During interviews with the BA representatives, they confirmed that role of each partner in that intervention was clearly spelt out. Each partner brought its own competency areas to contribute. Like infrastructure advocacy to the Government was taken by ICICI and HDFC with Tata Motors and ICDS representative as team members. HLL took behaviour change as their prerogative; core area of capacity building was given to ICICI Ventures and TATAs on the knowledge systems part of it. McDonalds was to fund a daycare programme where all anganwadi centres will



Source: Illustration by author Adapted from www.bhavishya.org.in

Fig. 7.3: The Organisational Chart for Bhavishya Alliance

have crèche facilities and would remain open up to 8 hours in a day. ICDS Commissionerate as Government partner in this initiative would train its entire staff and Nirmala Niketan, an academic institution would provide necessary technical and training inputs. The basic MoU template or generic contents were not shared.

Discussion and Findings

The assessment criteria for evaluation the PPP case studies used for the analysis is adapted and referred from criteria developed by Raman and Björkman (2000) and Bhat *et al.* (2007) in their independent studies. These studies cited determinants like leadership and ownership, contracting design, funding and risk sharing and monitoring as determinants to the success and sustainability of a PPP. Table 7.2 gives a brief comparison of the three cases. Since, Government is a key partner in these PPPs, the same criterion is useful to understand its role in partnering with the private actors for health services. Before discussing these three PPP cases on select criteria, it is imperative to know their current status as of now to know their sustainability and scalability after four years since this study.

Dilaasa services on extending support to women began in April 2005 at Bandra Bhabha Hospital, Mumbai. The contract was for a period of 3 years. Presently the services at Dilaasa are taken over by the municipal hospital. CEHAT phased out when its contract with BMC ended in 2007. With success of this PPP in one hospital, CEHAT took to mainstreaming Dilaasa in other municipal hospitals of the city. It initiated advocacy, training and capacity building of medical staff to set-up Dilaasa centre in municipal hospitals like Kurla Bhabha Hospital and M.T. Agarwal Hospital in partnership with the Health Department of the BMC and hospital leadership (Dilaasa and Pehel, 2005). Dilaasa is currently functional in two municipal hospitals of Mumbai.

The partnership between Bhavishya Alliance and Maharashtra State Government was struck in 2005. The assumption of partnership was that the Government would strengthen its programmes through managerial and technical interventions from corporate sector and NGOs without committing huge finances, while the corporate sector were partnering out of their obligation and responsibility to contribute

Table 7.2: Description of PPP cases on select criteria

Study Components	*Dilaasa, CEHAT*	*Mother NGO Scheme*	*Bhavishya Alliance*
Nature of the PPP	Joint Venture NGO-Mumbai Municipal Corporation Partnership on domestic violence	Contracting out model Maharashtra State Government and NGOs for RCH services	Multi-stakeholder partnership between Corporates, NGOs and Maharashtra Government for combating child malnutrition.
Participating entities in the PPP	1. Public Health Department of the BMC, Bhabha Hospital 2. CEHAT, an NGO	1. Ministry of Health Family Welfare, MoHFW, District RCH Society 2. NGOs acting as Regional Resource Centres (RRCs), Mother NGOs, Field NGOs, Service NGOs	1. Dept. of WCD, Dept. of Health, GoM, State Nutrition Mission. 2. Hindustan Unilever, HDFC, ICICI, McKinsey, McDonalds, Taj Group of Hotels, Nike Foundation, TCS. 3. Sneha, Institute of Health Management Pachod (IHMP), Seva, Chetna 4. Synergos, UNICEF 5. Nirmala Niketan, Inst of Hotel Management, Aurangabad
Objectives	Institutionalise domestic violence as a critical public health concern by establishing one-stop crisis-centre in public hospitals for women facing violence in homes and families.	Increase access and coverage of government reproductive and child health services in under-served and un-served area through various NGOs.	Strengthen government programmes by empowering the partners with necessary knowledge and skills to address the complexities of child malnutrition, through developing affordable and sustainable solutions.
Who initiate the partnership	CEHAT initiated the partnership with the Health Dept. of the BMC taking cues from Malayasian experience.	Union Ministry of Health as a centrally sponsored scheme. In Maharashtra –DoWCD, State RCH Society and District RCH Society.	Consortium of international private parties –Synergos Institute USA, Unilever Group and UNICEF.
Funding arrangement	There is no funding from the BMC but indirect inputs are provided for infrastructure, staff and medical assistance. Project funded by Ford Foundation.	Grant-in-aid from GoI to State RCH society to MNGOs	Corporate partner contribute their expertise in developing specific initiatives like management systems, IT support or technical support, trainings etc.

towards the cause of under nutrition (Bhavishya Alliance, 2007). In 2008 when this study concluded, most partnerships in Bhavishya Alliance were formed, but the operations on ground had not begun. As per the current status, the initiative has ceased its operations since 2010. There are no apparent reasons visible in the public domain for its failure and the initiative's website is also not functional.

Progress on Mother NGO scheme is not promising. Agreements between the State RCH Society and NGOs began operationalising in 2005. Duration of the contract is short term, for 3 years from August 2005, extendable up to 5 years on its performance. As per officials from Maharashtra State RRC which is FPAI, till 2007 the scheme was still in the process of training and finalizing MNGOs, FNGOs and SNGOs. As against a high rhetoric of covering all districts in Maharashtra, currently there are only 5 MNGOs working in 6 districts working with 18 other FNGOs and 6 SNGOs under the RCH-II programme. The analysis proceeding would throw determinants and reasons for the successes and failures of these three cases.

Contractual Framework

Both Dilaasa and Bhavishya Alliance model of PPP is of hybrid in nature and they do not fall into any of the available models of PPPs. As per the contracting design, PPP models of the 3 case studies can be illustrated below in Figure 7.4. Dilaasa and Bhavishya Alliance resemble a joint venture type of a PPP. Joint Venture is a partnership where two or more partners commit certain share of resources (not necessarily financial), to establish a new organization or a programme. In Dilaasa, while the Government provided infrastructure and personnel support, CEHAT provided technical and training support. The main strength of such a PPP is that it is jointly owned by the partners who contribute equally; share equal risks thus, are equally committed to ensure its success and sustainability. Secondly although Dilaasa is a PPP, the services are still provided by the Government which is its main responsibility, and not by CEHAT, NGO. In Bhavishya Alliance also, the main partners jointly established it as an NGO and then roped in the Government agency as an equal partner.

The Mother NGO scheme on the other hand is an example of contracting-out model of PPP. Here the Government is paying a fee

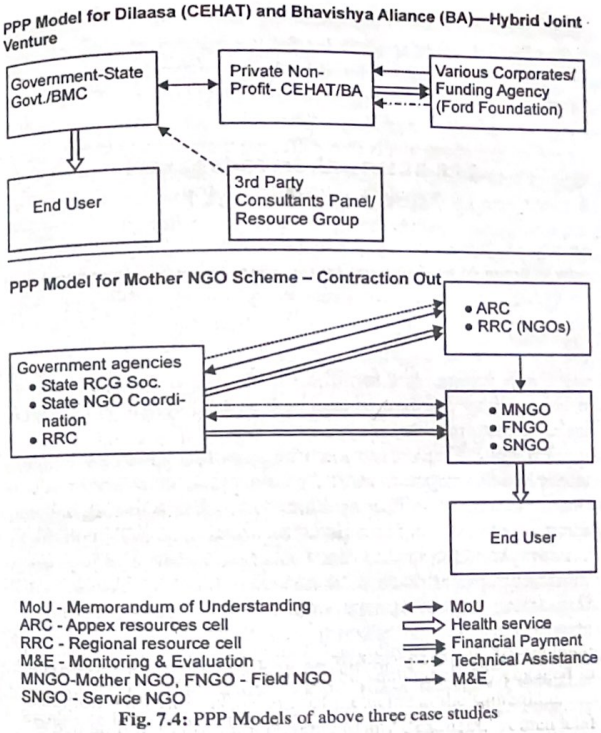


Fig. 7.4: PPP Models of above three case studies

to the NGOs to build capacities of functionaries and communities, and deliver services with or without Government infrastructure. A detailed MoU is signed between the Mother NGO and the District RCH Society. However, most of the contents of MoU are focused on exercising 'control' over the NGO, while the specification on service delivery is extremely brief and general. The contract mentions delineation of roles for NGOs for the actual delivery of services as per the GoI 'guidelines' which states need to follow. There is little

scope for innovation or one could say more room for manipulation, both of which could result in ineffective delivery of services.

Contract is heavily biased in favour of the Government, as if prepared without any consultation with NGO partners. There is over-emphasis of rigid reporting and monitoring systems to multiple agencies at various levels thus diffusing their accountability. Such a type of contracting arrangement mires the Government into keeping a close eye on NGOs, rather than capitalise on strengths and experience of NGOs to strengthen its own service delivery systems. PPP in Mother NGO scheme is not based on mutual understanding and trust between partners and may not be sustainable for long term.

In only Dilassa model of PPP, did the actual provision of services remained in the hands of the state. For Bhavishya Alliance, the action plans were mainly on paper and services had not begun in 2008 during this report writing. And for MNGO scheme, reproductive and child health services will be delivered by Service NGOs in un-served and under-served areas and not by the Government.

Type of PPP model has a bearing on access, quality and costs of public health services. In India the state largely enters into a contract in or contract out PPP in health services. Examples include Seva Rural Gujarat, Urban Slum Healthcare project, Adilabad of Andhra Pradesh, Arpana Swasthya Kendra Delhi, Karuna Trust Bangalore, Chiranjeevi Yojana Gujarat, Mobile Health Service Sunderbans etc. Contracting is aimed at improving service access in geographically underserved areas, to improve quality of services and also to reduce the expenditures on the service by the poor. International experience indicates that contracting is effective only when used to deliver services in predominately poor areas and not for general population. For instance, contracting was successful in Bangladesh Urban slums project where there were high concentrations of poor residents. However, there are conflicting findings on contracting mechanisms like Cambodia's experience of contracting NGOs to provide primary health care to general population in nine rural districts between 1999 and 2001 was largely successful (Brad Schwartz and Bhushan, 2004).

Most of the PPP models fall under either demand side or supply side strategies. Demand side strategies include vouchers and insurance mechanisms like community health insurance, social health insurance and micro-credit. Remaining PPPs are all supply based strategies

including contracting, social marketing, and social franchising. Studies strongly suggest that most PPPs in India are exclusively 'supply' oriented initiatives which eventually may not be effective in realizing the objectives of improved access, affordability, quality and equity in health services (Institute for Health Sector Development, 2004).

Experiences from other countries suggest that promising results are achieved when there is a combination of supply and demand side interventions like vouchers, insurance and risk pooling mechanisms, either within the same PPP or in more than one PPP for a particular health intervention (*ibid.*). For instance Janani in Bihar and Jharkand offers RCH services in partnership with its State Department of Health and Family Welfare through PPP models like franchising, social marketing, contract in, contract out and subsidies. The demand is generated through providing subsidies and access to services is increased by the remaining strategies.

Leadership and Ownership

Studies indicate that programmes where State Governments initiate a PPP or are involved from inception stage have more chances of success and are sustainable than a centrally sponsored PPP arrangement. It is so because of a strong sense of ownership resulting in pursuing the programme like case of Yeshaswani scheme in Karantaka, Urban Health Posts in Andhra Pradesh and Chiranjeevi scheme in Gujarat. These were directly implemented by the State Governments. It is unlikely that a centrally administered uniform model would succeed in diverse health settings in our country (WHO, 2001). The case in point is the MNGO scheme. Being a centrally sponsored scheme, the State Governments view it as being forced, with the only role of utilizing Central grants. Also with the scheme being decentralized, there was a leadership crisis at various levels—ARC at national level; state RCH society and RRCs; district RCH society and finally at MNGO level. This created a serious vacuum in leadership and procedural delays. ARC is responsible for technical inputs, training and overall coordination among RRCs in coordination with the State Governments. However, ARC was ineffective in uniting all its NGOs for shared unity of purpose, commitment or partnership

orientation towards the cause. On the contrary, most NGOs were seen as competing with one another for maximum funding than for sharing knowledge or problem solving. Secondly, the relationship between NGOs and Government authorities resembled a buyer-contractor relation rather than that of equal partners. This adversely affected the ownership and commitment of various NGOs, which formed the very backbone of the scheme.

Dynamism and responsiveness of the medical superintendent of the municipal hospital, who led Dilaasa as a Programme Director, was crucial element in its success. It led to high ownership from the hospital on the whole. The leadership of the hospital's superintendent was instrumental in establishing Dilaasa as one of the wards of the hospital. Line of authority and accountability were clear as staff at Dilaasa including CEHAT project coordinator reported directly to the superintendent.

In Bhavishya Alliance, its governing council was the supreme decision-making body that provided leadership and guidance to the programme. It comprised senior leaders from all major partners in the Alliance including the State's Rajmata Jijau Mother and Child Health and Nutrition Mission, Hindustan Unilever, ICICI Bank, Tata Industries, Boston Consulting Group, Population Foundation of India, SNEHA, Tata Council for Community Initiatives, HDFC and UNICEF. At the next level, there was a core team headed by a CEO and programme officers deputed from State Nutrition Mission, UNICEF and HUL. The leadership got diffused in many powerful players as they were jointly leading the initiative. The CEO responsible was a managerial post and hired for the job. The position was not mandated to provide the leadership to the alliance. Also with multiple type of State agencies involved like the Department of Women and Child, the ICDS Commissionerate, Rajmata State Nutrition Mission etc., there was no clear leader or leaders who represented the state as a whole and took decisions on behalf of all.

Financial Management and Risk Sharing

There is limited evidence on the financial management of PPPs, but existing research show that irregularities in flow of funds have been cited as one of the major weaknesses of PPPs, where it involves

exchange of funds from the Government to the private player. Usually, the funds are routed from Central department to State departments, then to commissionerates or directorates at state level, to district or *zilla parishads* and finally to the agency. Many times the delays are also from the end of NGOs as they are not able to submit utilization certifications on time. Either ways, funding from Government has always been associated with inadequacy, delays, inflexibility and subjected to burdensome scrutiny and oversight (Annigeri *et al.*, 2004). However, one exception has been the Chiranjeevi Yojana in Gujarat where the private gynaecologists receive an advanced amount from the Government to perform institutional deliveries free of cost to BPL women.

It is evident that Government indulges in partial treatment and is biased towards the private for-profit sector in disbursing funds. It meant that while private for-profit agencies get their full reimbursements, NGOs are usually not given full budgetary support but only for sustenance purposes (Raman and Björkman, 2000). For instance, Karuna Trust Bangalore gets maximum up to 90 per cent grants for management of a PHC as remaining 10 per cent funds, is supposed to be raised from other sources. Contrary to this case, a Government-owned and corporate-managed, Rajiv Gandhi Hospital in Raichur Karnataka gets full reimbursement of all its expenses plus a service fee. Government's assumption that NGOs would raise the remaining funds from other sources during the course of PPP, seldom materializes. Thus, NGOs continue to sustain in low budgets in a PPP, which has adverse implications on the quality of services provided by them.

Dilaasa PPP involved no funding from the BMC. BMC provided indirect inputs through infrastructure (space in the hospital), staff and medical assistance for the centre. The initiative was sustaining through funds from Ford Foundation to CEHAT. In Bhavishya Alliance too there is no exchange of funds between Government and alliance or between Government and partnering NGOs. However, role and responsibility of the State Government varied from contract to contract. For instance depending upon the core competency of the corporate partner, they contributed their expertise in activities like developing management systems, IT support or technical support, trainings for the Government.

Corporate partner funded only in select initiatives like ICICI sponsored training of Government Health Department and ICDS staff at National Institute of Nutrition at Amravati; Taj Group of Hotels funded training rural youth in hospitality management and nutrition; refurbishment of health posts; setting up of nutritional rehabilitation centres; production and distribution of fortified and complementary weaning foods etc. The Government was to use management competencies of the corporate sector in strengthening its systems. While interviewing senior project staff, it was reiterated that the Maharashtra Government's involvement could be described as 'opening its windows for the winds of change of come in' without substantial investment of funds.

Because of no funding commitments both from the NGO or the Government, the only motivation that was binding the partners together was to exert on the issue at hand. In MNGO scheme, GoI released Rs. 16 lakh per MNGO as grant-in-aid to State RCH Society, which then releases it to district RCH society, in 3 yearly installments after appropriate evaluations. MNGOs can retain only 20 per cent of the amount for its operations and distribute remaining to its 2 or more FNGOs working in its district. It has been reported that this funding to NGOs is delayed as like in many other Government programmes. In addition, the budget does not provide for adequate resources to hire qualified personnel in NGOs, in which case NGOs dump additional load on the existing staff. NGOs find it difficult to sustain their activities from limited funding from the Government. The trend has adverse implications on the performance and sustainability of the Mother NGO scheme.

Most PPPs in India involved government to reimburse expenses or provide grant-in-aid to the NGOs (Raman and Björkman, 2000). Most of the time, this fund disbursal was mired in red tapism, thus, adversely affecting the partnership. On risk sharing, there is higher risk on the government especially when it funds PPPs because it is ultimately responsible for the services and if private provider falters, the responsibility will be entirely on the government. The MNGO model of PPP holds this observation true. Government invested financial resources to contract out service delivery to NGOs, without considering the risks associated with under-performance or variations in quality or access of services by NGOs. NGOs too are uncovered on risks if

payments are delayed or not made. There is also no mention of any incentives for NGOs who perform exceptionally well or penalties for those who would not conform to service delivery outcomes.

Monitoring

Like any public programmes PPPs too need timely monitoring and evaluations more so when both public and private partners are involved, for various objectives—like for quality management, assessing service delivery outcomes to ascertain effectiveness, efficacy, equity and ease of access.

In Dilaasa, the monitoring of services is done by CEHAT through case presentations of women victims in weekly meetings. Here the social worker of the hospital presents few cases in presence of a panel of consultants (5 consultants jointly inducted by BMC and CEHAT). Such reporting helps the programme team gets a feedback to enhance their skills and gain more knowledge to deal cases in a better way. CEHAT brings these consultations out as reports however records of the cases are kept confidential. Bhavishya Alliance had a similar way to receive feedback of its programmes. It had an Internal Resource Group (IRG) of 5 members, mainly activists and experts. IRG assesses progress of the Alliance' projects in the field and bring forth the community concerns to the attention of the Governing Council on a monthly basis. Monitoring in both Dilaasa and Bhavishya Alliance was not in hands of the government, but done by third party that was a group of external experts or a funding agency.

However, in MNGO scheme, various state agencies were monitoring the scheme. A system of periodic reporting and monitoring resulted in many kinds of records and registers to be maintained by all the NGOs. These records were record of baseline data, indicators under each objective and activity, inventory records, financial records and staffing records. In addition, the MNGO was monitored at various levels of government like the State RCH society, State NGO coordinator, district RCH society and to RRCs.

Multiple government agencies involved in monitoring makes the exercise complex, repetitive and cumbersome. It also diffuses and confuses accountability of various partners as MNGOs are reporting to practically all levels of government agencies—State

RCH society, District RCH society, RRCs and State NGO coordinator. It can be extremely de-motivating and frustrating for NGOs to comply with such stringent norms of monitoring and at the same time be expected to deliver quality services, train and monitor smaller NGOs and above all, sustain scheme operations by raising external funds. With such high demand of monitoring on the shoulders of the Government agencies, it can hardly contribute in improving services at grassroots by way of support and constructive critique of its NGO partners. Evaluation reports about the current status and performance of the scheme across India, since 2005 were not available with ARC, Delhi. This is so when there was an extensive monitoring and information system (MIS) for the scheme created in partnership with National Informatics Centre (NIC), GoI.

Although the responsibilities of NGOs are clearly stated in the MoU, the government hardly conducts monitoring reviews in intervals to monitor the quality of services for mid-term corrections. Studies indicate that NGOs find it tough to conform to stringent bureaucratic procedures and documentation for reporting, monitoring and evaluation of services under the partnership arrangement (Bhat *et al.*, 2007). Most NGOs lack capacities, resources and are short of trained manpower, to comply with the requirements. Studies have also indicated that state and district health officials take no active role in monitoring the scheme. Thus, despite government investing considerable resources in M & E, it ultimately remains ineffective.

Conclusions

There are three main lessons emerging from each of the cases evaluated in the study. Dilaasa succeeds as a joint venture type of a partnership because of number of evident reasons. Firstly, the partnership was initiated by CEHAT, an NGO that acted upon complete dearth of services for a hospital based crisis centre for women victims of domestic violence. This conclusion falls in line with similar observations made by other studies that partnerships initiated by NGOs were more stable and effective than those started by the government. Secondly, CEHAT envisioned establishing Dilaasa not as its own unit running in a municipal hospital, but as a

ward of the hospital itself. This ensured ownership by the state along with sustainability and scalability of the initiative. Finally, since Dilaasa was not funded by the State, but by a third party agency, quality monitoring was effectively achieved.

Bhavishya Alliance was a multi-stakeholder type of a PPP where the role of the state was more of a passive recipient of what the private sector was giving. Since there was no commitment of finances on the part of the government, state representatives were only one among many partners to set the agenda. In addition, the failure of the partnership can be attributed to two faulty assumptions on issue of child malnutrition. The first assumption stems from the neo-liberal framework followed by international donor agencies, that nutrition being a multi-sectoral problem requires managerial, technical and governance inputs from a cross-section of actors. The second assumption was that state services are poor because of lack of resources and hence there is a need augment and synergize with diverse resources in the private sector. Many social sciences studies have provided evidence that malnutrition is socio-political issue that cannot be tackled alone with managerial strategies. Also the problem of the state is not lack of finances but effective utilization of funds for equitable outcomes.

The Mother NGO partnership like many other contracting PPPs was hard to sustain as they are literally driven by written word. Such partnerships are not dynamic enough to resolve issues through mutual understanding and trust. Also in such a contracting-out PPP, the service delivery shifts (completely or partly) from the hands of the Government to the private player. Studies have pointed out that contract out partnerships demands elaborate monitoring on part of the Government, for which it has a poor track record of monitoring its own services (Harding and Preker, 2001). Also most PPPs in India are supply based strategies like contracting or social marketing which again face risk of sustainability owing to overlooking demand and sources of funding (Institute for Health Sector Development, 2004). For instance, if an NGO/corporate has taken up running of a PHC, a patient may still choose not to come to the PHC and instead go to a rural quack. Mere provision or ease of access of a service cannot always ensure desirable demand for it.

Instead of contracting health services to private actors and create parallel systems, government can involve private players to strengthen its own service delivery systems through other PPPs like social marketing, hospital autonomy, joint ventures, performance management where the onus of delivering services still rests with the government and it is directly accountable to people. PPPs initiated by the government usually lack leadership. Government must in consultation with partners, identify leaders who could act as a champion facilitator in directing the partnership, coordinate with all stakeholders and ensure its effectiveness. This leader could be an individual, groups of individuals, a committee/board with representation from all partners.

Health is a state subject, but at the same time being highly privatized, most states lack policies to interact with private health sector and also to engage them in any partnership. Private providers are extremely heterogeneous and diverse while government lacks an effective regulatory mechanism to register them. Policy makers seem to be excited about the idea that great changes in public health can be brought about without substantial increase in public fund allocation, through the magic *mantra* of public private partnership. But there are a number of policy lessons to be learnt from handful of PPPs already implemented. Locally applicable models of partnership are more likely to be successful. It is quite unlikely that a centrally administered model would work in diverse health settings in the country.

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Note

1. There is no one agreed upon definition of a PPP. PPP is one where there is a written understanding through an agreement or a Memorandum of Understanding (MoU) about the terms of reference, risks, investments, roles and responsibilities of the participating parities. This is the definition which has been considered for the study (Goyal, 2008).

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